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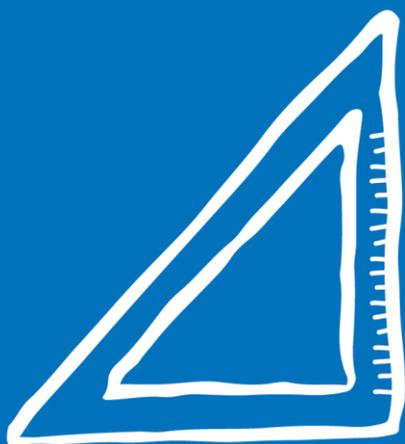
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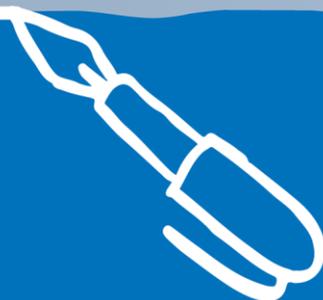
Monitoring Report No. 1

The Tasmanian Out-of-Home Care System and “Being Healthy”

Out-of-Home Care Monitoring Program 2018-19



Commissioner
for Children
and Young
People Tasmania



OCTOBER 2019

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Monitoring Report No. 1
The Tasmanian Out-of-Home Care System and “Being Healthy”
Out-of-Home Care Monitoring Program 2018-19

Author: Commissioner for Children and Young People Tasmania

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Acronyms and Abbreviations

AIHW	Australian Institute of Health and Welfare
ATSICPP	Aboriginal and Torres Strait Islander Child Placement Principle
CAMHS	Child and Adolescent Mental Health Service
CCYP	Commissioner for Children and Young People (Tas)
CSO	Child Safety Officer, an employee of the Department of Communities Tasmania
CSS	Child Safety Service, within Children and Youth Services in the Department of Communities Tasmania
CYS	Children and Youth Services, within the Department of Communities Tasmania
DCT	Department of Communities Tasmania
DoE	Department of Education (Tasmania)
DoH	Department of Health (Tasmania)
DoJ	Department of Justice (Tasmania)
DHHS	Department of Health and Human Services (Tasmania)
FKAT	Foster and Kinship Carers Association Tasmania
MHCT	Mental Health Council of Tasmania
NDIS	National Disability Insurance Scheme
OOHC	Out-of-home care
Royal Commission	Royal Commission into Institutional Responses to Child Sexual Abuse
SCP	Special Care Package
SNAICC	Secretariat of National Aboriginal and Islander Child Care
TasCOSS	Tasmanian Council of Social Services

Glossary

Care Team: A care team brings together those people involved in providing care and protection to a child or young person in OOHC for the purpose of sharing information and making decisions about the delivery of a child or young person's care. At a minimum, members should include the carer, OOHC care worker, case manager, therapist/clinician (if engaged), parent and/or significant family members and child or young person (as appropriate). It may also bring in other members such as school social worker, general practitioner, paediatrician or other medical specialist, Aboriginal liaison worker, drug and alcohol worker, mental health worker, youth justice worker and other specialist services including secondary consultant services.¹

Child Safety Service (CSS): The role of the CSS is to protect children and young people who are at risk of abuse or neglect. In Tasmania, the safety of children and young people is covered by the *Children, Young Persons and Their Families Act 1997*.²

Children and Youth Services (CYS), Department of Communities Tasmania: CYS provides a range of services that contribute to ensuring children, young people and their families are safe, nurtured and well. CYS provide statewide services comprised of: CSS, Adoptions and Permanency Services, Services to Young People including Community Youth Justice and Ashley Youth Detention Centre, Family Violence Counselling and Support Service.³

Department of Communities Tasmania (DCT): This is the Tasmanian Government Agency with administration responsibility for OOHC. "DCT" is used throughout the report to refer to, where relevant, its associated divisions including CYS (of which the CSS is a part).⁴

Family based care or home-based care: In this form of OOHC, a child is placed in the home of a carer who is provided with a contribution for the cost of care for expenses for the care of the child. There are four categories of home-based care: relative or kinship care, foster care, third-party parental care arrangements and other home-based OOHC.⁵

Family group home: A home for children provided by a government department or community-sector agency that has live-in, non-salaried carers who are reimbursed and/or subsidised for providing care. This type of OOHC is not currently provided in Tasmania.⁶

Foster care: A form of OOHC where the caregiver is authorised and provided a contribution for the cost of care by the state/territory for the care of the child. (This category excludes relatives/kin who are provided a contribution for the cost of care.)⁷

Kinship care: A form of OOHC where the caregiver is either:

- a relative (other than parents); or
- considered to be a family member or a close friend; or
- a member of the child or young person's community (in accordance with their culture); and
- who is provided a contribution for the cost of care by the state/territory for the care of the child.⁸

For Aboriginal and Torres Strait Islander children, a kinship carer may be another Indigenous person who is a member of their community or a compatible community or from the same language group.⁹

Other home-based OOHC: A care type where the child is in home-based OOHC, other than with relatives/kin who are provided a contribution for the cost of care or in foster care.¹⁰

Out-of-home care: Overnight care for children aged 0 – 17 years, where the state makes a financial payment or where a financial payment has been offered but has been declined by the carer.¹¹

OOHC provider: An organisation which provides OOHC placements. This term includes non-government organisations and the Department of Communities Tasmania.¹²

Problem sexual behaviour: Sexual behaviour or behaviours by children under 10 years old that are outside the typical range for age and/or stage of development.¹³

Residential care: Where the placement is in a residential building whose purpose is to provide placements for children where there are paid staff.¹⁴ It appears through monitoring activities that the term “residential care” is used by OOHC providers to describe OOHC arrangements provided to children and young people by paid staff on a rostered 24/7 basis. Within this broad definition, arrangements of this sort ranged from a single child or young person living in a house with paid staff to two or more children and young people (who may or may not be related) living in a house with paid staff.

Respite care: A form of OOHC used to provide short-term accommodation for children and young people, where the intention is for the child to return to their prior home. In family-based OOHC, this may be planned and regular to give the child’s usual carers, parents or guardians a break.¹⁵

Sexually abusive behaviour: Harmful sexual behaviour or behaviours by children aged 10 to less than 18 years old and which have legal consequences.¹⁶

Third-party guardianship: Transfer of guardianship to a third party is where a person other than the Secretary may be granted guardianship for a child or young person under a care and protection order. Under such an order, the guardian has the same rights, power, duties, obligations and liabilities as a natural parent of the child or young person would have.¹⁷

Commissioner's Message and Recommendations



Thank you for taking the time to read this first report of the Commissioner for Children and Young People's independent monitoring of Tasmania's out-of-home care system.

This report explores what our out-of-home care system looks like, who is in it, how it is being reformed, and how we can strengthen it.

Independent, systemic monitoring of our out-of-home care system is important because it contributes to oversight of the out-of-home care system, which in turn improves the accountability of all those within it – from Government Ministers, to Government Departments, non-government providers of services, and carers, to name just a few.

My intention is that through the Out-of-Home Care Monitoring Program, areas where we are doing things well can be highlighted, as well as areas in which we can do things better.

Most importantly though, I hope that through increased awareness of my role of independent external monitoring of out-of-home care in Tasmania, children and young people in out-of-home care understand that someone is keeping an eye on the system that is designed to care for them and will say something if things are not as they should be.

There are currently over 1,300 children in out-of-home care in Tasmania, with the number of children in out-of-home care increasing every year. When a child or young person is placed in out-of-home care, the State is obliged to take on the full responsibilities of a parent – and this means promoting and protecting the best interests, rights and wellbeing of the child or young person while they are in out-of-home care.

At the very least, the State should ensure a child or young person is placed in a loving, caring and safe home; has food, clothes and access to other material basics; their health is attended to; they are able to learn, to socialise and participate in their community; they are able to participate in decision-making which affects them if they want to; they have connection with their family if it is safe for this to occur; and they have connection with their culture and community.

Since being appointed as Commissioner for Children and Young People, I have had the great pleasure of meeting many children and young people who are in or who have lived in Tasmania's out-of-home care system. Many of these children and young people have had a positive experience in out-of-home care and enjoy good health and wellbeing. However, I am acutely aware that this is not the case for all children and young people in out-of-home care.

Through monitoring activities, it has become apparent that more needs to be done to ensure that all children and young people in out-of-home care in Tasmania can be assured that they receive the quality of care necessary to support and promote positive wellbeing outcomes.

Further, collaborative, systemic work is required to ensure that everyone in the out-of-home care system in Tasmania:

- Listens to and takes account of the views, opinions and preferences of children and young people in out-of-home care;
- Understands what is required to promote and protect the wellbeing of children and young people and to work towards achieving favourable wellbeing outcomes;

- Is accountable for meeting allocated responsibilities within the system; and
- Collaborates and works in partnership to protect and promote the best interests and wellbeing of children and young people in out-of-home care.

There is no doubt that the Tasmanian out-of-home care system is facing a number of challenges, including significant growth in the number of children entering out-of-home care, as well as the need to adapt to ongoing reform, including implementation of recommendations of the Royal Commission into Institutional Responses to Child Sexual Abuse, the Strong Families, Safe Kids Redesign Project, the associated Out-of-Home Care Foundations Project and implementation of the recommendations made by former Commissioner Morrissey in his 2017 review of out-of-home care in Tasmania.

I acknowledge that work currently underway in the Department of Communities Tasmania, Department of Health and Department of Justice is directly relevant to the recommendations I make in this report. My recommendations are not intended to amount to a new reform agenda – rather, they are designed to strengthen the foundations of our out-of-home care system. In this way I hope to contribute to the current significant reform agenda underway in our child safety system more broadly, a reform agenda which I support. It is my strong view that we are at a pivotal point in the reform process, a point at which previous successive reform processes have failed, and that we must now push, invest, and plan ahead positively to achieve a better child safety system for our children and young people.

Adverse comment process

Before outlining my Recommendations, I wish to point out that section 21 of the *Commissioner for Children and Young People Act 2016* (Tas) provides that I am not to include in a report any comment that is adverse to a person unless the person has been provided with the opportunity to respond.

On 6 September 2019, I provided a confidential draft of this report to the Secretaries of the Department of Communities Tasmania, Department of Health and Department of Justice inviting them to respond to anything in the draft report they considered constituted “adverse comment”.

Departmental responses have been taken into account and incorporated into this report as appropriate.

Recommendation 1: Making sure children and young people in out-of-home care have a say about their care and their lives.

As noted in Chapter 1 of this report and described in more detail in the [Monitoring Plan 2018-19](#), the Monitoring Program has a cross-cutting theme of the participation of the children and young people in out-of-home care. Chapter 5 of this report details findings related to participation identified through monitoring activities.

While I welcome the introduction of the new position of Child Advocate for children and young people in out-of-home care, monitoring activities have identified the need for further work to be done to promote the participation of children and young people in decision-making affecting their lives. First, out-of-home care providers, especially non-government providers, would

benefit from additional support to establish and strengthen participatory mechanisms for children and young people within their organisations. Second, there is scope to improve the extent to which case and care planning processes genuinely include the voices of children and young people in out-of-home care. Consequently, I recommend:

1. **That the Tasmanian Government encourages and empowers children and young people in out-of-home care to express their views and participate in decisions affecting them, by:**
 - a. **Ensuring all out-of-home care providers have mechanisms in place for children and young people in out-of-home care to communicate their views about their care, as well as concerns and complaints, consistent with Recommendation 12.10 of the Royal Commission into Institutional Responses to Child Sexual Abuse (the Royal Commission).**
 - b. **Ensuring that children and young people in out-of-home care have their voices heard in the development and review of Case and Care Plans and participate in day-to-day decision-making that affects their lives.**
 - c. **Establishing a visitor program funded by the Tasmanian Government, initially focusing on children and young people in out-of-home care who are living in non-family-based care settings.**
 - d. **Ensuring that visits from Child Safety Officers occur regularly and in accordance with policies of the Department of Communities Tasmania.**
 - e. **Consistent with former Commissioner Morrissey's Recommendation 6C, expediting the establishment of a Tribunal in Tasmania, that can review decisions about children and young people's wellbeing while they are in out-of-home care.**

Recommendation 2: Making sure everyone involved in the care of children and young people in out-of-home care is doing a good job.

I acknowledge that the Government of Tasmania has already commenced work to strengthen the quality and accountability of the out-of-home care system. The Quality and Continuous Improvement Framework for out-of-home care is under development and the Government is progressing implementation of recommendations of the Royal Commission into Institutional Responses to Child Sexual Abuse which are relevant to the quality, safety and accountability of the Tasmanian out-of-home care system. Some of these Royal Commission recommendations relate directly to the out-of-home care system, while others, such as the introduction of a Child Safe Organisations Framework, are to be implemented more broadly.

These reform initiatives are, in my opinion, critical to ensuring that Tasmania has a robust and accountable out-of-home care system which promotes the wellbeing of children and young people. In particular, the development of a Quality and Continuous Improvement Framework incorporating standards is urgently required.

Further, I am concerned that, even after the development of a Quality and Continuous Improvement Framework, it is unclear how this framework will be implemented, and the extent to which independent external oversight will be included is also unknown.

In other jurisdictions, a variety of mechanisms provide external independent oversight of out-of-home care. In New South Wales, the Office of the Children's Guardian is responsible for accrediting statutory out-of-home care providers, based on their compliance with the NSW Child Safe Standards for Permanent Care, 2015. Agencies must be accredited by the Children's Guardian to provide statutory out-of-home care in New South Wales. In Victoria, the Commission for Children and Young People oversees and enforces compliance by Victorian organisations that provide services or facilities for children, including out-of-home care, with Victoria's Child Safe Standards.

Similarly, external oversight involving licensing is in use in Queensland, and in New Zealand, National Care Standards regulations approved under the *Oranga Tamariki Act 1989* came into effect on 1 July 2019.

Tasmania now has an opportunity to learn from other jurisdictions and embed standards within a more comprehensive and robust quality system which includes independent external oversight.

It is important to acknowledge that the Department of Communities Tasmania has a dual role as both system owner and provider of out-of-home care in Tasmania. In terms of improving the overall accountability of the system, there may be significant benefits in ensuring a clearer distinction between the activities of the Department of Communities Tasmania as provider of out-of-home care and as system owner. Consequently, I recommend:

- 2. That the Tasmanian Government strengthens the quality, safety and accountability of the out-of-home care system in Tasmania by:**
 - a. Implementing a robust 'purchaser-provider' model for out-of-home care in Tasmania by more clearly delineating the role of the Department of Communities Tasmania as system owner from its role as provider of out-of-home care.**
 - b. Progressing the development and implementation of a Quality and Continuous Improvement Framework for Out-of-Home Care in Tasmania, which includes Tasmanian standards and ensuring there is a specific standard (or standards) which incorporate(s) the National Principles for Child Safe Organisations.**
 - c. Ensuring that implementation of the Quality and Continuous Improvement Framework:**
 - (i) is appropriately resourced and includes rigorous quality assurance processes;**
 - (ii) occurs in accordance with an Implementation Plan which is publicly available; and**
 - (iii) occurs in a staged manner as follows:**
 - A. the capacity of the existing independent external oversight of out-of-home care currently undertaken by the Commissioner for Children and Young People is expanded and resourced to undertake systemic monitoring based on agreed standards;**
 - B. the introduction of a system of accreditation of out-of-home care providers, including the Department of Communities Tasmania, based on compliance with the agreed standards.**

- d. Ensuring that communication processes between the Department of Communities Tasmania, non-government out-of-home care providers and carers are improved, so that:
- (i) critical up-to-date information is shared about a child or young person in out-of-home care in a timely manner;
 - (ii) children and young people can receive timely answers to everyday questions such as: “Can I dye my hair?”; “Can I go on a sleepover?”; and “Can I go on a school excursion?”;
 - (iii) there is a clear delineation of responsibilities for the care of a child in out-of-home care including for organising health care and during crisis situations; and
 - (iv) non-government out-of-home care providers are aware of and have access to applicable Departmental policies.
- e. Putting in place, as a priority, overarching Funding Agreements for all non-government out-of-home care providers delivering Special Care Packages to ensure quality and consistency of care.
- f. Extending any examination of the model and cost of care for children and young people in out-of-home care with the most complex, specialised needs to include an investigation of mechanisms to promote Tasmanian Government agencies working more collaboratively and sharing accountability for achieving wellbeing outcomes for children and young people in out-of-home care.

Recommendation 3: Making sure everyone involved in the care of children and young people in out-of-home care knows about the child they are caring for, what they need and how they are going.

The collection, management, analysis, use and reporting of data was an area of focus for the Monitoring Program during the first monitoring cycle from 1 July 2018 to 30 June 2019. The Monitoring Program has identified some data sharing and data system capacity and capability challenges, including:

- The capacity of the Department of Communities Tasmania to collect, manage, analyse, use and report on, within reasonable timeframes, key data about the Tasmanian out-of-home care system generally and about the children and young people who are in that system.
- The need to support non-government out-of-home care providers to develop their capacity to measure and report on the wellbeing outcomes of children and young people placed with them.
- Notable gaps in data collected about children and young people with disability and in relation to Aboriginal children and young people.

Consequently, I recommend:

3. That the Tasmanian Government strengthens and improves the capacity of the Department of Communities Tasmania and non-government out-of-home care providers to collect, manage, analyse, use and report on data relevant to the Tasmanian out-of-home care system generally and on the wellbeing outcomes of children and young people in out-of-home care in Tasmania, including by:
 - a. Commissioning an independent review to determine data system capacity, capability and resourcing requirements to support effective system oversight and purchasing arrangements which promote positive wellbeing outcomes for children and young people in out-of-home care.
 - b. Supporting non-government out-of-home care providers to improve their ability to report on the wellbeing of children and young people placed with them.
 - c. Finalising the indicators for the *Outcomes Framework for Children and Young People in Out of Home Care in Tasmania* and initiating a process of regular reporting on the wellbeing outcomes of children and young people in out-of-home care, including to the Commissioner, as recommended by former Commissioner Morrissey in his 2017 review into out-of-home care.

Recommendation 4: Making sure we know about and promote Aboriginal culture.

Aboriginal children and young people continue to be overrepresented in out-of-home care, including in Tasmania. We need to consider how to do things differently to better support Aboriginal children and young people and their families in Tasmania.

During this monitoring cycle, I did not examine in detail implementation of the Aboriginal and Torres Strait Islander Child Placement Principle in Tasmania, however the Monitoring Program has identified areas of practice requiring improvement.

Monitoring activities identified that throughout the monitoring period, Aboriginal identity was either not known or not recorded for a significant number of children in out-of-home care. This is simply unacceptable. I have recently been advised by the Department of Communities Tasmania that there has been significant progress rectifying this situation. Ascertaining and recording Aboriginal identity is a necessary precursor to ensuring that all Aboriginal children and young people in out-of-home care in Tasmania benefit from cultural planning and that decision-making accords with the Aboriginal and Torres Strait Islander Child Placement Principle.

Monitoring activities also identified the potential for much greater involvement by Aboriginal organisations in ensuring that the wellbeing and best interests of Aboriginal children and young people are promoted and protected. To harness this potential, we need to embrace Aboriginal leadership, foster genuine partnerships and build capacity to enable a new and different approach.

Consequently, noting the overrepresentation of Aboriginal children and young people in the child safety system, I recommend:

4. That the Tasmanian Government:

- a. Ensures that the Aboriginal and Torres Strait Islander Child Placement Principle is embedded in legislation, policy and practice, including an increased focus on cultural planning.**
- b. Ensures the participation of representatives of Aboriginal communities and organisations in service design, delivery and individual case decisions, and otherwise promotes and invests in genuine partnerships with Aboriginal communities to support self-determination.**
- c. Ensures all those involved in decisions regarding Tasmanian Aboriginal children and young people in out-of-home care are appropriately trained to ensure they have an understanding and appreciation of Tasmanian Aboriginal history, heritage and culture.**
- d. Ensures the Aboriginal identity of children and young people in out-of-home care is appropriately and promptly ascertained and communicated to carers and to non-government out-of-home care providers.**
- e. Funds and develops, in collaboration with representatives of Aboriginal communities and organisations, the establishment of a therapeutic ‘on country’ residential program for Aboriginal children and young people which is delivered in Tasmania by Aboriginal people.**

Recommendation 5: Making sure children and young people in out-of-home care can be healthy.

During the monitoring cycle from 1 July 2018 to 30 June 2019, the Monitoring Program included a focus on “being healthy” (one of the six wellbeing domains of the *Tasmanian Child and Youth Wellbeing Framework*).

Issues identified and considered included mental health and experiences of trauma, the availability of and access to health services, access to health assessments, how the processes of the Department of Communities Tasmania such as Case and Care Planning impact upon the health status and health care of children and young people in out-of-home care, and the extent to which children and young people in out-of-home care can actively participate in “being healthy”.

Without access to accurate and up-to-date data about the children and young people placed with them, out-of-home care providers are hampered in their work to promote wellbeing and positive outcomes.

Monitoring activities also identified that many, although certainly not all, children and young people in out-of-home care may experience serious mental health conditions, emotional issues and behavioural concerns, as well as a wide range of other health conditions. Monitoring activities also highlighted that many of these children and young people face lengthy waits for access to specialist health care, especially psychological and psychiatric treatment.

It should be acknowledged that I did not set out to collect quantitative data about types of health services accessed or waiting lists for health services for children and young people in out-of-home care.

It is acknowledged that the primary cause of health difficulties for children and young people in out-of-home care is adverse circumstances experienced prior to entering out-of-home care.

It is also important to acknowledge the important role carers play supporting children and young people to improve their health while in out-of-home care.

I commend the provision of a paediatric Out-of-Home Care Clinic, funded by the Department of Health, which is available to children and young people in out-of-home care living in the South of Tasmania. However, the Monitoring Program found that equivalent health assessments and reviews are not as readily available to children and young people in out-of-home care who reside in the North and North West of Tasmania, which suggests regional inequity in access to health services.

Consequently, in response to the demonstrated need to improve health care planning and access to health services, particularly mental health services, for children and young people in out-of-home care, I recommend:

5. That the Tasmanian Government:

- a. Ensures that all children and young people entering out-of-home care in Tasmania receive a preliminary health assessment with a General Practitioner within one month of entering out-of-home care and a comprehensive paediatric health and developmental assessment within three-to-six months of entering care.**
- b. Implements a policy of priority access to health services for children and young people in out-of-home care in Tasmania.**
- c. Establishes and appropriately resources a dedicated paediatric out-of-home care clinic in the North and North West of Tasmania to redress the inequitable access to health services experienced by children and young people in these regions.**
- d. Ensures each of the paediatric out-of-home care clinics are resourced with sufficient multi-disciplinary allied health expertise to meet the needs of children and young people in out-of-home care in Tasmania.**
- e. Ensures that personal health information of children and young people in out-of-home care is up-to-date and available to non-government out-of-home care providers, carers and health professionals, in a timely manner.**

Leanne McLean

Commissioner for Children and Young People

1. The Monitoring Program



1.1 The Commissioner for Children and Young People

The Commissioner for Children and Young People ('the Commissioner') is an independent statutory office established by the [Commissioner for Children and Young People Act 2016 \(Tas\)](#).

Broadly speaking, the Commissioner's role is to promote, monitor and review the wellbeing of all children and young people in Tasmania, noting the Commissioner's general functions outlined in [section 8](#) of the *Commissioner for Children and Young People Act 2016 (Tas)*. The Commissioner is required to carry out these statutory functions according to the principle that the wellbeing and best interests of children and young people are paramount and must observe any relevant provisions of the United Nations *Convention on the Rights of the Child*.¹⁸

Other principles that govern the Commissioner's work are as follows:

- Children are entitled to live in a caring and nurturing environment and to be protected from harm and exploitation;
- The interests and needs of children and young people who are disadvantaged for any reason or vulnerable should be given special regard and serious consideration;
- The contributions made by children to the community should be recognised for their value and merit;
- The views of children on all matters affecting them should be given serious consideration and taken into account; and
- Parents, families and communities have the primary role in safeguarding and promoting the wellbeing of children and should be supported in carrying out their role.¹⁹

The Commissioner may make recommendations in respect of the effects of any legislation, proposed legislation, documents, government policies, practices or procedures, or other matters relating to the wellbeing of children and young people.²⁰

1.2 The role of the Commissioner in monitoring OOHC

In the 2017-18 State Budget, the Tasmanian Government committed dedicated resources to the Commissioner to conduct independent systemic monitoring of OOHC in Tasmania. This commitment arose from the Tasmanian Government's decision to accept all seven recommendations made by former Commissioner Morrissey in his January 2017 report of his review of out-of-home care (OOHC), [Children and Young People in Out of Home Care in Tasmania](#). Former Commissioners Morrissey's Recommendations are set out in Appendix 1.

Following the release of Commissioner Morrissey's report, the Hon Jacquie Petrusma MP, then Minister for Human Services, wrote to then Commissioner Morrissey on 31 March 2017, stating: "I want to assure you that this Government is 100 percent committed to implementing all of your recommendations as we want to improve the lives of children and young people in OOHC".²¹

The overarching aim of the Commissioner's monitoring of OOHC is to promote and protect the rights and wellbeing of children and young people in OOHC in Tasmania.

The key considerations and guiding principles for the Commissioner's OOHC Monitoring Program are outlined in [Laying the Foundations: A Conceptual Plan for Independent Monitoring of Out-of-Home Care in Tasmania \(April 2018\)](#) ('the Conceptual Plan'). The focus of the Monitoring Program for 2018-19 is set out in detail in the [Out-of-Home Care Monitoring Plan 2018-19 \(July 2018\)](#) ('the Monitoring Plan 2018-19').

Monitoring activities began formally in July 2018 during the tenure of former Interim Commissioner David Clements and were continued by Commissioner Leanne McLean upon her commencement as Commissioner in November 2018.

This report outlines the monitoring activities undertaken during 2018-19.

As outlined in the [Monitoring Plan 2018-19](#), monitoring activities are child-centred with particular importance placed on considering the processes in place to facilitate the expression by children and young people of their views and opinions and otherwise promote their wellbeing and best interests while in OOHC.

The Monitoring Program has been informed and supported by an Expert Panel established by Interim Commissioner Clements in December 2017. The Expert Panel is chaired by the Commissioner and its membership is as follows:

- Professor Sharon Bessell, Crawford School of Public Policy, Australian National University;
- Professor Daryl Higgins, Institute of Child Protection Studies, Australian Catholic University;
- Dr Greet Peersman, the Australia and New Zealand School of Government (ANZSOG); and
- Professor Kitty te Riele, Peter Underwood Centre, University of Tasmania.

Members were appointed because of their expertise in child protection; education (particularly alternative education programs and programs for children at risk of disengagement from the education system); engagement with and participation of children and young people; and monitoring and evaluation.

1.3 Monitoring activities undertaken in 2018-19

Consistent with the [Monitoring Plan 2018-19](#), monitoring activities undertaken are set out below.

1.3.1 Regular Data Monitoring

Throughout the monitoring cycle from 1 July 2018 to 30 June 2019, data was sought from various sources including:

- The Department of Communities (DCT);
- The Child Advocate – OOHC in the DCT;
- Other Tasmanian Government agencies; and
- Non-government OOHC providers and advocacy groups.

Provision of data to the Commissioner on a regular basis by the DCT has in part been constrained by:

- Indicators under the *Outcomes Framework for Children and Young People in Out of Home Care in Tasmania* are yet to be finalised; and
- A proposed Quality and Continuous Improvement Framework describing standards and performance measures for OOHC is not yet available.

In turn, the collection and reporting of data focused on outcomes for children and young people in OOHC by agencies and organisations is limited.

Due to a lack of routine information on the service level activities of OOHC providers within the Tasmanian OOHC system, and to elicit information relevant to wellbeing outcomes for children and young people in OOHC, questionnaires were distributed by the Commissioner ('CCYP questionnaires') to all OOHC providers in August 2018 and February 2019. These CCYP questionnaires requested data for the calendar year 1 January to 31 December 2018 in two six-month blocks. Information collected through the CCYP questionnaires was analysed and findings are outlined in this report. A copy of the CCYP questionnaire can be viewed [here](#).

1.3.2 Monitoring Visits

In September and October 2018, Interim Commissioner Clements and monitoring team members visited all OOHC providers in Tasmania. In March, April and May 2019, Commissioner McLean and monitoring team members undertook a further round of monitoring visits to OOHC providers in Tasmania, and in June 2019, Commissioner McLean visited an OOHC provider based in the Northern Territory. Further information about these OOHC providers can be found in Chapter 2 of this report.

During 2018-19, Interim Commissioner Clements and Commissioner McLean also consulted with advocacy organisations, peak bodies and other key stakeholders.²²

Monitoring visits provided opportunities to learn more about the services delivered to children and young people in OOHC, and for OOHC providers and other stakeholders to discuss the OOHC system

from their perspective.

1.3.3 Thematic Monitoring

As outlined in the [Monitoring Plan 2018-19](#), monitoring during 2018-19 incorporated a thematic approach by focusing on "being healthy" – one of the six wellbeing domains outlined in the *Tasmanian Child and Youth Wellbeing Framework*. The Tasmanian Government's *Outcomes Framework for Children and Young People in Out of Home Care* is aligned to the *Tasmanian Child and Youth Wellbeing Framework* and therefore includes specific outcomes and success factors for all children in OOHC under the domain of "being healthy".

Additionally, monitoring included a focus on the cross-cutting theme of "children and young people's participation". "Participation" refers to children and young people having their voices heard and being actively engaged in decision-making processes around matters that affect their lives or are otherwise important to them. Associated with this is the importance of facilitating participation by providing children and young people with information and any assistance or support they may require to participate.²³

In September 2018, Interim Commissioner Clements sought submissions from individuals, organisations and agencies with knowledge and experience of factors affecting or influencing the health status of children and young people in OOHC in Tasmania. As part of this process, the Interim Commissioner also sought to understand children and young people's participation – or their ability to influence decisions that affect them – in relation to preventative health strategies, health care services and health outcomes. Respondents were asked to answer all or

some of the questions outlined by Interim Commissioner Clements (see [here](#)).

1.3.4 Engagement with children and young people

The Commissioner undertook work to identify ways of ascertaining the views of children and young people in OOHC, including through existing consultative and other mechanisms, noting the fundamental and important need to do so in a manner that does no harm to children and young people. This ‘try, test and learn’ approach acknowledged the challenges inherent in engaging with children and young people who are in, and move between, a variety of OOHC placement types and circumstances (including different guardianship arrangements).

Access to information is a necessary precondition to a child or young person deciding whether to express a view or otherwise participate.²⁴ Therefore, in this first year of monitoring, there was a focus on promoting awareness among children and young people in OOHC of the Commissioner’s role, the Monitoring Program and its aims.

Engagement activities during the monitoring cycle from 1 July 2018 to 30 June 2019 are described below.

Fact Sheet

A child and youth friendly [‘fact sheet’](#) was developed in consultation with children and young people through the CREATE Foundation (Tas). Importantly, the fact sheet sends a clear message that the Commissioner cares about what is happening for children and young people in OOHC and is interested to know what is working well for them, as well as what can be improved. The fact sheet was distributed to children and young people in

OOHC via OOHC and other service providers, including the DCT.

Youth Round Table

In April 2019, Commissioner McLean conducted a consultation session with young people at a CREATE Foundation (Tas) Youth Round Table (‘Round Table’) in Campbell Town. During this session, young people were invited to express their views on what it means to be healthy, and on what is working and what needs improving within the OOHC system to keep children and young people healthy. Outcomes from this consultation are included in this report.

The Postcard Project

Awareness of the Monitoring Program among children and young people in OOHC was also promoted through the design and distribution of a postcard and supporting video. The postcard sought to ascertain the views of children and young people in OOHC aged 10 years and above by asking what “being healthy” means to them. The postcard and link to the online video were distributed through OOHC providers (including the DCT), foster and kinship carers with the assistance of the Foster and Kinship Carers Association Tasmania (FKAT), and Aboriginal health services providing services to Aboriginal children and young people in Tasmania, some of whom are in OOHC.

While the postcard did not elicit any responses, it is hoped that it assisted to raise awareness of the Monitoring Program among children and young people in OOHC.

Meeting with children and young people in OOHC

During the monitoring cycle from 1 July 2018 to 30 June 2019, potential opportunities for direct engagement with children and young people in OOHC were explored with OOHC providers, including the Department of Communities Tasmania (DCT). In May and June 2019, Commissioner McLean met informally with several children and young people in non-family-based care, with the support of three non-government OOHC providers.

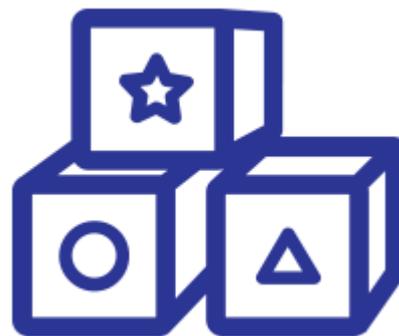
1.4 Monitoring in a changing policy and practice environment

It is important to acknowledge that the Monitoring Program has been developed and conducted in an environment of ongoing national and Tasmanian reform to child protection and OOHC. Outlined below are some of these reform processes.

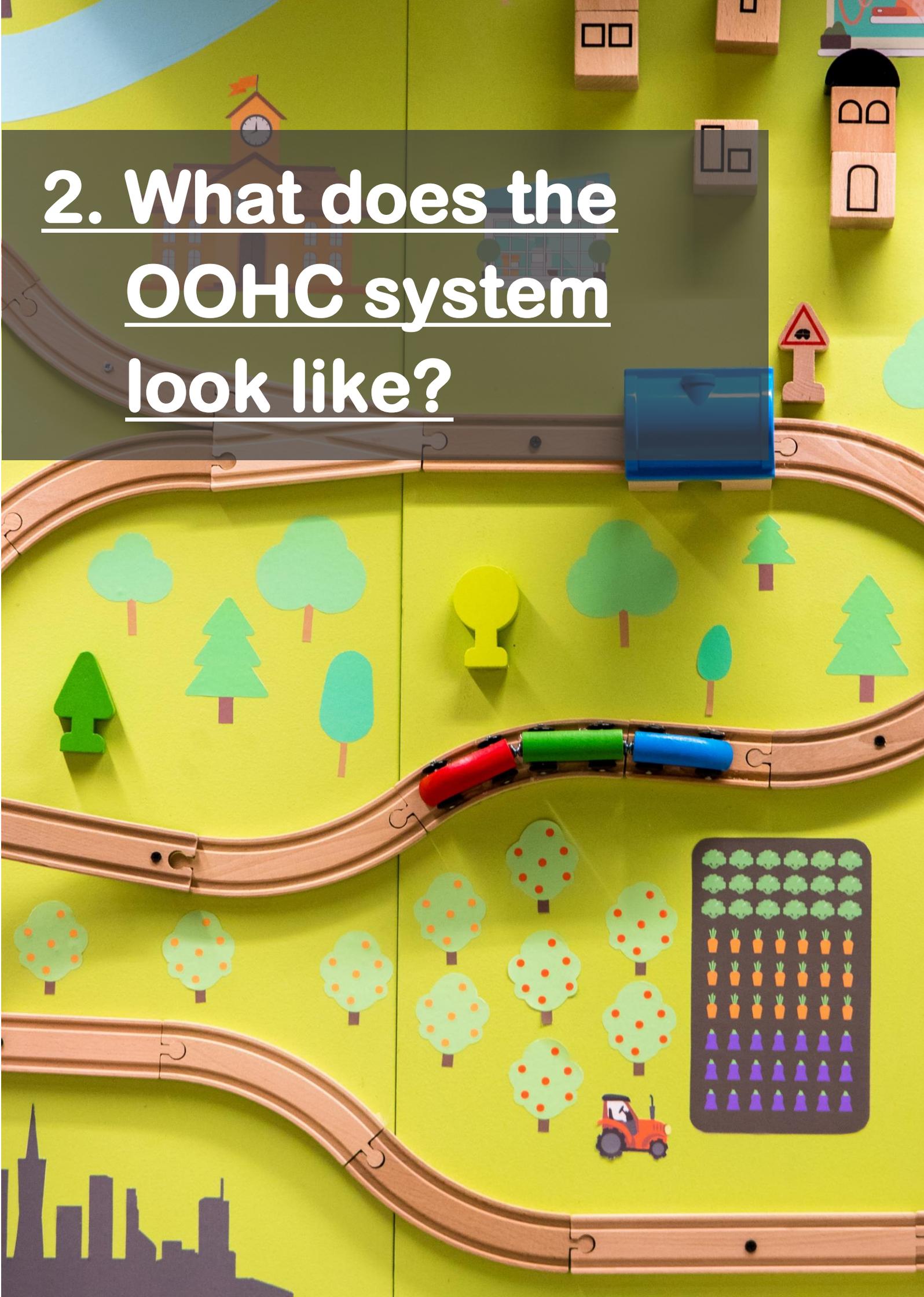
- Implementation of the [Strong Families, Safe Kids Redesign Project](#) of the Tasmanian child protection system continues, with a major focus on early intervention to reduce the number of children and young people entering OOHC.
- The [Strategic Plan for Out-of-Home Care in Tasmania 2017-2019](#), which incorporates recommendations made by Commissioner Morrissey in his 2017 report on OOHC, is being progressively implemented.
- The DCT is undertaking specific actions to improve and strengthen its quality assurance processes, and to identify how supports can be better provided to those children in OOHC with highly complex needs.
- The Tasmanian Government has committed to strengthening the permanency of OOHC placement processes, noting this is also a Priority Area in the [Fourth Action Plan 2018-2020](#) under the *National Framework for Protecting Australia's Children 2009-2020*. Work is underway to develop a permanency framework for children and young people in the child safety system in Tasmania.
- Improving outcomes for Aboriginal and Torres Strait Islander children and their families is a strong focus of the Fourth Action Plan 2018-2020, particularly through ensuring implementation of all five elements of the ATSI CPP.²⁵ The DCT, in consultation with Aboriginal communities in Tasmania, is developing an action plan aimed at strengthening Tasmania's compliance with the ATSI CPP.
- Implementation of the NDIS has clear implications for those children and young people in OOHC with disability, with complexities arising around determining responsibilities for funding particular supports. It is noted that the [NDIS Quality and Safeguards Commission](#) commenced operation in Tasmania on 1 July 2019.
- In its [Final Report](#), the Royal Commission made 409 recommendations. Volume 12 of the report dealt with contemporary OOHC and included 22 recommendations. Additionally, other recommendations in the report – especially those related to child safe principles and standards – are directly relevant to the provision of OOHC.²⁶
- The Tasmanian Government released a [Tasmanian Response to the Royal Commission](#) in July 2018 and a [First Year Action Plan 2018-19](#) in October 2018.

- On 1 November 2018, the Tasmanian Government officially entered the [National Redress Scheme](#) for Institutional Child Sexual Abuse, established in response to recommendations of the Royal Commission.
- A key government initiative is also the extension of support to care leavers to help them transition to independence. Young people and their carers now have the option of remaining with their carer up to the age of 21 years, supported by an allowance.

Progressive implementation of these and other reform activities at both a national and state level has a direct impact on the delivery of OOHC in Tasmania and will continue to influence future monitoring activities.



2. What does the OOHC system look like?



2.1 What is the service model for delivering OOHC in Tasmania?

Tasmania's out-of-home care (OOHC) system is made up of a number of organisations and individuals, including the Department of Communities Tasmania (DCT) as both system owner and provider, carers and non-government providers whose OOHC services are purchased by the DCT.

The Child Safety Service (CSS) within the DCT provides case management for children and young people who are under the guardianship and/or custody of the Secretary. In performing this function, Child Safety Officers (CSOs) are required to abide by principles outlined in Part 1A of the *Children, Young Persons and Their Families Act 1997*.

2.2 Who provides OOHC placements to Tasmanian children and young people?

During the period 1 January 2018 to 31 December 2018, 15 organisations provided OOHC placements for Tasmanian children and young people (see Table 1). These organisations are referred to in this report as OOHC providers. Of the 15 providers, 14 provided OOHC placements in Tasmania and one provided OOHC placements in the Northern Territory for Tasmanian children and young people.

The number of OOHC providers varied over the calendar year with one provider discontinuing services and two providers commencing.

Tasmanian children and young people under the guardianship of the Secretary of the DCT may be placed with Many Colours 1 Direction, a non-government organisation providing OOHC placements

in the Northern Territory. Many Colours 1 Direction aims to provide culturally relevant and therapeutic out-of-home residential care to indigenous and non-indigenous youth on a wilderness property outside of Darwin. One OOHC provider (which has now ceased providing OOHC placements in Tasmania) was a 'for-profit' organisation and six OOHC providers (Mosaic Support Services, Multicap, Total Support Services, Devonfield Enterprises, Possability and North West Residential Support Services) were specialist disability providers. The DCT is both an OOHC provider and system owner.

OOHC providers in Tasmania varied considerably in their size and in the range of services they provide to children and young people in OOHC. Some also provided services other than OOHC.

“In 2018, 15 organisations provided OOHC placements: 14 provided OOHC placements in Tasmania and one provided OOHC placements in the NT. The number of OOHC providers varied over the year.”

The DCT is the largest provider in the OOHC system in terms of the number of children and young people in the Department's care. The number of children placed with individual non-government OOHC providers varied, with some non-government OOHC providers indicating they hope to increase their capacity to provide OOHC placements.

Table 1: OOHC providers during 1 January to 31 December 2018

OOHC provider	Website
Anglicare Tasmania	https://www.anglicare-tas.org.au/
CatholicCare Tasmania	https://www.catholiccaretas.org.au/
CYS – Department of Communities Tasmania	https://www.communities.tas.gov.au/children-and-youth-services
Devonfield Enterprises Inc	http://www.devonfield.com.au/
Glenhaven Family Care	http://www.glenhaven.org.au/
Kennerley Children’s Homes Inc	https://kennerleykids.org.au/
Key Assets	https://www.keyassets.com.au/about-us/office-location/tas/
Life Without Barriers	https://www.lwb.org.au/
Many Colours 1 Direction (based in the Northern Territory)	http://www.mc1d.org.au/
Mosaic Support Services	https://mosaictas.org.au/
Multicap	https://www.multicap.com.au/
North West Residential Support Services Inc	https://www.nwss.org.au/
Possability	http://possability.com.au/
StGiles	https://www.stgiles.org.au/
Total Support Services	http://totalsupportservices.com.au/

2.3 What types of OOHC placements do OOHC providers offer?

Table 2 outlines the types of OOHC placements provided during the period 1 January to 31 December 2018 by OOHC providers who submitted a completed CCYP questionnaire to the Commissioner. It should be noted that some providers only provided OOHC placements for part of the 2018 calendar year. This table shows that the DCT provided foster care, kinship care, respite care, independent living and third-party guardianship, and was the largest provider of foster and kinship care. Table 2 also shows that most of the non-government organisations who responded to the CCYP questionnaire provided respite care, emergency care and residential care, with fewer of these non-government organisations providing relative or kinship

care, foster care, sibling group care and independent living (refer to the Glossary for definitions of the types of care).

Four non-government OOHC providers advised the Commissioner that they provided care to sibling groups during some or all of the 2018 calendar year.

Eight organisations provided some form of non-family-based care – described by some OOHC providers as “residential care”. It appears that the term “residential care” is used by some OOHC providers to describe OOHC arrangements provided to children and young people by paid staff on

a rostered 24/7 basis. Within this category of OOHC placement, arrangements ranged from a single child or young person living in a house with paid staff on a rostered 24/7 basis to two or more children and young people (who may or may not be related) living in a house with paid staff on a rostered 24/7 basis. Only CatholicCare Tasmania is specifically funded to provide a defined therapeutic residential care service; this service is statewide and can include up to four children and young people living in a house with paid staff in a rostered 24/7 care arrangement.

“Non-family based or “residential care” arrangements ranged from a single child or young person living in a house with paid staff on a rostered 24/7 basis to two or more children and young people (who may or may not be related) living in a house with paid staff on a rostered 24/7 basis.”

Table 2: Types of OOHC placements provided by organisation, Tasmania, 1 January to 31 December 2018 based on responses to the CCYP questionnaires

Organisation	Relative or kinship care	Foster care	Respite care	Emergency care	Care to sibling groups	Residential care	Independent living	Other*
Anglicare Tasmania	X	X	✓	X	X	✓	X	X
CatholicCare Tasmania	X	X	X	✓	X	✓	X	X
Children and Youth Services	✓	✓	✓	X	X	X	✓	✓
Devonfield Enterprises Inc	X	X	X	X	X	✓	X	X
Glenhaven Family Care	X	✓	✓	✓	✓	✓	✓	X
Key Assets	X	✓	✓	✓	✓	X	X	X
Kennerley Children's Homes Inc	✓	✓	✓	✓	✓	X	✓	X
Life Without Barriers	X	✓	✓	✓	X	✓	X	X
Mosaic Support Services	X	X	✓	✓	X	✓	X	X
Multicap	X	X	X	X	X	✓	X	X
Possability	X	X	✓	✓	✓	✓	X	X

*Other placements were noted as 3rd Party Guardianship.

Refer to the Glossary for definitions of these types of OOHC placement.

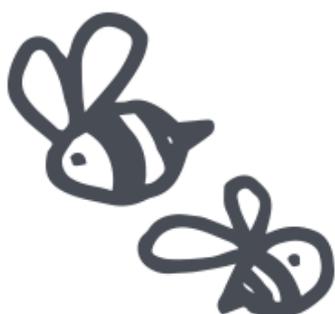
Many Colours 1 Direction, North West Residential Support Services, StGiles and Total Support Services did not submit completed questionnaires and are therefore not included in this table.

2.4 What are Special Care Packages?

Some children and young people in OOHC require specialised care with highly intensive wrap-around services over extended time periods. In Tasmania, this type of care is often facilitated through Special Care Packages (SCPs). Introduced as part of OOHC reforms in 2014, SCPs are the most intensive – and expensive – form of care for children and young people in OOHC and have therefore been a particular focus of monitoring activities. It is noted that for the purposes of this report, SCPs are regarded as a care type supported by a specific funding arrangement and not an OOHC placement type.

SCPs were described as follows in the Request for Proposals issued in May 2015 by the then Department of Health and Human Services (DHHS):

Special Care Packages are developed to match a specific child's extra-ordinary level of need for care, including therapeutic, medical, disability or similar supports. This specialised care type addresses the needs of children who require specific supports that are not available through one of the other care options. This type of care is to provide time limited services for children and young people with the most extreme level of need and is the most intensive service type in the continuum of care.²⁷



In 2015, following the Request for Proposal process, the then DHHS established a Register of providers to deliver SCPs. The six successful providers were:

- Possability
- Kennerley Children's Homes Inc
- Key Assets
- Life Without Barriers
- Safe Pathways (this provider stopped providing services in 2017)
- Australian Childhood Foundation (this organisation provides therapeutic services only).

These individualised packages of support are now funded by the DCT which has advised, in relation to children accessing SCPs that:

For these children, the behaviours occur with such intensity and duration that:

- their ability to learn and participate in everyday activities and events is impacted;
- they are unable to be supported in mainstream services and schooling;
- placement in family-based care with volunteer foster carers is not possible; and
- a placement in which there are no other children is necessary (one-to-one care).²⁸

Consequently, under an SCP, care and support is mostly provided on a 24-hour basis by paid support workers in a residential property managed by a non-government OOHC provider. Some children and young people placed in therapeutic residential care may also have some or all of their care and support funded through an SCP.

While this type of care is usually time limited, there are some children and

young people who have lifelong medical and other needs and will require this intensive level of support right through to 18 years of age when they leave care and they transition to other adult based services.²⁹

The Tasmanian Government has committed more resources to this care type, as advised by the Minister for Human Services, the Hon Roger Jaensch MP, in the 2019-20 Budget Estimates Committee A hearing:

Additional funding of \$16.9 million has been allocated to meet the growth in demand for OOHC services, particularly for children in specialised placements with complex needs.³⁰

According to the Funding Agreements for the four non-government OOHC providers on the Register and listed above, who provided OOHC placements via SCPs in Tasmania during the monitoring cycle, “service provision is dependent upon the submission and acceptance by the Department of a quote based upon the costs specified in the Service Provider’s proposal in response to the Request for Proposal... as well as the development of an appropriate Therapeutic Plan for a child”.

Monitoring activities have identified that during the 2018 calendar year, ten other OOHC providers that were not on the Register also provided OOHC placements for children and young people who were in receipt of SCPs, on a case-by-case basis:

- Anglicare Tasmania (commenced provision of OOHC in the second half of 2018)
- CatholicCare Tasmania
- Devonfield Enterprises Inc
- Glenhaven Family Care
- Many Colours 1 Direction (providing placements in the Northern Territory)
- Mosaic Support Services
- Multicap Tasmania
- North West Residential Support Services Inc
- StGiles
- Total Support Services.

Six of the non-government organisations (some on and some not on the Register) providing OOHC via SCPs were disability-specific service providers.

In his January 2018 report on SCPs, the Auditor-General noted that:

DHHS³¹ currently uses, on a case-by-case basis, providers that are not on the register. The reasons cited for this include:

- some children were already under the care of other providers and DHHS did not want to provide undue disruption to the child (continuity of service)
- the demand for placements is greater than the capacity of the approved providers to deliver
- providers used had an existing relationship with DHHS (their ability to deliver the service was known).³²

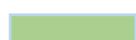
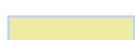
Table 3 outlines information gathered through the distribution of CCYP questionnaires to OOHC providers in which providers were asked whether they provided SCPs and if so, to provide data on the number of individual children in receipt of an SCP during 1 January to 31 December 2018. Table 3 shows the number of SCPs in each region by provider for the specified time periods, which was just over 60 for both time periods. (It is important to note that these figures may be subject to double counting and therefore must be viewed with caution.)

Many Colours 1 Direction, North West Residential Support Services Inc, StGiles and Total Support Services did not submit completed questionnaires and are therefore not included in Table 3.

Through monitoring activities, the Commissioner was advised that these organisations also provided placements through SCPs during the period 1 January to 31 December 2018. SCPs are discussed further in Chapter 6 of this Report.

Table 3: Number of individual children in receipt of a Special Care Package, by region and organisation, Tasmania, 1 January to 31 December 2018 based on responses to the CCYP questionnaires

OOHC provider	January to June 2018			July to December 2018		
	South	North	North West	South	North	North West
Anglicare Tasmania				3		
CatholicCare Tasmania	4			3		
Children and Youth Services						
Devonfield Enterprises Inc			7			7
Glenhaven Family Care			1			8
Key Assets	1	1	1			
Kennerley Children's Homes Inc	4					
Life Without Barriers	9	1		8	1	2
Mosaic Support Services	3			3		
Multicap			2			2
Possability	18	3	8	18	3	8
Total	39	5	19	35	4	27

 Organisation stated they provided SCPs in this region
  Organisation stated they did not provide SCPs in this region

3. Children and young people in OOHC in Tasmania



3.1 Overview

This chapter provides an overall description of the children and young people in OOHC in Tasmania, based on regular data monitoring activities conducted by the Commissioner, publicly available national datasets and information obtained from OOHC providers in Tasmania during monitoring visits.

Acknowledging the over-representation of Aboriginal children and young people in OOHC, this chapter includes a particular focus on Aboriginal children and young people, and descriptors of the legislative, policy and practice frameworks which aim to promote their wellbeing.

Given the prevalence of children with disability in OOHC, this chapter also considers issues relevant to the quality of care they receive.

National data has been used where necessary for context, or where the accuracy of the data collected during monitoring activities cannot not be assured. Several data accuracy issues were identified during analysis of responses to the CCYP questionnaires. These include:

- Difficulties obtaining an accurate count of children and young people in OOHC – and by OOHC provider – because they may have moved between placement type and/or OOHC providers during the relevant period. Further, not all OOHC providers responded to the CCYP questionnaires.
- Difficulties collating information from OOHC providers due to inconsistencies in their approaches to providing information, including missing data.

The Commissioner takes responsibility for any errors or discrepancies between the information given to the Commissioner by OOHC providers and the data presented in this report. The data presented are also subject to caveats, which are provided in the data sources.

3.2 How many children live in OOHC in Tasmania?

The DCT reports monthly on the number of children and young people in OOHC in Tasmania on the publicly available Human Services Dashboard published by the Tasmanian Government.³³ The figures from 1 January 2018 to 31 December 2018, which is the period covered by CCYP questionnaires (see Chapter 1 for more information), are included below in Table 4 and thus go beyond the most recent data from the Australian Institute of Health and Welfare (AIHW).

According to the Dashboard, there were 1,305 children living in OOHC in Tasmania in December 2018. Please note there is a discrepancy between the AIHW figure for 30 June 2018 and the Dashboard figure for June 2018. The most recent statistics from the AIHW show that, as of 30 June 2018, there were 1,272 children living in OOHC in Tasmania.³⁴



Table 4: Number of children in OOHC, as at the end of each month, Tasmania, January 2018 to December 2018³⁵

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
1,243	1,245	1,259	1,255	1,256	1,276	1,256	1,263	1,279	1,295	1,299	1,305

Significant growth in OOHC has occurred, with the number of children in OOHC increasing every year for the past five years, with the numbers rising by 218 (21 per cent) from 30 June 2014 to 30 June 2018. This increase reflects the fact that, since 2015, the number of children coming

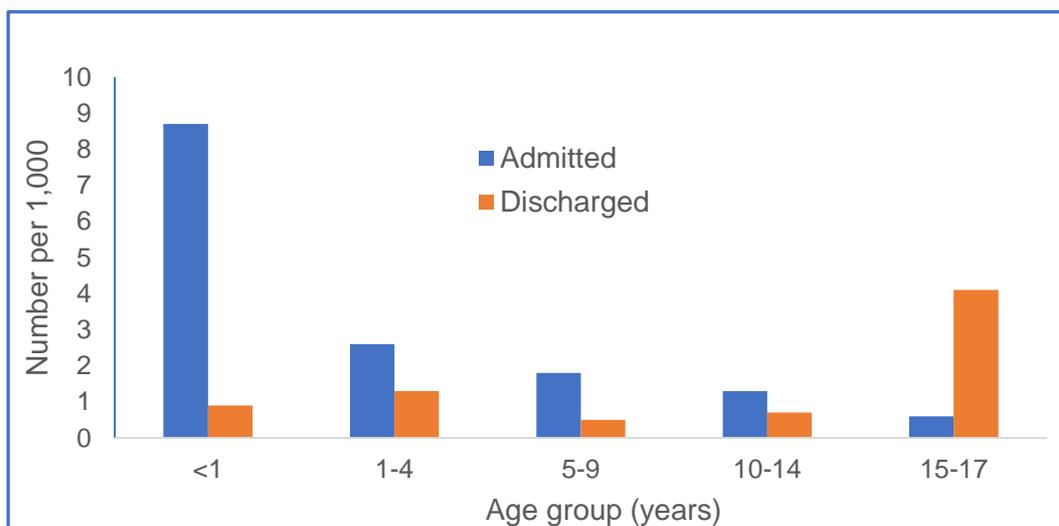
into care has consistently outnumbered the number of children leaving care (see Table 5). The different age distributions for admissions and discharges show that children are being admitted to OOHC at a younger age and are remaining for longer (see Chart 1).

Table 5: Trend in children admitted to and discharged from OOHC, Tasmania, 2013-14 to 2017-18³⁶

	2013-14	2014-15	2015-16	2016-17	2017-18
Admitted to OOHC	208	194	242	208	223
Discharged from OOHC	220	188	153	158	153
Increase/decrease in number of children in OOHC	-12	6	89	50	70

Data in this table are subject to caveats which can be reviewed in the source material.

Chart 1: Children admitted to, and discharged from, OOHC, by age group, Tasmania, 2017-2018 (Number per 1,000)³⁷



3.3 How long did children live in OOHC during 2018?

Of the 1,272 children in OOHC in Tasmania at 30 June 2018, 84.7 per cent had been continuously in OOHC for 1 year or more.³⁸ This figure includes 26.7 per cent who had been in OOHC for between 2 and 5 years, and 47.2 per cent who had been in OOHC for 5 years or more. The remaining children (15.3 per cent) had been in OOHC for less than 1 year. In comparison to other states and territories, Tasmania had the second highest proportion of children who had lived continuously in OOHC for longer than 5 years.

3.4 How old were the children living in OOHC in Tasmania in 2018?

Although age range data for children in OOHC was requested from OOHC providers, due to the data reliability issues outlined above, exact numbers could not be verified and therefore national data is reported here.

In 2018 in Tasmania, 21.1 per cent of children in OOHC were under the age of 4 years, with most children aged between 5 and 14 years (63.4 per cent). Tasmania's age breakdown of children in OOHC is comparable to national data.³⁹



3.5 What are the living arrangements for children in OOHC in Tasmania?

While a range of different living arrangements are provided for children in OOHC (shown in Table 6), 94.0 per cent of children in OOHC in Tasmania live in home-based care, with Tasmania having the third highest rate of children living in foster care placements compared to other states and territories. The largest proportion of children in OOHC were living in foster care in Tasmania (45.8 per cent), whereas nationally the largest proportion of children in OOHC (51.0 per cent) were living in kinship care. Nationally, there were nearly 200 children living in family group homes, however family group homes are not currently used as an OOHC placement in Tasmania.

Over 17 per cent of children in OOHC in Tasmania were in third-party guardianship, which is a significantly larger proportion than nationally (1.4 per cent). Refer to the Glossary for a definition of third-party guardianship.

The DCT has advised that, during 2018, six Tasmanian children and young people were placed at a residential facility in the Northern Territory run by Many Colours 1 Direction. These children and young people were aged between 12 and 16 years at the time of placement and were all under the guardianship of the Secretary of the DCT.

Table 6: Children in OOHC by type of placement, 30 June 2018 – Tasmania and Australia⁴⁰

Type of placement	Tasmania	%	Australia	%
Kinship/relative care	383	30.1	23,341	51.0
Foster care	583	45.8	18,012	39.4
Third-party parental care	223	17.5	627	1.4
Other home-based care	7	0.6	602	1.3
Residential care	71	5.6	2,638	5.8
Family group homes	0	0	189	0.4
Independent living	4	0.3	187	0.4
Other (incl. unknown)	1	0.1	160	0.3
Total children	1,272	100.0	45,756	100.0

Data in this table are subject to caveats which can be reviewed in the source material.

3.6 Aboriginal children and young people in the Tasmanian OOHC system

3.6.1 How many Aboriginal and Torres Strait Islander children live in OOHC?

In Tasmania in 2017-18, approximately one quarter of all children in OOHC were Aboriginal.⁴¹ This contrasts with 10.3 per cent of all Tasmanian children and young people identifying as Aboriginal and Torres Strait Islander.⁴² The number of children with Indigenous, non-Indigenous and unknown status in OOHC in Tasmania and Australia is provided in Table 7. The rate per 1,000 children aged 0-17 years by recorded Indigenous status is provided in Table 8. This table shows that, in Tasmania and nationally, the rate of children in OOHC is much higher for ‘Indigenous’ children than for ‘non-Indigenous’ children. However, it is important to note that for Tasmania the

high proportion of children and young people with an ‘unknown’ Indigenous status affects the reliability of data disaggregated by Indigenous status.^{43*} It is therefore likely that the number of Aboriginal children in OOHC in Tasmania is higher than reported.

The over-representation of Aboriginal children and young people in OOHC is not unique to Tasmania. The Royal Commission into Institutional Responses to Child Sexual Abuse noted that Aboriginal and Torres Strait Islander children and young people are significantly over-represented in contemporary OOHC in all jurisdictions.⁴⁴

Tasmanian Aboriginal children and young people under the guardianship of the Secretary, may be placed in a therapeutic residential OOHC setting in the Northern Territory run by Many Colours 1 Direction.

* ‘Indigenous’ and ‘Non-Indigenous’ is the terminology used by AIHW in reporting their national statistics. ‘Indigenous’ includes children and young people who identify as Tasmanian Aboriginal.

Table 7: Children in OOHC, by Indigenous status in Tasmania, 30 June 2018, Tasmania and Australia (number)⁴⁵

	Indigenous	Non-Indigenous	Unknown	All Children
Tasmania	333	561	378	1,272
Australia	17,787	27,470	499	45,756

Data in this table are subject to caveats which can be reviewed in the source material.

Table 8: Children in OOHC, by Indigenous status in Tasmania, 30 June 2018 (rate per 1,000 children)⁴⁶

	Indigenous	Non-Indigenous	Unknown	All Children
Tasmania	29.7	5.5	na	11.2
Australia	58.3	5.3	na	8.3

Data in this table are subject to caveats which can be reviewed in the source material.

3.6.2 What are the legislative, policy and practice frameworks for Aboriginal children and young people in OOHC in Tasmania?

Section 10A of the *Children, Young Persons and Their Families Act 1997* provides as follows:

In performing or exercising a function or power under this Act, a person is to –

- (a) uphold the principles set out in sections 10B, 10C, 10D, 10E, 10F and 10G as far as practicable; and
- (b) have regard to any national standards or charters relating to the rights or treatment of children published by the Commonwealth Government that are relevant.

The *National Standards for Out-of-Home Care* include two standards directly relevant to Aboriginal and Torres Strait Islander children and young people in OOHC (refer to Box 1 on the following page).

[Section 10G](#) of the *Children, Young Persons and Their Families Act 1997* (Tas) acknowledges the major self-determining role that Aboriginal families, kinship groups, Aboriginal organisations and communities have in promoting the wellbeing of Aboriginal children in Tasmania, including through contributing to the making of a decision under the Act in relation to a child. The Act also outlines other elements of the ATSI CPP intended to guide decision-making around placement of an Aboriginal child in OOHC, discussed in more detail below.⁴⁷

Aboriginal and Torres Strait Islander Child Placement Principle

The ATSI CPP was developed in recognition of the inter-generational trauma caused by policies and practices which have seen the forced separation of Aboriginal and Torres Strait Islander children from their families, communities and culture. The ATSI CPP seeks to

prevent those practices from continuing or occurring again and to promote the self-determination of Aboriginal and Torres Strait Islander communities.

It is important to acknowledge that the ATSI CPP is often incorrectly understood as being limited to a hierarchy of preferred placement options for Aboriginal and Torres Strait Islander children who have been removed from the care of their parents.⁴⁸

Box 1: Relevant standards in the National Standards for Out-of-Home Care

Standard 3: Aboriginal and Torres Strait Islander communities participate in decisions concerning the care and placement of their children and young people.

Standard 10: Children and young people in care are supported to develop their identity, safely and appropriately, through contact with their families, friends, culture, spiritual sources and communities and have their life history recorded as they grow up.

Preferred placements are just one of five core elements of the ATSI CPP, the others being: prevention, connection, partnership and participation. As the Secretariat for National Aboriginal and Islander Child Care (SNAICC) has said, the broad aims of the ATSI CPP are to:

- ensure an understanding that culture underpins and is integral to safety and wellbeing for Aboriginal and Torres Strait Islander children and is embedded in policy and practice;
- recognise and protect the rights of Aboriginal and Torres Strait Islander children, family members and communities in child welfare matters;

- increase the level of self-determination of Aboriginal and Torres Strait Islander people in child welfare matters; and
- reduce the over-representation of Aboriginal and Torres Strait Islander children in child protection and OOHC systems.⁴⁹

Connection to culture is associated with improved emotional, social and physical health for Aboriginal and Torres Strait Islander children and their families. Positive cultural connection can assist in the development of Aboriginal and Torres Strait Islander children's identity, fostering high self-esteem, emotional strength and resilience.⁵⁰

In 2017-18, Tasmania's placement of Aboriginal children in OOHC with relatives or kin, other Aboriginal carers or in Aboriginal residential care, was the second lowest in the nation after the Northern Territory.⁵¹ In 2017-18, 42.6 per cent of Aboriginal and Torres Strait Islander children in OOHC in Tasmania were placed with relatives or kin, other Aboriginal and Torres Strait Islander carers or in Aboriginal and Torres Strait Islander residential care. This is 22.6 per cent lower than the national percentage of 65.2 per cent.⁵²

As the *Baseline Analysis of Best Practice Implementation of the Aboriginal and Torres Strait Islander Child Placement Principle* for Tasmania has noted:

These statistics – particularly the poor rate of placement with family – demonstrate that Tasmania has a significant way to go to achieve compliance with the intent of the Aboriginal and Torres Strait Islander Child Placement Principle.⁵³

The Tasmanian Government has accepted in principle Recommendation 12.20 of the Royal Commission which

calls on state and territories to fully implement the ATSI CPP.⁵⁴ It is noteworthy that in the Tasmanian Government's *First Year Action Plan 2018-19*, no commitment was made to progress implementation of Recommendation 12.20 during 2019.⁵⁵

3.6.3 What did the Commissioner's Monitoring Program find?

The Commissioner's Monitoring Program found that the DCT's ability to fully implement the ATSI CPP appears to be hindered by difficulties in determining and recording the Aboriginal status of children and young people in OOHC. The CCYP questionnaires asked OOHC providers to specify the number of individual children and young people who identified as Aboriginal for each placement type during 1 January to 31 December 2018. However, due to the large number of children and young people whose Aboriginal status was unknown, it was difficult to obtain an accurate count of Aboriginal children and young people in OOHC in Tasmania. The Commissioner has since been advised that significant work has been done resulting in the percentage of children with an "unknown" Aboriginal status being reduced to about 2 per cent.

The Commissioner found that some non-government OOHC providers often did not know the Aboriginal status of children and young people placed with them. Some non-government OOHC providers reported not always knowing the Aboriginal status of a child upon referral from CYS and were unclear as to whose responsibility it is to ascertain whether a child or young person placed with them identifies as Aboriginal. This is problematic because this knowledge is a necessary precursor to compliance with the ATSI CPP.

Even when Aboriginal status is known, it is unclear whether or to what extent Aboriginal organisations are included in, or take the lead on, decision-making about placements for Aboriginal children and young people in OOHC. CYS has advised the Commissioner that they engage with Aboriginal organisations regarding placement decisions, however, given the findings above, it is unlikely that this occurs for all Aboriginal children and young people.

Placing Aboriginal children and young people with non-Aboriginal families can have an adverse impact upon their wellbeing. In its submission on "being healthy" in OOHC, the Tasmanian Aboriginal Corporation stated that:

Disconnection from community and culture has a negative effect on Aboriginal and Torres Strait Islander children and young people in OOHC when placed in non-Aboriginal placements. Primarily this loss of connection results in their views not being heard.

Additionally, the Commissioner has found that Aboriginal cultural planning is not being consistently conducted for all Aboriginal children and young people in OOHC. Non-government OOHC providers have indicated that they require assistance with cultural planning as most do not have the internal resources to develop Cultural Plans for Aboriginal children and young people. Specifically, some of these OOHC providers appeared unsure about how to appropriately develop Cultural Plans, and about their responsibilities in this respect. The lack of cultural planning adversely impacts the overall wellbeing and cultural safety of Aboriginal children and young people in OOHC in Tasmania.

During the monitoring cycle from 1 July 2018 to 30 June 2019, the DCT and non-government OOHC providers expressed

an interest in developing their knowledge and understanding of issues for Aboriginal children and young people in OOHC and in investigating ways in which working in partnership with Aboriginal communities in Tasmania can be enhanced and improved.

3.6.4 What health services are available for Aboriginal children and young people?

Very few of the submissions regarding “being healthy” provided detailed comments about the provision of health care for Aboriginal children and young people in OOHC in Tasmania. The submission from the Tasmanian Aboriginal Corporation noted a lack of data on the health outcomes of Aboriginal children and young people in OOHC who engage with health care services or preventative health strategies. This submission took a holistic view of the health of Aboriginal children and young people in OOHC, by linking health with improved adherence to the ATSI CPP, noting that “this can only be achieved if partnerships occur between statutory bodies and community controlled Aboriginal health services”. Additionally, this submission called for greater support for family based carers to assist Aboriginal children and young people to maintain connections with their community and culture, as one means of improving their health and wellbeing.

Chapter 6 of this report canvasses ways in which we can better promote the wellbeing of Aboriginal children and young people in the child safety system in Tasmania.

3.7 Children and young people with disability in OOHC

3.7.1 How many children with disability live in OOHC?

AIHW data indicates that at 30 June 2018 the proportion of children and young people with disability in OOHC in Tasmania was 18.3 per cent compared to 13.9 per cent for Australia. Data about disability is not currently collected in a systematic way in other states and territories, thereby making comparisons difficult.⁵⁶ The Commissioner acknowledges that:

As disability is a multidimensional and complex concept, there might be differences across jurisdictions in how disability is defined, including which health conditions are classified as a disability. There are also differences in how information about disability is captured in jurisdictional processes and client information systems.⁵⁷

The heightened risk of vulnerability for children with disability in OOHC was detailed by the Royal Commission.⁵⁸

The Royal Commission noted that children and young people with disability are over-represented in statutory OOHC.⁵⁹

The Commissioner notes Recommendation 12.2 of the Royal Commission, which calls on the Australian Government and state and territory governments to prioritise enhancements to the Child Protection National Minimum Data Set to include data identifying children with disability.⁶⁰ The Tasmanian Government accepted this recommendation in principle, indicating that it will work with other jurisdictions to achieve enhancements to the Child Protection National Minimum Data Set through relevant agencies and portfolios while also noting that “the feasibility requires further consideration”.⁶¹

3.7.2 What NDIS-funded supports are available for children with disability in OOHC?

Section 34 of the *National Disability Insurance Scheme Act 2013* limits the supports that will be provided or funded under the NDIS. According to the *Principles to Determine the Responsibilities of the NDIS and Other Service Systems* agreed by the Council of Australian Governments, the states and territories are responsible for meeting the needs of children with disability in OOHC, including making reasonable adjustments. The NDIS will fund reasonable and necessary disability support needs of children with disability in OOHC, where they are required due to the impact of the child's impairments on their functional capacity and are additional to the needs of children of similar ages.

Examples of these supports may include disability-specific and carer parenting training programs, skills and capacity building for children with disability, respite and outside of school hours care, home modifications, therapeutic and behaviour support, and equipment and transport needs.⁶²

3.7.3 What did the Commissioner's Monitoring Program find?

Some non-government OOHC providers were unable to provide data to the Commissioner on whether they had children or young people with disability in their care.

Several children and young people in OOHC in Tasmania received funding for supports through both the NDIS and the CSS in the DCT. In the 2018 calendar year, six OOHC providers – Mosaic, Devonfield, Multicap, North West Residential Support Services, Possability and Total Support Services – were also

disability-specific service providers. In some cases, non-government OOHC providers delivered both NDIS- and CSS-funded supports for the same child or young person. The Commissioner also heard that some children and young people with disability originally entered the care of a non-government provider for respite care and then transitioned to an SCP with the provider.

“The Commissioner has been told that staffing costs to stay with a child in OOHC while in hospital are not funded by the DCT or the NDIS.”

Some disability-specific providers of OOHC indicated that there was a lack of clarity about the division of funding responsibilities between the NDIS and the DCT for some supports for children with disability in their care.

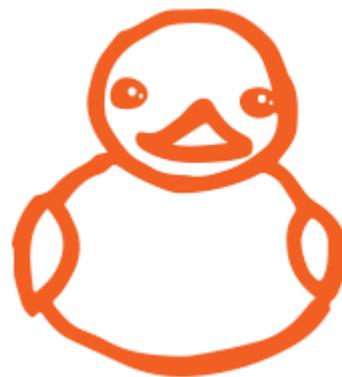
Some non-government OOHC providers also noted gaps in NDIS and DCT funding for some supports. For example, the Commissioner has been told that staffing costs to stay with a child in OOHC while in hospital are not funded by the DCT or the NDIS. The Commissioner also found that some children and young people with disability and/or complex needs are cared for on a 24-hour basis by paid support workers in a private home managed by the provider.

The Commissioner has been advised by the DCT that as at 30 June 2019 there were 33 children with disability on orders cared for on a 24-hour basis. These children and young people have a range of disabilities including physical, intellectual and sensory disabilities. This excludes any young person with a

disability residing in therapeutic residential care.

The Commissioner acknowledges that, when properly managed and resourced, this 'one-child' residential care model may provide the most appropriate placement option for some children and young people with disability. However, on the information available, it is unclear whether this placement option promotes better wellbeing outcomes for children and young people with disability than other placement options. In saying this, the Commissioner is not intending to be critical of individual OOHC providers or of the quality of the care they provide for children and young people with disability through residential or non-family-based placements.

One way of promoting the wellbeing of children and young people with disability in 'one child' residential care placements would be to establish an independent visitor program which prioritises visits to children and young people in non-family-based care, including those with disability, a matter discussed further in Chapter 5.



4. The health of children and young people in out-of-home care



4.1 Overview

Consistent with the Monitoring Program's thematic focus on "being healthy" during the first monitoring cycle from 1 July 2018 to 30 June 2019, this chapter discusses the Commissioner's findings about the health of children and young people in OOHC and their access to health services. Further findings relating to children and young people "being healthy" while in OOHC are included in Chapter 5 (which deals with children's participation) and in Chapter 6.

It should be noted that the Commissioner's monitoring activities and consideration of issues affecting the health of children and young people in OOHC focused on information shared by service providers and information contained in submissions to the Commissioner. The Commissioner did not set out to undertake specific data collection on the prevalence of health conditions experienced by children and young people in OOHC, compared to those not in OOHC. Nor did the Commissioner's monitoring activities include data collection on the types of services known to and/or accessed by children and young people in OOHC across the public and private sectors or information on waiting lists. Comparisons of service access between children and young people in OOHC and other cohorts were also not undertaken.

Submissions advised that children and young people in OOHC may present with a wide range of physical and psychological health conditions, as well as physical, neurological, developmental, social, psychological and behavioural difficulties. Submissions also noted that children and young people in OOHC exhibit a higher prevalence of chronic and complex conditions, and experience

poorer health outcomes than the general population of children and young people.

Submissions frequently noted that the primary cause of health difficulties for children and young people in OOHC was adverse circumstances experienced prior to entering OOHC. For many children and young people, these adverse experiences – typically abuse and/or neglect – have resulted in trauma and attachment issues, which may negatively impact on their mental health, social and emotional behaviour, and engagement with schools and services.

However, it is also important to acknowledge that not all children and young people in OOHC experience the health conditions detailed below, and not all children and young people in OOHC are unhealthy or unable to improve their health. Nationally, children and young people in OOHC who responded to the CREATE National Survey in 2018, rated their health at 82.5 on average, on a scale from 0 (very poor) to 100 (excellent), which reflects a favourable view of their own health.⁶³

“Submissions frequently noted that the primary cause of health difficulties for children and young people in OOHC was adverse circumstances experienced prior to entering OOHC.”

4.2 Mental health conditions and social, emotional and behavioural concerns

In submissions, the most commonly cited health conditions reportedly observed in children and young people in OOHC were mental health conditions. One submission stated: “Australia-wide, children in care experience significantly poorer mental health outcomes than children who have never been in care, in many instances stemming from an underlying, and sometimes hidden, history of trauma in the form of physical, sexual or emotional abuse or neglect”.

Submissions advised that a wide range of mental health symptoms and conditions, as well as social, emotional and behavioural concerns, have been observed in children and young people in OOHC. It is important to note that these conditions may also be observed in the general population of children and young people in Tasmania.

Mental health conditions and symptoms observed in some children and young people in OOHC include: self-harm, suicidal ideation or suicide attempts; anxiety, depression and low mood; personality disorders; obsessive compulsive disorder, inattention and Attention Deficit Hyperactivity Disorder (ADHD); separation anxiety, eating disorders; and problem sexual behaviour and sexually abusive behaviour. (Refer to the Glossary for definitions.)

Social, emotional and behavioural concerns which have been observed in children and young people in out-of-home care include: hoarding, soiling, hypervigilance, risk-taking behaviour, antisocial behaviour, issues with impulse control and emotional regulation, and being bullied. Children and young people in OOHC themselves reported to the

Commissioner their concerns about social relationships, including issues with bullying and social media.

Submissions frequently noted that children and young people in out-of-home care may have complex trauma, usually arising from adverse childhood experiences. Complex trauma may result in symptoms of anxiety and depression, and problems with mood regulation, impulse control, self-perception, attention and memory. Trauma can also have long-lasting and wide-ranging effects on the relationships and academic performance of children and young people.

Young people in OOHC who attended the CREATE Round Table in April 2019 highlighted mental health as an important element of good health – “being healthy is not just physical, it’s mental”. These young people viewed health as a holistic phenomenon which extends to:

- Social health and connectedness – “having someone to talk to”, “being around other people”, “being with people you trust”, “being with people who care about me” and “making sure your friends are okay”.
- Being treated equally within their foster families – “being treated the same as biological kids” in terms of rules and material possessions, and not being viewed by their carers as “messed up weirdos because we have no family”.⁶⁴

Informed by these views and opinions, CREATE’s report into the Round Table of April 2019 with young people in OOHC encouraged the Commissioner to consider young people’s social health – including their ability to maintain friendships and other social connections, resolve conflict and regulate their emotions – as an important element of “being healthy”.

4.3 Other health issues observed in some children and young people in OOHC

In addition to mental health and social, emotional and behavioural conditions, a wide range of other conditions were noted in submissions about other health issues that may be experienced by children and young people in OOHC. These included:

- Developmental issues and intellectual disabilities – including autism and sensory issues, failure to thrive and poor growth, and developmental delays in speech and language, as well as fine and gross motor skills.
- Dental health problems – including tooth decay and poor development of teeth due to parental neglect, poor dental hygiene and/or diet.
- Asthma and allergies – which may be poorly controlled, with exacerbations being a frequent trigger for GP visits or attendance at Emergency Departments.
- Immune system issues – including high rates of upper respiratory infection, otitis media and tonsillitis, as well as frequent influenza, colds and general illness.
- Vision and hearing issues – sometimes arising from malnutrition, excessive screen time or infrequent attendance at infant and child health screenings.
- Malnutrition – arising from inadequate nutritional intake, which may lead to poor growth and other health issues.
- In-utero effects of maternal substance use – including Foetal Alcohol Syndrome Disorder.
- Substance use issues amongst some young people.
- Continence and toileting issues.

Young people in OOHC who attended the CREATE Round Table in April 2019, and met with the Commissioner on other occasions, displayed a sound understanding of the importance of good nutrition, exercise and self-care for maintaining physical health.

It is important to note that not all children and young people in out-of-home care experience any of the health conditions described in this chapter.

4.4 Health services for children and young people in OOHC

4.4.1 Availability of health services

Children and young people in OOHC access universal health services as part of their daily lives. Health services are available in the public and private health systems in Tasmania, with access to the private system dependent on a decision being made to enable a particular child or young person to access this form of health care. There is significant variability in the geographical distribution of health services in Tasmania – with fewer services available in the North and North West.

Additionally, there is a health service offered exclusively to children and young in OOHC in the South of Tasmania. Established in 2011, the OOHC Clinic at the Royal Hobart Hospital is staffed by paediatricians and paediatric registrars, who conduct health assessments and make referrals to surgical services and other appropriate specialists. A child and adolescent psychiatrist also attends this clinic monthly. The Commissioner has

been advised that there are no allied health services available within the OOHC Clinic. Additionally, as the OOHC Clinic operates in the South of the state only, there is a need to consider whether such a clinic should be expanded to the North and to the North West of Tasmania.

4.4.2 Access to health services

Several submissions on “being healthy” expressed concern about children and young people in OOHC being unable to access health services in Tasmania in a timely manner. Additionally, the Legislative Council’s inquiry into Acute Health Services identified major health service gaps and difficulties in this state, noting that “the Tasmanian Health Service is facing increasing demand for acute health services and is currently unable to efficiently or effectively meet this demand”.^{65 66} Difficulties in providing comprehensive health care for children and young people in OOHC are not exclusive to Tasmania, with significant issues observed in other states, including: “complex referral processes, restricted public health service capacity and lengthy waiting lists, lack of financing, and difficulties for carers and child-protection managers in navigating health systems”.⁶⁷

Submissions to the Commissioner reported significant waiting lists for accessing public health services, including Oral Health, optical services, and ear, nose and throat (ENT) services. Such delays can lead to children and young people developing preventable conditions and disability. In relation to oral health, the Commissioner has been advised that Oral Health Services Tasmania provides free universal dental services to all Tasmanian children and, with the exception of access to general anaesthesia, there are no waiting lists. Children and young people in OOHC are automatically booked appointments when

they enter the system, are categorised as high risk and are provided with six-monthly recalls.

At present, priority is not given to children and young people in OOHC over the general population for access to health care services in Tasmania. Some submissions proposed prioritisation of this cohort, which has occurred in other Australian jurisdictions, with one submission stating: “they are already so far behind – they should be prioritised”.

4.4.3 Access to mental health services and trauma care

The Commissioner has been told that in Tasmania, demand exceeds supply for outpatient mental health care services generally, including for children and young people in OOHC. This affects access to services across the continuum, from early intervention services through to services for those children and young people with more complex and severe mental health conditions.

The DoE observed in their submission that the mental health needs of students in OOHC are often not addressed as quickly or as comprehensively as necessary, impacting on both the child or young person and other students in the school setting.

Submissions noted a shortage of specialised psychologists and psychiatrists for children and adolescents and inconsistencies and gaps in eligibility to access services.

A shortage of inpatient mental health care for children and young people in Tasmania was also noted in several submissions, along with an absence of inpatient health care for alcohol and drug addiction or eating disorders. In their submission to the Legislative Council’s

Inquiry into Acute Health Services, the Royal Australian and New Zealand College of Psychiatrists outlined the situation for Tasmanian children and young people:

Young people requiring inpatient care in each region are admitted to the paediatric unit of the hospital, or the adult psychiatric unit if too unwell to be accommodated in the paediatric unit. Neither facility is appropriate for their care and there is a high level of risk associated with accommodating young people with mental illness in adult psychiatric facilities. Young people require developmentally appropriate care, in safe and developmentally appropriate environments, with specialist multidisciplinary staff.⁶⁸

The Commissioner understands that the new Adolescent Unit at the Royal Hobart Hospital (RHH), which is due to be completed by March 2020, will have dedicated inpatient mental health beds for adolescents. The Commissioner has been advised that the Launceston General Hospital building project is due for completion in the latter half of 2020, and that throughout the project, beds will continue to be available for adolescent mental health patients and will be utilised according to clinical need.⁶⁹

The Chief Psychiatrist advised the Legislative Council Estimates Hearing in June 2019 that the overall proportion of beds available in the new adolescent units in the RHH and LGH available for mental health patients is not yet known, however there will be two beds in each of those new units specifically designed for those with high risk mental health needs.⁷⁰

The Commissioner acknowledges that there are a number of services (private and public, funded by the State and Federal Governments) providing specialist psychological and psychiatric treatment to children and young people in OOHC. The Commissioner has been advised that as

part of the Mental Health Reform Program, a review of the model of care for the CAMHS is proposed, focusing on the integration of service responses for adolescents across community and inpatient settings. The Commissioner has also been advised that this will provide a model of care around the new designated adolescent mental health beds at the Royal Hobart Hospital and Launceston General Hospital and their links to existing Child and Adolescent Community Mental Health Services.⁷¹

In its Youth Suicide Prevention Plan, the Tasmanian Government committed to ensuring that children and young people in OOHC have access to resilience-promoting programs, and to explore opportunities for children to have priority access to mental health and other health services (refer to Box 2). However, the current status of work to progress these actions is unclear.

Box 2: Youth Suicide Prevention Plan for Tasmania 2016-2020, Tasmanian Government

Activity 1.2: Focus on children in out-of-home and their carers to ensure they have access to programs that build skills and resilience.

Activity 1.3: Explore opportunities for children in out-of-home care to have priority access to mental health and health services.

Several submissions noted a link between trauma and mental health conditions for many children and young people in OOHC. As noted in one submission, traumatic experiences and subsequent symptomology can impinge on children and young people’s mental wellbeing and relationships, and may pose risks to the stability of their OOHC placements and their engagement with health services:

The development of trauma and challenges with attachment have a significant negative impact on the mental health of children in OOHC and affect all of a child’s interactions, including with their family of origin, their carers, at school and any other agency with which children and young people are required to engage.

The Tasmanian Government has committed to providing trauma-informed therapeutic supports for young people in OOHC (refer to Box 3), although the status of work to implement this Action is unclear.

Several submissions identified a need for greater knowledge about and provision of trauma-informed care for children and young people in OOHC in Tasmania, with some submissions calling for greater education and training in trauma-informed practice for OOHC providers, foster carers and health professionals. The provision of early, intensive therapeutic treatment for children and young people in OOHC was emphasised, with one submission stating: “there must be an assumption that all kids come with a trauma background and that they need psychological care as a matter of priority and urgency without an official diagnosis”.

Some OOHC providers also noted that introducing trauma-informed therapeutic foster care placements in Tasmania would provide an “opportunity for children with high needs to be accommodated in a home situation that offers professionally

trained and skilled carers that can provide the appropriate level of care”. In its *Family Based Care Discussion Paper*, the DCT proposed the introduction of therapeutic foster care placements in Tasmania, however outcomes from this consultative process are not yet available.

Box 3: Youth at Risk Strategy of the Tasmanian Government

Action #8 – Provide targeted support for young people in OOHC.

The Tasmanian Government recognises that highly vulnerable young people, who have experienced significant trauma, require specialised support and treatment options. The Government is committed to investing in appropriate trauma informed therapeutic supports for young people in OOHC. These supports will provide young people in OOHC with the best chance of reaching their full potential.

5. Participation of children and young people in out-of-home care



5.1 The Commissioner’s monitoring of participation

During the monitoring cycle from 1 July 2018 to 30 June 2019, the Commissioner sought to understand the extent to which children and young people in OOHC are supported to express views and opinions on matters affecting them and to participate in decision-making should they wish to do so. In the CCYP questionnaires, OOHC providers were asked to provide information about any mechanisms and processes within their organisation which facilitate these processes, and the Call for Submissions asked individuals and organisations the following question:

How do you take into consideration the views of children and young people in out-of-home care about their health and any health care services and preventative health strategies delivered to them?

In this chapter, the Commissioner discusses the importance of children and young people in OOHC participating in decisions which affect them should they wish to do so. The extent to which they do participate is also discussed, relying on information provided in submissions and gathered through monitoring activities focused on “being healthy” in OOHC.

5.2 The significance of participation for children and young people

The right of all children to have a say in all matters which affect them, and for their views to be taken seriously, is set out in Article 12 of the *Convention on the Rights of the Child*.⁷² Additional information about this “right to be heard” is provided in the [Monitoring Plan 2018-19](#) and the [Conceptual Plan](#).

The *Children, Young Persons and Their Families Act 1997* (Tas) and the *Commissioner for Children and Young People Act 2016* (Tas) expressly acknowledge the importance of ensuring that children and young people can participate in decision-making processes.

Section 10F of the *Children, Young Persons and Their Families Act 1997* is extracted below:

If a decision is, or is to be, made under this Act in relation to a child –

- (a) the child –
 - (i) should be provided with adequate information and explanation about the decision in a manner that the child can understand; and
 - (ii) if appropriate having regard to the child's maturity and understanding, should be provided with the opportunity to respond to the proposed decision; and
 - (iii) if appropriate having regard to the child's maturity and understanding, should be provided with the opportunity to express his or her views freely; and
 - (iv) should be provided with assistance in expressing those views; and
 - (v) the views of the child should be taken into account, having regard to the child's maturity and understanding.

The Commissioner has specific legislative functions to promote and empower the participation of children and young people and to encourage and promote the establishment by organisations of appropriate and accessible mechanisms for the participation of children and young people in matters that may affect them.⁷³

The importance of promoting children and young people’s participation in OOHC is recognised in child protection policy at a

national level, as reflected in the *National Framework for Protecting Australia's Children* and the *National Standards for Out of Home Care*.⁷⁴ At the state level, “participating” is included as one of six interrelated wellbeing domains in the Tasmanian Government’s *Tasmanian Child and Youth Wellbeing Framework* and the DCT’s *Outcomes Framework for Children and Young People in Out of Home Care Tasmania*. The right of children and young people to be consulted and listened to seriously is also included in the *Charter of Rights for Tasmanian Children and Young People in Out of Home Care*.

The Royal Commission also emphasised the importance of ensuring that appropriate processes are in place to facilitate and encourage children and young people in OOHC to express their views on matters that affect their lives, to promote their safety in organisational settings. For additional information, refer to Recommendation 12.10 of the Royal Commission.⁷⁵

Notwithstanding these legislative and policy imperatives to promote the participation of children and young people in OOHC, it is acknowledged there are challenges in ensuring that children and young people in the child protection system, including in OOHC, have meaningful opportunities to participate in decision-making processes. These barriers to participation are well-documented; some of them are unique to children. The Commissioner makes the following observations:

- Participation for children and young people in the child protection system cannot be readily achieved by introducing new policies, processes, and procedures in isolation from considering cultural values and organisational structures.

- It is critically important to foster strong relationships between children and young people and child protection workers to enable children and young people to express their views and have their voices heard.
- The role of foster carers in promoting the participation of children and young people cannot not be underestimated.

A more detailed discussion about these systemic challenges is included in the [Monitoring Plan 2018-19](#).

5.3 Challenges for participation in OOHC

The Commissioner’s monitoring activities identified a number of challenges to children and young people in OOHC participating in decision-making processes affecting their lives.

5.3.1 Case and Care Planning

The CSS provides case management for children and young people who are under the guardianship and/or custody of the Secretary of the DCT. This includes responsibility for ensuring that Case and Care Plans are up-to-date and comprehensive.

OOHC providers have noted that Case and Care Plans are a potentially valuable tool to collect and record the views of children and young people.

The importance of care planning for children and young people in OOHC is reflected in Standard 4 of the *National Standards for Out-of-Home Care* (refer to Box 4 on the following page).⁷⁶ A Case and Care Plan covers four general areas: health and wellbeing, education, identity and social needs, and contact with family of origin.

Box 4: Care planning in the National Standards for Out-of-Home Care

Standard 4: Each child and young person has an individualised plan that details their health, education and other needs.

What this means: The care planning process is to be focused on the wellbeing of the individual living in out-of-home care. The care plan is to include the views of the child and young person where appropriate and developed in partnership with carers, families and significant others. Where applicable, this approach will include cultural plans.

The DCT expressed a commitment to the Case and Care Planning process in their submission to the Commissioner on “being healthy”:

Case and Care Planning is a key element in supporting quality care for each child and young person in Out of Home Care. It will remain the strategy of choice for engaging the child or young person, carers and others in a common approach to the child or young person’s care.

The DCT’s *Case and Care Planning Guidelines* [dated 14 January 2009] notes that:

If a child is able to form and express views as to his or her ongoing care and protection, those views must be sought and given serious consideration taking into account the child’s age and maturity.

However, CREATE Tasmania has advised the Commissioner that “the current template for the plans is not conducive to the process of engaging and meaningfully interacting with children and young people”.

5.3.2 Case and Care Planning for “being healthy”

One of the key areas covered by a Case and Care Plan is the health and wellbeing needs of the child or young person, including:

- identification and management of specific health conditions e.g., asthma, vision and hearing;
- dental care (including orthodontic treatment);
- immunisations;
- developmental assessments and the child’s appropriate developmental milestones;
- specialist health assessments, including by paediatricians;
- need for specialist therapies, e.g. speech therapy;
- development and maintenance of a physically active lifestyle;
- provision of a healthy diet; and
- emotional wellbeing.

This basic information is foundational to efforts by OOHC providers and carers to engage children and young people in their health and use of health care services. However, the Commissioner has found that the DCT does not always send to non-government OOHC providers in a timely fashion more in-depth health information, including information about cumulative harm, Health Assessments or Therapeutic Plans. This constrains the capacity of non-government OOHC providers to deliver responsive and individualised care to the child or young person placed with them.

Additionally, when relevant health information is either missing or out-of-date in Case and Care Plans, and

accompanying reports are not provided, the potential for children and young people to actively participate in “being healthy”, and the efforts of OOHC providers and carers to enable this participation, is significantly constrained.

5.3.3 Care Team Meetings and visits by Child Safety Officers

Care Teams are multidisciplinary teams established by CSOs to oversee coordinated care to each child or young person in OOHC. The DCT’s current *Policy and Practice Advice on Care Teams* [effective from 1 May 2010] states that “care teams are integral to the provision of good care” and these meetings “will occur every month for the first year of placement with more regular meetings with individual members of the care team if specific issues arise. After the first year, the frequency of meetings may be reviewed according to the child’s needs”.

Regular Care Team Meetings and direct engagement by CSOs with children and young people were frequently mentioned by OOHC providers as potential enablers of the participation of children and young people in OOHC, particularly when the agenda and meeting minutes are written in a child-friendly manner to facilitate understanding and engagement. It is understood that children and young people can either attend these meetings or have their views and wishes conveyed to the Care Team by their CSO.

However, submissions also advised that the potential for Care Team Meetings to facilitate participation is not always realised because, for example, meetings are not held regularly, with one non-government OOHC provider noting in their submission that some children and young people have not been the subject of a Care Team Meeting in over a year.

Additionally, infrequent visits by CSOs to children and young people in OOHC was identified as a barrier to participation.

5.3.4 Barriers to participating in health service provision

Some submissions noted that children and young people in OOHC can experience barriers to participation when using health services. It is acknowledged that the barriers identified, including those outlined below, may apply equally to children and young people who are not in OOHC:

- **Feeling ‘talked about’** – medical professionals sometimes speak with adults about personal or sensitive matters that the child or young person may feel embarrassed about, as though they are not in the room.
- **Feeling frustrated by very long waits at clinics for appointments to start** – one submission advised that wait times of two-to-four hours at public clinics are not uncommon, leading to children and young people experiencing “understandable difficulty in remaining regulated in the appointment”.
- **Wanting more time with practitioners during appointments** – to allow children and young people to develop rapport with practitioners so that “they feel safe and comfortable to ask questions and talk about things they find hard to discuss”.
- **Feeling uncomfortable about the health care modality** – some children and young people feel uncomfortable when engaging in ‘talk therapy’ during health care, leading to them being exited from services due to perceived disengagement.

5.4 Strategies for facilitating participation in OOHC

5.4.1 Strategies employed by OOHC providers

The Monitoring Program found that OOHC providers generally value and are committed to enabling the participation of children and young people placed with them. While OOHC providers' understanding of the concept of participation varies, non-government OOHC providers were generally able to describe how their organisation engages and supports children and young people to be involved in decisions affecting their lives, including through the following:

- Conducting various formal collaborative processes with the CREATE Foundation (Tas) (e.g. via DCT-funded Round Table discussions).
- Developing organisational frameworks for embedding the participation of children and young people into providers' organisational practice.
- For one non-government OOHC provider, employing a Child Advocate for their residential care program (advertised in June 2019) and establishing a resident advisory panel to inform program development, policies and procedures.
- For another provider, establishing a 24/7 telephone number for children and young people to call.
- Introducing 'open door' policies which encourage children and young people to talk to managers of OOHC providers at any time.

It is difficult to assess the extent or success of these participation mechanisms and processes as there is currently no measurement tool available.

Information about the extent to which children and young people feel that these mechanisms facilitate their ability to inform decision-making has not been collected by the Monitoring Program.

5.4.2 The new Child Advocate and a proposed Visiting Program

The Commissioner welcomes the appointment of the Child Advocate for children and young people in OOHC. Commencing in July 2018 and based in the DCT, the Child Advocate's role is to provide advocacy services for and on behalf of all children and young people under the custody and/or guardianship of the Secretary of the DCT. Some OOHC providers cited the appointment of the Child Advocate as an enabler of participation for children and young people in OOHC.

However, in former Commissioner Morrissey's 2017 report on OOHC in Tasmania, he recommended the implementation of other participation mechanisms:

Recommendation Six:

Ensure that mechanisms are in place to seek out and listen to the individual voices of children and young people in the OOHC system, including by:

- a. Establishing a visiting program for individual children and young people in OOHC – which incorporates an individual advocacy component.
- b. Reviewing the CSS Policy on visiting children in OOHC and reporting publicly on compliance with it.
- c. Expediting the establishment of a Tribunal in Tasmania vested with jurisdiction that includes decisions made about children's wellbeing in OOHC.

Although in April 2018, the Tasmanian Government issued a Request for Grant Proposals (RGP) for "funding for an organisation/s to deliver the Children in

Out of Home Care Community Visitor Program (2018–2020)”, it is understood that no further action has been taken to progress this initiative.

The Commissioner has been informed by the DCT that funding for a Community Visitor Program for children and young people in OOHC has been repurposed by the DCT in association with the appointment of the Child Advocate.

Although the Tasmanian Government accepted former Commissioner Morrissey’s Recommendation 6C above in relation to establishing a Tribunal, progress implementing it is unclear.

For the reasons outlined in former Commissioner Morrissey’s 2017 review of OOHC in Tasmania and, given that children and young people generally report less favourable outcomes in residential care than those living in other types of OOHC⁷⁷, the Commissioner is of the opinion that, at the very least, a visitor program should be established for children in non-family-based residential or rostered care in Tasmania. Furthermore, such a program would provide an important means of promoting the voices of those children and young people with complex needs and/or disability who are placed with rostered carers in a house on their own.

5.4.3 Improving Case and Care Planning

In their submission on “being healthy”, the DCT acknowledged that current Case and Care Planning processes are not always effective in listening to or conveying children’s and young people’s voices:

...there is a mix of practice across the State with regard to engaging children and young people in the planning process. There are many examples of very positive practice that includes the

voice of the child in case and care planning. There are also areas where this can be improved. DCT specifically notes that feedback from the Child Advocate that some children in OOHC feel that some CSOs have not taken on board the expressed views of the child or young person.

Importantly, the DCT notes that “ongoing effort is required to improve the consistency and quality of Case and Care planning across the State”. The DCT has advised the Commissioner that this work is underway:

CYS [Children and Youth Services within the DCT] is undertaking a project to develop and improve case and care planning systems through consultation, the development and implementation of policies, procedures, tools and training, relating to high quality care and care planning in Child Safety Services [within CYS]. One of the aims of the project is to ensure that children and young people in care are actively and positively engaged, in a developmentally appropriate manner, in the development of plans regarding them.

The Monitoring Program has found, too, that some Aboriginal children and young people in OOHC have not had a Cultural Plan prepared for them, or if they have had one prepared, the Plan was often developed without ascertaining adequate knowledge of the child’s cultural identity and community connections or their views.

5.4.4 Strategies for facilitating participation in “being healthy”

In submissions provided by a range of organisations, various strategies to encourage and support children and young people to take an active interest in matters relevant to their health were described. All of these strategies are relationship-based; they entail engaging in age-appropriate and open conversations with children and young people or with their carers.

Strategies included:

- “Supporting children and young people to understand what good health is; why they are deserving of it; and how this can support them to have a successful life”.
- Approaching engagement with children and young people in OOHC with “an underlying attitude of respect and validation for their thoughts and feelings”.
- Remembering that “uncertainty and lack of information provoke feelings of powerlessness and anxiety in children and young, and that it is possible to have truthful, child-friendly conversations about difficult issues”.
- Exploring younger children’s ideas and preferences through developmentally appropriate activities such as stories, imaginative play and art.
- Conducting child-focused conversations to draw out information from children and young people about their health concerns and needs, including on sensitive subjects such as mental health, sexuality, and drug and alcohol use.
- Conducting pre-planned visits and unannounced visits to children and young people in OOHC, inviting them to talk about their health needs or concerns.
- Bringing children and young people into decision-making processes about their health care, including by engaging them in Case and Care Planning.
- Including family and foster and kinship carers in conversations, where appropriate, to provide opportunities for advocacy.

Another strategy described in submissions aimed to facilitate the participation of children and young people in OOHC generally as a means of facilitating their participation in “being healthy” specifically. This entails providing opportunities for children and young people to express their views, make complaints and provide feedback about all of their experiences in OOHC. As a young participant of the CREATE Round Table told the Commissioner, “having a say in *all* matters concerning *your* life” is important for the health of children and young people in OOHC.⁷⁸



6. Improving the OOHC system for children and young people



6.1 Overview

The previous chapter of this report identifies several opportunities for promoting and improving the participation of children and young people in out-of-home care (OOHC).

This chapter highlights additional ways in which Tasmania's OOHC system can better promote the wellbeing of the children and young people in OOHC in Tasmania, focusing on the following:

- Implementation of the Aboriginal and Torres Strait Islander Child Placement Principle (ATSICPP).
- Quality, accountability and safety of organisations, services and programs, including in the delivery of Special Care Packages (SCPs).
- Data collection, management, analysis and reporting.
- Case management for achieving wellbeing outcomes, including "being healthy".

Where appropriate, information and findings specific to monitoring activities focused on children and young people in OOHC "being healthy" are used to provide practical examples or demonstrate the issue under discussion.

6.2 Implementation of the Aboriginal and Torres Strait Islander Child Placement Principle

Background information relevant to this section can be found in Chapter 3 of this report.

6.2.1 Build on initiatives of the Department of Communities Tasmania

The Department of Communities Tasmania (DCT) has expressed a commitment to

improving implementation of the ATSICPP, recently advising the Commissioner that:

Tasmania is committed to the actions under the Fourth Action Plan of the National Framework for Protecting Australia's Children 2009-2020 and recognises that there is significant work to do in further embedding the ATSICPP.⁷⁹

The DCT has also advised that work is underway with the Secretariat of National Aboriginal and Torres Strait Islander Child Care (SNAICC) to improve child protection practice to achieve outcomes for Aboriginal and Torres Strait Islander children that keep them safe and connected to culture. In May 2019, SNAICC held a two-day workshop with the Child Safety Service (CSS) and the Tasmanian Aboriginal Corporation to identify progress and barriers to full implementation of the ATSICPP.⁸⁰

Additionally, as part of the Strong Families, Safe Kids Redesign Project, the Tasmanian Government has committed to the employment of Aboriginal Liaison Officers within the CSS to "better support and work more closely with the Aboriginal community".⁸¹ These positions are due to commence in the period October to December 2019. Further, the Commissioner has been advised that the DCT intends to develop a workplan for 2019-20 directed towards implementation of Active Efforts to embed ATSICPP with local Aboriginal communities.⁸²

However, SNAICC's report observes:

Although Tasmania is currently in the process of redesigning its child protection system, at this stage the reform documents of the Strong Families, Safe Kids initiative (and the previously completed out-of-home care reform) do not set out any reference to Aboriginal and Torres Strait Islander self-determination or any significant emphasis on Aboriginal and Torres Strait Islander participation in child protection decision-

making or system or service design and delivery.⁸³

6.2.2 Embrace Aboriginal-led responses in OOHC

The Commissioner for Children and Young People in Western Australia has called for new ways of working with Aboriginal community controlled organisations (ACCOs):

This means rather than Aboriginal people being ‘engaged’ or ‘consulted’ as ‘advisors’ or ‘co-designers’ of services and policies, they are authorised and empowered to own, direct and make strategic decisions about policies, funding and allocation of resources, program/service design, implementation and evaluation.⁸⁴

Relevantly, Victoria’s *Wungurilwil Gappagduir* (which means ‘strong families’ in Latji Latji) marks the first tripartite agreement between Victorian Aboriginal communities, the child and family services sector, and the Victorian Government. It reflects a shared commitment to improving outcomes for Victorian Aboriginal children and families, and those residing in Victoria, with aims and objectives based on the overarching principle of Aboriginal self-determination.⁸⁵

However, in its April 2018 report, SNAICC observed that the Tasmanian Government did not appear to be implementing policies which would lead to greater power, control and responsibility by Aboriginal organisations in the operation of the OOHC system:

There are no available policy documents – reform documents or otherwise, including the recent OOHC reform agenda – that commit to or promote self-determination, partnership, ACCO participation or ACCO capacity.⁸⁶

Subsequent to the publication of SNAICC’s report, in September 2019, the Tasmanian Government signed the

Closing the Gap Partnership Agreement between the Coalition of Aboriginal and Torres Strait Islander peak bodies and the Council of Australian Governments (COAG) Parties. Upon its signing, the Hon Roger Jaensch, Minister for Aboriginal Affairs, stated “this historic agreement ensures the equal participation and shared decision making by Aboriginal and Torres Strait Islander people on Closing the Gap”.⁸⁷

Aboriginal children and young people in OOHC in Tasmania who are under the guardianship of the Secretary can be placed with Many Colours 1 Direction, which is an OOHC provider located in the Northern Territory. While the Commissioner is not critical of the quality of care provided by Many Colours 1 Direction, it is evident that no equivalent placement option or program is currently available in Tasmania. Therefore, the Commissioner is of the strong opinion that the Government should facilitate and fund a therapeutic ‘on country’ residential program for Aboriginal children and young people which is delivered in Tasmania by Aboriginal people.

6.3 Establish a robust quality and accountability system

6.3.1 The Tasmanian journey towards a Quality and Continuous Improvement Framework, including agreed standards for OOHC

The DCT performs a dual role as an OOHC provider as well as the owner of the Tasmanian OOHC system. As system owner, one of its key responsibilities is to assure quality. This quality assurance role requires that there are robust monitoring and oversight mechanisms in place, including quality standards. Further, appropriate separation is required between the DCT’s two distinct functions as system owner and a provider of OOHC.

Funding Agreements provided to the Commissioner indicate that the majority of OOHC providers in Tasmania with such Funding Agreements are required to deliver services in accordance with the *National Standards for Out-of-Home Care*.⁸⁸ However, it has become apparent from monitoring activities that there is a highly variable level of understanding amongst non-government OOHC providers in Tasmania about their obligation to comply with the *National Standards for Out-of-Home Care*. The extent to which the DCT conducts formal quality assurance processes to monitor non-government OOHC providers' performance against these standards is unclear.

The Commissioner has found that there is broad support for the introduction of robust quality assurance processes, including standards that are specific to the provision of OOHC, because this would provide a consistent set of guidelines and expectations regarding the quality and standard of service delivery. Monitoring activities also indicate that, to date, quality assurance for OOHC provision in Tasmania occurs largely because of the goodwill of non-government OOHC providers, who are committed to their own quality systems, rather than as a requirement that is externally assessed or regulated. Providers with this level of commitment to quality are to be applauded, however consistency across the system is required and there is a clear need for a Quality Framework incorporating standards that are specific to the provision of OOHC in Tasmania.

In his 2017 review of OOHC in Tasmania, former Commissioner Morrissey called on the Tasmanian Government to develop and adopt standards for the provision of OOHC in Tasmania and provide regular reports on compliance with these

standards. This recommendation has been accepted by the Tasmanian Government and is reflected in two priority actions under the *Strategic Plan for Out of Home Care in Tasmania 2017 – 2019*: Priority Action 5 – “Develop an out of home care Quality and Regulatory Framework”; and Priority Action 6 – “Implement systems and processes for consistent data capture and reporting against defined standards”.

Additionally, Action #11 of the *Youth at Risk Strategy* commits the Tasmanian Government to “develop a Regulatory and Quality Framework for OOHC that meets the needs of vulnerable youth”.⁸⁹

The Commissioner was advised by the DCT in June 2019 that the development of a Quality and Continuous Improvement Framework for OOHC in Tasmania is in its final stages, however the Commissioner understands that further consultative processes are planned to progress this important work.

The Commissioner is concerned that, even after the introduction of a quality framework, delivery of OOHC services to children and young people in Tasmania will remain relatively unregulated compared to other systems providing services to Tasmanian children and young people, such as the education and early childhood education and care systems and the NDIS service system (see Box 5 on the following page).

6.3.2 The importance of independent, external oversight

Tasmania does not have a system of accreditation, registration or licensing for OOHC providers.

The Final Report of the Royal Commission emphasised the importance of independent accreditation processes for

providers of OOHC. Recommendation 12.5 states:

In each state and territory, an existing statutory body or office that is independent of the relevant child protection agency and out-of-home care service providers, for example a children’s guardian, should have responsibility for:

- a. receiving, assessing and processing applications for accreditation of out-of-home care service providers
- b. conducting audits of accredited out-of-home care service providers to ensure ongoing compliance with accreditation standards and conditions.⁹⁰

In its response to the Royal Commission, the Tasmanian Government “noted” rather than “accepted” this recommendation, stating: “the Tasmanian Government notes this recommendation has some linkages to the OOHC Foundations Project, but implementation will place an additional resource impost on the DCT, which will require further consideration”.⁹¹

Accreditation, registration or licensing systems for OOHC providers are in place in some other Australian jurisdictions, including, for example, NSW and Queensland. In NSW, the Office of the Children’s Guardian is responsible for accrediting statutory OOHC providers, based on their compliance with the NSW Child Safe Standards for Permanent Care 2015. Agencies must be accredited by the Children’s Guardian to provide statutory OOHC in NSW. According to the NSW Office of the Children’s Guardian, accreditation of OOHC providers has several benefits:

Undergoing accreditation can help agencies to:

- have a common understanding of good practice
- work towards quality improvement
- make systematic judgements about performance against standards

- encourage greater scrutiny of outcomes and quality by service users.⁹²

Box 5: NDIS Quality and Safeguarding Commission

On 1 July 2019, the NDIS Quality and Safeguards Commission (the NDIS Commission) became operational in Tasmania. The NDIS Commission is “an independent government body that works to improve the quality and safety of NDIS services and supports, investigates and resolves problems, and strengthens the skills and knowledge of providers and participants”. Once it is operational in all states and territories, the NDIS Commission will provide a single, national registration and regulatory system for providers that will set a consistent approach to quality and safety across Australia. The NDIS Commission registers providers. Registered providers will be required to comply with the NDIS Practice Standards, the NDIS Code of Conduct and requirements for incidents management, complaints management, worker screening and behaviour support including restrictive practices if applicable.

Source: NDIS Quality and Safeguards Commission, *Fact Sheet: Then and Now for Providers in TAS*, March 2019, <https://www.ndiscommission.gov.au/sites/default/files/documents/2019-03/factsheet-then-and-now-tas-final-and-accessible.pdf>

In Queensland, the *Child Protection Act 1999* provides for a system of licensing care services and approving individual carers to provide care for children and young people to ensure compliance with the Statement of Standards in the Act. The Queensland Department of Child Safety, Youth and Women is responsible for deciding applications for licenses and carer approvals, as well as monitoring ongoing compliance with licence and approval requirements.⁹³ The Government of Queensland is considering

adopting an accreditation model for authorising care service providers which would entail ongoing compliance and periodic review to ensure services continue to meet specified standards.⁹⁴

In Victoria, the Commission for Children and Young People oversees and enforces compliance by Victorian organisations that provide services or facilities for children, including OOHC, with Victoria's Child Safe Standards.

In New Zealand (NZ), the Commissioner for Children and Young People has undertaken independent monitoring of OOHC and youth justice facilities for some time. Recently, regulations for New Zealand National Care Standards were approved under the *Oranga Tamariki Act 1989* and are now in place. These standards will form the basis of a new monitoring and assessment function, which after design and implementation within government, will be transferred to the NZ Office of the Children's Commissioner for full implementation.

Given Tasmania's progress to date in developing a Quality and Continuous Improvement Framework, an opportunity now exists to consider how such a framework will be implemented, including independent, external oversight, to ensure the quality of our OOHC system is in line with recommendation 12.5 of the Royal Commission.

Introducing a system of accreditation for providers of OOHC, including the DCT, would be a significant shift from existing independent monitoring arrangements, which are systemic in nature. It is the Commissioner's view that if we are to achieve the robust, consistent approach to quality applied in other service areas such as disability care, Early Childhood Education and Care, and education, a

system such as this will be ultimately required.

A shift to a system of accreditation based on assessment of individual OOHC providers, including DCT, against an agreed set of standards, would require consideration of legislative change, well planned implementation over a suitable timeframe and sufficient resourcing. In the meantime, and at the very least, the capacity of the existing independent external oversight of OOHC currently undertaken by the Commissioner for Children and Young People could be expanded and resourced to undertake systemic monitoring based on agreed standards.

6.3.4 Moving towards a Child Safe Organisations Framework

The Royal Commission made several recommendations designed to make institutions child safe.

In February 2019, the Prime Minister and the Minister for Families and Social Services announced that all Australian Governments had endorsed the National Principles for Child Safe Organisations.⁹⁵

The National Principles give effect to recommendations of the Royal Commission relating to the child safe standards and provide guidance on key actions and performance measures in implementing the standards. They provide a nationally consistent approach to cultivating organisational cultures and practices that foster child safety and wellbeing across all sectors in Australia.⁹⁶

In *Protecting Our Children: First Year Action Plan 2018-19*, the Tasmanian Government committed to the development of options for a child safe legislative framework in Tasmania that supports the intent of the National

Principles for Child Safe Organisations and provides a plan for the implementation of the Royal Commission's recommendations relating to Child Safe Standards and a Reportable Conduct Scheme in Tasmania. This work was planned to occur in January to June 2019 however, as at the date of writing, was under development

Recommendation 6.10 of the Royal Commission calls for monitoring and enforcement of child safe standards to be undertaken by an independent oversight body:

State and territory governments should ensure that:

- a. an independent oversight body in each state and territory is responsible for monitoring and enforcing the Child Safe Standards. Where appropriate, this should be an existing body.
- b. the independent oversight body is able to delegate responsibility for monitoring and enforcing the Child Safe Standards to another state or territory government body, such as a sector regulator.
- c. regulators take a responsive and risk-based approach when monitoring compliance with the Child Safe Standards and, where possible, utilise existing regulatory frameworks to monitor and enforce the Child Safe Standards.

The Tasmanian Minister for Human Services, the Hon Roger Jaensch MP, advised in June 2019 that:

We have started the work to establish a legislated child safe organisations framework which will span from organisational leadership through to policy and procedures that govern service delivery, responses to incidents and continuous improvement. The overall intent is to develop a legislative framework that will give effect to the progressive implementation of child safe standards, compliance regimes and a reportable conduct scheme.⁹⁷

The Child Safe Organisations Framework will apply to all organisations which work with children or young people, including schools, sporting organisations and OOHC providers. In relation to the National Principles for Child Safe Organisations, the Minister for Human Services advised the House of Assembly Estimates Committee A in June 2019 that:

the DCT is currently assessing all options for independent monitoring and enforcement and a timeline for establishing external oversight and monitoring with service providers.⁹⁸

There are obvious linkages between the development of the Child Safe Organisations Framework in Tasmania and the development of a Quality and Continuous Improvement Framework for OOHC. The Commissioner's view is that the standards contained within the new Quality and Continuous Improvement Framework should include a child safe standard which reflects the National Principles.

6.3.5 Effective communication between the system owner and OOHC providers

The DCT has an important role in setting clear expectations for the quality of services provided to children and young people in OOHC, including through conveying policy and practice guidance to contracted non-government OOHC providers.

The Monitoring Program has found that the DCT and non-government OOHC providers are motivated to develop and maintain good communication with each other, especially in relation to individual children. As one non-government OOHC provider has commented, "we all know it is a challenging space. Creating ideas and solutions together is important". Some providers have reported favourable

experiences of collaborative effort and close communication with the DCT's staff, especially in the North West of the state. However, communication issues between the DCT and non-government OOHC providers are frequent and a source of concern amongst providers – with most wanting to see communication improve.

Funding Agreements provided to the Commissioner during the monitoring cycle included a requirement that non-government organisations providing OOHC placements during the monitoring cycle ensure their practice is consistent with CYS policies, including the Child Protection *Practice Manual* (the Manual). However, during monitoring activities it became apparent that the Manual – which contains the policy and practice advice governing the care of children and young people in the child safety system, including OOHC – is not readily available to all contracted non-government OOHC providers, or if it is, providers are not aware of how to access it.

Consequently, non-government OOHC providers have varying understandings of the DCT's requirements; in some cases, providers rely on their own organisation's policies and practices or seek one-off guidance from the DCT when a specific matter arises. Many non-government OOHC providers also noted variable interpretation and implementation of policies by CSS staff – resulting in inconsistencies between the three regions of the state, and in some cases, within regions.

Children and young people living in non-family-based care placements with non-government OOHC providers report facing lengthy waits for approvals from the DCT for relatively insignificant matters, including permission to buy recreational items such as bicycles, to stay overnight

with friends or dye their hair. Examples were also provided of children and young people facing lengthy waits for approvals from the DCT for permission to attend school excursions, sometimes resulting in children missing excursions. These findings are consistent with the issues identified in Anglicare Tasmania's research into educational challenges in foster care.⁹⁹ These types of everyday requests are to be expected from children and young people, and all efforts should be made by the DCT to respond to them within a reasonable timeframe.

Inconsistencies in practice and difficulties ascertaining information about policies and practice are cited by non-government OOHC providers as creating challenges in care provision at key times (for example, during an emergency placement or when a crisis arises requiring approval from the DCT to expend additional funds to meet the extraordinary needs of a child or young person).

“These types of everyday requests are to be expected from children and young people, and all efforts should be made by the DCT to respond to them within a reasonable timeframe.”

Non-government OOHC providers have reported that the DCT's staff members are not always available to communicate with them or to assist them with decision-making during a crisis with a child or young person. Examples were provided to the Commissioner of the DCT's staff members not returning urgent phone messages or being unable to provide effective direction to a provider during a crisis, particularly one that occurred outside normal working hours. During

these situations, confusion about responsibilities constrains effective risk management, which at times poses significant risks to: (a) the safety and wellbeing of the child or young person, paid staff members, foster carers or members of the public; and (b) property owned by the provider, other organisations, foster carers or members of the public.

6.4 Review and strengthen the administration of Special Care Packages

6.4.1 Non-government OOHC providers' views of Special Care Packages

Chapter 2 of this report contains general information about the provision of OOHC through SCPs. Through monitoring activities, the Commissioner has been made aware of several concerns held by some non-government OOHC providers about SCPs. Some of these concerns are directly referable to the fact that, in some cases, OOHC is being delivered via SCPs without the benefit of an overarching funding agreement between the DCT and the non-government OOHC provider, leading to a lack of clarity for providers about the DCT's expectations and uncertainty about the basis upon which they are engaged to provide services via SCPs.

The specific issues this raises for non-government providers in their day-to-day work include:

- Inconsistencies in the way SCPs are administered across providers and wide variations in the costs of SCPs charged by providers, including instances in which providers have not received the DCT's formal acceptance of their quotes or feedback on

therapeutic plans, as well as providers sometimes experiencing significant delays in disbursements of funds by the DCT.

- Some non-government OOHC providers advised the Commissioner that they were unsure of the policies, procedures and guidelines applicable to the provision of OOHC through SCPs and were unsure about who to contact in the DCT for assistance.
- The DCT sometimes provides insufficient information to a non-government OOHC provider about a child or young person upon referral under an SCP.

The issue of risk was also raised as a concern by non-government OOHC providers in terms of assessing and managing risk for children and young people with highly complex needs, as well as risks to staff working with them. Some non-government OOHC providers indicated that their assessment of risk is constrained by a lack of clarity regarding which organisation is responsible in high-risk situations (i.e. the OOHC provider or the CSS).

Non-government OOHC providers identified staff recruitment as a challenging aspect of their work, with concerns raised about the qualifications and experience of staff, particularly in relation to working with and supporting children and young people with complex trauma-based behaviours.

Other issues and concerns include: difficulty in accessing houses on the private rental market and the quality of houses being used by non-government OOHC providers; step-down options from SCPs frequently not being available; and some children and young people entering the care of a non-government provider for

disability respite care and then being transitioned to a SCP on an ad hoc basis.

Non-government OOHC providers also indicated there was a degree of confusion and complexity regarding the provision of supports and services to children and young people in OOHC with disability, noting limitations on supports that can be funded through the NDIS.

Non-government OOHC providers did however also acknowledge that there have been some good outcomes achieved for children and young people in receipt of SCPs, and the size of the funding delivered to individual children via SCPs was noted as an enabler for achieving outcomes for some of the wellbeing domains.

6.4.2 Build on work to improve the delivery of OOHC via SCPs

Information in briefings provided by the DCT indicate that the DCT is strengthening the oversight and monitoring of the delivery of SCPs, including by:

- Aligning SCP funding arrangements with the Department of Communities Tasmania Grants Governance processes.
- Extending the DHHS Quality and Safety Requirements for Funded Community Service Organisations to Service Providers of SCPs.
- Implementing quality and financial scrutiny of individual SCPs to ensure services quoted are delivered and align with the agreed therapeutic plan. The Australian Childhood Foundation has been contracted by the DCT to conduct independent reviews of the delivery of SCPs.
- Implementation of strategies to manage the demand for SCPs

including a focus on reunification and increasing capacity of government and non-government family-based care providers.

- Direct invoice funding arrangements for providers of OOHC services including through SCPs to include the completion of audited acquittals of funding expenditure.

The Commissioner also understands that other initiatives designed to improve the DCT's purchasing and monitoring of services generally will apply to SCPs.

Further, the DCT is committed to improving service provision to children and young people with highly complex needs to reflect best practice.¹⁰⁰ The Minister for Human Services, the Hon Roger Jaensch MP said in the 2019-20 Budget Estimates Committee A hearing:

We have made a commitment to have a close look at the way that these most complex cases are managed in the future and to take advantage of best practice and changes that are underway in other jurisdictions in Australia and overseas. The complexity of costs of servicing these most complex cases are increasing and the number of them is increasing. That is happening everywhere, not just here. To meet the needs and expectations of how we look after those kids here in the future we have to work out how to do that in the best interests of the kids with better outcomes but also in a manner in which we can have greater control over our costs so that that we can deal with more of them as they arise This includes looking at other models internationally and interstate and step-down approaches to reintegrate these children back into their communities. Services that are being considered are more effective and less intensive than the highly supported 24/7 rostered care. This work will inform future funding needs in future years.¹⁰¹

The Commissioner notes that it is important that decisions regarding the placement of a child on a SCP reflect the

needs and best interests of the child, rather than the cost of the SCP compared to other options.

6.4.3 Strengthen inter-agency collaboration for children and young people in OOHC

Given the requirement for specialised care with highly intensive wrap-around services for some children and young people with complex needs in OOHC, there is a need for increased cross-agency collaboration to better support this cohort to achieve positive wellbeing outcomes. The Commissioner acknowledges existing cross-agency collaboration between the DCT and the DoE for children and young people in OOHC in Tasmania¹⁰² and notes that in its *Strategic Business Plan for 2018-19*, CYS, lists one of its “critical areas of medium to long term focus” as: “multidisciplinary (cross agency) case plans and support for children, young people and their families”.¹⁰³ However, further cross agency collaborative work is needed to ensure that all aspects of a child or young person’s wellbeing is supported and addressed.

Commissioner Morrissey emphasised cross-agency collaboration in his exploration of the role of the corporate parent in his 2017 report into OOHC, stating:

The imperative for the State as the ‘corporate parent’ is to move from ‘worker’ thinking to ‘as a good parent’ thinking, to consider how the child is, what the child thinks and aspires to, what brings meaning to the child’s life and what the child finds important and hopes for. This will require a deep human empathy and respect for the child whom, we as a community (the State) have taken on as we would our own child. With all of the responsibilities this entails.¹⁰⁴

The notion of greater cross-agency collaboration for ensuring the wellbeing of children and young people in OOHC has

been formalised in other countries through re-defining the role of the corporate parent through legislation. As explained by the Children and Young People’s Commissioner Scotland:

In simple terms, a corporate parent is intended to carry out many of the roles a loving parent should. While they may not be able to provide everything a parent can, but they should still be able to provide the children and young people they’re responsible for with the best possible support and care.¹⁰⁵

Corporate parenting is now enshrined in Part 9 of the *Children and Young People (Scotland) Act 2014*. The Act names organisations with statutory corporate parenting responsibilities for children in OOHC and describes accountability mechanisms.¹⁰⁶

Schedule 4 of the Act lists the Corporate Parents in Scotland, including the Scottish Ministers, the Commissioner for Children and Young People in Scotland, the Police, and health and welfare agencies.

Likewise, the New Zealand *Children’s Act 2014*, amended by *the Children’s Amendment Act 2018* assigns responsibilities to:

“children’s Ministers” – *children’s Ministers* means the Ministers of the Crown who for the time being —

- (a) have relevant portfolio responsibilities for 1 or more of the children’s agencies (but excluding all related Associate Ministers of the Crown, if any); or
- (b) are designated by the Prime Minister as children’s Ministers for the purpose of this Part

“children’s agencies” – children’s agencies means those departments of State or instruments of the Crown that are, with the authority of the Prime Minister, for the time being responsible (alone, or with 1 or more other departments or instruments) for the administration of all or

any provisions of 1 or more of the following Acts:

- (a) *Domestic Violence Act 1995*
- (b) *Education Act 1989*
- (c) *New Zealand Public Health and Disability Act 2000*
- (d) *Oranga Tamariki Act 1989*
- (e) *Policing Act 2008*
- (f) *Social Security Act 2018*
- (g) any other Act or Acts for the time being prescribed under subsection (2).¹⁰⁷

It is the Commissioner's view that mechanisms similar to those described above are worthy of consideration in Tasmania, to effectively share legislated responsibility and accountability for the wellbeing of children and young people in OOHC.

6.5 Data collection and reporting for the OOHC system

6.5.1 Develop an Outcomes Framework for OOHC

Improving outcomes for children and young people in OOHC is a focus of ongoing national and state reform initiatives. At the national level, the Commonwealth, state and territory governments have committed to improving outcomes for children and young people in OOHC under the *National Framework for Protecting Australia's Children 2009-2020*¹⁰⁸ including specific actions under its *Fourth Action Plan 2018-2020*.¹⁰⁹

At the state level, delivering better outcomes for children and young people in OOHC is also a priority area under the Strong Families, Safe Kids Redesign Project, associated OOHC Foundations Project reforms and through implementation of the *Strategic Plan for Out of Home Care in Tasmania 2017-2019*.¹¹⁰

In response to Recommendation 7B of Commissioner Morrissey's report, the

Tasmanian Government has developed an outcomes framework specific to children and young people in OOHC in Tasmania. The *Outcomes Framework for Children and Young People in Out of Home Care Tasmania* ('the OOHC Outcomes Framework') was released by the DCT in October 2018, using the wellbeing domains in the *Tasmanian Child and Youth Wellbeing Framework*.¹¹¹

The *OOHC Outcomes Framework* is seen by the Tasmanian Government as "the first step in improving care to children and young people because it establishes clear expectations of what successful out of home care looks like".¹¹² The rationale for the *OOHC Outcomes Framework* is that "outcomes for children and young people in out of home care should be the same for any child in the community and they have the right to the same expectations and hopes for their lives and future".¹¹³ A primary objective of the *OOHC Outcomes Framework* is "to provide a means to monitor and report on how the outcomes for children and young people in out of home care change over time. It will identify areas of strength as well as those which require further improvement".¹¹⁴

Outcome indicators and the process for monitoring and reporting on the *OOHC Outcomes Framework* will be included in a companion document which is currently being developed by the DCT. The *OOHC Outcomes Framework* and its companion document will provide an important accountability mechanism alongside the Quality and Continuous Improvement Framework. As such, the Commissioner encourages the DCT to finalise these indicators and detail the processes for reporting against the indicators as soon as possible.

6.5.2 Develop providers' capacity to measure wellbeing outcomes

In the absence of a set of indicators to measure outcomes for children and young people in OOHC, the Commissioner sought to determine whether and how OOHC providers measure outcomes for children and young people who are in their day-to-day care.

In the CCYP questionnaires, the Commissioner asked OOHC providers for information about how they measured outcomes for children and young people based on the six domains of the *Tasmanian Child and Youth Wellbeing Framework*:

- Being loved and safe
- Having material basics
- Being healthy
- Learning
- Participating
- Having a positive sense of culture and identity.

The Commissioner's monitoring activities found that data collection mechanisms vary amongst non-government providers, from manual methods in Excel spreadsheets to more sophisticated client management systems which are custom designed and built and cloud-based.

The collection of wellbeing outcomes data for children and young people in OOHC, framed around the domains of the *Tasmanian Child and Youth Wellbeing Framework*, was noted by OOHC providers as a data gap. OOHC providers reported that they collect very little evidence of achievement of outcomes across the wellbeing domains. While OOHC providers hold a large volume of data about the children and young people in their care, these data are not always systematically collected or readily

accessible. For example, information may be recorded in case notes, Care Team Meeting minutes, Case and Care Plans or internal reporting mechanisms such as checklists, audits and critical incident reports. However, due to its format, these data are not easily extracted for analysis or reporting purposes and it is unclear whether they are analysed by providers. Responses of providers to questions about their collection of wellbeing outcomes data also varied according to the wellbeing domain in question.

Overall, OOHC providers indicated an openness to further develop methods to ascertain and measure the wellbeing outcomes of children and young people in their day-to-day care. The Commissioner notes that some providers are in the process of improving and upgrading their data collection capabilities, particularly in relation to outcomes data.

6.5.3 Strengthen the capacity of the Department of Communities Tasmania to provide data to the Commissioner

Ensuring that data on the wellbeing outcomes of children and young people is collected, analysed, used and reported upon is a key responsibility of the DCT and is also foundational to its oversight role as system owner.

Regular access to reliable data is also essential to the performance of the Commissioner's OOHC Monitoring Program. In his 2017 review of OOHC, former Commissioner Morrissey called on the Tasmanian Government to:

Establish independent external oversight and monitoring of the OOHC system, including by providing the Commissioner for Children and Young People with six-monthly reports on compliance with Standards and other agreed indicators of the wellbeing of children and young people in the OOHC system in Tasmania.

In early 2018, Interim Commissioner Clements commenced discussions with the DCT about the provision of quarterly data reports to the Commissioner, which would include data on OOHC wellbeing outcomes. Although some progress has been made in establishing this regular flow of data, reports provided to the Commissioner during the monitoring cycle from 1 July 2018 to 30 June 2019 were incomplete.

Three observations can be made about this:

- As set out in *Children, Young Persons and Their Families Act 1997 (Tas)*, where orders provide for the Secretary of DCT to be the guardian of a child or young person, the Secretary is ultimately responsible for the wellbeing of that child or young person. For the Secretary to exercise this responsibility, the DCT needs to have a base level of knowledge about the wellbeing of each child and young person in OOHC. While this information might reside with individual staff members employed by either the DCT or non-government OOHC providers, or be collected in individual case files, it is desirable that the DCT holds this knowledge in a more comprehensive, accessible and systemic manner.
- As the system owner, the DCT is ultimately responsible for ensuring that the services it contracts or provides to children and young people in OOHC contribute to the achievement of positive wellbeing outcomes for those children and young people. Having knowledge of wellbeing outcomes for children and young people is a necessary precursor to the performance of this oversight role.

- Given that the DCT is a direct provider of OOHC services, it has a self-evident responsibility to be knowledgeable about the wellbeing of the children and young people who are directly in receipt of its services.

6.5.4 Strengthen the capacity of the Department of Communities Tasmania to measure health outcomes

The Commissioner's monitoring has found that the DCT also has significant data gaps relevant to the health of children and young people in OOHC. The Commissioner acknowledges that while better reporting and health outcomes for children in OOHC should be progressed, care must be taken to ensure such reporting does not identify, either directly or indirectly, any child.

In their submission, the DCT advised the Commissioner that it prepares an Out of Home Care Outcomes Indicator Report which includes data on immunisations, oral health, hospital admissions, and referrals to CAMHS and to Alcohol and Other Drug Services for children on guardianship and custody orders. The DCT advised that:

While it may be reasonable to assume that all children and young people in OOHC have experienced personal trauma to some degree, the Tasmanian data is inadequate to support this assumption, and/or to respond reliably to the questions as to physical and mental health conditions that most impact the OOHC cohort.

In the DCT's responses to both of the Commissioner's questionnaires, the DCT acknowledged that "a lack of data on the health attributes of children in care" hinders the DCT's achievement of health outcomes for children and young people in OOHC care.

The Commissioner's consideration of other potential sources of data on the health of children and young people in

OOHC in Tasmania has also revealed significant gaps in data collection, analysis, use and reporting. The Tasmanian DoH is a potentially useful source of data for this cohort, however DoH advised in their submission that:

Children and young people in OOHC constitute a sub-group of Tasmania's population which is not separately identified in published data or in data collected by Public Health Services (PHS). Data sources relevant to the "being healthy" domain of the OOHC monitoring program are likely limited to data collected by service providers in the OOHC system.

Another potential source of health data on children and young people in OOHC is the data collected by the Tasmanian Government for the Australian Institute of Health and Welfare (AIHW) via its national survey of the views of children and young people in OOHC. The Second National Survey, conducted in 2018, covered eight indicators from the *National Standards for Out-of-Home Care*, but these data were only available at the national level, and none of the indicators relate to health at this stage.¹¹⁵

Additionally, the OOHC Clinic is planning to undertake research to assess and report on the outcomes of children and young people in OOHC who attend the clinic, but early data is not yet available. Non-government sources of data about the health of children and young people in OOHC include the CREATE National Survey, released in March 2019, although this data is mostly reported at the national level.¹¹⁶

The lack of health data on children and young people in OOHC – whether from non-government OOHC providers or Government – is consistent with an overall lack of health data on children and young people in the general population of Tasmania. In this regard, the DoH

advised the Commissioner that: "currently, with the exception of immunisation data collected by Public Health Services, the National Health Survey is the only source of data for Tasmanian children and young people for nutrition, physical activity and selected chronic conditions".

6.6 Strengthen case management for achieving outcomes, including "being healthy"

6.6.1 Clarify responsibilities and focus on relationships

Several submissions noted that the DCT's case management practices are, at times, hindering achievement of favourable wellbeing outcomes for children and young people in OOHC, including for "being healthy".

Submissions to the Commissioner called for greater delineation between the roles and responsibilities of CSOs, OOHC providers and carers in relation to organising health care for children and young people in OOHC. Responsibility for initiating and coordinating health care currently resides with the DCT (given its case management role) thus limiting the extent to which non-government OOHC providers can access medical treatment for a child or young person placed with them. According to submissions, this arrangement can lead to missed health care appointments, poor continuity of care, incomplete immunisation status and underdiagnosis or misdiagnosis of mental health conditions for children and young people in OOHC.

The quality and salience of the information contained in Case and Care Plans has been raised as a concern, with non-government OOHC providers advising that many Case and Care Plans are significantly incomplete or out-of-date. On

some occasions, non-government OOHC providers have accepted a child or young person into their day-to-day care without knowing crucial information about them, such as their cultural identity, medical needs or any contact arrangements with family, let alone their views and preferences. These findings are consistent with data reported at a national level: for the period 2017-18, the DCT reported that only 55.1 per cent of children in OOHC in Tasmania had a current documented case plan (i.e. that had been reviewed or approved in the previous 12 months).¹¹⁷

At the CREATE Round Table held in April 2019, young people in OOHC emphasised the importance of improving case management for their health and wellbeing. In particular, these young people identified the need for regular and ongoing visits by case workers who would:

- (a) check on their health and safety of a child or young person in care, and view the condition of their homes; and
- (b) develop a relationship with the child or young person, so that the child knows that “they have someone there for them”.¹¹⁸

The importance of establishing trust between young people and their workers was raised several times during the Round Table. These young people wanted to know that their case worker “won’t be leaving anytime soon” and they will maintain confidentiality when appropriate: “if a kid tells you something and they are not in danger, keep it confidential”. Suggestions were made for improving the quality of CSOs’ relationships with young people, including: “having more time and listening to what the young person is saying”; “making sure they do come over every few weeks”; and

doing fun things with them, such as eating out.¹¹⁹

6.6.2 Consider placement stability and relational permanency

Both the *National Standards for Out-of-Home Care* and the *Fourth Action Plan 2018-2020* of the National Framework for Protecting Australia’s Children underline the importance of placement stability for children and young people in OOHC (see Box 6). Multiple, short-term or unsuitable placements, along with multiple failed reunification attempts, were identified in some submissions to the Commissioner as an exacerbating factor for poor health outcomes for children and young people in OOHC. According to some submissions, these types of placements are associated with developmental delay, learning difficulties, emotional and behavioural difficulties, self-harm, anxiety, sleep

Box 6: Stability in the National Standards for Out-of-Home Care and the Fourth Action Plan

National Standards for Out-of-Home Care

Standard 1: Children and young people will be provided with stability and security during their time in care.

What this means: Children and young people living in out-of-home care are to experience security, stability, continuity of relationships and social support. These are vital to healthy emotional development and provide strong predictors of better outcomes for children.

Fourth Action Plan 2018-2020 of the National Framework for Protecting Australia’s Children 2009-2020

Priority Area 3: Improving outcomes for children in out-of-home care by enhancing placement stability through reunification and other permanent care options.

problems and substance abuse for children and young people in OOHC.

Unsuitable or unsafe placements, in which children and young people are placed with children exhibiting problem sexual behaviour or sexually abusive behaviour, may also contribute to poor health outcomes, as these placements are thought to increase the risk of children or young people being abused or engaging in problem sexual behaviour or sexually abusive behaviour themselves. (Refer to the Glossary for definitions.)

At the CREATE Round Table, young people in OOHC told the Commissioner that not having to move homes repeatedly and maintaining daily routines for meals, hygiene and sleep were significant factors affecting their overall health and wellbeing. As noted by one young person, achieving this kind of placement stability within OOHC would require “not moving the child at the first inconvenience”.¹²⁰

Additionally, frequent changes of placement and corresponding changes in place of residence for children and young people in OOHC may make it difficult to maintain continuity of care with a local General Practitioner (GP) or to access a new GP in their new location. As advised in a submission to the Commissioner, this has flow-on effects, characterised by reduced referrals to allied health and paediatric specialist care and also “greatly increases the risk of fragmented care, with health issues and emerging problems going untreated or there being a significant delay in treatment”.

Several submissions underlined the value of “relational permanency” for children and young people in OOHC, which is achieved by promoting connections across families and care contexts and ensuring the maintenance of sibling and other family

relationships. As one submission noted, “relationship permanency for children in OOHC needs to be deliberately cultivated”. This view is supported by the Royal Australian and New Zealand College of Psychiatrists – in their Position Statement on the mental health needs of children in OOHC, they linked stability and security with mental health outcomes for this cohort, recommending that: “there should be timely decision making in relation to the best interests of children in OOHC and their need for stability and security in their environment”.¹²¹

In fulfilment of the Tasmanian Government’s election commitment to strengthen the “permanence of placement process”, the Government is currently developing a *Permanency Framework* which will “define the suite of care arrangements that will best support positive, long-lasting relationships and connections for all children and young people that come into contact with, or are in the CSS system, including Aboriginal and Torres Strait Islander children”.¹²²

6.6.3 Ensure personal health information is shared as necessary

Several submissions identified either the absence or inadequacy of health information about children and young people in OOHC as a significant issue for maintaining continuity of health care, achieving positive health outcomes and adequately managing acute health risks.

This particularly arises upon intake to OOHC and when children and young people transition between providers (refer to Box 7 on the following page). Delays with the provision of the child or young person’s Medicare cards to carers for payment of health care can extend for weeks or months, frequently leaving carers out of pocket.

Box 7: Frequently missing health information

- Diagnoses
- Allergies, including anaphylaxis
- Medication regimens
- Family medical history
- CHaPS (Blue) Book
- Immunisation records
- GP name and details
- Mental health assessment reports
- Medicare card
- Health care card

Standard 5 of the *National Standards for Out-of-Home Care* includes an expectation that children and young people will have their own written health record (refer to Box 8).

The roll-out of the MyHealth Record electronic health system may improve sharing of critical health information for children and young people in OOHC in Tasmania, with the DCT advising the Commissioner that the MyHealth Record is being implemented for children in care under the age of 14 years who are under the guardianship of the Secretary.

6.6.4 Ensure health assessments are conducted in a timely manner

Submissions consistently noted that health assessments for children and young people in OOHC are not always conducted in a timely manner. Participants at a stakeholder forum about “being healthy” in OOHC (which was arranged by the Mental Health Council of Tasmania (MHCT) and the Tasmanian Council of Social Services (TasCOSS) to inform their submission to the Commissioner) noted that, in the North and North West of Tasmania, where the OOHC clinic does not operate, paediatric assessments of children and young people entering care are sometimes

delayed and are sometimes not conducted at all.

Submissions reported that children and young people in OOHC face long waiting lists for paediatric developmental behavior appointments and for both urgent and non-urgent paediatric ear, nose and throat treatment.

The importance of timely health assessments for children and young people in OOHC is reflected in Standard 5 of the *National Standards for Out-of-Home Care* (refer to Box 8).

Box 8: Health assessments in the National Standards for Out-of-Home Care

Standard 5: Children and young people have their physical, developmental, psychosocial and mental health needs assessed and attended to in a timely way.

What this means: The child or young person’s physical, developmental and psychosocial and mental health needs are to be identified in a preliminary health check. Children and young people are to have their own written health record which moves with them if they change placements.

The DCT acknowledged to the Commissioner that missed or delayed health assessments for children and young people in OOHC pose a risk to their health, noting that:

...children and young people in OOHC in Tasmania are not routinely subject to comprehensive health and mental health screening, assessment and regular ongoing monitoring. As a result, not only can emerging health conditions go undetected, and need unmet, the opportunity for early intervention is lost.

Many submissions to the Commissioner called for the provision of assessment services for all children and young people upon entry to OOHC, regardless of where in the state they reside, which would include: hearing, vision and dental assessments, medication reviews, immunisation screening and speech assessments, as well as psychological or psychiatric health assessments with regular review periods.

Conclusion

During the course of monitoring activities, it became apparent to me that there are many individuals who are passionate about and committed to promoting the wellbeing of children and young people in OOHC in Tasmania. I wish to acknowledge and convey my thanks and appreciation to all those who care for, provide support and assistance to, or advocate for, the rights and interests of children and young people in OOHC in Tasmania.

I also wish to convey my thanks to the organisations – government and non-government – and individuals, who made submissions on matters covered in this report, who responded to my requests for information or data, or in other ways contributed to this report.

I have been particularly privileged to be able to meet and talk with children and young people in our OOHC system.

My planning for the next cycle of my independent, external monitoring of the OOHC system is now underway. As I move into the next OOHC monitoring cycle, my planning and monitoring activities will be informed by what I have learned in the first monitoring cycle and by my ongoing engagement with children and young people, their carers, OOHC providers, advocacy organisations and other key stakeholders including Tasmanian government agencies.

I sincerely hope that my findings and recommendations contribute to our collective efforts to promote positive wellbeing outcomes for all children and young people in OOHC in Tasmania.

Leanne McLean
Commissioner for Children and Young People Tasmania

Appendix 1: Recommendations made by former Commissioner Morrissey¹²³

One: Prioritise the development of a strategic plan and implementation plan for the OOHC Reform. Ensure the strategic plan incorporates strong governance and oversight.

Two: More closely integrate the OOHC Reform and the CPS Redesign, and provide the resourcing required for successful and ongoing implementation, including by providing dedicated funding for implementation teams.

Three: Establish an independent expert oversight committee to provide assistance and guidance to those implementing the child protection and OOHC reforms, accompanied by robust reporting arrangements on progress.

Four: Establish an ongoing consultative panel of young people who have had experience of the OOHC and child protection systems, and who are therefore well-placed to contribute directly to the reform processes.

Five: Establish independent external oversight and monitoring of the OOHC system, including by providing the Commissioner for Children and Young People with six-monthly reports on compliance with Standards and other agreed indicators of the wellbeing of children and young people in the OOHC system in Tasmania.

Six: Ensure that mechanisms are in place to seek out and listen to the individual voices of children and young people in the OOHC system, including by:

- A. Establishing a visiting program for individual children and young people in OOHC – which incorporates an individual advocacy component.
- B. Reviewing the CSS Policy on visiting children in OOHC and reporting publicly on compliance with it.
- C. Expediting the establishment of a Tribunal in Tasmania vested with jurisdiction that includes decisions made about children’s wellbeing in OOHC.

Seven:

- A. The Tasmanian Government develop and adopt Standards for the provision of OOHC in Tasmania and provide regular reports on compliance with these Standards.
- B. Noting the work currently being undertaken on child wellbeing as part of the Child Protection Redesign, the Tasmanian government also develop an Outcomes Framework specific to children and young people in OOHC in Tasmania

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