Chapter 6

Out-of-home care models and supports

> There is a particular onus on us, as an Australian society when we have taken over responsibility for that child…it is important to make sure that we take that responsibility for fewer children because we have invested a lot more a lot earlier to prevent that large number—an increasingly large number—coming into the care and responsibility of the State but, when we do, it then becomes absolutely imperative that we provide the best quality care, which really is dependent on having the best supports for those carers.[1] Dr Daryl Higgins, Melbourne hearing, 20 March 2015

6.1 This chapter examines the following terms of reference:

> (c) current models for out of home care, including kinship care, foster care and residential care;
>
> (e) consistency of approach to out of home care around Australia;
>
> (f) what are the supports available for relative/kinship care, foster care and residential care; and
>
> (g) best practice in out of home care in Australia and internationally.

6.2 As discussed in Chapter 4, children and young people in out-of-home care have a range of complex needs, requiring a greater level of support. The committee heard that across jurisdictions, the existing models of care do not consistently support these needs.

6.3 This chapter assesses models of delivery and support for the three main forms of care (foster, relative/kinship and residential care) across jurisdictions and makes suggestions for changes based on best practice examples. It assesses specific issues for each type of care, as well as cross jurisdictional issues that affect all care types.

6.4 Specific models of care for Aboriginal and Torres Strait Islander children will be examined in Chapter 8. Specific models of care for children with disability and other groups will be examined in Chapter 9.

Types of care

Numbers of children and young people

6.5 As noted in Chapter 1, the three main types of out-of-home care are relative/kinship care, foster care and residential care. In 2012-13, these three types of care accounted for around 96 per cent of children and young people in out-of-home care. Most children were in relative/kinship (47.9 per cent) and foster care (42.6 per cent) placements, with a significantly smaller proportion in residential care (5.5 per cent).[2] Table 6.1 shows the breakdown of children and young people by type of care

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1 Dr Daryl Higgins, Deputy Director, Research, Australian Institute of Family Studies (AIFS), *Committee Hansard*, Melbourne, 20 March 2015, p. 3.

2 Australian Institute of Health and Welfare (AIHW), *Submission 22*, Table 6.

at 30 June 2013. Table 6.2 shows the proportion of children in the three main types of care across jurisdictions at 30 June 2013.

Table 6.1 – Children in out-of-home care, by type of placement, states and territories, 30 June 2013

Type of placement	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Foster care	7,091	2,069	4,492	1,465	1,102	445	209	399	**17,272**
Relative/kin	9,730	3,248	3,026	1,619	1,190	303	291	19*****	**19,426**
Other home-based care	0	695	0	0	6	235**	20	202	**1,158**
Total home-based care	*16,821*	*6,012*	*7,518*	*3,084*	*2,298*	*983*	*520*	*620*	***37,856***
Family group homes	19	0	0	191	N/A	22	0	4	**236**
Residential care	480	495	618	150	330	25	38	75	**2,211**
Independent living	93	33	0	0	29	5		2	**162**
Unknown	9	2	0	0	N/A	32	0	41	**84**
Total	**17,422**	**6,542**	**8,136**	**3,425**	**2,657**	**1,067**	**558**	**742**	**40,549**

* In the NT's client information system, the majority of children in a relative/kinship placement are captured in the foster care placement type.

** In Tasmania, children under third party guardianship orders are counted under 'other-home based care'.

Source: AIHW, Submission 22, Table 6.

Table 6.2 – Proportion of children in main types of care, 30 June 2013

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Foster care	40.7	31.6	55.2	42.8	41.5	41.7	37.5	53.8	42.6
Relative/kin	55.8	49.6	37.2	47.3	44.8	28.4	52.2	2.6*	47.9
Residential care	2.8	7.6	7.6	4.4	12.4	2.3	6.8	10.1	5.5
Other	0.7	11.2	0.0	5.5	1.3	27.6	3.5	33.5	4.0

* In the NT's client information system, the majority of children in a relative/kinship placement are captured in the foster care placement type.

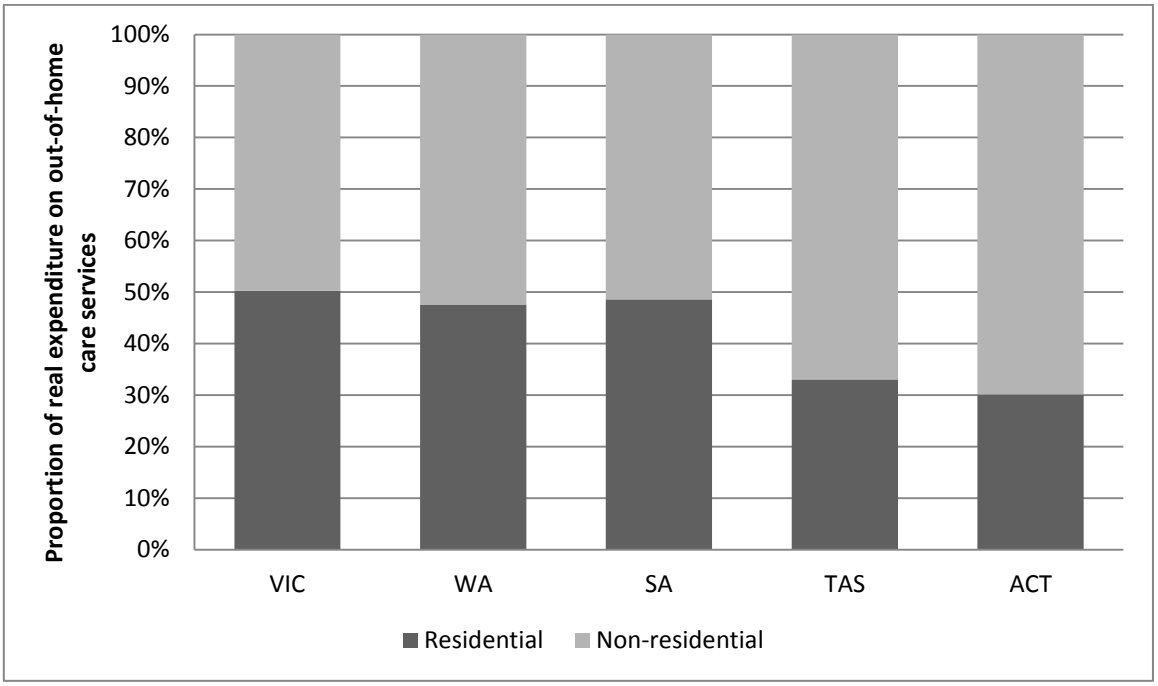
Source: AIHW, Submission 22, Table 6.

Funding for types of out-of-home care

6.6 Despite residential care placements accounting for just 5.5 per cent of children in care nationally, in some jurisdictions, expenditure on residential care accounts for over half of all expenditure on out-of-home care services.[3]

6.7 Data collected by the Productivity Commission on annual real expenditure by type of care (available for Victoria, WA, SA, Tasmania and the ACT only) indicates that expenditure on residential care is significantly higher than non-residential care (relative/kinship care and foster care). Figure 6.1 shows the proportion of spending on residential and non-residential out-of-home care across jurisdictions for 2013–14.

Figure 6.1 – Proportion of real expenditure on residential and non-residential care, 2013/14



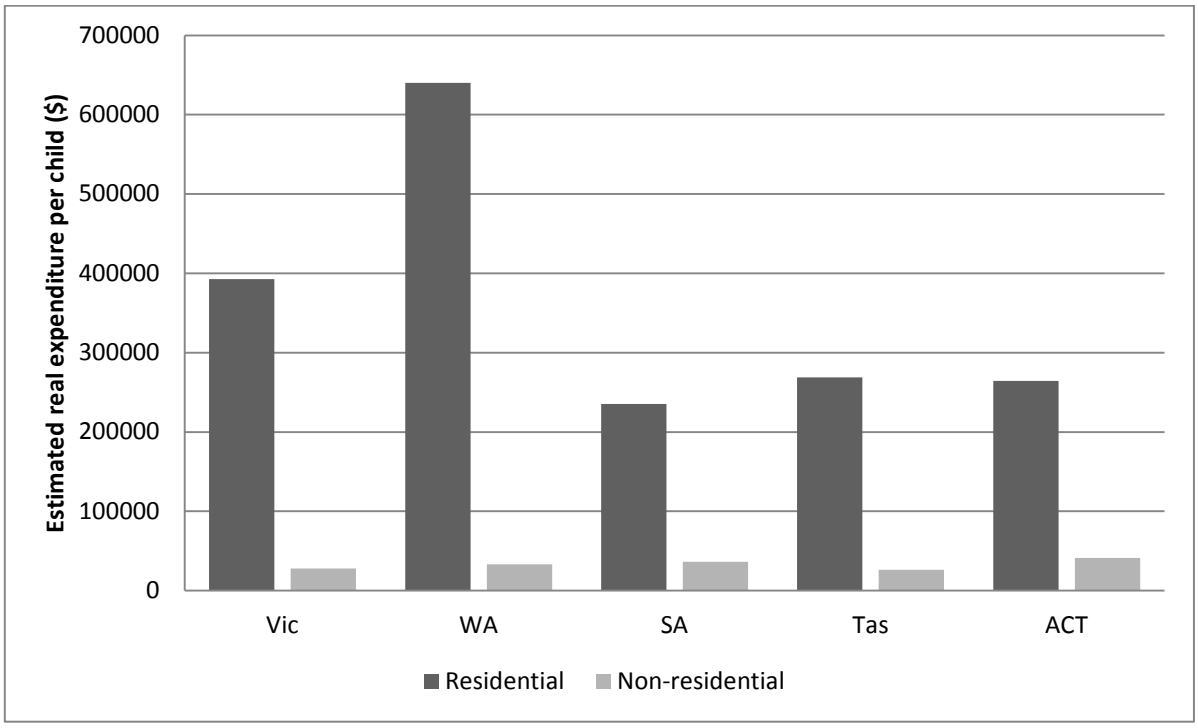
Source: Productivity Commission, Report on Government Services, Table 15A.3.

6.8 States and territories spend a significantly higher amount per child on residential care than non-residential care. Across jurisdictions, estimated real expenditure per child for residential care is between 6 and 19 times higher than

3 The Productivity Commission notes that data on the breakdown of expenditure by type of care is not available for all jurisdictions. Data measuring the annual real expenditure on residential and non-residential out-of-home care are not comparable across jurisdictions. See: Productivity Commission, *Report on Government Services 2015*, p. 15.51.

non-residential care.[4] Figure 6.2 shows the estimated real expenditure per child for residential and non-residential care across jurisdictions for 2013–14.[5]

Figure 6.2 – Estimated real expenditure per child for residential and non-residential out-of-home care services, 2013/14



Source: Productivity Commission, Report on Government Services, Table 15A.3.

Relative/kinship care

6.9 As discussed in Chapter 4, relative/kinship care has the potential to provide greater stability and more positive long-term outcomes for children and young people than other forms of care.[6]

6.10 All jurisdictions support statutory relative/kinship care as the preferred form of care for children and young people. As noted in Table 6.2, in most jurisdictions children are placed in relative/kinship care more than any other type of care.[7]

4 Productivity Commission, *Report on Government Services*, Table 15A.3.

5 The Productivity Commission notes that these are proxy indicators and must be interpreted with care as they do not represent a measure of unit costs. Expenditure per child in care at 30 June overstates the cost per child because significantly more children are in care during a year than at a point in time. In addition, the indicator does not reflect the length of time that a child spends in care. See: Productivity Commission, *Report on Government Services 2015*, Box 15.23.

6 See: Ms Meredith Kiraly, Research Fellow, Department of Social Work, University of Melbourne, *Committee Hansard*, Melbourne, 20 March 2015, p. 23.

7 AIHW, *Submission 22*, Table 6.

Relative/kinship care is the preferred option for Aboriginal and Torres Strait Islander children, consistent with the Aboriginal Child Placement Principle.[8]

6.11 The committee notes that many of the issues experienced by relative/kinship carers discussed below were also identified in the committee's 2014 inquiry, *Grandparents who take primary responsibility for raising their grandchildren*.[9]

Support for relative/kinship care placements

6.12 The committee heard that relative/kinship carers are more likely to be disadvantaged than other types of carers.[10] A report by the Social Justice Social Change Research Centre found that relative/kinship carers were predominantly female, older, more likely to have lower incomes, to be in public rental accommodation, less likely to be employed, or to have a university qualification than foster carers.[11] Relative/kinship carers were more likely to have an income from a Centrelink pension or benefit with a gross weekly income between $80 and $1 000. One third of the relative/kinship carers had a weekly income of less than $500.[12]

6.13 Dr Marilyn McHugh, a research fellow from the University of New South Wales, found that compared to foster carers, relative/kinship carers:

> …are usually older, in poorer health, on lower incomes, and more reliant on income support payments…are less likely to be employed or have university degrees or to receive training, case planning or supervision. Indigenous kinship carers are particularly vulnerable: most in strained financial circumstances have generally high levels of material disadvantage, including poor or inadequate housing. Many have sibling groups in their care.[13]

6.14 Berry Street, an out-of-home care service provider in Victoria, also highlighted that the often complicated relationship between relative/kinship carers and the parents of children can add stress and complexity compared with other types of care:

> …kinship carers have a very different relationship with the birth parents – family relationships can be fraught, contributing to stress and mental health

8 AIHW, *Child Protection Australia 2012–13*, p. 4.

9 See: Senate Community Affairs References Committee, *Grandparents who take primary responsibility for raising their grandchildren*, October 2014, p. 21.

10 Additional Information, Ms Meredith Kiraly, 'A review of kinship carer surveys: the 'Cinderella' of the care system?' *Child Family Community Australia Paper*, no. 31, 2015, p. 7, received 24 March 2015, http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Out_of_home_care/Additional_Documents (accessed 10 August 2015).

11 Ainslie Yardley, Jan Mason & Elizabeth Watson, *Kinship Care in NSW: Finding a way forward*, Social Justice Social Change Research Centre, University of Western Sydney, 2009, pp 31 – 36.

12 Yardley, Mason & Watson, *Kinship Care in NSW*, p. 35.

13 Quoted in: Association of Children's Welfare Agencies, *Submission 94*, p. 2.

> problems. In some cases kinship carers may be ill equipped for their role due to a range of complex factors. These vulnerabilities can pose additional risk for the children and young people in care.[14]

6.15 The committee heard that the current model of relative/kinship care do not adequately support carers to meet the increasingly complex needs of children entering care. Berry Street noted submitted that the:

> …current approach to kinship care and level of resourcing does not adequately recognise or acknowledge that the kinship clients essentially have similar profiles and needs to those of other clients of the home based care system.[15]

6.16 A large number of submitters and witnesses called for increased financial and practical supports for relative/kinship care across jurisdictions, including increases to reimbursements and allowances and access to training, case workers and support groups.[16] The Commission for Children and Young People Victoria (CCYPV) submitted that relative/kinship care is the fastest growing form of out-of-home care placement, but that 'the development of a considered and robust model of kinship care has not kept pace with the growing demand'.[17]

6.17 In particular, submitters highlighted the need for increased supports for informal relative/kinship carers that do not receive any support from statutory child protection authorities. Ms Meredith Kiraly noted the need for ongoing support 'is critical to the wellbeing of children and carers in both statutory and informal kinship care'.[18]

6.18 A recent study into kinship care by the Benevolent Society, in partnership with the Social Policy and Research Centre (SPRC) and the Aboriginal Child, Safety, Family and Community Care State Secretariat (AbSec), found that kinship carers lack adequate support and appropriate, accessible services for them and their children, including counselling, medical, educational and financial or case worker support. The study highlighted the need for a well-resourced practice framework to support relative/kinship carers and their families.[19]

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14 Berry Street, *Submission 92*, p. 7.

15 Berry Street, *Submission 92*, p. 7.

16 See: AASW, *Submission 18*; OzChild, *Submission 19*, Barnardos Australia, *Submission 20*; Benevolent Society, *Submission 30*; Child Wise, *Submission 31*; Mirabel Foundation, *Submission 36*; Salvation Army, *Submission 40*; Karen Lizasoain, *Submission 48*; Baptcare, *Submission 50*; Wanslea Family Services, *Submission 60*; Western Australian Council of Social Service (WACOSS), *Submission 51*; University of Melbourne Department of Social Work, Child, Youth and Families Research Cluster, *Submission 66*; PeakCare, *Submission 84*.

17 CCYPV, *Submission 45*, p. 16.

18 Kiraly, 'A review of kinship carer surveys', p. 25.

19 Benevolent Society, *Submission 30*, p. 4; Marilyn McHugh, *A Framework of Practice for Implementing a Kinship Care Program* (report for The Benevolent Society). Social Policy Research Centre, University of New South Wales, July 2009.

Specialist support for relative/kinship care placements

6.19 The committee heard that specialist support services for relative/kinship carers and children in relative/kinship care placements are limited. Across most jurisdictions, relative/kinship care placements are approved and supervised by government.[20] Unlike foster care, where community service organisations (CSOs) are funded to provide case management support to carers, relative/kinship carers rely on government departments for ongoing support, including allocation of caseworkers.[21]

6.20 The committee heard that ongoing support for carers is limited due to resourcing constraints, and in some cases, carers are not allocated caseworkers to provide additional support:

> …many of these children's cases sit on a list of 'unallocated' cases. Where cases are allocated, workloads only allow for a minimum level of casework driven by urgent need.[22]

6.21 Witnesses expressed concerns about the impact of the lack of ongoing support provided to relative/kinship carers. Mr Julian Pocock, Director of Public Policy at Berry Street, told the committee at its Melbourne hearing:

> …it is not tolerable for the system in Victoria and elsewhere to proceed on a basis where we have some children and young people in placements which are subject to external monitoring and scrutiny and where external auditors come in and ask questions and review files and see what is happening to kids; and we have another part of the system—and in Victoria it is half of the system now—still run by the department in kinship care, which is not subjected to any external monitoring or any standards—no-one comes in to review what is happening to those kids. From the perspective of the child, it should not be a lottery as to whether or not you end up in the placement that has some benefit of external monitoring or a placement that does not.[23]

6.22 In some jurisdictions, organisations are funded to provide some support to relative/kinship placements. However, this differs across jurisdictions and depends on the capacity of the organisations to deliver services. The committee heard that the Victorian government funds 25 CSOs to provide Kinship Care Support Programs to approximately 750 children (around 25 per cent of children in relative/kinship care

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20 In WA, SA, Tasmania and NT, relative/kinship carers are assessed and supported by government departments only.

21 State and territory governments, answers to questions on notice, 30 April 2015 (received May-June 2015).

22 University of Melbourne Department of Social Work, Child, Youth and Families Research Cluster, *Submission 66*, p. 19.

23 Mr Julian Pocock, Director, Public Policy, Berry Street, *Committee Hansard*, Melbourne, 20 March 2015, p. 6.

placements). The remaining children are managed by government child protection authorities.[24]

6.23 The committee heard that the implementation of supported relative/kinship care programs across jurisdictions is inconsistent. In the committee's view, specialist relative/kinship care organisations, such as the Mirabel Foundation in Victoria, may provide a good example of supported relative/kinship care placements (see Box 6.1).

Box 6.1 – Best practice – Mirabel Foundation – Kinship carer support

The Mirabel Foundation (Mirabel) was established in Victoria in 1998 to assist children living in kinship care arrangements due to parental drug use. Mirabel stated that it is currently supporting more than 1300 disadvantaged children throughout Victoria and New South Wales. More than 65 per cent of these children are placed in statutory out-of-home care kinship placements, with the remainder placed informally.

Mirabel noted it was established to fill a gap in services available to kinship carers and their children and has developed a series of programs in response to growing need and a body of tailored research. The programs Mirabel has identified as most needed and beneficial to kinship families include:

- Assessment of needs and referral to specialist services
- Telephone counselling and support
- Crisis support and assistance
- Kinship carer support groups and therapeutic children's groups
- Recreation program
- Educational support
- Individual child/youth support
- Children and family events and camps
- Respite care and family holidays
- Youth ambassador outings
- Advocacy

Source: Mirabel Foundation, Submission 36, p. 4.

6.24 The committee heard that there are few best practice models for supported relative/kinship care in Australia or internationally. Professor Cathy Humphreys and Ms Meredith Kiraly from the Department of Social Work at the University of Melbourne submitted that:

> dedicated kinship care support programs are in their infancy everywhere, as is the exchange of information about policy and practice. No Western country has yet developed a coherent model of protective kinship care and associated support services. Many jurisdictions regard kinship care as a form of foster care that can operate more independently. This leads to difficulty in appreciating the need of children and carers for casework and

24 Rachel Breman, 'Peeling back the layers – kinship care in Victoria', Baptcare Research Unit, October 2014, p. 8; University of Melbourne Department of Social Work, Child, Youth and Families Research Cluster, *Submission 66*, p. 19.

> other support and also in establishing appropriate standards of carer assessment, supervision and monitoring.[25]

6.25 Professor Humphreys and Ms Kiraly recommend further research be undertaken to:

> …develop a model of statutory kinship care using local and international knowledge that may underpin the development of policy and practice to support children in kinship care, their carers and their parents.[26]

Financial support

6.26 The committee heard that in some jurisdictions, relative/kinship carers receive lower rates of financial reimbursement than foster carers. Evidence suggested that although relative/kinship carers are eligible for the same carer allowances as foster carers, in practice, relative/kinship carers do not receive the higher allowances available for complex placements.[27]

6.27 In Western Australia, Ms Judith Wilkinson from Key Assets stated that children in relative/kinship care placements have a range of complex needs:

> Kinship carers look after children right across the spectrum—that is, from what might be called 'low needs', although there really are no low-needs children who come into care, to extremely high-needs children who, if they were not in kinship care, might be looked after by specialised fostering services or residential care.[28]

6.28 A 2014 report into kinship care in Victoria by Baptcare found that the complexity of kinship placements is often not acknowledged.[29] Baptcare suggested that 'the current funding model, based on the presumption that most placements only require low level of support, is inadequate to meet the needs of these kinship care families'[30] and recommended that:

> …the kinship program model be reviewed, accompanied by a better funding structure and allocation of resources so that children placed in kinship care receive equitable care compared to children in other out of home care programs.[31]

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25 University of Melbourne Department of Social Work, Child, Youth and Families Research Cluster, *Submission 66*, p. 20.

26 University of Melbourne Department of Social Work, Child, Youth and Families Research Cluster, *Submission 66*, p. 23.

27 See: Baptcare, *Submission 50*, p. 4; Child Wise, *Submission 31*, p. 21.

28 Ms Judith Wilkinson, State Director, Key Assets WA, *Committee Hansard*, Perth, 16 February 2015, p. 14.

29 Graham Dangerfield & Rachel Breman, 'Policy Briefing Paper: Complexity in Kinship Care in Victoria', October 2014. See: Baptcare, *Submission 50, Attachment 1*, pp 1–4.

30 Baptcare, *Submission 50*, p. 4.

31 Baptcare, *Submission 50*, p. 4.

6.29 The CCYPV noted in its submission that in Victoria, relative/kinship carers are only reimbursed more than the 'general base rate' (between $7 000 and $11 000 per year) in exceptional circumstances.[32] The CCYPV noted the difference between caregiver reimbursements for relative/kinship carers and foster carers could be as much as $25 000 (based on the difference between the base rate for relative/kinship carers of $11 454 per year compared to the complex placement rate for foster carers of $36 187). The CCYP submitted that:

> the financial burden to kinship carers are under is not reasonable, viable or sustainable. At present kinship carers receive less than the base rate for foster carers – it is an inequitable system and ultimately, the children miss out.[33]

Assessment process

6.30 Relative/kinship carers are required to be assessed by child protection authorities, including police, criminal, child protection and working with children background checks. In some cases, this is similar to the assessment process for foster carers, but with some flexibility. For example, in Queensland, the assessment process for relative/kinship carers is 'less structured due to the family connection that already exists between the relative/kinship carer applicant, the child and the child's parents'.[34]

6.31 However, owing to resourcing constraints, relative/kinship carers may not be fully assessed for suitability prior to being placed with a child.[35] In some cases, children may remain in placements with carers who have not been assessed:

> [O]ften it is a police check that is done and that is it. There is a pre-assessment that is supposed to be done within two weeks. Pressures on protective workers often mean that that spins out for a number of weeks, and the proper assessment that is supposed to be done within eight weeks often spins out for many months.[36]

6.32 Once a child enters a relative/kinship placement, resourcing pressures mean that the child is unlikely to be moved, regardless of whether it is the most appropriate placement:

> By the time the child has been in placement for weeks or months, systemic factors bias the assessment towards ratification of the status quo unless it is patently dangerous to the child. Among these are reluctance to disrupt the

32 CCYPV, *Submission 45*, p. 19.

33 CCYPV, *Submission 45*, p. 19.

34 Queensland Government, answer to question on notice, 30 April 2015 (received 19 May 2015).

35 University of Melbourne Department of Social Work, Child, Youth and Families Research Cluster, *Submission 66*, p. 19

36 Ms Meredith Kiraly, Research Fellow, Department of Social Work, University of Melbourne, *Committee Hansard*, Melbourne, 20 March 2015, p. 23.

> existing care arrangement, and frequently, a lack of alternative care options.[37]

6.33 As discussed in Chapter 4, the pressure to put 'bums in beds' may result in children being placed in unsuitable placements. Ms Kiraly noted that the lack of assessment for relative/kinship carers created a double standard compared with foster carers:

> I do think if the state mandates a placement as out-of-home care, then we are saying it is a safe place and providing a care allowance is also indicating that we would not dream of placing a child with a foster carer without them being fully assessed.[38]

Training support

6.34 The committee heard that relative/kinship carers have limited access to training and ongoing support, especially compared with foster care.[39] The Benevolent Society's study found relative/kinship carers receive much less training than foster carers, with the majority saying that they hadn't received any training.[40]

6.35 Across most jurisdictions, there was no mandatory relative/kinship training. Although carers had access to voluntary training, many courses were not specific to relative/kinship carers. Table 6.4 outlines the key differences between training and ongoing support for relative/kinship carers and foster carers across jurisdictions.

37 University of Melbourne Department of Social Work, Child, Youth and Families Research Cluster, *Submission 66*, p. 19

38 Ms Meredith Kiraly, Research Fellow, Department of Social Work, University of Melbourne, *Committee Hansard*, 20 March 2015, p. 30.

39 State and territory governments, answers to questions on notice, 30 April 2015 (received May-June 2015).

40 Yardley, Mason & Watson, *Kinship Care in NSW*, p. 35.

Table 6.3 – Ongoing training support for relative/kinship carers

Jurisdiction	Relative/kinship care	Foster care
NSW	Mandatory course must be completed within three months Voluntary relative/kinship specialist training	Mandatory training
Victoria	Voluntary relative/kinship specialist training	Mandatory pre-service training Specialist training as required
Queensland	Voluntary No specific relative/kinship training	Mandatory pre-service and in-service training
WA	Voluntary No specific relative/kinship training	Mandatory 'Fostering with Skill and Care' course (workbook and 19 hours of workshops)
SA	Mandatory courses (Infant Care and Child Safe Environment) Voluntary No specific relative/kinship training	Mandatory training
Tasmania	Voluntary No specific relative/kinship training	Mandatory (non-legislated) training
Northern Territory	Mandatory course (six modules) Voluntary abuse and abuse prevention training	Mandatory course (six modules) Voluntary abuse and abuse prevention training

Source: State and territory governments, answers to questions on notice, 30 April 2015 (received May-June 2015).

6.36 The committee heard that a small number of jurisdictions offer specialist relative/kinship care training. For example, the Victorian Government funds support sessions for relative/kinship carers, which are delivered by the Australian Childhood Trauma Group, Anglicare Victoria and Berry Street. This training aims to assist carers to understand and manage complex behaviours and issues using a trauma-informed approach. Victoria also launched culturally appropriate training for relative/kinship carers of Aboriginal and Torres Strait Islander children and professionals in 2014-15.[41]

Peak body

6.37 There is no national peak body for relative/kinship carers to advocate and work with government. In other jurisdictions, peak bodies represent both

41 Victorian Government, answers to questions on notice, 30 April 2015 (received 22 May 2015).

relative/kinship carers and foster carers. NSW advised ongoing support for foster carer and relative/kinship carers is provided through two peak carer organisations: Connecting Carers NSW (CCNSW) and Aboriginal State-wide Foster Carer Support Service (ASFCSS). Both CCNSW and ASFCSS are funded to provide advice, information and support.[42]

6.38 Some jurisdictions have specific peak bodies for relative/kinship carers, for example the Kinship Carers Victoria, established in 2010 as an extension of Grandparents Victoria (see Box 6.2).[43]

Box 6.2 – Best practice – Kinship Carers Victoria

The Victorian Department of Human Services (DHS) funds Kinship Carers Victoria (KCV), the peak body for kinship carers.

KCV's aim is to have kinship carers in Victoria supported in their role according to their needs and the needs of the children they care for. KCV's roles include:

- identify, promote and represent the views of kinship carers in decision making processes;
- inform carers to enable them to better perform their role as carers;
- advocate the needs of kinship carers with decision makers; and
- promote and assist in the delivery of programs designed to support kinship carers.

KCV received funding from DHS to develop a *Kinship Carers Handbook* which has been used as a support guide for kinship carers, including grandparents, to provide them with information on a range of areas including financial assistance, legal matters, cultural connections, health and well-being and education and learning.

Source: Victorian Government, answers to questions on notice, 30 April 2015 (received 22 May 2015); Kinship Carers Victoria, http://kinshipcarersvictoria.org/ (accessed 25 May 2015).

6.39 The committee heard there are a number of support organisations across jurisdictions that provide assistance to relative/kinship carers. However, funding to these bodies differs across jurisdictions, creating uncertainty and inconsistency.[44] Professor Humphreys and Ms Kiraly from the University of Melbourne recommended Commonwealth funding be allocated:

> for a national peak body for kinship care in Australia that has sufficient resources to collect relevant data, commission research, advocate for appropriate services for kinship carers and children in their care, and coordinate State and Territory kinship care peak bodies as they are established.[45]

42 NSW Government, answer to question on notice, 30 April 2015, (received 14 May 2015).

43 *Kinship Carers Victoria*, http://kinshipcarersvictoria.org (accessed 25 May 2015).

44 University of Melbourne Department of Social Work, Child, Youth and Families Research Cluster, *Submission 66*, p. 24.

45 University of Melbourne Department of Social Work, Child, Youth and Families Research Cluster, *Submission 66*, p. 24.

Committee view

6.40 The committee notes that evidence received by the committee concerning the lack of financial and practical support for relative/kinship care supports the findings of the committee's previous inquiry into grandparent carers.

6.41 The committee acknowledges that relative/kinship carers are assuming greater responsibility for an increasing number of children who have increasingly complex needs in statutory out-of-home care. As discussed in Chapter 4, the committee acknowledges the benefits for the wellbeing of children and young people in being placed with and connected to their families.

6.42 The committee is concerned statutory and informal relative/kinship carers are not able to access the same financial and practical supports (including training and case workers) as foster carers. In particular, the committee is concerned that the complex needs of children in relative/kinship care are not recognised, meaning relative/kinship carers are not able to access higher rates of financial allowances.

6.43 The committee notes the lack of supported kinship care placement models across jurisdictions for statutory and informal carers. Models provided by some service providers, such as the Mirabel Foundation, which attempt to improve the level of support for children in relative/kinship placements were of particular interest to the committee.

6.44 The committee supports increasing the capacity of emergency respite services to allow child protection authorities to properly assess relative/kinship carers prior to placement, rather than placing 'bums in beds'. This would help to improve safety and stability for children and facilitate more positive outcomes.

6.45 The committee also supports the establishment of a national peak body to represent statutory and informal relative/kinship carers across jurisdictions, including individual and collective advocacy. The committee consider the establishment of a national peak body would benefit children and carers in relative/kinship placements.

Foster care

6.46 The committee heard there are significant issues with Australia's volunteer based model of foster care. Berry Street and the University of New South Wales argued that foster care in Australia is in a 'state of crisis' due to out-dated policies and practices, inadequate resources, difficulties in preventing rapid staff turnover, and difficulties in recruiting and retaining volunteer foster parents.[46]

46 Berry Street, *Submission 92, Attachment 1*, Dr Marilyn McHugh & Ms Anita Pell, 'A New Model of Support, Education and Payment for Foster parents: Call to Action for State and Federal Governments and Community Sector Organisations', September 2013, p. 4.

Recruitment and retention

6.47 Submitters and witnesses argued that there are significant challenges in recruiting and retaining appropriately skilled volunteer foster carers across jurisdictions, particularly for specialist foster care services.[47]

6.48 In 2013–14, AIHW reported that across most jurisdictions (except WA and the NT), more households exited foster care than commenced foster care, highlighting that the attraction and retention of appropriately skilled foster carers is a high priority across Australia.[48]

6.49 The Foster Care Association of Victoria submitted that in Victoria, there has been a significant increase in non-active carers (approved carers not actively caring for children), indicating that experienced foster carers may be choosing not to provide foster care placements.[49]

Financial support

6.50 It was put to the committee that a key reason for the difficulties in recruiting and retaining appropriately skilled foster carers is the inadequate level of financial support. Mr Bernie Geary, the Victorian Commissioner for Children and Young People, told the committee that the issue of foster carer allowances had been discussed over a long period:

> [T]en years ago when I first came into the job as child safety commissioner I talked to the bureaucrats about what was happening with foster care, why was it diminishing? It is diminishing because foster carers are saying to me 'I would be a foster carer but I can't afford it.'[50]

6.51 The committee heard that foster care allowances have been in decline for some time across jurisdictions. Dr Marilyn McHugh from the Social Policy Research Centre (SPRC) at the University of New South Wales highlighted that across jurisdictions, the weekly subsidy for parents is generally less than the cost of caring for a child. This assessment is based on estimates of the cost of caring for a child developed by the SPRC, known as the foster care estimate (FCE).[51]

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47 See: Foster Care Association of Victoria (FCAV), *Submission 11*, p. 3; Dr Kim Backhouse, CEO, Foster Care Association of Tasmania, *Committee Hansard*, Hobart, 12 March 2015, p. 10.

48 For jurisdictions where data were available, 2 208 households commenced foster care and 1 755 households exited foster care. AIHW, *Child Protection Australia 2013-14*, p. 58.

49 The number of non-active carers in Victoria increased from 302 in 2013 to 428 by March 2014. See: FCAV, Carer snapshot trend 2010-2014, *Submission 11, Attachment A*, p. 1.

50 Mr Bernie Geary, Commissioner for Children and Young People Victoria, *Committee Hansard*, 20 March 2015, p. 41.

51 Dr McHugh notes that the calculation of FCEs should be considered as estimates only due to inconsistencies in payment regimes across jurisdictions, including supplementary allowances and age categories. See: Berry Street, *Submission 92, Attachment 5*, Dr Marilyn McHugh, 'Victoria's declining foster care allowances: a comparative analysis,' University of New South Wales, Social Policy Research Centre, August 2014, p. 1.

6.52 Mr Andrew McCallum, CEO of the Association of Children's Welfare Agencies, argued that foster carers should be paid commensurate to the support they provide:

> A major issue associated with this is that we are still expecting volunteers in many cases to do some of the most difficult work within the system...So there is an issue around how we resource a system that is built around known therapeutic care models for out-of-home care, foster care, residential care and so forth that will mean more resources for fewer kids, because we would hope to build a system that would not be driving itself. At the moment we have a system that is self-perpetuating.[52]

6.53 Similarly, Ms Judith Wilkinson, Chair of the Children's Youth and Families Agency Association in WA, told the committee of the importance of providing incentives for volunteer carers:

> There is a lot to be said—and foster carers will say this themselves—for maintaining volunteer carers, but they have to be properly supported financially, and there has to be an element of reward in the allowance they get which does not then attract the attention of the ATO in terms of paying tax on that element.[53]

6.54 A number of submitters and witnesses, including the Foster Care Associations of Victoria and Tasmania, recommended increasing the subsidies available to foster carers to cover the actual cost of supporting children in foster care, taking into account education, medical, allied health and recreational expenses.[54] In addition to increased subsidies, these witnesses suggested the Commonwealth government provide tax exemptions and incentives to foster carers. Mr Geary also told the committee that tax incentives were needed:

> [I]t belies good sense to think that we do not properly support our foster carers. Give them a break. If that is a tax break, if that is what is needed, give it to them.[55]

6.55 For example, in the UK, foster parents receiving a Foster Parent Fee are regarded as self-employed for tax purposes and carers earning up to a maximum of £10 000 (AUD $15 365) plus allowances, do not pay tax on their income from fostering.[56]

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52 Mr Andrew McCallum, CEO, Association of Children's Welfare Agencies (ACWA), *Committee Hansard*, Sydney, 18 February 2015, p. 58.

53 Ms Judith Wilkinson, Chair, Children's Youth and Families Agency Association (CYFAA), *Committee Hansard*, Perth, 16 February 2015, p. 14.

54 See: FCAV, *Submission 11*, p. 3; Dr Kim Backhouse, Foster Care Association of Tasmania, *Committee Hansard*, Hobart, 12 March 2015, p. 10; Ms Katie Hooper, *Committee Hansard*, 20 March 2015, p. 28; Ms Judith Wilkinson, Key Assets, *Committee Hansard*, Perth, 16 February 2015, p. 14; Mr Bernie Geary, *Committee Hansard*, Melbourne, 20 March 2015, p. 41.

55 Mr Bernie Geary, Commissioner for Children and Young People Victoria, *Committee Hansard*, Melbourne, 20 March 2015, p. 41.

56 Berry Street, *Submission 92, Attachment 1*, p. 50.

6.56 The Foster Care Associations of Victoria and Tasmania also suggested improved access to 'ongoing training, practical support and regular respite for carers',[57] as well as funding for individual and collective support and advocacy.[58]

6.57 The committee heard that the volunteer model of foster care does not attract the highly skilled carers required to address the complex needs of children and young people. Ms Anita Pell from Berry Street told the committee:

> The children are more challenging, the families that they come from are more complex and our system is much more complex than it was. The carers that we are trying to recruit are a very different profile of carer that we need.[59]

6.58 The differences in foster care allowance rates across jurisdictions will be discussed in more detail below.

Professional foster care

6.59 To address the challenges in recruiting, supporting and retaining foster carers and addressing the complex needs of children in care, a number of submitters and witnesses recommended introducing a model of professional foster care.[60] The Child and Family Welfare Association of Australia submitted that:

> …foster care is an increasingly difficult model to sustain as many children's needs can only be met by having a full-time at home carer and the voluntary nature of the work precludes sufficient income being available.[61]

6.60 One of the key advantages to a professional foster care model would be to provide a home-based care option for children and young people with complex needs who would otherwise be admitted to residential care. According to MacKillop Family Services, 'professional foster care has the potential to fill a gap between foster care provided by volunteers and residential care'.[62]

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57 FCAV, *Submission 11*, p. 3.

58 Dr Kim Backhouse, CEO, Foster Care Association of Tasmania, *Committee Hansard*, 12 March 2015, pp 9 – 10.

59 Ms Anita Pell, Senior Adviser, Berry Street, *Committee Hansard*, Melbourne, 20 March 2015, p. 14.

60 See, for example: Child and Family Welfare Association of Australia (CFWAA), *Submission 65*, CCYPV, *Submission 45*; Berry Street, *Submission, 92*; Ms Judith Wilkinson, Chair, Children's Youth and Families Agency Association, *Committee Hansard*, Perth, 16 February 2015, p. 14.

61 CFWAA, *Submission 65*, p. 6.

62 Mackillop Family Services, *Submission 70*, p. 5.

6.61 Support for the implementation of a professional foster care model included reforms at the Commonwealth level to taxation and industrial law.[63] Anglicare Victoria argued that current taxation and industrial policy:

> …works against the employment of a full time professional to allow the employment of a professionalised 'in-home care' service option for children and young people as an alternative to residential care when volunteer foster care placements are not available.[64]

6.62 The removal of barriers at the Commonwealth level to allow the introduction of a professional foster care model was supported by the Victorian and ACT Governments.[65]

Cost savings

6.63 Dr McHugh argued that a professional foster care model would deliver significant cost savings to government by diverting children away from residential care. In a professional foster care model, children with complex needs who would otherwise be placed in residential care could be supported by a full-time, professional foster carer.[66] Dr McHugh estimated that a proposed professional foster care model developed by the SPRC and Berry Street (see Box 6.6) would cost $86 900 per placement, significantly less than the maximum funding allocation per placement for residential care services in Victoria of $233 448 per placement.[67]

63 Ms Mary McKinnon, National Director of Practice and Quality, Life Without Barriers, *Committee Hansard*, Sydney, 18 February 2015, p. 49; Mr David Pugh, CEO Anglicare NT, *Committee Hansard*, Darwin, 2 April 2015, p. 2.

64 Anglicare Victoria, *Submission 101*, p. 6.

65 See: ACT Government, *Submission 16*; Victorian Government, *Submission 106*.

66 Association of Children's Welfare Agencies NSW, *Submission 94*, p. 5.

67 Berry Street, *Submission 92, Attachment 3*, Dr Marilyn McHugh, *A Stitch in Time: Projected Downstream Savings to Government: Foster Care Integrated Model*, Social Policy Research Centre, University of NSW, 2013, p. 7.

Box 6.3 – Best practice – Foster Care Integrated Model

The Foster Care Integrate Model (FCIM), developed by Berry Street and the SPRC, consists of four interlinked components:

- foster parent recruitment, training and assessment;
- placement support;
- foster parent network support; and
- financial resources.

Dr Marilyn McHugh suggests implementation of FCIM's therapeutic model 'is not only likely to result in better outcomes for children and young people in care, but will also result in significant cost savings for government at all levels'.

A report by the SPRC commissioned by Berry Street estimates the implementation of the FCIM model will require an initial substantial cost to establish, but by improving outcomes for children will result in significant cost savings for all levels of government expenditure, including social welfare, health services, juvenile justice, education and homelessness.

Source: Berry Street, Submission 92, pp 5–6; Berry Street Submission 92, Attachment 3, pp 6–7.

ACIL Allen Consulting review of professional foster care

6.64 As part of the second action plan (2012-15) of the National Framework, the then Department of Families, Housing, Community Services and Indigenous Affairs engaged ACIL Allen Consulting on behalf of the Standing Council on Community and Disability Services Advisory Council to undertake a review of the barriers and opportunities for developing models of professional foster care. The review defined professional foster care as:

> [H]ome-based care; targeted at children and young people not able to be placed in more traditional forms of home-based care; providing intensive care integrated with specialist support services; receiving a salary commensurate with level of skill; and participating in ongoing competency based training.[68]

6.65 The review was presented in October 2013 and found there was a clear and demonstrated need and demand for a professional out-of-home care service system that could result in significant cost savings to states and territories. The review noted the National Framework and the National Standards provide an 'important enabling environment' to progress the implementation of professional foster care models.[69]

6.66 The review recommended two options for consideration by state and territory community and disability services ministers:

- national agreement be sought on the policy parameters to enable professional foster care in Australia (including the preferred model of professional foster

68 ACIL Allen Consulting, *Professional Foster Care: Barriers, opportunities and options,* Report to the Department Of Families, Housing, Community Services And Indigenous Affairs, October 2013, p. v.

69 ACIL Allen Consulting, *Professional Foster Care*, p. vi – vii.

care and subsequent clarification of taxation and industrial relations issues required to enable the model), and the subsequent development and endorsement of a Framework for Professional Foster Care under the Second Action Plan; or

- agreement to the development of a nationally consistent set of skills, competencies and (over time) accreditation for professional foster carers, underpinned by national workforce development and planning.[70]

6.67 The committee notes this review has not yet been considered by COAG. The committee notes the Australian Children's Commissioners and Guardians agreed to write to the Minister for Social Services in May 2015 commending the report and seeking an update on the government's response.[71] Several submitters recommended the 'prompt consideration' of the review and 'determination of a plan to remove barriers to the implementation of professional foster care'.[72]

Committee view

6.68 The committee recognises the importance of volunteer foster carers in the statutory out-of-home care system. The committee is concerned about the long-standing challenges in recruiting and retaining suitable foster carers to meet the increasingly complex needs of children and young people entering out-of-home care. The committee supports the consideration of a national approach to supporting foster carers, including the accreditation of carers.

6.69 The committee acknowledges that professional foster care has significant support across jurisdictions and that it may provide an opportunity to deliver better outcomes for children in care, particularly those children with complex needs. While noting the complex issues and barriers involved in introducing a model of professional foster care, the committee considers these can be overcome. The committee notes the importance of tailoring a professional foster care model that will best meet the needs of Australian children and young people, such as the FCIM model proposed by Berry Street.

6.70 The committee notes the ACIL Allen Consulting review of professional foster care models. It is the committee's view that the recommendations of this review should be considered as a matter of priority with a view to introducing a best practice professional foster care model across all jurisdictions.

Residential care

6.71 The committee heard there are a variety of residential care facilities across jurisdictions. The Australian Association of Social Workers noted that models of

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70 ACIL Allen Consulting, *Professional Foster Care*, p. vi – vii.

71 Australian Children's Commissioners and Guardians (ACCG), *Meeting Communique*, 20-21 May 2015, https://www.humanrights.gov.au/our-work/childrens-rights/publications/australian-children-s-commissioners-and-guardians-communiqu-0 (accessed 2 July 2015).

72 See: MacKillop Family Services, *Submission 70*, p. 6; CECFW, *Submission 99*, p. 19.

residential care vary from 'small to larger settings, with full time carers or shift work carers, for children in transitional or permanent care'.[73] For example, in Victoria, the average size of residential care facilities is four occupants, and has declined from an average of 6-8 occupants.[74]

6.72 Most residential care facilities are administered by NGOs, rather than directly by state and territory child protection authorities. Information provided to the committee by state and territory governments indicated that most jurisdictions outsource responsibility for managing residential care facilities to NGOs, including data collection and training of staff.[75]

6.73 Across all jurisdictions, young children are generally placed in home-based care. However, older children with complex needs are more likely to be placed in residential care. Anglicare submitted that for children with complex and challenging behaviours, residential care becomes the 'default option'.[76] The Victorian Auditor-General's 2014 report into residential care provided the following profile of children entering residential care:

> [C]hildren in residential care have generally been exposed to multiple traumas in the form of family violence, alcohol and drug abuse, or sexual, physical and emotional abuse since they were very young. They may have a parent who is in prison or a struggling single parent with mental health issues. Some have been born to mothers who were very young, often with a violent partner. They usually have other siblings in care, and one of their parents may also have been in care as a child. They are usually known to child protection at an early age. They come to residential care typically as a young adolescent, having experienced a number of placements in home-based care that have since broken down or were only available for short periods of time. They often come to residential care with little warning and with few belongings. On their 18th birthdays, if not before, they leave the protection of the state.[77]

6.74 In some cases, children may be placed in residential care because of breakdowns in foster care or relative/kinship placements. The Western Australian Government told the committee that of the 4 237 children in care at 30 June 2014, 82 had entered residential care from a foster care breakdown and 46 from a relative/kinship breakdown.[78]

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73 AASW, *Submission 18*, p. 15.

74 Anglicare Victoria, *Submission 101*, p. 7.

75 See: State and territory governments, answers to questions on notice, 30 April 2015 (received May–June 2015).

76 Anglicare Australia, *Submission 87*, p. 15.

77 Victorian Auditor-General, *Residential Care Services for Children*, 26 March 2014, p. ix, http://www.audit.vic.gov.au/reports_and_publications/latest_reports/2013-14/20140326-residential-care.aspx (accessed 10 August 2015).

78 WA Government, answers to questions on notice, 30 April 2015 (received 18 May 2015).

Funding models and costs

6.75 As noted in Chapter 4, outcomes for children in residential care are significantly worse than other forms of care. A number of submitters noted that despite the high costs of delivering residential care services, particularly therapeutic programs that require additional levels of staffing and support services, outcomes for children in residential care are poor.[79]

6.76 As Figure 6.2 shows, the cost of residential care per child is significantly higher than other forms of care. In Victoria, the average cost per placement for residential care is $392 631 per year, compared with $27 980 for non-residential care. In Western Australia, the cost is much higher, with an average of $640 244 per child for residential care, compared with $33 307 for non-residential care.[80] The Victorian Auditor General's 2014 report noted that placements for some children with significant and extreme needs cost close to $1 million per year.[81]

6.77 The committee heard that despite the high level of expenditure on residential care, current funding models are not adequate to meet the high demand for residential placements. In March 2014, the Victorian Auditor-General found that Victoria's residential care system was 'unable to respond to the level of demand and growing complexity of children's needs' and had been operating beyond capacity since 2008.[82]

6.78 Declining numbers of foster carers was said to be a contributing factor to the demand for residential care. For children with complex needs, Berry Street noted for children with complex needs:

> placement in residential care becomes a default placement option. Children who might have been placed with trained and supported foster carers face the prospect of being placed in residential care alongside highly traumatised young people who are still recovering from their own childhood trauma and may pose a risk to other children.[83]

6.79 Support for a range of flexible funding models that focuses on the needs of the child was expressed by Mr David Fox from MacKillop Family Services:

> What we need is funding that is able to allow the sector to be innovative in developing new models of service delivery that are responsive, not to the fiscal environment, but to the needs of the child or young person in care. What we need is a suite of flexible models that are responsive to the needs of young people.[84]

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79 See: CCYPV, *Submission 45*, p. 10; Baptcare, *Submission 50*, p. 4; Families Australia, *Submission 77*, p. 18; Berry Street, *Submission 92*, pp 6–7.

80 Productivity Commission, *Report on Government Services*, Table 15A.3.

81 Victorian Auditor-General, *Residential Care Services for Children*, 26 March 2014, p. xi.

82 Victorian Auditor-General, *Residential Care Services for Children*, 26 March 2014, p. x.

83 Berry Street, *Submission 92*, p. 5.

84 Mr David Fox, Director of Operations, MacKillop Family Services, *Committee Hansard*, Melbourne, 20 March 2015, p. 12.

Training support

6.80 A number of submitters and witnesses noted the need for trained staff who had the capacity to address the complex needs of children and young people placed in care. The Salvation Army explained:

> Residential workers and residential care is not about a house with some people who look after kids; it is about an environment where day in and day out staff have the capacity to influence the behaviour the wellbeing and the future trajectory of young people.[85]

6.81 The committee heard that one outcome of the existing funding structures is lack of adequate training and development for residential care workers.[86] Anglicare suggested that 'the funding structure in place dictates that the people who provide support in these settings are among the least qualified and are the least paid.'[87] Similarly, the Tasmanian Government noted that staffing in some residential care arrangements:

> …is characterised by staff that do not have specialist professional training or accreditation (which is currently unavailable), inadequate supervision and limited access to training. This has resulted in situations where the only service provided to the most chaotic and vulnerable children, is adult monitoring rather than specific care intervention.[88]

6.82 The Victorian government has recently introduced a unique approach to address the lack of training for residential care workers. The Residential Care Workforce Quality Initiative is in the early stages of development (see Box 6.4). The committee considers that an evaluation will need to be undertaken to assess whether this initiative may provide a best practice model for other jurisdictions.[89]

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85 Mr John Avent, Manager (Retired), Westcare, Salvation Army, *Committee Hansard*, Canberra, 16 April 2015, p. 14.

86 See: RANZCP, *Submission 17*; AASW, *Submission 18*; Salvation Army, *Submission 40*; Commission of Children and Young People, Victoria, *Submission 45*; Anglicare, *Submission 87*.

87 Anglicare, *Submission 87*, p. 11 & 18.

88 Department of Health and Human Services, Tasmanian Government, *Submission 1*, p. 9.

89 Victorian Government, *Submission 106*, p. 10.

Box 6.4 – Best practice – Residential Care Workforce Quality Initiative

The 2014 Victorian Auditor-General's Report into residential care found the lack of qualifications, skills and training for carers in residential care facilities contributed to poor outcomes for children. The report noted therapeutic models of care showed better outcomes for children largely because these models focus on building staff capacity.

In response to recommendations from the Auditor-General, the Victorian Government introduced the Residential Care Workforce Quality Initiative in 2015.

The initiative involves:

- development of a future capability framework, including consideration of the introduction of a minimum qualification for residential care workers; and
- piloting of a professional support program which comprises training and specialist support to embed theory into practice.

Source: Victorian Government, Submission 106, p. 10; Victorian Auditor-General, Residential Care Services for Children, 26 March 2014, p. x.

Committee view

6.83 The committee is concerned that outcomes for children and young people in residential care are poor compared with other forms of care. The committee acknowledges that the way residential care is funded and delivered facilitates these poor outcomes, and that a disproportionate amount of funding is allocated to a model that does not support children and young people.

6.84 As discussed in relation to relative/kinship carers, the committee notes demand pressures affect the ability of child protection authorities to place children in appropriate placements. However, evidence to the committee suggests that available residential care facilities do not provide appropriate accommodation or support for children and young people.

6.85 The committee acknowledges the importance of having trained specialist staff to assist children and young people in residential care, particularly those with complex needs. The committee supports the development of nationally consistent training for all residential care staff.

Cross-jurisdictional issues

6.86 In addition to the specific issues discussed throughout this chapter, the committee identified a number of cross-jurisdictional issues that affect relative/kinship, foster and residential care placements, including:

- implementation of therapeutic models;
- financial support;
- carer qualifications and
- role of the non-government sector.

Therapeutic care

6.87 A number of submitters and witnesses expressed strong support for the introduction or expansion of 'therapeutic models' of care to address the trauma many

children and young people experience as a result of separation from family, abuse or other issues.[90] The importance of culturally appropriate therapeutic care was highlighted as particularly significant for Aboriginal and Torres Strait Islander communities, particularly relative/kinship carers.[91]

6.88 The committee heard that 'therapeutic care' is not clearly defined and can be applied across a range of different types of care. A 2011 study by the Australian Institute of Family Studies (AIFS) into residential care noted that therapeutic models of care respond to:

> …the complex impacts of abuse, neglect and separation from family. This is achieved through the creation of positive, safe, healing relationships and experiences informed by a sound understanding of trauma, damaged attachment, and developmental needs.[92]

6.89 AIFS noted that because there is no clear definition of therapeutic care, it is difficult to identify how many therapeutic models currently operate around Australia.[93] Mr Julian Pocock from Berry Street told the committee:

> [T]his tag of therapeutic care and trauma-informed practice, in our view, is being slapped on things right across the out-of-home care system without a sector-wide and a nationally agreed robust framework of: what is therapeutic care and what are the essential elements that make care therapeutic and deliver good outcomes for kids?[94]

6.90 Some jurisdictions have implemented, or plan to implement, therapeutic models across residential care and foster care placements.[95] Queensland is currently trialling four therapeutic residential care facilities.[96] Victoria is piloting and

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90 See: OzChild, *Submission 19*; Child Wise, *Submission 31*; Salvation Army, *Submission 40*; Commission for Children and Young People, Victoria, *Submission 45*; Baptcare, *Submission 50*; Child and Family Welfare Association of Australia, *Submission 65*; Life Without Barriers, *Submission 68*; MacKillop Family Services, *Submission 70*; Family Inclusion Network, Victoria, *Submission 75*; Berry Street, *Submission 92*; Association of Children's Welfare Agencies, *Submission 94*.

91 Aboriginal Family Law Services, WA, *Submission 46*; NPY Women's Council, *Submission 61*; Northern Territory Council of Social Services, *Submission 72*; Indigenous Issues Committee of the Law Society of NSW, *Submission 73*.

92 Sara McLean, Rhys Price-Robertson & Elly Robinson, 'Therapeutic residential care in Australia: taking stock and looking forward,' *National Child Protection Clearinghouse Issues*, no. 35, 2011, p. 2.

93 McLean, Price-Robertson & Robinson, 'Therapeutic residential care in Australia,' p. 6; Child and Family Welfare Association of Australia, *Submission 65*, p. 4.

94 Mr Julian Pocock, Director, Public Policy, Berry Street, *Committee Hansard*, Melbourne, 20 March 2015, p. 11.

95 See: Department of Health and Human Services, Tasmanian Government, *Submission 1*; ACT Government, *Submission 16*; Queensland Government, *Submission 69*; Victorian Government, *Submission 106*.

96 Queensland Government, *Submission 69*, pp 4-6.

implementing therapeutic models of foster care and residential care.[97] Under its five year out-of-home care plan, the Victorian Government aims to increase the number of therapeutic residential care place to 140 by the end of 2015, with a long-term view that all residential placements will be therapeutic.[98] Similarly, as part of its five year out-of-home care strategy, the ACT Government plans to introduce annually reviewed therapeutic assessments and plans for all children upon entering care.[99]

6.91 A range of CSOs, including Berry Street, Baptcare, the Salvation Army and Connections Uniting Care also deliver a range of therapeutic services, from early intervention to residential care.[100] Berry Street submitted children and young people in out-of-home care have a 'right' to therapeutic treatment.[101]

6.92 However, the committee heard that the majority of children in care do not have access to therapeutic supports. A 2011 study by the Centre for Excellence in Child and Family Welfare estimated that just four per cent of children and young people are placed in an 'articulated and adequately resourced therapeutic framework'.[102] Mr Basil Hanna, Chairman of the Community Sector Roundtable for NGOs and Government in Western Australia, told the committee that although all jurisdictions recognise the importance of therapeutic models, few have been implemented:

> We know that providing them with a home and a safe place and love and nurture, for a large majority of these children, is not enough. And we know that is because a trauma from abuse causes impairments of the development pathways of a child's brain. We know the effects of that, and we know what will happen to these children's lives if we leave them untreated. We know that there will be a massive cost to society as they become adults, whether in prisons or in relationships or in mental health, or just the fact that, cognitively, they cannot function as well as other children will function in schooling. Yet when they come into out-of-home care, with all this knowledge that we have, we still have a system that, whilst acknowledging it is an issue, does not really address it.[103]

97 Victorian Government, *Submission 106*, p. 7.

98 Victorian Government, *Out-of-home care: a five year plan*, March 2014, p. 33.

99 ACT Government, *Submission 16*, p. 7.

100 See: Connections Uniting Care, *Submission 10*; Salvation Army, *Submission 40*; Baptcare, *Submission 50*; Berry Street, *Submission 92*.

101 Berry Street, *Submission 92*, p. 7.

102 Centre of Excellence in Child and Family Welfare (CECFW), 'Their Needs: improving outcomes, options and systems in out-of-home care', *Issues Paper Two – Protecting Victoria's Vulnerable Children Inquiry 2011*, p. 11.

103 Mr Basil Hanna, Chairman, Community Sector Roundtable for NGOs and Government, *Committee Hansard*, Perth, 16 February 2015, p. 17.

6.93 A number of witnesses recommended the establishment of a nationally agreed practice framework for trauma informed therapeutic care to assist governments and service providers in implementing a broader range of therapeutic supports.[104]

Relative/kinship care

6.94 As discussed throughout this chapter, the complex needs of children in relative/kinship care placements are often not recognised. As a result, carers are not supported to address the trauma and abuse experienced children in these placements. A number of submissions supported the introduction of a supported model of relative/kinship care that better supports children and carers.[105]

6.95 The committee notes there are few best practice models for therapeutic relative/kinship care in Australia or internationally.[106]

Foster care

6.96 A number of submissions highlighted the importance of specialist or therapeutic foster care programs to address the needs of children in out-of-home care.[107] The committee heard that all jurisdictions provide both a 'general' and 'specialist' model of foster care, depending on the needs of children.[108] For example, Key Assets provides general and specialised models of care in WA, SA, Queensland and NSW.[109] Key Assets told the committee that its specialist model of care is informed by a therapeutic 'team parenting framework' to stabilise placements for children with complex needs (see Box 6.5).

104 See: Mr Gregory Nicolau, *Committee Hansard*, Canberra, 16 April 2015, p. 27; Mr Julian Pocock, Director, Public Policy, Berry Street, *Committee Hansard*, Melbourne, 20 March 2015, p. 11; Berry Street, *Submission 92*, p. 7.

105 See: University of Melbourne Department of Social Work, Child, Youth and Families Research Cluster, *Submission 66*; AASW, *Submission 18*; OzChild, *Submission 19*, Barnardos, *Submission 20*; Benevolent Society, *Submission 30*; Child Wise, *Submission 31*; Mirabel Foundation, *Submission 36*; Salvation Army, *Submission 40*; Karen Lizasoain, *Submission 48*; Baptcare, *Submission 50*; Wanslea Family Services, *Submission 60*; WACOSS, *Submission 51*.

106 University of Melbourne Department of Social Work, Child, Youth and Families Research Cluster, *Submission 66*, p. 20.

107 See: OzChild, *Submission 19*, p. 7; Ms Sonia Brown, *Submission 38*; Berry Street, *Submission 92*.

108 See: State and territory governments, answers to questions on notice, 30 April 2015 (received May–June 2015).

109 Key Assets, *Submission 88*, p. 5.

Box 6.5 – Best Practice – Key Assets Team Parenting Framework

Team Parenting provides a systemic framework for stabilising foster care placements. The framework consists of four key phases:

Phase 1 – Stabilising the placement within the agency

Phase 2 – Providing appropriate response to the young person's needs

Phase 3 – Modelling appropriate emotional responses

Phase 4 – Building resilience

Key Assets reports that based on evidence from the initial application of the framework in the United Kingdom and Australia, Team Parenting has demonstrated its effectiveness in positively impacting both trauma and attachment related disturbances and the challenges associated with children in foster care placements.

Source: Key Assets, Submission 88, pp 7–10.

6.97 There is no national data on the numbers of children accessing the specialist programs that operate in all Australian jurisdictions.[110] The committee notes that there are also no comprehensive examinations of therapeutic foster care across jurisdictions.[111]

6.98 Mr Rob Ryan, State Director for Key Assets in Queensland, told the committee that:

> [T]here is no magic bullet in any one location. The key to it is putting the resources in place for all carers...Anyone who is managing and supporting children in care requires wraparound support…[112]

6.99 The Victorian Government supports two models of therapeutic foster care: the Take Two program (see Box 6.6) and the Circle Program (see Box 6.7). The committee heard that because of funding restrictions in Victoria, fewer than 10 per cent of children in out-of-home care receive support through the Take Two program, and only seven per cent of children in foster care in Victoria have access to the Circle Program.[113] Berry Street submitted that the Circle Program has not been expanded, despite positive evaluations of the benefits of the program.[114]

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110 Berry Street, *Submission 92, Attachment 1*, p. 11

111 In 2011, the then Queensland Department of Communities undertook a review of specialist foster care models as part of a discussion paper on professional foster care. The review identified examples of 'enhanced' foster care in NSW, Victoria, Queensland, Western Australia and South Australia. See: Queensland Department of Communities, *Specialist Foster Care Review: Enhanced foster care literature review and Australian programs description*, 2011, https://www.communities.qld.gov.au/resources/childsafety/foster-care/sfc-literature-review-australian-programs-description.pdf (accessed 27 May 2015).

112 Mr Rob Ryan, State Director, Key Assets, *Committee Hansard*, Brisbane, 17 April 2015, p. 26.

113 Margarita Frederico et. al., *The Circle Program: an Evaluation of a therapeutic approach to Foster Care*, Centre for Excellence in Child and Family Welfare, Melbourne, 2012, p. 14.

114 Berry Street, *Submission 92*, p. 12.

Box 6.6 – Best Practice – Take Two Program – Berry Street

The Take Two program is a developmental therapeutic program for children and young people in the child protection system in Victoria. It has operated since 2004.

The Take Two program is led by Berry Street in partnership with:

- La Trobe University Faculty of Health Science;
- Mindful Centre for Training and Research in Developmental Health; and
- Victorian Aboriginal Child Care Agency (VACCA).

The Take Two program is funded by the Department of Human Services and accredited by the Australian Council on Healthcare Standards until 18 February 2018.

The Take Two program is an intensive therapeutic service for children who have suffered trauma, neglect and disrupted attachment. The program aims to provide high quality therapeutic services for children of all ages and those important in their lives. It also aims to contribute to improving the service system that provides care, support and protection for these children.

In its submission, Berry Street noted 'the impact of the Take Two program and availability of therapeutic care has been profound'. A 2010 review of the Take Two program found it accepted 1063 referrals between January 2004 and June 2007. The highest percentage of children referred were over 12 years old. Aboriginal and Torres Strait Islander children made up 167 (16 per cent) of referrals. The central message of the review was the 'positive and meaningful changes in the lives of children who receive Take Two intervention'.

Berry Street notes limitations on funding mean that less than 10 per cent of children and young people in out-of-home care in Victoria receive support through the Take Two program.

Source: Berry Street, Submission 92, p. 12; 'Therapeutic care', Berry Street, http://www.berrystreet.org.au/Therapeutic (accessed 25 June 2015).

Box 6.7 – Best practice – The Circle Program

The Circle Program was introduced by the Victorian Department of Human Services in 2007 within the context of ongoing reform to improve outcomes for children and young people who have experienced abuse and/or neglected and were placed in out-of-home care. 97 placements in The Circle Program are available across Victoria.

The Circle Program has five key program components:

- enhanced training;
- intensive and well-integrated foster care support;
- therapeutic service to family members;
- specialist therapeutic support; and
- support network for the child and young person.

These components surround the child or young person in placement. As the child or young person benefits from these components, so the carer also engages and develops as an informed and confident therapeutic care provider.

The Circle Program is delivered by range of non-government agencies, including MacKillop Family Services, Anglicare Victoria and Salvation Army Westcare. Training for carers and professionals was developed and delivered by Australian Childhood Foundation and Berry Street Take Two.

A 2012 evaluation of The Circle Program by the Centre for Excellence in Child and Family Welfare found there are positive outcomes for children and young people referred to The Circle Program. The findings of the evaluation suggest The Circle Program can achieve excellent early intervention results for children and young people at risk to prevent them from becoming entrenched in the care system and experiencing developmental harm, and can also achieve excellent results where children and young people in out-of-home care experience complex and entrenched difficulties.

The review recommends the Circle Program be expanded to be an option for all children and young people entering foster care.

Source: Margarita Frederico et. al., 'The Circle Program: an Evaluation of a therapeutic approach to Foster Care,' Centre for Excellence in Child and Family Welfare, Melbourne, 2012, pp 7 – 19.

6.100 It was put to the committee that one of the key challenges to implementing therapeutic models of foster care is the high cost involved compared with existing models of care. Mr Rob Ryan from Key Assets told the committee that:

> The problem is that economically it is challenging. It is not a cheap exercise to support all children in foster care the way that they should be.[115]

6.101 However, a number of submitters suggested that although therapeutic care is expensive, it may be more cost effective than placing children in residential care. Mr Ryan told the committee that:

> …where you invest money to support families and carers with a wraparound support model you have a better chance of success. The money that we save initially here is a false economy when these kids are churned

115 Mr Rob Ryan, State Director, Key Assets, *Committee Hansard*, Brisbane, 17 April 2015, p. 27.

> through the system and end up in residentials costing half a million dollars a year.[116]

Residential care

6.102 A number of submitters expressed strong support for therapeutic models of residential care, noting the benefits of a therapeutic model in supporting and improving long-term outcomes for children and young people.[117] The Salvation Army submitted that 'a comprehensive and therapeutic response is critical to support and improve long term outcomes for children and young people in out of home care'.[118] MacKillop Family Services submitted that therapeutic residential care was well-resourced:

> …allowing for more innovative and responsive staffing arrangements, higher staffing ratios, better training for staff and carers and access to therapeutic professionals.[119]

6.103 A number of submitters supported the implementation of nationally consistent therapeutic care models for all residential care facilities.[120] MacKillop Family Services recommended that 'all residential care should be funded and delivered from a therapeutic perspective' accompanied by increased funding commensurate to delivering enhanced therapeutic services.[121]

6.104 The committee heard that Victoria's therapeutic care model offers a good example for other jurisdictions (see Box 6.8). An independent evaluation undertaken by Verso Consulting of Victoria's therapeutic care pilot program found that the model provides better outcomes for children and young people than standard residential care.[122] Dr Nicholas Halfpenny from MacKillop Family Services told the committee of the benefits of the Victorian model:

> For a very long time, residential care has been the end of the line. I think it has been a place where young people who have been too hard to place anywhere else have been and the system has waited for them to turn 18, so they age out of the system. I think that the model in Victoria—therapeutic

116 Mr Rob Ryan, State Director, Key Assets, *Committee Hansard*, Brisbane, 17 April 2015, p. 27.

117 See: Life Without Barriers, *Submission 68*; CFWAA, *Submission 65*; AASW, *Submission 18*; NTCOSS, *Submission 72*; Salvation Army, *Submission 40*, p. 6; Baptcare, *Submission 50*.

118 Salvation Army, *Submission 40*, p. 6.

119 MacKillop Family Services, *Submission 70*, p. 6.

120 See: Salvation Army, *Submission 40*, p. 14.

121 MacKillop Family Services, *Submission 70*, p. 5.

122 Verso Consulting, *Evaluation of the Therapeutic Residential Care Pilot Programs: Final Summary & Technical Report*, 4 November 2011, pp 4 – 5, http://www.dhs.vic.gov.au/about-the-department/documents-and-resources/reports-publications/evaluation-of-the-therapeutic-residential-care-pilot-program (accessed 10 August 2015).

> care model—has been a great development. It has really reanimated residential care as a better care option for young people.[123]

Box 6.8 – Best practice – Therapeutic Residential Care model, Victoria

In 2007, the Victorian Department of Human Services piloted the therapeutic residential care model. The pilot was extended to 12 sites in 2008 and is delivered by Community Service Organisations (CSOs). Therapeutic residential care provides a therapeutic specialist linked to each home, an increased number of staff, mandatory trauma-informed training, planned care transitions including matching of clients, and provision of a more home-like environment.

An independent evaluation conducted by Verso Consulting in 2011 of Victoria's therapeutic residential care model found that the model achieved better outcomes than standard residential care. These improved outcomes included:

- improvements in placement stability;
- improvement in quality of relationships and contact with family;
- significant improvement over time in quality of contact with their residential workers;
- increased community connection;
- improvements in sense of self;
- increased healthy lifestyle and reduced risk taking;
- enhanced mental and emotional health;
- improved physical health; and
- improved relationships with school.

The Victorian Auditor-General's 2014 report into residential care noted 80 placements have been funded under this model. CSOs delivering a therapeutic placement receive a loading of $74 850 on top of their current funding level. The Commission for Children and Young People noted therapeutic placements accounted for around 17 per cent of residential care placements in Victoria.

Source: Victorian Government, Submission 106, p. 7; Centre for Excellence in Child and Family Welfare, Submission 99, p. 19; CCYPV, Submission 45, pp 17–18.

6.105 Mr Gregory Nicolau, CEO of the Australian Childhood Trauma Group, suggested that the Jasper Mountain Centre in the United States provided the best example of therapeutic residential care in the world (see Box 6.9).[124] Mr Nicolau explained that, in the Jasper Mountain model:

> children are sent away from the home in which they have been abused and live in a large residence on the top of a mountain. It provides an intensive residential treatment program with a therapeutic school; a short-term residential centre; a treatment foster care program; a community based "wraparound" program and crisis response services. The facility offers a

123 Dr Nicholas Halfpenny, Director of Policy and Quality, MacKillop Family Services, *Committee Hansard*, Melbourne, 20 March 2015, p. 8.

124 Mr Gregory Nicolau, CEO, Australian Childhood Trauma Group, *Committee Hansard*, Canberra, 16 April 2015, p. 26.

combination of traditional psychological and psychiatric interventions with innovations in treating abused and emotionally disturbed children.[125]

Box 6.9 – Best practice – Jasper Mountain residential care

Jasper Mountain, established in 1982 and based in Oregon in the United States, provides a continuum of programs that meets the complex needs of children and their families. Jasper Mountain's programs are aimed at children aged 3 to 12 with backgrounds of abuse and neglect.

Programs offered by Jasper Mountain include intensive residential treatment, an integrated therapeutic school, a short-term residential centre, treatment foster care, community based wraparound and crisis response services.

The Stabilisation, Assessment and Family Evaluation (SAFE) Centre provides an alternative to psychiatric hospitalisation. The length of time children stay in the program ranges from 3 to 90 days. Placements are generally supported by child protection and mental health authorities.

An outcome data report by Jasper Mountain on 13 children discharged from the intensive residential treatment program in 2013 indicated:

- most of the problem behaviours children entered the program with were eliminated;
- all children experienced an average 59 per cent improvement in clinical goals and objectives; and
- 75 per cent of children showed an improvement in relationship skills and ability to attach and bond.

Source: Jasper Mountain Centre, http://www.jaspermountain.org/index.htm (accessed 27 May 2015).

Committee view

6.106 The committee recognises the potential of therapeutic models of care that address trauma and abuse to improve outcomes for children and young people in out-of-home care. The committee is of the view that therapeutic foster care and residential care models has contributed to better outcomes for children and young people than existing forms of care. However, the committee is concerned these models are undertaken on a relatively small scale and are only available to a small proportion of children and young people.

6.107 Although there is a high cost in the short-term to deliver therapeutic models, the committee considers that it is essential to ensure children and young people receive the support to address trauma and abuse. The committee also recognises the potential long-term benefits for children and young people, and significant cost savings for all levels of government.

6.108 The committee also notes no consistent definition or application of the way 'therapeutic care', as it is currently applied and sees benefit in the development of national standards and guidelines for therapeutic care.

Financial support for home-based carers

6.109 Most financial support for home-based carers is provided by state and territory governments via carer allowances, which differ based on the age of the child

125 Australian Childhood Trauma Group, *Submission 9*, p. [6].

and the assessed complexity of their needs. Direct Commonwealth funding specifically for carers is generally limited to family assistance and income support payments.[126]

6.110 The committee heard that the allowances for home-based carers differ widely across jurisdictions. For example, the 'general' allowance rate for a child aged under five years old in the Northern Territory is $225 per fortnight, whereas in Queensland, it is $463 per fortnight.[127]

6.111 Table 6.3 outlines the estimated carer allowances available for relative/kinship and foster carers. As discussed above, while relative/kinship carers are eligible for the same base rate allowances as foster carers, few relative/kinship carers are able to access the additional special needs allowances. This data was only received from some jurisdictions and does not include additional allowances and reimbursements available for specific purposes (for example, school fees, birthday presents, pocket money).

126 The most commonly claimed Commonwealth family assistance and income support payments for which foster carers and relative/kinship carers are eligible include the Foster Child Health Care Card; Double Orphan Pension; Family Tax Benefit; Schoolkids Bonus; Carer Payment; Childcare Benefit; Grandparent Child Care Benefit; Childcare Rebate; Parenting Payment; and Newstart Allowance. See: DSS, *Submission 78*, pp 9–10.

127 See: NT and Queensland Governments, answers to questions on notice, 30 April 2015 (received May-June 2015).

Table 6.4 – Relative/kinship and foster carer allowances

Jurisdiction	Fortnightly allowance	Additional special needs allowances
NSW	$455 - $688	Special needs + 1: $683 - $1031 Special needs + 2: $903 - $1360
VIC	$285.50 - $456.74	Intensive: $344.97 - $851.31 Complex: $923.12 - $1,443
QLD	$463 - $542	High support needs: $162 Complex support needs: $210 - $632
WA	$363.15 - $492.05	$72.63 - $393.64
TAS	$383.00 - $507.00	Level 1: $619.50 - $744.00 Level 2: $935.50 - $1060.00
NT	$225.30 - $966.60	Higher rates for children with complex needs Remote area loading for parents in remote locations

Source: Responses to Questions on Notice, May-June 2015

6.112 A number of submitters recommended that the committee consider 'the role the federal government might play in working with the states and territories to encourage national consistency to home-based care reimbursements.'[128]

Carer qualifications and training

6.113 The committee heard that there is a lack of consistency in qualifications and training for carers in all types of care across jurisdictions.

6.114 All carers are required to complete a range of checks prior to being approved as carers, including 'working with children' checks, administered by state and territory authorities.[129] Witnesses recommended the introduction of a national working with children check to allow carers to transition more easily between jurisdictions. Mr David Pugh from Anglicare in the Northern Territory told the committee, that in relation to foster carers:

128 See: Ms Maria Scott, General Manager, Baptcare, *Committee Hansard*, Melbourne, 20 March 2015, p. 6; University of Melbourne Department of Social Work, Child, Youth and Families Research Cluster, *Submission 66*, p. 23; OzChild, *Submission 19*, p. 6; CFWAA, *Submission 65*, p. 9.

129 See: State and territory governments, answers to questions on notice, 30 April 2015 (received May–June 2015).

> …when we recruit people from other states to come and work with us, it can take up to three months for their working-with-children clearance to be made, even though they have a clearance in another state. That is unnecessary red tape and it is a further barrier to employment.[130]

6.115 Some consistency across jurisdictions has been achieved through the adoption of the *Step by Step* assessment package and the *Shared Families, Shared Lives* training program developed by the Association of Children's Welfare Agencies and the *Our Carers Our Kids* course for carers of Aboriginal and Torres Strait Islander children.[131]

6.116 In June 2011, a national program for training foster parents, *Community Services Training Package CHCO8: Foster Care Skill Set*, was developed by the Community Services and Health Industry Skills Council. Completing units in the skill set package may provide credit towards Certificate IV in Child, Youth and Family Intervention, and Certificate III or Certificate IV in Children's Services.[132] However, submitters highlighted that there are no available data on how many foster parents have participated in or completed this training.[133]

6.117 There is no equivalent nationally consistent training for relative/kinship carers and workers in residential care facilities. The committee heard that in most jurisdictions, residential care is outsourced to the non-government agencies which are responsible for training carers.[134]

6.118 A number of submitters suggested establishing a national database for authorised carers across different types of care, which would include information on demographics, qualifications and experience.[135]

Role of the non-government sector

6.119 The committee heard the role of NGOs in the delivery and management of out-of-home care services varies widely across jurisdictions. Services may be delivered by CSOs (non-profit societies, associations or clubs established for community service purposes) or NGOs (non-profit non-government agencies).

6.120 Recent state and territory inquiries into child protection systems have suggested that the involvement of NGOs in delivering out-of-home care services may

130 Mr David Pugh, CEO, Anglicare NT, *Committee Hansard*, Darwin, 2 April 2015, p. 2.

131 University of Melbourne Department of Social Work, Child, Youth and Families Research Cluster, *Submission 66*, p. 17.

132 Training package details: CHC08 - Community Services Training Package, https://training.gov.au/Training/Details/CHC08 (accessed 13 May 2015).

133 Berry Street, *Submission 92, Attachment 1*, p. 16.

134 See: State and territory governments, answers to questions on notice, 30 April 2015 (received May–June 2015).

135 See, for example: Ms Alison Kearns, Expert Witness, Australian Association of Social Workers, *Committee Hansard*, Canberra, 16 April 2015, p. 55.

be beneficial.[136] Under the *Keep Them Safe* framework, NSW is moving towards using non-government organisations to deliver all out-of-home care services.[137] The proportion of children in out-of-home care provided by NGOs in NSW increased from 26.1 per cent in 2011-12 to 50.9 per cent in 2013-14. In 2013-14, care arrangements for 2 061 children were transferred to NGOs.[138]

6.121 The committee sought advice from all states and territories on the current role of the non-government sector in delivering out-of-home care services across the relative/kinship, foster and residential care. Table 6.4 outlines the differences between jurisdictions in the way services are delivered, including the number of NGOs accredited/authorised to deliver services.

136 See: Queensland Government, *Taking Responsibility: A roadmap for Queensland Child Protection*, June 2013, p. 192; *Report of the Special Commission of Inquiry into Child Protection Services in NSW: Executive Summary and Recommendations*, November 2008, p. xx.

137 NSW Government, *Keep Them Safe*, http://www.keepthemsafe.nsw.gov.au/ (accessed 21 April 2015).

138 NSW Government, answer to question on notice, 30 April 2015 (received 14 May 2015).

Table 6.5 – Role of non-government sector in delivering out-of-home care services across types of care

Jurisdiction	Foster care	Relative/kinship care	Residential care
NSW	14 NGOs (28 NGOs for foster and residential care)	Not available	18 NGOs accredited (28 NGOs for foster and residential care)
Victoria	Not available		All NGOs (except 2 facilities)
Queensland	22 NGOs Government/CSO co-delivery		26 NGOs
WA	11 NGOs Government/ NGO co-delivery	Government only	12 NGOs Government/ NGO co-delivery
SA	NGOs	Government only	Government/NGO co-delivery
Tasmania	3 NGOs	Government only	3 NGOs – therapeutic 2 NGOs – cottage care 3 NGOs – emergency and respite care
Northern Territory	Government only		Government/ NGO co-delivery 3 NGOs – residential care 4 NGOs – community-base care

Source: State and territory governments, answers to questions on notice, 30 April 2015 (received May-June 2015).

6.122 The role of government in foster care services delivered by NGOs differs across jurisdictions. For example, in Queensland, the government retains responsibility for approving carers, licensing care services, case management and referring all clients, funding services and monitoring service performance. In NSW, the government is responsible for funding, but most other services are undertaken by NGOs.[139]

6.123 Some jurisdictions, like NSW and Victoria, use a case management model where NGOs provide case management and a range of services for children, young people and their families and carers and other stakeholders. In other jurisdictions, case

139 See: NSW and Queensland Governments, answers to questions on notice, 30 April 2015 (received May–June 2015).

management is the responsibility of government agencies, and NGOs provide support services or case coordination.[140]

6.124 The WA Government advised the committee that 35 per cent of children in out-of-home care were supported by CSOs.[141] The Western Australian Council of Social Services (WACOSS) noted services delivered by CSOs have 'dropped down to about 10 per cent from about 25 per cent 15 years ago'.[142]

6.125 The committee heard that inconsistencies in the role of NGOs provide challenges for NGOs working across jurisdictions. Life Without Borders submitted that:

> [I]f a placement broke down in NSW, Life Without Barriers would be able to continue to support the child or young person following a placement breakdown if an alternative relative/kin option was able to be secured. Under the same scenario in the NT, Life Without Barriers would not normally be able to arrange alternate placements with relative/kin for children and young people as the funding agreement in place is individualised and linked to the placement and not to the child.[143]

6.126 The Alliance for Children at Risk, a representative group of non-government agencies in WA, noted it has developed a set of principles aimed at 'building the capacity of the community sector and also ensuring a better focus on trauma and also strengthening the regulation of the sector'.[144] One of the key principles is to increase the proportion of out-of-home care services delivered by CSOs to 50 per cent.[145]

6.127 Some submitters, however, did not support increasing the role of NGOs in delivering out-of-home care services. For example, Mr George Potkonyak, a solicitor with experience of child protection in NSW, submitted that 'private interests will always prevail over the interests of children if the system is in private hands.'[146]

6.128 The committee also notes there is no national performance framework for NGOs engaged in out-of-home care services. The National Children's Commissioner, Ms Mitchell, highlighted the positive impact of performance based contracting in the United States in reducing the overall numbers of children in out-of-home care.[147]

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140 Life Without Barriers, *Submission 68*, p. 6.

141 WA Government, answer to question on notice, 30 April 2015 (received 18 May 2015).

142 Mr Chris Twomey, Director of Policy, WACOSS, *Committee Hansard*, Perth, 16 February 2015, p. 8.

143 Life Without Barriers, *Submission 68*, p. 6.

144 Mr Chris Twomey, Director of Policy, WACOSS, *Committee Hansard*, Perth, 16 February 2015, p. 8.

145 WACOSS, *Submission 51*, p. 4.

146 Mr George Potkonyak, *Submission 27*, p. [7].

147 Ms Megan Mitchell, National Children's Commissioner, *Committee Hansard*, Sydney, 18 February 2015, p. 2.

Committee view

6.129 The committee notes the lack of national consistency across a range of issues related to support for children and carers, including carer allowances, carer qualification and support and the role of NGOs in delivering out-of-home care services. The committee is concerned that these differing approaches may have a negative impact on children and young people placed in care.

6.130 The committee is particularly concerned that there is a wide discrepancy in the amount that home-based carers are reimbursed across jurisdictions. The committee supports increasing the rates of allowances to a nationally consistent amount, commensurate with the actual costs of caring for children.