Stability Planning and Permanent Care Project 2013–14

Final Report

Department of Health & Human Services

State Government Victoria

Stability Planning and Permanent Care Project 2013–14

Final report

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This report describes the findings of the Stability Planning and Permanent Care action research project undertaken by:

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Contents

Project timelines

This report contains the findings of the Stability Planning and Permanent Care Project, undertaken by the Department of Health and Human Services (then known as the Department of Human Services).

The Stability Planning and Permanent Care project was undertaken to conduct research recommended by the Protecting Victoria's Vulnerable Children Inquiry (2012). The Inquiry recommended the research because it was unable to identify the reasons for the apparent harmful delays in achieving permanent care arrangements for children placed in out of home care by the Children's Court of Victoria as a result of abuse or neglect.

The project brief was to identify the barriers to earlier resolution of permanency in a child's care arrangements, to test strategies to overcome those barriers, and to make recommendations for changes to policy, practice and legislative to promote more timely decisions and outcomes.

Project component	Dates
Consultations, scoping, establishment of reference Group, appointment of project manager	August – December 2012
Recruitment of project staff	November 2012 – January 2013
Commencement of project staff	January – March 2013
Initial review of cases in scope	January – April 2013
Action research	May 2013 to March 2014
Documentation of project	April to August 2014
Completion of project report	September 2014
Publication of project report	June 2015

A. Executive Summary

This executive summary provides an overview of the project and a summary of the project's findings and recommendations.

The Stability Planning and Permanent Care project was undertaken to conduct research recommended by the Protecting Victoria's Vulnerable Children Inquiry (2012), The project was undertaken during 2013 and early 2014, and employed 24 project staff for 12 months, most of whom commenced in February and March 2013. The project answered to a reference group consisting of a wide range of stakeholders

The project cohort consisted of children aged under 10 as at January 2013, who had been in out of home care for more than a year, with particular emphasis on those without a clear permanency plan and those with a permanent care case plan but no permanent care order. The project teams conducted an initial review of all of these cases in the first months of the project and collected detailed data for analysis.

Having eliminated some cases from the initial sample (for instance because the child had already returned home), there were 1,332 cases in the cohort about whom data was collected. There were 160 children in this cohort who were found to have an appropriate reunification case plan, and so there were 1,172 children where some more detailed data was collected.

Finally there were 336 children amongst the remaining 1,172 who were assessed as being in an appropriate long-term placement, even though there was no permanent care order. The most detailed data was collected on the remaining 836 children who did not have a viable reunification case plan and who were not placed in an appropriate long-term placement.

The second stage of the project used an action research methodology in which the project teams provided a consultation service to allocated workers and undertook direct casework and case planning where appropriate. They also developed a training package and provided professional development sessions, in response to an early finding that many practitioners lacked the skills, knowledge and confidence to undertake long-term casework that focussed on timely permanency resolution. Where gaps were identified in practice resources such as assessment frameworks, the project workers developed documents and templates for use in the field.

The evidence base developed by the project consists of several elements:

- Analysis of high level data available in CRIS helped to provide a context for the work of the project and the key data can be found in part 2 of this report
- The initial review of each case in the cohort provided baseline data that is described in Appendix 1 to the report. Relevant findings from the initial case review can also be found at the beginning of each chapter in part three of the report
- Project workers completed templates on each of the cases from the action research stage of the project, as well as some more detailed case summaries to illustrate particular points. The action research findings are summarised at the beginning of each chapter in part 3 of the report and excerpts from the templates and case studies are quoted from throughout part three
- The project team managers provided monthly reports to the central project manager, which identified progress on cases and emerging issues. These helped to determine the focus of the project and contributed to the content of part 3 of the report
- The views of carers were canvassed directly at meetings and forums, and some carers participated in a survey. The views of carers and the results of the carer survey are described in chapter 3.13

The key findings and recommendations of the project are summarised in the next section, and are also contained in context in part 3 of the report. Each chapter in part 3 covers one of the main themes of the project. Each chapter starts with a summary of relevant findings from the initial case review and from the action research stage of the project and then provides a more detailed description of the issues and attempts to address those issues. Key findings and recommendations are highlighted in text boxes> Relevant quotes from project documents are included to illustrate some points.

B. Summary of findings and recommendations in each chapter

2 Background information

Finding 1. The data analysis undertaken as part of the project showed that the average length of time from a report being made to a permanent care order being made in 2012–13 was 56 months, and that this reduced to 52 months once the action research phase of the project got under way.
Finding 2. The proportion of children in out of home care who had been in out of home care for less than 1 year decreased from 49% in 2002 to 26% in 2013.

3.1 Children

Finding 3. Children may feel embarrassed if they are too easily identified as being placed in out of home care, and may feel stigmatised if their status deprives them of opportunities afforded to their friends and peers.
Recommendation 1. That a legal framework should be developed within the *Children, Youth and Families Act 2005* that clearly enables the Secretary to make decisions or authorise the child's carer to make decisions about the child while the child is in their care. Decisions that have a long-term impact should require the agreement of the child's birth parents where the plan is for reunification, unless otherwise ordered by the Children's Court.

3.2 Additional needs of children

Finding 4. There were 497 additional support services provided to the 836 children placed with intended permanent or long-term carers, and a further 207 services required but not provided.

Recommendation 2. Permanent carers should be able to access resources to address the special needs of children in their care and to ameliorate the impact of harm and trauma. Where this isn't achieved by arranging provision of services to meet foreseeable needs during case planning for permanent care, the establishment of a placement support service to which permanent carers can apply for assistance if needs arise later on should be considered. Consideration could also be given to giving permanent carers priority access to government provided or funded services.

3.3 Aboriginal children

Finding 5. 28% of the children in scope were Aboriginal. This is a very significant degree of over-representation. Most of these children did not have a cultural support plan, placing them at risk of losing connection with their kin, their identity, their land and their culture.
Finding 6. A cultural support plan had been completed for 26 out of 39 (67%) Aboriginal children subject to a guardianship to the Secretary order, but for only 19 out of 127 (15%) Aboriginal children in out of home care for more than a year and subject to other orders (mainly custody to the Secretary orders).
Finding 7. There are often delays in conducting Aboriginal Family-led Decision Making (AFLDM) processes and meetings. The processes and meetings are often poorly planned and documented. They are not always conducted in a culturally sensitive manner and do not always include people who would be important participants if they were present.
Finding 8. AFLDM convenor positions, as well as other positions where Aboriginal applicants are required or preferred, are often vacant for lengthy periods due to a shortage of qualified Aboriginal people with the necessary qualifications and experience, and with a desire to work in the child protection field.
Finding 9. There are a variety of views held by Aboriginal people and organisations about permanent care, and there are also differing views amongst Child Protection practitioners. There is a need to create a stronger consensus so as to avoid delays to permanency resolution that are caused by the potentially conflicting views of professionals involved in each case.
Finding 10. Aboriginal children, on average, spend about 40% more time in out of home care than non-Aboriginal children. The over-representation of Aboriginal children in out of home care is partly caused by proportionately more Aboriginal children entering care, but it is also caused by the longer periods that Aboriginal children spend in care.
Finding 11. In 2012-13 Aboriginal children, on average, waited one year and 4 months longer (70 months = 30% longer) for a permanent care order than non-Aboriginal children (54 months)..

Recommendation 3. Funding should be provided and processes should be designed so that all Aboriginal children placed in out of home care have a plan to meet their cultural needs. A plan will always be required, but the extent of the plan required may depend on the case plan objective, the length of time the child is expected to be placed in out of home care and the extent to which carers are connected to the child's culture and community.
Recommendation 4. The department should hold discussions with Aboriginal organisations to develop a dispute resolution process where there is disagreement between the department and an Aboriginal organisation about whether the child's current carers are the best potential permanent carers for an Aboriginal child.
Recommendation 5. The department should develop a strategy to improve the operational capacity of Aboriginal organisations and to address the under-representation of qualified and experienced Aboriginal professionals in the broad child protection field where Aboriginal children are so over-represented.
Recommendation 6. Because the AFLDM program has not been able to complete AFLDM processes in the numbers expected, and nor has it been able to improve compliance with cultural plan requirements, there should be a review of how the program is delivered, supported and resourced.
Recommendation 7. The department should hold discussions with the Commissioner for Aboriginal Children and Young People and with Aboriginal agencies to create a better understanding of when it is appropriate for applications for Permanent Care Orders to be made in relation to Aboriginal children.
Recommendation 8. Consideration should be given to making long-term Guardianship to Secretary orders available to children of any age where a carer has been identified who can care for the child until they are 18, but where the carer or an Aboriginal agency does not agree to a permanent care order being made.

3.4 Siblings

Finding 12. Planning for siblings to be placed together is often inadequate and, where they are placed separately, contact arrangements are often insufficient to maintain long-term relationships between siblings. This is a significant loss for a child in out of home care or alternate permanent care as siblings can provide the most enduring relationships throughout a person's life.

Recommendation 9. Decision makers should be required to consider the care history of the child's siblings and the importance of promoting the child's membership of their sibling group when making care and permanency decisions.
Recommendation 10. The department should promote ongoing contact between siblings in all circumstances and should review existing policy and practice advice with regard to the case management and case planning of siblings and should explore the benefits of convening combined care team meetings where siblings are placed separately in out of home care.

3.5 Parents

Finding 13. Adoption is rarely raised as an option in child protection case planning. Only one case in the project cohort had a case plan for adoption. Some permanent care orders are made by consent. Where consent is forthcoming, a discussion should be had as to whether adoption may be a better option for the child.

Recommendation 11. Adoption should be discussed and considered as an option in those cases where parents are willing to consent to a permanent care order, especially if the child is still very young.
Recommendation 12. Services should be provided for the birth parents of children who require permanent alternate care to assist them in coming to terms with the loss of their child and the need to establish suitable contact arrangements, and also to provide referrals to services that may assist them in other ways that might be needed.

3.6 Case Planning

Finding 14. Of the children who had a long-term or permanent care case plan and who were not in a placement planned to be their final placement, only 61% had a stability plan recorded on their file, and many of these plans were very basic. In the cases with a stability plan, 32% of the plans had not been completed within the statutory timelines described in the Children, Youth and Families Act section 170(3).

Finding 15. The stability planning framework in the Children, Youth and Families Act has failed to achieve the timely decision making that was intended.

Finding 16. Case plan categories in the Child Protection database include "Time Limited Assessment". Several cases had been classified in this way for far longer than a specific assessment would take to complete. One case had been categorised in this way for more than 2 years. The distinction between other case plan categories was not always clear, and this led to inconsistency in their use and a lack of clarity about their purpose.

Recommendation 13. The Act should be amended to incorporate a more comprehensive permanency planning framework with clear timeframes applying to both Children's Court and departmental case plan decision making processes.

Recommendation 14. The current stability planning timelines in the Children, Youth and Families Act should be reviewed and timelines should be applied to achieving reunification as well as to achieving permanent or long-term alternate care arrangements. Efforts should be focused on achieving reunification within 12 months wherever possible. A further 12 month period of planned reunification can also be justified where it is assessed, based on evidence of progress already made, that reunification is likely be achieved during the second period of 12 months. Permanent or long-term alternate care arrangements should be sought for children who have been in out of home care for more than 2 years – and earlier if reunification is clearly not going to be achieved.

Recommendation 15. The description of each type of case plan must include a clearly expressed objective to drive purposeful action. This is best achieved by adopting the permanency planning hierarchy (family preservation, family reunification, permanent care or adoption, long-term care). The permanency planning framework has the additional advantages that it drives planning from the start of intervention and requires a clear timeframe for decision making and review.

Recommendation 16. All references to "non-reunification case plans" are to be removed from program documentation and replaced by a reference to "permanent care case plans" or "long-term out of home care case plans" (or "transition to independence" for planned care-leavers) whichever is the most appropriate.

Recommendation 17. That the department review the advice provided to case planners and practitioners about what the basic minimum requirements for the development of case plans are, with particular reference to the involvement of parties in the process, as required by section 11 of the Children, Youth and Families Act.

Recommendation 18. Case plan formats in CRIS (the child protection electronic client records system) are too complex and cumbersome and need to be simplified. The basic case plan should only include key decisions about where the child lives, who they have contact with, what the permanency objective is and which services are to be provided. All case plans should be documented in such a way that their existence and their contemporaneity can be easily monitored in data that can be extracted from client relationship information system

3.7 Child Protection allocation capacity and workloads

Finding 17. Children and families have to deal with numerous changes of worker, and this causes delays in the process of implementing and resolving case plans. It also means that relationships have to be made and ended and that no single worker is directly familiar with any substantial part of the case. The average child in the project cohort had experience 10.4 different workers during the period of intervention (and up to 29). Where there was contracted case management children typically also had two contracted agency workers, although some had as many as 11.
Finding 18. The more structured and task-oriented casework conducted in larger offices with specialist teams is intended to promote efficiency and case throughput and assist in managing workloads. Further analysis of the losses and gains arising from such arrangements may be warranted compared to the potential for better engagement and more timely outcomes arising from the consistent allocation of one worker to a case where this is possible.

Recommendation 19. That a KPI, or KPIs, be implemented to raise the profile and to measure the effectiveness of permanency planning and long-term casework.
Recommendation 20. The recent introduction of an area-based service model may provide opportunities to replicate some of the improved allocation continuity and consequently more timely permanency outcomes that are often achieved at smaller offices. Consideration should be given to how best to optimise these opportunities within the area-based model.
Recommendation 21. The various report and assessment formats in CRIS, along with the auto-populate functions of CRIS, should be reviewed so as to promote the production of concise documents that clearly explain assessments and recommendations and their rationale and – as a result – provide better assistance to decision makers and participants in the decision making process.
Recommendation 22. The program's expectations about the desirable frequency and nature of client contact by practitioners need to be more clearly promoted and monitored, along with continuity of workers who have contact with clients.

3.8 Skills, knowledge and capacity of professionals

Finding 19. The project found that the workforce required additional professional development and practice support in undertaking long-term casework in general and in developing, implementing and communicating clear permanency plans in particular. Use of authority in a constructive way to advocate for the child's needs seemed to be a particular issue for many workers.
Finding 20. Project workers found that, at least in some cases, the changes of worker and the divided responsibilities involved in contracting case management to community services had created delays in progressing permanency planning.

Recommendation 23. The department should ensure that permanency objectives are pursued by contracted case management organisations in a timely manner and ensure that the process of establishing contracting arrangements does not create unnecessary delays in progressing permanency planning.

3.9 Court decision making

Finding 21. The system encourages negotiated outcomes because the alternative is a lengthy adjournment for a contest during which time little progress or change in the family may be achievable. Negotiated outcomes are, by their nature, compromises, and there are instances where practitioners believe that the child's needs are not properly met.
Finding 22. The lengthy delays accompanying contested cases contribute to poor outcomes for children, as children spend lengthy periods of uncertainty in out of home care while the case plan direction is resolved, and during which period the contest may hinder progress being achieved by their family towards resuming care.
Finding 23. Although it is not the intention of the Children, Youth and Families Act, project workers reported that the culture that has developed in the Children's Court over many years seems to have skewed the issue of proof that a child is in need of protection close to a finding of parental guilt.
Finding 24. There needs to be a better fit between court and case plan decision making so as to provide both legal and administrative support to the most appropriate intervention plan for the child.

Recommendation 24. That a decision by the court to order the placement of a child in out of home care for more than 6 weeks should, wherever possible, be accompanied by a finding that the protection application has been proved.
Recommendation 25. That the Children's Court should not make an interim accommodation order if an application has been proved and if there is sufficient evidence to make a protection order.
Recommendation 26. That a family reunification order should be one of a new set of protection orders that would enable the court to make decisions that have a clear objective (family preservation, family reunification, long-term or permanent care). Orders should also contain a timeframe in which the objective is to be achieved. This would make the intention of orders apparent, and also remove conflicts between the intent of the order and the case plan.
Recommendation 27. That the Children's Court should continue to explore ways of resolving matters using alternate dispute resolution processes and more informal processes in the court itself.
Recommendation 28. That the department should submit separate reports to the Children's Court regarding proof and disposition, and that the issues of proof and disposition should be considered separately and consecutively by the court.
Recommendation 29. Where a decision is made by the court to order the placement of a child in out of home care, a new type of order that specifically promotes family reunification should be available, except in those few cases where it is already apparent that the child will not be able to return to their parents' care.

3.10 Assessment and support of carers

Finding 25. There is a range of views about what financial and other support should be provided to carers. The actual support provided to different carers varies, and not always for clear and consistent reasons. Where support is not available, carers experience distress and, if support has to be paid for, hardship. The fear of a lack of support being provided was a major deterrent to people volunteering to become carers, and it also deterred foster and kinship carers from becoming permanent carers of children already in their care.

Recommendation 30. That the Kinship Carer Assessment Part A be renamed "Kinship Carer Initial Safety Assessment" and that the Part B assessment be renamed the "Kinship Carer Safety and Wellbeing Assessment".

Recommendation 31. That the Kinship Carer Assessment "Part D" framework developed by the project workers be adapted for inclusion in the Child Protection practice manual and for use in the field. Part C and D assessment frameworks also require a clear name: perhaps "Kinship Carer Safety and Wellbeing Review" and "Kinship Permanent Carer Assessment".

Recommendation 32. A review of the adequacy of assistance provided to permanent carers should be conducted. The review should include consideration of the adequacy of financial and practical assistance, access to services and provision of support.

Recommendation 33. That a post-placement support service be established to provide advice, counselling and financial assistance where needed and referrals to other services for permanent carers in need of assistance.

Recommendation 34. That a directory of available services and financial and other assistance available to permanent carers and long-term carers be compiled, regularly updated and made easily accessible to Child Protection case planners, practitioners and carers.

Recommendation 35. That agency foster care targets should take account of the desirability of conversions to permanent care where appropriate and not create actual or perceived disincentives to conversions.

Recommendation 36. That long-term orders placing a child in the care of the Secretary be made available to children of all ages who are in a stable placement intended to last until at least their 18th birthday, with the consent of the carer and with the consent of the child if aged 10 or older (this now being the accepted age at which children can give instructions).

Recommendation 37. A consistent statewide framework to assess the suitability of prospective permanent carers should be developed and implemented. The framework should be reviewed periodically to ensure the continuing relevance of the contents.

Recommendation 38. An agreement or protocol between the department and Births, Deaths and Marriages should be developed to promote clarity and consistency when trying to resolve issues to do with birth certificates, passport and any application regarding a name change.

3.11 Contact (access) and permanent care

Finding 26. Contact conditions on permanent care orders are often arrived at through a process of negotiation that is focussed on the parents' wishes and the carer's wishes, rather than an assessment of the child's best interests.

Finding 27. Contact conditions sometimes make it harder to recruit permanent carers for a child (or to persuade kinship or foster carers to become permanent carers), and sometimes threaten the stability of permanent care placements. Court ordered contact conditions, even if initially appropriate, are inflexible and may be in force for many years after they have ceased to be appropriate. A potentially contested and expensive application to the court is needed to vary the conditions.

Recommendation 39. There is no simple solution to the issue of contact and permanent care orders. The potentially conflicting rights and wishes of the child, the carer and the child's birth family somehow need to be accommodated. Contact conditions need to:

- Ensure that contact is in the child's interests
- Be flexible over time as the child's needs and wishes change
- Provide for an ongoing relationship between the child and their birth family (parents, siblings, significant kin)
- Not jeopardise placement stability or place unreasonable demands on the carer
- Be mediated by assistance from a permanent care support service where this is necessary
- Not create conflict that has a negative impact on the child
- Not cause the child to miss out on activities with the carer family or with schools or friends that are important to them.

3.12 Revocation of permanent care orders

Recommendation 40. That the Children, Youth and Families Act should be amended to require birth parents to seek the leave of the court to make an application to revoke a permanent care order.

1. Introduction

Background to the project

There were 82,075 reports made to Child Protection in Victoria in 2013–14. Where it is assessed that a reported child may be in need of protection, Child Protection practitioners will investigate the matter. More than 20,000 investigations were undertaken in 2013–14, while other reports were responded to by the provision of advice, information or referral to services.

In some instances where the protection of a child cannot be achieved in any other way, an investigation leads to a protection application being made to the Children's Court of Victoria. If satisfied that the child is in need of protection, the court can make a protection order and over 3,000 reports in 2013–14 resulted in this outcome.

Many children made the subject of a protection order are placed in out of home care because they are not safe in their parents care. In most instances these children return home once the problems at home have been addressed. For some children a safe return home cannot be achieved, and other long-term (and preferably permanent) care arrangements need to be secured.

In 2011, the Victorian government commissioned an inquiry into Child Protection. The *Protecting Victoria's Vulnerable Children Inquiry* (PVVCI) report, published in January 2012, found that:

> In Victoria there were 203 permanent care orders made in 2009–10. The average age of children when they commence permanent care orders is around 6.5 years, and the average age of children on permanent care orders is 10.5. Nearly 90 per cent of these orders were made more than 2 years after the initial substantiation of harm. The average time taken between a child's first report and their ultimate permanent care order, at just over five years, is too long. For children who have been abused and known to statutory child protection services at a young age, it takes too many years for a permanent care order to be granted when this is necessary to ensure their safety and wellbeing. During this time, many children are subjected to multiple placements, compounding psychological harm.[1]

The five years referred to in the PVVCI report represent a period of instability and uncertainty for a child and may cause further harm to children who have been placed in care after they have already suffered significant harm in their own family. Five years is a long time even for an adult, but children experience it as a far longer time. Five years constitutes most of the child's lifetime at the point where a typical permanent care order is made.

The PVVCI was unable to determine why it took so long to formalise alternate permanent care arrangements, and the government funded an action research project to identify the barriers to more timely permanency resolution and to recommend changes to policy, practice and legislation to address those barriers. This report documents that project.

Project methodology

The Stability Planning and Permanent Care Project (the project) was funded by the Victorian government.

A project reference group was established in September 2012 that included representatives from across the child protection, placement and family services sector to guide the project. Advice on methodology was also obtained from an academic advisory group.

[1] *Report of the Protecting Victoria's Vulnerable Children Inquiry*, State of Victoria, Department of Premier and Cabinet, January 2012, page 229.

The project staff consisted of a central project manager, 7 child protection team managers, 15 child protection practitioners located in child protection offices across the State, and one practitioner located at the Victorian Aboriginal Child Care Association (VACCA).

Their initial task was to review the approximately 1,600 children who had been identified from the Child Protection program electronic client record system (CRIS) as being under 10 years of age and placed in out of home care for more than 12 months, or subject to a permanent care case plan without a permanent care order. This process consisted of reviewing the information in the CRIS client file and interviewing child protection practitioners and contracted community services workers to validate the data. The initial review, which required up to 100 questions to be answered on each case, collected case characteristics that could assist in identifying any issues causing delays to permanency resolution.

A summary of the findings of the initial review is attached as Appendix 1 to this report, and the survey tool that was used is attached as Appendix 2. Relevant key data from the initial review is also shown at the beginning of each section of the main report.

The second phase of the project was the action research phase. Project workers prioritised cases that were confirmed as meeting the project cohort criteria in the initial review. Project workers intervened by offering advice and support to case planners, case practitioners and agency staff. They also, where appropriate, undertook case planning and case work to promote permanency.

Project workers were required to collect qualitative and quantitative date on each case they worked on, and this data was collected by the completion of a template on 707 of the cases where intervention occurred. Relevant data from these templates is summarised at the beginning of each section of the main report.

The case consultation and casework activities enabled the project to clarify the key issues involved in resolving permanency and to test strategies to overcome barriers that were identified.

Project workers also undertook a range of programmatic work in order to address barriers which resulted from deficiencies in professional development and program resources. For example, training packages were developed and delivered to divisional child protection practitioners and information sheets and assessment frameworks were developed to provide practitioners with necessary resources to support their practice.

Consultations were held with groups of carers and potential carers to elicit their views on the relevant factors that impacted upon their capacity and willingness to care for children in out of home care, especially with regard to potential permanent care arrangements. These consultations were followed by a survey of carers. Their views are described in this report.

Nearly one hundred more detailed case studies were documented in order to highlight the types of issues identified. Quotes from these case studies occur throughout this report to illustrate particular issues. Section 534 of the *Children, Youth and Families Act 2005* prohibits publication of any matter that contains particulars likely to lead to the identification of a child who is the subject of an order made by the Children's Court of Victoria. All reasonable precautions have been taken to ensure that the case studies contained in this report have been adequately de-identified so as to comply with this requirement.

The report describes the issues identified and the outcomes achieved, and it highlights key project findings and recommendations.

This is the most comprehensive research ever undertaken about issues related to permanency planning and permanent care in Victoria.

The project provides a solid evidence base for improvements to policy, practice and legislation to better meet the need to achieve timely permanency in care arrangements for children placed in out of home care.

2. Background information and project data

This section provides background data on issues relevant to the project and also explains in more detail how children were identified as being part of the project cohort and some of the high level findings in relation to the action research cohort.

2.1 Background data

Family reunification

Permanency planning promotes family reunification as the most desirable outcome for children in out of home care, provided that the child is unlikely to suffer further significant harm within the family. Where reunification is indicated it is critical this occurs as quickly as possible because this:

- reduces the period of harmful uncertainty experienced by the child
- minimises disruptions to attachments and family relationships
- where it can be safely achieved quickly, is more likely to be enduring.

The following table shows the number of children returning home each year from 2000–01 to 2011–12 broken into cohorts of children who had spent particular lengths of time in care before returning home. So, for example, in 2000–01 there were 2,444 children returned to the care of their parents and 59 of these children had spent more than 5 years in out of home care (highlighted in red). In 2011–12, there were 2,247 children returned to the care of their parents and 273 of these children had spent more than 5 years in out of home care (highlighted in blue). [2]

Table1: Number of children reunified per year, by time in care

ReUnification Period	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	Total
Less than 6 months	1560	1663	1595	1480	1409	1241	1166	1088	1074	1079	1035	1126	15516
6 months to less than a year	346	352	317	338	341	322	290	268	280	290	303	277	3724
1 year to less than two years	292	330	262	283	300	269	319	297	288	370	322	272	3604
2 to less than 5 years	187	244	272	285	269	270	278	266	296	352	287	299	3305
5 years or more	59	91	117	118	135	156	198	227	180	235	247	273	2036
Grand Total	**2444**	**2680**	**2563**	**2504**	**2454**	**2258**	**2251**	**2146**	**2118**	**2326**	**2194**	**2247**	**28185**

The following table shows the same data but expressed as a percentage of children returning home each year from 2000–01 to 2011–12 broken into cohorts of children who had spent particular lengths of time in care before returning home.

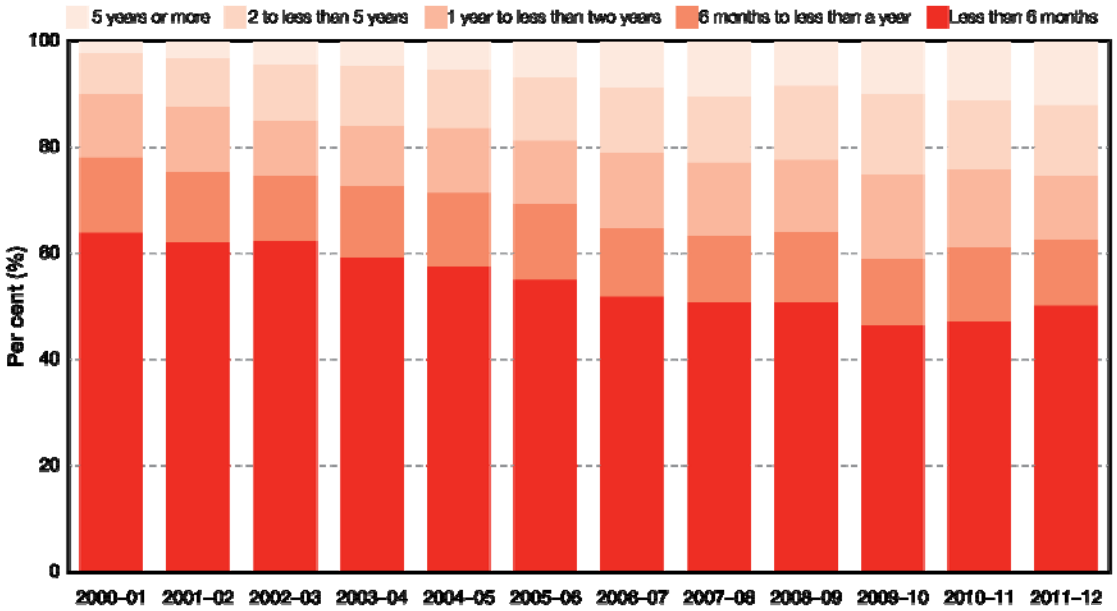
Table 2: Percentage of children reunified per year, by time in care

ReUnification Period	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	Total
Less than 6 months	63.8%	62.1%	62.2%	59.1%	57.4%	55.0%	51.8%	50.7%	50.7%	46.4%	47.2%	50.1%	55.1%
6 months to less than a year	14.2%	13.1%	12.4%	13.5%	13.9%	14.3%	12.9%	12.5%	13.2%	12.5%	13.8%	12.3%	13.2%
1 year to less than two years	11.9%	12.3%	10.2%	11.3%	12.2%	11.9%	14.2%	13.8%	13.6%	15.9%	14.7%	12.1%	12.8%
2 to less than 5 years	7.7%	9.1%	10.6%	11.4%	11.0%	12.0%	12.4%	12.4%	14.0%	15.1%	13.1%	13.3%	11.7%
5 years or more	2.4%	3.4%	4.6%	4.7%	5.5%	6.9%	8.8%	10.6%	8.5%	10.1%	11.3%	12.1%	7.2%
Grand Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

As can be seen in the table above and the graph below, the proportion of children returning home after less than 6 months in out of home care (the blue component of each bar in the graph) fell from 63.8% in 2000–01 to 50.1% in 2011–12. At the other extreme, the proportion being returned home after 5 years or more in care increased from 2.4% to 12.1%. It is clear from this comparative data that it took proportionately longer to reunify children with their families in 2011–12 compared to 2000–01.

[2] All data in this report is derived from the Child Protection electronic client record system (CRIS) except where otherwise stated.

Graph 1: Percentage of children reunified per year, by time in care



Little attention has been paid to trends in the period of time taken to achieve reunification. Although the primary focus of the project was on barriers to achieving timely alternate permanent care, information was inevitably collected along the way about barriers to timely family reunification. The barriers were found to be similar for both outcomes and include:

- Longer and more contested court hearings delaying final outcomes
- Delays in case planning and case plan implementation caused by unresolved court matters, review processes and related to workload management issues (including changes of practitioner, increased case contracting and periods awaiting allocation)
- Lack of available alternate permanent carers resulting in attempts to reunify being pursued for longer periods
- Raising of thresholds to manage increasing demand on the Child Protection service leading to children who enter the child protection and out of home care system having higher needs.[3]

The increased time that children spend in out of home care before reunification is important background information. It means that children are in care for longer periods of time before plans for permanent alternate care are made. This in turn means that children are likely to have experienced more trauma and be older and therefore harder to place with permanent carers unless their current kinship or foster carer is prepared to become the child's permanent carer.

Permanent care orders

The Children's Court of Victoria can make a permanent care order which grants custody and guardianship to the child's carer or carers "to the exclusion of all other persons"[4] when it is not in the child's best interests for the child's parent to resume custody and guardianship of the child.[5]

The project's aims were to identify the barriers to resolving permanent care arrangements in a timely way, and to test and identify strategies to overcome those barriers. This evidence was then to be used as the basis for proposed changes to policy, practice and legislation.

[3] Demand on the Child Protection service more than doubled from 37,100 reports in 2000–01 to 82,075 reports in 2012–13. In the same period, the investigation rate fell from 36% to 26%.

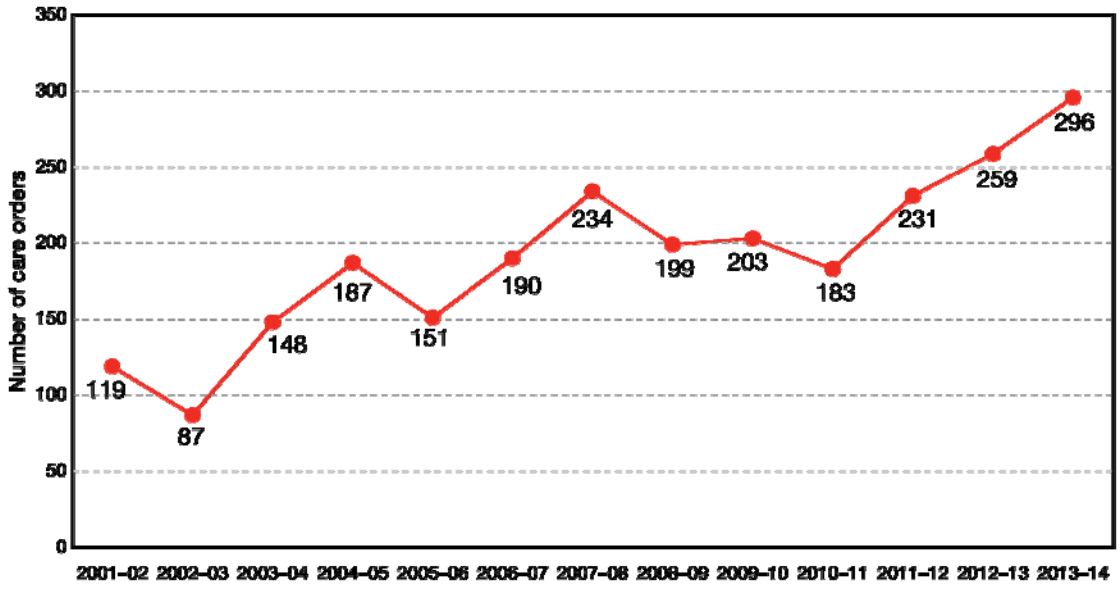
[4] Children, Youth and Families Act 2005 section 321.

[5] Children, Youth and Families Act 2005 section 319

It is too simplistic to measure the impact of the project purely in terms of the number of permanent care orders made, since other arrangements – including successful reunification – may achieve permanency in care arrangements for a child.

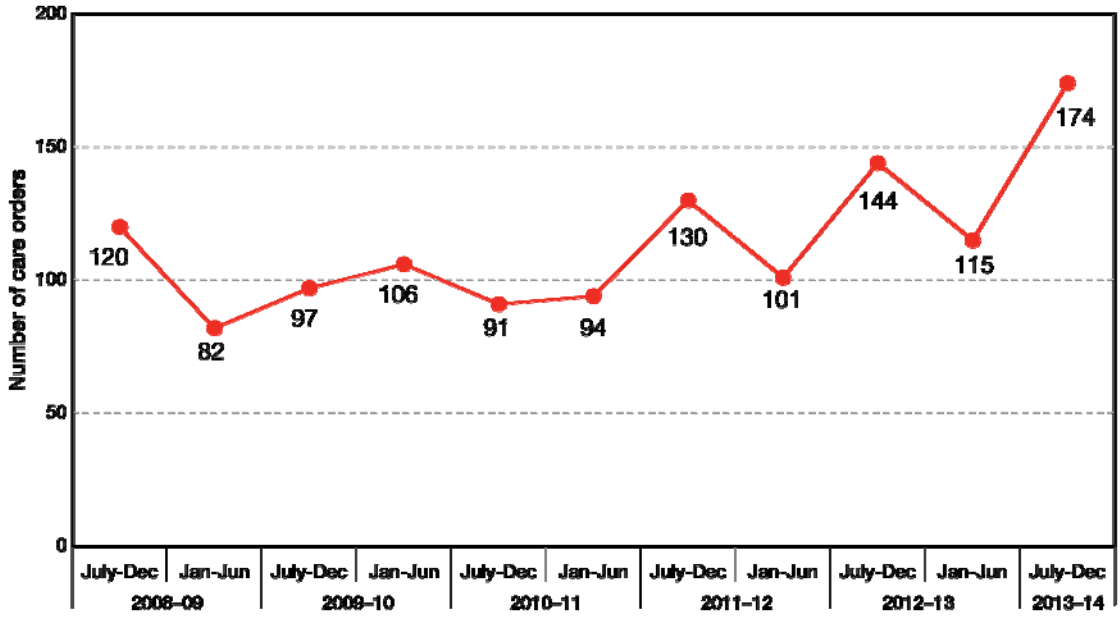
However, it could be expected that the project would have an impact on the number of permanent care orders being made during the latter part of 2013 and into 2014. The data in the next graph shows that there were 296 permanent care orders made during 2013–14, and that was the most ever made in a single year.[6]

Graph 2: Permanent care orders issued each year 2000–2013



The number of permanent care orders made in the 6 months from 1 July 2013 to 31 December 2013, when the project was into its action research phase, was 174 as shown in the next graph.

Graph 3: Permanent care orders issued each half year July 2008 to December 2013

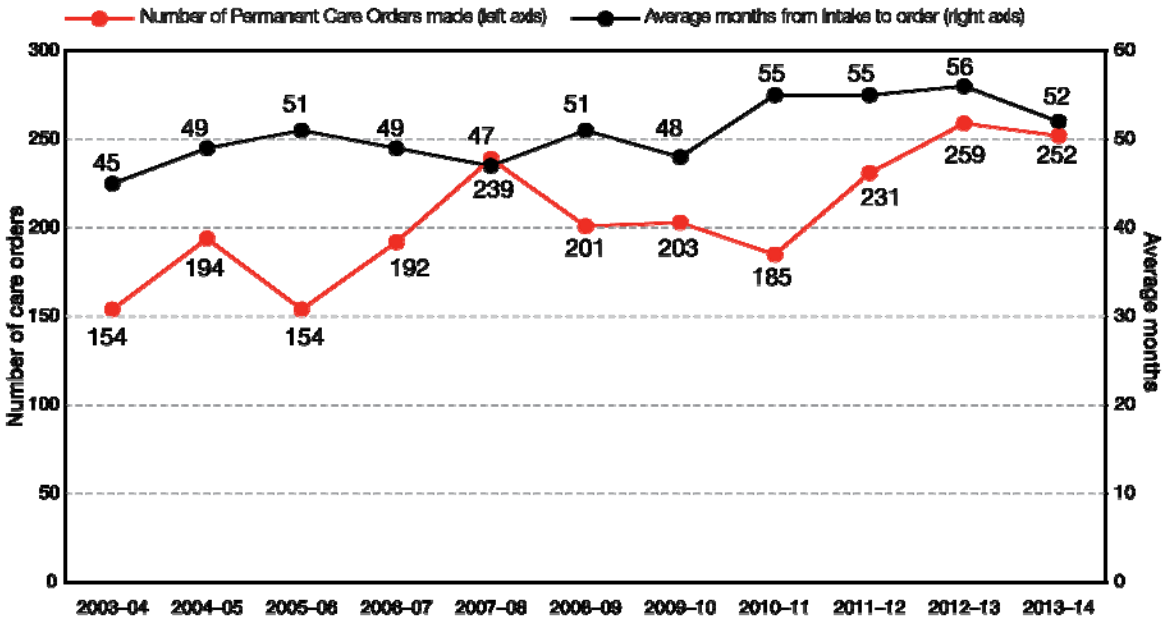


[6] The low number of permanent care orders made in 2006 and the high number made in 2007 evident in the graph are explained by the introduction of the Children, Youth and Families Act in 2007.

Permanent care orders – time taken from intake to order

The following graph shows how many months, on average, it has taken from a report being received at Child Protection intake to a permanent care order being made each year since 2003–04.

Graph 4: Permanent care orders made each year and average months from report to order. [7]



The graph shows that in 2003–04 the 154 permanent care orders made were made, on average, 45 months after the report that led to this outcome.[8] By 2012–13, it took on average 56 months to achieve the same outcome for the 259 permanent care orders that were made. The overall trend up until 2012–13 indicates a gradual increase in the period of time required.

Even at the beginning of the series it was taking on average nearly 4 years to achieve a permanent care order, which is a very long period of uncertainty in the life of a child. The finding of 56 months in 2012–13 is similar to the average period of 5 years (60 months) referred to in the analysis contained in the Protecting Victoria's Vulnerable Children Inquiry.[9]

A direct impact of the project was that the average for the 252 orders made in the period from July 2013 to April 2013–14 reduced to 52 months.

Finding 1. The data analysis undertaken as part of the project showed that the average length of time from a report being made to a permanent care order being made in 2012-13 was 56 months, and that this reduced to 52 months once the action research phase of the project got under way.

[7] The data for 2013–14 is incomplete and only includes Permanent Care Orders made before 30 April 2014.

[8] In many cases there had also been previous reports to Child Protection where the outcome was for the child to remain in, or return to, the care of their parents.

[9] The same source data was used and it is not known why the PVVCI finding could not be exactly replicated. It must be assumed that the methodology used by the Inquiry differed.

2.2 Identifying the cohort for the initial case review

The following table shows the 4,982 children in out of home care and subject to a Children's Court order in Victoria on 4 January 2013, just prior to the commencement of the project. This data excludes children subject to permanent care orders on that date, as well as children in voluntary and respite care.

The data also shows how long each child had been in out of home care since the most recent report to child protection, but excludes any previous periods in out of home care as a result of previous reports. Finally, the data also shows the case plan recorded in the CRIS database, if any.

Table 3: All children in out of home care on 4 January 2013 excluding children on Permanent Care Orders[10]

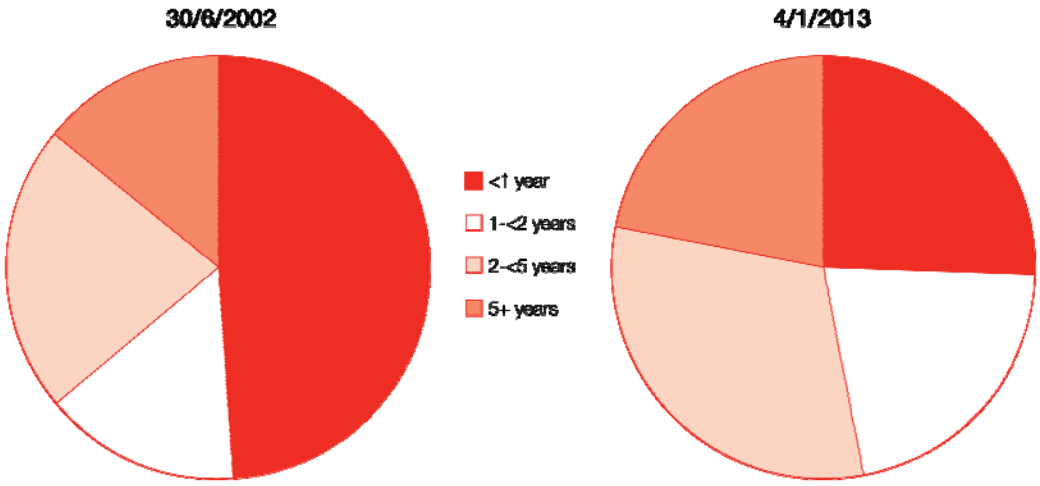
	Time since first entry to care in this case (years)																	
Case Plan	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**Total**
Adoption	1	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	**3**
Closure Plan	2	14	14	10	4	6	0	0	0	0	0	0	0	0	0	1	0	**51**
Long-term placement – no return to family anticipated	72	197	180	181	129	99	95	80	40	41	26	10	15	4	6	5	4	**1,184**
Long-term placement with a view to permanent care	25	91	92	108	66	59	43	19	11	11	4	1	0	2	0	0	0	**532**
No contemporary plan found in CRIS	652	175	25	4	4	3	8	12	15	14	6	4	12	2	8	1	1	**946**
Not stated	192	185	114	91	77	37	37	37	26	17	13	10	18	9	6	0	1	**870**
Permanent Care	10	59	59	71	63	49	36	14	8	12	11	10	15	7	7	0	2	**433**
Remaining with family through provision of support services	80	66	38	27	21	9	3	4	0	2	0	1	0	0	0	0	0	**251**
Reunification	170	195	59	34	16	4	5	1	1	0	0	0	1	2	0	1	0	**489**
Time Limited assessment	73	91	29	22	2	0	3	2	0	1	0	0	0	0	0	0	0	**223**
Grand Total	**1,277**	**1,074**	**610**	**549**	**382**	**266**	**230**	**169**	**101**	**98**	**60**	**36**	**61**	**26**	**27**	**8**	**8**	**4,982**

The 4,982 children in the table above can be compared with the 3,769 children in out of home care (using the same criteria) on 20 June 2002 to show the proportion of children who had been in care for specific time periods[11], as shown in the two following pie charts:

[10] It can be seen in this table that 946 (19%) of these cases did not have a current case plan recorded in the case plan component of CRIS. Many of these cases did have a documented case plan, but the plan had not been properly recorded in CRIS.

[11] The data for the children in out of home care on 30 June 2002 is derived from Table 4.9 on page 61 of *Public Parenting – a review of home based care in Victoria*, Department of Human Services, June 2003.

Graphs 5 and 6: Proportion of children in care on 30/06/2002 and 04/01/2013 by length of time in care.



Finding 2. The proportion of children in out of home care who had been in out of home care for less than 1 year decreased from 49% in 2002 to 26% in 2013.

The cohort of children in out of home care on 4 January 2013 had spent proportionately more years in out of home care than the cohort from 30 June 2003. The proportion in out of home care for less than a year declined from 49% to 25.6% over this period, while the proportion in out of home care for 1 to 2 years, 2 to 5 years and for five or more years all increased significantly. This data bears out evidence throughout this report of child protection intervention processes generally taking an increasing amount of time to reach resolution.

Children who had been in out of home care for less than one year were excluded from the project cohort as it was assumed that, at least in most cases, the children had not been in out of home care long enough for significant delays to have occurred in permanency planning. This left 3,705 children who had been in out of home care for more than a year on 4 January 2013.

Children aged 10 or older were excluded from the project cohort. This was partly to create a manageable number of cases in scope, but it is also the case that many older children are harder to place permanently. Most permanent carers are reluctant to take on the care of older children, and so the older children who have been in the care system for many years are often harder to place permanently. Some of the older children have also suffered harm caused by lack of continuity and permanency in their care arrangements and this may have caused problem behaviours to develop that would be hard for carers to manage. Once these older children are excluded, there were 1,804 children potentially remaining in scope on 4 January 2013.

Finally, children who had viable family reunification or family preservation case plans were excluded so that only those with unclear case plans or case plans for long-term or permanent out of home care were included in the cohort. This reduced the initial cohort to the 1,498 cases in the next table.

Table 4: All children aged under 10 in out of home care for at least one year on 4 January 2013 excluding children on Permanent Care Orders and excluding family reunification, family preservation and closure case plans.

Case plan	1	2	3	4	5	6	7	8	9	11	Total
Long-term placement – no return to family anticipated	66	63	61	39	32	16	17	12	4	1	**311**
Long-term placement with a view to permanent care	74	74	78	51	37	23	8	4	5	0	**354**
No contemporary plan found in CRIS	97	14	2	1	3	2	4	4	0	0	**127**
Not stated	116	48	53	36	20	14	12	5	1	0	**305**
Permanent Care	46	52	63	48	43	20	9	3	6	1	**291**
Time Limited assessment	73	19	14	1	0	2	1	0	0	0	**110**
Grand Total	**472**	**270**	**271**	**176**	**135**	**77**	**51**	**28**	**16**	**2**	**1,498**

Project staff conducted a review of case files to determine the case plan where the data in CRIS was not clear ("not stated", "no contemporary plan" in the table). Children in other case plan categories were also checked to see if they met basic cohort criteria. Some children had already been returned home, placed on permanent care orders or had their 10th birthday before the full initial review was conducted. A small number of children aged under 10 who had been in care for less than a year, but who had permanent care case plans that had already been made were added to the cohort. There were 1,332 cases in scope after this preliminary stage of the initial review process was completed.

Placement type

The majority of children in scope were in kinship placements

Of the cases that met project criteria on 28 February 2014, the majority of children (860 = 69.5%) were in kinship placements, and most of the remainder (340 = 27.5%) were in foster care) as shown in the next table.

Table 5: Children meeting project cohort criteria on 28 February 2014 by placement type

Placement type	cases	per cent
Foster care	340	27.5%
Kinship care	860	69.5%
Permanent care*	26	2.1%
Residential care	12	1.0%
Total	**1238**	**100.0%**

* the 26 children in this category were in placements with specifically recruited permanent carers where a permanent care order had not yet been made.

2.3 The action research cohort

Following confirmation of the cohort, an initial case review of each file was undertaken. Appendix 1 provides an analysis of the initial findings, while Appendix 2 contains a copy of the survey tool that was used.

Having completed the detailed survey, question 100 asked the project worker to identify what the most significant barrier to resolving permanency was in each case. The following table groups these responses (where a primary reason was identified).

Table 6: High level findings of the initial review. [12]

Primary reason for delay in stability planning and permanency resolution	cases
Availability of potential permanent carer	122
Potential permanent carer but barriers (contact, finance, services etc) prevent PCO	69
Potential permanent kinship parents not assessed yet	56
Contact issues	50
Delays in case planning and case plan implementation caused by court contests	45
Case reviews	32
Inappropriate reunification case plan	28
Child has significant behavioural issues	20
Case plan does not support permanency resolution	20
Delays in case planning (other than court)	19
Current carers not endorsed for permanent care	17
Numerous changes of placement	14
Lack of parental consent	14
No stability plan	13
No current case plan	13
Child's special needs (physical or mental health, disabilities)	12
Potential permanent foster parents not assessed yet for conversion	11
No (recent) AFLDM meeting held	11
Changes of allocated worker	10
Stabiility plan prepared outside statutory timelines	8
Sibling group size	7
Aboriginal child and application of Aboriginal Child Placement Principle	6
Inappropriate long-term OOHC placement	6
Case not currently allocated	4
Inappropriate protection order	4
Referral to VACCA's permanent care program: waiting times	4
Lack of Cultural Support Plan	3
Lack of Family Group Conference	2
No established care team	2
Other	12
Total	**634**

Following the initial case review, the project workers prioritised cases from the review for intervention. Priority was determined by the need for intervention to achieve progress, and also by opportunities to address a complete range of issues and to test strategies. A record was completed for each case where substantial assistance was provided or substantial action undertaken. There were 707 such records completed. Other cases in the cohort also benefited from the consultation service provided by the project team and by the professional development opportunities provided to program workers.

The following table summarises information from the action research that relates to the information collected above in the initial case review. But instead of answering the question “What is the main reason

[12] The table uses the term “access” that was current at the time of the initial review. The Act was amended to substitute the term “contact” later in 2013.

for delays in stability planning and permanency resolution?" the next table answers the question "What was the main barrier (and the second and third most important barriers) identified where attempts were made to address the barrier in the action research phase?" The results are ordered according to the frequency that an issue was identified as the main barrier. The red, orange, yellow and green highlights show the most commonly identified issues in each column.

Table 7: Main, second and third barriers identified during action research[13]

Barriers identified to be addresses	Main barrier	Second barrier	Third barrier	All
Stability/permanency plan not made or not appropriate	156	40	31	227
Completion of unrelated permanent care assessment	47	20	11	78
Completion of kinship carer assessment	44	55	7	106
No recent case plan	34	18	8	60
Carer unwilling to become permanent carer	33	11	21	65
Unavailability of suitable placement	32	16	9	57
Incongruence between case plan direction and Children's Court order and conditions	31	23	11	65
Family disputes about plan for stability/permanency	29	23	20	72
Contact	26	80	44	150
Worker's knowledge of stability/permanency planning	21	14	12	47
Care wasn't prioritised	19	27	21	67
Delays in completion of cultural support plan for an Aboriginal child	19	17	17	53
Quality of care issues (current carer/intended permanent carer)	17	15	12	44
Delays in holding an Aboriginal Family Led Decision Making meeting	16	3	10	29
Completion of foster care conversion assessment	15	10	8	33
Cultural issues for an Aboriginal child	14	13	18	45
Court contests	13	11	12	36
Current carer not suitable as permanent carer	13	5	0	18
Time taken to get matter heard in Court	12	5	10	27
Child has behavioural issues	10	29	24	63
Family not involved in plan for stability/permanency	10	10	6	26
Internal review of case plan	10	10	14	34
Lack of allocated worker	9	11	1	21
Child has complex physical health needs	8	19	3	21
Agency doesn't support permanent care	7	13	10	30
Need for counselling and therapeutic support	6	1	5	12
Time taken to complete case plan requirements	6	13	8	27
Court adjournments	5	177	8	30
Carer's knowledge of stability planning and permanency planning	4	7	4	15
Child has development delay/intellectual disability	4	13	7	24
Court orders and conditions	4	7	6	17
Need for other support	3	7	5	15
Family issues for an Aboriginal child	3	7	5	15
Size of sibling group	3	8	11	22
Financial support for carer	2	14	28	44
Age of carer	1	5	0	6
Carer unwell	1	2	2	5
Family Led Decision Making not held	1	0	1	2
AFLDM not held	0	2	0	2
Age of child	0	0	1	1
Child has mental health needs	0	2	7	9
Education performance/attendance issues	0	3	0	3
Need for medical support	0	1	0	1
Need for school support	0	1	0	1
Worker not supportive of stability/permanency decisions	0	5	1	6
Total	689	609	444	174

[13] 18 cases with no data are excluded from this table. The red, orange, yellow and green highlights show the 4 most commonly identified main barriers as they appear in each subsequent column

The difference in the results in the previous two tables is interesting. Where the initial case review identified that lack of an alternate permanent carer was the most frequent primary reason for delay, the action research focused on the lack of an appropriate stability plan in 156 cases out of 689 (22.6%)' and in another 71 cases (10.3%) as the second or third most important barrier addressed.

This different emphasis may arise from a more detailed knowledge of the cases but it probably also reflects an inherent bias in the focus of the action research. Project workers inevitably tried to address the things that were amenable to practice solutions on a case by case basis, while issues such as a lack of potential carers were generally beyond their control and only amenable to policy solutions. Consequently, the action research focused strongly on completing and improving plans and assessments, while noting policy and legislation issues along the way.

Despite the different emphasis in each table, both contain very similar items, and the "availability of a suitable placement" was still identified as either a main, second or third barrier in 57 cases in the action research table. Issues related to contact are also prominent in both tables. Many of the items in the two tables are cross-linked. For example, the lack of availability of a suitable carer in the first table could be partly addressed by the completion of carer assessments that feature so strongly in the second table.

The next table shows which actions were judged to have had the most impact on the barriers identified.

Table 8: Most influential and successful actions taken in relation to main, second and third barriers

	Barrier			
List the action taken that was the most influential and successful	**Main**	**Second**	**Third**	**All**
Participated in consults re progressing stability and permanency planning	147	88	60	295
Assistance with permanent care assessments	41	14	2	57
Training or PD delivered to DHS staff and/or Agency staff	20	26	8	54
Participated in consults where there is dispute regarding stability/permanency decisions	15	4	4	23
Chaired case plan meetings	9	7	1	17
Transfer to more appropriate team/work unit	9	1	2	12
Referral to Permanent Care Program	6	3	1	10
Assistance with kinship assessments	4	7	1	12
Assistance with case plans	3	3	1	7
Attended care team meetings	3	3	7	13
Assistance preparing cultural support plans	2	0	0	2
Assistance with AFLDMs	2	1	1	4
Stability plan created	2	11	4	17
Assistance with contact	1	0	3	4
Assistance with court matters regarding contact	1	1	0	2
Assistance with court matters regarding stability planning	1	1	2	4
Assistance with FLDMs	1	0	0	1
Following up with agencies/services that provide support	1	11	10	22
Locating parents and families who have not had contact with child protection for some time	1	0	0	1
Writing Permanent Care Court Reports	1	1	0	2
Assistance in obtaining a PCO	0	1	0	1
Giving evidence in court	0	0	1	1
Preparation of genograms	0	5	5	10
Reviewed and amended case plans	0	6	1	7
Grand Total	**270**	**194**	**114**	**578**

The provision of consultation and advice to practitioners about how to progress stability and permanency planning was the most commonly successful action, which is unsurprising given the focus of the project. Project workers met with practitioners, discussed cases, answered questions and offered advice. The fact that this was such a successful way of creating positive change suggests a lack of capacity in the Child Protection program and in contracted agencies to provide this support to practitioners. As other findings of the project suggest, this is partly a matter of workloads and partly a product of inexperience

and gaps in skills and knowledge. Team managers and practice leaders may not always have the necessary skills and experience in the area of permanency planning, but – even where they do – they may not have the time to familiarise themselves with a case enough to offer the best guidance.

The next most common categories in the table above focus on: providing assistance in completing permanent care assessments, providing training and providing consultation and advice where stability and permanency decisions are in dispute. Some of the other actions taken to address the second and third barriers, such as following up with support agencies, attending care team meetings and completing genograms, were also successful.

The next table shows the order type and placement type for each of the 707 children in the action research cohort where project intervention occurred.

Table 9: Current Children's Court Order and Current Placement Type

	Type of placement						
Current Protection Order	**Returned home**	**Kinship Care**	**Foster care**	**Permanent care**	**Residential care**	**No data**	**Total**
Interim Accommodation Order	1	13	20				**34**
Interim Protection Order		1					**1**
Supervision Order	4	2					**6**
Supervised Custody Order		34					**34**
Custody to Secretary order		247	174		3		**424**
Guardianship to Secretary order		69	85	2	3	1	**160**
Permanent Care Order		23	13	1		1	**38**
Closed		1					**1**
No data	1	2				6	**9**
Total	**6**	**392**	**292**	**3**	**6**	**8**	**707**

There were 424 children (60%) in the cohort subject to a custody to the Secretary order and 160 (22.6%) subject to a guardianship to the Secretary order. There were 38 children (5.4%) already subject to permanent care orders by the end of the action research where the issues still being addressed involved providing support to the carer and child. Of these 38 children, 23 were placed with kin, 13 were placed with foster parents who became permanent carers and one was placed with a specifically recruited permanent carer. There were 392 children (55.4%) in kinship care placements and there were 292 children (41.3%) in foster care placements although, as noted, a few of these had already been converted to permanent care placements.

The following table shows the proportion of children allocated to a contracted agency, which was 211 (29.8%) and the proportion with an allocated Child Protection practitioner (67.8%). There were also three unallocated cases, five where the case had been recently closed and nine with no allocation data provided.

Table 10: Allocation status of cases in the action research cohort.

Allocated to:	**Total**
Contracted Agency	211
Child Protection Practitioner	479
Unallocated (Child Protection)	3
Closed	5
No data	9
Grand Total	**707**

Delays in casework were therefore not generally a result of cases not being allocated. As will be shown in this report, many of the delays are caused by factors that allocated practitioners have little or no control over, such as carer availability and lengthy review processes and court contests.

The report also shows that allocation does not always enable barriers to be addressed that are within the control of practitioners. Cases may not be prioritised, or practitioners and planners may lack the skills or confidence to undertake the tasks (such as carer assessments) and make the decisions that will enable permanency to be achieved in a more timely way.

3. Issues identified by the Stability Planning and Permanent Care Project, including findings and recommendations.

Project findings

This section describes the findings of the project.

The detailed issues, findings and recommendations are thematically grouped as follows.

3.1 Children

3.2 Additional needs of children

3.3 Aboriginal children

3.4 Siblings

3.5 Parents

3.6 Case planning

3.7 Child Protection allocation capacity and workloads

3.8 Skills, knowledge and capacity of professionals

3.9 Court decision making

3.10 Assessment and support of carers

3.11 Contact (access)

3.12 Revocation of permanent care orders

3.13 The views of carers

The findings are supported by both quantitative and qualitative data.

The case examples, carer feedback and other similar information are drawn from the case studies and templates completed by project staff, records of consultations with caregivers, and a survey of current and prospective foster and permanent carers.

The views of the children in scope (all of whom were under the age of 10), their parents and their families were not directly canvassed in a systematic way. They emerge from the casework undertaken and the case examples included in the report.

3.1 Children

Initial case review findings:[14]

- 28% of the children in scope were Aboriginal
- Of the 1,332 children in scope, 720 (54.1%) were boys
- There was an unusually large cohort of 120 boys aged 6 years old
- A significant proportion of the children had special needs and behavioural problems (see section 3.2)

Findings from action research data:

- Of the 707 children in the action research phase of the project, 424 (60%) were subject to custody to the Secretary orders, which are orders that tend to leave key permanency decisions unresolved.

Many children were living in placements in which carers were awaiting completion of an assessment of their suitability to be a permanent carer. Cases in which this barrier was addressed in the action research included:

- 106 cases where an assessment of a kinship carer as a permanent carer was required
- 78 cases where a specifically recruited permanent carer's assessment was required
- 33 cases where an assessment of a foster carer to become a permanent carer was required

Children's needs

Of the 1,332 children in scope for the initial case review, there were 160 with reunification case plans assessed as viable, leaving 1,172 children for more extensive review. Of those 1,172 children there were 336 children already placed with a carer who was intended to be their long-term or permanent carer. These children were not as thoroughly reviewed in the initial review process because permanency had been partially achieved, even if it had yet to be formalised. They remained part of the project's cohort for the second action research part of the project along with the 836 children who had been in out of home care for more than a year and who were still in a short or medium term placement.

The following table makes these distinctions clearer.

Table 11: A breakdown of the cohort of children in scope for the project

Cohort	Children in scope	Part of initial review cohort	Prioritised as part of action research cohort
Children aged under 10 in out of home care for more than one year, or with a permanent care case plan but no permanent care order	1,332	Basic characteristics only	No
As above – 160 children with a viable family reunification case plan excluded	1,172	Basic characteristics plus case plan details	Yes
As above – a further 336 children already placed with an intended long-term or permanent carer excluded	836	Complete survey	Yes

[14] All of the chapters in section 3 start with some of the more relevant findings from the initial case review and from the action research. More detailed findings from the initial review can be found in Appendix 1, while the action research findings provide the content for each chapter.

The underlying premise of the research, and of the PVVCI finding and recommendation, is that it is harmful for children to be placed for a significant period of time in a situation where their long-term care arrangements are unclear. Where children have already suffered abuse and neglect in their own families, one form of harm compounds the impact of the other. The longer children remain in care, the more their attachment to their birth parents and their own family is weakened. In the absence of an alternate carer to whom they can form a permanent attachment, children's wellbeing, development, and ability to form healthy relationships are all likely to be compromised.

These premises are supported by research. There is a great deal of relevant research on the related issues of permanency, attachment and healthy child development. A very brief summary is provided here.

"Barth (1997; p. 616) cites evidence from child development experts that 'multiple placements are a developmental hazard; children benefit from consistent and uninterrupted parenting and suffer from the reverse'. Stability of placement is associated with positive outcomes in the transition to adulthood for young people leaving care (Cashmore & Paxton 1996). Family stability greatly facilitates child development. For children in care, stable and nurturing carers can bolster their resilience and ameliorate the negative impacts of previous instability (Harden 2004)."[15]

Attachment theory provides a major theoretical foundation for permanency planning.

"Attachment is the 'deep and enduring connection established between a child and carer in the first several years of life' (Levy & Orlans 1998; p.1). The quality of this attachment impacts on an individual's social functioning, well-being and competency and can have a profound influence on every aspect of his or her life.

Attachment is most crucial in a child's first three years of life (Berk 2000; Bowlby 1969), during which there are four stages of attachment development. The stages are not necessarily linear and children may experience them at varying ages due to individual and contextual differences:
1) pre-attachment phase (generally birth to 6–8 weeks)
2) attachment-in-making phase (generally 6–8 weeks to 6–8 months)
3) 'clear-cut' attachment phase (generally 6–8 months to 18 months, and up to 3 years)
4) formation of a reciprocal relationship phase (generally 18 months to 2–3 years and on).

How a child experiences these stages not only establishes their attachment style with a carer but also has been shown to influence their personality and perception of self and others – their 'internal working model' (Berk 2000; Bowlby 1969). So a child who experiences responsive, nurturing and consistent caregiving is more likely to be securely attached and have a positive self image. This optimistic view of the self also extends to others who are perceived as trustworthy, caring and protective (Howe, Dooley & Hinings 2000). In contrast, a child who experiences inconsistent, unresponsive or insensitive caregiving can develop an insecure attachment style and have an internal working model that perceives themselves, their environment and others negatively or as untrustworthy (Berk 2000). Attachment theory highlights the importance of children having the opportunity to experience and maintain positive relationships. Knowledge of different styles of attachment by children facilitates understanding of why some children may exhibit extreme reactions to separation (protest, sadness, detachment) and the 'symptomatology they develop once they are confronted with returning to their original family after a long period of fostering' (Gauthier, Fortin & Jeliu 2004; p. 382)."[16]

A child's racial and ethnic identity is also an important part of their development and must be incorporated into permanency planning for Indigenous children and children from culturally and linguistically diverse (CALD) families.

[15] Tilbury, C and Osmond J, Australian Social Work (2006), 59, 3, 265–280. *Permanency Planning In Foster Care: A Research Review And Guidelines For Practitioners*. Located at http://macha.itc.griffith.edu.au/dspace/bitstream/handle/10072/11263/PPreview_ASW.pdf?sequence=1 page 4

[16] Tilbury, C and Osmond, pages 5–6

"Racial and ethnic identity formation is an important developmental task for children from preschool through to adolescence, and children need to have experiences that promote a healthy sense of self and collective belonging (Harden 2004). Aboriginal and Torres Strait Islander children in care may face particular challenges in the process of cultural identity formation. Children's lack of knowledge or understanding of their Aboriginality as a result of being placed in out-of-home care has been linked to poor emotional well-being and mental health problems in later life, with negative outcomes for individuals and communities (Cunneen & Libesman 2000). This literature suggests that racial and ethnic identity should be factored into all aspects of permanency planning, necessitating the involvement of family members and Indigenous community child protection agencies in planning."[17]

In summary, where children experience changes in care arrangements and uncertainty about future care arrangements, this can have a negative impact on their development and on their reaching their developmental potential. It can also have an ongoing negative impact on their relationships with others and their ability to form relationships as well as undermining the child's sense of their own identity and worth.

There is potentially serious damage caused by breaking attachments and that is why children must only be separated from their families when it is absolutely necessary. Where children have to be separated from their families for their protection, the objective of permanency planning must be to return children to their parents' care as soon as possible provided that this is likely to be a safe and enduring arrangement. Where this cannot be achieved within a timeframe that does not seriously compromise the child's wellbeing and development, the objective must generally be to find another family that the child can become a part of permanently. Other long-term care arrangements may be necessary where an alternate permanent care family cannot be found, but these may not be as successful in promoting children's optimum healthy development.

It is also important to avoid moving children from one placement to another, especially if attachments have been formed. Ideally, the child will only experience one placement, but this is impossible to achieve in all cases. The current system of recruiting and assessing some carers as foster carers and others as potential permanent carers makes a change of placement inevitable unless the foster carer decides to become a permanent carer.

"Sometimes, initially they [children] will be placed with a temporary foster family until a more permanent place is found for them. The first placement can be one in which they can find some healing and peace. This can be a really powerful time for them because they're coming out of a scary and abusive situation into a place where they are safe. They are feeling nurtured for the first time in their life and then sometimes they get ripped out of that situation. Something can break in them."

"Often they don't want to move again and they've just had enough. Sometimes they are taken far away from their school and friends and don't know anyone at all, and they can be incredibly lonely."[18]

The most harmful scenarios are to return the child home and then have them re-enter care, or for the child to remain in short or medium term placements but without any certainty about future care arrangements. Both of these scenarios fail to create continuity or permanency in care arrangements and further disrupt the child's primary attachments. They therefore run the risk of further compromising the child's ability to attach to carers and form other relationships in future. They may also promote the development of emotional and behavioural difficulties that will make it harder for a parent or carer to create or sustain a long-term or permanent care arrangement for the child.

[17] Tilbury and Osmond, page 8

[18] http://www.nspcc.org.uk/Inform/publications/casenotes/clcasenoteslookedafterchildren_wdf80622.pdf

Normalising the experience of children in out of home care

Finding 3. Children may feel embarrassed if they are too easily identified as being placed in out of home care, and may feel stigmatised if their status deprives them of opportunities afforded to their friends and peers.

While it was not a focus of the project, one of the issues that arose in consultation with stakeholders was the need to normalise the experience of children placed in out of home care, particularly where the child is in long-term or permanent care. A wide range of issues can cause a child in out of home care to feel stigmatised, and some of these derive from limitations on what the carer can authorise, what has to be referred to the department for a decision and what needs the consent of the child's birth parents.

Children in out of home care may experience delays in getting permission for things as varied as school excursions and camps, medical treatment, a haircut and a passport for a trip overseas with their carer family. Children may suffer embarrassment, frustration and distress. For example, it is not unknown for a child in out of home care to be the only child in their class at school to miss out on an excursion because of delays in arranging consent by the department or a refusal by a birth parent to provide consent. These issues need to be addressed and resolved in a more child-centred way.

Recommendation 1. That a legal framework should be developed within the Children, Youth and Families Act that clearly enables the Secretary to make decisions, or authorise the child's carer to make decisions, about the child while the child is in their care. Decisions that have a long-term impact should require the agreement of the child's birth parents where the plan is for reunification, unless otherwise ordered by the Children's Court.

There is very little information about the lives of children in care that is expressed in the words of the children. The following are a selection of statements by children and young people in out of home care from across Australia included in a publication by the CREATE organisation:[19]

It's hard when you have to move away from current carers when you have just settled in. You feel you're safe and cared for then you have to move into a completely different environment.
(Female, 15 years)

All siblings should be able to contact each other unless there is a strong reason not to. I have brothers in care I have never seen or I haven't met.
(Female 10 years)

There is too much paper work to be able to do stuff. You don't feel normal like your friends.
(Female 12 years)

Being excluded from school photographs for no specific reason, except it is a...[department]… policy that shouldn't apply to all children.
(Male 13 years)

We should be able to make our own decisions instead of everyone making it for us. We should be able to go to a friend's house without asking ...[the department]… first. We should also have a bit of freedom and learn how to take care of ourselves without people panicking.
(Female 14 years)

There should be more support offered to children in need. The support system is good but if the care system could be a little more involved in the kids' lives, it would make more of a difference.
(Male 15 years)

19 McDowall, J. J. (2013). Experiencing out-of-home care in Australia: The views of children and young people (CREATE Report Card 2013). Sydney: CREATE Foundation.

My…[worker]… is really good, more like a big sister. She doesn't tell me what to do; she guides my decision-making. I've had her for 2.5 years.
(Female 17 years)

Yes, I think that children in care should have the right to freedom of choice, when it comes down to transitioning from care, and choosing where and who they want to live with.
(Female 17 years)

If the other kids (in the household) get bought games and clothes, I get games and clothes. And I get hugged and kissed and told I'm loved the same as the others.
(Male, 13 years)

I feel sad when I have to pack up and leave people that I have grown close to.
(Female, 12 years)

It was hard moving schools and having to make so many changes and fit into so many different families and to make new friends.
(Female, 12 years)

Feels confused; moving to places that I've never been before, new rules, some rules are good some are not.
(Male, 12 years)

I am with my grandparents I feel very happy with my grandparents because they take great care of me and love me.
(Female, 12 years)

I have only had one placement and I like it here.
(Female, 14 years)

I didn't understand why I was being moved around so much.
(Female, 14 years)

It wasn't nice to be moved around so much, it felt like people didn't care about me.
(Male, 15 years)

They are nice to me and make me feel part of the family.
(Male, 15 years)

It is really hard to make friends when you are continuously moving. Also I never get a chance to complete a year at one school.
(Female, 16 years)

You can't get settled 'cause you're worried you will get moved again.
(Female, 17 years)

The statements above are by children and young people in out of home care and the youngest is 10 years old. The focus of this project was children under the age of 10. Younger children are obviously less likely to be able to make clear, consistent and informed statements about what they want, and this poses a problem for practitioners and decision makers, especially where they have not developed a relationship with the child.

It is important for Child Protection practitioners to be aware of what children in out of home care are likely to be feeling. Case planners and magistrates rarely if ever have direct contact and must rely on practitioners to be able to inform decision makers about the views and wishes of the child. One of the main challenges in child protection work, and for decision makers in the department and the Children's Court, is to be able to step back from the competing views of adults and focus on the child's needs.

3.2 Additional needs of children

Initial case review findings:

- There were 232 children (17.4%) in the sample of 1,332 who were assessed as having a developmental delay or an intellectual disability or were otherwise in the Disability Services Target Group, and a further 21 where an assessment outcome was pending
- 144 children (10.8%) had complex medical needs and 168 (12.6%) had mental health issues – and 30 of these children had both
- 355 children (26.7%) had significant behavioural issues and 128 children (9.6%) had school performance or attendance issues – and 102 children (7.7%) had both

Findings from action research data:

Of the 707 children in the action research cohort

- 63 children had behavioural issues identified as being among three main barriers that the action research attempted to address
- 21 children had complex physical health needs among the three main barriers that the action research attempted to address
- 24 children had developmental delay or an intellectual disability among three main barriers that the action research attempted to address
- 9 children had mental health needs among three main barriers that the action research attempted to address
- Other children had additional needs to be met that were not among three main barriers that the action research attempted to address

Children with high and complex needs

A wide range of services were being provided to meet the needs of children in the project cohort, and there were also many services required that were not being provided. Some of the children had very high and complex needs that would pose major challenges for the child's carer. The following is an example of one child with high and complex needs.

Case example. Child with high and complex needs. [20]

J is a 10 year old boy, with high needs, including epilepsy, autism, and an array of other complex features including developmental delay and an inability to communicate verbally. He wets the bed regularly, sometimes soils himself, has tantrums, attempts to abscond at every opportunity, is unaware of roads and safety and seeks negative attention.

Children who are placed in out of home care have already suffered the trauma of being harmed and of being separated from their families, and some children in out of home care are also born with special needs. These children are often doubly disadvantaged. Their parents were unable to provide proper care for them, and their particular needs may have been neglected for some time before they entered out of home care. In some cases, even devoted carers who are receiving support still struggle to meet the needs of a traumatised child with high needs.

[20] All case examples in this report are based on case studies documented by project workers. Where possible, the original words from case studies are used. Section 534 of the *Children, Youth and Families Act 2005* prohibits publication of any matter that contains particulars likely to lead to the identification of a child who is the subject of an order made by the Children's Court of Victoria. All reasonable precautions have been taken to ensure that the case studies contained in this report have been adequately de-identified so as to comply with this requirement.

Case example. High needs as an obstacle to a permanent care order.

K has significant behavioural issues. K was medically assessed in late 2012 in support of a funding application for extra supports at school under the 'Severe Behaviour Disorder' program. She was assessed as having a range of behaviours which were 'oppositional defiant'. At home her kinship carer describes K's more difficult behaviours as upending furniture when angry, and destroying toys and clothes. She also talks of her love for K and her wish to provide her ongoing care. At the time of the first assessment visit it became apparent that K's carer continued to struggle with her care. The support services involved with K and her carer, whilst engaged and working alongside the family, had not managed to significantly reduce K's behaviours at home or at school. A permanent care order is not currently viable due to the child's special needs and the need for further resources for the placement

The following table provides the data that was collected on this issue and, as can be seen, the services most commonly providing additional support were medical, followed by educational, speech therapy and psychiatric services. The right hand column shows the services not being provided, which could be due to waiting lists, cost or other reasons.

Table 12: The needs of children not placed with intended long-term and permanent carers.

	Additional support that child is receiving	Support needed that child isn't receiving
Disability worker	16	11
Educational support	81	23
Medical/paediatrician	137	19
Mentoring programs	2	3
Other	169	118
Psychiatric	32	17
Speech	60	16
no support or no data	339	629
Grand Total	**836**	**836**

There are many reasons why services and support required by the child may not be provided. These include the capacity of services (and the use of waiting lists), financial costs that the carer is unable to bear, the location of services, lack of knowledge on the part of carers about how to access services, and carers' fear that asking for help may lead to others questioning their ability to cope.

Children may develop behavioural problems for a range of reasons, or a series of compounding reasons. Uncertainty about their future care arrangements and the lack of a secure attachment may, for example, be compounded after a permanent care placement has been found by conflict between permanent carers and birth parents about contact arrangements.

Finding 4. There were 497 additional support services provided to the 836 children placed with intended permanent or long-term carers (left hand column of table: 836 – 339 = 497), and a further 207 services required but not provided (right hand column of table: 836 – 629 = 207).

Recommendation 2. Permanent carers should be able to access resources to address the special needs of children in their care and to ameliorate the impact of harm and trauma. Where this isn't achieved by arranging provision of services to meet foreseeable needs during case planning for permanent care, the establishment of a placement support service to which permanent carers can apply for assistance if needs arise later on should be considered. Consideration could also be given to giving permanent carers priority access to government provided or funded services.

Over 200 children, or roughly 17%, were found in the initial review to have a disability or an Early Childhood Intervention Service assessment of developmental delay. Disabled children obviously have special needs but are not necessarily hard to find carers for because of their disability.

It is traumatised children with challenging behaviours who are likely to be the hardest to find carers for, and there are children both with and without disabilities or developmental delay who have those characteristics.

The forthcoming National Disability Insurance Scheme is intended to improve the provision of services to all disabled people, and it will be important to ensure that disabled parents of vulnerable children are assisted through the NDIS to provide enduring parental care, and that disabled children in out of home care are also assisted.

Case example. Impact of behavioural problems on placement stability:

During this time they have both experienced significant placement changes as a result of their extremely difficult and often violent behaviours toward other children, their carers and themselves. N has been restrained by the Police who had to use pepper spray to calm him down after his mother failed to attend access with him. He is now residing in a special residential unit (one to one care). N's placement is a specialised placement whereby he lives on his own, with two staff members, who have been court ordered to supervise him 24 hours a day. If any children are going to be placed with him they have to be assessed by the Principal Practitioner.

3.3 Aboriginal children

Initial case review findings:

Barriers to resolving permanency for Aboriginal children were as follows:

- Aboriginal children constituted 28% (235) of the 836 children in the project's cohort of cases who were not already in a placement intended to be permanent
- A cultural support plan (CSP) had been prepared for only 45 (19.1%) of the 235 Aboriginal children who were not already in a placement intended to be permanent.
- An Aboriginal family-led decision making (AFLDM) meeting had been held with respect to 87 (37%) of the 235 Aboriginal children in a placement intended to be permanent at some time during Child Protection involvement.
- Of the 235 Aboriginal children in this cohort, 85 (36.2%) were placed with an Aboriginal primary carer. Where the child was in a kinship placement, the rate was 60.6%.

Findings from action research data:

Of the Aboriginal children in the action research cohort, the following were amongst the three main barriers that the action research tried to address:

- 53 children with delays in making a cultural support plan
- 45 children with other cultural issues to be addressed
- 31 children with delays in holding, or a failure to hold, an Aboriginal family-led decision making meeting
- 15 children with delays as a result of unresolved family issues

Finding 5. 28% of the children in scope were Aboriginal. This is a very significant degree of over-representation. Most of these children did not have a cultural support plan, placing them at risk of losing connection with their kin, their identity, their land and their culture.

Aboriginal children constituted 28% of the children in the project's cohort of cases awaiting a permanent care placement. All of these children should, according to departmental practice guidelines, have the benefit of a cultural support plan to maintain their connection to community and culture. Most of these children did not have a cultural support plan. A properly documented cultural support plan had been prepared for only 45 (19.1%) of the 235 Aboriginal children who were not already in a placement intended to be permanent.

Cultural Support Plans and Aboriginal Family Led Decision Making processes

Finding 6. A cultural support plan had been completed for 26 out of 39 (67%) Aboriginal children subject to a guardianship to the Secretary order, but for only 19 out of 127 (15%) Aboriginal children in out of home care for more than a year and subject to other orders

The project found that Child Protection practitioners generally viewed the preparation of a cultural support plan as a task that should be undertaken by Aboriginal organisations. This was partly because they felt that they lacked the skills and knowledge to create a cultural support plan. Aboriginal organisations were initially only funded to create cultural support plans where the child was subject to a guardianship to the Secretary order (as required by the Children, Youth and Families Act s176.1).

As the Act only requires a cultural support plan to be developed where a child is subject to a guardianship to the Secretary order, there was no funding provided to Aboriginal organisations to develop plans for children subject to custody to the Secretary orders who were the majority of cases in scope. Child Protection practitioners did not believe that they were capable of creating such a plan.

However, the Aboriginal project team member was able to provide resources for Child Protection practitioners to at least commence work on the plan since some of the content (e.g. a family tree and history) is standard information that should be collected about all children in out of home care, and a "life story book" should be created for all children in long-term or permanent out of home care.

Recommendation 3. Funding should be provided and processes should be designed so that all Aboriginal children placed in out of home care have a plan to meet their cultural needs. A plan will always be required, but the extent of the plan required may depend on the case plan objective, the length of time the child is expected to be placed in out of home care and the extent to which carers are connected to the child's culture and community.

Because the funding for the completion of cultural support plans was initially only provided for children subject to Guardianship Orders, additional funding was provided for Aboriginal family-led decision making convenors to undertake some of the cultural support plans. The Aboriginal family-led decision making process involves locating the child's kin and community and involving them in the development of a plan for the child's future care arrangements and maintenance of family and cultural connection. Much of the information gathered as part of the Aboriginal Family-Led Decision Making (AFLDM) process is also required for a cultural support plan.

There are cultural support plan formats and templates that have been developed by DHS and by Aboriginal Community Controlled Organisations such as the Victorian Aboriginal Child Care Agency. These can be used by practitioners in Child Protection or Aboriginal Community Controlled Organisations to prepare a cultural support plan. Some of these formats are quite complex and detailed and it was found that many Child Protection practitioners lacked the confidence to start making the plan.

Even if a cultural support plan cannot be completed, Child Protection practitioners should be encouraged to start preparing it where delays are occurring. The child's family and kin can provide further details about the child's place in the Aboriginal community. Some children belong to more than one Aboriginal community and the resolution of those issues is complex.

A further issue with "completion" is that the cultural support plan is supposed to be a living document that is added to throughout the child's life. From this perspective, the plan is never actually completed.

One of the project teams compiled the following list of issues in relation to preparing cultural support plans and convening AFLDM meetings. While these issues may not all occur in all parts of the state all of the time, they are certainly common and widespread.

Issues arising in relation to the completion and usefulness of cultural support plans and Aboriginal family-led decision making processes[21].

1. "Work completed through the Aboriginal Family-led Decision Making (AFLDM) process is not clearly documented. For example, home visits that occur and information gathered during the visit are not recorded. Lots of information is lost through this process, especially information that relates to the information needed to complete the cultural support plan (CSP) or any stories that are relayed from the family to the AFLDM Convenor or Community Convenor that can be included in the CSP.
2. If an AFLDM meeting does happen, some of the information gathered during the initial meetings with family members is reported and recorded, however if a meeting does not happen or this information is not shared at the meeting the information is lost as it is not generally recorded elsewhere. Individual home visits or phone calls with family members in relation to pre-planning and preparation for the AFLDM meeting are generally not recorded, either that they have happened or what has been discussed and what information gathered.
3. AFLDM minutes are not clearly recorded on CRIS, which means decisions and agreements are not clear or known by workers and cannot be followed through. This has created problems where agreements were not followed through with and family members have become unhappy, but

[21] This list was provided by one of the project teams.

workers cannot find a record of what was agreed to and by whom. There are also agreements made that are not supported by case planners, and this also creates issues in terms of who is funded and facilitating agreements made.

4. There appears to be a big time lapse between when the AFLDM referral is made and when the meeting occurs or the CSP is completed. On many files a referral was made, however there is no further information about whether the referral was accepted or rejected, if there was a decision that it was not an appropriate time for the child/family for an AFLDM or CSP to be completed, and in many cases there did not appear to be any further information/discussion about the AFLDM referral. For example, in one case the referral was made in November 2011 for a CSP to be completed for a child subject to a GSO, and the case has only recently (September 2013) been allocated to a Community Convenor to complete the CSP.
5. Many completed CSPs are poor quality. For example, there are lots of gaps in information included and there is limited information included in terms of specific plans of how a child is to maintain a connection to their culture, community and land, and how the carer can support the children in this (beyond the blanket statements of children attending NAIDOC week and other community events). This is especially important for children with non-Aboriginal carers or for children not living in the area that is the traditional land of the family. The CSPs were missing the specific information about the family's Aboriginal/cultural heritage. The family clan, totem, traditional language and other specific information was not included. CSPs are often missing basic information from the file, including details of parents, sibling and significant others.
6. The genogram completed for a CSP is generally completed on the example in the CSP document, which means only the parents, grandparents and great grandparents are included, with 1 box on the maternal and paternal sides for aunts and uncles to be listed. This means the genogram is very basic, and fails to include the partners and children of the aunts and uncles, parents or grandparents that have had multiple partners, half siblings, or any other family members that do not fit in the pre-existing boxes to be included. This genogram format does not allow for the complexity of many of the families we work with.
7. AFLDM often do not run as per the process outlined in practice guidelines, and generally run in a similar (formal) manner to case plan meetings. Sometimes family members are not invited and family members are not given the time to discuss the issues amongst themselves without professionals present. This does not encourage family engagement or family involvement in and ownership of decision making.
8. There is confusion amongst workers and community convenors as to the role of workers and convenors in the AFLDM process, for example who is responsible for making contact with the child's parents and family members.
9. There is also limited planning prior to the meeting occurring: who will take minutes; who will book the room and make arrangements for family members to get to the meeting; who will decide/arrange for the children to attend the meeting.
10. Carers and families have raised concerns that the AFLDM meetings are not culturally sensitive or culturally appropriate. In many situations where the child is male and the meeting includes male family members (sometimes only male family members), there is a female DHS Convenor and female Community Convenor, which has upset and frustrated the family involved. Also, the lack of inclusion of community members (such as elders) from the area that a family originate has also upset and frustrated family members."

Finding 7. There are often delays in conducting AFLDM processes and meetings. The processes and meetings are often poorly planned and documented. They are not always conducted in a culturally sensitive manner and do not always include people who would be important participants if they were present.

Case example. Delays in cultural plans and AFLDM meetings leading to delays in permanency resolution.

A referral was made in late 2011 for a cultural support plan (CSP) to be completed however, the ACCO worker allocated the role of completing L's CSP had left their role without making any progress on the CSP. The plan was commenced in late 2013 after the project team worker and allocated Child Protection case manager contacted and requested the CSP for L be completed as a matter of urgency due to the drift with the case. Prior to contacting CSP worker in late 2013, the project worker spent significant time to locate the father (as his whereabouts had been unknown for a number of years) and the project worker and allocated worker had met with the father to discuss L, case progress (including permanent care) and the need for a cultural support plan. The father had limited information, only knowing where of L's birth and knowing nothing about his family history. Since the project's involvement, the cultural support program has made progress in locating members of L's extended family and obtaining information to be included in the CSP and the CSP was finally completed in early 2014.

In the case example above, whether a permanent care application should be lodged remained a point of contention between Child Protection and the relevant Aboriginal organisation, as the child was placed soon after birth with carers outside the child's Aboriginal community.

If the original referral for a CSP and the early holding of an AFLDM had gained a quick response, options within the child's family and community may have been identified earlier.

This case illustrates a dilemma which arises in practice quite often when an Aboriginal child is placed with non-Aboriginal carers and there is a lengthy delay in holding an AFLDM and completing a CSP. Should the child be planned for permanent care with their current carers in order to build on their existing attachment and sense of security, or should the child be moved to a placement within their original family or community (if one is available) in order to better promote connection to family, community and culture? There is a legitimate argument about what the child's best interests are in these cases, with Child Protection practitioners tending to place a higher priority on not breaking the existing attachment (particularly if the child was placed when young and can recall no other carers) and Aboriginal organisations tending to place more importance on community and cultural connection.

Recommendation 4. The department should hold discussions with Aboriginal organisations to develop a dispute resolution process where there is disagreement between the department and an Aboriginal organisation about whether the child's current carers are the best potential permanent carers for an Aboriginal child.

At present, there is no means of quickly resolving cases where there is disagreement between the Child Protection case planner and the relevant Aboriginal organisation. Section 323 of the Act forbids the Court to make a permanent care order to a non-Aboriginal carer where an application is contrary to the advice of the Aboriginal agency.

Finding 8. AFLDM convenor positions, as well as other positions where Aboriginal applicants are required or preferred, are often vacant for lengthy periods due to a shortage of qualified Aboriginal people with the necessary qualifications and experience, and with a desire to work in the child protection field.

Clearly there are issues to resolve regarding the resourcing and support available to convenors of AFLDM meetings and to professionals preparing cultural support plans that would improve the practice and outcomes of AFLDM processes as well as lead to more timely preparation of comprehensive cultural support plans.

Recommendation 5. The department should develop a strategy to improve the operational capacity of Aboriginal organisations and to address the under-representation of qualified and experienced Aboriginal professionals in the broad child protection field where Aboriginal children are so over-represented.

As an additional issue, several of the project teams noted long periods where AFLDM convenor positions lay vacant because of difficulties in recruiting. This seems to be a problem when trying to fill all positions where Aboriginal applicants are required or

preferred and the department should discuss with ACCOs ways of supporting Aboriginal people to gain the qualifications and experience required for these positions.

Only 87 (37%) of the 235 Aboriginal children in a placement intended to be permanent had been the subject of an AFLDM at some time during Child Protection involvement. An opportunity had therefore been lost in the majority of cases early in the intervention to mobilise the extended family and community to the maximum extent in making arrangements for the care of the child. This meant that opportunities may have been missed to find kin who may have cared for the child and who may be able to care for the child if the child could never safely return home. An AFLDM meeting (and the process of organising it) is also a potentially rich source of information for the cultural support plan.

Finding 9. There are a variety of views held by Aboriginal people and organisations about permanent care, and there are also differing views amongst Child Protection practitioners. There is a need to create a stronger consensus so as to avoid delays to permanency resolution that are caused by the potentially conflicting views of professionals involved in each case.

Recommendation 6. Because the AFLDM program has not been able to complete AFLDM processes in the numbers expected, and nor has it been able to improve compliance with cultural plan requirements, there should be a review of how the program is delivered, supported and resourced.

The lack of AFLDM meetings was at least partly caused by the model which requires two conveners – one from an Aboriginal organisation and one from the department. If either of these positions is vacant, it is not always possible to quickly find a replacement although, as noted above, it is the Aboriginal convenor positions that are harder to recruit to, while there are other case planners within DHS who can more easily cover vacancies in departmental convenor positions. If the position of an Aboriginal convenor is vacant, consideration should be given to another Aboriginal person from a local Aboriginal organisation taking on that role.

Case example. Delays in cultural plans and AFLDM meetings:

A cultural support plan has been opened on CRIS [the electronic client file] however no information has been added to the plan and no evidence of contact with family members to gather cultural information could be found on the CRIS file. Little information has been noted on B's file in relation to his Aboriginal heritage. Case notes on B's CRIS file indicate an AFLDM had been discussed but as yet, no AFLDM has been held. This meeting could be used to establish kinship networks and locate suitable family members to have contact with B.

Capacity issues and lack of consensus in the Aboriginal community

Aside from difficulties in recruiting Aboriginal professionals there is also a difficulty in recruiting Aboriginal permanent carers and this may have several causes which require further investigation:

- Potential Aboriginal carers may be opposed to the idea of permanent care and of being permanent carers for cultural and historical reasons related to the Stolen Generations. Traditional Aboriginal child-rearing practices involving sharing responsibility for children rather than providing parents with exclusive responsibility for the child's care may conflict with the notion of a permanent alternate carer.
- The higher proportion of Aboriginal children placed in out of home care places disproportionate demands on the Aboriginal community to provide kinship placements.
- The higher proportion of children in the overall Aboriginal population also places disproportionate demands on Aboriginal adults as carers of children.
- The higher proportion of Aboriginal parents experiencing comparative socio-economic deprivation means that risk factors such as parental substance abuse and family violence are more common in the Aboriginal community than in the broader community (though the difference is much smaller when compared to non-Aboriginal parents experiencing comparative socio-economic deprivation)
- Many permanent carers in the non-Aboriginal community are grandparents and, because of lower life expectancy and greater health problems as evidenced in the "Closing the Gap" strategy, there are

proportionately fewer Aboriginal grandparents available and healthy enough to provide long-term care for children.

Compounding the reasons why Aboriginal people may be unwilling or unable to put themselves forward as potential permanent carers is a reluctance by some members of the Aboriginal community to ever give up on the possibility that parents might be able to resume care of their children at some point. Many potential carers have had direct and distressing experiences of the care system in their own childhood or have been affected by the experience of parents or other close relatives. These understandable cultural and historical reasons create a reluctance to accept the need for permanent care in some cases, even though this conflicts with mainstream research findings about the harmful impact on children's development of extended periods of uncertainty in their care arrangements.

Aboriginal organisations represent their communities and express the widely held fear that current state welfare practices are creating or will create a new "stolen generation". These fears have to be recognised and can be too easily dismissed. It is a fact that a disproportionately high number of Aboriginal children are still removed from their families, and that many of these children become separated from their family and their culture in ways that are hard to rectify later. Current policies are intended to protect children from harm not to promote assimilation and destruction of culture, but even though the intentions are different, the outcomes can be similar for too many Aboriginal families and their children.

Child Protection practitioners reported many cases where they felt that progress had been made towards implementing a permanent care case plan, but where this was not supported by Aboriginal agencies who need to support any application for a permanent care order under the Children, Youth and Families Act section 323. On the other hand, some professionals at Aboriginal agencies cited examples of where they felt that Child Protection practitioners were too hasty in attempting to implement permanent care case plans.

This can be frustrating for Child Protection practitioners, but an understanding of the historical and cultural context is the key to understanding why such "delays" may occur. Clearly there are very complex issues here that require resolution if all agencies are to work together effectively.

Recommendation 7. The department should hold discussions with the Commissioner for Aboriginal Children and Young People and with Aboriginal agencies to create a better understanding of when it is appropriate for applications for Permanent Care Orders to be made in relation to Aboriginal children.

Recommendation 8. Consideration should be given to making long-term Guardianship to Secretary orders available to children of any age where a carer has been identified who can care for the child until they are 18, but where the carer or an Aboriginal agency does not agree to a permanent care order being made.

Comparative timeliness of permanency resolution for Aboriginal children

An analysis of the data shows the impact of the failure to resolve these differences about permanency on the length of time that Aboriginal children remain in out of home care. The project cohort data discussed earlier was based on children under the age of 10 who had been in out of home care for more than a year.

In order to illustrate the overall impact of slower permanency resolution in cases involving Aboriginal children, the following graph and tables use data that also includes children in out of home care for less than a year. As can be seen in the graph and the second of the two tables, the proportion of all children aged under 10 and in out of home care who had been in care during this episode for more than 2 years on 4 January 2013 was about 48%. The proportion for non-Aboriginal children was 43% and the proportion for Aboriginal children was 62%.

Graph 7: Comparative number of years children aged under 10 had been in out of home care on 4 January 2013 by Indigenous status

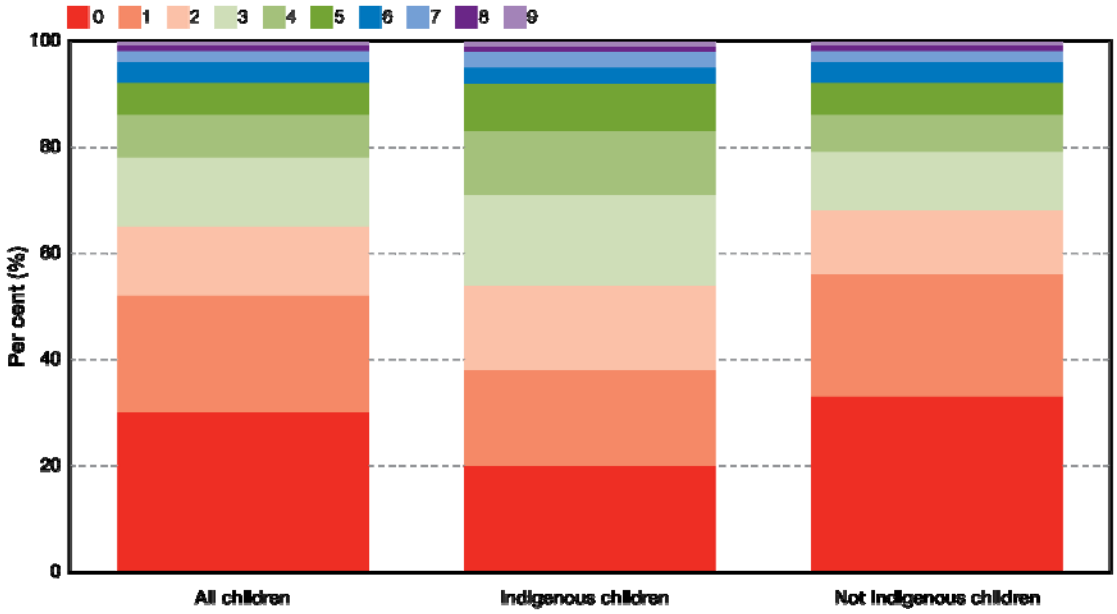


Table 13: Comparative number of years children aged under 10 had been in out of home care on 4 January 2013 by Indigenous status

Number of cases	Time since first entry to care in this case (years)											
Indigenous status	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**11**	**All**
Not Indigenous	562	388	196	191	121	95	62	36	21	9	2	**1,683**
Indigenous	93	83	73	80	55	40	15	15	7	7	0	**468**
All	655	471	269	271	176	135	77	51	28	16	2	**2,151**
Number of cases	**Percentage of cases by time since first entry to care in this case (years**											
Indigenous status	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**11**	**All**
Not Indigenous	33.4%	23.1%	11.6%	11.3%	7.2%	5.6%	3.7%	2.1%	1.2%	0.5%	0.1%	**100.0%**
Indigenous	19.9%	17.7%	15.6%	17.1%	11.8%	8.5%	3.2%	3.2%	1.5%	1.5%	0.0%	**100.0%**
All	30.5%	21.9%	12.5%	12.6%	8.2%	6.3%	3.6%	2.4%	1.3%	0.7%	0.1%	**100.0%**

The graph and tables above demonstrate that the average length of time that non-Aboriginal children under the age of 10 had been in out of home care (prior to reunification or permanent care) was less than 2 years, while for Aboriginal children the average was nearly 3 years.

Finding 10. Aboriginal children, on average, spend about 40% more time in out of home care than non-Aboriginal children. The over-representation of Aboriginal children in out of home care is partly caused by proportionately more Aboriginal children entering care, but it is also caused by the longer periods that Aboriginal children spend in care.

Data from CRIS also shows that, in recent years, between 14% and 17% of children entering out of home care were Aboriginal. Aboriginal children were 21.7% (468 out of 2,154) of all the children in the table and graph above, and they were 28.5% of children who had been in care for more than 2 years.

One of the key drivers for the project was the PVVCI finding that it takes, on average, 5 years from a report being made to Child Protection to a Permanent Care Order being made. The data available to the project is as shown in the following table.

The table below shows the number of permanent care orders made each year in total and for both Aboriginal and non-Aboriginal children, and the average length of time from the first report to the making of a permanent care order.

Table 14: Permanent care orders each year, and average time from intake to order

	All children		Non-Aboriginal children		Aboriginal children	
Financial year	Number of permanent care orders	Average months from intake to order	Number of permanent care orders	Average months from intake to order	Number of permanent care orders	Average months from intake to order
2008–09	202	50	189	50	13	52
2009–10	203	47	188	46	11	63
2010–11	185	54	168	54	17	54
2011–12	231	56	226	54	33	70
2012–13	259	56	226	54	33	70
Total	**1080**	**53**	**980**	**52**	**100**	**60**

Finding 11. In 2012-13 Aboriginal children, on average, waited one year and 4 months longer (70 months = 30% longer) for a permanent care order than non-Aboriginal children (54 months).

The data for the most recent year available – 2012–13 – shows that there were a total of 259 permanent care orders made and, on average, the order was made 56 months (4 years and 8 months) after the intake report (highlighted orange). There were 226 permanent care orders made on non-Aboriginal children and 33 made on Aboriginal children. The average length of time from intake to permanent care order was 54 months (4 years and 6 months) for non-Aboriginal children (highlighted green) and 70 months (5 years and 10 months) for Aboriginal children (highlighted red). The average figures over the 5 year period are less extreme, but still show that the average length of time for Aboriginal children was 60 months (5 years) compared to 52 months (4 years and 4 months) for non-Aboriginal children.

This data demonstrates two things. Firstly, it demonstrates that where it is judged that a permanent care order is in the best interests of an Aboriginal child it took an additional one year and 4 months to reach this outcome in 2012–13. Secondly, it shows that 12.7% (33 out of 259) of permanent care orders made in 2012–13 were made for Aboriginal children, even though Aboriginal children constituted about 28% of the children in scope for the project.

The additional delays experienced by Aboriginal children are partly a product of the lack of a consensus about whether and when it is in the best interests of Aboriginal children to be placed on permanent care orders. If agreement cannot be reached either at a general level or in specific cases, it may be necessary to develop other strategies to increase the number of Aboriginal children who are placed in out of home care in placements who are provided with sufficient security and cultural and community connection.

3.4 Siblings

Initial case review findings:

Siblings can be a barrier to permanency resolution when large sibling groups need to be placed together, but potential carers are only willing to care for small sibling groups. Where siblings are placed separately, arrangements need to be made for them to maintain meaningful contact

The initial case review found that, amongst the children in the project cohort, there were:

- 240 children in Out Of Home Care who had no siblings in Out Of Home Care
- 441 children in Out Of Home Care who lived with all their siblings in Out Of Home Care
- 325 children in Out Of Home Care who lived with some of their siblings
- 272 children in Out Of Home Care who did not live with any of their siblings in Out Of Home Care
- 54 children where there was no clear data (which is a concern in itself).

Findings from action research data:

- The size of sibling groups was a barrier to achieving permanency in 22 out of the 707 cases that the action research tried to address, although it would have been a factor in many more cases where placement together or contact arrangements were not addressed in the action research.
- Instances where siblings were placed separately sometimes had good contact arrangements between the siblings, but this was not so often the case where siblings were managed in different teams, and in different offices.

Permanency planning for sibling groups can be highly complex. Siblings may enter care at different times, sometimes after an interval of several years, and the carer of a sibling already in care may not be willing or able to care for other siblings who come into care later.

Case example. Planning for siblings:

The SP&PC Project team have worked to provide a permanent care assessment on each carer, while highlighting the impact that the Child Protection intervention is having upon the children's family network. The carers have not been supported equally or encouraged to work through conflict in an open and transparent manner and the children will not have positive contact with extended family members unless some counselling or mediation is put in place. This case has highlighted the need for functioning care teams to meet around sibling groups so that planning for the sibling group as a whole is the overall goal and case work is not dictated by the nature of relationships between respective carers and DHS.

Recommendation 9. Decision makers should be required to consider the care history of the child's siblings and the importance of promoting the child's membership of their sibling group when making care and permanency decisions.

Where siblings enter care at different times a whole range of issues come into play. If all of the child's older siblings have been placed permanently before the child was born, the viability of successful family preservation or reunification must be in more doubt than in cases where siblings are still at home or are planned for reunification. If extensive attempts are made to maintain the child in their parents care or return to their parents care, this may take a lengthy period of time during which the chances of placing the child with their siblings (if reunification proves to be unworkable) will gradually diminish. This therefore places the child at risk of separation from their siblings as well as their parents.

While parents provide the child's strongest attachment when they are young, it is siblings who often provide the most enduring relationships through life. The sort of scenario considered here raises a very difficult dilemma for people making decisions about the child, including the Children's Court, the case planner, the parents and the permanent carer of the child's siblings.

Recommendation 10. The department should promote ongoing contact between siblings in all circumstances and should review existing policy and practice advice with regard to the case management and case planning of siblings and should explore the benefits of convening combined care team meetings where siblings are placed separately in out of home care.

Children who are separated from their siblings in care may be case managed by different practitioners or case planned by different case planners and they are also likely to have different care teams. In these circumstances, case plan development and implementation may serve to reinforce the separation and diminish and prospects of siblings being placed together in the future or of contact arrangements being able to sustain an ongoing sibling relationship.

Case example. Separation of siblings.

Drift has taken the form of inadequate attention to establishing sibling contact, delay in making a non-reunification decision, and the consequences of the latter in the form of a foster care conversion by default and the non-exploration of permanent care options with existing sibling placements.

Another complication is that children may be members of blended families and, if the two parents separate, there may need to be different plans for the children depending on who their parents and other relatives and potential kinship carers are.

Case example. Failure to recognise the importance of sibling contact.

T has older half-siblings in an existing legalised permanent care placement. These carers were not able to take T into their family unit, and it appears to have been at least two years since he has had contact with these siblings. There is no evidence of the placement agency (or the foster or permanent carers) taking any initiative to re-establish sibling contact.

There are also the children's different needs to consider. Some of the children may have significant disabilities, while others do not. The older children may have a stronger connection to their school, their sporting and other social activities and their network of friends.

In addition to the characteristics of children and families there is also the impact of the child protection system. As noted elsewhere, delays in resolving permanency can lead to children developing behavioural problems. A carer who is able to adequately care for three relatively settled children may struggle with the responsibility of caring for three siblings who are hard to manage.

Finding 12. Planning for siblings to be placed together is often inadequate and, where they are placed separately, contact arrangements are often insufficient to maintain long term relationships between siblings. This is a significant loss for a child in out of home care or alternate permanent care as siblings can provide the most enduring relationships throughout a person's life.

Case example. Delays causing siblings to be separated.

Of particular concern was [that the] siblings [were] in three separate placements…..D and his siblings had a range of placements together for the first three years in out of home care. As the children's behaviours became increasingly challenging, the sibling group was separated in late 2009.

Case example. Failure to establish sibling contact.

Despite the number of his siblings in care, and the relative geographical proximity of three of them, X has still had no contact with his brothers and sisters. He came into care as an infant and has been in care continuously in that time, yet at the age of 2, has had no sibling contact. There were many changes of worker during the early months of his life, but it can only be concluded that sibling contact was not perceived to be a priority. I believe that while this issue can sometimes take place in a climate of crises and placement changes, it can sometimes take place in the context of placement stability (when other more volcanic cases take precedence). X had the same case manager between early 2012 and mid 2013 (i.e. between the ages of 5 months and 16 months), and during this time there are no efforts recorded on file to contact the carers of other siblings to explore relationships between the children...

3.5 Parents

Initial case review findings:

The initial case review did not canvass the characteristics or views of parents.

From other program data it is known that the majority of parents are living, or have lived, in homes where family violence has occurred. It is also known that substance abuse and mental health issues are quite common. These factors are both causes and products of relative socio-economic disadvantage. It is also known that a high proportion of parents where Child Protection intervenes are sole parents, that many parents rely on benefits for income or have a low income if they work, and that a high proportion live in public housing.

These characteristics confirm what has long been known: that social isolation and economic marginalisation tend to undermine the functioning of families and parenting capacity. This is not to say that people with these characteristics cannot be good enough parents, but it is statistically more likely that the more of these characteristics that are present in families, the more likely that Child Protection intervention will be needed.

Findings from action research data

- Parents are represented in the data indirectly, through the number of action research cases where the main barriers that were addressed included court contests and adjournments and family disputes. The lack of direct information about parents is a shortcoming of the project.

Reunification and relinquishment

The majority of children who are placed in out of home care return to their parent's care. There is evidence that the sooner children are reunified with parents, the more likely is the success of reunification. There should be some caution about this evidence, because it should not be interpreted as a reason to return children home while sustainable changes have not been made.

The evidence might only indicate that the parents with the fewest changes to make, and the greatest motivation to make those changes, are the parents most likely to have their children successfully reunified with them. Another important issue is the extent to which assistance can be offered to the parents to make the changes required and the impact on the child of delays in offering parents the assistance they need.

Some parents are unable to ever resume care of their children and can acknowledge that their children would be better off cared for by someone else – kin in many instances, but also sometimes foster parents who may become permanent carers. This type of case is straightforward because there is consent to long-term or permanent care arrangements. Where parents appear to be willing to relinquish their role as parent of a child, adoption by consent should be discussed as an option – especially if the child is still very young.

Finding 13. Adoption is rarely raised as an option in child protection case planning. Only one case in the project cohort had a case plan for adoption. Some permanent care orders are made by consent. Where consent is forthcoming, a discussion should be had as to whether adoption may be a better option for the child.

Recommendation 11. Adoption should be discussed and considered as an option in those cases where parents are willing to consent to a permanent care order, especially if the child is still very young.

Those cases that are the most difficult to resolve are those where parents believe that they are capable of making sufficient changes to resume care of their children, but where their children are unable to return to their care currently and where there is little apparent progress being achieved. In

these cases, the parents' wish to have their children home may not be backed by evidence of change, or changes may be occurring too slowly bearing in mind the child's developmental needs. These are the cases that feature most prominently in this project, and where the parents needs and wishes may not be consistent with decisions that promote the child's best interests.

Contact between children and birth parents

The gap between the parents' desire to care for their child and their ability to do so was sometimes also played out in relation to contact. Parents sometimes demanded frequent contact as part of a case plan or as a condition on an order and were then unable to attend. This could be much more damaging to their relationship with their child than less frequent but reliable contact arrangements.

Case example. Parents' attitudes to contact:

The impact of the parents' inconsistent contact with J has been that [J's] relationship with [her parents] has deteriorated and she identifies her carer as being her mother and her carer's ex-husband as her father. J's carer supervises contact between J and her parents when it occurs. This is generally appropriate, however consistent contact would need to occur for J to build her relationship with her mother and father. J's parents are both young and their lifestyle impacts on their capacity to attend access consistently.

There is strong agreement about the importance of children in out of home care having contact with their birth parents and siblings, but it is not simply a case of the more the better, even where the case plan is for reunification. Assessing the appropriate frequency and nature of contact is more complex. This is discussed further in section 3.11.

Each case is different and, in some cases, it may even be preferable for there to be no contact at least for an agreed period.

Case example. Parent's attitudes to contact:

[The mother] also understood D and K did not want to have contact with her and she said… [she] …would wait until they were ready to make contact with her when they are older. [She] wanted a connection between D and K and their new sibling. She requested that photos be exchanged between her and the carers so the children knew of each other and could make a connection when they were ready. [The carers] were agreeable with this request by the children's mother.

If contact does occur there is also the vexed issue as to what form it should take (where, when, for how long and how often?). There are also other considerations such as what subjects may or may not be discussed by the child and their birth parent, and whether contact should be supervised in order to ensure that nothing inappropriate is said or done. A project worker touches on some of these issues in the following case study.

Case example. The potential value of contact:

Recent contact between F and his mother has included conversation between F and his mother about past events that led to F being in care, his mother's addictions etc, and has included the prospect of F one day returning to live with his mother..... It has been suggested that the supervising worker was irresponsible for allowing this conversation to take place, and that such conversations are "de-stabilising" for F. I disagree. I believe that such conversations where a child is trying to understand how things have come to be, and a parent is giving honest answers, taking responsibility and to some degree apologising for her actions and inactions, are healing and unique. To suggest that contact between parents and children should be as vacuous as the McDonalds playgrounds that they often take place in is not real and a wasted opportunity to nurture parent/child relationships and understanding for the child. I completely support intervention in contact where a parent is unhelpfully "stirring the pot" – e.g. telling a child they'll be home next week. Access can be an opportunity for healing; too often in non-reunification situations it is seen as a condition on an order (sometimes a necessary evil) to be carried out.

Where children are placed in out of home care, the nature of contact should reflect the case plan. Where the case plan is for the reunification of child and parent, the contact should ideally incorporate periods that replicate everyday life. For example, contact might include a meal at the parents' house. Where the child will never be reunified with their parents, contact might be modelled more on the relationship of a favoured relative and involve parents attending carer family events or taking the child on outings.

Parents needs

Parents of children who are placed on permanent care orders have high needs of their own. Relinquishing a child voluntarily or having a child removed permanently are both distressing events for parents and there are very few services available to support parents in coming to terms with this. The unresolved feelings of parents in this situation may contribute to the difficulties in establishing contact arrangements that are most beneficial to the child.

Parents often have other needs that have contributed to the child being placed permanently. These can include chronic mental health problems or medical issues, substance abuse and family violence as well as underlying issues such as their own experience of having been maltreated as children.

Recommendation 12. Services should be provided for the birth parents of children who require permanent alternate care to assist them in coming to terms with the loss of their child and the need to establish suitable contact arrangements, and also to provide referrals to services that may assist them in other ways that might be needed.

Support for parents tends to fall away dramatically once a decision for permanent alternate care has been made. Parents are likely to need assistance to come to terms with the loss of their child and to establish suitable contact arrangements. They may also need support to access services to address other needs they may have. It may be that the provision of support and counselling to parents experiencing the loss of a child could reduce the length and intensity of contested case planning and court decision making processes and facilitate negotiated outcomes.

Parents with disabilities

Some parents who are unable to care for their children have disabilities. While many disabled people are able to care perfectly well for their children, there are others whose disabilities affect their capacity to provide care or who also have other issues compromising their ability to be a parent. Many of these parents accept that they cannot adequately care for their child, even when extensive support by extended family and services has been provided.

In some instances, the extended family will make arrangements for the care of the child and may formalise these arrangements in the Family Court. In other instances, a report is made to Child Protection and a Children's Court protection order is made.

Consent to permanent care or adoption in these situations needs to be handled with great sensitivity in order to ensure that the consent is provided on an informed basis or with the support of a legal guardian. As with other parents who relinquish voluntarily, carers should be found who can include the birth parents in the child's life. The best solution in some cases will be to support an application by a kinship carer to the Family Court, or an adoption application.

Some recent research undertaken by Anglicare in Tasmania[22] about the experience of parents in the Child Protection system canvassed the views of parents. Parents made many comments, including the following:

> They don't return your phone calls. You can ring, leave an urgent message, can you please call me, they don't call you. Sometimes they don't even go back into the office and they don't turn up. And then they don't even follow up the call the next day half the time. The reason behind all that is the lack of resources…. they don't have time to return the phone calls.

[22] http://anglicare-tas.org.au/docs/research/parents-in-the-child-protection-system-research-report.pdf

I'm really happy with my worker at the moment. He listens and he actually does things that he says he's going to. If you call he'll call you back that day, so you don't have to keep on chasing them up. He's kept me really informed and he's taken time. He's really good and he's really going into action and going into bat for me.

In the whole hierarchy of importance in Simon's life, although we were his family, we were shunted to the back of who is responsible. There were things which made my jaw grind and I would be holding my words very carefully at some of the meetings thinking that if I say something that can come across too harsh, I am playing into their hands, 'we better watch that parent'. So you are playing it very carefully, trying to sound reasonable, trying to comprehend what's going on. And at the same time you get the feeling that you are the last person in a chain of this child's importance and you don't really have too much impact. At one meeting after two years they asked 'what do you want?' They had never asked before. No one had previously wanted to know.

The new child protection worker has been very supportive and since she's been on board I've had a lot of communication with her. She is very positive, very hands-on; she comes and does the home inspection. She says that she wants things positive for me, for things to work out right so Jake can come home. This is what you should do; "let's work on how we can do this". And the boss, she's been a gem to work with, really good towards me.

What we're finding is you can have a great relationship with a child protection worker but they have to go and talk to their superior and the whole thing turns to shit. The worker must feel completely undermined and you can see that in their body language. Because your case worker comes to your home, you have that engagement so they are seeing things from the ground point of view whereas the superiors are in their office. It sounds like there is a bit of a gap, and that they are coming from maybe more of a policy, clinical point of view. So there's this tension between what is actually happening at ground level and what is actually happening at their level.

In my case I've had two workers that I could deal with and get on with but as soon as management saw that happening they were changed. I went through about half a dozen different workers. If they see you get close they will pull out the case worker. At the start I had a good worker. She was A1. The way we were working in the six months I would have had my children home. But when we got to that point of reunification she lost her job as a case worker because she became too emotionally involved with our case. I think if I still had her the children would be home now. I had a new worker and I had to explain everything all over again.

A lot of the Department don't understand. Maybe if they sat down and asked the parents what was it like to go through, that it might be different. But then a lot of people in there don't have kids either, so they don't know what it's like to raise three kids of your own. Until you have kids, you will not understand what it is like to have your kids taken away from you or to go through all this, you just don't understand. I hate it when people say they understand because a lot of people don't understand.

They say you have to be a certain sort to get your children back and you have to do this and this and this but there is no model or structure there for you to look at. So what is the goal then, what is the final goal that I need to reach? I reach this goal and you take that away from me when the final goal is the children coming home. So you want my family to be like this, but where's the model. I can't see what you want me to do because I'm getting all these mixed messages.

There is obviously a mixed range of views expressed by these parents, all of which would be familiar to Child Protection practitioners in Victoria. The project did not collect this sort of information, but at an anecdotal level project workers heard all of these views expressed.

What is clear from these comments (and also from a wide range of other research) is that a positive and sustained working relationship between parent and practitioner which is focussed on promoting necessary changes is the most likely to get results. While this might seem to be no more than common sense, it is very hard for this kind of approach to be sustained when there are competing priorities that may lead to the re-allocation of cases and where staff departures and promotions also cause the re-allocation of cases. This issue is discussed further in section 3.7.

3.6 Case planning

Initial case review findings:

- Out of 1,332 cases confirmed as part of the project cohort, 1,149 (86%) were found to have evidence of a current case plan in the client file.
- There were 836 children under the age of 10 who had been in out of home care for more than a year who were not already placed with foster or kinship carers who might become long-term or permanent carers. Of these 836 children, 510 (61%) had a stability plan specifying what long-term or permanent care arrangements were required. Of those 510 cases, a stability plan had been prepared within the statutory timelines (Children, Youth and Families Act, section 170) in 347 cases (42% of the total).

Findings from action research data

Of the 707 cases in the action research cohort, action was taken to address:

- 227 cases where the stability/permanency plan had not been made or was not adequate
- 60 cases with no recent case plan or case plan review
- 34 cases where a formal review of the case plan was causing delays

The case planning framework

When a child is made the subject of a Children's Court protection order, the department is required to prepare a case plan within 6 weeks of the order being made and to provide a copy of the case plan to the family within a further two weeks.

Although there is no legislative requirement, planning has to commence earlier than this. As soon as a decision is made to intervene, the intervention must be planned. There is no specific legislative requirement to document a case plan before a protection order is made. Decisions such as what services to provide to a family and whether or not to issue a protection application and seek a protection order are all case planning decisions made before the start of any court process, and the court processes may take many months to resolve if matters are contested.

The fact the Act does not require a case plan until after the final order is made, and that it is quite common for there to be a many months between an application and a final order creates a lengthy period of time in many cases where little progress can be made on implementing any plans for children. Parents may be advised by their legal representatives not to cooperate with the department during this period. This, in itself, creates a period where children are placed in out of home care but where no planned intervention can occur, and therefore contributes to the child spending longer in out of home care before some form of permanency resolution can be achieved.

Finding 14. Of the children who had a long term or permanent care case plan and who were not in a placement planned to be their final placement, only 61% had a stability plan recorded on their file, and many of these plans were very basic. In the cases with a stability plan, 32% of the plans had not been completed within the statutory timelines described in the *Children, Youth and Families Act 2005* section 170(3).

Aside from the requirement to prepare a case plan once a final order is made, the Children, Youth and Families Act also provides a set of principles – the best interests principles (section10) – to govern all actions and decisions, principles to govern the decision making process (section 11) and additional principles to consider when the child is Aboriginal (sections 12–14). These principles promote a focus on the child's best interests as being paramount and require the participation of families and others in the decision making process.

Despite this legislative framework, the project found that many cases had experienced delays in case planning even after a protection order had been made. Where a case plan existed it often lacked a clear objective and did not identify what might trigger a case plan review and when. As a result, there were often lengthy periods in which the existing case plan for the child had been overtaken by events, or simply by the passage of time, but had not been thoroughly reviewed.

Stability plans

The Children, Youth and Families Act introduced the concept of stability planning which it defines as a plan for the stable long-term out of home care of a child (section 169) and prescribed timelines within which a plan should be prepared (section 170). The project found that this formulation had significant flaws:

1. It did not drive timely reunification by providing clear timelines for the achievement of that goal
2. It placed a focus on stability in out of home care, which was generally interpreted as stability in the current placement rather than determining the best long-term or permanent care arrangements that could be made for the child (including consideration of siblings)
3. The timelines were used as a trigger to start thinking about making a stability plan rather than as the maximum period allowed to finalise a plan
4. There was no similar obligation placed on the Children's Court in its decision making, and this created a disjuncture between the court and case plan decision making process, where case plans were often inconsistent with the current protection order and its conditions.

Finding 15. The stability planning framework in the Children, Youth and Families Act has failed to achieve the timely decision making that was intended.

Recommendation 13. The Act should be amended to incorporate a more comprehensive permanency planning framework with clear timeframes applying to both Children's Court and departmental case plan decision making processes.

Case example. Stability or permanency?

This is a case in which the “stability” of the placement would appear to have been a major contributor to the drift of the case and the non-addressing of ‘Stability’ as intended in the Act. The same case manager was allocated between January 2011 and August 2012; there are only 31 case notes in these 19 months.

The proportion of cases that had a documented stability plan where children required a long-term or permanent placement was, at 61%, disappointingly low, and many plans were made outside of the timelines.

This, of course, was one of the key issues that the project needed to understand. The timelines (Children, Youth and Families Act s170) were supposed to drive more timely permanency resolution, and yet they had clearly failed to have the impact intended and that delays in arranging alternate permanent care had actually increased. The graph in section 2.1 showing the average number of months from intake to permanent care order shows that an average of 47 months in 2007–08 (the first full year under the current legislation) had grown to an average of 56 months in 2012–13.

Key factors identified as contributing to delays in stability planning were:

- Lengthy court contests (sometimes of up to a year or more) creating periods of time where the capacity to involve families in case planning was limited or non-existent as a result of the conflictual relationship in the court setting
- A misinterpretation of the Act so that the timelines provided were treated as a trigger to start to make a stability plan, rather than as the maximum time in which one should be completed
- A focus of case plans on what needed to happen in the short or medium term to address immediate risk issues, with less consideration about how long-term permanency could be achieved. The

legislation requires that stability plans be made and this is often interpreted as having been fulfilled if a stable placement has been created, even where there is no clearly articulated plan for how to make this or another placement truly permanent.

- The initial case plan usually involves a plan to enable the child to return home, but these plans do not always have clear criteria for the circumstances when this can happen, with the result that reunification sometimes continues to be the objective even where little or no meaningful progress towards that goal has been made
- Changes of practitioner and of case planner sometimes seemed to lead to previous progress, or lack of progress, not being acknowledged. The views of the previous practitioner were often viewed sceptically and, where a case had been approaching a decision for a change of plan from reunification to permanent care, the new practitioner or case planner seemed to feel obliged to re-visit the entire plan which often led to parents being given one more chance even when the previous practitioner had concluded that further attempts at reunification were bound to fail
- The majority of children subject to protection orders who are in out of home care are subject to a custody to the Secretary order. This order places the child in care, but does not have a clear objective and, in many cases, the department was found to be working towards permanent care while the order and the conditions attached to the order were more consistent with family reunification. For instance, the initial conditions of the order may have been aimed at achieving reunification by ordering frequent contact between the child and their birth parents and by requiring parents to undergo treatment or receive services to address deficits in parenting capacity, and these may not have been changed when the case plan changed. This seemed to reflect reluctance on the part of some practitioners to seek changes to orders and conditions. This reluctance may have been partly a lack of confidence in advocating a course of action, but it also reflected an unwillingness to engage in a lengthy contest which would further delay decisions and also consume a significant amount of the practitioner's limited time.

Case example. Stability or permanency?

Despite the length and apparent stability of the foster placement and the period of time since a non-reunification decision was made, there is no evidence of a stability plan or even a case note which indicates whether a permanent care order has been discussed with the carers (or why it has not been discussed). Stability planning has been of the traditional variety where a recommendation to remain in the current placement has been seen to constitute stability.

Case example. Case plan tasks not related to case plan objective.

The case plan is for non-reunification, yet the tasks required are that the boy's mother undertakes drug screening, addresses parenting concerns and has her mental health illness stabilised. There has not been a consultation between the case manager/team manager and Adoption and Permanent Care Team.

Permanency planning

The most appropriate initial case plan is for family preservation if it is safe for the child to remain at home or for family reunification if the child has to be placed in out of home care.

Where the case plan is for family reunification both Child Protection and the Children's Court have to strike a balance in their decision making. It is important to ensure that children are able to return home as soon as it is safe to do so, and also to give parents time to address any protection issues before that can occur. On the other hand, it is important to avoid placing the child in out of home care for lengthy periods without any clear sense of whether or when they will go home since this is also harmful to the child.

All cases are different, and children go home in a matter of days, months or years, but it is generally true that the sooner reunification occurs the more likely it is to be successful. All child protection systems have become aware of the need to minimise harm caused by instability in care arrangements where a

series of short or medium term decisions lead to a child growing up in a variety of care settings and developing attachment, behavioural and other problems as a result.

A permanency planning framework is designed to address these issues.

> "Permanency planning is a case planning process aimed at securing stability and continuity for children in out-of-home care. Permanent options cover the spectrum of placement prevention, reunification, supporting children and carers in kin, foster and residential placements, and adoption. Permanency planning is conceptualised as having relational, physical and legal dimensions: relational permanence pertains to children having the opportunity to experience positive, caring and stable relationships with others; physical permanence denotes stable living arrangements; and the legal dimension pertains to the legal arrangements of a child's custody and guardianship."[23]

Importantly, the evidence is that permanency in the sense of security is more important to children than permanency in the sense of stability. A study in NSW found that:

> Stability and, more importantly, a sense of [emotional] security in care were highly significant predictors of young people's outcomes four to five years after they left care. As Jackson and Thomas (1999) pointed out, "stability on its own is not the end of the story" and is not necessarily desirable in itself if the child is unhappy or the placement does not meet the child's needs….Stability is important because it allows children to 'put down roots' and develop a network of relationships and because, as Jackson and Thomas (1999) outlined, it is likely to be a pre-condition for continuity in schooling, friendships, health care, and familiarity with the neighbourhood and local community
>
> While both stability and sense of security were interrelated, young people's sense of security was a more significant predictor of their outcomes after leaving care than stability per se. This is consistent with Jackson and Thomas's distinction between stability and continuity, and Schofield's emphasis on the importance of 'felt security'. It is also consistent with the role of a lasting relationship with at least one significant adult in children's lives in promoting resilience (Andersson, 2005; Gilligan, 2001; Lahti, 1982; Rutter, Giller & Hagell, 1998; Sinclair et al., 2005).[24]

Appropriate timeline for permanency decisions

Where the system does not drive timely decision making, children tend to drift in care. The stability planning timelines in section 170 of the CYF Act were supposed to be the driver. They provide a timeline for making a decision about whether a child will go home and, if not who will care for the child in the long-term. The timeline is age related and is 12 months for children aged under 2, 18 months for those aged 2 to 6 and 2 years for children aged 7 and older.

In other jurisdictions, shorter timelines have been introduced. For example, NSW has implemented a timeline of 6 months for children under the age of 2 and 12 months for older children[25].

Recommendation 14. The current stability planning timelines in the Children, Youth and Families Act should be reviewed and timelines should be applied to achieving reunification as well as to achieving permanent or long term alternate care arrangements. Efforts should be focused on achieving reunification within 12 months wherever possible. A further 12 month period of planned reunification can also be justified where it is assessed, based on evidence of progress already made, that reunification is likely be achieved during the second period of 12 months. Permanent or long term alternate care arrangements should be sought for children who have been in out of home care for more than 2 years – and earlier if reunification is clearly not going to be achieved.

[23] J Osmond and C Tilbury, 'Permanency Planning Concepts', (2012) 37(3) *Children Australia* 100. (quoted in *Permanency planning and adoption of children in out-of-home care – Briefing Paper no. 03–2013*, Roth/NSW Parliamentary Research Service, April 2013

[24] *Permanency planning and* adoption of children in out-of-home care – Briefing Paper no. 03–2013, Roth/NSW Parliamentary Research Service, April 2013, page 6.

[25] Permanency planning and adoption of children in out-of-home care – Briefing Paper no. 03–2013, Roth/NSW Parliamentary Research Service, April 2013, page 20.

Whatever the timeline, there is an obligation to make every reasonable attempt to provide the services that may assist the family to reunify before the timeline is reached, and this is asserted in section 10(3)(a) of the Children, Youth and Families Act (Best Interests Principles). This raises issues of service and system capacity and the prioritisation of service provision.

Organisational issues

Some of the case plan descriptions that can be chosen in CRIS are also unhelpful. For example "long-term placement – no return to family anticipated" explains what is not going to happen but does not clearly explain how the child's needs for continuity, stability and permanency are planned to be met.

Finding 16. Case plan categories in the Child Protection database include "Time Limited Assessment". Several cases had been classified in this way for far longer than a specific assessment would take to complete. One case had been categorised in this way for more than 2 years. The distinction between other case plan categories was not always clear, and this led to inconsistency in their use and a lack of clarity about their purpose.

Some Child Protection practitioners worked within an operational structure where there were different family reunification teams and teams devoted to managing long-term or permanent care. The practitioners in the family reunification teams sometimes seemed to have a blinkered view of the child protection role that was encouraged by this structure. Their sole focus was reunification rather than a more balanced approach that would seek to promote reunification while also making it clear to parents that there were timelines to work to, goals to be achieved within those timelines and alternative plans that would be developed if reunification could not be achieved within those timelines.

Recommendation 15. The description of each type of case plan must include a clearly expressed objective to drive purposeful action. This is best achieved by adopting the permanency planning hierarchy (family preservation, family reunification, permanent care or adoption, long term care). The permanency planning framework has the additional advantages that it drives planning from the start of intervention and requires a clear timeframe for decision making and review.

Some practitioners seemed to feel that not sending a child home was a failure, when success should really be measured by achieving the most appropriate form of permanency (whether this is reunification or alternate long-term or permanent care) within a timeframe consistent with the child's needs. Because of this perception of failure, reunification was often pursued for far longer than could be justified by the amount of progress on the part of parents to make changes. Sympathy for the parents could take precedence over promoting the child's best interests.

On the other hand, practitioners in case management teams where a decision had been made that the child could not safely return home often viewed the case plan as a "non-reunification" case plan. This terminology is very inadequate to describe the plans required, since it only describes what the plan is not. The use of the term non-reunification is so ubiquitous in the Child Protection program that it is even used in some of the case examples by project workers scattered through this report.

Recommendation 16. All references to "non-reunification case plans" are to be removed from program documentation and replaced by a reference to "permanent care case plans" or "long term out of home care case plans" (or "transition to independence" for planned care-leavers).

An additional problem with a structural division between reunification teams and case management teams is that it creates another transfer point in the program and therefore another change of practitioner and case planner in a system where there are already too many changes of allocated practitioner. Each change contributes to the overall delays in finalising permanency and a change at this point means that the development and implementation of a permanent or long-term out of home care case plan will be undertaken by practitioners who have a more limited personal experience and understanding of the history of the case.

Accountability for case plans

Another issue noted by project workers was that there is little accountability for case planning in the current structure and operations of the Child Protection program. Child Protection practitioners are managed by team managers and most are also supervised by the same team manager. The team manager supports and advises practitioners in developing and implementing the case plan and is also the person who makes the case plan. Other jurisdictions separate out these roles, and some even employ independent case planners. The current approach may have more merit at the front end of the program where decisions often have to be made quickly in the context of an evolving investigation, but a different approach may be better in the context of considered long-term planning.

There is scope within the current operational structure of the Child Protection program to develop more independence in making case planning decisions so that the practitioner's immediate manager is not also to the person who makes the case planning decisions. Where key decisions are being made, the case planner could be a manager or senior practitioner from another team.

If this practice were to be widely adopted it would ensure that the practitioners are not making recommendations to a case planner who played a key role in developing the recommendations. This is particularly important in trying to minimise "drift" and delay in the decision making process. A manager who is partly responsible for delays in the process, for whatever reason, may be insufficiently concerned about the impact of those delays. Another better way of broadening the decision making process is the use of the family-led decision making model for making case plans.

Project teams also found examples of poor practice in case planning where workload pressures had left time for only superficial case planning processes. Meetings between the practitioner and the family and without a case planner present were documented as case planning meetings even in some contentious cases.

There may be some cases where there is already agreement between families and the department where a review of the case plan can be conducted in this way, but key decisions and changes to the case plan objective where there is no agreement are better made in a meeting or series of meetings where the case plan chairperson is present and all interested parties have an opportunity to participate.

Recommendation 17. That the department review the advice provided to case planners and practitioners about what the basic minimum requirements for the development of case plans are, with particular reference to the involvement of parties in the process, as required by section 11 of the Children, Youth and Families Act.

Where a case plan report had been prepared there were instances where the parents had not been involved in the development of the report and were first given a copy of the report at the actual case planning meeting. It is unrealistic to expect all of the issues to be thoroughly discussed at a case plan meeting where people have only just been told what is recommended.

Better practice, where the practitioner had thoroughly discussed the issues with the family prior to the meeting and developed the recommended case plan in discussion with them could actually save time, by reducing the degree of disagreement about the case plan and its implementation and associated court orders and conditions. If this process led to agreement, there may not be a need for a formal meeting.

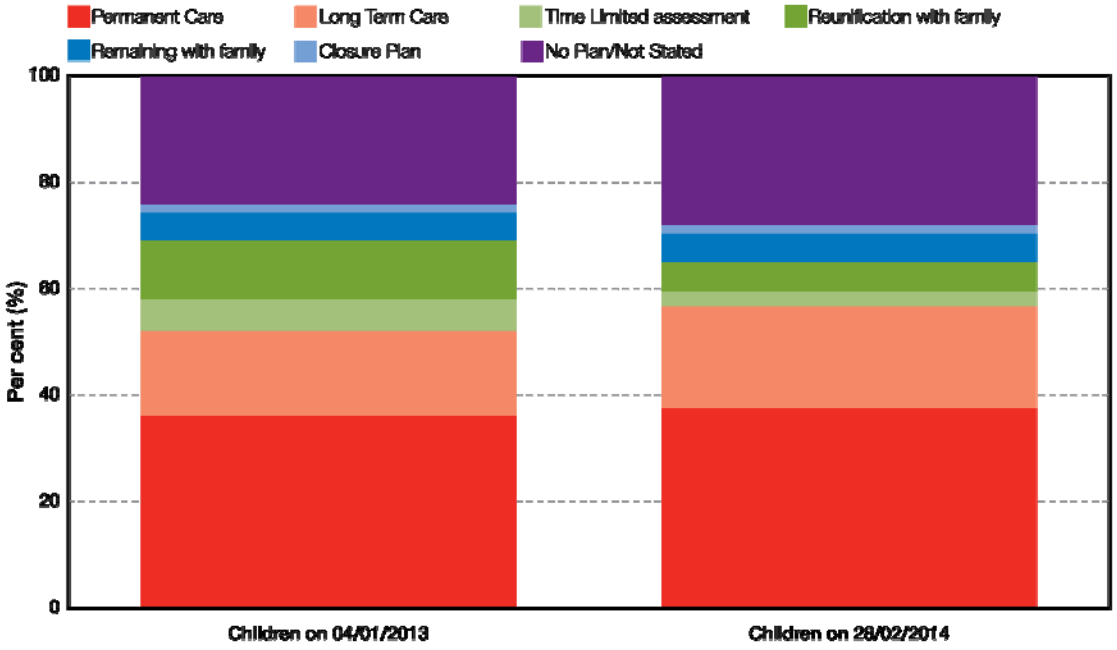
The data in the following graph and table compares the case plans recorded in CRIS for open Child Protection cases at the beginning and end of the project. In the first two columns, the number and percentage are for children aged under 9 years old that had been in out of home care for at least 12 months on 4 January 2013. The two right hand columns show children aged under 10 years old that had been placed in out of home care 14 months later for at least 26 months on 28 February 2014. In other words, these are almost exactly the same children 14 months later.

Of the children identified on 4 January 2013, 407 children are no longer captured by the data on 28 February 2014, because their case had been closed: either because a permanent care order had been made or because they had returned home.

Table 15: Comparative case plan data at project start and end.

	Children under 9 years old on 04/01/2013		Children under 10 years old on 28/02/2014	
Case plan	Number	Per cent	Number	Percent
Permanent Care	579	36.0%	451	37.5%
Long-term Care	255	15.8%	230	19.1%
Time Limited assessment	103	6.4%	34	2.8%
Reunification with family	176	10.9%	67	5.6%
Remaining with family	83	5.2%	65	5.4%
Closure Plan	24	1.5%	19	1.6%
No Plan/Not Stated	390	24.2%	337	28.0%
Grand total	**1,610**	**100.0%**	**1,203**	**100.0%**

Graph 8: Comparative case plan data at project start and end.



The graph shows that the proportion of children with each type of case plan had not changed significantly. On the other hand, there was a reduction of 148 children who had permanent care case plans between January 2013 and February 2014, which suggests significant progress in resolving cases identified with permanent care case plans in January 2013. Some of the children with permanent care case plans in the 2014 cohort would not have had a permanent care case plan in January 2013, so the actual number of permanent care orders gained in this cohort was certainly more than 148. The data in section 2 shows that 289 permanent care orders were made in 2013 and the majority of these would have come from this cohort.

There was a significant reduction in cases with a case plan of “time limited assessment” in February 2014 and this is also a positive result as it means that case plans had been resolved with long-term and permanent objectives.

The very large number of 390 cases with no recorded case plan at the beginning of the project had fallen to 337 by February 2014, although the proportion in February 2014 was higher (at 28%) than in January 2013 (24.2%). While this represents progress it is obviously still a very concerning number. The project found that many of these cases do have documented case plans but that the document is created outside of the CRIS database or is not properly recorded in CRIS and is therefore not picked up in the data. This reflects a more general weakness in program data, which is dependent on accurate data entry occurring in the first place.

Recommendation 18. Case plan formats in CRIS are too complex and cumbersome and need to be simplified. The basic case plan should only include key decisions about where the child lives, who they have contact with, what the permanency objective is and which services are to be provided. All case plans should be documented in such a way that their existence and their contemporaneity can be easily monitored in data that can be extracted from CRIS

If some Child Protection practitioners are avoiding the use of the case plan formats in CRIS because they are too complex or onerous – as seems to be the case – then this will need to be addressed as part of any other modifications to CRIS arising from this project.

3.7 Child Protection allocation capacity and workloads

Initial case review findings:

- Children in the project cohort had had an average 10 or 11 different Child Protection practitioners since they entered care (2 children had had one practitioner and, at the other extreme, 2 children had had 29 practitioners)
- The number of allocated practitioners was not simply a function of how long children had spent in out of home care. One child who had been in out of home care for one year had had 19 different practitioners.
- Where the case was contracted to an agency, children had (also) had an average of 2 or 3 workers (108 children had had one agency worker, while 2 had had 11 agency workers)

Findings from action research data

- Very few of the cases in the action research cohort were unallocated and action was taken in relation to allocation in only 21 cases. Only 3 cases were unallocated following intervention.
- Allocation in itself does not guarantee prioritisation and purposeful action. The action research cohort also included 67 cases where intervention had focused on overcoming barriers to resolving permanency by cases not being prioritised

The impact of changes of practitioner cannot be measured exactly, but is clearly significant because:

- New practitioners needed time to familiarise themselves with a new case
- There was a tendency for new practitioners to re-visit matters that were considered settled by the previous practitioner. This may suggest a lack of trust in the previous practitioner's judgement, but it seems more commonly to be a product of the new practitioner not being part of the process that arrived at earlier decisions and therefore not feeling any sense of ownership or commitment to them.
- While the impact of practitioner changes cannot be exactly measured, they must contribute to the often noted delays in completing assessments and reports. This is borne out by the observation of project staff that smaller Child Protection offices that have generic teams (and therefore no structural transfer points) often process cases with fewer delays because the same practitioner can be allocated from early in the process to the end.
- Changes of practitioner have a direct impact on children, families, carers and agencies, who also have to form a relationship with a new practitioner. Project workers would hear comments like "I wish I could have my old worker back. S/he really understood what was going on" and "I didn't like my new worker as s/he didn't even seem to have read the file."

One of the ways that the Child Protection program manages its overall workload is to segment the work according to the phase of intervention. Intake practitioners receive a report and conduct an initial assessment. Response practitioners investigate the most serious reports and initiate court proceedings. Case management practitioners supervise court orders and manage the disposition of Protection Applications and all secondary applications to the Children's Court. Workers in placement agencies assume responsibility for contracted case management of many of the children who are placed in out of home care and subject to a protection order.[26] These structural transfer points guarantee changes of practitioner and case planner on cases where a protection order is made. When a case is transferred to a new team there is also often a period where the case is awaiting allocation.

It is widely acknowledged by carers, parents and professionals that a change in the allocated practitioner and periods where there is no allocated practitioner can both lead to delays in progressing case plans.

[26] There are currently about 1,700 children where case management is contracted in this way.

Case example. Structural transfer points causing re-allocation and delays.

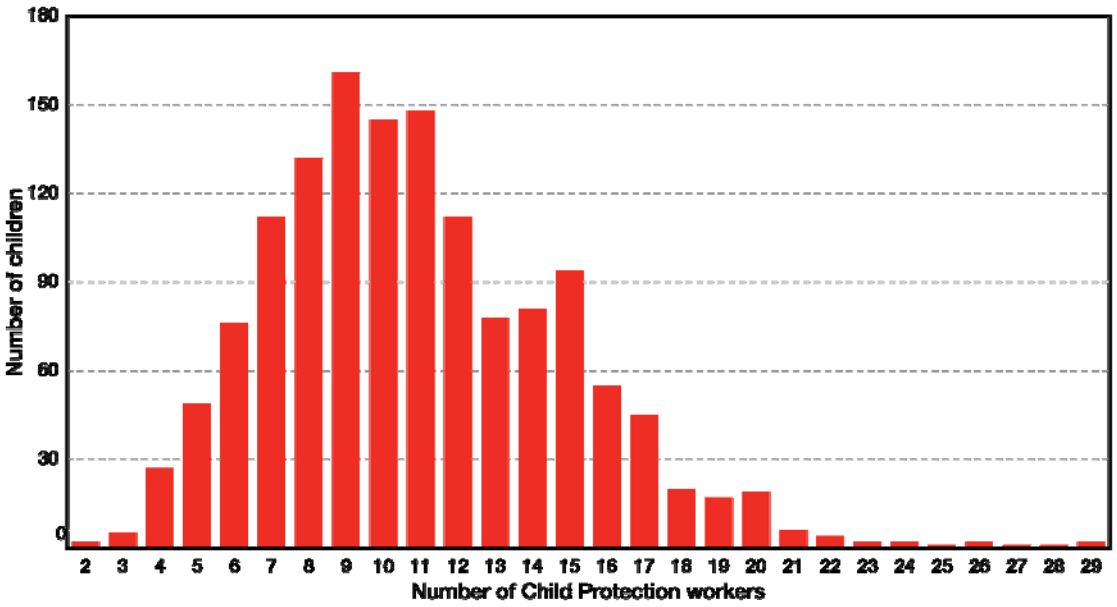
"Stability planning was assessed as being inappropriate as the overall focus of the case manager and case managing team was to transfer the case to the case contracting team, instead of completing the required permanent care assessment, which is likely to have caused further delays and case drift. Also there is no stability plan on file for U. This barrier remains unaddressed, because despite prompting and encouragement from the project team to complete the required tasks to progress the case to permanent care, the required tasks remain incomplete and the case has now been transferred to the case contracting team. Worker allocation was assessed as a barrier because U's case has been unallocated (or allocated to a team manager) for 20 of the 45 months her case has been open with Child Protection. The case was allocated at the time the project team had contact with the case and it is now allocated to a case contracting worker. The project team would have been able to assist with this case and complete the above tasks within the timeframes of this project; however the overall goal of the allocated case manager/case managing team was to transfer the case to the case contracting team. This case study has been written to highlight the culture within the region of cases being transferred to the case contracting team when very few tasks need to be completed to progress a case towards permanent care."

In addition to these structural transfer points between practitioners (and between managers and case planners) there are also other changes of practitioner caused by practitioners leaving the program or being assigned or promoted to different positions. Because of high workloads, cases are constantly re-prioritised and cases may be de-allocated because no urgent work is currently required.

The result is that many children and families have to contend with a bewildering number of case practitioners, all of whom will have different styles and approaches.

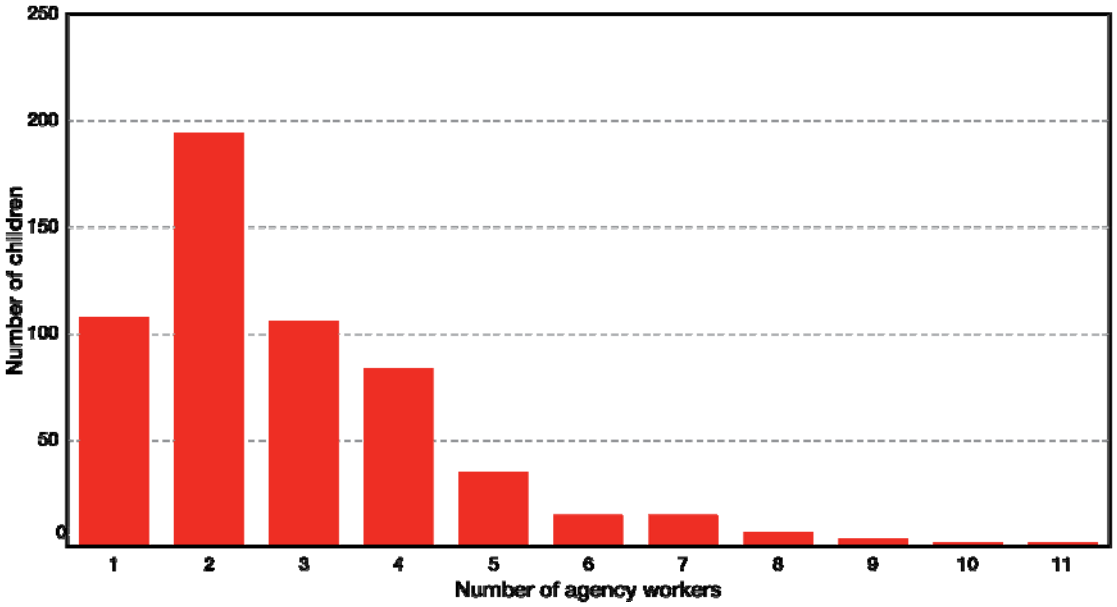
The data in the following table shows the number of primary allocated Child Protection practitioners that each of 1,398 children who broadly met project cohort criteria at the beginning of the project had had since the report had been received. Only 2 of these children had had only had one practitioner, and the most common number of practitioners that a child had allocated up until 4 January 2013 was 9. Many children had had more than 9 practitioners, with some children having had more than 20. The average number of practitioners that each child had had was 10.4.

Graph 9: Number of Child Protection practitioners per child in this episode of intervention



A total of 572 children in this cohort of cases were also subjects of contracted case management arrangements and therefore had allocated agency workers as well as child protection practitioners overseeing case management. The next graph shows that of these 572 children, 108 had only had one agency worker, while the largest group of 194 children had had two agency workers. The numbers here are smaller because a contract is usually tied to a specific placement and therefore usually to the same worker unless the worker moves to a different position.

Graph10: Number of contracted agency workers primarily responsible for a child in this episode in care



It might be assumed that the number of Child Protection practitioners each child had had would be proportionate to the amount of time they had been placed in out of home care. While this was generally true, the following table shows that there were significant exceptions to this correlation. There were 2 children (siblings: highlighted in green in the table) who had been in out of home care for 3 years and who had already had 29 different primary allocated Child Protection practitioners, and there were 3 other unrelated children (highlighted in yellow) who had had more than 20 practitioners in 3 years.

Many of the children who had been in out of home care for one year had had numerous allocated practitioners including one highlighted in pink who had had 19 practitioners.

Table 16: Number of allocated Child Protection practitioners compared to years in care

	Time since first entry to care in this case (years)									
Number of allocated primary Child Protection workers	1	2	3	4	5	6	7	8	9	ALL
2	2	0	0	0	0	0	0	0	0	2
3	3	0	0	2	0	0	0	0	0	5
4	18	7	2	0	0	0	0	0	0	27
5	41	2	3	1	1	1	0	0	0	49
6	49	17	5	2	1	2	0	0	0	76
7	65	24	16	2	4	1	0	0	0	112
8	61	39	11	8	9	3	0	1	0	132
9	52	55	25	10	11	2	3	2	1	161
10	46	25	39	19	8	4	3	1	0	145
11	37	21	40	14	22	9	4	1	0	148
12	20	23	23	20	9	9	5	3	0	112
13	8	14	16	20	8	5	3	2	1	78
14	9	9	22	13	12	9	5	1	1	81
15	10	13	23	24	15	4	2	1	2	94
16	3	5	14	9	7	6	5	2	4	55
17	6	7	7	11	3	3	1	3	4	45
18	0	0	8	7	3	0	1	1	0	20
19	1	0	2	6	0	3	4	1	0	17
20	0	0	3	3	6	6	1	1	0	19
21	0	0	1	0	2	1	2	0	0	6
22	0	0	1	0	0	2	1	0	0	4
23	0	0	0	0	0	0	0	2	0	2
24	0	0	1	0	0	0	0	1	0	2
25	0	0	0	0	0	0	0	0	1	1
26	0	0	0	0	2	0	0	0	0	2
28	0	0	0	0	1	0	0	0	0	1
29	0	0	2	0	0	0	0	0	0	2
Total	**431**	**261**	**263**	**171**	**124**	**71**	**40**	**23**	**14**	**1398**

The data presented above shows the number of practitioners allocated to a child and the number of years a child had been placed in out of home care. The data does not include additional periods where the case was awaiting allocation. In these circumstances the primary contact for a child and their family would be the team leader or manager responsible for the case. Where there were several periods or lengthy periods where the case was awaiting allocation there could have been more than one team leader of manager who would have been the primary contact, and these would have been in addition to the number of practitioners shown in the table above.

Finding 17. Children and families have to deal with numerous changes of worker, and this causes delays in the process of implementing and resolving case plans. It also means that relationships have to be made and ended and that no single worker is directly familiar with any substantial part of the case. The average child in the project cohort had experience 10.4 different workers during the period of intervention (and up to 29). Where there was contracted case management children typically also had two contracted agency workers, although some had as many as 11.

Defining permanency planning as not being urgent is perhaps understandable in the context of the focus on immediate risk in child protection work, but it is too narrow a vision for proper practice. There is little point in prioritising investigations and bringing children into care to protect them from harm if the children placed in out of home care (which is an urgent crisis for the child and their family) are then sent to the end of the queue for any intervention to promote permanent reunification or permanent alternate care. .

A reflection and also a driver of this narrow focus is that the process of assessing and investigating reports is constantly monitored by the program's key performance indicators (KPIs). The KPIs measure how quickly reports are responded to and whether or not investigations that result in substantiation are re-substantiated within a specific timeframe.

There are no high level reported KPIs for the effectiveness of long-term case work, although there is data collected for compliance with case plans being made when a new order is made by the Children's Court. It is, or should be, possible to measure:

- when case planning decisions are made and whether the objective is for family preservation, family reunification, permanent or long-term out of home care
- whether and when case plans are reviewed and whether planning objectives change
- the number of changes of allocated practitioner in any specified time period or phase of intervention
- whether or not a child placed in out of home care has siblings placed in out of home care, and whether the child lives with any or all of their siblings[27]
- whether or not Aboriginal children placed in out of home care have a current cultural support plan
- whether or not the Aboriginal Child Placement Principle has been complied with
- the average length of time between a child entering care and being returned home and whether a child who returns home subsequently re-enters care
- the average length of time between a child entering out of home care and long-term or permanent care arrangements being planned and implemented.

All of these measures should be considered for adoption as program KPIs so as to raise the profile of long-term casework within the program, and also to focus program managers on promoting effective long-term casework practice and timely permanency resolution.

Recommendation 19. That a KPI, or KPIs, be implemented to raise the profile and to measure the effectiveness of permanency planning and long term casework.

Case example. Changes of practitioner.

Since the initial Protection Application in August 2011 [i.e. 2 years previously], J.. [has been].. allocated to nine Child Protection Practitioners. He has [also] had an aggregate of six months in which his case management was not allocated.

Case example. Prioritisation of cases.

The case was unallocated and was managed by a Team manager. The case was not prioritised to achieve permanency at this time due to lack of resources and the crisis driven nature of the current work environment… The intervention of the SPPC Project has made the case progress to Permanent Care in a timely manner with the matter currently in court awaiting an outcome.

[27] This data (and much other data) was collected during the initial case review process and is documented in *The Stability Planning and Permanent Care Project initial findings* report which is attached as Appendix 1 to this report

Changes of practitioner cause delays in the development and implementation of case plans and also run counter to a great deal of research that emphasises the importance of a well-established positive relationship between practitioner and family if positive outcomes are to be promoted.[28]

Finding 18. The more structured and task-oriented casework conducted in larger offices with specialist teams is intended to promote efficiency and case throughput and assist in managing workloads. Further analysis of the losses and gains arising from such arrangements may be warranted compared to the potential for better engagement and more timely outcomes arising from the consistent allocation of one worker to a case where this is possible.

Some project staff worked on cases in smaller rural offices as well as metro and regional offices. Many smaller offices have teams that work generically across all phases of the child protection process. Where this was the case, the same practitioner sometimes held responsibility for a case from the original investigation through to children entering care and then either being reunified with their parents or placed in long-term or permanent care.

Where this was the case, project workers observed that the continuity of an allocated practitioner often led to better engagement with families and faster resolution of permanency planning – both for reunification and for long-term or permanent care. In some instances, project teams decided not to assist smaller offices because cases were generally progressing in a more timely way than cases in larger offices. The recently introduced area-based model for service delivery may provide unexplored opportunities for improvements in this regard.

Recommendation 20. The recent introduction of an area-based service model may provide opportunities to replicate some of the improved allocation continuity and consequently more timely permanency outcomes that are often achieved at smaller offices. Consideration should be given to how best to optimise these opportunities within the area-based model.

Case example. Delays caused by changes of practitioner and manager.

The transfer of this case through three different programs, requiring three different case managers and three different team managers has generally disrupted the flow and progression of this case. When being transferred between programs there is a tendency for case drift to occur whilst previous decisions and assessments are scrutinised, and practitioners "get up to pace" with the details of the case.

Carers provided feedback at the carers' forum held as part of the project and also in a survey conducted after the forum in which there was a repeated message that a trusted practitioner could make all the difference.

In response to the question "*In your experience, what are the greatest enablers to placement stability*?" answers included:

- "A trustworthy, non judgmental person who understands the needs of Permanent Care or adopted children and can be a sounding board and provider of advice. We were fortunate to have this in our social worker, but it can be the luck of the draw."
- "A competent and supportive DHS worker".

Responses to the question "What are the greatest barriers to achieving a permanent care order for the child/ren in your care?" included:

- "The ever changing workers, who DO NOT read files to keep abreast of what has been happening"
- "Child Protection's inability to maintain a stable workforce… Poor staff retention results in excessive case [re]allocation which then results in case drift and poor engagement with families."
- "Unallocated cases, slow and tardy case work (often least experienced workers),"

[28] "The most important condition for success is the quality of the relationship between a child's family and the professionals responsible. Terms used in the research publications vary…. but each implies a conscious attempt to incorporate the family into the investigation and protection plan, including those situations where children need to be looked after away from home." Cite Department of Health, *Child Protection: Messages from Research* HMSO, London, 1995, page 45.

Case example. Benefits of consistent purposeful casework:

No suitable permanent care placement was available when the decision was made for J to be placed in a Permanent Care placement. The Permanent Care program did not have any suitable carers accredited to place J with, nor the time to recruit carers, train, assess and accredit them. [The] SP&PC Project worker sourced a prospective permanent care couple, completed the permanent care assessment and presented the couple to panel for accreditation.

Once the couple were accredited… the SP&PC worker undertook the monitoring of the transition plan and placement once J was in their care. Throughout this process, SP&PC worker also attended Care Team meetings, Case Plan meetings and meetings with J's parents, along with the Case Manager. SP&PC worker supported the Case Manager to write the permanent care Court Report.

SP&PC worker wrote the Regulation 18 Report for Court.

SP&PC worker attended Court and continued to monitor J's progress in the placement until the case was closed.

As the case manager left during these processes, SP&PC worker took on more of the responsibility to manage the progress of the case, in an effort to provide continuity and ongoing support to J, his permanent carers and other support workers.

SP&PC worker instigated and implemented a counselling/therapeutic treatment plan for J, in an effort to support him with the change in his life situation and to work on his behavioural issues.

SP&PC worker proactively engaged the parents in the permanent care process, which resulted in them attending Court to agree to the making of the Order; and also facilitated access between them, J's siblings and J; something that had not yet occurred. They attended two accesses prior to the Permanent Care Order being finalised. This facilitated the development of a friendly and co-operative relationship between the Permanent Carers and J's parents.

The re-prioritisation of work impacts on progressing permanency plans. The cases that are prioritised are always those cases where children are at the highest immediate risk of harm. This may be because they are at risk at home, or sometimes where they are placed in out of home care. Or the likely harm may simply be that a placement is thought to be at risk of breaking down. "Stable" cases were viewed as being a lesser priority.

Case example. Prioritisation of cases.

The main barrier that needed to be addressed was the lack of priority or time given to cases that are "stable". Protective workers daily tasks are crisis driven and this child in a stable placement was of low priority. During the assessment process the case manager received a phone call from her team manager questioning her decision to attend an interview for the permanent care assessment instead of prioritising another case. The case manager felt conflicted about her decision and believed the permanent care assessment interviews were seen as "less important.

While it is understandable that such cases are prioritised, the effect is to de-prioritise cases where the child is currently safe. This approach fails to recognise the child may suffer serious cumulative harm as a result of the lack of clarity about future care arrangements and delays in making those arrangements.

Case example. Impact of change of Child Protection practitioner.

From my attendance at care team meetings, I identified having so many stakeholders as a significant barrier. The K siblings are part of a pilot project between [agency] and [Aboriginal agency]. A cultural support worker is attached to the care team to ensure cultural safety is occurring in the children's placement, school, access etc. The care team was advised this was approximately a 6 month role and would include the completion of cultural support plans. As the placement is also a [program] target, the [Agency 2] is involved to provide therapeutic consultancy to the care team. The Aboriginal agency also continued their involvement and were consulted in relation to all significant decisions relating to the children. There appeared to be role confusion, frustration and differing views. Each agency was operating from their own [perspective]. A new cultural support worker was allocated to the care team in [mid-] 2013. The worker questioned the appropriateness of a non-reunification case plan and queried if the children did not move to Permanent Care, if that meant the children's mother could still pursue reunification. It appears that workers (including the Child Protection Practitioner) struggled to accept a 'non-reunification' case plan that they were not involved in, and therefore questioned if it was appropriate.

Child Protection practitioners generally (and appropriately) approach cases where children are placed in out of home care on the basis that the best outcome is for the child to be reunified with their parents as soon as possible. In working through this process, practitioners are aware of all of the efforts devoted to that end. Where the viability of reunification has to be ruled out, the practitioner is familiar with the background and has a basis on which to make a case for alternate permanent care.

If there is a change of practitioner, the new practitioner lacks the personal experience of that process and the case file is no substitute for it. Newly allocated practitioners are often inclined to re-assess the case and, in some cases, to re-activate a reunification case plan. The other members of the care team may have their own reasons for encouraging the practitioner to re-assess the case and change the case plan direction, and this may further delay any progress being made on the case.

Another example of a situation where a practitioner's natural reluctance to separate children and parents permanently is where a baby is born to a mother whose previous children have all been permanently placed in out of home care. While it is very hard to separate a newborn from their mother, there would need to be some evidence that the mother had made significant changes in her life for any assessment to realistically suggest a different outcome for the newborn. Delaying the decision risks causing harm to the newborn, either in the mother's care or through being placed in out of home care with a short-term carer who cannot be their permanent carer. Delays also sometimes cause the unnecessary placement of siblings in different placements.

Because the project workers had a mandate to focus only on long-term cases which may otherwise have had little priority and were protected from the demands of the program's overall workload, they were able to focus consistently on the cases and take purposeful action over many months. Being given permission to work in this way was all that it took to achieve significant progress on some cases. The project workers were highly skilled and experienced, but this is also true of many members of the Child Protection workforce more generally (which is where the majority of the project workers were recruited from), with the exception of recent recruits to Child Protection who need to gain experience.

The Child Protection program has to find the right balance between resourcing intake and investigation activity and resourcing the long-term case work demands on Child Protection and community services that result from that activity. Identifying children at risk and those who have suffered harm, bringing them into care and then not having the capacity to adequately develop and implement case plans inevitably leads to some children eventually suffering further harm.

Recording assessments and reports

There were instances where practitioners had not completed assessments and reports that were required to progress the case further. Case plan reports, court reports, carer assessments and other documents have a standard template in CRIS. In many instances these were poorly used and sometimes they were avoided. As noted earlier, a significant proportion of cases had case plans recorded outside of the CRIS template,

CRIS "auto-populates" information elsewhere in the CRIS client file into the templates. This is intended to be an efficiency measure and to ensure that important information is not over-looked. Paradoxically it may have the opposite effect. Documents that have been auto-populated are meant to be reviewed and unnecessary information deleted, but the general practice is to leave all of the auto-populated information in the document. The use of auto-population:

- Creates dauntingly large documents that practitioners are hesitant to complete and that decision makers find hard to read.
- Tends to import irrelevant as well as relevant detail.
- Treats what is relevant as the same for all cases
- Encourages a passive approach to documenting assessments by fostering reliance on the database to provide content
- Impedes thinking by practitioners about what is relevant and therefore hinders analysis and clear assessment, and leaves decision makers with less confidence in recommendations.

Recommendation 21. The various report and assessment formats in CRIS, along with the auto-populate functions of CRIS, should be reviewed so as to promote the production of concise documents that clearly explain assessments and recommendations and their rationale and – as a result – provide better assistance to decision makers and participants in the decision making process.

The general approach and practice framework in Child Protection has tended to focus on case management rather than casework. Casework focuses on developing relationships with children and parents and other parties to create change, while case management is more focused on coordinating service provision and placing increased reliance on agency workers to form relationships.

While the case management approach has its advantages, it has led to practice where Child Protection practitioners only see the children they are responsible for infrequently, if at all. This can lead to cases becoming files for practitioners rather than actual children, and leaves older children wondering what decisions are being made and why. The lack of contact with children by the practitioners making and recommending decisions is even more of an issue where case management is contracted to other agencies, where only the agency worker has contact with the child.

On the other hand, it would not be desirable for the child to have contact with a frequently changing practitioner either. For best practice, the program should allocate a practitioner who has consistent contact over a long period of time. Consideration needs to be given to whether and how this level of service can be delivered.

Recommendation 22. The program's expectations about the desirable frequency and nature of client contact by practitioners need to be more clearly promoted and monitored, along with continuity of workers who have contact with clients.

The CREATE Foundation advocates for children and young people in care and the following statements were made by children about how they would like to be treated by Child Protection practitioners. Their comments suggest that a more meaningful relationship with their worker would be preferred:[29]

[29] http://www.gcyp.sa.gov.au/2014/02/young-people-from-create-give-tips-to-adults-about-respect/

Get to know us, not just reading the file.

Talk about what has been written down in notes or minutes and why.

Ask my permission to take notes in meetings.

Offer for young people to write their own notes to add to their file, from their perspective.

Remember we are still people not a file.

We don't choose them' (social workers) but it would be good if we could get properly matched to the right worker, including gender preferences.

Young people want to get to know their social worker.

Know my interests…who we are.

Spend time with the young person. Case notes and logging in diaries takes time away from spending time with you.

Make sure you enjoy your job because if you do not, that comes across.

More communication always helps to build relationships.

Listen to me every day, what I have to say

3.8 Skills, knowledge and capacity of professionals

Initial case review findings:

The skills, knowledge and capacity of professionals were a barrier to resolving permanency because:

- Many practitioners in the Child Protection program and in community services had a poor understanding of the requirements of permanency planning, leading to unfocussed case plans and casework and delays in completing necessary assessment and review processes.
- Professionals (both practitioners and case planners) were too easily persuaded to give parents "one more chance" when available evidence indicated that parents were not capable of making necessary changes
- The respective roles of Child Protection practitioner, community service placement support worker or contracted case manager and, where the child was Aboriginal, Aboriginal agency worker were not always clearly defined, and this sometimes led to nobody taking responsibility for necessary actions.

Findings from action research data

In the action research cohort of 707 cases, intervention included attempts to address the following barriers:

- 47 cases where the practitioner's knowledge of stability and permanency planning was limited
- 6 cases where the allocated practitioner was opposed to the case plan

The interventions assessed as most influential and successful included

- 318 cases where consultation and advice was provided about progressing permanency plans (295 cases) or resolving disputes about plans (23).
- There were also 54 cases which were progressed as a result of the stability and permanency training developed and delivered by project workers to both Child Protection and agency workers.

Child protection practitioners

There has been a great deal of focus on the investigation and risk assessment skills of Child Protection practitioners over the past two decades or more. This focus, which is not unique to Victoria, is driven by public concern about cases reported in the media where children have been seriously harmed or have died where a report had been received but insufficient action had been taken to prevent a distressing outcome.

Getting the right balance in investigation and risk assessment is hard to achieve. It is understandable that the public would prefer that there be no tragedies involving vulnerable children in future. However, there can be no absolute certainties and there will always be some unfortunate incidents in which children suffer harm or worse. When these occur, the pressure to find ways of improving initial assessments is understandably very high. As has often been said, Child Protection practitioners are damned if they do intervene (because it may prove to be unnecessary and can cause families unnecessary trauma) and damned if they don't (because unforeseen tragedies sometimes happen).

Because of the focus on this central dilemma at the "front end" of child protection work, there has been much less attention paid to long-term casework where children are subject to protection orders and placed in out of home care. There has been far less public concern (or at least far less media coverage and public debate) about what happens to children in care over the past 20 years. The recent inquiries into the historical abuse of children in care may be changing this although the focus is mainly on what has happened in the past rather than what may be happening now.

The dilemmas take a different form in long-term case work. On the one hand, it is desirable to return a child to their parents' care as soon as it is safe to do so, while on the other hand it is desirable to make alternate permanent care arrangements where reunification cannot be achieved soon enough to meet

the child's needs for continuity and permanency in their care arrangements. If the child is returned to their parents care too soon, the child may suffer further harm and be returned to out of home care. This is very harmful to a child. It not only exposes them to further harm, but it also further damages their relationship with their parents, and erodes any trust they may have in professionals to make the right decisions for them. It also condemns the child to a longer period of uncertainty about their future care arrangements unless they are lucky enough to be able to return permanently to their previous carer.

But how soon is too soon to attempt reunification, and how long is too long to maintain the attempt to achieve reunification? It is very easy to sympathise with parents who may be facing the loss of their child, and professionals all inevitably bring their own experience of their own family to these very difficult decisions. The evidence suggests that the longer a child is in out of home care, the less likely it becomes that reunification will be successfully achieved. The evidence also shows that long periods in care without permanency can cause great damage to the child's development and ability to form relationships which may make them harder to place permanently in another family.

There are specific skills required to work with birth parents while also safeguarding the best interests of a child who is on out of home care. The practitioner has to be supportive of parental change while, at the same time, focussed on the child's needs and be willing to confront the parents if changes are not being made fast enough. Where a practitioner has these skills there also needs to be a clear case plan for them to work within.

As in most child protection work, particularly with younger children, it is necessary to support the parents and even enter into an alliance with the parents to try to address protective issues and facilitate family reunification. The majority of the interaction in this scenario is between the practitioner and the parent. The danger is that this approach to the work becomes collusive rather than supportive of change and that the child's needs become a secondary consideration rather than the primary consideration.

This is a very difficult balance to strike, and practice in the Child Protection program and by agency staff was often seen to fall short of what is required. Some practitioners were apparently not prepared to make clear statements to the child's parents that there were limits to how long the child could wait before alternate plans would need to be made.

In order to avoid an approach which is to one sided, some jurisdictions and some practitioners advocate for a practice approach often called "parallel planning", where attempts at reunification occur alongside attempts to identify potential alternate permanent carers if safe reunification proves to be unachievable. This sort of approach is rarely followed explicitly in Victoria[30], except where the child's carer has stated they would be prepared to care for the child permanently if reunification is unsuccessful. Otherwise, planning for permanent care generally commences at the point that reunification is ruled out as a realistic prospect. In all cases, there at least needs to be a plan which contains clear parameters and timelines so that parents know from the beginning of an intervention what needs to change, how quickly it needs to change and what will happen if changes do not occur quickly enough, but these sorts of clear statement were often absent from case files and practice.

Some practitioners appeared to view the imposition of clear timelines as making threats that are inconsistent with being supportive of the parents making changes and, as noted elsewhere, these practitioners tended to view abandonment of attempts at reunification as failure. This perspective, however understandable, is overly sympathetic to the parents' views and wishes and insufficiently considerate of the child's needs, where alternate permanent placement is sometimes the best achievable outcome rather than a "failure".

Finding 19. The project found that the workforce required additional professional development and practice support in undertaking long-term casework in general and in developing, implementing and communicating clear permanency plans in particular. Use of authority in a constructive way to advocate for the child's needs seemed to be a particular issue for many workers.

[30] There is a project currently being undertaken by Connections Uniting Care that pilots the approach in the outer South Eastern suburbs of Melbourne.

Many practitioners were found to be practicing within a narrowly investigative framework where the main consideration was whether the child was at risk of significant harm. Children placed in out of home care could be viewed as "safe" from this perspective and therefore did not receive allocation priority. If allocated to a child protection practitioner or contracted to a community service, the focus of the work might be on supporting the placement and managing contact arrangements rather than the more important work of achieving progress towards permanent reunification or permanent alternate care.

Some foster and kinship carers expressed a view that children were left in their care for lengthy periods in an unplanned attempt to ensure attachments developed and that the carer would then feel obliged to offer to become the child's permanent carer.

Project workers perceived a general lack of urgency about long-term case work even thought it is well documented that successful reunification is best promoted where the child has been in out of home care for a short period. This is because longer periods in out of home care weaken the child's attachment to the parent and the parent's bond with the child. Where children "drift" in out of home care they gradually develop behavioural and attachment problems that will also make it harder to recruit an alternate permanent carer for them, and harder for carers to manage the child's behaviour.

There were some specific skills deficits identified in Child Protection practitioners when assessing the capacity of kinship carers and foster carers to become permanent carers, and a lack of confidence in contributing to the creation of cultural support plans for Aboriginal children.

These shortcomings need to be understood in context. The narrow focus of child protection practice is something that has developed over many years, and individual practitioners are, in following this approach, enacting the dominant concerns of the program and of the public. The lack of focus and urgency in some of the work is a result of high workloads and prioritisation of cases in order to manage demand and reported risk. It is the responsibility of the program to provide support, advice and professional development opportunities to improve long case planning and practice.

The relatively low profile and reportedly low status of long-term casework within the Child Protection program is unfortunate. It is potentially the most rewarding part of practice, because permanent outcomes, whether reunification or permanent care, are always a cause for celebration and a sense of a job well done. It is also perhaps the most important and skilful part of practice and the hardest to get right.

Case contracting to community services

Many cases where children are placed in out of home care, including many cases in scope for the project, are contracted to community services who provide placement services inclusive of case management. The intention is that the Child Protection case planner is responsible for making the case plan and conducting annual reviews and reviews caused by changes of circumstance. Progress towards case plan implementation is monitored by a Child Protection contract manager while actual case work is undertaken by the worker at the contracted agency, and a 3 monthly progress report is provided to the contract manager.

Finding 20. Project workers found that, at least in some cases, the changes of worker and the divided responsibilities involved in contracting case management to community services had created delays in progressing permanency planning.

In practice, there is not always a clear case plan direction when children are placed in out of home care, the contract manager may have difficulty in obtaining progress reports and the agency worker may view their role as being confined to supporting the current placement rather than developing a permanency plan.

From a structural point of view, the contracting process also entails delays caused by allocation to a new practitioner within Child Protection (the contract manager) a different case planner, a new allocated (agency) worker and a new agency worker's manager or supervisor. As noted elsewhere, this may entail a loss of knowledge about the case and a tendency to go back to the beginning in terms of developing and implementing a case plan.

The contract with the placement agency arises from that agency's responsibility for the child's current placement. The placement agency is no doubt in a good position to support the child's placement and the child within the placement, but this may not be the best arrangement where a permanency plan needs to be developed and implemented. There are potential conflicts of interest: is the agency primarily responsible for supporting the carer or the child? For example, as noted elsewhere, there was some evidence that foster care programs were concerned to retain foster care placements to meet performance targets and sometimes discouraged carers from converting to permanent care as this would become a placement lost to the foster care program.

Recommendation 23. The department should ensure that permanency objectives are pursued by contracted case management organisations in a timely manner and ensure that the process of establishing contracting arrangements does not create unnecessary delays in progressing permanency planning.

Issues identified by project workers in relation to contracted cases:

- Contract managers may see their role as passively monitoring the work of the contracted case manager, rather than taking responsibility for actively promoting case plan implementation and progress.
- A view exists in some agencies that there is no need to progress a case to permanent care until the current protection order is due to expire.
- There is a view held by some community service staff that if the child's parents won't agree to a permanent care order, then a permanent care application should not be made.
- The time delays from de-allocation by the case management team, acceptance by the contract management team, contracting to a community service then allocation to a contracted case manager/worker leads to delays/disruptions to stability planning. It is not uncommon that the stability planning either does not commence until allocation to a contracted case manager or 'goes back to square one' because of the time passed and because original discussions with the parties have lost continuity or have not been recorded adequately.
- Because of the inadequate stability component in the contract agreement with an agency, the contract can be non-specific in respect to what has to be done to progress the case to permanent care (if that is the best stability direction). This issue has been raised by project practitioners with case contracting teams. While the teams are aware of the problems, they are under pressure from management to accept transfers from the case management teams to reduce workload blockages. This means of resolving workload issues may improve capacity in other teams but is detrimental to case plan progress for the children where case management has been contracted.
- One divisional project team found that in one area office the lack of liaison meetings with contract agencies had contributed to case drift which is not identified or formally addressed. Other area offices hold scheduled liaison meetings. As a result of project intervention, liaison meetings have started on a limited basis in the area office where they did not occur, and there are some promising signs and agreement in principle. The divisional project team would like to have seen formal implementation of regular liaison meetings which would ideally be written into the contracts.

The research undertaken by Anglicare in Tasmania and referred to at the end of section 3.5 ("Parents") in this report also canvassed the views of child protection practitioners. The views expressed by child protection practitioners and copied here would likely be replicated if the research was repeated in Victoria:[31]

[31] http://anglicare-tas.org.au/docs/research/parents-in-the-child-protection-system-research-report.pdf

We do our best to work in partnership with every family we work with but the depth of that partnership and the success of that partnership varies greatly from family to family. There are some where there is little or no partnership because they want nothing to do with us or they don't take responsibility, or when their child is in care they disengage. Other families we are able to work really closely with and it can fluctuate depending on the situation. In order for families to work successfully with child protection we need to have a shared understanding of the risks. A family needs to be acknowledging those, we need to be negotiating what we can on the child protection side, but unless a shared understanding has developed a successful collaboration doesn't happen. It's almost impossible to work with a lot of the families. You are the enemy; it's as simple as that.

Once we get into legal proceedings it's almost like there's a two track system. You might have a reasonable working relationship but in court it's quite negative and very adversarial. We can get really tied up in legal proceedings but we also try to continue our case work, but it does affect our relationship with them and normally in a negative way. It stops parents from making change too. They are so angry and frustrated by the court process and the things that you want sorted out that they won't focus on making changes, they don't have the capacity for whatever reason. It's all taken up on this legal process, which is really intimidating. Especially if they are opposing the Order or your application and they think that they will get their kids back and they hang on with their hopes on that outcome instead of continuing to progress.

Often they won't leave a message. Reception doesn't take messages here and they put them through to our voicemail. They say I've rung four times and you check your voicemail and there's not a message left because they won't speak to a machine. The other problem is because most people are using mobile phones they screen their calls. We attempt to return the call but they see a private [blocked] number and are not sure who it is and won't answer. If parents choose never to answer private numbers they are probably not going to receive our calls. At the same time we can't say we're perfect because there are times when we don't return calls but I can guarantee that everyone does their best to keep in communication.

3.9 Court decision making

Initial case review findings:

Court decision making was a barrier to timely permanency resolution when there were:

- protracted Children's Court contests that prevented case plan finalisation – often for many months and sometimes for one or even two years – during which time engagement with the family to make any necessary changes was often difficult and sometimes impossible to achieve
- protection orders and conditions that were inconsistent with the case plan direction, and which left families and professionals unclear as to what was required of them
- negotiated outcomes that did not adequately promote the child's best interests

Findings from action research data

In the 707 cases in the action research cohort, delays caused by court decision making were addressed as barriers in

- 93 cases with lengthy court contests (36 cases) or with lengthy or numerous adjournments (30 cases) or where there were delays in getting the matter heard (27 cases)
- 82 cases where the Children's Court order and conditions were inconsistent with the case plan (65 cases) or where other delays resulted from court orders and conditions (17 cases)

Initiating court proceedings

When Child Protection investigates a report and assesses that a child is in need of protection, an intervention plan is developed. This plan may consist of an agreement with the family about services to be provided and changes to be made. If this sort of voluntary plan cannot achieve sufficient safety for a child, a Protection Application can be issued to be heard in the Children's Court.

The Children's Court has to make two major decisions. Firstly, the court has to decide on *proof*: is the child in need of protection? Secondly, the court has to decide on *disposition*: what protection order should be made (if any), and what conditions should be attached to the order?

The Court is rarely in a position to make a decision about disposition at the first hearing, but it may be in a position to decide on proof. The child is usually made the subject of an Interim Accommodation Order at the first hearing until decisions about proof and disposition are made at a further hearing at a later date. An Interim Accommodation Order states where the child should reside and places relevant obligations on parties to the case. Similar processes occur where a protection order already exists but where an application to breach, vary, extend or revoke the order is being made.

Proof and disposition

The Children, Youth and Families Act constructs proof and disposition as separate issues requiring separate reports, and this was also the case under previous legislation. Proof should usually be a relatively simple matter – is the child in need of protection, or not? If the child is found to be in need of protection, the matter of disposition may be more complex – what services may the child and the child's parents need, should the child be placed in out of home care, where will the child be placed, what protection order and/or conditions will best secure these arrangements?

The court has increasingly tended in recent years to consider the two issues together and Child Protection has provided a combined report to meet the court's needs.

This process of considering proof and disposition at the same time has sometimes created negotiated outcomes that do not properly meet the child's needs. For instance, negotiations may lead to conditions on orders (disposition) being consented to on the basis that some of the grounds for protection (proof)

will be dropped. Where children are too young to have a voice, this is a process in which the child's assessed needs may be traded against the parents' wishes.

There is no doubt that there are occasions where a negotiated outcome is preferable to a contested one. One key advantage of a negotiated outcome is that the matter is settled immediately rather than months or even years later. But project workers also found many instances where Child Protection practitioners felt that they had been guided by the court process or their own legal representatives into accepting outcomes that were not in the child's best interests. Neither poor negotiated outcomes, nor lengthy contests are in the child's best interests.

Finding 21. The system encourages negotiated outcomes because the alternative is a lengthy adjournment for a contest during which time little progress or change in the family may be achievable. Negotiated outcomes are, by their nature, compromises, and there are instances where practitioners believe that the child's needs are not properly met.

The department's legal representatives have an experienced view of what outcomes are likely to be acceptable to the court, and their advice is often based on this view. Over time, this has led to case planners trying to second guess the court's likely decisions and the legal representative's advice. It is as though the entire system has gradually shifted its expectations as a result of trying to assess what may be acceptable to the court where parents are contesting, rather than arguing a position based on an assessment of a child's best interests. There were many instances where Child Protection practitioners felt that they were being asked to modify their instructions, even where they felt that those instructions were based on sound assessment and were necessary to protect the child from further harm.

Currently, the system may deliver the worst of all possible worlds, where a child is removed from their parents' care and placed in out of home care, but where planning for reunification cannot commence during the many adjournments that result from a contest. It is not uncommon for parents to be advised by their legal representatives to withhold cooperation from the department as cooperation may weaken their position in a contest. This means that children stay in out of home care longer than is necessary, and this reduces the likelihood of successful reunification.

Finding 22. The lengthy delays accompanying contested cases contribute to poor outcomes for children, as children spend lengthy periods of uncertainty in out of home care while the case plan direction is resolved, and during which period the contest may hinder progress being achieved by their family towards resuming care.

Case example. Numerous hearings:

From early 2010 to late 2012, there were over 40 Court hearings for the siblings and a final contested hearing in October 2012

Case example. Lengthy court processes:

N and his sister have been subjects to Interim Accommodation Orders since 2011. The court reports indicate that the case plan for N is permanent care. However, given his age, difficult behaviours, the aggressive nature of his mother and the impact of contact on the children; it would be very difficult for him to achieve permanency. There has also been no case plan meeting to discuss this with their mother and father who seem intent on having them returned to the mother's care. N meets the legislative requirements for stability planning as he has been in out of home care since 2011, however without resolution of the court matters and a final order in place, stability cannot be achieved. Initial consultation occurred with the team manager regarding the barriers, but the barriers remain a result of the children's complex behaviour, the Court delays, several adjournments and mother and father both seeking their time in court. The court has also refused to make orders in relation to the children, with the case now booked for a contest in 2014, by which time the children will have been subject to Interim Accommodation Orders and an unresolved case plan for over two and a half years.

Taking a step backwards from the process, the situation in the previous case example seems paradoxical. Disposition is being contested, but the court's decisions have had the effect of placing the children in out of home care for more than two years while the matter is settled. A far better outcome from the child's point of view would have been for a protection order to be made within the first few weeks placing the child in out of home care. This would have meant that the last two years could have been spent trying to create a situation where the children could return home. Instead no progress has been made towards reunification and the children's escalating behavioural problems also make it harder to find a suitable alternate permanent carer.

Recommendation 25. That the Children's Court should not make an interim accommodation order if an application has been proved and if there is sufficient evidence to make a protection order.

In order to create a way out of this impasse, it would be useful if the court could make an order that places the child in out of home care and also guarantees to parents that the objective is to return the child to their care as soon as possible. The current custody to Secretary order offers no such guarantee and the name of the order is also rather intimidating with its criminal sounding name.

Recommendation 26. That a family reunification order should be one of a new set of protection orders that would enable the court to make decisions that have a clear objective (family preservation, family reunification, long term or permanent care). Orders should also contain a timeframe in which the objective is to be achieved. This would make the intention of orders apparent, and also remove conflicts between the intent of the order and the case plan.

Less adversarial processes

Previous reviews of the Children's Court of Victoria have all suggested that there would be benefit in the court adopting less adversarial processes and exploring other means of dispute resolution.

> The current adversarial nature of the court process militates against effective planning for the welfare and wellbeing of children.[32]

> The Panel believes there is a need to modify the operation of the adversarial paradigm in the Children's Court.[33]

> …submissions argued that current adversarial processes promote a lack of mutual trust and respect between welfare professionals, legal practitioners and court officers when they come together to make decisions about a vulnerable child.[34]

The Children's Court has itself declared its interest in modifying the approach to promote dispute resolution by agreement.

> Almost all submissions, including the Children's Court's, sought a greater focus on alternative dispute resolution processes by agreement[35]

[32] The report of the Panel to oversee the consultation on Protecting Children: The Child Protection Outcomes Project Kirby, Freiberg and Ward, DHS, April 2004, page 6

[33] Kirby et al, page 40

[34] *Report of the Protecting Victoria's Vulnerable Children Inquiry* (PVVCI), Volume 1, Cummins, Scott and Scales, Dept of Premier and Cabinet Victoria, Volume 2, January 2012, page 103

[35] PVVCI, Volume 2, page 103

Amongst other recommendations, the PVVCI recommended:

> The Children's Court should be empowered under the Children, Youth and Families Act 2005 to conduct hearings similar to the Less Adversarial Trial model used by the Family Court under Division 12A of the Commonwealth Family Law Act 1975.[36]

Recommendation 27. That the Children's Court should continue to explore ways of resolving matters using alternate dispute resolution processes and more informal processes in the court itself.

An approach that was less adversarial and more focused on problem solving might be more easily achievable if the Children's Court gave further thought to implementing the provisions in the Children, Youth and Families Act that the court should, as far as practicable, "minimise the stigma to the child and his or her family" in any proceedings (section 522), and "must conduct proceedings before it in an informal manner, and must proceed without regard to legal forms and …..may inform itself on a matter in such manner as it thinks fit, despite any rules of evidence to the contrary".(section 215)

These provisions open up a wide range of potential interpretations and practices, but the Children's Court is still relatively formal and seems most comfortable with procedures similar to other courts, including contested hearings which are often highly adversarial. Other approaches may be more successful in achieving better outcomes for vulnerable children.

The problem with the adversarial approach is that matters often become a contest between the parents and the department whereas the best solutions arise from all parties focusing on the needs of the child. The primary responsibility of the Children's Court is not only to protect people's rights. The Children, Youth and Families Act section 10(1) states that the child's best interests must be the paramount consideration and that this includes consideration of the child's need for protection from harm and of their developmental needs as well as the child's rights. These three elements must be considered as more important than the rights of other parties where they are in conflict.

In most other jurisdictions, the relevant court is less adversarial. Practitioners who move from other Australian jurisdictions are often surprised by the extent of the adversarial nature of the Children's Court of Victoria. In many European jurisdictions, the matters of proof and disposition can be dealt with in forums other than a court.

Where the equivalent of a protection application is made in Scotland, the matter is referred by the Reporter (who is answerable to the Sherriff's Court but employed independently) to the Children's Panel, where the Reporter presents the matter. If "proof" is contested, the matter is referred to the Sherriff's court to decide upon "proof" alone. The matter then returns to the Children's Panel, which is comprised of three lay people who decide upon the appropriate Order (advised by the Reporter if necessary). Decisions of the Panel can be reviewed by the Sherriff's Court but a review is rarely requested because the court has already proved the application and the need for intervention. The system also has the advantage that the community, as represented by the three lay members of the Children's Panel, is involved in decisions made to protect children.

It may not be possible to construct this sort of model in Victoria, but it is certainly possible to develop an approach where "proof" is dealt with quickly before considering arguments about disposition, which could then be dealt with more clearly and without the argument becoming clouded by matters of proof. This approach would also enable the consideration of disposition to be more clearly focussed on the child's best interests rather than on whether or not the parents have done something "wrong".

[36] PVVCI, Volume 1, page lviii

In the case example earlier in this section, where children had been placed on Interim Accommodation Orders for over 2 years without any resolution to the case, it is hard to see how such a case could not be proved, even if there needed to be a contest to decide on disposition. If the children were not in need of protection, why place them in out of home care for such a lengthy period of time? If the matter had been proved, the extent of the contest may have been contained and the matter decided earlier.

Recommendation 28. That the department should submit separate reports to the Children's Court regarding proof and disposition, and that the issues of proof and disposition should be considered separately and consecutively by the court.

Proof and blame

Project workers reported that the culture that has developed in the Children's Court seems to have skewed the issue of proof close to a finding of blame or guilt. This is not the intention of the legislation, where the key issue is whether the child is in need of protection. The Children, Youth and Families Act (section 162), and the Children and Young Persons Act 1989 before it (section 63), define when a child is in need of protection primarily in terms of whether the child has suffered harm or is likely to suffer harm and whether the parent has not protected or is unlikely to protect the child from harm of that type.

There is nothing in this formulation that necessarily implies blame. The intention is not to label parents as child abusers but to ensure that children are protected from harm, preferably by their own families. The majority of child protection cases involve parents who are struggling to cope with the responsibilities of parenthood while also trying to deal with other issues such as mental health problems, family violence, substance abuse, poverty and social isolation. Any attribution of blame can be resolved through criminal proceedings in another court if an offence has been committed.

Finding 23. Although it is not the intention of the Children, Youth and Families Act, project workers reported that the culture that has developed in the Children's Court over many years seems to have skewed the issue of proof that a child is in need of protection close to a finding of parental guilt.

Failure to attend or provide assessments

Currently children might be subject to an interim accommodation order or orders for many months until a final hearing. While this is often because matters have been adjourned for a contest, other factors also contribute. These include parents who fail to attend hearings and hearings where assessments and reports requested by the court have not been completed.

Case example. Impact of parents' failure to attend court:

At a Permanent Care application first listed for hearing in February 2013, both parents attended this hearing and advised they were not in agreement with the application for a permanent care order. The matter was listed for a total of three Directions Hearings (between mid 2013 and early 2014.). The first two hearings were rescheduled as the children's parents failed to attend the first hearing and were late to the second.

The Court must uphold the rights of parents, but their failure to attend and the resulting delays in decision making have an impact on the rights of the child. If parents are unable to make arrangements to attend a hearing without good reason, there must be some doubt about their ability or motivation to properly care for the child who is the subject of the hearing.

Where assessments and reports are not provided, the court will have to consider the validity of reasons given for the delay but, as in other situations, will also have to consider the impact of delays on the child: Children, Youth and Families Act section 10(3)(p).

Conflicts between case plans and protection orders

As well as instances where case planning decisions were delayed by unresolved matters in the Children's Court, the project also found cases where case plans had been made before the Children's Court had granted an order consistent with the case plan, as shown in the following case example.

Finding 24. There needs to be a better fit between court and case plan decision making so as to provide both legal and administrative support to the most appropriate intervention plan for the child.

Case example. Conflict between case plan and court order:

Case planning for permanent care was incongruent with the directions of the Children's Court, where the Magistrate had directed that reunification must be attempted. ... The Supervised Custody Order should have been breached and the matter taken back to Court before any case planning for long-term out-of-home care/permanency occurred. This has resulted in a long drawn out Court process, with many adjournments and a lengthy contest.

One of the key findings of the project is the need to create a better fit between court decision making and case planning decision making so that case plans and court orders align to promote a particular objective, rather than either working against each other or failing to provide clarity about the objective.

The Protecting Victoria's Vulnerable Children Inquiry made recommendations in relation to the protection orders that the Children's Court can make. There are three points which are relevant in the context of this project;

"The Inquiry considers that a court should not be involved in case management and case planning particularly in rapidly changing situations. There are other bodies with expertise more suited to case planning, provided that they are guided by transparent principles and practice, are accountable and are appropriately monitored"[37]

"The current scheme of protective orders under the *Children, Youth and Families Act 2005* should be simplified. This can be achieved by reviewing the scope and objectives of each order and their current utility"[38]

"The court should only impose "conditions relating to child-parent contact or contact with siblings and other persons who are significant in the child's life (if appropriate to the type of order sought) and conditions that intrude on individual rights namely the exclusion of individuals from a child's life and drug and alcohol screening"[39]

As noted in the section on case planning, the custody to Secretary order is a problematic order as it splits parental responsibility and keeps all case planning options open. As a result, the order does not drive resolution of whether or not the objective should be to return the child home, and nor does it clearly establish who can make long-term decisions about the child.

[37] Report of the Protecting Victoria's Vulnerable Children Inquiry (PVVCI), Recommendation 63, Vol. 2, page 398

[38] Report of the Protecting Victoria's Vulnerable Children Inquiry (PVVCI), Recommendation 63, Vol. 2, page 404

[39] Report of the Protecting Victoria's Vulnerable Children Inquiry (PVVCI), Recommendation 63, Vol. 2, page 404

In general, the child's legal guardian has the power to make long-term decisions about a child while the person with custody can make day to day decisions about the child's care. The development of a permanent care case plan where a child is subject to a custody to the Secretary order, while permissible, is problematic because the child's parent retains legal guardianship under such an order and has the right to make long-term decisions about the child.

Recommendation 29. Where a decision is made by the court to order the placement of a child in out of home care, a new type of order that specifically promotes family reunification should be available, except in those few cases where it is already apparent that the child will not be able to return to their parents' care.

It is also often the case that conditions attached to a custody to the Secretary order hinder the implementation of a permanent care case plan. For instance, in preparing a child for permanent placement and the granting of a permanent care order, the frequent contact that may have been ordered to support a reunification case plan may no longer be appropriate. The department has no discretion in this regard unless the child is subject to a guardianship to Secretary order, and returning the case to court for a variation of conditions may trigger an extended period where the whole matter is contested and where progress on implementing the case plan is halted.

This is a difficult area, because the Court must be free to make decisions in the child's best interests while bearing in mind the rights of others, while the department has to be able implement case plans on the same basis. The department cannot bind the Court to a particular course of action and, as noted by the Protecting Victoria's Vulnerable Children Inquiry, the Court should not stray into managing the details of the case plan.

The conditions attached to orders straddle the grey area between court decision making and case plan decision making. While there was a view expressed that the court attaches too many conditions to orders, there was also an alternate view that – to a large extent – the court is attaching conditions to orders that have been requested by the department.

As noted elsewhere in this report, a new range of orders that more closely aligns the range of protection orders with the range of possible case plans would assist in better aligning court and case plan decision making, and promote earlier resolution of cases.

3.10 Assessment and support of carers

Findings of consultation with carers:

Carer support issues created a barrier to resolving permanency because:

- Carers were reluctant to lose the support of Child Protection and/or community services in managing contact between the child and the child's family, or in managing the relationship between the carer and the birth parents
- Carers believed their payments would reduce when a permanent care order was made
- Carers were concerned about becoming responsible for the potential costs of accessing services to meet the child's additional needs, such as health, dental and therapeutic services
- Carers were concerned about the potential for there to be future applications by the birth parents to vary contact conditions or revoke the permanent care order, and that they would have to fund any contested hearing.

Findings from action research data

Of the 707 cases in the action research cohort, the following barriers were the focus of intervention:

- 106 cases where an assessment of a kinship carer as a permanent carer needed to be completed
- 78 cases where a specifically recruited permanent carer's assessment needed to be completed
- 65 cases where the current carer was unwilling to become a permanent carer (although possibly willing to offer long-term care without a permanent care order).
- 44 cases where the current carer may be willing to offer long-term or permanent care, but where there were concerns about the quality of care being provided
- 44 cases where the anticipated loss of financial support entitlements deterred potential permanent carers
- 33 cases where an assessment of a foster carer as a permanent carer needed to be completed
- 30 cases where a placement agency did not support the conversion of a foster placement to a permanent care placement
- 18 cases where the current carer had been assessed as unsuitable as a permanent carer

There were also numerous cases where the needs of the child were assessed as being a barrier to permanency resolution and where the carer may have been reluctant to take on full responsibility for the child if not adequately supported. These cases included:

- 63 cases where the child had behavioural issues
- 24 cases where the child had a developmental delay or intellectual disability
- 21 cases where the child had complex medical needs
- 12 cases with a need for counselling and therapeutic support
- 9 cases where the child had mental health needs
- 30 cases where other supports were required

Carer assessment

Assessment of carers is a complex task. People have all sorts of motivations for wanting to become foster carers and permanent carers, while kinship carers often become carers at extremely short notice and without necessarily seeking such a role.

It is not unknown for carers to harm the children in their care, although this is thankfully rare now that the background and criminal records of potential carers are routinely checked as part of the assessment process. It is also now promptly acted upon when it does occur with a proper process for investigations

into the quality of care being provided. However, children can suffer harm as a result of instability in care arrangements as well as from poor standards of care.

Case example – Unstable care arrangements

T came into care in early 2009 and spent 3 months in his first foster placement before moving to a second placement where he stayed for fourteen months. This latter placement ended when the foster parents separated. T went to another placement for a month before returning to the carers, who had reconciled. He remained in this placement until early 2012 when the carers again separated. T remained in the care of the female carer and then with the male carer (supported by the female carer's mother). T spent some months in a 'share-care' arrangement between the two foster parents before they reconciled again early in 2013. In mid 2013 a Quality of Care investigation too place following a domestic incident involving one of the foster carers' children. T remained in the placement. In late 2013 the placement agency became incidentally aware of the female carer's intention to leave her husband; an intention was expressed by senior management at the agency to address this with the foster family, but at the time of writing this appears to have not yet occurred.

The case example shows a series of events that contributed to instability in care arrangements. It is possible that the child suffered a degree of harm from the changes described, but it is also likely that it is only with hindsight that most of the changes in care arrangements could have been predicted. The example does show one dimension of what must necessarily be a very comprehensive assessment of potential carers – the stability of the relationship between the members of couples who wish to be carers.

Another important dimension is the impact on the carers and other family members of introducing a child or children into the family. Carers who have children of their own may face dilemmas in how they divide their attention between their own children and their foster children. On the other hand, there are also people who wish to become carers, especially permanent carers, who have no children of their own and who may not be able to have children of their own. There are obvious challenges in assessing the suitability of a person or a couple to care for children when this is something that they have not previously done.

Kinship carers are often grandparents, or they are aunts and uncles or other relatives and sometimes family friends. There are clear advantages in placing children with kin. Kinship placements can usually more easily maintain the child's connections to their siblings and extended family, and they may also be best able to maintain any cultural connections of the child. Many kinship carers are highly motivated to care for a child precisely because they are kin.

Child maltreatment can be inter-generational and assessments have to confront this issue when assessing kin. There are grandparents whose relationship with their own children has broken down and who might wish to try and "get it right" if given a second chance. These situations may be accompanied by conflict between the child's parents and grandparents, and this can be highly damaging to the child. So while there is a preference for a child to be placed with kin, this has to be tempered by a clear-eyed assessment of the complexities of family relationships.

Despite these qualifications, most placements of children in out of home care are with kin, and most kinship placements are successful. It is long established practice that children be placed with kin where possible, because it is more consistent with the aim of keeping families together than placing children with unrelated foster carers. The preference should be stated explicitly in the Act.

Case example – kinship care issues.
B has experienced at least seven placements including four kinship placements. One of these kinship placements (with his paternal aunt and uncle) broke down due to B's high needs. Another kinship placement (with his paternal grandparents) had been endorsed for permanent care by both [Aboriginal agency] and Child Protection but was ended due to quality of care issues in 2011.

While prospective foster carers and permanent carers are generally assessed by foster care or adoption and permanent care agencies, most kinship carers are assessed, at least initially, by Child Protection practitioners.

Children are often placed with kin at extremely short notice and with little more than a basic safety check being conducted. Following what may initially have been an emergency placement, there follows a Part A assessment of a kinship carer which is designed to make sure that the carer can – on a short term basis – meet the child's immediate needs and ensure that the child will not suffer significant harm. If the placement is for more than 3 weeks, there is a Part B assessment to be undertaken that is a more comprehensive assessment of the carer's abilities and appropriateness to care for the child in their care.

Completion of Part A and Part B assessments competes with other Child Protection work for priority and is often delayed for lengthy periods as a result. One project team proposed a change to the naming of the assessment components, so as to convey a sense of their importance, and this seems to be a reasonable proposal.

Kinship carer assessment part C is intended to be a 12 month review of the Part B assessment, but this does not occur very frequently, partly because Part B assessments have often not been completed. There is no assessment framework for when kinship carers wish to become permanent carers. Project teams developed a "Part D" assessment for this purpose.

Recommendation 30. That the Kinship Carer Assessment Part A be renamed "Kinship Carer Initial Safety Assessment" and that the Part B assessment be renamed the "Kinship Carer Safety and Wellbeing Assessment".

Recommendation 31. That the Kinship Carer Assessment "Part D" framework developed by the project workers be adapted for inclusion in the Child Protection practice manual and for use in the field. Part C and D assessment frameworks also require a clear name: perhaps "Kinship Carer Safety and Wellbeing Review" and "Kinship Permanent Carer Assessment".

Case example – kinship care issues.
The children have continued to reside with their maternal grandmother. At times their mother has resided with them but when her mental health illness flares up, she has had to be removed from the home. Of concern is that this has happened on more than one occasion and it has required the intervention of Child Protection and Police to have the mother removed from the home. This raises the question around the maternal grandmother's ability to protect the children from future harm by making prudent decisions around the appropriateness of their contact with their mother

Carer Support

There are also different views of how carers should be rewarded. At one extreme are those who believe that carers should "do it for love" and that offering compensation will attract people with the wrong motivation. Then there are those who believe that foster carers should be compensated for additional expenses they incur, and

Finding 25. There is a range of views about what financial and other support should be provided to carers. The actual support provided to different carers varies, and not always for clear and consistent reasons. Where support is not available, carers experience distress and, if support has to be paid for, hardship. The fear of a lack of support being provided was a major deterrent to people volunteering to become carers, and it also deterred foster and kinship carers from becoming permanent carers of children already in their care.

departmental caregiver payments are an expression of this view, although many carers would say that current levels of payment do not cover all costs incurred. Finally there is a view that carers ought to be paid a wage, in order to attract more carers and more skilled carers to what – in this model – becomes a profession. A case can be made for all three approaches, and the current model or a fully professionalised model is not inconsistent with some carers foregoing payment if that is their wish.

Each Australian state sets its own level of caregiver payments. The project worker based in Wodonga observed that carers in Albury in NSW are paid almost twice what carers are paid in Wodonga, and that this creates an incentive for carers to engage with the NSW Department of Community Services rather than with DHS Victoria. Even in parts of the state where competition with NSW was not an issue, there was still a widely held view that the level of financial assistance provided was too low, particularly where carers were paying for additional services and support.

Recommendation 32. A review of the adequacy of assistance provided to permanent carers should be conducted. The review should include consideration of the adequacy of financial and practical assistance, access to services and provision of support.

Raising caregiver payments for permanent carers would clearly incur a cost to the department, but this could be offset by a reduction in case management costs where additional long-term carers became prepared to convert to being permanent carers.

The majority of permanent carers are not specifically recruited to offer permanent care to a suitable child, but are kinship or foster carers who agree to become the permanent carer of a child already in their care. Where a kinship or foster carer becomes a permanent carer they are moving from a situation where the department is ultimately responsible for the child's care and also makes caregiver payments, and where the department (some kinship care placements) or a community service (other kinship care placements and all foster care placements) are responsible for supporting the placement and the carer.

In agreeing to the making of a permanent care order, carers are often anxious about losing the support they may have become accustomed to. This support often takes the form of arranging and supervising contact, providing higher level carer payments, arranging and paying for therapeutic services for the child and can also include other forms of practical and financial support.

Case example. Carer support obstacles to permanency.

In [our region] flexi-packs are no longer available (the packs helped pay for school uniforms/books/respite/transport to access/fees). If there was a sufficient rationale and it was approved, carers were given $1,000 per year with a letter and told not to ask for additional funding for a year. Removal of the flexi-pack has meant that carers do not want to obtain Permanent Care Orders as there is no support once the order is made.

Case example. Carer support obstacles to permanency.

The Aboriginal agency permanent care team referral was made and they completed their assessment, however the placement was not endorsed at the panel due to the agency requesting a funding package for G which was not available in the region.

Carers were anxious about whether they would be able to retain these types of support and how they would cope with any new demands placed on them as their child developed and grew. For many carers, the continuation of this support and shared responsibility was preferable to the uncertainties of how they would cope in the future without support. In some instances, children with special needs would place additional burdens on carers and there might be a need to fund treatment, secure respite arrangements, pay for modifications to accommodation and purchase special vehicles.

Recommendation 33. That a post-placement support service be established to provide advice, counselling and financial assistance where needed and referrals to other services for permanent carers in need of assistance.

There is only a limited amount of funding available for such arrangements (in some divisions it is called the Placement Establishment Service, but this service does not seem to be widely known about by Child Protection practitioners), and not all requests could be met. This sometimes created an obstacle to creating permanent care placements.

One of the project teams noted that "… kinship carers often struggle to provide support to children, but practitioners are not well versed in the available carer supports, and established services are not being fully utilised. For example, Anchor Kinship Care service is provided with kinship funding to help support kinship placements. There are vacancies at Anchor but they are unfilled. Most practitioners seem to be unaware that this service is available…"

Recommendation 34. That a directory of available services and financial and other assistance available to permanent carers and long term carers be compiled, regularly updated and made easily accessible to Child Protection case planners, practitioners and carers.

As a result of the fragmented knowledge that was held by professionals about services and supports, carers were often poorly informed about the assistance that might be available to them if a permanent care order was made and this misinformation could then be spread across carer networks.

There were also several project workers who stated that they thought that foster care agencies were encouraging foster carers *not* to consent to a conversion to permanent care so that the agency would not lose a foster carer from their books as this would affect the agency's ability to meet a target number of foster carers available. While this is only anecdotal, there was a widespread view that this practice occurs and it might be worth considering whether the requirement for foster care agencies to reach agreed targets is creating perverse incentives in the system and creating obstacles to permanency resolution.

Recommendation 35. That agency foster care targets should take account of the desirability of conversions to permanent care where appropriate and not create actual or perceived disincentives to conversions.

Case example. Myths about permanent care and perceived agency obstruction.

There was conflict between C's carer and the home based care agency (Agency A), which resulted in the carer moving home based care agencies to Agency B. It should also be noted that the case manager from Agency A also moved agencies and now works with Agency B and continues to be C's carers' worker. J's carer [Cs brother] remains managed by Agency A. The allocated Child Protection worker advised there are some Quality of Care (QoC) concerns in relation to C in his placement, which relate to C's attachment to his carer – these are not new concerns.

Project team manager made suggestions about how this can be assessed – including observations and assessments by Child Protection… "C's carer advised she would never go to permanent care "because your payments stop". C's carer also advised she was told never to go to permanent care and raised a number of other issues (myths) about permanent care, and when corrected about these issues / myths on permanent care, C's carer stated she would be willing to go to permanent care.

The allocated case manager approached the project team and requested they attend a care team meeting with both carers and [both] agency case managers to discuss permanent care and answer any of the carers questions. The project team agreed to this. The allocated worker was able to promptly arrange a time / date to meet with J's carer, and advised J's carers are very keen to progress towards permanent care with J. The allocated worker also advised the Agency B worker managing C's case refused to book a meeting with the carer, stating they had not discussed permanent care with the carer and they were not willing to schedule a meeting. The allocated Child Protection worker (with suggestions from the project worker) attempted to encourage Agency B to arrange a meeting with the carer, however these attempts were unsuccessful and a meeting was never arranged.

While the issues described in this section can create obstacles to carers who may consider becoming permanent carers, there are also some placements where a permanent care order would be

inappropriate and where the carer will need ongoing support and case management. Where placements are intended to be ongoing until the child reaches the age of 18 and where it is in the child's best interests for this to be the case, it is unnecessarily intrusive, stigmatising and distressing for the Guardianship order to require review every 12 months and for the Children's Court to be asked to extend the order very 2 years where there has been no change in circumstances.

Since the Children, Youth and Families Act was implemented in April 2007, the Children's Court has been able to make a Long-term Guardianship to the Secretary Order once a child reaches 12 years of age, and with the consent of both the child and the carer. Where this sort of order is made, the order continues for as long as the placement continues. These requirements could be changed so that younger children could be provided with long-term security and continuity where a Permanent Care Order cannot be made.

Recommendation 36. That long-term orders placing a child in the care of the Secretary be made available to children of all ages who are in a stable placement intended to last until at least their 18th birthday, with the consent of the carer and with the consent of the child if aged 10 or older (this now being the accepted age at which children can give instructions).

The project workers also noted that there is no consistent assessment framework being applied by all Adoption and Permanent Care services to determine the suitability of prospective permanent carers, and that the components of some frameworks seem to be unnecessarily invasive or anachronistic and are applied by some agencies and not others.

Case example. Unnecessarily invasive or anachronistic assessment framework components.

A point of unease in an otherwise smooth assessment process occurred at the time of the completion of the Medical Assessment required for prospective applicant for adoption/permanent care. This medical assessment identifies the need for HIV antibody and Hepatitis C testing for 'males only' who are unable to sign…Question 7 …: 'I have not engaged in male to male anal intercourse without a condom since January 1980'. Current medical advice should be sought to see if this condition remains applicable or whether it should apply to all applicants or be withdrawn. I informed my manager of my concerns…. Fortunately, with the carers' generosity of spirit the medical reports were completed. D and L were approved as Y and J's permanent carers by the… Permanent Carer Panel.

Case example. Unnecessarily invasive or anachronistic assessment framework components.

There is a current requirement [by a particular agency] that further children cannot be placed with a family for 2 years after a placement. Pregnancy should be avoided for 15 months after a placement and a doctor will check a female applicant is not pregnant. Infertility treatment cannot be undertaken for 12 months after the placement. These requirements are seen to be out-dated and a barrier to permanent care.

Assessment frameworks have to provide a reliable guide as to the suitability of carers, but it is also important to be respectful towards people who are making a genuine offer to care for someone else's child. On the other hand, it is important to be sure that invasive questions that may cause offence are actually necessary to complete a proper assessment, and that their purpose is properly explained. It is not so long ago that single people or divorced people were viewed as inappropriate adoptees, and the relevance of assessment criteria needs to be constantly reviewed and updated.

Recommendation 37. A consistent statewide framework to assess the suitability of prospective permanent carers should be developed and implemented. The framework should be reviewed periodically to ensure the continuing relevance of the contents.

Carers also experienced, or feared they might have to experience, other frustrations that would impact on them and their own family and on the child in their care.

Some carers wished that the family name of the child in their care could be changed to be their family name. They saw this as a way of having to avoid constant questions about why they had a child with a different name which could be potentially embarrassing and stigmatising for both them and the child. If the child had the same family name they felt that this would normalise the child's experience at school and in other social situations. This is obviously a highly sensitive issue, and can only be resolved on a case by case basis.

Case example. Changing the child's name.

A requested name change was turned down by Births, Deaths and Marriages but then overturned when the permanent carer had indicated she was willing to appeal to VCAT/Ombudsman and had sought legal advice in relation to the matter. Despite the birth mother of the child being deceased and the birth father's whereabouts not known and him never having contact with the child, the Permanent Care parents were instructed by Births, Deaths and Marriages to get consent from them for a name change. They had quoted s25 of the Act but the permanent carer put to them that s26, para 5 was the relevant section for name change, particularly clause 13 and its amendments which give discretion to the relevant authority to give approval for name change without permission of parents.[40]

Permanent carers also experienced great frustration with regard to obtaining birth certificates and passports for their child. Generally, this can only be done with the consent of the birth parents. Where birth parents are uncooperative or have a fear of the child disappearing overseas, consent is unlikely to be given. If the child does not have a passport this may mean that families have to abandon activities such as overseas holidays or, alternately, that they maintain those activities for their own children but leave behind the child in their permanent care with kin or with a respite carer. Either their own children or the permanent care children miss out when this sort of choice has to be made.

The issue of changing the child's family name to that of the permanent carer is an unresolved issue, as the two following pieces of advice indicate. Further discussion and consultation with stakeholders, including Births, Deaths and Marriages, may enable a resolution of this issue, but resolution was not reached during the life of the project.

Summary of advice provided by Births, Deaths and Marriages (BDM) to the project:

- There is not an absolute right for a change of name, but BDM will consider the application and will request biological parents to consent.
- The change of name should be either sanctioned by biological parents if alive (preference); or BDM would prefer that there be a discrete condition or notation on the Permanent Care Order that will be recognised by BDM with specific wording such as "...the child to be known as… ".
- The fact that there continues to be contact between the child and the child's biological parent(s) and that there is a legal avenue to revoke the Permanent Care Order means that, if the name is changed, BDM may have to justify a decision to change a child's name to VCAT.
- BDM are unclear what the policy position of DHS is regarding changing a child's name.
- BDM also flagged potential issues for obtaining a passport.

40 Births, Deaths And Marriages Registration Act 1996 – Section 26.

"…..(4) The Court may, on application by a child's parent, approve a proposed change of name for the child if satisfied that the change is in the child's best interests.

(5) If the parents of a child are dead, cannot be found, or for some other reason cannot exercise their parental responsibilities to a child, the child's guardian may apply for registration of a change of the child's name."

Summary of legal advice obtained by DHS

A Permanent Care Order grants custody and guardianship to the permanent carer “to the exclusion of all other persons” (Children, Youth and Families Act section 321(1). Guardianship includes "all the powers, rights and duties that are, apart from this Act, vested by law or custom in the guardian of a child", other than custody rights. This would include the right to change the child's name. It is not the same as a Family Law order, as those orders result in both parents retaining guardianship rights although they are separated, so they don't provide power for one parent to change a child's name without the consent of another.

Despite the lack of clarity, there are carers who have successfully applied for a change of a child’s name in recent years, as well as carers whose applications have been unsuccessful. Actual outcomes seem to be as inconsistent as the advice available.

Recommendation 38. An agreement or protocol between the department and Births, Deaths and Marriages should be developed to promote clarity and consistency when trying to resolve issues to do with birth certificates, passport and any application regarding a name change.

Where there is a change of name it is very important for the child to know their original name or be easily able to find out what it was, as well as who their birth parent and family are. This information can be of immense psychological benefit in the context of the identity development of the child and may also be of practical benefit in terms of finding out information about any hereditary pre-disposition towards the development of health problems.

Permanent Care and Adoptive Families, a carer support group in Victoria, has produced some very useful fact sheets providing information to carers on many of the legal issues affecting carers that are covered above. These fact sheets, which will need to be updated to reflect any changes in policy and legislation, can be found in the resources link at http://www.pcafamilies.org.au/ and are a handy resource for carers.

Case example. Changing the child’s name. (email from carer to project worker 5 months after the end of the project).

Just a quick note to let you know that all is well here in sunny [place name]. A continues to thrive and is such a happy, and fun loving little darling. She is four and a half and off to regular school next year having attended three year old and currently four year old kinder. I can't remember exactly, but I think she is going to party number nine so far this year. She attends swimming lessons every week. Slow progress but she certainly has fun. Accesses continue to be arduous but certainly manageable. [Birth mother] finally agreed to have [father’s family name] removed from her birth certificate as long as we put her name on it. Consequently, A's birth certificate says “A…...[mother’s family name as a middle name] [carer’s family name]”. We're happy with that.

3.11 Contact (access) and permanent care[41]

Initial case review findings:

The initial review of cases undertaken at the beginning of the project found that:

- Contact was a barrier to achieving a permanent care order in about 28% of cases.
- Contact was a barrier in 12% of the 245 cases when the contact was already supervised by the carer or unsupervised
- Contact was a barrier in 42% of the 280 cases where contact was supervised by a Child Protection or community service worker. Within this latter group of 280 there were also 69 cases (27%) where it was not clear whether contact arrangements were a significant barrier.

Findings from action research data

Of the 707 cases in the action research

- 150 cases had contact arrangements addressed as one of the barriers to permanency resolution

Disputes or fears about the level of contact that might be available if a permanent care order was made lay behind some parents' decision to contest applications for permanent care orders.

Contact (previously known as access) was one of the most controversial issues covered in this project. There are divergent views about the level of contact that is appropriate for a child to have with their parents[42]. It is generally considered that contact should be more frequent when the case plan is seeking to return the child home safely, and less frequent when the child is placed permanently with another family.

However, while this may seem like common sense, there is no evidence to support this general approach:

> "There is no evidence that by imposing more frequent contact arrangements on children in long-term care there will be an increased likelihood of children returning home or maintaining or improving attachments."[43]

> "A striking finding was that the pattern of reunification was similar for infants with both high-frequency and lower-frequency family contact arrangements. While further analysis of subsets of the data would be of value to explore this further, it does point to a flaw in the general assumption that high-frequency family contact leads to improved rates of family reunification." [44]

A more general overview of available research in this area suggests that research cannot currently provide any answers:

> "Decision-makers confront the following questions: how much contact should there be, with whom, under what circumstances, when, where and how. It is tempting to think that there should be clear answers to these questions – and that this review can attempt to provide them. However, it needs to be

[41] The Children, Youth and Families Act 2005 was amended in December 2013 – towards the end of the project – to replace references to "access" with "contact". The term "contact" is used except where "access" is the term used in quoted material.

[42] Parents attitudes to contact are also referred to in Section 3.5.

[43] Is all contact between children in care and their birth parents 'good' contact? Discussion paper. Dr Stephanie Taplin, 2005 DoCS, page 15.

[44] High-frequency family contact: a road to nowhere for infants. Cathy Humphreys and Meredith Kiraly, Child and Family Social Work, 2010, page 9

stated clearly at the outset that this is not the case. 'Research surrounding contact cannot provide a blueprint for practice; decisions must be sensitively dealt with on a case-by-case basis' (Neil, 2004: 5,)."[45]

While there is agreement on the importance of maintaining contact, it is also the case that establishing a contact regime that is beneficial can be very difficult:

"When the likelihood of the child returning home is high, 'contact is valued because it promotes the child's return home' (Masson, 1997: 225); and contact also aims to 'assist the birth parent in resuming the primary caregiving role' (Victorian Department of Human Services, Adoption & Permanent Care Procedures Manual, 2000). Alternatively, when the child has been placed in out-of-home care on a long-term basis, the emphasis on maintaining contact with the birth family shifts to a process of preserving links with the child's biological and cultural heritage.

Child welfare practitioners attest to the benefits of contact in terms of children's identity and links with birth family members: 'a lot of children go home quickly now … we've been developing this [contact] strategy over the past five years and we have noticed children and young people seem to do better when they can have their roots confirmed' (Gillard, in Rickford, 1996: 32). However, despite the well documented benefits of contact (Haight et al., 2001; Hess & Proch, 1993; Milham et al., 1986; Proch & Howard, 1986), Rickford cautions that: 'negotiating and setting up good contact arrangements has proved to be easier said than done' (1996: 32). Reasons for this may include:

- evidence of distress in the child which can be correctly or incorrectly attributed to the parent and may lead to a reduction in contact
- complex interpersonal relationships – for example, feelings of resentment, anger, fear, anxiety and grief by both birth parents and children
- an impersonal visiting environment which can affect the way in which children and parents interact
- travel – costs, distance and time constraints (Rickford, 1996)."[46]

It is very hard to generalise. For example, a child may be permanently placed with their maternal grandmother and both grandmother and child may have daily contact with the child's mother if the mother lives in the same home or nearby. Such scenarios are not unknown, especially if the child's mother has a disability.

There are cases where birth parents choose not to have contact or where contact is denied for safety reasons. In some cases contact with the child's parents is so traumatic (or potentially traumatic) for the child and cases where contact would place the child at so much risk that no contact is allowed. An example of such a case might be where the child has been sexually and physically abused and both parents were involved in the abuse and lack insight.

Most cases are not so extreme, and a judgement has to be made as to the level of contact that will maintain the

Carer feedback. "The biggest barrier for us was the birth parents' demands for high frequency access (i.e. once a fortnight). We finally settled on 6 times a year, but when every visit is traumatic for our child and takes time for her to recover, the number of visits should be fewer."

Carer feedback. "When a child becomes hysterical when told they 'have to see' mum/dad; or the child runs away from school on the afternoons when they know they will be picked up for visits with mum/dad; why are these conditions continued using the reason "it's Court directed". Surely re-traumatising the children is not what the Court wishes to do? (Submission to the project by the Mirabel Foundation)

[45] *Contact between children in out-of-home care and their birth families – literature review*, Dorothy Scott, Cas O'Neill and Andrew Minge, DoCS NSW, July 2005, page 1

[46] *Contact between children in out-of-home care and their birth families – literature review*, Dorothy Scott, Cas O'Neill and Andrew Minge, DoCS NSW, July 2005, page 4

child's connection to their family while also maintaining the stability of their permanent placement.

A further complication is that the Children's Court contact conditions are currently set until the child is 18 unless a party is willing and able to make an application to vary the conditions.

The conditions imposed when the permanent care order is made may be affected by the contact regime up to that point. Earlier in the life of the case, the court may have attached a condition about contact arrangements to a custody to Secretary order consistent with an initial reunification case plan. If the child remains on a custody to the Secretary order until the permanent care order is made, these conditions may have remained unchanged because of the difficulties in gaining agreement to any changes and an unwillingness by Child Protection practitioners to delay case plan implementation to contest the contact conditions.

As a result, contact conditions that may be already inappropriate for a transition to permanent care can then have a significant influence on the conditions attached to a permanent care order. Parents are often understandably reluctant to see any reduction in existing contact conditions. The Child Protection practitioner may be unwilling to contest the contact conditions if there is consent to the permanent care order itself. An agreement may be proposed by legal representatives: the child's parents will not contest the application for a permanent care order provided the existing contact conditions are not changed. The Child Protection practitioner can accept the agreement in order to enable the court to make a permanent care order on the day, or can insist on contact conditions that may be more in the child's best interests even where that involves a potentially adjournment for a contest.

Seeking a permanent care order without making suitable contact arrangements provides the child with a secure placement, but with contact conditions that may reflect the parents' wishes rather than the child's needs and that may ultimately undermine the stability of the placement. Fully contesting the case to gain a permanent care order with sustainable contact conditions holds out the possibility of an order and conditions that are in the child's best interests (although no guarantee), but at the expense of often waiting many months for a final outcome during which time the child's ongoing insecurity may contribute to the development of behavioural problems that undermine the stability of the placement.

Neither of these options is in the child's best interests, and it is easy to see why the option of conceding apparently inappropriate contact conditions is often chosen.

One of the reasons why contact is such a difficult issue is that the birth parents and the permanent carers might have completely different views about what is appropriate, and both parties can confuse their own needs with the child's.

Finding 26. Contact conditions on permanent care orders are often arrived at through a process of negotiation that is focussed on the parents' wishes and the carer's wishes, rather than an assessment of the child's best interests.

Case example. Disputes about contact.
Children M and Z, respectively, had court-ordered contact visits with their parents twice per week, in addition to two phone calls per week, despite there being a permanent care case plan in place. The carers reported that the children's behaviour following contact would severely deteriorate, and the children would exhibit aggression and anxiety. The contact visits could not be supervised by the kinship carer, due to threats of violence from the parents. An application was made to reduce the contact visits to once per month, however this was contested by the parents, further delaying the progression to a permanent care order. The parents frequently fail to attend court hearings, and there were 19 adjournments over the course of Child Protection involvement, and for most of that time the children have been subjected to a contact plan that reflects a reunification case plan, despite the permanent care case planning decision having been made more than 2 years ago. The children have remained in a stable placement with their grandmother since they were removed 3.5 years ago. Their primary attachment is to their grandmother.

Birth parents tend to want conditions that provide for frequent contact and generally view this as being best for the child too, while permanent carers tend to want conditions that do not subject the child to being unnecessarily upset as it is they who will have the task of settling and reassuring the child after each contact. It can take days, or even weeks, for a child to recover any equilibrium after an upsetting contact.

A compounding factor is that a very high proportion of birth parents have a fluctuating ability to comply with contact arrangements, as a result of substance abuse or mental health issues. This then creates situations that are unsettling to the child because the parent fails to attend for an arranged contact rather than because contact occurred and was distressing. Carers expressed a high degree of resentment that they were placed under so much pressure to ensure that court ordered contact occurs even when it distresses the child, but that there were no consequences for parents who failed to attend, and who left the carer to cope with the impact that may have on the child.

Carers felt very strongly about this issue. They expressed a range of views, including that they were legally the child's parent and therefore ought to be able to determine contact arrangements in the child's best interests in the same way as they were able to make all other decisions about the child. Carers also felt that they should be able to make contact arrangements because they were responsible for helping the child to cope with the trauma of contact where the child did not want it, and the disappointment of children who did want contact where a parent failed to attend.

Carer feedback. "I would like to see faster decision making about whether a child should go into permanent care - the longer reunification with birth parent goes on, the more trauma and difficulty for the child. I think asking the birth parent for consent for things such as travel during the first 12 months should not have to occur - birth parent in our circumstances regularly fails to show for access yet we've had to endure objections about simple travel plans. I also think if the placement is going particularly well legalisation should proceed before the 12 months is up. This provides certainty and emotional safety for the child. I also think that if birth parent/s fail consistently to show up for access then an automatic reduction in the number of accesses should occur."

Excluding the minority of cases where birth parents pose a danger to the child, there is general agreement amongst carers and professionals that some level of contact is always in the child's best interests – at least until such an age where the child is old enough to make those decisions.

Carer feedback. "One of our permanent care children has been severely affected each time an access visit is organised with his birth mother. On average, she [the birth mother] only attends approximately one out of every six organised access opportunities and it has been this way for approximately 10 years (before moving into permanent care and 7 years of permanent care). This could be changed by reducing the number of required access visits with birth family members who are frequent non-attenders. It is particularly frustrating when an access visit required interstate flights other than just a short drive because it builds up the expectations of disappointment in our son over the days before the flight, during the flight, and after access - he can't go straight home and be in familiar surroundings."

There are also some parents who fail to keep to agreements and some carers who are inflexible about contact and who fail to comply with contact arrangements and find reasons not to comply. While practitioners do not want to disrupt a placement that is otherwise working well, the child's needs are not being met in these situations and the practitioner has to balance competing needs and priorities.

Case example. Carers' attitudes to contact.

J has been in the current foster placement for four years and it has been an excellent placement. Not excellent is the fact that there is no contact between J's carers and his mother, and I believe none has occurred in the past. In my view J is "walking a tightrope", acutely conscious that both his carers and his mother want him to live with them and, I suspect fearful that at some level he will lose one if he chooses the other. Treading such a fine line is difficult for any child; the knowledge that the adults in question do not know each other (and in this case the intuition that they hold ill-feelings towards each other) makes the predicament even more difficult. I have advocated to the foster care worker that it is important that they get to know each other, not to become best friends, but as part of a process of humanising ("un-demonising") each other, but this has not been taken up.

Finding 27. Contact conditions sometimes make it harder to recruit permanent carers for a child (or to persuade kinship or foster carers to become permanent carers), and sometimes threaten the stability of permanent care placements. Court ordered contact conditions, even if initially appropriate, are inflexible and may be in force for many years after they have ceased to be appropriate. A potentially contested and expensive application to the court is needed to vary the conditions.

A balance has to be struck between the parents' wishes and the child's needs. But some consideration of the needs and responsibilities of carers should also be included in determining contact. Part of assessing the child's contact arrangements might need to have regard to whether the level of contact is preventing a match with a potential permanent carer.

"When determining an initial plan for long-term care, workers should consider the difficulty in recruiting new long-term foster or adoptive parents if contact regimes are onerous. Unrealistic plans can jeopardise the child's chance of finding a secure new family." [47]

Where the child is already placed and also after the permanent care order is made, decision makers should have regard to the possibility that the level of contact that is ordered may place unreasonable expectations on the carer and affect the quality and perhaps the durability of the placement..

Because the permanent care order is automatically associated with case closure by Child Protection the carer loses any existing support Child Protection may have provided in relation to contact arrangements. Several carers felt that there ought to be ongoing support offered by a service, though not necessarily Child Protection. Others wondered whether contact centres used in connection with Family Court orders could be made available to Child Protection. This was investigated and seems to be theoretically possible, but there are high demands on Family Court contact centres and Child Protection cases may struggle to gain priority, and a more informal setting is always to be preferred, subject to satisfying the need to protect the child's safety and wellbeing.

Some carers do receive ongoing support from placement agencies, including assistance with managing contact, but not all carers who would like this support receive it. As recommended in the previous section of this report, the establishment of a dedicated support service for permanent placements would increase the number of carers willing to become permanent carers, improve the quality of the placements and reduce the number of placement breakdowns. All of these factors would contribute to savings that could help fund the service.

[47] Contact between children in permanent foster care and their parents and family. Practice Paper on Child Welfare Decisions, Barnardos Australia, 2013, page 2.

Finally, there are other issues to consider with regard to the impact of contact on children other than the potential for upset or disappointment. Frequent contact can involve children missing out on after school or weekend sporting and social activities or activities with the family that they are permanently placed with. It can also involve frequent travel, sometimes over quite long distances. This can mean spending time in a car on a frequent basis and, for younger children and especially babies and infants, at times that disrupt sleep and other routines. All of these factors, because they impact on the child, may have a significant impact on the permanent carer. There needs to be some room for negotiation in the child's best interests to vary otherwise rigid court-ordered contact conditions.

Recommendation 39. There is no simple solution to the issue of contact and permanent care orders. The potentially conflicting rights and wishes of the child, the carer and the child's birth family somehow need to be accommodated. Contact conditions need to:

- Ensure that contact is in the child's interests
- Be flexible over time as the child's needs and wishes change
- Provide for an ongoing relationship between the child and their birth family (parents, siblings, significant kin)
- Not jeopardise placement stability or place unreasonable demand on the carer
- Be mediated by assistance from a permanent care support service where this is necessary
- Not create conflict that has a negative impact on the child
- Not cause the child to miss out on activities with the carer family or with schools or friends that are important to them

"Orders for high frequency visiting with associated infant travel are generating stress for parents and infants. Parents are frequently unable to maintain the level of contact ordered by the Court, sometimes even when they confirm arrangements; thus infants' routines are unnecessarily disrupted. However, it is not necessarily the frequency alone that is the problem, but factors interacting with frequency, such as: separation of the infant from her/his primary caregiver for visits with family; travel for both parents and infants; infant care by multiple strangers; and poor environments for visits."[48]

[48] Baby on Board: Report of the Infants in Care and Family Contact Research Project, Alfred Felton Research Program, School of Nursing and Social Work, University of Melbourne. Cathy Humphries and Meredith Kiraly Feb 2009. page 66.

3.12 Revocation of Permanent Care Orders

Findings from consultation with carers:

Potential permanent carers had reservations about applications being made for permanent care orders as they did not believe that the orders offered real permanency when the child's birth parents could, at any time, apply for revocation of the order.

Carers were also concerned about bearing the cost of contesting an application by a birth parent. One carer claimed to have spent $60,000 on such a contest.

These were contributing factors to the lack of available permanent carers.

Findings from action research data

In the action research part of the project, the following barriers were addressed which were partly caused by these fears:

- 65 cases where a current foster or kinship carer was unwilling to become a permanent carer
- 57 cases where no suitable permanent placement was available
- 15 cases where the carer had a poor understanding of stability and permanency planning

Carers fear, if they make the emotional commitment to a child, that they may later on have to cope with a significant loss if the permanent care order can be revoked. This feeling was shared by all carers and potential carers who attended the project's carer consultation forum. Even carers who had been the permanent carers of a child under a permanent care order for some time shared the anxiety that the order may be revoked. This has an unavoidable impact on the quality of the relationship they have with the child in their care.

Carers also felt anxious about the possibility of having to fund any contest against an application to revoke the order.

Many carers are part of carer support organisations. Carers gain a great deal from being in touch with other carers, but one downside is that stories about orders that are revoked and about the costs of funding a contest may raise the anxieties of other carers. At a carers forum held as part of this project one carer stated that they had spent $60,000 contesting an application to revoke a permanent care order.

Data provided by the Children's Court for applications to revoke a permanent care order received between April 2012 and February 2014 shows 25 applications as shown in the following table.

TABLE 17: Applications to revoke a permanent care order resolved by the Children's Court since May 2012

			Outcome		
Applicant	**Instigated by**	**Applications**	**revoked**	**struck out**	**withdrawn**
Carer		1	1		
Child		1	1		
DHS	Carer	10	10		
	Child	1	1		
	DHS	7	7		
Parent		5		4	1
Grand Total		**25**	**20**	**4**	**1**

One application was made by a carer, one by a child and 5 by birth parents. There were 18 applications (in relation to 14 families) made by the department and 10 of these (8 families) were made on behalf of carers and one on behalf of a child. The 5 applications made by birth parents (which included a sibling group of three and two individual children) were all unsuccessful. The applications by the department, carers and children were all successful.

The data suggests that permanent carers have little to fear from applications made by birth parents. For carers the issue is not how often applications to revoke are made or how likely it is that they will have to deal with an application. As long as there is the possibility of an application to revoke a permanent care order there can be no certainty for carers (or the child) that the care arrangement is truly permanent, and carers (and children) will experience some level of anxiety as a result.

In the survey of carers referred to in Section 3.13, one respondent stated that the greatest enabler of placement stability was:

> Certainty for the prospective parents. So many wonderful prospective parents are too afraid to become foster parents or permanent care parents for fear that they will bond with the children and the children will be taken from them.

Where a birth parent lodges an application to revoke a permanent care order, notice of the application is served on all parties, including the carer, the child (if old enough) and the department. Carers and children can be very distressed by the receipt of such notices although, as the data above shows, the applications are rarely successful. In order to save unnecessary distress, it would be preferable if the applicant had to seek the leave of the court to make an application to revoke a permanent care order. This would at least avoid the distress caused by vexatious applicants and those with an insufficient basis to support an application.

Recommendation 40. That the Children, Youth and Families Act should be amended to require birth parents to seek the leave of the court to make an application to revoke a permanent care order.

3.13 The views of carers

The department, the parents and the child (if old enough) are generally active participants in the case planning and court decision making processes. Their views are considered and advocated for. The views of carers are less well represented in decision making processes and are sometimes not even sought.

Following one of the consultation sessions with carers and prospective carers, on online survey was conducted and 46 carers and their advocates responded. A grouped summary of the responses is provided below and this is followed by some more detailed responses.

Table 18: In your experience, what are the greatest enablers to placement stability? (some respondents chose more than one):

Enabler	Number of responses
Ongoing post-permanency support: social work, behaviour management, therapeutic, education:	24
Clear and early case plan decisions to minimise placement changes and harm suffered before permanency:	9
An experienced, competent, supportive departmental and/or agency worker:	7
Financial support:	6
Education training for prospective carers so that they know what to expect:	5
Being able to make decisions regarding the child/autonomy/trust:	5
Carer commitment:	3
Support of extended family:	3
Single assessment for foster and permanent carers:	3
Predictable, regular contact at reasonable intervals:	3
An advocate to assist with departmental expectations:	3
Legal support and information about legal processes:	3
Funding for specialist services:	3
That the child knows they have a safe place to call home:	3
Respite care:	2
Legal certainty about the future:	2
Consistency between different parts of the department	1
Support by the birth family for the permanent care placement	1
Fewer court hearings and delays	1

Table 19: What are/were the greatest barriers to achieving a permanent care order for the children in your care? (some respondents chose more than one):

Barrier	Number of responses
Lengthy case planning processes → case drift → ”damaged” children:	10
Lack of pre- and post- permanent care order support (financial, service provision, education):	9
Numerous court adjournments/lengthy legal process:	6
Changes of departmental workers/new workers unfamiliar with the case/periods where not allocated:	5
Contact: supervision, impact and frequency:	4
Inconsistencies with departmental requirements and between changing case workers:	4
Process of foster carers being assessed as permanent carers was disrespectful:	4
History of temporary care arrangements:	4
Non-attendance of birth parents at meetings/hearings:	4
The extent of legal and departmental requirements	1
Unable to afford legal representation to become party to proceedings	1
Lack of support for birth parents	1
Fear that birth parents would seek revocation of permanent care order	1
Department wanting kinship carers to bear the cost of an application to the Family Court	1
Getting approval as a permanent carer	1
“Accusations”	1
Delays caused by the foster care agency	1
Complications caused by need to maintain Aboriginal cultural connections	1

Table 20: What elements of the current placement system would you most like to change, and how? (some respondents chose more than one):

Desired change	Number of responses
Earlier case plan decision to stop attempting reunification and to seek permanent alternate care:	12
Easier access to post-permanent care order support and therapeutic services:	11
More realistic court ordered contact conditions:	5
Easier conversion from foster care to permanent care – one assessment:	5
Respect towards carers/less invasive assessment processes:	4
Better and easier to access financial support:	3
Improved legal assistance for carers:	3
More experienced and consistent departmental/agency worker:	3
Need more immediately available information about entitlements, support networks, advocacy:	2
Shorter legal processes/legislated timelines:	2
Keep siblings together, even when placed at different times:	2
More effective carer recruitment:	2
More use of open adoption rather than permanent care, so that carers become the child's legal parents and beyond 18th birthday:	2
Enable child's name to be changed	1
Unnecessary requirement to have a police check run on members of our own extended family before they can visit	1
Independent review of DHS decisions, e.g. re. Financial support	1
Better funding of placement provider services	1
More child-focussed/less adversarial legal process	1
Carers to be consulted about case plan decisions before they are made	1
Enable carers to make decisions, e.g. about the child's education	1
Less emphasis on conversion from foster care to permanent care	1

Considering all three tables together, and grouping together related issues, the things that assist permanency resolution or are barriers to permanency resolution or most need to change are:

1. the provision of support, especially after the permanent care order is made (44 responses across all 3 tables)
2. more timely case planning and an earlier decision to pursue a permanent care order as the best outcome for the child (33 responses)
3. more consistency/fewer changes of worker (19 responses)
4. consultation with, respect and trust of carers (15 responses).

Provision of support, particularly post-order support requires consideration of funding a specific support service for permanent carers or some other means of ensuring that permanent carers can easily access the services they need.

Case planning delays are often related to lengthy court processes, and the adoption of a permanency planning framework and a better fit between case plans, court orders and decision making processes recommended in this report would address many of the problems identified.

Changes of practitioner are largely related to program structure and demand management strategies, and these require review in the light of the findings of this project, especially in section 3.7.

Issues related to consultation, trust and respect are primarily about the quality of practice. The answers here are probably less to do with additional procedures and more to do with a stronger emphasis on case work approaches and values. These are also essentially issues that reflect on the relationship between the practitioner and the carer, and are therefore also aspects of consistent allocation.

There are a wide range of views expressed in the responses that follow. These responses are the more detailed versions of some of the comments tabulated above. The responses speak for themselves and are included without comment as a means of ensuring that carers' views are represented in this report.

The most rewarding (and rather corny) moment for my family was the issuing of the order, The magistrate had obviously taken the time to read the report and spoke to use in such a lovely way, acknowledging us as doing a wonderful thing. We were surprised by this, as at no point in our interaction with the system did we get this type of feedback. You don't go into permanent care seeking the pats on the back, but it was very gratifying that we were acknowledged in this way and felt we had made the difference to not only our son, but the broader community.

Lawyers should not be put into position to ask childeren where they would like to live. Have no understanding of child development and child's sense of loyalty to parents. Cannot communicate in a child appropriate manner. Should be Panel of Experts who make decisions on children's welfare not Magistrates and Lawyers. Parents should not be given a new chance again and again. Permanency is more important.

Less attempts at reunification with birth parents. In our case there were four attempts, all lasting less than 2 months. If there were not max attempts in place, there is no incentive for them to really try, and in the meantime the child is bounced from carer to carer with no long-term solution resolved earlier.

Foster caring is one of our best experiences

Given that PC placements in effect are as permanent as open adoptions, PC children have the right to participate in their new forever family as much as adopted children. Of course it is important wherever possible to retain a link the child's birth parents and identify but not at the expense of feeling separate from or different to their permanent family.

Putting the child's interest before the Parents with regards to access arrangements i.e. encouragement of the Community based activities which the children enjoy.

My husband and I receive no financial assistance to care for our Grandson. I currently pay $600 a month for 3 days a week childcare. I believe kinship carers should receive a payment that would help cover the large out of pocket expenses that come with raising children. We are currently trying to prepare for retirement and due to income are not eligible for Centrelink payments. Our income is assessed as though our grandson is our own child. I think this is unfair. We have worked all our lives and brought up our three children under our own steam. Raising a grandchild at our ages is hard enough without having high childcare expenses too.

There needs to be a cultural shift in the way staff and programs think about permanent carers if you want to attract carers long-term. I suspect there are would be many more people willing to take on the care of a child if they were supported better by a responsive systems that was ready to address the emotional needs of carers and families. I think it would be an incentive to carers if there was ENHANCED access to services for children and carers once an order is made – that rewards the child and family for making this commitment; that opens doors to services rather than slams them, that finds way to support care families rather than shame them when they seek financial support. I am aware of one family who had the care of a child for six years, and who, when he entered an angry adolescence and was seeking answers about his trauma asked DHS for support. They were told the only way they could reengage the family (who by now had perm care) and offer supports was to take out a notification. The family were totally devastated by this. They were unable to pay for private therapy and unsure how to navigate the mental health system and felt the only way to get services for their son was to involve child protection, who subsequently intervened on the basis of emotional harm. The placement eventually broke down and all the people in that family (most all of their son) failed to get the support they so desperately needed. What an appalling situation for people who had been exemplary carers for more than 20 years, and what a devastating outcome for their young son. Finally, may I also comment on what we perceive to be the TOTALLY second rate assessment, support and assessments of kinship carers. In our permanent care assessment there was an absolute lack of rigour – my husband and kids were not interviewed despite my suggestion of setting up times, there was very little discussion about parenting styles or how we manage conflict etc. I know that these form part of a foster care assessment, and can only assume that no one cares about the kids and carers in kinship placements. Or is there an appalling lack of funding and resources for kinship programs to do their job properly? Our case manager seemed quite competent, but largely absent; was clearly afraid to advocate on our behalf to a reluctant DHS and largely took the view that we not “rock the boat”. Not good enough. Talk to kinship carers and programs about what is really going on – I am afraid it paints a sorry picture.

We know of so many wonderful parents and potential parents who are incredibly keen to become foster parents and permanent carers, but they are completely turned off the possibility by the many, many horror stories coming out of the sector

I would like to see faster decision making about whether a child should go into permanent care – the longer reunification with birth parent goes on, the more trauma and difficulty for the child. I think asking the birth parent for consent for things such as travel during the first 12 months should not have to occur – birth parent in our circumstances regularly fails to show for access yet we’ve had to endure objections about simple travel plans. I also think if the placement is going particularly well legalisation should proceed before the 12 months is up. This provides certainly and emotional safely for the child. I also think that it birth parent/s fail to show up for access then an automatic reduction in the number of accesses should occur. Finally I believe that permanent care children should be able to have their surname legally changed to take on their forever family’s surname (especially where children are very young and so unlikely to experience identity crisis as a result). This assists with the integration of the child and sense of belonging with their forever family.

Maybe I’m dreaming, but we NEED a non-adversarial court system. So much time and energy is wasted arguing with legal reps seeking a “win” rather than professionals working in the best interest of children and families. Make courts a place that ACTUALLY prioritises children.

I love having my grand kids and helping other grand parents

I have fostered around 40 children over the years. I think the whole child protection system has deteriorated badly. The needs of the child must be paramount and they are not. I have felt like stopping fostering lately simply because I am sick to death of dealing with young ignorant DHS workers who make unrealistic demands on foster carers and make very poor decisions around the care of children simply because they have no real understanding of child development. Foster carers are treated with no respect and their work is not appreciated. No wonder they leave the system in droves.

The NAME needs to change. “Permanent Care” How does a child identify himself? Not adopted. Permanent Care. It is a meaningless phrase only used by those on the inner circle. The general public don’t know it. There’s no box to tick on school enrolment (Foster/Adopted). And it is a misnomer…permanent…UNTIL 18?

The social worker we had was a very wise, experienced, thoughtful woman with grown children of her own and an understanding of what we were all experiencing. I can’t speak highly enough of her. She diplomatically supported our son’s birth mother and us in the first few meetings and helped us build a good rapport. She gave us good advice about so many aspects of the placement that we still draw on a few years in. The effectiveness of the system is predicated on good, experienced workers with the skills to navigate an extremely fraught process with huge implications for all who are involved and consequences – good and bad – that are for life.

Appendix 1

Stability Planning and Permanent Care Project

An analysis of the findings of the initial case review process

Introduction

The Stability Planning and Permanent Care Project has been funded by the Victorian government as a key initiative following issues identified in the Protecting Victoria's Vulnerable Children Inquiry report (2012) – notably that, on average, it is 5 years after a child is reported that a Permanent Care Order is made. Those 5 years are generally a period of instability and uncertainty for the child and their carers.

The 12 month action-research project aims to identify those children aged under 10 where stability planning and permanency resolution needs to be achieved, and to identify the barriers to planning for the stability of children in out of home care and to resolving permanent arrangements for alternate care where children cannot safely return to their parents' care.

The project workers consist of a central project manager, 7 Child Protection Team Managers, 16 Child Protection Practitioners, and one worker located at the Victorian Aboriginal Child Care Association (VACCA). Where possible they intervene to improve practice and assist practitioners to achieve better and more timely outcomes. This can be achieved in some cases, and in others the project can only identify and quantify the barriers and propose possible longer term solutions.

The initial task of the project was to review the 1,500 children who had been identified from the Child Protection program database (CRIS) as being aged under 10 and placed in out of home care for more than 12 months without a stability plan, or subject to a permanent care case plan without a permanent care order.

The review consisted of reviewing the information in the CRIS database and then interviewing Child Protection Practitioners and contracted community services workers to validate the data.

This paper describes the findings of that review.

PART A – summary of findings.

Basic summary.

The findings of this analysis of the initial review data suggests that the following are the key priorities for further attention, both at a case level and at a systems level, in order to minimise delays in stability planning and resolving permanency.

a) Processes for the recruitment, assessment and support of potential permanent carers
b) Lack of timely assessment of kinship carers
c) Delays in the preparation of cultural support plans for Aboriginal children
d) Disincentives for foster and kinship carers to "convert" to permanent care
e) Delays caused by court contests (with contact a key issue) and delays in the case planning process (including delays in developing stability and cultural support plans, as well as lack of use of Family Led Decision Making processes)
f) Lack of resources to make arrangements to meet the child's particular needs, especially where the child has significant behavioural issues,
g) The impact of changes of placement and changes of worker (as well as periods of no allocation).

Detailed summary.

1. There were 1,332 children in scope after the review had eliminated cases where, for example, a child had returned home or a permanent care order had been made. Those remaining in scope were children who had been in out of home care for more than one year and who required some action to promote stability planning and permanency resolution.
2. 367 of the children (27.6%) were Aboriginal
3. 720 of the children (54%) were boys, and there was a large cohort of 6 year old boys in scope – 104 boys compared to 60 girls who were 6 years old.
4. South and North divisions had the highest proportion of children subject to Guardianship to Secretary Orders while West and especially East had the lowest proportion. This is important for two reasons:
    a. Guardianship Orders allow the department to set the contact regime and other relevant conditions and ensure their consistency with the case plan, while Custody to the Secretary Orders allow the Court to set these parts of a case plan by the attachment of conditions to the order.
    b. Aboriginal agencies are currently funded to prepare cultural support plans for children subject to Guardianship to Secretary Orders (90 in Table 5, next page) but not for children subject to Custody to Secretary Orders (223 in Table 5).
5. The Children, Youth and Families Act 2005 best interests principles refers to the desirability of siblings being placed together in Out Of Home Care (Children, Youth and Families Act section 10.3.q). In the review cohort there were:
    a. 240 children in Out Of Home Care who had no siblings in Out Of Home Care
    b. 441 children in Out Of Home Care who lived with all their siblings in Out Of Home Care
    c. 597 children in Out Of Home Care who did not live with all of their siblings in Out Of Home Care, and 272 of these who did not live with any of their siblings in Out Of Home Care
    d. 54 children where there was no clear data
6. Only 79 of the children in the survey did not have any of the special needs surveyed (disability, mental health, medical, school, behavioural). Where children had special needs that were creating a barrier to resolving permanency, this was usually because of the child's behavioural problems.
7. The length of time children had been in Out Of Home Care varied from division to division. In East division about 64% of children had been in OOHC for less than 3 years, while in North division this proportion was only 50%.

8. As a direct result of being in OOHC for a shorter average time, the children in East division were also younger on average, had experienced fewer changes of worker and had had fewer placement changes.
9. The 1,332 children reviewed had had 3,403 placements, and there had been 615 "placement breakdowns". Clearly, most placement change – which causes instability – is generated by factors other than placement breakdown. Many of these factors are likely to be systemic and result from a lack of suitable placements meaning that children need to be initially placed with carers who are not available for long enough or who are unable to meet other requirements for the child's care thus creating the need for another placement to be found.
10. Of the 1,332 children, 86% had a current statutory case plan (6 week, annual or otherwise reviewed).
11. There is a need to review the terminology and more clearly differentiate between case plan types (e.g. "long-term placement – no return to family anticipated" and "long-term placement with view to permanent care"). The terms "stability", "stability plan" and "stability planning", "permanency", "permanency planning" and "permanent care" also need to be more clearly differentiated and more consistently used.
12. Of the children in the survey, 58.9% had not had any reunification attempts with their birth family but 20.9% had had one failed attempt and several children had more than one failed attempt, including one child with 13 failed attempts.
13. Only 7.3% of the children in scope had been the subject of a Family Group Conference in the preceding 12 months.
14. Of the children who had a long-term or permanent care case plan and who were not in a placement planned to be their final placement, only 61% had a stability plan recorded on their file, and many of these plans were very basic. In the cases with a stability plan, 32% of the plans had not been completed within the statutory timelines (Children, Youth and Families Act 2005 section 170.3).
15. On a statewide basis, and in the cases where the type of permanent placement being sought was known, 64.5% were kinship permanent placements, 20.0% were planned foster care conversions and 15.5% required permanent care "stranger" families to be found. The extent to which this division is driven by the availability of different types of placement remains a question to be answered.
16. Potential permanent carers had been identified in about 60% of all cases across the state where there was a permanent care case plan, although there was significant variation between divisions: under 40% in South division, about 65% in North and in West, and over 75% in East
17. Of the cases in scope, 59% were allocated to a Child Protection worker. The lowest rates were in the North and the West divisions. However, these two divisions had higher rates of contracted allocation and lower rates of unallocated cases overall. The overall statewide allocation rate for cases in scope, including contracted cases, was 90.2%. This was very close to the statewide average allocation rate at the time the survey was conducted (February to June 2013), but this sample includes a higher proportion of contracted cases: 31% as compared to about 13.5% of all post intake cases statewide.
18. A CSO worker was most likely to be the allocated worker where there was a permanent care case plan or a case plan of long-term placement with a view to permanent care. This means that any action to promote more timely permanency resolution will rely to a large extent on engaging Child Protection contract managers and CSO workers in the process.
19. The low rate of stability plans on client files where there was an allocated Child Protection worker (52.5%) is something that requires further examination.
20. The number of children who had an established care team was about half of the total. Children in North division were far more likely to have a care team (64.2%) than those in East division (32.6%), South division (39.6%) or West division (45%). On a statewide basis, 46.7% of care teams met either quarterly or less than quarterly, while most of the rest (44%) met monthly.
21. An internal case plan review (under section 331 of the Children, Youth and Families Act) by a more senior manager had been held in 19.5% of cases statewide, with very little divisional variation apart from a lower rate of 17.1% in West division.

22. Where reviews were held, a similar proportion had an impact on the stability and permanency aspects of the case plan in East division (44.4%), North division (40.4%) and West division (39.5%), while only 15.2% of reviews had a similar impact in South division.
23. There were 285 children (and their parents) subject to Protection Order conditions that were inconsistent with a current case plan for long-term or permanent placement. This was 34.1% of all cases in scope. The majority of these children (233 = 81.8%) were subject to Custody to the Secretary Orders.
24. It might be thought that kinship carers would be better able to tolerate more frequent contact, because of their own kinship relationship with the child's parents. The survey suggests that there is almost exactly the same tolerance of contact frequency by foster carers converting to permanent care as there is by kinship carers, measured by cross-referencing the frequency of contact with carer's identification of its frequency as a problem for them.
25. Nearly 70% of children had contact with their mother at least quarterly and nearly 30% at least weekly. This compares to 45% at least quarterly and 16% at least weekly for contact with fathers. Half of all fathers had had no contact at all in the previous 6 months, compared to 25% of mothers. These differences may be at least partly accounted for by different levels of contact being ordered for mothers and fathers.
26. Contact with siblings and with other kin was more frequent than with fathers but less frequent than with mothers. The many cases where contact with siblings and other kin had not been recorded suggest that it is seen as less important to arrange contact with siblings or, where it occurs, to record it.
27. Mothers had significantly more contact with children placed in foster care than those placed in kinship care, which is perhaps surprising. Fathers had slightly more contact with children in kinship care than foster care. Siblings (other than those the child was living with) had much more frequent contact where the child was in a kinship placement.
28. As might be expected, contact was supervised by the carer in most kinship care placements, while Child Protection supervised half of all contact in permanent care "stranger" placements – as shown in Graph 30. The responsibility was shared more evenly between Child Protection, agencies and carers where the child was in a foster placement planned for conversion to permanent care.
29. Where the main reason for contact being a barrier was correlated with the intended permanent care placement type, there were some interesting differences. Permanent care "strangers" were the most concerned about the impact on the child, as well as being concerned about conflict with the child's birth parents. Kinship carers were primarily concerned about conflict with the child's birth parents (to whom they were closely related), while foster carers were also concerned about conflict with parents but more concerned than the others about the location of contact, which often referred to distance to be travelled.
30. Where inadequate supports were identified by carers as an obstacle to obtaining a Permanent Care Order, foster carers appeared to be most concerned about lack of financial support and lack of support with contact arrangements. Kinship carers were mainly concerned about inadequate financial support. Permanent "stranger" carers were most concerned with contact to services, particularly counselling (though the numbers of identified permanent "stranger" carers were small).
31. There were 235 Aboriginal children who had been in care for more than a year and who were not placed with a long-term or permanent carer. Of these, 87 (37%) had been the subject of an Aboriginal Family-Led Decision Making meeting, and over 40% of these meetings had been held more than a year previously.
32. A cultural support plan (CSP) had been prepared in only 19.1% of the 235 cases. While East division had completed CSPs in 50% of their cases, the rate in the other three divisions was between 0% and 16%. Where an AFLDM meeting had been held there was a small improvement in the proportion of cases with a CSP. The statewide rate improved from the 19.1% to 29.9%.
33. There was a much higher level of compliance with the requirement to consult with ACSASS, which had occurred in 179 (76.2%) of the 235 cases. Compliance was especially high in West and East divisions.

34. Of the 235 Aboriginal children in this cohort, 85 (36.2%) were placed with an Aboriginal primary carer. Where the child was in a kinship placement, the proportion with an Aboriginal primary carer was 60.6%
35. The findings of this analysis of the initial review data suggests that the following are the key priorities for further attention, , both at a case level and at a systems level, in order to minimise delays in stability planning and resolving permanency.
    a. Processes for the recruitment, assessment and support of potential permanent carers
    b. Lack of timely assessment of kinship carers
    c. Delays caused by court contests (with contact a key issue) and delays in the case planning process (including delays in developing stability and cultural support plans, as well as lack of use of Family Led Decision Making processes).
    d. Lack of resources to make arrangements to meet the child's particular needs, especially where the child has significant behavioural issues,
    e. The impact of changes of placement and changes of worker (as well as periods of no allocation).

PART B – all children reviewed and in scope

1. Children in scope – location, Aboriginal status.

The initial review excluded some cases that had been incorrectly identified in the CRIS database as being in scope, and Table 1 shows that there were 1,332 children still in scope following these initial exclusions. 367 of these children (27.6%) were Aboriginal. The table also shows the uneven distribution of cases between the 4 DHS divisions.

Table 1. Children in each division by Aboriginal status

	Aboriginal?				
Reporting division	**No**	**Yes**	**no data**	**Total**	**% Aboriginal**
East	187	60	3	250	24.0%
North	212	138		350	39.4%
South	214	84		298	28.2%
West	349	85		434	19.6%
Grand Total	**962**	**367**	**3**	**1332**	**27.6%**

Table 2 shows how the children were distributed in terms of the area that the case management team is responsible for or located in. As can be seen, only 5% of children in Casey/Cardinia were Aboriginal, while over 40% in Hume/Moreland, Mallee (Mildura) and Outer (East) Gippsland were Aboriginal.

Table 2. Children in each area by Aboriginal status

	Aboriginal?				
Location of primary case management team	**No**	**Yes**	**no data**	**Total**	**% Aboriginal**
East – Goulburn	47	30	3	80	37.5%
East – Inner Eastern Melbourne	48	9		57	15.8%
East – Outer Eastern Melbourne	54	8		62	12.9%
East – Ovens Murray	37	13		50	26.0%
North – Hume Moreland	35	31		66	47.0%
North – Loddon	83	43		126	34.1%
North – Mallee	20	16		36	44.4%
North – North Eastern Melbourne	74	48		122	39.3%
South – Casey Cardinia	19	1		20	5.0%
South – Cheltenham	28	13		41	31.7%
South – Dandenong	43	18		61	29.5%
South – Frankston	28	7		35	20.0%
South – Gippsland Central	60	20		80	25.0%
South – Gippsland Outer	21	17		38	44.7%
South – Gippsland South West	14	9		23	39.1%
West – Barwon	80	20		100	20.0%
West – Brimbank Melton	89	13		102	12.7%
West – Central Highlands	72	29		101	28.7%
West – South West	43	12		55	21.8%
West – Western Melbourne	46	7		53	13.2%
West – Wimmera	18	3		21	14.3%
no data	3			3	0.0%
Grand Total	**962**	**367**	**3**	**1332**	**27.6%**

2. Children in scope – age and gender

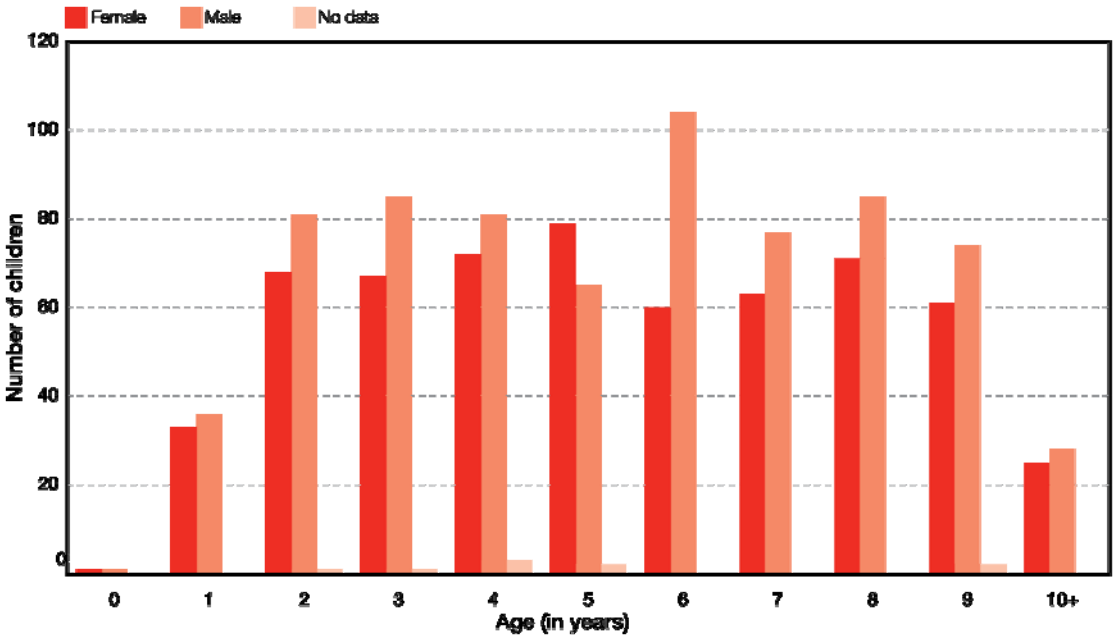
Of the 1,332 children in scope, 720 (54.1%) were boys (Table 3). The 10 year olds in the table are children who have turned 10 between January 2013 and June 2013.

Table 3. Children in scope by age and gender

Age on 30 June	Female	Male	no data	Total
0	1	1		**2**
1	33	36		**69**
2	68	81	1	**150**
3	67	85	1	**153**
4	72	81	3	**156**
5	79	65	2	**146**
6	60	104		**164**
7	63	77		**140**
8	71	85		**156**
9	61	74	2	**137**
10+	25	28		**53**
no data	3	3		**6**
Grand Total	**603**	**720**	**9**	**1332**

As can be seen in Graph 1 below, there is a large cohort of 6 year old boys where it is apparently hard to resolve permanency.

Graph 1. Children in scope by age and gender



3. Protection Orders

Table 4 and Graph 2 show the number and proportion of protection orders that children in scope are subject to in each division.

South and North divisions have the highest proportion of Guardianship to Secretary Orders while West and especially East have the lowest proportion. This is important for two reasons:

- Guardianship Orders allow the department to set the contact regime and other relevant conditions and ensure their consistency with the case plan, while Custody to the Secretary Orders allow the Court to set these parts of a case plan by the attachment of conditions to the order.
- Aboriginal agencies are currently funded to prepare cultural support plans for children subject to Guardianship to Secretary Orders (90 in Table 5, next page) but not for children subject to Custody to Secretary Orders (223 in Table 5).

Table 4. Children in scope by type of Protection Order

	Child's current order							
Reporting division	Custody to Secretary	Custody to Third Party Order	Guardian-ship to Secretary	Interim Accommodation Order	Interim Protection Order	Supervised Custody Order	no data	Grand Total
East	159		33	10		30	18	**250**
North	189		94	19	4	41	3	**350**
South	152	1	85	23	1	22	14	**298**
West	309		84	15	1	24	1	**434**
VIC	809	1	296	67	6	117	36	**1332**

Graph 2: Proportion of Protection Orders in each division

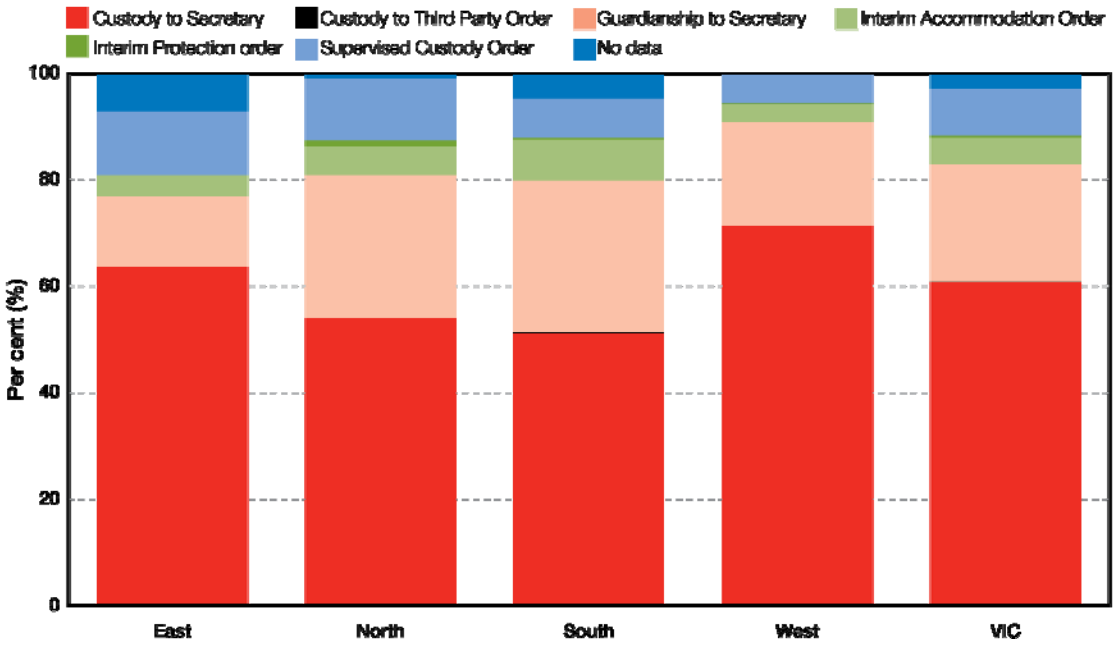


Table 5. Aboriginal children in scope by type of Protection Order

Aboriginal children	Child's current order						
Reporting division	Custody to Secretary	Guardian-ship to Secretary	Interim Accommodation Order	Interim Protection Order	Supervised Custody Order	No data	Grand Total
East	46	6	1		6	1	**60**
North	66	43	11	3	14	1	**138**
South	49	27	5		2	1	**84**
West	63	14	1		7		**85**
Grand Total	**224**	**90**	**18**	**3**	**29**	**3**	**367**

4. Siblings

Table 6. below compares the number of siblings that a child has in Out Of Home Care with the number of siblings that they live with. So, at the top left, there are 240 children in OOHC in the project's scope who have no siblings in Out Of Home Care. Below that there are 79 children in Out Of Home Care who have one sibling in Out Of Home Care that they do not live with.

The yellow cells show children who live with all of their siblings who are in Out Of Home Care (although there may be some siblings under 18 who are not in Out Of Home Care, or who are over 18).

The orange cells show children who are not living with all of their siblings in Out Of Home Care.

There were:

- 240 children in Out Of Home Care who had no siblings in Out Of Home Care (green highlight)
- 441 children in Out Of Home Care who lived with all their siblings in Out Of Home Care (yellow highlight)
- 597 children in Out Of Home Care who did not live with all of their siblings in Out Of Home Care (orange highlight), and 272 of these did not live with any of their siblings in Out Of Home Care
- 54 children where there was no clear data

Table 6. Siblings in Out Of Home Care

	Siblings in OOHC child lives with							
Number siblings in OOHC	0	1	2	3	4	5	no data	Grand Total
0	240						36	**276**
1	79	230					1	**310**
2	78	72	136					**286**
3	49	75	43	51				**218**
4	33	33	13	9	20		1	**109**
5	10	13	11	3	2	4		**43**
6	9	6	7	2	2			**26**
7	3	7	9	5				**24**
8	4	2	2	1				**9**
9	3	2						**5**
10		1						**1**
11	2	1	5					**8**
18	1							**1**
no data	1						15	**16**
Grand Total	**512**	**442**	**226**	**71**	**24**	**4**	**53**	**1332**

5. Specific needs of the child.

There were 232 children (17.5%) in the sample who were assessed as having a developmental delay or an intellectual disability or were otherwise in the Disability Services Target Group, and a further 21 where an assessment outcome was pending.

Table 7. Disability and Developmental Delay

Under 6, Early Childhood Intervention Service assessment – developmental delay	122
Over 6, assessed Intellectually disabled through Disability Services Target Group	83
Over 6, assessed Intellectually disabled through Disability Services Target Group – outcome pending	11
Over 6, in Disability Services Target Group but no Intellectual disability	37
Over 6, in Disability Services Target Group but no Intellectual disability – outcome pending	10
No disability or developmental delay	1069
Total	**1332**

280 (21.2%) of the children had complex medical health needs and/or mental health issues. Of these:

- 114 children (8.5%) had complex medical health needs,
- 136 (10.2%) had mental health issues and
- 30 children (2.3%) had both complex medical health needs and mental health issues.

Table 8. Complex Medical needs and Mental Health issues

	Mental health issues			
Complex medical health needs	**No**	**Yes**	**no data**	**Total**
No	1027	136	3	1166
Yes	111	30	3	144
no data	3	2	17	22
Grand Total	**1141**	**168**	**23**	**1332**

381 children (28.8%) had significant behavioural issues and/or significant school performance or attendance issues. Of these:

- 253 children (19.1%) had significant behavioural issues,
- 26 children (2.0%) had significant school performance or attendance issues and,
- 102 children (7.7%) had both significant behavioural issues and significant school performance or attendance issues.

Table 9. Significant behavioural and school issues

	Educational Performance/Attendance affecting placement stability			
Significant behavioural issues	**No**	**Yes**	**no data**	**Total**
No	879	25	52	956
Yes	242	102	11	355
no data	5	1	15	21
Grand Total	**1126**	**128**	**78**	**1332**

Only 79 of the children did not have any of the specific needs measured in this section. Where such specific needs were present, the review identified factors that were most likely to be a barrier to achieving permanency.

By far the most important barrier in terms of the child's special needs was whether the child had significant behavioural issues that impacted on achieving permanency, and this was the case with 221 children, as shown in Table 10.

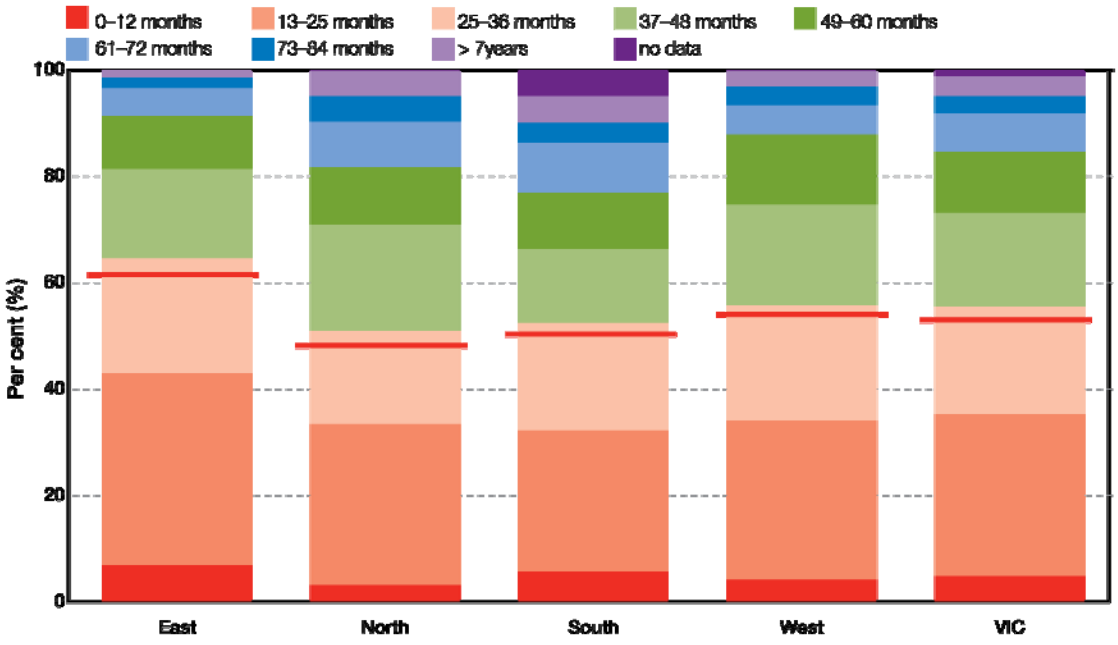
Table 10. If any of the child's specific needs are relevant, which is most likely to impact on achieving permanency?

impacts on achieving permanency	Total	% of total
Under 6, Early Childhood Intervention Service assessment – developmental delay	15	1.1%
Over 6, assessed Intellectually disabled through Disability Services Target Group	11	0.8%
Over 6, in Disability Services Target Group but no Intellectual disability	4	0.3%
Complex medical health needs	64	4.8%
Mental health issues	47	3.5%
Significant behavioural issues	221	16.6%
Educational Performance/Attendance affecting placement stability	11	0.8%
none relevant	959	72.0%
Grand Total	**1332**	**100.0%**

6. Total time on Out Of Home Care (all care episodes).

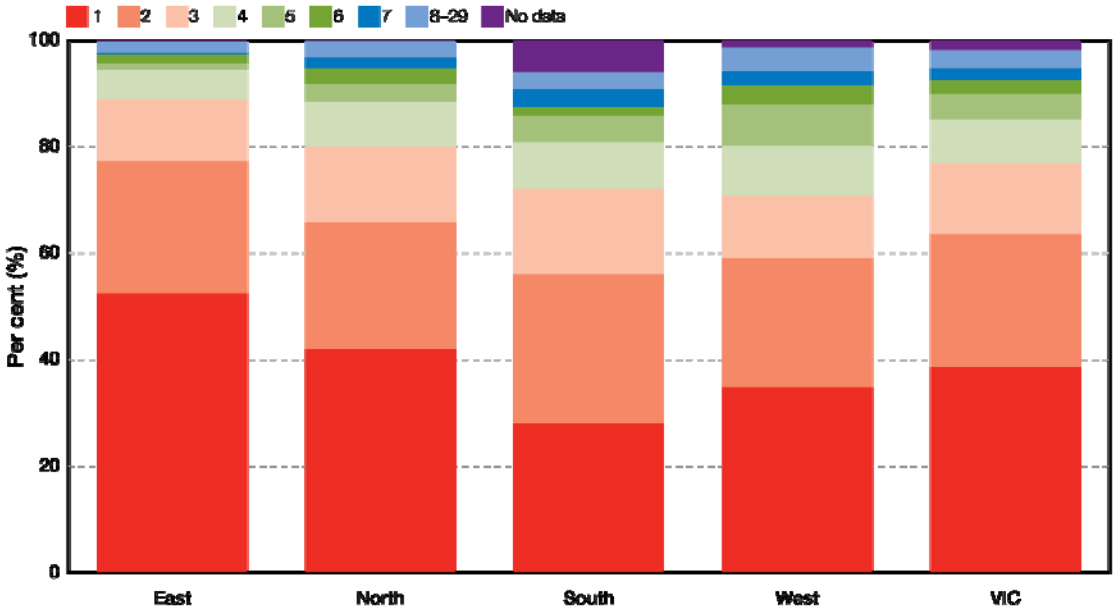
The length of time children had been in Out Of Home Care varied from division to division. In East division about 64% of children had been in OOHC for less than 3 years (under the red line in the vertical bar), while in North division this proportion was only 50%.

Graph 3: Time in care (all care episodes)



As a direct result of being in OOHC for a shorter average time, the children in East division were also younger on average, had experienced fewer changes of worker and, as shown in Graph 4, had had fewer placement changes.

Graph 4: OOHC placements in child's life



7. Placement breakdowns

Placement breakdowns may occur for a number of reasons, but generally involve a decision by the carer that they cannot care for the child for as long as had been planned.

As the bottom row of Table 11 shows, 953 out of the 1,332 children had never had a placement breakdown but 451 of these had nevertheless had more than one placement (highlighted in yellow) and 7 had had 8 or more placements.

208 children had experienced one placement breakdown. Of the 208 children who had had one placement breakdown, 60 had had 3 placements (orange highlight), 26 had had 4 placements (green), 20 had had 5 placements (blue), and so on.

In total, the table shows that the 1,332 children had had 3,403 placements, and that there had been 615 "placement breakdowns"[49]. Clearly, most placement change – which causes instability – is generated by factors other than placement breakdown.

Table 11. Placements and placement breakdowns

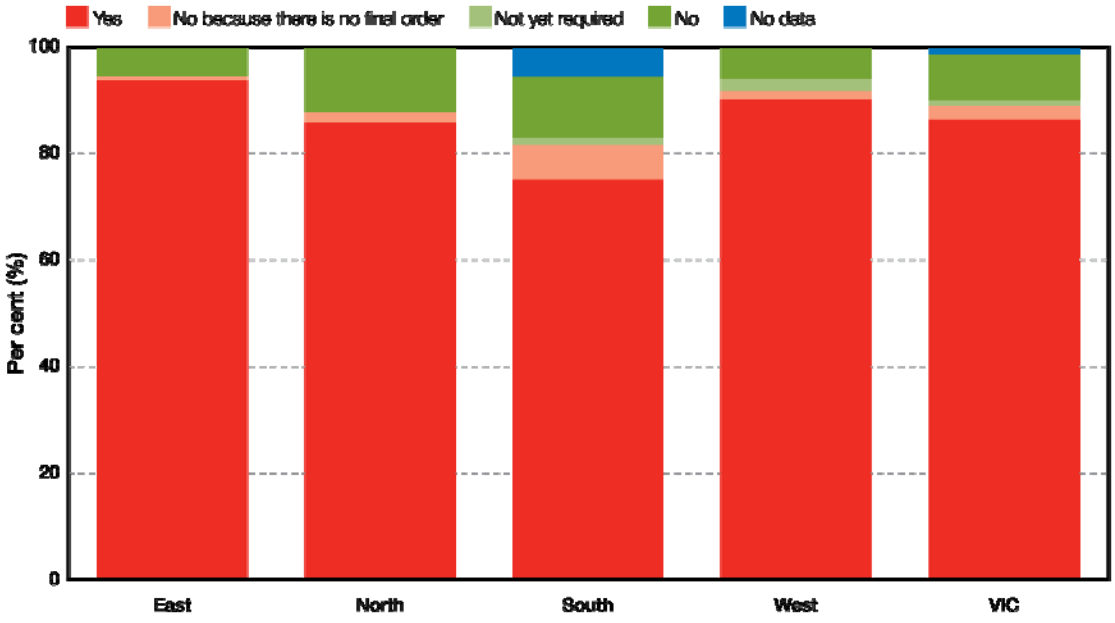
	Placement breakdowns						
OHC placements child's life	0	1	2	3	4+	No data	Grand Total
1	502	8			1	1	512
2	258	69	3			3	333
3	95	60	19	1		3	178
4	50	26	25	8		1	110
5	19	20	17	4	4		64
6	7	12	5	5	5		34
7	7	6	6	5	5	1	30
8–29	7	7	14	4	10	3	11
No data	8					18	
Grand Total	**953**	**208**	**89**	**27**	**25**	**30**	**1332**

[49] The right hand column in Table 11 shows 612 children who have had one placement, 333 children with two placements etc, making a total of 3,403. Similarly, the bottom row shows 208 children who had experienced one placement breakdown, 89 who had had 2 placement breakdowns etc, making a total of 615 placement breakdowns

8. Statutory Case Plans

It is a requirement of the Children, Youth and Families Act 2005 that a case plan be developed within 6 weeks of a protection order being made. The majority of cases in the sample did have a current statutory case plan, as shown in Graph 5. Whether or not the case plan was appropriate was addressed later in the review.

Graph 5: Evidence of current statutory case plan?



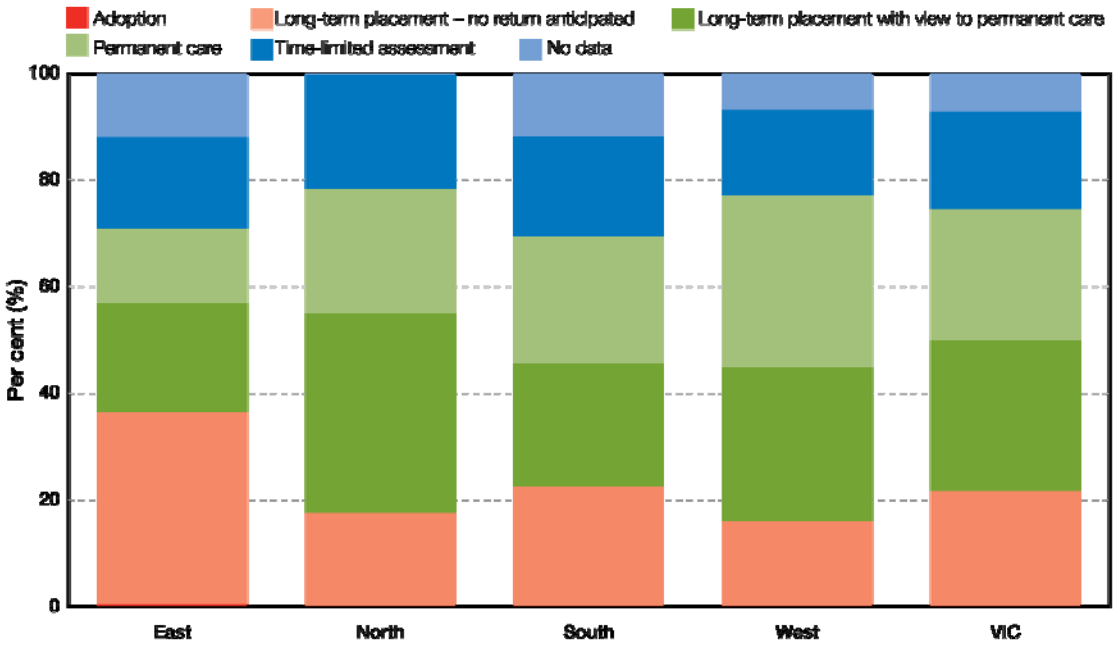
The reasons for delays in making a case plan (whether or not there was a current one identified) are shown in table 12. The most common reason was “workload” (103 cases), but there were also 47 cases delayed by reviews or appeals and 68 cases where other reasons were given.

Table 12. Reasons for delay in making a statutory case plan

	Reasons for delay in Case Plan						
Evidence of current statutory Case Plan	**Issues gathering information**	**No allocated worker**	**Parent/family disruptions**	**Reviews and Appeals**	**Workload**	**No data**	**Grand total**
No data	1				1	17	**19**
No	7	3	12	18	40	35	**115**
No because there is no final order	4		11	2	2	16	**35**
No yet required						14	**14**
Yes	16	13	11	27	60	1022	**1149**
Grand total	**28**	**16**	**34**	**47**	**103**	**1104**	**1332**

Graph 6 shows the proportionate distribution of each type of case plan in each division. It can be seen that the West division has the highest proportion of permanent care case plans (the light green part of the vertical bar). Whether this results from more permanent care case plans being made, or from it taking longer to resolve permanency requires further study.

Graph 6: What is the case plan?



One of the findings of the reviews was that the two categories “long-term placement with a view to permanent care” and “long-term placement – no return to family anticipated” were not clearly differentiated and that the classifications were used almost interchangeably.

This is a specific example of a more general need to review the terminology used in this field, as even the over-arching terms “stability” and “permanency” are not used in any consistent way.

PART C – children in scope once 160 children with appropriate reunification case plans are excluded.

9. Excluding children with an appropriate reunification case plan

160 of the children in the sample were judged to have an appropriate reunification case plan. These children were excluded from subsequent questions, so the size of the remaining sample was reduced from 1,332 to 1,172. (A further cohort was also excluded by a later question).

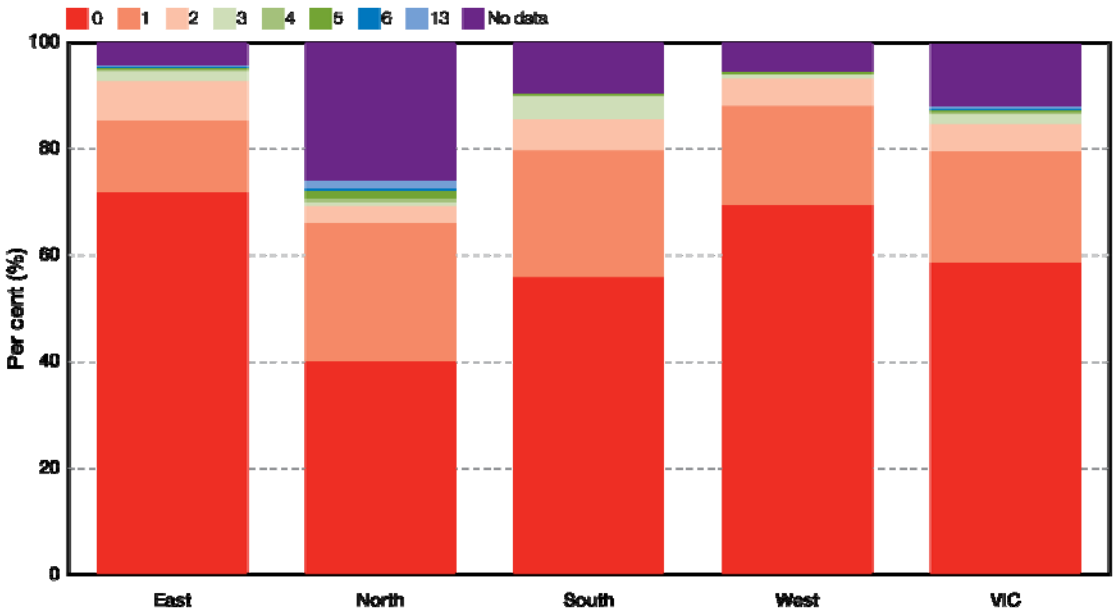
Table 13. Is there an appropriate reunification case plan? Those remaining in scope.

	Reporting division				
If there is a reunification case plan, is it appropriate?	**East**	**North**	**South**	**West**	**Grand total**
Yes	48	40	29	43	**160**
Whole sample	250	350	298	434	**1332**
Those now remaining in scope	202	310	269	391	**1172**

10. Reunification attempts.

Of the children in the survey, 690 out of 1,172 (58.9%) had not had any reunification attempts with their birth family (see Graph 7), but 245 (20.9%) had had one failed attempt and several had more, including one child with 13 failed attempts. The proportions varied between divisions as shown in Graph 7. The smallest proportion of failed attempts was in East division, while the largest was in North division.

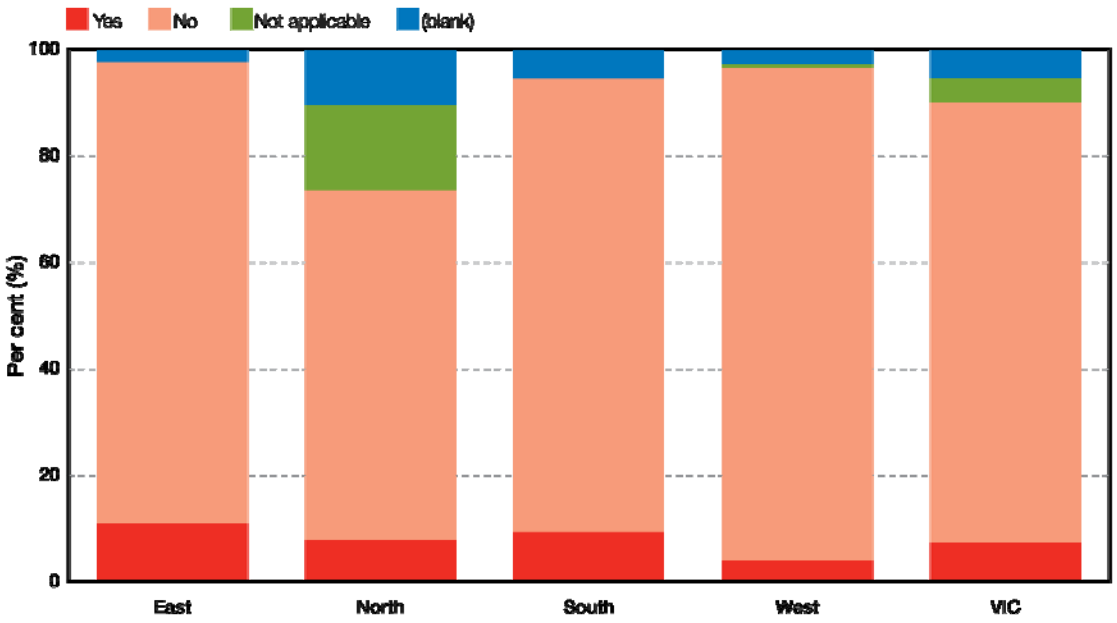
Graph 7: Number of reunification attempts



11. Family Group Conferences

Only 86 children out of the 1,172 in scope (7.3%) had been the subject of a Family Group Conference in the preceding 12 months. The proportion was highest in the East and lowest in the West. This may be partly a result of FGC's tending to be held in the first year of a child being in care, as the children in the East had generally been in care for a shorter period of time (Graph 3 above), but it may also be related to resources issues.

Graph 8: FGC held in past 12 months?



PART D – children in scope once 336 children already in appropriate long-term placements are excluded.

A further 336 children were removed from scope of the review (though not necessarily of project casework) on the basis that they were already in an appropriate long-term or permanent placement. Those remaining in scope for the review are shown in the bottom line of the table below.

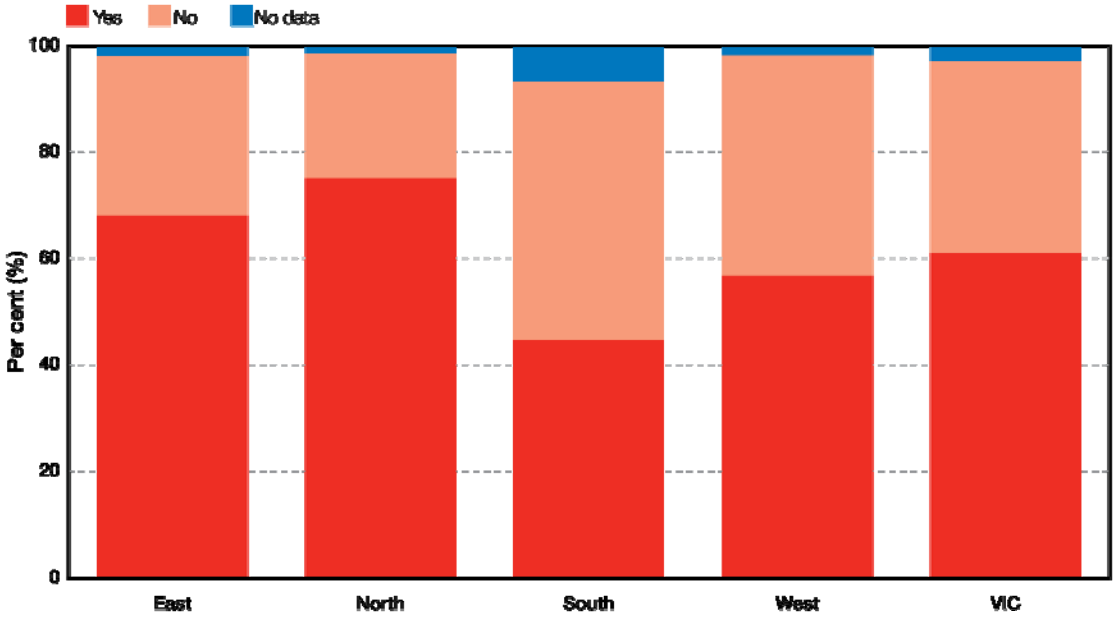
Table 14. Is the child currently in an appropriate long-term placement?

Is the current long-term placement appropriate	East	North	South	West	VIC
Yes	70	50	47	169	336
No	292	310	269	391	1172
Those no remaining in scope	132	260	222	222	836

12. Stability Plans

The majority of children had a stability plan recorded on file: 510 (61%) out of 836. Rates varied from about 44% in South division to about 74% in North as shown in Graph 9.

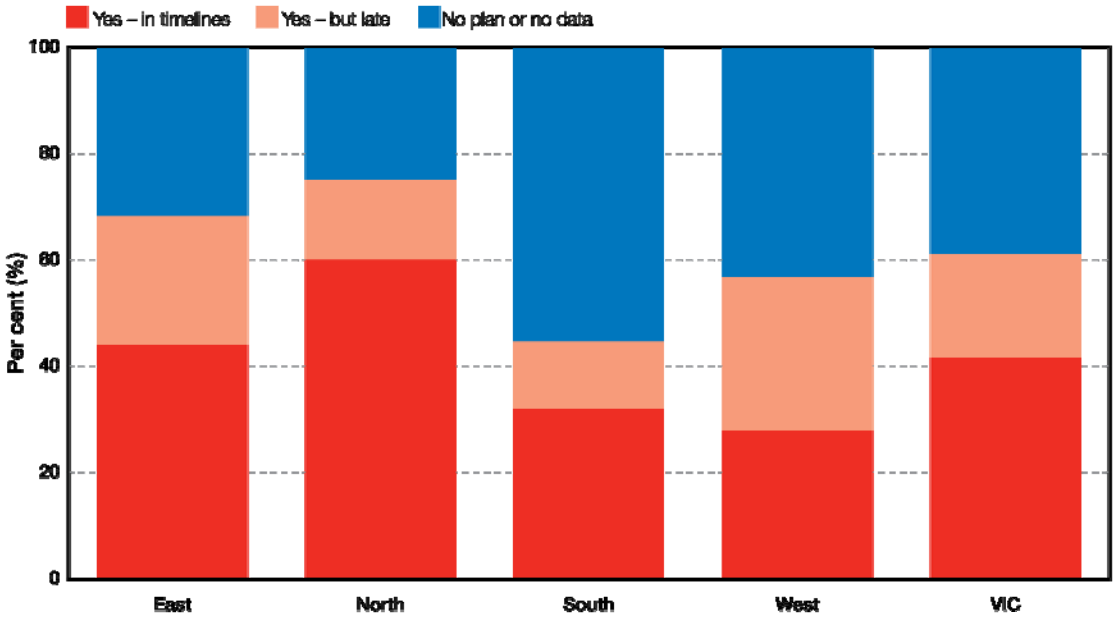
Graph 9: Stability Plan recorded on file?



The survey also asked whether a stability plan had been completed within the statutory timelines (Children, Youth and Families Act section 170), and this showed that many were not.

As can be seen from Graph 10, 163 of the 510 stability plans were made late. While West division had a higher proportion of cases with stability plans than South (Graph 9), South had a higher proportion made within the timelines (Graph 10).

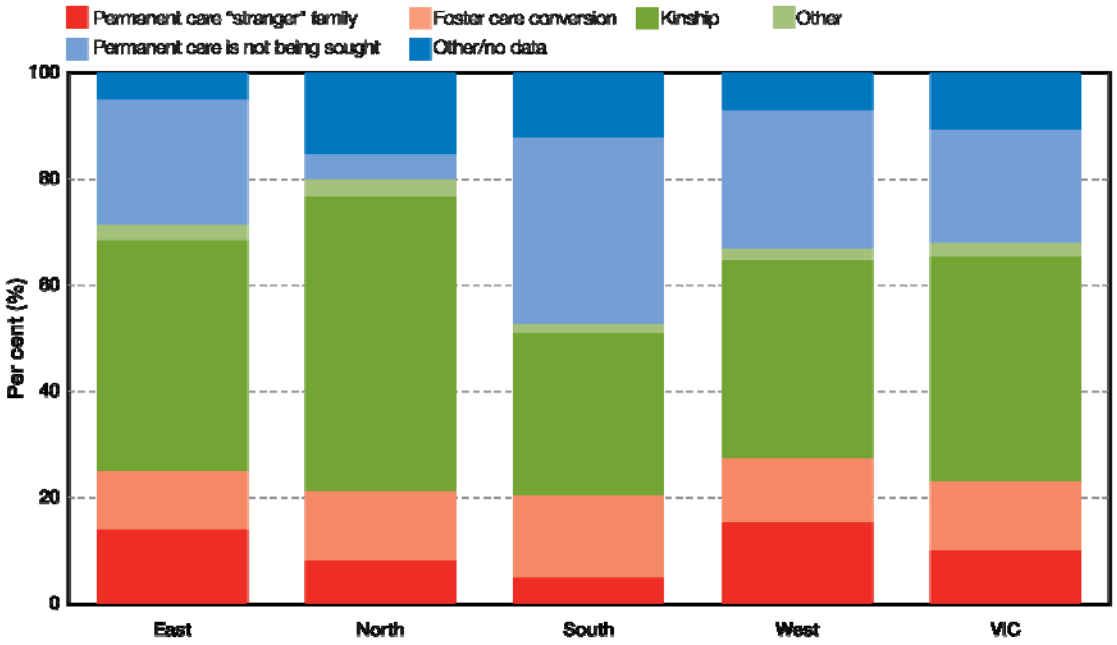
Graph 10: Compliance with Children, Youth and Families Act section 170 stability timelines



The type of placement being sought varied between divisions. On a statewide basis, and in the 561 cases where the type of permanent placement being sought was known, there were 362 (64.5%) kinship permanent placements, 112 (20.0%) foster care conversions and 87 (15.5%) permanent care "stranger" families being sought. The extent to which this division is driven by the availability of different types of placement remains a question to be answered.

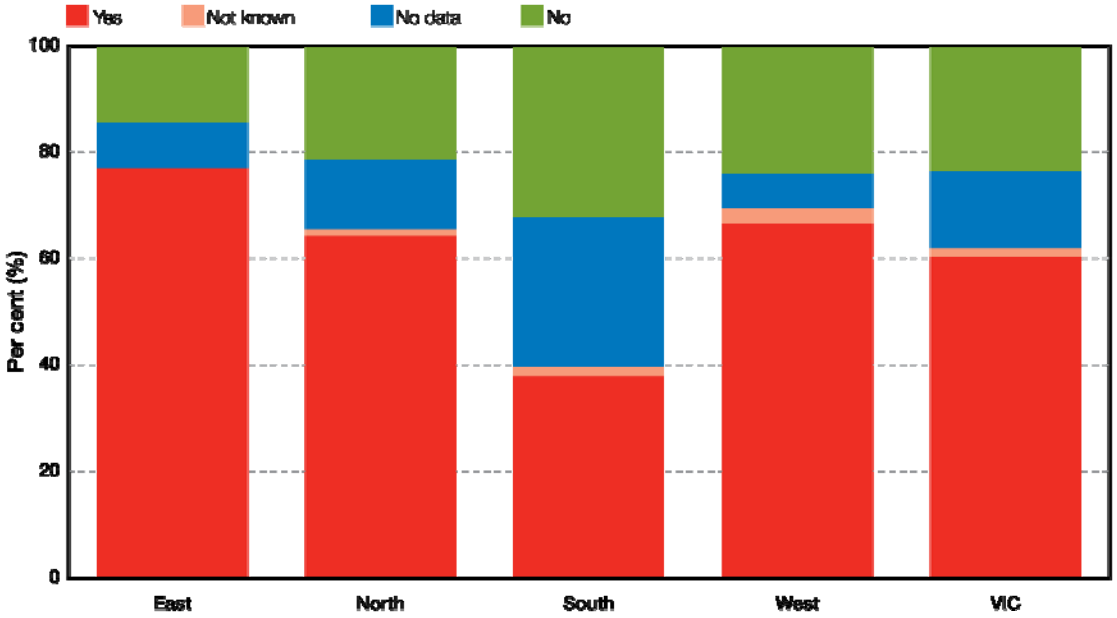
Permanent care with a "stranger" family was most commonly sought in West division, while kinship care was most favoured in North. Whether this reflects practice preference or placement availability is unclear and would require further study.

Graph 11: Type of permanent care placement being sought



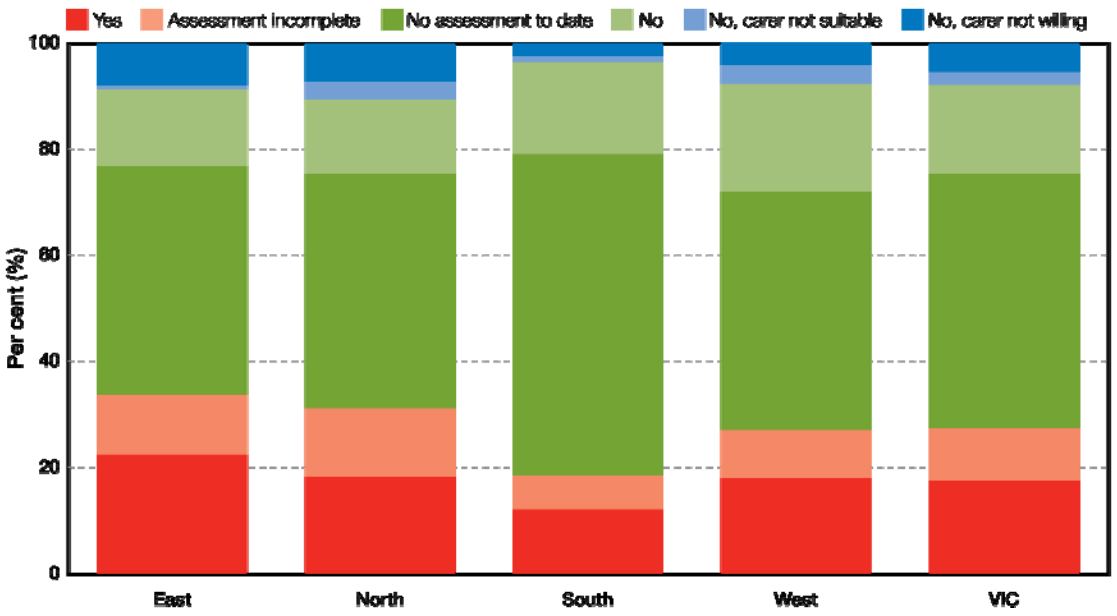
Having identified the type of placement for a permanent care case plan, the question was then asked whether a suitable placement had been identified. A permanent placement had been identified in about 60% of all cases across the state where there was a permanent care case plan, although there was significant variation between divisions: under 40% in South division, about 65% in North and in West, and over 75% in East (Graph 12).

Graph 12: Have permanent carers been identified where there is a permanent care case plan?



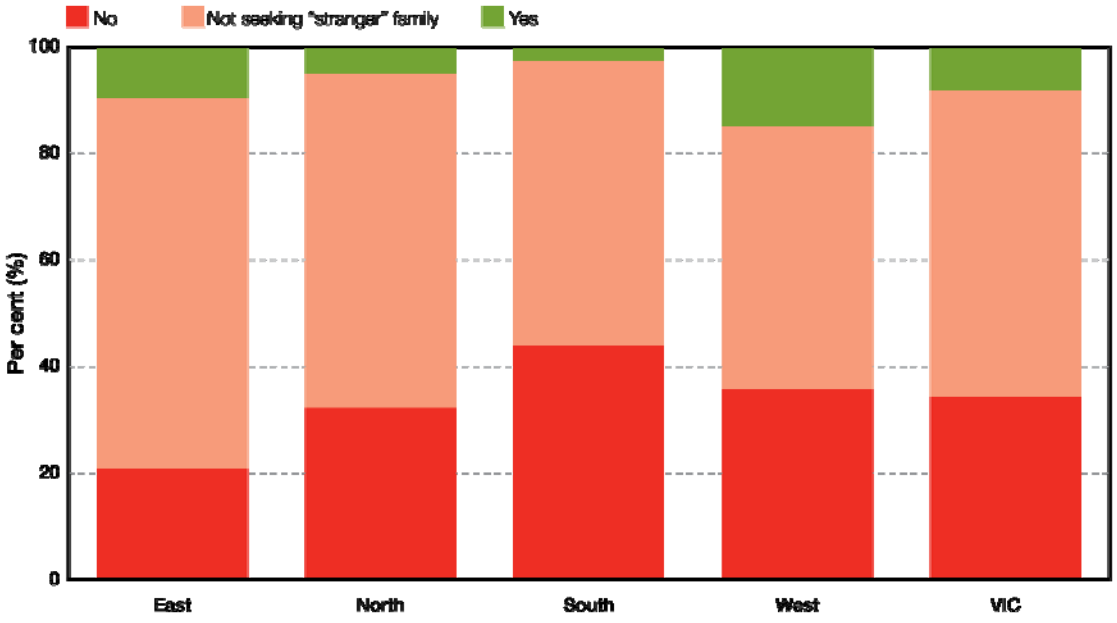
A follow up question asked whether the current carer has been assessed as able to provide permanent or long-term care. The answers showed that 25% had been assessed as not appropriate/willing or able and a further 50% had not been assessed at all.

Graph 13: Is the carer assessed as appropriate to provide long-term or permanent care?



After removing the cases where the current carer had been assessed as appropriate or where an assessment was incomplete, there were 539 cases where the next question asked whether a referral had been made to a Permanent Care Program for a suitable “stranger” family to be identified. The answer in Graph 14 below was that only 39 had been referred, and that 162 of the remainder had not been referred, although it might be assumed that they needed to be.

Graph 14: Referred to Permanent Care Program?



13. Allocation status

491 (59%) of cases across the state were allocated to a Child Protection worker (see Graph 15 and Table 15).

The lowest rates were in North and in West divisions. However, these two divisions had higher rates of contracted allocation and lower rates of unallocated cases overall.

The overall allocation rate, including contracted cases, was 90.2%. This was very close to the statewide average allocation rate at the time the survey was conducted (February to June 2013), but this sample includes a higher proportion of contracted cases (31% as compared to about 13.5% of all post intake cases statewide).

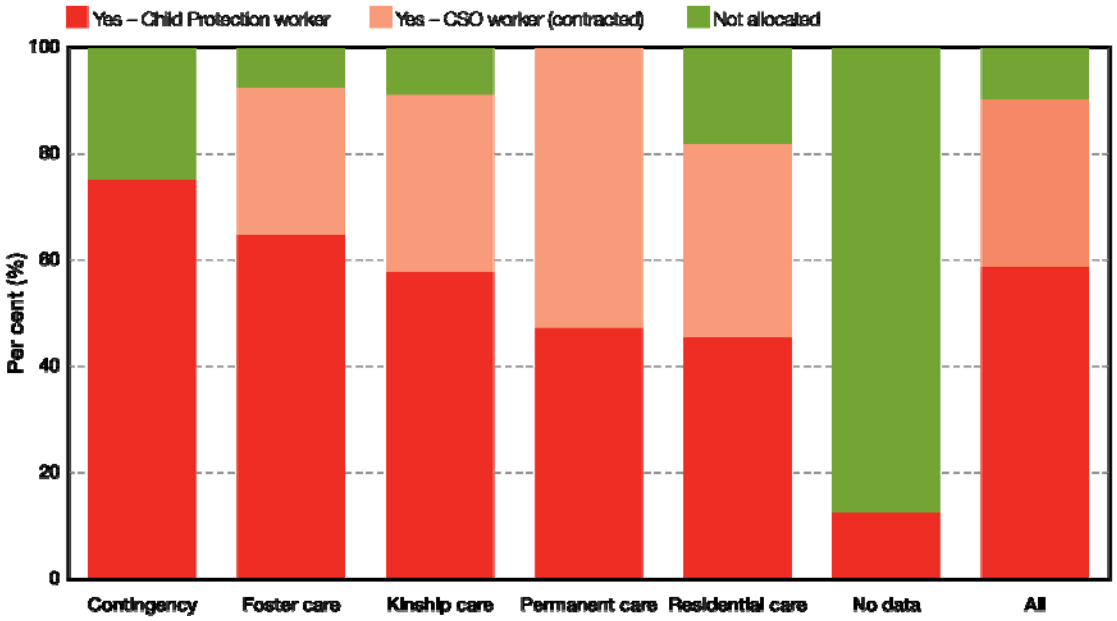
Graph 15: Does the case have a currently allocated worker?

Table 15. Is the case currently allocated?

	Reporting division				
Is the case currently allocated?	East	North	South	West	VIC
Not allocated	16	19	33	14	82
Yes – CSO worker (contracted)	25	105	44	89	263
Yes – Child Protection worker	91	136	145	119	491
Grand Total	132	260	222	222	836

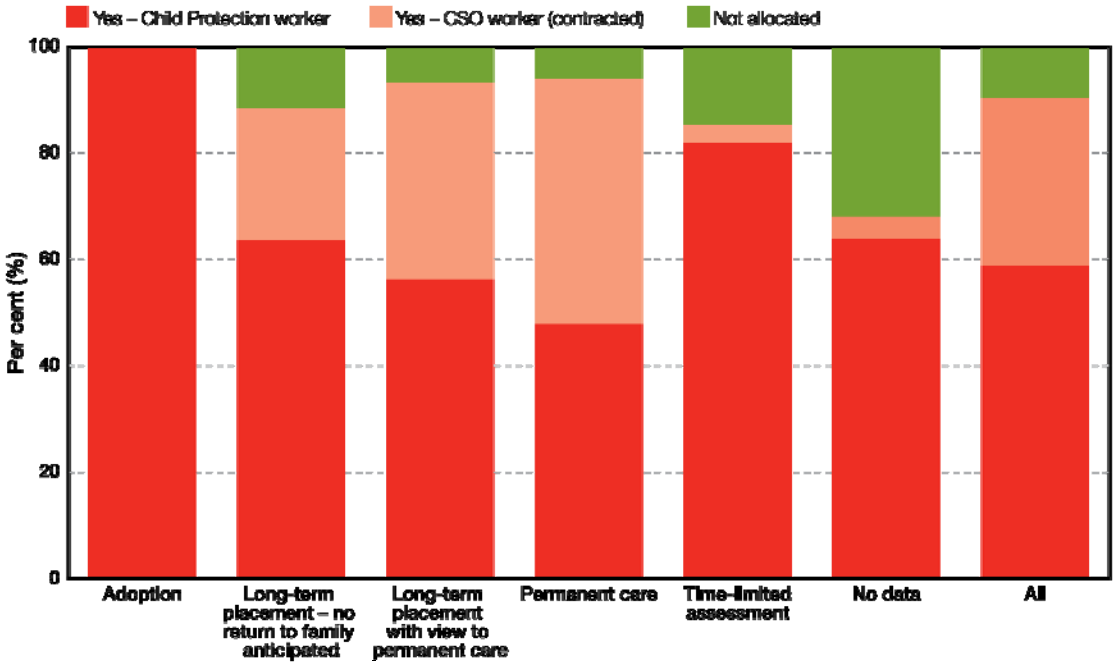
Graph 16 shows allocation status by placement type. Interestingly, a higher proportion of children in this cohort who were in a kinship placement were contracted to a community service (CSO) than children in foster care.

Graph 16: Allocation type and placement type



Graph 17 shows that a CSO worker was most likely to be the allocated worker where there is a permanent care case plan or a case plan of long-term placement with a view to permanent care. This means that any action to promote more timely permanency resolution will rely to a large extent on engaging Child Protection contract managers and CSO workers in the process.

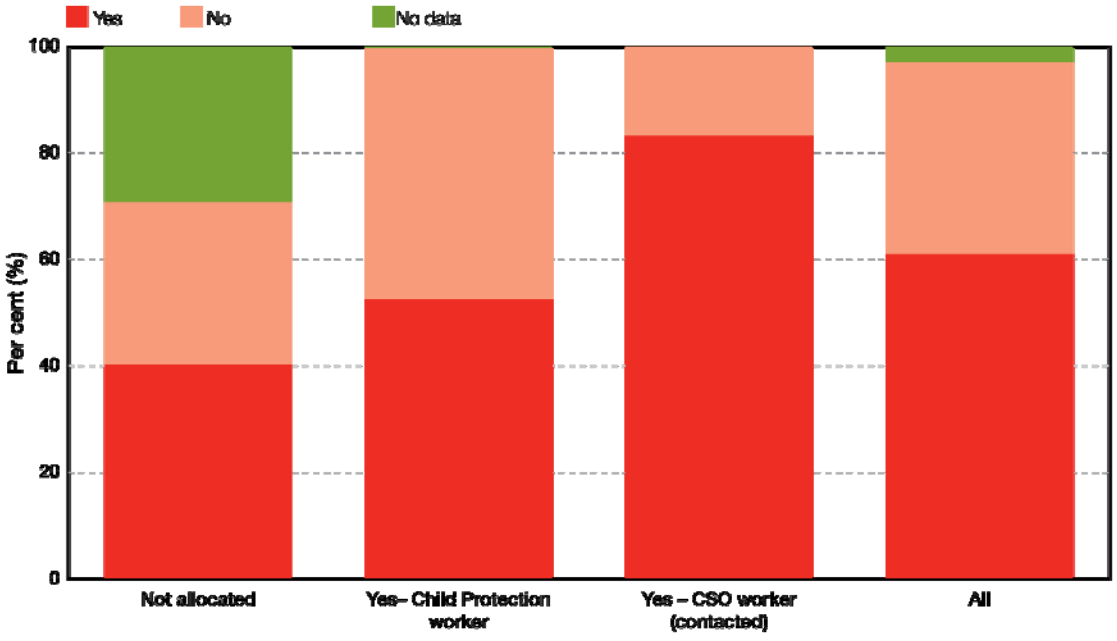
Graph 17: Allocation type by case plan type



Graph 18 compares the allocation type with whether there was a stability plan on the client file. As can be seen, there was far more likely to be a stability plan where the case was allocated to a CSO worker (219 out of 263 cases, or 83.3%) than where the case was allocated to a Child Protection worker (258 out of 491 cases, or 52.5%).

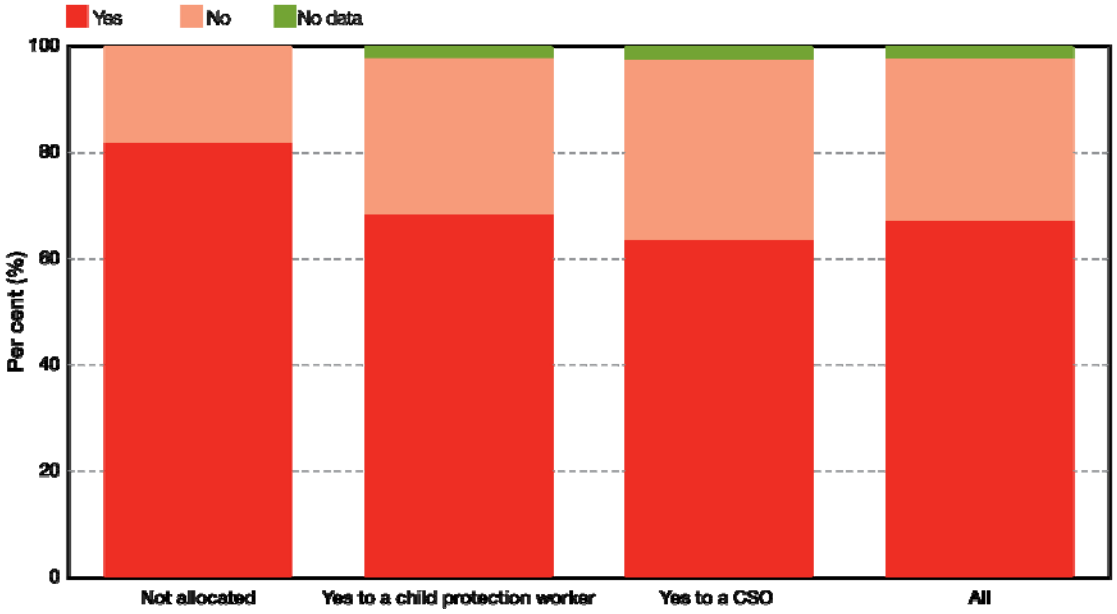
This may be partly related to the increased likelihood of a CSO worker being the allocated worker when there was a permanent care case plan as shown in Graph 17 above. It is also true that the review found many stability plans to be incomplete or of poor quality. Despite these qualifications, the low rate of stability plans on client files where there was an allocated Child Protection worker is something that requires further examination.

Graph 18: Stability plan on file by allocation type



Although there was less likely to be a stability plan where the case was allocated to a Child Protection worker, the plans that were done were slightly more likely to be done within timelines than were the case was allocated to a contracted CSO worker – 176 out of 258 cases (68.2%) where there was a Child Protection worker allocated, compared to 139 out of 219 (63.5%) where a CSO worker was allocated.

Graph 19: Where there was a stability plan, was it completed within statutory timelines (by allocation type)?

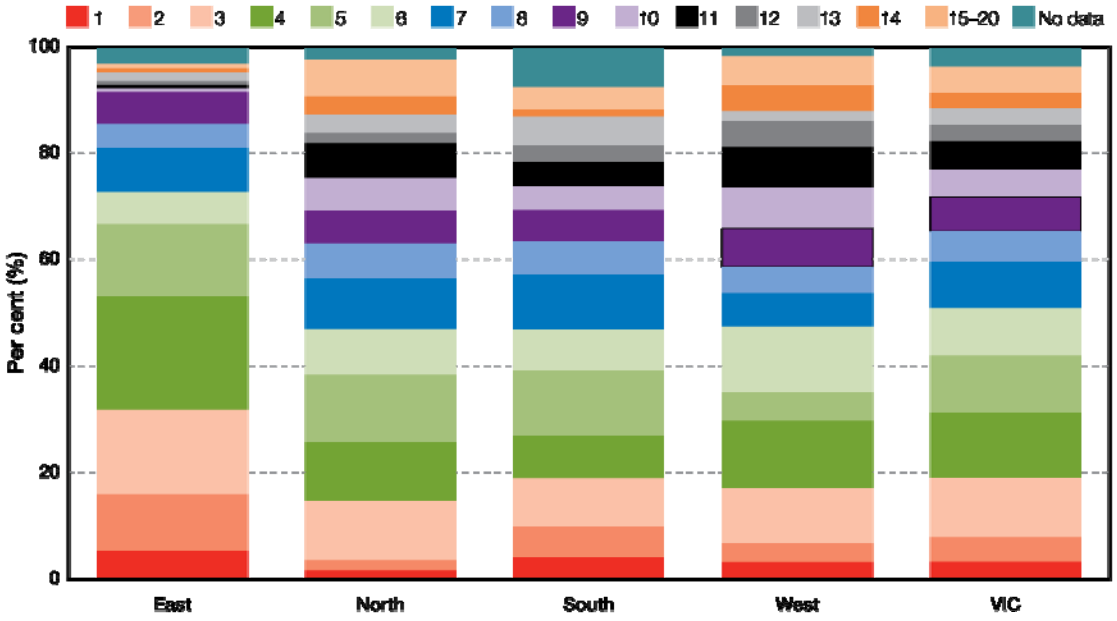


Graph 20 shows the number of workers (both Child Protection and CSO) allocated to each case during the current episode of out of home care, bearing in mind that all of these children had been in out of home care for more than a year.

As can be seen, over 50% of children in East division had had 4 workers or less. The other 3 divisions had rates of between 25% and 30% where there had been 4 workers or less. The different performance by the East partly reflects the fact that children had spent less time in care on average. Several factors could contribute to this, including:

- faster permanency resolution (which could be due to good practice, more timely case planning, greater allocation consistency or lower thresholds for care entry and therefore easier resolution)
- less complex needs, on average
- greater availability of more appropriate placements
- a more stable staff group

Graph 20: Number of allocated workers (CP and CSO) this care episode, by division



14. Support provided to the child other than by the allocated worker

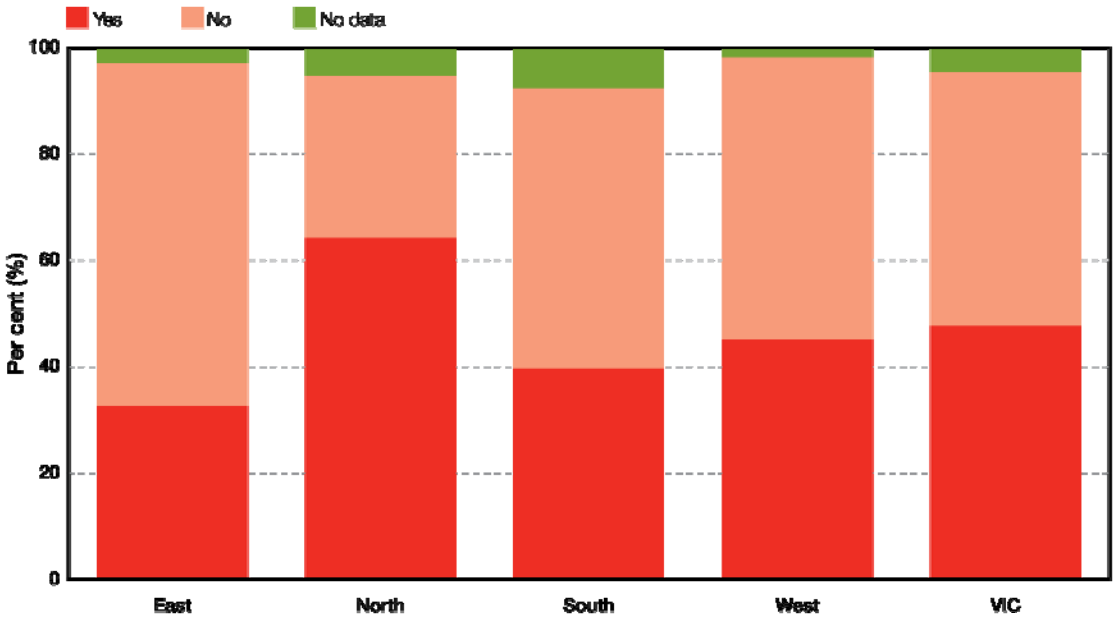
Table 16 shows the types of support that were provided to the children in scope, and the types of support that were needed but not provided. There were 497 types of support offered to the children in addition to any support offered by the allocated worker, with the most common being medical support (137 children) and "Other" types of support (169). Of the 207 children identified as needing a type of support that was not being provided, 118 were in the "other" category. Further work needs to be done to identify what this category consists of.

Table 16. Support provided and support required

	Additional support that child is receiving	Support needed that child isn't receiving
Disability worker	16	11
Educational support	81	23
Medical/paediatrician	137	19
Mentoring programs	2	3
Other	169	118
Psychiatric	32	17
Speech	60	16
no support or no data	339	629
Grand Total	836	836

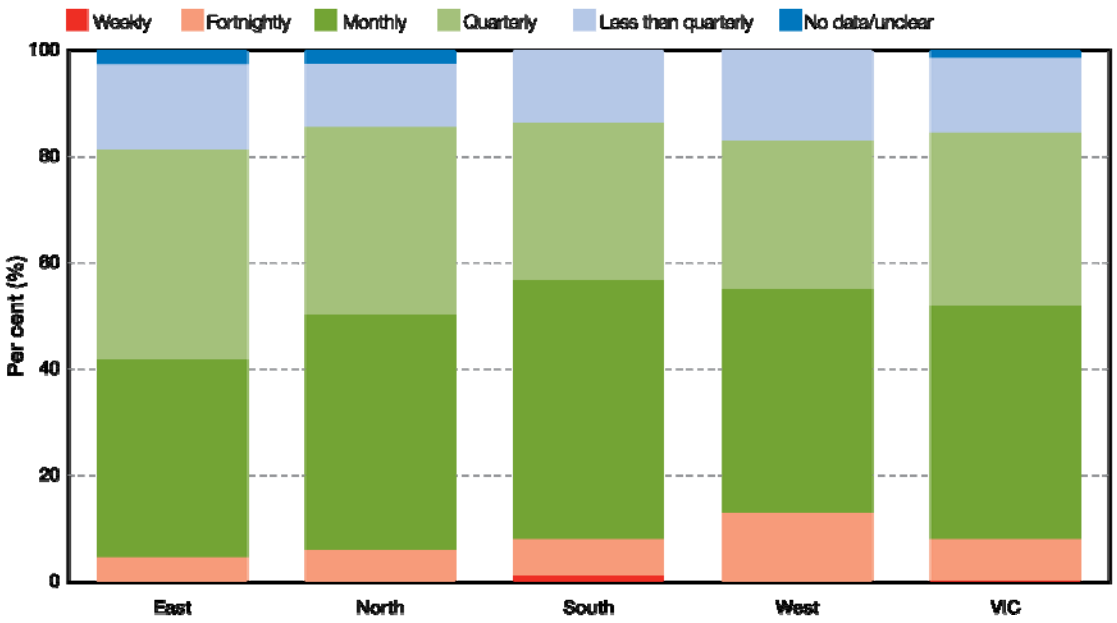
Ensuring additional support is provided for a child, where needed, is a task for the care team. As can be seen in Graph 21, the number of cases where there was a care team established statewide was about half of the total (398 out of 836 cases = 47.6%). There was considerable regional variation. Children in North division were far more likely to have a care team (64.2%) than those in East division (32.6%), South division (39.6%) or West division (45%).

Graph 21: Was there an established care team?



Where a care team was established, there was a wide range in terms of how often the team actually met, as shown in Graph 22. On a statewide basis, 46.7% of care teams met either quarterly or less than quarterly, while most of the rest (44%) met monthly. Interestingly, children in East division were less likely to have a care team (Graph 21) and, where they did have a care team, it met less often that in other divisions (Graph 22.)

Graph 22: Frequency of care team meetings



15. Internal case plan reviews

An internal case plan review by a more senior manager (Table 17) had been held in 19.5% of cases statewide, with very little divisional variation apart from a lower rate of 17.1% in West division.

Table 17. Has an internal review been conducted?

	Reporting division				
Internal review held?	**East**	**North**	**South**	**West**	**VIC**
No	101	201	159	179	640
Yes	27	52	46	38	163
no data/unclear	4	7	17	5	33
All	132	260	222	222	836
% "yes"	**20.5%**	**20.0%**	**20.7%**	**17.1%**	**19.5%**

Where reviews were held, a similar proportion had an impact on the stability and permanency aspects of the case plan (Table 18) in East division (44.4%), North division (40.4%) and West division (39.5%), while only 15.2% of reviews had a similar impact in South division.

Table 18. Did the review (where held) impact on the stability/permanency plan?

Review outcome impact on plan?	**East**	**North**	**South**	**West**	**VIC**
No	10	30	37	22	99
Yes	12	21	7	15	55
no data/unclear	5	1	2	1	9
All	27	52	46	38	163
% "yes"	**44.4%**	**40.4%**	**15.2%**	**39.5%**	**33.7%**

16. Conditions placed on Protection Orders, including contact.

There are many children subject to plans for permanent or long-term out of home care who are subject to Custody to the Secretary Orders. The conditions attached to Custody to the Secretary Orders are not always consistent with the direction of the case plan.

For example, frequent contact may have been an appropriate condition when there was still a possibility of reunification, and so might conditions that required parents to improve their parenting skills or learn to manage their substance abuse issues. Such conditions are of much less relevance (if any) to a case plan where the child will remain in the care of others.

These inconsistencies arise from a fundamental problem in the system in Victoria. The *Children, Youth and Families Act 2005* (and its predecessor the *Children and Young Persons Act 1989*) assign case planning responsibility to the Secretary of DHS (and through her to her delegates), while all orders apart from Guardianship Orders can have conditions attached to them by the Children's Court.

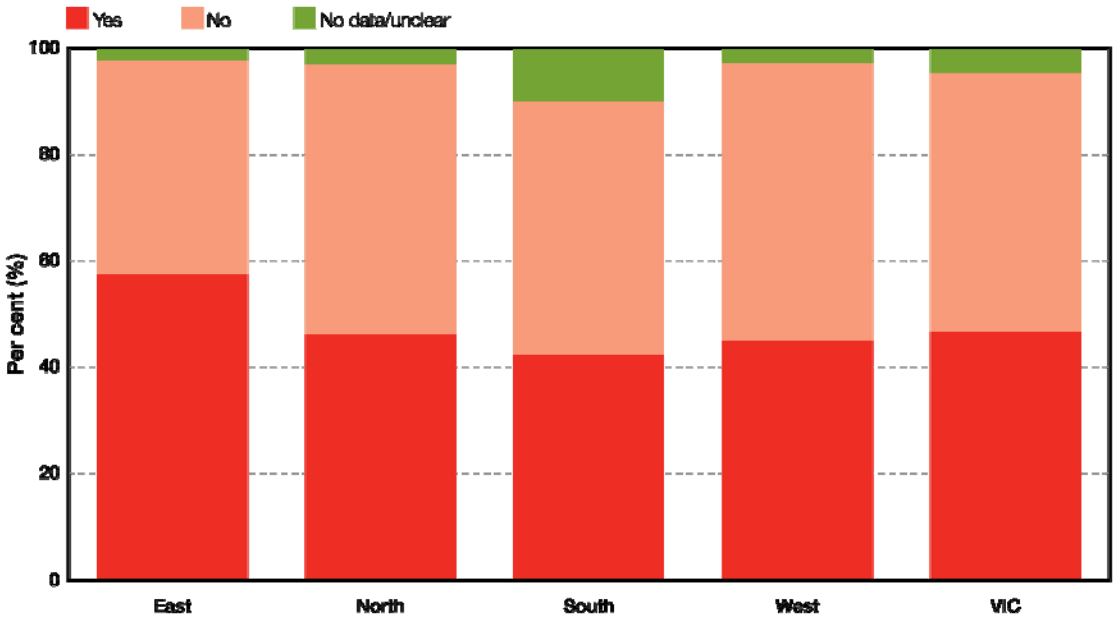
These conditions can specify where the child lives, when and where the child has contact with their parents and other kin, what services should be provided to parents and children, what tasks parents should complete and so on. In effect, these conditions become the case plan. Where the department assesses that a child in care is not going to be able to return safely home in any timeframe that is reasonable, a case plan for permanent or long-term placement may be made, but the conditions attached to orders by the Court may not be consistent, as was the case for 285 children in this survey (See Table 19 below). This situation creates a stand-off where reunification is unsafe, but long-term and

permanent plans cannot be progressed, because potential carers are understandably wary of taking on long-term responsibility where there is still uncertainty about the child's case plan.

The following section looks at various aspects of this issue.

Graph 22 shows that about half of the children in the survey where there was a case plan for long-term or permanent care were subject to orders with conditions that were consistent with reunification. East division (57%) had the highest proportion of Orders that supported a permanent care case plan, while South division (42%) had the lowest.

Graph 23: Do the current protection order conditions support permanent or long-term care case plans?



When the question about appropriate conditions is correlated with case plan types, the 285 cases highlighted in yellow in Table 19 below (34.1% of the total) would seem to be problematic, because there is a long-term or permanent care case plan and an order with conditions that do not support that case plan.

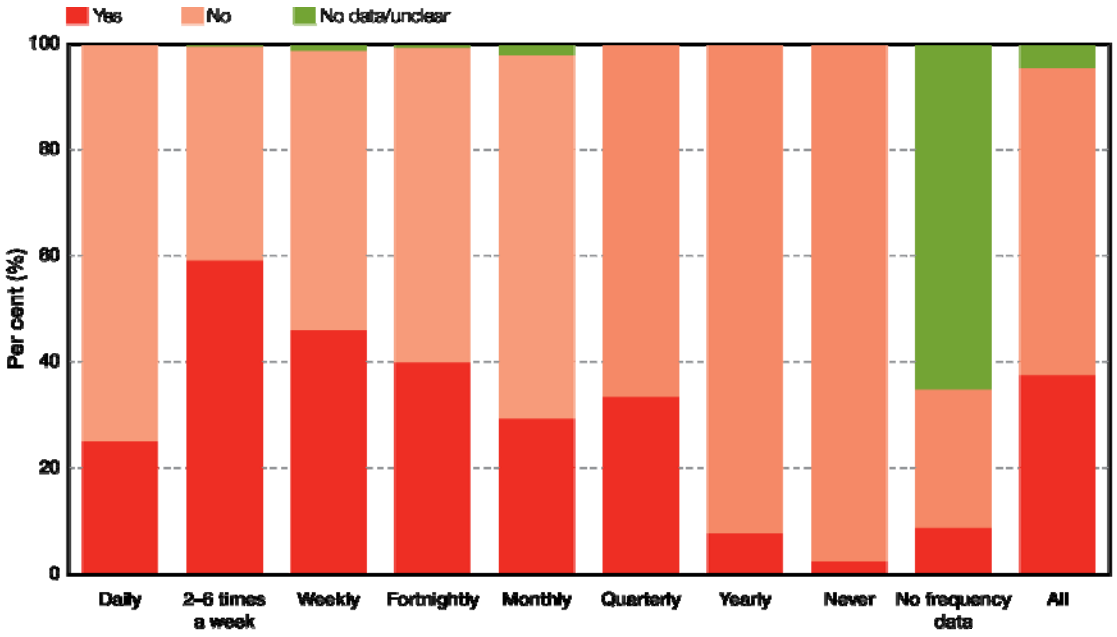
Table 19. Do the order conditions support a permanent or long-term care case plan?

	Type of case plan						
Order conditions support PCCP?	Adoption	Long-term placement – no return to family anticipated	Long-term placement with view to permanent care	Permanent care	Time-limited assessment	no data	All
No		72	115	98	99	23	407
Yes	1	41	148	180	11	9	390
no data/unclear		8	2	2	12	15	39
All	1	121	265	280	122	47	836

Contact is a key issue in resolving permanency. Permanent Care Orders assign parental responsibility and guardianship to the carer, but usually have contact conditions attached over which the carer has no control. This can place carers in a very difficult situation where contact is seen to be onerous due to frequency, distance, potential conflict and the impact on the child. Carers have expressed the view that the parents' rights are prioritised over the child's rights in setting enforceable contact conditions.

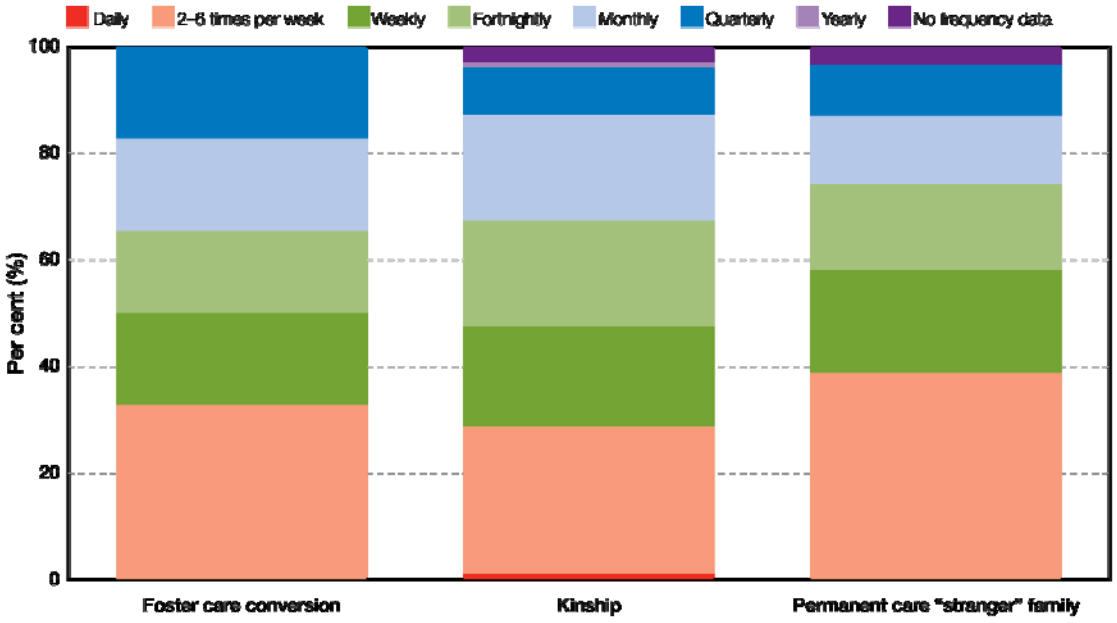
Graph 24 shows that frequency is clearly an obstacle to permanency in 313 (37.4%) out of 836 cases, and that it is generally more likely to be an obstacle the more frequent it is.

Graph 24: In contact an obstacle to permanency (by contact frequency)?



It might be thought that kinship carers would be better able to tolerate more frequent contact, because of their own kinship relationship with the child's parents. Graph 25 suggests that there is almost exactly the same tolerance of contact frequency by foster carers converting to permanent care as there is by kinship carers. Permanent cares who are "strangers" are shown in the graph as being proportionately more tolerant of frequent contact, but this may be because the child has yet to be placed or the permanent care order is yet to be made for these cases to be in scope.

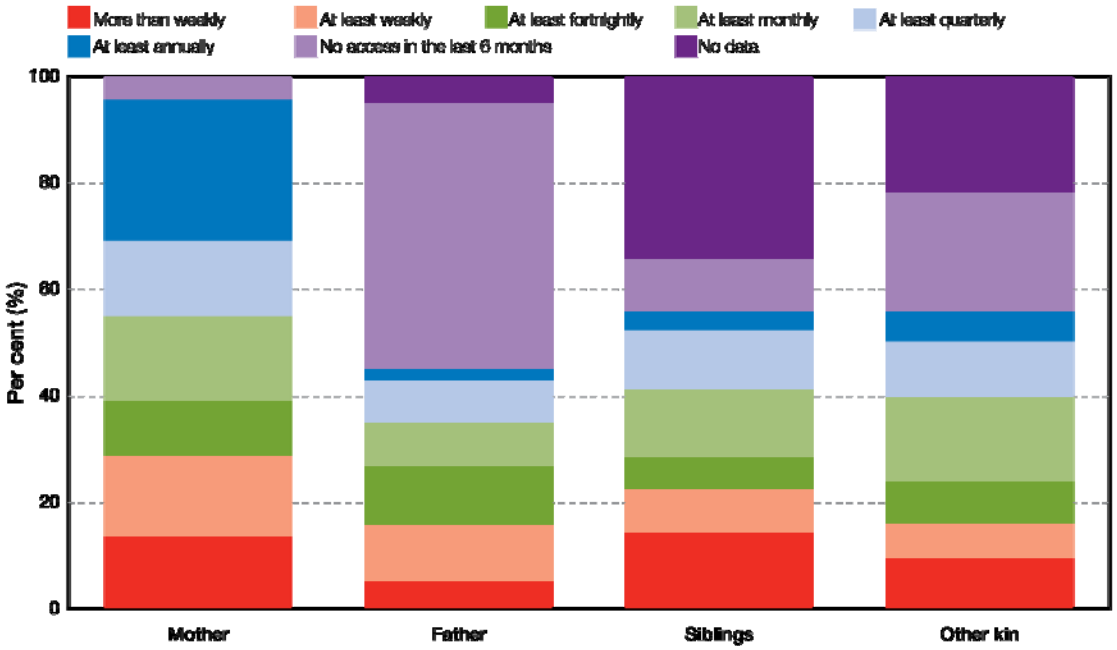
Graph 25: Where contact is an obstacle to permanency and the type of intended permanent care placement is known



The frequency of contact with mothers, fathers, siblings and other kin is shown in Graph 26. As can be seen, the frequency of contact is greatest with mothers, where nearly 70% of children had contact at least quarterly and nearly 30% at least weekly. This compares to 45% at least quarterly and 16% at least weekly for contact with fathers. Half of all fathers had had no contact at all in the previous 6 months, compared to 25% of mothers.

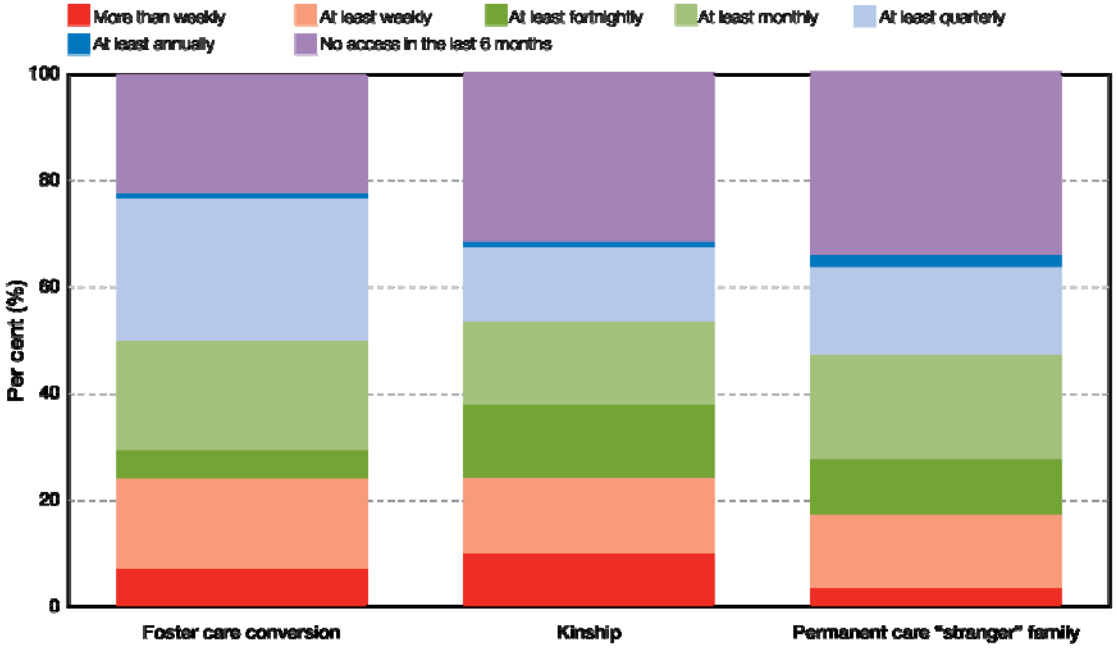
Contact with siblings and with other kin was more frequent than with fathers but less frequency than with mothers. The many cases where contact with siblings and other kin had not been recorded suggest that this is seen as less important. There was no data in 34% of cases about contact with siblings. The data refers to actual face to face meetings, and there is little information about other forms of contact that may be occurring (on-line, phone), some of which carers may be unaware of.

Graph 26: Contact frequency with family/kin



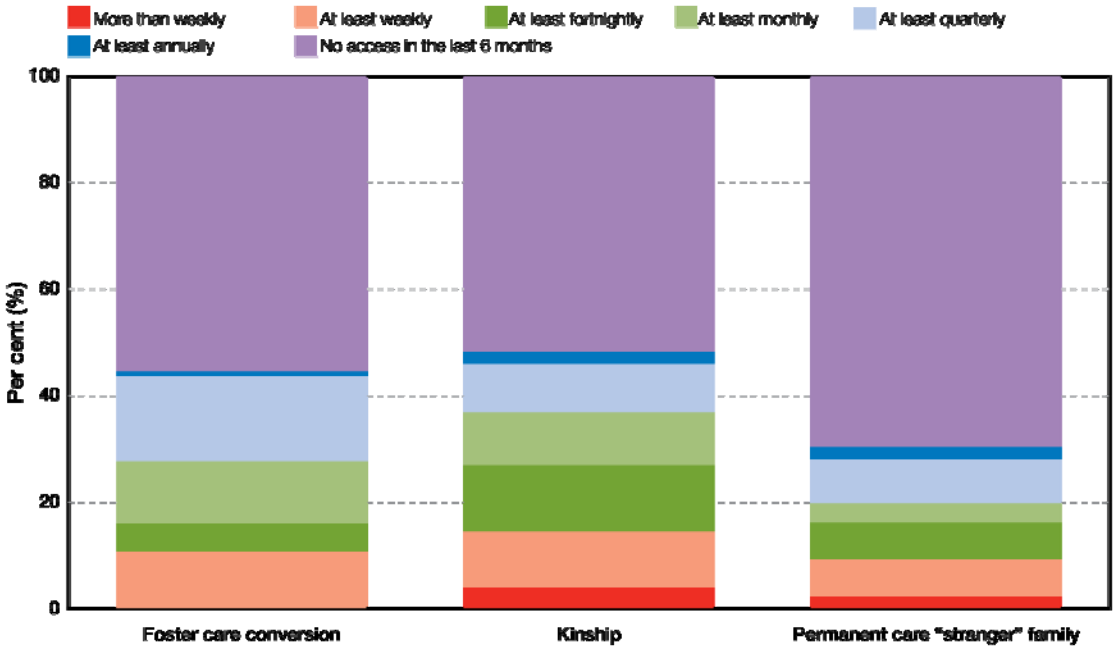
The frequency of the child's contact with their mother might be assumed to be more frequent where the child is in a kinship placement, but Graph 27 (which excludes cases with no data, as do the similar graphs on the next two pages) shows that this is not the case and that the greatest frequency of contact at least quarterly is where the child is on foster care (77%) rather than kinship care (65%).

Graph 27: Frequency of contact with mother by intended permanent care placement type (where known)



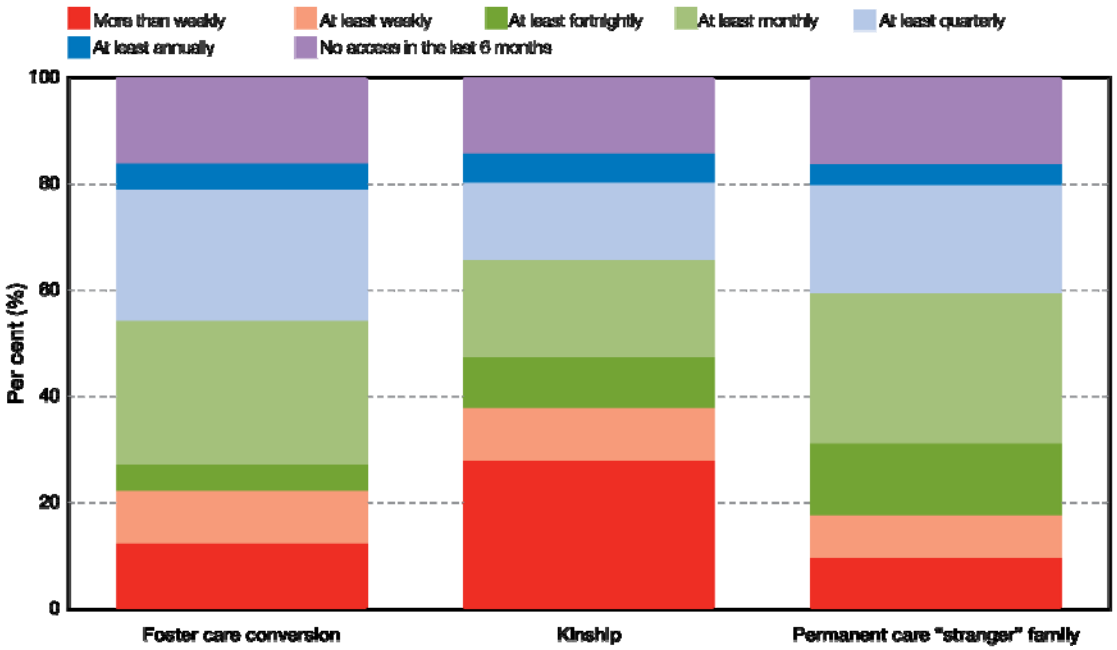
While fathers generally had less frequent contact than mothers, Graph 28 shows that – unlike mothers – the contact they had was slightly more frequent when the child was in a kinship placement.

Graph 28: Frequency of contact with father by intended permanent care placement type (where known)



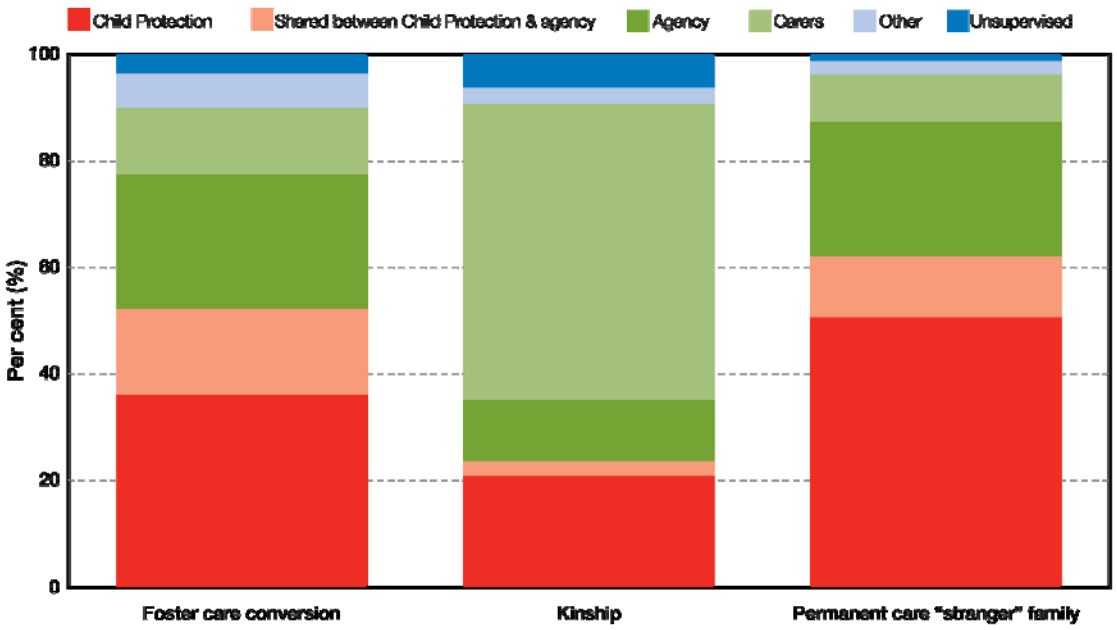
When it came to the frequency of contact between children in placements and their siblings (other than those they lived with), Graph 29 shows that where contact was occurring it was much more frequent where the child was in a kinship placement.

Graph 29: Frequency of contact with siblings by intended permanent care placement type (where known)



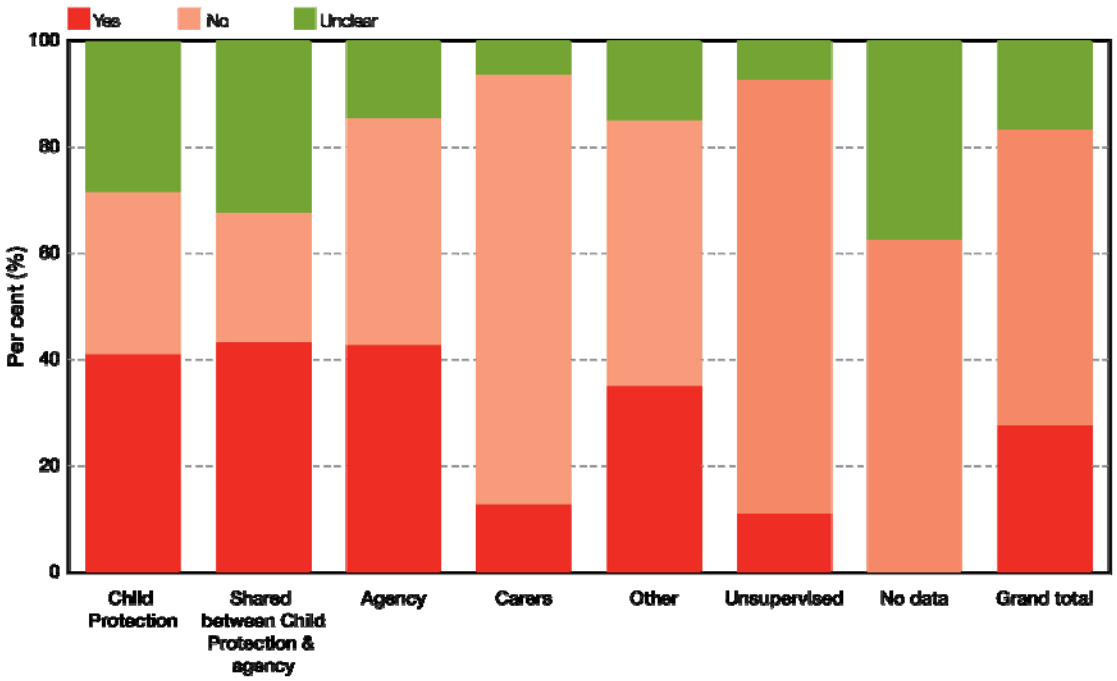
As might be expected, contact was supervised by the carer in most kinship care placements, while Child Protection supervised half of all contact in permanent care "stranger" placements – as shown in Graph 30. The responsibility was shared more evenly between Child Protection, agencies and carers where the child was in a foster placement planned for conversion to permanent care.

Graph 30: Who supervises contact by intended permanent care placement types (where known)?



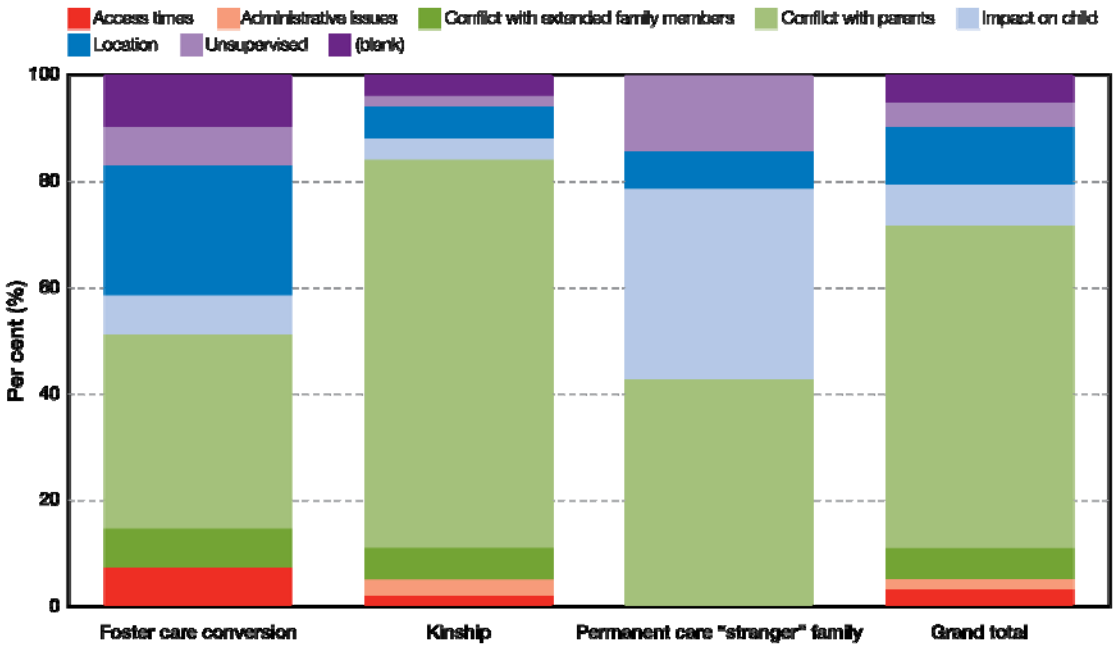
Graph 31 below shows what might be assumed as obvious: that where carers supervise contact, contact is less of a barrier to a permanent care order – although there are still 28 cases where it is a barrier even though carers supervise it.

Graph 31: Is contact a barrier to a permanent care order and who supervises contact?



Where the main reason for contact being a barrier in was correlated with the intended permanent care placement type, there were some interesting differences. Permanent care "strangers" expressed the most concern about the impact on the child, as well as being concerned about conflict with the child's birth parents. Kinship carers were primarily concerned about conflict with the child's birth parents (to whom they were closely related), while foster carers were also concerned about conflict with parents but more concerned than the others about the location of contact, which often referred to distance to be travelled.

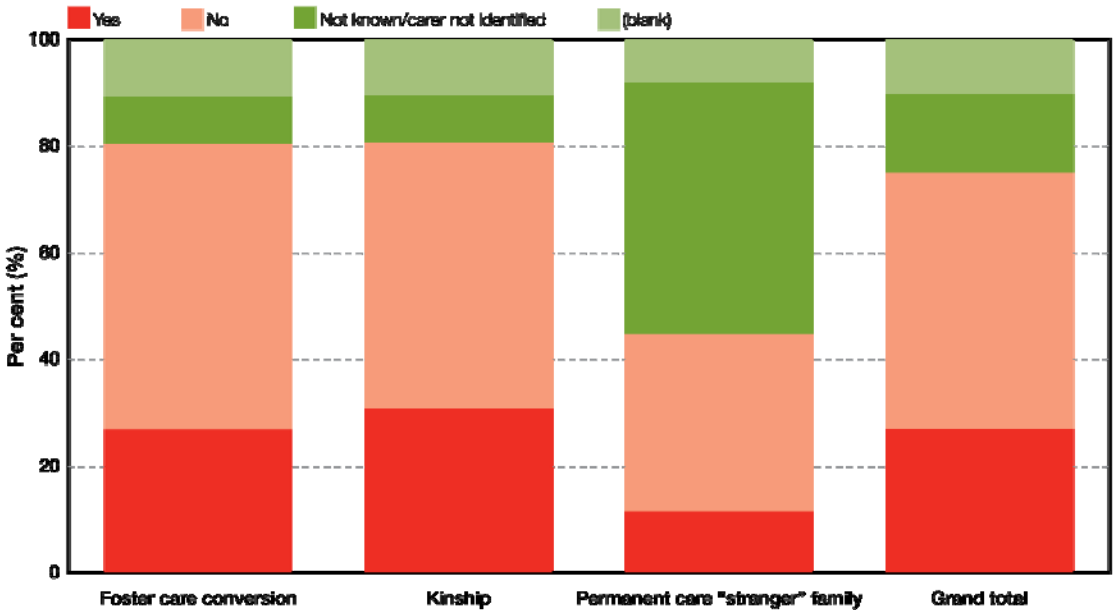
Graph 32: Main reason why contact is a barrier, by type of intended permanent care placement (where known)



17. Availability of services and supports.

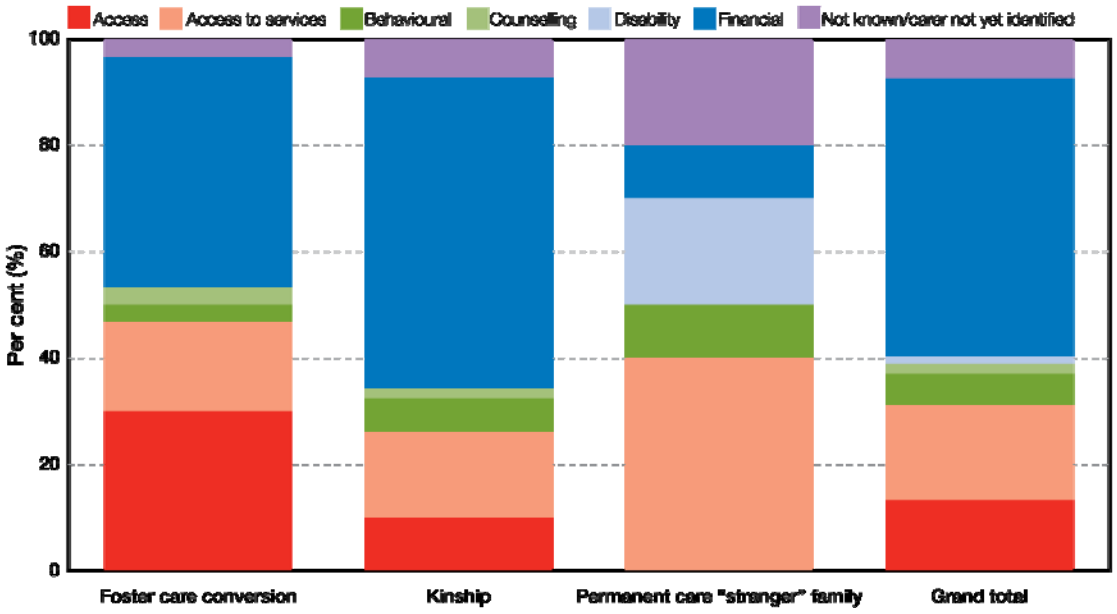
Foster carers and kinship carers had similar views the extent to which the availability of services and supports were an obstacle to seeking a permanent care order, with 27% of foster carers having that view and 31% of kinship carers having that view. The lower rate for permanent “stranger” carers resulted from the many cases where the carer had yet to be identified. When these cases were removed the proportion was 22%.

Graph 33: is the availability of supports a barrier to a Permanent Care Order, by type of intended permanent care placement (where known)?



The differences between different types of carer were noticeable. Foster carers appeared to be most concerned about lack of financial support and lack of support with contact arrangements. Kinship carers were mainly concerned about inadequate financial support. Permanent “stranger” carers were most concerned with access to services, particularly counselling (though the numbers of identified permanent “stranger” carers were small).

Graph 34: Kind of support or services that were lacking where this was a barrier to a Permanent Care Order



18. Aboriginal children.

Of the 836 children with a plan for long-term or permanent placement, and who were not already placed in an appropriate long-term or permanent placement, there were 235 who were identified as Aboriginal (Table 20, yellow highlight).

Table 20. Is the child Aboriginal?

	Reporting division				
Aboriginal/TS Islander?	East	North	South	West	VIC
No	106	152	157	186	601
Yes	26	108	65	36	235
All	132	260	222	222	836

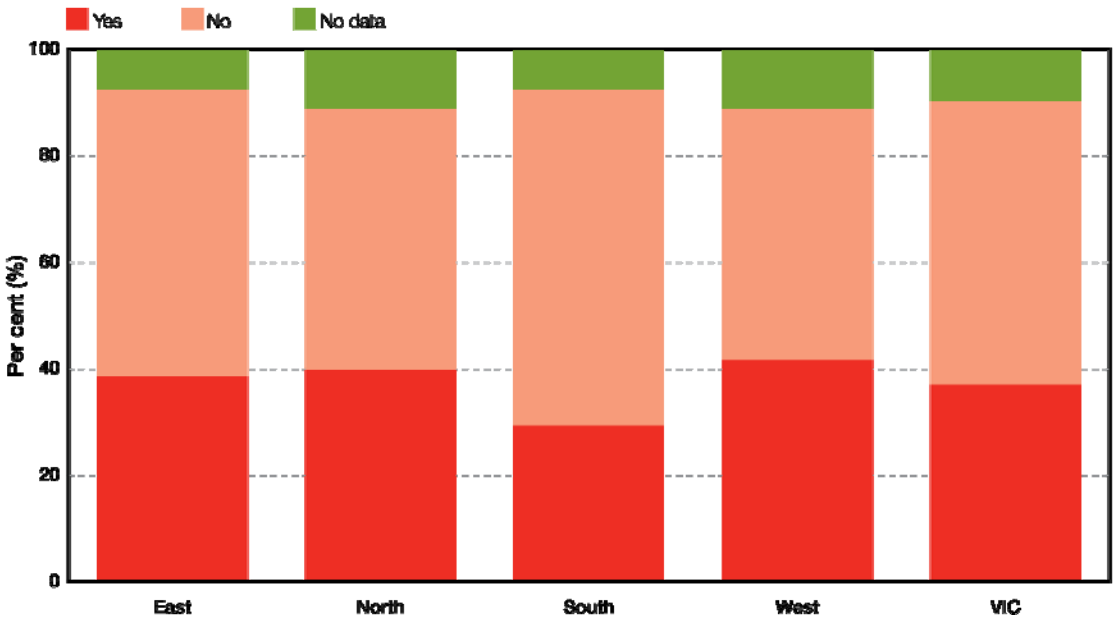
When asked whether the child's parents were Aboriginal, there were 85 children with both parents Aboriginal (Table 21, green highlight), 82 with an Aboriginal mother and non-Aboriginal father (blue), and 49 children with an Aboriginal father and non-Aboriginal mother (yellow). There were also some children where the parents' Aboriginal identity was not known.

Table 21. Aboriginal mother or father?

	Aboriginal father?			
Aboriginal mother?	Yes	No	No	All
Yes	85	67	15	**167**
No	48	359	17	**424**
No data/Not known	1	3	241	**245**
All	**134**	**429**	**273**	**836**

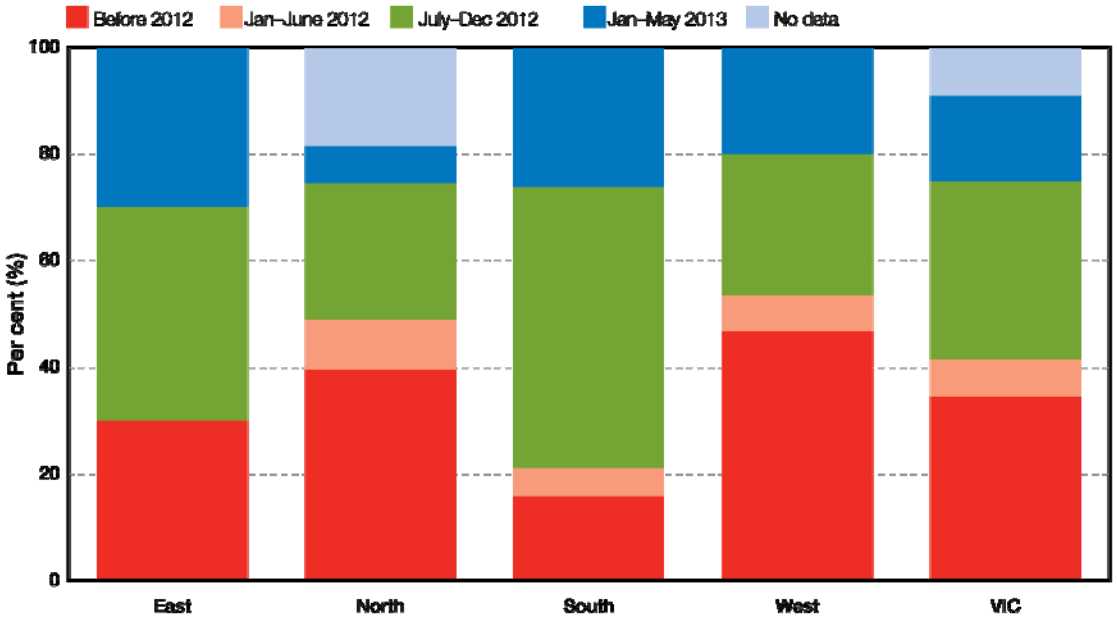
An Aboriginal Family-Led Decision Making (AFLDM) meeting had been held in respect of 87 (37%) of the 235 Aboriginal children in scope (Graph 35) at some time during Child Protection involvement. The range for divisions was between 29.2% (South) and 41.7% (West).

Graph 35: Has an Aboriginal Family-Led Decision Making (AFLDM) meeting been held?



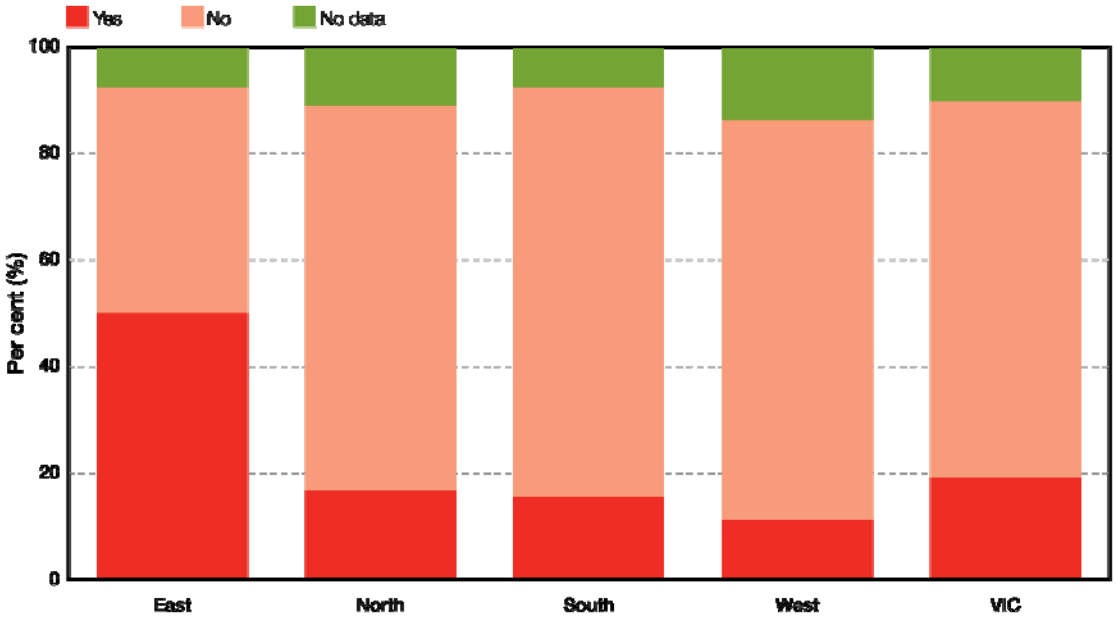
When asked how recently an AFLDM meeting had been held in the 87 cases where there had been one, the range was quite broad, with over 40% of the 87 AFLDMs having been held more than a year previously, as shown in Graph 36.

Graph 36: When was the last AFLDM held?



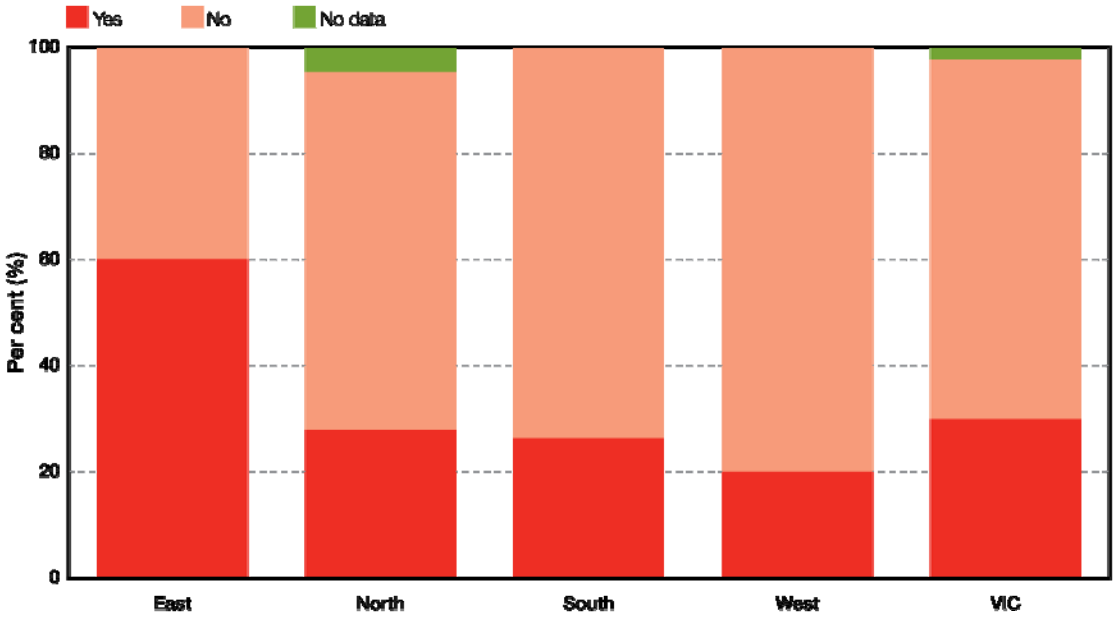
A cultural support plan (CSP) had been prepared in only 45 (19.1%) of the 235 cases. While East division had completed CSPs in 50% of their cases, the rate in the other three divisions was between 0% and 16%.

Graph 37: Had a Cultural Support Plan been prepared?



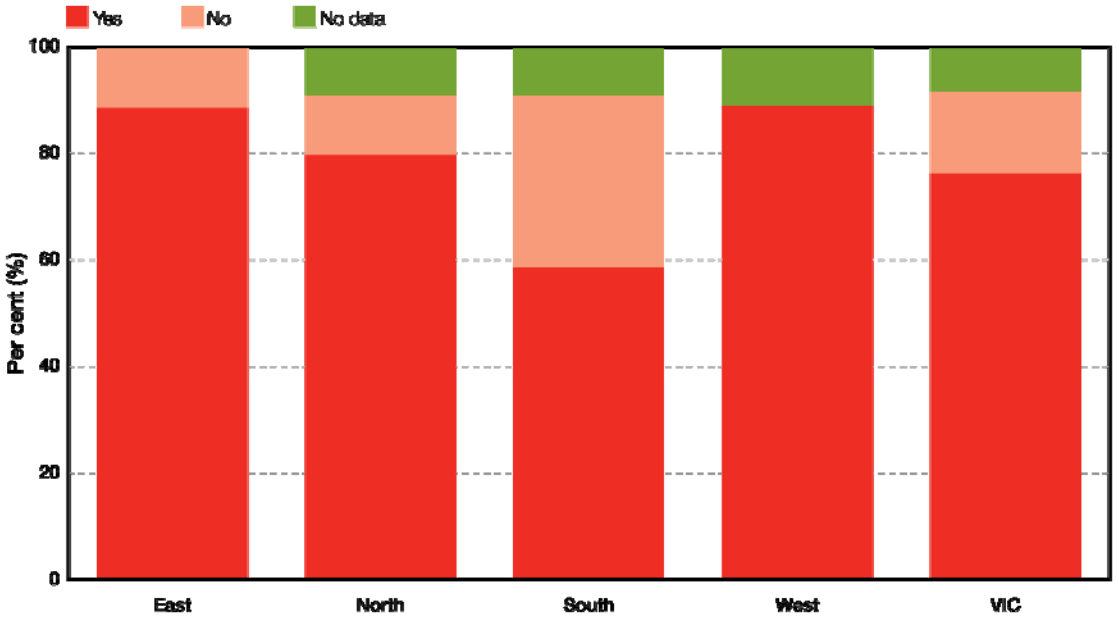
Graph 38 shows whether the 87 cases that had had an AFLDM meeting also had a cultural support plan. Where an AFLDM meeting had been held there was a small improvement in the proportion of cases with a CSP. The statewide rate improved from the 19.1% seen in Graph 37 to 29.9%.

Graph 38: Cultural Support Plans prepared where that had been AFLDM



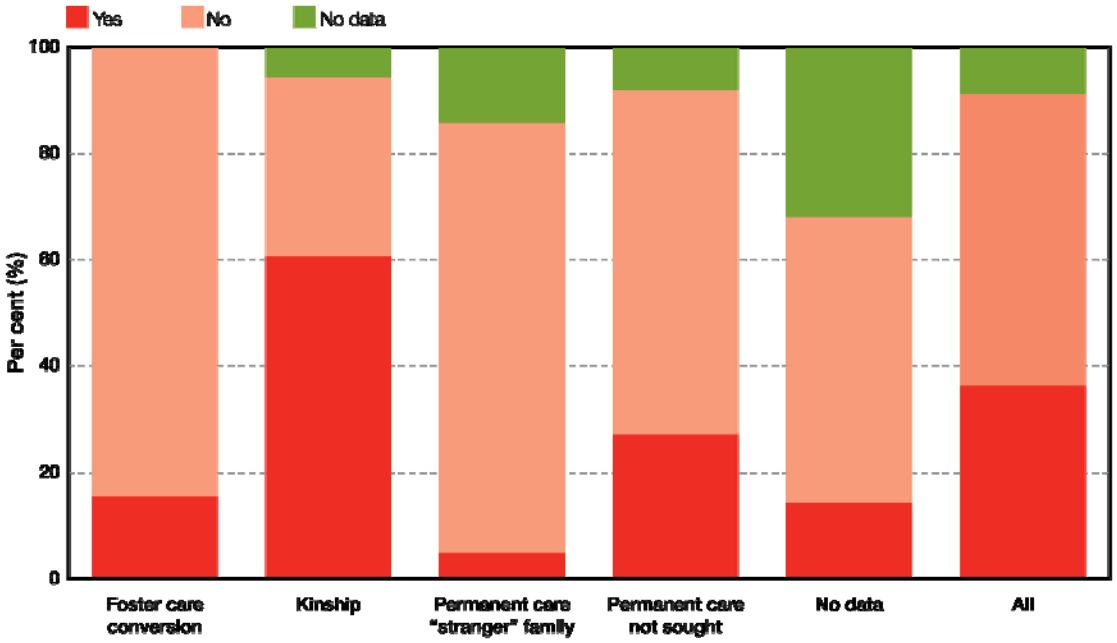
There was a much higher level of compliance with the requirement to consult with ACSASS, which had occurred in 179 (76.2%) of the 235 cases (Graph 39). Compliance was especially high in West and East divisions.

Graph 39: Had a consultation with ACSASS occurred?



Of the 235 Aboriginal children in this cohort, 85 (36.2%) were placed with an Aboriginal primary carer. Where the child was in a kinship placement, the rate was 60.6% (Graph 40)

Graph 40: Is the child's primary carer Aboriginal?



PART D – primary reason for delays in stability planning and permanency resolution.

Having completed the survey, the project workers were asked to reflect back on the questions and identify the issue that was contributing the most to delays in stability planning and permanency resolution.

The primary issues identified in relation to the 835 children in scope in Part C of this paper are grouped together in Table 22 below.

Table 22.

Primary reason for delay in stability planning and permanency resolution	cases
Availability of potential permanent carer	122
Potential permanent carer but barriers (contact, finance, services etc) prevent PCO	69
Potential permanent kinship parents not assessed yet	56
Contact issues	50
Delays in case planning and case plan implementation caused by court contests	45
Case reviews	32
Inappropriate reunification case plan	28
Child has significant behavioural issues	20
Case plan does not support permanency resolution	20
Delays in case planning (other than court)	19
Current carers not endorsed for permanent care	17
Numerous changes of placement	14
Lack of parental consent	14
No stability plan	13
No current case plan	13
Child's special needs (physical or mental health, disabilities)	12
Potential permanent foster parents not assessed yet for conversion	11
No (recent) AFLDM meeting held	11
Changes of allocated worker	10
Stabiility plan prepared outside statutory timelines	8
Sibling group size	7
Aboriginal child and application of Aboriginal Child Placement Principle	6
Inappropriate long-term OOHC placement	6
Case not currently allocated	4
Inappropriate protection order	4
referral to VACCA's permanent care program: waiting times	4
Lack of Cultural Support Plan	3
Lack of Family Group Conference	2
No established care team	2
Other	12
Total	**634**

NB – the red marks in the table above are not significant.

Project team workers were also asked about secondary and tertiary barriers. To a large extent, the grouped categories in the table incorporate the combinations of primary, secondary and tertiary causes of delay that were found.

As can be seen, the most important factor contributing to delays was the lack of available permanent carers (122 children). This was followed by carers needing additional support to consider a Permanent Care Order (69 children) and delays in assessments (56 cases). Contact issues and court contests (which are often largely or partly about contact issues) came next with 50 and 45 cases.

The next few categories refer to case planning and case review related delays, and these are followed by a long list of other less frequent issues.

Section	Item no.	Data item
Client Details	1	CRIS Client ID
	2	Location of child's placement
	3	Location of primary case management team
	4	Child's first name
	5	Child's family name
	6	Date of birth
	7	Sex
	8	Is the child Aboriginal or Torres Strait Islander?
	9	Child's country of birth
	10	Main language spoken by primary birth parent
	11	Date current episode of care commenced?
	12	What order is the child currently subject to?
	13	How many siblings in out of home care does the child have? (full and half siblings)
	14	How many siblings in out of home care does the child live with?
	15	Is the intention to place the child with siblings in out of home care who they are not already placed with?
	16	If the child is under 6 years, has Early Childhood Intervention Service (ECIS) or an ECIS service provider assessed the child as having a developmental delay?
	17	If the child is 6 years or over, have they been assessed as having an intellectual disability through the disability support target group process?
	18	If the child is 6 years or over have they been assessed as being in the disability service target group but do not have an intellectual disability?
	19	Does the child have complex physical health needs?
	20	Does the child have mental health issues?
	21	Does the child have significant behavioural issues?
	22	Does the child have educational performance or attendance issues affecting placement stability?
	23	If items 16 to 22 are relevant, which one impacts or is likely to impact on achieving permanency?
Placement Data	24	Total time of all episodes of care in months
	25	How many out of home care placements have there been in the child's life (including voluntary placements more than 1 month)?
	26	How many placement breakdowns has the child experienced?
	27	Current placement type
Case Planning	28	Is there evidence of a current statutory case plan?
	29	What is the date of the current case plan?
	30	If there is no case plan, is the case plan overdue?
	31	If there are delays in case planning, please specify the main reason.
	32	What is the case plan?
	33	If there is a reunification case plan is it appropriate?
	34	How many reunification attempts have there been?
	35	Has a family group conference occurred in the last 12 months?
	36	If there is a long-term out of home care plan is it appropriate?
	37	If yes, specify why the long-term out of home care plan is appropriate?
	38	Is the long-term out of home care placement appropriate?

Section	Item no.	Data item
	39	Is there a stability plan recorded on the file?
	40	If there is a stability plan was it completed within the timelines in the legislation?
	41	What type of permanent care placement is being sought?
Assessment and Decision Making	42	If child is in a kinship placement, has a Part A and B assessment been completed?
	43	If the child is placed with kith/kin have carers been assessed to provide permanent care?
	44	If the child is placed in foster care, has the carer been assessed to provide permanent care (ie conversion)?
	45	If the foster carer was assessed as not appropriate please specify the reason.
	46	For children with a permanent care case plan, has an assessment of identified extended family been undertaken?
	47	Have permanent carers been identified to provide permanent care?
	48	If there is a permanent care plan, has consultation occurred with the Permanent Care and Adoption Team?
	49	Are the child's current carers endorsed as the child's long-term or permanent carers?
	50	If a permanent carer(s) has not yet been endorsed, what is the primary reason?
	51	If current carers are not endorsed as permanent or long-term of home carers, has a referral been made to the permanent care program?
	52	If a referral has been made to the permanent care program, how many months has the child been on the waiting list?
Allocation and Support	53	Is the case currently allocated?
	54	How many allocated child protection or contracted agency workers has the child had during this episode of care?
	55	If the case is unallocated to child protection or contracted, how long has it been unallocated for in months?
	56	Other than the allocated or contracted worker, is the child receiving additional support?
	57	Are there types of support that are required but the child is not receiving?
	58	Is there a constituted care team?
	59	On average, how frequently has the care team met during this episode of care?
	60	Is there evidence of case reviews occurring at least once a year and or at critical intervals?
Internal Review and Courts	61	Has an internal review been held in regard to this child?
	62	Did the review outcome impact implementation of the permanency plan?
	63	Are the order and conditions able to support a permanent care case plan?
	64	Was the order made with the consent of one or both of the child's biological parents?
	65	If the child is subject to a final order, how long in months was an IAO in place before the final order was made?
	66	If a child is subject to a permanent care case plan and placed with permanent carers, has an application for a permanent care order been made?
	67	If yes, when is the permanent care order to be heard in months?
	68	If an application for a permanent care order has been made is it being contested?
	69	If the child is with an endorsed permanent carer and an application for a permanent care order hasn't been made what is the primary reason?
Achieving Permanency	70	Do the current nature and/or frequency of parental or other contact create an obstacle to stability planning and permanency resolution?
	71	How frequently is the child required to have contact with others in total?
	72	How frequently does the child have contact with his/her father?
	73	How frequently does the child have contact with his/her mother?
	74	How frequently does the child have contact with his/her sibling's?

Section	Item no.	Data item
	75	How frequently does the child have contact with his/her other kith and kin?
	76	Who supervises contact?
	77	How many of the supervised contacts in total are supervised by the carer?
	78	Is the carer managing contact a barrier to a permanent care order?
	79	If the carer managing contact is a barrier, please specify the primary reason.
	80	If the carer managing contact is an issue, please specify the second issue
	81	Is the availability of additional support a barrier to a permanent care order?
	82	If the availability of additional support is a barrier, what is the primary support the carer feels they personally lack?
	83	If the availability of additional support is a barrier what is the second support the carer feels they lack?
	84	If the availability of additional support to the child is a barrier, what is the primary support the carer feels the child lacks?
	85	If the availability of additional support to the child is a barrier, what is the second support the carer feels the child lacks?
	86	For children placed with permanent carers, what is the primary barrier to seeking a permanent care order?
Aboriginal Children (additional questions)	87	Does the child have an Aboriginal mother?
	88	Does the child have an Aboriginal father?
	89	Where does the child's mother live?
	90	Where does the child's father live?
	91	Has an Aboriginal family decision making conference occurred?
	92	When did the most recent Aboriginal family decision making conference occur?
	93	Has a cultural support plan been prepared?
	94	When was the cultural support plan completed?
	95	Is there evidence of appropriate consultation with ACSASS during this episode of care?
	96	Are one or more of the current primary carers an Aboriginal person?
	97	Has there been a referral to VACCA's permanent care program?
	98	Has the Aboriginal family been involved in the case planning process?
Ranking	99	Considering the age of the child and the stability provisions in the legislation, have there been issues that have impacted on achieving stability and permanency within an appropriate timeframe?
	100	If there was an issue, which one was the most important?
	101	If there was an issue, which one was the second most important?
	102	If there was an issue, which one was the third most important?
	103	If there were no issues that affected stability and permanency, what contributed most to achieving stability and permanency?
Case Study	104	Should this be written up as a case study to illustrate issue or good practice?
	105	Should this be written up as a case study?