



INCA CONSULTING

**A national comparison of carer screening,
assessment, selection and training and
support in foster, kinship and residential
care**

Research project 4.10

Final Report

Project team

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PREFACE

On Friday, 11 January 2013, the Governor-General appointed a six-member Royal Commission to inquire into how institutions with a responsibility for children have managed and responded to allegations and instances of child sexual abuse.

The Royal Commission is tasked with investigating where systems have failed to protect children, and making recommendations on how to improve laws, policies and practices to prevent and better respond to child sexual abuse in institutions.

The Royal Commission has developed a comprehensive research program to support its work and to inform its findings and recommendations. The program focuses on eight themes:

1. Why does child sexual abuse occur in institutions?
2. How can child sexual abuse in institutions be prevented?
3. How can child sexual abuse be better identified?
4. How should institutions respond where child sexual abuse has occurred?
5. How should government and statutory authorities respond?
6. What are the treatment and support needs of victims/survivors and their families?
7. What is the history of particular institutions of interest?
8. How do we ensure the Royal Commission has a positive impact?

This research report falls within theme four. The research program means the Royal Commission can:

- € obtain relevant background information
- € fill key evidence gaps
- € explore what is known and what works
- € develop recommendations that are informed by evidence, can be implemented and respond to contemporary issues.

For more on this program, please visit:

www.childabuseroyalcommission.gov.au/research.

EXECUTIVE SUMMARY

Introduction and objectives

In June 2015, the Royal Commission into Institutional Responses to Child Sexual Abuse conducted public hearings in relation to out of home care (OOHC) and allegations of child sexual abuse occurring in OOHC settings (Case Study 24). In December 2015, the Royal Commission commissioned national research to answer the following questions:

- € What policies and processes does each state or territory government have in place for carer screening, assessment, selection, training and support to prevent or respond effectively to child sexual abuse in foster care, kinship care and residential care settings?
- € What policies and processes do non-government (NGO) providers of OOHC services have in place for carer screening, assessment, selection, training and support to prevent or respond effectively to child sexual abuse in foster care, kinship care and residential care settings?
- € What are the factors that help facilitate the implementation of these policies and processes to prevent or respond effectively to child sexual abuse in foster care, kinship care and residential care settings?
- € What are the barriers to the implementation of these policies and processes to prevent or respond effectively to child sexual abuse in foster care, kinship care and residential care settings?

Methodology

The research entailed:

- € a review of documentation including, but not limited to, submissions to the Royal Commission in response to the questions asked under Case Study 24
- € interviews and small group discussions with representatives of relevant state and territory government agencies
- € interviews and small group discussions with representatives of non-government providers of OOHC services
- € interviews and small group discussions with representatives of relevant peak organisations, training organisations and researchers.

Summary of findings

The research highlighted the variability across jurisdictions in terms of some key contextual factors:

- € the mix and balance of government and NGO service provision across the various care types

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- € the range and mix of care models, including semi-professionalised or paid carer models, different therapeutic care models, and wraparound care arrangements
 - € the degree to which there are legislated or stipulated requirements for the tools and frameworks for assessing carers and the training provided to carers
 - € the arrangements for monitoring, oversight and accountability in relation to OOHC service provision and adherence to standards relating to carer assessment, training and support
 - € the challenges of providing training and support to a dispersed carer population, including many in rural and remote areas
 - € the status of current reforms and practice improvements relating to the protection of children and young people in care.

It was clear from the review of documents and interviews with key informants that government and non-government agencies pay significant attention to the issue of child sexual abuse in OOHC. Through legislation and/or policy provisions for carer screening, assessment, training and support for carers, clear efforts are made to ensure that children and young people are safe from sexual abuse and that the trauma they have suffered due to prior abuse is addressed through the care they receive. Moreover, recent systemic improvements are designed to provide stronger protections and better meet the needs of children and young people in care. There is a strong current focus on developing trauma-informed care models, though this is clearly an area under development. Some jurisdictions also focus on providing kinship carers with training and appropriate support, which have historically been lacking.

The carer screening processes, including probity checks, generally have a statutory basis. OOHC providers must conduct a National Police Check, Working With Children Check and referee checks of all OOHC carers. In some jurisdictions, the screening process is significantly strengthened through mandatory reference to a carers register and data held by child protection agencies and other OOHC providers.

Further assessment of potential carers is more strongly guided and overseen by some jurisdictions than others. A number of widely used frameworks for carer assessment and pre-authorisation training include reference to the issue of sexual abuse of young people in care. Some informants believed that a number of emerging tools provide a deeper and more rigorous assessment, and better preparation for the provision of trauma-informed care. Carer assessments are performed by different people in different jurisdictions, including commercial subcontractors in some instances. Some informants called for the accreditation of training in the processes of carer assessment.

Difficulties in attracting and retaining foster carers, a limited pool of residential care workers and high staff turnover were noted as barriers to meeting the demand for OOHC placements and providing high-quality care that helps to prevent child sexual abuse. A

number of informants noted that it was incumbent on agencies to implement carer recruitment strategies to achieve stable and sustainable placements. Informants also said agencies should provide a work environment (for foster carers and/or residential care workers) that supported their professional development and helped them cope with the psychological demands of their work.

It was clear that the assessment of kinship carers (beyond basic probity checks) was generally less rigorous than for foster carers due to a policy-based assumption about the relative safety and wellbeing of children being cared for by kin. In particular, the concerning practice of renewing the 'emergency care' designation of kinship placements in lieu of a full and proper assessment was often seen as a risk factor. Practices in this regard seemed to be improving, particularly as kinship care placements are transitioned to the non-government sector.

There have been some promising developments in terms of the assessment tools, training and support available to carers of Aboriginal and Torres Strait Islander children and young people. However, informants generally reported a paucity of culturally appropriate training materials addressing child sexual abuse, and under-use of currently available materials.

In terms of the availability of training for carers, many organisations offer training in the prevention of child sexual abuse, providing child safe environments, reporting abuse, managing disclosures, dealing with problematic sexual behaviours and providing care for traumatised children. A large array of suitable training products is available for residential care workers, foster carers and kinship carers, though informants reported more materials tailored to the needs of kinship carers would be of benefit.

Government agencies, NGOs, peak organisations and specialist training organisations provide ongoing training and learning materials through various channels and in a variety of formats. However, the uptake of training can be affected by such things as the lack of encouragement to attend, inability to attend due to location, lack of time and transport issues. Some agencies address these barriers by establishing clear attendance expectations for carers, providing alternative attendance modes (for example, self-paced learning or video conference) and offering childcare and other practical support. There was also a reported effort to treat carers more professionally and to support their professional development through training. Informants suggested that greater recognition of the training would be beneficial, including recognition as formal training that can contribute to a qualification.

Informants widely acknowledged that where kinship care placement support, in particular, was provided by government, there was a lack of attention to the needs of carers, including Aboriginal and Torres Strait Islander kinship carers. Informants generally agreed that the needs of children in kinship care could be as significant as those in foster care and that, if anything, the support needs of kinship carers could be greater than those of foster carers.

In short, many informants saw a degree of risk (of the occurrence of child sexual abuse) in the policies and practices of their jurisdictions in relation to kinship care.

Some training and learning material on the dynamics of the sexual exploitation of young people in care is available to agency staff and residential care workers, though it is clear that more emphasis should be given to this topic, particularly for foster and kinship carers. It is noteworthy that the issue of the sexual exploitation of young people in residential care has been given significant recent attention through training in some jurisdictions. Other jurisdictions have been working at a systemic level to better coordinate responses by child protection agencies and the police.

As OOHC placements have transitioned to the non-government sector, there has been greater emphasis on ensuring carers receive the support they need to provide a quality care environment and meet the high support needs of children and young people. Providers spoke of the effort to move towards a ‘partners in care’ culture that puts the needs of the young person at the centre of all decision-making.

LIST OF ACRONYMS

ACF	Australian Childhood Foundation
ACT	Australian Capital Territory
ACWA	Association of Children’s Welfare Agencies
COAG	Council of Australian Governments
CCWT	Centre for Community Welfare Training
CSO	Community Service Organisation
CSS	Community Service Sector (WA)
CYS	Children and Youth Services (Tasmania)
CYPS	Child and Youth Protection Services (ACT)
DCP	Department for Child Protection (WA)
DCF	Department of Children and Families (NT)
DECD	Department for Education and Child Development (SA)
DHHS	Department of Health and Human Services (Victoria)
FCA	Foster Care Association (NT)
FACS	Department of Family and Community Services (NSW)
JIRT	Joint Investigation Response Team (NSW)
NGO	Non-government organisation
NSW	New South Wales
NT	Northern Territory
OCG	Office of the Children’s Guardian (NSW)
OOHC	Out-of-home care
OPG	Office of the Public Guardian (Qld)
OSP	Office of the Senior Practitioner (NSW)
SA	South Australia
VACCA	Victorian Aboriginal Childcare Agency
WA	Western Australia

1. INTRODUCTION

Background

The Royal Commission into Institutional Responses to Child Sexual Abuse is undertaking a comprehensive research program to support its work and address the Terms of Reference. The research is examining various aspects of prevention, reporting and responding to allegations of child sexual abuse as well as support and redress.

In June 2015, the Royal Commission conducted public hearings in relation to out of home care (OOHC) and allegations of child sexual abuse occurring in OOHC settings. At 30 June 2014, there were 43,009 children in Australia's OOHC system¹, including statutory foster care and kinship care, and a small but growing number in residential care. The Royal Commission heard from a range of institutional informants as well as individuals – some of whom had lived in OOHC – about a number of issues that increase the likelihood of sexual abuse in OOHC, and decrease the likelihood of an appropriate response where abuse occurs. Submissions were made by all state and territory governments and many NGOs. These submissions and the hearing transcripts are publicly available on the Royal Commission's website under Case Study 24: <http://www.childabuseroyalcommission.gov.au/public-hearings/case-studies>.

Children in OOHC are vulnerable to sexual victimisation due to a range of factors including previous sexual and other victimisation, social and economic deprivation, and family dysfunction.² It is critical that safeguards are in place to protect children from sexual abuse in OOHC and that agencies, staff and carers respond effectively to concerns or allegations of child sexual abuse. Carer screening and assessment, as well as ongoing monitoring, training and support, is fundamental to protecting children from abuse. However, data gathered in preparation for the Royal Commission's OOHC public hearings suggested that processes for screening, assessing, monitoring, training and supporting carers differ markedly across care types, jurisdictions and providers.

Study terms of reference

In December 2015, the Royal Commission commissioned national research to answer the following questions designed to help formulate its report and recommendations:

- € What policies and processes does each state and territory government have in place for carer screening, assessment, selection, training and support to prevent

¹ Productivity Commission (2015). Report on Government Services: 'Child protection'. Australian Government, Canberra.

² Australian Institute of Health and Welfare (2013). Child Protection Australia: Child Welfare Series (Vol. 55), Australian Institute of Health and Welfare, Canberra.

or respond effectively to child sexual abuse in foster care, kinship care and residential care settings?

- € What policies and processes do non-government providers of out of home care services have in place for carer screening, assessment, selection, training and support to prevent or respond effectively to child sexual abuse in foster care, kinship care and residential care settings?
- € What factors help facilitate the implementation of these policies and processes to prevent or respond effectively to child sexual abuse in foster care, kinship care and residential care settings?
- € What are the barriers to implementation of these policies and processes to prevent or respond effectively to child sexual abuse in foster care, kinship care and residential care settings?

In answering these questions, the research was to explore whether there are specific considerations in the implementation of these policies in the different forms of OOHC (residential, foster and kinship), and among different groups of children (for example, Aboriginal and Torres Strait Islander children, children with a disability, or children from culturally and linguistically diverse backgrounds). The research was to consider forms of statutory OOHC only (that is, it did not include consideration of voluntary OOHC).

The Royal Commission further refined the scope of the research to pay particular attention to the following areas of interest, identifying where possible any evidence of best practice:

- € support of Aboriginal and Torres Strait Islander kinship carers
- € training of carers, including qualifications and the professionalisation of foster carers
- € child sexual exploitation – particularly determining the extent to which it is a focus of carer assessment, training and support
- € therapeutic care – particularly determining the extent to which it involves trauma-informed care, and the barriers and facilitators to implementation.

Acknowledgements and study limitations

This research project had clear terms of reference (as set out in section 1.2) that established some boundaries for areas of inquiry. The project is but one component of the Royal Commission's exploration of the issue of child sexual abuse in OOHC in Australia. Notably, it did not draw directly on the voices of children or care leavers who have been victims of sexual abuse, or on the voice of carers. The Royal Commission has commissioned other research projects and undertaken public and private hearings that examine additional facets of the issue of child sexual abuse in OOHC, including hearing the accounts of the survivors of sexual abuse. When published, further research can be found at:

<http://www.childabuseroyalcommission.gov.au/policy-and-research/our-research/published-research>

The scope of the project did not allow for a review of Australian or overseas literature. Rather, the study relied on policy documentation, state and territory responses to the issues to be examined under Case Study 24 and in-depth interviews with government representatives, NGOs and peak organisations. It is acknowledged that the body of existing literature provides further insight into the screening, assessment, training and support of out-of-home carers and could be usefully considered in conjunction with this report.

It should be acknowledged that important features of the OOHC sectors in each state and territory contribute to a child sexual abuse prevention and response framework, beyond carer screening and assessment, training and support. Examples include policies and practices relating to the reporting of sexual abuse and the handling of allegations and disclosures, case management of OOHC placements, placement decision-making, placement monitoring, and transition to other forms of care. It is further acknowledged that there are not always clear distinctions between these components of the OOHC 'system' – carer support is a key component of the case management role, for example. In order to contain this report to the Terms of Reference, a conscious effort has been made to limit the discussion to *carer screening and assessment, training and support*.

The research set out to examine *current* policies and practices that work to prevent and respond to child sexual abuse in OOHC. The research *did not* explore the effectiveness of existing policies and practices or the adequacies or failings of past policies and practices. To reiterate, the study sought to describe policies and practices for carer screening, assessment, training and support, and the barriers to, and enablers of, the implementation of these policies and practices. It should also be noted that the findings represent a point in time, and very recent or newly planned reforms may not be reflected in the information presented.

There is significant complexity in the OOHC systems across Australia and in the issues of relevance to the prevention of, and response to, child sexual abuse. The authors have relied on the expert opinion of many people across the sector and a large volume of documentation. This report is intended to be comprehensive and accurate, but it does not necessarily provide an exhaustive discussion of every relevant issue.

The research was based on interviews with a relatively small number of willing participants, particular NGO providers of OOHC services. It should be noted that some NGOs declined to participate in the research and others did not respond to the invitation to participate. It is possible that the descriptions provided of current practices with regard to carer screening, assessment, training and support represent reasonably good policy

Conversely, it is possible that a degree of substandard practice was not unearthed through this research.

Section 3 of this report sets out the operating context of the OOHC sector in each state and territory. It was not the intention of the study to compare or weigh up the strengths and weaknesses of approach in each jurisdiction. A national perspective was taken but it is important that the different state and territory contexts are explained.

Definitions

Out-of-home care

The legal definition of out of home care (OOHC) varies across jurisdictions in Australia, and generally includes both voluntary and statutory care. This report examines only statutory care, defined as care provided to children away from their parents and pursuant to a court order, due to concern that the child is at risk of significant harm. This study examines the following care types:

- € foster care, which refers to the placement of a child in a family setting with non-related carers
- € statutory kinship care (also known as relative care or family care), which refers to the court-ordered placement of a child in the care of relatives.
- € residential care, which refers to care provided in a community-based setting by paid direct-care staff.

Aboriginal and Torres Strait Islander children must be placed in accordance with the Aboriginal and Torres Strait Islander Placement Principle. The principle states the *preferred* order of placement for an Aboriginal and Torres Strait Islander child who has been removed from their birth family. The preferred order is for the child to be placed with:

- € the child's extended family (kin)
- € the child's Aboriginal and Torres Strait Islander community (kith)
- € other Aboriginal and Torres Strait Islander people.

Child sexual abuse

Having regard to the Terms of Reference, the Royal Commission has adopted a working definition of child sexual abuse that includes instances of abuse perpetrated by an adult and those perpetrated by another child:

Any act which exposes a child to, or involves a child in, sexual processes beyond his or her understanding or contrary to accepted standards. Sexually abusive behaviours can include the fondling of genitals, masturbation, oral sex, vaginal or anal penetration by a penis, finger or any other object, fondling of breasts, voyeurism, exhibitionism and exposing the child to or involving the child in pornography (Bromfield, 2005). It

includes child grooming which refers to actions deliberately undertaken with the aim of befriending and establishing an emotional connection with a child to lower the child's inhibitions in preparation for sexual activity with the child.

Institution

The Terms of Reference of the Royal Commission define an institution as:

Any public or private body, agency, association, club, institution or other entity or group of entities of any kind (whether incorporated or unincorporated) and however described and includes for example an entity or group of entities (including an entity or groups of entities that no longer exists) that provides or has at any time provided activities, facilities, programs or services of any kind that provide the means through which adults have contact with children including through their families and does not include the family.

Child sexual abuse is deemed to have occurred in an institutional context if the abuse occurs on the premises of an institution, where activities of an institution take place, or in connection with the activities of an institution; or it is engaged in by an official of an institution in circumstances (including circumstances involving settings not directly controlled by the institution) where the institution has, or its activities have, created, facilitated, increased or in any way contributed to (whether by act or omission) the risk of child sexual abuse or the circumstances or conditions giving rise to that risk; or it happens in any other circumstances where an institution is, or should be treated as being, responsible for adults having contact with children.

2. METHODOLOGY

This section describes the methods used to conduct the research.

Ethics approval

In accordance with the National Statement on Ethical Conduct in Human Research, an application for non-ethics committee review of a low-risk research project was submitted to the Royal Commission and independently reviewed.. Approval was given for the project on 17 March 2016. The ethics approval pertained to research to be undertaken with representatives of NGOs (but not to research with representatives of state and territory governments). A participant information sheet and consent form were developed for the purposes of obtaining informed consent to make use of the information provided.

Document review

A desktop review of publicly available documents was conducted. The documents included:

- € submissions made by state and territory child protection agencies to the Royal Commission for Case Study 24, along with supporting materials
- € submissions made by various NGOs to the Royal Commission for Case Study 24, along with supporting materials
- € state and territory policy and practice documents sourced from departmental websites
- € a Royal Commission position paper on preventing and responding to child sexual abuse in OOHC settings
- € a number of pieces of existing research, discussion papers and policy positions (please refer to bibliography)
- € analyses, background information and other materials prepared by Royal Commission staff members (for example, fact sheets and comparative tables).

Information relevant to the research questions was extracted to develop a preliminary ‘picture’ of each jurisdiction’s OOHC landscape. It was used to inform the research team for the primary research phase and to develop qualitative discussion guides.

These materials were systematically reviewed and information was extracted where it was pertinent to the objectives of the research. The materials are extensively referenced throughout this report.

Interviews with state and territory governments

A request was made by the Royal Commission to each state or territory government to identify suitable representatives with whom the research team could discuss the research questions. Each of the jurisdictions (except Queensland) nominated senior staff within the agency or agencies responsible for OOHC and child protection. One or more face to face

meetings (and follow-up phone interviews where required) were conducted with each nominated representative. Queensland declined to nominate interview participants but provided a written response to the research questions.

A discussion guide (see Appendix A) was developed in consultation with the Royal Commission and was used to guide discussions. All meetings with jurisdictional representatives were audio-recorded.

Interviews were also conducted with selected government-based individuals, including children's commissioners or guardians.

In total, 46 people representing state and territory government agencies contributed via interviews and small group discussions. A profile of these respondents is included in Appendix D.

Interviews with non-government agencies and other stakeholders

A range of NGOs was identified and invited to participate in the research. It included providers of OOHC services (including those involved in placement management, carer recruitment, and training and support), state or territory or national peak OOHC organisations, and organisations with a child protection or training focus. Representatives from NGOs were interviewed for the study. These interviewees included:

- € representatives of organisations that provided submissions to Case Study 24 and were identified through other desk research
- € representatives of a random selection of NGO OOHC providers from lists of contracted agencies made available by state and territory governments
- € suggestions from Royal Commission staff and advisors, jurisdictional government representatives, NGOs and peak OOHC organisations.

Organisations were approached initially by email or phone and provided with a participant information sheet and consent form. Interviews were then conducted by telephone, or face-to-face where possible. In many cases, multiple representatives of organisations took part in the discussions. Discussion guides for NGO providers and peak organisations were used to guide discussions and are available in Appendix A. Interviews took 30–120 minutes, dependent on the availability of informants.

In total, 54 individuals from 33 organisations were involved in the interviews and small group discussions. A breakdown of organisation types is included in Appendix D. It shows that informants were drawn from all states and territories and represented a range of different perspectives across the OOHC sector.

3. KEY FEATURES OF AUSTRALIAN OOHC SYSTEMS

The material set out in this section is based on the review of submissions made by state and territory governments in relation to the issues to be considered in Case Study 24, along with publically available information sourced via the internet. The material presented here is also informed by the interviews with representatives of state and territory governments.

Overview

The legislative and structural arrangements for OOHC vary considerably between Australian states and territories. Broadly speaking, key points of differentiation include:

- € *The mix and balance of government and NGO service provision*, both overall and by care type. For example, in Western Australia and the Northern Territory, NGOs play a significant role in recruiting and supporting foster carers, but case management is retained by government. In Victoria, foster carers are recruited, supported and case managed by NGOs, but kinship care largely remains the responsibility of government. At the other end of the spectrum, the majority of foster and kinship carers in NSW are recruited, supported and case managed by the NGO sector.
- € *Geographic context*, particularly with regard to remoteness and distance, with which most states and territories have to contend. This is especially so in jurisdictions such as Western Australia, the Northern Territory and Queensland, where the challenges of case management, training and support are compounded by distance.
- € *Population context*, most significantly the large proportion of children in OOHC who are Aboriginal and Torres Strait Islander. Nationally, Aboriginal and Torres Strait Islander children are around 10 times more likely to be in statutory care than non-Aboriginal and Torres Strait Islander children³, and Aboriginal and Torres Strait Islander children account for the majority of children in OOHC in jurisdictions such as the Northern Territory (85 per cent) and Western Australia (52 per cent⁴).
- € *The range and mix of care settings*, including a range of institutional care types (such as residential care, therapeutic care homes, family group homes and secure care facilities) as well as a range of home-based care types (short- and long-term foster care, kinship/relative care, permanent care, emergency foster care and targeted care packages for high-need children).
- € *The range and mix of care models*, including semi-professionalised or paid carer models, different therapeutic care models and wraparound care arrangements.

³ Australian Institute of Family Studies (2015). 'Child protection and Aboriginal and Torres Strait Islander children', CFCA Resource Sheet, September 2016, Child Family Community Australia, <https://aifs.gov.au/cfca/publications/child-protection-and-aboriginal-and-torres-strait-islander-children>.

⁴ *ibid*.

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- € *The degree of change occurring in OOHC systems as a result of reform processes.* Western Australia, for example, commenced its extensive reform implementation in 2016. Tasmania is mid-way through a major reform process. Other jurisdictions are continuing to draft and implement legislative and structural reforms of various kinds.
 - € The degree to which there are stipulated requirements for the tools and frameworks to be used for carer assessment and the inclusions in the training provided to carers.
 - € Arrangements for monitoring, oversight and accountability in relation to OOHC service provision. Depending on the jurisdiction, these functions may be the responsibility of the government child protection agency and/or an independent statutory body.

Australian Capital Territory

Legislation

The *Children and Young People Act 2008* (ACT) provides the legislative basis for OOHC in the ACT. The Act was first amended in November 2015 to facilitate the changes that were outlined in the new *A Step Up for Our Kids* OOHC strategy.⁵ These changes came into effect in 1 January 2016. Further amendments to the Act were made in 2016 and will come into effect once the transition is completed in mid-2018. The OOHC system is also underpinned by the *Working with Vulnerable People (Background Checking) Act 2011* (ACT) which commenced on 8 November 2012.

Roles and responsibilities

Responsibility for OOHC sits with Child and Youth Protection Services (CYPS) in the ACT Government's Community Services Directorate (CSD). *A Step Up for Our Kids*, launched in 2015, provides a shared policy framework that supports the work of the government and non-government sectors in delivering OOHC services. *A Step Up for Our Kids* is delivered in partnership with ACT Together, a consortium led by Barnardos involving Premier YouthWorks (a residential care provider), the Australian Childhood Foundation, OzChild and Relationships Australia. Case management responsibilities under the new strategy are transitioning to the new consortium. Transition of both foster care and kinship care to the NGO sector commenced in early 2016 and was due to be complete by July 2016. The Director-General Community Services Directorate retains parental responsibility until full transition to the new service system, scheduled to occur by mid-2018.

5 Office of Children, Youth and Families (2015). *A Step Up for Our Kids – One Step Can Make a Lifetime of Difference*, ACT Government, Canberra, <http://www.communityservices.act.gov.au/ocyfs/out-of-home-care-strategy-2015-2020/out-of-home-care-strategy-2015-2020> (accessed 28 June 2016).

As at June 2015, 53 per cent of children and young people in OOHC in the ACT were in kinship care, 37 per cent in foster care and 5 per cent in residential care.⁶ A further 5 per cent were in ‘other home-based’⁷ care or boarding school.

Key policy influences

A number of issues and challenges prompted the ACT to develop a new OOHC strategy. These challenges included:

- € growth in numbers of children and young people entering care
- € the over-representation of Aboriginal and Torres Strait Islander children and young people in care
- € poor life outcomes for many care leavers
- € a shortage of foster carers
- € the increasing costs of OOHC.⁸

In addition, some key external reviews had identified deficiencies in the purchasing and delivery of OOHC services. These reports were:

- € Public Advocate (2011), *Emergency Response Strategy for Children in Crisis in the ACT*
- € Public Advocate (2012), *Review of the Emergency Response Strategy for Children in Crisis in the ACT*
- € Auditor-General (2013), *Performance Audit Report of the Care and Protection System*.

A Step Up for Our Kids is designed to provide a continuum of service from early intervention through to post-care support. It focuses on strengthening accountability mechanisms in the delivery of OOHC services through:

- € registration of all non-government providers against Suitable Entity criteria that map directly to the *National Standards for Out of Home Care*⁹
- € ensuring that carer approvals are reviewed and renewed every three years
- € improved procurement strategies based on the delivery of outcomes for children and young people
- € strengthened contract management and quality assurance
- € strengthened and independent regulation through the Human Services Registrar

6 AIHW (2016). *Child Protection Australia 2014–15*, Table A33, p. 101.

7 ‘Other home-based care’ is predominantly children placed on third-party parental responsibility care orders. Previously, these children were included in the foster care category. These placements are different from foster care as they involve granting sole parental care and custody of child to a third party.

8 Office of Children, Youth and Families, *op. cit.*

9 Department of Families, Housing, Community Services and Indigenous Affairs & National Framework Implementation Working Group (2011). *An outline of National Standards for out-of-home care*, Australian Government Canberra, July 2011.

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- € new independent advocacy support and engagement services providing autonomous support to birth families, foster and kinship carers, and children and young people with a care experience
 - € a focus on compliance with record-keeping requirements.

Screening and assessment

Foster care

All foster carer applicants (and any other adults living in the home) are subject to national criminal record checks, a child protection record check and a Working with Vulnerable People (WWVP) check. The 2015 amendments to the *Children and Young People Act* included a streamlined process for applying for and granting approvals for carers, with both foster and kinship carers subject to one assessment and approval process by which they are endorsed as an Approved Carer.

Screening and assessment of foster carers is undertaken by OOHC providers, with funding agreements requiring use of an ‘agreed assessment tool’ for screening prospective carers. Before their assessment is completed, foster carer applicants must complete a competency-based training program and psychosocial assessments. The Legislative amendments enable OOHC providers to authorise Approved Carers – however, a transitional arrangement is in place until providers establish a robust process to undertake these responsibilities. Until this time, providers refer all checks and a completed carer assessment to CYPS, which passes them on to the centralised Carer Assessment and Linking Panel (CALP), which includes representatives from CYPS, ACT Together, carers and cultural representatives.

The CALP provides quality assurance and consistency in decision-making. The CALP provides a recommendation to the delegate who has responsibility for granting the authorities to become an Approved Carer on behalf of the Directorate.

CYPS considers any offences by a carer applicant or other adult in the home. The Act requires that prior to a child or young person being placed with a carer (foster or kinship) the carer must be deemed a ‘suitable entity’ as defined by the Act. In deciding suitability, CYPS considers convictions, offences involving violence, offences against a child or young person, and proven non-compliance with a legal obligation in relation to providing services for children or refusal of a licence in relation to the same.

ACT Together fulfils the requirements of both the ACT and NSW carer registration processes, given the movement of carers between the two jurisdictions.¹⁰

¹⁰ Interview with CSD staff for this project.

Kinship care

All prospective kinship carers in the ACT must undertake preliminary screening prior to a more comprehensive assessment process. CYPS initiates the Preliminary Carer Assessment process, which involves checking the carer's national criminal history (and that of any other adults in the home) and child protection history, and a WWVP check. Where a prospective kinship carer, or any person aged 18 or over who is living in the carer's house, has a relevant conviction¹¹ or findings of guilt, CYPS considers these on a case-by-case basis.¹² Staff may conduct an interview with the prospective carer to allow them an opportunity to provide details and explore their insight into the incident/offence and how they have changed their behaviour since the event.

Assessment of kinship carers commences once suitability in terms of criminal and child protection checks has been established, and the prospective carers have been subject to a 'home and environment safety check' by CYPS.¹³

No child may be placed with a kinship carer prior to commencement of the Preliminary Carer Assessment, even where 'emergency action' has taken place. When an unplanned placement is necessary (for example, following emergency action), kinship carers are advised that if the checks disclose information that was not previously disclosed by them to the CSD, the placement may not continue. In this circumstance, kinship carers are required to sign a declaration of any criminal offences or previous involvement with a child protection authority.¹⁴

The Comprehensive Carer Assessment for both kinship and foster carers takes approximately eight weeks. This process addresses psycho-social aspects of the carer's suitability, including their expectations of the child or young person, as well as their parenting style and experience, attitude to the birth parents, and physical and mental health. It also considers the abuse history of the children, and the availability of formal and informal supports to the family. The assessment is referred to the CALP as a quality assurance mechanism.¹⁵

CYPS has a Kinship Care Assessment and Support Team to support kinship carers. One of the team's tasks is to undertake interim risk assessments to enable children to be placed in the care of a relative in the short term while court orders and/or more comprehensive carer checks and assessments are pursued. The team has begun using the Winangay Aboriginal Kinship Carer Assessment Tool to assist with risk assessments. This is a

11 That is, an offence relating to the provision of services for children or young people, an offence against a child or young person, an offence involving violence, a sex offence, an offence involving dishonesty or fraud, an offence involving the possession or trafficking of a drug of dependence or an offence against an animal.

12 ACT Government, *op. cit.* p. 5.

13 *ibid.*, p. 8.

14 *ibid.*, p. 8.

15 *ibid.*, p. 8.

strengths-based and culturally appropriate tool that assists Aboriginal kinship carers to identify their strengths, areas of concern and support needs.¹⁶

Residential care

CSD is responsible for one residential facility in the ACT: Narrabundah House. It operates under the auspices of Bimberi Youth Justice Centre and is staffed by youth workers engaged and trained at Bimberi. Prospective staff members are subject to national police checks, a child protection history check and WWVP registration, as well as SafeSelect psychometric testing, a medical assessment and a structured interview process.

As at 1 October 2016, all other residential care is provided through the ACT Together consortium.

Training and support

Foster care

Prior to becoming a foster carer, applicants must complete *Positive Futures Caring Together*¹⁷, a 10-module training program, with two modules specifically focused on identifying and responding to children and young people at risk, including:

- € possible indicators of sexual abuse in children
- € how to respond to a child or young person who discloses abuse
- € legal and ethical responsibilities to report abuse
- € the process for making a Concern Report.

The training includes four national units of competency, which count toward a Certificate IV in Child, Youth and Family Intervention. This training must be completed prior to carer approval being granted. A trauma module was recently added to this course to improve carer knowledge about trauma.

The Australian Childhood Foundation (ACF) is engaged by the Community Services Directorate to provide Trauma Informed Care in Practice Training/Foundation Training to foster and kinship carers, CYPS staff and OOHC agency staff. The four-day course is spread over two weeks and covers:

- € the language of the brain and trauma
- € what trauma-informed care really means
- € how important relationships are
- € how to make sure you look after yourself, and why this is so important
- € why kids behave in the way they do, and why you respond in the way you do

¹⁶ Winingay (2014), Winingay resources – the development process, http://winingay.com.au/resource_development.php (accessed 26 September 2016).

¹⁷ Centre for Excellence in Child and Family Welfare, 'Positive Futures Caring Together: An Accredited Training Program for Foster Carers in the ACT', <http://www.cfecfw.asn.au/act-accredited-foster-care-program> (accessed July 2016).

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- € who you are as a carer
 - € lots of ways to deal with the challenges, celebrate the fun times and notice changes.

Carers who have completed Foundation Training are invited to attend any or all of a range of one-day workshops focusing on the application of trauma-informed approaches.

ACT Together also offers a range of face-to-face and online training options for carers (and staff) and promotes access to journal articles and other forms of professional support. However, there is currently no training specifically tailored for Aboriginal and Torres Strait Islander carers.

Melaleuca Place, which was funded by the ACT Government in 2012, provides therapeutic support for individual children in care, and specialised support for carers and workers relating to the care of their clients. It also hosts the trauma training provided by CYPS and ACT Together. The risks of child exploitation are recognised in training and resources.¹⁸

CSD has published a range of carer resources to assist carers (foster and kinship) in understanding the scope and responsibilities of their role. A series of information sheets for carers provides information on topics such as reviewable decisions, understanding separation, sharing information, case conferences, child development and trauma. Practice guides are also available on subjects such as recognising abuse and neglect.

Kinship care

The *Positive Futures Caring Together* training program and other training offerings on the CSD training calendar are offered to kinship carers, but are not mandatory. Kinship carers are also able to undertake the *Trauma Informed Care in Practice Training/Foundation Training* delivered by ACF, as well as follow-up training in the application of trauma-informed approaches.

Kinship carers are supported by CSD's Assessment and Support Team and have access to a Carer Liaison Officer who is independent of the operational area of CYPS.¹⁹

Residential care

Training for Narrabundah House and Bimberi staff is based on a core capabilities framework covering quality decision-making, reporting child abuse and neglect, and compliance with the legislative framework provided by the *Children and Young People Act*. The core training program is five days per week, for seven weeks.²⁰

18 ACT Government, 'Melaleuca Place Trauma Recovery Centre: Fact Sheet 1', http://www.communityservices.act.gov.au/__data/assets/pdf_file/0020/615017/Melaleuca-Place-Trauma-Recovery-Centre-Fact-Sheet-one.pdf (accessed July 2016).

19 ACT Government (2015), op. cit., p. 10.

20 *ibid.*, p. 9.

Carer Support

Carers ACT operates the new Kinship and Foster Care Advocacy Support Service, providing independent support for kinship and foster carers experiencing difficulty in their caring role. This service also provides a mechanism to support and empower carers in resolving issues with service providers and CYPS.

New South Wales

Legislation

The *Children and Young Persons (Care and Protection) Act 1998* (NSW) (the Act) provides the legislative basis for the provision of OOHC in NSW. The Act specifies that statutory OOHC is where care is provided for more than 14 days either pursuant to a care order of the NSW Children's Court or by virtue of the child or young person being a 'protected person' under s135A of the Act.

Roles and responsibilities

The statutory responsibility for OOHC in NSW rests with the NSW Department of Family and Community Services (FACS). In response to the Wood Special Commission in 2008²¹, FACS embarked on a gradual transition in the provision of OOHC services to the non-government sector, commencing in 2012. The transition was to take five years for non-Aboriginal children in care (new and existing) and 10 years for Aboriginal children and young people. As at 30 June 2015, 54 per cent of children and young people in statutory OOHC in NSW were placed with NGOs. For Aboriginal children and young people in statutory OOHC, 47 per cent were in a placement supported by an NGO.

The NSW Child Assessment Tool (CAT) is used by FACS to identify the appropriate care for a child or young person who has been the subject of a court order to be placed in contracted OOHC with an NGO and where a placement could not be found with relatives or kin. Six categories exist that determine placement into foster care, intensive foster, residential care and intensive residential care.

As at 30 June 2015, 46.8 per cent of children in OOHC in NSW were in relative or kinship care, 44.7 per cent in foster care and 3.1 per cent in residential care.²²

There are 86 designated agencies that can provide OOHC services in NSW²³, 28 of which are approved to provide both foster and residential care services. FACS operates one

21 Wood, J. (2008). *Report of the Special Commission of Inquiry into Child Protection Services in NSW*, State of NSW through the Special Commission of Inquiry into Child Protection Services in NSW, Sydney.

22 NSW Department of Family and Community Services response to the Royal Commission into Institutional Responses to Child Sexual Abuse, Case Study 24, February 2015.

23 Office of the Children's Guardian, list of designated agencies, viewed at <http://www.kidsguardian.nsw.gov.au/out-of-home-care/statutory-out-of-home-care/designated-agencies>

residential facility – Sherwood House, a therapeutic, secure care facility for up to six children. Other residential care placements are made with one of 27 NGO providers.

The Act (s13) specifies that Aboriginal or Torres Strait Islander children entering OOHC should, wherever practical, be placed with a member of their family or kinship group, or with a member of the Aboriginal or Torres Strait Islander community to which the child belongs. Where this is not practical, the child may be placed with another suitable person, in consultation with members of the child’s extended family and/or community.

The Children’s Guardian is established under the Act as an independent statutory office.

The mandatory accreditation scheme has operated since 2003 and the Children’s Guardian is responsible for the accreditation of agencies providing statutory OOHC. Accreditation is a prerequisite to provide statutory OOHC in NSW and applies to government and non-government providers.

The Children’s Guardian’s functions were expanded in 2013 to include administration of the WWCC and encouraging organisations to develop their capacity to be safe for children.

The standards and other criteria for use in determining accreditation are approved by the Minister for Family and Community Services on the advice of the Children’s Guardian. The standards were revised in 2010 and again in 2015 to reflect legislative amendments and child protection reforms. The current standards, which took effect on 1 December 2015 are the *NSW Child Safe Standards for Permanent Care*.

The standards provide the basis for provider accreditation and re-accreditation. There are 23 standards that relate to all aspects of the delivery of OOHC and that respond to the key legislative requirements for OOHC provision. The standards set out the indicators of compliance that designated agencies are expected to demonstrate.

Several of the many indicators are directly relevant to the prevention of child sexual abuse, such as:

- € there is ongoing monitoring of the safety and suitability of the care environment
- € the need to protect children and young people from abuse and harm underpins all areas of the agency’s work with children and young people
- € people who work with and care for children and young people undergo suitability assessments prior to being engaged by the agency
- € people who work with and care for children and young people receive training on child protection and child safety
- € children and young people in care are educated and supported to recognise behaviour that makes them feel unsafe or uncomfortable and are encouraged to report concerns.

There are also specific indicators for the recruitment of staff and volunteer carers, the assessment and selection of carers, and carer training, development and supervision.

Key policy influences

Increasing pressures on, and deficiencies in, the NSW OOHC system became evident through the Wood Special Commission of Inquiry into Child Protection Services in NSW (2008). The inquiry report²⁴ highlighted the increasing demand for OOHC services, and the impacts on capacity and service delivery, and recommended a gradual transition of OOHC services to the non-government sector. The Wood Inquiry observed a number of benefits likely to be derived by transferring OOHC services to the non-government sector, including a greater capacity to implement reforms and innovative service models more efficiently, and the preferences of clients to engage with an NGO – which is perceived as independent and non-judgemental – rather than a government agency.²⁵

The NSW Ombudsman's 2012 report *Responding to Child Sexual Assault in Aboriginal Communities*²⁶ prompted increased focus on information sharing between jurisdictions and agencies in relation to children and young people in OOHC.²⁷

Screening and assessment

Little policy distinction is made between the screening, assessment, training and support processes for foster carers and kinships carers in NSW.

Foster and kinship care

Designated agencies are required to perform a set of probity and suitability checks prior to authorising a carer – labelled as 'pre-authorisation' checks. They include²⁸:

- € a 100-point identity check
- € a Working With Children Check (WWCC)
- € a National Police Check
- € other designated agency check (if the individual is already listed on the NSW Carer's Register – see below)
- € a Community Services Check – performed by FACS to identify if any information is held about the prospective carer on the Key Information and Directory System (KiDS) (such as Risk of Significant Harm reports and allegations of reportable conduct)
- € a health check

24 Wood, op. cit.

25 NSW Department of Family and Community Services, response to the Royal Commission into Institutional Responses to Child Sexual Abuse, Case Study 24. February 2015.

26 NSW Ombudsman (2012). *Responding to Child Sexual Assault in Aboriginal Communities: A report under Part 6A of the Community Services (Complaints, Reviews and Monitoring) Act 1993*, NSW Government, Sydney.

27 NSW Government (2015). *Responding to Child Sexual Assault in Aboriginal Communities: NSW Government's Progress Report to the 2012 Ombudsman's Report*, NSW Government, Sydney.

28 NSW Department of Family and Community Services, op. cit.

€ a referee check (at least two).

The pre-authorisation probity check also includes a National Police Check and KiDS record check for household members aged 16 and over.

The NSW Carer's Register is a secure, restricted-access database of information about authorised carers and people who apply to become authorised carers (including household members). The register allows designated agencies to identify individuals who have previously been authorised as a carer by another agency so that information may be shared by the two agencies about that individual and their past record as a carer. The register includes information about the outcomes of past applications for carer authorisation and the surrendering, cancelling or cessation of past authorisations, along with any reportable allegation investigations that have been, or are being, investigated. Recent amendments to the Act *require* designated agencies to share information about a prospective carer where that information is known to exist.

Designated agencies are also required to ensure that a code of conduct is sighted and signed by the prospective carer and that pre-authorisation training is undertaken. It is not stipulated what pre-authorisation training is required, but according to both NSW government and NGO representatives, *Shared Stories, Shared Lives*²⁹ is used by FACS and by many NGOs.

Where an OOHC placement is transferred from FACS to an NGO, the carer must be re-authorised using the statutory process described above.

It is important to note that while the above carer authorisation process is required of all designated agencies, there are additional policies and processes used by individual agencies to screen and assess carers. These are discussed in Section 5 of this report.

Residential care

NGOs providing residential care are responsible for their own recruitment and are subject to legislative requirements as well as contractual obligations pursuant to their funding agreement with FACS. Residential care providers are also required to comply with the *NSW Child Safe Standards for Permanent Care* and their conditions of accreditation. This includes residential care provided by FACS.

The Sherwood therapeutic secure care program is managed and operated directly by FACS. The clinical program design, client case formulation, behaviour support planning and staff training are purchased from a private agency. Direct care workers are contracted from personnel management agencies working in the youth work sector. Security services are also purchased from a security company. Direct care staff members are recruited by the

²⁹ Shared Stories, Shared Lives was developed by the Association of Child Welfare Agencies (ACWA) and comprises nine two-hour training modules, including one on abuse and trauma. See <http://www.acwa.asn.au/acwa/fostering-nsw/foster-care-resources/shared-stories-shared-lives>

employment agency and attend an interview with the program manager. Staff members must have completed the following:

- € a national criminal history records check
- € WWCC
- € Minimum Certificate III (for direct care workers)
- € licensing by the Security Licensing and Enforcement Directorate of the NSW Police Force (for security staff).³⁰ Security staff are not licenced unless they have a clear national criminal check).

Training and Support

Foster and kinship care

Designated agencies are required – through contractual arrangements with FACS and in meeting the standards set out by the Office of the Children’s Guardian (OCG) – to provide carers with training on child safety protection and child safety. While the extent and appropriateness of the training is assessed by the OCG through its compliance monitoring work, there is no stipulated curriculum or inclusions for carer training.

Foster and kinship carers in NSW access training and support through their own agency, as well as through the FACS-funded carer agency Connecting Carers NSW, which delivers training across a range of topics. Carers may also attend peer support groups, including Aboriginal and Disability peer support.

The NSW Government provides financial support for the work of the Association of Children’s Welfare Agencies, Centre for Community Welfare Training (ACWA/CCWT) to provide a variety of training courses for people who work in the NSW community welfare sector. ACWA/CCWT is a registered training organisation offering a range of training courses under a specific OOHC stream. Courses relevant to the prevention of child sexual abuse³¹ include:

- € Out of Home Care Fundamentals
- € Carer Screening and Assessment using *Step by Step*
- € Delivery of *Shared Stories Shared Lives* (train-the-trainer)
- € Case Work and Case Management
- € Handling Allegations and Disclosures
- € Cultural Identity for Children and Young People from Migrant and Refugee Backgrounds in OOHC
- € Partners in Care/Collaborative Practice
- € Therapeutic Parenting

30 NSW Department of Family and Community Services (2015). op. cit.

31 2016 calendar of CCWT courses (OOHC stream), viewed at <http://www.acwa.asn.au/Pages/cdsbystream.php?stream=Out+of+Home+Care>

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- € Working with Young People Who Have Experienced Trauma
 - € Working With Children Under 12 with Sexual Behaviour Problems.

The course offerings of ACWA/CCWT are predominantly aimed at residential care staff and OOHC case workers from both FACS and NGOs. However, many of the courses are suitable for, and open to, foster and kinship carers. According to ACWA/CCWT, approximately 30 training sessions relevant to the OOHC sector are provided across 13 NSW locations each year. The training is provided on a fee-for-service basis.

In addition, the NSW Government provides financial support to Connecting Carers to train and support foster and kinship carers throughout the state. Connecting Carers operates a telephone support line, ongoing training, and peer support and advocacy through regional teams of coordinators and also volunteers who are all foster carers or kinship carers themselves. It offers regional training sessions of relevance to child sexual abuse³² including on the following topics:

- € parenting a child with trauma
- € child sexual assault
- € trauma-informed parenting practice.

Some NGOs also use online carer training to support access and engagement with carer learning.

Training has also been developed for members of Joint Investigation Response Teams (JIRT) (comprising FACS, NSW Police and NSW Health staff who jointly investigate identified child protection matters). While developed for JIRT, the training is offered more broadly across the OOHC sector.³³ It has included a Foundation Skills Course on the dynamics of child sexual abuse, a workshop on Safety Planning for Adolescents with Sexually Abusive Behaviours, a Sibling Sexual Abuse self-directed e-learning package and a course on Engaging Young People with a Disability.

FACS and residential care staff

Each NGO provider of residential care is required by its contract to have appropriately trained staff, consistent with the national standards. It is left to each agency's discretion as to how that is achieved, which may or may not include in-house or externally provided professional development.

FACS has developed, and provides, further training for its staff, residential care workers and NGO case workers, including the following³⁴:

32 Connecting Carers training calendar, viewed at <http://connectingcarersnsw.com.au/services/training/>.

33 NSW Department of Family and Community Services, response to the Royal Commission into Institutional Responses to Child Sexual Abuse, Case Study 24. February 2015.

34 *ibid*.

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- € the Reparative Parenting Group Program – a train-the-trainer program to help FACS and NGO agency staff to educate themselves about the impact of trauma and attachment disruption
 - € *Raising Them Strong*³⁵, a train-the-trainer course aimed at supporting Aboriginal kinship carers
 - € the *Cybersmart Program* – educating carers about how to better monitor the online activity of children and young people.

The Office of the Senior Practitioner (OSP) within FACS was established to provide practice leadership and support, and to develop and promulgate best practice to practitioners within FACS and beyond. The OSP has developed the *Care and Protection Practice Standards*, which cover supporting and working collaboratively with carers.

Northern Territory

Legislation

The *Northern Territory Care and Protection of Children Act 2007* (NT) provides the legislative basis for OOHC in the Northern Territory (NT).

Roles and responsibilities

Territory Families is the lead agency for OOHC in the NT. Within Territory Families, the OOHC Division is responsible for the placement of children in care, coordination of local and international adoptions, recruitment, assessment, the training and support of carers, the operation of residential care facilities and coordination of therapeutic support to children in OOHC. The Division was established in 2013, after the 2010 Board of Inquiry into the child protection system in the NT³⁶, to provide more centralised coordination and accountability for OOHC services in the NT.

Managing the Territory's OOHC system is complex, due to significant geographical, cultural and socio-economic issues. In particular, limited infrastructure and services in remote mainland Aboriginal and Islander communities affects the ability of agencies to deploy staff and deliver services.³⁷

35 NSW Department of Family and Community Services (2011). *Raising Them Strong – Support for Aboriginal Kinship and Foster Carers in NSW*. http://www.community.nsw.gov.au/_data/assets/pdf_file/0007/319768/raising_them_strong_book.pdf

36 Bamblett, M., Bath, H. & Roseby, R. (2010). *Growing them Strong. Together: Promoting the safety and wellbeing of the Northern Territory's children, Report of the Board of Inquiry into the Child Protection System in the Northern Territory 2010*, Northern Territory Government, Darwin.

37 Northern Territory Government (2015). *Northern Territory Government Submission to the Royal Commission Into Institutional Responses to Child Sexual Abuse: Preventing and Responding to Allegations of Child Sexual Abuse Occurring in Out-Of-Home Care*.

On 30 June 2014, there were 918 children in OOHC in the NT, which represents growth of 23 per cent over the previous 12 months. Approximately 85 per cent of children in care in the NT are Aboriginal or Torres Strait Islander.³⁸

OOHC services are provided through four models of care: foster care, residential care, kinship care and family day care. Territory Families is responsible for case management of all children in care.

As at June 2014, 47 per cent of children and young people in OOHC in the NT were in foster care, 3.2 per cent in kinship care, 32.1 per cent in other home-based care and 9.8 per cent in residential care.³⁹ The percentage of kinship carers is small as many relative, aboriginal carers are authorised as foster carers in the NT (see footnote (i) of the referenced ROGs table, and more specifically ROGs table 15A.24, which shows that at June 2014, 262 or 33.6 per cent of Aboriginal children in OOHC were placed with aboriginal relatives or kin).

Residential care is provided by a mix of NGOs and Territory Families. There are currently 16 facilities including group homes and larger facilities. However, Territory Families aims to transition children and young people from the residential sector to home-based care. Those in residential care typically have moderate to high behavioural and emotional needs, and exhibit challenging behaviours due to previous care or family life experiences which preclude foster care options.

All foster and kinship care placements, case management and support are managed by Territory Families.

Family day care is delivered by three agencies, primarily in metropolitan areas. The model is a variation on the family day care childcare model which extends the hours of care to 24 hours, 7 days a week. Carers are qualified early childhood educators, are registered as a childcare organisation and are remunerated on a fee-for-service basis. There are currently more than 500 placements, supported by approximately 270 carers.⁴⁰

The NT's OOHC system is currently under review and significant changes are likely over the next year or two.

Key policy influences

In addition to the 2010 Board of Inquiry, a significant influence on the OOHC system was the Inquiry into the Protection of Aboriginal Children from Sexual Abuse, which investigated the nature and extent of child sexual abuse in remote communities. The

38 *ibid.*

39 Australian Institute of Health and Welfare (2016). *Child Protection Australia 2014–15*, Table A23.

40 Interview with DCF staff for this project.

inquiry's 2007 report, *Ampe Akelyernemane Meke Mekarle: 'Little children are sacred'*⁴¹, recommended the establishment of a Children's Commissioner, enhanced employment screening and information sharing, the establishment of Family and Children's Services as a division in its own right within the Department of Health and Community Services and the permanent establishment of a Child Abuse Taskforce.

Carer screening and assessment

Foster and kinship care

Territory Families authorises carers and does not distinguish between kinship carers and foster carers in the assessment process. All carers are required to have the same level of screening and assessment. Screening includes police checks, Working With Children Check and a departmental record check. New carers are authorised for one year and then reviewed. Existing carers are reviewed every two years.⁴²

Carers are assessed against the Care and Protection of Children (Placement Arrangement) Regulations. Staff use the Carer Assessment Guidelines and the Authorised Carer Assessment report to record the decision and its outcomes.

Assessments take up to 12 weeks. All adults in a household must be assessed, which significantly delay the finalising of kinship carer assessments in households with several adults. According to Northern Territory Government representatives, delays are common where the carer household is in a remote community. Kinship carers may have an interim assessment and be conditionally approved as emergency placements while full checks are conducted.

The decision to approve a foster carer or kinship carer considers:

- € the outcomes of the screening checks of the applicant and household members
- € other reports and information related to the applicant's previous carer experience and personal attributes (including contact with other jurisdictions where the individual has been a carer, and contact with employers where that is considered relevant or necessary)
- € observation of, and interviews with, the applicant and his or her family
- € observation and assessment of the home physical environment
- € resources used through the assessment process (including notes and documents produced by carer assessment staff)
- € feedback from trainers on the individual's skills, behaviours and ability to comprehend relevant information.

41 Northern Territory Government (2007). *Ampe Akelyernemane Meke Mekarle: "Little children are sacred"*. Report of the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse. http://www.inquirysaac.nt.gov.au/pdf/bipacsa_final_report.pdf.

42 Northern Territory Government 2015, op. cit.

Residential care

Screening of prospective residential carers is undertaken by Territory Families and incorporates a Criminal History Check and Working With Children Check. There is no minimum qualification requirement for residential care workers.

Training and support

Foster and kinship care

Training requirements for kinship carers and foster carers are theoretically the same. However, they differ significantly between foster care and family day care.

Foster and kinship carers must engage in training pre-placement and this forms part of their assessment. There is no requirement for ongoing training once registered. The training includes:

- € aspects of behaviour management; practical housekeeping
- € Aboriginal culture and cultural responsiveness; standards of care
- € charter of rights for children in care
- € concepts of 'safe' caring and protective strategies
- € risk management and safety
- € key documents for the child
- € understanding harm and trauma
- € managing stress and behaviour.

This mandatory training must be undertaken before a child is placed with the carer, but in some instances (for example, where emergency placement is required) it is undertaken after placement. The modules on behaviour management, standards of care, safe caring and protective strategies deal with the identification of signs of sexual abuse in children, encouraging disclosures, and appropriate responses to disclosures of sexual abuse.⁴³

Training is delivered by a dedicated Territory Families trainer. The Foster Care Association (FCA) NT is funded by Territory Families to provide support and some training to foster and kinship carers in Darwin, Alice Springs, Katherine and Tennant Creek.

Territory Families is ultimately responsible for providing support to carers, and funds the NT Foster Care Association to provide some advocacy, training and support to foster carers in Darwin, Alice, Katherine and Tennant Creek. Carer support strategies include the employment of case workers, the In-care Support Unit, Aboriginal Family Support Worker, telephone support and access to an Employee Assistance Counselling program.

Family day care

43 *ibid.*

Family day carers must attend pre-placement training as well as ongoing monthly training. Each FDC central authority agency is responsible for training their carers via in-house and/or external training.

Family day carers are supported by specialist staff such as Heritage and Cultural Advisors, 24/7 phone support and resource officers provided at a ratio of one officer per 15 carers.

Residential care

Delivery of residential care staff training is the responsibility of each provider. Prior to commencing work at the facility, all staff members are required to undertake shadow shifts and complete DCF's mandatory child protection training program. They must also complete an orientation program covering topics such as Mandatory Reporting of Child Abuse, Duty of Care and Reportable Incidents, and Responding to Sexualised Behaviour. Training participation and attendance is monitored through a monthly training report that is sent to the OOHC Executive.

NGO providers also deliver induction training. To help manage burnout, staff are typically rostered so they spend some of their time with children who have high needs and some time with those who have moderate needs (for respite). This means the same level of training is delivered to all staff members.

Queensland

Legislation

The *Child Protection Act 1999* (Qld) (the Act) and the associated Child Protection Regulation 2011 (the Regulation) underpin the child protection system in Queensland. These set out the requirements for the approval of a carer application and the licensing of care services. The regulation of care aims to ensure that the legislative standards of care and the *Charter of Rights for a Child in Care* are met for all children placed in OOHC. In 2014, in response to the Child Protection Commission of Inquiry recommendations, the Act was amended (see below).

Roles and responsibilities

The Department of Communities, Child Safety and Disability Services (the Department) is the lead agency responsible for child protection and OOHC. Most OOHC services are provided by NGOs under service agreements with the Department. The Department itself provides around 27 per cent⁴⁴ of foster and kinship care in Queensland.

The Queensland Family and Child Commission (QFCC) was established by the Queensland Government in 2014 following a recommendation by the Queensland Child Protection Commission of Inquiry. The QFCC's role is to promote and advocate for the safety, wellbeing and best interests of children and young people, and the responsibility of

⁴⁴ Queensland Government, written response to research questions, 14 June 2016.

families and communities to protect and care for children and young people and to improve the child protection system. The QFCC oversees the child protection system by monitoring, reviewing, evaluating and reporting on the performance of the child protection system and associated reform initiatives.

The Office of the Public Guardian (OPG) is an independent statutory office that reports to the Minister for Justice and Attorney General. The OPG is responsible for the promotion and protection of the rights of children in OOHC, including the ability to provide individual advocacy for children in the child protection system.

As at June 2014, 52 per cent of children and young people in OOHC in Queensland were in foster care, 40 per cent in kinship care and 8 per cent in residential care.⁴⁵

At the time of writing, 41 licensed OOHC providers were funded by the Department, providing foster and kinship care, intensive foster care, residential care, safe houses, supported independent living and therapeutic residential care.

Key policy influences

Significant reforms to the OOHC system in Queensland were initiated in response to the 2013 Child Protection Commission of Inquiry report⁴⁶, including additional investment of \$406 million over five years (beginning in 2014–15), focused on reducing the number of children and young people in the child protection system, revitalising child protection front-line services and refocusing system oversight on learning, improving and taking responsibility. The Commission of Inquiry also recommended the transfer of foster and kinship care services to NGOs. The Department states that it will be implementing changes in line with this as part of the reform process.⁴⁷

The Department of Premier and Cabinet has a lead coordination role across all government agencies. Other significant reforms include:

- € an overhaul of mandatory reporting requirements
- € expansion of early intervention family support programs
- € establishment of a regional Aboriginal and Torres Strait Islander family services model
- € a new practice framework to improve decision-making and strengthen casework
- € use of OOHC needs assessments
- € developing an evidence-based, trauma-informed, therapeutic framework for residential care.

⁴⁵ AIHW, op. cit., Table A33.

⁴⁶ Queensland Child Protection Commission of Inquiry (2013). *Taking Responsibility: A roadmap for Queensland child protection*, June 2013.

⁴⁷ Queensland Government, written response to research questions, 14 June 2016.

The Department's recognition of the importance of preserving and enhancing Aboriginal and Torres Strait Islander children's identity is articulated in its *Aboriginal and Torres Strait Islander Child Placement Principle (Policy Statement CPD609-1)*, which states that whenever possible, an Aboriginal or Torres Strait Islander child should be safely maintained in the care of their family and community.

Screening and assessment

Foster and kinship care

Foster and kinship carer assessment may be undertaken by the Department, staff of a foster and kinship care service or a contracted fee-for-service professional. Some steps of carer assessments can only be undertaken by the Department, as outlined below. All assessors are required, as a minimum, to use the Department's foster carer assessment report templates and user guides.

The assessment includes mandatory steps including:

- € personal history checks for applicants and household members (the Department)
- € Blue Card checks to establish suitability for working with children, for applicants and household members (facilitated by the Department with the Public Safety Business Agency, Department of Justice and Attorney-General)
- € comprehensive assessment interviews with applicants and all household members
- € completion of mandatory pre-service training for foster carers (this is optional for kinship carers)
- € use of a discretionary referee (person undertaking the assessment or at the request of the Department) and medical checks (as decided by the Department), where necessary
- € a comprehensive assessment report.

Assessment interviews with a carer applicant explore the applicant's personal background, including their experience of childhood and any personal experiences of abuse. Assessing personal background information can provide insight into the way the applicant currently provides care to their own children and intends to provide care for a child in care. This includes a review of whether the applicant has worked through any traumatic experiences and emerged with strengths that will assist them to provide quality care. It is a legislative requirement that the Department only grant approval or renewal as a carer to an applicant who is a "suitable person" as defined by Schedule 3 of the Act and Part 4 of the Regulation.

Residential care

Assessment of prospective residential care workers may be undertaken by the employing NGO or the Department. All direct care workers must have a Blue Card check (valid for three years) and a suitability check (valid for two years). The Act requires that the methods

for the selection, training and management of OOHC staff are suitable. This includes methods for assessing that potential staff members have the necessary skills to undertake their role.

Licensed OOHC providers must comply with the *Human Services Quality Framework* to be approved, including recruitment, induction and supervisory processes resulting in quality service provision. Once certified, the organisation must complete relevant action and improvement plans and demonstrate ongoing compliance with the *Human Service Quality Standards* (HSQS) to maintain their licence. Three-year certification audits and 18-month maintenance audits are conducted by external certification bodies to ensure compliance with the HSQS. Residential care services are subject to one announced and one unannounced inspection per year, when client files are reviewed and discussions are held with children if they are present during the inspection.

Training and support

Foster and kinship care

The information below describes foster carer training requirements in Queensland. Kinship carers are encouraged to attend the training for foster carers, but it is not a mandatory requirement for the renewal of their certificate of approval as a carer.

As part of the mandatory training requirements, foster carers are required to complete three modules that focus on child sexual abuse:

- € Module 1 (pre-service): Introductory information on child sexual abuse
- € Module 2 (pre-service): Effects of child sexual abuse and how a carer can respond to a disclosure or behavioural indicators
- € Module 3 (standard training): Caring for children and young people who have experienced sexual abuse. The purpose of this module is to assist foster carers to understand the signs and signals children and young people may exhibit when they have experienced sexual abuse and understand the impact of sexual abuse on a child and their behaviour. The training develops foster carers' skills in caring for children who have experienced sexual abuse, and their understanding of the role of professional and other support services in caring for children with a sexual abuse history. Completion and competency in this module is a requirement before a foster carer's first renewal of their certificate of approval as a carer.

Advanced 'Positive and Protective' carer training modules teach foster carers about the indicators of sexual abuse and how to respond to disclosures of sexual abuse, as well developing their skills for teaching children and young people about sexuality and self-protection.

NGO providers may require that carers undertake additional training that is not mandated – for example, in relation to trauma-informed care, anger management and violence.

In 2015, the Department commissioned PeakCare to advise on a ‘best fit’ trauma-informed therapeutic framework and provide advice and options for its implementation. The resulting *Hope and Healing Framework* sets out a foundation for supporting and working with children in residential care in a way that considers and responds to trauma, and is therapeutic in approach. The Department is in the consultation stage – the framework is expected to be rolled out by December 2018.⁴⁸

The Department’s Complex Case Advice and Practice Support (CCAPS) team has specific modules written for foster and kinship carers and direct care staff caring for children who have sexually abused other children. The CCAPS also delivers residential care forums, and foster and kinship care workshops in partnership with Griffith Youth Forensic Service or skilled private practitioners. These training packages include content to assist carers who care for children and young people who have engaged in problematic sexual behaviours and/or sexually abusive behaviours or are at risk of engaging in these behaviours. This training is delivered on request to departmental staff, non-government partners and direct care workers.

The needs of children who have experienced previous sexual abuse are supported through case management. Needs assessments include the impact of a child’s sexual abuse history, and they are undertaken to inform a child’s case plan and therapeutic supports. Other case management support strategies include safety planning, seeking suitable placements, active supervision, developing the child’s circles of safety and support, ongoing monitoring, working in partnership with key stakeholders supporting children and young people, and review of the child’s needs and safe family contact that protects the child from adverse influences or re-traumatisation. The Department states that carers are provided with full and detailed information about a child’s child protection history (including their history of sexualised behaviours, if applicable).

In March 2015, the Department launched its *Strengthening Families Protecting Children Framework for Practice*, a three-year plan of targeted training, coaching and resource development for child safety staff. In the first 12 months of implementation, more than 3,000 staff members from across the government and NGO sectors participated in the framework training. Intensive Practice modules have been delivered statewide, focusing on engagement, assessment and planning with children, young people and families.

⁴⁸ Queensland Government, written response to research questions, provided 14 June 2016.

In August 2016, the QFCC published the *Strengthening our sector strategy 2016–19*⁴⁹ and *First Action Plan 2016–17*. The strategy aims to strengthen the capacity and capability of the child and family support sector and establish a positive culture in the way the sector supports children and families. The first action plan includes foundational work to support capacity building for the sector and address workforce training and career development issues (including consideration of qualifications) across the whole child and family sector in Queensland. Unpaid carers (that is, foster and kinship carers) are not currently in scope for this work.

South Australia

Department for Child Protection

The new Department for Child Protection (DCP) commenced operation on 1 November 2016 as a result of the [Child Protection Systems Royal Commission](#), headed by Justice Margaret Nyland.

The DCP assumed the functions of the former Office for Child Protection and Families SA, which were transferred from the former Department for Education and Child Development (DECD) and focused solely on the business of child protection.

As this report is historical in nature the naming conventions that applied prior to 1 November 2016 have been used. That is, reference is made to the former Office for Child Protection, Families SA and DECD throughout this section. Any changes that may have been made to roles and functions under the new department are not reflected in this report.

Legislation

The *Children's Protection Act 1993* (SA) is the over-arching legislation governing the care and protection of children in South Australia. The *Family and Community Services Act 1972* (FaCS Act) governs the licensing and monitoring of alternative care services in the state.

Roles and responsibilities

Families SA in the DECD Office for Child Protection oversees OOHC services in the state. Families SA is responsible for the assessment, selection and training of kinship carers, who are directly accountable to the Department. NGOs are responsible for the recruitment, selection and support of foster carers. Both the government and NGOs provide residential care services, and both are responsible for the selection, training and support of their own residential staff.

49 Queensland Family & Child Commission (2016). *Strengthening our sector: A strategy for working together for a responsive and sustainable service system across the child protection and family support sector* (Consultation Draft). <https://www.qfcc.qld.gov.au/sites/default/files/For%20professionals/Strengthening%20the%20Sector%20draft%20strategy.pdf>

As at June 2014, 44.4 per cent of children and young people in OOHC in South Australia were in kinship care placements, 40.8 per cent in foster care, 14.2 per cent in residential care and 0.5 per cent in independent living arrangements.⁵⁰

Families SA may periodically enter into service agreements with service providers that are not licensed under the FaCS Act, usually in order to make emergency accommodation placements – this is known as emergency care. Emergency care service providers must act in accordance with the same standards required of licensed OOHC providers.

Under the Children’s Protection Act, the Office of the Guardian for Children and Young People has the power to individually advocate for the rights of children and monitor their wellbeing in OOHC. The Guardian also provides advice and recommends systemic reforms to the Minister, who can also refer matters to the Office of the Guardian for Children for investigation.

Key policy influences

In response to escalating reporting of child abuse and neglect in the 1990s, the South Australian Government commissioned the Review of Child Protection, which resulted in the report, *A State Plan to Protect and Advance the Interest of Children*⁵¹. The report highlighted the relationship between socio-economic disadvantage and child abuse and neglect, with particular attention to the needs of Aboriginal children. It informed the development of *Keeping them safe: The South Australian Government’s child protection reform program*⁵², now the policy framework for child protection reform in South Australia.

Other key developments in South Australia that have helped to shape the child protection system include the:

- € Children in State Care Commission of Inquiry (2008)⁵³, for which the terms of reference were to investigate allegations of sexual abuse of children in State care and allegations of criminal conduct resulting in the death of children in State care.
- € Child Protection Systems Royal Commission (2016)⁵⁴, the report of which includes a section (Part IV) dealing with child abuse and neglect in OOHC.

50 AIHW, op. cit., Table A33.

51 Layton, R. (2003). Our best investment: A state plan to protect and advance the interests of children, Government of South Australia. http://apo.org.au/files/Resource/child_protection_review_fu.pdf

52 South Australian Department for Families and Communities 2004, *Keeping Them Safe: The South Australian Government Child Protection Reform Program*, South Australian Government.

53 Mullighan, E. P. (2008). *Children in State Care Commission of Inquiry: Allegations of sexual abuse and death from criminal conduct*, presented to the South Australian Parliament by the Hon. E.P. Mullighan QC, Commissioner, Children in State Care Commission of Enquiry, Adelaide, South Australia.

54 Nyland, M. (2016). *The life they deserve: Child Protection Systems Royal Commission Report, Volume 1: Summary and Report*, Government of South Australia.

Screening and assessment

Foster and kinship care

Foster and kinship carers in South Australia are subject to child-related employment screening, which includes a Working with Children and Other Vulnerable People check, undertaken by the Department for Communities and Social Inclusion. In addition, background checks are conducted by NGO OOHC providers as part of their standard recruitment processes. Screening involves:

- € a national criminal record history check
- € information from South Australian government databases such as child protection information
- € publicly available information sourced from professional registration bodies relating to persons disciplined or precluded from working with children or vulnerable people
- € information from the South Australian Police, courts and prosecuting authorities, including information about charges for alleged offences (regardless of the outcome of those charges)
- € expanded criminal history information obtained from other jurisdictions.

All carer household members over the age of 18 are required to have a child-related employment screening check. Screening is monitored by the NGOs and the Service Accountability Unit within the Office for Child Protection, DECD.

Foster carers are assessed in accordance with the FaCS Act and using the *Step by Step* assessment tool and the *Standards of Alternative Care in South Australia (2008)*. DECD is also trialling the use of the Winangay assessment tool⁵⁵ for Aboriginal carers, in partnership with Aboriginal Family Support Services.

Registration as a foster care provider in South Australia requires an annual licence, and NGO providers must satisfy the requirements of an annual review of premises, policies, procedures and standards of care.

Kinship carers are assessed by the Placement Services Unit within the Office for Child Safety, DECD, using an internally developed psycho-social assessment of carers' motivation and capacity to care for a specific child. The psycho-social assessment complies with the *Standards of Alternative Care in South Australia*⁵⁶ which are consistent with the *National Standards for Out of Home Care*.

⁵⁵ Winangay Resources, op. cit.

⁵⁶ Department for Education and Child Development (DECD), Families SA (2015). Responses of the State of South Australia to Areas to be examined in Case Study 24 to the Royal Commission into Institutional Responses to Child Sexual Abuse.

There is a provider panel, and anyone providing a service to the Department in the non-government sector has to be on this panel. To qualify to be on the provider panel, a number of criteria must be met. These include financial viability, evidence of providing a child safe environment, and demonstrated compliance with carer screening requirements, among other criteria.

Residential care

Assessment of NGO residential care workers is conducted by each NGO. DECD ensures, in partnership with the NGO, that all staff members undergo the required child-related employment screening.

Assessment of emergency care workers is conducted by each emergency care provider. The contract between Families SA and each provider details expectations that all employed workers are required to undergo child-related screening.

To become a Child and Youth Worker (OPS3) or a Child and Youth Support Worker (OPS2), employed directly by Families SA, applicants must undergo a comprehensive screening process including a child-related criminal history check, psychometric testing and pre-employment medical assessment.

Vacancies in Families SA, Residential Care are widely advertised, and the online application process includes other screening questions. Applicants are chosen by a selection panel convened by the DECD. Shortlisted applicants are invited to complete a suitability assessment, and those who are further shortlisted are interviewed by the selection panel. A panel report is written and forwarded to the Office for Child Protection for approval.

Training and support

Foster and kinship care

Schedules attached to DECD Service Agreements with OOHC agencies set out the compulsory training that service providers must provide to carers. These schedules state that the service provider must provide competency-based training to carers on topics covered in *Shared Stories Shared Lives South Australia Training Package*, including:

- € Foster care in context
- € Bonding and attachment
- € Grief and loss
- € Abuse and trauma
- € Identity and birth family contact
- € Responding to challenging behaviours
- € Team work
- € Maintaining cultural connections, and
- € The story continues (life story work, concluding placements and dealing with the demands of being a carer).

In addition, training on mandatory reporting of child abuse and neglect is compulsory for all foster carers.

Service providers must provide quarterly data to the DECD Registration and Contract Services Unit, Office for Child Protection, on training provided to carers.

Foster and kinship carers are supported by Placement Support Workers who visit the carer's home at least once every eight weeks for support and supervision.

The Department runs regular meetings with non-government OOHC providers to discuss emerging issues and are now engaging kinship carers in that process.

The Department has an Intensive Placement Support team that supports emergency care placements and their contracted carers.

A number of changes to the OOHC system have been proposed, and are likely to be given impetus with the finalisation of the South Australian Child Protection Systems Royal Commission report, published in August 2016.

With an increase in the number of children being placed in emergency care, concerns have been raised by a number of sector stakeholders, including the Guardian for Children and Young People⁵⁷, regarding the standards of these services in terms of training, capacity and support compared with licensed services. The 'churn' of staff in these services has been identified as a particular concern.

Residential care

Residential care staff are supported by professional development and training including an initial six-week full-time block of training and mentoring, both in classes and the workplace. The training includes some accredited modules from Certificate IV in Child Youth and Family Intervention. As a condition of their employment as a Child and Youth Worker and Child and Youth Support Worker, new appointees are required to complete the remaining modules over the following 12-month period.

All staff are required to complete child safe environments training. There are no specific training resources or programs for Aboriginal carers or carers of Aboriginal children, though there is a cultural competency unit in the mandated induction training.

The Department has a practice framework for workers in residential care facilities which includes 10 practice guidelines based on the *National Standards for Out of Home Care*. This includes a guide on responding to sexualised behaviours, supported by training.

57 Office of the Guardian for Children and Young People (2015). *Report on interim emergency care for children under guardianship*, Government of South Australia, Adelaide. http://cfc-sa.org.au/wp-content/uploads/bsk-pdf-manager/45_Interim-Emergency-Care-Public-Report-2015.pdf

The Department has developed a series of practice guides for residential care staff:

- € *A Residential Care Practice Guide: Understanding and working with sexualised behaviour*, which addresses identifying and categorising sexualised behaviour, provides evidence-based causes of sexualised behaviour and offers strategies for preventing concerning sexualised behaviour and responding to sexualised behaviour, specific to residential care settings
- € *A Residential Care Practice Guide: Understanding and responding to abuse and neglect*, which outlines the impact of abuse and neglect in residential care and provides strategies for identifying and preventing abuse and protecting staff from false allegations
- € *A Residential Care Practice Guide: Understanding Cyber Safety and Responsible Use of E-Technology*, which helps carers teach children how to use technology appropriately, as well as offering advice on setting personal and professional boundaries for using technology, and responding to inappropriate or illegal use of technology.

Tasmania

Legislation

The *Children, Young Persons and Their Families Act 1997* (Tas) provides the legislative basis for OOHC in Tasmania. The Tasmanian *Registration to Work With Vulnerable People Act 2013* provides the basis for the Working With Children or Vulnerable People (WWCVP) Check that is now mandatory for all OOHC carers in Tasmania.

Roles and responsibilities

Children and Youth Services Tasmania (CYS) has the statutory responsibilities relating to vulnerable children and young people as prescribed in the Act. The Child Safety Service within CYS manages OOHC functions through Intake, Response and Case Management teams and via regional OOHC teams.

OOHC in Tasmania is provided through several streams:

- € Foster care – provided by CYS and three contracted NGOs
- € Relative or kinship care – provided by CYS
- € Sibling group care – provided by an NGO (Key Assets)
- € Residential care – provided by an NGO (CatholicCare)
- € Special care placements – provided through a register of NGO placements.

As at 30 June 2015, 40.8 per cent of children and young people in OOHC in Tasmania were in foster care placements, 28.2 per cent in kinship care, 22.7 per cent in other home-based care and 5.9 per cent in family group homes or residential care.⁵⁸

In addition, the Australian Childhood Foundation (ACF) has been contracted to develop a framework and process for building the capacity of foster carers and kinship carers, in particular through the provision of trauma-informed care training for carers and agency staff. ACF is also contracted to provide consultancy for problematic placements, child behaviour problems and dealing with particular needs or types of trauma. Part of the ACF's remit is the provision of therapeutic services for children and young people, including those who have experienced sexual abuse and young people exhibiting problematic sexualised behaviour.

Key policy influences

A process of reform is underway in the Tasmanian OOHC sector. Phase 1 of the reforms is largely complete and has remodelled service delivery for sibling group care, residential and therapeutic care (as described above) as well as the provision of Special Care Packages for children with extraordinary needs. Phase 2 of the reforms is soon to take place and will feature a reform of the processes for recruiting, training, approving and supporting foster carers. The Phase 2 reforms will allow CYS to formally register and deregister carers, and establish consistent assessment and training requirements for foster carers. Phase 3 will address the model for supporting kinship care placements, although according to representatives of CYS, the nature of these reforms have yet to be developed.

Concurrent to the reforms has been the development of a new Practice Manual to support a consistent approach across CYS and to provide staff with clear direction and guidance through a uniform approach to policy, procedure and practice.

The Tasmanian Government considers the reforms to be an important strategy for addressing issues associated with growth of an OOHC system that has been “unplanned, uncoordinated and piecemeal”.⁵⁹

Carer screening, assessment and authorisation

Foster and kinship care

The WWCVP replaces the Good Character Check screening program. WWCVP registrations are valid for three years and are centralised with the Tasmanian Department of Justice. A national police check is at the heart of the WWCVP check. Authorisation of foster and kinship carers is also dependent on the result of checks of potential carers (performed by CYS) against child protection records, including any previously recorded notifications. Records are also checked in relation to family violence history through the

58 AIHW, op. cit., Table A33.

59 Response by the State of Tasmania to the areas to be examined, Case Study 24 – Preventing and responding to allegations of child sexual abuse occurring in Out of Home Care, Paragraph 22, p. 4.

Family Violence Management System and liaison with Tasmanian Family Violence Counselling and Support Service.

In addition to using the WWCVP check for all new carers, there has been a process of retrospectively performing the check for all existing carers.

The Act does not detail the process that is to be used for further assessing carers. As noted in the Tasmanian Government's submission to the Royal Commission, "*policies and procedures exist requiring explorative competency based interview and assessment, health checks, housing checks, as well as WWCVP check*".⁶⁰

The assessment process for kinship carers consists of a Preliminary Assessment (same probity checks as for foster carers), a Secondary Assessment (for long-term placements) and referee checks to assess the kinship carer's capacity to meet the longer-term needs of the specific child.⁶¹

All departmental foster carers must also undergo an annual review that is undertaken by the OOHC team.

Residential care

Service providers are required to have procedures in place to ensure that all staff and volunteers are "fit and proper persons", meaning they are:

- € capable of providing an adequate standard of care
- € understand the needs of consumers and their children (where relevant)
- € are of good character and suitable to be entrusted with the care of consumers.⁶²

Service providers must provide personal references and evidence of police checks at the request of the Department.

Training and support

NGO providers are required, under the terms of their funding agreement, to "ensure that all staff, carers, employees or volunteers are appropriately qualified and skilled, and where appropriate, credentialed and registered; and provided with adequate support, training, debriefings and directions to enable them to effectively perform their duties".⁶³ Beyond this broad requirement, there are no stipulations on the amount and type of training that must be provided.

CYS maintains an internal training unit that provides a calendar of training sessions available to carers and agency staff. CYS is currently working with ACF to add value to

⁶⁰ *ibid.*, paragraph 81, p. 11.

⁶¹ Response by the State of Tasmania to the areas to be examined, Case Study 24 – Preventing and responding to allegations of child sexual abuse occurring in Out of Home Care.

⁶² *ibid.*, paragraph 73, p. 10.

⁶³ *ibid.*, paragraph 93, p. 13.

the suite of training courses that has been available. The Foster and Kinship Carers Association of Tasmania is also funded to provide training and support for carers. The Association advertises sessions run by specialist practitioners and others that may be attended by carers.

The training that is provided to carers is overseen by regional CYS OOHC team, though there is no formal framework to monitor compliance or standards in relation to training. Generally, there is no formal accreditation process for OOHC providers beyond acceptance of a tender to perform the work.

Reportedly, clear commitments have been made by the recently contracted providers of residential and sibling group care in relation to the ongoing training and support provided to carers. However, in lieu of the planned Phase 2 reforms, there is little structure around the provision of training for foster and kinship carers. As set out in the Tasmanian Government's submission to the Royal Commission:

“There is no formal ongoing training package for departmental carers (beyond induction training) and there are currently no formal on-going training assessments and training plans for carers.”⁶⁴

Furthermore:

“While no dedicated training is available for kinship carers related to the signs or impact of child sexual abuse, support and advice is provided, through ongoing case management, where issues of concern are raised by the carer.”⁶⁵

The Phase 2 reforms will establish a stronger framework for training of foster carers, with particular emphasis on sexual abuse. As set out in the submission, *“this will enable a more strategic, needs-based and consistent approach to supporting and training carers, both in kinship and foster care arrangements”*.⁶⁶

As a precursor to the upcoming reforms, in 2014, CYS engaged Berry Street to conduct pilot carer training sessions for carers and agency staff on the impact of trauma on children and understanding behavioural responses. As noted in the submission, a high percentage of participants expressed a desire for the training to be made available to all carers, with more intensive follow-up training. This training has now been embedded in the OOHC system through the Phase 1 reforms as part of the service delivered by ACF for carers and agency staff.

64 *ibid.*, paragraph 103, p. 14.

65 *ibid.*, paragraph 99, p. 14.

66 *ibid.*, paragraph 110, p. 15.

Residential care

The funding agreement conditions of NGO foster care providers also apply to residential care providers, namely that they are required to ensure staff are appropriately qualified, skilled, credentialed and registered, and provided with adequate support.

Victoria

Legislation

The *Children, Youth and Families Act 2005* (Vic) and the *Child Wellbeing and Safety Act 2005* (Vic) provide the legislative framework for the care and protection of children in OOHC. In 2014, Parliament passed the *Children, Youth and Families Amendment (Permanent Care and Other Matters) Act 2014* (Vic). The amendments have sought to simplify Children's Court orders and remove barriers to establishing permanent placements, as well as increase penalties for offences relating to the protection and exploitation of children, and authorise carers to make decisions on specified issues about the children in their care.

Roles and responsibilities

The Department of Health and Human Services (DHHS) carries the statutory responsibility for OOHC in Victoria. The models of OOHC currently operating in Victoria include home-based care (kinship care, foster care and permanent care), residential care (community-based residential facilities for children and young people who are unable to be placed in home-based care and secure welfare services, which is a time-limited option for young people who are at substantial and immediate risk of significant harm), and lead tenant arrangements (a semi-independent environment in which those aged 16–18 live with one or two approved adult volunteer lead tenant/s who work collaboratively with paid program staff). Targeted care packages may also be available to provide wraparound supports tailored to a child's needs.

As at June 2014, 54.9 per cent of children and young people in OOHC in Victoria were in kinship care, 17.2 per cent in foster care, 22.1 per cent in other home-based care and 5.1 per cent in residential care.⁶⁷

Community Service Organisations (CSOs) are funded and subject to service agreements for provision of foster care, the majority of residential care services, therapeutic residential care services and 750 of the approximately 5,000 current kinship care placements.⁶⁸ DHHS directly case manages the majority of kinship placements, delivers secure welfare services and operates a therapeutic residential care home. A further type of care is permanent care, which involves granting permanent guardianship and custody of a child to a third party via a permanent care order. Unlike adoptions, permanent care orders do not change the legal status of the child, and they expire when the child turns 18 or marries.

⁶⁷ AIHW, op. cit., Table A33.

⁶⁸ Interview with DHHS staff for this project.

Key policy influences

Victoria's child protection system has been the focus of several major inquiries, reviews and reports including the:

- € Victorian Ombudsman's report into Victoria's child protection program⁶⁹ and out-of-home care system⁷⁰
- € report of the Protecting Victoria's Vulnerable Children Inquiry⁷¹
- € *Betrayal of Trust* report from the Parliamentary Inquiry into the Handling of Child Abuse by Religious and other Non-Government Organisations⁷²
- € Victorian Auditor-General's Residential Care Services for Children report.⁷³

Key protection initiatives arising from these reviews include:

- € the establishment of a Child Protection Operating Model for statutory child protection
- € implementation of child-safe standards and an independent oversight system similar to the reportable conduct scheme in NSW (in progress)
- € new criminal offences for adults who fail to respond appropriately to child sexual abuse, including grooming and mandatory reporting requirements for all adults aged over 18
- € improvements in residential care workforce capability
- € removal of the time limitations for civil claims involving criminal child abuse
- € development of partnerships and practices to respond to the sexual exploitation of children and young people in OOHC.⁷⁴

New *Child Safe Standards* apply to all organisations that work with children in Victoria. Compliance with the compulsory standards commenced on 1 January 2016 for OOHC agencies. Standard 4 requires that organisations have in place '*Screening, supervision, training and other human resources practices that reduce the risk of child abuse by new and existing personnel*'.⁷⁵ The standards will be embedded in legislation and will empower the Commission for Children and Young People to inquire into organisations' child safety systems.

69 Victorian Ombudsman (2009). *Own motion investigation into the Department of Human Services Child Protection Program*, Melbourne, November 2009.

70 Victorian Ombudsman (2010). *Own motion investigation into Child Protection – out of home care*, Melbourne, May 2010.

71 Cummins, P. (2012). *Report of the Protecting Victoria's Vulnerable Children Inquiry*, Department of Premier and Cabinet, Melbourne, January 2012.

72 Family and Community Development Committee (2013). *Betrayal of Trust. Inquiry into the Handling of Child Abuse by Religious and Other Non-Government Organisations*, Parliament House, Melbourne.

73 Victorian Auditor-General (2014). *Residential Care Services for Children*, Melbourne, March 2014.

74 Victorian Government (2015). *Victorian Government response to areas which will be examined in the public hearing, submission to the Royal Commission into Institutional Responses to Child Sexual Abuse*, Case Study 24, p. 8.

75 Department of Health and Human Services (2015). *An overview of the Victorian child safe standards*, Government of Victoria, <http://www.dhs.vic.gov.au/about-the-department/documents-and-resources/policies,-guidelines-and-legislation/child-safe-standards>.

Screening and assessment

Under the Act, an OOHC service must have regard to prescribed matters before approving a person as a foster carer or residential carer. Prescribed matters include the person's criminal history, suitability, fitness, medical (including psychiatric) health, skills, experience and qualifications.⁷⁶

Foster care

CSOs funded to deliver foster care services are responsible for recruiting, assessing, approving and training carers. They must conduct police record checks on all carers and adult household members (including adults who regularly stay overnight). International police checks must be conducted for applicants who have spent more than 12 months overseas in the past 10 years. Failing that, three additional referee checks from people who knew the applicant while in that country must be conducted. A Working with Children Check must be conducted for foster carer applicants and any adult household members who will have a parenting role.⁷⁷

CSOs use the mandatory *Step by Step Victoria* assessment tool or *Step by Step Aboriginal Assessment Tool* to assess applicants' suitability to become foster carers. The tools are designed to be used with the mandatory pre-service training, *Shared Stories, Shared Lives Victoria* and *Our Carers for Our Kids*. The carer assessment process involves interviews, in which the key competencies are assessed (including *provide a safe environment that is free of abuse*), home and environment check, discussion with the children of the household, and review by a foster care panel with representation from the CSO, DHHS and other relevant professionals.

Prior to the review by the foster care panel, the OOHC service provider must undertake a disqualified carer check and ensure the person has not been disqualified from providing care. Following review and approval by the foster care panel, the CSO must register the carer on the Register of Carers within 14 days. CSOs must formally review approved carers annually. Many CSOs have developed their own review tool based on core requirements and competencies in *Step by Step Victoria*. Annual reviews are structured and are conducted through visits to the carer's home. If there is a significant change to the carer's accreditation status, the reviews must be presented to and approved by the foster carer panel.

Carers providing therapeutic foster care (through the Circle Program) are assessed after completing the mandatory pre-service training, and again after Circle Program training. The Circle Program also has an accreditation panel.

Kinship care

Prior to kinship care placement, the carer must be assessed and approved by the Department. The assessment process has three stages, comprising a preliminary

⁷⁶ Victorian Government, op cit, p.14.

⁷⁷ *ibid.*, p. 14.

assessment conducted prior to the placement, a comprehensive assessment for placements likely to be longer than three weeks, and an annual review every 12 months. Preliminary assessments are often undertaken in the context of an emergency removal of a child and court proceedings, and include police checks, a check of DHHS's Client Relationship Information System and discussion with the carer about safety and their preparedness to work with the Department. Placement of a child in the care of, or in contact with, a person with a disclosable criminal record must be approved by a divisional Director (or other executive officer) prior to placement. Where the police check identifies a Category 1 offence, the placement cannot proceed unless the Director, Office of Professional Practice has endorsed the placement. Police record checks must be repeated every three years.⁷⁸ At present, kinship carers are not required to hold a Working with Children Check, but legislation to introduce this requirement was introduced into Parliament on 25 October 2016.⁷⁹ If the Working with Children Check amendments are passed, it is expected that the policy noted above will be updated.

DHHS acknowledges that a different level of rigour is applied to kinship carer assessment vis-à-vis foster carer assessment, and the reasons for this relate to the circumstances under which approval is sought and the Department's capacity to follow up on assessments.⁸⁰ As in other jurisdictions, Victorian legislation prioritises kinship care, and the court often leans toward kinship carers as long as the preliminary assessment has not revealed significant safety concerns. This is regardless of whether DHHS has reservations about a carer's ongoing capacity to meet a child's or young person's long-term needs.⁸¹

Lead tenants

CSOs are responsible for recruiting and assessing lead tenants and the staff who work to support the program. This includes a Working with Children Check, a police check and direct contact with three personal referees and any previous organisations in which the applicant has had a lead tenant role. As with foster carer assessments, where applicants (and partners) have spent 12 months or more overseas during the past 10 years, an international police check must be conducted, or overseas referee checks conducted.

Residential care

CSOs funded to provide residential care services are responsible for probity checks for residential care employees (the exception being Hurstbridge Farm and secure welfare services, where responsibility remains with DHHS). Historically, the Certificate IV in *Child, Youth and Family Intervention (Residential and out of home care)* has been the preferred qualification, although not mandated. In May 2016, the Victorian Government announced the allocation of \$8 million to immediately upskill residential care workers to support the introduction of a minimum qualification by the end of 2017. Training in the Certificate IV

78 Victorian Government, op. cit., p. 16.

79 t. Working With Children Amendment Bill 2016.

80 ibid.

81 Victorian Government, op. cit., paragraph 10.

has already commenced. Around 62 per cent of staff members have a relevant qualification, but this is expected to increase with the introduction of a minimum qualification requirement.

All residential carers must undergo a disqualified carer check before employment and be registered on the Department's Register of Carers within 14 days of the disqualified carer check having been undertaken. CSOs also must ensure that staff employed through a labour hire agency undergo police and Working with Children Checks, and ensure they comply with the department's policy *Labour Hire Service Procedures: Engaging Labour Hire Agency Residential Care Staff in Out of Home Care Services*.⁸² These procedures specify roles and responsibilities when recruiting, selecting and engaging contract workers.

Training and support

A departmental and sector governance group has been working on a carer training strategy that will seek to better engage and manage foster and kinship carers in training. Issues that will be addressed in the strategy include: building the capacity of carers in understanding their roles and responsibilities, behaviour management approaches to children and young people, understanding family context, understanding trauma, and understanding the key relationships and court processes.⁸³

Foster care

Foster carers and other adults with a caring role in the household must complete the mandatory pre-service training, *Shared Stories, Shared Lives Victoria* or *Our Carers for Our Kids* (for Aboriginal people applying to become foster carers). The training comprises eight modules, including an 'Experience of abuse' module offering guidance on recognising the signs of child sexual abuse, responding to disclosures about child sexual abuse and preparing a carer's own child for what to do in the event that their foster-sibling discloses abuse.

DHHS assists foster carers to access state-funded specialist carer training programs, as required. Foster carers approved to provide therapeutic foster care (via the Circle Program) are required to undertake both generalist and specialist mandatory pre-service trauma-informed training.

Permanent care

In the 2016–17 budget, the Victorian Government announced the establishment of a support hotline for permanent carers. This was the first time such a service had been substantially funded.⁸⁴

⁸² Department of Health and Human Services (2015). *Labour Hire Service Procedures: Engaging Labour Hire Agency Residential Care Staff in Out of Home Care Services*, Victorian Government, Melbourne, May 2015.

⁸³ Interview with DHHS staff for this project.

⁸⁴ *ibid.*, paragraph 17.

Kinship care

Kinship carer training is not mandatory, but kinship carers are able to access training on a voluntary basis. The Victorian Government funds the Australian Childhood Trauma Group, and Anglicare Victoria to deliver information and support sessions to kinship carers. The primary aim is to provide information, establish networks and improve the understanding of the children in their care, including those affected by trauma. This training does not specifically address child sexual abuse, but assists carers to understand and manage complex behaviours and issues using a trauma-informed approach.⁸⁵

Typically, kinship carers who are case-managed by CSOs (about 15 per cent of placements) are able to access all the training and support opportunities that CSO managed foster carers can access.⁸⁶

The relative benefits and disadvantages of CSO versus Departmental case management is expected to be addressed in a soon-to-be completed review commissioned by DHHS on kinship care in Victoria. The report looked at aspects of the kinship care service model, including the delivery of case management by contracted CSOs. The report could not be obtained at the time of writing, but DHHS reported that it was developing responses to address many of the key issues raised.⁸⁷ DHHS stated that the capacity of Child Protection staff to support kinship carers can be compromised by a number of factors that distinguish them from CSOs – for example, the focus being on the child rather than the carer, larger caseloads, and the need to prioritise children in need of protection living at home.⁸⁸

The Victorian *Kinship Carer's Handbook* provides information to on a range of topics including cultural connection, legal and financial matters, child health and wellbeing, education and child protection, and looking after themselves.

Training for all kinship carers (including those case contracted and those case-managed by Child Protection) will soon be incorporated into the foster and kinship carer training framework.⁸⁹ Recent legislative changes reinforcing the legislative preference for kinship arrangements for those children who cannot live safely are expected to contribute to a continued increase in kinship care placements, and a focus on increased training and support for kinship carers.

Residential care

Residential care workers currently do not require a minimum qualification. However, this will be a requirement by the end of 2017. CSOs funded to provide residential care services are responsible for ensuring direct care workers have appropriate training, undergo an

⁸⁵ Victorian Government (2015). op. cit., p. 20.

⁸⁶ Interviews with various CSOs for this project.

⁸⁷ Interviews with DHHS staff for this project.

⁸⁸ *ibid.*

⁸⁹ *ibid.*

induction process and complete mandatory training. The recent introduction of random auditing by DHHS includes a review of staff qualifications and training.⁹⁰

Therapeutic residential care workers must undergo mandatory training in trauma therapeutic practice. Known as *With Care*, it is provided under the *Residential Care Learning and Development Strategy* funded by DHHS.

Western Australia

Legislation

The *Children and Community Services Act 2004* (WA) (the Act) provides the legislative basis for OOHC in Western Australia. The *Children and Community Services Legislation Amendment and Repeal Act 2015* (WA) implemented a number of recommendations of a legislative review of the original Act as of 1 January 2016.

Roles and responsibilities

In Western Australia, OOHC is managed by the Department for Child Protection and Family Support (DCPFS) and encompasses foster care (including relative or kinship care) and residential care. Approximately half (51 per cent) of OOHC placements in Western Australia are relative (kinship) care.⁹¹ General foster care accounts for 36 per cent of OOHC placements, the majority of these provided by DCPFS and only one-quarter provided by community service sector (CSS) organisations.⁹² The Department manages 22 residential homes, while the community sector largely runs a network of family group homes. These homes cater for young people with moderate to high behavioural and emotional needs, acting as a stepping stone to a foster placement, a permanent OOHC placement or reunification with their family. Family group homes have a live-in specialist carer and additional specialist support. Children may also be placed in specialised foster placements, disability placements and transitional high-needs placements.

Responsibility for OOHC case management remains with the Department, with the exception of a small pilot of contracted case management. There are no plans at present to extend contracted case management further to CSS organisations.⁹³

90 *ibid.*

91 Western Australian Government (2015). *Submission to the Royal Commission into Institutional Responses to Child Sexual Abuse – Case Study 24*, paragraph 22(a).

92 *ibid.*, paragraph 22(b).

93 Interview with DCP staff for this project.

Key policy influences

The 2007 Ford Review⁹⁴ made a number of recommendations in relation to increasing the range, resourcing and quality of the Western Australian OOHC system. The Ford Report has guided the development and organisation of OOHC in the state ever since.

DCPFS is proposing a suite of reforms to the OOHC system over the next five years, which are detailed in the policy document *Building a Better Future*.⁹⁵ The key areas for future reform include:

- € introducing a new care model
- € developing an OOHC system that promotes stability and certainty for children in line with the government's permanency planning policy
- € growing the community service sector
- € measuring key aspects of children's development, and strengthening the Rapid Response Framework, to promote a whole-of-government focus and accountability for achieving outcomes.

Screening and assessment

Prior to commencing work or caring for a child, all Department and CSS care workers and carers, and the spouses or de facto partners of foster carers, are required to undergo a criminal record check, a Working with Children Check and a DCP record screening check. In an emergency, a child may be placed with a relative or significant other foster carer who has not yet had a Working with Children Check, but a check must be applied for within five days, or the child must be removed. DCP also reviews any previous records of any contact between the carer and the Department on Assist (electronic records system) and conducts a home visit.

Foster care (including kinship care)

In Western Australia, 'foster care' includes care by both relative (kinship) and general (non-kinship) carers, and the screening and assessment procedure is the same. All foster care applicants are required to complete a mandatory 19-hour pre-approval training program. Applicants are assessed against five competencies, outlined in the Regulations. They must be able to demonstrate that they:

- € can provide care for a child in a way that promotes the wellbeing of the child, promotes the child's family and interpersonal relationships, and protects the child from harm
- € can provide a safe living environment for a child

94 Ford, P. (2007). Review Report – Review of the Department for Community Development, Government of Western Australia. http://www.merredin.com/merredin/d/Residents/Your_Community/Government_Portal/Department_for_Child_Protection/Downloads/FXQZZ639L6QKMTE12KI2P3UA9UC4CZ/0A2UICTV6IL2OM3.pdf/DCDRPTFordReview2007.pdf

95 Department for Child Protection and Family Support (2016). *Building a Better Future: Out-of-home care reform in Western Australia*, Government of Western Australia, April 2016.

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- € can work cooperatively with officers, a child’s family and other people when providing care for a child
 - € can take responsibility for the development of his or her competency and skills as a carer
 - € is a person of good character and repute.⁹⁶

Foster carer assessment is outsourced to independent assessors who provide a report and recommendation to an assessment panel. The assessment process includes interviews and home visits to assess the applicant’s capacity to work as part of a team; respond to a child’s emotional, educational, psychological and physical needs; provide a safe home, free of abuse; and take responsibility to learn and develop as a carer.⁹⁷ Currently, each CSS organisation convenes a panel to review assessments, approve new foster carers and review existing carers. These panels include representatives from the CSS organisation, DCP district office and other relevant organisations. Under the OOHC reforms, DCP plans to move to a centralised foster care approval panel. DCP has proposed the centralised panel as a way of addressing concerns about inconsistency and variable standards across the districts.⁹⁸ The reform is a source of significant disagreement with the community service sector⁹⁹, which is concerned it will cause unnecessarily long delays and poorer outcomes due to a lack of local knowledge and nuance in the process.

Residential care

Residential care staff need to meet the criteria in their job description. A Certificate III and/or Certificate IV in Community Services (Protective/Residential Care) or approved equivalent, or equivalent experience in working with or caring for children who have experienced trauma, is essential. New direct care workers are often first placed in a casual pool, from which permanent positions are filled. The Department feels this process has resulted in better-quality recruits and higher rates of retention.¹⁰⁰ New residential and secure care employees undertake orientation or ‘shadow’ shifts with more experienced employees before they work with children on their own in a care facility.¹⁰¹

Training and support

DCP provides the mandatory pre-service training for foster care applicants. In addition, CSS organisations may require carers to undertake additional training, such as *Sanctuary* or other trauma-informed care training. A number of CSS organisations require their carers to undertake a minimum number of training courses each year.¹⁰²

96 Western Australian Government, op. cit., paragraph 54.

97 Department for Child Protection and Family Support (2016). Steps to becoming a foster carer (web page). <https://www.dcp.wa.gov.au/FosteringandAdoption/InterestedInFosterCaring/Pages/Stepstobecomingafostercarer.aspx>

98 Interview with DCP staff for this project.

99 Based on various discussions with NGOs and peak agencies in Western Australia.

100 Western Australian Government, op. cit., paragraph 63.

101 *ibid.*, paragraph 64.

102 Interviews with various CSS organisations in Western Australia for this project.

DCP has developed learning pathways (beyond the mandatory training) for all Department and CSS carers and residential employees. Programs include *Therapeutic Crisis Intervention*, *Responding to Concerning Sexual Behaviours in OOHHC*, *Protective Behaviours*, and *Attachment and the Impact of Trauma*. The learning pathways include workshops, eLearning and face-to-face programs.

Western Australian carers live across a vast geographic area and come from culturally and linguistically diverse backgrounds. This has given rise to self-directed and electronically delivered programs. The Department's Learning and Development Centre (LDC) created the LDC Mobile App¹⁰³, which allows remote access to the Department's training calendar and online courses. The LDC provides some face-to-face programs via video conference to allow easier access to learning and development for carers and employees, particularly those who reside in regional or remote areas.

As an alternative to face-to-face modules in district offices, foster and relative carers can also participate in modules delivered via video conference. A distance education package can be delivered as a complete self-paced course, in a one-on-one format during the assessment period or as a means for carers to review its content.

Residential and secure care facilities use the *Residential Care (Sanctuary) Framework* to support and work therapeutically with children in care. In 2014, the Department was certified by the international Sanctuary Institute.

103 See <https://cpfs.moodle.com.au/course/info.php?id=727>.

4. SCREENING, ASSESSMENT, TRAINING AND SUPPORT FOR FOSTER CARERS

Foster carer screening and assessment

Screening and probity checks

All jurisdictions require screening of foster carers before they are further considered for authorisation as carers. Typically, this involves:

- € an identity check
- € a Working With Children Check, Working With Vulnerable People Check or similar
- € a National Police Check
- € a health check
- € a referee check.

The variations in requirements from jurisdiction to jurisdiction are generally subtle – for example, in terms of the validity period of a WWCC.

In some jurisdictions, most notably NSW, WA, Victoria and SA, the above probity checks are augmented by a Community Services Check and reference to a Carer's Register. A Community Services Check entails the interrogation of information held by government agencies in relation to, for example, allegations or reports of child abuse and neglect, or domestic violence. The Carer's Register, most notably the one that operates in NSW, allows agencies to establish any history relevant to a prospective carer's abilities to foster a child and, in particular, whether a prospective carer has previously been de-registered by another agency. In NSW, agencies are required by law to exchange information if a carer is already on the Carer's Register.

In performing probity checks, the jurisdictions deal differently with information about prior, unsubstantiated claims against a person applying to be a foster carer. In some jurisdictions, the legislation does not permit enquiries into unsubstantiated claims. In Western Australia, the Form 395 Record Check permits the Department for Child Protection to consider allegations made against an applicant in previous employment or contacts with the Department if there are reasonable grounds to consider the applicant a threat to a child's wellbeing.

In those jurisdictions that do not have a mandated or effective means of performing a community services check, some concern was expressed by informants about the adequacy of the WWCC and National Police Check. In particular, they noted that someone who had been the subject of a domestic violence order would not be flagged in the National Police Check unless they had breached the order.

Assessment of potential foster carers

There is more variability across jurisdictions and between different OOHC providers in terms of the process for assessing the suitability of potential foster carers. The following policies were observed:

- € mandatory use of a particular assessment tool
- € an assessment tool (for example, *Step by Step*) being stipulated as a minimum, with agencies given flexibility to use other assessment tools
- € no stipulation of how assessments are to be performed other than that potential carers are to be ‘properly assessed’.

Step by Step is probably the most widely used carer assessment tool. The tool was redeveloped (and revised in 2015) by the Association of Childhood Welfare Agencies in collaboration with a number of NGO OOHC providers. *Step by Step* is designed to be used by assessors trained in its use and allows an exploration of a potential foster carer’s capacity to provide trauma-informed care for a particular child. The tool allows for ‘entry point’ assessment as well as the assessment of carer suitability to provide permanent or restorative care. See http://www.acwa.asn.au/ccwt/specialist-programs/step-step-2016_for_more_information.

The *Step by Step* assessment tool is generally used in conjunction with the carer pre-service training program *Shared Stories, Shared Lives*, which features 18 hours of material covering the following topics:

- € Foster care in context
- € Bonding and attachment
- € Grief and loss
- € Abuse and trauma (including sexual abuse)
- € Identity and birth family contact
- € Responding to challenging behaviour
- € Team work
- € Maintaining cultural connection.

ACWA offers training to OOHC providers on the use of *Step by Step* and delivery of *Shared Stories, Shared Lives*.

Step by Step and *Shared Stories Shared Lives* are most widely used in NSW, Victoria, Tasmania and South Australia. Western Australia, Queensland, the ACT and the Northern Territory have adopted other assessment and pre-service training tools as their standard (as detailed in section 3 of this report).

In jurisdictions where it is permitted, some NGOs have opted to use their own carer assessment tools that they believe are ‘sharper’ and allow a better assessment of the

suitability of carers. In particular, some NGOs have developed assessment tools and processes that involve, for example:

- € psychometric assessments
- € a deeper analysis of social and family history
- € the use of scenarios (for example, problematic sexual behaviour of a young person) to test responses
- € including a young person with experience of being in OOHC on the interview panel (having first received training on interview technique).

One NGO representative reported that their assessment process ensured that all children of the prospective carer (whether living with them or not) were spoken to as referees. This was said to be an important and instructive thing to do. The representative said: *“We’ve had women who report having been victims and not endorsing their parents’ application.”*

Although *Step by Step* has its advocates across the sector, making use of alternate assessment tools was thought, by some, to provide a better assessment:

“What we’re getting is depth about carers, and really getting them to think about their experiences and what they have to bring to children. There are carers who are not being approved, which I think is a really good sign that we’re doing it in a way that is weeding out people who should actually not be caring for children.” (NGO)

A particular concern was voiced about the application of *Step by Step* or any other assessment tool in that the tool was only as good as the people who use it. There was particular concern that the training in the use of *Step by Step* and *Shared Stories, Shared Lives* was not accredited (that is, not Nationally Recognised Training) and was not subject to restrictions on who could deliver it. Informants suggested, in particular, that delivery of *Shared Stories, Shared Lives* to prospective carers was at times substandard and generally lacked consistency in delivery. The manifestation of this problem was reportedly seen in *Step by Step* assessments that were thought to be too superficial. One interviewee said: *“When I read the assessments [that had been done previously], I wasn’t left feeling that I knew anything about these carers.”* In contrast, it was noted that in the ACT, successful completion of the accredited *Positive Futures Caring Together* pre-service training results in a statement of attainment for four units of competency from the Certificate IV in Child, Youth and Family Intervention.

Some NGO representatives reported carer assessment processes that clearly went above and beyond any minimum requirements. One agency, for example, reported that its foster carer assessment process involved 5–7 face-to-face interviews over a two- or three-month period. Another reported that up to 36 hours of face-to-face time was required before approving a carer. Clearly this is labour-intensive. However, it was noted that as well as using the process to identify any risks of abuse, intensive assessment underpinned an effort

to strive for stability in the placement and ensuring high-quality care for the child. In turn, this minimised the costly and disruptive task of trouble-shooting or finding a new placement for the child if the placement breaks down. When asked about the sustainability of such a rigorous assessment process, the following comments were made:

“It is labour-intensive. When we’ve tried to cut back on the assessment process, we’ve seen poorer outcomes.” (NGO)

“You have to evidence everything from multiple sources. It’s confronting for people to lay themselves bare in this way but we support people through it. We unfortunately have to be suspicious of everybody.” (NGO)

“We refuse to fast track it. It’s not worth it for the children or our organisation.” (NGO)

“We’re a risk-averse organisation. We only take calculated risks in the interests of diversity. We don’t make assumptions – for example, about single males.” (NGO)

Some NGOs reported building a dedicated assessment team that had developed strong skills and expertise. Developing good interviewing techniques was a particular focus. Other NGOs reported that their case managers perform assessments to establish a good working relationship with the carer from the outset. In short, it was clear from the interviews that the assessment process was seen as a crucial component of ensuring safe, therapeutic and sustainable care for a child in need.

Both government and NGO providers of foster care placement services reported that carer recruitment, screening and/or assessment was at times subcontracted to specialist commercial agencies. In some instances, government agencies contract the entire function to external providers. Some concern was expressed about the risk inherent in this practice. In particular, one informant perceived that government sought out the lowest cost provider without sufficient regard for quality or rigour. Some NGOs also reported that at times they subcontracted carer assessments in response to workflow issues. This was reportedly done with some reluctance even though the capacity and practices of external providers were thought to be very good. It was further noted that ultimately, the quality control over, and responsibility for, the assessments rested with the NGO provider.

Foster carer training and support

Ongoing training for foster carers

Beyond specifying the use of an appropriate pre-authorisation training module, many jurisdictions do not specify an ongoing training curriculum for foster carers. Reference is made to ‘providing appropriate training’ in service agreements and the like, but there are

mixed practices in terms of the level of oversight of whether, and what, training is provided to foster carers.

Ongoing training is provided to foster carers via:

- € government-funded foster carer networks and peak bodies (for example, Connecting Carers in NSW, and The Foster and Kinship Carers Association of Tasmania)
- € government, internal training units
- € professional training organisations (such as ACF, Bravehearts and ACWA/CCWT), procured by individual agencies or by government for statewide delivery
- € training modules developed by larger NGOs
- € workshops delivered by clinical or sector specialists
- € abridged or modified versions of professional (for example, case manager) training, delivered to carers by case managers
- € papers, journal articles and other printed resources.

Government and non-government agencies have different requirements for the degree to which foster carers participate in ongoing training or learning activities. For example, some NGOs reported that participation in a certain modicum of training was written into carer agreements and this was assessed during annual carer reviews. Other agencies reported ‘strong encouragement’ for their carers to participate in ongoing training and learning activities, but no hard requirement. Other agencies seemed to offer ongoing training in a more passive way to interested carers. Naturally, some agencies are more vigilant than others in ensuring that carers participate in beneficial learning activities. However, it was clear from the interviews that there has been a recent emphasis on encouraging carers to participate in specialist training that would be of benefit to the child in their care. Some jurisdictions are clearly thinking about approaching foster carer training in a more strategic way. As one informant said:

“To date there hasn’t been an expectation to participate in any ongoing training necessarily. Over the last couple of years that’s been getting a bit better. What we’re looking at now is that there’s an absolute expectation that carers will participate in regular ongoing training.” (Government agency)

Agencies reported that a wide variety of training products were accessed by, or provided to, carers. These products covered range of subjects designed to prevent sexual abuse, provide therapeutic care for children who had suffered sexual abuse and generally improve the quality of care. The following topics, among others, were covered in training that was delivered or offered to foster carers:

- € Providing child safe environments

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- € Appropriate physical and emotional boundaries for the child/carer relationship
 - € Identifying risks of sexual abuse
 - € Responding to suspicions or allegations of sexual abuse
 - € Understanding sexual behaviour in children and young people
 - € Managing problematic sexual behaviour
 - € Managing disclosures of sexual abuse
 - € Caring for children who have suffered sexual abuse and other forms of trauma
 - € Cybersafety
 - € Teaching protective behaviours.

NGOs and government providers generally agreed that there was a sufficient amount of quality training and learning products for foster carers to assist with the prevention of, and response to, child sexual abuse.

In Tasmania, the ACF has been contracted by the state government to provide six training sessions on child trauma to *all* foster carers, including sexual abuse. In other jurisdictions, agencies generally work to identify the training needs of particular carers or training that will assist in addressing a particular issue or type of trauma that a child has experienced. It was reported that one of the roles of a case manager was to identify training opportunities that would benefit the carer, the child or both, and to encourage participation in that training.

Supporting foster carers

Of course, offering training is a small part of the support foster carers require. Informants stressed that offering a therapeutic care environment to a (likely) traumatised child requires much more than training for the carer. A high level of contact between the case manager and the carer is crucial to:

- € allow the placement and family dynamics to be monitored through observation and discussion with carer and child
- € identify and access external services or interventions that meet the needs of the child
- € build trust, transparency and open communication
- € build child safety or behaviour management plans
- € assist in instances of disclosure of sexual abuse or reportable conduct – for example, sexual abuse suffered at the hands of another child.

Informants noted the efforts to create ‘partnerships in care’ between the carer, placement agency and government were crucial in developing a more supportive system and, by extension, better preventing and responding to child sexual abuse. It was further noted that the needs of children entering foster care were becoming more complex (or at least better understood) and that the traditional model of placing children with ‘caring

volunteers' was becoming increasingly inadequate. Following are some quotes to illustrate these points:

"It's not just about attending a training session once a month. There needs to be many, many layers of what we put in place." (NGO)

"By building a partnership ... you then sort of pull everything together into a circle, and the chances of something happening to a child are much lessened. The opportunity for a child to speak to various different adults is heightened, and so we begin to have then a system that is robust, and one where hopefully things that shouldn't be happening aren't, or are picked up immediately." (Government agency)

"Our models of care haven't changed, but who they're fostering has moved up the chain. They're now fostering kids with really complex issues. We're not skilling those people up to the extent we need to." (NGO)

"The demands and needs of the service system have moved beyond the voluntary service model." (NGO)

"I think one of the challenges that we've been addressing is the relationship between the Department and carers, and the stronger that relationship is, the more likely the carers are to attend training ... That's been a challenge over the last 10 years, and one that's just beginning to shift now ... carers are seen as part of the team as opposed to just someone who lives on a farm and looks after children." (Government agency)

A number of NGO representatives reported that many of the placements that had been transitioned to them from government providers had been grossly under-supported. In fact, one NGO representative reported that they had encountered some carers who had not been visited by a case manager in over five years. While it was acknowledged that case management practices had generally improved and caseloads reduced, some informants thought that government case managers were still not always overseeing and supporting placements to the degree they ought to.

Barriers and enablers

Informants reported that there was sometimes reluctance on the part of carers to act as a 'partner in care', to participate in training and to take up the support offered by a case manager. This was often the case for placements that had been transitioned from government to the NGO sector or from one NGO to another. Where the carer was not accustomed to having such a high level of contact with a case manager, there was often some resistance from the carer, initially at least, to work 'in partnership' with the agency. While this was considered a barrier, NGOs reported that they *insisted* on this high level of contact. Ongoing carer reluctance was interpreted as a risk factor, with further action taken as required, including re-placing the child in some instances.

However, NGOs generally reported that carers would eventually ‘come around’ to the more supportive model of placement support and the higher expectations placed on them. One NGO representative said, *“We monitor training attendance. It’s part of their carer agreement or contract. Rather than baulking at it, people have embraced it.”*

Informants commonly reported that carers often found it difficult to attend training because of:

- £ work or family commitments
- £ geographic isolation or lack of transport
- £ nervousness about attending training with others, particularly if the training topic relates to child sexual abuse.

Providers reported using a number of strategies to overcome these barriers, including:

- £ offering a mix of group and one-on-one learning opportunities
- £ facilitating training sessions in a range of locations and at community venues
- £ providing training sessions at various times during the week
- £ providing access to online, self-paced learning tools such as the ACF SMART (Strategies for Managing Abuse Related Trauma) Program and WA’s Learning Development Centre Mobile App, noting that suitable online learning products were limited in number and scope
- £ facilitating attendance by video- or tele-conference (for example, via Skype)
- £ providing childcare for carers, a crèche or children’s activities
- £ providing modest incentives, rewards or recognition for attending training.

Both NGOs and government agencies noted the financial barrier to providing training for their foster carers. While some training products and learning resources were free, tailored training products often had to be purchased to meet particular needs. Smaller NGOs, and smaller states and territories, made particular note of the financial barrier:

“I mean, we’re a small jurisdiction. We don’t have a lot of carers, we don’t have a lot of workers, so we try and maximise what we can put in place for both our carers and our staff.” (Government agency)

“There’s a financial component. I mean we’re a very small jurisdiction, and we can’t always – we rarely can do things with full bells and whistles, but we certainly try.” (Government agency)

“We are funded to provide training but we simply can’t afford to do everything that we would like for our carers.” (NGO)

Some smaller NGOs noted that there was usually an effort to combine resources with other providers to procure training at a lower per-head cost.

5. SCREENING, ASSESSMENT, TRAINING AND SUPPORT FOR KINSHIP CARERS

Kinship care is the fastest growing form of OOHC in Australia. Nationally, kinship care accounts for 47 per cent of OOHC placements.¹⁰⁴ In some jurisdictions, up to 55 per cent of children in statutory care live with relatives.¹⁰⁵ A steady decline in the availability of foster carers, and an increase in the number of children requiring placement¹⁰⁶ have, in part, led to kinship care being the predominant model. More importantly though, there is recognition in policy and placement principles of the advantages of kinship care over other forms of care. Kinship care has the advantages of preserving family, reducing separation trauma, maintaining a sense of belonging and being loved, maintaining a sense of security and stability and preserving cultural identity¹⁰⁷. The sense of security that a placement with kin can provide for a child has been linked to improved long term outcomes for the child¹⁰⁸.

Becoming a foster carer is a planned event, and the process of assessment occurs and is completed in readiness for the future placement of an unknown child with the carer. In comparison, kinship carers typically take on the role of caring for a grandchild, niece/nephew, cousin etc in the context of an emergency. It is an event they may not have foreseen and which they are not able to prepare for in advance. Approaches to carers are made on the same date the placement commences. Placements are likely to initially be viewed as short-term in nature. The very nature of a placement of this type means that the pre-assessment process applied to foster carers cannot be applied and some form of provisional assessment is required ahead of a more comprehensive assessment being completed.

Despite its growing importance, the kinship care sector has historically been characterised by a lack of attention around screening and assessment, and the training, support and monitoring needs of this diverse group of carers. Policies and practices around kinship care have largely been borrowed from the foster care sector, but have been insufficiently sensitive to the distinct contextual differences of kinship carers. Kinship carers – many of them ageing grandparents – are often disadvantaged due to poverty or financial hardship, declining health and low levels of education and employment. These circumstances are frequently coupled with a lack of preparation, skills, support and knowledge about the

104 Australian Institute of Health and Welfare (2015). *Child Protection Australia 2014–15*. Child Welfare Series, No. 63, Table A33 (figures rounded).

105 *ibid.*,

106 Bromfield, L. & Osborn, A. (2007). Kinship care NCPC Brief No. 10, Australian Institute of Family Studies, October 2007.

107 Boetto, H. (2010). 'Kinship care: A review of issues', *Family Matters*, 85, 60–67.

108 Cashmore, J. & Paxman, M. (2006). Predicting after-care outcomes: the importance of felt security. *Child and Family Social Work*, Volume 11, Issue 3, 232-241.

services and supports available, for providing care to children and young people who themselves often have complex problems.^{109,110}

The research undertaken for this study found that, while greater attention is starting to be paid to the processes to support kinship carers in some jurisdictions, the sector remains what has been described as ‘the Cinderella of the care system’.¹¹¹

Kinship carer screening and assessment

Different policies and practices: kinship carers versus foster carers

Jurisdictions commonly reported that they do not distinguish between foster carers and kinship carers in terms of screening and assessment. However, informants reported that in practice, jurisdictions typically had some form of provisional assessment to enable short-term emergency placement with relatives.

In all jurisdictions, police and record checks are undertaken, criminal histories reviewed and child protection records checked at the time of a kinship care placement. All jurisdictions except Victoria¹¹² and Tasmania require a Working with Children Check for prospective kinship carers and any other adults in the household. In most jurisdictions, a home environment assessment and interview with potential kinship carers take place. It is at this point that the processes for screening and assessment for kinship carers and foster carers commonly diverge.

Whereas a child will usually not be placed with a foster carer until a comprehensive assessment (including pre-service training) is complete, kinship carers are often granted care of a child after the minimum probity and safety checks are done. While child protection agencies have a policy of following up emergency kinship assessments with further checks and a comprehensive assessment, informants reported that often these processes are not completed in a timely way, or at all. It was reported that this situation arose due to the:

- € the high workloads of child protection agency staff members
- € the placement not being assigned a case manager
- € the priority given to finding placements for other children in need
- € the difficulties of undertaking assessments in rural and remote areas.

109 Broomfield & Osborn (2007). op. cit.

110 Boetto, H. (2010). op. cit.

111 Department of Social Work Child, Youth and Families Research Cluster University of Melbourne (2014). Kinship Care: The Cinderella of the Care System?, Submission to the Parliament of Australia Senate Standing Committees on Community Affairs: Out of Home Care, University of Melbourne.

112 Plans are being made by Victoria to introduce the Working with Children Check for kinship carers.

The following quotes illustrate these issues:

“Each of the [kinship carer] assessment processes are quite robust, but where there are weaknesses is around the capacity of child protection workers to come back to Part B [that is, the full assessment] because of other competing demands and caseloads. Once we’ve removed a child and placed them in care and assured their safety, child protection staff will frequently be required to move on to the next child who might need to be removed from home and placed in care, and so their ability to go back and complete the Part B quite often becomes strained. We’ve got room for improvement there, and it’s primarily a result of a capacity and resourcing issue amongst the Child Protection program to do that work.” (Government agency)

“... there are significant issues in placing children in kinship care in emergencies, when the placement, by default and without adequate assessment, becomes long term. Once the child is placed, it can become difficult to move the child if the placement proves to be inappropriate, and in spite of the inadequate initial assessment.” (Peak OOHC agency¹¹³)

Risks associated with less rigorous assessment of kinship carers

Child protection agency representatives pointed out that it is not always possible to identify all risks when screening and assessments are made in an emergency context and a protection order is being sought from the court. This is in relation to both the primary kinship carer/s as well as other family members and other people who might stay at or visit the household. Often, the real circumstances of a family’s situation become apparent over time, and what was deemed a safe placement at first might later be reconsidered by child protection or NGO caseworkers as unsafe or inappropriate for the child’s needs:

“Our registration schemes are not intended to regulate family relationships. It’s not to say it’s been difficult, it’s just been one with a bit of added complexity.” (Government agency)

“It’s a very cursory tick-a-box assessment. Usually the arrangements for kinship care are more complex than in foster care placements. It’s often grandparents and highly complex family dynamics.” (Peak OOHC agency)

“Even though [the child protection agency] may identify some reservations at that point about the carer’s capacity, the court will generally lean to, and is required through legislation to lean to, a kinship carer if there’s one available and they’re not considered a safety concern. So there’s a slightly different threshold because of the pre-existing relationship – and the way in which children enter the system and are placed in

113 Centre for Excellence in Child and Family Welfare (2016). The response of the Centre for Excellence in Child and Family Welfare to the Royal Commission into Institutional Responses to Child Sexual Abuse Consultation Paper – Institutional Responses to Child Sexual Abuse in Out of Home Care, April 2016, p. 19.

out of home care is very different and requires very different procedures and processes.”
(Government agency)

Concerns were raised by some informants that the less rigorous screening and assessment provisions required for emergency care are sometimes used by child protection agencies to expedite kinship care placements that are not necessarily urgent. More worryingly, it was reported that the designation of a placement as an ‘emergency’ placement could be, and in some jurisdictions were, extended in lieu of going through the rigours of a full carer assessment:

“So it just evaporates and the child is left in a potentially unsafe environment. This is a really important point, actually, as the legislation is not clear, so the way you read the legislation is there’s nothing that prevents the Department from doing that.”
(Government agency)

Remoteness adds another layer of complexity to the effectiveness of screening and assessment processes for kinship carers. Some informants said that a different level of rigour is often applied to screening and assessment for remote area placements compared with city/town placements:

“We’re sort of nit-picking on pool gates in town, while carers in the more remote areas haven’t got food in the fridge.” (Government agency)

Monitoring shifting household membership is another issue that becomes more challenging in remote communities. It may mean that after the initial assessment, no further assessments are undertaken even though new, unscreened adults may have joined the household.

On the other hand, the requirement for all adults in a household to have Working with Children and police checks is a major cause of system delays, particularly so in remote Aboriginal communities where overcrowding can be common. Relatively high rates of contact with the criminal justice system also make it more likely that one or more members of the household will have a criminal record, requiring higher-level assessment by the child protection agency, and further delays.

Informants flagged a need for specialist training for child protection staff to carry out kinship care assessments, particularly where they are geographically or culturally distant from the community where the placement is located. One NGO that specialises in Aboriginal OOHC placement support in a regional area noted the importance of having an understanding of the community, the relationships between members of the kinship carer’s family and social networks, and the local social issues that may present risks to the child. It was further noted that ‘having an ear to the ground’ and being in a position of trust within the community helped greatly in monitoring and supporting placements. This

example can be viewed as good practice but also highlights the deficiencies in common practice.

Aboriginal and Torres Strait Islander kinship care

If there is a prevailing view among policy-makers that family members intrinsically have the knowledge and capacity to care for their own, this is especially so in relation to Aboriginal and Torres Strait Islander kinship carers. In all jurisdictions, there are Aboriginal Placement Principles, or similarly named principles, to ensure that young Aboriginal and Torres Strait Islander people entering OOHC can maintain their familial and cultural connections. Some concerns were raised by a number of peak organisations in relation to the rigid application of Aboriginal Child Placement Principles. In particular, some informants thought that there was sometimes a reliance on these Principles to alone guarantee the wellbeing of children and young people. They thought there was potential for placement decisions to be made under the Principles without reliance on further assessment of the carer, which could place children and young people at risk of sexual abuse. Furthermore, some informants claimed that the Aboriginal Placement Principles, as important as they are, allowed governments to relinquish the responsibility of ensuring that the placement was supported. In other words, it was the view of some informants that the Aboriginal Placement Principles were, at times, inappropriately applied by practitioners.

Informants noted that Aboriginal kinship carers often experience a high level of stress due to multiple levels of disadvantage, including financial stress. They also noted that there is often a reluctance on the part of Aboriginal kinship carers to talk about sex and sexual abuse.¹¹⁴ Informants believed this stemmed in part from Aboriginal people's inter-generational experience of abuse and trauma.¹¹⁵ It was noted that these factors present further barriers to properly supporting carers but that these issues need to be worked through rather than simply accepted:

“It’s about finding ways of opening up that dialogue, of starting the conversations with carers.” (Aboriginal NGO provider)

In summary, informants acknowledged that Aboriginal Placement Principles were very important, but alone they provided no guarantee of a child's wellbeing and safety. Moreover, they stressed that the Principles should always be applied alongside standard placement policies that provide for a rigorous assessment of carers.

114 VACCA interview for this project.

115 VACCA (2015). VACCA's Report for the Royal Commission into Institutional Responses to Child Sexual Abuse, Case Study 24: Preventing child sexual abuse in out-of-home care and responding to allegations of child sexual abuse occurring in out-of-home care in all Australian jurisdictions, February 2015, p. 8.

Kinship carer training and support

Training requirements

Across the jurisdictions training for kinship carers, either pre-placement or post-placement, is encouraged but not mandatory. Even where pre-placement training is made a requirement in policy, compliance is reportedly variable in practice, and training in these contexts tends to focus on navigating departmental process rather than developing carer knowledge and skills:

“We find with many Departmental policies is that while it may be there in writing, it doesn’t always take place.” (Peak OOH agency)

“There’s a very large conversation going on now about whether or not [kinship carers] should have to participate in training . . . But there’s no reason in my mind that kinship carers would not also participate in training.” (Government agency)

“In terms of an induction process, in terms of how we support them, it’s much more ad hoc in its beginnings. So it’s about how does our system respond to that and how do we make sure that they do get access to training in a way that isn’t just a bit of a sheep dip where everyone gets the same training? It’s recognising that there’s some similarities, some information has to be the same, but it’s also that they are family carers so they’re different.” (Government agency)

Kinship carers rarely come to the role in a truly voluntary way. Unlike foster carers, kinship carers usually are asked to take on a child or children by the child protection agency and are not given the time to prepare for their role. In particular, it is rare that kinship carers are required or have the opportunity to undertake pre-assessment training prior to taking a child or young person into their care.

Barriers to kinship carer training

Informants typically noted that while kinship carers can access many of the training calendar programs that are available to foster carers, on the whole there is a low level of uptake by kinship carers. There are a number of barriers to greater participation in training by kinship carers, including:

- € participation not being mandatory or strongly encouraged
- € lack of available training tailored to the specific needs of kinship carers – available training is typically the same as that provided to foster carers
- € lack of access to training programs by widely dispersed, regionally and remotely located kinship carers.
- € lack of training resources – there was reportedly only one departmental trainer in a certain jurisdiction
- € poor accessibility in terms of transport, hours and the availability of childcare

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- € lack of knowledge about available training
 - € lack of interest by some carers, many of whom have already raised children or who have been caring for their child relatives for some time – one informant said, “*Some people just want to be carers and left alone, they don’t want a lot of support*”
 - € lack of culturally specific training and support for carers of Aboriginal and Torres Strait Islander children and young people
 - € lack of resources for carers with low literacy levels.

Provision of support

The provision of support to kinship carers was widely acknowledged to be inadequate. In most jurisdictions, kinship care case management largely remains with the jurisdictional child protection agency. The exceptions are NSW and the ACT, which are currently transitioning both foster care and kinship care to the NGO sector, and Victoria where around 15 per cent of kinship placements are managed by the NGO sector. The most significant barrier to providing support to kinship carers in all jurisdictions was reported to be the capacity of caseworkers to provide effective individual support. Government provider individualised support. Indeed, in some jurisdictions a significant number of kinship care placements were reportedly not allocated to a caseworker.

In some jurisdictions (including Western Australia and Victoria) NGOs are funded to provide training and support to selected kinship carers – for example, where the therapeutic needs of the child have been assessed as high. Feedback from stakeholders in these jurisdictions suggested that these kinship carers tended to receive a higher level of support, through regular support worker contact, assessment of training and other needs, advocacy and linkages to other services, carer support groups, access to the NGO’s training program and other activities. NGOs commonly reported that they do not distinguish between foster carers and kinship carers in terms of the priority given to assessing their needs and providing necessary support. However, NGO representatives noted that the differential in agency funding for supporting foster and kinship care placements had some bearing on the support that could be provided:

“We’ve done a lot of work with our carers to shift the relationship to become more rigorous and structured. It’s about providing support versus supervision. So when we go in we’re having a structured discussion about how they’re going and what their needs are. It’s shifted the relationship to something that’s more professional, and the expectations are higher on both sides.” (NGO provider)

“At the moment there are a lot of kinship carers getting nothing. At least if the [NGOs] did more of the case management, they’d be getting a service.” (Peak OOHC agency)

There was general consensus that there is significant room for improvement in the area of support to kinship carers. Informants noted that placing a child with kin provided no guarantee that the child’s wellbeing and safety could be protected. It was further noted that the needs of a child in kinship care could be the same or greater than those of a child in foster care. Several informants expressed the view that children and placements should be assessed in terms of the support required, *regardless* of their designation as ‘kinship’ or ‘foster’ care placements.

In some jurisdictions, changes to assessment and approval requirements for kinship carers and/or transition to non-government providers has caused some upset with existing carers

who wonder why, as family members who have been caring for the child for some time, they are subject to what they see as invasive new checks:

“I mean, you’re talking about the minority but, really, they were just questioning why, given that they’ve been carers for quite some time and they were aunts or uncles, why they were required to have this check.” (Government agency)

Further, informants noted that kinship carers would often not satisfy the requirements of the assessments for foster carers in terms of their capacity to provide care and protection to a young person. While the benefits for a child of remaining attached to family should not be under-estimated, kinship carers can require a greater degree of support than other types of carers:

“When you think that the majority of our kids in care are in family care situations as well, there really needs to be a lot more supports and systems and processes in place to ensure that we have got some oversight of those care arrangements. I still don’t think we’ve nailed it.” (Government agency)

“Kinship care is under-scrutinised and under-supported. It’s a dangerous space.” (Government agency)

“The assessment, health screening, therapeutic training needs to be a whole lot better. It shouldn’t be acceptable that generational abuse is occurring to kids in care.” (NGO provider)

“There’s a real confusion both within the system and in the community about who’s responsible for supporting relative carers. If they’ve got a child in their care, they might be a relative, but they might not necessarily know the circumstances that’s brought those children into care. So are they informed about trauma, are they informed around mental health issues, the circumstances that have brought the child into care? I think what we’re hoping to do is make sure that that information is accessible to them earlier, and that they receive the information in a way that makes sense for them and that they can then go and get any external support that they might need.” (Government agency)

Overcoming the barriers to training and support for kinship carers

The research identified some encouraging policies, programs and practices that aim to bridge the known gaps in kinship carer assessment, training and support:

- € *Winingay* is a not-for-profit, Aboriginal community-controlled organisation incorporated in NSW in response to concerns about the disproportionate number of Aboriginal children and young people in OOHC and the lack of support for Aboriginal kinship carers. It developed a culturally appropriate tool to assess and support existing Aboriginal kinship carers, with pro-bono input from Aboriginal OOHC workers, AbSec, the Benevolent Society, the Office of

the Children's Guardian (NSW) and others. It has since developed a separate assessment tool for new kinship carers and a kinship carer information pack. Further training resources are under development. Resources are only available to OOHC practitioners who undergo training offered by Winingay. The Winingay tools were being formally evaluated at the time of writing.

- € The Victorian Government funds selected NGOs to deliver information and support to kinship carers around establishing networks and improving understanding of children in their care, including those affected by trauma.
- € The *Tracks to Healing* training program for kinship carers of Aboriginal children and young people, developed by the Australian Childhood Trauma Group and the Secretariat of National Aboriginal and Islander Child Care, has been piloted in Victoria. A *Kinship Carer's Handbook* has been developed to provide information to kinship carers on a range of topics including cultural connection, legal and financial matters, child health and wellbeing, education, child protection and looking after themselves.
- € Other Victorian NGOs such as Grandparents Victoria and Child Wise, and peak OOHC agencies such as the Centre for Excellence in Child and Family Welfare, provide tailored training and support to kinship carers. They do this through support groups, face-to-face training, and providing information and resources.
- € The *Step by Step* tool has been adapted for use in the context of Aboriginal kinship and foster carers in Victoria, including the training resource *Our Carers for Our Kids*.
- € *Yarning Up About Child Sexual Abuse*¹¹⁶ is a short booklet developed by Child Wise, in collaboration with VACCA, to inform and educate carers about child sexual abuse.
- € *Yarning Up About Trauma*¹¹⁷ is a training program developed by Berry Street, in collaboration with VACCA, designed for Aboriginal and Torres Strait Islander child and family workers.
- € In NSW, Aboriginal kinship placements are being transitioned to designated Aboriginal community organisations (or OOHC providers working in partnership with Aboriginal community organisations). In other jurisdictions, many organisations specialise in supporting OOHC placements for Aboriginal children.
- € The Aboriginal Child, Family and Community Care State Secretariat (NSW) (AbSec) is a not-for-profit organisation that works closely with the NSW Government on policy development. It also supports Aboriginal community-controlled providers of OOHC services. It supports the Aboriginal State-wide

116 Child Wise (in collaboration with VACCA), *Yarning Up About Child Sexual Abuse*. http://childwise.blob.core.windows.net/assets/uploads/files/Online%20Publication/Yarning_Up_Booklet.pdf

117 <http://www.snaicc.org.au/wp-content/uploads/2015/12/02683.pdf>

Foster Care Support Service (ASFCS), which provides a free telephone advice and advocacy service for the carers of Aboriginal children.

- € *Raising Them Strong* is a training resource that has been developed for Aboriginal kinship and foster carers. The resource includes topic cards and a DVD and was developed by NSW FACS and AbSec.¹¹⁸
- € In the ACT, an Aboriginal Kinship Care Support Team has been established to support carers of Aboriginal children in kinship placements.
- € In Western Australia, the government's Learning and Development Centre has focused on developing e-learning tools for kinship carers to address the distance and remoteness issues experienced in that state.
- € A pilot is currently underway in the Pilbara region of Western Australia of a partnership with a local Aboriginal community-controlled health service to provide carer support in this remote region.

118 http://www.fosteringnsw.com.au/wp-content/uploads/stories/documents/Resources/raising_them_strong_book.pdf

6. SCREENING, ASSESSMENT, TRAINING AND SUPPORT OF RESIDENTIAL CARE DIRECT CARE STAFF

Screening and assessment in practice

All states and territories stipulate the probity checks that must be undertaken before an individual can be employed to provide direct care, either by a government agency or by an approved or contracted NGO. Although there are subtle differences between jurisdictions, this usually involves an identity check, Working With Children Check, National Police Check and referee checks. Some states and territories stipulate the qualifications that are required of direct care staff and the pre-service training that must be undertaken, while other jurisdictions require only that ‘appropriate’ qualifications and experience are in evidence. NGOs that provide residential care services are often free to establish their own employment criteria to meet the contractual obligation to the relevant government agency but also to meet their own standards and organisational values.

Some government agencies and NGOs reported making use of recruitment agencies or labour hire firms to find, screen and interview suitable candidates for positions. Others reported undertaking all recruitment work internally and described a highly rigorous selection process that involved a series of interviews, psychometric assessment, and careful checking of work history and references. One agency reported that a young person (with a history of being in OOHC) formed a part of the selection panel (the young person having been trained in interview technique).

NGOs and government agencies reported that the selection process for direct care staff involved a rigorous induction. This included, for example, the completion of *Shared Stories*, *Shared Lives* training along with training on reportable conduct procedures and induction courses such as those dealing with trauma-informed care. Following the induction, direct care workers typically worked through an orientation or probationary period where they observed and were ‘buddied up’ with an experienced staff member and interacted with young people in care only while under supervision. Agencies reported that this probationary period lasted for up to six months.

“They have to have minimum Cert. III, they have to have First Aid, they have to have WWCC and Police Check. They’re interviewed by our people and then if they’re found to be acceptable, they start buddy shifts system and we use that as a proving time and get rid of them if they’re no good.” (Government agency)

A number of informants thought the lack of a mandated requirement in some jurisdictions to recruit direct care workers of a minimum qualification or level of experience was a significant issue. They considered it a weak requirement that at times resulted in the recruitment of direct care workers who were under-qualified and under-skilled to respond

to the complex needs and challenging behaviours of children in their care:

“The government policies are clear in terms of child protection checks. The larger risk, however, is that there are no minimum requirements around the qualifications, training or support required. Once they’ve gone through all the obligatory checks, there’s no mandated policy for ensuring the staff are safe to work with children on an ongoing basis” (NGO)

“They just throw backpackers in, or straight out of uni and have no social work qualifications.” (Children’s Commissioner)

“In normal circumstances they probably meet the threshold but in our residential care we have kids with such high complex needs, such early childhood trauma that staff don’t have the level of training needed or specialised care or therapeutic service model. They bundle them all in together with staff that just have no idea how to handle the dynamics, not just individually but with the groups, and it is just a recipe for disaster.” (Children’s Commissioner)

In some jurisdictions, informants further noted that while the issue of the qualifications of direct care staff (or lack thereof) was a significant issue, there was not any consensus on what the minimum qualification should be. Nor was there consensus on the skills and competencies required by direct care workers. Informants noted that the personal attributes of direct care workers – rather than their qualifications – was what made them suitable for the work. It was thought that the commitment of providers to on-the-job training, supporting further education, and providing supervision and mentoring was more important than nominating a minimum qualification.

Informants routinely noted that – in some locations at least – it was not easy to find suitable staff to work as carers in residential settings. A workforce shortage or lack of a suitable ‘talent pool’ was thought to give rise to the low calibre of carers that was sometimes observed. Furthermore, the rigours of the job and the aspiration to work in other, less demanding settings resulted in a high degree of ‘burnout’ and staff turnover:

“Staff turnover is always a problem.” (Government agency)

“When you’re talking residential care, you need to have a core – ideally everyone needs to be more stable but we’re talking about a workforce that . . . often they’re older people or they’ve been re-skilled into this sort of work because of injury or the sort of work they used to do no longer exists.” (Government agency)

“They’re not super paid – it’s not a super paid profession. I think you do it partly because you want to help. I think that’s hopefully a core value within any person that

becomes a carer. But ... they move around the agencies for sure or they get better jobs in a different agency.” (Government agency)

“Obviously there’s going to be a lot of places ... anywhere outside of the metropolitan area where it’s going to be problematic because of the pool of population ... you’re going to be recruiting whoever you can, and I think that’s a problem because not everyone is suited to this sort of work.” (Government agency)

A number of respondents referred to a particular shortage in the availability of suitably qualified and experienced Aboriginal and Torres Strait Islander direct care workers to work in residential care settings. Apart from the small available labour pool, informants noted that there was some historical and cultural reluctance by Aboriginal and Torres Strait Islander people to work in the ‘child protection’ field:

“A really complex situation in terms of children’s complex needs and cultural challenges with often not the most skilled people working on both sides, either the agency or government.” (Peak OOH agency)

It is important to note that several informants refuted the notion that a limited labour pool resulted in a lower calibre of direct care workers. Rather, they believed that it put the onus on agencies to recruit carefully, and patiently, and to provide a good working environment with sound staff development and support structures:

“They’re like any other workplace provider – they need to motivate, encourage, train, have job satisfaction, do all of those sorts of things to retain the workforce.” (Government agency)

“You’re bringing people that on the surface appear suitable, but you need to develop them, do the training, the buddying, the debriefing work with them, put them through the Cert. III.” (NGO)

“It’s not the transients that they want to hire. None of the providers want to hire people who are transients. They want to have long-term relationships, and then they want to develop those staff to have a career progression through their own agencies.” (Government agency)

One informant, while acknowledging the pressures brought about by a limited labour pool, said it was incumbent on agencies to work within that dynamic and to find innovative ways to recruit the best staff:

“I think things like agencies being creative about forging relationships with the local provider of training courses to identify people early that they could approach ... they go and do a presentation about ‘this is my agency and I’d love you to come and work for me, and these are the great things that we do’. I think it’s being proactive and on the

front foot rather than ‘Oh my God, we’ll just advertise and see who we can get’.”
(Government agency)

Training and support for direct care workers

The jurisdictional requirements for training and supporting residential care workers are mostly generic in that they require ‘appropriate training and support’ to be provided. Agencies are typically asked to demonstrate what training was provided to meet accreditation standards, though the frameworks for monitoring compliance are more developed and ‘active’ in some jurisdictions. It is notable that in some jurisdictions (for example, NSW), a component of the funding formula is dedicated to carer training. In other jurisdictions, the funds are supplied for placements only.

The NGO representatives who were interviewed typically described how mandatory training was provided to all staff members, including on child protection issues and child safe organisational practices. They also described how training needs assessments were undertaken for individual direct care workers so that skill deficiencies could be addressed and so that the person’s professional development could be supported. The interviews revealed a wide variety of training courses and delivery modes accessed by residential care providers.

These included:

- € courses developed by state or territory government agencies
- € courses developed in-house by (larger) NGOs
- € training provided by in-house psychologists or clinical support staff
- € courses offered by specialist providers such as the Australian Childhood Foundation, Association of Children’s Welfare Agencies/Centre for Community Welfare Training and Bravehearts
- € training on the Sanctuary Model, delivered by McKillop (trauma-informed care and organisational culture)
- € bespoke training offered by specialist practitioners and sector experts
- € attendance at conferences and seminars
- € the use of international training materials (for example, those provided by Community Care UK)
- € use of the SMART (Strategies for Managing Abuse Related Trauma) online training package developed by the Australian Childhood Foundation
- € reading papers and journal articles.

Barriers and enablers to accessing training

It is important to note that the major training providers have strong links to government and NGO OOHC providers and, through industry reference groups, respond to emerging

issues, best practice and demand for training on particular topics. Informants noted that some jurisdictions are better served by training providers than others. The eastern states appear to have readier access to the training offerings of the organisations mentioned above. The Association of Children’s Welfare Agencies/Centre for Community Welfare Training provides training in NSW only, unless specifically requested and contracted to provide it elsewhere. It was evident from the interviews that access to a comprehensive suite of training for direct care staff depended on there being a local provider and/or support from government for the procurement of training.

Difficulties in accessing training were further compounded for direct care staff located outside metropolitan centres. Some NGO representatives noted that the cost of sourcing and attending training was a barrier, particularly where the funding model provided no specific training allowance. Representatives of some smaller NGOs noted that they had to be prudent about the staff training they purchased and, where possible, joined with other providers in purchasing training products, to reduce the per-person cost.

To return to the issue of staff turnover discussed above, some informants noted that while it was important to properly equip direct care workers to meet the therapeutic needs of children in their care, the ‘investment’ could be wasted if the person moved on.

Further supporting carers

Beyond training residential care workers, agencies reported a range of other ways in which carers were supported in their roles. Firstly, both government and NGO providers had access to clinical support in the form of in-house or consultant child psychiatrists and other specialists. These specialists work directly with the child or young person but also provide professional development and practical support to carers. One informant noted that practice support was an emergent and positive trend in recent years.

Agencies also noted the following as ways in which carers were supported:

- € Proving structured supervision and practice feedback, on both a regular and an annual review basis
- € Convening regular practice meetings, to discuss practice and individual case-related issues
- € Rostering shifts to provide variety and relieve carer/child relationship tensions (balancing this with the need to provide continuity of care for the resident young people).

Informants noted that these supports were designed to support professional practice and, by extension, the quality of care provided to young people. They also noted that these measures were designed to support the wellbeing of direct care workers and to, hopefully, help retain them as staff members. By extension, these supports were thought to create a

care environment that reduces the risk of sexual abuse and better cares for young people who have experienced prior abuse.

7. DISCUSSION OF FURTHER ISSUES

This section notes topics that were explored through the research but that have not been addressed in detail in this report, namely:

- £ the development of therapeutic and trauma-informed care models
- £ sexual exploitation as a form of child sexual abuse
- £ the professionalisation of foster care.

The breadth of the research project and the short time that could be spent with research participants meant that these topics could only be explored in a limited fashion. It should be acknowledged that these issues are complex and that fuller explorations can be found in the references provided to existing literature.

The development of therapeutic and trauma-informed care models

As noted in the Royal Commission consultation paper on out of home care¹¹⁹, the National Therapeutic Residential Care Workshop held in Melbourne in September 2010 defined therapeutic residential care as:

“... intensive and time-limited care for a child or young person in statutory care that responds to the complex impacts of abuse, neglect and separation from family. This is achieved through the creation of positive, safe, healing relationships and experiences informed by a sound understanding of trauma, damaged attachment, and developmental needs”.

The research interviews revealed that there was a clear focus among OOHC providers on trauma-informed care and therapeutic practice in terms of the training that was being accessed. In fact, all government and NGO OOHC providers interviewed reported that they had accessed and/or delivered trauma-informed care training of some kind for their carers. Many noted that embracing training on trauma-informed care was an important part of a shift towards adopting a trauma-informed care model, whether that be in residential or other forms of OOHC.

While the high level of engagement with training on trauma-informed care might indicate a sectoral shift towards trauma-informed models of care, some stakeholder comments suggested that this was not universally the case. It was often noted that the terms ‘trauma’ and ‘trauma-informed care’ were often used liberally without, necessarily, an understanding of what they meant. In short, they were sometimes used as ‘buzz words’. For example, in 2015, the Queensland Government undertook research among organisations providing

¹¹⁹ Royal Commission into Institutional Responses to Child Sexual Abuse 2016, *Consultation Paper: Institutional Responses to Child Sexual Abuse in Out-of-Home-Care*, p. 101.

residential care that included questions about the model of care.¹²⁰ The research highlighted that many of the organisations providing residential care have a limited understanding of what it means to work from a trauma-informed, therapeutic perspective.

A number of informants thought the absence of a consistent trauma-informed framework for OOHC (on a state or territory, or national basis) has given rise to service providers adopting inconsistent and variable models and practices. They said that providers consequently did not share a consistent language or framework for practice from which to guide and ground the delivery of trauma-informed care.

However, some good progress towards developing a shared understanding of trauma-informed care and bringing consistency to practice was observed in some jurisdictions. In Western Australia, the Residential Care (Sanctuary) Framework was introduced in 2012, and the Department for Child Protection and Family Support became the first government agency in Australia to be certified by the Sanctuary Institute.¹²¹ In Queensland, the Hope and Healing Framework has been released as the trauma-informed therapeutic framework to be implemented throughout Queensland's residential care services by December 2018.

In some other jurisdictions, discrete programs provide trauma-informed care to children and young people with a high level of need. In NSW, the Intensive Foster Care Program provides for placements with an authorised foster or kinship carer who can offer additional therapeutic support for children or young people with high or complex needs.¹²² In Victoria, the Circle Program¹²³ recruits and trains specially selected carers to provide therapeutic, trauma-informed care to selected children, with the aim of supporting a recovery from the effects of trauma.

Sexual exploitation as a form of child sexual abuse

Government and NGO providers, along with peak organisations and other informants were aware of the interest that the Royal Commission has shown in child sexual exploitation as a form of child sexual abuse. Recent instances, both in Australia and overseas, of the organised sexual exploitation of young people in OOHC have also brought the issue to the fore for governments and OOHC providers. It was clear that the vulnerability of young people in care to being sexually exploited was well understood. One informant from a government agency said, "*I think residential care houses are like honeypots – they will draw the flies.*"

120 Queensland Government Department of Communities (2015). *Trauma-informed framework for residential care project: Final Report (Stage One)*.

121 Western Australian Government (2015). op. cit., paragraph 97.

122 NSW Department of Family and Community Services response to the Royal Commission into Institutional Responses to Child Sexual Abuse, Case Study 24. February 2015.

123 Victorian Government Department of Human Services (2007). *The Circle Program – a therapeutic approach to foster care. Program Guidelines May 2009*, viewed at http://www.dhs.vic.gov.au/__data/assets/pdf_file/0006/590496/circle-program-guidelines-may-2009.pdf

Across the country, however, it was clear that there were marked differences in terms of the degree of action that had been taken on the issue in residential care and OOHC generally. It is apparent that Victoria has led the way in developing a comprehensive response to the issue. Recent Victorian initiatives that have been extended across the OOHC system include:

- € the provision of statewide training to all residential care workers and others on the extent and dynamics of the exploitation of young people and effective disruptive strategies
- € the development of an across-agency Enhanced Response Model (ERM) to manage instances of children being missing from care, including mechanisms for collecting and sharing information about the involvement of suspected perpetrators. This project includes numerous practice changes for child protection agencies and Victoria Police that ensure that a response to sexual exploitation is collaborative, victim-centred and systematic across the state. A six-month trial of the ERM commenced in May 2016 in five locations throughout the state. The 57 children identified as within scope will receive additional supports to the existing practice. The ERM will be evaluated, with findings and feedback used to inform refinements to the model with the aim of statewide rollout in 2017¹²⁴
- € changes to the Client Relationship Information System to support sexual exploitation prevention practice, including how information is collected, storing of possible perpetrators' details, and the use specialist sexual exploitation reports/templates. The Department of Human Services is also looking at opportunities to systematically share information across systems
- € the appointment of practice leaders with a specific focus on child sexual exploitation, to assist care teams across the Department of Human Services to identify and understand sexual exploitation and to effectively respond where it is occurring
- € development of a policy framework for supporting young people who are, or are at risk of, being exploited. This includes the development of age-appropriate learning tools that direct care workers can use to support their discussions with young people (currently under development)
- € the *Lookout Program* – a 'virtual school' for young people in OOHC developed by the Victorian Department of Education that will provide a delivery channel for education on sexual exploitation and grooming.¹²⁵

In the ACT, training was provided to all residential care workers in 2015 on the vulnerabilities of young people in OOHC to sexual exploitation, the indicators of its

124 Summary of interview with DHHS staff for this project, paragraph 20(d).

125 <http://www.education.vic.gov.au/about/programs/health/Pages/lookout.aspx>

occurrence and effective responses for carers. In Queensland, the Royal Commission Professional Response Group has begun to target practice leaders across the OOHC sector to develop a deeper knowledge of child sexual exploitation. In other jurisdictions, the issue of child sexual exploitation was reportedly addressed in a less discrete way through policy, practice manuals and training on child sexual exploitation (that is, as one form of child sexual abuse).

While systematic training *per se* may not have been provided in all jurisdictions, informants reported that the growing awareness of the issue provided the basis for reflective practice and ongoing efforts to improve prevention and response. Some noted a historic tendency on the part of residential care providers to ‘view it as a police matter’ and for Police services to not take action in the absence of a complaint from the victim or evidence that a ‘crime’ had been committed. Informants reported a growing realisation that, in order to prevent exploitation from occurring, residential care providers needed to ‘take ownership’ by:

- € providing a stimulating environment, ensuring strong engagement between residents and workers
- € being more proactive in trying to disrupt efforts to groom and/or exploit young people in care
- € collecting evidence and diarising events to support a police report
- € developing a close relationship with the police, schools and others to provide the basis for a coordinated effort to disrupt exploitative relationships with young people in care.

While some residential care providers were reportedly very attuned to the issue and had developed strong frameworks to address it, others were thought to be lagging behind:

“Some [NGOs] are reaching those conclusions and some of them are doing something about it. Again, I think the agencies work on the bell curve and there will be some agencies that aren’t recognising at all or they’re recognising a little bit and it’s all too hard and push that back on the department to do because they report to the helpline without doing much themselves. So they see themselves passively, seeing and passing on, so not an active participant in the solution.” (Government agency)

As the above findings would suggest, there was a tendency for the discussions with stakeholders to focus on child sexual exploitation in the context of residential care rather than other forms of OOHC. When prompted, research participants acknowledged that thinking on the issue should be widened to ensure there were better protections in place for children and young people in foster and kinship care. It was noted that a variety of cybersafety training resources were available to foster and kinship carers but little that went into further depth. It was thought that some carer-focused training on recognising grooming behaviour, disrupting the behaviour and effectively responding to the suspicion of sexual exploitation would be of benefit.

Informants noted that the issue of sexual exploitation in OOHC needed to be addressed not just through training, but rather through an effective systemic response, as the following quotes suggest:

“I think our tolerance for it is decreasing, which is good, but there’s a whole lot of ifs and buts when you start talking about child sexual exploitation.” (NGO)

“I mean, with my experience about providers, particularly our residential care providers, is that they’re quite attuned to that sort of thing, and I think specifically around the electronic devices that kids have access to and who they’re contacting and how it’s being done. I think that it’s not that they’re unaware of it, and I think it’s being monitored in an ongoing way, but at the end of the day it becomes a criminal matter.” (Government agency)

“The problem is that our response to potential child sexual exploitation is very fragmented. We’ve got all of these things in place, we’ve got police, we’ve got supervision, we’ve got [oversight agency] looking at these things and we’ve got the helpline ... and we’ve got people aware of these things and reporting it through but the response in these cases can be quite difficult to target.” (Government agency)

“I think our staff have a very good awareness. I think it’s about the system being able to respond to the extent of the problem.” (NGO)

Professionalisation of foster care

A number of prior studies have been undertaken to develop and discuss options for models of foster care that can be described as ‘professionalised’. These models have been put forward as a means of addressing a shortage of foster carers and improving the quality of care for children and young people who cannot live with their families. A study undertaken by ACIL Allen Consulting on behalf of the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs¹²⁶ considered the benefits, barriers and opportunities to developing a professional model of foster care. The study considered the minimum skills sets of carers, remuneration structure, tax treatment, legal parameters, and national, or state or territory policy parameters. The study identified a number of countries in Europe and North America that have developed models of foster care featuring payments designed to recognise the professional skills of carers. Notably, the study identified three Australian models of professionalised care – two of which were never implemented and another that had been in place for only two years. The development of professionalised models of care in Australia was described as ‘nascent’.

126 ACIL Allen Consulting (2013). Professional Foster Care: Barriers and Options.

Another study undertaken by Berry Street and the University of NSW¹²⁷ makes a case for developing more professionalised models of foster care and proposes the use of the Berry Street Foster Care Integrated Model. The model features, among other things, a carer payment as well as a child allowance and enhanced clinical and peer support.

The interviews with representatives of governments, NGOs and peak organisations included limited discussions around the idea of a professionalised model of foster care in Australia. Generally, informants saw that this would have benefits in better supporting carers and better recognising their work. Indeed, many thought that a certain amount of professionalisation already existed, in the sense that some carers had access to ‘special care packages’ for higher-needs children. A model of professionalisation can also be seen in the NT in the care of younger children who are the subject of a placement order under the traditional family day care model. Care is provided on a 24/7 basis, in a home setting by a paid, qualified Early Childhood educator (see section 3.4 for more detail).

However, some informants saw that it was problematic to create a model of fully professionalised foster carers that are paid a salary in addition to a child maintenance allowance. There was concern that salaried carer positions might attract people for the wrong reasons, and some informants questioned whether it was desirable to have people caring for children in need ‘just for the money’:

“Paying a salary detracts ... creates a very different context that impacts on attachment with the child.” (NGO provider)

Most importantly, a number of informants saw that the workplace health and safety issues associated with providing professional 24-hour care within the home – effectively making the home a workplace – erected barriers that were difficult to overcome:

“One of the continuing difficulties with it is that the moment you start paying people salaries for looking after kids in their own home, then you start raising work health and safety issues and the issue of how it is you pay a salary which covers someone 24/7, which nobody is required to work 24/7 for any salary.” (Government agency)

“Certainly that’s the threshold question for us as a Department, is what capacity have we got to influence the circumstances of a carer’s home to ensure that it reflects what’s required of us as an employer in terms of a workplace.” (Government agency)

Informants also questioned ‘where the money would come from’ and struggled to see a situation where the existing volume of children in foster care would be cared for by salaried carers, presumably paid by state and territory governments.

127 McHugh, M. & Pell, A. (2013). *Reforming the Foster Care System in Australia. A New Model of Support, Education and Payment for Foster Parents*. Berry Street, Victoria.

On the other hand, some informants felt that a professionalised foster care system was the way forward, due to the increasingly difficult task of recruiting and retaining volunteer carers and ensuring they have the skills and capacity to raise children with increasingly complex needs. In some people's view "you get what you pay for", and several people made references to working models of carer professionalisation that exist in the UK, Ireland and Scandinavia.

Informants did, however, see some potential in a professional foster care model for high-needs children who might otherwise be placed in residential care. It was envisaged that qualified carers (say, with social work qualifications) could provide a cost-effective means of providing a higher level of therapeutic care, in a relatively riskfree way. Following are some typical quotes:

"Four kids in residential costs \$1.2 million, \$300,000 per bed. We could get fantastic outcomes if we gave that money to a family to work with children. They would do a better job than what we're doing in resi care." (Government agency)

"The child-on-child setting is a huge risk in resi. Having a professional foster care workforce would help reduce this." (NGO)

It was clear from the interviews that professionalisation means different things to different people. For some, it means simply that carers are paid or compensated. Others consider it an important way of ensuring that foster carers are treated professionally, even though they may technically be volunteers:

"There's nothing stopping us from treating foster carers as professionals." (NGO)

An important component of treating foster carers more professionally was recognition of the training that they were required to undertake. A number of informants thought that, as the requirements to attend training courses increased, there should be efforts to allow carers to undertake accredited training that would contribute to a proper learning pathway and qualification.

8. SUMMARY AND CONCLUSIONS

The research set out to examine the policies, processes and practices used by government and non-government agencies to screen, assess, train and support OOHC carers, as a means of preventing and properly responding to the sexual abuse of children and young people in care. The research highlighted the variability across jurisdictions in terms of some key contextual factors:

- € the mix and balance of government and NGO service provision across the various care types
- € the range and mix of care models, including semi-professionalised or paid carer models, different therapeutic care models, and wraparound care arrangements
- € the degree to which there are legislated or stipulated requirements for the tools and frameworks to be used for carer assessment and the inclusions in the training provided to carers
- € the arrangements for monitoring, oversight and accountability in relation to OOHC service provision and adherence to standards relating to carer assessment, training and support
- € the challenges of providing training and support to a dispersed carer population, many located in rural and remote areas
- € the status of current reforms and practice improvements to improve the protections for children and young people in care.

It was clear from the review of documents and interviews with key informants that both government and non-government agencies pay significant attention to the issue of child sexual abuse in OOHC. Through carer screening, assessment, training and support, clear efforts are made to ensure that children and young people are safe from abuse and that the trauma they have suffered as a result of prior abuse is addressed through the care they receive. Moreover, recent and planned systemic improvements are intended to provide stronger protections and better meet the needs of children and young people in care. In particular, there is a strong current focus on developing trauma-informed care models, though this is clearly an area of current practice development. Some jurisdictions are also focusing on ensuring that kinship carers are trained and offered the same supports as other carers.

Screening and assessment of carers

The process of screening carers and the probity checks that must be undertaken, generally have a statutory basis. There are more similarities than differences across jurisdictions in terms of the need to conduct a National Police Check, Working With Children Check and referee checks of all OOHC carers. In some jurisdictions, most notably NSW, the screening process is strengthened through mandatory reference to a carer's register and

data held by child protection agencies and other OOHC providers. Government agencies and NGOs see clear potential for the establishment of a national carer's register.

The approach to the further assessment of potential carers is more strongly guided and overseen by some jurisdictions than others. A number of widely used frameworks for carer assessment and pre-authorisation training include reference to the issue of the sexual abuse of young people in care. Tools are also emerging that some believe provide a deeper and more rigorous assessment and better preparation for the provision of trauma-informed care. Care providers report various practices in terms of who performs carer assessments, including the use of commercial (subcontracted) agencies. Informants noted that the tools and frameworks used for assessing carers were only as good as those using them, and some called for the accreditation of training in carer assessment.

Difficulties in attracting and retaining foster carers, a limited pool of residential care workers and high staff turnover were noted as barriers to meeting the demand for OOHC placements and providing high-quality care. However, a number of NGO representatives who were interviewed stressed that this did not affect their efforts to properly identify, screen and assess potential carers. A number of informants noted that it was incumbent on agencies to implement carer recruitment strategies to achieve stable and sustainable placements, and to provide a work environment (for foster carers and/or residential care workers) that supported their professional development and helped them cope with the psychological demands of the work.

It was clear that the assessment of kinship carers was generally less rigorous than for foster carers. The concerning practice of renewing the 'emergency care' designation of kinship placements in lieu of a full and proper assessment was often reported. Practice in this regard seems to be improving, particularly as kinship care placements are transitioned to the non-government sector. However, government agencies reported many barriers to ensuring the same level of scrutiny and support for kinship carers as for other types of carers.

There have been some promising developments in terms of the assessment tools, training and support available to carers of Aboriginal and Torres Strait Islander children and young people. However, informants generally reported a paucity of culturally appropriate training materials that address child sexual abuse, and under-use of those that are currently available.

Training and support

In terms of the availability of training for carers, many organisations offer training in the prevention of child sexual abuse, providing child safe environments, reporting abuse, managing disclosures, dealing with problematic sexual behaviours and caring for traumatised children. A large array of suitable training products is available for residential

care workers, foster carers and kinship carers, though more materials tailored to the needs of kinship carers would be of benefit.

Ongoing training and learning materials are provided through various channels and in a variety of formats, with training and support offered by government agencies, NGOs, peak organisations and specialist training organisations. The uptake of available training, however, can be affected by a lack of encouragement to attend or an inability to attend due to location, available time or transport issues. Some agencies address these barriers by establishing clear attendance expectations on carers, ensuring that alternative attendance modes are available (for example, self-paced learning or video conference) and that childcare and other practical support is provided. Agencies reported efforts to treat carers more professionally and to support their ‘professional development’ by providing quality training. It was suggested that greater recognition of the training undertaken would be beneficial, including its recognition as formal training that can contribute to a qualification.

Particularly where kinship care placement support is provided by government, it was widely acknowledged that not enough attention is given to the support needs of kinship carers, including Aboriginal and Torres Strait Islander kinship carers. The resources dedicated to support for kinship and foster carers were thought to differ. It was generally agreed that the needs of children in kinship care could be as significant as those in foster care and that, if anything, the support needs of kinship carers could be greater than those of foster carers. In short, many informants saw a degree of risk in the policies and practices of their jurisdictions in relation to kinship care.

Some training and learning material on the dynamics of sexual exploitation of young people in care is available to agency staff and residential care workers, though it was clear that more emphasis should be given to this topic, particularly for foster and kinship carers. It is noteworthy that the issue of the sexual exploitation of young people in residential care has been given significant recent attention through training in some jurisdictions. Other jurisdictions have been working at a systemic level to better coordinate the response by child protection agencies and the police.

As OOHC placements have transitioned to the non-government sector, there has been greater emphasis on ensuring that carers receive the support that they need to provide a quality care environment and to meet the high support needs of children and young people. Providers spoke of efforts to move towards a ‘partners in care’ culture that puts the needs of the young person at the centre of all decision-making.

Some providers reported that assessments of carers’ training and support needs were undertaken on a case-by-case basis, and that training and other support was offered or ‘prescribed’ as required. This included, support and training to respond to children who have experienced prior sexual abuse, deal with problematic sexual behaviour, and respond to children ‘missing from care’ and at risk of sexual exploitation. It was noted, however,

that the ability to provide this level of individualised support was contingent on a strong trauma-informed care model and a realistic case management load. Establishing and monitoring national standards in this regard would be consistent with the pursuit of the sixth outcome of the National Framework for Protecting Australia’s Children: “child sexual abuse and exploitation is prevented and survivors receive adequate support”.

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APPENDICES

Appendix A: Discussion guide – Government agencies

A national comparison of carer screening, assessment, selection, training and support in foster, kinship and residential care

Interview schedule: Government agencies

Introduction

Inca Consulting has been engaged by the Royal Commission into Institutional Responses to Child Sexual Abuse to conduct research into the prevention of, and response to, child sexual abuse in out-of-home care (OOHC) settings. As the information sheet sets out, we are exploring the policies and processes of each state and territory government for carer screening, assessment, selection, training and support in order to prevent or respond effectively to child sexual abuse in foster care, kinship care and residential care settings. We are also exploring the barriers and enablers to the implementation of these policies and processes. There are also various issues that have emerged through analysis of submissions, public hearings etc that we would like to explore with you in detail.

Please note that we have thoroughly reviewed the submissions and supporting materials already provided to the Royal Commission by the relevant agencies in this State Territory.

Please refer to the information sheet that we have provided for other details about the research.

Could you please start by telling me a bit about your role and the functions of the unit/division that you represent.

Strengths and weaknesses of existing policies and processes

1. What would you say are the strengths of this state/territory's approach to screening, training and supporting (including foster care, kinship care and residential care)
2. Are there any weaknesses that you see in current policies and processes? What are the reasons that these weaknesses exist?
3. In terms of improving systems, policies and processes for screening, training and supporting carers, what do you see are the priorities for this state/territory? Are there other national priorities that you see?

Provider practice

4. How easy or difficult is it for government and NGO providers to comply with policies and stipulated processes for screening, training and supporting carers? What systemic or other pressures exist that may make it difficult for providers to fully comply?
5. Are there providers that have put in place particularly good systems, policies or processes that go above and beyond what is required by the service agreement? What allows these providers to develop and implement good practice?

The carer 'workforce'

6. To what degree are the dynamics of the residential care workforce important in offering broad quality of care and preventing and responding to child sexual abuse in residential care settings? Are there particular workforce issues that introduce a risk of system failure (for example, staff turnover, remuneration, qualifications and accreditation)? What could be or is being done to address these issues? What are the challenges here and what would assist?

7. To what degree do current models of foster care prevent sexual abuse and allow effective responses in these settings? What potential is there for working towards professionalisation of the foster care 'workforce'? What benefits would this deliver? To what degree and how would it contribute to a reduction in child sexual abuse in foster care settings? Are there other foster care models (internationally and in other states) that you know of that could be introduced or trialled in Australia?

Kinship care (including Aboriginal and Torres Strait Islander kinship care)

8. What are the particular challenges associated with providing carer screening, training and support in kinship care settings? Are policies and processes as strong here as they are for foster or residential care?

9. What are the particular challenges associated with providing carer screening, training and support in Aboriginal kinship care settings?

10. What support is specifically available for Aboriginal and Torres Strait Islander kinship carers in this state/territory? Are there culturally appropriate training materials for carers that address the issues of child sexual abuse? How adequate are these? What cultural awareness training is provided to case managers and other departmental staff? Again, how adequate is this?

Child Sexual Exploitation

11. How is child sexual exploitation made explicit as a form of child sexual abuse in this state/territory? What policies and processes exist to help carers identify and respond to instances of child sexual exploitation? Are you aware of any training or support for carers that addresses this issue in an effective way?

12. What potential is there to strengthen the approaches to preventing and responding to the sexual exploitation of children in OOHC through carer screening, training and support? What would need to be done? What are the challenges here?

Trauma-informed care

13. What is the model of care that is used for children who enter OOHC having already experienced sexual abuse? What training or support is provided to carers of children who have experienced prior sexual abuse? How effective is this and how does it need to be improved?

14. How is this prior abuse recognised in making placement decisions and monitoring placements, so as to maximise the therapeutic potential for the child? What are the

challenges in finding the right placement for these children? Are there clear policies in place?

15. How are reports of sexually harmful behaviours exhibited by children in OOHC managed? Again, what training and support is offered to carers to identify these behaviours and to respond appropriately?

16. Are there particular therapeutic models that you are aware of that could potentially be applied in this state/territory? What would be the challenges in making use of such models?

Child education and awareness

16. What activities are undertaken to educate children in care about protective behaviours with regard to sexual abuse? What other efforts are made to empower children in care or to give children more 'agency'.

17. What more could be done in this area? What would be the challenges associated with undertaking this form of prevention?

Systemic review

18. When child sexual abuse does occur in OOHC settings, what, if any, process is in place to examine the systemic factors that may have failed to prevent the abuse from occurring, particularly in the area of screening, training and support for carers? How do these investigations influence policy and practice?

Other matters

19. We intend to speak with a range of NGO providers of residential care and foster and kinship care support. We have made some preliminary selections but hope that you may be able to identify some others that you think would have a useful perspective. We want to speak to a range of providers – large and small – and ensure that we include some organisations that provide residential care or placement support to Aboriginal children, children with a disability and children with high care needs.

Appendix B: Discussion guide – Non-government OOHC providers

Preventing Child Sexual Abuse in OOHC settings

Interview schedule: NGO providers

Introduction

Inca Consulting has been engaged by the Royal Commission into Institutional Responses to Child Sexual Abuse to conduct research into the prevention of, and response to, child sexual abuse in out-of-home care (OOHC) settings. As the information sheet sets out, we are exploring the policies and processes in each state and territory (in government and the non-government sector) for carer screening, assessment, selection, training and support in order to prevent or respond effectively to child sexual abuse in foster care, kinship care and residential care settings. We are also exploring the barriers and enablers to the implementation of these policies and processes. There are also various issues that have emerged through analysis of submissions, public hearings etc that we would like to explore with you in detail.

Please note that we have thoroughly reviewed the submissions and supporting materials already provided to the Royal Commission by the relevant agencies in this state/territory and by some NGOs.

Please refer to the information sheet that we have provided for other details about the research.

Could you please start by telling me a bit about your role in this organisation. Could you please also tell me about:

- € the types of care and services provided by this agency (for example, residential care, foster and kinship care placement and support)
- € your geographic footprint
- € the number of placements that you manage
- € the profile of the children you place/care for (especially in terms of disability, Aboriginal status, and culturally and linguistically diverse status)
- € any philosophy or value set that underpins your services.

Carer screening

[EXPLORE RESIDENTIAL, FOSTER AND KINSHIP CARE AS APPROPRIATE]

1. Please describe the policies and processes that you follow for screening potential carers. What, if anything, does this agency do beyond what is required by the funding body/accrediting agency? Why do you do these additional things and how effective is the approach?

2. How easy or difficult is it to apply mandated policies and processes, as well as the particular policies and processes used by this agency? In your view, are the requirements of government appropriate and effective as a means of preventing child sexual abuse in

OOHC? Are they workable from a provider point of view? Are there times when your screening policies and practices are not fully applied or where screening is deemed less appropriate? In what sorts of circumstances or for what sorts of carers? What risks does/could this introduce?

3. What changes or improvements in carer screening would you like to see, in order to improve the prevention of, and response to, child sexual abuse?

[SEEK ACCESS TO WRITTEN MATERIALS ON SCREENING POLICIES, TOOLS ETC]

Carer training

[EXPLORE RESIDENTIAL, FOSTER AND KINSHIP CARE AS APPROPRIATE]

4. Please describe the pre-placement and ongoing training that is provided for carers. What are the main components of this training? How has the training structure and content been developed? Does this agency use training materials developed by other organisations? What has guided decisions about what training to use and how to deliver it?

5. How is the issue of child sexual abuse specifically addressed through training? Please describe in detail how this topic is addressed.

6. How effective are the training products/modes that you use? How could they be improved so as to better prevent child sexual abuse?

7. What are your policies and practices with regard to who receives training, what components are mandatory or voluntary, when training is provided and so forth? Are there particular kinds of carers that have higher/lower training needs?

8. [FOR AGENCIES THAT SUPPORT KINSHIP CARE] To what degree is the training for kinship carers the same or different to that provided to foster carers? Is the approach to training modified for particular types of carers – for example, Aboriginal and Torres Strait Islander carers or people in remote locations?

9. How easy or difficult is it to apply mandated policies and processes for carer training, as well as the particular policies and processes used by this agency? In your view, are the requirements of government appropriate and effective as a means of preventing child sexual abuse in OOHC? Are they workable from a provider point of view? Are there times when your training policies and practices are not fully applied? In what sorts of circumstances? What risks does/could this introduce?

10. What changes or improvements in the requirements for carer training would you like to see, in order to improve the prevention of, and response to, child sexual abuse?

[SEEK ACCESS TO WRITTEN MATERIALS ON TRAINING POLICIES, TRAINING CONTENT ETC]

Carer support

[EXPLORE RESIDENTIAL, FOSTER AND KINSHIP CARE AS APPROPRIATE]

11. Please describe the ongoing support that is provided for carers. How is it made available to them? In what areas do carers need the most support?
12. What are your policies and practices with regard to who receives support and when? Are there particular kinds of carers that have higher/lower support needs? Are there circumstances (for example, due to geography) where providing support is a challenge?
13. [FOR AGENCIES THAT SUPPORT KINSHIP CARE] To what degree is the support for kinship carers the same or different to that provided to foster carers?

What support is (or would be) provided to carers in circumstances where sexual abuse of the child is perceived as a risk, suspected or substantiated, while they are in care? Do you have specific policies or processes to govern this?

14. How easy or difficult is it to apply mandated policies and processes for supporting carers, as well as the particular policies and processes used by this agency? In your view, are the requirements of government appropriate and effective as a means of preventing child sexual abuse in OOHC? Are they workable from a provider point of view? Are there times when your policies and practices are not fully applied? In what sorts of circumstances? What risks does/could this introduce?
15. What changes or improvements in the ways that carers are supported would you like to see, in order to improve the prevention of, and response to, child sexual abuse?

[SEEK ACCESS TO WRITTEN MATERIALS ON CARER SUPPORT POLICIES, TOOLS ETC]

The carer 'workforce'

16. [FOR RESIDENTIAL CARE PROVIDERS] To what degree are the dynamics of the residential care workforce important in offering broad quality of care and preventing and responding to child sexual abuse in residential care settings? Are there particular workforce issues that introduce a risk of system failure (for example, staff turnover, remuneration, qualifications and accreditation)? What are the main workforce issues faced by this agency? What needs to be done to address these issues? What are the challenges here and what would assist?
17. [FOR FOSTER CARE PROVIDERS] To what degree do current models of foster care prevent sexual abuse and allow effective responses in these settings? What potential is there for working towards professionalisation of the foster care 'workforce' [EXPLAIN AS NECESSARY]? What benefits would this deliver? To what degree and how would it contribute to a reduction in child sexual abuse in foster care settings? Are there other foster care models (internationally and in other States) that you know of that could be introduced or trialled in Australia?

Child sexual exploitation

18. How is child sexual exploitation perceived as a risk and as a form of sexual abuse? How is it made explicit as a form of child sexual abuse in the training that is provided to carers? What policies and processes exist to help carers identify and respond to instances of child sexual exploitation? Are you aware of any training or support for carers that addresses this issue in an effective way?

19. What potential is there to strengthen the approaches to preventing and responding to the sexual exploitation of children in OOHC through carer screening, training and support? What would need to be done? What are the challenges here?

Trauma-informed care

20. What is the model of care that is used for children who enter OOHC having already experienced sexual abuse? What training or support is provided to carers of children who have experienced prior sexual abuse? How effective is this and how does it need to be improved? What would help your organisation to provide a better model of care for these children?

21. How is this prior abuse recognised in making placement decisions and monitoring placements, so as to maximise the therapeutic potential for the child? What are the challenges in finding the right placement for these children? Are there clear policies in place?

22. How are reports of sexually harmful behaviours exhibited by children in OOHC managed? Again, what training and support is offered to carers to identify these behaviours and to respond appropriately?

Child education and awareness

23. What activities are undertaken to educate children in care about protective behaviours with regard to sexual abuse? What other efforts are made to empower children in care or to give children more 'agency'.

24. What more could be done in this area? What would be the challenges associated with undertaking this form of prevention?

Other comments

25. Are there any other comments that you would like to make about effective screening, training and support for carers as a means of preventing child sexual abuse in OOHC?

Appendix C: Discussion guide – Peak organisations

Preventing Child Sexual Abuse in OOHC settings

Interview schedule: Peak bodies and advocacy groups

Introduction

Inca Consulting has been engaged by the Royal Commission into Institutional Responses to Child Sexual Abuse to conduct research into the prevention of, and response to, child sexual abuse in out-of-home care (OOHC) settings. As the information sheet sets out, we are exploring the policies and processes of each state and territory government for carer screening, assessment, selection, training and support in order to prevent or respond effectively to child sexual abuse in foster care, kinship care and residential care settings. We are also exploring the barriers and enablers to the implementation of these policies and processes. There are also various issues that have emerged through analysis of submissions, public hearings etc that we would like to explore with you in detail.

Please note that we have thoroughly reviewed the submissions and supporting materials already provided to the Royal Commission by the relevant agencies in this State Territory.

Please refer to the information sheet that we have provided for other details about the research.

Could you please start by telling me a bit about your role and the functions of the organisation that you represent. Which States and Territories do you operate in?

Strengths and weaknesses of existing policies and processes

1. What would you say are the strengths of current policies and processes in regard to screening, training and supporting carers (including foster carers, kinship carers and residential care workers)?
2. Are there any weaknesses that you see in current policies and processes? What are the reasons that these weaknesses exist?
3. Are there particular States/Territories where you think policies and processes are particularly strong in terms of protecting children in OOHC from sexual abuse? Are there particular States/Territories where existing policies and processes are lacking, in your view? What are the features of these policies and processes?
4. In terms of improving systems, policies and processes for screening, training and supporting carers, what do you see are the main national priorities?

Provider practice

5. How easy or difficult is it for government and NGO providers to comply with policies and stipulated processes for screening, training and supporting carers? What systemic or other pressures exist that may make it difficult for providers to fully comply?

6. Are there providers that have put in place particularly good systems, policies or processes that go above and beyond what is required by the service agreement? Are you aware of any particularly good tools or models that are used for carer screening, training and support that address the issue of child sexual abuse? What allows these providers to develop and implement good practice?

The carer 'workforce'

7. To what degree are the dynamics of the residential care workforce important in offering broad quality of care and preventing and responding to child sexual abuse in residential care settings? Are there particular workforce issues that introduce a risk of system failure (for example, staff turnover, remuneration, qualifications and accreditation)? What could be or is being done to address these issues? What are the challenges here and what would assist?

8. To what degree do current models of foster care prevent sexual abuse and allow effective responses in these settings? What potential is there for working towards professionalisation of the foster care 'workforce'? What benefits would this deliver? To what degree and how would it contribute to a reduction in child sexual abuse in foster care settings? Are there other foster care models (internationally and in other States) that you know of that could be introduced or trialed in Australia?

Kinship care (including Aboriginal and Torres Strait Islander kinship care)

9. What are the particular challenges associated with providing carer screening, training and support in kinship care settings? Are policies and processes as strong here as they are for foster or residential care?

10. What are the particular challenges associated with providing carer screening, training and support in Aboriginal kinship care settings?

11. What support is specifically available for Aboriginal and Torres Strait Islander kinship carers? Are there widely available, culturally appropriate training materials for carers that address the issues of child sexual abuse? How adequate are these?

Child sexual exploitation

12. How is child sexual exploitation made explicit as a form of child sexual abuse across the States and Territories? What policies and processes exist to help carers identify and respond to instances of child sexual exploitation? Are you aware of any training or support for carers that address this issue in an effective way?

13. What potential is there to strengthen the approaches to preventing and responding to the sexual exploitation of children in OOHC through carer screening, training and support? What would need to be done? What are the challenges here?

Trauma-informed care

14. What are your views on the adequacy of care that provided to children who enter OOHC having already experienced sexual abuse? How effective is the training or support is provided to carers of children who have experienced prior sexual abuse? Are

you aware of any particularly good therapeutic care models? What opportunities are there to improve the quality of care for children who have previously been a victim of child sexual abuse?

15. How well do current requirements for carer screening, training and support provide a basis for managing sexually harmful behaviours that may be exhibited by children in OOHC? What opportunities do you see for better addressing this issue through carer screening, training and support? Again, are you aware of any therapeutic models that could be used to address this issue?

Child education and awareness

16. What are your views on the activities that are undertaken to educate children in care about protective behaviours with regard to sexual abuse?

17. What more could be done in this area? What would be the challenges associated with undertaking this form of prevention?

Other comments

18. Are there any other comments that you would like to make about effective screening, training and support for carers as a means of preventing child sexual abuse in OOHC?

Appendix D: A breakdown of NGO and government research participants

NGOs, OOHC peak organisations, training organisations and others were interviewed as follows:

By state/territory	
NSW	3
Tasmania	2
Victoria	3
Western Australia	3
Northern Territory	3
ACT	3
South Australia	2
Queensland	5
National or multi-jurisdiction	9
Total	33

By organisation type	
NGO provider of OOHC services	18
Peak/advocacy organisation	9
Professional Association	3
Training/other service provider	3
Total	33

Government agency representatives were interviewed as follows:

Agencies represented	Number of representatives
ACT Child and Youth Protection Services Children and Young People's Commissioner	10
NSW Department of Family and Community Services Office of the Children's Guardian	8
Qld	0
NT Department of Children and Families Office of the Children's Commissioner	3
WA Department for Child Protection and Family Support Commissioner for Children and Young People	8
SA Department of Education and Child Development Guardian for Children and Young People	6
Tas Children and Youth Services	3
Vic Department of Health and Human Services	8
Total	46