Service Closures Inquiry

An Inquiry into the experiences of children and young people affected by the 1997/98 closure of substitute care services

This report has been identity protected. Individual names and other identifying details have been changed.

Community Services Commission
July 2000

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Contents

Acknowledgements ... *i*

Executive Summary ... *iii*

Recommendations ... *viii*

PART A: Background

1 Introduction ... *1*

2 Methodology ... *5*

3 Reasons for service closure ... *8*

PART B: ...Characteristics and placement histories of children and young people affected by service closure

4 Characteristics of the children and young people ... *11*

5 Placement changes ... *14*

PART C: Experiences of children and young people affected by service closure

6 Support needs of the children and young people ... *21*

7 Planning and support ... *23*

8 Placements ... *29*

9 Current circumstances ... *37*

10 Concluding comments and observations ... *40*

11 The way forward ... *42*

Appendices ... *42*

A copy of this report, incorporating confidential case studies, has been forwarded to the Department of Community Services. The case studies have not been publicly released, in order to preserve confidentiality of the children and young people involved in this Inquiry.

In the case examples used in this report, all names, and some identifying characteristics, of children and young people have been changed.

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In particular, we express our gratitude to the children and young people who were affected by service closure and who were willing to give their time and share their experiences with the Inquiry.

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Commission staff involved in the Inquiry were Marina Paxman (project coordination, questionnaire design, data analysis, interviews); Anita Tang (project management); Julie Withers, Kathy Karatasas, Kate Foy (interviews). This report was written by Monica Wolf.

Executive Summary

Conduct of the Inquiry

Between November 1997 and September 1998, a number of government and non–government residential services providing intensive support for children and young people in out–of–home care closed. The Community Services Commission conducted an Inquiry into the circumstances and experiences of children and young people who were affected by these closures. The Inquiry commenced in April 1999 under s83(1) (d) of the *Community Services (Complaints, Reviews and Monitoring)* Act 1993.

The government services were Ormond and Minali, two large Department of Community Services (DoCS) facilities which were established to provide short–term care and therapeutic intervention for children and young people in care. The closure of the facilities was in line with government policies on devolution of large institutions, and was also in response to ongoing issues of concern about the safety and well–being of residents in the facilities, particularly Ormond.

In the non–government sector, five services closed. These agencies had been contracted by DoCS to provide long–term, community–based residential care services with intensive support for groups of up to six young people. The services closed due to decisions either on the part of DoCS or the agencies themselves not to renew expired contracts.

Methodology

The Inquiry was conducted in two stages. Stage one considered the key characteristics, circumstances and placement details of 37 children and young people affected by service closure, based on the DoCS Client Information System (CIS) and individual case plans. This number represented around half of the 70 children and young people affected by service closure in NSW. Stage two explored the circumstances and experiences of 14 of the children and young people in more detail, through review of case plans and other documentation, and interviews with the children and young people, their case workers and agency management.

Characteristics and placement histories of 37 children and young people affected by service closure

Characteristics of the children and young people

All 37 children and young people were state wards, or had been discharged from wardship by the time of service closure. Of the 37, 17 had resided at either Ormond or Minali and 20 with non–government agencies.

The majority (25) of the children and young people were male. Most of the children and young people (23) were aged between 13 and 16 years, with eight being 11 years of age or younger. Over half had a reported disability, with some of the children and young people having multiple disabilities. Over half had had contact with the juvenile justice system.

Number of placements

According to CIS data, which the Inquiry found tended to under–report placement change, the number of placement changes ranged from one to 14, with nine children and young people experiencing three or more changes. Of these nine children and young people, three experienced an excessive seven placement changes, and one a disturbing 14 placements. Overall, the degree of change indicated some failure of planning and placement processes.

Type of placement

In just over half of cases able to be assessed, the type of placement identified in the child or young person's case plan matched the actual placement made following closure. In just under half of relevant cases, the planned placement type did not match the placement made. The Inquiry could not assume that outcomes were poor where plans did not match placements. However, in five cases, the recorded placement following closure included crisis refuges, detention, and 'lost in the system', all indicating an unsatisfactory outcome.

In regard to the placement current at July 1999, the planned placement matched the current placement in approximately two–thirds of cases able to be assessed. The length of time between service closure and current placement ranged from 10 to 20 months. That the planned placement matched the current placement indicates, with some qualification, a reasonable placement outcome for most of the 37 children and young people. However, for a small but significant group, data indicated particularly negative outcomes subsequent to closure, including suicide, detention and excessive placement changes. It is not possible to suggest a causal link between service closure and such outcomes. However, it can be said that for some children and young people involved with the Inquiry, the care system failed to provide the early intervention, planning, individual attention and aftercare necessary to achieve positive life opportunities and outcomes.

Experiences of 14 children and young people affected by service closure

Support needs of the children and young people

Interview data paints a picture of the 14 children and young people involved in stage 2 of the Inquiry as being vulnerable and having high to very high support needs, often related to behavioural problems, reported disability and contact with the juvenile justice system.

Planning and support
In some cases, planning around service closure was timely, inclusive and appeared to be appropriate to the child's needs. In a significant number of cases, however, planning was less than adequate. The Inquiry observed that:

- while case conferences were a key feature of planning prior to closure, two young people had neither a case conference nor a case plan to guide placement;
- case reviews appear to have been used only in response to crisis, rather than as a monitoring tool;
- not all key parties, including children and young people and their families, were involved in case conferences or key decisions related to placement;
- the use of needs assessments to guide planning and decision–making was low;
- case plans generally stated a goal in line with principles of permanency planning, but often failed to meet the range of criteria which represent current policy and good practice.

The level of support provided to the children and young people at the time of closure varied from high to very low. A number of children and young people indicated that they needed a higher level of support than that provided to them.

Placements
For the children and young people involved in the Inquiry, high support needs and behavioural difficulties reportedly made locating placements problematic and in some cases, led to eviction from residential services or removal from care situations. Case workers raised concerning issues of cost being a key factor in some decisions to reject the most appropriate placements and/or to restrict support services.

Placement changes
Most of the 14 children and young people experienced a significant number of placement changes following service closure, with the majority experiencing four or more changes. Placement change was not always a negative event, particularly when part of a longer–term plan. In many cases, however, placement changes represented a crisis or significant disruption for the children and young people.

At the time of interview, which was between 12 and 20 months following service closure, six children and young people were no longer in their planned placement because the placement had broken down. Breakdowns were due to a range of factors, including violence perpetrated against others, rule breaking, and general discord between the child or young person and carers.

Most of the children and young people had also experienced short–term placements. Six had had between two and ten short–term/temporary placements between closure and the time of interview.

Continuity of care

A key issue for most of the children and young people was the lack of continuity of care which accompanied frequent placement changes. Most had seen a significant turnover of District Officers or non–government case workers. Only three of the children and young people had the same case worker at closure and at the time of interview.

Current placement and circumstances

At the time of interview, the majority of the children and young people had been in their current placement for a relatively short period of time, four months or less. Nine of the 14 were in placements considered to be permanent or long–term.

The majority of children and young people said they felt better off in their current situation than at service closure. Overall, eight of the 14 children and young people told the Inquiry they were 'happy' in their current placement. Two said they were 'ok' and two indicated they were unhappy. In the majority of cases, the children and young people rated themselves as being 'better off' now than when they were living in the closed service in key areas of their life, including education, employment and training; health and well—being, and personal safety and security. The most frequently reported area where young people considered themselves 'worse off' related to contact with, or proximity to, friends and family.

Concluding comments and observations

Overall, as a significant event in the lives of vulnerable children and young people, the process of service closure and the follow up support and assistance provided appeared to be good for a few, adequate for most, but particularly poor for some.

The Inquiry noted significant diversions from accepted planning policy and procedure and good practice. It was also apparent that the difficulties and outcomes experienced by children and young people were influenced not only by the event of service closure, but moreover by broader structural issues in the care system.

Case workers and the children and young people identified a range of strategies which could have improved the process of transition and longer–term outcomes. These strategies included more intensively supported placement options; improved worker/carer training; early provision of specialist support to children and young people in care; more time to locate placements and more support in circumstances of service closure/placement

change; more involvement of children and young people in placement decision–making; and better provision of practical assistance to children and young people in care.

The way forward

The provision of substitute care in NSW is undergoing considerable change. The Children and Young Persons (Care and Protection) Act 1998 will see a greater emphasis on family support and early intervention; more clearly delineated roles and responsibilities for DoCS and non–government agencies and carers; and creation of a Children's Guardian. In addition, new service models based on a brokerage approach are being developed and private, for–profit agencies are emerging in the care system. There is also a growing tendency to place adolescents, many of whom have high support needs, in SAAP services. Within this environment of change, however, old problems continue, such as lack of access to specialist support services, difficulties in recruiting suitably skilled carers and insufficient aftercare.

This Inquiry has highlighted the implications of poor planning and service development in the lives of already vulnerable children and young people. It is important that reform processes learn from past mistakes and rectify basic deficiencies within the system. In this context, a focus on service standards, measurable outcomes for children and young people and transparent monitoring and review mechanisms is critical.

Recommendations

Recommendation 1

The Department of Community Services, and relevant service providers, should ensure that predictable placement changes, such as service closure resulting from the expiry of contracts, are planned in such a way to ensure that:

- options relating to possible alternative funding arrangements, which enable existing placements and case workers to be retained, are fully explored;
- adequate time between notification of service closure and cessation of funding is provided to enable appropriate alternative placements for children and young people to be secured;
- the expressed needs of children and young people are given paramount consideration in placement planning; and
- preparation for change, and support following change, is able to be provided to children and young people. This should include provision of detailed information and the opportunity for children and young people to get to know their new placement prior to moving.

Recommendation 2

The Department of Community Services and non–government service providers should use the information contained in this report, and the *NSW Standards for Substitute Care Services* (particularly standard 2.6 *Moving in Care*), to review and improve placement planning procedures and monitoring mechanisms to ensure:

- meaningful involvement of children and young people and key stakeholders, including parents, in decisions related to appropriate placement;
- adequate assessment and monitoring of the child or young person's circumstances and needs;
- case plans which clearly identify strategies to meet the needs and goals of the child or young person, consistent with ensuring their protection; continuity and stability of care; and maintenance of culture and relationships.

Recommendation 3

The Department of Community Services should address the issue of lack of suitable intensively supported placement options for children and young people with high support needs, particularly those with disabilities and/or challenging behaviours. Review should take account of the outcomes of the *Review of Intensive Out Of Home Care Support Services* and *Framework for the Development of Intensive Out Of Home Care Support Services*[1], and encompass specific issues relating to:

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[1] Clark, Robin (1997) Deakin Human Services, Australia.

- the need for specialist support services, including counselling, skills development and tutoring, for children and young people with high support needs in out of home care;
- the impact of the cost of placements on placement decisions in relation to children and young people with high support needs;
- the level of carer training, preparation and experience required to ensure the provision of appropriate care for children and young people with high support needs; and
- training and support necessary to ensure that carers and residential care staff are able to respond appropriately to children and young people with challenging behaviours.

Recommendation 4

The Department of Community Services should review the process of recording placement changes on departmental data systems for children and young people in out of home care, to ensure that Departmental client data provides an accurate and up to date record of all placement changes. Placement histories should include:

- all placement changes, including those of very short duration; and
- placement changes made within non-government services contracted to support children and young people in out of home care.

Recommendation 5

The Children's Guardian should ensure that the issues and recommendations raised by the Inquiry are considered and addressed in the conduct of their role at both individual and systemic levels.

PART A: Background

1 Introduction

At the request of the Minister for Community Services, the Community Services Commission conducted an Inquiry into the circumstances of children and young people who were affected by the closure of a number of non–government substitute care services, and the government centres Ormond and Minali, in 1997/98. The Inquiry commenced in April 1999 under s83(1)(d) of the *Community Services (Complaints, Reviews and Monitoring)* Act 1993.

The terms of reference for the Inquiry were to:

- identify current placement circumstances of children and young people affected by the service closure[2];
- assess the adequacy of current placements against identified needs and expressed wishes of child or young person, as documented in case plans;
- examine whether the planning processes associated with the transition of children from one placement to another conformed with established policy and procedures; and
- identify difficulties experienced by children and young people in the process of service closure.

To address these terms, the Inquiry was approached in two stages. The first stage considered the circumstances and placements of 37 children and young people affected by service closure, using the Department of Community Service's (DoCS) Client Information System (CIS) and where available, case plans. This represented just over 50 per cent of all children and young people affected by service closure[3]. The second stage explored the experiences and circumstances of 14 children and young people affected by service closure, through interviews with the children and young people, their case workers and agency management.

This report is presented in three parts: *part one* provides background information and describes the process of the Inquiry; *part 2* describes the findings of stage 1 (with some case studies drawn from stage 2 interviews), and *part 3* describes the findings of stage 2.

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[2] 'current' at the time of the Inquiry. For placement data, 'current' in part 2 refers to the latest placement recorded on CIS data as at June/July 1999. Case plans were current as at April 1999. In part 3, the circumstances and placements of the children and young people were current as at the time of interview (August and September 1999).

[3] A total of 70 children and young people were affected by the closure of government and non–government services. This figure is based on data relating to the period prior to closure (Ormond and Minali admission and discharge statistics and DoCS Client Information System data for non-government services).

1.1 The closures of services in 1997/8

The services which were the subject of the Inquiry closed during 1997 and 1998[4]. *Table 1* below identifies each service and the model it operated under, the date the service closed, the number of children and young people affected by closure and the number included in this Inquiry.

Non–government organisations

Agencies managing the five non–government services which closed had been contracted by DoCS to provide community–based residential care services with intensive support for groups of up to 6 young people. The majority were 'model 3' contracts, a term used by DoCS to describe services designed for children and young people who had been assessed as needing a medium to long term period of residential care with high intensity supervision. One service provided care for three children and young people under a 'model 2' contract. Model 2 services provide for less intensive levels of support within a residential setting.

Generally, the non–government services closed either because they did not seek to renew their contract with the Department or because they were unsuccessful in their bid to renew their contract. In two of the five cases, the agencies were able to continue providing services to children and young people in their care through negotiation of alternative funding.

Government services

Ormond and Minali were two large DoCS residential facilities for children and young people requiring care. The facilities in theory provided emergency care for up to 72 hours, assessment care for up to six weeks and therapeutic care/intervention for up to three months[5]. In practice, however, a large number of young people were staying in Ormond and Minali for very long periods of time. In October 1997, the then Minister for Community Services, the Right Hon. Ron Dyer, MLC, announced that Ormond and Minali would close. Closure of the facilities was in keeping with the government's strategy of devolving large institutions, and was also, in part, a response to allegations made public which raised serious concerns about the standard of care and the safety of residents at Ormond[6]. Ormond closed in June 1998, although most

[4] Three young people interviewed for this Inquiry were further affected by a second closure, that of Baptist Community Services in December 1999. The circumstances of these three young people along with another 12 young people in care of Baptist Community Services at the time of closure are being reviewed under s11(1) *Community Services (Complaints, Reviews and Monitoring) Act* 1993.

[5] Community Services Commission (May 1999) *Group Review Report: The experiences and progress of 17 young people in substitute care*. (page 7)

[6] Community Services Commission (April 1999) *The Ormond Centre–A Complaint Investigation into Institutional Care of Children*. The Commission's investigation substantiated many of the complaint allegations, including that staff were inadequately trained to work with disturbed state wards; behaviour management strategies were inconsistent in quality and implementation; there were instances where residents' behaviour put other residents at risk of physical and/or sexual abuse; and

residents were moved early in that year, and Minali closed in September 1998. Both facilities continued some operation after this period. Ormond established three 'transition houses' to accommodate young people moving from the facility to alternative placements. Minali continued to accommodate young people in one of its cottages, in order to provide temporary care while permanent placements were located.

From the outset, the Inquiry recognised that the circumstances and experiences of the children and young people in Ormond and Minali were likely to vary significantly from those placed with non–government organisations. Although some young people stayed at Ormond and Minali for much longer periods than the stated maximum of three months, the facilities were designed as short–term placements for children and young people awaiting more appropriate placements. They were also institutions and, as noted above, were recognised as problematic environments. In contrast, non–government model 3 and model 2 services catered to up to six children and young people only and were intended to be medium to long term placements. These services were established to provide a suitable environment for children and young people in need of intensive care.

instances where staff could not provide the necessary intervention to prevent situations escalating to crisis levels. (page 5; 13-14)

Table 1. Services affected by closure 1997/98 and number of young people involved in the Inquiry (source: DoCS admission/discharge data; interviews)

Auspice	*Location*	*Description of model*	*Date service closed / funding ceased (1)*	*No. young people affected by closure*	*No. young people included in stage 1 of the Inquiry (2)*	*No. young people included in stage 2 of the Inquiry*
Non–Government						
Wesley Mission/ Dalmar	North Sydney	Model 3 residential care, one premises	January 1998	3	2	
Wesley Mission/ Dalmar	Orana Far West (Dubbo)	Model 2 residential care, one premises	March 1998	3	3	
Burnside	Campbelltown	Model 3 residential care, two premises	November 1997	7	6	***Total NGO = 5***
Barnardos	Illawarra	Model 3, community placement program with one residential facility	Not affected	6	6	
Hunter Mission	Newcastle	Model 3 residential care, one premises. Changed to community placement program with a number of premises	March 1998	5	3	
Government						
Ormond	Northern Sydney	DoCS congregate care facility providing intensive support services	June 1998	18	7	
Minali	Cumberland/ Prospect	DoCS congregate care facility providing intensive support services	September 1998	28	10	***Total Govt = 9***
TOTAL				**70**	**37**	**14**

(1) *The 'date closed' may vary from the date children and young people moved out*
(2) 'Stage 1' and 'stage 2' and the method of sample selection are detailed in section 1.2 'Methodology'

2 Methodology

2.1 Stage 1 of the Inquiry

Stage 1 examined the circumstances of a sample of the 70 children and young people affected by service closure through a review of case file information.

Of the 70 children and young people, the following were excluded from the sample:

- Children or young people whose circumstances had been reviewed in the conduct of any previous Commission work[7]; and
- Children and young people in Ormond and Minali who had been accommodated for less than six weeks during the two months prior to closure of the service. This limitation was applied to ensure a focus on children and young people whose placement could not be viewed as short–term.

This selection method resulted in a sample of 37 children and young people. Of the 37, 17 were from Ormond and Minali and 20 were from non–government organisations.

Following requests from the Commission, case workers provided the Inquiry with the child or young person's case plan at the time of service closure and the case plan current at April 1999. The Department of Community Services provided the Inquiry with each child's contact details and CIS placement history data from the time of service closure to June/July 1999.

A stage 1 interim report was provided to DoCS and the Minister for Community Services, the Hon. Faye Lo Po' in November 1999[8].

2.2 Stage 2 of the Inquiry

Stage 2 of the Inquiry involved interviews with children and young people affected by service closure and their case workers. Interviews were conducted in August and September 1999. This stage also incorporated interviews with managers of the non–government agencies which closed.

Each of the 37 children and young people who were included in stage 1 and who were able to be located were invited to participate in an interview.

[7] For example, children and young people resident in Ormond and Minali whose circumstances were reviewed in Community Services Commission (May 1999) *Group Review Report: The Experiences and Progress of 17 Young People in Substitute Care.*

[8] This report includes additional material to that available at the time the interim report was prepared, and takes into consideration issues raised by the Department in their response to the report.

Twenty children and young people subsequently agreed to an interview, nine from Ormond and Minali and eleven from non–government services[9].

The current case workers for the interview group were also asked to participate in an interview. All case workers initially agreed to an interview and all but one were interviewed[10].

Interviews were structured using separate questionnaires for children and young people, for case workers and for service managers. One or two Inquiry staff conducted the interviews.

The interviews with children and young people focused on:

- their experiences at closure, including involvement in planning for transition;
- their experiences since closure; and
- their current circumstances.

The interviews with case workers focused on similar issues to the young people's questionnaire.

The interviews with service managers were directed to ascertaining the process leading to closure and the broad effect of closure on consumers.

Exclusions from stage 2 analysis

At a later stage in the Inquiry, it became apparent that a number of the children and young people were not strictly affected by service closure.

In interviews with agencies providing the services, it was ascertained that two agencies, Barnardos and Burnside, were able to negotiate alternative funding packages which enabled them to continue to provide services to children and young people in their care[11]. Seven of these children and young people had been included in stage 1 of the Inquiry and six had been interviewed for stage 2.

For the Commission, the question was whether these young people, who were in a practical sense unaffected by service closure, were within the scope of the Inquiry. It was decided that the seven children and young people would be included in the stage 1 analysis, given its focus on the circumstances of those in care at the time of closure. In addition, the approach of the agencies in dealing with service closure was relevant to the Inquiry.

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[9] Of the 17 children and young people who were not interviewed, seven did not wish to participate; in 4 instances case workers reported that the child and/or family was in crisis and should not be approached for interview; in 4 cases contact addresses were unknown; in one case the young person was before the criminal court and in one case the young person had moved interstate.

[10] One case worker cancelled several planned meetings and was subsequently unable to be interviewed.

[11] In the case of Burnside, this arrangement was the case for only one young person.

However, it was decided that the six children and young people who participated in interviews would be excluded from the stage 2 analysis of the Inquiry, which focused more strongly on the experiences of closure. This decision was made due to the fact that the children and young people's circumstances and experiences, including placement changes, could not be taken as being related to the experience of service closure.

Children and young people included in stage 2 analysis

Table 3 provides an overview of some key characteristics of the 14 children and young people included in the stage 2 analysis, in comparison to the stage 1 sample of 37 children and young people.

Table 3: Characteristics of the sample of young people affected by service closure for stage 1 and stage 2 of the Inquiry (source: CIS case plans, interview data)

Characteristics	*Stage 1 sample*	*Stage 2 sample*
Placement at time of closure		
• Ormond/Minali	17	9
• Non-government	20	5
Gender		
• Male	25	10
• Female	12	4
Cultural background[12]		
• Aboriginal	4	1
• Non-Aboriginal	30	13
• Unknown	3	-
Disability		
• **Reported disability**	21	11
• No reported disability	16	3
Contact with Juvenile Justice		
• Reported contact	21	9
• No reported contact	16	5
Total	*37*	*14*

In comparison to the stage 1 sample, the group considered in stage 2 had a higher representation of children and young people from Ormond and Minali. This is primarily due to the exclusion of the six children and young people from non–government services, as described above. There was also a greater proportion of children and young people with a reported disability in the stage 2 group.

2.3 Methodology limitations

[12] In recording Aboriginality, the Inquiry did not attribute Aboriginality to children and young people in cases where workers reported an Aboriginal background but the child or young person did not self–identify.

The methodology had limitations, most of which related to data sources:

- the majority of case workers interviewed were not the same as those involved with the young people at closure. Their knowledge of the situation at closure was therefore limited, and drawn largely from files rather than experience;
- for children and young people, questions which required them to reflect back on events at the time of service closure appeared to be difficult to answer. This may be in part due to the high level of mild intellectual disability amongst the group interviewed, and/or the time that had elapsed since the closure. In addition, not all young people answered all questions, and in one case, the interview had to be terminated; and
- CIS placement history data often proved to be inconsistent with information provided by case workers and/or children and young people.

To some degree, all of the above issues limited the reliability and quality of the data gathered by the Inquiry.

3 Reasons for service closure

The following describes the background to closure for each of the agencies considered in the Inquiry. Information regarding non–government services was gathered through interviews with agency staff.

3.1 Non–government services

The majority of non–government services which closed had been contracted to provide model 3 services for a period of three years. One service was contracted to provide a less–intensively supported model 2 service. While the contracts were time limited, not all services operated within the context that funding was finite. Whether services were prepared for an end to the funding contract appears, according to agencies interviewed, to have had an effect on future placement planning.

Dalmar submitted for continuation of its two model 3 contracts, one in the metropolitan area and one in a regional area. Following negotiation with DoCS regarding service models and funding levels, Dalmar received approximately six to eight weeks notice that the contracts would not be renewed. According to the service, the timeframe complicated the search for appropriate alternate care placements. One child did not have a placement until very late on the day that the unit was closed.

Hunter Mission received formal advice that it had been unsuccessful in its bid for a renewal of its model 3 contract approximately four weeks prior to when the service would need to close. The organisation had re–applied for a contract with a redesigned service based on a community placement model,

but this was not approved by DoCS. The service indicated to the Inquiry that it was unsuccessful in gaining a new contract due to the budget being more than the Department was prepared to pay.

Burnside reported to the Inquiry that its initial intention had been to operate the contracted service on an ongoing basis. However, during the course of the contract, Burnside was unable to reach agreement with the Department about adequate levels of funding for the service. As a result, the organisation decided to view the contract as finite, and to close the program at the conclusion of the contracted period. This decision was taken approximately six months prior to the end of the contracted period. One young person in the Burnside group was not affected by closure, as the service was able to continue to provide accommodation and support through different funding arrangements. In this case, the model 3 house targeted for closure was transferred to model 2 funding, with the young person remaining as a model 2 client.

Barnardos' end of contract did not lead to closure of the service. In negotiation with local DoCS management, Barnardos' service provision was able to continue through an agreement to shift funding from a model 3 contract to Individual Service Plans (ISPs). All children and young people remained in their placements and no aspect of service delivery ceased. The six children and young people were unaware of the administrative change. Three clients were, however, at the age of discharge and thus experienced some changes at the time, not related to service closure. For these clients, aftercare funding was negotiated with DoCS and using Barnardos' own resources, services were offered to them.

According to some of the non–government service providers, the length of time between confirmation of closure and the closure itself had a significant impact on placement planning.

Where non–government agencies operated on the basis that contracts were finite, it appeared that they were better equipped to take a considered approach to locating appropriate alternative placements, and/or to instituting a planned 'wind down program'. One agency stressed to the Inquiry that a reasonable lead up to closure following decisions not to renew contracts would be a critical factor in decreasing the impact of closure on children and young people, and enabling full and careful placement planning.

The following case study indicates the impact of lack of planning on the children and young people affected by closure:

Case study
Sam, aged 16 at the time of service closure

Sam had been living at the non–government service for 17 months prior to its closure. The service had anticipated a continuation of its model 3 funding contract.

The case worker interviewed for the Inquiry had found no transition plan on file and concluded that a transition plan had not been constructed for Sam. Sam was interstate visiting his mother at the time the service closed, so was unable to contribute to the placement decision. Sam told the Inquiry that the agency *"never told me* (that the service was going to close), *they just did it".*

The most effective agency response was clearly that which averted the need for the service to close. As noted above, Barnardos was able to negotiate alternative sources of funding to continue service provision to the children and young people in their care. Burnside was also able to achieve this for one young person. These organisations achieved an administrative change which left young people largely unaffected by closure.

3.2 Government services

As noted earlier, the closure of Ormond and Minali was in line with government policies on devolution of large institutions. It was also in response to ongoing issues of concern about the safety and well–being of residents identified in the facilities, particularly Ormond[13].

While Ormond closed in June 1998, most Ormond residents were moved in February 1998, some four months following the public announcement of plans for closure. Minali closed ten months after the announcement of closure, in September 1998.

[13] Community Services Commission (April 1999) op cit (page 5).

PART B: Characteristics and placement histories of children and young people affected by service closure

The following is an analysis of the key characteristics, circumstances and placement details of the 37 children and young people affected by service closure. The table at *Appendix 1* provides a summary of this data. Case studies are drawn from interviews conducted in stage 2 of the Inquiry.

4 Characteristics of the children and young people

4.1 Status, age and gender

All of the 37 children and young people involved in the Inquiry were state wards, or had been discharged from wardship at the time of service closure.

Of the 37 children and young people, 25 were male and 12 were female.

The largest proportion (62 per cent) of the sample were aged between 13 and 16 years. Eight children were 11 years or younger at closure, with the youngest being nine years of age. Six of these children were residing in either Ormond or Minali when the services closed. Two of the youngest, aged 10 years, had been living at Minali for six months. It is of significant concern that children this young were placed in short–term congregate care for this period of time, particularly in facilities with a reputation of not being able to meet the needs of residents.

4.2 Disability

Table 4 below shows the number of children and young people in the sample who had a reported disability, and the type of disability.

As the table indicates, over 50 per cent of the Inquiry population of children and young people affected by service closures were reported to have a disability, with some experiencing multiple disabilities.

Data relating to the number of children and young people with a disability who are in care is generally lacking[14], and it is not possible to accurately ascertain a comparative level of disability among young people in care in NSW. However, it is clear that the level of disability within the Inquiry

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[14] Llewellyn, Gwynnyth (October 1999) *Living options–creative solutions: When children with disabilities can't live at home*. Paper presented to a joint ACROD NSW, ACWA and Community Services Commission Forum, 5 October 1999. Page 6.

population is significant. Figures supplied by DoCS indicate that some 8 per cent of wards in care at June 1999 had a disability[15], a figure comparative to disability levels in the general community. Other research suggests a higher level of disability amongst children in care[16].

Table 4: Young people with a reported disability affected by service closure (source: case plans, file notes and interviews)

Type of disability reported	*Government services*	*Non-government services*	*Total n*	*Total %*
Reported disability				
Mild intellectual disability	2	4	6	16.2
Moderate-severe intellectual disability	-	1	1	2.7
Mild intellectual disability & ADHD/ADD	-	3	3	8.1
ADHD/ADD	2	3	5	13.5
Developmental disability & ADHD/ADD	1	-	1	2.7
Oppositional defiant disorder	2	-	2	5.4
Dyslexia & learning disorder		1	1	2.7
No reported disability	9	8	17	45.9
Missing	1	-	1	2.7
Total	*17*	*20*	*37*	*100.0*

4.3 Contact with Juvenile Justice

Over half the children and young people affected by service closures had contact with the juvenile justice system or adult correctional system. The Commission's report *Just Solutions–Wards and Juvenile Justice* estimates that in comparison to the general youth population, wards are at least 16 times over–represented in detention and 6.5 times over–represented amongst young people under Department of Juvenile Justice supervision[17].

Proportionally, more males than females in the Inquiry's sample had contact with the juvenile justice system, either prior to or following service closure. While one third of females in the Inquiry sample had some involvement with juvenile justice, over two thirds of males had such contact.

In two instances, individuals committed serious offences following service closure which resulted in their detention in adult jails, one following discharge and the other at age 15. Both of these young people were Aboriginal.

[15] DoCS Information and Research Unit, April 4 2000. Source: Integrated Substitute Care Database.
[16] For example, Szwarc, B. (1992) *Changing particular care: A national survey of children in non–government substitute care in Australia*. National Children's Bureau of Australia Inc. Llenlees Press, Victoria. The study estimates that up to 40 per cent of children in care in NSW had a disability.
[17] Community Services Commission (March 1999) Just Solutions–Wards and Juvenile Justice (page 18)

5 Placement changes

5.1 Length of time living in the service that closed

Table 5 below identifies the length of time that children and young people had been resident in the services prior to closure.

Table 5 shows that the shortest period for which a young person had been living in a service prior to its closure time was two months, at a DoCS facility. The longest was 54 months at a non–government service.

Table 5: Number of young people by length of time in service that closed (source: CIS data)

Service provider	*Months*			*Inquiry sample*	
	1-3	4-12	More than 12	Missing data	Total n
Non-government:					
• Barnardos, Illawarra Area	-	-	6	-	6
• Burnside, South West Sydney Area	1	1	4	-	6
• Dalmar Child & Family Services	1	2	2	-	5
• Hunter Mission, Hunter Area	1	2	-	-	3
Government:					
• Ormond	1	4	1	1	7
• Minali	1	7	1	1	10
Total	5	16	14	2	37

As noted previously, Minali and Ormond were intended to be short–term placements. However, of the 17 children and young people who resided at Ormond and Minali, all but two were there for longer than the maximum three months. The length of residence ranged from two to 22 months. For the majority (approximately 60 per cent), their residence at Ormond or Minali was six months or less, with the average stay being 4.3 months.

In contrast, the non–government services were funded to provide longer–term, more individualised care for up to three years. Half of the 20 children and young people residing in non–government services had been there for more than twenty-eight months. Only four of the 20 had been there for less than six months, with three of these children and young people having resided in the service for only two months.

5.2 Number of placements

Table 6 shows the number of placements experienced by children and young people in regard to service type, based on CIS data from the time of service closure to June 1999[18].
Of the 37 children and young people, three are not recorded on CIS data as having any placement changes and six were discharged.

For the remaining 28 children and young people, CIS data indicates that the number of placements between service closure and their current placement[19] ranged from one to 14.

Although recognising that placement changes are not always a negative event, a high number of placement changes must indicate increasing instability for the child or young person. Nine of the 28 children and young people experienced three or more changes. This level of change is a likely indicator of less than optimum planning to meet these young people's needs through appropriate and stable placement.

Table 6: Total number of placements (Source CIS Data)

Number of placement changes following closure	*Young people who left government services*	*Young people who left non-government services*	*Total (n)*
Discharged from wardship	–	6	6
Nil *(1)*	–	3	3
One	6	3	9
Two	7	2	9
Three	4	1	5
Four	–	–	–
Five	–	–	–
Six	–	–	–
Seven	–	3	3
Eight	–	–	–
Nine	–	–	–
Ten	–	–	–
More than ten	–	1	1
Missing data		1	1
Total	*17*	*20*	*37*

(1) Nil change indicates the service continued under other funding arrangements.

Of the nine, three young people experienced an excessive seven placement changes, including an 11 year old girl and a 14 year old boy. One young person experienced an extraordinary—and disturbing—14 placements in a

[18] It should be noted that the Inquiry found that CIS data tended to under–report placement changes. This issues is further explored in *section 3.3* (refer *table 7*).
[19] The period of time between service closure and interviews ranged from 12 months to 20 months, with the average being just over 15 months.

period of 17 months[20]. While this degree of change was not common, it is concerning that it happened at all.

The following case study highlights the vicious cycle that placement change may precipitate:

> ***Case study***
> ***Tina, aged 14 at the time of service closure***
>
> Tina had been living in the non–government service for two months prior to its closure. Tina's case worker told the Inquiry that Tina's support needs were intensive.
>
> Tina's first placement following closure was a crisis refuge. Tina remained in the refuge for a month, at which time she was evicted for an alleged assault on another resident. The case worker told the Inquiry that from the youth refuge, Tina moved to short–term foster care for one month. The placement was terminated early as the carer was unable to deal with her behaviour. She was then moved to a crisis placement in a motel, and following this, to a short term foster care arrangement with a relative while awaiting a placement in a long–term accommodation service. Tina moved to the service for seven months, but was again evicted for behavioural issues. Tina's last recorded move, where she was at the time of interview, was back to her relative's as a short–term foster care placement.
>
> Tina's caseworker told the Inquiry that the need to stop reactive responses to Tina's situation was recognised, but unable to be fully addressed due to a combination of competing priorities, high workload and lack of suitable placements.

5.3 Placement changes

The DoCS *Working with Children and Families Practice Manual* identifies a range of policies and procedures related to case management and planning for children in out of home care. An important criteria for assessing the placement of the children and young people affected by service closure would have been whether placement was in accordance with assessed needs and approved case plans for the child and family[21].

For the purposes of stage 1 of the Inquiry, whether the planned placement was achieved for the 37 children and young people has been taken as

[20] Information drawn from stage 2 interview data.
[21] DoCS (August 1997) *Working with Children and Families Manual*, 11–49; 11–54; 11–58.

indicating some degree of appropriate planning. However, the data available to the Inquiry did not enable assessment of whether matches or mismatches of placements identified in case plans to initial and final placements were a result of inadequate planning, or simply changes of circumstances or altered choices. Further, the data did not enable conclusions to be drawn regarding the quality of placements for all 37 children and young people. For example, a case plan goal of foster care and an outcome of independence may be either a positive or negative outcome, depending on the capacities and wishes of the young person.

Case study
Peter, aged 10 at the time of service closure

The transition plan for Peter was, following an interim stay with a relative, long–term foster care. Peter said he had talked about moving with case workers, but did not remember *'any big case conferences'*. He had rated foster care as his fourth preference, after living by himself, going to boarding school and being restored to his father.

Peter's first placement post closure was with foster carers. After a short period of time, however, he left this placement of his own accord and self–placed with his mother.

Records indicate that a case conference was held after this self–placement, and Peter's case plan was amended to reflect the aim of long–term restoration with his mother. A high support case management program was also implemented to assist Peter and his family in achieving this aim.

Nonetheless, the following overview does provide indicators that planning for closure was, in some cases, inadequate and likely to have contributed to poor outcomes for children and young people.

Planned placement at closure and initial placement

Analysis of the data provided in *Appendix 1* indicates that in 17 of 30 cases (57 per cent)[22], the proposed placement type identified in the case plan at closure matched the actual placement type achieved immediately following closure[23].

[22] Assessment of identified placement against actual placement discounted six young people who were discharged, (as no CIS data was available on placement post discharge), and one young person for whom information was missing.
[23] This analysis regards young people in services which continued operating under different funding arrangements as having achieved their 'planned placement'. 'Approved carers', 'foster care', 'professional care' and 'unrelated care' have been taken as meaning the same in terms of match, as have 'group home' and 'residential care'.

For 13 of the 30 children and young people, (43 per cent), their first placement did not match the placement identified in the case plan at the time of closure. In one case, this was because there was no plan at closure. In at least five other cases and considering only placement type, the first placement indicates a poor outcome. Three young people were placed in refuges, including a 13 year old boy with reported ADHD and developmental disability. The whereabouts of one young person was unknown, and another was placed in detention on serious charges of murder.

Planned placement and current placement

Overall, in 20 of 28 cases able to be assessed[24], the planned placement matched the current placement. Of the 13 children and young people whose initial placement did not match that proposed in their case plan at closure, 7 had achieved their planned placement in their current placement[25], and one young person had been discharged from care. The remaining five children and young people, however, had still not attained their planned placement in their current placement.

Current circumstances

In regard to placement type only, the circumstances of many children and young people involved in the Inquiry were in line with current case plans. As noted previously, data available to the Inquiry did not enable assessment of the quality, appropriateness and stability of these placements.

For some of the 37 children and young people involved in the Inquiry, however, the circumstances of their current placement indicate a negative outcome. One young woman committed suicide some 19 months and two placements following service closure. Another young woman aged 16 moved from juvenile detention to an adult correctional centre following murder charges. One young man experienced 14 separate placements following closure and prior to his discharge from wardship.

It is not possible to suggest a causal link between the process and impacts of service closure and the poor outcomes of these young people. Clearly, a range of factors would have impacted on and influenced their life circumstances. However, it can be said that for some children and young people in the Inquiry, the care system failed to provide the early intervention, appropriate planning and individual attention and aftercare required to achieve positive life opportunities and outcomes. Further, regardless of cause and effect propositions, experiencing the closure of a service and having to move can only be a disruptive, unsettling and potentially risk–increasing event for already vulnerable individuals.

[24] Eight young people had been discharged and no data was available on placements after discharge. In addition, data was missing for one young person.

[25] The 'current' placement refers to the final placement listed in CIS data provided to the Inquiry in June/July 1999. The case plan referred to here was that current at the time of the last placement, and may have differed to the plan at closure.

Case study
Steven, aged 16 at the time of service closure

CIS data records that Steven had 14 placement changes between service closure and mid 1999, ten of which were short–term in nature. Steven told the Inquiry he remembered seven changes, and also a period of homelessness. At the time of interview, Steven had been discharged from wardship and was living in a house with an older man he met at a railway station, who offered him board and lodging for $100 per week. Steven spends most of his time riding his bike around the streets.

The case worker noted that transition planning 'wasn't done really well'. Steven had had a number of different case workers since closure, but no contact with any workers since leaving care.

Prior to his discharge, Steven had been told about aftercare services, but couldn't recall what he'd been told, nor could he remember his entitlements. He felt he needed this information written down. Steven told the Inquiry that he needed help to stay on the right path; guidance, support and encouragement; and money. Steven asked the Inquiry interviewer if she could tell his DO that he needed help with a range of issues, including getting some counselling; information about his disability, and information about aftercare services.

PART C: Experiences of children and young people affected by service closure

Sections 3.1–3.4 below draw on case studies and supporting data to identify key observations and themes in relation to the individual experiences of the 14 children and young people involved in stage 2 of the Inquiry[26], and the Inquiry terms of reference. The case studies were developed from analysis of interviews with the children and young people and their case workers, supplemented by information contained in case files. The case studies in full have been provided to DoCS as an appendix to this report, but have not been publicly released.

6 Support needs of the children and young people

Table 3 in part 2 describes the characteristics of the 14 children and young people interviewed for the Inquiry.

In the majority of cases, case workers reported to the Inquiry that the children and young people had high to very high support needs. Their needs were often linked to, or compounded by, identified behavioural problems, disability and involvement with the juvenile justice system.

According to case workers and file information, many of the children and young people had behavioural problems, which in a number of cases had impacted significantly on the capacity of case workers to locate and maintain the young person in an appropriate placement.

> *Workers always underestimate his needs and behaviour……..they think they can deal with him but they can't. Services are under–resourced…….Refuge workers do not have the experience for real behavioural problems that come from years of abuse.* Case worker

And as observed by one young person:

> *The kids who were easier were put in foster care. The kids who had more troubles did not get foster care. They* (the workers) *would say 'why would we put you in foster care?' It was so unfair.* Female, 16

[26] In some instances, data was not available for all of the 14 children and young people. Where the total number referred to is less than 14, this is noted.

Nine of the fourteen children and young people interviewed had a reported disability. In almost all cases, the disability was cognitive. The lack of adequate responses available within the substitute care sector for children and young people with a disability is well recognised[27]. These children and young people are highly vulnerable, and evidence indicates that foster care for children and young people with higher support needs is hard to find and hard to maintain[28].

Case study
Alice, aged 13 years at the time of service closure

Alice has a conduct disorder and a history of behavioural problems, and records indicate a need for a therapeutic environment.

Alice's case worker noted that placement options were extremely limited for her. Restoration was not an option and she had been assessed by medical officers as being inappropriate for foster care. Alice could not be placed in a therapeutic service as she does not suffer from a psychiatric disability. Following service closure, Alice was placed with a service providing longer–term, intensively supported residential care.

The case worker told the Inquiry that this service had subsequently failed Alice, and expressed concern about quality of service provision. The case worker said the placement had changed following an incident where Alice was placed in a juvenile detention centre. The service provider would not allow her to return to the residential unit, as she was considered a danger to other residents. However, the service failed to locate an immediate alternative placement for Alice, even though bail had been granted, so she remained in detention for a period of three weeks. Six weeks later, Alice was moved again within the same NGO but under a crisis individual package on her own.

Eight of the fourteen children and young people had had contact with the juvenile justice system, either prior to or following service closure. In six of the eight cases, the young people in contact with juvenile justice also had a disability. The high level of contact with the juvenile justice system is a further indicator of the level to which young people experiencing service closure were at risk.

[27] For example, Ageing and Disability Department (November 1996). *Children with disabilities and out–of–home care*. Draft discussion paper.
[28] Lewellyn, Gwynneth October 1999. op cit page 6.

For the 14 children and young people, contact with juvenile justice ranged from a single charge of theft resulting in a good behaviour bond to serious assault charges leading to detention. Some contacts were seen as situational:

> "(his) *criminality began following service closure and appears to be a result of his frustration with isolation. This was contained and specific to a period of time when he was living on a farm and feeling very alone."* Case worker

For other young people, contacts were ongoing and of significant concern to workers:

> *They said I was a danger to the other kids. I wasn't allowed to go back there after I was in Reiby.* Male aged 14

Most recent charges for two of the young people were for malicious damage, brought against them by the residential services they had been placed with.

Overall, interview data paints a picture of the children and young people affected by service closure as being vulnerable and needing relevant intervention and high levels of skilled support in their living situation. From the experiences of the children and young people, however, the care system often appeared incapable of providing appropriate placements and/or the support and resourcing needed to ensure positive outcomes.

7 Planning and support

7.1 Planning

Appendix 2 provides an analysis of planning processes associated with the transition of children from one placement to another. Processes are assessed against key criteria identified in the DoCS *Working with Children and Families Manual*.

Service closure was a significant event for the children and young people, in that it represented placement disruption and change. However, unlike many placement breakdowns or disruptions experienced by children and young people in care, service closure should have been a predictable and known event. As such, it would be expected that planning for the event would adhere to both established policy and good practice.

In some cases, planning appeared to be timely, inclusive and appropriate to the needs of the child:

> *At first I went to live at home for a week or two, then I moved to a unit that had staff. This was planned so I could see what it was like to live at home again. I knew I would be there only a couple of weeks. It was*

> *planned that I would spend weekends at home while I was living at (service) and this happened.* Male aged 14, now restored.

Overall, however, planning processes associated with service closure and the care of young people following closure were often less than adequate. This was in terms of both accepted policy and procedure, and also in regard to the disruptive effects experienced by children and young people.

Case study
Michael, aged 10 years at the time of service closure

According to Michael's case worker, no case conference which involved the service to which Michael was moving was held, nor was a copy of the case plan forwarded to the new service. Michael told the Inquiry that he did not attend a planning meeting prior to service closure, but that he was aware he would be moving to short–term foster care until a longer–term foster care placement could be found.

Michael's case worker believed that things could have been handled better for Michael through preparation of a detailed case plan prior to closure and more communication between the closing service and the new service provider. In addition, the case worker stated that there should have been resolution of outstanding issues for Michael and provision of records to the new service to ensure that the service was fully informed about Michael's history. The case worker also noted that Michael came to his new placement with no possessions, no clothes and no toys.

Nine months after leaving the closed service, Michael was placed in a permanent foster care placement.

In a number of instances, case workers' understanding of planning processes around service closure differed from those of the children and young people. In particular, case workers tended to report a higher level of involvement of children and young people in planning than did the children and young people themselves.

Case study
Kylie, aged 15 years at the time of service closure

Kylie's case worker told the Inquiry that a case planning meeting was held prior to closure. Kylie told the Inquiry the meeting was 'great'. A transitional case plan was prepared, which briefly covered future placement; preparation for the change; school and departmental responsibilities. The plan identified placement with the model 3 group home as an overall objective.

The case worker stated that the initial two placements were part of a planned process of change, and that placement in a transitional unit enabled staged progress to transfer to the group home, including visiting for dinner to see the home and meet the workers. The case worker said that *"Kylie was involved at every stage of the transition…..fully informed and the transition accommodated her needs"*.

Kylie told the Inquiry her planned placement was the transitional unit, and that was where she wanted to go and she was happy there. In regard to the group home, she said she was not prepared for the move out of the unit, and that *"they didn't say nothing"*. Kylie did not recall visiting the group home prior to her move there: *"…they drove me there and that was it"*. She said she would have like to have seen inside, and met the workers before moving in. However, Kylie said things had worked out well for her.

Taking into account both case workers' and young people's views, key observations that can be made from the analysis of interview data, (as summarised in *appendix 2)* include:

- Case conferences and case plans were a key feature of planning prior to closure. However, two young people had neither a case plan relevant to service closure nor a case conference to guide appropriate placement. Since closure, the frequency and regularity of case conferences were inconsistent. Around half the case workers interviewed and just under half the children and young people interviewed thought that case conferences should be held more frequently. Case reviews appear to have been used as a crisis response following closure, rather than a tool to monitor progress.

- Not all key parties, including children and young people and their families, were involved in case conferences or in decisions related to their placement post closure. The majority of young people felt they had been given no explanation for the decisions reached about placement, and a significant number felt negative about their transition case plan:

  No one told me where I was going. (a worker from the closed service) *picked me up from camp and told me I was going to live in a place called (service name) and that there was a lady there who I knew from before…. (The worker) dropped me off.* Female, aged 11 years

- The use of assessments to inform case decisions and plans appeared to be very low, both prior to closure and in subsequent placements.

- Case plans—where appropriate—generally stated a goal in line with principles of permanency planning, but often failed to meet the range of criteria which represent current policy and good practice. For example, while most case plans identified the needs of children and young people, few appeared to incorporate clear, measurable strategies to achieve long term goals.

- Regardless of the planning process, around half of the children and young people had experienced placement breakdown since service closure, and the majority had experienced a placement change in response to an emergency or crisis situation:

  I had to move because they only take people for a couple of months. It would not have made any difference to my life if I could stay longer. It was the placement that I had to have, otherwise it was the streets.
  Male, 16 years

Case study
Geoff, aged 13 years at the time of service closure

According to Geoff's case worker, no case conferences or case plan reviews had been held since Geoff moved into his current placement, a period of seven months. No case conferences were planned.

The case worker noted that ideally, conferences should be held six–monthly and reviews three–monthly. However, workload issues and other priorities have impacted on this work in Geoff's case, as *"Geoff is not considered to have as intensive needs as other young people in the service"*. The case worker noted that "DoCS didn't want 'over–support' of the family", to let them develop their own independence and support systems. The case worker also noted, however, that since service closure, Geoff had had risk of placement disruption, deterioration of health/behaviour, and involvement in criminal activity.

From interview data, it appears that contact between Geoff and the contracted service provider averaged twice–weekly, and contact with his case worker was occurring on a monthly basis. Planning meetings had been held by the non–government service with Geoff, and with his mother.

Geoff told the Inquiry that he thought there should be more contact with the support agency workers, and was unhappy that there are no regular meeting times and that plans aren't followed through by workers.

7.2 Support

The children and young people reported that they received a varied level of support at the time of closure. Less than half visited their new placement prior to moving there (six of thirteen). While the majority of children/young people reported that their case worker visited them in their new placement, four reported that they received no visit between the time of closure and the time of interview.

Post closure, the level of contact between the children and young people and case workers varied, often depending on factors such as placement type and the level of crisis or instability being experienced by the child or young person. Contact was reported as ranging from six times each week for a 14 year old male in foster care, to no contact over a seven month

period for a 14 year old male in residential care. The majority of young people, however, saw their case worker at least weekly.

> ***Case study***
> ***Paul, aged 13 years at the time of service closure***
>
> Paul's case manager considers that Paul is actively involved in case conferences, which have been held regularly each month post closure. He has at least seven case based meetings per month to address different needs and objectives. His case manager has contact with Paul six times per week, including via telephone, home visits and after school visits. Interview data indicates that all key support principles, such as speaking with the young person privately; following up on issues of concern; and keeping the child informed, are being adhered to.
>
> Paul told the Inquiry that he enjoys case conferences and would like more contact with his case worker.

Three case workers stated they 'should have more' contact with the child or young person, eight said the current level of contact was 'about right', and three stated a preference for less contact. Inadequate contact between the children and young people and their District Officer was more likely to be identified as an issue by both young people and case workers, than was the level of contact between children and young people and their non-government case worker. While this may generally reflect the changed role of District Officers in the context of contracted case management, three District Officers interviewed expressed a view that contact was inadequate, and noted caseload and competing priorities as a key reasons for this:

> *I would like to have more contact, but am constrained by my workload….we don't provide enough service to wards.*
> District Officer
>
> (It is) *difficult to provide good service when other matters take priority, such as the 'under ones' policy and court matters.* District Officer

From the perspective of children and young people, six stated they would like more contact with their case worker and seven said the current level of contact was 'about right'.

> ***Case study***
> ***Shelley, aged 11 years at the time of service closure***
>
> Shelley's case worker stated that contact with Shelley occurs at least three times each week. Both the case worker and Shelley see this level of contact as being about right, and Shelley emphasised that she thought her present case worker *"really listens"*.
>
> Case conferences were not being held frequently, and plans are for annual conferences. The caseworker told the Inquiry that infrequency of conferences was due to the stability and long term nature of the placement. Shelley told the Inquiry she didn't know if she had had a case conference in the last year, and didn't care about them.

A number of young people clearly needed a higher level of support than that being provided them. For example, one young person who had recently been discharged was living in a situation of concern to workers, and told the Inquiry he had no knowledge of aftercare support, no understanding of his disability and needed support to locate counselling and to access education. His case worker told the Inquiry that aftercare and support were available, but none had been provided and that provision was 'dependent on the young person's take up of offered services'.

Some young people indicated a need for more support in specific areas, for example, help with schooling through the provision of tutoring, financial assistance and personal issues:

> *I have just left my violent boyfriend. I would have liked more support from staff. They knew what was going on, but didn't want to talk to me about it. I think they were waiting for me to bring it up with them.* Female, aged 16

8 Placements

8.1 Placement options

One of the key issues raised by case workers during the Inquiry was that planning, no matter how well done, was only beneficial if appropriate options were available within the community, and if resources were adequate to pay for appropriate care.

As noted above, the children and young people who were affected by service closure had, in most cases, extremely high and specific support needs. Behavioural difficulties reportedly made it problematic for some of the young

people to be placed, and in some cases, led to a number of young people being evicted from services or removed from carers:

> *I was charged with assault. It should have been my long–term placement, but they wouldn't let me go back because I was a danger to the other kids there.* Male, 13 years

> *I was coming home off my face drunk….(The service) gave me a warning, but I got busted the next night, so they kicked me out.* Female, 16 years

In one case, the young person could not access the most appropriate therapeutic residential facility. This was because the facility was restricted to young people with a psychiatric disability and the young person had been diagnosed as having a learning, rather than a psychiatric, disability.

In two cases, case workers told the Inquiry that the options assessed as being most appropriate were not taken up due to cost.

Children and young people were also aware of the issue of cost:

> *I wanted to live in (town) by myself, but they said it would cost too much, something like 17 million dollars.* Male, aged 11

Some evidence was also presented that support services were also restricted due to costs:

> *…They fund and support assessments but do not provide funding for services and supports that the assessments suggest…..an assessment recommended counselling* (for the young person) *for six months, but the Department would only supply the funds for one month.* Case worker

Case study
David, aged 15 years at the time of service closure

David's case worker noted that prior to David's initial move and during his transitional placement, a range of options were canvassed for him but had failed to eventuate. A number of services would not take David due to his behaviour, and he had failed to attend interviews on a number of occasions.

The case worker told the Inquiry that one placement in a model 3 service—which David liked and which was able to provide intensive support—could not be taken up, due to the Area Executive's lack of understanding of his needs and subsequent unwillingness to approve the placement budget.

David's case worker believed that David's behaviour required an intensively supported placement from the outset. This had been difficult to achieve due to lack of appropriate placements and also, the cost of placements that were suitable.

David's case worker noted that: *"It would have been far more cost effective and person effective if David was placed in a model 3 back then, because he missed out on so much now that he can never retrieve."* The case worker told the Inquiry that David's behavioural problems had been underestimated, and that this underestimation had led to inappropriate placements in under–resourced services.

8.2 Length of time in the service that closed

For the 14 children and young people, the length of time spent in the closed service ranged from two months to 37 months.

It is interesting to note that the length of time in the service that closed may have had some relationship to the length of time spent in the initial placement following closure.

Five of the eight children and young people who were in the closed service for six months or less prior to closure spent a relatively short time in their first placement. Of these five children and young people, all stayed in their first placement for 12 weeks or less, with three remaining for only four weeks. Of the five children and young people, the placement of only one was planned to be short term. For the remaining four, three were in placements which broke down and one chose to leave a foster care placement.

Six children and young people were in the closed service for eight months or more prior to closure. Of these, the shortest length of time spent in their first placement was 13 weeks. Most, however, were in their first placement for 28 weeks or more (two for 28 weeks, one for 50 weeks and one for 60 weeks).

There appeared to be no link between length of time in the service prior to closure and number of placements.

8.3 Placement data

Identifying the extent of placement change proved to be difficult, due to discrepancies between CIS placement history data and data provided by case workers. *Table 7* below lists the recorded placement changes for the 14 children and young people, according to CIS and case workers.

Table 7: Placement changes (source CIS, case worker interview data)

Child/ Young person	*Placements reported closure to June 1999)*	
	CIS Data	Case Worker Interview data
1	1	4
2	3	10[29]
3	1	4[30]
4	2	2
5	Missing	1
6	2	3
7	7	6
8	1	6
9	1	3
10	2	2
11	3	4
12	1	2
13	3	4
14	14	14

From analysis of interview data, case plans and CIS data, it appears that CIS data generally under–records placement changes. This appears to be in part due to:

- Transitional units established by Ormond and Minali do not appear to be recorded as a placement change by CIS;
- Placement changes within non-government services contracted to support children and young people are not always recorded. Rather, CIS appears

[29] Dates are unclear for this young person, but at least ten placement changes were experienced by June 99.

[30] Data from young person’s interview, as no interview with case worker was conducted.

to record the child's move to the non–government service as a singular placement change; and

- Crisis placements of very short duration do not appear to be systematically recorded on CIS.

According to case worker information, the majority of children and young people experienced a significant number of placement changes following service closure. In the longer term, instability through frequent placement change has been shown to have a detrimental effect on social, emotional and academic development[31].

For the children and young people involved in the Inquiry, placement change was not always a negative event. In some cases, change was perceived as being positive by both children and young people and case workers. This was primarily where change represented a move from an unhappy situation or where it was part of a planned process to achieve a longer–term goal:

> *Best thing that happened was my case manager pulling me out of* (foster placement)….*she recognised that the same thing was happening again and got me out right away. That was great, she could see the signs.* Female, aged 16

> *Placement changes within* (service) *were considered positive, because he wanted to move from a specific type of placement to another…..he wanted to move from a one–on–one arrangement to a family unit arrangement.* Case worker

In many cases, however, data indicates that placement changes often represented a crisis or significant disruption in the lives of the children and young people.

Of the nine children and young people who were not in the placement that had been planned for at closure by the time of interview, three indicated that they were not because they had been there and moved on, and the move was positive. Six children and young people who were no longer in their planned placement had been there and the placement had broken down. Breakdowns were due to a range of factors, including violence perpetrated against others, rule breaking, and general discord between the child or young person and carers.

> *Her transition from* (closed service) *to* (new service) *was a challenge for all concerned. She was obviously experiencing loss from the closure of her first long term placement in care and the experience of being let down and rejected, yet again.* Case worker

[31] Cashmore, J and Paxman, M. (1996). *Longitudinal Study of Wards Leaving Care.* Social Policy Research Centre, University of NSW. Page 22.

> *It might have worked out if more pocket money was given to me.* (If) *better workers were employed, not shit ones.* (If) *police were not called as often to deal with stuff.* Male, aged 15 years

For 11 of the 14 children and young people, at least one placement post closure was short–term. In five of these cases, the short–term placement was recognised by the young person as being part of a planned transition. In six cases, however, the children and young people had experienced between two and ten short–term/temporary placements between closure and August/September 1999. Overall, these figures represent a very high reliance on interim measures, which for some children and young people resulted in undue disruption. Case workers told the Inquiry that short–term placements contributed to behavioural issues, inadequate case management, educational disruption and general lack of stability for the child or young person:

> *The problems created* (by short–term placements) *included disrupted schooling, isolation, particularly for placements located on farms—he was always saying that he needed friends.* Case worker

Case study
Paul, aged 13 years at the time of service closure

Case plans and interview data indicate that Paul experienced six placement changes in the 15 months since closure. Four of these placements were short–term, with three, including a crisis stay in a hotel, being planned as temporary. The fourth placement was intended to be permanent, but could not be continued due to a health problem within the family. Two of Paul's six placements broke down.

The case manager told the Inquiry that placement break down could have been prevented by improved foster carer selection, training, preparation and commitment, and ensuring that Paul had access to his sibling.

8.4 Involvement in placement decision making

Of thirteen children and young people, six told the Inquiry that their planned placement was where they wanted to go, but of these, only two remained in that placement at the time of interview. Six children and young people indicated their first placement was not their choice. Of these, only one was still in that placement.

While not achieving their first choice of placement does not appear to be a factor in how enduring the initial placement was, consideration of the child or young person's view in key decisions was a key issue in the Inquiry. Five of the 14 young people told the Inquiry, for example, that the reasons for placement decisions post closure had not been explained to them. Those children and young people who perceived they were not given a say expressed anger and frustration at the process. Some perceived that having their choices ignored led to inappropriate placements and unnecessary instability:

> (I)*did get there* (desired placement) *eventually after four other short–term placements…..I wanted to go with* (related carer) *anyway. It just took a long time to get there.* Male, 15 years

> *They organised a placement for me and I was accepted but I would not go and live there, so they said I had to find my own accommodation.* Male, 17 years

> *The case conferences were held but they don't listen to what I have to say. DoCS didn't even turn up to the last one. We had to ring them and tell them they weren't there.* Female, aged 16

8.5 Continuity of care

A further issue raised by frequent placements was the accompanying regularity by which key workers changed. The number of District Officers and key workers a child or young person has in care impacts on the level to which they are able to build trusting relationships with their worker, and can significantly affect their experience of care[32].

Most of the children and young people had seen a significant number of changes in District Officers and/or non–government case workers. Only three young people had the same case worker at closure and at the time they were interviewed for the Inquiry. According to case workers, seven of the children and young people had between two and six District Officers in the period between closure and August/September 1999. Five had between two and five changes in non–government case worker. As noted by one case worker:

> *There is so much changeover in DoCS staff that DOs do not really know these kids, and the NGOs accepting them do not know them at all. This has resulted in poor matching of residents, their needs……and leads to further placement disruption.*

[32] Cashmore, J and Paxman, M. (1996) op cit, page 62

Illustrative of the loss of continuity that frequent turnover of District Officer or case worker presents to young people is the children and young people's recollection of these changes. Most reported a higher number of changes than their case worker, some were unable to answer or didn't know if they had a District Officer, and others noted excessive numbers of workers in their lives, such as "10 or 20" and "heaps of others".

A few children and young people said they were not disturbed by the changes:

> *I don't mind changing DOs. I knew them all anyway.* Male, aged 15.

Most, however, expressed some level of unease with loss of continuity:

> (It's) *good having lots of workers.* (When they leave) *that's really bad because you get to know someone really good and they have to leave and I don't want them to.* Female, aged 16.
>
> *One thing I didn't like was I wasn't allowed to visit or see any of the workers from* (closed service). (Worker) *who used to take me fishing told me that he wasn't allowed to see me anymore.* Male, aged 13 years.

Case study
Greg, aged 13 years at the time of service closure

Greg's first move was to a youth refuge, but this placement broke down following alleged violence by Greg against a worker. From the refuge, Greg moved to a foster care placement, which also broke down. According to the case worker, the breakdown was due to Greg's violent behaviour, and he was again placed in a refuge. From this crisis placement, Greg moved to the model 3 group home.

According to the case worker, Greg's behaviour deteriorates when there are inconsistencies or unknowns in his life, including when his placement or case manager changes. The case worker told the Inquiry that the foster care placement 'could have been done better', and that continuity of care was a significant issue for Greg and other young people in care. The worker noted that Greg's move from the Area and loss of contact with his DO had been a negative for him, but that his behaviour had been improving with continuity of care.

9 Current circumstances

9.1 Current placement

Table 8 outlines the current placement[33] of the 14 children and young people, the length of time they had been in the placement and whether the placement was considered permanent.

Of the 14 children and young people, nine were in placements considered to be permanent or long–term. At the time of interview, the majority of the children and young people had been in their current placement for a relatively short period of time, four months or less.

Table 8. Current circumstances (source: interview data, case plans)

Current age of child/ young person	*Placement type*	*Length of time in placement*	*Permanent or long term?*
11	Foster care	4 months	yes
12	Model 3 residential group home	20 months	yes
13	Individual placement (1:1 support)	4 months	no
13	Restored	1 month	yes
13	Restored	7 months	yes
14	Professional carer	3 months	yes
14	Individual placement (1:1 support)	Missing	no
14	Foster care	4 months	yes
15	Kinship care	7 months	yes
16	Residential care	3 weeks	no
16	Semi-independent youth accommodation	2 weeks	yes
16	Model 3 group home	8 months	yes
16	Residential program	3 months	no
18	Discharged (boarding arrangement)	3 months	no

The Inquiry asked the children and young people to describe, on a scale of 1–10, with 10 being 'the best', their feelings at the time of service closure and at the time of interview. *Table 9* details the responses.

[33] 'Current' in part 3 relates to the time of interview (August/September 1999). The length of time between service closure and the time of interview ranged from 12 to 20 months.

Table 9: Child/young persons feelings (rated 1–10, with 10 'the best') at closure and current (source: young people's interviews)

Current age of child/ young person	*Feelings 1–10 at closure*	*Feelings 1–10 in current placement*
11	Missing ('really unhappy')	Missing ('alright, better')
12	7	5
13	0	10
13	5	5
13	4	9
14	1	'20'
14	1	5
14	Missing	Missing
15	5	10
16	3	7
16	3	8
16	Missing ('really scared')	Missing ('not scared at all, fine')
16	Missing ('uncertain')	Missing ('heaps safe and secure')
18	8	10

The vast majority of young people rated their feelings as better in their current situation than at service closure. This is likely to indicate bad feelings associated with service closure as well as satisfaction with their current placement:

> *….we got so screwed up in the head that I thought it (*poor service practice and inappropriate behaviour of other residents*) was normal. I even got scared of leaving (closed service) – weird, huh! But I was too scared of the outside world.* Female, aged 16

Case study
Suzi, aged 15 years at the time of service closure

Suzi told the Inquiry that she had very much wanted to leave the service that was closing, which she said was a violent and abusive environment, but had enjoyed living in the service's transitional unit and had not wanted to move on from there. Suzi told the Inquiry that *"I wanted to get out of living with other kids….I got a black eye in* (service*) by another kid, and assaulted by the youth workers. You never know if you were going to be the next one to cop it."*

Suzi said her views were not listened to at case conferences prior to her move from the transitional unit. She said she had constantly refused to go into foster care, and had wanted to live independently, and that the service had informed her of the decision for her to be placed in foster

care but had not included her in it. Suzi told the Inquiry that things could have been done better *'If they listened and gave me a say'*.

Overall, eight of the 14 children and young people told the Inquiry they were 'happy' in their current placement. Two said they were 'ok' and two indicated they were unhappy.

> *(I'm happy) because I can stay here, because they'll be my parents.* Male, aged 13

In 12 of 14 cases, the children and young people did, however, rate themselves as being 'better off' now than when they were living in the closed service in key areas of their life, including:

- education, employment and training;
- health and well—being,
- personal safety and security;
- access to professionals.

The most frequently reported areas where young people considered themselves 'worse off' related to contact with or proximity to friends and family (five cases), and recreational activities (three cases).

Case workers views generally accorded with those of the child or young person in regard to areas where they were better or worse off in their current placement.

10 Concluding comments and observations

For the children and young people who participated in the Inquiry, it is evident that the processes associated with, and experiences of, service closure were not uniform. At the time of closure, many had experience of a range of factors that increased their vulnerability, particularly at a time of instability, including disability and involvement with the juvenile justice system. It is also apparent that circumstances following closure were influenced by a multiplicity of personal, situational and structural factors, including but not limited to the event of service closure.

While children and young people's experiences varied, inadequate planning was the most evident and consistently defined difficulty associated with the process of closure. As one case worker noted to the Inquiry:

> *Transition between placements is an important time, it can always be done better and smoother in hindsight. Transitions happen for lots of reasons and often the transition is not ideal. For some there can be no handover period.*

However, service closure should have been a predictable and well–controlled event enabling a smooth transition for children and young people, particularly in the case of Ormond and Minali, which had the advantage of a greater lead–time to closure and additional resources to assist with transition. For many, this was not the case. That significant diversions from accepted planning policy and procedure and good practice were noted is of significant concern.

Most of the children and young people who were interviewed by the Inquiry stated that they were happy or 'ok' in their current placement. Most judged their relative well–being as being better in their current situation than at the time of service closure. However, the Inquiry's analysis indicates that for some children and young people, service closure represented the first of a new series of disruptions and disappointments in their lives.

For a small but significant number of children and young people within the Inquiry sample, there was an apparent failure of the care system to provide the timely intervention, support and level or type of care necessary to enable them to achieve positive life opportunities and outcomes.

Overall, as a significant event in the lives of vulnerable children and young people, the process of service closure and the follow up support and assistance provided appeared to be good for a few, just adequate for most, but particularly poor for some.

In regard to what could have been improved, the views of case workers and the children and young people themselves are illustrative. According to case

workers, strategies that could have improved the process of transition and increased the likelihood of better longer–term outcomes included:

- increasing the number of intensively supported placement options available to young people with high support needs;
- improving carer training and preparation and ensuring that carers' experience equates to the needs of the children and young people;
- provision of direct and early assistance to children and young people in care, especially in relation to behavioural issues, such as counselling, anger management and social skills development;
- more time to locate appropriate placements; and
- more time with young people to prepare them for change.

Those children and young people who expressed an opinion about how things could have been done better for them at the time of closure and afterwards were quite consistent in their view. The most common strategies identified were:

- more involvement in planning and more attention to listening to their views;
- more support in the transition (for example, visiting and spending time at the new placement prior to moving; workers visiting them in their new placement);
- improved assistance with practical issues, such as information about options, financial assistance and tutoring;
- 'better' or 'good' workers, who were well–trained and consistent in work practices, and respectful of the privacy and rights of children and young people.

These views, and the observations of the Inquiry, indicate that the circumstances and experiences of the children and young people, the adequacy of their placements, and the difficulties experienced by them, were influenced not only by the singular event of service closure, but also by broader structural issues related to the care system in general. The issues raised by the Inquiry highlight the need for, and importance of, monitoring, review and overall promotion of the welfare of children and young people in care. In this context, the implementation of the Children's Guardian will provide a significant opportunity to address both individual and systemic issues within the substitute care system.

11 The way forward

The provision of substitute care in NSW is undergoing considerable change. The *Children and Young Persons (Care and Protection)* Act 1998 will see a greater emphasis on family support and early intervention; more clearly delineated roles and responsibilities for DoCS and non–government agencies and carers; and creation of a Children's Guardian. In addition, new service models based on a brokerage approach are being developed and private, for–profit agencies are emerging in the care system. There is also a growing tendency to place adolescents, many of whom have high support needs, in SAAP services. Within this environment of change, however, old problems continue, such as lack of access to specialist support services, difficulties in recruiting suitably skilled carers and insufficient aftercare.

This Inquiry has highlighted the implications of poor planning and service development in the lives of already vulnerable children and young people. It is important that reform processes learn from past mistakes and rectify basic deficiencies within the system. In this context, a focus on service standards, measurable outcomes for children and young people and transparent monitoring and review mechanisms is critical.

Appendices

Appendix 1: characteristics and circumstances of children and young people affected by service closure

Appendix 2: Conformity of established planning processes with established policy and procedure

Appendix 3: Case studies (not for public release)

Appendix 1: Characteristics and circumstances of children and young people affected by service closure

In the following table:

- The data source for each category is CIS, unless otherwise indicated
- N/A = not applicable;
- U/K = unknown

Appendix 1: Characteristics and circumstances of the children and young people

Age *At close*	*Gender*	*Govt/non–Govt*	*NESB / ATSI* [34] *(source: varied)*	*Reported disability (source: varied)*	*Contact with Juvenile Justice (source: varied)*	*In closed service (months)*	*Case plan at closure (source: non-government services and DoCS case plans)*	*First placement type (source: CIS, case file notes, interviews*[35]*)*	*Total number placements*	*Current*[36] *placement*	*Current*[37] *case plan (source: case plans)*
9	M	Govt	NESB	No	No	4	Restored	Group home	2	Restored	Restored
9	M	Govt	N/A	No	No	U/K	Foster care	Professional care	1	Professional care	Foster care
10	M	Govt	N/A	Yes	No	6	Approved carers	Foster care	1	Foster care	Foster care
10	M	Govt	N/A	Yes	Yes	6	Approved carers	Restored	2	Foster care	Approved carers
10	M	Govt	N/A	No	No	2	Foster care	Foster care	2	Foster care	Foster care
13	M	Govt	NESB	Yes	Yes	5	Group home	Group home	1	Group home	Individual placement (24hrs, 1:1)
13	M	Govt	N/A	No	Yes	22	Group home	Group home	2	Res. care	Restored
11	F	Govt	NESB	No	No	4	Restored	Group home	2	Restored	Restored
13	M	Govt	N/A	Yes	Yes	4	Approved carers	Foster care	3	Approved carers	Group home
15	M	Govt	N/A	No	Yes	8	Community placement	U/K	3	U/K	Refuge
15	F	Govt	N/A	No	Yes	10	Foster care	Foster care	1	Foster care	Group home
15	F	Govt	N/A	Yes	No	19	Group home	Residential care	1	Res. care	Group home
15	F	Govt	U/K	No	U/K	2	Refuge or residential	Other	2	Independent	Deceased/ suicide
13	M	Govt	N/A	Yes	Yes	6	Group home	Refuge	2	Res. care	Group home
16	F	Govt	N/A	Yes	Yes	5	Transition flat	Residential care	1	Res. care	Professional care
16	M	Govt	U/K	U/K	Yes	U/K	Family member	Refuge	3	SAAP	Refuge
15	F	Govt	N/A	No	Yes	11	Supported accommodation	Independent	3	Independent	Independent
16	F	Non-govt	N/A	No	No	53	Independent supported	Not affected	0	Not affected	Independent supported

[34] In cases where young people were identified by workers as Aboriginal, but did not self–identify as Aboriginal, the Inquiry did not record Aboriginality as a characteristic.
[35] Placement information has been drawn primarily from CIS data. The Inquiry used other data to clarify CIS category of 'other'.
[36] 'Current' as per CIS data received by the Inquiry in June and July 1999.
[37] 'Current' as per the most recent caseplans received by the Inquiry, dated on or prior to June 1999.

Appendix 1: Characteristics and circumstances of the children and young people

Age at close	*Gender*	*Govt/non–govt*	*NESB / ATSI*	*Disability*	*Contact with Juvenile Justice*	*In closed service by months*	*Case plan at closure*	*First placement type*	*Total number placements*	*Last Placement*	*Current case plan*
11	F	Non-govt	N/A	Yes	U/K	9	Approved carers	Foster care	7	Foster care	Professional care
11	F	Non-govt	N/A	Yes	No	37	Group home	U/K	U/K	U/K	Group home
13	M	Non-govt	N/A	Yes	Yes	5	Foster care	er care	1	Other	Foster care
13	M	Non-govt	N/A	Yes	Yes	7	Approved carers	roved carers	3	Unrelated	Approved carers
13	M	Non-govt	N/A	No	No	8	Professional care	Unrelated person	7	Family member	Professional care
14	M	Non-govt	ATSI	Yes	No	2	Foster care	Refuge	7	Foster care	Foster care
14	M	Non-govt	U/K	No	Yes	2	Restored	Restored	1	Restored	Restored
15	F	Non-govt	ATSI	Yes	Yes	45	Foster care	Detention	1	Detention	Gaol
16	F	Non-govt	N/A	Yes	No	54	Independent supported	Not affected	0	Not affected	Independent supported
16	M	Non-govt	N/A	Yes	Yes	2	Restored	Group home	14	Independent	Independent
16	M	Non-govt	N/A	No	Yes	10	Independent supported	Discharged	Discharged	Discharged	Restored
16	M	Non-govt	ATSI	No	Yes	35	Independent supported	Not affected	0	Not affected	Independent supported
16	F	Non-govt	N/A	Yes	No	17	No plan	Group home	2	Independent	Independent supported
17	M	Non-govt	N/A	Yes	Yes	More than12 months	Independent supported	Discharged	Discharged	Discharged	Independent
18	M	Non-govt	N/A	No	Yes	36	Independent	Discharged	Discharged	Discharged	Independent
17	M	Non-govt	N/A	No	Yes	37	Independent	Independent	2	Independent	Independent
18	M	Non-govt	ATSI	Yes	Yes	35	Independent supported	Discharged	Discharged	Discharged	Gaol
18	M	Non-govt	N/A	Yes	Yes	28	Independent	Discharged	Discharged	Discharged	Independent
18	M	Non-govt	N/A	Yes	No	30	Independent supported	Discharged	Discharged	Discharged	Restored

Appendix 2: Conformity of planning processes with established policy and procedure

The following table reports planning processes around service closure against relevant policies and procedures contained in the DoCS' *Working with Children and Families Manual*[38].

[38] Data reported refers to the number of valid responses received. Where less than the total sample of 14, the number is indicated.

	Case Management and Meeting Individual Needs Criteria	Relevant Indicators	Inquiry findings
1	Case conferences held to review a case plan during ongoing action phase	Case conferences held: • at critical points of a child's placement in care • before the end of restoration action • to develop leaving care and after care plans (9-16 to 9-17)	• Case workers told the Inquiry that case conferences were held for 12 of the 14 children and young people prior to closure. • Information provided by case workers indicate that of 10 children and young people reported to have had a case conference since closure, seven had had two case conferences or less in the period since closure[39]; and three young people had had three, four and 13 case conferences respectively. • In regard to the last placement change of nine young people, case workers reported that a case conference was held in seven cases. • A little over half of all case workers indicated that frequency of case conferences was 'about right' and just under half said they 'would like more'. Five of 12 children and young people said the frequency was 'about right', five said they 'would like more' and two indicated they 'would like less'.
2	All significant parties participate in case conference Case conferences facilitate informed casework decision making, using relevant information	Case conferences involve: • key workers • client • family • those who may have continuing role with them Issues are identified and discussed	• Interview data and case planning review indicated that not all key parties were involved in case conferences. Case workers said that the child or young person was invited to attend the transition case conference in four of nine cases where conference invitations were known. In regard to family, family were invited in two of six cases where invitations were known. • Of 13 valid responses, seven children and young people said they had not attended case planning prior to closure. Only

[39] 'Since closure' varied from 12 months to 20 months.

		(9-16 to 9-18)	one of those that attended could recall their parents also attending. • In regard to the last placement change, six case managers employed ALL of the following as planning strategies: - Assessment prior to placement change; - Case plan review to address disruption; - Case conference; - Views of young people listened to. In the remaining seven cases, case conferences were the most likely strategy not to be employed. • In reference to the past year, nine of 13 of the children and young people said they were happy with how case conferences had been run.
3	Every child and young person has an active and current Case Plan	• All case plans to be approved by Assistant Manager • Case plans reviewed at least every 6 months (9-13, 9-14, 9-18)	• Information provided to the Inquiry suggests that 12 of the 14 children and young people had a case plan current at and relevant to service closure. • Case workers indicated that plans had been approved by Assistant Managers in seven of the 12 cases. In the remaining five cases, workers did not know if plans had been approved. • For three children who were restored to their families, case workers indicated that two had a case plan to support the child and the family. • For four young people near the age of discharge from wardship, case workers told the Inquiry that leaving care plans were being developed in all cases. In three of these cases, planning began at least three months prior to discharge. • Of 13 valid responses, 11 children and young people indicated that they had not received a copy of their current case plan. • In regard to the child/young person's last placement change, case workers indicated that they had informed the carer/ family/young person of new case plan goals in eight of 11

			cases.

4	Case Plan determines goals of intervention, consistent with protection of child, continuity and stability of care and maintenance of culture and relationships.	Case plan should specify: • long term plan for child, and address permanency planning • agreed short term strategies to achieve goal • contingency strategies • timelines for each task • roles and responsibilities for all involved • key worker • who will tell child/young person and family about plan • resources required to achieve goals • review date/time (9-13)	• Review of case plans for the 14 children and young people suggests that few plans met all specifications. A number were assessment focused and highlighted needs, but few of these plans identified concrete strategies to meet such needs. A number were focused principally on the short–medium term, with minimal consideration given to strategies to achieve permanency planning. Most lacked contingency strategies; details of how child/family would be told about goals; and resources required to achieve goals. • Of 12 children and young people, four felt 'positive' about their transition case plan, four felt 'negative', three 'knew nothing about it' and one felt neither negative or positive. • Of 13 valid responses, nine children and young people indicated that they were given no explanation of the reasons for decisions made in case planning prior to closure.
5	Case plans are regularly reviewed to ensure progress and to incorporate changes. Where change involves other agencies, review should involve case meeting.	• Reviews of case plans held with key people, at least 6 monthly, or upon significant events Significant events include: • risk of placement disruption • actual placement disruption • behaviour or health of child/young person deteriorates • child or young person involved in criminal activity • major change in family or carer's situation or structure (9-19 to 9-20)	• Frequency and regularity of case reviews appeared to vary considerably. From data provided by case workers, it seems that only one young person was receiving regular and frequent reviews (held quarterly since closure). In other cases, reviews ranged in regularity and frequency from 'nil', to one review nine months post closure followed by five over three months. Information presented to the Inquiry indicated that for most young people, case reviews were most likely to be held where the young person was experiencing crisis or other significant event. • Case workers indicated that in nine of ten cases where there was placement disruption, the case plan was reviewed to address this.

	Assessment Criteria	**Indicators**	**Inquiry findings**
6	A Child and Family Needs Assessment is conducted regularly for children in out-of-home care as a way of regularly reporting on their current circumstances	Assessment should consider the child's: • development history, • behaviour, • relationships, • physical, social, emotional and spiritual development, • health, • education, • employment, • current functioning, • identity needs, and • view of the world. Assessments should also consider: • social context of family, • assessment of parents/carers • parent/child relationship • placement dynamics (9-5 and 9-6)	• Of 12 responses, only one case worker indicated that a Child and Family Needs Assessment was conducted prior to closure. Nine said such an assessment was not conducted, and two did not know.
7	Assessments are current and up-to-date	• Assessments conducted or updated within last 6 months and remains appropriate to child's current circumstances (9-1)	• 'Other' assessments since closure were conducted in eight of 13 cases, according to case workers. Of these eight, the number of assessments ranged from one (in one case) to seven (also in one case). • From data received, it appears that in only four cases had assessments been undertaken in the previous six month period.

8	Process of assessment and decision making is as inclusive as possible Assessment information is used to develop or review case plans	• Involves communicating with clients and other agencies to obtain info • Families and carers should participate in assessment to provide and confirm info • Assessment considers the privacy/dignity of child and family, is non-discriminatory and free of bias (9-2) • Case planning follows assessment • Outcome identified in assessments are used to develop case plans (9-6 and 9-13)	• Of a total of 13 cases, case workers indicated that as part of casework support: - In all 13 cases, they had liaised regularly with other agencies; - In 12 cases, they had spoken to the young person in private; - In all 13 cases, they had kept the child informed of decisions. • Of ten appropriate cases, five case workers said that removal from the child or young person's last placement was based on assessment. • Five of 13 case managers told the Inquiry that the child/ young person had contributed to the placement decision at closure. Four said they did not contribute and four did not know. Four of 13 children/young people told the Inquiry they had felt listened to in planning prior to closure. Seven said that the planned placement was not where they wanted to go.
	Permanency planning criteria	**Indicators**	**Inquiry findings**
9	Case plan goals reflect permanency planning principles	• Case plans specify long term and stable placements • Case plans promote the continuity of significant relationships • Case plans provide for placements which keep siblings together, or actively promote ongoing relationships between siblings Options include: • restoration • adoption	• Of 14 case plans reviewed, six had a stated goal of permanent care outside the family with foster carers/approved carers; three had a goal of restoration; two aimed for independent living and three were focused primarily on medium term goals. • Seven of 13 children and young people had experienced placement breakdown since service closure. • Nine of 13 children and young people had experienced crisis placement since service closure. In two cases, crisis placement had occurred once; in four cases twice; in one case each, four, five and twelve times.

		• long term placement with a family (3-5, 9-7 and 9-13, 11-123 and 11-131)	• In none of the four cases where children and young people had siblings in care were they placed with their siblings. File information and interview data indicates that lack of adequate access to siblings was an issue in two cases.
	Placement procedures criteria	**Indicators**	**Inquiry findings**
10	Placement into residential care should only be made where assessment shows this is the best option to meet needs of the child/young person.	• Residential care the approved case plan goal • Case plan identifies needs of child/young person, expected duration of placement • Case plan identifies strategies for returning young person to community (11-58)	• In six cases where the planned placement was residential care, assessment was used to determine that residential care was the best option in only three of the cases.
11	Placements are planned in accordance with policy directives regarding siblings	• Siblings should be placed together unless needs of individual children not able to be met • Assessments should focus on collective needs of siblings (3-5, 9-7, 11-58)	• Four children and young people had siblings in care. In no case was the planned long–term placement with their sibling(s). It appears that in only one case was the reason for this based on assessment of the individual needs of the children.
12	New placements appropriately planned, prepared and supported	• Placements only to occur when assessment has been conducted and indicates this is the most appropriate option. • Case conference held prior to, or soon after, placement • Carers to be given all relevant information about child and their needs, including case plan goals and strategies • Arrangements for financial support	• In regard to the last placement change experienced by the children and young people, case workers told the Inquiry that: - Assessments had been undertaken prior to placement change in four of nine relevant cases - A case conference was held in seven of 11 relevant cases - Support had been provided prior to placement breakdown in seven of nine relevant cases - Carers, family and the young person were informed of new case plans and goals in eight of 11 applicable cases - Support was provided to young people in the early stages of the placement in 10 of 11 cases.

		and payments in place when placement commences • Supervising staff to maintain close contact with child in early stages of placement (11-49 to 11-52, 11-54 to 11-57, 11-58 to 11-59)	• In 10 of 14 cases, children and young people said they had discussed the current placement prior to moving there. • 9 of 14 children and young people said they had visited their current placement/met with carers prior to moving in. • In 11 of 13 cases, children and young people noted that the caseworker visited them while they were settling into their new placement.