Report on interim emergency care for children under guardianship

Government of South Australia
Office of the Guardian
for Children and Young People

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Introduction

The Guardian for Children and Young People is obliged, under the *Children's Protection Act* 1993¸ to monitor and report on the circumstances of children under the guardianship of the Minister and to advise on systemic reform.[1]

The Guardian has been concerned about the placement of children in interim emergency care under commercial arrangements[2] since 2004 and has monitored the numbers of children in such arrangements since 2005.

In 2006-07 the number of children in this type of out of home care (OOHC) placement rose to 86 at one point and has remained stubbornly high since. It is a problem peculiar to South Australia. While other Australian states and territories have used motel-type accommodation for short periods and for small numbers, none have relied on it to the same extent. This begs the questions of why and what to do.

[1] Section 52C(1)(c).

[2] For the purposes of this report 'interim emergency care' will mean the care of children in short-term rented accommodation with carers engaged through an agency on eight hour rotating shifts . Over time the department has used different terms to define this type of care, the latest being 'commercial care'.' Interim emergency care' has also been used in the past to encompass a wider group of children, where the properties have been government owned but the carers are casually employed agency workers.

Interim emergency care is the emergency placement of children under the guardianship of the Minister in motel-type accommodation[3], with direct care being provided by commercial operators and case management provided by Families SA, Department for Education and Child Development (the department).

This accommodation is expensive, is inappropriate for already vulnerable children because it is not a home-like environment, and has inconsistency and discontinuity of carers. The instability and uncertainty for children is universal. This type of placement must be a last resort and the length of stay minimal.

There is no disagreement with this position. Nobody *wants* to place children in this type of care; it is for lack of choice.

[3] Motel-type accommodation includes motel room, rented apartment, bed and breakfast accommodation, caravans, holiday houses and holiday units.

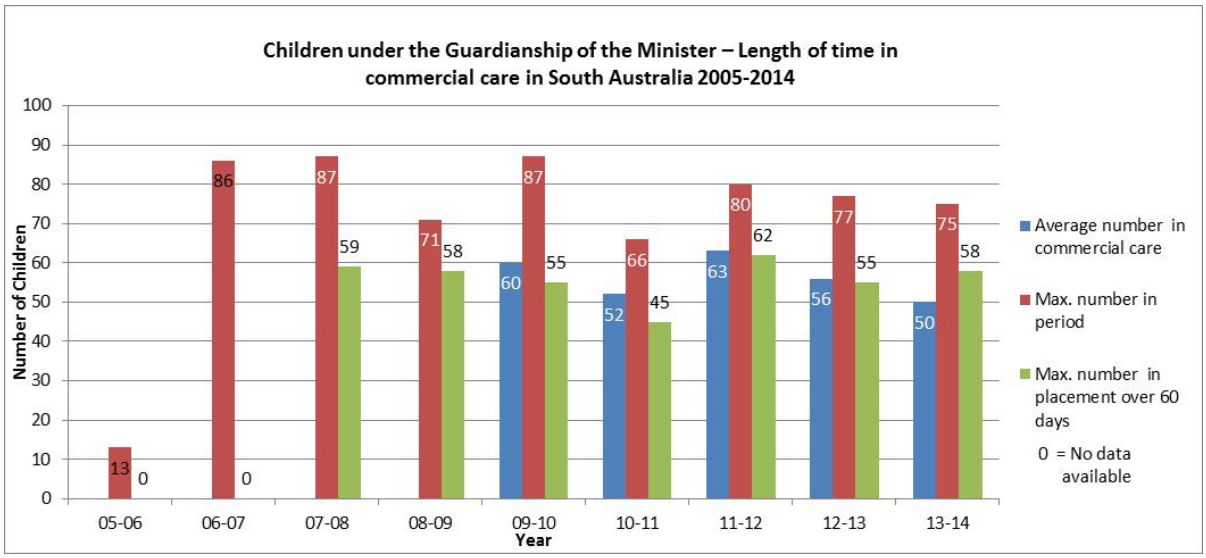
Synopsis

Since 2006-07, the maximum number of children in interim emergency care at any one time has remained around 80 each year, and averages at 56. Nearly two-thirds of the children are in these placements for over 60 days, with almost a third for over 18 months. In 2012-13 and 2013-14 the average number declined to 50.[4] (See Figure 1)

Based only on snapshot data[5], that is, a single point of time in the year, the proportion of Aboriginal and Torres Strait Islander children steadily increased to almost half. Infants have been placed in this arrangement, sometimes as part of sibling groups. The average age of the children since 2009 has remained at around ten years.

At any one time there are between 15 and 20 children living in interim emergency care for excessively long periods. Most are children and young people with complex needs.

Figure 1



[4] Information provided to *The Advertiser* of numbers in 2014-15 shows that there was a further fall for a few months, followed by a rise again to 78 by December 2014. Novak, L 'Our children failed' *The Advertiser* 12 January 2015

[5] The snapshots were taken for 31 May in 2009, 2011, 2013 and 2014. Point-in-time data should be treated with caution because it may be distorted by particular circumstances.

History

In late 2004, the Guardian recommended as a matter of urgency that service agreements and practice guidelines be put in place with the commercial operators providing the casually employed carers, and that negotiations re-commence with not-for-profit agencies to provide emergency care. These recommendations were reiterated in 2005 and 2006, and were largely accepted by the department.

In late July 2006, the department funded another 108 OOHC placements for children until 30 June 2008 which were then to be integrated into the broader system.[6] An *Alternative Care Directions* statement was released in 2011 which promised to create a more robust OOHC system. However the expected action plan did not follow.

The high numbers of children in emergency arrangements continued, as did the extended stays, and in mid-2012 the Office of the Guardian (GCYP) commenced active monitoring of the circumstances of children who had been in interim emergency care for 18 months or more. [7]

In early 2013, the Guardian analysed the data on children in commercial care 2005-2013, and identified a number of issues for discussion with the department. This analysis coincided with the June 2013 announcement that the department would hire at least 360 full-time residential care workers on term contracts to replace expensive casual carers and eliminate the need to place children in motels.[8]

In November 2014 the Guardian convened a roundtable discussion on children in commercial care bringing together a small group of senior officers from government and non-government agencies and universities.

The following themes emerged from the discussion.

- Build further capacity in the government and non-government out of home care (OOHC) sector, particularly in delivering care to children with high needs.
- Restore public confidence in the OOHC system.

[6] *Emergency Accommodation Strategy*, Family Services SA, 12 October 2006.

[7] The review meetings ceased for a period of time from August 2013 to July 2014 at the request of the department.

[8] It was projected that this would save around $20 million a year, with savings allocated to therapy services for children and supervision and training of staff. Novak, L Families SA hiring new staff *Adelaide Now*, 10 June 2013.

- Analyse the circumstances of children in interim emergency care to identify groups of children and the obstacles to alternative placements specific to each group.
- Diversify the models of foster care and correct any disincentives to growing the size of family-based care.
- Joint government and non-government planning and strategy development, including articulation of shared purpose, workforce planning and commitment to a continuous quality improvement program.
- Expand and diversify the funding base of OOHC, and child protection more generally.

Discussion

South Australia relies on this type of placement for children in need of out of home care far more than any other Australian state or territory. Whilst detailed information about the placement of children in emergency care is not formally shared among child protection departments, anecdotal reports indicate that motel-type placements are rare in other states and territories. Some have used it in the past, to greater and lesser degrees, but the use of it now is low, if at all.

The quality of day-to-day care provided in these settings varies hugely and rotating shift care is not a supportive family-type environment. GCYP has received reports of, or witnessed, problems such as frequent absconding, inconsistency in boundaries and approach to behaviour, missed schooling, lack of personal belongings, and isolation.

In almost every case, interim emergency care is not an appropriate placement for children, especially for long periods of time, yet there has been an over-reliance on interim arrangements for over eight years. The department's unwritten policy is that children should be placed in this type of accommodation for a maximum of 21 days[9], and there have been repeated attempts by the department to address the problem.

Why interim emergency care is used

A paucity of suitable family-based placements appears to be at the core of the problem. The net growth in foster care has slowed but the reasons are not entirely clear. For some years, this was compensated by growth in kinship care placements. The shrinking of choice in foster care has resulted in limited placement matching and reduced opportunity for respite placements, both of which increase the chance of placement breakdown, putting further pressure on the OOHC system. The growth of OOHC in response to demand has largely been in residential care and interim emergency care.

The shortage in family-based placements is compounded by lack of capacity among foster and kinship carers for caring for children and young people with high and complex needs. Therapeutic foster care is relatively under-developed and constrained by budget, and some children cannot be placed in congregate care settings because of the high risk to themselves or others. Interim care arrangements continue for very long periods for want of a better option.

Despite intended as a temporary measure, interim emergency care is routinely used for children with high and complex needs. Funding has followed this trend, resulting in a distortion towards emergency care and away from the deeper development of therapeutic care.

[9] The department advised GCYP that approval for an extension of stay over 21 days must be given by a director who is expected to seek an explanation for the long stay.

There is need to more closely identify the groups of children and young people who are accommodated in such emergency arrangements, what the specific obstacles are to providing suitable placements and what types of response are required for each group. The planning is best done across OOHC due to the interdependence of emergency accommodation with short and longer term arrangements for children.

The problem with stopping the use of commercial care abruptly is that, at present, it would only result in further growth in residential care with the added consequence of rushed recruitment and training of residential care workers.

Growth in residential care

In South Australia, the use of residential care is relatively high, at more than double the national rate. The rapid growth in residential and interim emergency care has detracted from investing time and resources into the full development of therapeutic residential and family-based care.

The speed of the growth, from 33 houses in 2008 to over 60 now, has impeded implementation of departmental plans for consistent quality improvements, including the closure of the old residential facilities.[10] It has also impeded active monitoring by GCYP of the circumstances of children in residential care.

Planning for reduction in the use of interim emergency care must also plan to reduce dependence on residential care for children.

Capacity and confidence

The providers of OOHC are a combination of government and non-government agencies. Since 1997 the OOHC non-government provision has been concentrated in a few organisations. While this is gradually changing to include more and different OOHC providers, the non-government sector is relatively under-developed in OOHC compared to some other states. This has resulted in less capacity for innovation and less confidence within government for transferring responsibility of some areas of work, such as case management for children in long-term placements and responding to notifications of suspected harm.

Lack of confidence is also evident in the child protection system as a whole, resulting in risk averse behaviour at all levels. The department is experiencing immense public scrutiny which has led to a climate of anxiety and loss of confidence. Additionally the best interests of children are sometimes overshadowed in the public conversation.

[10] Three of the six oldest facilities have only very recently closed.

Expansion of family-based care

Beyond the expansion of 'general' foster care, there is need to extend the range of types of family based care such as:

- Professionalising part of the foster care system, at least with greater financial incentives to compensate for lost earnings in alternative employment and with associated expectations of higher qualifications and engagement in skills development.
- Providing improved levels of support to foster and kinship carers to care for children with high needs.
- Residential care workers being engaged in different types of work, such as working within a child's family home to support the family.

South Australia has had significant growth in the use of kinship care, now slightly exceeding the national average proportionately. This trend should be accompanied by practices and opportunities to further strengthen kinship care for improved stability for children and high quality of care.

There should be examination of any unintended disincentives to growing the size of family-based care, such as the use of quotas or inflexible contracts, low numbers of assessment workers or delays in assessment or registration.

Policy development and planning

Looking after children in OOHC in South Australia is shared between the government and the non-government sector, but the overriding impression is that there is disconnection between the two.

Several factors contributed to this, including a history of deals done outside of the agreed procurement process (notably in 1997) and competition for scarce resources, leading to distrust. There is also a lingering impression that SA non-government organisations are not robust or big enough to sufficiently and effectively broaden their services.

The contractual arrangements of government have been described as complex, limiting and overly scrutinised, thereby absorbing a lot of time and not supporting non-government organisations to be innovative. Requirements for licensing also have not been extended to government services making the playing field uneven.

Regardless, there are frequent calls for joint planning and development of strategy, commencing with discussion of values, shared direction and purpose.

Workforce planning needs to accompany OOHC planning, including capacity and expectation of continuous improvement in the quality of care and the qualifications and skills of carers. At present the residential care workforce is predominantly those with certificate level qualifications but the goal should be to raise this. There is need too for immediate investment in the professional guidance and supervision of carers employed casually, and the on-site presence of staff to influence professional practice.

Creating richness in the roles of carers and workers by improving satisfaction, professional development, and recognition of skill, will help improve retention and quality of care.

Population groups

The data shows that some very young children, sibling groups, children with disabilities, and Aboriginal children feature in commercial care arrangements.

There is a very real dilemma in placing large sibling groups, because, in most cases, it is best to keep them together, but there are few families who can take more than one or two children. It is additionally complex because the level of need of each child within a sibling group often varies considerably. New thinking and planning is required about the best OOHC models for sibling groups

For children with disabilities, the further engagement of disability service agencies may result in more family based options, including more support to foster and kinship carers engaged by other agencies. However, the workforce issues are significant in the disability sector, with a relatively under-qualified and underpaid workforce.

For Aboriginal children, Aboriginal community opinions could be more vigorously sought for possible solutions to maintain children within their families. The 2014 consultation led by the Secretariat of National Aboriginal and Islander Child Care has laid the groundwork for more detailed discussion. There may also be opportunities to engage a wider range of Aboriginal people in creative solutions, particularly those who are outside of the most immediate children's protection area but who may be willing to contribute to it with ideas, influence, or other support.

Monitoring

The monitoring of circumstances for children in commercial care is a mix of different approaches. It appears to depend substantially on the availability and attentiveness of the social worker allocated to the child. This also applies to children whose placement is under strain and who may end up in interim emergency care. This returns then to the quantum and allocation of financial and human resources for child protection services.

Financing

Planning for the provision of out of home care without the need for interim emergency care, would result in a clearer picture of financial allocations and shortfalls. The move away from dependence on interim emergency care will only work properly if other options are established first and this requires additional funds, at least on a temporary basis. There is some opportunity now with a slight fall in the numbers of children requiring out of home care, to re-allocate from within the budget.

At the same time though, alternative sources of funding should be explored, which may be for the broader child protection system, if not for out of home care. Social impact bonds (private investment with financial returns based on performance, backed by government) are being tried overseas and in NSW in placement prevention and reunification services. The SA government has progressed its plans for this form of financing with a recent call for expressions of interest in a 'bond product'.

Conclusion

Interim emergency care is universally regarded as inappropriate except for the shortest time and only as a last resort. The following advice is based on analysis of the information available to GCYP and discussion with others, but the details were not confirmed with others.

Immediate action

- Examine the case plans for every child in interim emergency care and refresh the referrals to alternative care providers. Simultaneously expand the number of therapeutic foster care placements.
- As part of this examination, identify any one-off supports to immediately improve the safety and wellbeing of the children in interim emergency care arrangements.
- Commence discussion with well-established disability service organisations in SA to develop, expand or support family-based care and residential care for children and young people with disabilities.
- Increase the on-site guidance and supervision of carers engaged in interim emergency care arrangements.
- Expand the 'assessment' section of residential care and strengthen the case planning for each child in temporary residential care with obligations for frequent review and senior officer oversight.
- Assess the disincentives to growth of family based care, such as the use of quotas in contracts, time taken for assessment and registration of carers, and barriers to respectful engagement with carers.
- Make the first budget submission for the provision of sound residential care and growth of therapeutic foster care.

Short-term (up to 12 months)

- Using the information from the review of each case plan, build the picture for groups of children (e.g. sibling groups, children with very high needs, children waiting on assessment of carers) and analyse what is required in suitable placements and the obstacles to more suitable placements.
- Convene a non-government and government working group to scope the task of OOHC planning.
- Address the disincentives to growth of family based care.

- Review foster carer training and assessment processes to recommend opportunities for streamlining carer registration.
- Examine the case plans for every child in residential care to identify children who are in such care for want of family-based care. Simultaneously expand the number of therapeutic foster care placements and specialist care for children with disabilities.
- Make the second budget submission for growth in family based care, care for children with disabilities, and further development of therapeutic residential and foster care.

Medium- term (up to two years)

- Develop and commence implementation of an OOHC plan, including shared directions, purpose and strategies, and with strong emphasis on outcomes based agreements and monitoring. Accompanying this is a plan for workforce development and quality improvement program based on the South Australian OOHC standards.
- Develop and commence a vigorous communications strategy to accompany the proposed changes.
- More vigorously pursue social impact investment products in placement prevention, family reunification, expansion of foster care and transition from residential care to family based care.

Acknowledgment

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