Office of the Children's Guardian

Strengthening out-of-home care and the broader child protection system

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Introduction

This report provides the Office of the Children's Guardian's (OCG) contribution to important issues raised in recent public reports from the NSW Advocate for Children and Young People, the NSW Auditor-General and the NSW Ombudsman, and related announcements in relation to the use of high-cost emergency placements, including Alternative Care Arrangements (ACAs), and the out-of-home care (OOHC) system more broadly.[1]

Of critical relevance to the proposals that we put forward to strengthen the broader system, the Department of Communities and Justice (DCJ) is currently undertaking a system review into OOHC, which was announced on 2 May 2024 by the NSW Government. This system review will examine the performance and sustainability of the current OOHC system, with a particular focus on the factors driving the use of high-cost emergency placements, including ACAs.

In 2023, former NSW and national Children's Commissioner, Megan Mitchell conducted an independent review into the circumstances of two children who were placed in long term residential care arrangements, including ACAs (the Mitchell Review).[2] The Mitchell review found that the children's wellbeing had been compromised in ACA arrangements.

Against this background and concerns identified through our role in monitoring the provision of statutory OOHC in NSW, from September 2023, we undertook a targeted review that looked into the circumstances of a number of children and young people in ACAs, to consider the adequacy of systems, policies and practices for monitoring the safety and quality of care in these placements.

The NSW Government has made a firm commitment to end the use of ACAs. While work is still underway to transition children to more suitable placements, in our report, we firstly draw attention to specific quality of care concerns that need to be addressed to protect and promote the rights of children who currently remain in ACAs and other forms of high-cost emergency care, until measures are taken to remove this fundamentally flawed part of the OOHC system. We acknowledge the NSW Advocate for Children and Young People's important work to date through her Special Inquiry into Children and Young People in ACAs[3] in amplifying the voices of children and young people in ACAs. Our considerations have been informed by this critical work.

What also needs to be acknowledged are the significant challenges associated with delivering high-quality care to children and young people in residential care more generally. Our targeted review highlighted many of the broader systemic failures of the current OOHC system. As reinforced in the NSW Auditor-General's recent performance audit into the oversight of the child protection system (NSW Auditor-General's report),[4] the out-of-home care system in NSW has been under significant pressure due to a range of factors, including carer and workforce shortages, and an unmet demand for services to support children and young people with complex needs. This has led to an increased reliance on high-cost, emergency placement arrangements in the absence of other suitable alternatives, including the use of ACAs.

The recent report by the NSW Ombudsman on the child protection system identified the need for far more effective monitoring of compliance and performance, and stronger governance

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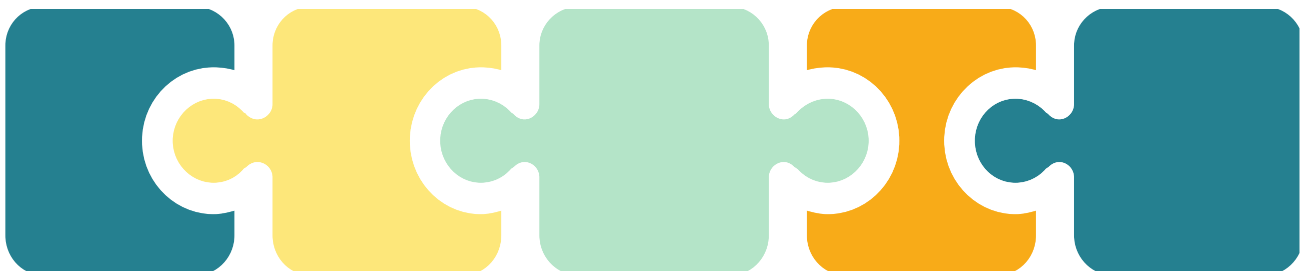
[1] NSW Advocate for children and Young People, *Moving Cage to Cage: an interim report of the Special Inquiry into children and young people placed into alternative care arrangements (ACAs)*, May 2024; Audit Office of New South Wales, *NSW Auditor-General's Report – Oversight of the Child Protection system (Performance Audit,* 6 June 2024; NSW Ombudsman, *Protecting children at risk: an assessment of whether the Department of Communities and Justice is meeting its core responsibilities*, July 2024.
[2] Department of Communities and Justice, *Summary report - Independent Review of two children in OOHC*, June 2023
[3] NSW Advocate for children and Young People, *Moving Cage to Cage: an interim report of the Special Inquiry into children and young people placed into alternative care arrangements (ACAs)*, May 2024.
[4] Audit Office of New South Wales*, NSW Auditor-General's Report – Oversight of the Child Protection system (Performance Audit,* 6 June 2024

arrangements across what has increasingly become a highly complex system – one that is operating in a 'disconnected' and 'fragmented' way.[5] The Ombudsman's report also highlights the sharp increase from 2017-18 to 2022-23 in the number of children in residential OOHC with a substantiated allegation that they had been abused while in care – from 23% to over a third of children living in residential care.[6] This reinforces the need to substantially strengthen the residential care system's capacity to provide child in these settings with 'safe, nurturing, stable and secure care environments'.[7]

In light of this work undertaken, in the second part of our report, we discuss a number of proposals to strengthen the broader child protection system through more robust oversight, governance and cross-agency leadership, while ensuring children and young people have a dedicated space to raise their concerns, and carers are provided with greater support.

As per section 141(2) of the *Children's Guardian Act* 2019, we recommend that this report be made public forthwith.



[5] NSW Ombudsman, *Protecting children at risk: an assessment of whether the Department of Communities and Justice is meeting its core responsibilities*, July 2024, p.2.

[6] From 2017-18 to 2022-23, there was an increase in the number (142%) and proportions (from 23% to 35%) of children in residential OOHC with a substantiated allegation that they had been abused while in care. NSW Ombudsman, *Protecting children at risk: an assessment of whether the Department of Communities and Justice is meeting its core responsibilities*, July 2024, p.5.

[7] Section 9(f) of the Children and Young Persons (Care and Protection) Act 1998.

Our internal targeted review of ACAs – highlighting systemic challenges

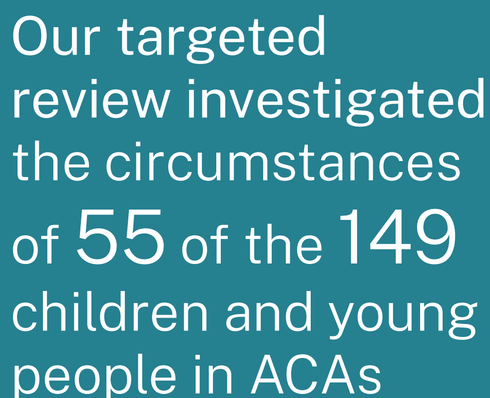
It is widely acknowledged that ACAs do not provide children and young people with the stability and support they need. In ACA arrangements, the day-to-day care and supervision of children and young people in ACAs is generally provided by labour hire workers, subcontracted by accredited out-of-home care agencies. Children and young people are typically cared for in unstable short-term accommodation settings such as motels, caravan parks, holiday rentals or serviced apartments.

ACAs and other types of emergency care arrangements have come under increased scrutiny. The Mitchell review found that the children's wellbeing had been compromised in ACA arrangements due to the high rotation of casual workers, the length of time children spent in ACAs, frequent changes in school and accommodation, and limited access to therapeutic support[8]. These findings accorded with what we had observed from our OOHC accreditation and monitoring work.

The Mitchell review also identified that oversight of subcontracting arrangements in relation to ACAs needs to be strengthened.

Against this background, late last year **we undertook a targeted review that looked into** the circumstances 55 of the 149 children and young people in ACAs at that point in time.

Our review was principally focused on **the adequacy of the oversight mechanisms and the related** systems, policies and practices for monitoring the safety and quality of care to these 55 children and young people. Our methodology for this monitoring review is provided in Appendix 1.



[8] Department of Communities and Justice, *Summary report – Independent Review of two children in OOHC,* June 2023.

Key issues and themes from our review

Our review identified a number of key issues which compromise the quality of care provided to children and young people in ACAs, including:

1. Inadequate oversight and monitoring of the care provided
2. An inability to guarantee that children are provided with the integrated supports and critical services which they need
3. Significant problems in attracting and retaining appropriately skilled staff
4. The significant over-representation of Aboriginal children and young people in ACA placements
5. Children being placed and continuing to remain in ACAs due to the lack of suitable care options, noting that the impact of this failure in the system is particularly acute for children and young people with complex needs.

Our key findings are outlined below.

1. Inadequate oversight and monitoring of the care provided

Across the accredited sector, there is agreement that all short-term emergency care arrangements are not appropriate for meeting the needs of children and young people in out-of-home care. However, ACAs pose particular risks to children and young people, as these placements are typically:

- supervised by staff employed by non-accredited providers through subcontracting arrangements between out-of-home care agencies and labour hire companies; and
- provided in temporary accommodation, such as a motel or hotel, over which the OOHC provider and the ACA provider have inadequate control.

Unlike other temporary emergency arrangements such as Individual Placement Arrangements (IPAs),[9] Short Term Emergency Placements (STEP),[10] the Interim Care Model (ICM)[11], ACAs effectively sit outside the accredited OOHC system. ACA providers are not accredited and the oversight of the quality of these arrangements sits with OOHC agency that subcontracts the care to the ACA provider.

Service agreements failing to serve as a quality assurance mechanism

It is a condition of accreditation that an OOHC agency must comply with OCG guidelines for the emergency authorisation of staff, where a worker is authorised in an emergency and where the worker is sourced from an external labour hire agency. If workers are sourced from an external

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[9] IPAs are temporary fee-for-service, bespoke arrangements provided by accredited residential care providers. In these arrangements, direct care of children and young people is predominantly provided by staff employed by the accredited residential care provider. IPAs are typically in accommodation managed by the residential care provider, or in long-term serviced apartments or rental accommodation.

[10] Children and young people in STEP are usually placed in one-to-one arrangements, rather than in group home models. These are intended to be up to 12 weeks duration and provided by accredited residential care providers, with direct care predominantly provided by staff employed by the accredited residential care provider. STEP arrangements are typically provided in accommodation managed by the residential care provider, or in long-term serviced apartments or rental arrangements.

[11] The ICM is a group home model provided by accredited residential care providers, for up to three months. Direct care is predominantly provided by staff employed by the accredited residential care provider. Accommodation is managed by the residential care provider or utilises long-term serviced apartments or rental accommodation.

agency, it is also a requirement that the OOHC agency develops a written Service Agreement with that agency.

The OCG has developed a 'Service Agreement Guide' to assist OOHC agencies in this process. The purpose of the service agreement guide is to clearly set out the roles and responsibilities of the OOHC agency and the subcontractor. Therefore, as our Guide intends, agencies' service agreements are meant to be a quality assurance mechanism.

However, our review highlighted that, while all OOHC agencies in the review had service agreements in place with ACA providers, there was a significant variation across the sector regarding the scope of these agreements, their implementation and how effectively they are being monitored and enforced.

To illustrate, our review found that compliance with service agreements was often monitored by frontline staff, such as caseworkers, who may not have the skills, or available time, to effectively monitor compliance with the contract requirements relating to critical quality of care issues impacting on the involved child or young person.

Furthermore, essential requirements under the service agreements relating to the skills, qualifications and training of ACA staff were not always enforced. While practice varied on this issue, a number of OOHC agencies solely relied on assurances from the ACA provider that all who were caring for children and young people in ACAs had been selected through an appropriate recruitment process, and that they possessed the necessary qualifications and skills to appropriately support the vulnerable children and young people in these high-risk arrangements.

Consequently, our review found that the service agreements were not serving as an adequate quality assurance tool. Instead, we found that the primary 'default' quality assurance mechanism for ACAs, related to the level and nature of supervision, casework and case planning undertaken by the OOHC frontline staff member allocated to work with the ACA provider and the involved child.

2. An inability to guarantee that the children are provided with the integrated supports and critical services needed

a. Inadequate risk assessments at the time of placement

All ACA arrangements in our review were established at very short notice. ACA providers often accepted referrals with very limited information about the child or young person.

In their service agreements with OOHC agencies, ACA providers are responsible for undertaking their own risk assessments before they agree to provide an ACA. However, we found that ACA providers were frequently managing risk reactively, once the *true* picture of the needs of the involved children and young people began to emerge post the placement. We were also concerned to find that most OOHC agencies relied solely on the ACA provider's assessment of potential risk in the care environment.

This evidence demonstrates system failure in connection with whether risks are being adequately identified, assessed, and appropriately managed in these settings. This system failure was especially evident during the early stages of an ACA placement.

b. Challenges for proactive and coordinated casework to support complex needs

From our review, the evidence shows that the ACA care environment is often not compatible with providing the effective and coordinated case planning that is required, to meet the needs of the children in these placements.

While all children and young people included in this review were visited in their ACAs by a caseworker employed by the OOHC agency, there was significant variation in practice across the sector in the support provided by the caseworker and their OOHC agency, including regarding the level and nature of critical collaborative work that was required to address the often complex needs of the involved children.

For example, incomplete or unclear information about the care needs of certain children and young people resulted in unacceptable delays before they were provided with critical supports.

In fact, a number of OOHC agencies and ACA providers that participated in this review noted that the 'ramping-up' of casework support will often only occur once a child or young person's circumstances have started to deteriorate. This highlights the unacceptably reactive nature of the 'delivery' of supports to children and young people who are in crisis in ACA settings.

c. Lack of consistent access to therapeutic support

Another serious issue identified from our review was the failure of this part of the 'system' to guarantee that children and young people in ACAs have access to the therapeutic supports that they require (including staff with right skills and experience to provide this type of support and for those many children with complex needs, access to expert therapeutic specialists when this is required).

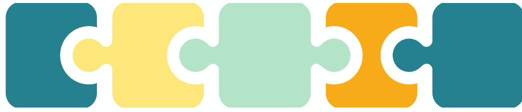
On this issue, it is important to acknowledge that some OOHC agencies that have experience in providing accredited residential care, and that subcontract the care of certain children to ACA providers, access their own in-house therapeutic specialists to directly support children and young people in ACAs, as well as working directly with the ACA staff to enhance their support of the involved children. Furthermore, a number of non-government OOHC agencies provide relevant in-placement training to ACA staff, relating to the implementation of behaviour support plans or include ACA staff in group supervision provided by the OOHC agency.

However, our review has found that providing these types of supports is much more challenging for foster care agencies that do not have therapeutic specialists with the expertise to work with children and young people in residential care environments. The evidence we obtained showed that agencies that only provide foster care are largely dependent on external services for therapeutic support (and that there is no guarantee that the therapeutic services will always be accessed to support a child when this is required).

Against this background, we found that these foster care services will often rely much more heavily on the ACA provider to try to ensure that the ACA agency 'staff' have the right experience and skills to support the needs of children and young people in residential care environments. Put simply, this presents an unacceptable risk to the children and young people in these ACA placements.

It is also important to stress that for children with particularly complex needs, placements in an ACA environment often present very significant risks to their safety and wellbeing.

We provide two cases from our review in the boxes below that illustrate the inadequacy of ACA placements, especially for children with complex needs, and the reactive and fragmented nature of service provision in these environments.



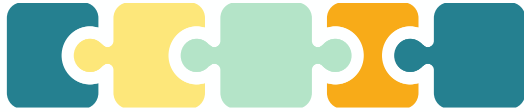
Barriers to accessing critical services and supports in an ACA placement

CK was 15 years old and had complex needs that made him eligible for NDIS services. At the time of our review, CK had been in an ACA for five months. CK had initially entered an interim care model arrangement after his family, who had been struggling to manage his increasingly complex behaviours, relinquished his care. Later, when his behaviour became too difficult to manage in the interim care group home model, CK was moved into an ACA.

In the absence of other placement options, the OOHC agency arranged an ACA for CK. As there was no suitable accommodation in the community in which CK's family lived, he was moved two-and-a-half hours away from his family. Unfortunately, CK's ACA accommodation was in an area with a high volume of holiday rentals, which resulted in his accommodation being repeatedly changed during the school holidays and on long weekends. On a positive note, CK received regular phone calls from his caseworker, who also travelled two-and-half-hours every three weeks to visit him. CK was also moved from one ACA provider to another. The original ACA provider requested additional funding to engage extra staff to supervise CK. This was following a series of incidents in which CK became distressed and the ACA staff were struggling to manage his behaviour. Ultimately, another ACA provider was engaged, with no additional staffing support.

CK experienced a delay of several months in accessing the services and supports he needed while in an ACA. Five months after entering the ACA, the agency undertook a comprehensive review of CK's circumstances. The review was prompted by the new ACA provider's reports that CK's behaviour was deteriorating. The review identified that CK had a funded NDIS plan at the time that he entered the ACA but there had been a failure to link him to critical services funded under the plan. In response, the review made a series of recommendations, including a referral for psychiatric assessment; the development of a more comprehensive behaviour support plan; more proactive engagement with CK's school to support his engagement in education; training and supervision for the ACA workers supervising CK; and the need for urgent action to be taken to move CK closer to his family.

CK's records indicate that casework activity intensified following the specialist review and that efforts were underway to move CK into a placement with an accredited provider, closer to his family.



A lack of access to intensive therapeutic care

During our review we were alerted to the circumstances of 'GW', a 12-year-old child with complex needs who had been in an ACA for 9 months. GW has been diagnosed with attention deficit hyperactivity disorder, oppositional defiant disorder and anxiety. GW entered an ACA following the breakdown of his foster care placement, despite additional supports being provided to GW and his carers to try and preserve the placement.

During this time in the ACA placement, GW had experienced eight changes in accommodation in a mix of serviced apartments and accommodation provided by housing providers, with frequent turnover of staff. GW was incarcerated two times and experienced an extended period of disengagement from school. Not surprisingly, his ACA workers struggled to support him and manage his behaviour.

At the time of our review, the OOHC agency was still trying to locate an appropriate intensive therapeutic care placement, as recommended by his psychiatrist – one that could provide staff with the necessary skills and experience to support children with complex needs

d. Lack of consistent access to 'after hours' assistance to manage crises

During our review, ACA providers also provided us with evidence of inconsistencies across the sector in terms of access to on-call systems to help manage crises after hours. While ACA providers advised that some OOHC agencies were very responsive to such crises, this was not always the case.

Of concern, none of the ACA providers involved in our review were aware of the 'Joint Protocol to reduce contact between children and young people in residential care and the criminal justice system'.[12] Among other things, this protocol is aimed at reducing the unnecessary involvement of police in less serious incidents that inevitably arise in residential care settings. Where police are involved, the protocol aims to promote responses which help prevent serious behavioural incidents involving children and young people in these settings in the future.

e. Lack of secure accommodation to maintain even short-term stability in ACAs

To meet the needs of children and young people in OOHC, it is critical that they be provided with stable accommodation. However, during our review, OOHC agencies reported that a further factor having a profound impact on the experiences of some children and young people in ACA arrangements is the lack of available housing accommodation.

In testing this evidence, our review of case file records showed that some children and young

[12] Joint Protocol to reduce the contact of young people in residential care with the criminal justice system | Family & Community Services (nsw.gov.au)

people in ACAs faced frequent changes in accommodation, particularly in areas where there is high tourist traffic, and agencies have to rely on short-term holiday rentals. We also found that a number of children and young people had been placed in an ACA far away from their family, community and school – this most commonly occurred in rural areas.

3. Significant problems in attracting and retaining well-skilled staff

Every OOHC agency we spoke to in this review noted the very real challenges in attracting and retaining skilled staff, especially in rural and regional areas.

In relation to ACA placements in particular, agencies reported a heavy reliance on labour hire staff to supplement their existing workforce. This is because labour hire companies are generally able to stand up teams in ACAs at very short notice.

We were encouraged to see strong evidence across the sector of an understanding of the requirements of the NSW Residential Care Workers Register,[13] and the completion of mandatory probity checks prior to staff being engaged to care for children and young people in ACAs. However, we found that it was less common for OOHC agencies to *independently* verify the skills and qualifications of subcontracted staff who work in ACAs.

While workers providing direct care to children and young people in ACAs must undergo safety and suitability checks, the evidence from our review demonstrates that the skills, training and experience of the ACA workforce varies considerably.

OOHC agencies operating in regional and remote areas experience significant shortages in skilled workers. We understand that in some instances they have had to rely on Sydney-based ACA staff who are prepared to relocate temporarily, as well as those who work on a fly-in/fly-out basis. Given the shortage of skilled and qualified workers, particularly in regional and rural areas, the requirements in the service agreements relating to ACA providers guaranteeing appropriately skilled and qualified staff, are clearly impossible to meet in some circumstances.

This reinforces the need to address the shortage of carers, as well as improve carer supports, to reduce the system's current reliance on ad hoc, short-term, emergency residential care arrangements.

[13] The NSW Residential Care Workers Register is a restricted access, centralised database of individuals engaged as residential care workers, individuals who apply to be engaged as a residential care worker and reach the referee check stage of the application process and individuals who are referred to an out-of-home care provider by a labour hire agency for work as a residential care worker. It is maintained by the Office of the Children's Guardian in line with the Children's Guardian Act 2019 and the Children's Guardian Regulation 2022.

4. The over-representation of Aboriginal children and young people in ACAs

Another matter of concern was the significant over- representation of Aboriginal children and young people in ACAs. At the time of our review, our data showed that 57% of the 149 children and young people in ACA placements were Aboriginal.

In its recent report, the NSW Ombudsman notes this over-representation in the use of emergency and temporary placements for Aboriginal children in out-of-home care has increased from 49% of all children in ACAs in 2020-21 to 56% in 2022-23.

These figures highlight the critical failings across the child protection and OOHC system for Aboriginal children and young people, and the huge disparities in outcomes.[14]

At the time of our review, 57% of the 149 ACA placements were Aboriginal

5. Children remaining in ACAs due to the lack of suitable care options

Our review highlighted many of the underlying challenges facing the sector in finding suitable alternatives to ACAs for children and young people. The impact of this failure in the system is particularly acute for children and young people with complex needs and underscores the critical need to expand innovative models of foster care, including professional carer models.

Of the 149 children and young people in ACAs on 18 September 2023, almost two-thirds had entered these emergency arrangements following a placement breakdown.

At the time of our review, of the 54 children and young people who exited ACA arrangement between 1 October 2023 and 14 November 2023:

- 14 were moved into another type of short-term emergency care arrangement (six into an IPA, seven into an ICM and one into a STEP arrangement)
- 8 were moved into another ACA which was supervised by a different ACA provider
- 7 were moved into intensive therapeutic residential care
- 18 were placed in foster care or relative/kinship care
- 2 young people were moved into semi-independent living arrangements
- 3 children and young people had “self-placed”
- 2 children and young people were restored to parental care.

Of significant concern is that over 40% of the children (22 of 54) who exited an ACA between 1 October 2023 and 14 November 2023, were placed into another ACA, or into another type of temporary emergency residential care arrangement.

[14] As reported by the NSW Ombudsman, from 2017-18 to 2022-23, the number of Aboriginal children entering OOHC increased significantly – by 26%, compared to a drop of 14% for non-Aboriginal children. Aboriginal children were nearly 12 times more likely to be in OOHC in 2022-23 than non-Aboriginal children (up from 9.5 times in 2017-18. NSW Ombudsman, *Protecting children at risk: an assessment of whether the Department of Communities and Justice is meeting its core responsibilities,* July 2024, pp. 39–40.

Our proposals for reform

Phasing out ACAs and supporting children in the interim

Every OOHC agency and some ACA providers participating in our monitoring review acknowledged that ACAs fundamentally undermine a core principle underpinning the *Children and Young Persons (Care and Protection) Act 1998* – namely, that children and young people in OOHC are entitled to safe, nurturing, stable and secure care environments.[15]

While our review indicated that some OOHC agencies provide intensive support to children and young people in ACAs through creative approaches, these strategies cannot entirely ameliorate the inherent instability children and young people experience in temporary arrangements.

Through her Special Inquiry into Children and Young People in ACAs, the NSW Advocate for Children and Young People's interim report, the voices of children with lived experience starkly revealed the critical risks to children in these settings, the high level of inconsistency in the quality of care, the lack of access to the most essential supports and services, the transient accommodation and the disconnection from family, community and culture in these placements.

Consistent with the Government's firm commitment to ending the use of ACAs, we do not support the recommendation from the Mitchell review that agencies providing short-term emergency care arrangements should be accredited. We are of the view that this creates too great a risk of further entrenching, and 'legitimising', this model of care within the system. We are also pleased to note that the Minister's recently announced system review of OOHC by DCJ will consider the efficacy of any subcontracting arrangements for future models of emergency care.

Following DCJ's establishment of a dedicated team in November 2023 to shift children from High-Cost Emergency Arrangements (HCEA) to more suitable arrangements, the number of children and young people in ACAs has dropped considerably. In June 2024, 48 children and young people were in ACAs, significantly fewer than the 149 children and young people in these placements in mid-September 2023.

While work is still underway to transition children from ACAs to more suitable placements, there is a critical need to ensure that ACAs, and all other forms of high-cost emergency care, are underpinned by much stronger quality assurance measures and are closely monitored, especially given the inherent risks to the children and young people in these placements.

On this issue, we recommend that work be undertaken to address our key findings discussed on pages 6–12 of this report to protect and promote the rights of children who will reside in ACA arrangements, and forms of high-cost emergency care, until measures can be taken to remove this fundamentally flawed part of the OOHC system.

[15] Section 9(f) of the Children and Young Persons (Care and Protection) Act 1998.

1. Proposals for broader reform of the system

We note that the DCJ system review into OOHC will consider wide-scale, systemic issues that have contributed to ACAs filling the gap in out-of-home care. In this context, we discuss below a number of proposals to strengthen the broader child protection system.

a. Establishing an expert advisory group for residential care

While our monitoring review largely focused on issues associated with ACAs, what also needs to be acknowledged are the very significant challenges associated with delivering high-quality care to children and young people in residential care generally.

In this regard, what NSW shouldn't be seen to be doing is to be waiting for the next news story which exposes unacceptable risks to children and young people in residential placements, before it puts in place arrangements to help identify and drive best practice in this area.

Against this background, we propose that a residential care expert advisory group be established as soon as possible (or some similar group of this nature). Such a group would need to have broad representation from service providers, as well as other relevant experts who 'support' children and young people in all forms of residential out-of-home care. Importantly, the voice of children and young people with lived experience should also be well represented on the advisory group.

The group's focus could include sharing emerging best practice relating to providing high quality residential care. It could also provide a forum to consider innovative models of care to replace the use of high-cost emergency care, including ACAs, and in this way, support the sector reforms that will arise from DCJ's review.

The expert advisory group could also work with other parts of the sector on how to reduce the number of children and young people in residential care, especially those who would have their needs better met by various home-based care arrangements (including intensive therapeutic home-based care).

We also note that the recent NSW Auditor-General's report correctly identified the critical need for high quality therapeutic support to be made available for *all* children and young people requiring such support in residential care settings. Therefore, the proposed group could also have a strong focus on closely examining how therapeutic supports can be guaranteed in all residential care environments.

b. Enhancing support for carers

The need for OOHC systems across the country to do better in recruiting, supporting and retaining carers is a significant challenge which needs to be met. For children and young people who are unable to live safely at home, it is generally preferable for these children and young people to be supported in home-based care with extended family, kin or someone well known to them. When this cannot occur, the next preference is for children to be placed in foster care.

Directly related to carer recruitment is the need to support carers. However, as recently reported in the NSW Auditor-General's report, DCJ and NGOs have faced significant challenges in finding enough carers for all the children in OOHC. This is despite concerted efforts to recruit new foster carers. There are also insufficient OOHC options for children with complex needs.

Directly related to the issue of carer recruitment is the need to substantially improve our support for carers. Examining this issue could include carefully considering the system for funding carer advocacy. The failure of the OOHC system to address this issue continues to result in placement breakdowns, with children and young people then often ending up in ACA

placements (or other forms of residential care that aren't designed to meet their needs). In addition, we know that the frustration experienced by current carers over their lack of support has served as a powerful disincentive for other members of the community to consider becoming a carer.

Against this background, the NSW Auditor-General's report highlighted the need to provide opportunities to identify the pressures on carers, to better understand their ongoing support requirements and to use these insights to improve resources and support to foster carers.

As part of our oversight function, we already meet directly with carers on an *ad hoc* basis. However, in recognition of the significant shortage of foster carers, and the need to better support carers in their critical roles, we are proposing to establish a carers engagement and advisory committee. It is envisaged that this forum will provide a more formal mechanism to gain insights into carers' perspectives and concerns.

To be effective, the committee would need to bring together carer representatives, senior leaders in the OOHC sector and peak bodies to contribute to sector-wide approaches to addressing issues impacting on foster carer recruitment, engagement, support and training. The carer's voice would need to feature prominently in the committee's discussions, with their perspectives and lived experience reflected in policy responses and concrete actions.

Based on our discussions with carers and other key stakeholders across the OOHC sector, it is clear that there would be a significant number of areas that could be explored by the committee, and this would need to be coupled with a strong commitment to joint work on delivering real progress in these areas. The following are but a few examples of the types of matters which the committee might wish to consider:

- barriers to recruiting and retaining carers in the current economic climate, with the proposed development of a sector-wide plan to address the key systemic issues that are impacting on the recruitment and retention of foster carers
- sector practices regarding carer training and support
- the impact of complaints (and the reportable conduct scheme) on carer retention and well being
- securing access to regular high-quality respite for children and young people in home-based care
- provision of support to keep Aboriginal and Torres Strait Islander children and young people in kinship arrangements and connected to culture, community and Country.

c. Improving data on the current carer workforce

Recent work has highlighted that current and reliable data is not available to provide a clear enough picture of one of the OOHC sector's most valuable resource – the carer community.

Regarding this issue, the OCG has been participating in a range of data related projects that focus on carer recruitment and re-engaging carers who have left the OOHC system.

This work has underscored the need for accurate and reliable data from across the whole OOHC system relating to the true picture of the effectiveness of different types of carer recruitment strategies; the efficiency of the system for following up initial inquiries from people wishing to consider becoming carers; the initial 'inquiry' to 'approved carer' conversion rate (and related timeframes for completing key steps in the carer assessment process); the rate of carers leaving their carer role (and the reasons); and a more informed profile of the current carer community, to inform strategic planning and the implementation of carer engagement

initiatives.

On a related note, the OCG is also responsible for the administration of the Carers Register and we are currently developing more sophisticated business intelligence reports for OOHC agencies to assist them in remediating their carer data. We are also considering enhancements to the Carers Register to gather further information about carers who may be authorised to provide care, but who, nonetheless, do not currently have placements.

We would welcome the opportunity to work with DCJ and the OOHC sector more broadly, on considering how our data systems', and related analysis of data holdings, should be enhanced to improve our recruitment, assessment, support, retention and utilisation of the outstanding service which the carer community provides.

d. Strengthening the broader child protection system through the right governance arrangements

As we have noted, weaknesses in our system for recruiting, supporting and retaining carers result in children and young people unnecessarily ending up in ACA placements, or in other forms of residential care which are also not fit for meeting their needs.

However, it is important that we don't adopt a myopic focus of only seeking to address challenges in the OOHC system, which is only one part of the broader child protection system. In this regard, what is important to recognise and deal with are the 'pain points' across the child protection system more broadly (i.e. the early intervention, family preservation, statutory child protection and OOHC components of what should be seen as one inter-related system).

As the recently released reports from the NSW Auditor-General[16] and the NSW Ombudsman[17] well demonstrate that there's much which needs to be done to deliver on the Government's desire to reform the child protection system. This includes delivering on a system in which there is a shared responsibility for keeping children safe,[18] together with a clear understanding of what this should mean in practice, with the right governance arrangements in place to identify and drive best practice across key domains (and to continuously track and respond to the outcomes).

To illustrate the interconnected components of the child protection system, we note that if NSW were to deliver on its goal of significantly reducing the number of children coming into care, while ensuring that children and their families are receiving the supports which they require, this would deal with the shortage of carers.

However, on this issue of broader system reform, it is critical we all recognise that 'fixing' the child protection system can't be tackled by DCJ alone – we need an evidence-based, multi-agency, integrated response, to address the needs of children and families who need our support.

Furthermore, given the significant challenge in delivering an integrated and evidence-based system of the kind that has been recommended in many reports over the past few decades, we note that this cannot be delivered unless there are strong governance arrangements in place to help both design and drive what's required. In this regard, we note that the NSW Auditor General's report referred to the existence of over 30 child protection governance committees, with an overall lack of clarity and accountability in relation to responsibility for leading system

[16] Audit Office of New South Wales, *NSW Auditor-General's Report – Oversight of the Child Protection system (Performance Audit,* 6 June 2024; Audit Office of New South Wales, *NSW Auditor-General's Report – Safeguarding the rights of Aboriginal children in the child protection system*, 6 June 2024.
[17] NSW Ombudsman, *Protecting children at risk: an assessment of whether the Department of Communities and Justice is meeting its core responsibilities*, July 2024.
[18] *Report of the Special Commission of Inquiry into Child Protection Services in NSW (2008)*

improvement.[19]

The recent NSW Ombudsman report notes the added complexity brought by the significant legal and policy reform and rapid expansion of service provision by the non-government sector in the NSW child protection system. Pointing to the need for far stronger governance arrangements, including effective monitoring of compliance and performance across the system, the report highlights how the system currently operates in what they describe as a "disconnected, fragmented way".[20]

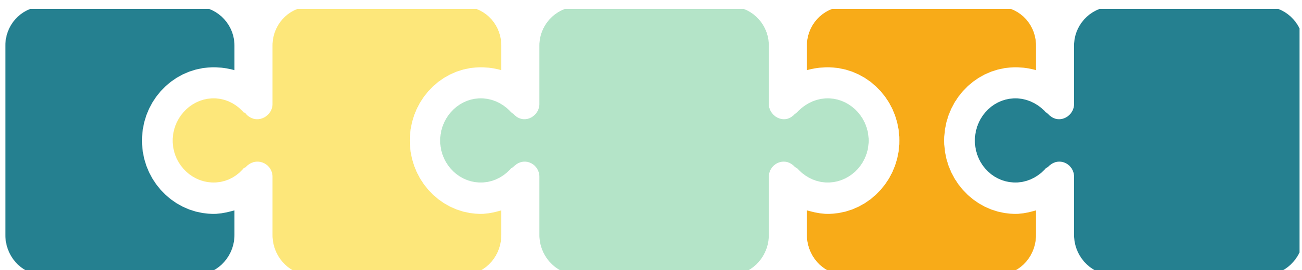
Therefore, there seems to be a very compelling argument – which has also been emphasised in a number of other independent reviews – that there is a need to put in place much more effective governance arrangements that draw upon the expertise and resources across a range of key sectors and disciplines, to enhance our capacity to strengthen the 'child protection' system as a whole, including the outcomes which are delivered.

In discussions with a number of stakeholders, they have referred to the former NSW Child Protection Advisory Council, which brought together senior representatives from across a range of key agencies, along with expert community representatives, to identify and promote key reform initiatives and opportunities.

While we haven't independently evaluated what was able to be delivered by the Council, there does seem to be a very compelling argument – which has been emphasised in several independent reviews - that there is a need to put in place much more effective governance arrangements that draw upon the expertise and resources across a range of key sectors and disciplines. The focus of such a forum would include enhancing capacity to strengthen the 'child protection' system as a whole, including the outcomes which are delivered.

If established, a governing entity of this kind would first need to establish its priorities, informed by the large body of existing evidence relating to what should be the focus of its attention. Consistent with well-established governance principles, it will be critically important to ensure that there's a strong and effective nexus between the focus of this governing entity and the interagency operating models that will be required to undertake the detailed system redesign and implementation work.

While we recognise that this won't be without its challenges, we also note that what constitutes good and effective governance, and related implementation practice which can lead to real and substantial reform, is not new territory.



[19] Audit Office of New South Wales, *NSW Auditor-General's Report – Oversight of the Child Protection system (Performance Audit*, 6 June 2024.
[20] NSW Ombudsman, *Protecting children at risk: an assessment of whether the Department of Communities and Justice is meeting its core responsibilities*, July 2024, p.2.

2. Strengthening oversight of the system

a. Establishing a complaint handling function for children and their carers

The OCG monitors the quality of care provided by OOHC agencies through a systems lens. This includes assessing casework practice relating to individual children and young people, and carers, for the purpose of determining whether an agency has appropriate systems in place to support the provision of services to children and young people.

While the regulatory responses available to the Children's Guardian in responding to quality-of-care concerns, such as imposing conditions on accreditation or shortening or cancelling accreditation, are appropriate responses when there has been a failure of an agency's systems, these regulatory tools are not sufficiently nuanced to provide an adequate response to address the individual needs of children and young people in OOHC, especially those who require more intensive support. The recent report by the NSW Ombudsman also highlights the sharp increase (142%) from 2017-18 to 2022-23 in the number of children in residential OOHC with a substantiated allegation that they had been abused while in care, representing around a third (35%) of all children living in residential care.[21]

As clearly articulated in the important work undertaken by the Advocate for Children and Young People, children and young people in residential care need to have a platform to raise their concerns about their experience in care. The lack of a child-centred, complaint handling function within the OCG is a critical gap in our oversight of the OOHC system.

35% of children living in residential care had been abused in care

***Ombudsman report**

Our regulatory powers also don't allow us to provide an adequate response to address the legitimate concerns of carers and this can in turn have very serious consequences for the children under their care, including placement breakdowns. While the OCG can receive complaints through our Reportable Conduct Scheme, this is restricted to the handling of reportable conduct-related matters.

Furthermore, the close examination of individual cases will often shed a bright light on how effectively an OOHC agency is implementing a number of the key OOHC standards that they are required to comply with.

We also note that our credibility as a regulator is, understandably, regularly questioned when we advise children or young people in care, or their carers, that we have no jurisdiction to directly deal with their complaints which will often be having a direct impact on their safety, welfare or wellbeing.

Against this background, we believe that consideration needs to be given to enhancing our legislative powers to allow us to directly deal with:

- complaints from children and young people in OOHC; and
- those who care for them.

However, in making this recommendation, we are not proposing that the NSW Ombudsman's jurisdiction in this area be diminished in any way whatsoever. We also note that any resulting

[21] NSW Ombudsman, *Protecting children at risk: an assessment of whether the Department of Communities and Justice is meeting its core responsibilities*, July 2024, p.5.

changes to our functions in this regard would not impact the Ombudsman's general powers to investigate, and report on, 'maladministration' by government agencies and certain non-government service providers, including for example, conduct that is unreasonable, improper, or contrary to law. For most matters, the exercise of our proposed complaint jurisdiction would generally be 'outcome focused', given the real benefits in seeking solutions, rather than just identifying problems in many of these matters.

b. Empowering the Children's Guardian to conduct placement reviews

We note that the Mitchell review also recommended that consideration should be given to commencing section 150(6) of the *Children and Young Persons (Care and Protection) Act 1998*.

This provision is not currently in force but if commenced, would provide for the Children's Guardian to review the placement of a child or young person who has been placed in OOHC by an order of the Children's Court, including children and young people on either temporary or long-term orders. The purpose of such review would be to determine whether the placement is adequately meeting the child's safety, welfare and wellbeing needs.

We note that commencing the provisions in section 150(6) of the *Children and Young Persons (Care and Protection) Act* would re-define the role of the Children's Guardian and would therefore require careful and considered consultation with the OOHC sector. Furthermore, if we were to be provided with complaint handling powers that we have proposed, including own motion complaint powers, we would effectively be in a position to conduct a review of the placement of a child in OOHC, in circumstances when we deemed this necessary to properly assess and address the child's safety, welfare and wellbeing needs.

On a related note, the issue of ensuring children receive high quality services has quite rightly been the subject of commentary in the NSW Ombudsman's review. We would support the observations made by the Ombudsman that it is timely for there to be a close examination of how the system can be strengthened to provide a much stronger focus on quality and whether the right outcomes are being delivered for children in OOHC.

Given the discussion above about expanding our oversight responsibilities, it is important to qualify our proposals by acknowledging that there is a fundamental issue yet to be resolved – that is, whether the whole oversight system is 'fit for purpose'.

c. Delivering an integrated oversight system

We note that the *Family is Culture* report[22] made recommendations to strengthen the NSW regulatory framework more broadly, including the establishment of a new, independent Child Protection Commission which would also include the appointment of an Aboriginal Commissioner.

We note that this recommendation is currently the subject of consideration by the Ministerial Aboriginal Partnership Group. Therefore, we don't believe it is appropriate for us to express a firm view on the issue, apart from noting that we are open to broad reform of the oversight system.

[22] M. Davis, *Family is Culture Final Report – Independent Review of Aboriginal Children and Young People in Out-of-Home Care in NSW*, October 2019.

Appendix 1: Overview of OCG's targeted monitoring review of ACAs (2023)

Purpose of review

From September to November 2023 the Office of the Children's Guardian (OCG) undertook a targeted review, focusing on alternative care arrangements (ACA). The purpose of the monitoring program was to review:

- OOHC providers' practices in establishing ACAs
- agencies' subcontracting arrangements with ACA providers
- the adequacy of oversight in terms of the safety and quality of these arrangements.

The review also included an assessment of the care records for some children and young people to consider the coordination of care while children and young people were in ACAs, and the support for children and young people transitioning into more appropriate care arrangements.

Methodology

Our review considered relevant practices in each Department of Communities and Justice (DCJ) district, as well as the five non-government OOHC agencies with the highest number of children and young people in ACAs, as of 18 September 2023.

The review also included discussion with the five ACA providers that were providing the highest volume of workers to care for children and young people in ACAs, as of 18 September 2023.

As part of the review, OCG assessors:

- examined agency records regarding 55 children and young people who were in ACAs during the review period. This included 35 children and young people in ACAs arranged by the Department of Communities and Justice (DCJ) and 20 children and young people in ACAs arranged by non-government OOHC agencies
- examined ACA exit notifications received by the OCG from OOHC agencies, between 1 October 2023 and 14 November 2023
- examined service level agreements between OOHC agencies and ACA providers
- reviewed information provided by DCJ regarding district practices in the monitoring and implementation of service level agreements, and the supervision and support for children and young people in ACAs
- met with the five ACA providers participating in this review, regarding their practices in establishing ACAs and working with OOHC agencies to support children and young people in these arrangements.
- met with principal officers and agency staff in the five non-government OOHC agencies participating in this review, relating to their monitoring and implementation of service level agreements and approaches to supporting children and young people in ACAs.

Detailed feedback on practice was provided to the individual agencies that participated in this review.

The profile of children and young people in ACAs at the time of review

On 18 September 2023, notifications provided to OCG indicated that of the 149 children and young people in ACAs:

- 98 were in ACAs arranged by DCJ and 51 in ACAs arranged by non-government OOHC agencies
- 92 had entered an ACA following a prior placement breakdown
- 57% were identified as Aboriginal children and young people, indicating significant over-representation.