Acknowledgements 2
Introduction 2
The Reform Landscape 4
Territory Families’ Quality Assurance Program 7
The October Visit 7
An Overview of the Standards 9
Young People’s Voices within Residential Care Facilities 11
Young People’s Voice in Case Management 17
Physical Restraint 26
Care Planning 29
Service Delivery and the NDIS 42
Leaving Care Planning 46
Therapeutic Interventions and Programs 50
Home Environment 52
Appendix One: Individual Recommendations 53
Appendix Two: References 54
ACKNOWLEDGEMENTS

During this monitoring visit, the Office of the Children’s Commissioner (OCC) was privileged to meet with and hear from a number of young people living in residential care in the Northern Territory. They welcomed us into their homes and they talked about their lives. Their views and experiences have influenced the findings and the recommendations of this report, and will continue to inform the work of the OCC.

The OCC also acknowledges the participation, cooperation and support of the service provider and its staff whose homes were monitored in this project’s first iteration.

Finally, the OCC acknowledges the time taken by Territory Families’ staff in participating in, and assisting with this process, particularly in light of the considerable demands those staff already have on their time.

INTRODUCTION

The report is the result OCC’s first round of monitoring in relation to residential care facilities in the Northern Territory. Residential care facilities have historically been considered to be ‘black boxes’; meaning how residential care services are run, and the experiences of young people within them, have not been transparent or well understood. [1]
For that reason, having independently gathered and publicly available information in relation to the experiences of young people in residential care facilities represents an important step in improving accountability and ultimately, outcomes for some of our most vulnerable young people.

Evidence provided to the Royal Commission into the Protection and Detention of Children in the Northern Territory (the Royal Commission) told a bleak story about the experiences of young people in residential care placements. The report of the Royal Commission set out that:

‘The children’s experiences in residential care were characterised by frequent absconding, substance abuse, offending and other high-risk behaviours, often in the company of other children in residential care. Placement staff struggled to manage their behaviours and, in many cases, would call the police. The children were often disengaged from support services education and pro-social influences, and dislocated from family, culture and community.’[2]

In addition, residential care has historically been offered in poorly maintained environments, with care staff who had insufficient training to meet the complex needs of the young people they cared for. [3]

On 30 June 2019, 1054 children were living in out-of-home care in the Northern Territory. 96 of those children were living in a residential care placement. 15% of those young people were included in this round of monitoring.

Residential care services are currently provided by a combination of six non-government agencies and Territory Families. One of those agencies is an Aboriginal organisation. The experience of young people in the care of each service provider will continue to be monitored on a rotating basis by the OCC.
THE REFORM LANDSCAPE

In November 2017 the Royal Commission released its final report. The report contains 227 recommendations, 82 of which relate to the Northern Territory’s child protection system. Combined, the recommendations provide a blueprint for fundamental redesign of the child protection system.

The Royal Commission’s key criticism of the Northern Territory’s child protection system was that it was a reactive system, designed to respond to harm after it occurred, rather than being designed to prevent harm from occurring in the first place. In order to reorient the child protection system toward being a proactive, preventative system, the Royal Commission’s central recommendation relating to child protection was that the Northern Territory Government (NTG) adopt a public health approach to child protection. Fundamentally, a public health approach to child protection is premised on using an evidence base to design programs and services that prevent harm occurring, as opposed to solely responding to harm when it occurs, as our child protection system did prior to the Royal Commission.

On 1 March 2018 the NTG announced its acceptance of the intent and direction of all recommendations within the report that related to the Northern Territory. In April 2018, the NTG released its implementation plan – Safe, Thriving and Connected: Generational Change for Children and Families. Since then, the NTG’s reform agenda has expanded to include recommendations from the Royal Commission into Institutional Responses to Child Sexual Abuse, and the NTG’s Early Childhood Development Plan: Starting Early for a Better Future. Together, these reports form the NTG’s Generational Change Reform.
The most recent official update of the NTG’s progress in implementing the Generational Change Reform is contained in the 2018-19 Annual Report of the Reform Management Office (RMO), which was published in November 2019. The RMO’s Annual Report details positive progress toward many of the Royal Commission’s recommendations. It can be found at https://rmo.nt.gov.au/.

Alongside the work detailed in the Generational Change Reform, which is focused on early intervention by supporting and strengthening families and communities to care for children safely, Territory Families is also undertaking a series of programs and projects designed to improve the experiences of young people who enter out-of-home care. A summary of those reforms can be found in Territory Families’ 2018-19 annual report. It can be found at https://territoryfamilies.nt.gov.au/about.


One aspect of the program is that General Residential Care (GRC) services – which have been examined in the October Visit – will be replaced with Intensive Therapeutic Residential Care (ITRC) services, beginning on 1 April 2020.

Young people are placed in residential care if they cannot be placed in kinship care, foster care or Purchased Home-Based Care. That is typically due to their complex needs or the extent of their challenging behaviour. At the moment, the sophistication and effectiveness of therapeutic services and responses delivered by residential care providers in the Northern Territory varies widely.
Territory Families’ transition to ITRC is designed to ensure that all children who are placed in residential care receive a consistent standard of individualised, evidence based and responsive therapeutic care in their placement.

ITRC is envisaged as being a short term placement, where children will receive a high level of professional and targeted therapeutic support that will then enable them to transition back to the care of their family, kinship care or foster care or to transition to independent living.

With that reform in mind, the recommendations of this report are designed to address three aspects of the residential care system. Firstly, any immediate risks to the wellbeing of young people in residential care homes. [4] Secondly, they are designed to ensure that young people are consistently receiving the standard of care articulated in relevant national standards, legislation and policy. Finally, they are designed, where relevant, to complement the reform framework identified in the report of the Royal Commission and the reform agenda committed to by NTG, particularly the transition from GRC to ITRC.
TERRITORY FAMILIES' QUALITY ASSURANCE PROGRAM

Following the Royal Commission, and due to the variation in the quality of therapeutic services in out of home care, Territory Families partnered with out of home care providers to implement a Quality Assurance Program (QAP). So far, the QAP has included an examination of residential care providers and purchased based care providers. As part of the QAP, Territory Families assess the degree to which service providers meet the standards set out in Territory Families’ Quality Assurance Framework. That framework is based on the National Out of Home Care Standards. Where those standards are not being met, Territory Families and the service provider negotiate quality improvement plans. Those plans are then subject to ongoing monitoring. The OCC’s monitoring program is designed to complement Territory Families’ QAP, by providing independent oversight and assessment of service provision in residential care.

THE OCTOBER VISIT

Between 14–25 October 2019, delegates of the Children’s Commissioner conducted monitoring visits to a sample of residential care facilities in Darwin and Alice Springs (the October visit). All of the facilities visited were operated by a single service provider (the Service Provider). [5]
The following issues were examined during the October visit:

- Young people’s voice within the residential care facility;
- Young people’s voice in case management;
- Care planning;
- Leaving care planning;
- The use of physical restraint;
- Therapeutic interventions and programs; and
- The home environments provided by the Service Provider.

As part of the October visit, the following sources of information were used:

- Interviews with and visits to young people living in the residential care homes;
- Records provided by Territory Families;
- Records provided by the Service Provider;
- Interviews with Territory Families staff;
- Interviews with staff of the Service Provider; and
- Inspections of the residential care home.

During the October visit there were 14 young people living in residential care homes run by the Service Provider. Three were female and 11 were male. 12 of the young people identified as Aboriginal. OCC staff visited 13 of the young people living in the residential care homes.
AN OVERVIEW OF THE STANDARDS

The provision of residential care in the Northern Territory is governed by a combination of national standards, legislation and policy.

In April 2009 the Council of Australia Governments (COAG) endorsed the *National Framework for Protecting Australia’s Children 2009-2020*. One of the 12 priority projects contained within that framework was the development of the 13 National Standards for Out of Home Care (the National Standards). Those standards form the basis of the OCC’s residential care monitoring framework.

In addition, in February 2019 COAG endorsed the *National Principles for Child Safe Organisations*. Those principles reflect ten standards recommended by the *Royal Commission into Institutional Responses to Child Sexual Abuse*. However, their scope goes beyond sexual abuse to cover other forms of potential harm. Those principles are incorporated in the OCC’s framework, where relevant to the provision of residential care.

The OCC’s framework also contains the legislative standards set out in the *Care and Protection of Children Act 2007* (NT) as they relate to the provision of residential care. The content and the delivery of the standards contained within the framework is informed by Territory Families’ policies and procedures.
FINDINGS AND RECOMMENDATIONS
Standard 2 of the National Standards sets out that children and young people should participate in decisions that have an impact on their lives. This standard is reflected in section 11 of the Care and Protection of Children Act 2007 (NT). Article 12 of the United Nations Convention on the Rights of the Child codifies that standard in the language of rights - the right of children and young people to have a say in matters that affect them, and for their views to be taken seriously. The Northern Territory’s Charter of Rights for Children and Young People in Out-of-Home Care similarly includes this right.

Ensuring that young people meaningfully participate in decisions that affect them is important for a range of reasons. Firstly, young people are experts in their own lives. Promoting the capacity and ability of young people to participate in decision-making processes is critical to understanding their experiences, perspectives, needs and challenges. Young people can provide unique information and insight into the practical operation of policy and programs, and whether they promote young people’s wellbeing, or whether they create barriers and problems. Ensuring that young people are listened to contributes to improved program design and service delivery. In addition, continually involving young people in decision making processes can improve their confidence, their communication skills and their sense of independence.
FINDINGS

The Service Provider has policy relating to young people’s participation in the operation of residential care facilities that sets out principles and procedures that meet Standard 2 of the National Standards.

The Service Provider has established mechanisms to facilitate young peoples’ participation in decision making in relation to food and daily activities.

In the October visits, there was no evidence of effective mechanisms to ensure that ad-hoc requests made by young people in relation to various aspects of the operation of the homes were reliably and adequately responded to.
**Policy**

The service provider subject to monitoring during the October visit has a robust policy relating to the participation of young people in relation to the operation of the homes they live in. The policy articulates how young people will be supported to participate, and clearly sets out the responsibilities of all staff members in operationalising the policy.

In terms of the day-to-day operation of the homes, the policy sets out that young people should be supported to make decisions around:

- Which services they use;
- The people they associate with;
- What they wear;
- How the house is furnished;
- The food they eat;
- Their daily routine;
- The activities they participate in; and
- Their lifestyle.

In addition, the service provider’s policy includes a commitment that young people will be involved in:

- The induction and training of new carers;
- The development and review of policies and procedures;
- Attendance at relevant meetings;
- Case conferences and clinical reviews in person, where possible; and
- Providing feedback to allow better management of the organisation.
The service provider’s policy relating to promoting young people’s voices within their residential care facilities provides a strong foundation upon which to develop practice that reflects and upholds young people’s right to do so.

**Weekly Planners**

In each of the homes visited during the October visit, there was evidence that efforts had been made to facilitate the participation of young people in the day to day activities that occur outside of school time. This primarily occurs by means of a visual weekly planner. The planner is designed to allow children, whether verbal or non-verbal, to contribute to deciding which activities will occur each day. We saw that young people did have a say over the activities that occurred outside of school hours. For young people who were not able to make those requests, our conversations with care staff demonstrated that they had a good understanding and knowledge of the types of activities that the young people enjoyed and ensured those activities occurred regularly.

During our visits to the homes, we saw that young people had participated in decorating the homes. Young people were generally happy to show us around the houses, particularly their bedrooms. We saw indications that young people had participated in decorating their bedrooms. Many of their bedrooms had photos of their family, paintings they had done or posters of their favourite movies.
In each of the homes we visited there was a weekly meal planner, designed to allow young people to participate in decisions about what they eat.

**Ad hoc Requests from Young People**

As well as having mechanisms to encourage young people’s participation in routine aspects of the house’s operation, such as choosing food and daily activities, it is important that residential care providers have mechanisms to ensure that they are also responsive to ad-hoc requests from young people in relation to the operation of the homes.

During the October visit we saw young people make some ad-hoc requests in relation to the day-to-day operation of the home. From the records available to the OCC. It does not appear that those requests were satisfactorily responded to. The following is one example of such a request:

“A 15 year old male we spoke to had recently entered the care of the CEO. At the time we spoke to him, he was in a residential care placement that did not have any other young people living there. He was frequently leaving the placement, and rarely staying there overnight.

During our conversation, he asked if he could have a friend come over to visit him at the placement to play video games with him. The request was made to one of his carers.

Service provider staff told the young person the matter would be discussed with Territory Families.

There is no record of the request being discussed with Territory Families, or further explored with the young person.”
RECOMMENDATIONS

1. Territory Families work with the Service Provider to ensure there are regular, formal and child-friendly opportunities for young people to provide feedback and make requests in relation to the operation of their homes.
YOUNG PEOPLE'S VOICE IN CASE MANAGEMENT

The standards set out in relation to young people's participation in the operation of residential care facilities, similarly apply to young people having a voice in the case management. Case management is an ongoing process of assessment, planning, implementation, monitoring, review and decision making to ensure the timely achievement of identified goals. Care plans are the primary tool used to achieve effective case management. Section 72 of the Act specifically requires the wishes of the young person to be taken into account when preparing, reviewing or modifying a care plan.

Precisely measuring the extent to which young people's voices are incorporated into care planning is a difficult task. There are often a range of complex factors that impact on Territory Families ability to act on the views and wishes of young people, while simultaneously meeting their best interests.

Whether or not young people feel they have been listened to, and whether they feel they have control over their lives is inherently subjective. The following case study illustrates the types of decisions in case management that young people can and should be a part of, and the significant amount of work required to ensure young people feel that they have been listened to.
CASE STUDY: CD

CD is a young man who has been in the care of the CEO since 2015. During the October visit significant work was being undertaken by Territory Families to plan for CD leaving care, as he approached his 18th birthday.

During the OCC’s conversations with CD described his vision for his life after he left care. One key aspect of what he wanted for his future related to further training and employment options.

CD’s leaving care plan included provision for support in ongoing training. However, the course that CD was supported to complete was in a field that CD had specifically said he was not interested in working in.

In his conversations with OCC staff, CD said that he did not know why he had not been able to complete the courses he wanted to.

CD’s leaving care plan indicates it may be possible for him to independently complete the course after having left care. However, Territory Families records do not demonstrate that CD was formally involved in preparing the leaving care plan and there is limited information in Territory Families records about clear and specific conversations with CD about those decisions.

Territory Families records and conversations with Territory Families staff demonstrated that extensive and careful case management went into many aspects of CD’s leaving care plan. Leaving care planning is a difficult process and in this case, like all others, a range of factors appear to have impacted on whether CD’s plans were supported by Territory Families.

However, that CD reported that he did not know or understand why he was unable to be supported to complete the types of courses he wanted to complete, despite the extensive work completed by Territory Families, underscores the need to ensure that young people are consistently involved and informed in the care planning process.
Despite the challenges in measuring whether young people have had a say in their case management, there are practice requirements articulated in policy and procedure, designed to maximise a case manager’s ability to ensure young people have an opportunity to participate in case management, and to maximise the likelihood that young people feel as though they have a say in what happens to them. Primarily, that is supposed to occur through frequent and meaningful contact.

**FREQUENCY OF CONTACT**

The most effective method of ensuring young people have a voice in case management is through regular contact between the young person and their case manager.

The frequency with which that contact should occur, and how it should occur is governed by Territory Families’ procedure, Monitoring Wellbeing of Children. That procedure requires that at minimum, a case manager must have face-to-face contact with every child that they case manage once every six weeks, or arrange for a third party to have face to face contact, if endorsed by the team leader or manager.[6]

**FINDINGS**

Territory Families’ Monitoring Wellbeing of Children procedure requires case managers to have face to face contact with each young person at least every six weeks. Territory Families had not complied with that requirement in 11 of the 14 cases considered in the October visit.
In a review of the most recent 12 month period, on average, young people were visited six times. [7]

According to the Monitoring Wellbeing of Children procedure, each child should have been visited nine times during that 12 month period. The lowest number of visits in that period was two and the highest was 17.

In reviewing the frequency of case manager contact, it was apparent that children with a limited ability to communicate, and with limited independence were less likely to receive regular and frequent visits from their case managers. There are a number of reasons why this would occur. Primary amongst those reasons is the number of young people and their varying complexities that each case manager is responsible for.

When explaining their limited contact with one of the young people they were responsible for, a case manager told us:

‘The squeaky wheel gets the oil... In child protection we deal with spot fires. If something happens we go and deal with that... When you have priority one and priority two investigations coming in and there’s only two staff members, it’s literally a case of ‘right, we’ve gotta go and check on this and check on that.’ If we are getting reports from a child’s carer that they are going okay... [In relation to young people on long term care orders and in care] ... because they are going okay we tend to leave them alone. Maybe if we only had responsibility for children on long term orders it would be different. That’s how I feel with my case load at the moment.’
The sentiment of that comment was reflected in our conversations with many of the case managers we spoke to. Case managers prioritising their workload in that way is understandable, necessary and inevitable in circumstances where individual caseloads prevent case managers from consistently fulfilling their obligations in relation to each of the young people they are responsible.

However, that young people with less independence, mobility and communication ability appear to be receiving fewer visits is of concern. Young people with those characteristics are almost exclusively reliant on their carers to have their needs met and to protect them from harm. They are therefore in situations of extreme vulnerability. One of the most effective mechanisms for reducing that vulnerability is to ensure there are a range of people familiar with the young person who are having regular contact with them, and undertaking ongoing assessments of their wellbeing. It is critical that along with the care provided by the Service Provider, Territory Families also provide this oversight.

That the workload of Territory Families front line staff is unmanageably high, has been a consistent theme in reports about, and investigations into, child protection in the Northern Territory over the last decade. Until that resourcing issue is addressed, the wellbeing of young people in out-of-home care in the Northern Territory will be compromised.
RECOMMENDATIONS

2. By 31 March 2020, Territory Families review the allocation of children’s case management, including consideration of the following:

- Whether having a child case managed by a case manager in a different region to which the child is placed is in the child’s best interests;

- The viability of having disability specific case managers; and

- The viability of having residential care specific case managers.
QUALITY OF CONTACT

The Monitoring Wellbeing of Children procedure sets out that face to face contact between a young person and their case manager should have the following characteristics:

- It should occur in a supportive and safe environment where the child can express themselves freely;
- The contact should include opportunities to voice their opinions, choices and concerns;
- There should be opportunity to speak away from those who may inhibit the child’s willingness to express themselves honestly without fear or embarrassment; and
- There should be planned contact times where priority safety and wellbeing issues from their care plan can be addressed.

FINDINGS

Record keeping in relation to face to face contact between case managers and young people frequently did not contain critical information, as required by the Monitoring Wellbeing of Children procedure.
From the available records it was not possible to assess whether case managers had complied with the requirements set out in the *Monitoring Wellbeing of Children* procedure. Case notes in relation to face-to-face contact typically did not contain complete detail in relation to who was present, where the visits took place, and if the child was provided the opportunity to share their views or provide any feedback.

The October visit demonstrated that there were varied levels of knowledge in relation to the content of the *Monitoring Wellbeing of Children* procedure, as it relates to the quality of face-to-face contact among the case managers interviewed.

Due to the difficulty in having formal, sustained conversations with the young people, the case managers interviewed typically described their face-to-face contact with the young people as being largely based around observation.

For example, one case manager described her visits to a young person as follows:

\[\text{His attention is drawn to what's happening with [the other house residents] or what's happening in the house. Usually when I visit during school holidays it will be at the placement because that way you can spend a bit of time. I can watch him do his activities and give him a clap and say, 'that's good'. For a couple of my clients, I like to visit them at school as well. I can get a bit of a picture that way...}\]
That description was largely consistent with the types of face-to-face contact detailed by other case managers who were interviewed.

The cohort of young people considered during the October visit contains people with a range of social, developmental and communication challenges. In some instances it will not be possible for case managers to have face to face contact that looks exactly as described in the Monitoring Wellbeing of Children procedure. However, for some young people, their contact with their case manager will be the only opportunity they have to express particular concerns, and every effort should be made to ensure that can occur.

RECOMMENDATIONS

3. Territory Families deliver regular, scheduled disability-focused training for all staff who case manage children with disabilities.
Residential care workers do not have the power to use physical restraint as part of caring for young people. The exception to this is where a young person with a disability has been assessed as needing some physical restraint in order to keep them safe. Physical restraint in that context constitutes a ‘restrictive practice’. In those circumstances, the proposed physical restraint must be incorporated into the child’s behaviour support plan. That plan must be submitted to the National Disability Insurance Scheme (NDIS) Quality and Safeguards Commission for approval and ongoing oversight.

Using physical restraint outside of those circumstances generally amounts to abuse. However, in certain limited circumstances using physical restraint may be warranted. For example, where it is immediately necessary to prevent harm to the child or to another person. Due to the inherent subjectivity in determining whether circumstances warrant the use of physical restraint, residential care staff face a difficult task in determining where the relevant threshold lies and what constitutes appropriate action. They are often required to make that assessment in rapidly developing situations and under significant amounts of pressure.

When physical restraint or force is used in relation to a young person, it is critical to ensure that a comprehensive investigation occurs to determine whether it amounted to abuse in care, or whether it was necessary in the circumstances to prevent immediate harm to the child or another person. Territory Families conducts those investigations pursuant to section 84A of the Act. [8]
FINDINGS

In the past 12 months, there were four allegations of abuse relating to the use of physical restraint or force, involving staff of the Service Provider.

 Territory Families did not respond in accordance with their procedure - Responding to Reports of Concern on Open Cases – in relation to three of the four allegations of abuse.

Service provider policy and training

The policy of the Service Provider monitored in the October visit is that physical restraint is never used as part of their provision of care, whether used as part of an NDIS Quality and Safeguard Commission approved Positive Behaviour Support Plan, or otherwise. Overall, the Service Provider appeared to have robust policy, training and practice in place to ensure care staff had sufficient skills and knowledge to avoid using physical restraint as part of caring for young people, wherever possible.

Staff working in the residential care homes are required to complete a therapeutic intervention training course designed to prevent crises from occurring, de-escalate potential crises, manage acute physical behaviour and reduce potential and actual injury to children and staff, without using physical restraint. In addition, the service provider has specialist staff who assist care staff to participate in reflective practice and incident review meetings, to ensure care staff have continued opportunities to develop their skills in relation to challenging or high risk behaviour from young people.
When visiting the residential care homes during the October visit, the staff we spoke to were able to describe aspects of the training they had received and apply that knowledge to the specific behaviours of young people in the facility. The staff-only areas of the homes contained clearly displayed training and learning resources re-enforcing the content of the therapeutic intervention training. OCC staff observed residential care staff successfully use verbal de-escalation techniques in response to a young person beginning to act in a physically aggressive manner.

**Investigations**

In the past 12 months Territory Families have received notifications of four instances of physical force or restraint being used by staff of the service provider in relation to young people in their care. Three of those instances were investigated pursuant to section 84A of the Act. One was subject to inquiries pursuant to s83B of the Act.

The small sample size and the unique facts of each instance mean it is not possible to draw systemic conclusions in relation to Territory Families’ investigations in relation to allegations of the use of physical restraint or force. However, there were procedural irregularities in relation to how each of the notifications were investigated, or otherwise responded to. It is noted that despite these irregularities, in each of the cases Territory Families' response involved sufficient information gathering and assessment to be confident that the child was not at risk of ongoing harm. The OCC has made individual recommendations in relation to those investigations.
CARE PLANNING

The Care and Protection of Children Act 2007 (NT) (the Act) gives Territory Families the statutory responsibility of safeguarding the wellbeing of children who are in the care of the CEO. Territory Families Care Planning for Children in Care policy sets out that ‘every child in care must have a comprehensive written Care Plan that identifies the case direction, their needs, the actions to be taken to meet their needs, decisions about placement arrangements, and contact between the child and their family or other significant people in their life.’

The care planning process and the required content of care plans is governed by part 2.2, division 1A of the Act and the Care Planning for Children in Care policy. Territory Families has also developed a Care Planning for Children in Care procedure.
CURRENCY OF CARE PLANS

FINDINGS

Of the 14 care plans reviewed, 11 had been completed and updated in the time frames required by section 74 of the Act.

Section 70 of the Act requires the CEO to prepare and implement a care plan as soon as practicable after the child is taken into the CEO’s care. Within two months of a child being taken into the CEO’s care, a review of the care plan must occur. [9]

Following that review, a further review must occur at least every six months. [10]

In addition, the CEO must conduct a review of the plan immediately following a death of the child’s parent or carer, a change in the child’s placement arrangement or following an extension or variation of the court order relating to the child. [11]
CARE PLAN MEETINGS

FINDINGS

Of the 14 care plans reviewed, seven did not comply with the requirement contained in Territory Families Monitoring Wellbeing of Children, that care plans be informed by a care plan meeting.

Territory Families’ care planning procedure requires that a meeting is held prior to a care plan being prepared. According to the procedure, ‘the care planning meeting provides an opportunity for all people with a direct and significant interest in the child’s lift to come together to feed into the needs and actions of the child.’

The procedure sets out that, where appropriate, the meeting should include:

- The child;
- The child’s parents;
- Other appropriate members of the child’s family;
- For an Aboriginal child, Aboriginal agencies and persons;
- The child’s carer; and
- Other persons with a significant interest in the child’s life such as their teacher, counsellor, specialist health worker, Youth Worker, Case Support Worker, CREATE NT support worker.
Of the 14 care plans reviewed, seven were informed by a care planning meeting. However, in the other seven instances, there was no evidence of a specific care planning meeting occurring. Preparing care plans without seeking the input from the full range of people who are involved in the young person’s life represents a missed opportunity to ensure a child’s care plan operates as a robust road map for the child’s care, and as a tool to promote accountability for those who are responsible for ensuring the child’s wellbeing.
IN VolvemEnt Of FaMily IN Care PlannINg

FINDINGS

Of the 14 care plans reviewed, two were developed in consultation with the family, as required by section 74(4)(b) of the Act.

Section 74(4)(b) requires Territory Families to have regard to the views of parents when a review of a care plan occurs. Territory Families’ care planning policy requires care plans to be prepared in consultation with family, where appropriate. In addition, section 73 of the Act requires Territory Families to provide a copy of a child’s care plan to each parent of the child unless the CEO considers it inappropriate or impracticable in the circumstances.

Of the 14 care plans reviewed, two were developed in consultation with the family. There are a range of reasons why it may be difficult for Territory Families to actively engage family members in the care planning process including an inability to contact them, and parents’ own circumstances preventing them from participating in the process. However, that only two of the care plans had direct family involvement is reflective of the fact that Territory Families do not have a relationship with most of the families of the children involved in the October visits and overall, insufficient efforts have been made to establish and maintain those relationships. This is discussed more fully, in relation to family contact, below.
FAMILY CONTACT

Standard 9 of the National Standards states that children and young people should be supported to safely and appropriately maintain connection with family, be they birth parents, siblings or other family members. This standard is reflected in Section 8(4)(a) of the Act which sets out that if a child is removed from the child’s family, as far as practicable, contact between the child and the family should be encouraged and supported. The importance of ensuring that young people in out-of-home care remain connected to their families through regular, safe contact is re-iterated throughout Territory Families’ policies and procedures. Territory Families Care Planning for Children in Care policy requires care plans to set out the contact arrangements between the child, their parents, siblings, family or any other significant persons in their life. An ongoing connection to family, culture and community is critical to the social and emotional development of children, particularly Aboriginal children. [12]

FINDINGS

Of the 14 care plans reviewed, two adequately set out contact arrangements between the young person and their family members as required by section 70(2)(c)(ii).

The connection between young people and their families, through regular contact has been insufficiently prioritised in case management as required by section 8(4)(a) of the Act.
Overall, a review of the contact between young people and their families demonstrated inconsistent compliance with the requirement that contact between the child and their family should be encouraged and supported.

- Five of the young people had been supported by Territory Families to have contact with their parents in the last 12 months.
- Three of those children had contact on a regular basis.
- Six of the young people had contact with a family member in the past three months.
- For two children, their most recent contact with family was between 3-6 months ago.
- For another two children, their most recent family contact was between 6-12 months ago.
- Four children had not had any contact with any family members in over 12 months.
- One child has been supported to have contact in his home community.

The case managers that were interviewed identified a range of systemic barriers to supporting young people to have contact with their families. The barriers faced in relation to each young person are slightly different.

Some case workers spoke of systems-based barriers posing challenges to arranging contact between children and their families. For example, one case manager was recently contacted multiple times by the mother of a child who has not had family contact in over 12 months. He explained:

Because we need to plan ahead, and we have, I think, a five day thing for trips - to try to get it through the managers. So it's like, [the child's] mum rang me the other morning and said 'can I go to Darwin today?' In an ideal world I'd love to say, 'oh yeah, I could probably get you on the bus tomorrow' but we physically can't do it because we need to get approval, we need to get stuff organised.
Because of delays in arranging the trip, the child's mother became angry with Territory Families, has not contacted the office again and the young person still has not seen his mother.

In another instance, a case manager had arranged for a 14 year old boy to visit his family in a remote community. The case manager reported that the trip was cancelled on the day it was meant to occur due to a dispute between Territory Families and the Service Provider about funding. The case manager reported that following the cancellation of the trip, her relationship with the young person broke down. The young person has not had any further contact with his family.

Other case managers pointed to historical safety concerns as a significant barrier to facilitating family contact, particularly in remote communities. Almost all case managers identified the size of their caseload as a primary barrier to ensuring regular and consistent contact between young people and their families due to the resource intensive nature of making contact with family, planning trips, preparing young people and attending the visits.

It is difficult to draw system-wide conclusions in relation to family contact from the small number of cases reviewed. However, each of the barriers identified, while valid, is not insurmountable. In fact, as demonstrated in the case study of EF below, the October visit revealed that with sufficient resourcing, planning and focus, many apparent barriers can be overcome, resulting in meaningful and invaluable contact between EF and his family.

Overall, a review of the nature of the barriers identified in the October visit demonstrates that family contact is not being prioritised to the extent it should be, particularly for young people who are on long term Protection Orders.
CASE STUDY: EF

EF is a 16 year old boy who has been in the care of the CEO since 2014. One of the primary reasons he entered care was that he had been the victim of physical assault in his home community that had left him with an acquired brain injury. The perpetrator of that assault continues to live in the young person’s home community. EF has number of other additional health and developmental difficulties. EF has a large extended family. Since 2014, Territory Families has had varying levels of contact with a number of those family members.

In late 2018, EF was assigned a new case manager. Before that, EF had not had contact with his family since 2016. EF had not been to his community since entering care in 2014.

In early 2019 EF’s case manager arranged for contact with EF’s family to occur in his home community. Before the visit, EF’s case manager travelled to the community to meet face to face with EF’s family to discuss the planning. The case manager liaised with the police and the council to ensure the perpetrator of EF’s assault was not in the community at the time of the visit. The case manager had contacted the community health clinic to develop a plan for how any emergencies could be managed and co-ordinated with the Service Provider to arrange for one of EF’s regular carers to also attend the visit.

Planning is underway for EF to visit his community again for an overnight visit.
CONTENT OF CARE PLANS

Territory Families use a uniform template for young people’s care plans. It is titled ‘My Care Plan’. The ‘My Care Plan’ template was introduced in January 2018, replacing a more formulaic and rigid template. ‘My Care Plan’ is intended to be a child-focused and child-friendly document that provides all relevant people and agencies clear information about the child, their needs and how those needs will be met.

FINDINGS

No care plans reviewed in the October visit provided sufficient specificity in identifying the child’s needs, how the needs would be met, who would be responsible and timeframes for actions to ensure accountability across all domains contained within ‘My Care Plan’.

It is important to ensure that young people in care are able to understand and participate in decisions about their lives. From that perspective, the introduction of ‘My Care Plan’ is positive change considering its clear child-focus and its demand for child-friendly information. However, those features cannot come at the expense of precise and complete information about the child’s needs. In the absence of clearly articulated actions, timeframes and the responsible person or agency, there is a fundamental lack of accountability in case management, and the young person’s needs are vulnerable to going unmet. The domains of Education and Health and Wellbeing are considered, below, to illustrate this point.
Section 70 of the Act requires Territory Families to ensure a young person’s care plan identifies the needs of the young person and outlines what measures must be taken to address those needs. One of those needs is education. The importance of young people remaining engaged in education and training is similarly articulated in standard seven of the National Standards for Out-of-Home Care. In practice, section 70 of the Act requires young people to: (1) have their particular educational or training needs assessed; (2) have an individual plan detailing how those needs will be met and; (3) receive the support identified in those plans.

Of the 13 school-aged young people whose care experiences were considered during the October visit, 12 were enrolled in school. Ten of those young people were attending on a regular and consistent basis. However, of the 13 care plans that were considered, five contained evidence that the young person firstly, had their particular training needs assessed and secondly, that there was a plan for how those needs would be met.
Standard five of the National Standards sets out that young people in out-of-home care must have their physical, developmental, psychosocial and mental health needs assessed and attended to in a timely way. This standard is reflected in section 70 of the Act, which requires care plans to identify the needs of the young person and outline the measures that will be taken to meet those needs. In line with section 70, a young person’s care plan must address their health and wellbeing needs.

Many of the young people who were part of the October visit have complex health and developmental needs. In some instances, the reason the young people are in care is entirely due to the complexity of their health needs.

Of the 14 care plans reviewed, there were eight in which it was not possible to discern the particular health needs of the child, or what actions would be taken to meet their needs. In an additional five care plans, some of the health needs of the young person were identified and some actions were articulated. However, there was only one care plan that provided sufficient detail and information to allow, for example, a new case worker to gain a comprehensive understanding of the young person’s health needs from reading the care plan.

Given the lack of information contained within care plans in relation to health and wellbeing, OCC staff separately considered the provision of health care through the NDIS.
RECOMMENDATIONS

4. By 30 April 2020, Territory Families provide mandatory training to all staff with responsibility for approving care plans on their obligation to ensure that care plans explicitly identify the needs of young people, how those needs will be met, who is responsible for meeting them and by when they must be met.

5. Following the provision of the above training, and until 30 April 2021, Territory Families conduct a review of the quality of care plans, including leaving care plans, for children on long term Protection Orders with a focus on ensuring the development of care plans that explicitly identify the needs of young people, how those needs will be met, who is responsible for meeting them and by when they must be met. This review should have a particular focus on contact arrangements between young people and their families and the cultural needs of young people. The review should include 20% of young people on long term Protection Orders.
SERVICE DELIVERY AND THE NDIS

FINDINGS

Territory Families' did not hold comprehensive, readily available information relating to the health and disability needs and related service provision, of young people in care.

Most case managers interviewed in the October visit did not have sufficient knowledge of the operation of the NDIS to ensure that young people in care had their needs accurately identified and timely access to NDIS supports.

Of the 11 young people for whom an application for NDIS funding has been made, over the last 12 months, none have had regular access to the necessary services identified in their NDIS plan.

The National Disability Insurance Scheme (NDIS) became fully available in the Northern Territory on 1 July 2019. The NDIS is designed to provide funding for people with a permanent disability so that those people can access support services in order to meet their needs and fulfil their goals.

The NDIS is an initiative of, and administered by, the Federal Government.
11 young people in the October visit had an application for NDIS funding made on their behalf. The particular needs and the services funded for each child varied, depending on the extent and the nature of each young person’s disability. However, over the past 12 months, none of those 11 young people had regular and consistent access to all of the necessary support services identified in their NDIS plans. The October visit revealed three key barriers in relation to service delivery and the NDIS.

The October visit revealed three key barriers in relation to service delivery and the NDIS.

Territory Families staff did not have access to readily available, comprehensive information relating to the needs and services identified in young people’s NDIS plans.

A review of records held by Territory Families and interviews with case managers demonstrated that Territory Families often did not hold comprehensive information about the scope of services identified in young peoples’ NDIS plans, which service providers were engaged to deliver services and whether or not, in practice, those services were being delivered. It was apparent during the October visit that in most instances, the bulk of the relevant information in relation to NDIS-related service delivery was held by the Service Provider. It is critical that the Service Provider hold that information given they are responsible for the day-to-day care of young people. However, Territory Families, as the legal parent of the young people, must similarly have clear and comprehensive records given they are ultimately responsible for ensuring that young people in their care have their needs met.
In some cases, Territory Families staff had limited knowledge in relation to the operation of the NDIS as it relates to young people in care.

The rollout of the NDIS commenced in the Barkly region in July 2016 and only became fully operational in the Northern Territory on 1 January 2019. In addition to grappling with a new, complex scheme, few case managers have specialist disability training, most only case-manage a small number of young people for whom an NDIS plan is needed, and opportunities for NDIS-specific training have been limited. As a result, from the October visit, it appeared that many of the case managers interviewed had a limited understanding of the operation of the NDIS and were not confident in working within the NDIS, impacting on their capacity to ensure that the young people they case managed received the support to which they are entitled.

There is a shortage of disability support providers in the Northern Territory, impacting on the provision of care to young people with disabilities.

During the October visit it was evident that some young people who had NDIS applications approved, and plans finalised were not receiving services due to the small number of service providers operating in the Northern Territory, and the consequent extensive waitlists for many specialist services, particularly occupational and speech therapy.

The number of service providers operating in the Northern Territory, and their capacity to provide services to young people in care is outside the control of Territory Families. However, when case managers do not necessarily have accurate records about which service providers should be working with young people in their care, which service providers are working with those young people, and do not feel confident negotiating the NDIS, it is difficult to be confident that all options have been explored in relation to securing service delivery to young people.
RECOMMENDATIONS

6. Territory Families develop a mechanism to ensure front line staff have the knowledge and skill to effectively case manage children with disability. The mechanism should do the following:

- Assist front line Territory Families staff to identify young people with a disability;
- Assist front line staff so that NDIS plans for young people accurately match their identified need;
- Assist front line staff so that NDIS plans are implemented; Assist front line staff to plan for young people who are leaving care who have an NDIS plan.

7. By 30 June 2020, develop a record keeping system to ensure the accurate and accessible recording of information relating to young people with a disability including:

- Whether a young person has a disability;
- Whether an application for NDIS assistance has been made for the young person and the status of that application;
- The needs of the young person identified in their NDIS plan;
- The service providers identified to meet the needs of the young person; and
- The schedule of proposed service delivery.
LEAVING CARE PLAN

Careful and rigorous planning is critical to ensuring the ongoing wellbeing of young people leaving care. As set out in the South Australian Child Protection Systems Royal Commission:

*Major challenges persist for young people leaving care ... Young people leaving care represent one of society’s most vulnerable and socially excluded groups. By comparison to the general population, care leavers are more likely to suffer disadvantages in several key areas as a consequence of their out of home care experience.* [13]

Section 71 of the Act requires Territory Families to modify a child’s care plan, if the child ‘is about to leave the CEO’s care’. Standard 13 of the National Standards and Territory Families Transition to Independence policy set out that planning for a young person leaving care should begin when the young person turns 15 years old. According to section 71 of the Act, that plan should be reviewed every six months. The leaving care plan must identify the needs of the child and outline measures to be taken to assist the child in meeting those needs. Section 86 of the Act requires the CEO to provide the leaving child with appropriate services and permits the provision of financial assistance for specific purposes.

In addition to the legislative framework, Territory Families have policies and guidelines to assist its staff in planning for young people leaving care, in a manner consistent with Standard 13 of the National Standards. The guidelines provide that the leaving care plan should be developed collaboratively, with ‘the young person, their caseworker, their carer/s, family, partner agencies and people they consider important in their life’.
They also articulate that the young person and planning participants must be given a copy of the leaving care plan.

OCC staff reviewed nine leaving care plans as part of the October visit.

**FINDINGS**

The leaving care plans reviewed during the October visit were not commenced when young people turned 15, as required by standard 13 of the National Standards. As a result, a range of critical tasks for those young people are outstanding.

Of the nine leaving care plans reviewing in the October visit, two included the direct involvement of family and therefore, did not comply with Territory Families Transition to Independence policy.

In 2017, the Royal Commission found that what was required to address inadequate leaving care planning was not law or policy reform, but rather, ‘changes in Territory Families practice and funding to ensure those legal and policy obligations are being consistently met’. [14]

Since then, Territory Families have implemented reform designed to improve leaving care planning practices. The most significant of those reforms is the introduction of a dedicated Transition from Care Officer (TCFO) in each region. Those positions were established in January 2018.
TFCOs are intended to support case managers and young people in the planning and preparation for their transition from care.

The focus of the TFCO role is to provide systemic support and provision of specialist knowledge relating to leaving care processes. Despite the introduction of TCFO’s a review of leaving care plans in the October visit suggested concerns raised in the Royal Commission remain.

The following is a summary of key tasks completed for the nine young people over 15 years old reviewed in the October visit:

- 2 had a bank account
- 8 had a birth certificate
- 7 had a Medicare card
- 1 had proof of Aboriginality (out of a possible 7)
- 1 had a health care card
- 5 had a form of photo identification
- 4 had a tax file number
- 0 had a passport
- 2 had appropriate Centrelink support
- 8 had eligibility assessment or application to NDIS complete
- 1 had an application for housing lodged with Department of Housing. Alternative housing had been secured for one young person
- 0 had an application to Office of Public Guardian completed

The requirement of TF to complete these tasks commence upon a young person reaching fifteen years of age, and are to have been completed upon the young person attaining 18 years of age.

Delays in commencing leaving care planning were apparent across all files reviewed. In addition, there was a lack of collaboration with families to develop plans in which they would be expected to have an ongoing role. Two leaving care plans had been informed by direct family involvement.
8. By 30 June 2020, Territory Families undertake an evaluation of the effectiveness of the Transition from Care Officer roles, including whether the role should be expanded, whether these should be stand-alone positions. Details of this evaluation to be provided to the Office of the Children’s Commissioner by 31 July 2020.
THERAPEUTIC
INTERVENTIONS AND
PROGRAMS

Standard five of the National Standards sets out that children in out-of-home care should have their physical, developmental, psychosocial and mental health needs assessed and attended to in a timely way. Typically, young people are placed in residential care environments because their needs cannot be effectively and safely met in a home-based placement option. Young people in residential care placements will often have complex emotional and behavioural needs. Because of the nature of those needs, residential care models should include therapeutic interventions and programs designed to support young people to transition into a home-based placement.

FINDINGS

The Service Provider has a clear model of therapeutic care.

Service Provider staff are consistently trained in the model of therapeutic care.

Service Provider staff have access to a variety of training and supervision tools to assist them to apply the therapeutic care model on a day to day basis.
THERAPEUTIC INTERVENTIONS AND PROGRAMS

The Service Provider monitored during the October visit has a therapeutic model of care that underpins their work within residential facilities. That model is complemented by a training program, designed to assist staff on a day to day basis to respond to young people in care in a therapeutic manner. That training is delivered on a rolling basis to ensure new staff are trained as quickly as possible.

In addition to the overarching therapeutic framework, the Service Provider provides professional support to its care staff through the operation of its clinical team. The clinical team is responsible for developing and reviewing individualised behaviour support plans for each child living in one of the Service Provider’s homes. Those plans are designed to provide a comprehensive road map for care staff in appropriately, and therapeutically responding to the individual needs and behaviours of each child. The clinical team provides training to the care staff in implementing the behaviour support plans.

Of the 14 children and young people identified through the monitoring process, eight had a behaviour support plan in place completed by the Service Provider. There were six children and young people who did not have such plans in place. Of the eight plans in place, seven were overdue for review and one was current. The Service Provider advised this was largely due to a vacancy in the clinical team.
As well as developing behaviour support plans and training staff in their implementation, the clinical team is responsible for facilitating a series of additional mechanisms designed to increase the capacity of care staff to provide therapeutic care. For example, the clinical team provides supervision, coaching, reflective discussions, monthly case consults and a high risk/high medical needs panel meeting.

During the October visit, therapeutic interventions were reported by staff in interviews, and observed in interactions between staff and young people. Staff generally appeared to be well attuned to the young people’s needs and could talk confidently about their challenging behaviours, and strategies and interventions that they implement to manage these.

**HOME ENVIRONMENT**

During the October visit, the OCC visited each of homes run by the Service Provider. The homes were spacious and had bedrooms for each of the children. A number of the properties had multiple communal areas which supported the staff being able to manage the complex behaviours of the young people, whilst ensuring co-residents could continue to spend time in the communal spaces and out of their bedrooms. A number of the homes had sensory areas where the children could engage in sensory play. The homes were decorated with soft furnishings, and personalised photographs and posters. The homes were maintained to a high standard. There were no concerns in relation to cleanliness or upkeep.
APPENDIX ONE: INDIVIDUAL RECOMMENDATIONS
APPENDIX TWO: REFERENCES


[4] Those individual recommendations are contained in a confidential annexure to this report. They are confidential in order to protect the privacy of the individual children.

[5] All child-identifying information has been removed from this report, to respect the privacy of the young people who participated. As a precaution the name of, and identifying information about the residential care service provider has also been removed.

[6] A third party includes members of the Northern Territory Police, staff from the Department of Health or Department of Education, and interstate child protection counterparts or out of home care providers.

[7] In determining this average, two children were not included. One of those children had only entered care in the past month. One of those children had highly complex needs, had spent the majority of the last year in detention, and was preparing to leave care. Because of those circumstances, his experience of care was largely atypical. He was visited 28 times.

[8] Territory Families can also conduct inquiries, pursuant to section 83B of the Act, where a child’s wellbeing appears to have been impacted, but there is insufficient information to indicate that the child has been, is being or will be harmed or exploited.

[9] Care and Protection of Children Act (2007) NT, s74(1)(a)
APPENDIX TWO: REFERENCES

[10] Care and Protection of Children Act (2007) NT, s74(1)(b)


