PARLIAMENT OF TASMANIA

DEBATES OF THE LEGISLATIVE COUNCIL

MOTIONS

Tasmanian Commissioner for Children and Young People's Monitoring Report No. 2: Key Data on Tasmania's Out-of-Home Care System 2020-22 - Consideration and Noting

[11.36 a.m.]

Ms WEBB (Nelson) - Mr President, I move -

> That the Commissioner for Children and Young People's Monitoring Report No.2 - Key Data on Tasmania's Out-of-Home Care System, 2020-21, be considered and noted.

Mr President, I have put forward this motion to provide an opportunity for our Chamber to discuss an area of significant responsibility for our state Government - the area of child safety and the provision of out-of-home care. As parliamentarians, we also have a role to play as part of the governance system that places the state in the role of parent to over 1000 Tasmanian children. We are all part of the oversight and monitoring of this important responsibility. A core principle of the Strong Families, Safe Kids reform process underway in our child safety system is that there needs to be shared community responsibility for responding to vulnerable families and ensuring support is provided to improve the safety of children and reduce the risk of removal from families. Reflecting on this report this place is one way that parliamentarians can step up and play our part in meeting that principle.

Before making comment on the report, I acknowledge that there are many skilled and dedicated Tasmanians who work in our child safety and out-of-home care systems. This is an extremely challenging area in which to work, and we rely on the professionalism and care that these Tasmanians bring to their work in supporting some of the most vulnerable families and children in our state. I thank them for the work they do, and I believe they require and deserve greater support from the state Government in that work.

Mr President, I will move on to the report. The Commissioner for Children and Young People is tasked with independent, systemic monitoring of Tasmania's out-of-home care system as a key part of oversight of that system. The intent of the Out-of-Home Care Monitoring Program is to improve the accountability and the safety and wellbeing of children in the out-of-home care system. I quote this from the report, page 1:

> Monitoring is important as it contributes to oversight of the Out-of-Home Care system, which in turn improves the accountability of those working within it - from Government Ministers to Government Departments, non-government providers of services, and carers, among others. In turn, accountability ensures that the safety and wellbeing of children in out-of-home care is, and remains, front and centre of everyone's minds. [OK]

The data monitoring is only one element of the commissioner's monitoring role. The commissioner also meets with, and listens to, young people in the out-of-home care system and reports on this through other publications as part of the monitoring cycle. However, today we direct our attention to this monitoring report and its focus on data.

I note the publication of this report was delayed. The report explains this as being due to lengthy delays in the provision of data by the data collection custodian, which was formerly the Department of Communities and is now the Department for Education, Children and Young People (DECYP). There were also lengthy delays in obtaining permission from the data custodian to publish previously unpublished data, and unforeseen issues relating to data quality which took time to resolve. Given these delays and the commitment to increasing transparency, the Commissioner for Children and Young People first published the original edition of this report in March 2023, which covered the 2020-21 period, with the stated intention of updating the report once more data was available. What we have here is the second edition, published in July 2023, which includes data up to the period ending 30 June 2022. Data in the report largely comes from publicly available sources, including the Australian Institute of Health and Welfare (AIHW), which publishes a child protection series, and also from the Productivity Commission, which publishes a child protection services data series. The report also includes previously unpublished data, provided by Communities Tasmania, now Department for Education, Children and Young People, in the form of quarterly children, youth and families reports. These reports are shared with the commissioner through a data-sharing arrangement and can only be published by the commissioner with the permission of the data custodian. I note the comments from the Commissioner for Children and Young People, that despite public interest in the Tasmanian out-of-home care system, 'there is a concerning lack of transparency regarding its operation'. That is on page 4 of the report. The commissioner notes, and I quote:

> While national reporting bodies publish some Tasmanian data, the Out-of-Home Care system remains largely opaque.

This opacity limits effective oversight of that system and the commissioner notes this limitation. She says it 'raises questions about how the Government is meeting its financial and social obligations to care for our most vulnerable children'.

Further, in the second edition, she says:

> I want to emphasise that the data quality issues that I commented on with the release of the first edition, remain.

Throughout the report, in instances where there was limited or no accurate data available, the opportunity to make explanatory comments was provided to the department, and those comments are included in boxes in the report. I must say, though, that in a number of cases I did not find the explanatory comments offered an adequate explanation for the data, or data gaps that were being noted in the report. I will speak more about that at relevant points of my contribution.

However, the commissioner does also acknowledge in the report that the Tasmanian Government has a commitment to greater transparency and accuracy in terms of data relating to our out-of-home care system, as clearly stated n page 1. The commissioner commends the Government for expanding its online data dashboard for the out-of-home care system and comments that she looks forward to learning more how DECYP will implement

evidence-based solutions to improve accuracy in data entry, data revision and review, and data reporting. These solutions are required to ensure that all data are reliable and reflect the experiences of children and young people in the out-of-home care system in Tasmania.

It is worth noting here, too, and outlining briefly, the broader context in which this report has been released by the Commissioner for Children and Young People. As I noted in my opening remarks, Tasmania's out-of-home care system has been undergoing a series of reforms for a number of years now, called the Strong Families Safe Kids project. Activity currently occurring under the Strong Families Safe Kids: Next Step Action Plan 2021-2023 and the Strong Family Safe Kids Next Step Action Plan 2021-2023 Implementation Plan is underway.

As part of those reforms, we also have seen the release of Tasmanian Out-Of-Home Care Standards in August 2022, which is an important element in improving quality within the system and it is good to see that now in place. Currently, I believe, there is in development an out-of-home care accreditation scheme based on those standards and also a carer's register, also important elements. It is surprising that they were not in place previously but pleasing to know that they are being delivered now.

Another important context is the recent departmental change in this space, the creation of a single department for services supporting children and families, that being the Department for Education, Children and Young People, DECYP. We must also note that the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings has been underway for some time and will soon report. Further reforms are anticipated in the area of child safety and out-of-home care as a result of that commission of inquiry. That is an important piece of context for when we are discussing this area of government responsibility.

As a final comment on context, I note that the Commissioner for Children and Young People is also undertaking an own-motion investigation into the introduction of a new approach to case management within the Child Safety Service. That investigation is examining the effect of the change in case management approach on the rights and wellbeing of children and young people in care, and I will make a comment on that later.

Having noted the context in which this report can be considered and discussed, I will move on to some content within the report. For clarity, as it is included in the report on page 8, I will note the national definition of out-of-home care that we have a clear understanding of what it is we are discussing here in terms of the data being reported. This is what it says on page 8 - (ok)

> Out-of-home care is overnight care for children aged under 18 who are unable to live with their families due to child safety concerns. This includes placements approved by the department responsible for child protection for which there is ongoing case management and financial payment (including where financial payment has been offered but has been declined by the carer). Out-of-home care includes legal (court-ordered) and voluntary placements, as well as placements made for the purpose of providing respite for parents and/or carers.
>
> Out-of-home care excludes:

- placements for children on third- party parental responsibility orders
- placements for children on immigration orders
- supported placements for children aged 18 years or over
- pre-adoptive placements and placements for children whose adoptive parents receive ongoing funding due to the support needs of the child
- placements to which child enters and exits on the same day
- placements solely funded by disability services, psychiatric services, specialist homelessness services, juvenile justice facilities, or overnight childcare services
- cases in which a child self-places without approval by the department.

The out-of-home care system does include foster care, relative or kinship care and residential care.

I will now turning to some key data in the report. On 30 June 2022, there were 1028 children in the Tasmanian out-of-home care system. The daily average of children in care in 2021-22 was 1049.4; two-fifths, or 40 per cent, of these children were Aboriginal and Torres Strait Islander children. Tasmania does continue to have a persistent over-representation of Aboriginal and Torres Strait Islander children in its out-of-home care system, five times higher than for non-Aboriginal and Torres Strait Islander children. The rate of 32.2 per 1000 Aboriginal and Torres Strait Islander children are taken into care in this state, compared to 5.9 per 1000 non-Aboriginal and Torres Strait Islander children. While the overall average daily number of children in care in Tasmania in 2021-22 represents a decline of 28.9 children compared to the year before, the percentage of Aboriginal and Torres Strait Islander children remains the same. There was an increase in their over-representation.

Nationally, Tasmania does not rate well. Tasmania continues to have the third highest rate per 1000 children of children in care among all Australian states and territories. This was consistent in 2022 with the year before at 30 June 2021. The Tasmanian rate of 8.9 per 1000 children is higher than the national rate of 8 per 1000 children.

Staying with raw number for the moment, the commissioner notes in the report that from 2018 to 2022 there was a decline in the number of children in care, with the rate per 1000 moving from, for example, 30 June 2021, being 9.4 to 8.4 on 30 June 2022. An explanation is provided and presented in a box on page 11 of this report and it notes this : (ok)

> A gradual reduction in the number of children in out-of-home care was an anticipated outcome of reforms under the Strong Families Safe Kids Project.

It goes on to describe the Social Wellbeing Model in the reforms and the advice and referral line model, which is the new point of entry and first support under the reforms. However, while it is nice to describe these reforms and their models, there is no way the Government is able to claim that the new model is causative to the decline in numbers between 2021 and 2022, as noted in the report by the Commissioner for Children and Young People with this comment: 'Data to support that explanation is not yet available.'

It is a clear statement and worth reflecting on the fact we cannot even say for certain at this time, based on data and information we have available, the reduction of number between 2021 and 2022 is a good outcome.

We are not able to say with confidence based on firm data that fewer children in care is due to more children having their needs met without being removed from their families, or that the number of children whose circumstances warranted being taken into care, has dropped. The reason we cannot say this with confidence is that the data is just not there. For example, in relation to the advice and referral line, the linchpin of the new model, the full suite of data has not yet been made public. That is my understanding. I have to ask, why not? What has prevented us from doing that alongside the development of the new model?

There is much work to be done, especially in relation to the collection and transparency of data, before we are able to make causative statements about the impact of the reforms which have been undertaken. I must say I find it somewhat disturbing that the Government seems keen to rush to do so. It seems reckless, to my mind, to have embarked on a major policy reform process in such a sensitive area, involving Tasmania's most vulnerable children and families, without ensuring that there were well-planned, robust and appropriately detailed data collection and analysis systems in place to measure, monitor and report on the impact and outcomes of that reform as it was undertaken.

In its response to this motion, the Government makes claims that the reforms implemented in the child safety and out-of-home care systems have resulted in fewer children being taken into care. Please, I implore people to keep two things front and centre of mind: firstly, the commissioner's report clearly states that data to support that claim is not yet available. Secondly, we are not even in a position to say with evidence-backed confidence, that the recent decline in numbers in out-of-home care is a positive outcome, because we do not have sufficient data to explain the cause of that decline.

I make note of a positive aspect of data presented in this report, and that is improvements in identification of children in the system who are Aboriginal Tasmanians. Previously, Tasmania had not collected data effectively on the Aboriginal and Torres Strait Islander status of children in this system and that has been problematic. Essentially, this has meant that a high proportion of children in care had their Aboriginal and Torres Strait Islander status marked as unknown. We would all recognise that to address an issue, you first have to understand the extent and the detail of that issue.

However, what we have seen, pleasingly, is that Tasmania has achieved a dramatic decrease in the proportion of children in the system with an unknown status. We have taken a good step forward in at least better understanding the extent of over-representation of Aboriginal and Torres Strait Islander children in our out-of-home care system.

The next, and most important, step is that we have to do the enormous work of effectively reducing that over-representation. In fact, under the 2021 Closing the Gap Agreement the Tasmanian Government has committed to reduce the rate of over-representation of Aboriginal and Torres Strait Islander children in care by 45 per cent by 2031. That is a firm target to be met, and not a very long time frame.

We know that Aboriginal and Torres Strait Islander children are best supported by their community and that Aboriginal communities are best placed to design and deliver effective programs to support families and children within their community. There is the Aboriginal and Torres Strait Islander Child Placement Principle. It is a national principle which provides guidance on best practice in the placement and support of Aboriginal and Torres Strait Islander

children. This principle sets out a hierarchy of preferred placement options for caregivers of Aboriginal and Torres Strait Islander children in care.

It says this(TBC):

> Placement of an Aboriginal or Torres Strait Islander child in out-of-home care is prioritised in the following way.
>
> (1) With Aboriginal or Torres Strait Islander relatives, or extended family members or other relatives or extended family members; or
>
> (2) With Aboriginal or Torres Strait Islander members of the child's community; or
>
> (3) With Aboriginal or Torres Strait Islander family-based carers if the above preferred options are not available. As a last resort, the child may be placed with:
>
> (4) A non-Indigenous carer or in a residential setting. If the child is not placed with their extended Aboriginal or Torres Strait Islander family, the placement must be within close geographic proximity to the child's family.

That is the principle that is laid out in the placement of Aboriginal and Torres Strait Islander children. In the report, it is noted on page 16:

[TBC]

> Additional requirements include that child protection decision-makers exhaust all possible options at one level of the hierarchy before considering a lower order placement. That placement must not occur until there has been a thorough consultation with representatives from the child's family and community to make sure all possible higher order placement options have been considered and regular placement review must also occur.

Unfortunately, as noted here in the report by the commissioner, while we have made improvements in collected data on the Aboriginal and Torres Strait Islander status of children in our system, there is still not adequate available and detailed data about the placement of Aboriginal and Torres Strait Islander children within the system. Because we do not have adequate date on placements, we are unable to determine the extent to which we are following best practice in alignment with the principle that I have just laid out. This is incredibly disappointing and it will clearly be essential to improve our data collection and monitoring of the placement of Aboriginal and Torres Strait Islander children so that the Government can be accountable for improving outcomes for that cohort of children and reducing the over-representation issue that we have in our system.

A comment in the report by DECYP is provided on page 17 in relation to implementing that national standard about placement and meeting the standard of active efforts in relation to that principle. In that comment box, DECYP says that there is work underway to improve data quality. It says that there is work at a national level under a national framework and an action plan for the period 2023-26 which includes targeted actions and activities to address

over-representation of Aboriginal and Torres Strait Islander children in child protection systems.

Further in that explanatory comment from DECYP, it says that the department will work alongside the Tasmanian Aboriginal community to development a jurisdictional plan to implement the principle across the system and will report annually on indicators and implementation progress.

I note that this comment, while laudable and pleasing to hear, unfortunately, also contains little detail about how that is going to be undertaken and what time lines it will be undertaken within. It does not necessarily give us anything to latch onto in terms of accountability and holding the Government or the department to progressing or delivering outcomes under the commitments that are being made.

It is still not clear how the Tasmanian Government proposes to meet the Closing the Gap commitment to a 45 per cent reduction in the rate of over-representation of Aboriginal and Torres Strait Islander children in our system by 2031. This is something we will need to be paying close attention to in coming times.

Looking at other cohorts of vulnerable children or children that would be regarded as particularly vulnerable in the system is data relating to children with a disability. The report notes that there is a lack of detailed data about the care experience of children with a disability in our out-of-home care system. That is primarily because children in the system with a disability are not well identified. National data from the AIHW indicates that at least one in five children living in care in Tasmania has a stated disability. The figure is at 22 per cent at 30 June 2022 - one in five. The true extent remains unknown because it is acknowledged that the data quality is poor. The report notes this:

[TBC]

> It is likely that the proportion of children in care in Tasmania with a disability is greater than 22 per cent as the disability status of more than one-third of children in care, 35.9 per cent, is recorded as not stated. This not stated group has only increased slightly from the period of 2020-21.

It was up 4 per cent across those years. It sounds like we are in a somewhat similar situation to the one that had recently been improved upon in relation to Aboriginal and Torres Strait Islander children in care, and that is that we are simply not effectively and reliably collecting information on the disability status of children in the state's care. A further complicating factor of this is that disability in not well defined nationally, which means any useful comparison beyond simple observation is limited and we are still struggling to have data that is of a sufficient quality to be reliably commented on.

I think we would all agree that accountability does require accurate and detailed data as a starting point. Essentially, we need to understand the vulnerability of children in our system so we can provide appropriate and effective care and support. Certainly, when it comes to disability this is absolutely essential.

I will not be commenting in detail on all aspects of the data presented in this report. I note that information is presented on the number of children admitted and discharged from care, the length of time children spend in care and the placement types of children in care, which I am not going to go into in great detail. There are a few particular areas dealt with in the report that

I will comment on in more detail. Those areas relate to: case management, particularly aspects that relate to care plans and visits; investment by Government in this system; and foster carer numbers.

Mr President, important data presented in the report relates to foster carers in our out-of-home care system. Foster care is the largest proportion of placement types in our out-of-home care system, at 52 per cent. Kinship care, which is also family-based care in a private home, is 42 per cent. The two of them total 94 per cent of placements. Foster care is provided through services managed by the department and through a mix of 13 non-government providers, both for-profit and not-for-profit organisations. By far the largest provider of foster care services is the department, which represents 68.8 per cent of foster care placements in 2021-22. So, the department is both the owner of the Tasmanian out-of-home care system and the largest provider of foster care services under it.

The report tells us that there are 248 active foster carer households, with current foster care or respite care placements in 2021-22. The report also tells us that this represents a decline in foster carer numbers. There are 14 fewer active foster care households in 2021-22, compared to the previous year. This is concerning, because foster care is the substantial backbone of our out-of-home care system. It is the most common placement type, and any decline in foster carer numbers affects the ability of our system to provide the support needed. It is important for us to ask, what do we know about this decline?

The commission of inquiry hearings last year featured evidence relating to foster carers. There is a lot of discussion about elements in our system where there may be vulnerabilities for children. It concerns me that perhaps there has been an impact on recruitment of foster carers as a result of context, like the commission of inquiry. Perhaps the Government has stopped recruiting from the time that became a matter of discussion, as a part of the commission of inquiry. It would be interesting to have the Government confirm whether we are actively recruiting foster carers now, and what has been done to do that active recruitment. Are we to understand that perhaps fewer people would be inclined or interested to become foster carers and that might be contributing to a decline in numbers?

My understanding is that non-government agencies providing foster care set quite high standards around foster caring and they do reject, or exit, foster carers from their service system at times who do not meet those standards. I am not sure that the same standards are applied within the departmental context which, as I mentioned before, is the largest provider of foster care. I am not sure about the movement of foster carers between non-government agencies and government-provided foster care services and where we sit with consistent standards there. As the backbone of our out-of-home care system, any decline in foster care numbers is concerning and probably deserves a clearer public explanation.

Another area of concern in this report relates to case management of children in our out-of-home care system. Case management services for all children in care, whether they are placed in a government or non-government service, are undertaken through the Child Safety Service. This includes a requirement to have individualised care plans for each child, and mandated visits for children in care. There are national indicators for case and care planning, which the report notes:

> Due to the implementation of the new Care Team model, accurate data about the numbers of children in care for whom individualised care planning has

> taken place, and the numbers of children who have been visited within appropriate timeframes, remains unavailable. [CHECKED - page 5 of report]

The commissioner says 'this must be urgently addressed'. [CHECKED page 5 of report]

I believe we would all agree that this is a fundamental aspect of accountability when it comes to the out-of-home care system, and I will focus on the data presented in the report relating to both case and care plans and to mandated visits.

The report presents information about case and care plans and it outlines Standard 4 of the National Standards for Out-of-Home Care and the requirement that -

> Each child and young person has an individualised plan that details their health, education and other needs … An individualised plan is essential to provide a child, or young person, with the opportunity to be actively involved in decision making about their lives. [CHECKED page 22 of report]

Standard 2 of the National Standards requires that '[c]hildren and young people participate in decisions that have an impact on their lives'. [CHECKED page 22 of report]

The report tells us then that for the period 2021-22, 47.7 per cent of children in care did not have a current case and care plan which had been approved in the 12 months previously. That number has increased by 1.7 per cent since the year before. That is coming close to half the children in care not having a current case and care plan which has been approved in the previous 12 months.

In presenting this already alarming number in the report, the commissioner notes, and I quote from page 22:

> However, due to the implementation of a new model of care, these data are not a reliable indicator for individualised planning for children and young people in care. At the time of publication, accurate data about individualised planning for children and young people under the new model remain unavailable. [OK]

Plainly, we do not know what percentage of children in out-of-home care have a case and care plan in line with national indicators, and that is simply not good enough. The explanation provided by DECYP and included in the report on page 22 expresses a commitment from the Child Safety Service to 'improving child-centred case coordination by developing a Care Team for every child and young person in out-of-home care'. [OK]

Commitments to improving are all well and good, but such statements are vague and tell us nothing concrete about what will be done, and to what standard, and when it will be fully implemented and reliably occurring. DECYP notes that

> A Care Plan is one output of a Care Team; and taken alone, should not be considered a sound proxy indicator for quality case planning and decision-making processes for children. [OK page 22 of report]

However, care plans feature as a national indicator, and it is one area that we are dramatically failing to meet in terms of those indicators. If this indicator alone is not sufficient to reassure us of the quality of case planning and decision-making, what measures or indicators is the department using to demonstrate those outcomes? The DECYP explanatory comment goes on to say:

> This commitment to Care Teams is through a genuine intent to ensure that every child and young person has a network of people who know and care about them, who are continuously and actively helping them to achieve their goals.
>
> This fundamental practice shift has progressed ahead of the capability of the information system to guide and capture this important activity in a way that can be accurately and meaningfully reported and monitored.
>
> The Child Protection Information System is being incrementally upgraded under an Integrated Client Information Program. System upgrades to better support the Care Team process are a clear priority. [OK report page 22]

Frankly, this is an astonishing comment. We are talking about one of the most sensitive responsibilities of a state government, when the state has decided to step in and remove a child from their family and take parental responsibility for that child. In that comment, the department is essentially saying: we are trying out a new way of working, we are really well-intentioned in that and we are trying to achieve best outcomes but we have pushed ahead with it before we had anything in place to tell us what impact it is having, how well it is working and whether it is achieving the outcomes that we want.

The department says that the reform changes which are currently partially implemented - noting it is also not clear to what extent they are implemented - cannot be accurately or meaningfully monitored and reported on at this point in time. Absolutely astonishing. These are our most vulnerable Tasmanian children, and we are not able to say accurately or meaningfully how well their care is being managed and whether it is delivering the outcomes for which the state, now in the role of their parent, is responsible.

In the DCEYP comment provided in the report there is no clarity on time frames for having the information system capability catch up to the changes already made, and no indication of when this apparent priority, yet incremental, upgrading of the information system will be completed. I presume that out of the public eye, the commissioner is asking these hard questions of the department. Perhaps this highly concerning situation was a trigger for the commissioner's own-motion investigation into the introduction of the new approach to case management which is currently in progress by the Child Safety Service.

While the commissioner's oversight role is crucial here and the results of her own-motion investigation would be important to assist in holding the Government accountable for its responsibilities in the area of child safety and out- of-home care, we cannot lose sight of our own responsibilities in this place to exercise scrutiny and hold government to account also.

Mr President, another key aspect of case management for all children and young people in care are the regular visits that are mandated for each child in care, and I quote this description from the report: (ok)

> Child safety officers have responsibility for case management for children in care. Communities Tasmania's policy states that, as part of their child management responsibilities, Child Safety Officers are to visit each child in care at least once in every 1-week, 4-week or 6-week period, depending on the type of child protection order to which the child is subject
>
> Visits by Child Safety Officers are essential for a range of reasons, including critically, to ensure that the child is safe, that they have access to the services and supports they need to stay well and that they are listened to and have a say in decisions that affect them.

That is quoted from page 23 of the report. The report then presents data available on visits that have been conducted. It says this: (ok)

> In 2020-2021, more than half (56.2%) of visits were conducted within required timeframes, while in 2021-2022, less than half (47,1%) of visits were conducted; this represents a fall of 9.1 per cent … While these data do not reflect the practice shift to Care Teams described in the below DECYP Comment, at the time of publication, there was no other data available to show visits to children and young people on orders …

I do note, Mr President, that there is another explanatory comment here, from DECYP to contextualise this observation that we are now looking at less than half cases visits being conducted as per standard.

> The DECYP explanatory comment says this: (ok)
>
> The Care Team approach is premised on the principle on that children do better when they are surrounded by a community of people who care about them and support them.
>
> Child Safety Officers are part of that community of support, but must work side by side with other people who know and care about the child who are critical to providing long-term and sustainable relationships and the relational safety that comes with this.
>
> Care Teams enable children to nominate people who are important to them and who they trust to support them. The Child Safety Service has begun to focus on purposefully expanding sustainable networks for children, and inviting those people to play their part in the Care Team.
>
> This doesn't remove the responsibility of Child Safety Officers to know children in care and monitor their safety, but seeks to create a more natural, consistent and meaningful support system for each child.
>
> The Child Safety Services committed to engaging well with children and young people in out-of-home care and improving the rate of child visits as well as the frequency of other forms of direct communication.

That all sounds lovely, but it does not tell us who is visiting these children to meet the mandatory requirements, why that is not being adequately recorded and reported, and when we can expect the monitoring and reporting system to catch up with the reforms being progressed in their absence. It also does not make clear where the fundamental responsibility lies for ensuring a visit takes place - where does the buck stop? It is my understanding that previously, before changes were made to shift to the care team model, the expectations were that visits were conducted by child support officers within the child safety system. They were to physically site and visit a child within the mandated time frames. Now, as I understand it, these visits may be conducted by anyone in the care team assembled around that child. That could be a support worker, a teacher, a foster carer or one of these other people identified as part of a community of support around the child. To me, this raises a whole raft of questions. Remembering that the visit is, and I quote: [TBC]

> … essential for a range of reasons, including critically to ensure that the child is safe, that they have access to services and supports they need to stay well and that they are listened to and have a say in decisions that affect them.

That prompts me to ask, are all members of a child's care team trained to undertake that role and that task if they are to be the ones who conduct these visits? To ensure the child is safe is a critical, fundamental responsibility. Are all care team members assembled around a child trained, as child safety officers certainly are, to identify signs of abuse, for example? What if the care team member who is conducting the mandated visit is a person who presents a risk of abuse to that child? How is the critical purpose of monitoring the safety of each child met by the mandated visit in that instance?

I also wonder who decides now when visits are to occur. Who allocates the task if it is to be undertaken by a care team member other than a child safety officer? Who records the details of the visit in an accountable way? Many questions and not enough clarity.

Let me be very clear, I have no doubt there is great benefit to drawing together a community of support around a child who has been removed from their family and is in our out-of-home care system. I can see great benefit from a coordinated, relational-based support system being created and nurtured around each child in our system. What is not clear to me in regards to the reforms on foot is the degree to which this means shifting the fundamental parental responsibility of the state via the child safety system for those children removed from their families and pointing key elements of that responsibility onto others in the community. That appears too opaque.

It would seem from this report we do not have an appropriately designed robust and accurate monitoring and reporting system in place for the model we are charging ahead to implement. Here are a few simple questions we should have a readily available answer to. How many children in the out-of-home care system have a care team? Who is responsible for ensuring that a child in out-of-home care has a care plan? Who is responsible for ensuring that a child in out-of-home care is being visited as per the mandatory requirement? Who is responsible for ensuring a care team meets regularly? Who is responsible for documenting and reporting on those activities of the care team? How can a government justify progressing a reform agenda in an area of supreme sensitivity such as child safety? There is no way of assessing its effectiveness or accurately demonstrating accountability.

My concern is in implementing a model based on the acknowledgement we are all responsible for child protection, that child safety is a community responsibility. We must be careful we do not leave accountability to no-one. Fundamental responsibility for these children still has to lie somewhere and that should be the state.

The final area I want to touch on in noting this report is that of funding for the Tasmanian out-of-home care system by Government. The report notes that expenditure data peaked in 2018-19 and has fallen off since then. It says this on page 24: (ok)

> Over the last 10 years there has been an overall upwards trend in the amount that the Tasmanian Government invests in care services.

That is on figure 7.

> However, since a peak in 2018-2019, Government investment, as measured by real recurrent expenditure across both residential and non-residential out-of-home care services, has declines by 18.9 million or 19.6 per cent.

That decline is very clear if we look at figure 7 on page 24 of the report. Also, beyond that raw recurrent expenditure amount, the other way to measure the level of government investment is by the unit cost of care which is how much the Government is spending per placement. In relation to that data, the report notes this: (tbc)

> For 2021-2022, a total of 465 183 placement nights in care were provided by the Tasmanian Government at a cost of $167.87 per night. This is the lowest amount spent on placement nights since 2016-2017. As the Productivity Commission notes, while decreasing investment per placement night may suggest improved service efficiencies, it can also indicate lower quality services.

At best, on both of those measures it seems clear investment peaked in 2018-19 and has subsequently been reduced. That requires a detailed explanation from the Government so it is clear what has changed across that period of time. We need to be able to understand whether the Tasmanian Government investment in the out-of-home care system is falling and, if so, why.

I note, when the commissioner released this report on 12 July 2023, the minister also put out a media statement in relation to it. I will quote one statement from that. The minister said:

> It is clear our reforms are working with the number of children in out-of-home care decreasing', Minister Jaensch said.

This is not a statement that withstands scrutiny. Naturally, we would all agree that we want to see fewer children entering the out of-home care system, fewer children removed from their families. However, that reduction must be derived from successfully supporting families who are vulnerable and providing sufficient effective support so that family environments are safe to ensure children who may otherwise have been removed are able to stay with their family.

To know whether we are achieving positive progress on this, we cannot just look at a raw decrease in out-of-home care numbers and claim success. Of course, we would primarily have to look at the level of need in the community for this kind of support for families, and the degree to which our service system is meeting that identified need. We would have to have a way of assuring ourselves that in all instances in which a child who is unsafe in their home to the extent that warrants removal, is responded to by our system and at this point there is no data or evidence-base available for scrutiny by the commissioner, by this parliament or by the public which demonstrates that this is what has occurred as a result of the reforms in progress. That is because there has not been an appropriate system designed and implemented in a timely fashion to monitor, measure and report on the impacts and outcomes of the reforms in progress.

Correlation does not equal causation. It is something we have to bear in mind here and it is my understanding that our family support service systems are significantly under pressure at this time and all programs in those systems are oversubscribed. Need is there and full need is not being met. I am speaking about programs such as the Integrated Family Support Service, the Intensive Family Engagement Service, ICE, supports for children and young people through programs such as the Targeted Youth Support Service, the TIS program and the Supported Youth Program, SYP. Of course, there are others.

It is the adequacy and success of programs such as those in our family support system that will ultimately drive down the numbers of children entering out-of-home care. We need to be able to demonstrate both their adequacy in meeting demand and their success in delivering the desired outcomes for families to be able to then comment overall on what is causing a successful reduction in numbers in our out-of-home care system. It is not clear to me that we can accurately and comprehensively do that at this time.

I note that the minister's media release from 12 July also said this:
[TBC]

> Costs associated with out of home care vary year-on-year depending on the number of children requiring care and the intensity of the care they need. There has been no reduction in program funding.

Reading between the lines here, it may be that what the minister is suggesting is that there was an increased intensity of need in, say, the 2018-19 financial year, requiring increased funding at that period of time and the intensity of need perhaps has subsequently declined. That may be what is suggested to explain the drop in expenditure of $18.8 million or 19.6 per cent between 2018-19 and 2021-22. If I could make an informed guess, I would wonder whether there was an increase perhaps in special care packages that peaked in 2018-19 and that maybe is now decreasing. That would explain potentially a reduction in funding, both as overall expenditure and measured as per placement nights in care.

Special care packages are for kids with complex needs. If in fact the drop in expenditure is explained by a drop in special care packages for example, what would have caused the drop in the need for special care packages in the last couple of years? It is not clear to me that there would have been a drop in complexity or a drop in need. Decoding the minister's statement, if there has been no decrease in program funding, as he claims, yet expenditure has gone down and he mentions intensity of need as the variable factor in expenditure, it seems to imply that intensity of need has decreased. However, it would be my understanding that complexity of need in this cohort of children is increasing, not decreasing. I believe this requires significant further explanation from the Government.

Are we funding fewer special care packages for example in our out-of-home care system compared to 2018-19? If so, is this because need has dropped or because of other factors? I do know that providers potentially are less available to deliver those special care packages. They are challenging to provide. They are expensive and they are difficult to staff. Complexity is expensive so a drop in expenditure at a time when I do not believe we would expect a drop in complexity is puzzling. If complexity is not decreasing in the cohort of children in our out-of-home care system, then questions need to be raised about the impact of decreasing expenditure on the wellbeing of children in that system. In the report, the commissioner raises concerns about access to services statewide, noting this on page 5:

[TBC]

> It is also essential during the implementation of the new care team model that every effort is made to ensure that all children in care, no matter where they live in Tasmania, have access to the same level of service.

Clearly, the commissioner is concerned that this is perhaps not currently the case, or at least cannot be shown to be the case in the data available. While we would all recognise the difficulty in Tasmania, with its decentralised population and its regional communities in delivering consistent quality services to all citizens statewide, in this area of child safety and out-of-home care the sensitivity is so high and the impact of poor-quality services and support is of such consequence that concerns raised, such as those by the commissioner in this report, cannot be ignored.

To conclude my comments on the report, I echo the acknowledgement that is made by the Commissioner for Children and Young People in her foreword, that these data -

> … do not tell us enough about the richness and complexity of the lives of children and young people who are in care in Tasmania. We cannot know or understand children and young people's experiences in care unless we ask them and listen to what they have to say.

I know that the commissioner is actively engaged in that direct listening to the voices and experiences of children and young people in our child safety and out-of-home care systems and I am mindful that we, as parliamentarians, are also part of the governance system that is legally responsible for caring for more than 1000 Tasmanian children. I encourage a commitment from all my colleagues here to also actively engage in listening to those voices and experiences, noting the concerning messages in the data presented in this monitoring report from the Commissioner for Children and Young People, the need to be informed and engaged is clear and present for all of us.

[…]

[3.01 p.m.]

Ms WEBB (Nelson) - Mr President, I thank those members who have made contributions on the motion. I very much appreciate that and it was really pleasing to have some extra reflections brought into the discussion. I will pick up on a couple of things to note briefly, in summary.

It is very positive to hear from the Government, through the contribution today, of that clear commitment expressed regularly on improving data quality and continuous improvement within this system. I do not doubt the genuine intent there.

I also do not resile from the comments I have made in the contribution today that we have charged ahead with reform without having an equally robust way of measuring and monitoring what we are doing and being able to demonstrate accountability. I look forward to that improving in line with the Government's genuinely expressed intent.

I do note that some ARL data, the advice and referral data, has been published in June. I did say there was not a full suite of data. I still do not believe it is a full suite of what we should be having visibility of there. Thank you for the clarification that there is some availability there.

I was disappointed not to hear comment in the Government's contribution on anything to do with Aboriginal Tasmanian children involved in the system and our Closing the Gap target commitment, nor anything about how we are purposefully moving towards meeting that target. That is a clear and fairly shameful area in terms of our performance and we need to be upfront in how we are better working towards meeting the target of Closing the Gap.

Thank you to the member for Rumney for her contribution. It was really thoughtful and added a lot to our discussion today. I appreciate and echo the sentiments expressed by the member for Rumney on those who work in the Child Safety Service area, foster carers and the work that they do. To have it put very plainly by the member for Rumney that services are at breaking point is important. The member is correct in talking about the limitations in speaking publicly about this if this is an area you work in and experience on a day-to-day basis. We are able, at least, to give some visibility to that area that those who are working in are not able to themselves.

Another very clear comment I appreciated in the member for Rumney's contribution was in relation to foster carers. The comment she made that we are losing good people really goes to the heart of it. We cannot afford to lose good people who are foster carers in our system. Clearly, the support needs to be improved to ensure that is not happening.

I thank the member for McIntyre for her contribution. They were really worthwhile observations you picked up, member for McIntyre, as did the member for Rumney, on that crossover we see. They are often referred to as crossover kids. Those are the kids that appear in our child safety and out-of-home care system, also our youth justice system and often, typically, in our homelessness system. There really is an axis there. In some ways, because of that known crossover, investment into this area is in fact cross-subsidisation. It is cross-subsidisation into our education, health and mental health systems, and our youth justice system, to improve outcomes there. You know this is not just investing in one area, this is a foundational cross-subsidisation of a whole range of areas that mean the greater investment is so worthwhile.

The member for McIntyre made note of older children between the ages of 10 and 17 being discharged from the system. Your point, member for McIntyre, made me reflect about children exiting the out-of-home care system between 10 and 17. That is a fairly sensitive time when children's behaviour can be quite challenging in foster care households. Yet, we also recognise it is a time when they really need support around them and a care environment, to

the extent that we put in place what was initially called the Home Stretch Campaign, where we would actually extend care in foster care beyond 18, recognising we all do not throw our kids out the door at 18 if they are in our home environment, but often are supported through beyond the age of 18. The Government, to its credit, and it was Mr Jaensch who did it, was the first state in Australia to adopt the Home Stretch Campaign call to extend some form care past 18 into those years of early adulthood for children in the out-of-home care system. That was a good initial commitment to look at doing that. When you spoke about it, member for McIntyre, it made me wonder where that is up to. It is something we can put further questions to the Government in another context. I wonder if we have continued our very positive early commitment to that concept and principle and whether we are expanding it. If there is - as you pointed out from this report - an increase in children being discharged from our out-of-home care system between the ages of 10 and 17 before extension of care is occurring, it could be a matter for concern.

Ms Rattray - We would like to think they have gone back to a stable home environment, but we do not know that now.

Ms WEBB - We do not know that. In that age bracket, many children do like to return to their family of origin and it is a choice for them to do that. In some cases, hopefully that is safe to do and a positive thing to return to their family of origin if it is a safe environment to return to. We would hope that is the explanation.

I do note, just to clarify for the member in terms of foster care services, the vast bulk of foster care is managed directly by the department. The report tells us 68.8 per cent - over two-thirds - are directly managed by the department. Those non-government service providers that are a mix of not-for-profit and for-profit organisations make up the rest. About 6 per cent of placements are in residential care, not foster care. It is an interesting system. I will reiterate that Tasmanian Government is both the owner of the child safety and out-of-home care system, and also the largest service provider providing and managing foster care.

Thank you to members for their contributions. It has been an important opportunity to discuss this really sensitive and critical service in our state. I will reiterate, to close, we have a role to play here of oversight and scrutiny. The state is taking responsibility for these children when they are removed from their families within this system and we are part of the governance of that. Thank you for stepping into that area and role today. I appreciate the contributions made.

Report noted and considered.