Anglicare Sydney
Questions on notice

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The Honourable Daniel Mookhey asked: *"In general, how long should the window for restoration be open?"*

I agree with the Safe Home for Life guidelines, referred to by Ms Hastings, and which I can confirm are as follows:

"Timeframes for restorative decisions

From 29 October 2014, the Children's Court must decide if it accepts FACS assessment of whether or not there is a realistic possibility of a child or young person being restored to their family within a certain timeframe: • for a child less than two years of age – within six months from the time an interim care order is made by the court allocating parental responsibility to a person other than a parent • for a child or young person two years of age and older – within 12 months from the time an interim care order is made by the court allocating parental responsibility to a person other than a parent.

These timeframes guide when a decision about restoration should be made, it is not the time frame in which restoration should occur. The court has the power to extend the timeframe when it is in the best interests of the child or young person." (Safe Home for Life, Permanent Placement Decisions Fact Sheet, FACS October 2014
http://www.facs.nsw.gov.au/__data/assets/file/0018/302472/3355_FACS-_SafeHomeForLife_PermPlacePrinciples.pdf

Page 65 of the transcript

The Honourable Daniel Mookhey asked: *"Are you able to provide us with the figure of the proportion of people in your care who are Indigenous? We have heard a lot of views, particularly from Indigenous people we had the opportunity of hearing from earlier, as to whether or not the sector is attuned to their needs. Either now or on notice do you have any statement about what you are doing in that space? Any evaluation that you are doing or any views that you have would be most welcome."*

Currently there are 152 children in our foster care program. Thirteen of these children are Indigenous. One child is in short term care and the other 12 are in permanent care. Of the foster carers one identifies as Aboriginal.

I have attached the section on our Indigenous case management from our case managers' handbook for your information.

Page 66 of the transcript

The Honourable Paul Green stated: *"We were talking about the transition from care after a person turns 18 and up to the age of 25. I note that it was in your submission. Is*

there anywhere that you have seen that they do that really well across the nation or the globe? If so please take the question on notice, in the light of the time."

Please refer to attachments, which include:

Ohio Fostering Connections December 2014 http://www.ohiofosteringconnections.org/
A Step Up for Our Kids (ACT Government October 2014)
Raising Our Children, Guiding Young Victorians in Care into Adulthood, (Anglicare Victoria April 2016)

I note that FACS are intending to increase funding for leaving care planning and requirements, but not to increase the age of leaving care/expiry of court order. While more funding is welcome I think the disadvantage for care leavers from the residential care system will remain, especially in relation to housing.

Jackie Palmer

12 September 2016

Family & Community Services

Safe Home for Life

Permanent placement principles

Children need stability to fulfil their potential. The safety, welfare and wellbeing of children and young people is improved by giving them a long-term, nurturing, stable and secure environment. From 29 October 2014, the *Children and Young Persons (Care and Protection) Act 1998* recognises this.

The changes to the legislation set out guiding principles for the permanent placement of a child or young person and the timeframes in which the Children's Court must make its decision about restoration.

The order of preference for the permanent placement of a child or young person is:

- family preservation or restoration
- guardianship
- open adoption (for non-Aboriginal children)
- parental responsibility to the Minister.

Preservation or restoration to family is always the preferred outcome if it can be safely achieved. When this is not viable, other placement options may be explored. Parental responsibility to the Minister is the least preferred placement arrangement for non-Aboriginal children.

The ordering of the permanent placement principles provides a guide for both casework decision making and the Children's Court. The Department of Family and Community Services (FACS) is required to demonstrate to the court that it has thoroughly examined each of the preferred placement arrangements in the order set out above.

Aboriginal children and young people

Adoption is not usually considered suitable for Aboriginal children, however legislation allows for the adoption of Aboriginal children as a final preference following parental responsibility to the Minister. Importantly, the Aboriginal and Torres Strait Islander Child Placement Principles continue to apply. Where restoration to their family is not considered possible and an Aboriginal child is unable to live with relatives or kin, a placement with a non-related person in the Aboriginal community or another suitable person may be considered in line with the child's best interests and in consultation with the Aboriginal community.

Timeframes for restorative decisions

From 29 October 2014, the Children's Court must decide if it accepts FACS assessment of whether or not there is a realistic possibility of a child or young person being restored to their family within a certain timeframe:

- for a child less than two years of age – within six months from the time an interim care order is made by the court allocating parental responsibility to a person other than a parent
- for a child or young person two years of age and older – within 12 months from the time an interim care order is made by the court allocating parental responsibility to a person other than a parent.

These timeframes guide when a decision about restoration should be made, it is not the timeframe in which restoration should occur. The court has the power to extend the timeframe when it is in the best interests of the child or young person.

Why do we need these changes?

Research demonstrates that children and young people develop their identity, values and cultural awareness when they live in a stable environment. A stable environment provides continuity of relationships in family, school and other settings and promotes attachment to caregivers. In most cases this should be with their family.

Relationships developed in infancy play a critical role in emotional and behavioural stability later in life. The changes regarding permanent placement aim to ensure at-risk infants have at least one secure relationship in this critical stage of development.

What it means in practice

Caseworkers, legal and judicial officers, and other practitioners need to think differently about permanent placement in order to apply the principles. The most significant shift in thinking will be the preference given to open adoption as a permanent placement option over placement in out-of-home care (except in the case of Aboriginal children).

The Children's Court may make a shorter order allocating parental responsibility to the Minister (or other suitable person) as a way to achieve permanent placement for a child in the long term. The court still has the power to make a range of parental responsibility orders it considers to be in the best interests of the child or young person.

The Children's Court also now needs to have all relevant evidence available (and if necessary, tested through cross examination at a hearing) before the time specified in the Act so that it can either accept or reject the FACS assessment of restoration. This has a direct impact on how long FACS has to prepare evidence and settle on a care plan to put before the court.

Further information

Visit the FACS website: www.facs.nsw.gov.au/safehomeforlife

3355. FACS 281014_Permanent placement principles

2.11 ABORIGINAL AND TORRES STRAIT ISLANDER CHILDREN AND YOUNG PEOPLE s 4,5

Anglicare is informed of the placement principles in the *Children and Young Persons (Care and Protection) Act 1998* for people from Aboriginal or Torres Strait Islander backgrounds. A preferred placement is with a member of their extended family or the kinship group to which the child or young person belongs. If a child or young person is placed with non-Aboriginal carers for more than a short duration, a cultural plan will be developed to promote opportunity for continued contact with their community and culture.

If FACS have explored all options with Aboriginal care providers and no Aboriginal carers are available, Anglicare may place a child with non Aboriginal carers. However it is important that the child or young person does not lose connection with their family, community and culture, so Anglicare will assist non Aboriginal carers caring for Aboriginal children or young people by gathering as much information as possible about the community they come from, and assisting connections with family, community and culture.

SNAICC http://www.snaicc.asn.au/policy/default.cfm?loadref=36 describes good practice as follows:
Where child removal is necessary:

developing a detailed profile of the child with details such as his or her extended family, health, education and language group based on information from relevant Aboriginal community based agencies

ensure that Aboriginal children that needed to be removed from home remain connected to their family, community and culture to the maximum extent possible.

Aboriginal placement principles according to legislation

The placement of an Aboriginal child or young person into out-of-home care will be done in accordance with the Aboriginal placement principles, with placement into a non-Aboriginal long term placement being a last resort. This procedure will be documented on the child's file. Principles of self-determination and participation in decision-making will be upheld.

When a child is referred to Anglicare, the agency will collect information in regards to the child's needs and the suitability of the referral. This includes the completion of the intake form, information gathered by FACS, pre-placement information form emphasising ethnicity and cultural aspects and needs, and appropriate matching processes. Should Anglicare assess that the agency cannot meet the needs of a specific Aboriginal child the referral will not be accepted.

The placement priority used by Family & Community Services when seeking placements for a child or young person from an Aboriginal or Torres Strait Islander community is:

A member of their extended family or kinship group.

A member of the Aboriginal or Torres Strait Islander community to which they belong.

Another Aboriginal or Torres Strait Islander family residing in the vicinity of their usual place of residence.

A suitable person approved by the Secretary (previously Director-General) of FACS, after consultation with the extended family or kinship group and Aboriginal or Torres Strait Islander welfare organisations.

Their identification with an Aboriginal or Torres Strait Islander group and expressed wishes are factors to be taken into account.

Aboriginal Consultation panel at FACS, along with Aboriginal community groups or elders may be given the opportunity to participate in significant decisions about a child or young person in care. Participation also means that Aboriginal community groups or elders will be given information on how the information that they provide will be used and kept (eg. minutes of the meeting to be sent to them.)

When an Aboriginal child is to be reunified with their family, appropriate Aboriginal support will be given to the child or young person and their family in order to ensure that restoration is successful. This should include contact visits with the family, the participation of the child or young person, the Aboriginal parents, Aboriginal elders and community. Liaison with FACS to ensure culturally appropriate services are utilised with families will also be available. Regular feedback will be given to the family in regards to decisions; children will also be involved in making decisions. Children will be encouraged and supported to attend cultural or spiritual/religious activities with their family.

Non-Aboriginal placements

Where a child is not placed with Aboriginal carers, extended family, kinship group or community to which the child/ young person belongs, Anglicare will ensure that a relevant cultural care plan is developed and reviewed, and that arrangements are made for the child/ young person to have continuing contact with his or her Aboriginal community and culture where possible.

When an Anglicare carer accepts the placement of an Aboriginal child, they will be given appropriate cultural awareness training. Carers will be given support to access resources to meet the cultural plan needs, and information regarding the principle of Aboriginal self-determination, especially with regard to its impact on care responsibilities.

Staff will be provided with training on Aboriginal Cultural Awareness, placement principles and cultural care plans.

Developing cultural plans

Cultural plans can be incorporated into the child's case plan with input, where possible, from the Aboriginal community as part of the process. The role of carers and case managers is to implement and advocate for these plans and make necessary connections to the Aboriginal community.

The type of information that would be included in cultural plans includes:

Child's personal details

Child's family, country, language group

The level of cultural understanding that the child may have

Identifying who in the child's family can assist in maintaining connections for the child

Genogram or family tree for up to 3 generations on both sides of the family

Significant cultural events and activities the child could attend.

A template for cultural plans is available at: http://www.cyf.vic.gov.au/__data/assets/pdf_file/0013/16402/cultural_support_plan_form.pdf

A summary of cultural identity information is to be placed on file and updated each year. See R drive: templates for casework: ATSI + CALD

Identity records

All records pertaining to Aboriginal or Torres Strait Islander children and young people will be maintained and permanently kept. Records may show some of the following

The ages, names and locations of close family relations or friends.

The totem of the child or young person.

The Aboriginal group to which the child or young person belongs.

The land to which the child or young person belongs.

Family names, which may bear some significance to the child or young person.

The Aboriginal child/young person will be given access to these records upon leaving care. Information in regards to family history, culture and linguistic background will be collected upon intake of an Aboriginal child and young person. This information will be shared with the child if they are agreeable. If the child does not want access to this information while they are in care, the information will be kept on file permanently. This information will be made available to the child upon request.

Practical ways of promoting aboriginal culture & identity with children

Interact and participate with the Aboriginal community & events, art exhibitions, concerts

Promote Aboriginal role models in sport, arts, community leaders

Collect Aboriginal pictures and articles, watch documentaries and discuss with child/ young person

Listen to Aboriginal music

Learn some meanings of Aboriginal place names.
See http://www.dnathan.com/VL/austLang.htm

Encourage the child's school to celebrate NAIDOC week

Visit the child's land or country and arrange to meet local Aboriginal community members

Encourage the child to use traditional Aboriginal designs in their work

Do Aboriginal focussed art and craft activities

Subscribe to magazines

Buy art works to display in the home

Display regional Aboriginal map of Australia – available from

http://www.aiatsis.gov.au/aboriginal_studies_press/aboriginal_wall_map/map_page

See www.abc.net.au/Indigenous for the latest Indigenous news, television programs and more

Aboriginal cultural resources

Information and resources for cultural care plans and life story work:

- AbSec Aboriginal Consultation Guide http://www.absec.org.au/publications/aboriginal-consultation-guide.html
- SNAICC - http://www.snaicc.org.au/
- Reconciliation Australia https://www.reconciliation.org.au/
- Link-up NSW Aboriginal Corporation http://www.linkupnsw.org.au/
- Working with Aboriginal Communities
  FACS http://www.community.nsw.gov.au/docswr/_assets/main/documents/working_with_aboriginal.pdf
- NSW Office of Communities- Aboriginal Affairs http://www.aboriginalaffairs.nsw.gov.au/
- Post-Adoption Resource Centre http://benevolent.org.au/connect/post--adoption--support--home
- NSW Registry of Births Deaths and Marriages http://www.bdm.nsw.gov.au/
- State Records Authority of NSW http://www.records.nsw.gov.au/
- Society of Australian Genealogists http://www.sag.org.au/

- NSW Gen Web http://www.nswgenealogy.com.au/
- AIATSIS Family History Unit http://aiatsis.gov.au/research/finding-your-family

Anglicare

Anglicare: Kathy Donnelly, Aboriginal Consultant
Anglicare's Reconciliation Action Plan 2014-2015: https://apps.anglicare.org.au/RDWeb/Pages/en-US/default.aspx

Academic resources

'Foster their culture' (2008)
Available from the Secretariat of National Aboriginal and Islander Child Care.
Contains information for carers regarding caring for children of Aboriginal or Torres Strait Islander heritage.

'Raising them Strong' booklet, with practical information and tips for raising Aboriginal children. (copies available from www.community.nsw.gov.au)

Higgins, J.R. and Butler, N. (2007). *Comprehensive support for Indigenous carers, children and young people.* 'Promising practices in out-of-home care for Aboriginal and Torres Strait Islander Carers, Children and Young People' (booklet 3). Melbourne: Australian Institute of Family Studies.

Various Academic resources are also available from Australian Institute of Aboriginal and Torres Strait Islander Studies. http://www.aiatsis.gov.au/home

Australian Indigenous Languages

Addresses, dictionaries, and place names of Aboriginal Australia
http://www.dnathan.com/VL/austLang.htm

Maps

http://www.aiatsis.gov.au/aboriginal_studies_press/aboriginal_wall_map/map_page

Tindale's Map of Aboriginal Tribal Areas – see

http://www.samuseum.sa.gov.au/tindale/boundaries_intro.htm

Special events

Special Aboriginal cultural events are listed at
http://www.musgraveparkculturalcentre.org.au/Major%20Events.htm

NAIDOC week
NAIDOC Week celebrates the history, culture and achievements of Aboriginal and Torres Strait Islander people. The Official National NAIDOC Website
is http://www.naidoc.org.au/default.aspx

Consultants

Kim Katon at Indigenous Identities: Research Training and Consultancy
kimkaton@kooee.com.au Ph 0415 938 850.

Publications

Koori Mail http://www.koorimail.com/
Koori Mail, Australia's National Aboriginal and Torres Strait Islander Newspaper
Produced fortnightly, Koori Mail is distributed Australia-wide, providing news, views, advertisements and other material of vital interest to Indigenous Australians and Australians interested in Indigenous affairs

National Indigenous Times http://www.nit.com.au/

Deadly Vibe http://www.vibe.com.au/

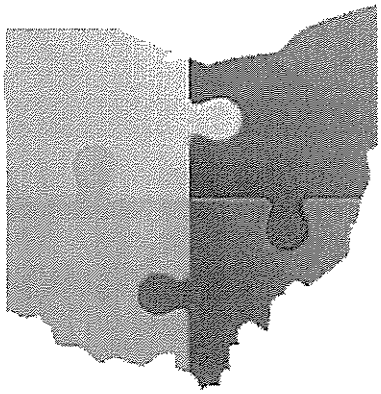
T.V.

Message Stick
(Repeat episodes aired on Mondays and Thursdays on ABC 1)
Message Stick is a half hour TV program about Aboriginal and Torres Strait Islander lifestyles, culture and issues. It features profile stories, interviews, video clips, short films and cooking segments and provides a slot where special half hour Aboriginal and Torres Strait Islander documentaries can be shown. It allows Aboriginal and Torres Strait Islander Australians to tell their stories in their own way.

December 2014

Ohio Fostering Connections:

Expanding supports for foster youth through age 21



Key Facts

- 1,000 Ohio youth "age out" of foster care each year at age 18
- As many as 3,000 former foster youth in Ohio could be eligible for extended support under the Ohio Fostering Connections Act
- Independent research shows that supporting Ohio foster youth through age 21 will: 1) improve educational attainment and earnings outcomes and 2) produce a net economic gain to Ohio taxpayers

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Generous support of Ohio Fostering Connections is provided by:

Dave Thomas Foundation For Adoption®

Cleveland Foundation

The Greater Cincinnati Foundation

Jim Casey Youth Opportunities Initiative

Lighthouse Youth Services

OACCA Ohio Association of Child Caring Agencies

starfish alliance

THE GEORGE GUND FOUNDATION

Table of Contents

What is Ohio Fostering Connections?

Each year, more than 1,000 Ohio youth "age out" of foster care at age 18. Research tells us that these young people are at high risk of homelessness, unemployment, insufficient education, dependence on public assistance, human trafficking and other obstacles to success.

Ohio Fostering Connections is a collaborative of local experts in the field of foster care and adolescent development with one objective: to advance Ohio's development and implementation of supportive services, including housing and case management, to youth aging out of foster care through age 21. The expansion would support young people in foster care as they avoid risks and build a strong foundation for successful adulthood.

The Fostering Connection to Success and Increasing Adoptions Act of 2008 provides federal matching funds to help states support foster youth through age 21. Prior to enactment of this law, states cut off foster care services at age 18. Since 2008, 26 states and the District of Columbia have created, or are in the process of creating, state-level legislation to extend supports to foster youth through age 21. Although Ohio has not yet passed its legislation, we have identified best practices from around the country that will enable Ohio to build the best program in the country for former foster youth.

In January 2014, Ohio Fostering Connections kicked off a yearlong effort 1) to conduct independent research and analysis of the need for and cost-benefit of expanding supports for young people in foster care and 2) to educate decision-makers and stakeholders. In January 2015, Ohio Fostering Connections will continue its work to educate the public and will launch a campaign for state-level legislation to extend supportive services for foster youth to age 21. The legislation will include a package of programs to help young people prepare for college and career. (*See page 14 for timeline.*)

Each year, successful implementation of the project would impact up to 3,000 young people, ages 18-21, who would be eligible to enroll in the statewide program.

Why do Ohio's youth aging out of foster care need extended support?

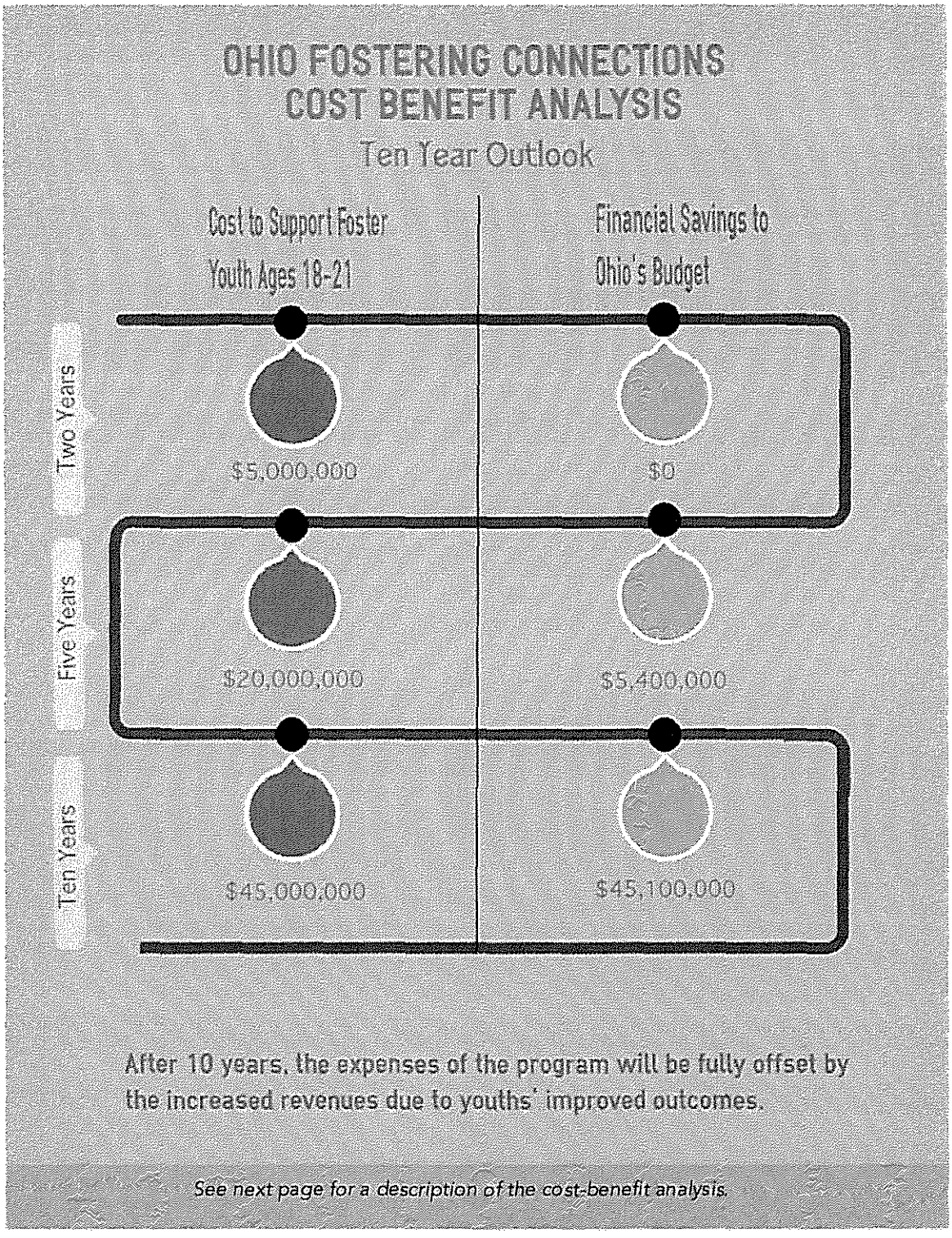
Ohio foster youth outcomes at age 19:

- 14% had a child
- 16% received financial assistance
- 24% worked part-time; 12% worked full-time
- 26% experienced homelessness within the last two years
- 36% were incarcerated
- 53% had not completed high school/GED

Source: National Youth in Transition Database (NYTD), 2013 Ohio Data

What are the benefits of implementing Ohio Fostering Connections?

- Access millions of additional federal funds to offer supportive services for young people (see pages 4-8 for a cost-benefit analysis)
- Decrease negative outcomes for young people, such as homelessness, incarceration and unemployment
- Engage young people as partners in establishing a foundation for successful adulthood
- Increase educational attainment
- Increase lifetime earnings potential due to increased educational attainment and employment stability



See next page for a description of the cost-benefit analysis.

Ohio Fostering Connections Cost-Benefit Analysis

The federal Fostering Connections and Increasing Adoptions Act of 2008 extends federal financial support to states that elect to provide supportive services to youth through their 19th, 20th, or 21st birthdays.

The cost of supporting foster youth during their transition to adulthood now has the potential to be matched with federal "Title IV-E" funds of the U.S. Social Security Act.

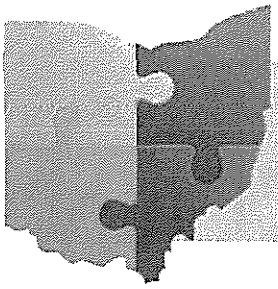
Extending the state's responsibility of supporting foster children through their 21st birthday has the potential to improve social, career, health, and educational outcomes, as well as produce cost-savings to Ohio taxpayers.

Ohio Fostering Connections commissioned Alvin S. Mares, PhD, MSW, LSW, Assistant Professor of Social Work at The Ohio State University, to conduct independent research on the outcomes, costs, and benefits of supporting young people who emancipate from foster care through their 21st birthday. Here are the key findings of that research.

Key Findings

Utilizing a conservative and evidence-driven approach, research revealed that:

- over a ten-year period, Ohio will benefit dollar-for-dollar by providing supportive services to young people who age out of foster care and to those who were adopted from foster care at age 16 or later.
- by year six of the program's statewide implementation, Ohio will benefit $1.06 for every $1.00 spent.
- by year 10, the benefit will rise to $1.81 for every $1.00 spent, surpassing net costs.



"Over a ten-year period, Ohio will benefit dollar-for-dollar by providing supportive services to young adults who age out of foster care"

Cost of core program services per cohort

Ohio Fostering Connections' legislative proposal includes four core program services, required under the Federal Fostering Connections Act: (1) Housing, (2) Case Management, (3) Administrative Review and (4) Extended Adoption Assistance.

Four Core Program Services	Formula for Cost of Core Program Services	Cost of Core Program Services per Cohort
(1) Housing	$1,472 average foster care cost at age 18 x 350 youth x 18 months average length of stay in program	$9,273,600
(2) Case Management	12 caseworkers x 3 years x $53,326 = $1,919,736 and 2 supervisors x 3 years x $67,952 = $407,712	$2,327,448
(3) Administrative Review	$800 per review x 350 youth x 1.5 years	$420,000
(4) Extended Adoption Assistance	5 percent of combined cost of housing, case management and administrative review	$601,052
Total Cost per Cohort (ages 18-21, years 1-3)		**$12,622,100**
Federal Share of Total Cost (60%)		$7,573,260
Ohio Share of Total Cost (40%)		$5,048,840

Core program services would cost $12,622,100 for one cohort over three years, with $7,573,260 (60%) covered by federal matching funds and $5,048,840 (40%) covered by Ohio.

See pages 11 to 13 for program recommendations for core services.

Cost of optional supportive services per cohort

If the State of Ohio chooses to offer supportive services beyond the four core services required in the federal Act, we recommend the following, which would cost $6,695,830 per cohort.

Optional Supportive Service	Formula for Cost of Optional Supportive Service	Cost of Optional Supportive Service
(1) Community College for Accelerated Youth	Average cost of attending 2-year, public Associate of Arts Degree program ($9,302 x 2 years x 126 youth)	$2,344,104
(2) Employment Training for Emerging Adults	Average cost of 1-year public certification program ($9,555 x 1 year x 74 youth)	$707,070
(3) Parenting Support for Struggling Parents	Average annual cost of raising 1 child ($10,256 x 2 years x 88 youth)	$1,805,056
(4) Community-Based Corrections Program for Troubled Young People	Average daily community-based corrections facility ($80 x 365-day average length of stay x 63 youth)	$1,839,600
Total Cost per Cohort		**$6,695,830**

The analysis in the table above is based on a Chapin Hall* study that identifies four groups of former foster youth as they transition into adulthood:

1) **Accelerated youth:** "living independently, beginning to raise children, completing their secondary education;"

2) **Emerging adults:** delaying some key adulthood benchmarks, such as living on their own, having children or completing school, while avoiding hardship;

3) **Struggling parents:** their reliance on public assistance and insufficient education is related to parenting; and

4) **Troubled/troubling:** most likely to be incarcerated, institutionalized, homeless or unemployed.

*Source: http://www.chapinhall.org/sites/default/files/publications/Midwest_IB4_Latent_Class_2.pdf

As illustrated in the graph on the previous page, these four groups of former foster youth could serve as a framework for providing supportive services beyond core supportive services. Additional supportive services could help: 1) "Accelerated Youth" earn an Associate's degree; 2) "Emerging Youth" earn career certification; 3) "Struggling Parents" work or go to school by covering the cost of raising a child; 4) a "Troubled" youth receive necessary interventions.

The costs of additional support services could be off-set through program consolidation or shared operations within state departments currently serving transition-aged youth. For example: 1) low-income, first generation college student funds could support Accelerated Youth; 2) Workforce Investment Act (WIA) out-of-school youth programs could support Emerging Adults; 3) Temporary Assistance for Needy Families (TANF) for Struggling Parents, and 4) Ohio Department of Mental Health and Addiction Services (OMHAS) programs and Ohio Department of Rehabilitation and Correction (ODRC) diversion programs for Troubled Youth.

Benefit Due to Improved Educational Outcomes and Higher Earnings

Educational Benefit Type	Total Benefit Due to Improved Educational Outcomes and Higher Earnings
High School Diploma	$1,746,181
Some college	$704,740
Associate of Arts Degree	$468,650
Bachelor of Arts Degree	$3,298,250
Support for Struggling Parents	$1,390,970
Intervention for Troubled Youth	$1,420,580
Total Benefit (over 5-yr period)	**$9,029,371**

Cost-Benefit Conclusion

Based on liberal cost and conservative benefit estimates, a positive return on investment to the State of Ohio of $1.08 for every $1.00 spent will be realized beginning in year 6 of the program.

The investment will grow through increased tax revenues associated with higher earnings achieved during adulthood (ages of 26 through 66) and through increased educational attainment during early adulthood (ages 18-20). *To review the complete cost-benefit analysis, visit ohiofosteringconnections.org.*

*"I'm a former foster child, as are my 12 siblings, and we would've benefited greatly from such a resource. Hopefully this legislation will help future foster children avoid some of the pitfalls and obstacles we endured." ~Maggie**

"Kids aging out of the system need the same kind of support we offer our own kids and they need to know there is someone there to catch them if they fall on their first try." ~ Jennifer

**pseudonyms used throughout report to respect and protect the identity of foster alumni who participated in focus groups and community forums*

Throughout 2014, Ohio Fostering Connections hosted a series of listening tours throughout Ohio with field experts, stakeholders, alumni of foster care and decision-makers.

What follows is a summary of what we heard— program recommendations for Ohio decision-makers as the Buckeye State considers expanding supportive services for foster youth to age 21.

How would it work?

Putting Ohio Fostering Connections into practice.

Who would be eligible for the Ohio Fostering Connections program and how would the program be implemented?

1. Ohio should follow the eligibility standards set in the federal Fostering Connections to Success and Increasing Adoptions Act of 2008. These standards include youth age 18 - 21 who aged out of foster care and who meet any one of the following criteria:
   - Completing secondary education or a program leading to an equivalent credential;
   - Enrolled part-time or full-time in: 1) an institution that provides post-secondary or vocational education; 2) a university or college, or 3) a vocational or trade school;
   - Participating in a program or activity designed to promote, or remove barriers to employment;
   - Employed for at least 80 hours per month; or
   - Incapable of doing any of the previously described educational or employment activities due to a documented medical condition.

2. Unlike Ohio's existing IV-E foster care program, which the Ohio Department of Job and Family Services (ODJFS) supervises and county public children service agencies (PCSA) administer, the Ohio Fostering Connections program should be centrally administered by ODJFS and sub-contracted to local agencies. Eligible local agencies should include ODJFS-certified private agencies and PCSAs.

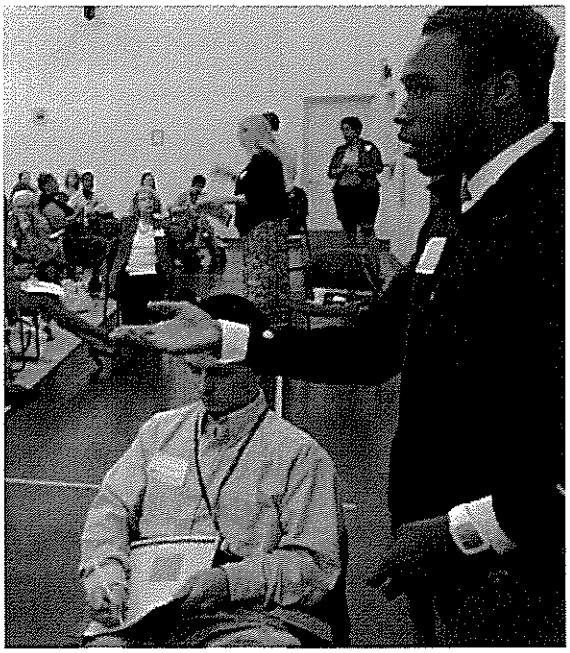
   ODJFS should update existing regulations regarding post emancipation services to align with the Ohio Fostering Connections programs.

3. Program services should be voluntary, easy to access, and youth-friendly. Young people who choose to exit the program should not be prohibited from re-enrolling.

4. Information about the availability of the Ohio Fostering Connections transition services should be presented and discussed with young people as part of the emancipation planning process and shared in a variety of youth-friendly formats.

5. Foster parents and other professionals working with transition-age foster youth should receive specialized training on the full range of transition services available under the Fostering Connections program so that they can help to link the youth with available services.

"I would have liked to transition into independent housing with more and more independence with time."
~Nadine, former foster youth



What should housing options look like?

1. Transition services available in the Fostering Connections program should include a variety of housing options that are appropriate 1) to varying levels of need for support and 2) to readiness for independence, including:
   - Foster and kin homes, host homes, group homes, residential centers
   - Transitional living and supportive housing programs, including housing targeted to the needs of particular groups, such as young parents, young people with disabilities, young people with a history of sexual offense, and young people with substance abuse disorders
   - On- and off-campus housing in post-secondary education settings
   - Housing cash stipends paid directly to young people enrolled in the program who meet an appropriate criteria

2. ODJFS should establish clear parameters for young people's admittance into housing settings that are restrictive, including group homes and residential centers. The State Departments of Developmental Disabilities and Mental Health and Addiction Services and their local boards should work with OJDFS to create a plan and provide appropriate services to enrolled young people with developmental disabilities and mental health and substance abuse problems.

> *"Most people I know who aged out of foster care became homeless. Any housing would have been good, so I would not be on my own. [When I turned 18], I couldn't get anything in my name and didn't know how to pay my bills."*
> *~Charlotte, former foster youth*

3. Case managers and other professionals involved in the Fostering Connections program should work in partnership with enrolled young people to identify the most desirable and appropriate housing and supportive service options. Young people should direct decisions about the most appropriate options. Young people should have the opportunity for a "pre-placement visit" before agreeing to participate in a particular housing program.

4. Participants should have access to transitional housing with increasing independence, consistent with healthy development and emerging adulthood, e.g. foster home, to independent living group home, to apartment or house. Young people should have the opportunity to make their own decisions and learn from mistakes.

> *"The housing arrangement should be up to the [young person] and there should be training on how to save money."*
>
> *~Andy, former foster youth*

What should case management and supportive services look like?

1. Case managers who serve young people, enrolled in the Fostering Connections program, should receive specialized training under parameters set by state government. Training should include hearing directly from foster youth who are in the process of transitioning and young people who have already emancipated from care.

2. The State of Ohio currently requires a transition-to-adulthood plan for each foster youth. As part of this plan, each young person should be equipped with a user-friendly tool-kit of information about available Fostering Connections supportive services.

3. Establishing life-long social connections should be a focus of case management for young people enrolled in the Fostering Connections program, including family-finding where appropriate.

"Aging out requires different and much more support—budget, apartment, expenses, management, teacher."
~ Nadine

4. A range of developmentally appropriate supportive services should be provided to young people enrolled in the Fostering Connections program, including but not limited to employment supports; developmental skills, relational skills, and hands-on life skills training; financial management; transportation; educational supports (including at the post-secondary level); access to mental health and addiction services; and assistance enrolling on Medicaid.

I needed someone to listen, someone to talk to. I wasn't looking for a handout- I needed advice. ~ Andy

How should Fostering Connections participants' cases be reviewed?

1. Ohio should adopt a hybrid case review model. Administrative reviews should be held every six months. Young people enrolled in the Fostering Connections program should have the option to request a formal court review in extenuating circumstances.

2. Young people enrolled in the Fostering Connections program need to participate in and, when possible, lead the administrative review process. Reviews should be convened in areas where the young people reside and scheduled based on their availability.

What is administrative review?
A full review of a young person's records, conducted by a team of eligible reviewers, to determine compliance with program requirements.

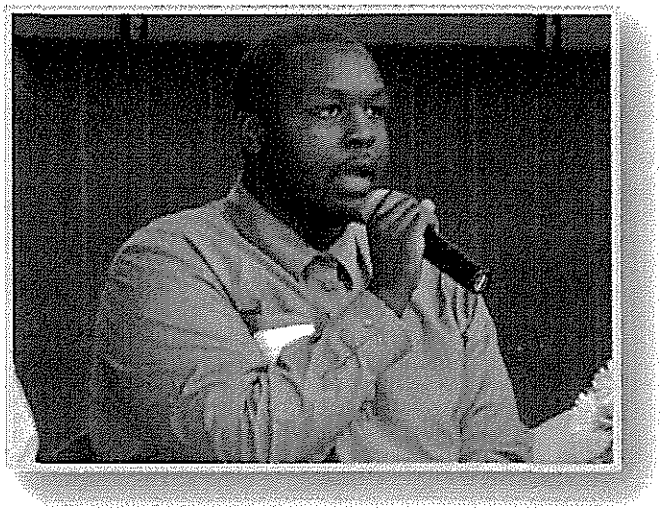
3. Administrative reviewers should be diverse. Young people should have the authority to request certain individuals be eligible reviewers. The reviewers should include the young people, caseworker, and other professionals and supportive figures deemed appropriate by all parties.

4. Free legal representation and consultation should be offered to program enrollees on relevant topics, such as landlord-tenant relations, identify theft or debt settlement.

Would Ohio Fostering Connections legislation disincentivize adoption of older youth in foster care?

Families of older youth who were adopted would be eligible for financial supports offered through the Fostering Connections legislation.

The adoption assistance extension, required by federal law, was designed to offset the costs of adopting older, qualifying foster youth.



How long would it take to implement the Ohio Fostering Connections program?

February 2015	Ohio Fostering Connections Legislation Introduced
June 30, 2015	Bill Passes into Law
July 1, 2015	12-month implementation planning starts
July 1, 2016	Statewide implementation occurs

Get Involved

Sign the petition.

Join more than 2,900 supporters of Ohio Fostering Connections.

Endorse.

Have your organization publicly endorse Ohio Fostering Connections.

Write your legislator.

Make sure your legislator knows that you support Ohio Fostering Connections.

---

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Contact.

Mark Mecum
Chair
Ohio Fostering Connections
mmecum@oacca.org
614-461-0014

Endorsements of Ohio Fostering Connections

Agape for Youth, Inc.
Beech Brook
Catholic Charities Corporation
CHOICES, Inc.
Center of Vocational Alternatives (COVA)
Cuyahoga Co. Division of Children & Family Services
Focus on Youth, Inc.
Foster Care Alumni of America – Ohio Chapter
Harmony Project
Justice for Children Project, Moritz College of Law
Juvenile Justice Coalition
Lighthouse Youth Services
Lowery Training Associates
Marjorie Curry & Associates, LLC
Mental Health & Addiction Advocacy Coalition
Montgomery Co. Office of Family and Children First
National Youth Advocate Program
Necco
O.H.I.O Youth Advisory Board
Oesterlen Services for Youth
Ohio Association of Child Caring Agencies
Ohio Family Care Association
Pressley Ridge
ProKids
Safely Home, Inc.
Schubert Center for Child Studies at Case Western Reserve University
Specialized Alternatives for Families & Youth
St. Joseph Orphanage
Starfish Alliance
The Buckeye Ranch
UMCH Family Services
ViaQuest Clinical Services
Voices for Ohio's Children
YWCA of Cleveland

ACT Government
Community Services

A Step Up for Our Kids

One Step Can Make a Lifetime of Difference

OUT OF HOME CARE STRATEGY 2015–2020

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BETTER SERVICES
Right SERVICE | Right TIME | Right DURATION

Acknowledgement of Country

The ACT Government acknowledges the traditional custodians of the ACT, the Ngunnawal people. The ACT Government acknowledges and respects their continuing culture and the contribution they make to the life of this city and this region.

Acknowledgements

The ACT Government acknowledges with thanks the contribution of the many individuals and organisations who participated in the development of the strategy including children and young people, carers, birth parent representatives, out of home care services, staff of CSD and other government and non-government partners.

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Disclaimer

Enquiries about this publication should be directed to:

Office for Children, Youth and Family Support
Community Services Directorate
GPO Box 158, Canberra ACT 2601

T (02) 6207 4544
E CBRstepsup@act.gov.au
W www.act.gov.au/CBRstepsup

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BETTER SERVICES

Contents

Minister's foreword

The ACT is a wonderful place to live. Its citizens enjoy one of the best lifestyles in the country, with high education, employment and income levels and access to an array of quality health, education and other services.

It may surprise many members of the ACT community to learn that there are around 600 children and young people who are in the care of the territory as they are unable to live safely with their own parents. This may be as a result of physical, sexual or emotional abuse or as a result of neglect.

We only get one chance at childhood. As the Minister for Children and Young People, I am committed to ensuring that the ACT's most vulnerable children have the chance of a good childhood, not one marked by fear, deprivation or insecurity. I am committed to ensuring that we support the ACT's families to do a great job of raising their children and young people. I am also committed to ensuring that children and young people who cannot safely live with their birth family have the care and support they need to become happy and healthy adults. Sadly, around the nation, life outcomes for many care leavers are less than optimal.

This strategy provides for new service initiatives to support high-risk families to safely parent their children and young people at home. Where this is not possible, the strategy seeks to better support children and young people in care for the future, including ensuring that wherever possible, children grow up in a secure, loving alternative family environment. The strategy also responds to a number of issues raised in reviews of child protection services in recent years. It seeks to place the out of home care system on a more equitable, cost-effective and sustainable footing for the future. It strengthens oversight and monitoring of out of home care services to safeguard and ensure high-quality services for children and young people.

The strategy builds upon an earlier commitment by the ACT Government to establish a trauma recovery service to address the behavioural and emotional difficulties experienced by many children and young people who have suffered abuse, neglect or sexual exploitation by the adults in their lives. The strategy recasts the out of home care system as a therapeutic, trauma-informed service system with the child or young person at the centre.

It is of concern to me that around one-quarter of the children and young people in care are Aboriginal and Torres Strait Islander people. Aboriginal and Torres Strait Islander children are significantly over-represented in the ACT child protection system as they are in other Australian jurisdictions and this is a matter of great unhappiness to Aboriginal and Torres Strait Islander communities and the broader community across the nation. I am pleased that a number of elements of the strategy will assist Aboriginal and Torres Strait Islander children and young people and families.

The Out of Home Care Strategy is one of a range of initiatives approved and funded by the ACT Government under the 'Better Services' banner. The strategy is a practical expression of the service delivery principles outlined in the *Human Services Blueprint*. It seeks to ensure that high-risk families receive support to parent their children successfully and that the needs of children and young people who come to the attention of child protection services are identified and addressed as early as possible. These approaches will deliver benefits to the individuals and families concerned and to the wider community.

This strategy is unabashedly child-focused. The vision for the strategy is *Children and young people in care—growing up strong, safe and connected*. Government alone cannot deliver this outcome for our vulnerable children. The support of the ACT community, its institutions such as schools and health services, and ACT families is needed in order to implement the strategy and make a difference. I commend the strategy to you.

Mick Gentleman MLA
Minister for Children and Young People

Executive summary

The *Out of Home Care Strategy 2015–2020* is a plan to guide the delivery of services for children and young people who cannot safely live with their parents.

The strategy has been developed by the Community Services Directorate (CSD) in consultation with young people, carers, out of home care agencies, peak bodies, non-government and government services over the course of a two-year period 2012–14. Extensive research has been undertaken to support the strategy. Many of the reports of these activities can be found on the CSD website at www.communityservices.act.gov.au/ocyfs/out-of-home-care-strategy-2015-2020.

There is a compelling need for change to address a range of challenges facing child protection and out of home care services around the nation. These include:

- continuing growth in numbers of children and young people entering care
- over representation of Aboriginal and Torres Strait Islander children and young people in care
- poor life outcomes for many care leavers
- difficulty in obtaining volunteer foster carers
- increasing costs.

The ACT Government endorsed the strategy in October 2014. It will be progressively implemented over a five-year period. Funding was provided in the 2014–15 ACT Budget to plan for the transition and to commence the change management process. A number of initiatives will commence during 2015 including training and legislative reforms to support rollout of the strategy, with the bulk of new services commencing operation on 1 January 2016. An Out of Home Care Taskforce has been established within CSD to drive reforms and an independent advisory panel will report to the Minister for Children and Young People on progress in implementing the strategy.

While the Out of Home Care Strategy is intended to transform outcomes for vulnerable children and young people and their families who have contact with the child protection and out of home care systems, it is important to acknowledge that the reforms build upon existing best-practice elements already in operation. New initiatives will not replace the current good practice happening in the sector; instead they will build on, strengthen and introduce some new service elements to address deficiencies of the current system and to incorporate emerging best-practice perspectives. The transformed service elements will make better use of existing resources as well as drawing upon additional investment that will be announced in the next ACT Budget. An operational framework, incorporating existing and new service elements, will be prepared in coming months. It will describe how out of home care services will operate in future and will be developed in conjunction with relevant government and non-government service providers.

The strategy

The *Out of Home Care Strategy 2015–2020* is unabashedly child-focused. It will recast services, both government and non-government around the child or young person's needs and will require changes to culture and practice to ensure that the voice of the child or young person is clearly heard.

The shared vision for the strategy is:

Children and young people in care—growing up strong, safe and connected

The vision statement expresses the government's commitment to maximising the physical and mental health and wellbeing of children and young people in care and their connection to family, community, culture, education and employment. The government is seeking a generational change which will mean that the next generation of care leavers will enjoy a sound basis for a successful adult life including enjoying a secure attachment to a family.

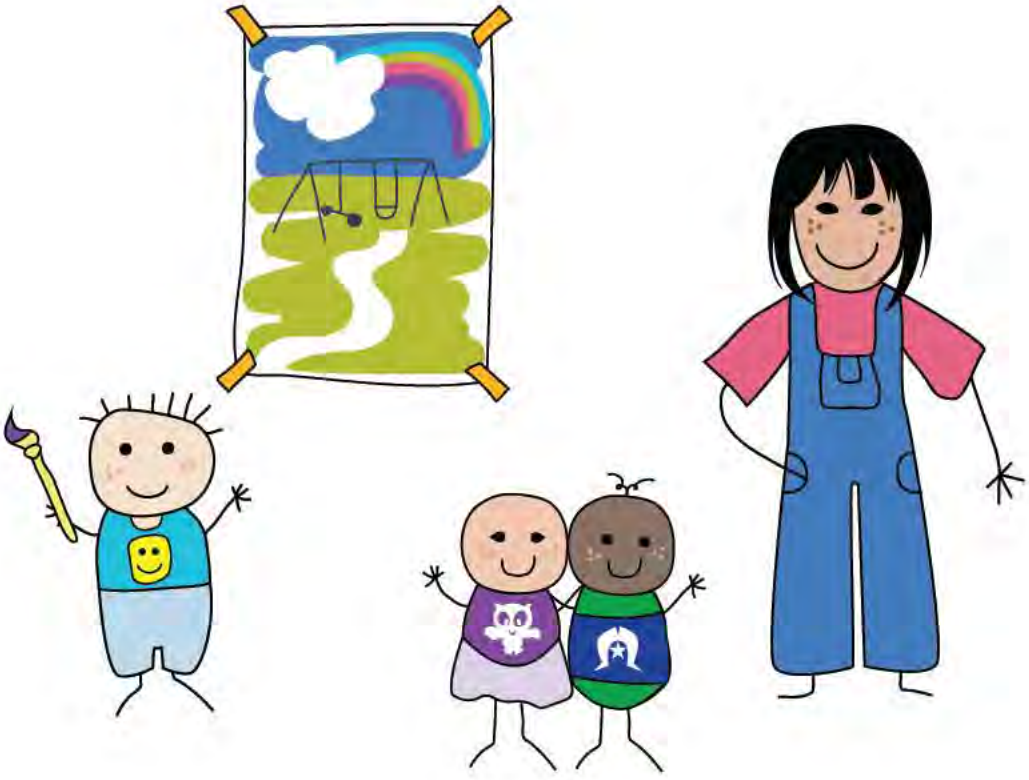
The strategy differs from its predecessor, the *Out of Home Care Framework*, in a range of ways. It represents a major departure from current practice in out of home care service provision.

- It will strengthen decision making around the child or young person and embed a culture of listening to the voices of children and young people.
- It recasts the out of home care system as a therapeutic, trauma-informed system of care.
- It shifts the pattern of investment to increase expenditure at the front end of the system, aiming both to minimise entries to care and also to identify children's behavioural concerns and special needs early and to provide flexible individualised funding to address those needs.
- It provides a greater share of the business and more autonomy to the non-government sector.
- It will offer alternative service options for keeping Aboriginal and Torres Strait Islander children and young people at home with birth families and independent cultural advice from Aboriginal and Torres Strait Islander community members to support children and young people in care.
- Where children and young people cannot return home safely, it aims to normalise children and young people's lives by exiting as many children and young people from care into permanent alternative homes as soon as possible.
- It strengthens oversight and monitoring including introducing a performance framework and performance-based contracting.

The Out of Home Care Strategy is based on an understanding that all children and young people who enter care have suffered trauma as a consequence of both the circumstances that led them to enter care and the loss of familiar relationships and environments. The strategy seeks to ensure all services to children and young people in care provide positive, safe, healing relationships and practices that are informed by a sound understanding of trauma, attachment and child development.

A fundamental plank of the system will be comprehensive developmental and psychological assessments for children and young people in placement prevention services or upon entering care, repeated at regular intervals, generally annually. The assessments will inform development of care plans including a therapeutic plan for each child or young person and also provide some more objective measures of child and young person wellbeing and progress over time. The assessments will also facilitate early access to National Disability Insurance Scheme (NDIS) packages where relevant.

The strategy comprises an array of new service initiatives and reform activity, which have been grouped into three domains.



Strengthening high-risk families domain

The strengthening high-risk families domain increases investment at the front end of the care system in order to divert children from entering long-term care. This domain is largely focused on managing risks associated with family of origin and it seeks to avoid drift into care and drift in care. There will be a strong emphasis on timely decision making, especially for infants and very young children. The services will need to be culturally proficient to meet the needs of Aboriginal and Torres Strait Islander families.

New services established for strengthening high-risk families will be delivered by non-government service providers upon referral from Care and Protection Services. These elements will sit within and complement the existing service system offered to families in the ACT. ACT government and non-government agencies will seek to offer families a comprehensive package of service options that effectively engage struggling families in order to meet the needs of vulnerable children and young people.

Key service initiatives include:

- **placement prevention services** operated by non-government providers to provide intensive in-home, practical support to families whose children are at high risk of entering the statutory care system. These services provide more intensive support than general community-based family support services and Care and Protection Services is the gatekeeper and commissioner of these services
- **reunification services** operated by non-government providers to provide similar services following entry to care dedicated to getting children and young people home safely as quickly as possible and supporting parents over a period of time to focus on their children's needs, so there is no reoccurrence of entry to care
- a **mother and baby unit** that will provide supervision and support for up to three months in a community-based setting to struggling mothers whose babies are at risk of entering care. The mother and baby unit differs from ACT Health's Queen Elizabeth II Family Centre which provides residential support for parents and babies or young children for a period of up to five days in a facility which is licensed as a hospital and staffed by health professionals
- **supported contact services** operated by non-government providers to provide for skilled paraprofessional staff to monitor and report upon supervised contact between parent and child and to coach and mentor parents in a hands-on manner during contact sessions
- **parent–child interaction programs** designed to improve the quality of the parent–child relationship and to change parent–child interactions in a positive direction. They will also assist carers, as well as birth parents, who are managing children with difficult behaviours.

Creating a continuum of care domain

The creating a continuum of care domain brings together all of the service elements in the strategy designed to support children and young people who cannot live with their birth families. This domain is largely focused on managing risks relating to child safety and wellbeing in care placements including assessing the suitability of carers and the availability of a home and support services matched to child need within a continuum of care. Providers will be tasked with finding permanent alternative families and achieving better outcomes for children and young people who remain in care long-term.

Key elements include:

- **external providers will offer a continuum of care** ensuring that responsibility for the child or young person's experience of care resides with one service provider
- **out of home care providers will assume case management** for all children on long-term orders and long-term care decisions will be delegated to providers to locate decision making as close as possible to the child or young person
- **kinship care** where children are on long-term orders will be outsourced
- **salaried foster care** will be introduced as a service for very complex children and young people
- **residential care services will have a strong therapeutic focus** and will cease to operate as stand-alone services but be provided as part of the continuum of care
- **a renewed focus on achieving permanent homes** for children and young people who cannot return to their birth families safely including adoption and Enduring Parental Responsibility Orders. The waiting period for an Enduring Parental Responsibility Order where a child is with a stable long-term family is proposed to be reduced to one year instead of the current two years
- **additional financial and other supports will be offered to care leavers** particularly those between 18 and 21 years to better approximate the leaving home experience of the wider population of young people
- **cultural advisers will be engaged** to provide independent advice regarding entry to care, placement decisions and cultural plans for Aboriginal and Torres Strait Islander children and young people in care
- **a child health passport** that travels with the child or young person will be introduced
- **the Education and Training Directorate (ETD), CSD and non-government providers will work together** to improve education and training outcomes for children and young people in care.

These elements will change many of the ways in which the government and non-government agencies currently provide out of home care services. However, there are some areas that have been working well and will remain the same including the assessment by Care and Protection Services of children and young people at risk of abuse or neglect, the role of agencies in attracting and recruiting carers, agencies' provision of support to foster carers when a child or young person is on an interim or short-term order, government's processing of international adoptions and agency provision of community respite.

Strengthening accountability and ensuring a high-functioning care system domain

The strengthening accountability and ensuring a high-functioning care system domain responds to some of the deficiencies identified in external reviews and audits of Care and Protection Services and out of home care. It includes activities designed to ensure the care system operates safely, effectively, efficiently, equitably and sustainably.

The strategy provides for the transfer of significant additional responsibility to non-government providers. Building the capacity and capability of the non-government sector to meet the challenges posed by new policy directions will be important along with building CSD capabilities in new or strengthened activity areas such as accreditation, quality assurance and performance contracting.

Key elements include:

- **governance arrangements will be refreshed** to support whole-of-system effectiveness
- **all non-government providers will be accredited** as suitable out of home care providers against an objective set of standards and carer approvals will be refreshed at regular intervals
- **procurement strategies will maximise value for money** and flexibility in purchasing
- **a workforce development strategy** will be developed, focusing on both capacity and capability, including cultural proficiency
- **contract management and quality assurance** of purchased services will be strengthened
- **a performance framework will be developed**. Providers will report regularly against key performance measures and non-government providers will be positively financially incentivised for achievement of targets
- **evaluation of the strategy** will occur at key points including a baseline study to ensure the strategy achieves positive outcomes
- **a focus on compliance with record keeping requirements** but also on ensuring comprehensive collection of information to support children in care and as care leavers, for example, Life Story books, cultural plans, school report cards and health information
- **an independent carer advocacy service will be established** to assist carers to resolve issues that arise with either Care and Protection Services or the non-government providers
- **an independent family advocacy service will be established** to provide birth parents and extended family members with information and support to address issues of concern with either Care and Protection Services or the non-government providers.

It is important to acknowledge that it is not possible to make the leap to a new therapeutic, trauma-informed care system overnight. It will be a journey necessitating awareness building, skills and knowledge development, development of new service models and organisational and program alignment over a number of years. It is a journey that will require significant collaboration between government and non-government sectors and across both sectors. It will also necessitate a willingness on the part of both government and non-government providers to embrace new ways of doing things in pursuit of better outcomes for children and young people.

Figure 1 Key elements of the Out of Home Care Strategy

A therapeutic trauma-informed system

Therapeutic Assessments, Plans, Supports and Training

Strengthening high-risk families

- Placement prevention services
- Reunification services
- Mother and baby unit
- Parent–child interaction programs
- Supported supervised contact

Creating a continuum of care

- Empowering children and young people
- Continuum of care
- Outsourcing case management and long-term decision making of all children and young people on long term orders
- Outsourcing kinship care
- Revised arrangements for reimbursement of carers
- Supports for permanency including greater accessibility to EPRs and adoption where appropriate

Decrease in number of children and young people in care

Positive life outcomes for children and young people who cannot live at home

Children and young people in care—

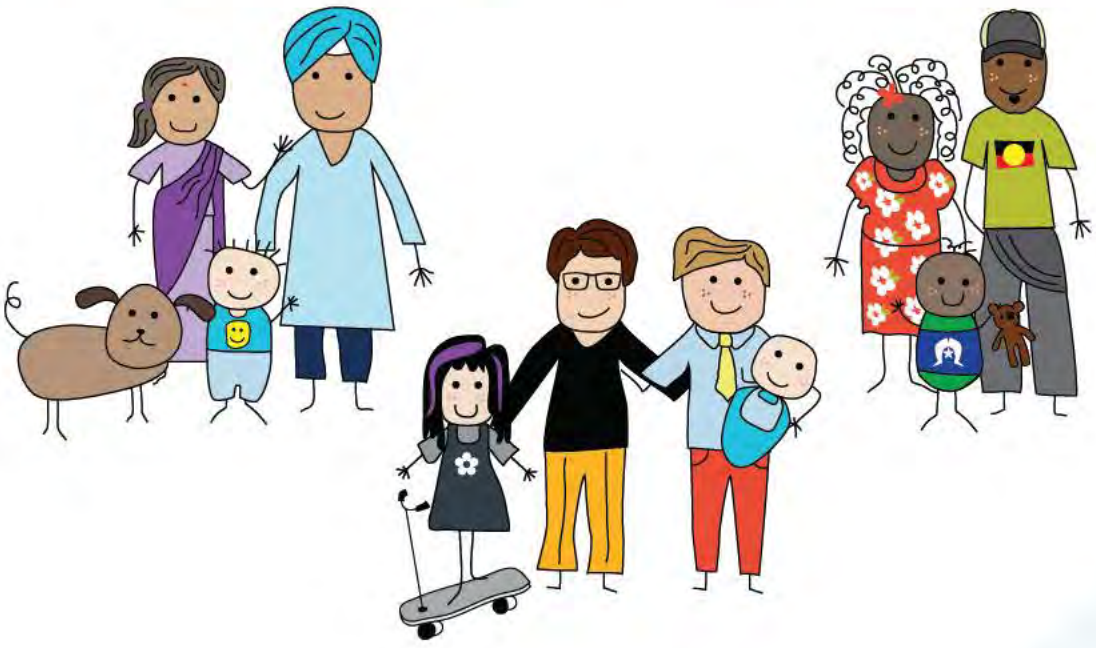
- Extended continuum of care for care leavers up to 21 years of age
- Salaried foster care
- Therapeutic residential model
- Independent cultural advice for Aboriginal and Torres Strait Islander children and young people
- Child health passport
- CSD/ETD Education Pathways Initiative

Strengthening accountability and ensuring a high-functioning care system

- Refreshed governance arrangements
- Accreditation and monitoring scheme
- Strengthened contract management
- Performance-based contracting
- Renewal of carer approvals
- Improved information managment
- Independent carer advocacy and support service
- Independent family advocacy and support service

Strengthened oversight and accountability

growing up strong, safe and connected



1 Introduction

1.1 What is the *Out of Home Care Strategy 2015–2020*?

The *Out of Home Care Strategy 2015–2020* is a plan to guide the delivery of services over a five-year period commencing 1 July 2015 for children and young people who cannot safely live with their birth parents.

Development of the strategy was initiated in response to the need to ensure the quality and supply of out of home care placements for children and young people in the care of the territory. A secondary aim was to strengthen supporting arrangements to ensure the best possible outcomes are achieved for children and young people, including enhancing cross-portfolio collaboration to meet the educational and health needs of children and young people in care. The strategy also responds to a number of deficiencies in the purchasing and delivery of out of home care services identified through three external reviews conducted in recent years. The reports of these reviews are:

- *Public Advocate: Emergency Response Strategy for Children in Crisis in the ACT 2011*
- *Public Advocate: Review of the Emergency Response Strategy for Children in Crisis in the ACT 2012*
- *Auditor-General: Performance Audit Report of the Care and Protection System 2013.*

1.2 What are the challenges facing out of home care in the ACT?

Research and modelling undertaken to support the development of the strategy suggests that unless action is taken, the ACT faces a crisis in out of home care within five years due to growth in the numbers of children and young people in care, carer shortages and increasing costs.

All jurisdictions in Australia are experiencing growth in numbers of children and young people entering care. In the ACT, the number of children and young people in care has grown on average by around five per cent per annum over the last decade and there are no grounds to believe that this pattern will cease without intervention. The introduction of the *Children and Young People Act 2008,* which commenced in 2009 has contributed to the growth in demand. It broke the 'rotating door' pattern of children entering and leaving care repeatedly by providing for restoration within two years or alternatively long-term orders, thus increasing demand for care places.

Of particular concern is the growth in Aboriginal and Torres Strait Islander children and young people in care. Around one-quarter of children and young people in care in the ACT identify as Aboriginal and Torres Strait Islander persons. This equates in 2012–13 to about 140 children and young people. Aboriginal and Torres Strait Islander children are significantly over-represented in the ACT child protection system as they are in other Australian jurisdictions. The ACT has the third highest rate nationally of Aboriginal and Torres Strait Islander children in care compared to their presence in the general population, with Aboriginal and Torres Strait Islander children and young people over represented by a factor of 13.

All jurisdictions are also struggling to gain and retain adequate numbers of suitable carers, partly due to demographic and lifestyle changes. Recruiting carers in the ACT is particularly difficult because of the very high rates of workforce participation by both women and men.

The shortage of placements means that there are limited opportunities to match a home to a child or young person's needs, creating increased rates of placement breakdown and additional psychosocial damage to the child as children and young people cycle through a hierarchy of carer arrangements.

The bottom line is that currently there are difficulties in matching children and young people with the right care and increasing difficulty in attracting carers. In addition, a significant number of kinship carers and some foster carers will age out of the system over the next decade. In 2013, nearly 60 per cent of kinship carers were aged 50 and over. Forty children are being cared for by kinship carers aged between 66 and 87.

The growth in demand for care places in all Australian jurisdictions has been mirrored by disproportionate growth in the costs of out of home care as child protection services have struggled to meet the increasingly complex needs of children in care; the response to the adverse findings of 18 inquiries into out of home care that have taken place in Australia over the past decade; and provide care places as the availability of foster carers declines.

Residential care is often used for young people whose homes with foster carers or kinship carers have broken down. Children and young people are cared for in a group of between two and six young people by shift workers. This tends to produce poor outcomes for children and young people. In the ACT 32 per cent of the out of home care budget is expended on just 7 per cent of children and young people who reside in residential care. This is not financially sustainable.

Finally, the current ACT care system is not delivering the desired quality outcomes for children and young people. Research, both nationally and internationally, indicates care leavers experience worse life outcomes than the general population. The experience of being in care can impact a child or young person long after they have left care in terms of their ability to gain an education, succeed in employment, build meaningful relationships and parent their own children satisfactorily, connect with their community and lead productive lives.

1.3 What does the current out of home care system look like?

The current care system in the ACT developed from outsourcing foster care and residential care in 2000. At the time, foster care and residential care were the two largest forms of care. A new Out of Home Care Framework was introduced in 2010 at which time changes were made to the quantum and format of allowances and contingencies, and services were re-tendered. Purchased services took the form of general and intensive foster care and general and intensive residential care on the basis of specified unit prices.

ACT Out of Home Care Standards were piloted in 2009. National Out of Home Care Standards were agreed by all jurisdictions in 2011 and are expected to form the basis of an accreditation scheme for ACT out of home care services. As part of this strategy the ACT will adopt the national standards as its own. The standards are child-focused, are written to be accessible to a wide audience, were subject to significant consultation and will reduce reporting burden for out of home care agencies who operate across jurisdictions. The standards will be incorporated into any future contractual arrangements for out of home care services.

In another significant development, new child welfare legislation commenced in 2009, the *Children and Young People Act 2008*. The Act reinforced the development of kinship care as a preferred option and strengthened the focus on either early reunification or permanency i.e. within two years. The effect of the Act was to reduce the common and damaging experience for children and young people in care of multiple entries to and exits from care interspersed with attempts at reunification.

The most significant development in recent times has been the steady growth in kinship care, which has resulted in Care and Protection Services again becoming the provider of the largest number of care places with 291 children managed by Care and Protection Services in kinship care at 30 June 2013. In 2011, CSD received funding to establish a kinship carer support team in recognition that kinship carers required more support than busy caseworkers could offer. This has been a successful initiative.

The engagement of external care providers in 2000 added value to the system through sharing responsibility for the care of these vulnerable children. However, these outsourcing arrangements also brought greater complexity to the operation of the system and the relationships between children, young people, carers, birth families, providers and Care and Protection Services by adding another agent into the mix. During consultations about the strategy, the single issue most consistently raised by all of these groups was the difficulties created by the three-way relationship between carers, Care and Protection Services and the foster care agencies. It results in duplication of effort, communication difficulties, delays in decision making and unnecessary conflict.

The electronic child protection record system, the Child and Young Person System (CHYPS), dates back to 1999 and has been the subject of criticism in every review of child protection conducted over the last decade. The lack of a shared information system linking Care and Protection Services and out of home care providers is inefficient. A project to scope the possibility of purchasing a new system or significantly upgrading the functionality of CHYPS was funded in the ACT Budget of 2013. The outcome of this project will be announced in mid-2015.

New legislation, the *Working with Vulnerable People (Background Checking) Act 2011*, commenced in the ACT on 8 November 2012 which aims to reduce the risk of harm or neglect to vulnerable people in the ACT. All persons who work with children, whether in a volunteer or paid capacity, have been required to obtain a Working with Vulnerable People check, including foster, kinship and residential carers and the frontline staff of non-government providers and of Care and Protection Services.

The ACT's child protection and out of home services are subject to external scrutiny by a number of oversight bodies, notably the Public Advocate of the ACT and the ACT's Children and Young People Commissioner.

During 2013, CSD announced an intention to integrate its two statutory services programs—Care and Protection Services and Youth (Justice) Services—and a Senior Director, Statutory Services has been appointed. Planning and consultations to give effect to this decision are underway. The final structure of statutory services will be influenced by the strategy.

The Public Advocate of the ACT serves a number of important functions within the child protection system and has quite broad ranging powers.

The Public Advocate:

- is empowered to provide individual advocacy for a child or young person who is, or who should be, subject to some form of state intervention, including through the mental health, juvenile justice or care and protection systems
- under provisions of the *Children and Young People Act 2008*, routinely receives key documents prepared by the CSD including Care and Protection Applications to the Children's Court, Annual Review Reports for children and young people in care and reports alleging abuse or neglect of a child for whom the Director-General has daily care responsibility and who is alleged to have been abused by an approved carer or during approved or Court ordered contact
- can also request information in relation to children and young people whilst performing a statutory function. In addition, under the *Court Procedures Act 2004*, the Public Advocate is entitled to appear, to be heard and to call witnesses in proceedings against a child or young person or a matter under the *Children and Young People Act 2008* or in relation to which this Act applies
- manages through an Executive Officer the Management Assessment Panel (MAP) process to facilitate the coordination of case planning and service provision for members of the community, including children and young people, whose complex service needs are poorly coordinated or not adequately met. MAP meetings are convened by an independent Chair appointed by the Minister
- ACT has a range of functions and responsibilities in relation to people who have a condition that impairs their decision making ability. The Public Advocate's guardianship function may commence for young people transitioning from care following the making of an ACT Civil and Administrative Tribunal order and upon the young person reaching adulthood.

The roles and functions of the ACT Children and Young People Commissioner (CYPC) are established under Sections 6, 14 and 19B of the *Human Rights Commission Act 2005* (ACT), and include:

- investigate complaints and concerns about the provision of services for children and young people
- consult with and listen to children and young people, and encourage government and nongovernment agencies to do the same
- make recommendations to government and non-government organisations on legislation, policies, practices and services that affect children and young people

- promote the rights of children and young people
- encourage and assist providers of services for children and young people to contribute to reviews and improve service delivery
- promote community discussion about the CYPC and services for children and young people
- conduct enquiries and reviews.

1.4 What does the strategy propose?

The new strategy represents a major departure from current practice and aims to reduce demand for out of home care places thus averting significant long-term costs to government and the community. It places a strong emphasis on preventing children and young people from entering care, reunifying them with their birth parents as quickly as possible and, where children and young people cannot go home safely, moving them into permanent alternative family settings as quickly as possible.

The strategy also aims to improve outcomes for children and young people by providing more flexible, child-focused services. It seeks to strengthen relationships around the child or young person and allow decision making to happen as close to the child or young person's lived experience as possible. The strategy recasts the out of home care system as a therapeutically-oriented, trauma-informed system of care. It also aims to make the system safer, more effective, efficient, equitable and accountable and to improve its financial sustainability over the longer term.

The strategy organises reform activity into three domains, all of which are underpinned by the commitment to a therapeutic, trauma-informed care system:

- **strengthening high-risk families**
- **creating a continuum of care**
- **strengthening accountability and ensuring a high-functioning care system.**

Further details about the initiatives that address these themes are provided in subsequent sections.

1.5 What is the strategy's vision?

The Out of Home Care Strategy's vision for out of home care services is:

The vision statement expresses the government's commitment to maximising the physical and mental health and wellbeing of children and young people in care and their connection to family, community, culture and education and employment.

The government is seeking a generational change which will mean that the next generation of care leavers will enjoy a sound basis for a successful adult life including enjoying a secure attachment to a family. The government wants children and young people in care to reach their full potential and to have hope and aspirations for their futures.

1.6 Will legislative change be required to implement the strategy?

Many of the new policy directions espoused by the strategy can be actioned within the framework of the current *Children and Young People Act 2008*. There are a few areas where the strategy's implementation would be assisted by legislative change.

Some potential amendments to the Act have been flagged at relevant points within this document. Further detailed consideration of possible legislative amendments will occur during the implementation period.

1.7 Does the strategy reflect the findings of the Royal Commission?

The Royal Commission into Institutional Responses to Child Sexual Abuse was established in January 2013 to investigate the abuse of children and young people in institutional settings including out of home care and to recommend systemic improvements to better protect children and young people in future.

The work of the Royal Commission has underlined the importance of safeguarding children and young people in out of home care from sexual abuse and exploitation and from abuses of power more generally by the adults charged with their care. The interim report of the Royal Commission, released on 30 June 2014, does not advance any recommendations; subsequent reports will. These recommendations will be carefully considered by the ACT Government once available.

In the meantime, this strategy strengthens safeguards for children and young people in care in a variety of ways including providing for formal adoption of the National Out of Home Care Standards, accreditation and monitoring of service providers and regular renewal of carer approvals. It is impossible to eradicate all risk in out of home care service provision, human nature being what it is. Ultimately, the best protection for children and young people in care is that they have a voice, that is, that they are empowered to participate in decisions about their own lives, and that they are engaged in a community which accepts responsibility for the safety and protection of all children and young people.

1.8 What needs to happen to ensure the strategy is successful?

The strategy will be rolled out over a five-year period and the government and non-government sector will develop detailed transition plans to guide the reform. In order to implement the strategy effectively significant cultural change is required across all parts of the sector. Relationships between Care and Protection Services, agencies, other support services and carers must be refreshed and strengthened.

CSD acknowledges that in the past relationships between different participants have been strained at times and there is a view from some stakeholders that the system is more adversarial in nature than it needs to be. Through the development of this strategy we have sought to understand the main issues and concerns for all parties and to address them as far as is possible within available resources. The Out of Home Care Strategy will seek to refresh and strengthen all relationships that contribute to the operation of the system and, in particular, relationships between carers and other participants, in order to acknowledge the key role and valuable contribution made by carers. Carers must be recognised as the child's primary healer in a trauma-informed, therapeutic care system.

1.9 How does the strategy align with other ACT Government frameworks?

Human Services Blueprint

The ACT Government has recently released a *Human Services Blueprint* which is a whole-of-government reform agenda designed to better utilise government investment in social outcomes. The blueprint is about:

- creating a better service experience
- improving economic and social participation, especially amongst disadvantaged Canberrans
- making services sustainable.

Key focus areas for the blueprint include:

- ensuring services are person-centred and better matched to a person's actual needs
- connecting government and non-government services so clients receive a joined up service response
- responding early to reduce future demand for higher cost services.

The Out of Home Care Strategy gives effective expression to the principles underpinning the blueprint with its strong focus on diverting children and young people from statutory care and, where children cannot live at home with their birth family, moving them into a permanent alternative family as quickly as possible. The strategy frees up funding to purchase flexible child-focused services which follow the child and provides a bigger share of the business to the non-government sector, confident that government and non-government services can work together to improve outcomes for vulnerable children and young people.

The Out of Home Care Strategy straddles the intensive services and statutory services domains of the service continuum.

Youth Justice Blueprint

The *Blueprint for Youth Justice in the ACT 2012–22* noted that children and young people in out of home care are over represented in the youth justice system. The blueprint identified the need to prevent child abuse and neglect and improve outcomes for children and young people who have been abused or neglected as part of a long-term strategy to reduce offending by young people and reduce their involvement with the youth justice system. The strategy will support integrated statutory services in the ACT and offer a service response both for children and young people on care orders and young people who are on youth justice orders and who cannot live at home with their birth families.

Whole-of-Government Aboriginal and Torres Strait Islander Agreement

CSD is currently leading the development of a whole-of-government Aboriginal and Torres Strait Islander Agreement with a focus on employment, health and housing, inclusive access to mainstream services, and targeted service offers to prevent entry into statutory services.

Achieving a reduction in numbers of Aboriginal and Torres Strait Islander children and young people in care is one of the key success measures for the Out of Home Care Strategy, however for the achievement to be meaningful, it must be the outcome of genuine improved safety and wellbeing for Aboriginal and Torres Strait Islander children and young people at risk.

Many Aboriginal and Torres Strait Islander community representatives have welcomed the strategy's focus on diverting children and young people from care through strengthening high-risk families. Implementing effective placement prevention and reunification services that deliver results for our vulnerable Aboriginal and Torres Strait Islander families is a key concern of the strategy. CSD will engage with the new Aboriginal and Torres Strait Islander Elected Body as the strategy implementation progresses to ensure it remains culturally appropriate.

Territory as Parent

While the *Children and Young People Act 2008* empowers the Director-General of CSD to exercise parental responsibility for children and young people in care, an important concept which underpins this strategy is that of 'Territory as Parent' enunciated by Cheryl Vardon, Commissioner for Public Administration in her 2004 report *The Territory's Children: Ensuring Safety and Quality Care for Children and Young People*.

In order to achieve the best possible outcomes for children and young people in care, it is important to harness resources across government, but particularly, the assistance of ACT Health and the ETD. The strategy requires all areas of the ACT Government to come together to support children and young people in care to ensure that they have the best possible chance to grow up to lead happy, healthy and productive lives.

An inter-directorate committee has been established to support the development and implementation of the Out of Home Care Strategy. It will meet at regular intervals over the next two years as the strategy is rolled out. Several specific initiatives have already been agreed between CSD and other agencies, including ACT Health's participation on the Strengthening High-Risk Families Panel to facilitate access to health services needed by vulnerable children and their families who are clients of statutory services and an Education and Training Pathways initiative which will bring the ETD and CSD together on an ongoing basis to plan for and monitor the achievement of improved education and training outcomes for children and young people in care.

National Disability Insurance Scheme

The development of the Out of Home Care Strategy has coincided with preparations for the ACT's trial of the NDIS. Disability is a significant issue for the Out of Home Care Strategy. It is generally accepted that children and young people with a disability are over represented within child protection services although little research has been conducted to identify their prevalence. Historically, some children with a disability came into care as a last resort in order to obtain services needed as a result of their disability. The Out of Home Care Strategy reflects the view that parents of a child or young person with a disability should not have to relinquish parental responsibility for their child in order to receive a service related to the child's disability. The NDIS should help to relieve pressure on parents of a child with a disability by providing reasonable and necessary supports, including early intervention supports, to children and young people with a disability.

The children of parents with a disability may also be over represented as clients of out of home care services. The parents with a disability who are at most risk of a child entering care are those with an intellectual disability. National and ACT child protection statistical collections do not currently identify the size of the population of parents with intellectual disabilities.

The Out of Home Care Strategy will seek to ensure those parents, children and young people with an entitlement access services through the NDIS. In particular, the introduction of comprehensive developmental and therapeutic assessments for all children and young people entering placement prevention services or care will help to ensure that eligible children and young people are identified.

Every child and young person in placement services or care will participate in regular therapeutic assessments that identify their therapeutic and support needs. This will ensure that children and young people receive the supports and services they need. Children and young people will be encouraged to have a voice in the assessment process and to choose services that they feel they will be able to engage with. These supports will follow the child or young person either back to their birth family or through care.

Through Strengthening High-Risk Families Services, birth parents with a disability will be encouraged and supported to access NDIS services and the parents and their support workers, with consent, will be invited to attend case planning meetings for the family to ensure all services are working together to keep the child or young person with their birth family.

2 A therapeutic trauma-informed care system

Children and young people are brought into care following exposure to significant abuse and neglect. Irrespective of the extent of trauma they experience prior to entering care, most children and young people will experience additional trauma through the process of entering care with discontinuity or permanent loss of familiar relationships, possessions and environments.

Traditionally, children and young people who entered care were placed in foster care and it was hoped that the child or young person would settle and flourish in a home-based setting. It is now quite clear that these traditional service responses failed many children and young people in care who went on to lead troubled lives as adults, often recreating poor parenting experiences for the succeeding generation. A common phenomenon was the breakdown of placements in adolescence as the young person attempted to make sense of why they weren't living with their birth parents and associated issues.

We are now far more aware that children and young people involved in the child protection system are exposed to a number of situations that increase their risk of experiencing not only trauma and disrupted attachments but also developing mental health problems. By the time a child has entered the care system, they may have already been exposed to multiple traumatic experiences including abuse, neglect, domestic violence, a family history of mental health issues, drug and alcohol abuse and family involvement with the criminal justice system. Aboriginal and Torres Strait Islander children and young people and their families often experience even greater disadvantage as they cope with intergenerational trauma arising from colonisation and dispossession. The ability of a child or young person to make sense of these traumatic experiences and develop meaningful relationships or attachments that may assist them to overcome the trauma, is hindered by the layering of one traumatic event upon another including entering care and the associated losses they may suffer of connection to family, culture, community, friends and their previous school. Negative outcomes can include anxiety, depression, post-traumatic stress, attachment problems, sexual behaviour problems, hyperactivity, anger and aggression, suicidal behaviour and other serious mental health issues.

Attachment theory suggests that the presence of caring and supportive adults is integral to a child and young person's sense of stability and safety as well as their ability to understand and recover from a traumatic experience. Therefore, the greater the level of support and care a child or young person can experience following a traumatic event, the greater the capacity for them to overcome traumatic events. Conversely, for children and young people who experience persistent trauma and where adults are either the source of trauma (e.g. an abusive parent) or who have a limited capacity to support the child or young person (e.g. families characterised by violence, homelessness or parental mental health concerns), the greater the likelihood the trauma will have a lasting impact on the child or young person's social and emotional wellbeing and development.

For children and young people in care, their experience can be made even more difficult by multiple placement breakdowns, instability and changes of key personnel, which further hinder their capacity to resolve trauma. Therapeutic interventions therefore need to maximise a sense of safety and stability and will require a clear, consistent and nurturing response to managing behavioural issues.

The increased use and availability of medical imaging technologies has furthered our understanding of exactly how the brain is altered following prolonged exposure to trauma and/or stress. Significantly, there is now growing evidence that persistently elevated levels of the stress hormone cortisol, can disrupt the developing architecture of the brain, including its size. This can then lead to permanent changes in brain structure and function including difficulties in learning memory and executive functioning.

These developments have coincided with the emergence of new theoretical frameworks that focus on trauma-informed therapeutic approaches to working with children and young people, and in particular focus on a child or young person's developmental age (as opposed to chronological age) and the importance of building safe and secure relationships as a means of recovery.

2.1 Therapeutic assessments and plans

A fundamental plank of the new care system will be therapeutic assessments and plans for every child and young person in care. This service will also be available for a period of time to children and young people in placement prevention services in order to ensure that any related problems are identified and treated as early as possible, for the child and young person's sake and to maximise parents' chances of successful parenting. The therapeutic assessments will also ensure that any child or young person who is eligible for an NDIS package is identified early.

Current arrangements for assessing the needs of children or young people entering care in the ACT are inconsistent. Children and young people will generally receive a health screening and may be subject to other assessments depending on their presentation. The results of assessments are not always effectively cross-referenced and integrated into case planning. There is no guarantee that a detailed holistic view of the child or young person has been reached and resources allocated to address identified needs. Carers are often unhappy about the quality of care plans and often complain that they have not been adequately consulted.

A range of stakeholders, in particular carers, who have been consulted on the development of the strategy identify the need to have a comprehensive therapeutic assessment of children and young people entering care to identify their needs.

The assessment will inform development of a therapeutic plan for every child or young person and will also inform the child or young person's care plan. The therapeutic plan will be developed with the child and young person so they have a voice and in consultation with their carer and significant others. The plan will focus on supporting their development, building self-regulation of emotions, establishing healthy relationships, identifying appropriate cultural responses to trauma, addressing any trauma-related behaviours and developing social skills. It will form a component of the care or case plan for the child.

The therapeutic plan will be reviewed and updated at regular intervals. The development of a therapeutic plan will also be available for a period of time to children and young people when they are being reunified with their birth parents, placed in a permanent care arrangement or as they transition from care. The plan will allow the supports to follow the child or young person wherever they are on their care journey and not lock services into a child or young person continuing with a particular family or service. The development of a detailed framework for the therapeutic assessment service will need to consider a range of matters including timeframes, tools to support assessments, integration of the plan into care or case planning and implementation, review processes and links to the NDIS.

With the possible identification of greater needs for children and young people in care it will be important for an array of government and non-government sectors to work together to ensure these vulnerable children and young people receive the right support at the right time.

Benefits

- More targeted focus on outcomes for children and young people.
- Development of a specialist team with experience and knowledge of the complex needs of children and young people who have experienced trauma and attachment difficulties.
- Developmental and behavioural needs identified and managed earlier so parents and carers are better able to manage the child's behaviour and families can continue to care for children long term.
- Regular review of therapeutic plans and increased carer input.
- Funds earmarked for therapeutic purposes.
- Objective time series evidence about improvements to a child or young person's wellbeing.

2.2 Trauma Recovery Service

Melaleuca Place, the new trauma recovery service which commenced operation on 1 July 2014, provides high-quality, trauma-informed therapeutic services to children from birth to age 12 who have experienced abuse and neglect and who are current clients of statutory services—either children in care or children in high-risk families receiving support from Care and Protection Services. Work is undertaken with children in the context of their care and support networks, utilising trauma and attachment informed interventions. Therapists work with the child, carers, birth parents, school personnel and any other relevant others for as long as required. Unlike some other programs in the ACT, Melaleuca Place will not require a child to be in a stable placement prior to beginning intervention.

Melaleuca Place will:

- provide services aimed at facilitating healing, recovery and positive life outcomes for children recovering from abuse and neglect
- provide evidence-informed, intensive therapeutic services for children who are clients of statutory services
- lead a trauma-informed, collaborative and flexible approach to service delivery
- enhance the capacity of the child's support network and the wider service system to better meet their developmental needs.

Melaleuca Place is expected to play a key role in supporting the transition to a trauma-informed care system. Increased awareness of childhood trauma across government and non-government service providers has been a by-product of collaborative work undertaken during 2013–14 to create the service.

Benefits

- Specialist assistance for children who are the clients of statutory services.
- Development opportunities for a wide array of service personnel in conjunction with the training and service delivery offered by the trauma recovery service.

2.3 Training in trauma-informed care

Carers are central to the delivery of a therapeutic, trauma-informed system of care as they exercise the primary day-to-day parenting role. They are the child's primary healer. Carers will be integral in contributing to the therapeutic assessments and there will be a strong emphasis on the role of carers in the Care Team. Many carers already have opportunities to train in trauma-informed models of care however this element will see that all carers, both foster carers and kinship carers, enjoy opportunities for in depth training on trauma-informed care over the coming years. Training will be tailored to the needs of carers and the child or young person they care for and to facilitate translation into practice.

Training will also be offered to staff of CSD and the out of home care providers and staff of other relevant government and non-government services, commencing in 2014–15 to lay the groundwork for the new system. This will build on the training already undertaken in the establishment phase of Melaleuca Place.

Benefits

- All staff and carers will be aware of the aims of the new service system and the underpinning trauma-informed practice framework.
- A skilled volunteer carer and paid workforce.

Transforming ACT out of home care services into trauma-informed, therapeutic care services will require a sustained effort over a number of years. It will require upskilling all participants in the care system, building the availability of a skilled workforce including increasing therapeutic resources in the ACT, and aligning organisational culture and service delivery practice with this approach.

3 Strengthening high-risk families domain

The strengthening high-risk families domain increases investment at the front end of the care system in order to divert children and young people from entering long-term care. In risk terms, it is largely focused on managing risks associated with family of origin and it seeks to avoid drift into care and drift in care. The interventions focus on providing practical support and 'hands on' parenting training on an intensive basis over an extended period of time to maximise the chances of success.

There will be a strong emphasis on assertive engagement with families with high risk and on timely decision making, especially for infants and very young children. Legislative amendments are proposed to shorten the maximum length of initial orders from two years to one year where the child is aged two or under at entry to care, in recognition of the importance of providing secure, loving relationships for very young children to lay the groundwork for healthy neurobiological and emotional development. During the one-year initial order period parents will need to demonstrate they are engaged with services or supports that will assist them to address the concerns that led to the child coming into care. Parents will not need to demonstrate 'perfect parenting' in the one-year period but rather will need to show they are committed to addressing their issues and can provide a safe enough environment for their child to return back to their home.

These services are intended to support Aboriginal and Torres Strait Islander families to stay together. The services will be expected to demonstrate cultural proficiency including an understanding of Aboriginal and Torres Strait Islander parenting practices and the ability to successfully engage families in the wider Indigenous community support system.

3.1 Placement prevention

Many children and young people who enter care are returned to the care of their birth parents within a short period, leading to questions about whether the risks to the child or young person might have been alleviated so the child or young person could have remained with their birth parents. Placement prevention services will focus on keeping children and young people at risk of coming into care at home with birth families. Preventing children and young people from entering care will have a benefit to their lives and those of their parents and will also see a substantial financial benefit to the community.

The core of the service model is a team of skilled paraprofessional workers based in a non-government agency who will provide intensive in-home supports, providing practical supports for the family and mentoring and coaching parents and engaging with children and young people. The workers may visit every day if necessary. The workers will be highly-skilled, trained and supported with structured supervision. Similar programs have been developed in Victoria and South Australia with continued success. The program will focus on empowering and building the capacity of parents, improving the physical circumstances in which children and young people live and providing ongoing monitoring of their safety.

It is proposed that placement prevention services are delivered by non-government organisations. Engagement with a non-government agency is more likely to be acceptable to families. It also enables the family to build a relationship with a service to which they can turn in future years if problems re-emerge.

Placement prevention will include skilling parents in engaging with their children, supporting parents with maintaining a safe comfortable home environment, maintaining a daily routine that ensures the safety and wellbeing of the children and young people, developing domestic skills and supporting parents to access services such as Child and Family Centres, mental health services and drug and alcohol services and attendance at early education and care services, health services and schools.

The placement prevention services will cater for families who have come to the attention of the child protection system and have been assessed as high-risk. Care and Protection Services will be the gatekeeper for entry to these services. The Care and Protection Services caseworker and the in-home support worker will work together to support these families and monitor child safety. Placement prevention services will work with clients for up to a year or longer in order for families to be able to make sustained changes.

The services will be particularly beneficial for parents with cognitive impairments (including intellectual and psychosocial disabilities) as the service will offer an individual response depending on the parents' often diverse needs.

Redirected and additional funding to prevent children and young people from coming into care will also allow service providers to think innovatively about the types of supports offered to families. For instance, there are some carers who would offer for a small family to come and reside with them in order to co-parent and role model new skills. This example may be appropriate for a short period of time to allow the family to get back on their feet and to build their networks in the community.

In terms of the *Human Services Blueprint*, which has been adopted by the ACT Government as a guide to future service development (www.betterservices.act.gov.au/human-services-blueprint), placement prevention services are an intensive service offer response to high-risk families. They bridge the gap between early intervention family support services which are open to all members of the community and statutory services. Currently, the ACT has limited structured intensive service responses for those children and young people at significant risk of entering the care system.

Benefits

- Increases safeguards, enabling Care and Protection Services to allow more children to remain at home with their birth family during the course of intervention.
- Reduces trauma for the child or young person associated with being removed from the birth home environment.
- Develops parenting and life skills of parents.
- Facilitates access by parents and children and young people to other government and non-government services to support the child or young person's health, education and developmental needs.
- Prevents further escalation of problems.
- Achieves downstream savings for mainstream services such as health, education and justice.

3.2 Reunification

The first objective of the care system when children and young people enter care is for them to be restored safely to the care of their birth families. Many children and young people who enter care are returned to their parents within a short space of time. Unfortunately many of the children and young people who return to the care of their birth families subsequently re-enter the care system. When there is careful planning and support, reunification is more likely to succeed.

At the present time, Care and Protection Services caseworkers manage the specialised and intensive work of reunification within very large diverse current caseloads. This makes it difficult to focus on intensive support work with birth parents and can adversely impact reunification success rates. Currently, there is not a specific, specialised and intensive service to assist families to have their children returned to their care.

The reunification service model is similar to the placement prevention services model, involving intensive in-home, practically-oriented support services provided by a team of skilled paraprofessionals employed by a non-government organisation. The service will aim to build parents' competency and skills whilst the child or young person is gradually returned home and then supported for a period of time to ensure reunification is successful.

Benefits

- Increased numbers of children, young people and parents successfully and safely reunified in a timely fashion.
- Reduced potential for trauma that can occur when children are returned to their birth families with minimal support.
- Reduced levels of children and young people re-entering care.
- Facilitates access by parents, children and young people to other government services and non-government services to support the child or young person's health, education and developmental needs.
- Better quality evidence to support Court hearings where reunification is unsuccessful.

3.3 Mother and baby unit

On occasion, Care and Protection Services takes infants into care from the hospital maternity ward in order to prevent mothers who are assessed as high-risk from taking their baby home. Where appropriate, mothers should have a chance to parent their child, even if they do not ultimately succeed. The ACT would benefit from an additional mother and baby facility to support mothers with very young children.

The proposed mother and baby unit will provide supervision and support for up to three months in a community-based setting to struggling mothers whose babies are at risk of entering care. The unit differs from ACT Health's Queen Elizabeth II Family Centre which provides residential support for parents and babies or young children for a period of up to five days in a facility which is licensed as a hospital and staffed by health professionals.

Karinya House, a homelessness service, accommodates and supports a small number of mothers and their young babies in a 24-hour supervised and supported environment however the current service is not able to meet the growing needs of the Canberra community. The government has agreed with Karinya House to meet the need for more care arrangements.

The mother and baby service would be used as part of the placement prevention or reunification elements of the Out of Home Care Strategy to support those women who are willing to care for their babies under supervision and to learn how to parent in a safe environment. Where a father is involved and the couple require a service of this type, it is proposed to extend the hours of placement prevention services to provide additional support in-home. The services may also be extended to support kinship carers who may need some assistance with caring for high needs babies.

Benefits

- This intervention program would allow mothers to remain with their babies while risk is closely monitored and they are supported to learn parenting skills.
- Reduced likelihood of these children coming into care.
- Improved health and wellbeing outcomes for vulnerable infants.
- Clear evidence based on direct observation to support legal action where a mother is demonstrably unable or unwilling to care for her child.

3.4 Supported supervised contact of children and young people with their families

When children and young people are removed from their parents' care a decision is made as to the level of contact a child or young person should have with their parents. This contact is often supervised and the information gathered during the contact is used to inform court action and case planning as well as to safeguard the child or young person. At the present time, transport and supervision services are, in many cases, provided by an ever-changing array of casual staff often with no qualifications. It is undesirable for children and young people who are already anxious to be transported by strangers. Further, contact is often only used to observe parents with their children and the quality of reports from contact supervisors is limited. This represents a wasted opportunity to both gain greater insight into the parent–child relationship and parenting abilities and to coach and mentor parents interacting with their child.

A well-developed framework to support the contact of children and young people with their families will better align contact to the child's developmental needs and assist with assessments of risk and enable the contact supervisor to coach and mentor parents during the course of the contact visit. The framework will also help children and young people to have a stronger voice in decision making about the purpose, duration, frequency and type of contact they have with people who are important to them. In many cases children and young people are able to have positive relationships with their birth families when they reside in care and this should be supported wherever possible.

Benefits

- The purpose of the contact is clearly identified therefore increasing its overall effectiveness.
- Potential to increase the success rate of reunification or permanence.
- More positive relationships between birth families, carers, children and young people.
- Assists in the trauma recovery of children and young people.

3.5 Parent–child interaction programs

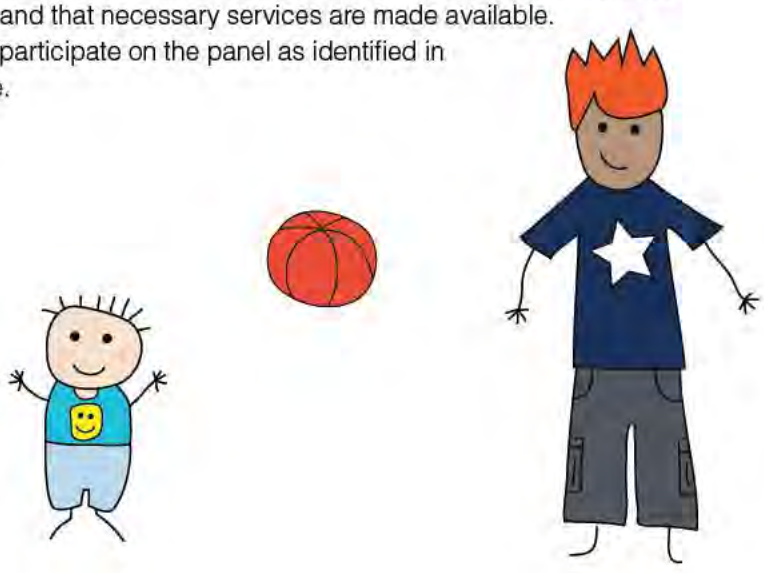
Providing additional intensive specialist support services for both birth parents and carers caring for children with emotional and behavioural difficulties will be important under the strategy in pursuit of maintaining children at home with birth parents or alternatively maintaining them with a kinship or foster carer.

The strategy will fund validated programs designed to assist parents to recognise and meet their child's emotional needs, foster a secure attachment, and to implement behaviour management strategies that focus on positive reinforcement to reduce oppositional and disruptive behaviours exhibited by the child. Research elsewhere suggests that where children and their parents or carers participate in programs of this nature, they are less likely to have further involvement with child protection services or to display problem behaviour at school. These services will provide additional options for families and carers seeking support alongside trauma specific services and services offered through the Children, Youth and Family Support Program.

Benefits

- Assists birth parents to develop appropriate parent–child attachments and to learn how to constructively respond to child behaviour, lessening the risk of harsh or inappropriate parenting.
- Reduced number of children and young people entering the care system and reduced risk to children remaining at home with their birth family.
- Increased support for carers who care for children with attachment and behavioural difficulties, resulting in placement stability.

It is proposed that implementation of the strategy be supported by a series of panels which bring together relevant service providers to provide quality assurance of service delivery activities and to advise on the progress and success of implementation of the strategy. A Strengthening High-risk Families Panel will be created which will oversee and monitor progress to ensure an active focus on placement prevention and reunification is maintained and that necessary services are made available. ACT Health has agreed to participate on the panel as identified in 5.6 Refreshed Governance.



4 Creating a continuum of care domain

The Creating a Continuum of Care domain brings together all of the service elements designed to support children and young people who cannot live with their birth families. The continuum of care is a seamless service that is resilient and responsive to the care needs of children and young people, providing continuity of care over time without fractures or gaps in the care experience of the child or young person. It is a system of care organised around the needs and lived experience of the child or young person.

This domain is largely focused on managing risks relating to child safety and wellbeing in care placements including the suitability of carers and the availability of a home matched to child and young person need within a continuum of care.

Providers will be tasked with providing a continuum of care and achieving better outcomes for children and young people who remain in care long term, including finding permanent alternative families for children and young people wherever possible. This is based on a view that having to rely upon government as your parent is a default arrangement and does not best satisfy a child or young person's needs for love and continuity and a 'normal life'.

A key feature of the reforms is that the non-government sector will gain a larger share of the out of home care business.

Within the continuum of care, providers will need to offer service models that can appropriately support Aboriginal and Torres Strait Islander children and young people and their carers in order to ensure children and young people have access to and are connected to community as they wish.

4.1 Empowering children and young people in care

No care system or service can claim to be therapeutic unless it prioritises active engagement with children and young people and hears and responds to the lived experience of the child or young person.

The strategy proposes to place children and young people at the centre of activity and to rethink how business is done in order to better meet the needs of the child or young person.

This proposition is not as simple as it sounds and will be challenging for both government and non-government providers. Hearing the voice of the child is operationalised in many different ways in ongoing work with and for children and young people. A commitment to a therapeutic approach and hearing the voice of the child will require both structural and cultural change in services and skills enhancement for a range of participants across the system. Both government and non-government services will need to hold themselves accountable for monitoring and reflecting upon their performance in this respect.

Care and Protection Services has undertaken several actions recently designed to facilitate hearing the voice of the child or young person. Care and Protection Services has trialled Viewpoint, a computer-assisted, self-interviewing software package for children and young people. It will be rolled out across all children and young people during 2014–15 and inform Annual Review Reports. Care and Protection Services has also incorporated requirements to record the views and wishes of children and young people into proformas developed for the Care and Protection Services Integrated Management System.

It is anticipated that the therapeutic assessments which will be conducted by specialist assessors will support government and non-government services to hear the voice of the child or young person. The assessor will bring a skilled, independent and child-focused perspective to assessing the child's wellbeing and planning for the child on an annual basis.

4.2 Continuum of care

A key initiative within the strategy is the contracting of a continuum of care. This means that a child or young person who is in long-term care will have just one organisation responsible for their care over the course of their time in care. This initiative is designed to empower organisations to develop a service system that reduces the need for children and young people to move to multiple homes. The present system of care might mean that if a family situation breaks down, the child or young person could find themselves moved to a totally different provider and service system. When one organisation is responsible for providing for all needs of children and young people and their carers it is believed that the experience for children will be improved; and agencies will be able to respond better and in a more timely fashion to ensure families get back on track when there are difficulties.

The strategy proposes that offering a continuum of care for children and young people provided by a single provider or a consortium of agencies is instrumental in delivering a system that best caters for the needs of very vulnerable children and young people. Children and young people need stable placements with opportunities to build relationships with people that will invest in them throughout their time in care.

Under the existing contracts, CSD purchases standalone foster and residential care services. In re-tendering out of home care services CSD will seek providers who are prepared to assume responsibility for a cohort of children and young people through to maturity, providing a suite of care arrangements that provide step up–step down options where intensity of care needs change for a child or young person. Services may choose to provide a residential care option or they may design for alternative supports that can be stepped up in intensity depending on the child or young person's needs.

Benefits

- The child or young person will be cared for long-term by a single provider or consortium of providers.
- Service providers will address emerging child or placement-related problems early and actively.

4.3 Case management

The strategy provides for case management of and long-term decision making for all children and young people on long-term orders (orders to 18 years) to be outsourced to non-government agencies. This will provide autonomy for providers in managing arrangements for the children and young people in their care and will assist in normalisation of the lives of these children and young people. Decisions will be able to be made more speedily and closer to the child or young person and their carer.

Care and Protection Services will continue to focus on the front-end of child protection and resolving risk in relation to birth families. Care and Protection Services will retain case management of all children and young people at risk of coming into care and any child or young person on a short-term or interim order. Care and Protection Services staff will be responsible for case managing those children and young people whom we are trying to keep at home with birth families or reunifying them with their birth family if they have been removed. Once the Children's Court has determined a child or young person cannot safely return home to their birth family and has made long-term orders, case management will be transferred to a non-government provider. When developing the service model for case management, it will be vital for government and non-government providers to clearly articulate the roles and responsibilities of the two agencies to reduce the potential for misunderstandings and to ensure that red tape reduction benefits are realised.

Currently the Act focuses primarily upon the responsibilities of birth parents, the Director-General and carers. The legislation will be amended to provide clarity concerning the roles and responsibilities of non-government providers. The amendments will enable delegation of long-term decision making to non-government providers so that they are able to exercise autonomy in making decisions about the children and young people on long term orders in their care.

It is recognised that non-government providers will need to maintain and build strong links across the wider government and non-government sector to ensure the children and young people they case manage can access timely and appropriate services.

Benefits

- An end to conflict created by the current three-way relationship between carers, agencies and Care and Protection Services staff.
- Greater investment and growth in the capability of the community sector.
- A reduction in red tape by allowing greater autonomy in decision making by the agencies.
- Opportunities for the non-government providers to innovate and tailor services to the child or young person and their birth or carer family's needs.
- Easier, quicker opportunities to secure permanency of the relationship where that is appropriate.
- A more normalised experience for children and young people in long-term care.

4.4 Outsourcing kinship care for children and young people on long-term orders

Currently, Care and Protection Services manage kinship care. Kinship care is preferenced in the ACT and this will continue. As a consequence, at the time they take a child or young person into care, Care and Protection Services seek to identify suitable relatives or friends of the family who are willing to care for a child or young person. Care and Protection then assess, approve and support the kinship carer. CSD established a dedicated kinship care support team in 2011 which has achieved excellent outcomes with kinship carers. Nevertheless, caseloads are higher than in the non-government sector. The strategy provides for the gradual outsourcing of kinship care and case management for the child or young person where children are on long-term orders.

CSD recognise many kinship care situations are inherently complex and kinship carers often have very different needs to foster carers. It should be acknowledged that some kinship carers do not require support and prefer to manage without assistance. However, it is important that where support is required, kinship carers can readily connect with it. Consultations and the kinship carer survey, conducted to support the development of the strategy, suggest that not all kinship carers are aware of entitlements or services.

Outsourcing management of kinship care to non-government providers where the placement is long-term will allow kinship carers to receive an equivalent level of support to that enjoyed by foster carers even if the services they are offered differ in some respects. The transfer of existing kinship carers to the non-government sector is likely to be staggered over three years.

Benefits

- Greater equity of access to support across kinship carers and foster carers.
- Service models that are developed specifically to meet the unique and often complex needs of kinship care arrangements.

4.5 Revised arrangements for reimbursement of carers

The strategy seeks to provide financial support for children and young people in care on a child-focused, flexible basis to the greatest extent possible, enabling payments to step up or down depending on a child's needs.

The majority of ACT carers currently receive the highest subsidy in Australia. The subsidy is intended to contribute towards the costs of the child or young person for day-to-day expenses such as food, household provisions and costs, clothing and footwear, school uniforms, daily travel, car restraints, gifts, pocket money, holidays, hobbies and extracurricular activities, general educational costs, general medical and pharmaceutical costs and general communication costs. Currently carers can receive four different levels of subsidy depending on the child or young person's needs. The subsidy also varies based on three age bands, creating 12 payment levels.

The Out of Home Care Strategy provides for an age-related core payment of the base subsidy with additional needs met on a flexible basis through what are called 'contingency payments'. The therapeutic assessments discussed earlier in this paper will assist in identifying the additional needs of the child or young person which will be funded as agreed through the child's care plan. Carers will play an integral role in the development of the care plan and will be encouraged to identify supports that will ensure the child or young person's placement remains as stable as possible. The plan will be reviewed regularly to ensure carers are able to identify and access supports as they are needed for the child or young person in their care.

Only a small proportion of children and young people in care currently attract higher subsidies. Carers who are currently receiving a higher subsidy will have payments grandfathered for existing care arrangements.

Currently, CSD purchases 36 days of respite care as part of the unit price. Very few carers receive the full respite care entitlement and many receive no formal respite care. For some carers respite is important, however, many carers prefer to keep the child or young person with them in order to maximise the child or young person's sense of security and to avoid potential behavioural and other problems that may arise from disruption to routines. As an alternative to respite, the strategy will enable additional support to be provided to carers where that is reasonable to enable a carer to spend quality time with a child or young person.

Benefits

- Greater equity and fairness in reimbursement for costs incurred in looking after a child or young person—currently there is scope for uncertainty and debate in allocation of higher subsidies.
- The proposal unlocks money that is currently tied up in fixed costs and allows best use of limited resources across the cohort of all children and young people in care on a needs related basis.
- More flexible use of discretionary funding, for example, some carers would prefer in-home help rather than respite to which they are all theoretically entitled but which only a minority receive.

4.6 Supports for permanency

There needs to be a greater focus on achieving permanence in a timely manner for children and young people who remain in long-term care. Permanence helps children and young people achieve good emotional wellbeing and supports all dimensions of their development. Permanency allows children and young people in care to feel secure and allows children, young people and carers to enjoy autonomy as a family. Early consideration of permanency supports the best possible developmental outcomes for all children and young people, but particularly very young children.

Permanency can be achieved through either an adoption order made by the Supreme Court or an Enduring Parental Responsibility order made by the Children's Court. For a variety of reasons, one order may be more suitable for a child or young person than the other. For example, adoption will not generally be considered for Aboriginal and Torres Strait Islander children and young people. This is because most Aboriginal and Torres Strait Islander advocates do not support adoption of Aboriginal children or young people because of past abuses and because adoption changes a child's legal identity, severing legal connections to the birth family. For each individual child and young person in care, consideration is required of the best option given their circumstances.

Care and Protection Services currently operates a small team to undertake adoption and permanent care work. With an increased emphasis within the strategy on permanency for children and young people the investment in permanency solutions will be enhanced, which may include registration of additional adoption agencies as part of non-government agencies providing a continuum of care.

Children need to develop secure attachments early in life. Legislative amendments are proposed to shorten the waiting period for an Enduring Parental Responsibility order (where a child or young person is in a stable long-term family) to one year, instead of the current two years. The process for obtaining an Enduring Parental Responsibility order will also be reviewed to reduce any duplication in the assessment process.

Benefits

- Greater emotional stability and sense of normalcy for the child or young person by giving them a sense of permanency.
- The increased availability of children and young people to join a family on a permanent basis may attract a wider range of carers.

4.7 Extended continuum of care for care leavers up to 21 years of age

Young people who leave the care system have much poorer outcomes than other young people when they transition to adulthood as evidenced by research. Improving life chances and life outcomes for care leavers is important not only for the individuals concerned but also for the wider community. It will reduce the downstream social and economic burden of the increased health and justice costs incurred by this cohort in adulthood. It will also break what is often an intergenerational cycle that sees the children of many care leavers taken into care.

Young people who are approaching the age of 18 and the end of their time subject to a Care Order often feel anxiety and uncertainty as to whether they will continue to be supported.

Under current arrangements, the majority of supports for young people cease at the age of 18 and young people are left to make their own way. This arrangement does not approximate the process and timing of leaving home for young people who are a part of the wider population.

In 2012, Care and Protection Services commenced providing a level of support for the first time to care leavers up to age 25. A small team of specialist caseworkers was established and brokerage funding was made available to assist care leavers with one-off expenses. This team has been highly effective in assisting young people however it is clear this service needs to be enhanced.

The Out of Home Care Strategy will:

- if needed, extend the therapeutic plan and any associated outlays to young people as they mature out of the care system
- extend the subsidy paid to kinship carers and foster carers in select cases where it can be demonstrated that the young person's wellbeing will otherwise be jeopardised by the cessation of subsidy at 18. This will be for a period of time not exceeding the young person's 21st birthday
- increase casework resources dedicated to supporting young people in care as they transition to adulthood. This will be particularly beneficial to Aboriginal and Torres Strait Islander young people when they seek to re-establish family and cultural connections.

Benefits

- Young people experience a positive transition into adulthood.
- Reduced downstream costs for other service systems such as health and justice.
- Aboriginal and Torres Strait Islander young people are supported to reconnect with family and cultural as they wish.
- Improved health and wellbeing outcomes for young people through access to supports including employment, training, education and health.
- This initiative will be welcomed by carers who often are continuing to support young care leavers at their own expense.

4.8 Salaried foster care

There are a small number of children and young people who present with very complex and challenging behaviours, generally because of their exposure to abuse and neglect. These children and young people often struggle to live and function in a normal home-based setting. This is coupled with carers struggling to be able to provide enough support and attention to the child or young person's needs whilst juggling their own careers, other children and other commitments.

Currently children and young people presenting with complex needs are managed in residential care or through very expensive, individualised, intensive support packages. These children and young people are often cared for by a roster of workers in a house owned by ACT Housing. This rotation means the child or young person will have difficulty building an attachment to a single caregiver and leads to continual disruption to the child or young person's routine as it is interpreted by many different workers.

The introduction of a small pool of salaried foster carers will add another option to the care system for those children and young people who will benefit from home-based care, are too young to enter residential care or have ongoing complex needs such as a disability. Salaried foster care can also provide a step down service to help move children and young people out of residential settings and into home-based care. It can also assist with catering for large sibling groups who are often spread across multiple kinship carers or foster carers due to lack of options. In this case, two carers, for example a couple or a mother and adult daughter, would be employed full-time.

Employment law, training and qualifications, health and safety, taxation and remuneration are all relevant considerations. Development of a professional foster care option is an action under the *National Framework for Protecting Australia's Children 2009–2020—Second National Action Plan 2012–2015.* State and territory child protection administrators are working with the Commonwealth Government on this issue, in particular, seeking a resolution to industrial relations barriers to 24/7 employment.

Only a small number of children and young people assessed as having very high needs will be eligible for salaried foster care services.

Benefits

- Better outcomes for children and young people, with complex needs, through provision of an intensive service within a normal home environment.
- Provides an option for large sibling groups.
- Significant cost-savings compared to residential care in both capital and operating costs.

4.9 Therapeutic residential model

Residential care accounts for 7 per cent of all children and young people in care in the ACT. Residential care is often seen as a placement of last resort for young people with complex needs and challenging behaviours, before they move to adulthood.

Residential care settings are commonly used to support young people who have suffered multiple family breakdowns or who have some other kind of very high need which makes finding a foster carer difficult.

The evidence base suggests that residential care does not generally result in positive outcomes for children or young people other than for those services which offer a robust, well-defined therapeutic model of service provision.

Residential care is not a preferred option in the proposed Out of Home Care Strategy. However, there is a continuing need at this time for residential care places. Consequently every effort must be made to ensure that residential care programs are genuinely therapeutic and allow young people to reside in a home that is focused on their long-term needs and on addressing the impact of abuse and neglect. Other appropriate uses of residential care might be to stabilise a young person before they are transitioned back to their birth parents or to a kinship carer or foster carer. Residential care may be used to offer mediation and much needed time out in these situations for the young persons and the family.

More agile, responsive residential care services are needed which can scale up or down in response to the needs of individual children and young people and of the service system overall. If this can be achieved, services will better meet the needs of children and young people as well as being more cost effective.

The current model for residential care is placement-based (the funding is attached to the purchased placement) rather than being driven by the needs of the young person. This initiative relates to increasing the flexibility of residential care so that there is a clear aim and therapeutic purpose to the service. The model proposes pricing based on a mix of fixed and variable costs to support residential care services. Children and young people in residential care will also attract the therapeutic payments which are identified and funded using the young person's therapeutic plan. Residential care will continue to be outsourced to non-government providers, but as part of a continuum of care, not as a standalone service.

There is an opportunity for residential care providers to propose innovative, new models of residential care, for example, step down supported transition from care living arrangements.

Benefits

- Young people will benefit from a more therapeutically-focused residential care environment.
- More effective utilisation of resources—funding is not tied up to the same extent as currently in underutilised facilities and fixed pricing but is freed up to be allocated to best meet the needs of children and young people in care.

4.10 Independent advice for Aboriginal and Torres Strait Islander children and young people

Aboriginal and Torres Strait Islander children comprise around 25 per cent of the children and young people in care in the ACT currently. To better support our Aboriginal and Torres Strait Islander children, action is being taken to strengthen placements and support for Aboriginal and Torres Strait Islander children and young people so that they can stay connected to their families, their culture and their country. Independent, community-based cultural advisors will assist in strengthening decision making about Aboriginal and Torres Strait Islander children and young people by advising on:

- placement of children and young people in care
- development of cultural plans
- transition from care arrangements.

Benefits

- Greater Aboriginal and Torres Strait Islander community participation in decision making.
- Greater identification of needs and support services for Aboriginal and Torres Strait Islander children and young people.
- Adherence to the National Out of Home Care Standards.

4.11 Child health passport

It is widely recognised that children and young people in care tend to have poorer health than the mainstream population as a result of the abuse and neglect experienced prior to entry to care and that the effects of early health disadvantage can last a lifetime. It is very important that the health needs of children and young people entering care are identified and addressed as early as possible.

ACT Health is actively involved in supporting vulnerable parents and children and young people in care through a variety of programs including the Child at Risk Health Unit (CARHU), maternal and child health programs, drug and alcohol programs, mental health programs and mainstream health care services.

Every child in care is required to have a health screen when they enter care and the CARHU provides services to most children and early adolescents, while The Junction Youth Health Services also assists with health screens for young people entering care.

CSD and ACT Health are building upon the existing base of services to develop a Child Health passport. A Child Health Passport is a mechanism to share important health and medical information about children and young people in care. Carers are frequently frustrated with the lack of information they receive about children and young people when they first come into care or move to a new home, including their health needs. The Child Health Passport is a record of a child's medical and health needs that accompanies the child on their journey.

Benefits

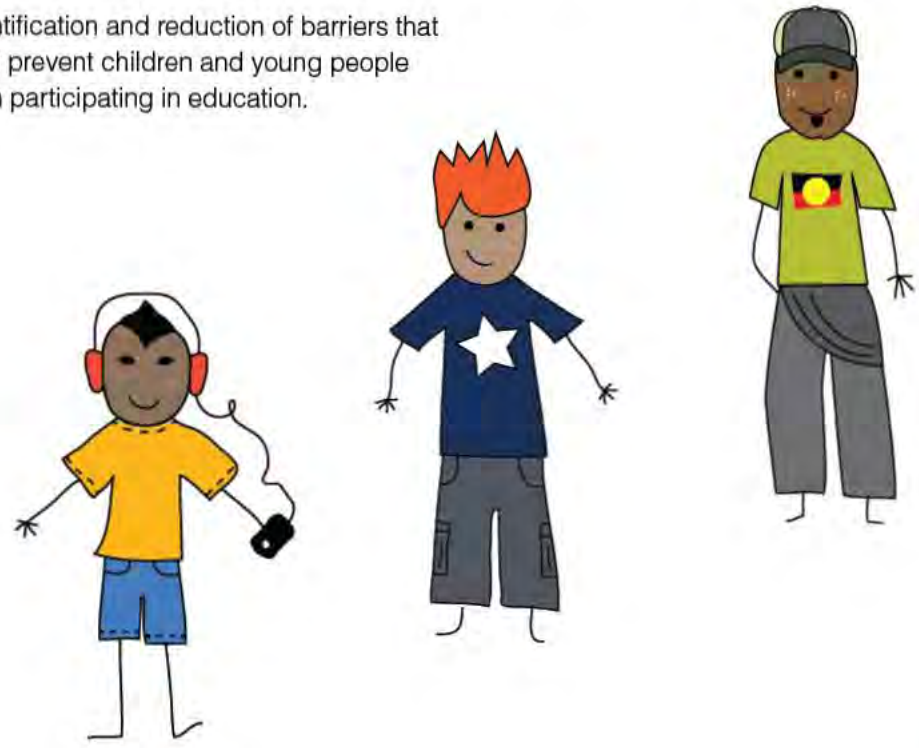
- Improved information sharing about the health background of the child or young person.
- Reduces the risk that the child's immediate health needs will be overlooked.
- Adherence to the National Out of Home Care Standards.
- This initiative will be welcomed by carers who feel at risk currently in receiving children without adequate health documentation.

4.12 Joint Education and Training Pathways Initiative

After family, a child or young person's teacher is often the most important person in a child or young person's life. Schools and teachers have an important role to play in supporting children and young people in care and helping them reach their potential. Improving education, training and employment outcomes for children and young people in care and care leavers is an important goal for the strategy. To this end, the ETD and CSD have agreed to establish an ongoing joint mechanism, along with non-government out of home care providers, to support children and young people in care with education and training needs. This may include assistance for carers to help children and young people access schooling, increased recognition of the impact of trauma on children and young people and its effects on school participation and greater access to programs that assist with socialisation and development.

Benefits

- Improved life chances as a consequence of improved education and training outcomes for children and young people in care.
- Identification and reduction of barriers that may prevent children and young people from participating in education.



5 Strengthening accountability and ensuring a high-functioning care system domain

The strengthening accountability and ensuring a high-functioning care system domain responds to some of the deficiencies in both purchasing and provision of out of home care services identified in external reviews and audits of Care and Protection Services and out of home care. It includes activities designed to ensure the care system operates safely, effectively, efficiently, equitably and sustainably.

Key systems outcomes sought include:

- a stronger, safer, more sustainable out of home care system with improved governance and regulation, an agreed performance framework, enhanced information sharing capabilities and consistency in policy and practice across agencies
- the most cost-effective and equitable application of available resources.

The strategy provides for the transfer of significant additional responsibility to non-government providers. Building the capacity and capability of the non-government sector to meet the challenges posed by new policy directions will be important along with building CSD capabilities in new or strengthened activity areas such as accreditation, quality assurance and performance contracting. CSD will actively engage with providers and other relevant parties to this end.

5.1 Accreditation and monitoring

When the territory removes a child or young person from their parents' care, it must actively exercise its duty of care to ensure that the child or young person is cared for in a safe environment and receives a better standard of care than she or he would have received at home.

It is important to acknowledge that it is not possible to eliminate all risk in the provision of out of home care for vulnerable children and young people. By its very nature, provision of care services for babies through to older teenagers necessitates acceptance of a variety of risks and requires a robust accountability and risk management framework to be wrapped around service delivery.

Reviews by the Public Advocate and Auditor-General have suggested that oversight and monitoring of the out of home care service system is currently inadequate. Additional investment is required to strengthen accountability mechanisms across the out of home care sector.

The ACT Government agreed in 2013 to the establishment of an out of home care accreditation scheme in response to the Auditor-General's performance audit of Care and Protection Services. The Auditor-General recommended that quality accreditation of out of home care community service providers should be undertaken by CSD allowing the Public Advocate and the Children and Young People Commissioner to independently monitor services. However, the Auditor-General specified that the accreditation function should not be in the Care and Protection Services Branch. This service is currently in development through the central policy area of CSD.

Ongoing quality assurance of services is also required beyond achievement of an accredited status. CSD needs to be able to undertake a high level of monitoring particularly in light of the proposed significant increase in the responsibilities of the out of home care agencies and the associated risk transfer.

The strategy provides for monitoring and evaluation of services to occur against a rigorous performance framework currently in development (see below). These activities will include observing the practices of the service, reviewing files and other relevant documentation, validating performance reports and interviewing children and young people, carers and birth parents about the service they receive.

Benefits

- Clear accountability mechanisms to provide assurance of the safety and quality of services.
- Increased confidence of government, the community and service users in the safety and quality of services.

5.2 Strengthened contract management

The strategy directs additional resources to strengthening contract and relationship management. CSD needs to be able to ensure that it is receiving best value from purchased services and to achieve this it must invest to a higher degree than previously in relationships with providers and in analysis of business outcomes to support strategic management of purchased services. In addition, more flexible child-focused purchasing arrangements will require a greater level of oversight and scrutiny to ensure children and young people are receiving the best possible care.

Benefits

- Strengthened accountability, value and outcomes from purchased services.

5.3 Performance-based contracting

An Out of Home Care Performance Framework is currently in development with a focus on both compliance with legislated and policy requirements and outcomes for children and young people. The framework will provide for a range of meaningful outcomes measures that are focused on obtaining outcomes that are in the best interests of the child or young person.

CSD is working towards introducing performance-based contracts for out of home care providers which will provide for regular performance reporting and which positively incentivise contracted services to meet key performance targets. Providers would be required to utilise the incentive funding to enhance services through investing in capacity building and innovation.

Benefits

- Clarity concerning the expectations of CSD as the purchaser of services.
- Continuous improvement of services driven through performance reporting and validation.
- Additional funding available to high-performing services for innovation and capacity building.

5.4 Adoption of the National Out of Home Care Standards

In July 2011, the National Out of Home Care Standards were published as an important achievement under the *National Framework for Protection Australia's Children 2009–2020*. The National Out of Home Care Standards were developed following significant consultation across Australia with the government and non-government out of home care sector.

The national standards are child and young person focused, are designed to improve outcomes for children and young people in out of home care and commit each state and territory to achieving better care for children and young people consistent with the principles of the United Nations Convention on the Rights of the Child.

The ACT is planning to adopt the National Out of Home Care Standards as its own. The standards support the objectives of the *Children and Young People Act 2008* and the vision of the strategy.

The standards will form a key element of the out of home care accreditation and monitoring scheme and will be reflected in contracts with out of home care service providers.

Benefits

- The standards are child- and young person-focused which complements the vision and direction of the strategy.
- Adoption of the national standards may reduce the reporting burden for agencies that operate across jurisdictions.
- The standards identify best practice in service responses for children and young people in care.

5.5 Renewal of carer approvals

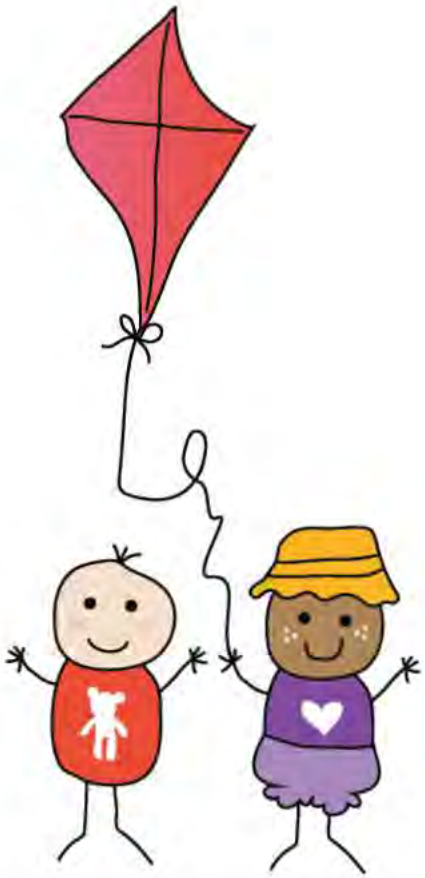
Assuring the continuing suitability of carers is an important element in terms of accountability for the wellbeing of vulnerable children and young people. Currently ACT carers are not subject to re-approval at regular intervals. This is out of step with other jurisdictions and represents a risk to children and young people. While the very great majority of carers are generous-spirited, law abiding citizens, in a small number of cases, carers or associates of carers are subject to substantiated abuse allegations or even criminal charges in relation to their conduct towards a child or young person in care.

Foster carers and kinship carers will be required to have their authority to care renewed every three years to ensure that children and young people are cared for by people and in circumstances that continue to meet the suitability requirements. Renewals will be tied to renewals of the Working with Vulnerable People Checks to minimise inconvenience. The renewal process should not prove onerous if out of home agencies have been staying in touch with carers and their circumstances and would be part of a continual assessment of the carer's situation.

Carers who parent children or young people subject to adoption orders or Enduring Parental Responsibility orders will not be subject to the carer renewal process as a court has already determined their ongoing suitability to care for the child or young person.

Benefits

- Assurance to government, community and service users as to carers' continuing suitability.
- Enables CSD and providers to accurately quantify the number of active carers.
- Provides a formal, structured opportunity at regular intervals for CSD and agencies to raise any concerns with carers.



5.6 Refreshed governance

Refreshed governance arrangements are required to strengthen the performance of the out of home care system.

Non-government providers will hold the biggest share of the business in the new environment and will be able to exercise more autonomy; however they will still need to work closely with CSD in supporting children and young people in placement prevention and reunification services and in relation to children and young people on short-term orders placed in foster care. In addition, while the Director-General, CSD may choose to delegate responsibility for long-term care decisions for children and young people on long-term orders to out of home care providers, she remains the responsible officer supporting the responsible Minister for the execution of the programs of CSD. It is important that she is assured that children and young people are receiving quality care and support that serves their best interests.

Joint governance mechanisms are required to plan and implement the new out of home care system and these will be established once service providers have been selected through an open tender process.

In addition to an overarching joint governance mechanism, a number of practice-focused panels with a mix of quality assurance and monitoring and coordination functions will be established which bring together representatives of out of home care providers and Care and Protection Services. As part of joint consideration of the number and focus of panel activity, operating arrangements for existing panels will be refreshed and standardised.

At a minimum, the panels proposed will include a Strengthening High Risk Families Panel which will regularly review cases where placement prevention or reunification is the goal, ensuring a strong focus on preventing entry to care and drift in care wherever possible and that necessary services are available.

A Continuum of Care Panel or a series of panels will also be required to support a range of activities in care services.

In some cases panels may include other members such as carer representatives or representatives from other government directorates or non-government programs. For example, ACT Health has agreed to contribute to the Strengthening High Risk Families Panel given the prevalence of substance abuse and mental health issues among families of children in care and the key role played by hospitals, Maternal and Child Health nurses and other ACT Health Personnel.

Benefits

- A shared understanding across all agencies and CSD of the strategic direction and progress in implementing the strategy on an ongoing basis.
- Improved consistency of response to service users across multiple providers and CSD.
- Sharing of information and practice wisdom will result in improved outcomes for clients and assist program development.

5.7 Information management

A quantum improvement in information management is required for out of home care services. Community expectations about the extent and quality of information collected to support children and young people in care has risen sharply in the information age.

Ideally, in an outsourcing environment, information would be shared seamlessly between Care and Protection Services and the out of home care agencies to support better outcomes for children and young people and to support the most efficient and effective operation of the system.

The current fragmented arrangements involving two separate case management systems—CHYPS for Care and Protection Services and Looked After Children Electronic System (LACES) (or MyStory in the future) for the non-government sector means that communication issues arise that impact the child and young person and carers and erode productivity. An electronic record project is underway to examine the feasibility of replacing CHYPS and sharing information with non-government providers electronically.

Additional investment is proposed to drive improved record keeping and information management, including improving compliance and to support developmental information initiatives such as Life Story work which ensure children and young people and care leavers have meaningful access to their life histories.

Benefits

- Better information and case management will result in improved outcomes for clients.
- Increased compliance with the *Territory Records Act 2002*.
- Improved information collections and processes for sharing information with current and former children and young people in care about their time in care.

5.8 Carer Advocacy and Support

If case management of children and young people is outsourced to non-government agencies there needs to be an established mechanism for individual carers to express any concerns and seek support about actions and decisions by either the agencies or Care and Protection Services.

A service that is independent of Care and Protection Services and the agency will be required to assist carers as they seek to negotiate and resolve issues with their agency in the first instance. This is envisaged as a small service, attached to an appropriate agency outside the out of home care sector that would employ a panel of fee for service advocates. There is no existing foster and kinship carer advocacy program in the ACT, although CSD does fund free access for carers to counselling services through Relationships Australia.

Benefits

- Practical expression of support for carers who experience difficulties in the role.
- Carers will have a support mechanism separate to Care and Protection Services and agencies.
- The service provides an opportunity to seek resolution of conflicts wherever possible without resorting to litigation.

5.9 Birth family advocacy and support

Many parents have access to advice and advocacy services if they are legally represented or supported by the ACT Disability, Aged and Carer Advocacy Service (ADACAS) or other community agencies with which they have a relationship. However, some birth parents may not qualify for an advocate or may not have been able to establish a satisfactory relationship with any individual or agency that might fulfill this role.

This service element aims to ensure that every parent who needs an advocate can have access to one. Grandparents and other members of the extended family may also feel they need independent advice and support to challenge decisions of CSD or the out of home care agency.

It is proposed to fund a small family advocacy service attached to an appropriate agency outside the out of home care sector to ensure that birth parents or other family members have the opportunity to discuss any concerns with a knowledgeable person and to explore their options in relation to decisions of CSD or the non-government out of home care provider. The service might also support parents when their child has been removed and they want some assistance to access appropriate support services.

Benefits

- Practical expression of commitment to parents' rights.
- The service provides an opportunity to seek resolution of conflicts wherever possible without resorting to litigation.

6 The way forward

It is important to acknowledge that it not possible to make the leap to a new therapeutic, trauma-informed care system overnight. Introduction of the proposed new care service system represents a major departure from current practice. It will be a journey necessitating awareness building, skills and knowledge development, the development of new service models and organisational and program alignment over a number of years. A significant effort will be required across both the government and non-government sectors to develop the new arrangements ahead of implementation and to drive extensive cultural change in order to see full and effective implementation of the new directions.

Implementation is a journey which will require willingness on the part of both government and non-government providers to relinquish old ways of doing things in pursuit of better outcomes for children and young people. It will of necessity involve taking calculated risks and a willingness to reflect on what is working well and what may need to be adjusted over time. Nevertheless, it is a journey worth taking and one that needs to be taken together in partnership.

In addition to the preparation period of 2014–15, which will involve intensive planning and change management work, there will be phased implementation of the strategy over its first three years of operation—2015–16 and 2017–18—to allow for such matters as the gradual building up of additional workforce elements and warm handover of kinship carers and the children and young people they care for to non-government providers.

An Out of Home Care Taskforce will be required for a period of two years to support the implementation of the new service system. Consideration is required of how best to support change management and capacity building in the non-government sector as well as in CSD and other relevant government agencies. Refreshing and strengthening relationships will be critical to the success of the strategy.

Equipping all participants to contribute to a therapeutic, trauma-informed system of care represents a substantial training and development exercise in its own right and substantial funding has been made available by the ACT Government to commence this task in 2014–15. Carers, both foster carers and kinship carers, must be acknowledged as central to the provision of a therapeutic, trauma-informed care system. Carers will be prioritised for initial training.

Other key activities include:

- development of an operational framework which describes in some detail how the many elements of the care system will work together
- procurement of service providers
- development of new service models
- legislative change
- development of, or amendments to, policies and procedures, including potential amendments to CHYPS
- development of a workforce strategy, including a training plan

- development and testing of the Performance Framework
- stakeholder communication program
- commissioning of a formal evaluation.

It will be important to invest adequately in implementation of the strategy, associated change management activities and evaluation mechanisms in order to deliver a well designed new care system with maximum chance of success in achieving stated objectives. It is important that there is a planned and smooth transition to the new system to the greatest extent possible which minimises risk for the clients, particularly children and young people, and for government, the directorate, service partners and the community.

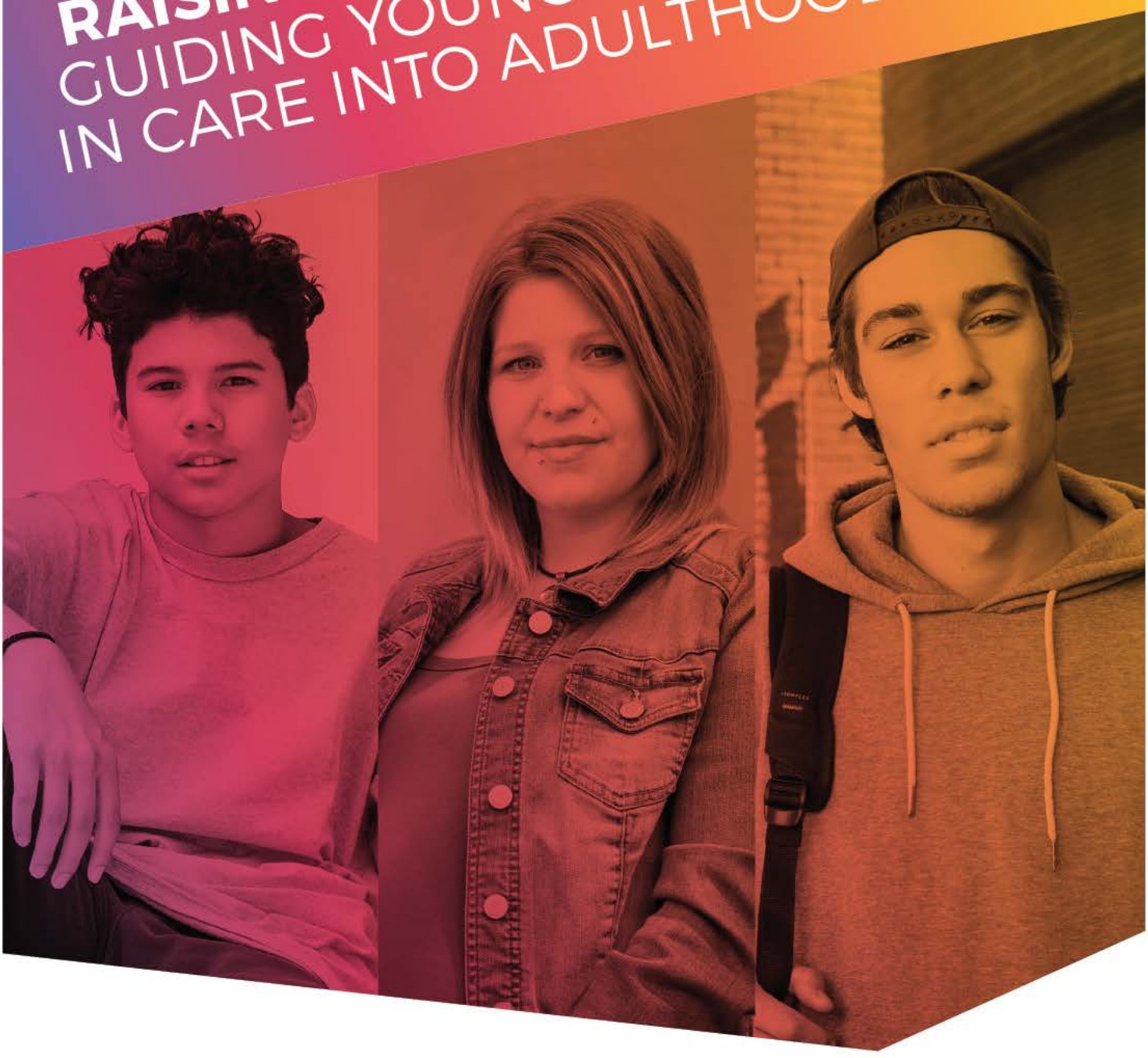
Joint governance arrangements will be finalised and established once service providers have been selected via an open tender process during 2015.

An independently-chaired review panel will report to the Minister for Children and Young People over the course of 2014–15 and 2016–17 on progress in implementing the Out of Home Care Strategy in recognition of the significance of this reform initiative to the future wellbeing of the ACT's vulnerable children and young people.

Notes

Anglicare Victoria

RAISING OUR CHILDREN: GUIDING YOUNG VICTORIANS IN CARE INTO ADULTHOOD.



Socioeconomic Cost Benefit Analysis by Deloitte Access Economics

April 2016

Report commissioned by Anglicare Victoria

BETTER TOMORROWS

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Glossary

ABS	Australian Bureau of Statistics
AB12	Assembly Bill 12
AHURI	Australian Housing and Urban Research Institute Limited
AIC	Australian Institute of Criminology
AIHW	Australian Institute of Health and Welfare
AOD	alcohol and other drugs
ASFA	*Adoption and Safe Families Act*
AWOTE	average weekly ordinary time earnings
CAS	Children's Aid Societies
CCSY	Continued Care and Support for Youth agreement
CPI	consumer price index
CSO	Community Service Organisation
DAE	Deloitte Access Economics
DALY	disability adjusted life years
NCVER	National Centre for Vocational Education Research
NPV	net present value
NSW	New South Wales
OOHC	Out of home care
UK	United Kingdom
USA	United States of America
VET	Vocational Education and Training

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Executive Summary

Context

While parents have the primary responsibility for raising their children and providing support, the *National Framework for Protecting Australia's Children 2009-2020*[1] notes that where the home environment is not safe enough for children, children are to be placed in the care of the state; in out-of-home care (OOHC). OOHC involves the placement of a child or young person with alternate caregivers who have legal custody of the child until the 18 years of age[2].

OOHC can be arranged either formally or informally. Informal care refers to arrangements made without intervention by statutory authorities or courts, and formal care occurs following a child protection intervention (either by voluntary agreement or a care and protection court order)[3]. The majority of children placed in OOHC are subject to child protection intervention[4].

In Australia, state and territory governments have a statutory responsibility for ensuring children are protected from harm caused by abuse and neglect. In Victoria, this responsibility is exercised by the Department of Health and Human Services (the Department). A key function of the Department's child protection role is providing OOHC to children and adolescents in need. For the vast majority of children, OOHC is provided either through a kinship care or foster care model. The latest figures from the Australian Institute of Health and Welfare (AIHW) reports that at 30 June 2014 there were 7,710 children in OOHC (both residential and non-residential) in Victoria and 43,009 children in OOHC across Australia.

A vast body of literature documents the multitude of inter-related, relatively poor life outcomes experienced by an inordinately high proportion of care leavers. The relative disadvantage experienced by this group spans from a number of confluent factors including a history of abuse or neglect, ongoing poor health, ongoing poor mental health, substance abuse, homelessness, poverty, unemployment and violence[5]. Traditional support structures – family, friendship circles and community – are more likely to be broken for this cohort, limiting the social support individuals can leverage to break the cycle of disadvantage which, if left unaddressed, has the potential to span several generations.

The disparities in care-pathways between children in out of home care (OOHC) and those resident in traditional care structures is poignantly highlighted in the abrupt and instituted end of formal state care at the age of 16-18 years. The state, as the effective parent, ceases to provide ongoing financial, social and emotional support as a care-giver. Indeed, where operational, current care leaving programs that seek to equip individuals for the exit from care at the age of 18 commence at the age of 15[6]. For this reason, for a young person in OOHC, the process of leaving care has commenced well before adulthood.

[1] Council of Australian Governments (2009)
[2] Council of Australian Governments (2009)
[3] Australian Institute of Health and Welfare (2015
[4] Australian Institute of Health and Welfare (2015)
[5] See for example: Mendes, Johnson, Moslehuddin, (2011) Osborn, & Bromfield, (2007)
[6] Department of Human Services (2012)

A review of Australian research, including a report by the Victorian Ombudsman, found evidence that some young people had little or no preparation for leaving care, and no leaving-care plan[7].

By contrast, young people in the general population are now more likely to continue to live with their parents well into their mid-20s, entering and exiting the family home several times as they pursue various personal development opportunities. Driven by the increasing uptake of post-schooling education, delayed marriage, the rising cost of housing and the increasing accessibility of travel, at present, almost 50% of people aged between 18 and 24 are still living with one or both parents[8].

While parents are increasingly providing support for their children well into their 20s, there are few supports available through governments to assist the young people for whom the State has assumed guardianship to make their transition to independent adulthood beyond the age of 18. The few disparate supports which *are* available to this population are broadly considered to be insufficient to substitute for the more holistic, flexible model of care provided to young adults in the general population[9]. Further, fragmentation between these currently available supports sees a number of young people move straight from the child protection system directly to welfare, the justice system or into homelessness supports[10].

There have been a number of calls to consider the extension of care, including in the findings of the Victorian 2012 Vulnerable Children's Inquiry[11]. However, such reform is yet to be either trialled or instituted comprehensively in any jurisdiction in Australia. Given the growing evidence reporting on poorer outcomes experienced by young people leaving care at age 18 years compared with those aged 21 years, it is timely and topical to re-open the discussion of extending care.

International developments

A number of jurisdictions outside of Australia that have implemented policies and programs to extend support for young people aged 18 years and older. In the United Kingdom (UK), a publically funded program termed 'Staying Put' provides for eligible young people who are in foster care at age 18 to voluntarily continue support provided by their foster carer to age 21. Ontario, Canada operates a model which provides a fixed sum of money to support independent living for young people in care aged 18 to 21 under its Continued Care and Support for Youth program. In California, state and federal funding provides for a flexible care model provided to young people in OOHC to the age of 21. Comparable programs are also available in other states across the United States.

Outcomes for young people participating in such programs have been investigated across a number studies and evaluations. These studies have reported that extended care supports:

- a higher level of engagement with **education** and improved **employment prospects**[12];
- improved **housing stability** and lower long-term reliance on public housing programs[13];

[7] Mendes et al (2011).
[8] ABS 'Australian Social Trends' 4102.0, June (2009)
[9] Mendes et al (2011)
[10] Mendes et al (2012).
[11] Cummins et al (2012).
[12] Courtney, M. (2015)
[13] Munro et al (2010)

- improved **physical and mental health outcomes** driven by improved access to care and early intervention[14];
- reduced incidence of **alcohol and drug dependency**[15];
- reduced interaction with the **justice system** including a reduced likelihood of incarceration[16]; and,
- improved levels of **civic participation and social integration**[17].

The findings in these studies are aligned with findings in literature which considers the value of investing in youth as they navigate the pivotal developmental phase into adulthood between 16 and 24. As the AIHW (2011) reports, "tackling health and wellbeing issues when they occur in adolescence is socially and economically more effective than dealing with enduring problems in adulthood"[18].

In sum, research finds that investing in the health and wellbeing of young people not only affects their immediate quality of life and productivity, but also shapes the future health of the whole population and, in a broader social sense, the health of society[19].

The current study

The objective of the current study is to consider the potential benefits that could flow – both to the individual and to the public – from introducing a program of support for Victorian children in all forms of OOHC that gives them the option to extend such care from the age of 18 to the age of 21.

Noting that no extended care program has been operational or studied in an Australian context on an ongoing basis, the paper draws upon international research to determine the marginal impact of providing extended care to young people in OOHC across several life domains. Specifically, our model considers the economic impacts of improved access to education and, relatedly, employment; improved housing stability; reduced interaction with the justice system; improved access to healthcare; and, reduced incidence of alcohol and/or drug dependence. Outcomes in each of these life domains were considered in the modelling on the basis that studies had reported that extended support impacted upon them. It is important to note that economic impacts consider the opportunity cost of expended resources.

In summary, the model is constructed to allow for the following:

- The user inputs a number of assumptions including:
    - the annual cost of the program;
    - program uptake rate if the program were offered;
    - the probability of outcomes occurring in each of the life domains with and without extended care;
    - the annual cost (for example welfare cost) or benefit (for example, income) associated with each outcome;

[14] Courtney et al (2007); O'Connell, Boat, & Warner (2009)
[15] Courtney et al (2007).
[16] Washington State Institute for Public Policy. (2010)
[17] Mason and Gibson (2004)
[18] Australian Institute of Health and Welfare (2011)
[19] Eckersley, R (2008)

  - the nominal growth rate for costs/benefits over time; and,
  - the discount rate.
- Using these inputs, the model calculates the *expected* lifetime stream of costs/benefits over a 40 year period. The expected value is calculated by multiplying the monetary value of an outcome by the probability that the outcome will occur.
- Each of the cost/benefit streams are returned to present value utilising the discount rate.
- The benefit to cost ratio is calculated by dividing the difference in costs between offering the program and not offering the program by the difference in benefits. The benefit to cost ratio can be interpreted as the expected dollar of value returned per dollar invested in the program.

Central to the calculation of model outputs is the assumed program uptake rate. This study assumes an uptake rate of 25% in line with the uptake of the 'Staying Put' program in the UK. It is assumed that the program will be made available to all children in OOHC irrespective of whether they are in residential or non-residential care at age 18. It is assumed that individuals who enter the program remain engaged in the program for the full three years (from 18 to 21). Recognising that there is some likely level of attrition, the sensitivity analysis relaxes the assumption of 100% program completion.

Other key assumptions draw upon findings from literature to quantify the direction and magnitude of potential impact from introducing an extended care model similar to those introduced and studied overseas. For example:

- **Education and employment.** Extended support can provide financial and personal support to encourage a higher level of engagement with education. A study in the UK reported that engagement in education more than doubled within a sample of individuals participating in the 'Staying Put' program. Related to this, education is linked in literature to improved employment outcomes including a higher probability of employment and higher lifetime earnings.
  - The model assumes that for every 100 young people aged 18 in OOHC who complete the program, nine will enter and complete post-schooling education, compared with 3.6 for 100 people who don't have extended support. Though this may appear low, this represents an improvement in education outcomes by a factor of 2.5.
  - Completing post-schooling education is assumed to relate to expected annual wage that is $14,525 higher than for individuals who do not complete education.
  - Further, the model assumes that completing education reduces the probability of becoming unemployed by 39%.
- **Homelessness and housing.** Extending care to 21 has been found to prevent homelessness among foster care leavers leaving home at 18. [20] It is theorised that this effect is driven in part by the increased preparedness for adulthood that an extra three years in care brings to the child.[21]
  - The model assumes that for every 100 young people aged 18 in OOHC who complete the program 20 fewer people will remain reliant on modelled housing support costs than if they had not entered the program.
- **Justice.** Studies reported that justice system interaction for individuals leaving care aged 21 was lower than for individuals who left care aged 18. It has been hypothesised that extended care to former foster youth during the transition to adulthood may help reduce the risk of arrest, by

[20] It may be possible that this protective effect extends beyond 21, but was not captured in the Midwest Evaluation due to both recall and selection bias in their data collection surveys.
[21] Dworsky & Courtney, (2010a).

maintaining the individual's tie to a social institution in the form of continued involvement in programs and/or relationships with agents of the child welfare system.[22]

- The model assumes that for every 100 young people aged 18 in OOHC who complete the program, 10 will engage with the justice system in any given year compared with 16 if they did not receive extended support.

Key findings

The modelling results show that under the assumed program cost and program uptake rate (25%), **the benefit to cost ratio of the program is 1.84.** That is, a dollar invested in the program is associated with an expected return of $1.84 in either savings or increased income.

Looking at benefits and costs which accrue primarily[23] to government – a pertinent statistic given the program outlay is assumed to be from public funds – **the benefit cost ratio of public spend is approximately 1.60.**

The care leaver population at June 2014 was estimated to be 524 young people. Multiplied over the 2015 care leaver population of 524, modelling results suggest the expected program cost for this group would be equivalent to $10.5 million. Multiplying expected benefits over the care leaver population of 524 reveals that expected benefits of program roll-out would be $19.3 million.

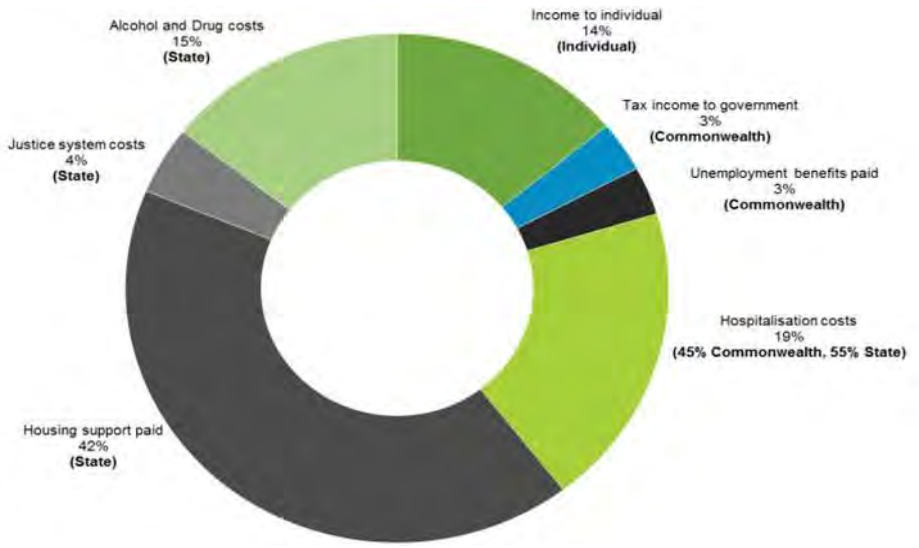
As Chart i shows, the greatest benefits are seen to exist in the estimated savings to housing supports, justice costs, and alcohol and other drug (AOD) costs. There are also saved costs that relate to Commonwealth spending, namely, the reduction in welfare costs and a proportionate reduction in hospital funding costs.

The modelling results have been calculated on the basis that program provision costs $27,833 per year, per program participant. Of note, this top down program costing is considered to be a reasonable estimate of the potential program cost on the basis of bottom-up costing recently undertaken by Anglicare Victoria. Anglicare Victoria calculated the potential per child expense of case worker support, carer reimbursement and program operational costs to estimate that the per child program cost would be equivalent to approximately[24] $28,000 per year[25].

The positive benefit cost ratios represented in the modelling results suggest that this total could in fact **increase to $51,312** per year, per program participant before costs began to exceed benefits.

[22] Lee, Courtney & Tajima. (2014)
[23] Noting that a small proportion of estimated AOD cost savings will also flow to society
[24] Note that the $28,000 per year program cost calculated by Anglicare excludes residential care which is typically more expensive to provide compared to other types of OOHC, such as foster care. In 2014, the AIHW (2015) reported children in residential care made up 5.5% of the total population of children in OOHC in Australia, and 6.7% in Victoria.
[25] Anglicare Victoria (2014).

Chart i Distribution of benefits



Sensitivity analysis was conducted on these results to understand how the modelling responded to changes in key input parameters. A central assumption is that 25% of eligible individuals will take up the option of the extended program and that all 25% will remain in the program voluntarily for three years.

Sensitivity analysis was applied to consider a different uptake pattern such that the initial uptake (for one year) is 80%, then drops to 50% in the second year, and finally sees 25% complete three years of the program. **In this instance the benefit to cost ratio was estimated to be 2.53.**

Sensitivity analysis was also conducted to determine whether the program would provide a positive return in a shorter time frame (20 rather than 40 years). **It was estimated that the benefit to cost ratio over a 20 year period would be 1.25.**

It should be noted that, in reality, socio-economic returns are likely to be higher than those estimated by the model, as a number of potential benefits including improved mental and physical health outcomes, and improved community engagement, could not be quantified due to lack of data. Such benefits are additional to those included in the model and as such qualitatively serve to increase the return to investment.

Key additional areas of such benefit include:

- **Mental health –** The duration and severity of mental illness may be improved by extension of exit age due to the reduction of disruption to young people's lives. Currently, youth in care start to be prepared from the age of 15 to exit the system by 18.[26] It is therefore plausible that many in the system start to become disengaged during their formative adolescent years aged 15-17, which has been identified as an issue especially toward the start of exit planning.[27] This hampers access to effective treatment as young people may experience uncertainty and disruption during this period and therefore delay treatment. Early intervention has also been identified to be important in

[26] Mendes, Johnson, & Moslehuddin. (2011)
27 Victorian Department of Human Services. (2012)

preventing the progression of mental illness and mitigating collateral effects on social, educational and vocational outcomes.[28]

- **Physical health outcomes –** The difference in physical health outcomes between 18 year old care leavers and those who stay in care to age 21 have not been extensively researched; however it has been postulated that young people who remain in care longer may experience physical health benefits as a result of improved education and employment outcomes associated with remaining in care longer than people who leave care at 18 years.[29] By increasing the time spent both in formal schooling and with an adult carer exerting a positive influence, extended care could also potentially increase levels of awareness, and usage of healthcare services that prevent future ill health.

  Intergenerational disadvantage – By encouraging continued education, extended care raises the probability of employment and the average income of care leavers, plus reduces the probability of criminal activity. Given that children's outcomes (health, education, income) have been found to be significantly associated with their parents' earnings and socio-economic status, extending OOHC beyond 18 years could reduce the intergenerational disadvantage experienced by care leavers and their own children.[30] Relatedly, research has linked adolescent mothers' lower educational outcomes to lower outcomes also for their own children[31]. It has been reported that staying in care beyond the age of 18 years may mitigate the risk of becoming pregnant, and therefore extending care may be one way to help reduce teenage pregnancy among the care leaver population.[32]
- **Social connectedness –** Children in OOHC may experience fragmented relationships with next of kin due to the physical separation brought about (and often legally required) through the OOHC arrangements, as well as because of the source of family abuse itself.[33] Researchers have identified the pivotal role that stability and connectedness play in establishing better outcomes of children in foster care[34]. It is postulated that, by offering the possibility of extended care, with associated greater potential stability in accommodation and care arrangements, children may experience continued connection to individuals where they had forged positive relationships, leading to improved emotional wellbeing and social benefits for young people in extended care.[35]
- **Disability Adjusted Life Years –** A commonly included method within cost benefit analyses for health policies or programs is the estimation of disability adjusted life years (DALYs).[36] Each DALY saved is very valuable, with the Department of the Prime Minister and Cabinet valuing a DALY averted (a year of healthy life saved) at $182,000 in 2014.[37] The modelling for this project has not considered DALYs in the calculation of benefits and has instead focussed on financial costs and savings. This means that the overall benefit of extending care estimated in the current model is conservative, since the value of these DALYs saved has not been included.

Together, these results and accompanying research put forward a sound socio-economic case for consideration of public investment in the future of young people in OOHC, beyond the age of 18.

Deloitte Access Economics

28 McGorry, P., Parker, A. & Purcell, R. (2006)
29 Hannusek & Woessman (2010); Johnston, G (2004); Levin, B (2003)
30 Mayer (2002)
31 Tang et al (2014)
32 Dworsky & Courtney (2010b)
33 Osborn & Bromfield (2007)
34 Tilbury & Osmond (2006)
35 Department of Families, Housing, Community Services & Indigenous Affairs with National Framework Implementation Working Group (2010)
36 Access Economics, with the Australian Safety and Compensation Council (2008)
37 Department of Prime Minister and Cabinet (2014)

1 Introduction

Anglicare Victoria commissioned Deloitte Access Economics to complete a study of the socio-economic costs and benefits of extending care exit from the age of 18 to the age of 21 in Victoria. This paper provides an overview of the study methodology and its findings.

1.1 A case for change

While parents have the primary responsibility for raising their children and providing support, the *National Framework for Protecting Australia's Children 2009-2020*[38] notes that where the home environment is not safe enough for children, children are to be placed in the care of the state; in out-of-home care (OOHC). OOHC involves the placement of a child or young person with alternate caregivers who have legal custody of the child until the 18 years of age.[39]

In Australia, state and territory governments have a statutory responsibility for ensuring children are protected from harm caused by abuse and neglect. In Victoria, this responsibility is exercised by the Department of Health and Human Services (the Department). A key function of the Department's child protection role is providing OOHC to children and adolescents in need. For the vast majority of children, OOHC is provided either through a kinship care or foster care model. The latest figures from the Australian Institute of Health and Welfare (AIHW) report that at 30 June 2014 there were 7,710 children in OOHC (both residential and non-residential) in Victoria.

A vast body of literature documents the multitude of inter-related, relatively poor life outcomes experienced by an inordinately high proportion of care leavers. The relative disadvantage experienced by this group spans from a number of confluent factors including a history of abuse or neglect, ongoing poor physical and mental health, substance abuse, homelessness, poverty, unemployment and violence.[40] Traditional support structures – family, friendship circles and community – are more likely to be broken for this cohort, limiting the social support individuals can leverage to break the cycle of disadvantage which, if left unaddressed, has the potential to span several generations.

The disparities in care-pathways between children in OOHC and those resident in traditional care structures is poignantly highlighted in the abrupt and instituted end of formal state care at the age of 16-18 years. The state, as the effective parent, ceases to provide ongoing financial, social and emotional support as a care-giver. A number of Australian studies have considered the relative impact of models for preparing youth for departure from state care – typically reporting mixed approaches and mixed results.[41] The question remains, however, whether young people aged 15 to 18 – who have already faced challenging life circumstances – have sufficiently developed independent living skills at an age where their peers are afforded the option to continue growing while under care, staying in place rather

[38] Council of Australian Governments (2009)
[39] Council of Australian Governments (2009)
[40] See for example: Mendes, P, Johnson, G., Moslehuddin, B (2011); CLAN (2008); Osborn, A. and Bromfield, L (2007)
[41] See for example: Owen, L., & Lunken, T. (2000); Raman, S., Inder, B., & Forbes, C. (2005). .;Ombudsman Victoria. (2010); London, Z. (2004); CREATE Foundation. (2010a).

than experiencing the disruption of moving and the discontinuity of immediate rather than gradual independence.

There is no jurisdiction in Australia which provides children in state care the option of accessing formal care and support beyond the age of 18. Internationally, however, there are examples of jurisdictions which have extended care to the age of 21.[42] Such studies have reported benefits extending beyond the individual, to social and economic benefits experienced by the community and the state. Reported benefits include reduced engagement in crime and higher rates of participation in education and employment.

There have been a number of calls to consider extension of care, including in the findings of the Victorian 2012 Vulnerable Children's Inquiry[43]. However, such reform is yet to be either trialled or instituted anywhere in Australia. Given this overarching policy focus, and the growing evidence reporting on poor outcomes experienced by young people leaving care at age 18 years compared with those aged 21 years, it is timely and topical to re-open the discussion of extending care.

1.2 The Victorian System

State government departments have a statutory responsibility for ensuring children are protected from harm caused by abuse and neglect. In Victoria, this responsibility is exercised by the Department of Health and Human Services (the Department), which receives reports of suspected child abuse and neglect from the general public and professionals and, where appropriate, further investigates these. One key function of the Department's child protection role is providing OOHC to children and adolescents in need.

In Victoria, and equally, across all states and territories in Australia, upon reaching 18 years of age, children in OOHC are legally recognised as independent and are required to leave OOHC and accommodation arrangements. This is in contrast to young people outside of the OOHC system in Australia where the age at which youth leave home has steadily been increasing over time. Currently, almost 50% of people aged between 18 and 24 are still living with one or both parents[44].

Table 1.1 displays the number of children discharged from OOHC by age group.

[42] See for example: Courtney, M.E., Dworsky, A., Peters, C.M., Pollack, H. (2009); Keller, T.E., Cusick, G.R., and Courtney, M.E. (2008) Munro, E., Lushley, C., National Care Advisory Service, Maskell-Graham, D., Ward, H with Holmes L (2012),
[43] Cummins, Scott and Scales (2012).
[44] ABS 'Australian Social Trends' 4102.0, June (2009)

Table 1.1: Children discharged from out-of-home care, by age group, states and territories, 2013–14

Age group (years)	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Number									
<1	95	177	62	47	21	9	5	22	438
1–4	335	552	283	166	76	42	37	49	1,540
5–9	365	462	287	165	88	59	33	35	1,494
10–14	513	490	322	232	95	49	45	66	1,812
15–17	1,159	806	566	207	205	61	59	61	3,124
Unknown	0	0	0	0	0	0	0	1	1
Total	2,467	2,487	1,520	817	485	220	179	234	8,409
Proportion (%)									
<1	3.9	7.1	4.1	5.8	4.3	4.1	2.8	9.4	5.2
1–4	13.6	22.2	18.6	20.3	15.7	19.1	20.7	21.0	18.3
5–9	14.8	18.6	18.9	20.2	18.1	26.8	18.4	15.0	17.8
10–14	20.8	19.7	21.2	28.4	19.6	22.3	25.1	28.3	21.6
15–17	47.0	32.4	37.2	25.3	42.3	27.7	33.0	26.2	37.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: Australian Institute of Health and Welfare 2015. Note: (1) The data for children exiting care include those who left care and had not returned in less than 60 days. Where a child exits care more than once during the year, the last discharge is counted. (2) Children who were discharged from care on their 18th birthday are included in the 15–17 age category. (3) Percentages exclude children of unknown age. (4) Percentages may not add to 100 due to rounding.

Care leaving programs which are in place to equip individuals for the exit from care at the age of 18 commence at the age of 15[45]. In this way, the process of exit has commenced even before a young person has become an adult. Further, a review of Australian research, including a report by the Victorian Ombudsman found evidence that some young people had little or no preparation for leaving care, and no leaving-care plan[46].

It should be noted that in Victoria, the *Children, Youth and Families Act (2005)* includes legislative responsibility to provide leaving care and after-care support for young people up to 21 years of age[47]. The Act requires that the Victorian Government assist care leavers with finances, housing, education, training, employment, legal advice, access to health services, and counselling support. However, such supports are broadly considered to be insufficient to substitute for the extension to a more holistic, flexible model of care[48]. Further, fragmentation between these supports sees a number of children redirect directly from child protection to the justice system or into homelessness supports[49].

1.3 Victorian care leaver outcomes

As reported above, young people in OOHC in Victoria receive legal protection and formal assistance from the government until they are 18 years old. At the age of 18, there is a substantial decrease in formal support for this group. A Victorian study reported findings from a survey of 60 young adults who

[45] Department of Human Services (2012).
[46] Mendes, Johnston and Moslehuddin (2011).
[47] Department of Human Services Victoria. (2008).
[48] Mendes, Johnston, & Moslehuddin (2011).
[49] Mendes, P; Snow, P; Baidawi, S (2012).

had been in care and found that they were experiencing significant disadvantage in a number of areas compared with the general population[50]:

- only a small percentage of care leavers surveyed were engaged with fulltime **employment or education**, and their average incomes were very low;
- low average incomes were associated with frequent problems with debt and **housing instability**;
- more than a third of the cohort had accessed **drug and alcohol** treatment services in the past 12 months;
- the cohort were vastly over-represented in the **justice system** in terms of spending time in correctional services; and

  half of those surveyed had sought help from a **mental health** professional in the six months before interview.

1.4 Extension of care: international experience

There are a number of international jurisdictions that have implemented policies and programs to extend care for young people aged 18 years and older. The types of care provided differ between each jurisdiction in terms of the care provided and the eligibility requirements for accessing this care.

United Kingdom

The United Kingdom (UK) has extended care provisions intended to model the role of a parent. These assist youth in care until they are 21 or 24 where the young person is in school or training. The *Children and Families Act 2014* legislates a duty for local authorities in the UK to support a 'Staying Put' arrangement, which is a voluntary, opt-in model whereby a young person, when they reach 18 years of age, makes an agreement with their foster carer to remain living with that person up to the age of 21 years[51].

To be eligible for entering into a 'Staying Put' arrangement, a young person must[52]:

- be looked after by a local authority (in partnership with their foster carer);
- be aged 16 or 17 years of age; and
- have been in foster care a total of at least 13 weeks since the age of 14 years.

In 2015, figures released by the UK Department for Education found that a quarter of young people (1,370 of 5,490) in foster care who turned 18 since the 'Staying Put' legislation was introduced remained with their foster carers[53]. It was suggested this uptake rate may have been lower than if less stringent entry criteria were adopted and/or more adequate funding had been provided to local authorities to support foster carers[54].

An evaluation of the pilot of the 'Staying Put: 18+ Family Placement Programme' for young people remaining in extended care, interviewed 32 young people at the age of 19, of which 21 had 'stayed put'. The paper looked at outcomes in education, employment and training, and housing.

[50] Forbes, Inder and Raman (2006).
51 The Children's Partnership 2015.
52 The Children's Partnership 2015
53 Children and Young People Now 2015.
54 Children and Young People Now 2015.

- **Education/employment:**
  - It was found that 55% of those who had stayed put were enrolled in full-time education, compared to 22% of those who had exited care. Additionally, 25% of young people who had 'stayed put' were engaged in full time training and employment, in contrast to 22% of those who had left care.
- **Housing:**
  - Across the sample, 41% of young people had taken a direct housing pathway, which involved moving straight from care to stable independent living in council or privately rented property. Of these individuals, 67% were those who had 'stayed put'.

United States of America, California

In the United States of America (USA), each state is responsible for establishing specific foster care practices and managing individual cases. However, the federal government strongly influences state child welfare policies through funding statutes, such as *Adoption and Safe Families Act (ASFA*) *1997* which is the primary law controlling placements in the foster care system[55]. Federal funding accounts for about half of the funding spent on child welfare in the United States, although the portion received by each state differs significantly.

California was one of the first states to extend care and receive financial incentives under the *Fostering Connections Act*. In 2010, California passed Assembly Bill 12 (AB12) to optionally extended foster care to the age of 21 years, and provides assistance for housing, healthcare, food and support programs[56]. To be eligible for this support, a young person must be living in an approved placement on their 18th birthday, have a signed mutual agreement with a case worker, and be:

- attending high school,
- enrolled in a college or vocational program,
- employed at least 80 hours a month, or
- participating in a program aimed at gaining employment, or unable to work/attend school because of a medical condition.

Qualitative research was undertaken between 2011 and 2012 on the implementation of the AB12. When asked about the capacity to implement extended care as envisioned in the AB12, one welfare agency suggested that the uptake rate to receive support had been higher than anticipated (no quantitative figure was provided as part of this research)[57].

Following the introduction of AB12 in 2010, a longitudinal study (CalYOUTH) was started in 2012, to evaluate the impact of the legislation extending care to the age of 21 on outcomes for foster youth. The study will have data collection waves between 2012 and 2017 in order to analyse the foster youth outcomes resultant of the legislation. As such, relevant further and more comprehensive research and analysis is expected to be available by 2018[58].

55 Atkinson, Melinda 2008.
56 Mosely and Courtney 2012.
57 Courtney, M. E., Dworsky, A., & Napolitano, L. (2013).
58 Courtney, M. E., Charles, P., Okpych, N. J., Napolitano, L. & Halsted, K. (2015).

However, a study evaluating youth in extended care in San Bernardino, California, analysed their educational and employment outcomes[59].

- **Education**
    - Among the sample of 426 youth, aged 18 to 22, 66.4% had completed Year 12 or equivalent and 50.5% were engaged in college or vocational training at the time. It is to be noted that the duration of being in extended care was found to be a statistically significant positive factor in educational outcomes, with 68.4% of youth not attending college or participating in vocational training during the first 6 months of their stay. By contrast, after two or more years in care, 85.7% were then attending college or vocational training.
- **Employment**
    - Across the sample, 19.7% were working 80 hours or more per month. This figure increased to 31.0% for those who had been in extended care for two or more years. Overall, duration in care was found to have a statistically significant positive effect on employment outcomes for youth in care.

Furthermore, focus groups in California with 39 youth in care, all of whom were aged 18, found favourable impressions of the extended care arrangements, on a qualitative basis[60]. The majority of the youth who were interviewed commented that the education, employment and training criterion attached to the option of remaining in care was beneficial for their future prospects, and that this would likely reduce rates of alcohol and drug dependence, and crime, as there would be less time to engage in such activity outside of work or education.

1.5 This study

The objective of the current study is to consider the potential benefits that may be realised over a forty year period – both to the individual and to the public – from introducing a program of support for Victorian children in OOHC which extends from the age of 18 to the age of 21. An estimate is provided of the quantum of public expenditure on such a program which, in the long-run, would see the public investment as net-neutral.

Noting that no extended care program has been operational or studied in an Australian context, the paper draws upon international research to determine the marginal impact of providing extended care to young people in OOHC across several life domains. Specifically, the model considers the financial impacts of improved access to education and, relatedly, employment; improved housing stability; reduced interaction with the justice system; improved access to healthcare; and, reduced incidence of alcohol and/or drug dependence.

A number of benefits qualitatively described in literature could not be included in the model, owing to lack of requisite quantitative data. These benefits are qualitatively discussed at the end of the report and should be taken as additional to those included in the model.

This report is structured as follows:

- **Chapter 2. Methodology.** An overview of the model structure and its limitations

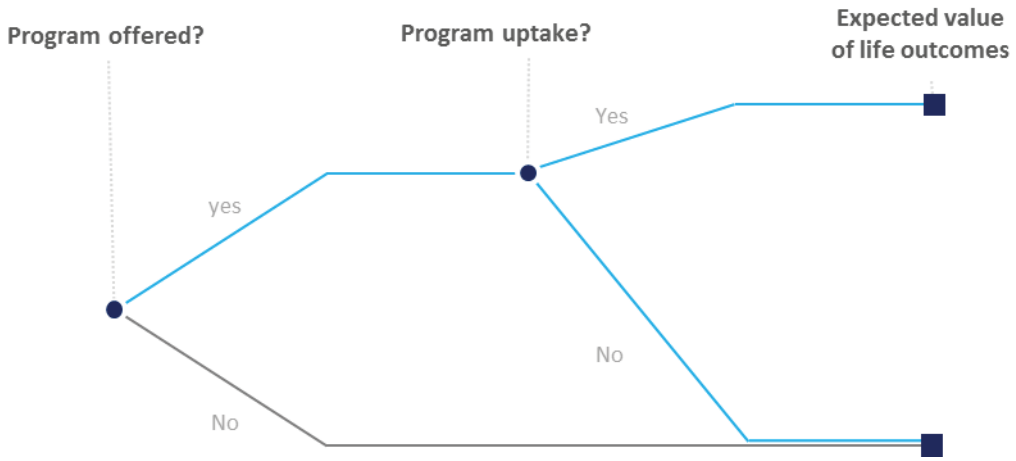
[59] Netzel, K. S. & Tardanico, M. B. (2014).
[60] Courtney, M. E., Dworsky, A., & Napolitano, L. (2013).

- **Chapter 3. Model inputs.** Key modelling assumptions and the literature which has informed them.
- **Chapter 4. Model outputs**. Model outputs and their interpretation/implications
- **Chapter 5. Discussion.** A broader qualitative discussion of potential impacts that could not be included in the model.

2 Methodology

The model is designed to quantify the net benefits of offering children in OOHC the option to extend support to the age of 21 compared against the current context where this support is not available. As such, the model compares two scenarios – one in which the program is offered on a voluntary basis, and one in which the program is not offered (base case).

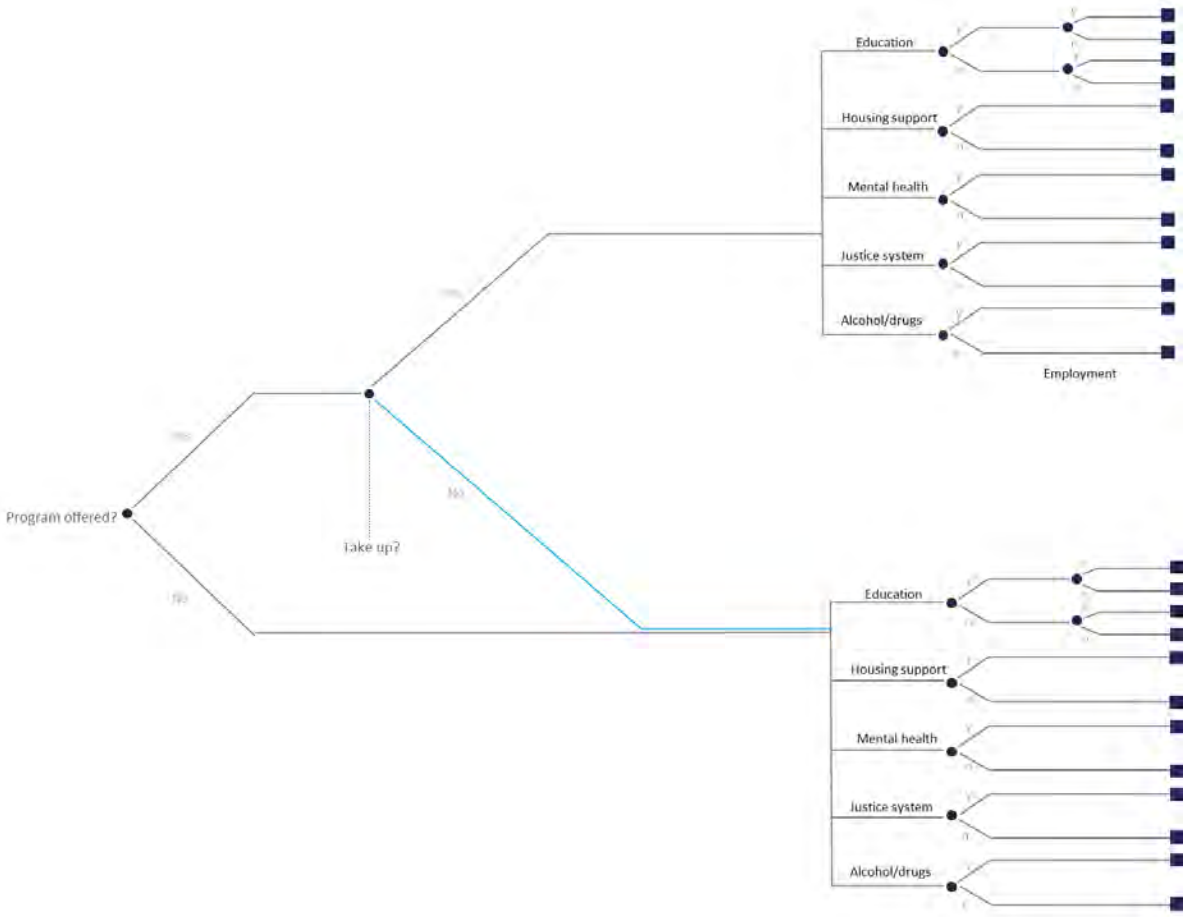
Figure 2.1 Model structure, program versus base case



Outcomes differ on the basis of whether an individual participates in the program or does not participate in the program. The model allows for the estimation of monetary outcomes (costs/savings) across five life domains: education and employment; housing; hospital spending; interaction with the justice system; and, alcohol and drug dependency. The probability of experiencing benefits (e.g. a higher wage) or avoiding costs (e.g. reduced justice system costs) is dependent upon program participation (Figure 2.2).

It is assumed that the individuals who *choose* not take up the program have the same outcomes as individuals who were never offered the program in the first place.

Figure 2.2 Model structure



The model takes a forty year perspective of an individual's life. This longer term perspective is justified on the basis that investments made in youth are likely to materialise over a longer term basis (with a lag). It is assumed that individuals are a part of the program for a three year period. This means that to unlock the benefits associated with extended care over the young person's lifetime, there is an upfront public funding cost.

The main model inputs are the probabilities associated with each arm, and the annualised value in 2015 dollars of each outcome. The user must also input any costs associated with a particular pathway, such as the cost of education. Using these key inputs, the model calculates the expected value of each arm.

> Expected value weights the value of possible outcomes by the probability that they will occur. For example, a 50% chance of the present value of $100 in savings is equivalent to 0.5*100= 50.

A benefit-to-cost ratio is calculated by comparing the relative present value of costs and benefits for the scenario where a program is offered against a scenario where the program is not offered. The benefit-to-cost ratio provides a measure of the level of return that can be expected for every dollar invested in a program.

Comparing the value of outcomes under the scenario where the program is offered against the value of outcomes where the program is not offered, the model calculates the maximum public spend which would, in present value terms, equalise program funding and long-term program benefits. That is, the model estimates the per child spend that would leave public expenditure neutral in present value terms.

> Present value is the total of a stream of outcomes that occur over time and is expressed in terms of the value of a dollar today ($2015). It is calculated to account for the fact that the value of money which is expended or saved in the future is not equivalent to the value of that same amount if it were realised today. To calculate the present value of outcomes, this study employs a discount rate of 7%.[61] Costs are inflated annually over time using a consumer price index (CPI) rate of 2.5%, except for wage and welfare costs which are inflated by average weekly ordinary time earnings (AWOTE) growth of 2.1% per annum, housing costs which are inflated by 2.25% per annum based on the national housing group within the CPI, and health costs which are inflated by 5.26% based on the health group within the CPI.[62]

2.2 Estimating model inputs

Model inputs were estimated using a series of assumptions informed by available literature.

The base case was developed drawing upon research conducted, where possible in Australia, studying outcomes for care leavers. Where this research was not available, outcomes were estimated by considering outcomes for care leavers aged 18 in the UK or USA.

Outcomes for care leavers aged 21 were estimated by drawing upon research from jurisdictions in which comparable programs are currently available (see Chapter 3). Studies which compared a 21 year old leaver population to an 18 year old leaver population were considered first. The differential between the populations was applied to the Australian base case to maximise relevance to the Australian policy setting.

It is important to ensure that the children in the program group have similar demographic and other characteristics to those who opt out or, if not, in linking outcomes to each group, confounding factors such as differences in initial socioeconomic or health state are controlled to the extent possible. This is also important in the sources studies in the literature from which the outcome effect sizes are based, as well as ensuring that the target population in Australia is a similar population to that in the source studies. We have done this as far as possible, noting that in some cases the target group in the literature was children in one form of OOHC (e.g. foster care), rather than all forms, and that there were also other factors in some cases where full matching or control was not known or not possible due to data limitations. Apart from such model input limitations, there are other model limitations noted in the next section.

A detailed description of modelling inputs and their sources is provided in Chapter 3.

[61] Harrison, M (2010)
[62] Australian Government: Commonwealth Superannuation Corporation. (2015).

2.3 Model limitations and interpretation

As is the case with most all socio-economic modelling exercises, the model presented in this paper presents a stylised representation of reality. The interaction between child protection and adult outcomes *is* complex and individualised. There is not a set path that individuals will pursue based upon decisions made as a teenager. The model, however, necessarily makes this simplifying assumption.

The model considers outcomes within five life domains. In reality, the impact of extended child protection is likely to span many more life domains and result in a far broader range of tangible and non-tangible outcomes. For example, the model considers outcomes relating to mental health but does not consider impacts relating to health more broadly. Literature finds, however, that support in earlier years can impact upon lifestyle choices which impact propensity to develop chronic health conditions.[63] Such chronic health conditions will have financial health system impacts and will further impact the individual's quality of life. It is important that such impacts are considered *qualitatively* alongside the quantitative outputs of the model.

Further, the model assumes that the five life domains that are considered are independent, that is, they do not interact with one another. This assumption is unlikely to hold in reality. For example, the propensity to develop an alcohol or drug dependency is strongly related to employment outcomes. Alcohol and drug dependency is also likely to make an individual more likely to commit crime. For tractability and due to data limitations, these interactions are not explicitly modelled; however, they should be considered in the interpretation of modelling results.

The modelled results are not an immutable description of future outcomes. Rather, they are a construct, derived from the best available evidence, to allow decision makers to weigh a representation of the lifetime benefits of extended care against immediate program costs. The modelled results must be considered with reference to the nature of underlying assumptions. Further, they are best considered alongside a qualitative discussion of outcomes that are not captured by the model.

[63] Osilla, K. et al(2014).

3 Model inputs

The model inputs were estimated using a series of assumptions informed by available literature. The model inputs and the rationale for their utilisation in the modelling exercise are provided in this chapter.

3.1 Program structure and costs

As discussed in Chapter 1, the way in which programs that extend support beyond the age of 21 are designed is highly varied across settings. Programs differ in the care which is provided – from blocks of financial support, to specified care arrangements. Programs also differ in who care is offered to – for example, whether residential care is included or not included. Conditions may be attached to participation such as the need to be enrolled in training or participating in education. Programs may also vary in whether participants can exit and re-enter care over time. Each of these structural elements of a program will significantly impact how much the program costs, and what outcomes can be expected.

It is assumed that young people across all care types will receive support under this model. However, the annual cost per young person participating in the program is assumed to be equivalent to the average cost per child to receive foster care in 2015 (adjusted for inflation to $27,833.45).[64] This is to reflect the level of support which is provided in the international programs from which this paper derives its impact estimates (studies from the UK, USA and Canada).

This assumption is employed to allow for the utilisation of available data. It is not employed on the basis that these international models are the best model for the Victorian context. Indeed, the optimal model would need to be determined with careful consideration of the needs of the Victorian OOHC population. It should be noted, however, that the model outputs – importantly, the type and magnitude of expected benefits – will be sensitive to the cost of the program implemented.

However, of note, this top down program costing is considered to be a reasonable estimate of the potential program cost on the basis of bottom-up costing recently undertaken by Anglicare Victoria. Anglicare Victoria calculated the potential per child expense of case worker support, carer reimbursement and program operational costs to estimate that the per child annual program cost would be equivalent to $28,076.[65] Note that this program cost calculation excludes residential care which is typically more expensive to provide compared with other types of OOHC, such as foster care. In 2014, children in residential care made up 5.5% of the total population of children in OOHC in Australia, and 6.7% in Victoria.[66]

[64] Productivity Commission (2016)
[65] Anglicare Victoria (2014).
[66] AIHW (2015)

3.2 Program uptake

Program participation is assumed to be voluntary. As such, it is assumed that every eligible individual for the program will have some probability of choosing to enter the program and, conversely, of choosing to not enter the program. The average probability of an individual choosing to enter the program is termed the 'uptake rate'.

The uptake rate in this study is derived from figures released by the UK Department of Education reporting on the rate of uptake of the 'Staying Put' program. The UK Department of Education reported that 24.95% of eligible individuals entered the 'Staying Put' program.[67]

Our study adopts this same uptake rate as a basis for modelling calculations. It is considered, however, that this rate may underestimate the likely participation rate should the policy be introduced with limited entry criteria and commensurately funded in Victoria. This is because participation in the UK program required that participants meet one of a number of other criteria such as conditional participation in education and or training.

To provide an appropriate range for the benefits calculation, the paper tests this assumption by applying a 50% uptake rate to test the sensitivity of outcomes.

3.3 Employment and education

Academic literature has long confirmed the conventional theory that sustained engagement in formal education is directly related to the realisation of positive life outcomes for individuals and societies.[68,69,70] The Australian Social Inclusion Board (2010) found that participating in education assists individuals in finding sustained employment; participate in community activities and to improve their wellbeing. Education also provides a pathway out of disadvantage, particularly for people in low socio-economic groups.[71]

While acknowledging that the returns to education materialise in multiple facets of life, for tractability, the modelling in this study focuses on the relationship between education and employment outcomes. Studies find that young people who do not complete school and/or continue to further education are more likely to become unemployed, stay unemployed for extended periods of time, or gain employment in lower paid jobs.[72,73,74] As such, these individuals are likely to earn lower wages, rely more heavily on welfare payments and accumulate lower levels of wealth across the span of their life.

Probability with and without intervention

[67] Children and Young People Now (2015)
68 Johnston, G (2004)
69 Levin, B (2003)
70 Hannusek and Woessman (2010)
71 Australian Social Inclusion Board (2010)
72 OECD (2001)
73 Levin, B (2003)
74 Rumberger, R and Lamb, S (2003)

Harvey et al (2015) found that within a sample of Australian care leavers, 11% had pursued further education beyond school. As such, the model in this paper assumes that a child exiting care at 18 has a probability of 0.11 of pursuing further education. Using the most recent National Centre for Vocational Education Research (NCVER) (2013) report, the base case probability of further education was adjusted for the expected rate of Vocational Education and Training (VET) course completion in Victoria (33.1%) to equal 0.036.[75]

No studies were found that compared education outcomes for individuals who remained in care until age 21 with individuals who exited care at 18 or younger. Munroe et al (2010) surveyed 206 young people who were eligible to participate in the 'Staying Put' study in the UK. Munroe et al (2010) reported that for the young people who *continued* to remain in care at 19, the probability of pursuing education was 55%, compared with 22% for those who left care before 18 years of age. That is, extending care more than doubled the probability of continuing in education. This finding is comparable to the Midwest study which reported that youth who extended foster care to the age of 21 were more than twice as likely to have completed at least a single year of college by age 21. [76]

The model assumes that a child exiting care at 21 has a probability of 0.036*2.5=0.09 of pursuing (and completing) further education.

The model treats the probability of employment as conditional on participation in education. It is noted that studies have found that employment outcomes can improve for individuals who receive extended support irrespective of education. For example, where extended support allows individuals to form and sustain professional networks in young adulthood. [77] Such pathways are not included in the current modelling exercise.

The 2015 survey results reported by the Australian Bureau of Statistics (ABS)[78] state that the average probability of employment for VET certificate holders is 0.58. We employ this assumption in our analysis, however, caveat that the ABS survey was cross-sectional, and as such, does not provide a measure of sustained employment. The figure is, however, conservative compared with NCVER (2014) estimates of employment in the six months following graduation from a VET course (78%).[79]

The same survey reports that for individuals who complete year 12, the probability of employment is 0.41. For individuals who do not complete year 12, the probability falls to 0.26. McDowell (2009) found that 35.3% of care leavers in Australia complete year 12.[80] Accordingly, it is assumed that the weighted probability of employment for individuals who do not pursue VET is (0.41*0.35)+(0.26*0.65)=0.313.

Monetary assumptions

The relationship between education and employment is clearly not standardised across individuals – the lifetime earnings of an individual is dependent upon a number of factors in addition to education.

[75] NCVER. (2015).
76 Courtney et al 2007.
77 Caspi et al (1998).
78 Australia Bureau of Statistics (ABS) (2015).
[79] National Centre for Vocational Education Research (2014)
80 McDowell 2009.

However, in order to incorporate this relationship into the model presented in this paper, a number of simplifying assumptions have been made:

- **Employment pathway.** In practice, individuals drop in and out of the workforce, change jobs and change the trajectory of their pay-scale as a result of these decisions. In this model, it is assumed that once an individual enters employment or unemployment, they remain in that state and at that wage inflated by AWOTE until they are 40. A wage differential is applied for individuals who enter employment after further education versus individuals who enter employment with no post-schooling education. Annual wage costs were calculated from the 2005 ABS Report 'Education and Training Experience in Australia'[81] and inflated using AWOTE growth rates to 2015 dollars, and thereafter. The average wage figure was cross-checked and found to be comparable to NCVER estimates of annual salaries for post-VET graduates.[82,83]

- **Cost and duration of education.** It is assumed that individuals who pursue education post-schooling will engage in a VET course for a single year. This is considered a reasonable assumption as a recent study found that the majority of care leavers (90%) enrolled in institutions of higher learning were doing so in vocational institutions.[84] A single annual cost of education, derived from a survey of the Victorian government's contribution to 19 VET Certificate-level courses is included in the model adjusted by the inputted probability of entering education.[85]

- Individuals who do not pursue VET are not further disaggregated. That is, no distinction is made in the model between those who complete year 12 and those who would not have completed schooling.

- **Welfare payment for unemployment.** The welfare payment that individuals received if unemployed varies by circumstance. The model assumes that all individuals who are unemployed receive the maximum rate of Newstart Allowance, inflated over time using AWOTE. The wage/welfare outcome assumptions and their sources are summarised in Table 3.1.

Table 3.1 Wage and welfare assumptions

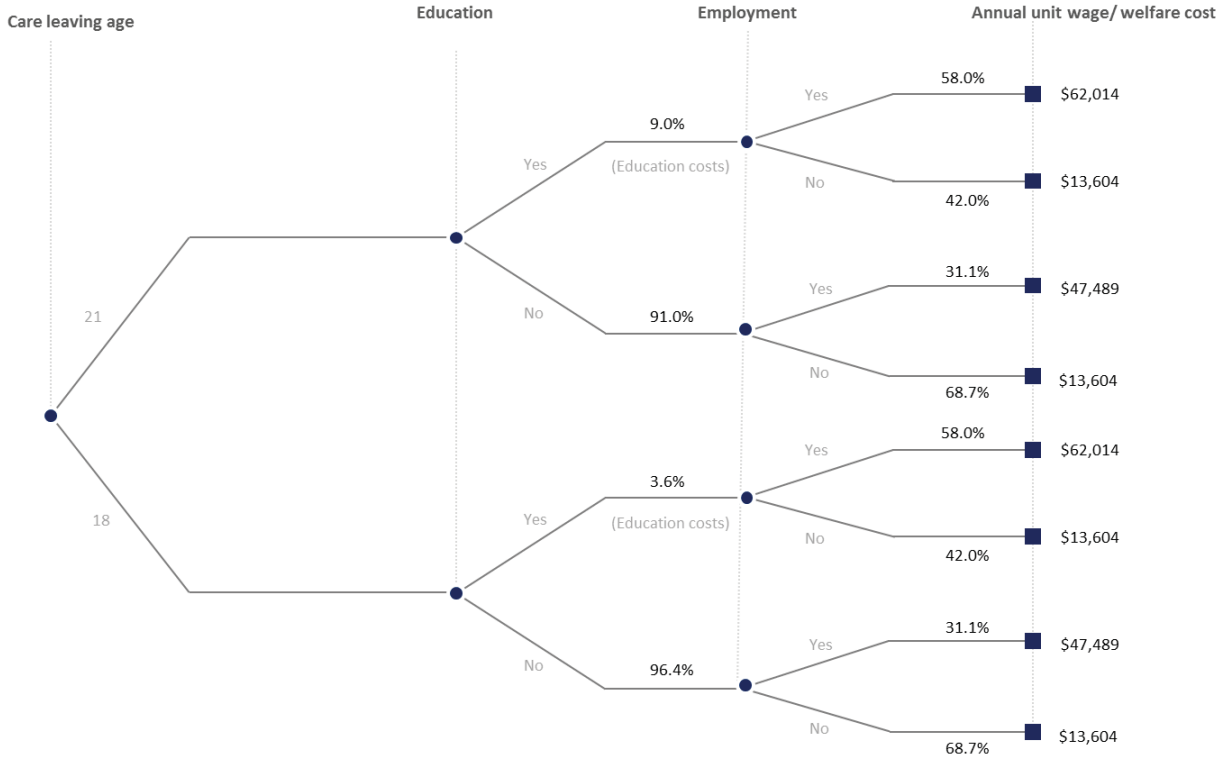
Pathway	Assumption	Source
VET qualification; employed ($2015)	$62,014.09	ABS (2005) [86]
No VET qualification; employed ($2015)	$47,488.95	ABS (2005) [87]
VET qualification; unemployed	$13,604	Department of Human Services (2016) [88]
No VET qualification; unemployed	$13,604	Department of Human Services (2016) [89]
VET course (single year)	$3,433.74	Derived using Victoria Polytechnic. (2016) [90]

81 Australia Bureau of Statistics (ABS) (2008).
82 National Centre for Vocational Education Research. (2015).
83 Australian Bureau of Statistics (2005).
84 Harvey et al 2015.
85 Victoria Polytechnic. (2016).
86 Australia Bureau of Statistics (ABS) (2008).
87 Australia Bureau of Statistics (ABS) (2008).
88 Department of Human Services 2016.
89 Department of Human Services 2016
90 Victoria Polytechnic. (2016).

Summary of assumptions

Figure 3.1 provides a summary of cost and probability assumptions used in this study.

Figure 3.1 Wage and welfare model assumptions



- Education and employment outcomes are modelled together, with the probability of employment taken to be conditional on participation in education.
- The probability of pursuing further (VET) education at 21 is estimated at 9%, whereas the probability at 18 is 3.6%.
- The probability of being employed having received VET education is 58%, while the probability of employment having received education below VET level is 31.1%.
- The cost of VET education is $3,433.74, while the annual earnings for an individual with VET qualification is $62,014.09. Earnings for the individual with education attainment below VET-level are estimated at $47,489 per annum.
- Those who are unemployed regardless of qualification level are estimated to receive unemployment benefits of $13,604 annually.

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3.4 Homelessness and housing support

Australian and international out of home care systems have seen a high correlation between being in care and experiencing both immediate and long-term housing instability, including homelessness. The range of housing outcomes generally entered into by care leavers includes homelessness, public housing services, and independent private housing rental, usually with government rental assistance.[91]

Most care leavers experience long-term housing instability as they often lack strong social connections with their original families, foster carers, friends and/or support workers. This makes it more difficult for such individuals to seek appropriate advice, borrow money or request temporary accommodation when independent housing means break down.

Housing instability also links to poor mental health outcomes, unemployment and alcohol and/or drug dependence.

Probability with and without intervention

The Forbes et al. (2006) study of Victorian care leavers found that the proportion of individuals leaving care at the age of 18 who are reliant on housing support was 39%.[92] While this prevalence rate was found for a sample study in 2006, it is considered to be stable for the current model.

In order to estimate the proportion of individuals who exit care at the age of 21, who would subsequently become reliant on public housing support, data from the evaluation of the UK 'Staying Put' program was used.[93] In the UK, of those who were able to directly enter stable housing, 67% had 'stayed put' until a later age in the system, compared to 33% who had left the system at 18. Hence, the public housing support reliance rate for those exiting care at 21 is considered to be half that of those exiting at 18. The model therefore assumes that 19.5% of those who leave care at 21 would be reliant on public housing support.

We note that the Midwest study suggests that extending foster care delays, rather than reduces, homelessness.[94] However due to the lack of longitudinal research measuring this effect, there is still no conclusive evidence of whether lowered homelessness rates are sustained with time or simply delayed to a later time. In light of this, we have chosen to use the 'Staying Put' study's homelessness estimates in our model based on the strong similarities between the UK and Australian populations.

Monetary assumptions

Given the often complex housing outcomes of care leavers across their lifetime, the following assumption was made in order to estimate the impact of the proposed intervention on homelessness and housing support related costs:

91 Johnson, G., Natalier, K., Mendes, P., Liddiard, M., Thoresen, S., Hollows, A. & Bailey, N. (2010).
92 Forbes, C., Inder, B. & Raman, S. (2006).
93 Munro, E. R., Lushey, C., Maskell-Graham, D., Ward, H. & Holmes, L. (2010).
94 Dworsky, A., & Courtney, M. (2010).

- **Pathway and cost weighting.** It is assumed that if an individual who is leaving care experiences housing instability, they will be eligible for, and reliant on, public housing support. This cost is considered in two parts: firstly, for daily general homelessness support to access or maintain social housing tenancy, and secondly, for daily support to help Indigenous people access or maintain social housing tenancy. These costs were annualised and weighted by the proportion of Indigenous and non-Indigenous children among those in care in Victoria (16.98% Indigenous, 83.02% non-Indigenous).[95]

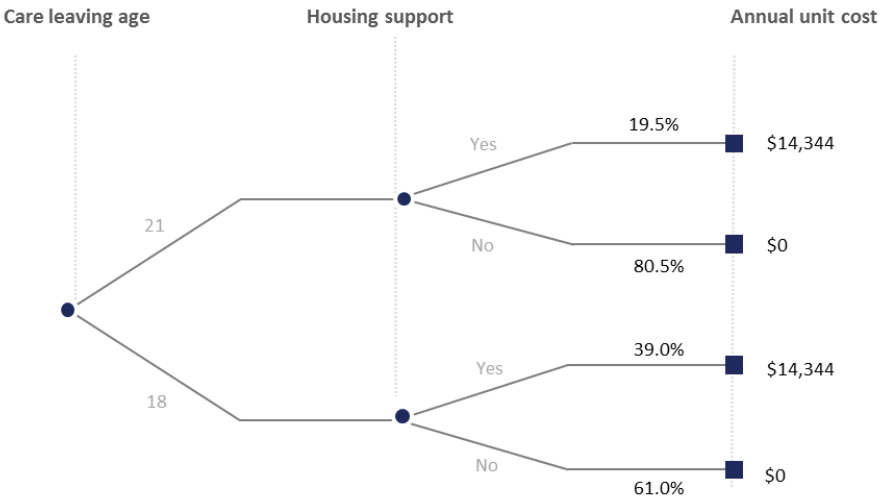
Separate Indigenous and non-Indigenous costs need to be considered as there is a significant difference between the two values, with the cost of Indigenous housing support close to four times that of general housing support. Furthermore, Indigenous children are significantly overrepresented in the out of home care system, with 62.7 of every 1000 Indigenous children in care, compared to 5.1 per 1000 non-Indigenous children in care, in Victoria. This is therefore likely to substantially impact end outcomes for the total care population.

The weighted annual unit cost of housing support by state government[96] was estimated to be $12,300.66 in 2011 dollars, as per research conducted by Zaretzky and Flatau for AHURI.[97] The cost was inflated forward from 2011 to 2015 dollars using the 2.25% growth rate of the national housing group within CPI to $14,344.46.

Summary of assumptions

Figure 3.2 provides a summary of cost and probability assumptions used in this study.

Figure 3.2 Homelessness and housing support model assumptions



[95] Australian Institute of Health and Welfare. (2015).
[96] Averaged across all State and Territory Governments except South Australia and the Northern Territory
97 Zaretzky, K. & Flatau, P. (2015).

- The probability of homelessness if exiting care at 18 is 39%, estimated from a Victorian study of care leavers. The probability of homelessness if exiting care at 21 is 19.5%, derived using UK estimates that show a later exit age halves the probability of homelessness (as compared to exiting at 18).
- The cost of housing support is estimated at $14,344.46. Acknowledging the difference in housing support costs between the Indigenous and general population, this figure represents an annualised cost that is weighted by the proportion of Indigenous and non-Indigenous children among those in care in Victoria.

3.5 Hospitalisations

The Midwest study reported a lower proportion of hospitalisations over a one year period among 21 year olds exposed to extended care compared with 19 year olds who were no longer in care. Research to understand the causal link between extended care and reduced hospitalisation rates revealed three potential drivers: better access and more appropriate use of primary care, delayed pregnancy (owing to improved family planning) and reduced rates of injury.[98] [99] [100] [101] [102] [103]

Probability with and without intervention

The Midwest evaluation reported that, at 21 years of age, 19.2% of the Illinois foster youth population had at least one hospitalisation episode in the previous year.[104]

Another study conducted in Illinois reported that 29.2% of young people who had left care aged 19 and below had experienced at least a single admission in the previous year.[105] Although the population surveyed comprised youth who experienced a year more of care than our modelled population, it also included those who had left care prior to 18. These effects are likely to work in opposite directions, so it is considered that 29.2% is a reasonable assumption to use in our model to represent the risk of hospitalisation for an 18 year old care leaver population on average.

We do also acknowledge that the Midwest study had found hospitalisation rates in Wisconsin (no care extension) at age 21 to be similar to the rate in Illinois (care extension offered till 21).[106] However, after considering the whole body of evidence, our approach in modelling some reduction in hospitalisation is believed to be a reasonable assumption – particularly as other healthcare costs which are noted in the discussion section of this paper (Chapter 5) have not been included in our model.

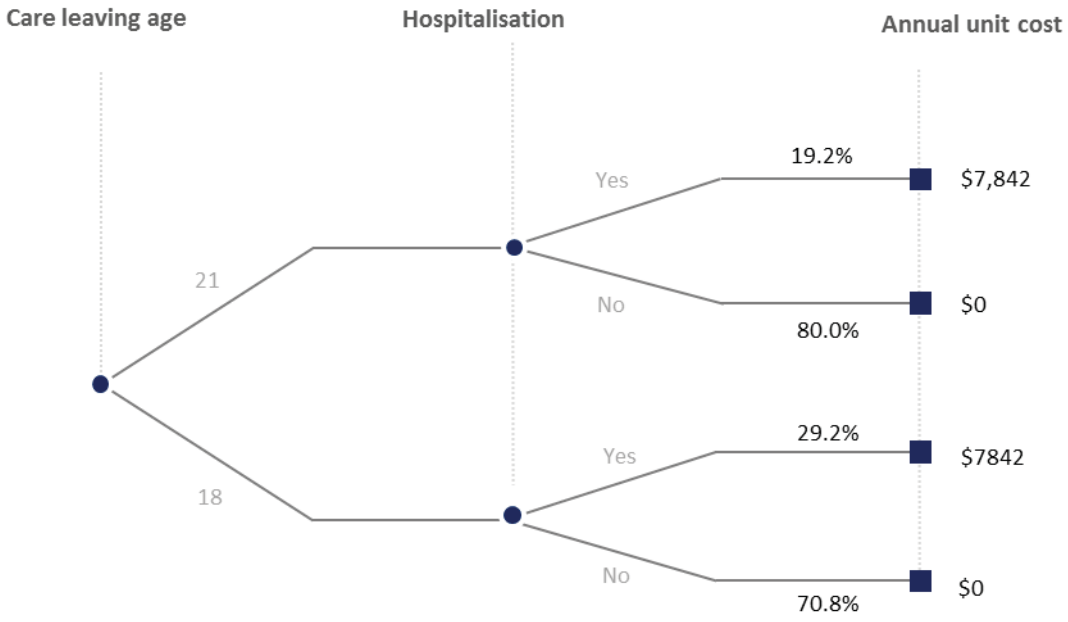
[98] Szilagyi, M.A., Rosen, D.S., Rubin, D. & Zlotnik, S. (2015).
[99] Guttmacher Institute. (2011).
[100] Australian Institute of Health and Welfare. (2008).
[101] Guttmacher Institute. (2011).
[102] Courtney et al (2007)..
[103] Joseph McDowall (2009).
[104] Courtney et al (2007).
[105] Courtney and Dworsky (2006).
[106] Courtney, M., Dworsky, A., Cusick, G. R., Havlicek, J., Perez, A. & Keller, T. (2007).

Monetary assumptions

In order to estimate the cost incurred by hospitalisations, the following assumptions were employed to model the impact of the proposed intervention on hospital care costs:

- **Number of hospitalisations avoided.** The Midwest study found that over a third of all individuals who reported hospitalisation during a year were likely to have had one or more hospital admissions in the year. [107] As such, the modelled number of hospitalisations avoided is 1*0.63+2*0.37=1.37.
- **Hospitalisation cost.** The average cost of admitted acute care in a public hospital, weighted by case complexity, was $5,725.05 in 2015 dollars nationally per separation, based on the 2012-13 National Hospital Care Data Collection[108]. Multiplied by the average number of separations per year for the sample population (1.37), the annual cost of hospitalisation was estimated at $7,842.32. This cost was inflated to 2015 using the national CPI growth for the health group, and thereafter.

Figure 3.3: Hospitalisation modelling assumptions



[107] Courtney et al (2007).
[108] Independent Hospital Pricing Authority. (2013).

- The risk of hospitalisation if exiting care at 18 is 29.2%, while this risk is estimated at 19.2% if exiting at 21.
- The cost of hospitalisation is estimated at $5,725.05, which is derived from the average number hospitalisation episodes avoided and average cost per acute hospitalisation episode in Victoria

3.6 Justice

Researchers in Australia and overseas have reported on the over-representation of care leavers in the justice system. It is thought that a confluence of factors may lead to this over-representation including inadequate accommodation or homelessness upon leaving care, poor educational experiences, underlying anger and resentment towards the state care system, and the absence of effective legal advocacy and support[109].

In the US, a comparison of a nationally representative population sample of youth, with a sample of mostly 25- and 26-year-old former foster youth, who have aged out of care, found higher rates of arrest after turning 18 (42% vs. 5% for women and 68% vs. 22% for men)[110].

A number of Australian studies have found a significant correlation between living in OOHC and criminal behaviour, for example:

- Research by the Victorian Department of Human Services in 2011 found that 9% of a sample of 151 care leavers in Victoria (aged 16 to 21) had spent time in custody since leaving care[111]. Of those who had been incarcerated since leaving care, 69% had been incarcerated once, 8% had been incarcerated twice, 8% were incarcerated three times and 15% were incarcerated four times.
- Another survey of 60 care leavers in Victoria found that almost 50% had some type of involvement with the police or justice system, and 12% had spent time in detention in the twelve months after exiting care[112]. This included a range of matters such as being charged with an offence, being served an intervention order, being evicted from a residence, and being a victim of domestic violence.

It has been suggested that reducing arrests may make a significant difference in the lives of these former foster youth, since an arrest in early adulthood may have long-term consequences on the ability of these individuals to participate fully in society[113].

Probability with and without intervention

To estimate the proportion of care leavers interacting with the justice system, the proportion of arrests were considered, given that arrests are the principal point of entry into the criminal justice system, at which point legal and correctional costs are incurred.

[109] Community Affairs References Committee, cited in Mendes (2009).
[110] Courtney, M. E., Dworsky, A., Brown, A., Cary, C., Love, K., & Vorhies, V. (2011).
[111] Department of Human Services. (2011).
[112] Forbes, Inder and Raman (2006).
113 Lee, J. S., Courtney, M. E., & Tajima, E. (2014)

The Washington State Institute for Public Policy study found that the proportion of individuals leaving care at the age of 18 who were arrested within the following two years was 16.3%, compared to 10.4% of those who had chosen to stay on until a later age, up to 21.[114]

The Midwest study found comparable outcomes, however reported that the benefit was more likely to be realised in females than males. It was estimated in the Midwest study that 18 year old care leavers were approximately twice as likely to be arrested as those who had stayed in foster care until a later age, with 22% of women being arrested after leaving care at 18, compared to 10.5% of women who had remained longer in care.

We apply the more conservative estimates of the Washington State Institute study – that is, we assume that they apply across the population irrespective of gender.

Monetary assumptions

To estimate the cost of a particular crime, the frequency with which the crime occurs needs to be established. A major difficulty in attempting to assess the costs of crime is the 'unknown' frequency of many types of crimes[115].

Research undertaken by the Australian Institute of Criminology (AIC) estimated the costs of crime by calculating the number of crimes that came to the attention of the authorities for 2011 plus those not recorded officially (using ABS crime victimisation survey data, also for 2011) [116]. A dollar figure was applied to each event of crime based on actual losses, intangible losses, and loss of output caused through the criminal conduct. Added to these costs were costs of preventing and responding to crime in the community including maintenance of the criminal justice system (police, prosecution, courts and correctional agencies).

To estimate the costs of crime and interaction with the justice system for care leavers, the following assumptions were made:

- **Type of crime.** Following initial entry and interaction with the criminal justice system, the model considers three levels of criminal outcomes as possible for care leavers: low, medium and high. These levels are based on the types of crime committed by care leavers as reported in Midwest evaluation of former foster care youth[117].
    - Low criminal involvement here refers to arrests, and it was found in the Midwest study that 25% of care leavers were soon arrested after exit.
    - Medium criminal involvement refers to all convictions, across all types of crime, as well as imprisonment for property- and drug-related criminal offences. It was found that 22% of care leavers had engaged in medium criminal activity.

[114] Washington State Institute for Public Policy. (2010).
115 Australian Institute of Criminology (2014).
116 Australian Institute of Criminology (2014).
117 Courtney, M. E., Dworsky, A., Brown, A., Colleen, C., Love, K. & Vorhies, V. (2011).

- High criminal involvement refers to imprisonment for violent crime, which applied to 4% of care leavers.

- **Cost of crime.** A weighted average unit cost was calculated based on the likelihood of committing a crime within any given year, and, if a crime was committed the probable severity of that crime. AIC costs were utilised to determine the cost of a low, medium or high crime and inflated from 2011 to 2015 using CPI, and thereafter. The costs included in this weighted average for each level of crime were as follows:

    - Low criminal involvement included thefts from vehicles, shop theft, other theft, and criminal damage, plus costs of justice (petty crime involving only police and administrative costs) – summing the AIC estimated costs for each of these types of crime plus justice costs, equates to $3,207.91 per year in 2015 dollars.

    - Medium criminal involvement included robbery, burglary, theft of vehicle and assault, plus costs of justice (police, legal aid, prosecution and court costs) – summing the AIC estimated costs for each of these types of crime plus justice costs, equates to $7,510.06 per year in 2015 dollars.

    - High criminal involvement included homicide and sexual assault, plus costs of justice (police, legal aid, prosecution, court costs, and corrective services) summing the AIC estimated costs for each of these types of crime plus justice costs, equates to $80,268.44 per year in 2015 dollars.

    - The weighted average was calculated by multiplying the probability that for any given year, the proportion of care leavers expected to interact with the justice system within a given year is 40% (355 of 590 care leavers surveyed as part of the Midwest evaluation[118]). Of these 40% a young person committing a particular type of crime (categorised as the levels described above in 'types of crime') by the cost of that level of crime. The multiplied figures were then summed to provide one figure: the weighted average of $3,570.88 in 2015 dollars.

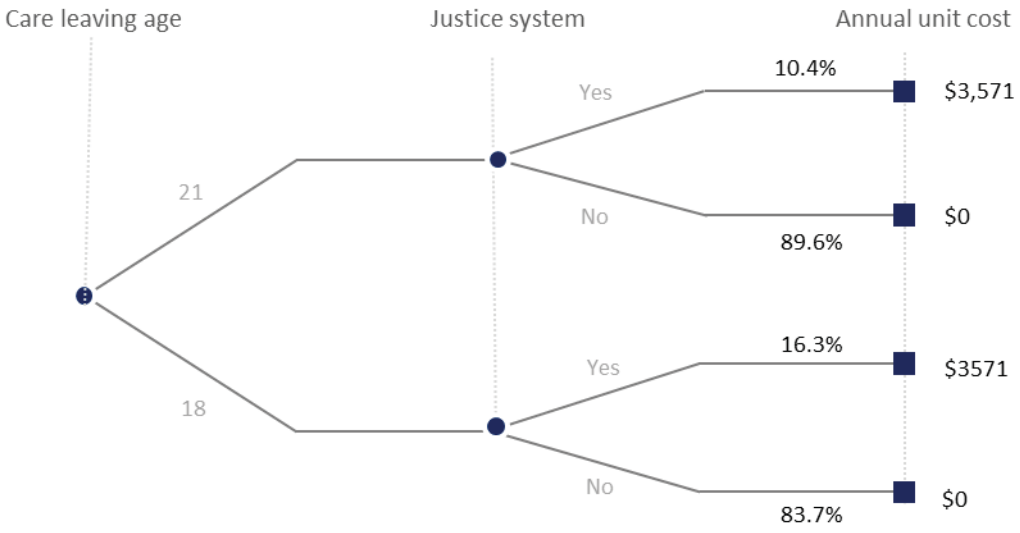
- **Pathway.** The type of crime and the number of times a young person interacts with the justice system over a lifetime will realistically vary for each individual. The model assumes that for any given year, of the individuals that ever enter the justice system, the average weighted annual unit cost would be incurred.

[118] Courtney, M. E., Dworsky, A., Brown, A., Cary, C., Love, K., & Vorhies, V. (2011).

Summary of assumptions

Figure 3.4 provides a summary of cost and probability assumptions used in this study.

Figure 3.4: Justice system model assumptions



- The probability of arrests for 18 year old care leaver is 16.3%, while those leaving at 21 have a 10.4% probability
- The cost of crime is estimated at $3,570.88 annually. This figure was derived by weighting the propensity and costs of criminal involvement across different severity levels.

3.7 Alcohol and/or drug dependence

Calculating the lifetime cost of alcohol and/or drug dependency is complicated by a number of factors. First, the dependency pathway is highly individualised – contingent upon factors such as the substance of abuse, timing and frequency of treatment interventions and, the individual's health, social and economic status. As such, the severity of episodes and frequency of relapse over a forty year period is not readily standardised.[119,120]

Relatedly, alcohol and/or drug dependency can be associated with a multitude of inter-related costs – spanning costs of healthcare, and societal costs. The model utilises an average cost per case of alcohol and/or drug dependency to society to determine a standardised cost per person.

119 Best, D. W. & Lubman, D. I. (2012).
120 Moos, R. H. & Moos, B. S. (2006).

Probability with and without intervention

The Midwest study estimated that the proportion of individuals leaving care at the age of 18 with alcohol and/or drug dependency, measured at age 21, was 15.8%.[121,122] As a comparable statistic was not found to be available in an Australian sample, it is assumed that the probability of alcohol or drug dependence for a child exiting care at the age of 18 is 0.158.

No research was found that isolated the impact of extended care on alcohol and/or drug dependency for youth in the years after they left care.[123] As such, a proxy for the effect of additional care on the probability of alcohol and/or drug dependency was employed.

Research indicates that the strength of social engagement and social networks in youth impacts upon the propensity to engage in risky behaviours including alcohol/drug abuse into adulthood. Participation in formal education is one mechanism for fostering improved social engagement and the formation of social networks.[124] The 2014-15 National Health Survey found that youth who complete year 12 are 84.4% less likely to abuse alcohol in adulthood than youth who leave school early (before year 10).[125]

The reduction in alcohol and drug dependency owing to engagement with education (a reduction of 84.4%) is used to calculate the impact of extended support on the likelihood of alcohol and drug dependency. Applying an 84.4% decrease to the probability of alcohol or drug abuse in the absence of extended care, it is assumed the likelihood of dependency under the scenario of extended care is 2.5%.

Monetary assumptions

Owing to the complexities in estimating lifetime costs for alcohol and/or drug dependency, the following simplifying assumption is employed to model the impact of the proposed intervention on AOD associated costs:

- **AOD pathway.** It is assumed that the cost imposed on society due to alcohol and/or other drug dependency by an individual is constant across their lifetime. The implication of this assumption is that where the true nature of costs are likely to be episodic – with peaks and troughs following episodes of relapse over an individual's life – the model considers a continuous, constant cost burden.

- **Average cost of AOD:** The weighted annual unit cost of alcohol and/or drug dependency is estimated to be $7,867.73. This was based on the total annual cost of alcohol and illicit drugs to society (considered separately) as reported by the Australian Institute of Health and Welfare (2011) to be $15.3 billion and $8.2 billion, respectively, in 2004-05 terms[126]. The values were inflated forward to 2015 terms using growth in national CPI. This aggregate cost was then calculated on a per affected person basis, with a more detailed description below.

121 Courtney, M., Dworsky, A., Cusick, G. R., Havlicek, J., Perez, A. & Keller, T. (2007).
122 Please note, prevalence rates in the study were calculated on the basis of sex. As such, a weighted average of the two rates has been calculated, based on the proportion of females and males in the study.
123 Best, D. W. & Lubman, D. I. (2012).
124 Best, D. W. & Lubman, D. I. (2012).
125 ABS. (2015).
126 Australian Institute of Health and Welfare. (2011).

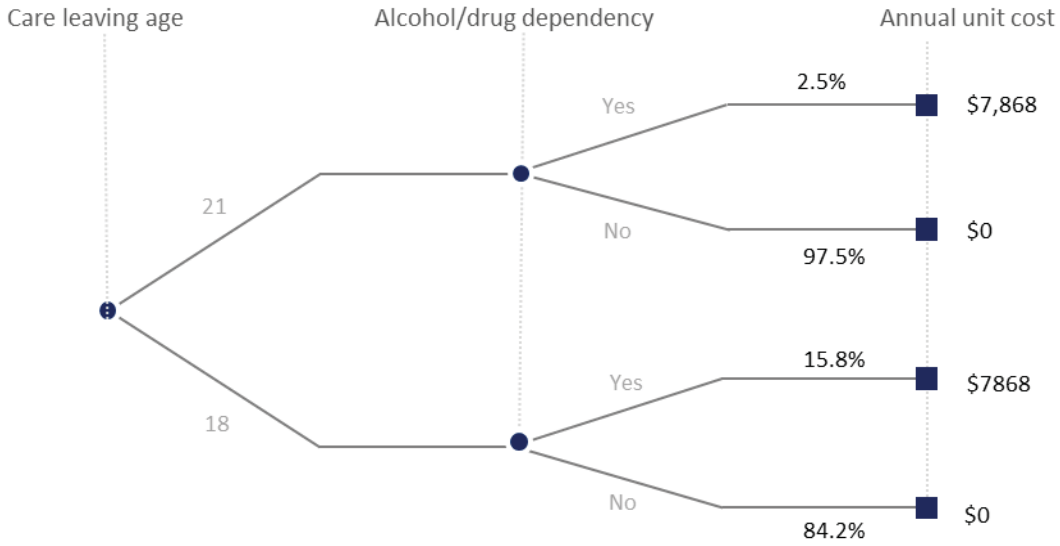
According to the 2013 National Drug Strategy Household Survey, the proportion of those aged 12 and over who had single-occasion or lifetime risky alcohol consumption behaviour[127] was 16.4%, and those aged 14 and over who used illicit drugs and/or pharmaceuticals for non-medical purposes on a weekly basis was 5.2%[128]. These prevalence rates were considered to be representative of alcohol and drug dependency, respectively. Using these rates, the total number of alcohol and drug dependent persons was calculated, in order to derive a unit cost of alcohol and illicit drugs incurred by society, found to be $6,088.68 and $10,586.61 respectively.

To estimate the general alcohol and/or other drug dependency cost, a weighted average of these costs was calculated, based on the relative proportions of those who were alcohol dependent only, drug dependent only, or dependent on both, of those who had alcohol and/or other drug dependency. These proportions were drawn from the 2001-02 US National Epidemiologic Survey on Alcohol and Related Conditions, which found that 8.5% had an alcohol disorder, 2% had a drug disorder, and 1.1% had both alcohol and drug disorders.[129] The relevant weights were therefore derived as 0.73 for alcohol-only, 0.17 for drug-only and 0.1 for both alcohol and drugs. These were considered to be appropriate for the purposes of the model, as risky alcohol consumption behaviour was more than three times as likely as weekly drug use. Further, given that 12.2% of daily drinkers in Australia used cannabis at least once in the past year, and 10.3% of daily drinkers had used other illicit drugs at least once, it is reasonable that there is not a high rate of co-dependency in Australia[130].

Summary of assumptions

Figure 3.5 provides a summary of cost and probability assumptions used in this study.

Figure 3.5 Alcohol and drug dependency model assumptions



[127] *Risky alcohol consumption is defined as more than 5 standard drinks per episode.*
[128] Australian Institute of Health and Welfare. (2015).
[129] National Institute on Alcohol Abuse and Alcoholism. (2008).
[130] Australian Institute of Health and Welfare. (2011)..

- The probability of alcohol or drug dependence for a child exiting care at the age of 18 is 15.8%. At 21, this probability has been estimated to be 2.5%.
- The weighted annual unit cost of alcohol and/or drug dependency is estimated to be $7,867.73. Weights used in the calculation were the cost of alcohol and illicit drugs to society, and the proportions of people with different alcohol and drug dependency combination types.

4 Model outputs

4.1 The base model

The primary modelling results put forward in this paper consider the benefits of a voluntary model of extended care. The model assumes that all participants who elect to take up the program in the first year do not drop-out of the program over the three year period. The uptake rate is assumed to be 24.95% of 18 year olds who are in any form of OOHC.

In 2015, there were 524 children in OOHC care aged 18 (the care leaver population). As such, this assumption implies that 131 of these young people would have adopted the program if it had been available. Inputs are as described in Chapter 3 and tabled in Appendix B.

Table 4.1 provides a summary of model outcomes.

Table 4.1 Present value ($2015) of costs and benefits over 40 years (uptake rate 24.95%), per 18yo child in OOHC in 2015

	Program not offered	Program offered	Difference between program offered/not offered
Total costs	124	20,139	**20,015**
Total benefits	56,520	93,381	**36,861**
Net benefits	56,396	73,242	**16,846**
Benefit to cost ratio			**1.84**

The expected expenditure per 18 year old child in OOHC to extend support to the age of 21 is $20,009 over a three year period. It should be noted that this $20,009 is not the same as the $27,000 input which relates to a single year program cost for an individual. This $20,009 is the *expected cost* of the program *over a three year period* per care leaver given an uptake rate of 25%.

Multiplied over the 2015 care leaver population of 524 (Table 4.2),[131] this equals $10.5 million. Multiplying expected benefits over the care leaver population of 524 reveals that expected benefits of program roll-out would be $19.3 million.

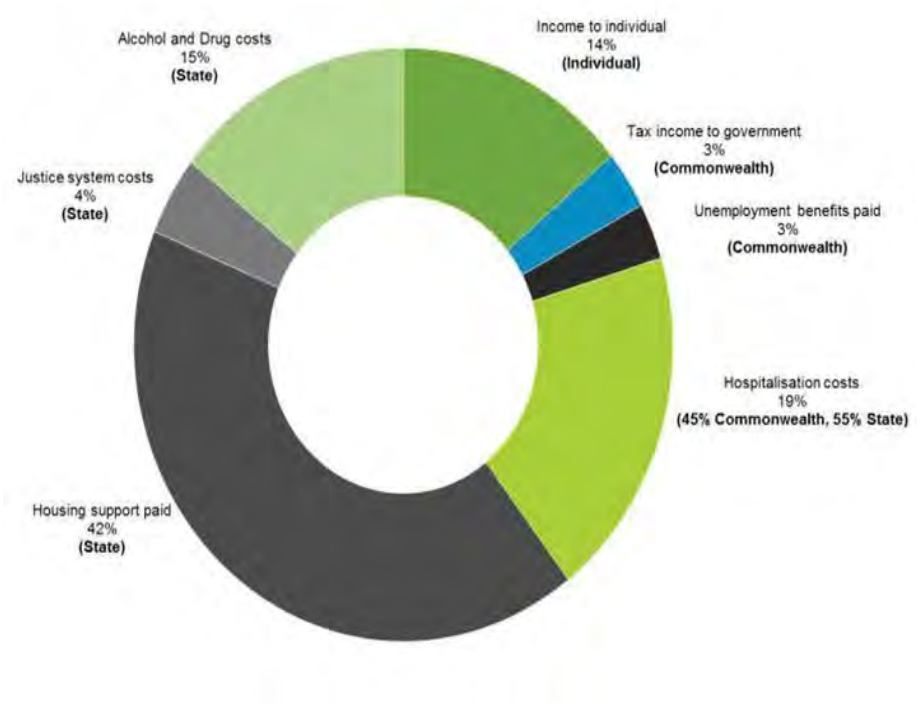
[131] Australian Institute of Health and Welfare (2014)

Table 4.2: Present value ($2015) of costs and benefits over 40 years (uptake rate 24.95%), per 18yo child in OOHC in 2015, total for 524 care leavers

	Program not offered	Program offered	Difference between program offered/not offered
Total costs	64,774	10,552,839	**10,488,065**
Total benefits	29,616,338	48,931,489	**19,315,151**
Net benefits	29,551,564	38,378,649	**8,827,086**
Benefit to cost ratio			**1.84**

As noted in Chapter 3, the benefits are comprised of increased revenue (to the individual and to the government through increased wages and hence taxation) and, reduced government expenditure across a number of portfolios (savings). As Chart 4.1 shows, the greatest benefits are seen to exist in the estimated savings to housing supports, justice costs and AOD costs. There are also saved costs that relate to Commonwealth expenditure, namely, the reduction in welfare costs and a proportion of hospital funding. It should further be noted that some components of housing support and alcohol and drug support is provided through federally funded grant funding.

Chart 4.1 Distribution of benefits



The modelling results find that under the assumed program cost and program uptake rate (25%), the benefit to cost ratio of the program is 1.84. That is, a dollar invested in the program is associated with an expected return of $1.84 in either savings or increased income.

Looking at benefits and costs which primarily accrue to Government – a pertinent statistic given the program outlay is assumed to be from public funds – the benefit cost ratio of public spend is approximately 1.60.

4.2 Sensitivity analysis

The modelling is reliant on a number of assumptions including those which relate to program uptake, program cost and timing.

This section considers the sensitivity of the findings to these key assumptions. Appendix D tables all results in further detail.

Overall, the finding that the program delivers positive returns was shown to be robust to variation in these assumptions, with the BCR ranging between 1.25 and 2.5 under variations to the key assumptions on program uptake, as outlined below.

Program uptake

The base model presented in this paper assumes that 24.95% of eligible individuals adopt the program where it is offered. It is noted, however, that uptake reported in the Midwest evaluation is higher (80%). To test the sensitivity of conclusions to the assumed uptake of 24.95%, the model was re-run, utilising a higher uptake rate of 50%.

Table 4.3 provides a summary of outcomes from this sensitivity analysis. As this change provides for a proportional impact in both costs and benefits, the benefit to cost ratio is not sensitive to the assumption.

Table 4.3 Present value ($2015) of costs and benefits over 40 years (uptake rate 50%), per 18yo child in OOHC in 2015

	Program not offered	Program offered	Difference between program offered/not offered
Total costs	124	40,235	**40,111**
Total benefits	56,520	130,031	**73,511**
Net benefits	56,396	89,796	**33,400**
Benefit to cost ratio			**1.83**

The base model assumes that individuals who adopt the program at 18 remain in extended care until the age of 21. That is, it assumes a 0% attrition rate. As a voluntary program, individuals will have the opportunity to leave – and, depending on the program design, re-enter – at various points between these ages. The model was re-estimated assuming an initially high uptake rate (80%) and then allowing for year-on-year attrition such that 50% participated in two years of the program and only 25% of individuals participated in three years of the program.

Naturally, it cannot be assumed that an individual who completes the program for a single year will receive the same benefits as an individual who remains in the program for three years. No analysis was found which allowed for the estimation of the marginal benefit attributable to every additional year of program participation. As such, the model assumes that benefits decline in a linear manner according to years of program participation.

Table 4.4 provides a summary of outcomes from this sensitivity analysis. The initially high uptake rate in this scenario drives the model to produce a higher benefit to cost ratio than in the base model.

Table 4.4 Present value ($2015) of costs and benefits over 40 years (uptake rate 80% in year 1, falling to 50% in year 2, and to 25% in year 3), per 18yo child in OOHC in 2015

	Program not offered	Program offered	Difference between program offered/not offered
Total costs	124	35,758	**35,634**
Total benefits	56,520	146,639	**90,119**
Net benefits	56,396	110,881	**54,485**
Benefit to cost ratio			**2.53**

Program cost

The base model in this analysis assumes that the cost of the program is $27,833 annually per program participant.[132] The positive benefit to cost ratio suggests however, that it is possible for this cost to rise before the program is net-negative.

Break-even analysis revealed that the program could cost $51,312 per program participant before the program became net negative.

Timeframe of analysis

The base model adopts a forty year time perspective on the basis that evidence provides that investments in the development of young people can have impacts well into adulthood. To test the sensitivity of the modelling results to this timeframe, the model was re-calculated on a 20 year time frame.

Table 4.5 provides a summary of outcomes from this sensitivity analysis. The benefit to cost ratio is lower than the base model however is still net positive.

Table 4.5 Present value ($2015) of costs and benefits over 20 years (uptake rate 24.95%), per 18yo child in OOHC in 2015

	Program not offered	Program offered	Difference between program offered/not offered
Total costs	124	20,179	**20,056**
Total benefits	19,699	44,753	**25,055**
Net benefits	19,575	24,574	**25,008**
Benefit to cost ratio			**1.25**

[132] Productivity Commission (2016). The annual cost per young person participating in the program is assumed to be equivalent to the average cost per child to receive foster care in 2015 (adjusted for inflation to $27,833.45)

5 Discussion of other potential benefits

A number of potential benefits of extended care were found in literature but were unable to be modelled on account of a lack of available data. These potential benefits are discussed in this chapter and should be considered as additional to the benefits modelled Chapter 4.

5.1 Mental health

Children and young people in OOHC are generally placed in the system due to violence, neglect or abuse in their family environment[133]. There is extensive literature which shows that there is a strong relationship between an unstable and damaging family experience for young people, and a range of mental illnesses, including post-traumatic stress disorder, depression and anxiety[134]. As the causative factors usually occur during childhood, the prevalence rates of mental illness among youth in OOHC are unlikely to change in light of an extension to care services until the age of 21; however, for the reasons outlined below, the duration and severity of illness may be improved by extension of exit age.

Currently, youth in care start to be prepared from the age of 15 to exit the system by 18[135]. It is therefore plausible that many in the system start to become disengaged during their formative adolescent years aged 15-17, which has been identified as an issue especially toward the start of exit planning[136]. This hampers access to effective treatment as young people may experience uncertainty and disruption during this period and therefore not seek appropriate mental healthcare to the extent they may with greater stability. Delayed treatment is likely to then have implications for future intensive access of the general healthcare system and mental health services, due to the increased likelihood of comorbidity and more chronic illness[137].

There is substantial qualitative literature which highlights the benefits of early intervention for mental, emotional and behavioural disorders among youth, including lower treatment costs across their lifetime, attributable in part to less intensive use of general and mental health services[138].

Early intervention has also been identified to be important in preventing the progression of the illness and mitigating collateral effects on social, educational and vocational outcomes[139]. Cost-benefit analyses of early intervention for mental health of adolescents found benefit-cost ratios between 3 and 28; however, these studies accounted for the direct effect of lower recurrent healthcare expenditure, as well as indirect effects of lower crime, higher productivity and reduced substance abuse.

Overall, there is a lack of data available to quantify the difference in mental illness costs for young people who leave care at age 18 compared to at age 21, aside from the substance abuse costs modelled

[133] Department of Families, Housing, Community Services and Indigenous Affairs (2011).
[134] Australian Institute of Family Studies. (2014).
[135] Mendes, P., Johnson, G. & Moslehuddin, B. (2011).
[136] Victorian Department of Human Services. (2012)..
[137] Grant, R. & Brito, A. (2010).
[138] O'Connell, M. E., Boat, T. & Warner, K.E. (2009).
[139] McGorry, P., Parker, A. & Purcell, R. (2006).

and the potential overlap with hospitalisation costs modelled. Hence, any improvement in other mental health outcomes and associated cost savings was not able to be modelled.

5.2 Physical health outcomes

In addition to poorer mental health outcomes, research suggests that young people in OOHC have been found to experience poorer physical health outcomes compared with the general population[140]. The main physical health challenges for care leavers have been identified as higher rates of illness and disability, higher rates of teenage pregnancy, risk-taking behaviour and self-harm and poor access to dental, optical and aural health services.[141]

The difference in physical health outcomes between 18 year old care leavers and those who stay in care to age 21 have not been extensively researched; however, available research does suggest that it is likely they extend beyond the modelled differences in hospitalisation costs. It has been postulated that young people who remain in care longer may experience physical health benefits as a result of improved education and employment outcomes associated with remaining in care longer than people who leave care at 18 years, due to the pathways outlined below. [142]

As noted above, sustained engagement in high quality education is directly related to the realisation of more positive life outcomes for individuals and societies.[143,144,145] As care leavers at 21 were found to experience higher levels of education and employment, the higher expected future earnings associated with this population presents an increased ability to afford private health insurance or make out of pocket payments for health services. Higher income may facilitate quicker access to elective medical services and high-demand procedures which typically involve long waiting periods (e.g. some organ transplant surgeries).

Lower formal education engagement rates among OOHC youth also raises the possibility of lower health literacy levels within the population. By increasing the time spent both in formal schooling and with an adult carer exerting a positive influence, extended care could also potentially increase levels of awareness, and usage, of healthcare services that monitor and prevent future ill health (e.g. blood pressure and weight monitoring, AOD treatment programs). As is the case with all preventative healthcare measures, although there can be short term costs of these services and actions, typically they lead to higher cost savings in the long run[146].

In sum, by improving education and thus potentially prevention and early intervention activities and reducing risk factors (e.g. alcohol and other drugs), extending care to 21 years could also potentially reduce the incidence of costly lifestyle-related diseases like certain respiratory, cardiac and liver illnesses.

[140] Courtney, M. E., Dworsky, A., Brown, A., Cary, C., Love, K., & Vorhies, V. (2011).
[141] Joseph McDowall, CREATE Foundation (2009).
[142] Raman, S., Inder, B., & Forbes, C. (2005).
143 Johnston, G (2004)
144 Levin, B (2003)
145 Hannusek and Woessman (2010)
[146] Vos T, Carter R, Barendregt J, Mihalopoulos C, Veerman JL, Magnus A, Cobiac L, Bertram MY, Wallace AL, ACE–Prevention Team (2010).

5.3 Intergenerational disadvantage

The modelling for this project considers a subset of impacts on the individual receiving extended OOHC and, to some extent, costs avoided by the community as a result of that individual's receipt of OOHC support. The model does not, however, account for intergenerational impacts of extending care. Intergenerational benefits of extended care are realised if and to the extent that these flow-on impacts serve to permanently alter the course of not only the individual participant's prospects, but the prospects of their children.

By encouraging continued education, extended care raises the probability of employment and the average income of care leavers. Given that children's outcomes (health, education, income) have been found to be significantly associated with their parents' earnings and socio-economic status, extending OOHC may bring future benefits to the children of those receiving extended care and support. [147]

The same may be said of the impact of reducing the incidence of criminal activity through extended care, since having a history of conviction has been linked with a reduced probability of securing employment.[148] Furthermore, the penalty for having a history of conviction may be especially severe for certain minority groups and thus also have a negative impact on disposable income.[149]

In light of the link between higher employment/income and both improved education and reduced criminal activity from extending care to 21 years, together with the link between higher parental income and child outcomes, extending care beyond 18 years could reduce the intergenerational disadvantage experienced by care leavers and their own children.

Teenage pregnancy

There is also growing research to indicate that intergenerational impacts of teenage pregnancy exist[150]. Mothers who have experienced teenage pregnancy have been found to experience lower educational status and worse employment outcomes relative to those who have not experienced pregnancy[151]. Moreover, the educational disadvantage perpetuates with the next generation – research has linked adolescent mothers' relatively lower educational outcomes to lower outcomes also for their own children[152], and also found that children born to teen mothers experience lower life satisfaction and personal income levels in adulthood.[153]

Furthermore, it has been shown that teenage mothers are 2.2 times more likely to have a child placed in foster care than those who delay child bearing until age 21, continuing the intergenerational cycle of poorer outcomes for young people in OOHC care when compared with the general population.[154]

[147] Mayer S.E. (2002).
[148] Mendes, P; Snow, P; Baidawi, S (2012).
[149] Pager M. (2003).
[150] Bradbury B (2011)
[151] Dworsky A, Courtney M (2010),
152 Tang et al (2014).
153 Lipman et al (2011).
[154] National Campaign to Prevent Teen and Unplanned Pregnancy, (2006)

Researchers using data from the Midwest evaluation reported that staying in care beyond the age of 18 years may mitigate the risk of becoming pregnant, and suggested that allowing young people to remain in foster care beyond age 18 may be one way to help reduce teenage pregnancy among this population[155].

5.4 Civic participation and social connectedness

As discussed throughout this report, children in OOHC are less likely to reach educational milestones, be employed, and more likely to experience behavioural problems and depression. They may also experience fragmented relationships with next of kin due to the physical separation brought about (and often legally required) through the OOHC arrangements, as well as because of the source of family abuse itself[156]. Many have also not been able to forge lasting friendships due in part to unstable living and schooling arrangements[157]. As a result, OOHC and foster youth have a higher rate of disengagement with key societal institutions such as the family, education, business (employment) and the wider community – all of which exert a stabilising effect on the wellbeing of both the individual and society in general.

Many researchers have now identified the pivotal role that stability and connectedness play in establishing better outcomes of children in foster care[158]. It is believed that connectedness facilitates access to opportunities and resources and provides a sense of belonging that strengthens a child's resilience.[159,160] A 2004 Australian study by Mason and Gibson surveyed children, young people, carers and workers in NSW who identified that the child's 'connections with others' was the overarching factor that impacted on their wellbeing.[161]

It is postulated that, by offering the possibility of extended care with associated greater potential stability in accommodation and care arrangements, children may experience greater continued connection to individuals where they had forged positive relationships, leading to greater improved emotional wellbeing and social benefits for young people in extended care[162].

5.5 Disability adjusted life years

A commonly included method within cost benefit analyses for health policies or programs is the estimation of disability adjusted life years (DALYs)[163]. DALYs are a globally accepted metric that allows researchers and policymakers to compare different populations and health conditions across time. A

[155] Dworsky A, Courtney M (2010),
[156] Osborn, A. and Bromfield, L (2007)
[157] Tilbury et al (2015*)*
[158] See for example: Tilbury, C., & Osmond, J., (2006)
159 Placing children in out-of-home care
160 Bowes, J. M. and Hayes, A. (2004)
161 Mason and Gibson (2004).
162 Department of Families, Housing, Community Services and Indigenous Affairs together with the National Framework Implementation Working Group (2010).
[163] Access Economics, with the Australian Safety and Compensation Council (2008).

DALY is the sum of years of life lost and years lived with disability, or a health condition, that reduces quality of life – such a liver disease[164]. One DALY equals one lost year of healthy life.

Specifically for the benefits modelled in this project, DALYs could be estimated and added for the reduction in health burden or disease associated with lower alcohol and drug consumption, reduced hospitalisation and reduced mental health issues.

The modelling for this project has not considered DALYs in the calculation of benefits, and has instead focused on financial costs and savings. Given that extending care to age 21 is considered protective for risk of hospitalisation, alcohol and drug use, and mental health issues, compared with leaving OOHC at age 18, it is expected that the DALYs benefits would accrue to a greater extent for extending care. This means that the overall benefit of extending care estimated in the current model is conservative, since the value of these DALYs saved has not been included. However, each DALY saved is very valuable, with the Department of the Prime Minister and Cabinet valuing a DALY averted (a year of healthy life saved) at $182,000 in 2014.[165]

[164] Access Economics with the Australian Safety and Compensation Council (2008).
[165] Department of Prime Minister and Cabinet (2014)

6 Conclusion

The overarching objective of OOHC is for all children to have access to stable and safe home environments that afford children in the child protection system equitable development opportunities to children who are not in the child protection system.

However, in Victoria, and equally, across all states and territories in Australia, upon reaching 18 years of age, children in OOHC are legally recognised as "independent" and are required to be exited from their care and accommodation arrangements. By contrast, young people in the general population are now, more than ever, more likely to continue to live with their parents well into their mid-20s, entering and exiting the family home several times as they pursue various development opportunities.

There have been a number of calls to action for considering the extension of care, including in the findings of the Victorian 2012 Vulnerable Children's Inquiry. However, such reform is yet to be either trialled or instituted comprehensively in any jurisdiction in Australia.

The current study considered the potential benefits that could flow – both to the individual and to the public – from introducing a program of support for Victorian children in all forms of OOHC that gives them the option to extend such care from the age of 18 to the age of 21.

Drawing upon international research to determine the marginal impact of providing extended care to young people in OOHC across several life domains. Specifically, the model considers the financial impacts of improved access to education and, relatedly, employment; improved housing stability; reduced interaction with the justice system; improved access to healthcare; and, reduced incidence of alcohol and/or drug dependence.

The modelling results find that under the assumed program cost and program uptake rate (25%), the benefit to cost ratio of the program is 1.84. That is, a dollar invested in the program is associated with an expected return of $1.84 in either savings or increased income.

Owing to data limitations and the intangible nature of some potential benefits, the modelling was not able to account for all benefits canvased in literature. As such, a number of benefits including implications for the sustainment of intergenerational cycles of disadvantage, social connectedness and the burden of disease. Such benefits are additional to those included in the model and as such qualitatively serve to increase the return to investment.

Together, these results and accompanying research put forward a sound socioeconomic case for consideration of public investment in the future of young people in OOHC, beyond the age of 18.

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Appendix B: Summary of key assumptions

Figure B.1 Illustration of model assumptions

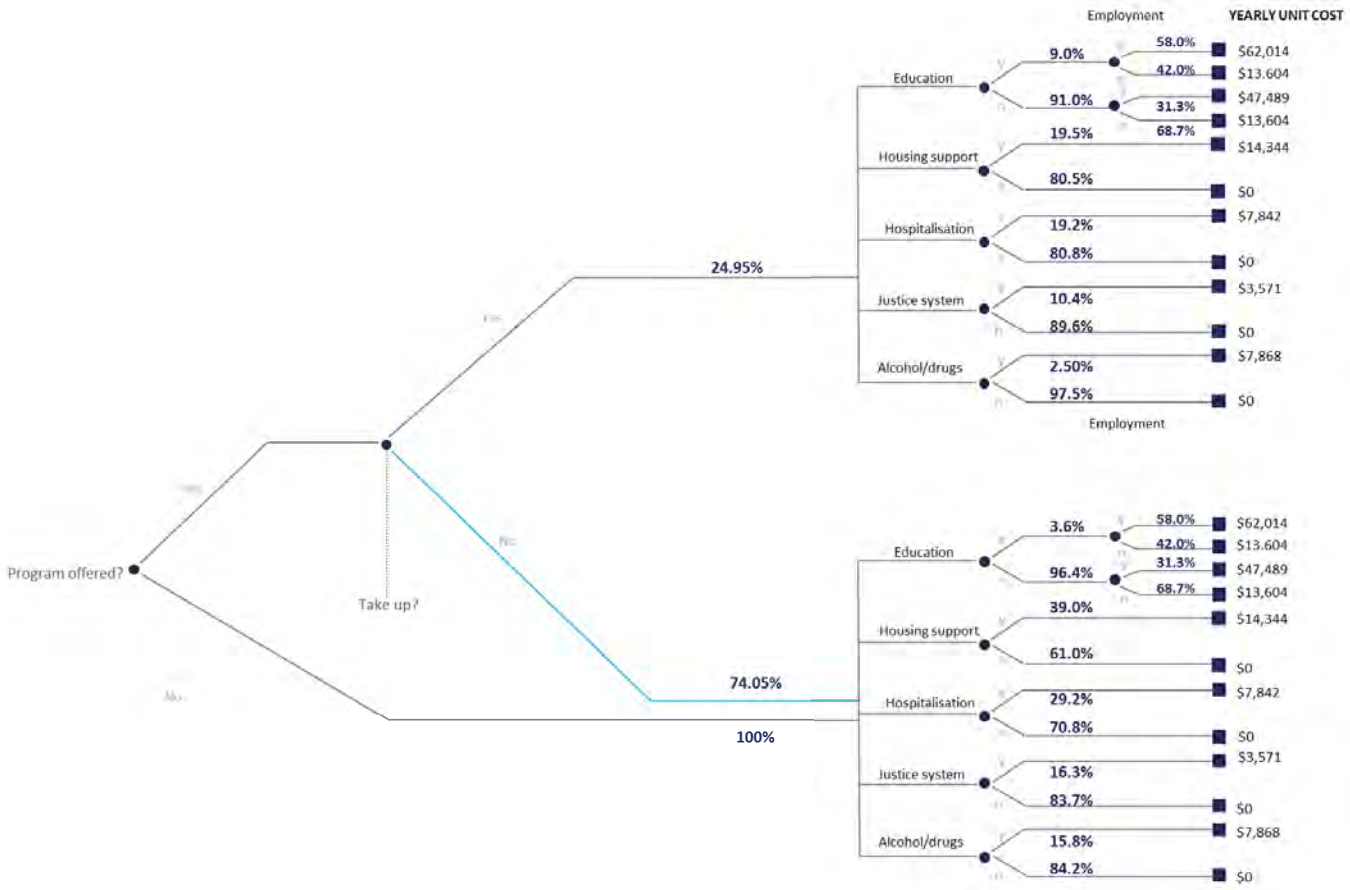

Table B.2 Base model assumptions and source

Variable	Assumption	Source
Program Uptake		
Program Uptake Rate	0.2495	UK Department of Education; Children and Young People Now (2015)
Employment & Education		
VET qualification; Employed ($2015)	$62,014	ABS (2005)
No VET qualification; Employed ($2015)	$47,489	ABS (2005)
VET qualification; Unemployed	$13,604	Department of Human Services (2016)
No VET qualification; Unemployed	$13,604	Department of Human Services (2016)
VET course (one year)	$3,433	Derived using, Victoria Polytechnic. (2016)
Pr. Further education (Age 18)	0.036	Harvey et al (2015)
Pr. Further education (Age 21)	0.09	Derived using Harvey et al (2015), and Munro et al (2010)
Pr. Employment (with VET)	0.58	ABS Education and Work (2015)
Pr. Employment (No VET)	0.313	Derived using ABS Education and Work (2015), and McDowell (2019)
Homelessness & Housing Support		
Housing support	$14,344.46	Derived using Zaretzy and Flatau (2015), and AIHW Child Protection Australia 2013-14 (2015)
Pr. Housing Support (Age 18)	0.39	Forbes et al (2006)
Pr. Housing Support (Age 21)	0.195	Derived using Forbes et al (2006), and Munro et al (2010)
Hospitalisation		
Cost of Hospitalisation episode	$7,842	IHPA Independent Hospital Pricing Authority (2013) National Hospital Care Data Collection 2012-13

Pr. Hospitalisation episode (Age 18)	0.292	Courtney et al (2006)
Pr. Hospitalisation episode (Age 21)	0.192	Courtney et al (2007)
Justice		
Cost to Justice system	$3,571	Derived using Australian Institute of Criminology (2014) and Courtney et al (2011)
Pr. Justice (Age 18)	0.163	Washington State Institute for Public Policy (2010)
Pr. Justice (Age 21)	0.104	Washington State Institute for Public Policy (2010)
Alcohol and/or Drug Dependence		
Cost of AoD dependency	$7,868	AIHW (2011)
Pr. AoD dependency (Age 18)	0.158	Courtney et al (2007)
Pr. AoD dependency (Age 21)	0.03	Derived using Courtney et al (2007), and ABS National Health Survey 2014-15 (2015)

Appendix C: Number of children in OOHC

Table C.1 shows that at 30 June 2014, there were 7,710 Victorians aged 0 -17 years recorded as living in OOHC. Across the nation, Victoria currently has the lowest rates of children living in OOHC at 6.0 per 1,000 children. This compares with the Australian average rate of 8.1 per 1,000 children and the Northern Territory where the rate is 14.3 per 1,000 children. The number of children in OOHC per 1,000 children in Victoria has increased faster than the national average from 4.5 to 6.0 over five years, compared 7.1 to 8.1 for Australia.

Table C.1: Children aged 0–17 in out-of-home care, states and territories, 30 June 2010 to 30 June 2014 (number and number per 1,000)

Year	NSW	Victoria	Qld	WA[(a)]	SA[(b)]	Tas	ACT	NT	Total
Number									
2010	16,175	5,469	7,350	2,737	2,188	893	532	551	35,895
2011	16,740	5,678	7,602	3,120	2,368	966	540	634	37,648
2012	17,192	6,207	7,999	3,400	2,548	1,009	566	700	39,621
2013	17,422	6,542	8,136	3,425	2,657	1,067	558	742	40,549
2014	18,192	7,710	8,185	3,723	2,631	1,054	606	908	43,009
Number per 1,000 children[(c)]									
2010	9.9	4.5	6.9	5.1	6.2	7.6	6.7	8.8	7.1
2011	10.2	4.6	7.1	5.7	6.7	8.3	6.7	10.2	7.4
2012	10.4	5.0	7.3	6.1	7.2	8.7	6.9	11.1	7.7
2013	10.4	5.2	7.4	5.9	7.4	9.3	6.7	11.6	7.7
2014	10.8	6.0	7.3	6.3	7.3	9.2	7.1	14.3	8.1

Source: Australian Institute of Health and Welfare 2015. Note (a) Data for 2009–10 for Western Australia are not comparable with other years due to the introduction of a new client information system in March 2010. Proxy data were provided for that year. (b) South Australia could only provide the number of children in out-of-home care where the Department is making a financial contribution to the care of a child. (c) Rates were calculated using revised population estimates based on the 2011 Census and should not be compared with rates calculated using populations or projections based on previous Censuses, including those published in previous editions of Child protection Australia.

Of the Victorian children in OOHC, 1,308 were identified as Indigenous. The rate of Indigenous children in care was 62.7 per 1,000 Indigenous children. This is much higher than the rate of non-Indigenous children at 5.0 per 1,000, and the state average of 6.0 per 1,000 children.

The vast majority of Victorian children in OOHC at 30 June 2014 were in home-based care – 7,145 or 92.7% of the total number of children in OOHC in Victoria. Of these 7,145 children, 515 were in residential care, 49 were in independent living, and one child's OOHC type was unknown. There were no children recorded as living in a family group home (Table C.2). For the children place in home-based care 3,877 were living with relatives or kin, 2,132 were living in foster care and a further 1,136 were living in other home-based care (Table C.2).

Table C.2: Children aged 0–17 in out-of-home care, by type of placement, states and territories, 30 June 2014

Type of placement	NSW	Vic[a]	Qld	WA	SA	Tas[b]	ACT	NT[c]	Total
Number									
Foster care[d]	*7,550*	*2,132*	*4,223*	*1,549*	*1,114*	*401*	*213*	*472*	*17,654*
Relatives/kin[d]	*10,044*	*3,877*	*3,306*	*1,821*	*1,162*	*302*	*318*	*17*	*20,847*
Other home-based care	*0*	*1,136*	*0*	*0*	*0*	*255*	*36*	*261*	*1,688*
Total home-based care	17,594	7,145	7,529	3,370	2,276	958	567	750	40,189
Family group homes	14	0	0	185	n.a.	29	0	9	237
Residential care	507	515	656	168	334	48	38	90	2,356
Independent living	66	49	0	0	21	1	0	5	142
Other/unknown	11	1	0	0	n.a.	18	1	54	85
Total	18,192	7,710	8,185	3,723	2,631	1,054	606	908	43,009
Proportion (%)[e][f]									
Foster care	*41.5*	*27.7*	*51.6*	*41.6*	*42.3*	*38*	*35.1*	*52*	*41*
Relatives/kin	*55.2*	*50.3*	*40.4*	*48.9*	*44.2*	*28.7*	*52.5*	*1.9*	*48.5*
Other home-based care	*0*	*14.7*	*0*	*0*	*0*	*24.2*	*5.9*	*28.7*	*3.9*
Total home-based care	96.7	92.7	92	90.5	86.5	90.9	93.6	82.6	93.4
Family group homes	0.1	0	0	5	..	2.8	0	1	0.6
Residential care	2.8	6.7	8	4.5	12.7	4.6	6.3	9.9	5.5
Independent living	0.4	0.6	0	0	0.8	0.1	0	0.6	0.3
Other/unknown	0.1	..	0	0	..	1.7	0.2	5.9	0.2
Total	100	100	100	100	100	100	100	100	100

Source: Australian Institute of Health and Welfare 2015. Note (1) Data(a) In Victoria, the 'foster care' category includes children in permanent care placements. These placements are different to foster care as they involve granting permanent guardianship and custody of a child to a third party via a permanent care order. Unlike adoptions, permanent care orders do not change the legal status of the child and they expire when the child turns 18 or marries. (b) In Tasmania, children under third-party guardianship orders are counted under 'Other home-based care' living arrangements. (c) In the Northern Territory's client information system, the majority of children in a relative/kinship placement are captured in the 'foster care' placement type. Approximately 45% of children in the 'foster care' placement type are placed in a relative/kinship household. (d) Where a child is placed with a relative who is also fully registered to provide foster care for other children, they are counted in the 'foster care' category for Victoria and Western Australia, whereas they are counted in the 'relatives/kin' category in Queensland and South Australia. Relatives/kin in some jurisdictions undergo assessment, registration and review processes similar to foster carers under the national definition, and are considered as (relative) foster carers in local practice, policy and reporting. (e) Percentages include children with 'other/unknown' living arrangements. (f) Percentages in the table may not add to 100 due to rounding.

Appendix D: Modelling results

Table D.1 Base model. Present value ($2015) of costs and benefits over 40 years (uptake rate 24.95%), per 18yo child in OOHC in 2015

Cost/benefit category	Program not offered	Program offered	Difference in cost/benefit	% change	Payer/receiver
Costs					
Program cost	-	19,969	19,969		Government
Cost of education	124	170	46	27%	Government
Total costs	124	20,139	20,015		
Benefits					
Income to individual	410,197	415,364	5,167	1%	Individual
Tax income to government	93,112	94,285	1,173	1%	Government
Unemployment benefits paid*	-233,188	-232,054	1,134	0%	Government
Housing support paid*	-107,237	-91,857	15,380	-14%	Government
Hospitalisation costs*	-70,032	-62,939	7,093	-10%	Government
Justice system costs*	-11,654	-10,064	1,589	-14%	Government
Alcohol and Drug costs*	-24,679	-19,354	5,324	-22%	Government and society
Total benefits	56,520	93,381	36,861		
Net benefits	56,396	73,242	16,846		

Note. Where benefits relate to costs *saved* a benefit is where there are fewer costs, that is, where a number is less negative. Please note that presented figures have been rounded.

Table D.2 Sensitivity analysis. Present value ($2015) of costs and benefits over 40 years (uptake rate 50%), per 18yo child in OOHC in 2015

Cost/benefit category	Program not offered	Program offered	Difference in cost/benefit	% change	Payer/receiver
Costs					
Program cost	-	40,018	40,018		Government
Cost of education	124	216	93	27%	Government
Total costs	124	40,235	40,111		
Income to individual	410,197	420,552	10,355	3%	Individual
Tax income to government	93,112	95,463	2,351	3%	Government
Unemployment benefits paid*	-233,188	-230,915	2,273	-1%	Government
Housing support paid*	-107,237	-76,416	30,822	-29%	Government
Hospitalisation costs*	-70,032	-55,818	14,214	-20%	Government
Justice system costs*	-11,654	-8,827	2,826	-24%	Government
Alcohol and Drug costs*	-24,679	-14,009	10,670	-43%	Government and society
Total benefits	56,520	130,031	73,511		
Net benefits	56,396	89,796	33,400		

Note. Where benefits relate to costs *saved* a benefit is where there are fewer costs, that is, where a number is less negative. Please note that presented figures have been rounded.

Table D.3 Sensitivity analysis. Present value ($2015) of costs and benefits over 40 years (uptake rate 80% in year 1, 50% in year 2, 25% in year 3), per 18yo child in OOHC in 2015

Cost/benefit category	Program not offered	Program offered	Difference in cost/benefit	% change	Payer/receiver
Costs					
Program cost		35,486	35,486		Government
Cost of education	123.61	272	148	55%	Government
Total costs	123.61	35,758.02	35,634.41	100%	
Income to individual	410,197.01	426,765.54	16,568.53	4%	Individual
Tax income to government	93,112.21	96,873.16	3,760.95	4%	Government
Unemployment benefits paid*	-233,188.20	-229,550.62	3,637.58	-2%	Government
Housing support paid*	-107,237.25	-81,183.95	26,053.30	-32%	Government
Hospitalisation costs*	-70,031.91	-42,950.57	27,081.34	-63%	Government
Justice system costs*	-11,653.59	-8,372.78	3,280.81	-39%	Government
Alcohol and Drug costs*	-24,678.54	-14,941.90	9,736.64	-65%	Government and society
Total benefits	56,519.73	146,638.86	90,119.13		
Net benefits	56,396.11	110,880.84			

Note. Where benefits relate to costs *saved* a benefit is where there are fewer costs, that is, where a number is less negative. Please note that presented figures have been rounded.

Table D.4 Sensitivity analysis. Present value ($2015) of costs and benefits over 40 years (uptake rate 24.95%) per 18yo child in OOHC in 2015, break-even analysis

Cost/benefit category	Program not offered	Program offered	Difference in cost/benefit	% change	Payer/receiver
Costs					
Program cost	-	36,815	36,815		Government
Cost of education	124	170	46	27%	Government
Total costs	124	36,985	36,861		
Income to individual	410,197	415,364	5,167	1%	Individual
Tax income to government	93,112	94,285	1,173	1%	Government
Unemployment benefits paid*	-233,188	-232,054	1,134	0%	Government
Housing support paid*	-107,237	-91,857	15,380	-14%	Government
Hospitalisation costs*	-70,032	-62,939	7,093	-10%	Government
Justice system costs*	-11,654	-10,064	1,589	-14%	Government
Alcohol and Drug costs*	-24,679	-19,354	5,324	-22%	Government and society
Total benefits	56,520	93,381	36,861		
Net benefits	56,396	56,396	0		

Note. Where benefits relate to costs *saved* a benefit is where there are fewer costs, that is, where a number is less negative. Please note that presented figures have been rounded.

Table D.5 Sensitivity analysis. Present value ($2015) of costs and benefits over 20 years (uptake rate 24.95%) per 18yo child in OOHC in 2015

Cost/benefit category	Program not offered	Program offered	Difference in cost/benefit	% change	Payer/receiver
Costs					
Program cost	-	20,009	20,009		Government
Cost of education	124	170	46	27%	Government
Total costs	124	20,179	20,056		
Income to individual	242,163	245,063	2,900	1%	Individual
Tax income to government	54,970	55,628	658	1%	Government
Unemployment benefits paid*	-137,826	-137,122	704	-1%	Government
Housing support paid*	-75,174	-63,771	11,403	-15%	Government
Hospitalisation costs*	-39,353	-34,873	4,480	-11%	Government
Justice system costs*	-8,045	-6,862	1,182	-15%	Government
Alcohol and Drug costs*	-17,036	-13,309	3,726	-22%	Government and society
Total benefits	19,699	44,753	25,055		
Net benefits	19,575	24,574	25,008		

Note. Where benefits relate to costs *saved* a benefit is where there are fewer costs, that is, where a number is less negative. Please note that presented figures have been rounded.

Appendix E: Australian-wide analysis

To supplement the Victorian-specific findings of this report, we have also investigated the impact of implementing an extended care program in other states and territories in Australia.

To conduct this analysis, the same base model is utilised – that is, a consideration of the economic impacts of improved access to education and, relatedly, employment; improved housing stability; reduced interaction with the justice system; improved access to healthcare; and, reduced incidence of alcohol and/or drug dependence. Where Victoria-specific inputs were utilised in the base model, these were updated on a jurisdictional basis to ensure that the modelling results reflect the circumstances of the state/territory which is being considered.

State-specific model inputs

A number of inputs remain constant across all state/territory models. For example, the discount rate, the nominal growth rates for costs and benefits over time and many of the probability inputs which were determined through international literature. A subset, however, were updated to relate to the specific state/territory under consideration.

The following table provides a summary of the inputs which were updated on a jurisdictional basis. Owing to state based differences in reporting, it is possible that the inputs may reflect slightly differing estimation techniques; however, every effort has been made to ensure consistency with the Victorian approach.

In some cases where data was not reported for a selection of jurisdictions, we have used an index representing the difference in relative costs/price levels (eg. CPI) among the other jurisdictions compared to Victoria, as an approximation technique (as demonstrated in the case of the VET Course costs). This reduces the amount of variability in estimation methods as it uses the Victorian estimate as a base value for the calculations.

Table E.1: Model inputs per state ($2015)

VIC	NSW	QLD	SA	WA	TAS	NT	ACT
Average cost of program (per child)[a]							
$27,833.45	$28,105.40	$28,047.61	$48,736.25	$37,173.94	$24,475.52	$52,351.66	$36,478.67
VET course completion rate[b]							
33.1%	34.0%	33.1%	38.0%	36.6%	25.7%	34.8%	40.8%
VET course fees (cost of education) [c]							
$3,433	$3,583.39	$3,473.49	$3,470.60	$3,522.66	$3,412.75	$3,438.78	$3,343.34
Proportion of Indigenous children in care[d]							
16.98%	35.84%	40.76%	29.91%	50.55%	22.01%	85.24%	25.08%
Cost of housing support[e]							
$14,344.46	$18,184.96	$19,421.01	$16,695.10	$21,882.56	$14,709.10	$30,602.47	$15,481.04
No. of children exiting care[f]							
524	854	474	145	190	66	52	34

[a] Costs were sourced from *Productivity Commission (2016)* except for NSW, QLD, and NT which were not reported and have been approximated in our analysis. To do this, we have calculated the proportionate difference between the expenditures on "all out of home care services" for NSW/QLD/NT against VIC's, and applied that to VIC's average cost of program per child

[b] All data in this category was sourced from *National Centre for Vocational Education Research (2014)*

[c] To estimate the cost of course fees for all states other than VIC, the difference between the Education CPI levels of each state was calculated against VIC's. This proportion was then applied to VIC's average VET course fees estimate.

[d] Data from all states were sourced from *Australian Institute of Health and Welfare (2015).*

[e] The same method used in the VIC calculations was applied to all states – i.e. a weighted average of the cost of housing support *(Zaretzky & Flatau 2015)* was calculated using each state-specific ratio between indigenous and non-indigenous children in care.

[f] All numbers were sourced from *Australian Institute of Health and Welfare (2015)* and estimated using the same technique as applied in calculating Victoria's estimate.

Model outputs

We summarise the model results for each state/territory at both the per-person, and care-leaver population levels. At the per-person level, the numbers represent the costs and benefits per 18 year old child in care. At the population level, the costs and benefits pertain to the total population of care leavers in each jurisdiction (as reported in Table E.1).

Victoria

The Victorian results are presented in the main body of this report, but have been replicated below in Table E.2 for ease of comparison with the results in the remainder of this chapter.

Table E.2: Present value ($2015) of costs and benefits over 40 years (uptake rate 24.95%), in 2015; Victoria

VIC (per person)	Program not offered	Program offered	Difference between program offered/not offered
Total costs	124	20,139	**20,015**
Total benefits	56,520	93,381	**36,861**
Net benefits	56,396	73,242	**16,846**
Benefit to cost ratio	-	-	**1.84**
VIC (all care leavers: 524)	**Program not offered**	**Program offered**	**Difference between program offered/not offered**
Total costs	64,774	10,552,839	**10,488,065**
Total benefits	29,616,338	48,931,489	**19,315,151**
Net benefits	29,551,564	38,378,649	**8,827,086**
Benefit to cost ratio	-	-	**1.84**

New South Wales

Table E.3 shows that under the assumed program cost and program uptake rate (25%), **the benefit to cost ratio of the program is 2.57.** That is, every dollar invested in the program is associated with an expected return of $2.57 in either savings or increased income.

Looking at benefits and costs which accrue primarily to government – a pertinent statistic given the program outlay is assumed to be from public funds – **the benefit cost ratio of public expenditure is approximately 2.33**.

The care leaver population at June 2014 was estimated to be 854 young people – the highest across all states/territories in Australia, reflecting the proportionately larger population. Multiplied over the 2015 care leaver population of 854, modelling results suggest the **expected marginal (the difference between costs if the program is offered, and not offered) program cost for this group would be equivalent to $17.3 million**. Multiplying expected benefits over the care leaver population of 854 reveals that **expected benefits of program roll-out would be $44.4 million**.

Table E.3: Present value ($2015) of costs and benefits over 40 years (uptake rate 24.95%), in 2015; New South Wales

NSW (per person)	Program not offered	Program offered	Difference between program offered/not offered
Total costs	134	20,346	**20,212**
Total benefits	28,585	80,620	**52,034**
Net benefits	28,451	60,274	**31,823**
Benefit to cost ratio	-	-	**2.57**
NSW (all care leavers: 854)	**Program not offered**	**Program offered**	**Difference between program offered/not offered**
Total costs	114,452	17,375,152	**17,260,700**
Total benefits	24,411,913	68,849,204	**44,437,291**
Net benefits	24,297,461	51,474,052	**27,176,591**
Benefit to cost ratio	-	-	**2.57**

Queensland

Table E.4 shows that under the assumed program cost and program uptake rate (25%), **the benefit to cost ratio of the program is 2.69.** That is, every dollar invested in the program is associated with an expected return of $2.69 in either savings or increased income.

Looking at benefits and costs which accrue primarily to government – a pertinent statistic given the program outlay is assumed to be from public funds – **the benefit cost ratio of public expenditure is approximately 2.44**.

The care leaver population at June 2014 was estimated to be 474 young people. Multiplied over the 2015 care leaver population of 474, modelling results suggest the **expected marginal program cost (the difference between costs if the program is offered, and not offered) for this group would be equivalent to $9.6 million**. Multiplying expected benefits over the care leaver population of 474 reveals that **expected benefits of program roll-out would be $25.7 million**.

Table E.4: Present value ($2015) of costs and benefits over 40 years (uptake rate 24.95%), in 2015; Queensland

QLD (per person)	Program not offered	Program offered	Difference between program offered/not offered
Total costs	126	20,296	**20,170**
Total benefits	18,796	73,057	**54,261**
Net benefits	18,669	52,761	**34,092**
Benefit to cost ratio	-	-	**2.69**
QLD (all care leavers: 474)	**Program not offered**	**Program offered**	**Difference between program offered/not offered**
Total costs	59,947	9,620,312	**9,560,365**
Total benefits	8,909,110	34,628,940	**25,719,830**
Net benefits	8,849,163	25,008,628	**16,159,465**

Benefit to cost ratio	-	-	**2.69**

South Australia

Table E.5 shows that under the assumed program cost and program uptake rate (25%), **the benefit to cost ratio of the program is 1.4.** That is, every dollar invested in the program is associated with an expected return of $1.40 in either savings or increased income.

Looking at benefits and costs which accrue primarily to government – a pertinent statistic given the program outlay is assumed to be from public funds – **the benefit cost ratio of public expenditure is approximately 1.27**.

The care leaver population at June 2014 was estimated to be 145 young people. Multiplied over the 2015 care leaver population of 145, modelling results suggest the **expected marginal program cost (the difference between costs if the program is offered, and not offered) for this group would be equivalent to $5.1 million**. Multiplying expected benefits over the care leaver population of 145 reveals that **expected benefits of program roll-out would be $7.1 million**.

Table E.5: Present value ($2015) of costs and benefits over 40 years (uptake rate 24.95%), in 2015; South Australia

SA (per person)	Program not offered	Program offered	Difference between program offered/not offered
Total costs	145	35,153	**35,008**
Total benefits	42,164	91,071	**48,906**
Net benefits	42,019	55,917	**13,898**
Benefit to cost ratio	-	-	**1.40**
SA (all care leavers: 145)	**Program not offered**	**Program offered**	**Difference between program offered/not offered**
Total costs	21,035	5,097,219	**5,076,183**
Total benefits	6,113,847	13,205,245	**7,091,398**
Net benefits	6,092,811	8,108,027	**2,015,215**
Benefit to cost ratio	-	-	**1.40**

Western Australia

Table E.6 shows that under the assumed program cost and program uptake rate (25%), **the benefit to cost ratio of the program is 2.17.** That is, every dollar invested in the program is associated with an expected return of $2.17 in either savings or increased income.

Looking at benefits and costs which accrue primarily to government – a pertinent statistic given the program outlay is assumed to be from public funds – **the benefit cost ratio of public expenditure is approximately 1.99**.

The care leaver population at June 2014 was estimated to be 190 young people. Multiplied over the 2015 care leaver population of 190, modelling results suggest the **expected marginal program cost (the**

difference between costs if the program is offered, and not offered) for this group would be equivalent to $5.1 million. Multiplying expected benefits over the care leaver population of 190 reveals that **expected benefits of program roll-out would be $11.0 million**.

Table E.6: Present value ($2015) of costs and benefits over 40 years (uptake rate 24.95%), in 2015; Western Australia

WA (per person)	Program not offered	Program offered	Difference between program offered/not offered
Total costs	142	26,856	**26,715**
Total benefits	2,529	60,420	**57,890**
Net benefits	2,388	33,563	**31,176**
Benefit to cost ratio	-	-	**2.17**
WA (all care leavers: 190)	**Program not offered**	**Program offered**	**Difference between program offered/not offered**
Total costs	26,946	5,102,724	**5,075,777**
Total benefits	480,572	11,479,730	**10,999,158**
Net benefits	453,626	6,377,006	**5,923,381**
Benefit to cost ratio	-	-	**2.17**

Tasmania

Table E.7 shows that under the assumed program cost and program uptake rate (25%), **the benefit to cost ratio of the program is 2.69.** That is, every dollar invested in the program is associated with an expected return of $2.69 in either savings or increased income.

Looking at benefits and costs which accrue primarily to government – a pertinent statistic given the program outlay is assumed to be from public funds – **the benefit cost ratio of public expenditure is approximately 2.36.**

The care leaver population at June 2014 was estimated to be 66 young people. Multiplied over the 2015 care leaver population of 66, modelling results suggest the **expected marginal program cost (the difference between costs if the program is offered, and not offered) for this group would be equivalent to $1.2 million**. Multiplying expected benefits over the care leaver population of 66 reveals that **expected benefits of program roll-out would be $3.1 million**.

Table E.7: Present value ($2015) of costs and benefits over 40 years (uptake rate 24.95%), in 2015; Tasmania

TAS (per person)	Program not offered	Program offered	Difference between program offered/not offered
Total costs	96	17,709	**17,613**
Total benefits	49,505	96,926	**47,421**
Net benefits	49,409	79,217	**29,808**
Benefit to cost ratio	-	-	**2.69**

TAS (all care leavers: 66)	Program not offered	Program offered	Difference between program offered/not offered
Total costs	6,368	1,168,814	**1,162,446**
Total benefits	3,267,342	6,397,135	**3,129,793**
Net benefits	3,260,974	5,228,321	**1,967,347**
Benefit to cost ratio	-	-	**2.69**

Northern Territory

Table E.8 shows that under the assumed program cost and program uptake rate (25%), **the benefit to cost ratio of the program is 1.94.** That is, every dollar invested in the program is associated with an expected return of $1.94 in either savings or increased income.

Looking at benefits and costs which accrue primarily to government – a pertinent statistic given the program outlay is assumed to be from public funds – **the benefit cost ratio of public expenditure is approximately 1.81.**

The care leaver population at June 2014 was estimated to be 52 young people. Multiplied over the 2015 care leaver population of 52, modelling results suggest the **expected marginal program cost (the difference between costs if the program is offered, and not offered) for this group would be equivalent to $2.0 million**. Multiplying expected benefits over the care leaver population of 52 reveals that **expected benefits of program roll-out would be $3.8 million**.

Table E.8: Present value ($2015) of costs and benefits over 40 years (uptake rate 24.95%), in 2015; Northern Territory

NT (per person)	Program not offered	Program offered	Difference between program offered/not offered
Total costs	132	37,736	**37,605**
Total benefits	-63,758	9,150	**72,908**
Net benefits	-63,890	-28,586	**35,303**
Benefit to cost ratio	-	-	**1.94**
NT (all care leavers: 52)	**Program not offered**	**Program offered**	**Difference between program offered/not offered**
Total costs	6,845	1,962,290	**1,955,445**
Total benefits	-3,315,418	475,797	**3,791,215**
Net benefits	-3,322,263	-1,486,494	**1,835,769**
Benefit to cost ratio	-	-	**1.94**

Australian Capital Territory

Table E.9 shows that under the assumed program cost and program uptake rate (25%), **the benefit to cost ratio of the program is 1.77.** That is, every dollar invested in the program is associated with an expected return of $1.77 in either savings or increased income.

Looking at benefits and costs which accrue primarily to government – a pertinent statistic given the program outlay is assumed to be from public funds – **the benefit cost ratio of public expenditure is approximately 1.61.**

The care leaver population at June 2014 was estimated to be 34 young people. Multiplied over the 2015 care leaver population of 34, modelling results suggest the **expected marginal program cost (the difference between costs if the program is offered, and not offered) for this group would be equivalent to $0.9 million**. Multiplying expected benefits over the care leaver population of 34 reveals that **expected benefits of program roll-out would be $1.6 million**.

Table E.9: Present value ($2015) of costs and benefits over 40 years (uptake rate 24.95%), in 2015; Australian Capital Territory

ACT (per person)	Program not offered	Program offered	Difference between program offered/not offered
Total costs	150	26,360	**26,210**
Total benefits	52,949	99,377	**46,427**
Net benefits	52,799	73,017	**20,217**
Benefit to cost ratio	-	-	**1.77**
ACT (all care leavers: 34)	**Program not offered**	**Program offered**	**Difference between program offered/not offered**
Total costs	5,102	896,232	**891,130**
Total benefits	1,800,279	3,378,801	**1,578,522**
Net benefits	1,795,177	2,482,569	**687,392**
Benefit to cost ratio	-	-	**1.77**

Discussion

An OOHC extension program would see a return to investment of between $1.40 to $2.69 per dollar spent (1.4 – 2.69 benefit cost ratio) in all Australian states.

Table E.10: Benefit to cost ratios for each state, ranked in descending order

State	BCR
QLD	2.69
TAS	2.69
NSW	2.57
WA	2.17
NT	1.94
VIC	1.84
ACT	1.77
SA	1.40

Half of the jurisdictions (WA, NSW, TAS and QLD) would at least double the monetary investment in benefits (2.17 to 2.69).

South Australia has the lowest benefit cost ratio at 1.40, driven predominately by the high cost of offering the program ($48,736 annually). The assumed cost of the program is calculated as the average cost of providing a year of foster care support. Jurisdictional variations are driven by both supply and demand factors such as the complexity of cases, cost of placement per night, information finding activities, family support services, order seeking, rurality and the general cost of labour. It is important to note that the program cost is, however, an assumption and will be highly contingent on the program design. If, for example, South Australia were to design a program that was costed to be equivalent to the median program cost across all states and territories ($32,292), the benefit to cost ratio would be expected to rise to 2.11.

We note that the cost of running an OOHC program in the Northern Territory was the highest at $52,351.66 but this was offset by a large savings in reduced housing support as a benefit of care extension. The Northern Territory's cost of housing support at $30,602 annually was significantly higher than the other jurisdictions due to the practice of remote location loading payments to foster care providers.

Overall, this broader state and territory analysis has revealed that the extension of support to the age of 21 would be expected to yield positive economic returns in all Australian jurisdictions.

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Contact us

Deloitte Access Economics
ACN: 149 633 116

Level 2, 8 Brindabella Circuit
Brindabella Business Park
ACT, 2609

Tel: +61 2 6175 2000
Fax: +61 2 6175 2001

www.deloitteaccesseconomics.com.au

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