Department of Children, Youth Justice and Multicultural Affairs

Intensive Family Support

Service Model and Guidelines

This document is for funded IFS providers and their workers as the key guide to inform work practices. It must be read in conjunction with the department's *Families Investment Specification* and the Service Agreement between the department and each service provider which includes the Queensland Government Service Agreement – Standard Terms for Social Services

2023 (Version 3.0)

Queensland Government

Version History

Version	Date	Comments
Version 1.0	February 2015	Final version
Version 1.1	July 2015	Incorporating feedback from services Introducing Common Assessment Tools trial
Version 1.2	January 2016	Incorporating feedback from services. Updates to Outcomes reporting Updated ICT – ARC
Version 1.3	February 2016	Includes Appendix – PCPP Updates to Common Assessment Tools Trial
Version 2.0	March 2018	Incorporating feedback from services Updated formatting Introducing process for working with IPAs Update to Common Assessment Tools
Version 2.1	October 2018	Updates in the line with *Child Protection Reform Amendment Act 2017* Removal of evaluation data collection assessment
Version 2.2	May 2020	Update regarding FAST's integration into ARC Updated counting rules for outcome measures Include Appendix Practice Principles – Domestic and Family Violence Appendix - Immediate Harm indicator paper Appendix – Information Sharing Guidelines comparison
Version 2.3	July 2022	Include new outcome measures information Update referral criteria Remove reference to FRE/FRRE Update and clarify 'non-engagement' reporting requirements to key referrers (Child Safety, Health, and Education)
Version 3.0	January 2023	Include Collaborative Case planning process and Assessment of Harm and Risk of Harm practice guide Revised referral criteria Enhanced cultural information, guidance, and expectations for service delivery to Aboriginal and Torres Strait Islander families Strengthen information on disability

Contents

Glossary and Acronyms

ARC	Advice, Referral and Case management information system
CALD	Cultural and Linguistically Diverse
CAP	Collaborative Assessment and Planning framework
CCR	Child Concern Report
CSSC	Child Safety Service Centre
DFV	Domestic and Family Violence
ECEC	Early Childhood Education and Care
FaCC	Family and Child Connect
FAST	Family Assessment Summary Tool
FGM	Family Group Meeting
FWS	Aboriginal and Torres Strait Islander Family Wellbeing Service
I&A	Investigation and Assessment
IFS	Intensive Family Support
IPA	Intervention with Parental Agreement
LLA	Local Level Alliance
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
P2i	Procure 2 Invest (replacement for OASIS)
PCPP	Principal Child Protection Practitioner
QFCC	Queensland Family and Child Commission
RIS	Child Safety Regional Intake Service
SDM	Structured Decision Making
SIG	FaCC and IFS Strategic Implementation Group
TFS	Tertiary Family Support
Child Safety	Tertiary child protection services
The department[1]	Department of Children, Youth Justice and Multicultural Affairs

[1] The department refers to the department responsible for administering and funding child protection services in Queensland (regardless of the title of the department at the time).

Note: While a collective term of **Aboriginal and Torres Strait Islander** is used throughout this document, it must be noted these are two separate groups with unique cultures. It may not always be appropriate to consider from a collective position and it is important to respect individual needs, preferences and experiences.

For broad information about the Queensland Government's policy framework and requirements, see *https://www.qld.gov.au/firstnations*

Note: While a collective term of **Cultural and Linguistically Diverse (CALD)** is used throughout this document, the CALD community is diverse and broad, from a range of unique cultures and can be described as 'communities with diverse languages, ethnic backgrounds, nationalities, traditions, societal structures and religions'. It may not always be appropriate to consider from a collective position and it is important to respect individual needs, preferences and experiences.

For broad information about the Queensland Government's policy framework and requirements, see *https://www.qld.gov.au/about/newsroom/making-a-multicultural-queensland*

Note: While a collective term for **disability** is used throughout this document, it must be noted that disability is diverse and broad in nature and may be visible or non-visible to others. It may not always be appropriate to consider from a collective position and it is important to respect individual needs and preferences.

For broad information about the Queensland Government's policy framework and requirements, see *https://www.qld.gov.au/disability*

1. Introduction

1.1 Purpose and Audience

This document (Version 3.0) replaces all previous versions of the Model and Guidelines

The **Intensive Family Support** (IFS) Model and Guidelines outlines the model of service delivery expected by the Queensland Government from service providers and their staff funded by the Department of Children, Youth Justice and Multicultural Affairs to deliver IFS services.

The document provides information on the service delivery context, reporting requirements and outcomes expected of funded IFS service providers and must be read in conjunction with:

- the contractual obligations set out in the Service Agreement with each service provider; and
- the requirements set out in the Families Investment Specification[2] which describes the intent of funding, Service Users and identified issues, service types, and associated service delivery requirements for services under the Families funding area; and
- any additional legislative requirements and/or formal advice or instructions provided by the department which may not yet be compiled in the document.

Service providers and staff are also recommended to be familiar with the *Family and Child Connect (FaCC) Model and Guidelines* given the connections between FaCC and IFS.

All related program documentation, guidelines and supporting information is available on the secure sub-site for FaCC and IFS service providers and approved staff located at the public Family and Child Connect website at *https://familychildconnect.org.au/secure/*. IFS managers must ensure all relevant staff have access to the secure website and stay abreast of any updates. To request access to the secure sub-site, please email childandfamilycommissioning@cyjma.qld.gov.au

1.2 Background

IFS works with families experiencing multiple and/or complex challenges to help make positive changes to their circumstances and prevent the need for Child Safety to intervene.

The 2012 Child Protection Commission of Inquiry[3] led by the Honourable Tim Carmody QC was the precursor to Queensland's reformed family support system. The Inquiry's overarching message:

[2] The Investment Specifications and other information about funding is available on the department's website at *https://www.cyjma.qld.gov.au/about-us/our-department/funding-grants-investment*

[3] See further details on the Carmody Inquiry at *www.childprotectioninquiry.qld.gov.au*

> *Parents (and families) should take primary responsibility for the protection of their children and, where appropriate, parents should receive support and guidance to keep their children safe at home. Government should intervene in a statutory role as a last resort to ensure the protection of children who are at significant risk of harm*.

There are 42[4] IFS services operating across Queensland. Departmental records indicate an average of 5,000 families are supported annually, of which 23% identify as Aboriginal and/or Torres Strait Islander.[5]

See available departmental data on the performance of all family support services (FaCC, IFS and Aboriginal and Torres Strait Islander Family Wellbeing Services at *https://performance.cyjma.qld.gov.au*

1.3 Governing framework

Legislation

Two key pieces of legislation are central to the practice of providing protection to children in Queensland.[6]

Child Protection Act 1999

The *Child Protection Act 1999* provides the overarching legislative framework for the protection of children in Queensland including the reporting of concerns. Of particular relevance to IFS is the legislation's emphasis toward preventative measures to reduce the risk of entering the statutory protection system:

- Alternative referral pathways to services for families who need support
  - The preferred way of ensuring a child's safety and wellbeing is through supporting the child's family (s. 5B(c))
  - Allows prescribed entities[7] to refer a family to a service provider where it is considered a child is likely to become in need of protection without support being provided to their family (s. 13B(2))
- Clear information sharing provisions to remove barriers to collaboration and coordination of service delivery (Chapter 5A)

[4] Current at time of publication.
[5] Based on 4-year period 2017-18 to 2020-21. Data sourced from https://performance.cyjma.qld.gov.au .
[6] Further significant pieces of legislation are outlined in the Model and Guidelines under Section 4 - Duty of Care.
[7] Prescribed entity means each of the following entities— (a) the chief executive of a department that is mainly responsible for any of the following matters— (i) adult corrective services; (ii) community services; (iii) disability services; (iv) education; (v) housing services; (vi) public health; (b) the police commissioner; (c) the chief executive officer of Mater Misericordiae Ltd (d) a health service chief executive within the meaning of the Hospital and Health Boards Act 2011; (e) the principal of an accredited school under the Education (Accreditation of Non-State Schools) Act 2001; (f) a specialist service provider; (g) the chief executive of another entity that— (i) provides a service to children or families; and (ii) is prescribed by regulation.

- The legal framework for reporting concerns about children to Child Safety including mandatory reporters (s.13E).
- Improving practice with Aboriginal and Torres Strait Islander children and families to reduce their disproportionate representation in the child protection system by acknowledging that stronger connections to kin, community, and culture result in better outcomes and the importance of family and community as the primary source of cultural knowledge.
- Additional principles for Aboriginal or Torres Strait Islander children including:
  - the right to self-determination (s.5c(1)(a)
  - recognising the significant and long-term effect of decisions on identity and connection with, family and community (s.5c(1)(b)
  - application of the five elements of the Aboriginal and Torres Strait Islander Child Placement Principle (Prevention, Partnership, Placement, Participation, and Connection (s. 5C (2)).

Appendix 2 *provides details about the expectations for Culturally Respectful, Safe and Responsive service delivery for Aboriginal and Torres Strait Islander Families*

Human Rights Act 2019[8]

The *Human Rights Act 2019* protects the rights of everyone in Queensland, regardless of residency, citizenship or visa status. The Act requires the Queensland public sector - Queensland Government departments and agencies, local councils, **and organisations providing services to the public on behalf of the state government** - to act and make decisions which are compatible with the rights it protects.

Of the 23 human rights protected in the Act, the following are directly relevant to the delivery of family support services:

- Protection of families and children (s. 26)
- Cultural rights for Aboriginal and Torres Strait Islander peoples (s.28)
- Cultural rights generally (s.27)
- Privacy and reputation (s. 25)

RESOURCE: For more information see https://www.qhrc.qld.gov.au/your-rights/human-rights-law

[8] The Act applies from 1 January 2020 to acts and decisions made on or after that date (it is not retrospective).

Oversight and review mechanisms

Oversight and review are integral to delivering an effective child and family support system.

Systemic and external overview - Queensland Family and Child Commission

The independent Queensland Family and Child Commission (QFCC) is established under the *Family and Child Commission Act 2014* to review and improve the systems that protect and safeguard children. The QFCC promotes, empowers, and raises awareness with families and communities, drives system accountability and advocates for change. The QFCC is also supporting cultural change in the sector.

RESOURCE: For more information about the QFCC see *https://www.qfcc.qld.gov.au*

Strategic oversight - FaCC and IFS Strategic Implementation Group

Established as a collaborative forum with the sector, the FaCC and IFS Strategic Implementation Group (SIG) provides strategic oversight and performance review of the FaCC and IFS programs.

Each service provider agency, along with relevant peak and government agencies are represented on the SIG. The forum is held bi-annually however ongoing dialogue can occur out-of-session as required.

Continuous improvement informed by practice, research, evidence, and policy developments is central to the SIG agenda.

Strategic Framework and Practice Tools

Two key strategic frameworks guide Queensland's child and family response and priorities[9]

- *Supporting Families Changing Futures 2019-2023*[10]
- *Our Way: a generational strategy for Aboriginal and Torres Strait Islander families* 2017-2037 (co-designed by the Queensland Government and Family Matters Queensland)

These strategic frameworks align with key national priorities to support children, young people and families, in particular (but not limited to):

- *Safe and Supported, The National Framework for Protecting Australia's Children 2021-2031*[11]
- *National Agreement on Closing the Gap*
- *National Plan to End Violence against Women and Children 2022-2032*

[9] See *www.cyjma.qld.gov.au/campaign/supporting-families* for detailed information about the child and family support system in Queensland.
[10] The Supporting Families Changing Futures framework is undergoing a review to outline the strategy post 2023.
[11] The National Framework at also outlines a range of additional national initiatives relevant to the objective of supporting children, young people and families. See *https://www.dss.gov.au/the-national-framework-for-protecting-australias-children-2021-2031*

What does this mean for Queensland practice?

The focus of practice in Queensland is directed at:

- a shift in service delivery to prevention and early intervention
- supporting families earlier to keep children safely at home
- meeting the cultural needs and requirements of Aboriginal and Torres Strait Islander children, families and communities
- improving outcomes for Aboriginal and Torres Strait Islander children and families, including:
  - building the capacity and capability of all child and family support services provided to Aboriginal and Torres Strait Islander children and families
  - ensuring that all engagement with Aboriginal and Torres Strait Islander children and families in the delivery of services is conducted within the appropriate cultural context
  - ensuring all Aboriginal and Torres Strait Islander families have the choice of receiving family support services from Aboriginal and/or Torres Strait Islander community controlled organisations.

Strengthening Families Protecting Children Framework for Practice

The *Strengthening Families Protecting Children Framework for Practice* [12] provides practice guidance for child safety professionals and non-government practitioners. The *Framework for Practice* outlines the foundations for a strengths-based, safety-oriented approach to enhance Queensland's child protection practice and deliver better outcomes for vulnerable children, young people and families in need.

The focus is directed at engagement, assessment, planning and organisational processes with a range of practice maps, tools and processes to strengthen the skills of both child safety professionals and non-government practitioners. The aim is to build collaboration through a common language and shared practice framework and to promote a shared understanding and consistent practice across the family support sector (FaCC and IFS services) and Child Safety.

2. The IFS Model and Practice Principles

The IFS program is targeted to **families experiencing multiple and/or complex needs** with children unborn to 18 years of age who may be at risk of entering the statutory child protection system without support.

The aim of IFS services is to provide intensive and extended, but time limited, in-home support to improve family functioning and safety for children by building the skills and capacity of parents/caregivers to a level that can be sustained by less intensive and more universally available services. While some families may need a longer intervention, it is anticipated that families will generally engage with the IFS for up to nine months.

[12] More information about the Framework for Practice is available in the Child Safety Practice Manual at *www.cyjma.qld.gov.au/childsafety/child-safety-practice-manual*

In order to meet the Queensland Government's funding intent, strategic commitments and legislative, policy and practice frameworks, the IFS program must follow the practice principles and model elements outlined below.

2.1 Practice Principles

Appendix 1 sets out the core evidence-informed practice principles central to best practice IFS service provision to vulnerable families, children and young people, regardless of background, culture, race, gender, sexuality, or disability.

In addition, there are specific tailored practice principles to respond to families with increased vulnerabilities and unique needs:

Aboriginal and Torres Strait Islander families

Aboriginal and Torres Strait Islander families continue to be disproportionately impacted by and within the child protection system and IFS services have an opportunity to make a significant difference for families. While Aboriginal and Torres Strait Islander Family Wellbeing Services are the specialist option for service delivery, a family has the right to choose. A mainstream IFS must be available and suitably responsive to Aboriginal and Torres Strait Islander families. Active application of the Aboriginal and Torres Strait Islander Child Placement Principle is not only applicable to statutory child protection and must be part of IFS practice.

Appendix 2 outlines the practice principles for responding effectively to Aboriginal and Torres Strait Islander children, young people and their families. A mandatory consideration is the Aboriginal and Torres Strait Islander Child Placement Principle and its active application.

At the core is acknowledgement of the negative legacy of colonialism in Australia and the historical and continuing intergenerational trauma on Aboriginal and Torres Strait Islander families.

The right to self-determination must be respected and a commitment made to prevent re-traumatisation. This is achieved by fostering genuine partnerships with cultural allies to maintain cultural integrity in service provision and by facilitating meaningful participation by families in decisions which impact their lives.

Families experiencing domestic and family violence

The high prevalence of domestic and family violence (DFV) in child protection matters is well established. The service system must be responsive to the complex intersection between DFV and child protection to help prevent children from entering or re-entering the child protection system.

The Safe and Together Model is the recognised framework for partnering with domestic violence survivors and intervening with perpetrators to enhance the safety and wellbeing of children.

A set of practice principles that align with the Safe and Together Model has been developed for IFS services to apply when working with families where DFV is a challenge. For further information see Appendix 3.

2.2 Core Elements of IFS Model

The core elements of IFS service provision are:

- Informed Consent
- Active Engagement
- Common Assessment Tools
- Risk Assessment
- Collaborative Case Planning
- Consultation with Principal Child Protection Practitioner
- Practical In-Home Support
- Parental Skills Development
- Specialist Interventions
- Brokerage Funds

Informed Consent

The intent of gaining consent is to ensure that families willingly engage with the service and take responsibility and ownership for achieving positive change.

Informed consent is critical to the service model. Family members need to agree to accept support by providing consent which includes permission to share information with other service providers that can assist them. There are numerous points at which family consent will be sought to share their personal information. Families have the option of limiting or not permitting information sharing with particular services or organisations. Further information on information sharing can be found in Section 3.

Active Engagement

Assertive outreach to engage families in their home or other community-based locations is an essential component of the model. This may include unannounced visits or cold calling to families who may have been referred without consent, or perhaps reluctantly agreed to a referral, and actively encouraging them to engage with available support.

Some of the key practices principles for engaging effectively with families[13] include:

- Treating family members with respect and courtesy
- Focusing on building the family's strengths
- Promoting positive relationships among parents and children
- Developing trust through sensitive and inclusive inquiry about their circumstances

[13] Bromfield, L., Sutherland, K., & Parker, R (2012) *Families with multiple and complex needs: Best interests case practice model*. Department of Human Services, Victoria

- Taking an active, caring, whole-of-family approach to their situation
- Focusing on the children's needs

RESOURCE: an evidence-informed IFS engagement tip sheet co-developed with the sector is provided at Appendix 5

Common Assessment Tools

IFS services utilise a suite of tools to assist in their work with families. These common assessment tools include the Collaborative Assessment and Planning Framework (CAP) and Structured Decision-Making Tools (SDM®).

SDM® tools are decision-support tools – they do not make decisions but help guide decisions therefore increasing consistency and accuracy across services within the system. The application of SDM® tools supports a comprehensive professional assessment that informs a service's decision making regarding their service delivery to families. The following SDM® tools are used in IFS:

- **Safety Assessment** - assesses a child's immediate safety with a focus on identifying factors that place a child in immediate danger.
- **Family Assessment Summary Tool** – identifies strengths and challenges that may assist or get in the way of the family achieving their case plan goals.

While the SDM® tools help support decision making, the CAP framework provides a method or guidance on how to work with a family to draw out their strengths and worries.

The CAP framework is designed to support a collaborative process of discussing, reflecting and recording assessment and case planning regarding child safety and wellbeing with the family. The CAP framework is used with families and other key stakeholders, including referrers, colleagues and other services, in order to support shared understanding and agreement on concerns and plans to address those concerns. The CAP framework can also be used in case consultation and supervision contexts as an organising framework, and as a prompt for family and safety-centred practice. The CAP framework is used throughout the duration of the work with a family.

These tools are a guide to practitioners and should not be relied upon in isolation and are intended to be combined with the professional expertise of the lead case manager and their supervisor.

Risk Assessment

The assessment of harm and risk of harm is a fundamental component of statutory child protection work. Risk assessment is an ongoing process of purposeful gathering and analysis of information to form a professional judgement about the severity and likelihood of future harm to a child. Given IFS service's position in the child protection continuum, workers must have a robust risk assessment framework to understand the risks to children and knowledge on how to reduce those risks to prevent escalation into the statutory child protection system.

IFS services previously used the Family Risk Evaluation (FRE) and Family Risk Re-evaluation (FRRE) to determine future risk of maltreatment, however a decision was made by the department to cease using the tools by 1 July 2022. A practice guide, which is adapted from the department's practice guide, has been developed to provide guidance to IFS services on understanding and assessing risk and ensures a shared understanding.

RESOURCE: The risk assessment guide for FaCC and IFS is provided at Appendix 6

Collaborative case planning – single case plan

Collaborative case planning is used to respond to families with multiple, complex and/or interrelated needs. The primary purpose of collaborative case planning is for families involved with multiple services to have a lead case manager and a single case plan that focuses on improving wellbeing and safety outcomes for the family. This approach prevents overlap or duplication of service delivery and enables the provision of a realistic and holistic intervention tailored to the needs of the family. Collaborative case planning involves a participative process whereby relevant agencies and practitioners alongside the family, plan and work together to determine the most effective way of delivering services to the whole family in the right order and at the right time.

Collaborative case planning supports a process of change for families and is a core process in the work of IFS services. The collaborative case planning process recognises that families have strengths alongside the challenges they are struggling with, and that families –first need support to identify the changes they want/need to make to ensure their children's safety and wellbeing, and then to effectively make and sustain those changes.

A collaborative case planning approach recognises that navigating community support services is not easy for families, who often need more than one service to meet their needs. Collaborative case planning places the onus on service agencies to work together to support families. Consent from the family for the service to contact other agencies with whom the family is involved is critical to the success of the approach.

Effective collaborative case planning requires:

- an agreed commitment by all stakeholders to working together in partnership
- shared goals of increasing safety and reducing the risk of harm to children and strengthening family functioning
- clear roles
- respectful relationships
- a high degree of trust between agencies
- accountability to partner agencies
- strong governance processes to drive implementation of the plan
- joint planning so that families are supported seamlessly; and

- collective ownership of responsibility for delivering results.

***Cultural considerations** should be at the forefront of any case planning and case work and may determine how the case plan is developed, who should participate and who is assigned to be the case manager for the family and whether the IFS is best placed to work with the family.*

Developing a single case plan is a participative process that will result in strategies to address the family's needs.

Family participation is empowering and crucial to the success of both case work and collaborative case management. It is important that the family, including children are involved in case meetings and discussions and lead the development of the case plan. Family participation, including the participation of children, should be encouraged at all family case planning meetings and requires careful pre-planning to ensure family members know what to expect, can participate fully in meetings and have realistic expectations about possible outcomes.

PRACTICE NOTE: While the family unit is the focus, the **child's voice** and best interests must not be overlooked. The United Nations Convention on the Rights of the Child protects children's rights to respect and participation (Articles 2, 3, 12,13). The QFCC advocated for the voices of children to be heard and their views taken into considered in all decisions affecting them. IFS practice can be informed by relevant research which shows how having a voice in family matters is considered a protective factor from harm and key in promoting children's well-being. Recommended reading - 'Why having a voice is important to children who are involved in family support services', Child Abuse & Neglect 115 (2021)

The single case plan should be family focused and set out:

- the details of which services the family has provided consent to share information with and for what purpose, including any specific restrictions
- the strengths and challenges for the family drawn from the FAST and consideration of the family's already existing informal support networks
- the goals for the family, including those of individual family members, and particularly goals linked to increasing child safety and wellbeing
- negotiated timeframes for achieving goals
- the support services being provided by each agency
- issues which arise during implementation of the case plan
- a long-term safety and support plan is developed by services, which includes transitions to step down services or other services and assistance to the family to engage with those services so change is sustained
- progressive assessments and case reviews involving all stakeholders.

Suggested process for developing the case plan is outlined in Appendix 7. This step-by-step process is designed to help scaffold the complex process of collaborative case planning. **It is not a prescriptive process** and workers will need to be flexible with how they work through each step, considering the individual needs of each family so that they are able to participate in the case planning process to the greatest possible extent.

Consultation with Principal Child Protection Practitioner

The Principal Child Protection Practitioner (PCPP), as an employee of the department, has an important role as a conduit between IFS and Child Safety. IFS services can access the PCPP to obtain expert generic child protection advice and guidance in accordance with Child Safety policies and procedures, statutory responsibilities, departmental objectives and current trends.

The PCPP can also be consulted about non-Child Safety referrals when, during active engagement, it becomes apparent that the presenting issues for the family are concerning and a child protection history check may confirm the family requires a greater level of intervention than provided by IFS.

The PCPP's role includes providing a case consultation service to IFS on complex cases and ensuring cases that may require statutory intervention are reported to Child Safety when necessary. Once an IFS service is in receipt of a referral, a case consultation can be sought with the PCPP. The PCPP provides advice and information in relation to specific cases with a focus on:

- the suitability of the referral to an IFS given the PCPP's child protection experience and if needed, access to child protection history on the Child Safety database
- whether the referral provides information indicating a child may be in need of protection and therefore requires a report to Child Safety
- assisting with the identification and prioritisation of needs for a child and family
- assisting in safety planning and assessment
- assisting in developing engagement strategies when working with a family resistant to accepting support
- undertaking a risk assessment
- assisting in negotiation with Child Safety in those instances where Child Safety has requested that an IFS jointly work with a family during an Intervention with Parental Agreement (IPA) due to the existing relationship between the IFS and the family.

RESOURCE: The *Principal Child Protection Practitioner Guidelines* provide further information on the PCPP role and is available on the FaCC secure sub-site: *https://familychildconnect.org.au/secure/*

Practical In-Home Support

***A cultural lens** must always be applied when working with Aboriginal and Torres Strait Islander families. The Queensland Government's Respectful Language Guide and the IFS Engagement Tips sheet are recommended resources for written and verbal communications. It is imperative there is a strong and respectful understanding of Aboriginal and Torres Strait Islander histories, cultures, family structures and parent and child-rearing practices.*

Practical in-home support is a critical element of delivering IFS. In-home support provides tailored and culturally appropriate interventions applied practically in the home environment where the skills and strategies are needed most. Practical in-home support interventions will respond to issues identified during the assessment period and the development of the family case plan. Examples include:

- establishing safe and practical routines
- providing basic advice on child development and attachment (appropriate to the skills of the in-home support worker and referring to a specialist counsellor, psychologist, or child health service where required)
- cultural support and cultural identification support provided by Aboriginal and Torres Strait Islander workers
- budgeting
- modelling basic skills in managing a household
- meal preparation and cooking (including shopping).

It is expected that practical in-home support will be available to families outside core business hours as necessary to develop and/or implement elements of family case plans (for example, early morning routine to prepare for school and evening meal preparation times).

Parental Skills Development

Assisting families with parenting skills and developing positive parent-child relationships is a critical component to improving the safety and wellbeing of children and their families and is core to the work of IFS. To strengthen their skills, services are encouraged to support practitioners to access relevant training in evidence-based parenting programs.[14]

Interventions and programs that help parents develop knowledge about child development and the factors that influence children's development, skills for interacting effectively with children, and tools that support parent-infant/child attachment, cooperative relationships will be provided both in the home and through external programs as needed. IFS staff must actively support parents to apply knowledge and skills gained from parenting programs to their home environment.

[14] Evidence-based programs supported by the Australian Government are listed at *https://aifs.gov.au/projects/evidence-and-evaluation-support/cfc-program-profiles*

Specialist Interventions

Specialist interventions, identified by the assessment, can be delivered by staff with relevant expertise within the IFS service, or by partnering with specialist services or linking families with external specialist services.

Depending on the identified needs of individual family members specialist intervention may include:

- domestic and family violence support services
- cultural support services
- counselling services
- relationship services
- mental health services
- youth services
- occupational therapy, physiotherapy and speech pathology
- drug and alcohol counselling
- specialist counselling and psychology services (e.g. trauma healing/counselling)
- paediatric services
- infant and early childhood health services
- early childhood education and school support

IFS services must establish strong links to local specialists in relevant fields of expertise as required by the families they work with and draw on the skills and expertise of workers in their Local Level Alliance. Access to specialists will be driven by the case plan and brokerage may be used for specialist services if required.

RESOURCE: The Australian parenting website at *www.raisingchildren.net.au* provides a wide range of expert information and resources which parents and professionals can be confident in using as a reference point.

Brokerage Funds

Brokerage is available to support families address their needs as outlined in the family case plan and to contribute to achieving case closure.

Brokerage can be used to increase protective factors and reduce risk factors for children, enhance a family's functioning and help maintain family relationships. As well as facilitating access to specialist services, brokerage may be used where existing funded, fee-free services are unavailable, fully subscribed or have long waiting lists.

For Aboriginal and Torres Strait Islander families, it may be suitable to use brokerage to access specialist cultural support and healing services in keeping with case plan goals.

Case workers report that brokerage often assists in building rapport with families, particularly in the early stages of working with a family.

Details and information about the application and use of brokerage are outlined in the Brokerage Funding Guidelines at Appendix 8.

3. Referrals and information sharing

3.1 Referral overview

Referrals can be made from a number of sources however referrals must meet specific criteria in order to be accepted by an IFS. Referral sources include:

- Child Safety
- Prescribed entities (for example: Queensland Health, Department of Education and Queensland Police)
- government and non-government agencies
- community
- families themselves (self-referrals)

Families experiencing the following challenges may be appropriate to refer to an IFS:

- Families under pressure due to a family member's physical or mental illness, substance abuse, disability or bereavement
- Significant parenting problems that may be affecting their child's development
- Domestic and family violence that is having an impact on their child but is not compromising their immediate safety
- Significant social/economic disadvantage or housing stress that may adversely impact on their child's care or development
- Young, isolated and/or unsupported families (including those with a previous care experience)
- Family conflict or family breakdown that may be affecting their child's development

3.2 Queensland Child Protection Guide

The Queensland Child Protection Guide is an on-line decision support tool that assists those who have concerns about a child or young person to make a decision about whether to make a report to Child Safety or refer to another service best placed to meet the family's needs. The guide is available statewide and supports professionals to report their concerns to Child Safety or refer the family to a support service, including a FaCC or IFS service.

RESOURCE: The Queensland Child Protection Guide and supporting instructions is accessed at *https://www.cyjma.qld.gov.au/about-us/our-department/partners/child-family/our-government-partners/queensland-child-protection-guide*

3.3 Referral criteria

Criteria for referring to an IFS for all referrers:

- There is a child or young person (unborn to under 18 years) in the family.
- Families are experiencing multiple and/or complex support needs requiring case management to prevent children from experiencing abuse or neglect within their family.
- Without intensive in-home family support, ongoing child protection involvement is likely to occur.
- Current concerns have:
    - low to moderate impact on the child's physical, psychological or emotional wellbeing where the likelihood of harm occurring in the future is high OR
    - harm has been substantiated by the department, the child is not in need of protection and the parent is willing to address the issues identified and the risk of harm occurring in the future is low.
    - Where impact is low and it is not likely to occur in the future, consider referring families to less intensive services.
- The child/ren are not currently in need of protection and the immediate safety of the child is not compromised.

Practice note: *Long term guardians may seek support from an IFS service where it is assessed that the required support can be provided and where the child is not the subject of current case work being undertaken by the department.*

3.4 Child Safety referrals - additional criteria

There are two types of referrals that an IFS service can receive directly from Child Safety:

- *Referral with consent*: A referral with consent can occur where: an investigation and assessment (I&A) of a notification has been undertaken by Child Safety and the case is now closed; or the family has been subject to an Intervention with Parental Agreement (IPA)/Child Protection Order (CPO), and the case is now closed or will be closed once the family engages and commences working with the IFS. In these cases, Child Safety will have had contact with the family and will

refer where intensive family support is deemed appropriate and the IFS referral criteria are met, to an IFS service with the family's consent.

- *Referral without consent:* Where Child Safety has made an assessment of concerns received and determined further investigation is not required, a Child Concern Report (CCR) is recorded. In this case, Child Safety will not have contacted the family. Where IFS is deemed an appropriate response, and the referral criteria are met, Child Safety may refer to an IFS without the family's consent. For CCR referrals, contact by the IFS may be the first time a family is informed there has been a concern about their family brought to the attention of Child Safety.

Additional criteria

Note: The additional criteria below were developed in collaboration with Child Safety and are provided to IFS services to assist in determining whether the referral is appropriate. This referral criteria will be incorporated into the Child Safety Practice Manual.

A Child Safety Officer (CSO) **must** consider the following before making a referral to IFS:

- Has the family been referred to secondary family support services in the past? If yes, consider the number, frequency and recency of the last referral when determining if a further referral is appropriate.
- If the family has not engaged in the past, are further referrals likely to have a different outcome? Consider what is different this time which indicates that the family will engage to address the challenges identified.
- If the family identifies as Aboriginal and/or Torres Strait Islander, is successful engagement more likely through referral to an Aboriginal Community Controlled Organisation IFS or an Aboriginal and Torres Strait Islander Family Wellbeing Service?
- After consideration of the family's child protection history, if there is evidence of substantial interventions with the family (including orders, previous IPAs etc), can the risks to the children be safely managed in the secondary sector?
- If the family has a referred child under 2 years, can those risks be appropriately managed in the secondary sector? Specific consideration should be given to parental drug use with children under 2 years.
- If the referral relates to domestic and family violence, can safety be created around the non-violent parent with additional supports? Cases assessed as at a high risk of lethality require a consultation with a PCPP and a collaborative response.
- A warm handover[15] between Child Safety, IFS service and the family must be considered for referrals post an Investigation and Assessment to establish meaningful consent.

[15] Warm handover is generally a face-to-face meeting between the family, Child Safety and IFS with the aim to increase the likelihood of engagement by the family with IFS

Following an investigation and assessment, consult a PCPP before making a referral to IFS if any of the following apply:

- an investigation and assessment was finalised with a child not in need of protection outcome, but a criminal investigation is underway in relation to alleged harm to a child caused by a person who lives with or spends time with the child.
- an investigation and assessment that included allegations of sexual abuse has not assessed harm or risk of harm caused by sexual abuse, but the family require support to address other risks.

The consultation with the PCPP is to determine whether risks to the child can be safely managed in the secondary sector.

The following circumstances have been identified as not appropriate for IFS, therefore referrals should <u>not</u> be made to IFS in the following circumstances:

Exclusions at Child Safety Intake (RIS):

Concerns that require a statutory response as per SDM screening criteria, including

- matters where a child has experienced or is at risk of experiencing cumulative harm
- allegations that a child has disclosed sexual abuse, or there is risk of sexual abuse by a person living with or spending time with the child
- a person who lives with or spends time with a child is alleged to have caused harm to the child, and a criminal investigation is underway.

Exclusions at closure of an Investigation and Assessment:

A child is assessed as having experienced harm or is at risk of experiencing harm caused by sexual abuse by a person living in the household, or who spends time in the household, and complex safety planning is required to ensure the child's safety (Note: It is not appropriate for IFS to provide surveillance or to monitor safety plans).

3.5 Other referral pathways

Referrals can also be made by prescribed entities, other government and non-government agencies, the community, and families themselves (self-referrals).

Family and Child Connect

Referrals from FaCC will be transferred via the ARC system after the FaCC has engaged with the family, assessed their needs and gained the family's agreement to be referred for support. The online referral form is located at *https://familysupportreferral.org.au*

Prescribed entities – referrals with or without consent

The *Child Protection Act 1999* enables prescribed entities (159M) to make referrals to FaCC, IFS services or other support services, without a family's consent to '*offer help and support to a child or child's family to stop the child becoming a child in need of protection*'.

The rationale underpinning this legislative provision is that sharing information takes precedence over the protection of confidentiality or an individual's privacy because the safety, welfare and wellbeing of children and young people is paramount. Although the legislation allows referrals to FaCC and IFS services (and between these services) without consent, best practice is that sharing information about a family should occur ***with*** *consent* and through engagement with the family wherever possible as this improves the likelihood of families choosing to engage.

Prescribed entities are responsible for managing delegations related to this role, including policy and procedural direction, guidance and support for their staff.

It should be noted that some prescribed entities, particularly the Department of Education, have their own internal policy to gain consent from the parents before a referral is made regardless of their legislative ability to make a referral without consent.

Professionals and other organisations – referrals with consent only

Any other professionals and organisations other than those listed as prescribed entities that identify families experiencing vulnerability and meet the referral criteria may, with the family's consent, refer the family to an IFS service.

In 2017, Early Childhood Education and Care (ECEC) services became Mandatory Reporters under the *Child Protection Act 1999* and received information on referring to IFS when a report to Child Safety is not required and the family meet the criteria for IFS. ECEC services are not prescribed entities and will therefore make referrals only with the family's consent.

Community referrals – referrals with consent only

Community members seeking assistance for vulnerable families who need support may refer a family, with the family's consent, to an IFS service or encourage the family to self-refer.

Self-referrals

Families may self-refer to an IFS service for support.

3.6 Unborn referrals

In general, referrals for unborn children can only be made to IFS with the pregnant person's consent.

The only exception is if there has been an Investigation and Assessment undertaken by Child Safety, a referral can be completed without consent as it is the choice of the pregnant woman to choose to engage. However, given discussions undertaken during an I&A, a referral without consent should be rare.

A referral (without consent) from a Child Concern Report for an unborn child can only be completed to a health service as this falls under Section 159H of the *Child Protection Act 1999*. All other referrals from a CCR to IFS, FaCC or FWS (not under Health) cannot be done without consent as Section 159MD of the *Child Protection Act 1999* does not support an unborn child.

3.7 Managing IFS Referrals

3.7.1 Feedback to referrers

In circumstances where Child Safety, Queensland Health or Department of Education refers a family to IFS and the family cannot be contacted or choose not to engage with the service, the IFS must contact/email the referrer to advise of the outcome. The information provided to the referrer should include the details of the IFS's attempts at engagement, what strategies have been used and over what timeframe. This will assist the referrer when/if they have contact with the family again to help decide if a further referral is appropriate.

If it is a Child Safety referral, the Child Safety Officer who receives this advice will make a record of the information which then becomes part of the client history for the family.

Email templates for this purpose are located on the FaCC and IFS Service Providers secure sub-site: *https://familychildconnect.org.au/secure/*

3.7.2 Prioritisation guidelines

IFS services will engage eligible families based on their professional assessment of criticality-of-need, considering the following combination of factors:

- Referrals from FaCC or Child Safety whereby the family is deemed to not currently be in need of protection, but the family is at high risk of entering the statutory child protection system without an intervention
- The child/ren is/are under 3 years old
- The degree of vulnerability of child/ren given consideration of factors such as developmental delay, physical/intellectual disability, health/medical needs and challenging behaviours etc.
- Child protection history, if known (e.g. more than one child concern report/notification recorded within a 12 month period, consideration of cumulative harm e.g. series or pattern of harmful events and experiences that may have occurred in the past or are ongoing)
- Complexity of need with multiple presenting factors (e.g. mental health, domestic and family violence, substance misuse, and disability issues, engagement in criminal activities)
- Social, environmental, cultural influences and networks (e.g. limited access to services, including housing)
- Other services currently involved, including the need for case co-ordination and/or access to more than one type of service.

3.7.3 Waitlist strategies

When there is no available worker to commence working with a family within 4 weeks this is referred to as on a '*Waitlist*'. If it becomes necessary to commence a waitlist because a family cannot be allocated to a worker, the following process should be established:

- Maintain regular phone contact with the family to check their status to review placement on the waitlist, reassessing if needs or risks have escalated, including a consultation with a PCPP
- Consider family's suitability for other available services and refer if appropriate
- Consider utilising brokerage money to fund support service whilst on waitlists
- After families have commenced their interventions with IFS, consider type of contact required to address issues, for example, home visits only to families assessed as high risk or with an immediate safety plan in place and other client contact to occur via phone or Skype/FaceTime
- When prioritising families, after issues of risk have been considered, consider referrals where the family has provided consent as the next priority

If the waitlist reaches capacity (defined as the service being unable to commence within 4 weeks of referral), the service may consider not accepting new referrals, but only if the following has been undertaken:

- Review all current open cases (in consultation with PCPP) to determine if any can be closed so new referrals can commence
- Discuss with referrers option of other referral pathways for families
- A local strategy has been established with the Local Level Alliance or Family Support Collective to manage waitlists across the service system

3.7.4 Managing sensitive referrals

There may be times when the IFS receives a referral that is deemed sensitive, such as referral of a family member of an employee. Best practice is to give the family the opportunity to choose whether they would like to receive support from the service. In these cases, the service should be particularly mindful of the family's privacy when contacting to offer support and consideration should be given to the best person in the organisation to make that contact. The ARC system allows for users with coordinator access to restrict particular workers (system users) from accessing information on a particular client. The worker would still see the client's name listed but would be unable to access the case information.

Should the family choose not to work with the service, efforts can then be made, with the consent of the family, to link them with an alternative appropriate service.

In extraordinary circumstances a service may advise a referrer that they are unable to accept a referral that is deemed sensitive, again being mindful of the family's privacy, and supporting a referral to another service for that referral.

3.8 Interface with Child Safety

Generally, IFS will not accept referrals where Child Safety has current involvement. However, there are some exceptional circumstances (for example: impending reunification, one child in a family is on statutory orders but other children in the same family are not, or while an investigation and assessment is being completed) where continued support by the IFS is appropriate despite the family being reported to or within the statutory system.

The appropriateness should be determined by an assessment of whether the situation meets the intent of the initiative – that is, the service is working with the family so that they do not enter or re-enter the statutory system. As such, an IFS intervention is not appropriate where the child is subject to ongoing statutory intervention. The department funds other services such as Tertiary Family Support (TFS) to work with families who enter the statutory system.

When Child Safety commences an Investigation and Assessment

If an IFS service is supporting a family and Child Safety begins an investigation and assessment, the service may continue to work with the family until the assessment is completed. However, if as a result of the investigation and assessment an ongoing statutory response is deemed appropriate, the IFS service must *immediately transition case management* to Child Safety.

Working with families subject to an Intervention with Parental Agreement

The one exception to IFS services working only with non-statutory clients is when an investigation by Child Safety has deemed that a child is in need of protection and the best means to protect the child is via an Intervention with Parental Agreement (IPA). If the family have a good working relationship with the IFS service, Child Safety may request that the IFS service remains involved until the family transition to an appropriate tertiary service. Appendix 9 details the guidelines surrounding joint work on an IPA case.

When an immediate harm indicator is identified on a Safety Assessment

If during an IFS intervention, the IFS worker identifies an Immediate Harm Indicator when completing their Safety Assessment, the worker must consult with the PCPP to confirm the presence of an immediate harm indicator and what must be included in the immediate safety plan to mitigate the danger.

If an immediate harm indicator is present and an immediate safety plan cannot be developed, the safety decision guidance from the SDM manual is that the child is unsafe. Child Safety must be notified.

If an immediate harm indicator is present and it is determined that an immediate safety plan can be developed (if the family and their network are willing and able to develop an immediate safety plan) then, following consultation with the PCPP, the IFS worker will work with the family and their network to develop an immediate safety plan and continue to support the family and their network in monitoring/reviewing the immediate safety plan.

If at any time the immediate safety plan is no longer able to keep the child safe, or the parents withdraw their agreement to the immediate safety plan, a report to Child Safety is required. If a report

to Child Safety is not screened in as a notification, IFS will continue to work with the family provided that the family continues to consent to IFS intervention. If the family no longer consents to the intervention, IFS will consult with the PCPP (if required), advise Child Safety that the family is no longer engaging, and close the case.

Appendix 10 provides detailed guidelines on this process.

3.9 Information sharing

Informed consent is critical to the service model. Family members need to agree to accept support by providing consent which includes permission to share information with other service providers that can assist them. There are numerous points at which family consent will be sought to share their personal information. Families have the option of limiting or not permitting information sharing with particular services or organisations. However, all families should be made aware of the duty of care service providers have to report significant harm or the risk of significant harm to relevant authorities, including Child Safety.

PRACTICE NOTE: Information sharing for families experiencing domestic and family violence must be guided by safety considerations, utilising the expertise of the domestic and family violence specialist.

Where a child or young person is able or it is appropriate for them to have some involvement in the work with their family, their views and wishes should also be considered when sharing information.

Where the adults in the family have different views about consent, the service will work to ensure the adult willing to engage with support is safely able to provide consent, including permission to share information, and access the services they need.

It is not always safe, possible, or practical to seek and obtain consent. Requiring consent can at times, prevent or delay a service engaging with a family and prevent the effective coordination of services where multiple services are involved. Professionals need to be able to share information about a child or their family so help and support is provided in a timely way to enable families to meet the protection and care needs of children.

Child Protection Act 1999

While information sharing with consent remains best practice, the *Child Protection Act 1999* now enables specialist service providers, including IFS and FaCC, to share information with each other, with other prescribed entities, and with other service providers to assess and respond to a child's needs or plan or provide services to a child or the child's family to decrease the likelihood of a child becoming in need of protection. Further details on information sharing with Child Safety can be found in Appendix 4.

Domestic and Family Violence Protection Act 2012

As IFS services do not fall within the definition of 'Prescribed Entity' under the *Domestic and Family Violence Protection Act 2012* in most circumstances information cannot be shared with other agencies and services without the client's consent. In 2017 an information sharing provision was introduced as an addendum to the *Domestic and Family Violence Protection Act 2012* which allows for IFS services to share relevant information in the following circumstances:

1. To assess whether there is serious threat to a person's life, health or safety. A Prescribed Entity may request information to assess whether there is a serious threat and IFS services through the Domestic and Family Violence Specialist, can provide relevant information without the client's consent if necessary.

2. To lessen or prevent a serious threat to a person's life, health or safety. A Prescribed Entity, Specialist DFV service or other support service, including IFS, can share relevant information without the client's consent if necessary, to lessen or prevent (manage) a serious threat.

In all cases, the IFS service must reasonably believe the information they are sharing will help with the particular purpose for which they are sharing the information. Decisions about information sharing need to be made with consideration of the individual circumstances of the child and family. Further information on sharing information pursuant to the *Domestic and Family Violence Protection Act 2012* can be found at *https://www.justice.qld.gov.au/initiatives/end-domestic-family-violence/our-progress/strengthening-justice-system-responses/domestic-family-violence-information-sharing-guidelines*

Sharing information without consent in relation to domestic and family violence

Services need to be clear about the ***purpose*** of why the information is being shared without consent. Is it for a child protection purpose (i.e. assessing a child's need for protection, assessing care needs/planning services or decreasing the likelihood of a child becoming in need of protection) or is it about helping to lessen or prevent a serious threat to a person's life, health or safety due to domestic and family violence?

Given IFS's fundamental purpose is to prevent children from entering the child protection system, the purpose of sharing information around risk associated with domestic and family violence would be to enable the service to work with the family to "*decrease the likelihood of a child becoming in need of protection*". If it is for this purpose, the *Child Protection Act 1999* Information Sharing guidelines are clear: a service provider (DFV service or specialist DFV worker) may give information to a prescribed entity (FaCC/IFS) to help decrease the likelihood of the child becoming a child in need of protection.

If FaCC and IFS services are facing barriers to information sharing under the DFVP Act to conduct their core business, then information sharing provisions under the CP Act can be used. It should be clearly articulated to the DFV service/specialist that the purpose of seeking their (DFV) information is to decrease the likelihood of a child becoming in need of protection.

A comparison of the *Child Protection Act 1999* and *Domestic and Family Violence Protection Act 2012* Information Sharing Guidelines can be found at Appendix 11.

4. Context for Delivering IFS Services

4.1 Hours of Operation

IFS services are required to operate for 52 weeks each year to receive referrals.

While IFS is not considered a crisis service, it will display flexibility and responsiveness in respect to working hours to maximise engagement and enable interventions with family members who may be working standard hours. IFS services should also be available to families outside core business hours as necessary to develop and/or implement elements of case plans.

Christmas/New Year period

If services choose to close during the Christmas/New Year period, IFS services must have an on-call arrangement in place which includes:

- Staff are rostered on for on-call support (with face-to-face contact if necessary)
- A voicemail option is available for callers to leave messages, and which directs callers to suitable resources, for example, websites and other appropriate helplines
- Information is provided to existing clients of these arrangements prior to the Christmas break

4.2 Role of the lead case manager

The lead case manager has responsibility for ensuring the family or individual family member receives the right mix of services, in the right order and at the right time.

The lead case manager acts as a single point of contact when a range of services are involved with that child or family and an integrated response is required. The lead case manager will be well-trusted by the family, able to negotiate access to services and have access to brokerage to support the case plan.

The lead case manager works with families to identify and prioritise their assessed strengths and needs to develop the single case plan, to deliver intensive support interventions and engage families with specialist services within or external to the IFS service, as required.

The lead case manager is responsible for the cycle of assessment, planning, implementation, and review of the family's case plan.

The role description of the lead case manager is to:

- support client engagement upon referral to the service
- seek informed consent from families to contact other services or practitioners the family is involved with
- develop an understanding of the primary needs of the family including consistent assessment of risks and needs using Common Assessment Tools determined by the department
- determine, access, or deliver the most appropriate service to provide culturally respectful and competent service delivery for Aboriginal and Torres Strait Islander and culturally and linguistically diverse families
- support the functioning of individuals and families through individual and/or family support, non-therapeutic counselling, and practical support
- act as a single point of contact for the family assuming responsibility for case management within the IFS
- advocate, negotiate and assist clients to access other services and maximise opportunity for optimum client participation in service delivery
- co-ordinate the delivery of actions agreed by relevant practitioners and services involved

4.3 Role of the Specialist Domestic and Family Violence (DFV) Worker

An experienced full-time worker with specialist knowledge and skills in domestic and family violence has been identified as a critical inclusion in the IFS team. This is in recognition of the high proportion of vulnerable families who are affected by domestic and family violence; the high level of risk that domestic and family violence poses to the safety of children, young people, and their families; and the specialist skills required to identify domestic and family violence, engage with affected families, and develop appropriate service responses.

The role is designed to:

- provide specialist advice especially during case discussions
- assist co-workers to screen for domestic and family violence
- undertake risk assessments where domestic and family violence is identified

The DFV Worker will:

- provide case managers with advice and support with engagement strategies for families affected by domestic and family violence, including strategies to assess, monitor and minimise risk to family members and workers
- participate in client home visits where appropriate
- support or work with case managers to engage all family members who require a service response, including fathers, and working with the whole family where it is safe to do so.

Although it is considered best practice that the DFV specialist does not lead case management or carry a caseload, the role will include a level of direct client-related work as appropriate, including risk assessment, risk management and safety planning. Where referrals to specialist domestic and family violence prevention and support services are identified as part of the case plan, the DFV specialist can assist family members to effectively engage with the appropriate service and continue to inform risk management strategies. In some cases, joint work with the specialist service and the IFS worker may be the best approach for the family.

There is potential for this role to be seconded from a specialist domestic and family violence service, providing information sharing protocols are adhered to.

The department supports a Community of Practice (CoP) specifically for DFV specialist workers in FaCC and IFS services. The Community of Practice, led by the Queensland Centre for Domestic and Family Violence Research (QCDFVR) at the University of Central Queensland, meets on a quarterly basis. QCDFVR also host a monthly peer support group stemming from the quarterly CoPs which is a response to the expressed need of the more isolated services.

Requests to join the DFV CoP can be made by emailing the Child and Family Team at childandfamilycommissioning@cyjma.qld.gov.au

4.4 Local Level Alliances

Local Level Alliances (LLA) are established in each catchment area to ensure the service system is more responsive to the local needs of vulnerable communities and families by fostering a connection between local community and government services (as initiated through the child and family reforms). They work to strengthen the service system and ensure that vulnerable families receive the right service at the right time.

The FaCC service is responsible for ensuring the LLA is resourced, supported and comprised with the appropriate representation. IFS services are core members of the LLA in their catchment and their active participation is critical to successful place-based integration and outcomes at the local level.

LLA members work towards achieving the following outcomes:

- Building community capacity to provide a more efficient service provision for families and a thriving local community.
- Improved and more direct referral pathways for families to access appropriate services.
- FaCC is embedded as an alternate pathway for families to be connected to the right support at the right time.
- Improved information sharing between providers to enable more coordinated and effective responses to families.
- Responses aligned to better support vulnerable families and strengthen service integration, such as a shared practice framework and resources.

- Contribute to service system integration through identification of available services and gaps, improvement in the alignment between the configuration of the service system and the needs of local families.
- Contribute to place-based planning for the development of an integrated suite of local services that provide families with responsive, accessible and effective support.

See more details on the LLA model in the FaCC Model and Guidelines.

4.5 Workforce – diversity and expertise

"Everybody should feel safe and respected when accessing services provided and funded by the Queensland Government. Good and accessible services deliver better outcomes for people, supporting them to achieve their goals, in turn improving the return Queensland gets on its investment" (Queensland Multicultural Policy: Our story, our future 2018).

Diversity

IFS services often work with families experiencing multiple and complex needs during times of heightened vulnerability when they are at risk of entering the statutory child protection system. Many families have had repeated contact with Child Safety and/or multiple secondary services due to entrenched intergenerational challenges that impact on their capacity to safely care for and nurture their children.

IFS services should aim to recruit a diverse team that reflects the cultures within the local catchment and a mix of male and female team members to maximise long term engagement and effective relationship building between families and the service.

All efforts must be made to address the disproportionate representation of Aboriginal and Torres Strait Islander children in care, including through representative staffing. Mainstream IFS services (those not operated by an Aboriginal and Torres Strait Islander Community Controlled organisations) are expected to recruit workers who identify as Aboriginal and/or Torres Strait Islander wherever possible.

The department recognises that the size and diversity of each IFS team may be impacted by factors such as individual funding allocations and remoteness of locality.

Expertise/Qualifications

The IFS program is designed to be delivered by highly skilled staff with qualifications commensurate with the knowledge and skills required to work effectively with this target group.

IFS case managers should hold university qualifications in human services or a relevant related field and have demonstrated skills in engaging families experiencing vulnerabilities. IFS services are designed to operate as professional multidisciplinary teams which include specialist family support

case workers, a full-time equivalent specialist domestic and family violence worker/s and workers with other relevant qualifications, skills and experience such as youth workers and early childhood health or education professionals.

In some circumstances, such as in remote parts of Queensland, recruitment of staff with appropriate skills and experience can be difficult and a mix of qualifications, cultural connections and knowledge of the local area, skills and life experience may be reflected in the team.

Where a particular level or type of qualification is required by the department and the preferred candidate does not have that qualification the following process applies:

1. The organisation must provide the regional contract manager with a rationale for deeming the candidate the best person for the position, including experience, knowledge, skills and any current qualifications or course enrolment. *Note: No identifying details of the candidate is required to be provided.*

2. The region will provide endorsement, in consultation with the commissioning area, that both the department and organisation can record as evidence of agreement (an email exchange is sufficient).

3. The organisation should encourage the staff member, once appointed, to pursue further qualifications. However, this should not be a condition of appointment or ongoing employment.

4. Should that employee leave the position, the organisation should seek to recruit someone with the required qualification.

4.6 Workforce capability – staff development, support and supervision

Organisations are expected to support all staff, including specialists, to successfully meet the requirements of their role. This may occur through structured induction, internal and external training in relevant skills development, professional supervision and encouragement to attain appropriate professional qualifications.

Services must ensure relevant staff are aware of the relevant legislation and guidelines impacting their work. A requirement is understanding the *Child Protection Act 1999*, particularly the principles of the Act, the additional principles for Aboriginal and Torres Strait Islander children, the reporting of child protection matters, privacy of information, and information sharing provisions.[16]

Access to and knowledge of the IFS Program Model and Guidelines by all relevant staff is essential.

Culturally capable and respectful practice must be a core component of staff induction, development and training.

[16] Other key legislation includes (not an exhaustive list): *Human Rights Act 2019, Public Guardian Act 2014, Family and Child Commission Act 2014, Working with Children (screening and risk management) Act 2000, Right to Information Act 2009, Information Privacy Act 2009, Public Records Act 2002, Community Services Act 2007*.

4.7 Deliver accessible, inclusive, quality and culturally safe services

Services must be accessible and inclusive and need to demonstrate their willingness, understanding, sensitivity and capability to work with people from diverse backgrounds. Families may be culturally and linguistically diverse (CALD), have refugee backgrounds, have disability or communication needs.

For Aboriginal and Torres Strait Islander families[17], active efforts must be made to help redress the disproportionate representation in the child protection system.

Practice note: Australian South Seas Islanders are a distinct cultural group with a unique history and position in Australian society. They are the Australian-born direct descendants of people who were brought (in the main) to Australia between 1863 and 1904 to work as indentured labourers in the primary industries.

Australian South Sea Islanders have little in common with more recent groups of migrants (including from Pacific Island nations), having been settled in Australia since the 19th century.

Nor are Australian South Sea Islanders indigenous, although some have dual or tri-cultural heritage through interrelationships with Aboriginal and Torres Strait Islander peoples, and many have shared some aspects of the disadvantage experienced by Aboriginal and Torres Strait Islander people *(Queensland Multicultural Policy: Our story, our future)*.

Specific strategies to facilitate reasonable access supports and remove barriers to seeking and participating in an IFS service is vital. Services should link with local organisations and expertise, such as multicultural groups, disability groups and engage interpreter and communication services when needed. It is also important to be aware of and plan around any significant cultural events or occasions which may impact on a family.

Resource: Information on multicultural affairs in Queensland such as statistical overviews and an online community resource directory on is available at https://www.cyjma.qld.gov.au/multicultural-affairs/multicultural-comunities

Disability

For clients with disability needs, services must be aware of the National Disability Insurance Authority (NDIA) which administers the National Disability Insurance Scheme (NDIS). IFS services have a role in linking families to support services that can assist them to access and navigate the NDIS when needed.

[17] Specific principles/requirements for Aboriginal and Torres Strait Islander families are provided in Appendix 2.

This may include help with:

- NDIS Access process
- NDIS Planning process
- Support families to remain connected with their NDIS Local Area Coordinator (when plan is in place)
- Support families when a review of their NDIS plan is needed (change in circumstances or a crisis)

Interpreter support
The department supports fee-free access to interpreters for funded service providers and clients from non-English speaking backgrounds who have difficulties communicating in English.

To access a telephone interpreter, services first apply for a Telephone Interpreter Service (TIS) code at: interpreting.services@communities.qld.gov.au

Once a service has a TIS code, this code is quoted each time a TIS is booked for interpreting services and TIS will bill the department.

Further information is available at:

https://www.csyw.qld.gov.au/about-us/funding-grants/non-government-organisation-access-interpreting-services

Support for hearing impaired

The department also supports fee-free access for services requiring the assistance of Deaf Services Queensland. If using Deaf Services Qld, services must provide a paid invoice to the department to seek reimbursement.

Client Satisfaction surveys

As part of delivery quality services Intensive Family Support Client Satisfaction Surveys also provide direct information from families about their experiences of the IFS program. Families who have engaged with an IFS service are requested to complete the survey at the conclusion of the intervention.

The online survey can be located at https://www.surveymonkey.com/r/ifs-cs-survey. Paper surveys can be obtained

Completion of the survey is voluntary and are anonymous. The responses are sent directly to the department and is collated independently by the department (not individual service). The results are presented to the SIG (annually) to monitor client satisfaction levels and identify any emerging issues.

4.8 Transferring active cases between IFS services

When a family receiving an IFS service is relocating to another catchment where an IFS service is available, the following transfer process applies:

1. Discuss with the family if they wish to work with another IFS service when they move to their new location.
2. If the family wishes to work with the new service, gain consent to speak to the appropriate service.
3. Contact the service, by phone to discuss the family's situation and timeframes for transfer. (Follow up with emails as appropriate)
4. A four-week period is allocated for case transfer, during which time the current service commits to continue working with the family until the new service allocates a worker. (This may depend on when the family is actually moving and extended, or shorter timeframes can be negotiated.)
5. The transferring family is prioritised by the new service, not added to a waiting list.
6. It is best practice for a warm handover meeting to occur where appropriate introductions take place and a verbal interaction between parties that will assist to pass not only the knowledge regarding a family but also the relationship and trust from service to service. Families may appreciate participating in a handover meeting where appropriate.
7. Contact should be made with other key stakeholders who have collaborated in the case management and single case plan. Where appropriate, they may also be included in a warm handover with the family.
8. A referral is made through ARC or email (if required) to the new service. Minimum requirements for transfer of information include the most recent assessments and the current case plan.
9. Once the electronic referral is accepted by the new service, the case is closed in the original service's ARC system.

4.9 Duty of Care

There are a range of service delivery requirements in place to help safeguard and protect children and young people, including reporting requirements, protecting the confidentiality and privacy of personal information of families, ensuring the quality of service delivery in human services is child-centred.

IFS services must adhere to the relevant provisions within the:

- *Community Services Act 2007*
- *Child Protection Act 1999*
- *Public Guardian Act 2014*
- *Family and Child Commission Act 2014*
- *Right to Information Act 2009*
- *Information Privacy Act 2009*

- *Public Records Act 2002*
- *Human Rights Act 2019*
- Any future legislation relevant to services administered and funded by the department responsible for child safety in Queensland.

Reporting child protection matters

It is a requirement that the IFS service reports to Child Safety if there is reason to suspect a child is experiencing significant harm. This includes if, after a referral, further information becomes apparent during assessment that leads the service to suspect a child has experienced significant harm.

All services that work with IFS clients, including brokered services or partnering services, must also be aware of this responsibility.

Information regarding reporting suspected child abuse is available at *https://www.cyjma.qld.gov.au/protecting-children.*

IFS services can consult the Child Protection Guide or their PCPP about suspected harm to children to determine whether a report should be made to Child Safety.

RESOURCE: The Queensland Child Protection Guide and supporting instructions is accessed at *https://www.cyjma.qld.gov.au/about-us/our-department/partners/child-family/our-government-partners/queensland-child-protection-guide*

Blue Card obligations

The Blue Card system under the *Working with Children (screening and risk management) Act 2000* relates to the creation of safe and supportive environments for children and young people when receiving services and participating in activities which are essential to their development and wellbeing.

It is a legislative requirement that people who work with children in regulated employment (which includes counselling and support) are suitable. This is assessed through the 'working with children' suitability notice (blue card). IFS services must meet all obligations under the blue card system and ensure appropriate practices to work with children and young people. This information must also be supplied to other services that are contracted through partnering or brokering to work with the child and family.

Child-related organisations who operate services regulated by the blue card system must also have a child and youth risk management strategy to help create a safe and supportive environment for children.

Information for organisations is available at *https://www.**bluecard**.qld.gov.au/*

Information privacy

The standard terms of Queensland Government contracts bind contracted service providers to comply with the *Information Privacy Act 2009.*

RESOURCE*:* See further information at *https://www.cyjma.qld.gov.au/resources/dcsyw/about-us/right-to-information/information-privacy-and-contracted-service-providers.pdf*

Risk Management

The funded organisations delivering IFS services need to develop risk management plans and be vigilant about implementing the identified risk mitigation strategies. This includes strategies to ensure worker and client safety.

Human Services Quality Framework

The Human Services Quality Framework (HSQF) is the quality assurance framework for assessing and promoting improvement in the quality of human services.

he HSQF was developed in collaboration with the non-government sector to maintain important safeguards for people using services while streamlining quality requirements. It incorporates:

- a set of quality standards, known as the Human Services Quality Standards, which cover the core elements of human service delivery
- an assessment process to measure the performance of service providers against the standards (assessment occurs at organisation level across all in-scope services)
- a continuous improvement framework, which supports the participation of people who use services in quality improvement.

Details about the Human Services Quality Framework is available at *https://www.dsdsatsip.qld.gov.au/our-work/human-services-quality-framework.*

**** SERVICE PROVIDER PEAK SUPPORT** **

The **Queensland Council of Social Services** (the peak body for the social service sector) provides support to service providers to understand their obligations and compliance responsibilities. QCOSS provides **Community Door** – a resource and information hub for community services sector which covers all facets of service provision.

It is recommended that services register to receive regular updates and take up the opportunities for training where possible *(https://www.qcoss.org.au/project/community-door/)*

5. Data Collection and Reporting

All IFS services enter client data on the Advice, Referral and Case management (ARC) information system developed by Infoxchange. Ongoing support can be accessed through the Infoxchange Helpdesk. There is also a user manual specifically for IFS services which can be found on the ARC landing page along with the latest news and tips. New staff should be trained by an experienced system user within the organisation.

Infoxchange provides a centralised help desk for ARC users, and issues or questions should be sent via:

- Email: srs-support@infoxchange.net.au or
- Infoxchange Helpline **1300 366 516** or **03 9418 7487**

When contacting the help desk please quote the web address you use to access ARC and the workgroup you belong to.

You can also find generic Service Record System (SRS) Frequently Asked Questions and a feedback page via the online help at *http://srs-support.infoxchangeapps.net.au/*

De-identified data is extracted monthly from ARC by the department to meet the whole of program reporting requirements of IFS services and other programs that use these systems. For IFS services, this occurs on approximately the 8th day of the month. Services are required to enter the data on a regular basis so that data accurately reflects the delivery of services to clients, however, all data needs to be up to date by the 8th day of the month.

The only exception is that some identified data is extracted to report on an escalation measure tracking progress from an IFS intervention to the statutory system. A small defined number of departmental staff undertake the data matching exercise.

IFS services can extract a range of reports from ARC including monthly reports on referrals and caseloads which contains comprehensive service delivery data, including hours of service.

5.1 Performance Management Framework

The *Performance framework for funded service providers* sets out the broader framework through which the Department of Children, Youth Justice and Multicultural Affairs will monitor and assess all the department's outsourced service delivery contracts. The framework promotes collaboration within a contract management relationship that encourages, recognises and promotes high performance by providers across the social services system. It involves a performance assessment approach which enables performance issues to be identified quickly and addressed before they become performance failures.

A supplementary guide to the Performance Framework, *Addendum: Performance framework for Intensive Family Support* has been developed specifically for Intensive Family Support Services as it is the first service type to transition to an outcomes-focused performance framework (from 1 July

2022). A copy of this is available on the the FaCC and IFS Service Providers secure sub-site: *https://familychildconnect.org.au/secure/*

5.2 Performance measures

To determine whether high-level objectives set out in service agreements are being delivered, IFS performance targets and thresholds have traditionally relied upon an outputs-focused approach. To date, primary deliverables have included a specified quantity of both case management hours and the number of service users (families) receiving support on a per annum basis. However, from 1 July 2022, the primary deliverable for IFS contracts will now be an outcome measure –

- **OM4.1.01**: *Number of Service Users with cases closed with all or majority of case plan goals achieved.*

This outcome measure is expressed as a proportion of the number of families who can be *potentially* supported. The number of potentially supported families will form the basis of a new target in the contracts. Downstream targets for consenting in-scope referrals and all/majority case plan goals achieved are set as a percentage of this new target.

IFS contracts will be structured around the following three targets:

1. The new target number of families measure – potential support cases – represents 61-62% of the total number of closed referrals (IS145) on average and is captured as a throughput measure:
    - **IS245:** *Number of in-scope Service Users[18] eligible to receive a service who have exited from the service*

2. The new target of consenting in-scope referrals – families that have engaged – is set at 75% of the total number of potential support cases and is captured as a throughput measure:
    - **IS134**: *Number of Service Users engaged*

3. The new outcome deliverable – families with all/majority of their case plan goals achieved – is set at 40% of the target number of families measure (rather than as a percentage of consenting cases):
    - **OM4.1.01**: *Number of Service Users with cases closed with all or majority of case plan goals achieved*

OM4.1.01 replaces the existing A01.2.02 Case management deliverables (specified hours and number of service users per annum). Current outcome measures (*OM2.1.08: Number of Service Users with improved life skills and OM2.1.01: Number of Service Users that have shown improvements in being safe and/or protected from harm*) have been removed from all IFS contracts.

[18] In scope cases for the new target measure are all contactable IFS referrals. Excluded are the early exit categories that include: already engaged; data entry error; duplicate referral; IFS response not required; inappropriate referral; moved out of area; other reason; outside catchment area; staffing or agency reason; supported referral to another service (at capacity); and unable to contact or locate family.

Appendix 1 – Practice Principles

Intensive Family Support (IFS) services adopt the following practice principles to provide best practice and positive outcomes for vulnerable families with children and young people:

Valuing and supporting families as the primary place of nurturing for children - The best way to promote the safety and wellbeing of children and young people and to protect them from harm is by supporting families to care safely for their children at home and by creating safe and supportive communities.

Building on strengths - Support and intervention builds on the strengths of the child, family and community, enhances capacity and resilience and addresses identified risks and/or problems. Service providers work collaboratively and in partnership with children, families, communities and other service providers where appropriate, to develop case plans and to make decisions.

Respecting and responding to family and community diversity and strengthening culture and connections - Family and cultural background has a strong bearing on the ways families and communities approach childrearing. Support and intervention respects and responds to diversity and promotes culture as a resource, seeking to build on the strengths and protective factors which particular cultural backgrounds may provide.

Holistic and integrated policy and practice - A holistic and integrated approach to service provision offers the greatest chance of longer-term success. In partnership with non-government organisations, government plays a leading role in bringing together relevant stakeholders and supporting genuine collaboration throughout planning, implementation, partnership development and evaluation.

Evidence-based policy and practice - Support and intervention is outcome driven and reflects contemporary research and evidence on what works best to achieve desired outcomes. Where appropriate, consideration is given to targeting activities and interventions toward the early years and other critical transition points to maximise investment and outcomes. Agencies commit to action learning processes and participation in the evaluation of service delivery both as part of the broader network of IFS services and in partnership with the department.

Purposeful, planned and matched to need - Supports and interventions are goal orientated and planned, within a sound theory of change. They are carefully coordinated and individually tailored to the specific nature and source of family difficulties. Parent engagement is maximised through family support based on goals that are specific and interventions that are well coordinated.

Relationship-based - Relationships are vital to service delivery. Workers aim for a therapeutic role and strive to develop a structured helping alliance with family members. Interventions will be delivered by appropriately trained, research informed and skilled staff, backed up by good management and supervision.

Tangible and non-tangible forms of assistance - A mix of practical, personal development, therapeutic and enabling services are utilised as appropriate:

- practical services address a specific need in the family, such as transport to medical appointments or respite care, establishing daily routines related to meals or getting to school
- personal support and development including information and advice, parenting skills courses, budgeting and household skills development
- clinical or therapeutic services include casework, counselling, emotional support, family mediation, anger management, domestic violence intervention programs, development of social supports
- enabling services to link the family to other supports via referral and advocacy (e.g. assist with access to housing, child care, emergency relief payment, rental assistance) and case management to coordinate service delivery.

Engagement and participation - Services focus attention on engaging families through the skills and persistence of their workers. The match between client need and services provided is considered crucial – if clients perceive the service is helpful they are more likely to stay engaged. Workers develop a partnership approach with parents that support parental engagement and responsibility. Multiple pathways into the service are utilised to encourage self-referral (where available) and reduce stigma for families[19].

Trauma-informed - recognises the prevalence of early adversity in the lives of clients, views presenting problems as symptoms of maladaptive coping, and understands how early trauma shapes a client's fundamental beliefs about the world and affects his or her psychosocial functioning across the life span. It incorporates core principles of safety, trust, collaboration, choice, and empowerment and delivers services in a manner that avoids inadvertently repeating unhealthy interpersonal dynamics in the helping relationship[20].

Principles of trauma-informed approaches and care include[21]:

- having a sound understanding of the prevalence and nature of trauma and its impacts on people's development and functioning
- organisational and operational practices promoting the physical, psychological and emotional safety of people who have experienced trauma
- adopting service cultures and practices that empower people in their recovery, by emphasising autonomy, collaboration and strengths-based approaches
- recognising and being responsive to the lived, social and cultural contexts of people, which shape their needs as well as their recovery and healing pathways
- recognising the relational nature of both trauma and healing

[19] Tilbury, C (2012) Intensive Family-Based Support Services for Aboriginal and Torres Strait Islander Children and Families: A background paper. SNAICC

[20] Levenson, J (2017) Trauma-Informed Social Work Practice. *Social Work*. Vol 62 (2).

[21] Articulated in the National Framework for Protecting Australia's Children 2021-2031, p.50 (See *https://www.dss.gov.au/the-national-framework-for-protecting-australias-children-2021-2031)*

Principles such as Aboriginal and Torres Strait Islander peoples' ownership, definition, design and evaluation of healing initiatives, and designing initiatives based on Aboriginal and Torres Strait Islander worldviews rather than Western health understandings alone, are other important considerations[22].

A trauma-informed approach does not necessarily require a service to provide therapeutic treatment addressing the symptoms of trauma.

[22] Quadara, A & Hunter, C (2016), Principles of trauma-informed approaches to child sexual abuse: A discussion paper, AIFS.

Appendix 2 – Culturally Respectful, Safe and Responsive Service Delivery for Aboriginal and Torres Strait Islander Families

Priority response to reduce disproportionate representation of Aboriginal and Torres Strait Islander children in statutory care

The steadfast commitment by the Queensland Government (and also at the national level) to take action to improves outcomes for Aboriginal and Torres Strait Islander families means a transformation in service delivery responses is a non-negotiable priority.

Our Way, a generational strategy for Aboriginal and Torres Strait Islander children and families 2017-2037

- *Our Way, a generational strategy for Aboriginal and Torres Strait Islander children and families 2017-2037* sets Queensland's strategic framework to achieve generational change over the 20 years of the strategy.
- The Our Way strategy is co-developed with Family Matters Queensland and guided by Aboriginal and Torres Strait Islander perspectives.
- The Queensland Government is a signatory to the Family Matters[23] national campaign's Statement of Commitment to ensure Queensland Aboriginal and Torres Strait Islander children and young people grow up safe and cared for in family, community and culture.

The Our Way Strategy [24] represents a whole-of-government and whole-of-community long-term commitment to work together to:

- ensure all Aboriginal and Torres Strait Islander children grow up safe and cared for in family, community and culture
- eliminate the disproportionate representation of Aboriginal and Torres Strait Islander children in the child protection system
- close the gap in life outcomes for Aboriginal and Torres Strait Islander children and families.

Four building blocks underpin the Our Way strategy:

- All families enjoy **access to quality, culturally safe universal and targeted services** necessary for Aboriginal and Torres Strait Islander children to thrive
- Aboriginal and Torres Strait Islander peoples and organisations **participate in and have control over decisions** that affect their children
- Law, policy and practice in child and family welfare are **culturally safe and responsive**
- **Governments and community services are accountable** to Aboriginal and Torres Strait Islander peoples

[23] Family Matters is a national campaign led by more than 150 Aboriginal, Torres Strait Islander and non-Indigenous organisations across Australia committed to eliminating the disproportionate representation of Aboriginal and Torres Strait Islander children in statutory out-of-home care, within a generation. Annual reports are published on jurisdictional progress towards reducing over-representation of Aboriginal and Torres Strait children in statutory child protection. See *www.familymatters.org.au* for more details.
[24] Implementation of the Our Way Strategy is supported by three-year action plans addressing priority areas across over three cycles of change. More information at https://www.cyjma.qld.gov.au/campaign/supporting-families/implementing-reforms/strategy-action-plan-aboriginal-torres-strait-islander-children-families.

The ENABLERS for the Our Way Strategy outline key focus areas which IFS services can consider as part of their strategies and practice

❖ Focus on the child	❖ Empower parents, families and communities
❖ Enable self-determination	❖ Set high expectations and positive norms
❖ Take a holistic and life-course approach	❖ Recognise culture as a protective factor
❖ Address trauma and enable healing	❖ Share power, responsibility and accountability
❖ Shift and balance investment	❖ Provide accessible and coordinated services
❖ Create partnerships	❖ Innovate, build evidence and adjust

The Aboriginal and Torres Strait Islander Child Placement Principle

The Aboriginal and Torres Strait Islander Child Placement Principle is enshrined in Queensland's child protection legislation. All IFS services must **actively** apply the relevant element/s of the Aboriginal and Torres Strait Islander Child Placement Principle in their work, practice and interactions with Aboriginal and Torres Strait Islander families.

Active efforts mean ensuring affirmative, active, thorough and timely interactions which align with the relevant element/s and the intent of the Principle.

Five elements of the Aboriginal and Torres Strait Islander Child Placement Principle

- ❖ Element 1: Prevention – protecting children's rights to grow up in family, community and culture by redressing the causes of child protection intervention
- ❖ Element 2: Connection – maintaining and supporting connections to family, community, culture traditions and language
- ❖ Element 3: Partnership – ensuring the participation of community representatives in service design, delivery and individual case decisions
- ❖ Element 4: Participation – ensuring the participation of children, parents and family in decisions regarding the care and protection of their children
- ❖ Element 5: Placement – placing children in out of home care in accordance with established placement hierarchy

In order to actively apply the Principle, it is important to understand its **aims**:

- embed an understanding that culture is integral to safety and wellbeing for Aboriginal and Torres Strait Islander children and young people and is embedded in policy and practice

- recognise and protect the rights of Aboriginal and Torres Strait Islander children, family members and communities in child safety matters
- support self-determination of Aboriginal and Torres Strait Islander people in child safety matters
- reduce the over-representation of Aboriginal and Torres Strait Islander children in child protection and out-of-home care systems.

RESOURCES: SNAICC has comprehensive research and resources on understanding and applying the Aboriginal and Torres Strait Islander Child Placement Principle. SNAICC also undertakes an annual review on implementation across each jurisdiction. To access these resources, see *https://www.snaicc.org.au/reviewing-implementation-of-the-aboriginal-and-torres-strait-islander-child-placement-principle-2020*

IFS role and responsibilities

IFS has an important role and responsibility as a mainstream secondary service to reduce the disproportionate representation of Aboriginal and Torres Strait Islander children in the statutory child protection system.

Aboriginal and Torres Strait Islander families are more likely to engage and feel safe and respected with organisations that are recognised for being actively engaged in the life of their community.

IFS services must place an emphasis on the active implementation of the Aboriginal and Torres Strait Islander Child Placement Principle and the provision of culturally safe support from a trauma-informed lens.

IFS services contribute to these commitments by ensuring their services and support for Aboriginal and Torres Strait Islander families is managed and delivered in culturally respectful, safe and responsive ways. This requires strong cultural capability across the key elements of service delivery, evidenced by:

Agency/service level

- The agency places importance on recognising the historical facts of Australian history, the ongoing legacy of colonialisation and the impacts of intergenerational trauma for Aboriginal and Torres Strait Islander peoples.

- The agency is clear in its policies and procedures that the services and support delivered are based on a healing framework and every care is taken to prevent the re-traumatisation of Aboriginal and Torres Strait Islander families.

- The agency is clear in its policies and procedures that racism is not tolerated in any form.

- The service develops effective links with local Aboriginal and Torres Strait Islander organisations and community representatives to help build a culturally safe profile. To aid the cultural safety of the service, it is strongly recommended that:
    - a **Cultural Practice Framework** is developed, implemented, and regularly monitored
    - the **Family Matters Cultural Reflective Practice Tool**[25] is actively used to deliver culturally capable service and to identify areas and plan for improvement

RESOURCE: The **Family Matters Cultural Reflective Practice Tool** is currently the only tool that ensures a cultural lens is applied to reflecting on application of the five elements of the Aboriginal and Torres Strait Islander Child Placement Principle (ATSICPP) while also aligning with both the Family Matters and the Our Way Strategy's building blocks and principles.

It invites signatories to challenge systemic racism, uphold children's rights, and transfer capacity to enable community controlled organisations to provide services based on community needs.

Details and supporting information on the Family Matters Reflective Practice Toolkit and template (including Queensland trial findings) is available at *https://www.familymatters.org.au/publications*

- The service provides practitioners with ongoing cultural supervision and accessible options to cultural advice.
- The physical features of the service outlet are characterised in a manner which is welcoming and without stigma for Aboriginal and Torres Strait Islander families and partners (for example featuring Aboriginal and Torres Strait Islander artefacts and symbols).

Staffing level

- All staff, with an increased expectation on practitioners, demonstrate strong understanding of the histories, cultures, traditions and customs of Aboriginal and Torres Strait Islander peoples, including common and relevant terminology.
- Practitioners demonstrate a strong understanding of the legislative requirements in providing services for Aboriginal and Torres Strait Islander families *(Child Protection Act 1999; Human Rights Act 2019)*.
- Practitioners acknowledge the strong protective factors of connections to kin, community, and culture.
- Practitioners work with a trauma-informed lens, practice deep listening, and take into consideration the impacts of accumulative harms and the need for healing responses.

[25] The National Family Matters Reflective Practice Tool was developed in 2019 to assist campaign signatories to assess their commitment to uphold the campaign principles and building blocks and to identify actions to take in accordance with each principle. Several Queensland IFS service providers have participated in trialling the tool and reported positive findings on its usefulness in progressing cultural capability and cultural safety in their service.

- Practitioners demonstrate strong understanding and capability regarding cultural differences in:
  - communication styles
  - engagement practices
  - yarning
  - child development
  - concept, language and potential concerns relating to disability[26]
  - child rearing and parenting styles
  - family structures

- Practitioners actively apply the elements of the Aboriginal and Torres Strait Islander Placement Principle in their interactions and decisions (in particular, the elements of prevention, partnership, participation and connection are relevant to IFS service delivery).[27]

- Practitioners are provided with sufficient support to work with Aboriginal and Torres Strait families recognising the building of trusting respectful relationships requires time and flexibility.

- Practitioners understand that for Aboriginal and Torres Strait Islander families, the importance of kin, extended family and the community in the raising of safe and happy children is paramount, and where appropriate, the significant extended family members should be encouraged and welcomed to participate in decision making processes.

- Practitioners should consult with cultural experts and services and be aware of and plan around any significant cultural events or occasions which may impact on a family. Of great importance is respecting the cultural practices, customs and protocols associated with the death of Aboriginal and/or Torres Strait Islander peoples in community (Sorry Business). This may require both staff and clients of the service to attend funerals and participate in Sorry Business or bereavement protocols. This is not considered a disruption of service delivery, but an important component of community and cultural life and supportive responses to people and communities grieving the loss of members of the community. Sorry Business is not a disruption to service delivery but an essential sign of respect.

- Practitioners recognise that longer periods of engagement may be required when working with Aboriginal and Torres Strait Islander families and to appreciate the importance of taking the time to build trusting respectful relationships and rapport.[28]

Practice note: Identification

Family Matters Report 2021:

The *Family Matters Report 2021* recommended that children and families be asked at their earliest engagement with the service system about their Aboriginal and Torres Strait Islander identity; this question is revisited regularly; and that their identity is recorded as early as possible.

[26] 'Disability' is a socially constructed concept from western culture and society. People from Aboriginal and Torres Strait Islander backgrounds may have a very different understanding of the concept and the use of the word may not exist. There are additional challenges such as fear of discrimination and of having a child with disability removed from a family's care (see Child Safety Practice Manual Practice Kit for more information).

[27] Only the element of 'placement' is not relevant as it is concerns children in the statutory arm of the children protection system.

[28] The department's Performance Framework for IFS (March 2022) acknowledges the flexibility and time required to work well with Aboriginal and Torres Strait Islander families.

Implementation measures must include training to practitioners on culturally safe ways to discuss and explore cultural identity with children and families.

There must also be protections against the de-identification of children without consultation with Aboriginal and Torres Strait Islander communities.

Families Investment Specification (Department of Children, Youth Justice and Multicultural Affairs):

A family is considered to be Aboriginal and/or Torres Strait Islander if a member of the family identifies as Aboriginal and/or Torres Strait Islander.

Child Protection Act 1999:

s.11 (3) A parent of an Aboriginal child includes a person who, under Aboriginal tradition, is regarded as a parent of the child.

s.11 (4) A parent of a Torres Strait Islander child includes a person who, under Island custom, is regarded as a parent of the child.

A **culturally safe place** for Aboriginal and Torres Strait Islander staff and families is characterised by the following factors (Queensland Child Safety Practice Manual).

- welcomes Aboriginal and Torres Strait Islander families and partners in the physical environment
- acknowledges the richness of Aboriginal and Torres Strait Islander cultures
- acknowledges the differences between Aboriginal and Torres Strait Islander cultures
- encourages ally behaviours
- does not stay silent in the face of inappropriate behaviour (even minor). Staying silent can be seen as condoning.
- recruits Aboriginal and Torres Strait Islander staff
- models an expectation of behaviour—we talk about children, families, partners and others as though they were sitting in the room with us
- expects growth to be uncomfortable
- has Aboriginal and Torres Strait Islander people on recruitment panels
- considers using storytelling questions in interviews
- understands the concept of cultural humility. Aboriginal and Torres Strait Islander people will often sell themselves short rather than talk themselves up. We need to be curious and ask them more
- knows that maintaining ‘cultural capital’ is essential. Aboriginal and Torres Strait Islander staff need contact with their mob and other Aboriginal and Torres Strait Islander staff to build capital and maintain a sense of self
- encourages collectivist responsibility
- ensures staff have genuine engagement in cultural learning

- has staff who accept their responsibility to educate themselves about Aboriginal and Torres Strait Islander history
- understands that Aboriginal and Torres Strait Islander history is Australia's shared history.

Cultural services / resources

- National crisis support line for Aboriginal and Torres Strait Islander peoples

13YARN [Thirteen YARN / 139276] is the national crisis support line for mob who are feeling overwhelmed or having difficulty coping. They offer a confidential one-on-one yarning opportunity with a Lifeline-trained Aboriginal and Torres Strait Islander Crisis Supporter who can provide crisis support 24 hours a day, 7 days a week.

13YARN empowers mob with the opportunity to yarn without judgement and provide a culturally safe space to speak about their needs, worries or concerns.

- Indigenous Triple P

Indigenous Triple P allows providers accredited in Primary Care, Group and/or Standard Triple P programs to tailor their delivery of the programs to suit Aboriginal and Torres Strait Islander families. Materials and content for Indigenous Triple P were created in consultation with elders from a variety of Aboriginal and Torres Strait Islander communities in Australia. Indigenous Triple P has been used with both Indigenous Australian families and aboriginal Canadian families. (Specialist programs - Triple P)

SOURCES OF TRUSTED EXPERT INFORMATION

There are many resources available to inform and support the understanding, development and delivery of culturally capable services. Recommended sources include:

- **Queensland Aboriginal and Torres Strait Islander Child Protection Peak Limited (QATSICPP)** *[https://www.qatsicpp.com.au]*

QATSICPP's mission is to develop policies and strategies to lead, resource and build the capacity of Aboriginal and Torres Strait Islander agencies who work alongside parents, families and communities to ensure the safety and wellbeing of children and young people. There is a wide range of expert resources available on their website to guide mainstream service practice when working with Aboriginal and Torres Strait Islander families. This support will continue to grow, with the establishment of a QATSICPP Centre of Excellence in 2022 to share collective knowledge and experience, and practice wisdom based on the evidence.

An example of a useful resource is *QATSICPP Practice Standards (2017)* – see *https://www.qatsicpp.com.au/our-work/practice-resources/*

- **Secretariat of National Aboriginal and Islander Child Care (SNAICC) – National Voice for our Children** *[https://www.snaicc.org.au*]

SNAICC is the national non-governmental peak body for Aboriginal and Torres Strait Islander children, working for the fulfilment of the rights of children, in particular to ensure their safety, development and well-being with connection to family and culture at the forefront.
There is a wide range of expert resources available on their website relating to Child Safety and Wellbeing; Early Childhood; and Child Rights. Also of relevance for IFS are the resources on Genuine Partnerships to support Aboriginal and Torres Strait Islander and non-Indigenous organisations on building partnerships for child and family service delivery.
See *https://www.snaicc.org.au/policy-and-research/*

A recommended resource is *Moving to Prevention research report: Intensive family support services for Aboriginal and Torres Strait Islander children (2015)* which provides a detailed account of the best practice elements to support services and practitioners in developing their practice to better support Aboriginal and Torres Strait Islander children and families – see *https://www.snaicc.org.au/moving-to-prevention-intensive-and-targeted-family-support/*

- **Family Matters: Strong Communities. Strong Culture, Stronger Children – Australia's national campaign to ensure Aboriginal and Torres Strait Islander children and young people grow up safe and cared for in family, community and culture** *[https://www.familymatters.org.au]*

Family Matters is led by SNAICC and aims to eliminate the over-representation of Aboriginal and Torres Strait Islander children in out-of-home care by 2040. Hundreds of supporters have officially made a commitment to the vision, including community organisations, community services, governments, parliamentarians, research institutions, universities, charities and peak bodies.

The Family Matters Report is an essential resource for IFS. The report is produced annually and examines what each Australian jurisdiction is doing to turn the tide on over-representation and the

outcomes for children. It also highlights solutions and strengths-based actions to invest in. In Queensland, the Our Way Strategy is co-designed by Family Matters Queensland and the Queensland Government (see details above).

❖ **The Healing Foundation** *[https://healingfoundation.org.au]*

The Healing Foundation is a national Aboriginal and Torres Strait Islander organisation that partners with communities to address the ongoing trauma caused by actions such as the forced removal of children from their families: *For Aboriginal and Torres Strait Islander people, healing is a holistic process, which addresses mental, physical, emotional and spiritual needs and involves connections to culture, family and land. Healing works best when solutions are culturally strong, developed and driven at the local level, and led by Aboriginal and Torres Strait Islander peoples*.

There is a wide range of expert information and resources on trauma and healing available on the Foundation's website.

❖ **Australian Institute of Family Studies (AIFS)** *[https://aifs.gov.au]*

AIFS conducts high-quality, impartial research into the wellbeing of Australian families, to inform government policy and promote evidence-based practice in the family services sector. The topic area 'Aboriginal and Torres Strait Islander families' provides a wide range of information. Examples of useful research and practice information include: *Working with Indigenous children, families and communities: Lessons from practice (2011*); *Enhancing the implementation of the Aboriginal and Torres Strait Islander Child Placement Principle (2015)* and *Child protection and Aboriginal and Torres Strait Slander children (2020)*.

Queensland Government resources:

❖ **Queensland Child Safety Practice Manual (CSPM)** *[https://cspm.csyw.qld.gov.au]*

The CSPM also has useful information which can be applied to family support practice.

- The Practice Kit on *Safe care and connection* to inform culturally capable practice with Aboriginal and Torres Islander children and families.
- The Practice Kit on *Disability in Aboriginal and Torres Strait Islander cultures* to inform understanding of disability and impacts from the perspective of people from Aboriginal and/or Torres Strait Islander backgrounds.

❖ **Aboriginal and Torres Strait Islander Family Wellbeing Services (FWS) Program Guidelines**

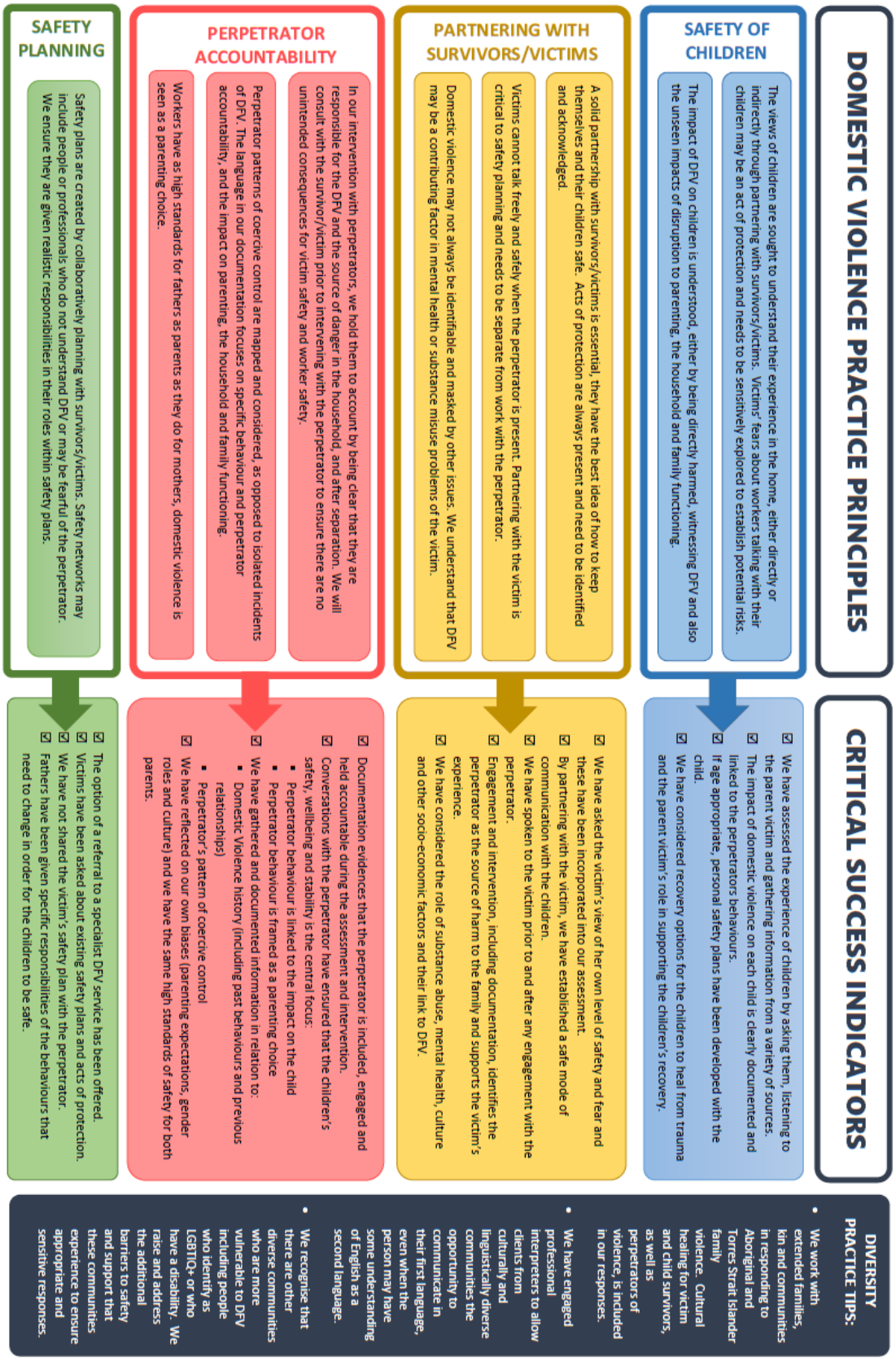
[accessible on the ARC landing page]

Aboriginal and Torres Strait Islander FWS are a critical component of implementing the Our Way Strategy. The service makes it easier for Aboriginal and Torres Strait Islander families in communities across Queensland to access culturally responsive support to improve their social, emotional, physical and spiritual wellbeing, and build their capacity to safely care for and protect their children. The Program Guidelines may be useful for IFS services. Information about the program is also available at *https://www.familywellbeinggld.org.au*

❖ **Aboriginal and Torres Strait Islander Respectful Language Guide** *[https://www.cyjma.qld.gov.au/resources/dcsyw/about-us/research/respectful-language-guide.pdf]*

The Respectful Language Guide was designed for government staff to make respectful, conscious and insightful choices of words, terms and language and is relevant for IFS services.

Appendix 3 – DFV Practice Principles



This document was developed by the Brisbane DV Project group comprising Child Safety, FACC, IFS and DV sector partners.
The Project group acknowledge the work of David Mandel and the Safe and Together Institute in the development of this document.
For further information, please contact Melanie Safonoff, CSYW. last update 05.19

Appendix 4 – Information sharing

Gaining a family's consent to share information is best practice and will facilitate a positive working relationship with the family. The informed consent of families is integral to the IFS service model operating within the child protection and family support system.

For consent to be informed and for people to fully participate in decision making, they should be given enough information to make the decision and should understand what they agreeing to. When seeking and obtaining consent, potential barriers to informed consent, such as disability, mental illness, age, culture or language should be identified and managed.

Seeking consent for sharing information underpins the development of engagement and a positive working relationship with a family.

When IFS services commence working with children and their families, they should inform them that their personal information may be given to other organisations in certain circumstances. People should also be informed when their information has been shared and the reasons it has been shared, unless doing so would create risks to them, the child or others.

Children and young people should be given the opportunity and supported to participate in decision making process relating to information sharing and have their views considered. The level of engagement of children in these processes needs to be based on their age, developmental stage and any particular needs.

When working with Aboriginal and Torres Strait Islander children and families, effective engagement needs to take into account the cultural and historical factors that have led to entrenched disadvantage and vulnerability within this community. Aboriginal and Torres Strait Islander peoples should be supported and empowered to participate in decision making processes.

Care also needs to be taken to respond to any cultural and language barriers to the participation and understanding of families from both Aboriginal and Torres Strait Islander and Culturally and Linguistically Diverse backgrounds.

It is not always safe, possible or practical to seek and obtain consent. Requiring consent can at times, prevent or delay a service engaging with a family and prevent the effective coordination of services where multiple services are involved. Professionals need to be able to share information about a child or their family so help and support is provided in a timely way to enable families to meet the protection and care needs of children.

Chapter 5A, Part 4 of the *Child Protection Act 1999* allows information to be shared without consent between entities. The sections enable broad information sharing about children and unborn children, where they may be at risk after they are born.

Section 159M defines the entities which can share information include Child Safety, prescribed entities (which includes specialist service providers) and service providers.

A key principle of the information sharing provisions is to obtain consent if it is possible, practical and safe to do so. It is best practice to seek a child or parent's consent to share their personal information. However, consent is not legally required to share information under the provisions.

The information sharing framework in the Act enables broad information sharing without consent for specific purposes between entities involved in the child protection and family support systems, namely:

- Entities may share information with each other to decide if they should inform Child Safety about suspected harm or risk to a child or that an unborn child may be in need of protection after they are born.

- Entities may give information to Child Safety to help it to investigate harm or risk of harm and assess a child's need for protection or an unborn child's need for protection after birth; or take other action or decide whether Child Safety suspects a child is in need of protection.

- Child Safety may also give entities information to help them decide whether and what information to give to Child Safety.

- Prescribed entities and service providers may give information to Child Safety to help Child Safety with the development or assessment of a child's case plan, assess or respond to, make plans or decisions or provide services to a relevant child or the child's family or offer help and support to a pregnant woman.

- Child Safety and prescribed entities may give service providers and other prescribed entities information to help assess or respond to a child's needs or plan or provide services to a child or the child's family to decrease the likelihood of a child becoming a child in need of protection.

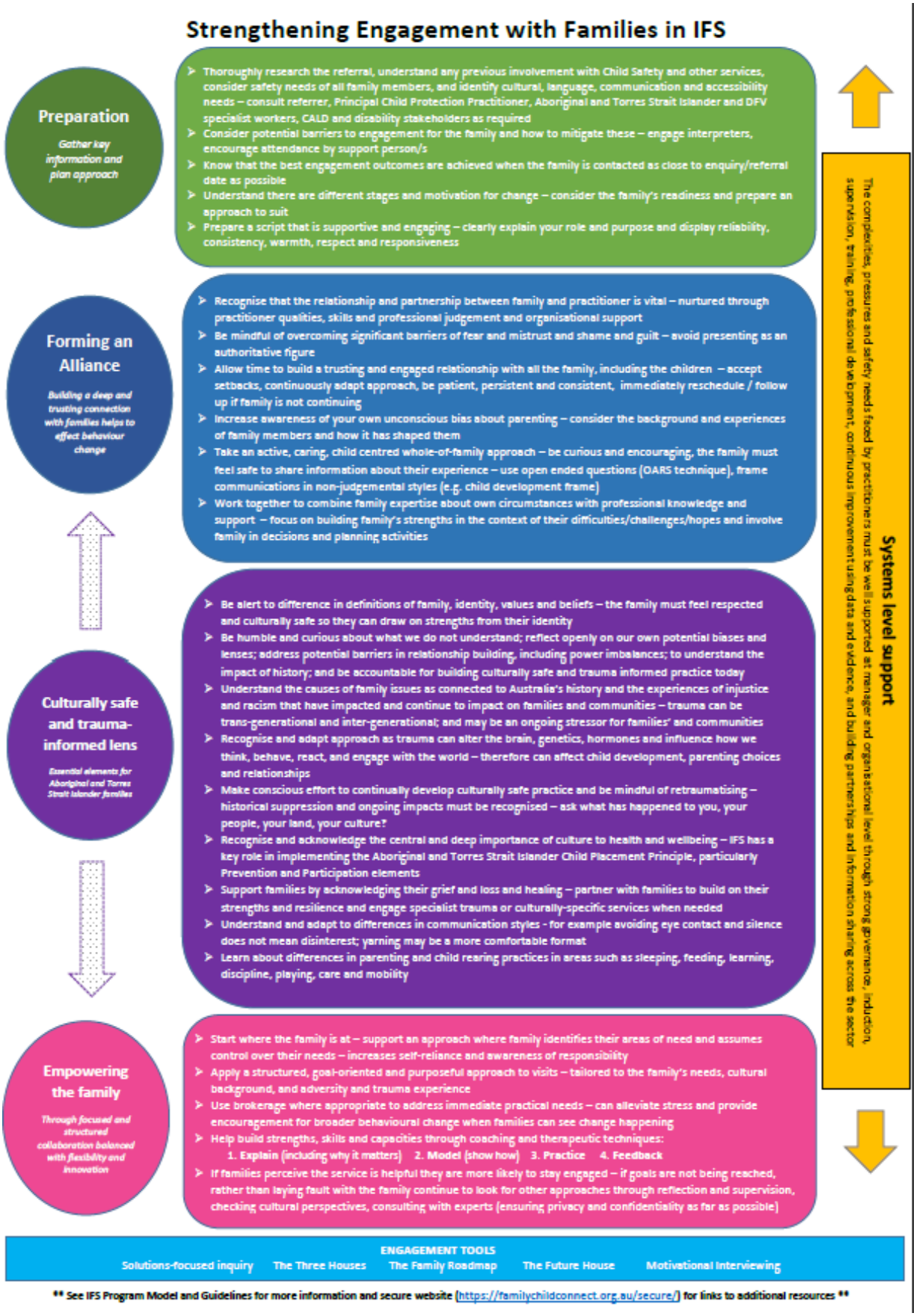
- A service provider may give information to a prescribed entity to help decrease the likelihood of the child becoming a child in need of protection.

- Child Safety and an independent Aboriginal or Torres Strait Islander entity for a child (independent person) may share information with each other to help the independent person facilitate the participation of the Aboriginal or Torres Strait Islander child or the child's family in decision making planning, or providing services to the child or child's family

An entity must reasonably believe the information they are sharing will help with the particular purpose for which it is sharing the information. Decisions about information sharing need to be made with consideration of the individual circumstances of the child and family.

The department has developed information sharing guidelines which are available at *https://www.cyjma.qld.gov.au/about-us/our-department/partners/information-sharing/child-family*

Appendix 5 – IFS Engagement tip sheet



Appendix 6 – Assessment of Harm and Risk of Harm

Introduction

The assessment of harm and risk of harm is a fundamental component of child protection work. Risk assessment is an ongoing process of purposeful gathering and analysis of information to form a professional judgement about the severity and likelihood of future harm to a child. Given FaCC and IFS's position in the child protection continuum, workers in these services must have a robust risk assessment framework to understand the risks to children, knowledge on how to reduce those risks to prevent issues from escalating and requiring statutory intervention. and understanding of when escalation into the child protection system is required.

This practice guide is adapted from the Department of Children, Youth Justice and Multicultural Affair's "*Practice guide: Assess harm and risk of harm*" thus ensuring a shared understanding between the department and the secondary family support system.

Key concepts

The concepts outlined below are used within child protection practice and provide a common language for use between the sectors. It also supports consistent practice so that the same indicators of harm and risk of future harm are considered for each family regardless of where they present.

The relationship between abuse and harm

Understanding the relationship between abuse and harm is crucial to assessing harm and risk of harm to a child. Abuse (an act of commission) can be physical, emotional or sexual. Neglect, which refers to acts of omission, is also referred to as a form of abuse. Abuse is what happens to a child. Harm to a child is the result of the abuse they experience. The *Child Protection Act 1999*, section 9, defines harm to a child as any detrimental effect of a significant nature on a child's physical, psychological or emotional wellbeing. The relationship between abuse and harm is illustrated by examples in Table 1.

Table 1: Relationship between abuse and harm

Types of abuse (actions/behaviours by parent/carer)	**Physical**	**Emotional**	**Sexual**	**Neglect**
	Hitting Punching Scalding Domestic and family violence	Scapegoating Rejection Persistent hostility Domestic and family violence	Penetration Sexual exploitation Exposure to pornography	Failure to attend to medical needs Poor hygiene/nutrition Inadequate supervision

Resulting harm *(impact experienced by the child)*	**Physical *(refers to the body)***	**Emotional *(refers to the ability to express emotions)***	**Psychological *(refers to the mind and cognitive processes)***
	Bruising Fractures Internal injuries Burns	Depression Hypervigilance Poor self esteem Self-harm	Learning and developmental delays Disorganised attachment Impaired self-image

Cumulative harm

Harm can be the result of a single act, omission or circumstance, or a series of acts, omissions or circumstances. The latter is referred to as 'cumulative harm', which occurs when a child has been harmed (or is at risk of harm) because of:

- an ongoing, adverse event or circumstance in their life (for example, ongoing neglect)
- an accumulation of adverse circumstances (for example, experiences of neglect, inconsistent and harsh discipline, exposure to harm).

Assessing cumulative harm requires a focus on the cumulative impact of recurring conditions, circumstances or incidents, which may not have met the threshold for tertiary child protection involvement previously. These conditions, circumstances or incidents may be the same in nature, such as ongoing neglect, or may be comprised of different abuse types.

Risk assessment and immediate safety

Risk assessment is a process that is focused on forming a professional judgement about the likelihood or probability that a child will suffer significant physical, psychological or emotional harm in the future, if nothing changes. Risk assessments are particular to a child, with a specific focus on identifying the likelihood and severity of future harm. Assessing a child's immediate safety has a focus on identifying factors that place a child in immediate danger. These are referred to as 'immediate harm indicators' and are identified through the completion of the SDM safety assessment.

Risk and protective factors

Factors that increase risk to a child are referred to as risk factors. Research has identified that risk factors are found more often in families where harm has occurred than in the general population.

Risk factors may be static or dynamic. A static risk factor is a one that doesn't change. For example, a person having a criminal history or child protection history is a static risk factor. Dynamic risk factors are risk factors that change over time. For example, low birth weight ceases to be a risk factor for abuse and neglect after a child attains one year of age.

Protective factors are attributes or conditions that mitigate the risk of harm to the child. A protective factor can influence the extent to which one or multiple risk factors can be mitigated. Where a protective factor is identified within a family, it must be verified before it can be assessed as mitigating or reducing identified risk.

For an Aboriginal or Torres Strait Islander child, worker bias can be reduced by understanding the lens through which the assessment is made and should be done through a full and proper assessment of strengths, needs and risks. Open and honest discussion about these factors with persons recognised as having cultural authority can promote collaborative practice and better decision-making based on actual, rather than perceived risk.

When identifying and considering risk and protective factors, it is important to be aware that:

- risk factors may exist among families where child abuse and neglect occur, this does not mean that the presence of these factors necessarily leads to child abuse or neglect
- an awareness of factors that contribute to risk or protection alone does not enable us to predict outcomes for a child (i.e. there is always uncertainty in child protection). Therefore, risk and protective factors need to be analysed to understand what they mean for the particular child, in their particular circumstances
- a strength is not the same as a protective factor. A strength can be harnessed to support future positive change but does not provide safety. A protective factor mitigates the risk of harm to a child. For example, a caregiver/parent asking for help or expressing a desire to want to change harmful behaviour is a strength, but it does not offer the child safety or mitigate the risk of harm unless the caregiver/parent accesses support and this results in meaningful, sustained change. It is important to be aware of disguised compliance when considering whether a caregiver/parent's behaviour is a strength or a protective factor. Disguised compliance is where a caregiver/parent gives the appearance of cooperation to avoid raising suspicion and to allay concern.

Refer to **Table 1 - Risk and protective factors** (page 65) for further information.

Process for risk assessment

Undertaking risk assessment in FaCC and IFS is not an additional task and should form part of our work with families. The purpose of a risk assessment is to begin to explore and understand the risk factors and safety needs of the child to help inform an effective response, that is, we need to understand the risks to know how to reduce them. Risk assessment informs how worried we should be about a family and helps to inform the harm/worry statements in the Collaborative Assessment and Planning (CAP) framework.

Every assessment is unique to a child and family and no checklist can be applied to all situations. The process involves workers remaining open-minded, while applying their professional, evidence-based knowledge and critical thinking to the child and family's particular situation and circumstances - *what is the likelihood of future significant harm for this child in this family?* It is not about what action is needed or what impact intervention may have – it is about the level and likelihood of future harm.

The four-stage process of risk assessment includes:

1. What is the purpose of the assessment?
2. Gather all relevant information
3. Analyse the information
4. Form a professional assessment

1. What is the purpose of the assessment?

Every assessment helps to inform a decision and if we are unclear about the decision we need to make, the assessment process will be impacted from the start. Therefore, to begin the process, workers should clarify the purpose of the assessment. Being clear about the purpose of the assessment is important because it helps the worker to reflect on what information might be needed and from what sources and decide the relevant issues to focus on.

If the assessment relates to an Aboriginal or Torres Strait Islander child, actively seek to involve an Aboriginal or Torres Strait Islander person with cultural authority who can provide cultural support and guidance to help clarify the matters relevant to the assessment and assist with facilitating the child and family's participation in the process.

The purpose of the assessment will impact on the extent of assessment undertaken. A comprehensive analysis of risk would likely occur for FaCC in Active Engagement (Response type 4) cases and a majority of IFS cases.

For example, for FaCC:

- *At referral*: brief assessment is made on receipt of a FaCC referral to determine if it meets referral criteria, look for any immediate risks (and whether these risks can be safely managed by FaCC) and determine response priority)
- *During engagement*: Does new information gathered during work with the family indicate that the child may need protection and require reporting to Child Safety?
- *During FaCC assessment (for Response type 4 – Active engagement):* Can the risks identified be managed by a referral to a less intensive support service or is a referral to IFS required to address the multiple and complex needs of the family?

For IFS:

- *At referral* - brief assessment is made on receipt of a referral to determine if it meets referral criteria, look for any immediate risks (and whether these risks can be safely managed by IFS) and determine response priority
- *During collaborative case planning*: Are there risks that must be included in the case plan to reduce the risk of future harm to the child/ren?
- *At case plan review*: Have some of the identified risks been addressed and are no longer impacting on the safety of the child/ren?
- *At closure*: Has the risk of future harm reduced such that Intensive Family Support can cease involvement with the family?

2. Gather all the relevant information

Once we are clear about the purpose of the assessment, the relevant information should be gathered in relation to the child; the caregiver/parents; the environment; the harm and abuse; the family and cultural context. This will enable the worker to identify the presence of factors that increase risk to the child/ren (what we are worried about) and the acts of protection/strengths and resources that mitigate against risk (what is going well).

The information to be gathered is unique to each assessment and specific to the decision that needs to be made. Depending on the purpose of the assessment the information may be gathered by:

- hearing the voice of and having purposeful interactions with the child, parents and family
- speaking with others who know about the child's situation
- requesting and sharing information with government and non-government agencies who are providing services or support to the child or caregiver/parents.
- directly observing and assessing of the quality of interactions between the child, caregiver/parents and others within the environment.

FaCC and IFS services operate on a voluntary engagement basis and therefore client consent is required before information can be shared or sought from other agencies or service providers. Further information regarding consent-based engagement and information sharing can be found in the FaCC and IFS Model and Guidelines.

On a case-by-case basis, consider what additional knowledge may be needed to help inform the assessment and who might be an appropriate source of professional knowledge. This may include professional knowledge or cultural knowledge. For example, seeking further information about the family's child protection history from the department through your Principal Child Protection Practitioner (PCPP) or seeking to understand cultural factors through Aboriginal and/or Torres Strait Islander practitioners in services and including the voices of those with cultural authority for an Aboriginal or Torres Strait Islander child. Cultural factors may include, for example, traditional child rearing practices or kinship structures for an Aboriginal or Torres Strait Islander child.

3. Analyse the information

This stage of the process requires the identification of risk and protective factors from the information that has been gathered, which are then analysed in the context of the child's situation to establish the interaction between them (refer to *Table of risk and protective factors below*).

Multiple risk factors may increase the likelihood of harm occurring, while the presence of protective factors may decrease the likelihood of harm occurring. For example, a parent's young age is considered a risk factor, however if that young parent resides with supportive and safe adults who are assisting with the infant's care, the infant may not be at increased risk. However, an infant is at

increased risk if they have a young parent who is also experiencing housing instability and abusing substances.

Analysis requires the application of critical thinking and exploring, and professional knowledge. It is not just about stating the information or considering risk and protective factors in isolation of one and other. Instead, it is about considering what the information means collectively for the particular child, in their particular situation. Consider:

- What is more likely to occur in the future, rather than less likely?
- What are adults/caregivers more likely to do/not do? When, where, and why?
- What is the child likely to experience? When, where, and why?
- What do you think will activate or trigger this future harm playing out? Think about people, place, time, certain events/situations/circumstances
- What do you think will prevent/inhibit this risk of future harm playing out? Think about people, place, time, certain events/situations/circumstances.

When analysing the information to understand and determine the risk and impact on the child:

- consider whether information that has been provided by the person we're worried about has been verified and if not, make all attempts to check the information for validity.
- consider the information about the child, their family and situation with what is known from research and practice experience.
- recognise indicators of harm, which may be physical, psychological or emotional. Consider that certain types of harm may not be observable until a later stage in the child's development
- distinguish a caregiver/parent's intention or motivation to safely care for and protect a child from demonstrated behaviour. Seek and verify examples of acts of protection.
- look for patterns of behaviour, including abuse and neglect, or protection. This helps to understand likelihood of future harm, i.e., is it possible or probable?
- recognise risk and protective factors, vulnerabilities and strengths, can be static or fixed – it's the dynamic variables (the ones that can change) that need to be tracked
- ensure each individual child's voice has been heard and they are visible
- consider information in the context of cultural knowledge and relevant cultural factors[29]

To assist to organise and analyse the information you have gathered, a Risk Assessment Analysis template is available to download from the FaCC and IFS secure sub-site which groups information into four quadrants: a child's vulnerability; the impact on the child; safety and probability.

4. Form a professional assessment

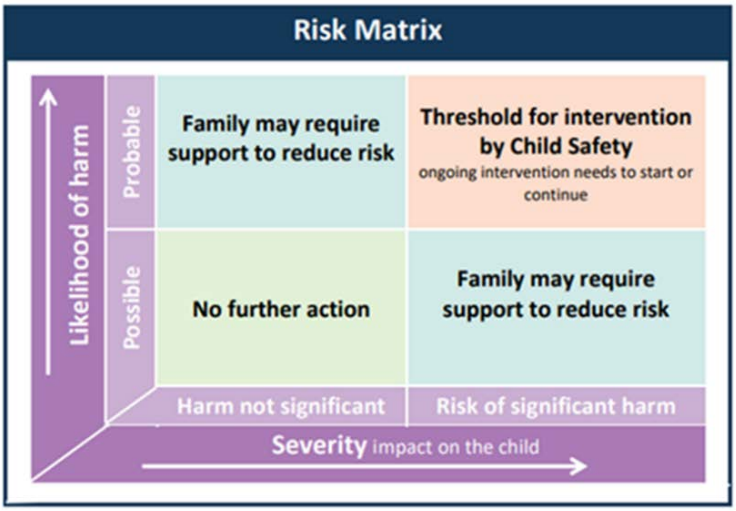
A professional assessment is formed by synthesising (bringing together) the analysis to determine the overall assessment of harm and risk of harm to a child. Although FaCC and IFS workers are not responsible for assessing outcomes in relation to whether a child is in need of protection (i.e. *the child has been harmed/at risk of harm AND does not have a parent able and willing*) it is important that workers are clear about the risk factors for that child so that these factors can be articulated and addressed as appropriate.

It is also important that FaCC and IFS workers understand departmental thresholds around risk of harm. Assessment about risk of harm is formed by bringing together the analysis of the information, with a particular focus on determining the *severity* and *likelihood* of future harm. The risk matrix (Figure 2 below) is used by the department and may be useful for FaCC/IFS services to understand

[29] Refer to snaicc_stronger_safer_together_report.pdf (dss.gov.au) for information about understanding strengths of Aboriginal and Torres Strait Islander child rearing practices, p29.

thresholds and when it is considered appropriate for referrals to be made to the secondary service sector.

Figure 2: Risk matrix



To use the Risk matrix:

- Identify the assessment of severity on the horizontal axis. This will be either: not significant, meaning that the child wouldn't be impacted, or they would be impacted, but the impact would not have a detrimental effect of a significant nature OR significant, meaning that the statutory threshold for harm would be reached.
- Identify the assessment of likelihood on the vertical axis. This will have been either: possible, meaning that harm may occur, but it is not likely OR probable, meaning that on the balance of probability, it is more likely than not that the child will experience harm.
- Identify the quadrant that corresponds with the assessment of severity and likelihood.

The Risk matrix provides three options:

1. **Threshold for intervention by Child Safety** – this quadrant reflects outcomes which suggest the child is in need of protection. Where the severity is assessed as significant, and the likelihood assessed as probable, ongoing intervention by Child Safety needs to occur. *Note: If during your assessment you conclude that the risk to the children falls within this quadrant, if possible, consult with your PCPP and decide if a report to Child Safety is required.*
2. **Family may require support to reduce risk** – this quadrant reflects the risk that is appropriately managed within the secondary family support sector, particularly Intensive Family Support. *Note: if your assessment of the family's circumstances falls within this quadrant, continue to work with the family to reduce the identified risks to a child and reduce the likelihood of escalation to the child protection system.*
3. **No further action** – there is minimal to no likelihood of future significant harm to a child, and therefore no further action needs to be taken. *Note: If your assessment of the family's circumstances falls within this quadrant, an intensive service like IFS may not be required and consideration should be given to a referral to less intensive family support services.*

Document

The full Collaborative Assessment and Planning framework or the 'Skinny CAP" can be used to document harm and risk of harm as well as the acts of protection/strengths and resources. If you have used the risk assessment analysis template, this should be attached to ARC. Your assessment can also be documented in your case plan, a case note, or referral documents.

Revise the assessment

An assessment of harm and risk of harm is a point-in-time assessment. Therefore, when a child or family's circumstances change or new information becomes available, then your assessment may change, and an updated assessment will be required to ascertain if or how the new information alters the risk and/or safety concerns. Begin the assessment process again, incorporating new information, analysing the child's situation in the context of their changed circumstances and document your new assessment.

Table 1 - Risk and Protective Factors

HARM/ABUSE FACTORS
Current injury/physical harm or condition is severe • The more severe an injury or condition, the more significant the impact is on child and the greater likelihood of future harm. • Multiple and/or recurring injuries are more likely to cause significant harm and indicate increased future risk of harm. • For infants, any incidents or evidence of shaking or other signs of injury or failure to thrive is significant. • For a child of any age, the location of injuries can increase the severity of the physical harm. For example, injuries to the head or face are more serious due to the potential for permanent brain, eye and ear damage. • Internal physical injuries may not be obvious. Behaviours such as flinching or a young child who is unable to be consoled/settled may indicate any underlying injury, however, there may also be no obvious or observable signs
Inconsistent explanations, denial or minimisation of harm by a caregiver/parent • When a caregiver/parent minimises current harm, justifies the abuse, cannot recognize or denies responsibility for the harm, this may lead to increased risk of harm. It may also suggest a non-accidental injury. • If the caregiver/parent minimises a child's physical injuries or illness and fails to seek medical attention, a child's condition can worsen causing further physical harm or death. • If a caregiver/parent is unable to accept or acknowledge how their actions have caused harm, the abuse is more likely to continue and have a cumulative effect, resulting in emotional or physical harm.
There is previous departmental history • Risk of harm increases if harm has previously been substantiated. In addition to any substantiated harm, all previous history including child concern reports, and unsubstantiated investigation and assessments should also be considered and critically reviewed; any record of concern may indicate cumulative harm. • A child may exhibit a variety of behaviours to indicate they have been significantly impacted by any previous concerns, such as being shy, withdrawn, exhibiting uncommunicative behaviours; hyperactivity, aggression, regressive behaviours; developmental delays; behaviours associated with anxiety or depression. These may be indicators of emotional harm. • If a caregiver/parent has been identified as a 'person responsible' for harm to a child in the past, it is more likely that harm will reoccur; either to that child, another child and/or the harm may become cumulative, unless significant positive and sustained changes have occurred in the relationship between the child and caregiver/parent and any other children in the family, the caregiver/parent's behaviour or caregiver/parenting skills or the family environment.
The pattern of harm is escalating • The harm is escalating over time, increasing in severity and/or frequency. • Previous concerns may relate to a different harm type to the current concerns and *all* past harm should be considered. • Consider all child protection history and information from other sources (for example family and network members, police, medical practitioners, school) so the pattern of harm can be better understood.

The pattern of harm is continuing but not escalating

- The more often harm has occurred in the past, the more likely it is to occur again in the future. Pattern of harm may be well established and have been occurring in the same way for a long period of time. Where harm has been occurring for longer periods of time, the behaviour is more likely to continue and the resultant (possibly cumulative) impacts are more significant. Behavioural patterns that have been in place for some time are more difficult to change and therefore, more likely continue (without intervention).
- Consider all past reports of harm, including those that did not meet the threshold for a notification or substantiation to determine future risk of harm and identify cumulative harm.

Perpetrator's access to the child

- The risk of harm occurring is increased if the alleged person responsible has access to the child.
- Research suggests that sexual abuse can be compulsive or addictive - people with a history of sexual offences against children have a high rate of recidivism.
- A child is more likely to be harmed if a person who is alleged to have sexually abused a child, is reasonably suspected of having sexually abused a child or has been convicted of perpetrating sexual offences against children has unlimited or unfettered access to a child.

The caregiver/parent has made a threat to cause serious harm to the child

- A caregiver/parent may make threats to harm the child, another family member or a pet. Threats involving weapons or implements increases the likelihood of emotional harm and where weapons or implements are accessible for the threat to be carried out, there is increased risk of physical harm, including death.
- Where the pattern of coercive control by a perpetrator of domestic violence includes threats, there is an increased risk of lethality, and well as physical and emotional harm.
- A child living in a fearful state due to threatening behaviour may exhibit withdrawal, regression, bedwetting and soiling, sleep disturbances, nightmares fearful responses, anxiety/agitation/hypervigilance or externalised emotional distress such as aggression. These may be indicators of emotional harm which may be cumulative in nature.

Chronic neglect is identified

- Chronic neglect has a cumulative impact on a child's functioning and their future emotional, behavioural, cognitive, social and physical development and well-being. The likelihood of neglect having an acute or cumulative impact on the child is increased by anything that stretches or places pressure on household resources or the caregiver/parents capacity (including their ability, availability and responsiveness); making it more difficult for the needs of child/ren to be met, contributing to or leading to neglect. This may include:
    - the number of children in the home with more children potentially placing increased demand on the caregiver/parents' capacity and household resources
    - the age of the children, with younger children (for example) requiring more of the caregiver/parents' time and attention for their care and supervision
    - the needs of the children where complex or challenging needs place increased demand on the caregiver/parents' capacity, time and resources,
- the caregiver/parents' capacity and availability may be limited or depleted by the impacts of coercive control in domestic and family violence situations, substance abuse or mental health concerns, poverty.

CHILD FACTORS	
Risk factors	**Protective factors**
Infant aged under 12 months • Infants are more vulnerable due to their dependency on their caregiver/parent for all their needs. • Risk of harm also increases if the infant: ➢ has been the subject child in a notification, including unborn. ➢ is the result of an unplanned pregnancy ➢ is born prematurely/drug dependent/subject to birth complications ➢ is of low birth weight ➢ has poor sleeping and/or feeding patterns; or ➢ has an illness or disability. • Rough or unsafe handling, slapping, kicking, pinching, or shaking can all result in significant physical harm or death. Shaking may result in physical harm causing brain damage, even without any external signs of injury. • If an infant is showing signs of or is diagnosed as 'failing to thrive' (resulting from neglect or other causes), a delayed response can result in significant illness, physical harm or death. Failure to obtain medical attention may result in physical harm. Poor attachment and lack of bonding may result in neglect of the child, rejection, scapegoating, or harsh discipline, resulting in physical or emotional harm.	**The child has skills and abilities that may provide a degree of self-protection** • To assess a child's capacity to protect themselves from harm, the type of harm and overall impact on the child needs to be considered. While children aged around 10 years and over are more likely to have problem solving and social skills and abilities, the impact of any previous trauma, special needs such as developmental delays, or learning/intellectual/physical disability must be considered. • The child's ability to remove themselves or seek assistance may be considered a protective factor in relation to physical harm, however, even though this may mean they can avoid physical injury, it is not the child's responsibility to protect themselves from harm. Where a child holds responsibility beyond their capacity or beyond what could be considered appropriate or reasonable, they may be at risk of emotional harm due to undue stress and responsibility. • Some measure of safety may be possible where the child has capacity to participate in and action a safety plan, with a safety and support network. This means that action is taken before a child is harmed. Seeking help during or after an incident that may have caused or contributed to further harm to a child is not a protective factor.
Unsafe sleeping practices • Unsafe sleeping practices are linked to infant deaths. Unsafe practices include: ➢ co-sleeping with a caregiver/parent affected by drugs (including some prescribed drugs) or alcohol ➢ ill-fitting mattress and bedding. ➢ cluttered cots - soft toys and pillows that can cover an infant's face. • For further information, refer to the Queensland Government website Safe sleeping (health.qld.gov.au)	**The child has an effective safety and support network, is monitored through these supports and has positive relationships with significant others** • The child has a safety and support network of significant people and professionals (such as school, day care, health staff), who know everything about the situation and are able to provide effective support to a caregiver/parent to safely care for an protect the child through actioning an agreed safety plan. Open, clear communication about expectations, roles and responsibilities is necessary if the

	safety and support network is to undertake an effective role in keeping the child safe. • A child may only seek protection from harm if there is a positive relationship within the safety and support network and the child has a sense of belonging to that environment. • Encouraging positive relationships and supporting this contact may counteract risk of harm as it assists the child in accessing already available supports.
Child aged under 5 years increases vulnerability • Children aged under 5 years are more vulnerable to harm as they are: ➢ reliant on their caregiver/parent to attend to their needs ➢ less verbal and are often less able to communicate their needs. Younger children will have limited expressive language and limited ability to communicate with adults and others outside the home or family (both in their independent access to other adults and in their communication ability) ➢ less able to seek assistance independently and/or may be isolated from others who may act protectively or could assist in meeting their needs or intervening for their safety and wellbeing. ➢ may display behaviour that challenges a caregiver/parent, causing the caregiver/parent to feel stressed and frustrated.	**Child with a strong sense of personal control** • A child may demonstrate a belief that they can control the impact of harm that has occurred, rather than the harm controlling them. Risk of harm may be mitigated if the child presents as resilient, autonomous, mature, can plan ahead, and is not dependent on others to find solutions to problems. • Characteristics of resiliency within a child may act to prevent the internalisation of the impacts of harm such as depression and anxiety. As indicated above, however, this should be considered careful as the impacts of having a high sense of responsibility on a child may also be harmful.
The child has diagnosed or apparent needs which increases their vulnerability such as developmental delays, physical or intellectual disability, medical concerns • Stresses and higher demands of managing daily care needs can affect the caregiver/parent's ability to meet the needs of the child, impacting on caregiver/parent-child attachment; communication; mobility and ability to access basic needs or supports both inside and outside the home. A child with more than one disability is at greater risk of harm, and the level of harm is also likely to be more severe and chronic.	**Connection to culture** • Strong connection to culture can promote a child's resilience. • There may be cultural factors that promote a child's health, safety and wellbeing, for example the presence of safe and effective kinship networks, an ability to engage in traditional food sourcing practices or customs that increase a child's sense of worth and place within their family. • Risk of harm to a child with strong cultural connections may be mitigated due to the child having developed strong resilience and having trusted community members to provide safety, guide and support them.

• A child with a disability or increased vulnerability may be: ➢ unable to communicate their concerns or disclose harm ➢ unable to protect themselves ➢ isolated and unable to access safe adults ➢ dependent on other people including people responsible for harm ➢ less likely to receive education on sex and personal boundaries, therefore less likely to understand or recognise this type of abuse.	
Adverse childhood experiences and past trauma • Any child who has experienced trauma, resulting in traumatic stress, is more vulnerable to harm (regardless of how the trauma was caused) and has decreased ability to protect themselves. They may be more likely to be significantly affected by any abuse or neglect they experience. Adverse childhood experiences contribute to disrupted neurodevelopment and can lead to social, emotional and cognitive impairment. This can manifest later in development in the adoption of health-risk behaviours, contributing to disease, disability and social problems and associated with early death or shortened lifespan. For further information about Adverse Childhood Experiences (ACEs), refer to the Emerging Minds website Adverse childhood experiences (ACEs) toolkit - Emerging Minds	
High risk behaviours • High risk behaviours can be related to any harm type and the behaviour may be an attempt to cope with the impacts of harm (including cumulative harm) or a way of expressing distress or unmet needs. High risk behaviours may include (but are not limited to): ➢ self-harming (for example cutting or burning) ➢ suicidal threats or behaviours ➢ substance misuse and sexually reactive or sexually abusive behaviours • The vulnerability of a young person who is engaging in high risk behaviour is heightened. Their capacity to protect	

themselves should not be over-estimated or assessed on their age or stage of development alone, but in the context of their mental and emotional functioning. • High risk behaviours can be the result of harm and can contribute to increased risk of harm. This may be due to increased caregiver/parental stressors in responding to these behaviours and/or conflict with the child and disruption of the caregiver/parent-child relationship. For children engage in high-risk behaviours, the caregiver/parent may be willing to protect the child or young person but not be able to, for example when the behaviours occur outside the home, due to the young person's physical strength and use of threat and/or violence.	
Youth Justice involvement or offending behaviour • Young people who have experienced abuse or neglect are at increased risk of offending, particularly when the abuse or neglect begins or continues into adolescence. • Other factors that may lead to offending behaviour include homelessness, anti-social or violent tendencies, developmental delays, reduced resilience, or poor impulse control. Children may engage in offending behaviour as a result of peer or social influences, developmentally related to changing influence of social and peers or to feel a sense of belonging and acceptance within a peer group. • Children engaging in offending behaviour, in particular children aged 12 and under, may have needs that are neglected or not adequately met by their caregiver/parent that could otherwise deter or redirect them from the offending.	
CAREGIVER/PARENT FACTORS	
Risk Factors	Protective factors
A caregiver/parent is refusing access to the child or the family is likely to flee • If a caregiver/parent is refusing access to a child, it may be to avoid further assessment of notified harms	**The caregiver/parent acknowledges harm to the child, takes responsibility for change, seeks appropriate treatment and assistance and/or has the capacity to prevent future harm**

	• A caregiver/parent who acknowledges their role in a harmful incident or condition and takes responsibility for their actions, may be more willing to engage with appropriate supports and work to change the harmful circumstances to ensure the future safety of the child. However, a caregiver/parent does not need to make an admission regarding harm to a child in order for them to act protectively and address the child protection concerns. Conversely, admission alone is not a protective factor. • A caregiver/parent's views on the harm needs to be considered as part of the broader risk assessment. In assessing their actual capacity to prevent future harm, their ability to protect must be assessed with particular emphasis on any impediments to that ability (for example, substance misuse, domestic and family violence, Family Court residency and contact orders). • If a caregiver/parent is providing an accurate account of how the injury or condition occurred and is seeking treatment and support for the child, this may indicate awareness and a degree of acknowledgement of the significance of the harm and risk of future harm. • Where appropriate and timely treatment or assistance is sought, the circumstances are more likely to change and reduce the likelihood of future harm.
Issues in the caregiver/parent-child relationship and connection • Where the relationship between the child and the caregiver/parent is absent, disrupted, disordered or under stress, the risk of harm is increased. • Secure attachment occurs when a primary carer provides consistent care and is responsive to the needs of the child - with a critical time for the development of secure attachment being from around six to eighteen months of age. • If a caregiver/parent is unable or does not respond to the child's needs, insecure attachment results, with a child showing avoidance or ambivalence to the caregiver/parent and others.	**Secure attachment between the caregiver/parent and child** • A secure attachment supports a child's healthy brain development, and social and emotional development, and helps a child to learn to regulate their emotions.

• Disorganised attachment is evident in some children who have suffered harm through impacts of chronic family violence, or whose caregiver misuses substances. Disorganised attachment in infancy has been linked to complex trauma and a higher risk of behaviour problems in later childhood, adolescence and adulthood.	
Caregiver/parental expectations of the child are unrealistic • A caregiver/parent may not recognise or be aware of developmental milestones and appropriate behaviour and disciplining techniques consistent with the age and developmental phase of their child. The caregiver/parent may place unrealistic expectations on the child physically, emotionally or psychologically or may find it difficult to recognise and respond to needs or challenges for the child's healthy development. • Where a caregiver/parent's expectations do not align with the child's actual or expected milestones, this may cause or contribute to caregiver stress. A child may have delayed access to early intervention to assist them in meeting development milestones if a caregiver/parent is unwilling or unaware of the child's support and intervention needs. • A child may be given responsibility to care for themselves and/or younger siblings beyond their capacity and maturity. Conversely, a child may be restricted from participating in age appropriate activities due to the caregiver's underestimation of what could be reasonable for a child of that age and development. *Note: Aboriginal and Torres Strait Islander child rearing practices and kinship systems can mean the roles and responsibilities for children differ from non-Indigenous definitions of family. Children and young people may take on responsibility in their family and community at a young age; such as caring for siblings or extended family members. This responsibility is determined by the family based on the need and the child's ability, and less likely to be related to the child's age.*	**A caregiver/parent has an effective and responsive safety and support network** • Secure and supportive relationships with other significant people may buffer against the effects of stress and facilitate positive coping strategies. • For example, where parent-adolescent conflict exists, a parent who has a positive relationship with extended family members may be able to access support and assistance prior to conflict occurring, including arranging family supports for the young person.

Young parental age or immaturity • Risk of harm generally increases for parents who lack maturity and emotional intelligence, acquired parenting knowledge and/or are less able to tolerate stress. These factors are not unique to young parents, however, given their less mature developmental phase these factors are often present for young parents, particularly those who have their first child when they are a teenager. • Young parental age may also correlate with other risk factors such as lower educational achievement, lower self-esteem, substance misuse and housing and financial pressures. Young parents social support systems are less likely to include peers and social interactions that are focused on or compatible with caregiving responsibilities.	
A caregiver/parent is impulsive • Research indicates that caregiver/parent who has poor impulse control may be more likely to engage in inappropriate caregiving practices such as negative comments, physical threats or physical behaviour management practices. There are numerous causes and contributing factors to impulsivity and this may also link to gambling, drug and alcohol use, or anger management which also impact on caregiving capacity.	
Lack of ability and willingness to prioritise the child's needs over their own • Immaturity and psychological or cognitive issues can impact on a caregiver/parent's ability to tend to the needs of a child over their own needs and wishes. • Substance abuse may impact on the caregiver/parents' ability to provide basic care to a child as their addiction makes it more difficult to attend to and respond to the needs of the child as a priority. • Coercive control may make it more difficult to recognize acts of protection by the survivor of domestic and family violence. It may appear that they are prioritizing the relationship with the perpetrator over the needs and well being of the children, therefore a full understanding of the perpetrator pattern and the full range of the	

survivor's protection is necessary to understand the potential harm and future risk of harm.	
A caregiver/parent's behaviour is violent and/or controlling • A person who uses violence (physical force) in any context is more likely to cause physical harm a child. • Use of violence contributes to the perpetrators ability to exert ongoing power and control over family members. Threats of violence may also indicate a likelihood of actual violence in the future. • Threat of violence may be a 'once off' however the resulting harm from ongoing fear can be cumulative. • Coercive control, even in the absence of physical violence or threats, increases the risk of harm to the child. • Domestic and family violence can limit a caregiver/parent's ability to meet a child's needs; or exacerbate existing concerns (such as substance use or mental health concerns). • If a child lives in a fearful environment and experiences their caregiver/parent being physical or verbally abused, the child may become wary of adults; overly compliant; experience mental health conditions, resulting in emotional harm.	
The caregiver/parent has experienced childhood abuse • Caregiver/parenting skills are believed to largely be learned/modelled from childhood experiences. The intergenerational transmission of abuse occurs when caregiver/parents who have been physically, emotionally or psychologically harmed as children use harmful caregiver/parenting behaviours on their own children. Childhood abuse may skew or diminish their perspectives of their own caregiver/parenting and impacts on their child. In their own caregiving, they may repeat the patterns of behaviour they experienced. • Caregiver/parents may also engage in other harmful caregiving strategies in an attempt to prevent or avoid repeating the patterns of their own childhood. For	

example, a caregiver/parent may isolate the child for fear that they will be sexually abused, preventing the child from accessing medical treatment or education.	
FAMILY	
Risk factors	**Protective Factors**
There is domestic and family violence • Any child with a caregiver/parent who has experienced domestic and family violence will be impacted in some way, considering the multiple pathways to harm caused by domestic and family violence. They may experience their caregiver/parent being physically abused, caregiver injuries, property damage, threats and manipulation, and/or intervening or experiencing harm from physical assaults and property damage. • A non-offending caregiver/parent's ability to protect and to meet a child's needs can be impacted by violence and coercion perpetrated by a partner or other family members. • The non-offending caregiver/parent may be or appear to be unable to act protectively due to the coercive control and violence, for example the perpetrator has made threats of murder or suicide if the non-offending caregiver/parent attempts to leave with the children. • The non-offending caregiver/parent may over-discipline a child in an attempt to control the child's behaviour and protect them from the perpetrator's violent and controlling behaviour.	**There is another safe adult actively involved, present and accessible who is able and willing to protect the child** • Consider the frequency and regularity of the child's contact with the protective person when assessing whether their involvement may reduce the future risk of harm. Another safe adults' involvement and presence may decrease the risk of physical harm and provide a positive role model for the person responsible for harm. • A protective person is someone who: ➢ is aware of the harm and wants to protect the child ➢ understands how harm occurred and acknowledges any likelihood of future harm ➢ does not pose a risk to the child themselves ➢ possesses significant influence with the child and their caregiver/parent ➢ will be able to effectively protect the child from the identified harm or risk of harm by their presence.
The family is experiencing a high degree of stress • Research indicates that increased stress for a family (and caregiver/parent) increases the likelihood of future harm for a child. • Family stressors may include separation/divorce; financial issues; physical or emotional isolation; health issues; and grief and loss. Larger numbers of children in a family or multiple births may also lead to increased stresses.	**There are clear household boundaries, routines and structure** Predictable routines can mitigate against chaotic stress and provide a sense of security to the child, promoting connection and well-being and supporting behaviour and household management, reducing caregiver/parental and household stress

The family is highly mobile • A highly mobile family decreases the opportunity for effective interventions to be established, increasing the likelihood of future harm to the child. It may be difficult to access historical or current information that helps inform the assessment as information may be lost or difficult to locate or access. Impacts for the child of high mobility may include disrupted education resulting in cumulative harm, isolation and disruption to peer and family relationships and basic materials need not being met.	
Single caregiver/parent family • Being a sole or single caregiver/parent is not in itself a risk factor but may be when other factors are present in the family. Research has identified single caregiver/parents face increased financial pressures, higher stress levels and isolation, often with less access to emotional and social supports. • When there is only one caregiver/parent, the care responsibilities fall to one person which can be associated with increased risk. Caregiver/parental stressors may lead to anxiety, depression and emotional issues, impacting on their ability to appropriately care and meet the needs of a child which may result in physical or emotional harm, including as a result of neglect. • The caregiver/parent may become a sole caregiver/parent because of separation, divorce or death of a partner, placing further stresses on the family through loss and grief.	
ENVIRONMENTAL	
Risk factors	**Protective factors**
The physical and social environment is chaotic, hazardous, and unsafe • A chaotic, unhygienic, unsafe environment can pose a risk to a child's health or safety. Exposure to bacteria or disease or hazards and heights may result in illness or injury causing physical harm. A child's social environment may hazardous due to the caregiver/parent's functioning and behaviour which directly contributes to the	**The family is supported by a safety and support network** • Contact with another professional or community agency may reduce caregiver/parental stress and increase their ability to cope. A professional support network may act to improve the family's functioning and reduce the likelihood and severity of future harm by enabling access to housing, income and support services.

environment being unsafe, unhygienic, or chaotic and risk of harm is increased. • Risk of harm will also depend on what safety strategies have been put in place by the caregiver/parent to protect the child in this environment. *Note: In some areas, housing may be limited and yet adequate by community standards. If community living conditions are not related to inadequate caregiver/parental provision of basic care, consider a referral to other relevant council or government services.*	• Where non-professionals, family and community members are actively supporting a family, this can also ameliorate stress, improve support, wellbeing and family functioning to reduce the likelihood of future harm. To be able to take protective action to mitigate risk, members of the network must be aware, available and able to take action and intervene in relation to the risk of harm.
Poor social networks and isolation from services • A lack of services; inability to access infrastructure such as parks, transport, shops, schools and child care; and low levels of social support can heighten the probability of harm as the child may not engaging in the community and intervention is not available. A child who is isolated may experience any type of harm, which may continue due to the absence of intervention and support resulting in cumulative harm. • Social isolation may be more prevalent in rural and remote areas, and for families of minority or marginalized groups. For example, post-natal care, and educational and child care facilities cannot be accessed, resulting in neglect of the child and subsequent developmental delays and associated harms.	**Adequate income and housing** • Fewer stresses by having basic housing and income can decrease anxiety, increase self-worth, support caregiver/parent-child relationships and buffer emotional harm and neglect.
Poverty impacting on food insecurity, employment opportunities and/or housing stability and homelessness • Poverty and unemployment may be linked to residing in a disadvantaged community, with associated inability to access services and locate and afford adequate housing. • Linked to low family income and other stressors, housing instability can impact on the child's learning, social and developmental needs. Housing instability and food insecurity may be the result of a caregiver/parent leaving a violent partner or household member - an action taken to protect the child.	Connection to culture or religion • Children, parents and families who experience a meaningful connect to their culture or religion can mitigate against harm through increased sense of worth and belonging, access to community/neighborhood supports and access to people and opportunities for cultural practices that support emotional wellbeing. For example, an Aboriginal mother residing in community may connect with a trusted elder and use traditional bush medicine to support her healing. These practices increase her feelings of wellness and ability to meet the needs of her child.

Cultural context • Cultural or religious beliefs or practices may be associated with behaviour that results in significant harm to the child. When assessing harm and risk of harm, information about the culture, beliefs, values and practices for the child and family should be obtained from the family and/or community with cultural knowledge and authority. • Where the harm is related to cultural or religious beliefs or practice and the behaviour is linked to the caregiver/parents' core values and beliefs, it is less likely they will recognise the behaviour as harmful, more likely they will justify or excuse the harm for cultural or religious grounds, and more likely that the behaviour will continue.	
Non-biological parent • The presence of a step-parent or a person undertaking a caregiving role as the partner of the parent can be a risk factor across all harm types. There is an increased risk of emotional abuse due to behaviours such as scapegoating or rejection, increased risk of sexual abuse and physical and emotional harm caused by a step-parent and increased risk of physical harm due to assault by a non-relative. Causal factors may relate to bonding and attachment issues, less sensitive care giving, poorer quality of interactions, and viewing caregiving as burdensome or not their role. • While a female partner may also cause harm to their partners child, research indicates that male partners are more likely to be responsible for harm.	

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Appendix 7 – Collaborative case planning process

This step-by-step process is designed to help scaffold the complex process of collaborative case planning. **It is not a prescriptive process,** and you will need to be flexible with how you work through each step, considering the individual needs of each family so that they are able to participate in the case planning process to the greatest possible extent.

Cultural considerations need to be at the forefront of case planning with families and will determine how the case plan is developed, who should participate and who is best placed to take the lead role in working with the family. As you work through this case planning process with Aboriginal and Torres Strait Islander families and culturally and linguistically diverse families, cultural considerations will need to be central to your planning and facilitation of every step.

Each of the steps below may take place over one or more meetings. With some families you may need to meet and discuss each step or element with the parents/caregivers first, before they are comfortable bringing this conversation to the children/young people and to their network. For other families, you may be able to work through each step with everyone meeting together, or a combination of the above.

1. Build understanding about the purpose of case planning

Families can only participate in processes that they understand, so the first step in the case planning process is to help families understand the purpose of case planning and the key steps in the process. Use language that you are comfortable with and that will make the best sense for this particular family. Here's an example of what you might say:

Our role is to support you and your family to make the changes you want to make for your family. What will things look like when you are able to be the parent you want to be for your kids? What needs to change so that your kids are not affected by the hard stuff that you're dealing with? We can make a plan together to help you make those changes and have the best possible support so that things don't slide back if things get tough again in the future. Let's have a look at this graphic to give you a bit more information about what making a plan together will involve.

The graphic on the previous page is designed to be used with families, or you may want to draw up some other way of visually representing the case planning process. However you decide to explain the process to families, it is important that families have a solid understanding of the WHY and WHAT of case planning.

2. Obtain consent for collaboration and information sharing with network

It is vital that everyone involved in supporting the family are working in the same direction and are guided by a single case plan. The second step in the case planning process is therefore to reach agreement with the family about who needs to be involved in the case planning process, and to obtain consent to contact and share information with the network.

Network members can include family, friends, neighbours, church members, school teachers, sporting club or other community group members, doctors or community health nurses, other professionals

involved with the family – basically anyone who is in their support group already or who is willing to be involved in supporting the family.

The development of the case plan will also involve input from the network (alongside and with the consent of the family) and as mentioned earlier, may happen within large meetings or may require a series of smaller meetings and conversations if large meetings are not comfortable for the family (especially in the beginning). If the family are not yet comfortable with involving a network (and assuming there is not the presence of danger that would require a network- supported safety plan), then the question of involving the family's support network can happen over time.

Collaborative case planning also involves collaboration with relevant agencies and practitioners, so that everyone is working together to determine the most effective way of supporting and delivering services to the whole family in the right order and at the right time. A collaborative case planning approach recognises that navigating community support services is not easy for families and places the onus on service agencies to work together to effectively support families. It is critical that sharing information with other agencies only happens with consent from the family.

Sometimes families may be reluctant to share information or provide consent to contact other professionals or services with whom they are or have been involved. This may particularly apply in situations where relationships with other stakeholders are perceived as fractured or vulnerable. Likewise, some professionals and service providers may be reluctant to share information that relates to the wellbeing of the family or their children. This can occur because consent has not been obtained or providers are not confident to share information with service providers who they don't know well. Developing open, transparent and respectful working relationships with other service providers is just as important as relationship building with families.

3. Collaboratively identify the family challenges and strengths

The next step in the collaborative case planning process is to have conversations with each member of the family and with as many of their network as are involved at the moment, to help everyone identify both the challenges or barriers that could make it difficult for the family to reach their goals, and the strengths and resources that the family can draw on and may help them to reach their goals. Three tools that can help with these conversations are the CAP framework, Three Houses tool, and FAST.

Using either the Skinny CAP or the full CAP framework, the left-hand column in the top part of the CAP framework (complicating factors in the full CAP) explores and documents those areas that haven't been going so well for the family and that have been making it difficult for the parents to be the parents they want to be. These are the areas that could get in the way of the family working toward or being able to achieve their goals.

The right-hand side of the CAP framework (either Skinny CAP or full CAP) explores and documents those areas that have been going well for the family, including times when they have been able to make sure their children are safe and protected from any harm, as well as the strengths and resources that the family and their network (including professionals) can identify. These are the actions of protection and strengths and resources that may help the family work toward and achieve their goals.

The Three Houses tool can be used with the children or young people to hear their views, and then this information can be integrated into the CAP framework as well as the FAST.

The FAST (Family Assessment Summary Tool) is a decision-support tool that helps review the assessment information gathered and documented within the top part of the CAP framework. Periodically pausing to use the FAST allows the worker to check whether the family's complete story has been collected, using a consistent set of domains and definitions that allow for consistent rating of the family's strengths and challenges. It ensures that all IFS workers consider strengths and challenges in a consistent format when case planning with families. The FAST needs to be completed with the family within 30-60 days of commencing work and then every six months during the period of ongoing work with the family.

Documentation: Once completed, the information from the FAST needs to be entered into ARC.

If any challenges and/or strengths identified by the FAST are not documented in the CAP framework, make sure that these are added to the CAP, so that everyone has one comprehensive assessment picture of what is happening for the family at this time.

4. Develop/confirm the worry and goal statements with family and network

The fourth step in the case planning process is to help everyone - parents/caregivers, children and young people, IFS and the family's network (including relevant professionals) - to either develop or confirm the worry statements and goal statements, based on the rigorous and balanced assessment that has been documented in the top part of the CAP framework and drawing on the FAST.

The worry statements describe what we are worried parents might do (or not do) in the future that could lead to the children being harmed. These worry statements identify the reason for our involvement and the concerns that must be addressed for the case to be closed. The goal statements are clear statements about WHAT the parents will be doing differently in their care of the children in the future to protect the children from the identified worries. The goal statements provide a vision for future safety and wellbeing for the children and provide the focus and direction for the case plan. Detailed information about how to develop the worry statements and goal statements is contained in the CAP manual.

Developing the worry statements and goal statements collaboratively with the family and network is a crucial step in the case planning process. The critical thinking required to develop these statements helps to focus everyone on the changes that need to happen in the family for the children to be safe and thrive. Even though this is a collaborative process, the critical assessment of professionals must not be diluted.

Documentation: Ensure these worry statements and goal statements are documented in the CAP framework.

There will need to be a worry statement to describe the future worry for each of the areas of past harm or imminent risk of harm, including any immediate harm indicators from the SDM safety assessment. And there will need to be a goal statement for each worry statement.

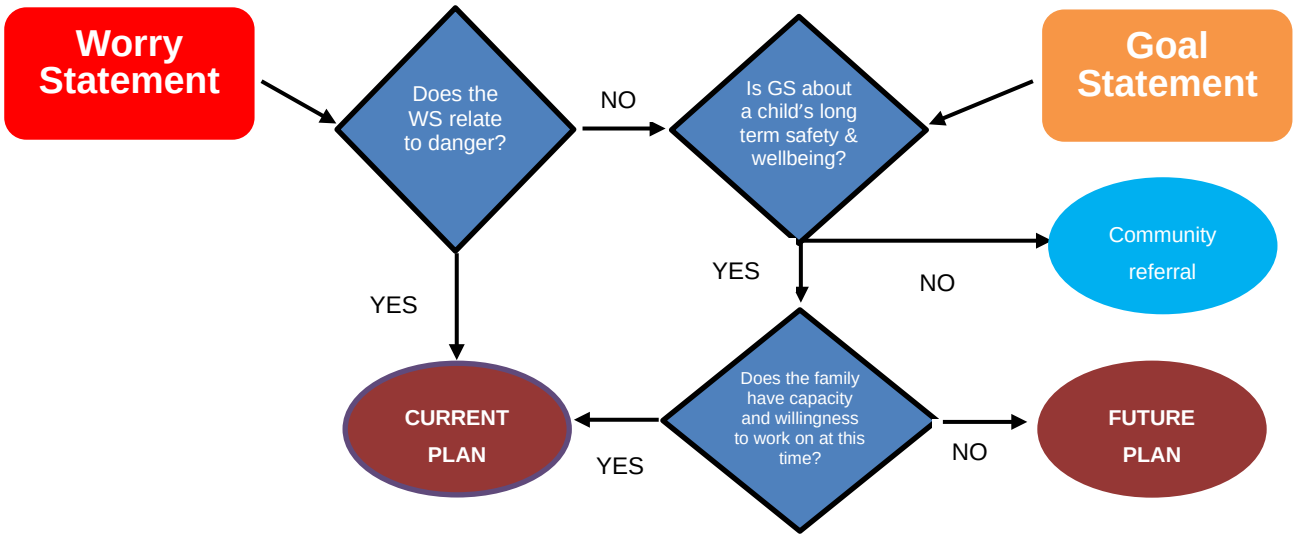
5. Collaboratively identify which worry statements and goal statements will be the focus of this case planning period

It is unlikely that the family will be able to work on all of their worry statements and goal statements during each case planning period, so it is important for everyone to decide which are the most important worry statements and goal statements to focus on first/next, and how many worry and goal statements the family are able to focus on at this time.

The next step in the case planning process is therefore to collaboratively prioritise the worry statements and goal statements, deciding what is most important to focus on first (or next). To do this, go through each worry statement and goal statement pair with the family and network and firstly identify if this worry/goal is about past harm or imminent risk of harm, including any immediate harm indicators from the SDM safety assessment. If the WS and GS pair are about the child's immediate safety, this **must** be included in the case planning period.

Even though IFS is a voluntary service, and the parents may not wish to address these worries, these are non-negotiables for IFS services and may necessitate difficult and challenging conversations whilst maintaining engagement with the family. Not addressing these worries means that the children will be in situation where they are in danger – imminent risk of immediate harm.

For the remaining WS and GS pairs, then collaboratively determine whether each WS and GS pair are about the child's long-term safety and wellbeing. If the answer is yes, that WS and GS pair can be either included in this case planning period (if the family have the capacity to work on this worry and goal at this time), or be carried across to the next or subsequent case planning period.



Documentation

For those WS and GS pairs that are to be included in this current case planning period, write them into the first two columns of the family case plan template. This family case plan template allows the case plan to be recorded visually WITH the family, so that there is an increased sense of understanding and ownership of the process.

The WS and GS pairs that are the focus for this planning period need to be entered into ARC.

Those WS and GS pairs that are not included in this first case planning period will remain in the CAP framework and be reconsidered for the second or subsequent case planning period.

6. Identify which challenges and strengths relate to each of the worry statements and goal statements pairs for this case planning period

For each WS and GS pair that will be the focus of this case planning period, now work with the family and network to identify which challenges and strengths from the FAST and CAP relate to each WS and GS pair. The challenges that relate will be those challenges that could make it more likely that this worry will happen or could get in the way of the family achieving this goal. These challenges will need to be worked on as part of the case plan. The strengths/resources that relate will be those that could help the family achieve this goal and therefore need to be considered/included as part of the case plan action steps.

Documentation

Write the related challenges and strengths into columns 3 and 4 of the family case plan template, beside the WS and GS pair that they relate to. Some challenges and strengths will relate to more than one WS and GS pair.

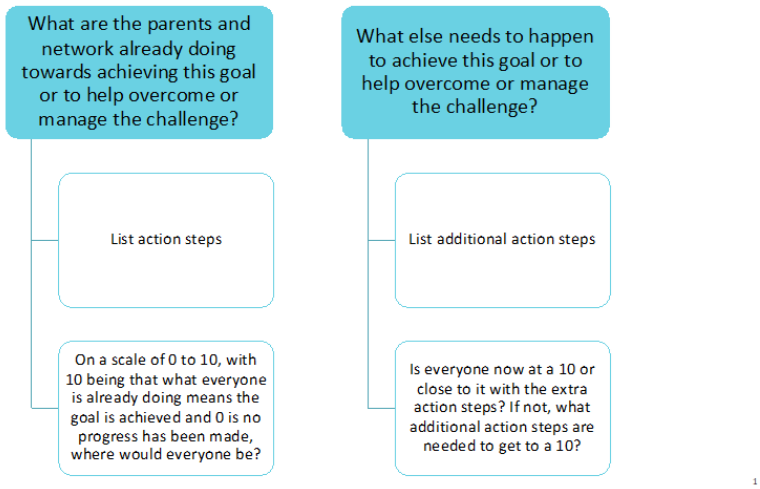
The details of the context needs to be recorded in the CAP framework (added to the relevant complicating factor or strength/resource). You may also want to add a little of this detail into columns 3 and 4 of the family case plan.

7. Work with the family and network to develop the action steps for each WS and GS pair (and for related challenges and strengths)

The action steps are the key planning elements in the case plan. These are the action steps that the family will take to work toward the goals, and the action steps that the network and professionals will take to support the family in achieving their goals. In the beginning, the action steps may contain more professional involvement, whereas as the family moves towards independence and sustainability, the action steps will increasingly describe actions by the family, with support by the network as needed.

For each goal statement, use a questioning approach such as the one suggested in the graphic below to invite everyone to collaboratively identify the action steps. You will notice that this process mirrors

parts of the CAP framework. This conversation can happen in a large group, or individually or in a small group and then be shared with others.



Remember, this is the ACTION part of the case plan, describing what everyone will do to work toward the goals, so the action steps need to be specific, achievable and to directly connect to the goal. One test of this is to ask everyone to identify how this action step will help the family move closer toward the relevant goal. The more concrete and achievable the action steps are, the more likely that the family will be able to put these steps into action and that the action steps will help the family to progress toward the goals.

Documentation

Write the action steps into column 5 of the family case plan template, beside the WS and GS pair that they relate to.

The action steps that relate to each WS and GS pair also need to be entered into ARC.

8. Integrate/Consider any existing immediate safety plan actions

If the family have an immediate safety plan in place (to protect the children from the identified immediate harm indicators), the action steps in the immediate safety plan will either need to be integrated into the case plan as part of the action steps for the relevant WS and GS pair, or will need to be kept as a separate immediate safety plan. This is a very important step in the collaborative case planning process, and it is vital to help everyone to pause and consider what is best for the family.

Having one plan will make more sense to some families, while other families prefer to have two separate plans. Whichever is the case, make sure that everyone understands that the case plan is about making long term changes to ensure the children's long-term safety and wellbeing, while the immediate safety

plan is about temporarily changing the care environment to protect the child from the danger while the family work toward achieving long term safety.

Either the separate immediate safety plan, or the immediate safety plan actions within the case plan, will need to be in place until the danger has been resolved (changes in behaviour demonstrated over time).

Documentation

Throughout the case planning period, as we support the family and network to informally review progress toward the goals (and to follow the immediate safety plan if one is in place), we document the progress within the CAP framework. It is a good habit to get into updating the CAP framework every week or two weeks, so that progress is not lost and so that everyone remains focused on progress toward the goals and next action steps toward the goals.

As we update the CAP framework, we are likely to be:

- Adding to strengths/resources and actions of protection as previous action steps are achieved.
- Updating complicating factors as issues are resolved or new issues emerge.
- Reviewing everyone's scaling position to reflect progress toward the goals.
- Identifying next action steps toward the case plan goals.

9. Write up the agreed case plan and make sure everyone has a copy

Everyone needs to have a copy of the family case plan. This can be a typed copy of the family case plan that you have written up on large paper with the family and network, or a print out of the case plan after you have entered the details into ARC. Ask the family to decide what format will most make sense to them and will be the easiest to implement.

A simplified version of the case plan can be developed that only contains the action steps. This 'fridge plan' lists the action steps to help everyone focus on what they have agreed to do and to keep this plan visible.

It is also possible to do a picture version of the case plan, that can help children and those who struggle with the written language to understand the case plan and the actions toward the goals.

10. Support the family and network in implementing the case plan

The majority of your work during the case planning period will be to support the family and network in implementing the action steps within the case plan. Our role is to facilitate a change process specifically guided by the family case plan. The best support we can offer to the family is to help them to stay on track and help them to reflect on how they are going in terms of progress toward the goals.

A case plan period typically lasts for three months, so you will need to support the family in working out which action steps they want or need to focus on first or next, and then you may need to help the family to break the action steps into smaller, achievable steps to be carried out over the next week or few weeks. Some of the action steps will be steps that the family can take on their own, and some of the

action steps will require significant support by yourself, the network or other professionals for the families to be able to take the action required (particularly in the beginning of our work with the family).

We also need to keep constant vigil on safety. If there is an immediate safety plan either alongside the case plan or integrated into the case plan, is it being followed? Is it working to protect the children from the danger? Does it need to be strengthened? If a danger has been resolved, a review SDM safety assessment can show this, and the immediate safety plan elements can be taken off the case plan.

11. Collaboratively review progress on the case plan

Every three months, it is important to pause for a formal review of progress toward the case plan goals. This review needs to be done collaboratively with the family and network, so that the review captures everyone's thinking and so that everyone has the opportunity to pause and reflect on progress.

Remember the process outlined in step 7 that helped everyone develop the action steps for each case plan goal? A similar process can be used to review progress toward each goal. This questioning approach uses the same four areas of inquiry from the CAP framework, focused on review of progress toward each goal.

Review of Case Plan Goals

Scale progress toward goal: 10 is goal is fully achieved, 0 is goal not achieved at all.		
0		10
What has happened/what actions have been demonstrated that has you scaling this high?	What do you think is getting in the way of greater progress toward this goal?	What else needs to happen/what additional action steps are needed for you to scale this goal at a 10 or close to it?

Goal 1

Scale progress toward goal: 10 is goal is fully achieved, 0 is goal not achieved at all.		
0		10
What has happened/what actions have been demonstrated that has you scaling this high?	What do you think is getting in the way of greater progress toward this goal?	What else needs to happen/what additional action steps are needed for you to scale this goal at a 10 or close to it?

Goal 2

For as many goals as needed.

Use this questioning approach to invite everyone to review progress toward each of the case plan goals:

- Where would everyone scale now for each goal?
- What has happened/what actions have they seen demonstrated that has them scaling this high?
- What has got in the way of the family making greater progress toward the goals?
- What else would need to happen for each person to scale at a 10 or close to it?

This review conversation can either happen with the family and network meeting together as a whole group or in a series of smaller conversations. There is no need to use a formal table for this review process. It is the process that is important, and it is usually easier for families to participate if the scale and columns are drawn up during the discussion and then worked through step by step in a visual manner (whiteboard or large paper) so that everyone can see the scaling and information being recorded within each column.

Documentation

The information from this review process is then summarised in the CAP framework so that the CAP contains an up-to-date record of assessment and planning information:

- Everyone's scaling position at this time.
- What has happened/what has been demonstrated that has someone scaling that high will be documented in RHS of CAP framework.
- What is getting in the way of progress toward the goal/has someone scoring that low will be documented in LHS of CAP framework.
- What else needs to happen to scale at a 10 for each goal will be documented in action steps (and will be carried across to the next case plan action steps if this goal is also included in the next case plan).

Within ARC, the extent to which each of the case plan goals has been achieved needs to be documented, according to the table below.

Outcome Values	Evidenced by
1 - Goal not achieved	• Scaling position for this goal is very low (0-1). • Caregivers have not yet demonstrated any actions of protection that are relevant to the goal.
2 – Goal partially achieved	• Scaling position for this goal is low to medium (2-4). • Caregivers have begun to demonstrate actions of protection relevant to the goal, but these are inconsistent and have not yet been demonstrated over time.
3 – Goal mostly achieved	• Scaling position for this goal is medium to high (5-7). • Caregivers are regularly demonstrating actions of protection relevant to the goal, but these are occasionally inconsistent or have not yet been demonstrated over a long enough timeframe to be confident that the protective behaviour will always continue.
4 – Goal fully achieved	• Scaling position for this goal is high to very high (8-10). • Parent is consistently demonstrating actions of protection relevant to the goal, and these actions have been demonstrated over a long enough timeframe to be confident that the protective behaviour will always continue.

12. Collaboratively assess if there is sufficient progress to close the case

Based on the review of progress toward the case plan goals, the critical question that now needs to be considered is whether there is now sufficient safety and wellbeing to close the case or whether another case planning period is needed to support the family in making further progress. This assessment needs to be informed by the views of the family and the network and is usually made with the support of a case

consultation or case closure panel. A number of key questions need to be considered as part of this assessment:

- **Are there any dangers (immediate harm indicators) still present?** The SDM Safety Assessment is the decision support tool that will help to make this assessment. If there were dangers present during our work with the family (and an immediate safety plan was in place), there would need to have been actions of protection demonstrated over time, that directly protect the child from the danger, to be able to assess that these dangers have been resolved.

  If any dangers (immediate harm indicators) are still present, case closure is not recommended as there continues to be imminent risk of serious harm.

- **Have the family made sufficient progress on all goal statements that relate to safety and wellbeing?** Our focus for case closure needs to be on all the goal statements that directly relate to the children's safety and wellbeing, including both the goal statements that were the focus of this case planning period as well as the other goal statements for this family (that will still be in the CAP framework but were not included in this case planning period).

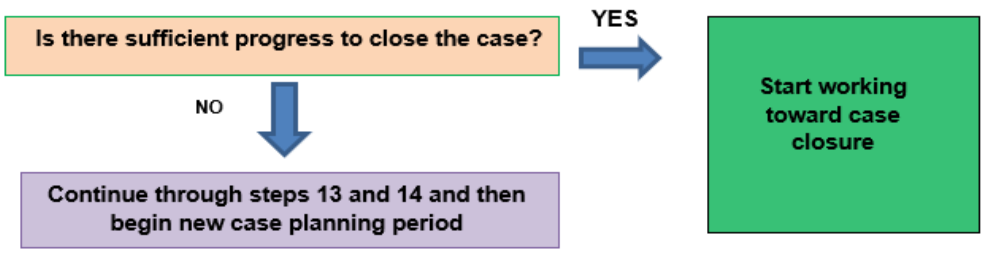
  We need to see sufficient progress on **all** the goals that relate to the children's safety and wellbeing. If there are any goals that relate to the children's safety and wellbeing that were not addressed in this case planning period, you will need to collaboratively review progress toward this goal with the family and network (using the process outlined in step 11). Even though this goal may not have been directly addressed by the case plan, there still may have been progress on this goal.

  At a minimum, we would want to see that there is general agreement by the family and the network (including professionals) that **all goals that relate to the children's safety and wellbeing have been fully achieved or mostly achieved**. This doesn't mean that everything needs to be perfect for the family or that every issue has been addressed, but it does mean that the serious concerns about the children's safety and wellbeing (both immediate safety and long-term safety) have been substantially addressed so that we no longer have serious concerns

  If any of the goals that relate to the child's safety and wellbeing have not been fully or mostly achieved, then case closure is not recommended – even if a majority of case plan goals have been achieved. A further case planning period is recommended to continue to support progress toward these goals.

- **Do the family have the support they need to be able to notice and respond to any future presence of danger for the children or increase of risk?** Ideally, this would include an active safety and support network and a long-term safety and support plan. The long-term safety and support plan would be developed collaboratively with the family, will provide clear guidance on what everyone will do in the future to maintain safety and wellbeing for the children, and identify how to reach out for support if people are worried. For some families though, a long-term safety and support plan and active network may not be possible, despite our best efforts.

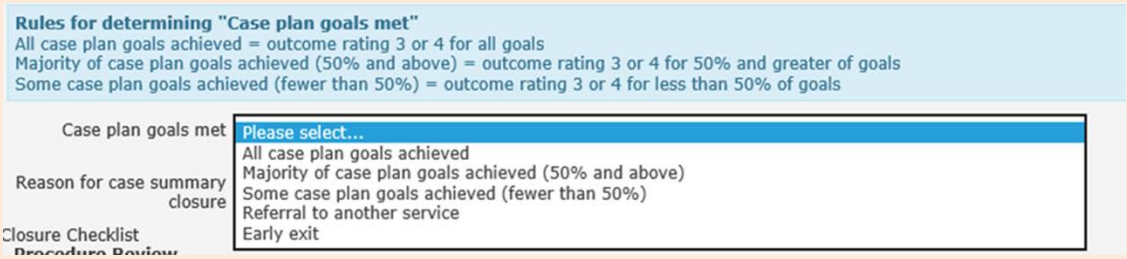
  The decision about whether or not there has been sufficient progress to close the case will then determine whether you start working toward case closure with the family, or whether a new case planning period is begun (with an updating of the case plan).

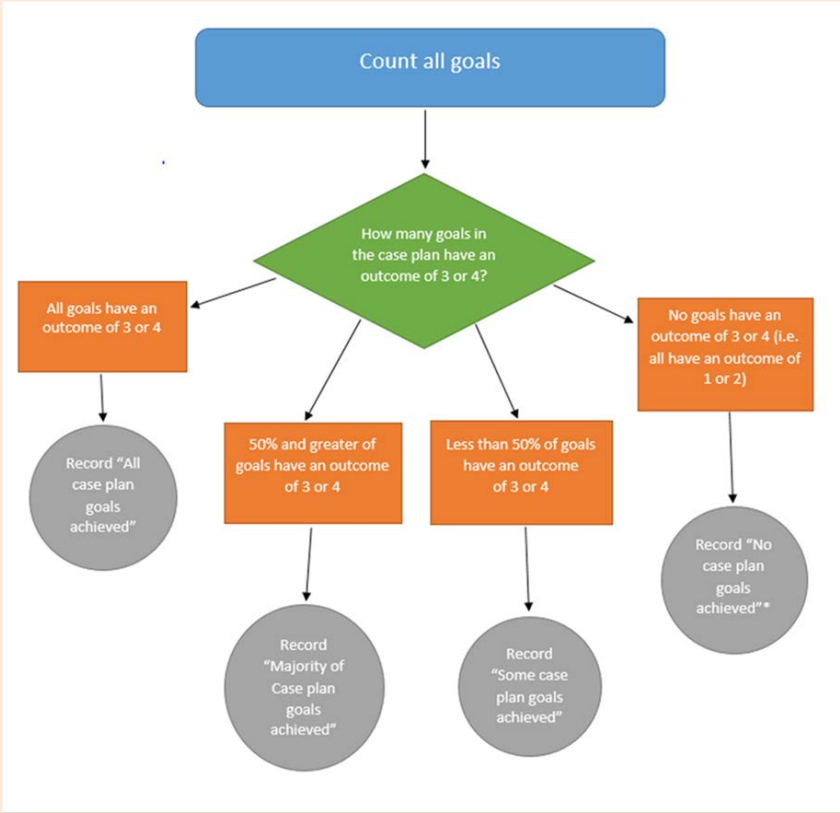


Documentation

The decision to either close the case or to continue working with the family needs to be documented within the action steps component of the CAP framework and would need to be evidenced by the information in the top part of the CAP (as per step 11 above).

If you are closing the case, the case summary closure tab on ARC needs to be completed, which asks you to identify the extent to which the goals have been achieved. *Note: you should count all goals over the life of the case, not just the goals for that case plan period*.





13. Collaboratively review family challenges and strengths.

If there has not been sufficient progress to close the case, then a further three-month case planning period is recommended to support the family in making further progress. The first step in beginning a new case planning period is to **collaboratively review the family challenges and strengths** to determine whether there have been any significant changes in the challenges that could get in the way

of the family reaching their goals, and/or in the strengths that could support the family in working toward their goals.

This assessment of challenges and strengths may only require reviewing the CAP framework if it is at the three-month mark. However, after six months a new FAST is required and should be included in your conversations with the family and their network.

Documentation

If there have been any significant changes in the family challenges and strengths, update this information in the CAP framework so that you (and the family and network) have one comprehensive assessment picture of what is happening for the family at this point in time.

When a new FAST is completed, the information from the FAST needs to be entered into ARC.

14. Collaboratively review WS and GS. Does anything need to change?

The second step in beginning a new case planning period is to **collaboratively review the family worry statements and goal statements**. Have there been any significant changes in the family's circumstances that require changes to the WS and GS. This could involve:

- A worry statement and goal statement pair being removed from the CAP framework if the worry statement has now been fully addressed, with the corresponding goal statement achieved. For this to occur, there would need to be actions of protection documented in the CAP that identifies the safety that has demonstrated over time to achieve this goal statement.
- Edits to the worry statements and goal statements that helps to focus or more clearly explain any of the worries and/or goals. It may be that in getting to know the family and network better, that everyone now has a clearer understanding of the context in which a worry may occur or a goal particularly needs to be demonstrated. Or we may understand the possible impact on the child more clearly. Or the family may feel more confident in explaining the worries and goals in language that makes better sense to everyone.
- A new worry statement and corresponding goal statement being collaboratively developed with the family and network if new concerns have arisen during the period of working with the family. If this has not already happened, then this is the time to pause and ensure that the new worry statement and goal statement has been collaboratively developed.

Documentation

Any changes to the worry statements and goal statements will need to be documented in the CAP framework and entered into ARC.

Begin new case planning period at point 5 in this case planning process.

Appendix 8 – Brokerage Funding Guidelines

Purpose

Brokerage funding purchases additional support, services and/or resources for a family that is unable to be provided by the lead agency. Brokerage funding can only be used for clients who provide their consent to engage with the service and have a case plan. Brokerage funding is intended to be used only when publicly provided or funded services are not available and must be linked to the case plan.

Brokerage funding should assist families to sustain their role as parents/carers specific to their needs. It is used to purchase services which:

- Assist family engagement, particularly for Aboriginal and/or Torres Strait Islander families, culturally and linguistically diverse families, and families with disability needs
- Reduce immediate risk or increase protective factors for children
- Support and sustain a family unit and child wellbeing
- Enhance a family's quality of family life
- Help maintain family and cultural relationships

***A cultural lens** must always be applied when working with Aboriginal and Torres Strait Islander families. It is imperative there is a strong and respectful understanding of Aboriginal and Torres Strait Islander histories, cultures, family structures and parent and child-rearing practices.*

Principles

The use of brokerage by Intensive Family Support (IFS) services and Family and Child Connect (FaCC) is guided by five principles:

1. **Client focused**
   Brokerage support is responsive to and driven by the needs collaboratively identified with the client, and is respectful of the rights, dignity and confidentiality of the client.

2. **Responds to identified needs and case plan goals**
   Brokerage funds can be administered for the purchase of goods, services or activities that respond to an immediate identified need to reduce risk or increase protective factors that impact on the safety and wellbeing of children and their families.

   Once a case plan is developed, brokerage funds can be used where necessary for the purchase of goods, services or activities directly linked to achieving outcomes.

3. **Flexibility**
   The use of brokerage is driven by choice and flexibility in services and can be applied at any point during the client's contact with the service.

4. **Avoid duplication of service provision**
   Brokerage funds are used to purchase goods, services or activities only when existing services, supports or resources cannot meet the identified needs of the client or are not accessible.

5. **Value for money**
   Interventions purchased with brokerage funds are to be as cost effective as possible. When deciding to commit brokerage funds, consideration is given as to whether the intended expenditure is the best use of resources to meet identified client outcomes.

Eligibility and Priority

Brokerage funds are available for individual clients according to their need for additional support, services and/or resources. The spending of brokerage funds must be clearly linked to a family's identified needs or case plan.

Wherever possible parents/caregivers should be encouraged to prioritise and take responsibility for costs relating to their children and brokerage used to assist with other expenses.

Brokerage funding can be pooled to provide services for a number of families, where the same need is identified for a number of clients.

> ***Note:*** *There is no cap on the amount of brokerage funding any one family may receive; services are expected to prioritise families and their needs in an equitable and sustainable manner.*

Types of Expenditure

Brokerage funds should purchase supports, services and resources on a short-term or episodic basis.

Examples of support covered by brokerage:

- Purchase of goods or services to address safety in the home or the safety of individuals. *For example: to access materials and trades people to repair doors/locks/ fencing in order to keep the home environment safe for toddlers and young children.*
- Purchase of white goods. *For example: the purchase of a washing machine to ensure the family's clothes and bedding can be regularly laundered.*
- Purchasing direct support services. *For example: to assist services to respond to the identified needs of Aboriginal and/or Torres Strait Islander families for cultural-related support; or to respond to identified needs for Culturally and Linguistically Diverse families to access mainstream services by purchasing interpreter services not available through the Telephone Interpreter Services.*
- Timely access to initial dental, health and speech therapy assessments and treatment. *For example: access to initial assessment by private practitioner to expedite entry into the public health system or specialist health services where public services are not available in the locality to meet specific needs of a client.*

- Mental health assessments. *For example: access to assessment by private practitioner for diagnosis and referral for diagnosed services in the public health system.*
- Accommodation/personal expenses. *For example: one off payment in times of financial crisis or to escape domestic and family violence.*
- School/education expenses and supplies. *For example: parents are not sending child/ren to school and it is identified that they cannot meet the financial costs of uniforms, books and general stationery items required.*
- The purchase of household items (explore options of local charity groups in the first instance). *For example: one off payment for essential items (such as bed and bed linen) to "set up" in new accommodation.*
- House cleaning. *For example: one off payment for cleaning and removal of excess rubbish for a family living in cluttered, unhygienic/unsanitary conditions and the service case plan is to work with the family to teach them general household living skills.*
- Respite care. *For example: referred child has a diagnosed disability and it is identified by the service that respite care would assist the family's coping strategies.*
- Child Care. *For example: while the parent(s) of the referred child is attending a parenting course or counselling sessions for a six week period, brokerage funding is used to meet the cost of ordinary child care.*

Service Gaps

Brokerage funds are frequently used to respond to gaps in the amount or quality of existing programs because:

- there is a gap between the demand for, and supply of, core community programs
- existing programs may be unable to provide a sufficient amount of support
- existing programs may have waiting lists of people needing a specific form of support and/or a time delay before assistance can be provided
- the type of support needed is not readily available
- existing programs may not be able to provide the necessary service quality or responsiveness

Limits on Expenditure

The amount of funds allocated to brokerage from the service budget must be negotiated and clearly recorded in the service agreement with the department. Up to $5,000 per $100,000 per annum (or 5% of total grant funding) is considered an eligible cost.

Family Support services are expected to quarantine brokerage funds from administration and organisational costs and cover the cost of administering brokerage funds within the general administrative costs of the service.

Brokerage is not to be the first or only service provided to clients with the exception of responding to immediate risk factors for children and their families.

Brokerage funds are only to be provided in the context of clients' identified needs and case plans. Case plans must demonstrate the use of brokerage as part of a range of strategies to support the client to address identified needs and achieve goals which lead to case closure.

Prior to using brokerage funds to purchase a support, service or resource, alternative sources that may be less expensive or free should be explored. If an appropriate service is available and able to meet their needs, then clients should be referred to that service.

Brokerage funds are not to be used to reimburse a worker already employed within the service.

Brokerage funds are not to be used for any other funded initiative or service type provided by the organisation.

Supports, services and resources which are more ongoing in nature do not fall within the parameters of Family Support brokerage.

Brokerage funds are provided for one off payments of goods or services and may not be used for the employment of staff or the subcontracting of services that form part of the existing service agreement with the department to another organisation or agency.

Accountability

The IFS services are required to:

- Ensure that brokerage funds provided by the department are used in accordance with these guidelines
- Record data about the use of brokerage as part of the client's records and in the Advice, Referral and Case management ARC system.
- Develop a policy and procedures for managing demand for brokerage, including clear eligibility requirements and assessment processes based on the principles outlined in these guidelines.

Appendix 9 – Working with Families subject to an Intervention with Parental Agreement

Principles

The following principles should be considered during the transition phase and to determine the exceptional circumstances when IFS continues to work with the family on an IPA:

- Families requiring an IPA are the highest risk families for Child Safety as they are assessed as being a child in need of protection and yet the child remains at home with the family during the intervention. Tertiary Family Support services are funded to deliver these specialist services.
- IFS interventions in IPA cases should be time limited until an appropriate tertiary service is identified and a warm handover has been successfully achieved.
- The PCPP must be consulted in all cases where an IFS intervention in an IPA case is being considered.
- The Family Group Meeting (FGM) is potentially an ideal opportunity for families to transition to their new service provider and therefore should be considered as an appropriate transitional platform.
- If there are exceptional circumstances when an IFS service should continue working with a family after the FGM due to the strength of the therapeutic relationship or other similar factors, interventions must be focused on achieving case plan goals.
- After consultation with all parties, the IFS service makes the final determination as to whether they continue working with the family once the family is on an IPA.
- IPA arrangements will be subject to review every three months or more frequently, by the IFS case manager, to ensure progress is being made.

Process

If a family already working with the IFS becomes subject to an IPA, the following steps should apply:

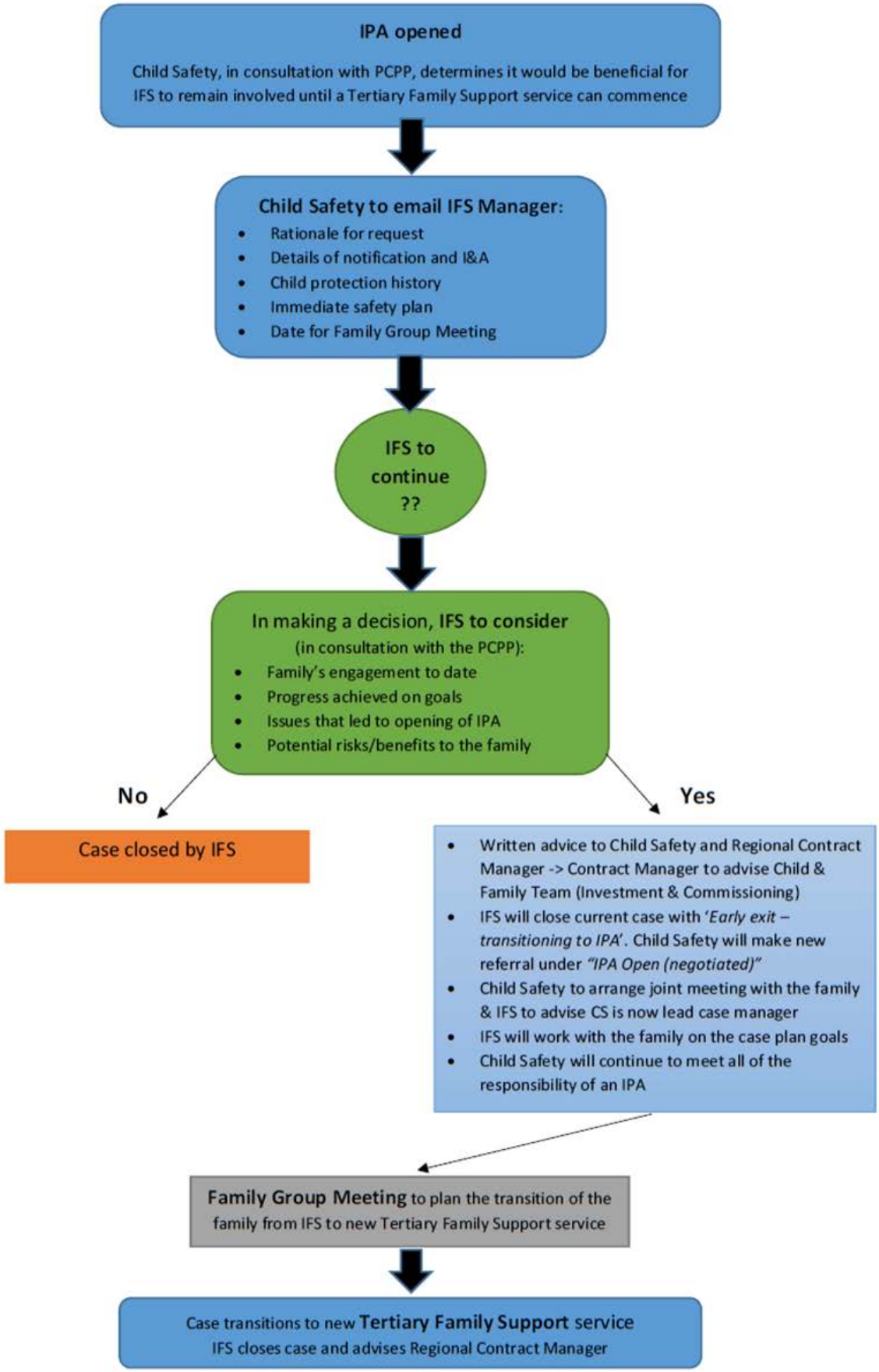
1. If Child Safety believe it would be helpful for the family to stay engaged with the IFS until a more appropriate service can be identified, following discussion with the PCPP, a request should be made in writing (such as an email) to the IFS service manager. This request should contain a rationale with supporting information, including details of the most recent notification, brief details of the assessment which has led to the IPA decision, child protection history, the immediate safety plan, a tentative date for the FGM, and the reasons why Child Safety would like continued IFS involvement.
2. In determining its response, the IFS should consider the family's engagement to date, their willingness to work with the IFS staff and specialist agencies, and the progress achieved on the goals identified in the IFS family case plan. Consideration should also be given to the issues that led to the IPA decision by Child Safety. In consultation with the PCPP the IFS should review the IFS case plan to date assessing the information from Child Safety, including child protection history. The PCPP can offer advice on the potential risks and benefits of the family continuing to work with the IFS until a tertiary support service is identified. At this stage, telephone conversations, email correspondence or a meeting could occur to discuss with Child Safety potential worries, gaps in information, recent events since the assessment or any other issues. Possible case plan goals (yet to be developed with the

family in the FGM), and potential work agreements are to be discussed to ensure there is agreement on service provision and timeframes for involvement, prior to meeting jointly with the family.

3. The IFS then makes a determination on the appropriateness of the family continuing with the service and advises Child Safety. As a record for both parties this advice should be a documented reply (email is sufficient) to the original request from Child Safety which outlines the possible case plan goals to be discussed with the family in the FGM and timeframes for joint work (keeping in mind that case plan goals are determined in a FGM with the family and their supports and representatives so some flexibility may be required).
4. The IFS should advise the Regional Contract Manager by email of the request and their determination with a brief non-identifying rationale. The Child Safety Officer and/or Team Leader should be copied into this email. The Contract Manager will provide that advice to the Child and Family Commissioning Team for their information.
5. Where the IFS determines it is not appropriate for the family to continue, the case will be closed.
6. Where the IFS determines it is appropriate for the family to continue working with the service, Child Safety should arrange a meeting with the family and the IFS. The goal of this meeting should be to discuss with the family the plan for Child Safety and the IFS to work in parallel until a handover can occur with an appropriate tertiary support service. It should be made clear to the family that Child Safety is now the lead case managers for the family and IFS will work hand in hand with them and inform Child Safety of any changes in circumstance for the family or any safety concerns for their children during this time. A family may have some ideas about how to work together during this period or may even prefer not to work with the IFS under these circumstances.
7. The IFS will close the current case under early exit *Transitioning to IPA*. Child Safety will refer the family under the referral type *IPA Open (negotiated)* - this is a new referral type in the ARC database. The IFS will open the referral as a new case for the family.
8. Child Safety is the lead case manager for an IPA and the IFS will work with the family on the case plan goals determined in the FGM with the family and Child Safety. This could also be a time that the family and IFS may wish to share the Single Case Plan developed with the family.
9. While the IFS is working with the family, Child Safety will continue to meet all of its responsibilities for an IPA, including contacts with the family, sighting children and contacting supports, e.g. schools. Some of these contacts may occur jointly with the IFS if both parties agree to this approach.
10. The IFS is required to provide Child Safety with information about the family's engagement and progress on the Child Safety case plan goals.
11. A Family Group Meeting (FGM) should be arranged by Child Safety as soon as is practicable and ideally include the IFS.
12. The FGM should determine the most appropriate tertiary service to work with the family and a plan for transitioning the family from IFS to that service.
13. In exceptional circumstances, the IFS may be identified as the most appropriate service to continue working with the family. The IFS may choose to review the case (processes 2 and 3) before making a determination on continuing to work with the family. In these cases, the

IFS should advise the Regional Contract Manager and provide that same advice to the Investment and Commissioning team.

14. When the IFS closes the IPA case, they should advise the Contract Manager who will provide that advice to the Children, Youth and Families Commissioning team.


IPA opened
Child Safety, in consultation with PCPP, determines it would be beneficial for IFS to remain involved until a Tertiary Family Support service can commence
Child Safety to email IFS Manager:
Rationale for request
Details of notification and I&A
Child protection history
Immediate safety plan
Date for Family Group Meeting
IFS to continue ??
In making a decision, IFS to consider
(in consultation with the PCPP):
Family's engagement to date
Progress achieved on goals
Issues that led to opening of IPA
Potential risks/benefits to the family
No
Case closed by IFS
Yes
Written advice to Child Safety and Regional Contract Manager -> Contract Manager to advise Child & Family Team (Investment & Commissioning)
IFS will close current case with 'Early exit – transitioning to IPA'. Child Safety will make new referral under "IPA Open (negotiated)"
Child Safety to arrange joint meeting with the family & IFS to advise CS is now lead case manager
IFS will work with the family on the case plan goals
Child Safety will continue to meet all of the responsibility of an IPA
Family Group Meeting to plan the transition of the family from IFS to new Tertiary Family Support service
Case transitions to new Tertiary Family Support service
IFS closes case and advises Regional Contract Manager

Appendix 10 – Responding to Immediate Harm Indicators

Principles

The following principles should be considered when an immediate harm indicator is identified:

1. Family and Child Connect (FaCC) and Intensive Family Support (IFS) are secondary prevention services designed to work with families to prevent their entry or re-entry into the child protection system.
2. Child Safety is a tertiary response system that works with families where there are significant concerns for the safety of children within their home.
3. The Safety Assessment is a structured decision-making tool common to both the secondary and tertiary sectors and the definitions should apply consistently across both sectors.
4. Using the Safety Assessment across both sectors supports clearer understanding and communication across sectors to achieve greater consistency in assessment and intervention.
5. Immediate safety plans must be rigorous and sufficient to mitigate the immediate harm indicator/s. It is the presence of a rigorous immediate safety plan that makes the difference between a child being unsafe and safe with a plan.

Process

If during an IFS intervention, the IFS worker identifies an immediate harm indicator when completing a Safety Assessment, the worker must consult with the PCPP to confirm the presence of an immediate harm indicator and what must be included in the immediate safety plan to mitigate the danger (non-negotiables).

If an immediate harm indicator is present and an immediate safety plan cannot be developed (if the family and their network are not willing or able to develop an immediate safety plan), the safety decision guidance from the SDM Safety Assessment is that the child is unsafe. Child Safety must be notified immediately.

If an immediate harm indicator is present and it is determined that an immediate safety plan can be developed (if the family and their network are willing and able to develop an immediate safety plan) then, following consultation with the PCPP, the IFS worker will work with the family and their network to develop an immediate safety plan and continue to support the family and their network in monitoring/reviewing the immediate safety plan.

An immediate safety plan must have sufficient rigour to mitigate the immediate harm indicator/s and include the following:

- Identification of the immediate harm indicators
- Worry statements that describe the specific actions or inactions of a carer that could result in a harm to the child
- Clear non-negotiables about what must be contained in the immediate safety plan
- ‘What if’ questions that support consideration of contingencies
- A specific set of actions/change that occur immediately so that the present danger is mitigated

- Who is in the family's network and responsible for actions
- A way to monitor the plan
- A specific time when the immediate safety plan will be reviewed.

If at any time the immediate safety plan is no longer able to keep the child safe, or the parents withdraw their agreement to the immediate safety plan, a report to Child Safety is required. When reporting to Child Safety, it is essential that the IFS share with the Regional Intake Service (RIS) the rationale for the identification of the immediate harm indicator (using the definitions in the Safety Assessment) and why an immediate safety plan was unable to be developed or maintained. The IFS worker can also request RIS to advise of their proposed response to the information which may be a Child Concern Report or a Notification with a 24 hour, 5 day or 10 day timeframe. The feedback can include information about the response, the rationale for the decision and the likely timeframes for any contact with the child or family.

If a report to Child Safety is not screened in as a notification, IFS will continue to work with the family provided that the family continues to consent to IFS intervention. If the family no longer consents to the intervention, IFS will consult with the PCPP (if required), advise Child Safety that the family is no longer engaging, and close the case.

If the report is screened in as a notification, the IFS worker, PCPP and Investigation and Assessment (I&A) Senior Team Leader will negotiate roles and responsibilities for the period prior to the commencement of the I&A. This will provide an opportunity for the IFS to highlight their worries and to discuss the immediate safety plan that is in place. The IFS worker must be confident the family is able and willing to implement the immediate safety plan as an IFS service is voluntary and cannot compel parents to present their children to be sighted by the worker or to take safety steps, such as applying for Domestic Violence orders.

There should be regular information sharing between IFS and the Child Safety I&A Senior Team Leader until the commencement of the I&A to ensure that the danger is able to be managed by the IFS. If at any point a family withdraws consent or the family are not willing or able to develop or sustain the immediate safety plan, an IFS worker will consult with their PCPP and then advise Child Safety of the change in circumstances. If there are significant delays in the commencement of the I&A, the IFS Manager may escalate the issue to the Child Safety Manager for further discussion and resolution of issues.

Once Child Safety commences their assessment, the PCPP, IFS worker and Child Safety should continue to communicate and coordinate to ensure that roles are clear and that work with the family does not impact on Child Safety's I&A process. IFS may stay involved as a support with the family's consent until the outcome of the investigation and assessment is determined.

At the completion of the investigation and assessment, if the child has been assessed by Child Safety as *not in need of protection*, Child Safety may request ongoing IFS involvement with the family. Child Safety must provide IFS with the most recent Safety Assessment, Family Risk Evaluation and brief details of the outcome of the assessment in an updated referral. This will ensure the IFS is aware of the level of risk to be managed. It is important the family consents to ongoing IFS intervention.

If Child Safety requires a non-government organisation to participate in a dual response (i.e. Child Safety requests an IFS representative to jointly assess an I&A), this is <u>not</u> a function of the IFS service. Assessment and Service Connect (ASC) has been funded by the department to partner with

Child Safety Officers, where requested, in the I&A process. A family may ask an IFS worker to act as a support to them during an I&A to assist them to understand the process.

For this approach to be successful, strong partnerships and ongoing collaboration between IFS workers, Child Safety and PCPPs is required to ensure all interventions focus on the safety, belonging and wellbeing of the children and their families.


Immediate harm Indicator is identified on Safety Assessment
IFS worker consults with PCPP – confirms presence of IHI and non-negotiables to mitigate danger
Can an Immediate Safety Plan be developed?
Yes
No
Immediate Safety Plan is developed with family
Report to Child Safety
No
Is it screened as notification?
Immediate Safety Plan remains in place and parents continue to consent
No
Yes
Child Safety Investigates. IFS, PCPP and Child Safety negotiate roles and responsibilities
Yes
Is the child in need of protection?
IFS works with family until case closed
No
Yes
Child Safety may request ongoing IFS involvement with the family's consent
Child Safety will remain involved and IFS will close the case

Appendix 11 – Information Sharing Guidelines: A comparison

The information sharing guidelines for both the *Child Protection Act 1999* (CPA) and the *Domestic and Family Violence Protection Act 2012* (DFVPA) provide key information about when information can be shared without consent. Both guidelines emphasise that obtaining consent is always preferable whenever safe, possible and practical. Given the intersection of child protection and domestic and family violence, FaCC and IFS workers should be aware of the key differences and understand their responsibilities in relation to both sets of guidelines.

For further detailed information, the respective Information Sharing Guidelines can be found here:

- *Child Protection Act 1999* Information Sharing Guidelines: *https://www.cyjma.qld.gov.au/about-us/our-department/partners/information-sharing/child-family*

- *Domestic and Family Violence Protection Act 2012* Information Sharing Guidelines: *https:www.justice.qld.gov.au/initiatives/end-domestic-family-violence/our-progress/strengthening-justice-system-responses/domestic-family-violence-information-sharing-guidelines*

CPA Guidelines	DFVPA Guidelines
Purpose	
To support and guide organisations and agencies within the Queensland child protection and family support to help ensure the safety and wellbeing of children. Specifically, enable particular entities to share information to – • make a decision about reporting suspicion of harm or risk of harm to a child to Child Safety • assist Child Safety to assess or investigate harm or risk of harm to a child or take other action • assess care needs and to plan services • decrease the likelihood of a child becoming a child in need of protection • facilitate participation of an Aboriginal or Torres Strait Islander child/family in decisions and making plans relating to the child.	To support practitioners to share information appropriately with one another in order to assess and manage DFV risk. Specifically, enable particular entities to share **relevant** information to— • assess whether there is a serious threat to the life, health or safety of people because of domestic violence; and/or • lessen or prevent a serious threat to the life, health or safety of people because of domestic violence (may include contacting or attempting to contact, or offering to provide assistance or a service to people involved in the DFV); and • refer people who fear or experience domestic violence, or who commit DFV, to specialist DFV services.
Safety takes Precedence	
The child's care needs, protection and safety take precedence over the protection of an individual's privacy by enabling information to be shared without consent for particular purposes.	Sharing information with consent is the preferred approach however the safety, protection and wellbeing of victims (including children) always takes precedence. In almost all circumstances, consent should **not** be sought from perpetrators to share their information. Before sharing information about a person to someone else, an entity should consider whether disclosing the

CPA Guidelines	DFVPA Guidelines
	information is likely to adversely affect the safety of the person or another person. The information may still be shared but the entity should take steps to help mitigate any identified risks (this includes determining a safe way to contact the victim without the perpetrator's knowledge).
Who is allowed to share information?	
The following entities are allowed to share information under the Chapter 5A Part 4 of the CPA. 1. The chief executive or authorised officer 2. Prescribed entities, including specialist service providers 3. Service providers	The following entities are allowed to share relevant information without consent under Part 5A of the DFVPA: 1. Prescribed entities 2. Specialist DFV services funded by government 3. Other service providers **Not** all entities can share information *both* ways. **Prescribed entities and specialist DFV services funded by government** can *give* information to, and *receive* information from, each other for purposes of *assessing* whether there is a serious threat due to DFV. **Other service providers** may *only give* information to a prescribed entity or specialist DFV service, to inform the receiving entity's *assessment* about whether there is a serious threat due to DFV. For purposes of *lessening or preventing* a serious threat because of DFV, **all three entities** may *give* and *receive* information. Depending on the services and programs provided, one organisation may incorporate multiple entity types. Individual positions within a service may also constitute different entity types.
Prescribed entities	
Prescribed entity means each of the following— (a) the chief executive of a department that is mainly responsible for any of the following matters— (i) adult corrective services; (ii) community services; (iii) disability services; (iv) education; (v) housing services; (vi) public health; (b) the police commissioner; (c) the chief executive officer of Mater Misericordiae Ltd (ACN 096 708 922);	***Prescribed entity*** means each of the following— (a) the chief executive of a department that is mainly responsible for any of the following matters— (i) adult corrective services; (ii) child protection services; (iii) community services; (iv) court services; (v) disability services; (vi) education; (vii) housing services; (viii) public health services; (ix) youth justice services; (b) the chief executive of another department that provides services to persons who fear or experience domestic violence or who commit domestic violence;

CPA Guidelines	DFVPA Guidelines
(d) a health service chief executive within the meaning of the *Hospital and Health Boards Act 2011*; (e) the principal of an accredited school under the *Education (Accreditation of Non-State Schools) Act 2001*; (f) a specialist service provider; (g) the chief executive of another entity that— (i) provides a service to children or families; and (ii) is prescribed by regulation.	(c) the commissioner under the *Ambulance Service Act 1991*; (d) the police commissioner; (e) the chief executive officer of Mater Misericordiae Ltd (ACN 096 708 922); (f) a health service chief executive under the *Hospital and Health Boards Act 2011*; (g) the principal of a school that is accredited, or provisionally accredited, under the *Education (Accreditation of Non-State Schools) Act 2001*; (h) another entity prescribed by regulation.
Specialist service providers	
Specialist service provider means a non-government entity, other than a licensee or an independent Aboriginal or Torres Strait Islander entity for an Aboriginal or Torres Strait Islander child, funded by the State or the Commonwealth to provide a service to— (a) a relevant child; or (b) the family of a relevant child. A relevant child is a child in need of protection or a child who may become a child in need of protection if preventative support is not given to the child or child's family. Family and Child Connect Service (FaCC), Intensive Family Support (IFS) and Assessment Service Connect (ASC) services are considered Specialist Service Providers.	***Specialist domestic and family violence service provider*** means a non-government entity funded by the State or Commonwealth to provide services to persons who fear or experience domestic violence or who commit domestic violence. This includes government funded men's behaviour change programs. Funded DFV specialists' positions in FaCC and IFS services are considered specialist DFV service providers funded by government. Principal Child Protection Practitioners (co-located with FaCC services) are considered prescribed entities. Sexual assault services are **not** treated as specialist DFV services however one organisation may provide sexual assault services and specialist DFV services funded by government.
Service Providers	
A **service provider** is a person providing a service to children or families, a licensee or an independent entity for an Aboriginal or Torres Strait Islander child. Examples of a person providing a service to children or families include a General Practitioner (GP), private counsellor or a worker in an Aboriginal and Torres Strait Islander health service. Services funded to provide domestic and family violence, sexual assault or women's health and wellbeing services would also be considered Service Providers.	A **support service provider** (or 'other' service provider) means a non-government entity, other than a specialist domestic and family violence service provider, that provides assistance or support services to persons who may include persons who fear or experience domestic violence or who commit domestic violence. Examples may include, but are not limited to: counselling, disability services, private health services (including private hospitals and general practitioners), housing, legal services (including solicitors and barristers), and sexual assault service providers.

CPA Guidelines	DFVPA Guidelines
A licensee is an organisation licenced under the Act to provide care for children in the chief executive's custody or guardianship. This means organisations that provide placement services such as foster or kinship care services or residential care services. An independent person for an Aboriginal and Torres Strait Islander child is an individual or an entity who facilitates the participation of the child and child's family in decision making processes.	These services may be provided either in a specific service entity or private practice.
When information can be shared without consent	
Reporting suspicion to the chief executive (s159MA) Entities may share information with each other to decide if they should inform Child Safety about suspected harm or risk to a child or that an unborn child may be in need of protection after they are born.	***Assessing a domestic violence threat (s169D)*** A prescribed entity or specialist domestic and family violence service provider may *give* information to any other prescribed entity or specialist DFV service provider if it reasonably believes a person fears or is experiencing DFV; and giving the information may help the receiving entity assess whether there is a serious threat to the person's life, health or safety because of the DFV. A support service provider (or 'other' service provider) may *only give* information to a prescribed entity or specialist DFV service provider if it reasonably believes a person fears or is experiencing DFV; and giving the information may help the receiving entity assess whether there is a serious threat to the person's life, health or safety because of the DFV. A support service provider is **not** able to *provide* information to, or *receive* information from, another support service provider, or to *receive* information from another entity under this provision.
Assessment or investigation (s159MB) Entities may give information to Child Safety to help investigate harm or risk of harm and assess a child's need for protection or an unborn child's need for protection after birth; or take other action or decide whether Child Safety suspects a child is in need of protection. Child Safety may also give entities information to help them decide whether and what information to give to Child Safety.	***Responding to a serious DFV threat (s169E)*** A prescribed entity, specialist DFV service provider or support service provider may *give* information to and *receive* information from, any other prescribed entity, specialist DFV service provider or support service provider if it reasonably believes a person fears or is experiencing DFV; and giving the information may help the receiving entity to lessen or prevent a serious threat to the person's life, health or safety because of the DFV.
Assessing care needs and planning services (s159MC) Prescribed entities and service providers may give information to Child Safety to help Child Safety with the development or assessment of a child's case plan, assess or respond to, make plans or decisions or provide services to a relevant child or	***Permitted uses of shared information (s169G)*** A prescribed entity or specialist DFV service provider may use information given to it under Division 2, Information sharing (DFVPA), s169D - 169F to the extent necessary to: a. assess whether there is a serious threat due to DFV;

CPA Guidelines	DFVPA Guidelines
the child's family or offer help and support to a pregnant woman.	b. lessen or prevent a serious threat due to DFV, including by: (i) contacting, or attempting to contact, the person or another person involved in the DFV; or (ii) offering to provide assistance or a service to the person or another person involved in the DFV. A support service provider may use information given to it under Division 2, Information sharing (DFVPA), s169E to the extent necessary to lessen or prevent a serious DFV threat, including by: a. contacting or attempting to contact the person or another person involved in the DFV; or b. offering to provide assistance or a service to the person or another person involved in the DFV.
Decreasing the likelihood of a child becoming a child in need of protection (s159MD) Child Safety and prescribed entities may give service providers and other prescribed entities information to help assess or respond to a child's needs or plan or provide services to a child or the child's family to decrease the likelihood of a child becoming a child in need of protection. A service provider may give information to a prescribed entity to help decrease the likelihood of the child becoming a child in need of protection.	
Facilitating participation of child or child's family (s159ME) Child Safety and an independent Aboriginal or Torres Strait Islander entity for a child (independent person) may share information with each other to help the independent person facilitate the participation of the Aboriginal or Torres Strait Islander child or the child's family in decision making planning, or providing services to the child or child's family. An independent person may give Child Safety information to help Child Safety provide or offer to provide services to the child or child's family.	