

Family Group Meeting Convenor Handbook

Second Edition | Version 2 | August 2022



The *Strengthening Families Protecting Children Framework for Practice* was developed with the assistance of Philip Decter, Raelene Freitag and Heather Meitner of the National Council on Crime and Delinquency (NCCD) A Child's Research Centre and Sonja Parker, Eleonora De Michele and Catherine Santoro of SP Consultancy. Copyright is jointly owned by Department of Communities, Child Safety and Disability Services, the NCCD A Child's Research Centre and SP Consultancy.

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Introduction

Background of collaborative family decision making

From 1 July 2016, Child Safety transitioned to the Collaborative Family Decision Making program (CFDM). CFDM aims to:

- implement collaborative family decision making throughout the child and family system
- provide a consistent and empowering experience of decision-making and case planning/support planning for children, young people and their families who are involved with Child Safety
- embed practices that uphold the *Strengthening Families, Protecting Children Framework for Practice* (Framework for Practice) principle that we listen to children's, families' and communities' views and involve them in planning and decision making
- provide resources to increase and ensure CFDM processes.

In addition to new approaches introduced with the CFDM program, departmental investment in CFDM changed the operational structures of FGM delivery. Operationally, terminology relating to Family Group Meetings and convenors changed. The program is called Collaborative Family Decision Making and the practice is called family led decision making.

Version History

Interim update July 2016

This interim update encouraged increased use of FGMs at other stages of decision making, co-convening approaches and incorporated training in FGMs delivered in 2015 by SP Consultancy. This update is consistent with CFDM intent and practice approaches broadly, however it does not provide specific practice and procedural detail on some of the new approaches that may be incorporated into CFDM.

This update reflects the changes to the case plan template on ICMS consistent with the Framework for Practice. Content throughout the handbook was updated to reflect strengths-based approaches and Framework for Practice assessment and planning techniques applied to the FGM planning and delivery.

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Following significant amendments to the *Child Protection Act 1999* and the Child Safety Practice Manual, the handbook has been updated to reflect changes in legislation procedures and practice guidance. Key amendments relevant to this handbook included the introduction of the Independent Aboriginal or Torres Strait Islander entity (and the cessation of the Recognised Entity), Child Placement Principle and amendments regarding permanency, case plans and case planning processes.

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Updates to reflect changes to use of Structured Decision Making tools.

Future editions

As the CFDM program and family-led decision making practice evolves, tools, resources and practice approaches will be developed in conjunction with regional staff, and an amended version of this handbook will be developed in the future.

Purpose of the Handbook

The Family Group Meeting (FGM) Convenor Handbook is a practical guide to assist new and experienced FGM convenors (and other officers who convene or are involved in the process of a FGM) to prepare for, and convene, a FGM. It also helps with developing and recording a case plan for a child subject to ongoing intervention (with parental agreement or a child protection order).

The handbook should be read in conjunction with the Child Safety Practice Manual (CSPM) and *Child Protection Act 1999*. There are references to the relevant sections of these documents in each chapter. FGM convenors are expected to apply their professional knowledge, experience and skills to undertake the 'Key steps' and reflect on the 'Practice considerations' detailed in this handbook.

Where applicable, a list of resources is included in the Handbook, FGM convenors should also refer to Child Safety's Intranet for the most up-to-date resources.

This handbook complements other training material developed for FGMs and other family-led decision making approaches.

Note on terminology: the FGM Convenor Handbook is intended to provide advice to convenors. To make the document more readable and personal, convenors are referred to as 'you'. However it is recognised that there are other internal and external stakeholders that will use this handbook for reference or guidance. In some cases those stakeholders will undertake or share responsibility for processes and activities that this handbook may refer to as the role of the convenor. Users of the handbook are encouraged to discuss their role and contribution with the child safety service centre manager and other staff.

As lead agency for child protection in Queensland, the Department of Child Safety Youth and Women ('Child Safety') works with families to support and strengthen their capacity to protect and care for their children. Family Group Meetings (FGMs) play an important role in case planning and decision making for children and their families at key points in child protection. Facilitating FGMs is an integral part of Child Safety's collaborative approach.

Child Safety's *Strengthening Families, Protecting Children Framework for Practice* (the Framework for Practice) is a strengths-based, safety-oriented approach that introduces collaborative assessment and planning processes into all critical decision making about children and families. Central to the Framework for Practice is the Collaborative Assessment and Planning (CAP) framework, which can be applied at any stage of Child Safety's involvement with a family. CAP-based FGMs and other family decision making meetings empower families in accordance with the principles of the Framework for Practice.

The CAP tool has been used throughout this edition of the handbook to demonstrate how a FGM should be facilitated and what information must be gathered and documented.

There is a suite of practice tools and processes to support FGMs including preparation and group decision making. FGM convenors and associated practitioners can match the tool and process to the needs of the child and family. As convenor, use your professional judgement to match FGM meeting content and processes to the needs of each individual family.

Purpose of Family Group Meetings

FGMs provide a forum for consultation, collaborative assessment and planning with the child and the child's family and community.

The purpose of FGMs is to provide family-based responses to a child's protection and care needs. They also ensure an inclusive process for planning and making decisions about a child's wellbeing and protection and care needs (*Child Protection Act 1999*, section 51G).

In accordance with current legislation and policy, a FGM **must** be convened to develop a case plan for a child (that is, an *initial* case plan) and **may** be convened to:

- review and prepare a revised case plan
- consider, make recommendations about, or otherwise deal with, another matter relating to the child's wellbeing and protection and care needs.

The Childrens Court may also order that a FGM be convened (*Child Protection Act 1999*, section 51H).

The Framework for Practice strongly encourages the inclusion of families in decision making during any phase of departmental intervention. Child Safety staff and FGM convenors are encouraged to look for opportunities to involve children and families in collaborative decision making wherever and whenever possible. This may include an independently convened family led decision making process at earlier stages, prior to a decision about protection, depending on the circumstances of the case. Aboriginal and Torres Strait Islander Family led decision making is also offered by the Family Participation program during investigation and assessment and ongoing intervention.

Further information about applying family-led decision making, in planning, assessment, monitoring and reviewing, is provided in Chapter 1 of this Handbook.

Values and principles

The manner in which FGMs are undertaken is based on the Framework for Practice, which includes a core set of values and principles.

Values

Values underpin and shape every part of our work — the way we respond to our clients and one another, how we structure our activities, how we set goals, form relationships, gather information, assess, plan and facilitate change. The values underpinning FGMs and collaborative family-led decision making are:

- family and community connection
- participation
- partnership
- cultural integrity
- strengths and solutions
- fairness
- curiosity and learning.

Principles

The principles give direction to convenors and other practitioners and help to translate the values into action. The principles underpinning FGMs are:

- We always focus on safety, belonging and wellbeing.
- We recognise that cultural knowledge and understanding is central to a child's safety, belonging and wellbeing.
- We build collaborative working relationships and use our authority respectfully and thoughtfully.
- We listen to a child's, families' and communities' views and involve them in planning and decision making.
- We build and strengthen networks to increase safety and support for children, young people and families.
- We seek to understand the impact of the past but stay focused on the present and the future.
- We are rigorous and hopeful in our search for strengths and solutions.
- We critically reflect on our work and continue to grow and develop our practice.

Role of the Family Group Meeting convenor

As FGM convenor, you have two functions — firstly, a prescribed role which involves completing specified tasks as required by the *Child Protection Act 1999*, and secondly, a convening role which involves using your skills and knowledge to effectively convene collaborative, family-led FGMs.

FGM convenors are delegated under the *Child Protection Act 1999* (section 51H) to convene an FGM, and you must convene FGMs in accordance with the requirements of that Act. This requires FGMs to provide family-based responses to a child's protection and care needs, and to facilitate an inclusive case planning and decision making process for the child.

FGM convenors are independent from the ongoing intervention provided by Child Safety and do **not** carry out case work tasks or make decisions about children subject to intervention by Child Safety. This independence is important to the integrity of the FGM process and enables convenors to engage with all participants to assist them to reach agreement about key items in the case plan.

Provide the child, members of the child's safety and support network with meaningful opportunities to participate in the development of the case plan and/or make decisions about the child's care and protection needs. Given the often adversarial nature of statutory child protection intervention, your role also includes listening carefully; engaging safety and support network members, Child Safety and other professionals in an open, fair and respectful manner; and facilitating and resolving conflict.

In your role as convenor, you bring together and use the Framework for Practice values and principles, the guidelines that support facilitated meetings and your child protection knowledge and professional skills.

The use of an independent FGM convenor is not always possible. There may be times when the case worker or Senior Team Leader working with the family facilitates the FGM. The Framework for Practice encourages case workers to hold CAP meetings with small or large groups of the child's family members, network members and other professionals in the course of their day-to-day decision making and case work. It is preferable to have an independent FGM convenor or private convenor in situations where the complexity of the child protection concerns, cultural considerations or the contentiousness of the case means independence from Child Safety is important.

For an Aboriginal or Torres Strait Islander child, a referral can be made to the Family Participation Program (FPP) to facilitate an Aboriginal and Torres Strait Islander family led decision making process with the family.

Private convenors

The *Child Protection Act 1999* (section 51I) makes provision for private convenors (non-departmental employees) to convene, or co-convene, a FGM. Most private convenors are recruited and managed by the CFDM program. A private convenor must be appropriately qualified. If a private convenor is engaged to convene a FGM, the departmental delegate must ensure the private convenor complies with Part 3A of the Act (case planning), and follows the same processes and responsibilities that apply to departmental convenors.

Private convenors could be a cultural entity or have specialist qualifications. This will depend on the circumstances of the case.

A referral may also be made to the Family Participation Program (FPP) to convene a family led decision making process that also meets the requirements for an FGM. In providing this service, The Family Participation Program are acting as private convenors under the Act.

Responsibilities of the Family Group Meeting convenor

You are responsible for completing prescribed tasks and implementing effective processes.

Prescribed tasks

The *Child Protection Act 1999* requires a FGM convenor to:

- provide relevant persons with reasonable opportunity to participate (section 51L)
- prepare participants to participate in the FGM (section 51M)
- obtain the views of persons who are unable to attend the FGM (section 51N)
- record the case plan developed at the meeting in the approved form (section 51O).

Processes

In convening collaborative meetings, a FGM convenor is responsible for:

- ensuring FGM preparations are culturally respectful, taking into account and actively mitigating the effects of power imbalances caused by differences in age, cultural/familial

positioning, gender, relationship factors and the use of statutory power

- modelling and encouraging respectful relationships, both during the preparation phase and during the FGM
- promoting a family-focused and strengths-based approach throughout the FGM process
- guiding the FGM process to build shared understanding and agreement between participants, so that everyone can take responsibility for a successful outcome
- being clear and transparent about how decisions will be made, what decisions are going to be made, and who is responsible for making each decision
- helping the group to reach collaborative decisions whenever appropriate
- encouraging all participants to contribute, including helping to organise their ideas and information, and guiding and managing the process of building agreement
- keeping the process on track and moving forward with all participants engaged, while making best use of time and resources.

Guidelines that support facilitated meetings with families

‘Nothing about us without us’

Child Safety has significant power to intervene in the lives of families and the parent-child relationship. This statutory power needs to be exercised if a parent is unable or unwilling to protect their child from significant harm. However, Child Safety has a responsibility to ensure that this power is exercised in ways that are respectful and preserve the dignity of family members. FGMs are designed to foster inclusiveness and collaborative decision making, so that the strength, capacity and empowerment of parents and families is enhanced rather than undermined by Child Safety’s involvement. The expression ‘nothing about us without us’ captures this commitment to ensuring that all planning about the family is done with the family.

Effective facilitation focuses on outcomes, process and relationships

An effective FGM convenor will:

- clarify the purpose of the meeting and design an agenda that will best assist the group
- guide and lead the discussion so the group can work through the agenda effectively while enabling everyone in the group to participate
- create opportunities and processes that enable the participants to build stronger working relationships with each other.

FGMs are part of the assessment, decision making and planning process

Family-led decision making practices, including FGMs, are a significant part of the overall assessment, decision making and case planning process. They are held at critical planning and decision making points along the child protection continuum and involve family members and

their networks in assessing and planning for the child's safety and wellbeing. They are not exclusively used *after* a protection decision has been made.

FGM coordination involves facilitating change

FGMs provide opportunities for family members, network members and professionals to get together to identify dangers for the child and work out a case plan with realistic and meaningful solutions. This is a change process, which may require family members to make significant shifts in the way they are living their lives. Facilitation is the key that helps people make the shifts that are required in a change process — understanding the need for change, seeing a different future and acknowledging that making a difference requires changes in their own thoughts, attitudes and behaviours.

Facilitation is a questioning approach focused on helping people to think through where they are, where they want to go and how they are going to get there.

The problems are usually complex and there are usually multiple (and different) views

There is often a range of factors that make it difficult for FGM participants to meet and talk about problems and work together to create solutions. The problems (or perceived problems) within the family are usually complex, and professionals and family members may hold very different views about the issues. There are understandably strong emotions associated with harm or perceived harm to a child and the removal of the child from the family's care, or the fear that this may happen. There may also be complicating factors that make it difficult for people to focus on the issues, such as substance use, mental illness, trauma or extreme stress.

Importance of being multi-partial

FGM convenors are independent from the ongoing intervention provided by Child Safety. This allows the convenor to step back from the detail and focus on the process and help the group work together. The idea of a convenor being 'multi-partial' means making sure everyone's voices are heard and each person's ideas are considered. The convenor should be perceived as being on everyone's side at all times.

Families are resourceful and can contribute to solutions

Effective facilitation starts from a position of equal respect for all participants, so that family members are given the opportunity to use their resourcefulness and contribute to solutions that provide for a child's safety. Family members are the experts on their own family. The best outcomes for a child result when families and their networks participate meaningfully in decision making about the child's safety, care and wellbeing.

Your role as convenor is to ensure that the structure and process of the FGM allows the family (and safety network) to participate to the greatest possible extent.

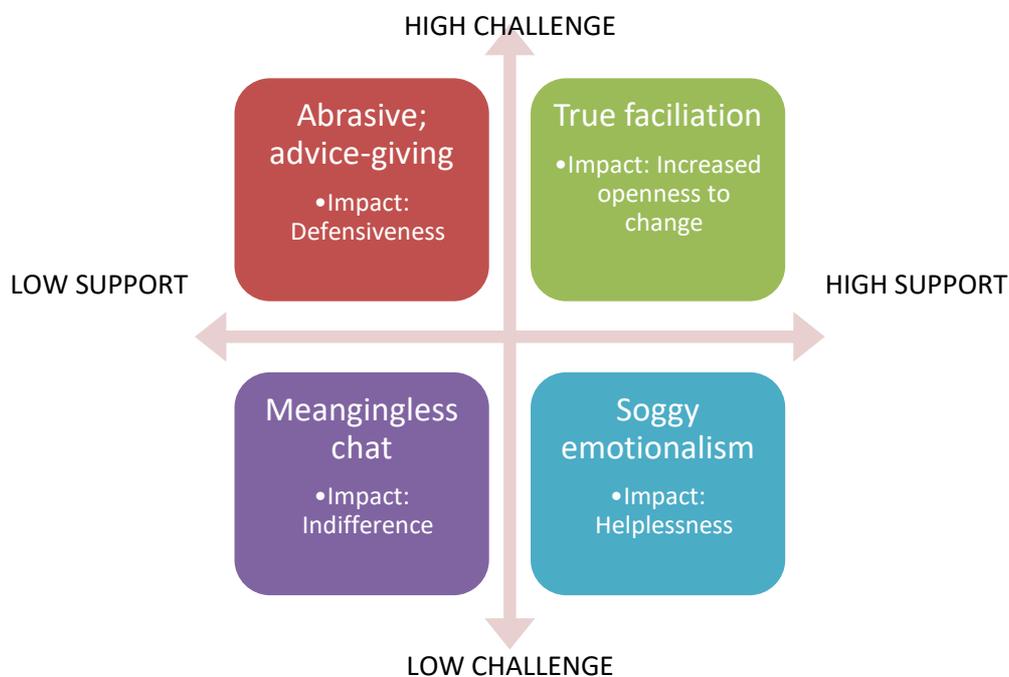
Facilitating FGMs involves managing authentic conversations

It is common for participants in FGMs to feel and express strong emotions, such as grief, anger, despair or frustration. While this can be difficult to manage, expressing strongly felt emotion is a legitimate and necessary part of people being fully present in the situation and being open to the process of change. It is important that the expression of emotion does not impede the meeting or get in the way of people being able to work collaboratively. Effective facilitation of

FGMs encourages participants to engage in authentic conversations, in ways that are respectful and enable the group to remain focused on working toward the desired outcome.

Facilitation supports and challenges the participants

FGM convenors need to simultaneously support and challenge the participants. If participants are supported without being challenged, they may walk away feeling well-supported and listened to, but without having been challenged to reflect on their assumptions or focus on the need for change. If participants are challenged without feeling supported, they may feel as if their views and positions are not understood and may become defensive and unwilling to change. To create a space where participants can speak honestly about their own positions and remain open to hearing the views of others, you need to offer both 'high support' and 'high challenge' as described by Jenny Rogers (2010) in her *Support and Challenge Matrix*:



Preparation, preparation, preparation

Good facilitation is all about preparation. It is your responsibility to make sure that before the meeting:

- all the participants are clear about the purpose of the meeting (and have participated in identifying the purpose, wherever possible)
- all the participants have as much information as possible about what will be covered during the meeting (process and content)
- any critical information that could significantly impact the meeting is shared beforehand, if possible (particularly information that is likely to be contentious, such as allegations or substantiation of harm to the child, critical incidents that have recently occurred, significant changes in the family's circumstances, and critical decisions that have recently been made, including applications to the Childrens Court and change in placement).

The convenor must make sure that participants have been prepared before the FGM. The child's CSO or Team Leader may oversee the preparation of parties participating in FGMs, but you should work closely with them to follow up on preparation. You can also provide support to ensure that all relevant members of the safety and support network are aware of the FGM and are supported as much as possible to join the FGM or have their views represented.

Involve children and young people in FGMs

The question is not *whether* a child or young person should participate in FGMs, but *how* should they participate. Participation ranges from the child attending all of the meetings, through to not attending and having someone else represent their views. In general, if the child is old enough to understand the purpose of the FGM and wants to attend, then they should attend as long as it is safe for them to do so. Decisions on the extent to which the child attends the meetings need to be made together with the child's parents, the child and Child Safety. For attendance to be a positive experience, the child needs to be prepared beforehand and supported during the meeting, and given feedback afterwards.

Involve carers in FGMs

The question is also not *whether* carers should participate in FGMs, but *how* they participate. In accordance with the *Child Protection Act 1999* (section 51L), convenors must give other people who have a significant relationship with the child, an opportunity to attend and participate.

Carers, including kinship carers, may participate in all or part of the meetings, or may provide information in another way as negotiated with the convenor (instead of attending the meeting in person). In circumstances where carers have a different cultural background from the family, this dynamic should be managed sensitively.

Carers contribute important information, such as the strengths and needs of the child, their parents and family members, and the child's daily care and support needs. This enhances the child's safety, wellbeing and belonging. Carers may also offer direct support or other resources.

Practice considerations for your role as a Family Group Meeting convenor

The following table by Michael Wilkinson¹ provides a summary of your role as a convenor. The role of the convenor is complex and it may take years before you feel comfortable and experienced in the role. You can read and study the skills, but the best way to feel more confident and competent is through practice.

Guide	You should design and plan the agenda and select tools that best help the group achieve the purpose. Then carefully guide the participants through each step of the meeting process.	
Motivator	From the beginning of the meeting to the closing statement, you should encourage and motivate the group to focus on their task. Pay attention to the energy of the group, establish the pace and maintain the	
Bridge builder	You should help everyone express their different views. Focus on identifying similarities that build bridges to consensus.	
Clairvoyant	Throughout the meeting, watch for signs of anxiety, fear, anger and disempowerment. Respond quickly to avoid dysfunctional behaviour.	
Praiser	At every opportunity, you should praise the efforts of participants, the progress made, and the results achieved. Praise well, praise often and praise specifically	
Peacemaker	It is almost always better to avoid a direct confrontation between participants. But should one occur, you should step in quickly, re-establish order and direct the group toward a constructive resolution.	
Taskmaster	You are ultimately responsible for keeping the meeting on track. This means interrupting irrelevant discussions, preventing detours and maintaining a consistent level of focus throughout the	
Active listener	At every opportunity, you should make a conscious effort to hear and understand the content, intent, meaning and feeling of what is said.	

Chapter 1: Preparing for a Family Group Meeting

This chapter will provide you with an understanding of your role in preparing for a FGM.

Welcome to Country resource

Protocols outlining the 'Welcome to Country' or 'Acknowledgement of Traditional Owners and Elders' that can be used at the beginning of a FGM when convening a meeting for an Aboriginal or Torres Strait Islander family can be found on the [Queensland Government webpage – Welcome to Country](#).

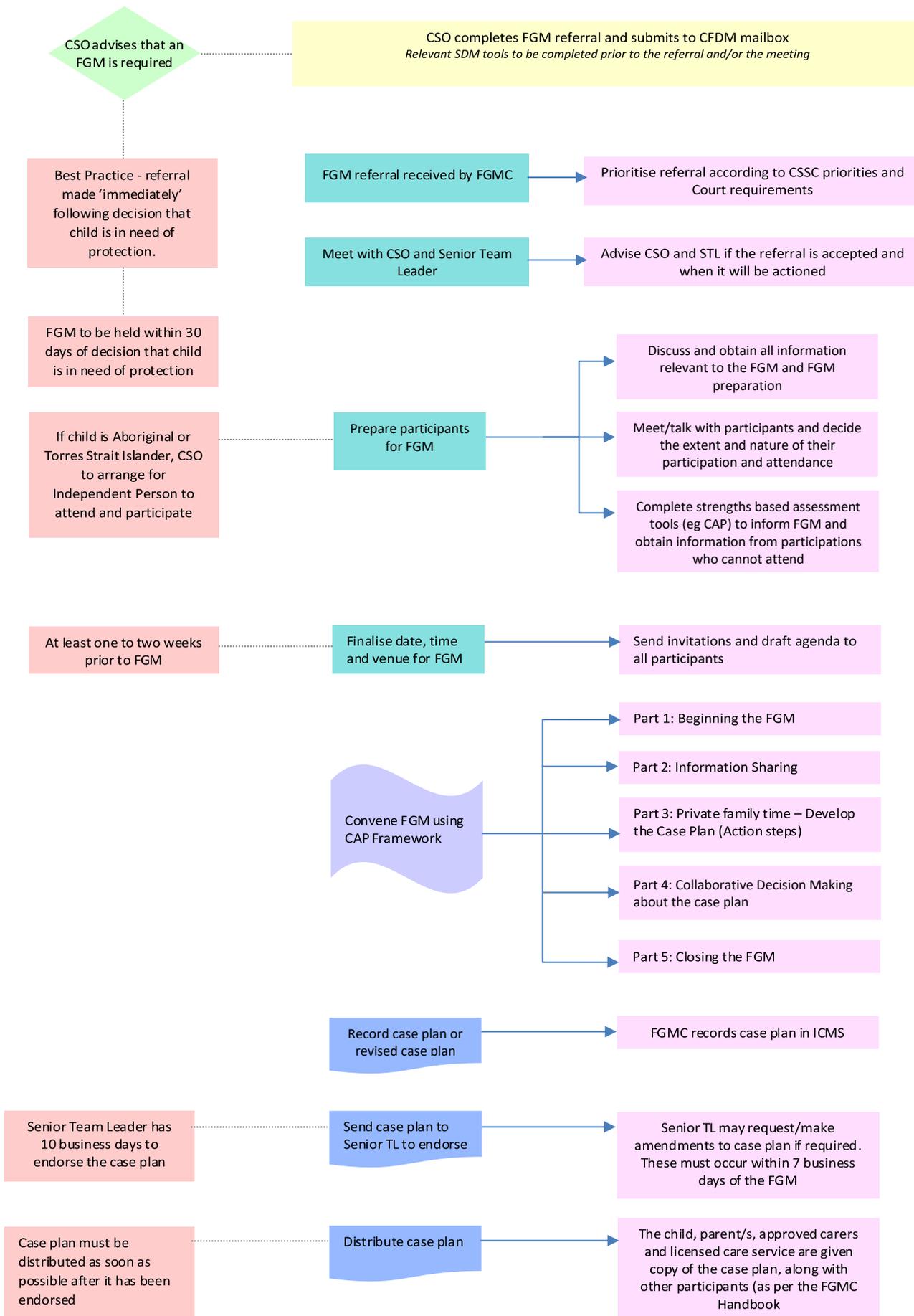
Aboriginal and Torres Strait Islander cultural considerations

If the child is Aboriginal or Torres Strait Islander, you must ensure there is reasonable opportunity for an Independent Person to attend and participate (unless the child family do not consent or it would have a significant negative effect on the child or another person's safety or wellbeing), and consider how the five elements of the Child Placement Principle [prevention, partnership, participation, placement and connection] will be demonstrated and applied in the FGM process and the case plan.

Also consider the following and discuss with the family prior to the FGM:

- The most appropriate way to begin the meeting, including the person to acknowledge the traditional owners of the land on which the meeting is being held and how this acknowledgement will occur, how to welcome and introduce participants to the FGM, and what is to be stated in the welcome and introduction.
- Any family issues or dynamics impacting on the FGM process.
- Any family group members, safety and support network members or significant others who is to be invited to FGM.
- The most culturally appropriate process to facilitate the FGM.
- The Child Safety's worry statements, goal statements and 'non-negotiables' for case planning.
- The most appropriate person to help family members to think through their views (across all elements of the CAP framework) and prepare participants for the FGM, if the family members views have not already been sought.
- Details of any service providers to meet the child's and family's needs such as the Family Wellbeing service.
- The most appropriate venue and time for the FGM.
- Any kinship care options from the child's family and community group that have not been explored and could be discussed at the FGM.
- The most appropriate cultural protocols for ending the FGM, who will end the meeting and how this will occur.

Flowchart: Family group meeting process using the CAP framework



Families from a culturally and linguistically diverse background

If the family is from a culturally and linguistically diverse (CALD) background, ask the family or appropriate community members about the cultural and family practices that need to be considered when preparing for the FGM (including the most appropriate cultural protocols for opening and ending the FGM), and whether an interpreter is required.

If the family refuse an interpreter consideration is to be given about why they have made this choice and efforts is to be made to explore other interpreters or services that the family may be more comfortable with. If the Child Safety Officer and FGM convenor have assessed the family's language skills and comprehension and are concerned about family's ability to understand what will be discussed at the FGM, organise an interpreter to be present. The family must be advised of this prior to the FGM.

Step 1: Referral and purpose of the Family Group Meeting

Within **30 days** of a decision being made that a child is in need of protection, or within the timeframe set by the Childrens Court on an adjournment (the lesser timeframe), a FGM must be held to develop an initial case plan.

As a minimum, the case plan must be reviewed every **six months**; however, it may be appropriate to review the case more frequently, taking into account:

- the child's age, circumstances and developmental needs
- any change that has a significant impact on the direction of the case plan, or where there are significant changes to the child's needs or safety
- the nature of the specific provisions, outcomes and actions of the case plan
- any anticipated problems with the plan
- the duration of the order (the shorter the order, the more frequent the case plan review should be) if a child protection order is in place.
- if the child turned 15 since the plan was developed and the plan does not already include actions to help the child transition to adulthood, a review would be required to include these actions

Convening a FGM to review and revise a case plan is particularly helpful when:

- there is disagreement between family members and Child Safety about the goals and actions to be included in the revised case plan
- the child's and/or parents' situation has changed significantly
- actions from previous case plans have not been completed
- changes to the revised case plan are being proposed which would significantly change the goals
- the family or Child Safety see benefit in holding an inclusive and family-led, independently-convened process to review the case plan.

When a FGM is to be held to revise a case plan, the FGM processes and responsibilities, and roles of the convenor are the same as if they were convening an initial FGM.

Note: Participants involved in the review of the case plan may or may not have participated in the development of the initial case plan, or in a previous case plan review or a previous FGM. If this is the case, time will need to be spent during the preparation phase to ensure that these participants understand the initial case plan and the FGM process.

Referral process and timeframes

To initiate the FGM process, the Child Safety Officer will complete a FGM referral form for you. The referral form clearly specify the purpose of the FGM. The Collaborative Assessment and Planning (CAP) tools or other tools, such as the Three Houses or Family Roadmap and activities recently completed with the family may also be provided to you.

Ensure you have received the completed referral with enough time prior to the FGM to be able to prepare for the meeting. It is necessary to allow sufficient time to find and meet with family, engage with them and develop a relationship sufficient to facilitate their participation in the FGM process. It is recommended that the Child Safety work group be informed of your timeframes to ensure sufficient time is allowed for receipt of referrals, in particular when considering legislated FGMs.

It is your responsibility as FGM convenor to advise Child Safety staff of the referral process as part of requesting a FGM in their child safety service centre or region. You also need to prioritise and record referrals received and ensure they are filed accurately upon completion of the FGM process.

Consult with the Child Safety Officer and others, if necessary, if there are any aspects or details on the referral form that are not clear.

Practice considerations for the referral process

- Principal Team Leaders are to meet with regional leadership teams on a regular basis to discuss the prioritisation of referrals (for example, priority could be given to court ordered FGMs or case plans that are being lodged as part of an application for a child protection order). Provide information about the number and type of referrals being received to assist planning by the child safety service centre.
- Meetings with the CSSC management teams will also assist to determine the nature and expectation of the role within the CSSC. This includes the role of FGM convenors in convening family-led decision making meetings at other stages of the case work cycle.
- Meet regularly with the Senior Team Leaders to discuss upcoming FGMs, any issues or trends arising in FGMs or any concerns regarding the quality of the referrals, case-related material or SDM assessments being received.
- Provide feedback to Senior Team Leaders and Child Safety Officers about the quality of referrals being received, what is working and what needs to be improved.
- Talk to the Child Safety work group about the current issues and trends with FGMs and any areas of improvement needed with the referral process and quality of information being received to assist in the preparation of FGMs.
- Liaise regularly with the Office of the Child and Family Official Solicitor to discuss upcoming court-ordered FGMs to assist in the prioritisation and planning.
- Establish your own learning and development plan about how you will work with Aboriginal or Torres Strait Islander children, families and communities in a way that is culturally appropriate and applies all five elements of the Child Placement Principle; prevention, partnership, placement, participation, and connection.

Referral information regarding decision making and assessments

Providing information to the FGM convenor is mainly through the FGM referral form. The Child Safety Officer may attach the most recent (approved) structured decision making (SDM) assessments or other relevant information to the FGM referral form to provide additional information. It is vital that you have all of the information you need before engaging with the family and preparing for the meeting.

When convening a FGM to review and revise a case plan, the Child Safety Officer must provide you with the FGM referral and the following supporting documentation (based on re-assessments):

- child strengths and needs assessment
- parental strengths and needs assessment
- safety assessment (where required) and any recent immediate safety plans that have been developed to address an identified immediate harm indicator
- completed review report (when applicable).

Note: When a child is subject to an order granting guardianship to a suitable person or a permanent care order and a referral is made to convene a FGM to review and revise a case plan, the parental strengths and needs assessment is **not** required to be completed. The child strengths and needs assessment is also **not** required to be completed *unless* a decision is made by Child Safety to vary the long-term guardianship order from a suitable person to the chief executive. However, it may be completed as good practice.

The table below identifies the SDM strengths and needs assessments that are used to inform the outcome of the case plan review.

Intervention type	Case plan review for an in-home intervention	Case plan review for CPO with a goal of reunification	Case plan review for a CPO with another primary goal other than reunification	
Structured decision making (SDM) assessment			<i>Custody or guardianship to CE</i>	<i>Guardianship to suitable person or permanent carer</i>
Child strengths and needs assessment (CSNA)	Yes	Yes	Yes	Not required– <i>unless</i> a decision to vary existing order (can be done as best practice)
Parental strengths and needs assessment (PSNA)	Yes	Yes	No	No

Step 2: Meet with the Child Safety Officer and Senior Team Leader

In preparing for the FGM, you must meet with the Child Safety Officer and Senior Team Leader who have current case management responsibility and the Cultural Practice Advisor (for Aboriginal or Torres Strait Islander children), to obtain more detailed information on the case and

ensure that they are clear on their assessment and are across all information included in the FGM referral.

During this meeting, request the following information:

- Information about the Child Safety's involvement with the family and the family's level of, and attitude towards, engagement with Child Safety during the investigation and assessment (for initial case plans) or ongoing intervention (for revised case plans), where that information is relevant to independently facilitating a FGM only. The FGM convenor does not undertake decision making in relation to this information.
- Information obtained from assessment and planning meetings undertaken to date with the family (which may be recorded within the CAP framework, the Three Houses tool or the Family Roadmap). This information needs to include the Child Safety's views and the views of the child, the parents, other significant family and network members, and other stakeholders across all elements of the CAP framework. This information forms the basis of the case planning discussions at the FGM.
- The worry statements and goal statements and the extent to which these statements have been developed collaboratively with the family, as well as the Child Safety's 'non-negotiables' for case planning. These 'non-negotiables' identify the actions that Child Safety must see in the case plan to be confident that the child is safe. Ideally, the worry statements, goals statements and non-negotiables will have been developed collaboratively with the family prior to the FGM, or at a minimum, Child Safety's views will have been shared with the family. The intent is that there will be no surprises for the family at the FGM. If this has not happened, discuss with the Child Safety Officer and Team Leader who is the best person to have these conversations with the family prior to the FGM.
- Specific key items to be included in the case plan, or revised case plan, which need to be discussed with participants during preparation (**Note:** specific key items must be included in a case plan or revised case plan when Child Safety decides to apply for an order granting long-term guardianship to a suitable person or a permanent care order). For further information, refer to the CSPM [Assess and prepare to develop the case plan](#) and Chapter 3 of this Handbook. Ideally the key items will have emerged through discussions prior to the FGM.
- Information about parental strengths and needs that have been identified or prioritised with the parents and recorded on the Parental Strengths and Needs Assessment (PSNA), for in-home and reunification cases. This will be discussed as part of the development of the current case plan.
- Complicating factors that may impact on the family's participation in the FGM process (such as history of violence, mental illness, disability, cultural/language) and how these could be overcome in planning the format of the meeting.
- Information about the child's ability to participate in the FGM process and any barriers to this participation (such as age, development, emotional impact on child). Also begin to identify, in consultation with the Child Safety Officer or Senior Team Leader, age-appropriate strategies to enhance the participation of the child in the FGM process. Remember, the child's participation is to be considered in a wider context, not just

attendance at the FGM.

- Information about whether the child or family have nominated an Independent Person to help their participation and whether the nominated person or entity has been assessed as suitable and agreed to be the Independent Person.
- The child's and family's cultural and language needs and the supports and strengths that connection to culture provides. Arrangements can be made to include these supports in the meeting and this will also inform the development or review of the Cultural Support Plan. Children, young people and families are encouraged and supported to have an Independent Person to help them have their say. Significant others who may be able to provide information in relation to traditions, custom, culture and community will also be encouraged to attend.
- Information about what planning has commenced if the young person is eligible for transition to adulthood, and the likely actions and outcomes that need to be included in the current case plan to effectively support and assist the young person with their transition from care to adulthood.
- Information about other kin/family/agencies that will attend the FGMs and their role, noting that you will also play an active role in supporting the family to identify stakeholders who may attend, or contribute, to the FGM.
- Information about the best place and time for the meeting to be held from the child and family's point of view.
- Information about any person whose participation is not in the best interest of the child or would be contrary to the purpose of the FGM. The FGM convenor has final decision making authority regarding this issue (*Child Protection Act 1999*, section 51L(4)).

Step 3: Organise date, venue and time

Discuss with the family where and how they would like the meeting to be run. For example, the family may have a special place they would like to meet. Organise the meeting based on the family's wishes, to encourage the family to take ownership of the meeting and its processes.

Venue

Having the meeting at the Child Safety Service Centre is to be avoided, unless this is the family's preference. Consider using an external venue in the first instance, such as the family's home a community centre or other common meeting space. This must be agreed with the family during preparation for the FGM, and you must ensure confidentiality at the external venue.

If the family cannot identify a suitable location, consider suggesting an Aboriginal or Torres Strait Islander Community Controlled Organisation or service and use their office for the meeting. Service providers working with the family may also suggest a suitable venue.

Consider the following issues when arranging the venue for the FGM:

- Accessibility, particularly for participants, including those with disability.
- The cultural appropriateness of the venue.
- The venue setting to support the participation of all people attending the FGM, including

- considerations for privacy, confidentiality and safety for all participants
- The size of the venue and whether space is available for private family time.
- The child's needs and whether the venue is conducive to the child's participation.

Time

A FGM may take between two to six hours. Be flexible with setting the time and date flexible as it may need to change to ensure that the child, their family and significant others are able to attend. Also consider whether child care can be provided to enable a parent to attend. Be sure to consult with the CSO and Senior Team Leader on setting the date and time of the FGM

Keep in mind that when a child attends a meeting, or when working with Aboriginal or Torres Strait Islander peoples or a family from a CALD background, allow more for participants to process information and work together to reach agreement about the case plan goals and actions. The family are discussing difficult topics and this will be tiring. If the meeting is expected to go beyond three hours, consider conducting the FGM over two sittings.

While encouraging timeliness, be prepared if family members do arrive late. The meeting may be difficult for some attendees due to personal circumstances and histories.

Catering and writing materials

Consider providing refreshments and writing materials for participants as these factors have been shown to impact positively on people's participation in FGMs¹.

Family travel expenses, catering and writing materials may be approved by the relevant financial delegate, under the *Child Protection Act 1999*, in accordance with Child Safety's Policy No. CPD598-7 *Child Related Costs — Client Support and Family Contact*. A Child Related Costs Approval Form is to be submitted to the CSSC manager prior to the FGM.

Step 4: Meet with the child

In preparing for the FGM, you must ensure the child understands the purpose and process of the FGM. Topics for discussion with the child include:

- The child's understanding of the FGM process, why an FGM is being convened, what a case plan is and how it affects them, and the nature of any significant decision to be made during the FGM.
- Who will be attending the FGM and what their roles are and the nature of the child's relationship with the participants.
- Any other family members, safety and support network members or significant people that they would like invited to the FGM.
- Whether they would like a support person (assistance can be provided to help locate a support person and prepare them for the meeting).

¹ Healy K, Darlington Y, Wiseman M, Smith T (2010/2011) 'Family Participation in Child Protection Policy and Practice: Project Report.'

- Their preferred format for the meeting including opening, closing and process for discussion. Be flexible in facilitating the meeting in accordance with what the child suggests would make them feel comfortable and encourage family discussion and collaboration.
- Cultural considerations and the five elements of the Child Placement Principle, if applicable. This includes having an Independent Person.
- Possible venues for the meeting (consider a comfortable space for the child's participation).
- Timeframes for the meeting.
- Any fears, worries or concerns that the child has about attending the meeting
- Any language or jargon that might be used at the meeting so the child can understand what is being discussed.
- How the child would like to participate in the meeting - do they feel comfortable attending face to face, would they prefer to participate by telephone, or prepare a written statement or video to be presented at the meeting? Who would they like to read their statement if they do not wish to, or would they prefer to draw some pictures or create some other artwork that can be displayed at the meeting? Would it be more appropriate for the child to only participate in part of the meeting?
- How they would like to receive feedback following the meeting and receive information about their case plan.

Before the FGM starts, you **must** discuss with the child:

- if, and how, they wish to participate in the FGM
- explore any concerns they may have about the case planning process and the FGM
- what issues or needs they would like discussed at the meeting
- what outcomes and actions they would like included in the case plan.

The Framework for Practice tools — the Three Houses or the Safety House — can be used to provide opportunities for the child (and their family) to participate in the meeting. If a CAP tool format is used in the FGM, the child's views can inform the assessment and planning components including the worry statements, goal statements and action steps.

In seeking the child's views, it is important to consider whether the child has already expressed their views to the Child Safety Officer or another professional. If this is the case, you can meet with the child (and look at their Three Houses together) to explore whether anything has changed in the child's views and whether there is anything they would like to change or add.

Research into participation suggests that it is the child's relationship with their worker that can determine the quality and level of participation in decision making or case planning forums. Therefore, depending on the child and the nature of their relationship with the Child Safety Officer, it may be more appropriate for the Child Safety Officer to meet with the child to discuss their views prior to the FGM, rather than the convenor.

Together with the Child Safety Officer and Senior Team Leader, decide who the most

appropriate person is (Child Safety Officer, CSSO, Cultural Practice Advisor, the convenor or someone else) to engage the child and prepare them for the FGM. If the child is attending, it is strongly encouraged that you meet with the child prior to the FGM to introduce yourself, explain the FGM process, who will be attending the meeting, and answer any questions that the child may have. It is important that the child has time to process the information and decide how they want to participate, and who they want to represent their views if they are not participating.

Also consider:

- The ability of the child to be able to participate in the meeting — this may involve speaking with the child's family, carer or counsellor for information about their ability to participate and the impact it may have on their emotional wellbeing.
- Any barriers to participation, such as age, development, disability, trauma, drug/alcohol use, emotional impact on child.

Use the Framework for Practice tools, such as the Three Houses and the CAP tool, or other strengths-based tools to discuss the following with the child:

- The purpose of the case plan and the worry statements, goal statements and 'non-negotiables' (also what is negotiable, what they can have a say in).
- The key items for inclusion in the case plan or revised case plan and the child's views on these. The child's perspectives on these can contribute to the CAP process undertaken during the FGM.
- Any relevant reports (if appropriate) and their views on these.
- Any potentially contentious issues that may arise in the meeting, any foreseeable conflicts that may occur and how these could potentially be handled (this may allay some of the child's fears).

Either you or the Child Safety Officer will ensure that a case note is recorded in ICMS detailing the discussion with the child, including their views and wishes in preparation for the FGM.

Aboriginal and Torres Strait Islander cultural considerations

If the child is Aboriginal or Torres Strait Islander, consider:

- the role of the Independent Person in supporting the child's participation
- the ability of the child to participate in the FGM and any cultural considerations regarding the preparation for this meeting
- who will prepare the child for the meeting or talk with the child about their views and wishes
- whether there are any gender-specific issues that require culturally respectful support.

Practice considerations for representing a child who does not attend the FGM

If the child does not wish to participate in the FGM, or it is not in the child's best interest to attend the meeting, you may consider: placing photographs of the child, or artwork that the child has prepared, in the meeting room; playing an audio or video recording of the child (with their permission); or keeping a chair empty to represent the child. These strategies are intended to maintain focus on the care and protection needs of the child at the meeting.

You may also remind all participants that they should speak and make plans as if the child was in the room. Conversations in the FGM always include consideration of the child's views and wishes.

Step 5: Meet with the child's parents

It is vital that parents understand the purpose and process of the FGM, and have the opportunity to participate in decision making about the FGM.

It is also essential that parents are given the opportunity to understand, and participate in, the planning process — to share their views and understand the Child Safety's views across all elements of the CAP framework — so that they are able to participate meaningfully in the development of their child's case plan.

Discuss the following with the parents:

- The purpose of the FGM and the child's case plan.
- Who will be attending the FGM and their role.
- Other family members, safety and support network members or significant people they would like invited to the FGM (**Note:** under the *Child Protection Act 1999* (section 51L(4)), only the FGM convenor can exclude particular persons from attending a FGM — not the parents, however, while section 51L(5) allows for a convenor to not include the Independent Person, the parent can also choose to not have an Independent Person under Section 6AA (3) (b)).
- Any issues to be included in the agenda.
- Contact details of the Independent Person/s, safety and support network members and other support people to attend the meeting. Explain the role of the support person in attending the FGM.
- Confidentiality provisions during the FGM and the dep Child Safety's complaints management system.
- Child Safety's reporting obligations to the Queensland Police Service. (*Child Protection Act 1999*, section 14(2)).
- Any difficulties managing their emotions and reactions during the meeting (if appropriate).
- The structure of the FGM and the emotional impact it may have on them, and where they can seek support following the meeting.
- Factors that may impact on the parents/family's or network member's participation in the FGM process (such as domestic and family violence, mental illness, disability, and culture/language) and how this could be managed — focus on what is required to facilitate a successful meeting.
- The purpose and importance of private family time during the FGM, and how this will occur, including what safety and support strategies parents would require.
- The most appropriate way to begin and end the meeting, including the most appropriate person to acknowledge the traditional owners of the land on which the meeting is being held and how this will occur (if applicable), how to welcome and introduce participants to the FGM and what will be stated in the welcome and introduction.

- Any special needs (such as language, disability).
- The suggested time, date, venue and length of the meeting.
- How they wish to participate in the meeting if they are unable to, or choose not to, attend the meeting (such as by teleconference or by providing written information).

One of the most important factors in the development of an effective case plan is the parents' understanding and critical thinking about what is happening in their family in terms of the safety and wellbeing of their child, and what needs to happen in the future to ensure their child is safe and protected. Prior to the FGM, parents must have the opportunity to share their views and to hear the Child Safety's views, across all elements of the CAP framework.

If parents have not had the opportunity to share their views and hear the Child Safety's views during investigation and assessment, then **it must occur prior to the FGM**. Discuss with the Child Safety Officer and Team Leader who is the best person to have these discussions with the parents. Remember, the Child Safety Officer is the person who needs to build a working relationship with the parents and these assessment and planning discussions can be at the heart of building positive and collaborative working relationships.

Ensure that the parents have had the opportunity to explore their views across all elements of the CAP framework and record this in a form they can bring to the FGM to support their participation. In particular, parents need to have:

- identified their worry statements and goal statements
- heard Child Safety's views on the worry statements, goal statements and non- negotiables for the case plan
- heard the key items specified by Child Safety for inclusion in the case plan or revised case plan and the parent's views regarding these.

Aboriginal and Torres Strait Islander cultural considerations

If the parents are Aboriginal or Torres Strait Islander, consider:

- any complicating factors impacting on the parents' ability to participate in the FGM process
- who the most appropriate person is to prepare the parents for the FGM and how they will be prepared
- the role of the Independent Person to support participation
- any factors that require culturally appropriate support during the FGM preparation process.

Practice considerations for representing a parent who does not attend the FGM

If the parent is unable or unwilling to attend the FGM, they may participate in other ways, either by telephone or preparing a written statement to be read at the meeting, or through the facilitation of a separate discussion (in exceptional circumstances). If the parents continue to be unwilling to participate in this process, the child's case plan can be developed in their absence.

Step 6: Meet with the child's carers

Foster and kinship carers are to have an opportunity to participate in the FGM, where they are considered to be of significance to the child, and the FGM convenor does not believe their participation would be contrary to the purposes of the meeting or not in the child's best interests.

Approved kinship carers will be encouraged to attend and participate in the entire meeting, including private family time. Approved foster carers would usually be encouraged (unless otherwise decided), to participate in information sharing and collaborative decision making about the case plan. However, they would not participate in private family time unless they are invited by the family.

As with all other participants, carers may participate in the FGM in person, by teleconference or by providing written information for consideration in the meeting.

Aboriginal and Torres Strait Islander cultural considerations for carers

If the carers are Aboriginal or Torres Strait Islander, consider:

- any factors impacting the carer's ability to participate in the FGM process
- who is the most appropriate person to prepare the carers for the FGM and how they will be prepared
- any gender specific factors that require culturally appropriate support during the FGM preparation process.

Deciding the carer's attendance and participation in the FGM

Comprehensive and effective case planning occurs with the full and meaningful participation of all the child's network and this includes the carers.

Consider the following specific factors when deciding the carer's attendance at, or participation in, the FGM:

- The nature and significance of the child's relationship with the carers, including the child's views about the relationship, the length of time the child has resided with the carers, and assessments by the Child Safety or service providers involved with the child or the carers.
- Legislated reasons for exclusion and whether these apply to the carers.
- Views of the parents and family members.
- The carer's views of the case plan and support they offer to the family and child.
- How much the carers will be impacted by the actions and outcomes in the case plan (for example, whether they are being asked to provide a significant amount of resources to the case plan).
- The impact of the carer's involvement in the FGM on the participation of parents or other family members in this process. In some cases, having the carers present can negatively impact on the parents' involvement in the FGM — the FGM convenor seeks this information during the initial meeting with the Child Safety Officer and Senior Team Leader.

- Sensitivity/privacy/confidentiality of information to be discussed at the FGM.
- The intent of the FGM — carers will be invited if a FGM is being convened to discuss making an application for an order granting long-term guardianship to the chief executive or to a suitable person and the intended plan is for the child to continue residing with the carers, or for the carers to become the guardian.

You can consider asking the carers to attend and participate only during certain parts of the meeting. For example, you may ask carers to leave the FGM after providing information about the child's progress in the placement (for example, strengths and needs) or to participate in discussions about family contact when the carers are being asked to transport children, or to participate in family contact arrangements.

Advise the carers of this and the reasons why this decision has been made when inviting them to participate in the FGM.

If the carers are not being invited to attend or participate in the FGM, you may speak to them prior to the meeting to seek any relevant information to support the case planning process, and advise the carers that their views and wishes will be shared at the FGM.

The Child Safety Officer will follow-up with the carers after the meeting to inform them of any significant decisions made at the FGM that directly impact on them and the child's placement.

Using the CAP framework, discuss the following matters with the carers:

- The key items for inclusion in the case plan or revised case plan, and their view regarding these.
- Strategies to encourage all participants to engage in only one FGM — *unless* concerns about domestic and family violence prevent this.
- Details of the child protection concerns and the reason for the Child Safety's involvement.
- Information about Child Safety's 'non-negotiables' and what elements of the case plan will be negotiable.
- Any needs that the child may have, such as education, health, therapeutic, behaviour support, cultural support, transition to adulthood; and what services or support the child and carer have been receiving or may require.
- Information about the child's strengths, achievements and routine.
- Options within the child's family group, or with significant others, for kinship placements, respite placements or other resources (for example, assisting with arrangements for family contact or transporting the child to appointments) that could be incorporated in the case plan, if applicable.

Obtaining the carers' perspectives on these case planning elements prior to the FGM can facilitate the CAP process undertaken during the FGM.

Step 7: Decide who will attend

The *Child Protection Act 1999* (section 51L) outlines the people who must be given a reasonable opportunity to attend and participate in the FGM. If a particular person's attendance or participation would conflict with the purpose of the meeting or not be in the child's best interest, you can decide that this person is not to attend the FGM.

The following people **must** be given the opportunity to attend and participate in the FGM (unless justifiably excluded from attending or participating):

- The child, unless it would be inappropriate because of their age or ability to understand.
- The child's parents.
- Other family members who are likely to make a useful contribution to the development of the case plan or revised case plan
- Other significant people in the child's life, for example, the child's approved foster or kinship carers.
- Any legal representative of the child.
- An Independent Person, if the child is Aboriginal or Torres Strait Islander and the family consents.
- The public guardian.
- Anyone else who the convenor considers likely to make a useful contribution to the development of the case plan, or revised case plan.
- Support person for parent or child.

The *Child Protection Act 1999* (section 51L(3)) states that a child's parent does **not** have to agree to a person participating in the FGM process, and you must advise the parents of this during the preparation process).

You **must** also allow the child or the child's parents to nominate a support person to attend and participate in the FGM (unless they are excluded).

After meeting with the Child Safety Officer or Senior Team Leader to discuss the FGM referral, or during the preparation with the child, their family and other participants, you may identify additional people to attend and participate in the FGM. The details of additional participants (where applicable) are to be discussed with the Child Safety Officer or Senior Team Leader. These participants will be invited, unless you decide that their attendance or participation would conflict with the purpose of the meeting, or not be in the child's best interest.

Excluding a person from attending a family group meeting

The *Child Protection Act 1999* (section 51L(4)) authorises the FGM convenor to exclude a particular person from attending or participating in the FGM, if the person's participation would conflict with the intent of the meeting or not be in the child's best interests.

People who can be excluded from the FGM include:

- the child's parents
- other people who have a significant relationship with the child
- the child's or the parent's nominated support person-
- the independent Person.

It is rare for a decision to be made to exclude a person, and only after all options to avoid exclusion have been discussed with the Senior Team Leader and Child Safety Officer. If you are having difficulty deciding whether to exclude a person from a FGM, further advice can be sought from the senior practitioner or manager.

Before making a decision about exclusion, clearly explain the purpose of the FGM and the role of participants in developing the case plan, prior to the meeting. Emphasise that the focus of the meeting is about the child's needs. Based on the person's response from this discussion, you can assess whether they are to be excluded.

If the FGM convenor decides that a particular person is to be excluded, the convenor **must**:

- advise the person of the decision and the reasons for exclusion
- provide the person with an opportunity to provide their view, and inform them that their view will be shared at the FGM, if appropriate
- record the reason for the exclusion as a case note in ICMS
- provide the person with information about the Child Safety's complaints management process.

Strategies to avoid exclusion

- If domestic and family violence or presence of a sexual perpetrator is an issue, separate FGMs can be facilitated to ensure the participation of all family members.
- Provide the opportunity for people to participate by teleconference, Skype or with written statements that can be read at the FGM.
- If participants have historical concerns or issues, attempt to deal with these before the FGM. This may involve asking the Child Safety Officer or Senior Team Leader to have a separate meeting to address any issues that the parents or family members may have prior to the FGM. This will allow the participants to focus on the needs of the child.
- Consider inviting other Child Safety or external representatives to participate in the meeting, or manage the family. For example, a Senior Practitioner, Cultural Practice Advisor or another CSO or Senior Team Leader, where it is identified that they may be able to build necessary relationships or de-escalate a situation.

Step 8: Prepare and inform all other participants

Prepare all other meeting participants — members of the child's family and community, support people, legal representatives and service providers — prior to the FGM.

Obtaining the views of the other participants about the case plan prior to the FGM can facilitate the CAP process during the FGM. The Framework for Practice provides a range of tools that can be used to prepare participants for a FGM.

Practice considerations for including service providers

In circumstances where only a small number of participants from the child's network will be attending, consider the number of professionals who may also be attending the meeting.

Inviting a large number of professionals may intimidate the family members attending the meeting, limit family members' participation in the development of the case plan, or result in a power imbalance.

Where it is likely that there will be more service providers than the child's family and community participating in the meeting, consider consulting with some professionals beforehand to obtain their views, rather than inviting all professionals to attend the FGM in person. Ask the family which professionals they would like to attend.

Step 9: Obtain information from any other person who is unable to attend

Speak with any other person who has been invited but is unable to attend the meeting, to obtain their views on the child's case plan. These views can then be shared at the meeting or incorporated into the case plan, where applicable.

Step 10: Invite participants

After the location, format and people to attend the FGM have been determined, you must write to the participants formally inviting them to attend the FGM.

This letter must include all the essential information required for a person to fully participate in the FGM. It must also include information about their obligations to maintain confidentiality (*Child Protection Act 1999*, section 188), Child Safety's complaints process, as well as Child Safety's obligation to provide information to the Queensland Police Service (*Child Protection Act 1999*, section 14(2)).

Templates of the invitation letters to invite various participants to the FGM can be found in Chapter 4s of the Child Safety Practice Manual (CSPM).

Agenda

The invitation letter will include an agenda to guide the FGM. This agenda will include all key items to be discussed in the child's case plan, or revised case plan (refer to Chapter 4, 3.2 *Develop Key Items in the Case Plan* of the CSPM, or Chapter 3 of this handbook), as well as any other topics requested by participants during preparation for the FGM. The agenda can be

revised to include other items suggested by participants at the beginning of the FGM.

Note: certain key items **must** be included in the revised case plan when the Child Safety decides to apply for an order granting long-term guardianship to a suitable person or a permanent care order. These items must also be included in the agenda (refer to [Assess and prepare to develop the case plan](#) and [Plan for the family group meeting](#) in the CSPM, or Chapter 3 of this handbook).

Practice considerations — preparing for a FGM

If separate family group meetings are required due to domestic and family violence
Separate FGMs will be arranged in situations where domestic and family violence is present.

Ensure that the Child Safety Officer confirms whether there is a current DVO and ask them to obtain a copy of the DVO from the parent or the police. You must document this in the case notes.

Where the decision is made that separate FGMs will be held, you must notify all participants of the separate FGMs and whether they are required to attend both meetings. You must also inform each parent that separate meetings have been facilitated and that the case plan will be finalised once both meetings have concluded.

Factors to consider when planning and making decisions about FGMs

- **Safety** — if there is any reason to believe that the physical or emotional wellbeing of the child (if present) or any participant could be compromised (such as previous, serious conflict in meetings or a history of physical violence), the family will not meet alone *unless* sufficient management and support strategies can be implemented to mitigate identified risks. This factor must be assessed on an ongoing basis from your first contact with participants, and throughout the FGM process.

Unless a participant has been excluded from attending the FGM, private family time may **not** be appropriate in instances where there is domestic and family violence.

- **Power differentials** — consider the family dynamics to ensure there is a balance of power within the room. This also means checking that each key participant has the support to participate in private family time. For example, you may decide not to use private family time if the child's mother attended the meeting alone but the estranged father has several of his family members in attendance. This could have a significant impact on the mother's sense of safety, ability to participate, and the balance of power.
- **Group size** — even if two people attend, private family time will still be offered to allow them to discuss plans as a family unit. With small numbers of family participants, you must be very careful to empower the family to ensure there is a level playing field between them and the professionals in the planning process.
- **Capability of group to reach agreement** — some family groups may find it difficult to work together to reach agreement. In these instances, structured facilitation may be a more appropriate strategy to ensure the family group stays on task and a case plan is developed. Consider this during your preparation for the FGM, through discussions with the family, Child Safety Officer, Senior Team Leader, and other service providers.

If the FGM is being held to review a case plan, existing records (such as case notes) may hold useful information about how the family group has participated in meetings previously, and how well the process worked. Continue to assess the family's capacity during the meeting if you are unsure about their ability to come together productively in private family time, or if you were unable to obtain relevant information (or little was known) about their functioning as a group prior to the meeting.

- **Private family time** — all reasonable attempts must be made to encourage the family group to have private family time if it is safe to do so. If family members express reluctance or uncertainty, discuss whether the implementation of specific safety or support strategies would change their views about participating in private family time. Following these discussions, if the family group remains unwilling to participate in private family time, they will not be forced to. Clarify this prior to the FGM.
- **Other considerations** — it may be necessary for you to make an assessment in the FGM that the family not meet alone, based on events or issues that arise during the meeting. You may determine that the FGM will continue with the family and professionals together.

Cultural customs also impact on each of the considerations above. For example, confidence in expressing views; or power differentials from cultural protocols and processes for reaching agreement may be quite distinct. For Aboriginal and Torres Strait Islander families, an appropriate advisory can assist with understanding and working with the family across these dynamics. For example, Aboriginal and Torres Strait Islander family groups may choose to have private 'women's business' time and private 'men's business' time, and then come together for private family time prior to making plans with the Child Safety.

If there is domestic and family violence but separate meetings will not be held

After consulting with the Child Safety Officer, Senior Team Leader, parents and other participants, and deciding that only one FGM will be held, discuss the ground rules for the meeting prior to, and at the beginning of the FGM with both parents and all other participants. Key points of discussion include, respect for everyone's views and ensuring everyone has an opportunity to participate, without fear or threat of violence or ridicule.

When convening the meeting, you will need to be aware of the power differentials that exist in the relationship and provide opportunities for both parents to participate. In exceptional circumstances, structured facilitation by the FGM convenor (rather than private family time) may be a more appropriate strategy to encourage participation in the development of the case plan.

Ensure that any domestic and family violence issues and the impact on the child's safety (and other family member's safety, where applicable) are addressed in the case plan. Be mindful of seating arrangements, and be prepared to stop the meeting if significant safety issues arise and cannot be immediately resolved during the FGM.

If parents have an intellectual impairment

If a parent has a disability, you will need to assess their understanding of what is likely to be discussed at the meeting and their ability to give informed consent for any decision made involving them (or their child) at the FGM. As part of your assessment, seek advice from the Child Safety Officer, Senior Team Leader or from the parent's doctor or other professional working with them (with the parent's consent).

Invite the parent's adult guardian (if applicable) or any other support person to assist the parent in the FGM. You will need to prepare the support person and the parents about what will be discussed at the meeting and the decisions that may be made. Decide whether a formal FGM is the most appropriate forum for the parent with a disability to participate in (and obtain their views about this, if possible). Consider holding a smaller meeting, or separate meeting with them and their support person, so they don't feel overwhelmed and information can be provided to them in a way they understand. Ask the Child Safety Officer to arrange another meeting with them, following the FGM, to discuss the case plan.

If the parent is willing and able to attend a formal FGM, ensure the support person is given time during the meeting to explain what is being discussed and answer any questions they may have. Consider using structured facilitation, or be available to assist the parent during private family time, if required. Make sure that appropriate breaks in the FGM are planned for, to allow the parent to take some time out if required.

If a parent has a mental health issue

During preparation for the FGM, obtain information from the Child Safety Officer or Senior Team Leader, and parent, about the parent's mental health diagnosis, the impact on their cognitive functioning and behaviour, and the effect of medication on their behaviour or concentration.

In consultation with the Child Safety Officer or Senior Team Leader prior to the FGM, decide whether the parent's mental health affects their ability to participate in the meeting, contribute to the development of the case plan, or if their attendance is in the child's best interest.

If it is agreed that their attendance is contrary to the best interest of the child and the intent of the meeting, you can request that the parent does not attend. You must speak with the parent during preparation to explain the reasons why they are being excluded, and to obtain their views to share at the meeting.

If you assess that the parent is able to participate in meeting, encourage them to invite an appropriate support person, or invite their mental health professional to attend the meeting. Ask the parent, support person or the mental health professional prior to the meeting to inform you if the parent begins to have difficulty engaging in the process during the meeting. If the person's behaviour is deteriorating, you can arrange for a break, end the meeting, or schedule another meeting to discuss the case plan with the parent.

During preparation, consider the FGM process and whether involving the parent by teleconference, or having a written statement from the parent might be more appropriate. Provide the letter of invitation and agenda to the parent and the support person prior to the meeting. If the parent's mental health issues are impacting on the child's safety, include actions in the case plan to address this need.

If a child requests a separate FGM from their parents

The child may ask to have a separate FGM from their parents. During preparation for the meeting, discuss with the Child Safety Officer or Senior Team Leader the reasons why the child wishes to have a separate meeting. Consider whether anything could be done to make them feel comfortable to attend a FGM, including safety and support strategies, or by providing the child's views in another way.

If a decision is made that separate meetings will take place, the Child Safety Officer or FGM convenor will inform the child that their parents will be advised of the separate meetings and ask for the child's permission to share their reasons with the parents (if this is appropriate).

Inform the child about what information will be shared with the parents to develop the case plan, and ask the child if they wish to provide a statement or prepare some questions for the Child Safety Officer or FGM convenor to ask participants during the FGM.

You must inform the child that the case plan will only be completed once all meetings (with the child and parents) are concluded, and that they will receive a copy of the case plan (this case plan will be explained and discussed appropriately with the child to ensure their understanding).

If one of the participants does not speak or understand English

During the preparation for the meeting, consult with Child Safety Officer or Senior Team Leader about the language needs of participants. Arrange for an interpreter to be available when preparing the participant for the FGM.

If a participant is unable to read English, you could ask the CSO to obtain financial approval for the letter of invitation and agenda to be translated into the participant's language.

It is also your responsibility to organise an interpreter for the participant at the meeting. Having an interpreter to attend the meeting is preferable. If this is not possible (for example, if the child safety service centre is in a remote location), you can arrange for an interpreter service over the phone. The Commonwealth Government's Translating and Interpreting Service (TIS) can be arranged online, for a cost. Go to [Translating and Interpreting Service \(TIS National\)](#).

The Child Safety Officer will submit the Child Related Costs Approval Form to the child safety service centre Manager approval. This must occur prior to the FGM.

If the parents cannot be located, or are unwilling to attend

The Child Safety Officer is responsible for attempting to locate the parents if their whereabouts are unknown. The Child Safety Officer will undertake this work as part of normal case planning and ongoing intervention activities. The Child Safety Officer will inform you of this situation during your preparation for the FGM.

If the parent is unable or unwilling to attend the meeting, seek to understand the reasons why the parent does not want to participate in the FGM, and whether any strategies or support could be offered to encourage their participation. If necessary, make all reasonable effort to engage the parent in the FGM through other means (such as through the parent's legal representative, a service provider working with the parent or another family member; or through written information using the CAP tools).

If the parent is unable to be located or remains unwilling to participate in the FGM through other means, advise the parent that the meeting will go ahead in their absence and a case plan will be developed without their input.

If the parent's cannot (even with additional support) or are unwilling to attend the FGM, a meeting with the extended family, the child and relevant services may still proceed. You must still provide a copy of the case plan to the parents after it has been developed.

Preparing for a Family Group Meeting Checklist

Have you:

- ensured that the child safety service centre is aware of the need to convene a FGM for a child in need of protection and the referral process to hold a FGM?
- ensured that the FGM referral process was managed appropriately, including receiving, storing and prioritising referrals?
- checked that the referral form includes enough relevant information about the care and protection issues, the Child Safety's concerns and goals, and the strengths of relevant parties for you to commence preparation for the meeting?
- discussed the 'non-negotiables' (Child Safety's minimum requirements for keeping the child safe) with the Child Safety Officer and Senior Team Leader?
- identified appropriate participants to attend the FGM in consultation with the Child Safety Officer, Senior Team Leader and family?
- prepared all of the participants for the meeting in accordance with the *Child Protection Act 1999* (section 51M)
- confirmed the participants are clear about the purpose and intended outcomes of the FGM process, prior to the meeting? Was this done in a culturally respectful way?
- obtained the views of the participants prior to the meeting, using strengths-based tools such as the CAP framework or other Framework for Practice tools, to understand their concerns, strengths, goals and possible actions?
- invited participants to the FGM in a timely and appropriate manner? offered flexible times and locations?
- provided age-appropriate opportunities for the child to participate in the preparation of the FGM? And developed an appropriate process for including the views of the child, if they are not attending?
- obtained and recorded the views from participants who cannot attend, or who are excluded from attending the FGM?
- sought information regarding the cultural needs of the participants (including timing and location) and made appropriate arrangements for their support people for the process?
- considered and planned for any cultural ceremonies or requirements for the family?
- ensured that the relevant child and family members were invited to nominate and have an Independent Person to help them participate?
- identified any barriers for participation and developed strategies to overcome these?
- maintained focus on the child at the centre of the process, particularly if discussions became challenging or contentious?

Chapter 2: Convening a Family Group Meeting

This chapter provides information about how to convene a FGM and how the Collaborative Assessment Planning (CAP) framework can be applied at each step of the convening process.

The CAP framework is consistent with the Framework for Practice and aligned to the case plan format. CAP and other Framework for Practice tools are just some of the tools you can use, depending on the circumstances of the FGM.

FGM convenors and other stakeholders can participate in discussions about FGMs through the 'Family Group Meeting' Yammer group. You can also participate in local practice forums and training, and partner with stakeholders such as the Family Participation Program (FPP) to develop your own strengths-based approaches to convening a FGM.

Note: each of the steps below can be shared with a co-convenor (where applicable). The respective roles of each convenor are to be planned in advance with the co-convenor.

Step 1: Beginning the Family Group Meeting

Opening

The FGM can be opened in whatever way the family would like (as discussed during the preparation phase). The family might like to start with a prayer or a welcome from one of the family; express a shared commitment to the child's safety and wellbeing; or show photographs or a video of the child if they are not present.

An Elder or another family member is to be invited (where applicable) to welcome and open the FGM. If the child is from a CALD background, the FGM will be opened by an appropriate person from within the relevant CALD community, or a family member, in a way that acknowledges and respects the family's culture.

Protocols outlining the 'Welcome to Country' or 'Acknowledgement of Traditional Owners and Elders' for the beginning of a FGM when convening a meeting for an Aboriginal or Torres Strait Islander family can be found on the [Queensland Government webpage: Welcome to Country](#).

Introductions

Encourage all participants to introduce themselves and how they are connected to the child.

Housekeeping information

Provide information about the location of toilets and fire exits and other important aspects specific to the venue.

Develop a Group Agreement with the group. This may include agreements on the use of mobile phones. You will need to strike a balance between maintaining uninterrupted discussion with the need to respond to urgent calls.

Establish an agreement for when, and how, a break can be called. If participants smoke, they may need to take time out. Time-out is also a good strategy for managing participants' emotions so that these feelings do not become disruptive to the meeting.

Purpose

Explain the format for the meeting. Discuss and confirm the agenda (refer to the agenda sent with the invitation letter and ask participants if they wish to add or change anything on the agenda).

The purpose of the FGM will have been explained during the preparation phase, so you can simply give a brief restatement of the purpose. Write the purpose in the middle section of the CAP framework map on a whiteboard, or on large paper that can be referred to at any point during the FGM, to maintain focus.

Ensure that all key items to be included in the case plan (or revised case plan) are noted. Once the agenda is confirmed, ensure that it is clearly stated, either on a white board, or on copies given to each participant so that they can refer to it during the meeting.

Negotiate agreements for participation in the meeting

Discuss with the participants about what agreements are needed to enable everyone to participate and work together. For example, participants agree to speak to each other politely, speak one-at-a-time, and respect different points of view.

Obtain consent from all participants that they will work within the agreement and will support each other (for example, by identifying when they see people not following the agreed rules).

Clear and respectful communication

Ensure that participants understand that the information they provide during the FGM is clear, true and respectful of any child or family member attending the meeting.

Other considerations

- Advise participants of the confidentiality obligations and the need to maintain and respect each other's privacy.
- Advise participants of Child Safety's obligation to share information with the Queensland Police Service and the inadmissibility of evidence (refer to at the end of this section 'Practice consideration').
- Acknowledge that some painful issues are likely to be discussed and suggest ways for participants to manage their emotional responses (for example, conduct meetings in separate rooms, suggest short breaks or allow participants some time out).
- Ensure that participants know they can ask to have a break at any time during the meeting.

Sharing information

It is your responsibility to inform participants at the outset of the meeting that:

1. Child Safety is obligated to share any information discussed at the meeting about incidents of harm to a child, with the Queensland Police Service — with or without the consent of the participants. This applies regardless of whether or not Child Safety suspects the child is in need of protection (*Child Protection Act 1999*, section 14(2) and 14(3)).

2. Anything said or done at the FGM is inadmissible in a criminal proceeding *unless* all people participating in the FGM consent *or* there is a criminal proceeding for an offence committed during a FGM (*Child Protection Act 1999*, section 51YA).

The following disclaimer or statement can be read verbatim to help participants understand Child Safety's obligations and what information will be shared with police:

Disclaimer/statement

Please be aware that if anyone talks about a crime or an offence against a child, I must inform the police of this information, by law. Apart from that, any information that we talk about in this meeting will remain confidential and cannot be used in any criminal proceedings before court, unless everyone agrees, or it relates to a crime committed during this family group meeting.

Note: if this statement is not read verbatim, you **must** still ensure that participants are informed at the beginning of the meeting.

Step 2: Information sharing

Family story

This is an opportunity for the participants to share what they would like everyone to know about their family, and their perspective on how Child Safety came to be involved with the family. This can be the most powerful part of the FGM. Often it will be the first time families have had the opportunity to tell their story. If the child is present, they may prefer to share all of their views at this early stage of the meeting, rather than during the corresponding element of the CAP framework. This will need to be discussed with the child during the preparation stage.

Who is in the family and what is their cultural identity?

If a genogram/ecomap/circles of safety and support has been discussed with the family before the FGM, this can be drawn on a large piece of paper and displayed on a wall, so that it can be referred to throughout the meeting. If this hasn't been developed, ask the parents to describe their family members and culture, and create a genogram or ecomap at this stage of the FGM. Explore the family's cultural values and traditions, and how they raise the child within the family. Consider the dual role of kinship carers (grandparents or aunty, as well as approved kinship carers).

Note: although approved foster carers do not meet the definition of 'family' under the *Child Protection Act 1999*, they are significant to the child and should be involved, where appropriate.

Child's views and wishes

The child's views and wishes are to be presented as early as possible in the meeting, to help participants stay focused on the child from the start. If the child is not present at the meeting, you **must** present the child's views and wishes to the participants in the way that the child identified during the preparation.

Use skills like reframing, para-phrasing, reflecting and active listening to assist the child to convey their message. Acknowledge that the child may be nervous or scared in sharing their views to their parents, worker or others at the meeting.

Working through the CAP framework with the participants

This is the most detailed, and challenging section of the FGM. If the CAP framework and tools has not been introduced to the family during the collaborative assessment and planning stage, you can explain the purpose of the CAP framework during the meeting. Draw the framework as you are introducing it, using a whiteboard or large pieces of paper. The more the CAP framework has been worked through with participants in the preparation phase, the more quickly you will be able to work through this during the FGM.

Information will have been recorded from CAP framework meetings and discussions by the Child Safety Officer from earlier assessment stages, or by the Child Safety Officer, Senior Team Leader, Cultural Practice Advisor, or yourself in preparing for the FGM. This information contributes to the CAP framework assessment and planning discussion in the FGM, as outlined in the section below on CAP elements.

Information from pre-planning may include perspectives from family members not attending the meeting, service providers, the child (if not attending) and others. This will assist with refining and confirming the information in the CAP framework tool used in the FGM.

The information provided by working through the CAP as a group will input directly into the case plan.

What's working well?

You can start with whichever part of the CAP framework is most appropriate for the family. Starting with what is working well usually helps participants feel more comfortable about sharing and hearing information, although some families prefer to talk about what has happened in the past. Starting with the scaling question can be a very effective way for participants to share their views across the top part of the framework.

If you have already worked through the CAP framework with the parents and the child before the FGM, you won't need as much detail as suggested below. Instead, the information that has already been recorded in the top four quadrants of the CAP framework (or the Three Houses) can be shared with everyone at this point and discussed (for example, either read out by the parents or child and recorded by you, or recorded on paper beforehand and displayed on the wall or whiteboard). Participants can then be invited to reflect on what they think is most important within each quadrant, and to add their thoughts about anything that is missing.

1. Start with what's working well. Ask everyone to write down the most important things they think the parents/family are doing well, or have done, to care for their child.
2. Encourage everyone to share their views, and ask which participant would like to start first, or suggest that the person who knows the parents best, goes first. Record everyone's views in the 'what's working well' column.
3. If the child is not present, ensure that the child's views are included (for example, ask someone to read the child's views from their Three Houses).
4. Ask if there is anything else that the parents and family are doing to care for the child and keep them safe. Add the responses to the 'What's working well' column. Use different questions to explore everyone's views (such as exception questions, relational questions).

5. Help participants sort the items into 'Protection and Belonging' or 'Strengths and Resources' (this analysis may be left out if time is an issue).

What are we worried about (past/current harm)?

This part of the CAP framework (and assessment process) is where there is most likely to be differences of opinion. Manage this by identifying the differences, explaining the purpose of talking about the past, and help the group to focus on future safety. For example, you might like to say:

“This next part of the meeting focusses on the past. We are going to spend some time talking as clearly and plainly as possible about what has happened to the child that has resulted in Child Safety becoming involved. This is an opportunity for Child Safety to tell us if they think the child has been harmed and how, or if they think the child could be harmed in the future and why. The family will also have a chance to talk about anything that has happened to the child in the past that you think has been harmful. It is important to talk about what has happened in the past because it helps us to know what might be a worry in the future. If we know this, then everyone can work together to change the future so that it is safe for the child and just as you want it to be. Talking about the past can be hard, but if we are able to get clear on this then you will be able to make a really good plan for the future”.

1. Ask the family members to identify what they think has happened to the child that led to Child Safety becoming involved with the family, or the child being taken into care.
2. Record participants' views in the 'What are we worried about?' column. Use follow-up questions to obtain clear responses about behaviour and impacts on the child. If the child is not attending, ensure that the child's views are presented (for example, ask someone to read the child's views from their Three Houses).
3. Group similar 'harms' together to avoid having a long list of similar or recurrent actions of harm. Continue asking 'what else?' until the participants have fully shared their views. Take time to acknowledge the family's openness and willingness to talk about these issues.
4. Ask the Child Safety representative and other professionals attending the meeting to identify if there is anything else that has happened that led to Child Safety's involvement (or the child being taken into care).
5. Explore any complicating factors that may not have been raised, by asking everyone (starting with the family) to identify anything that is happening in the family, or issues that the family is facing, that they think are making it difficult for the parents to safely care for their child or to work with Child Safety.
6. Help the group sort the items into 'Harm' or 'Complicating factors' (this further analysis may be left out if time is an issue).

What are we worried about (information provided by the Child Safety Officer)?

The information provided by the Child Safety Officer may vary depending on the type of case plan being developed — whether it is an initial case plan for ongoing intervention, or a revised case plan.

In discussing the worries, the Child Safety Officer will re-confirm the 'key items' to be incorporated into the case plan, or revised case plan, including items about when Child Safety decides to apply for an order granting long-term guardianship to a suitable person.

It is the Child Safety Officer's responsibility to share the following information to be incorporated into the initial case plan:

1. Strengths, resources and acts of protection and belonging.
2. What is working with this family — positive factors, strengths and resources that the family have available and are using to support them, any acts of protection, successes, achievements and improvements noted since the last case planning meeting.
3. Details of harm, complicating factors and future worries (the reasons for current Child Safety intervention and why the child was assessed as being in need of protection).
4. Any relevant information from assessments by other professionals that highlight needs of the child or parents.
5. Child Safety's goal and any 'non-negotiables', such as critical areas of need to be addressed through the case plan goals and action steps (the 'non-negotiables' will have been identified through the completion of the relevant SDM assessments and the CAP process with the family and stakeholders).

It is your role as FGM convenor to ensure that participants understand the information provided by the Child Safety Officer and ask for clarification by the Child Safety Officer if necessary.

Also be mindful that the information provided by the Child Safety Officer may be distressing to the child or their parents. You can ask for a short break in the meeting if they wish to leave the room.

Ensure that the parents, carers (where applicable) and other family members are given the opportunity to respond to the information provided by the Child Safety Officer, and share their perspectives about the child's care and protection needs.

What are we worried about (Safety Scale)

1. Introduce the Safety Scale and the two end positions (0 and 10), and draw the scale underneath the top four quadrants (or two columns), on the board. Explain that the scaling question is a tool to help participants identify where they think things are right now, and focus on what needs to happen moving forward. Emphasise that the 10 does not represent perfect parenting — it indicates that things are going well enough that Child Safety and the family are satisfied that the child will be safe.
2. Ask participants to think about what has been discussed so far (what has been going well and what people are worried about), and indicate on the scale how safe they think the child is at the present time. As each participant indicates their scaling position, record it on the scale and ask them to identify the most important thing they think the parents/family are doing to support their reason for the scaling position. Distinguish the important item from the 'What's working well' column (for example, use an asterisk).
3. It is common to have a wide range in scaling positions, and reinforce to participants that this is ok. The purpose of the scale is to help participants understand each other's point

of view and perspective.

What needs to happen?

If the worry statements and goal statements have already been developed with the family before the FGM, you won't need to work through this part of framework in as much detail. Instead, the worry statements and goal statements can be shared and discussed with participants at the FGM (for example, either read out by the parents/child and recorded by the convenor, or recorded on paper beforehand and displayed on the wall or whiteboard). Participants can then be invited to reflect on what they think is most important within the worry statements and goal statements, and add their thoughts about anything that is missing.

Future worries

1. Introduce worry statements to help participants express what they think might happen to the child in the future, if nothing changes.
2. Ask participants to identify what they think Child Safety is worried might happen to the child in the future, if nothing changes. Also ask about their worries for the child. Posing this question to the family and network allows them to reflect on Child Safety's views and think through the future worries, before hearing Child Safety's views. Use follow-up questions that focus on the parent's behaviour and the impact on the child, to seek specific worry statements. If there are worries that the family and network are not considering, ask them to look back at the identified harm and complicating factors to help them to think about future worries. Write the worry statements as '*Child Safety, (mum, dad, family, etc..... is worried that....*' and make it clear to participants that you will ask Child Safety's representative for their views next. Take time to acknowledge the family's openness and willingness to talk about these issues.
3. Ask the Child Safety representative to identify the worry statements that best reflects the Child Safety's worries, and if there is anything else to be added to the worry statements. Use follow-up questions that focus on possible action or inaction of the parents and the impact on the child, to seek specific worry statements.
4. Ask if anyone shares these worries, even to a small extent, and add their name to the worry statements (for example, '*Child Safety and Debra are worried that*'). If the child is not present, ensure that any worries identified by the child are included.
5. Ask the Child Safety representative to identify if there is anything else they are worried might happen to the child, in their parents' care in the future. Record these worry statements. Ensure that additional worry statements are not just a rewording of already identified worry statements.
6. If the Child Safety representative adds new worry statements, ask the family and network if they are also worried about any of these things happening, or if they know of anyone else who is worried about these things. If so, record their names to the worry statements.
7. Ask participants if they have any additional worries about the child in the future that has not yet been noted. Check if these worries are captured, or partially captured by an existing worry statement and either add content or create a new worry statement.

Goal statements

1. Introduce goal statements to encourage participants to identify the goals for the child and family that address the worry statements.
2. Work through the worry statements one at a time. Ask the parents and network to look at each worry statement and identify what they want to see, what they think Child Safety wants to see, how they will make sure the worries don't happen and be confident that the child will be safe and well. If parents are finding it hard to identify the goals, focus on their behaviour identified in the worry statement and ask participants to reflect on what they want to see the parents doing instead. Use follow-up questions to frame the goals in positive terms (for example, what people *will* do, rather than what they *won't* do) and focus on the care of the child. Ensure that the child's views are included.
3. Invite the Child Safety representative to provide feedback on what part of the goal statement addresses Child Safety's concerns and what else they think should be included in the goal statement.
4. Continue until goal statements have been developed for each of the worry statements.
5. Ensure that participants understand the goal statements. Ensure that the goal statements contain everything that Child Safety's and the family want to see included, and feel confident that the child will be safe and well in the future.
6. Discuss how long Child Safety and the family would need to reach these goals before they would be satisfied that the child's safety and wellbeing is met. Record the timeframe to the goal statements.

Practice considerations***Goal statements vs action steps***

The needs identified by the Child Strengths and Needs Assessment and Parental Strengths and Needs Assessment strongly informs goal statements and actions steps to meet the goals. When developing the case plan, be careful not to include actions in the goals section, or too many needs under one goal. This can make the case plan difficult to understand, and may impact on the quality of the case plan during subsequent intervention.

Road maps for reunification

For a reunification case plan, consider recording the actions or goals in the format of a road map, detailing the steps towards reunification. Actions can be addressed over time; however the goal will always remain consistent. This provides the family with a clear path towards reunification and gives a sense of empowerment as they have some insight into what needs to happen for the child to be returned to their care. It can also demonstrate accountability and transparency by Child Safety in working towards reunification.

However, be careful to explain to the family that the road map may change depending on their progress in meeting the actions or goals of each case plan, and any other unforeseen circumstances that may arise. This will be stated in each case plan.

When developing the case plan when reunification is the primary goal, be clear about the alternative goal and the concurrent plan. During the case planning process, you or the Child

Safety Officer must explain to the parents that Child Safety is required to undertake permanency planning for every child.

If the child is Aboriginal or Torres Strait Islander, the case plan must show how it is consistent with the connection principle of the Child Placement Principle.

Non-negotiables

Talk about the 'non-negotiables' and explain what Child Safety wants included in the case plan to achieve the goals for the child and the family.

Ask the parents and other participants if they have any other non-negotiables that they think need to be included. Add these to the non-negotiables list if there is agreement.

Note: Chapter 4 provides further detail about how to discuss and record worry statements, harm statements, goal statements, non-negotiables and action steps for the case plan.

Information from service providers

Invite service providers to share information about the services or resources they can provide to help the family achieve the goals. Ensure beforehand that the family feels comfortable about the service provider attending the FGM. Provide time for the family, network and Child Safety representative to ask questions about the provider's services or resources.

If the family are already involved with the service, you can ask the service provider to give feedback about the child, parents and family, their strengths, and any areas for improvement. Any worries they have for the child need to be addressed in the case plan.

This information can be recorded in the shared CAP framework tool (whiteboard or paper) used during the FGM (possibly after the service provider has left, depending on privacy and relationships).

You can ask service providers to leave the meeting after they have shared their information, before the development of the case plan, unless the child or parent asks them to stay, or their presence is necessary for the case plan.

You must ensure that the views of people **not** attending the meeting, and information about resources and support offered by a prescribed entity or service providers unable to attend, are presented at the meeting.

Aboriginal and Torres Strait Islander and CALD families

When working with an Aboriginal or Torres Strait Islander child and family, or a from a CALD background in a FGM, be conscious of the following:

- Silence — give people time to process information; do not misinterpret their silence as understanding or consent; silence can also convey concern, disagreement, nervousness or that they are still thinking about what was said.
- Differences in body language — eye contact, tone of voice.
- Gender differences — women's and men's business (for example, some issues in a FGM may be more appropriately discussed between the female participants).

- Use of language — words may have different meanings for Aboriginal and Torres Strait Islander and CALD families.
- If using an interpreter, give them time to translate what is being said for the participant.

Break after every couple of sentences, or ask the interpreter how often they would like participants to stop talking, so they can accurately convey the message to the participant.

Ensuring the child's safety and wellbeing during information sharing

It is your responsibility to ensure the child's safety and wellbeing for the duration of their participation in the FGM. The child is entitled to have a support person attend the meeting, and regularly check with the child how they are feeling. If the issues being discussed are having, or could have, a detrimental impact on the child's emotional wellbeing, you can arrange for the child to have a break, or leave the meeting for a period of time.

In some cases it would be appropriate for the child to leave the meeting after they have shared their views, and return towards the end of the meeting to share their opinion about the key items developed in their case plan. The child may request this, or it may have been decided during the preparation phase that this would be in the child's best interest. Also ensure that the appropriate person talks to the child about the FGM and any emotions the child is feeling (so long as the child wants to engage in this discussion).

Disagreement about child protection concerns or intervention

FGMs can be emotionally charged, and family members may become upset, confused, sad or angry. It is important that you validate participants' emotions and acknowledge that their responses are understandable. It is important to be non-judgmental, compassionate and allow expression of emotion for the meeting to progress and be effective. For example, you might reinforce the parent's commitment and positive motivation as demonstrated by attending and being involved in planning for their child, and thank them for being passionate and advocating on behalf of their family. Validating participants' feelings is a respectful way of engaging and building a strong platform for collaborative planning.

You may also need to keep the family on track if they become distracted by any disputes they may have with Child Safety. First ensure that the family understands Child Safety's position (the Child Safety Officer can re-clarify Child Safety's position for the family, if necessary). Use your conflict resolution and mediation skills and remind participants that the focus of the FGM is to develop a case plan to address the child's future needs.

Consider the following steps to keep the meeting moving forward:

1. Acknowledge any concerns and points of disagreement, reiterate that trust and respect must be earned, and discuss what the family needs in order to trust Child Safety enough to work together.
2. Inform participants that any points of disagreement can be noted in the case plan.
3. Remind participants that the focus of the FGM is to improve the child's safety and wellbeing.
4. Reinforce that agreement about past harms and future worries is not necessary. Instead, the focus is on agreement about working towards a safe future for the child.

5. Inform participants that they can express their views about the application for a child protection order in court, not the FGM. Or remind them about the Child Safety complaints process if the ongoing intervention does not involve the court.
6. Suggest that the participants agree to disagree, and focus on the case plan items that can be negotiated.
7. Consider inviting the Child Safety Officer or Senior Team Leader to explain the implications for the family if the case plan cannot be developed through the FGM process (the Child Safety Officer and Senior Team Leader are responsible for developing the case plan).
8. If disagreements continue to impede discussion about the case plan, you may consider adjourning the meeting for a short break to speak with the family about what can be done to help them move forward. Ask them what they need from the meeting, what they need from you as the convenor, and whether there something they need to say to be able to move on.
9. If the family is still too upset to proceed, you may need to close the meeting and agree to come back together at a later date.

Breaks

You may need to take one or two breaks during the FGM, depending on the needs of the participants and the amount of time required for each segment. As you are working through the CAP framework, try to take breaks *at the end* of a CAP element rather than during one.

Step 3: Private family time — developing the case plan

During the FGM (as arranged during the preparation phase), the family and network meet for private family time (or with you as convenor if that is what the family wants) to develop the case plan actions to achieve the goal statements.

Private family time involves the child's family and significant others coming together in a private space to discuss worries and goals and, where possible, reach agreement about actions to be undertaken to achieve the goals and timeframes in the child's case plan. The use of private family time encourages families to take responsibility for protecting their child (*Child Protection Act 1999* section 5B(b)) and is consistent with the Framework for Practice values and principles. For Aboriginal and Torres Strait Islander peoples, the use of private family time also enables greater opportunity for self-determination (Section 5C(1)(a)).

Kinship carers may participate in private family time (this must be negotiated sensitively with the parents and other family members).

The recommended process for private family time is:

1. Advise the family that private family time is an opportunity to discuss, in private, all the issues raised and brainstorm ideas to address worries and achieve goals.
2. Ask the family to think about what they want to include in the case plan, and what they think Child Safety would need to see included in the case plan.
3. Double-check that the family and network remembers and understands any non-

negotiables set by Child Safety.

4. Advise the family which areas or items to work to reach agreement on.
5. Provide the family and network with a copy of the CAP framework that has been used in the FGM (for example, worry statements, goal statements and non-negotiables).
6. Advise the family that attending services does not ensure safety, and the goal and related action steps are not to be a list of services that the family or parents will attend.

Where the family identifies a service as part of the action steps, it must be clearly linked to a specific behavioural goal so that everyone knows what their attendance will achieve. For example, if the goal statement is *'Mary (mother) will be able to deal with her sadness and anger in ways that allow her to also safely care for, and supervise, Ben (the child)'* and it is linked with a 'non-negotiable' statement *'Ben will always be cared for by a sober person and will not see mum drunk'*, then the action steps might be:

- *Mary will work with a counsellor to figure out ways to cope when she is sad and angry that doesn't include getting drunk. Mary will be able to show that she can use these coping strategies to manage her feelings without abusing alcohol for six months, when the plan is reviewed.*
 - *If Mary has a slip-up and decides to drink, she will call Auntie Karen when she has her first drink so that Karen can come straight over and pick up Ben. Karen will let the counsellor know so that Mary and the counsellor can talk about the slip-up.*
 - *Mary, Karen, Child Safety and the counsellor will meet once a month to make sure that Mary is getting the support she needs to become a safe and sober parent.*
7. Identify any other case planning areas that are not covered by the goal statements and ask the family to include their ideas in the case plan (such as placement, family contact visits, health, education, cultural support plan).
 8. If the child is in the parent's or family's care at this time **and** there are concerns about the child's immediate safety, the case plan will need to include actions that address the concerns currently managed by the immediate safety plan (as per the Structured Decision Making Safety Assessment Tool). The immediate safety plan does not remain in place once a case plan is established.

Prior to the commencement of private family time (where applicable), the FGM convenor ensures that the family are aware of the following:

- All workers and non-family members, except as otherwise stated, will leave the room and will not return unless asked.
- Family members can have time-out and return.
- Resources are available to aid the family in their planning (for example, butcher's paper, pens, brochures about available supports and services, copy of worry and goal statements and 'non-negotiables').
- You are available, if required, to answer questions the family may have or to act as a scribe or convenor.
- During the meeting, the family may request that professionals clarify issues or provide additional information.

- You should be notified to assist in the resolution of any conflicts that cannot be resolved by the family (if the conflict is serious and detrimental to the development of the plan, you can decide in consultation with the family to terminate private family time and resume the FGM to reach agreement).
- You will help turn the ideas into a specific case plan.
- The family is clear about any tasks, and the participants have everything that they need.

Once the family has been made aware of this information, you (the convenor) and any other professionals then leave the room.

Once the family group has agreed on their plan, you will resume facilitation of the FGM to work through the proposals with the other participants. Once these key items are established, they can be reflected in the case plan.

Private family time is the *preferred strategy* for engaging family members and significant others in the FGM process and you are responsible (during preparations) for providing information about the purpose, importance and benefits of private family time, and discussing with participants what safety and support strategies would encourage them to utilise private family time. The preparations stage will help you decide whether or not private family time is appropriate for the particular family and their circumstances.

Practice considerations

The benefits of private family time

- It is empowering for the family to develop strategies on their own to address child protection concerns.
- It provides an opportunity for the family to talk to each other about information they heard in FGM, without professionals being present.
- When the family has a sense of ownership of the case plan, they are more likely to commit to, and follow through on, the plan.
- Family members may be more open about, and willing to discuss, their strengths and needs and the impact on the case plan if non-family members and professionals are not present.
- Professionals can end up either facilitating or inadvertently controlling the discussion outside private family time.

What if private family time is not appropriate?

Consult with participants, the family (if the child is Aboriginal or Torres Strait Islander, this may be with the support of the Independent person), the Child Safety Officer and Senior Team Leader during preparation to decide whether private family time is appropriate. This decision can also be made at any time during the FGM.

If, after all considerations, you decide that private family time is not appropriate and will not be used at the FGM, you will need to use structured facilitation.

Structured facilitation

When a decision is made during preparation that private family time is not appropriate, you can facilitate the development of action steps through structured facilitation.

The CAP framework tool is used to guide structured facilitation. You can work through this with the family and other participants to help them develop action steps, address the worry statements and achieve the goals.

Step 4: Collaborative decision making about the case plan

The family invites the FGM convenor, other professionals and, where applicable, carers, back into the room to discuss the details of the plan they have developed. This includes their suggested action steps to meet the goal statements and address the worry statements. While it is the family who presents their plan, it is important that you manage the process of answering questions, providing feedback and making decisions about the case plan, so that the process remains constructive.

The key decision is whether the family plan is sufficient to achieve the goals while maintaining the safety, belonging and wellbeing of the child. Work through each goal and associated action step and ask everyone involved to score the plan against each goal. A score of 10 indicates they believe the action steps are strong enough to achieve the goal at all times, a score of 0 indicates that the action steps will not achieve the goal.

If someone scores lower than 10, ask them what else they would need to see included in the case plan to reach a score of 10, to have confidence that the goal will be achieved and the child will be safe and well. Often, the issue that prevents professionals from providing a score of 10 relates concerns monitoring of the plan. Make sure that there is enough detail in the plan about how it will be monitored and reviewed.

Continue this scoring and reviewing process for each goal until everyone scores 10. This is the point where the family plan becomes a collaborative case plan.

If there are elements of the plan that require Child Safety or service providers to organise or fund services or resources, you must confirm their agreement. Clarify if approval can be obtained quickly, or if time is needed for seeking approval. If time is needed, clarify when approval will be possible and how it will be conveyed to you.

Practice considerations

- Check that all participants understand and agree to a goal and action step being included in the case plan. This can be done after each action is agreed.
- Check that the actions are recorded appropriately. This can be achieved through the meeting minutes, recorded on a white board or on a project screen for everyone to read. The CAP framework can form the template for recording the actions.
- Check that the agreed goal/outcomes/actions are in line with the 'S.A.F.E.T.Y' principles (see Chapter 4 for more information).

- Note disagreements over goals or actions in the case plan, and advise participants.
- Answer any questions that participants have about the agreed action steps.
- After the meeting, transfer the approved goals and actions and other CAP elements into the ICMS case plan form (see Chapter 3).
- Apply a similar level of collaborative review to all other elements of the case plan, including the cultural support plan, transition to adulthood, contact plan and any other relevant plans.

Step 5: Closing the Family Group Meeting

The following actions are to be taken to close the FGM:

1. Ask participants how they are feeling. Make sure everyone is clear about who will do what and the timeframes for completion or review.
2. Answer any questions that participants may have about the meeting and clarify any issues raised.
3. Advise participants that the items agreed at the meeting will be recorded in the case plan.
4. Inform participants that the case plan will be endorsed by the Senior Team Leader within 10 business days *unless* (where the Senior Team Leader did not attend the FGM) the Senior Team Leader determines that all or part of the plan is impracticable or not in the child's best interests.
5. Explain to participants the options available if the Senior Team Leader decides that all or part of the plan is impracticable or not in the child's best interests (see Chapter 3).
6. Make sure the family and safety network receive a copy of what was discussed in the FGM, to take away with them (for example, photos of documents, printouts from whiteboard).
7. Advise which participants will receive a copy of the case plan once it has been endorsed.
8. Advise participants of the process if there are any disagreements about what has been recorded in the case plan.
9. Inform participants that they can speak to the Child Safety Officer if they have any questions about the case plan (once they receive a copy).
10. Inform participants of the timeframe for reviewing the case plan. Convenors could even consider setting another date at this point of the meeting.
11. Acknowledge the work that has been done at the FGM and the effort by everyone who participated in the meeting. Acknowledge the difference this will make for the child and towards achieving the goals.
12. Invite the family to provide feedback on the FGM and the process (for example, using a tool such as the 'Measuring success' checklist below). Be open to feedback participants give about the FGM. Feedback can be provided by the family after the FGM, if that is preferable for the family.

13. Invite the family to close the FGM.

Once the meeting has ended, transfer all the agreed goals and action steps and other CAP framework information into the case plan document in ICMS. Chapter 3 outlines the process for recording and distributing the case plan.

Measuring success

FGM convenors and Child Safety's case management staff are encouraged to obtain feedback from families on the FGM process, evaluate the FGM experience by families and look across multiple FGMs to identify how the process can be improved. Methods of feedback and evaluation could include surveys of participants and feedback through third parties.

You can use the table below to self-reflect on the FGM, and apply it to the family and other participants for obtaining their feedback about the FGM process. The three reflection categories below can be applied to each of the steps of the FGM process including the preparation process, and the meeting itself.

Results	Process	Relationships
The 'What'	The 'How'	The 'harmony'
Did the FGM result in: <ul style="list-style-type: none"> <input type="checkbox"/> The making of informed decisions? <input type="checkbox"/> A clear understanding of who will do what following the FGM? 	Did the process used in the FGM: <ul style="list-style-type: none"> <input type="checkbox"/> Encourage participation? <input type="checkbox"/> Facilitate information exchange or decision making? <input type="checkbox"/> Incorporate cultural approaches to ensure the meeting was culturally respectful? 	Were the participants: <ul style="list-style-type: none"> <input type="checkbox"/> Open and honest? <input type="checkbox"/> Respectful and courteous?

Practice considerations

If a participant discloses information about a suspected criminal offence in relation to the harm of a child

If a participant disclosed information about a suspected criminal offence involving a child at the FGM, you must advise the discloser (the person sharing the information) that you are now obliged to inform the QPS of what has been said.

Inform the discloser that:

1. QPS will decide how to proceed once they receive the information. Further, the information provided will be inadmissible in a criminal proceeding if the matter reaches prosecution stage.
2. The information will be recorded in the case notes in ICMS.
3. Child Safety may take further action based on the information provided, if it reaches the threshold for a child protection notification.

Also take the following actions:

1. Advise the Senior Team Leader (if the Senior Team Leader was not present at the FGM) about what was disclosed at the meeting so they can decide whether any further action by the Child Safety is necessary.
2. Record the information in ICMS.

Then follow procedures outlined in the Child Safety Practice Manual procedure (Receive and respond at intake) Report information to the Queensland Police about notifying the QPS of the harm or alleged harm. Note the actions taken to advise the police of the disclosed information. This information (if relevant) will be taken into consideration when assisting participants reach agreement about the outcomes and actions in the case plan.

If a participant is under the influence of a substance or unable to meaningfully participate in the FGM

On occasion, participants may attend a FGM under the influence of a substance or, for whatever reason, unable to participate meaningfully. Substances may include alcohol, legal substances (such as prescription medication) or illicit substances. Withdrawal from substances, or unmanaged mental health problems, may also cause a person to present as unwell and may impact on their ability to engage in, and contribute to, a meeting.

Behaviours that may cause concern include:

- slurring of words
- appearing to nod off, or present as sleepy or drowsy
- being unable to focus or concentrate on the meeting or the conversation
- constantly interrupting, pacing or fidgeting.

If you believe the participant is not able to effectively engage in the meeting, you may consider:

1. Refer participants to the rules regarding behaviour and participation. You could then describe your observations that are causing concern, and engage the group in deciding how to proceed. For example, ask whether anyone else is concerned about the behaviour. Ask other participants whether they think the person can actively participate. Consider rescheduling the meeting.
2. Call a break and speak to person. Share your concerns about their behaviour and discuss how they will be able to focus and contribute. Talk about any concerns about not being able to consent if they are under the influence.
3. Explain your observations and concerns to the family group and any plans you have discussed with the individual. Ask the family to share any worries they have about proceeding with the meeting given the person's presentation.
4. If the other participants are comfortable with developing a plan for managing the person's behaviour, then it is ok to proceed with the FGM. If not, discuss with the family whether the meeting should be postponed.

When considering these options, you will need to think about your own personal safety (and the safety of the other participants) in dealing with the person causing concern. Also, consider the significance of the person to the child (for example, how you deal with a parent's support person may be different from how you deal with a parent).

You will also need to ensure the affected person's safety. Do not hesitate to call for an ambulance if you believe they are in need of medical attention.

If the perpetrator of sexual abuse to the child is participating in the FGM

Ask the Child Safety Officer to provide you with any risk assessments of the participant's sexual offending and risk to the child (or to other children). If these assessments have not yet been undertaken, this action will be written into the case plan (it may be that the case plan will need to be reviewed within a shorter period of time to allow for the completion of the assessment). The outcome of assessments will have a direct impact on the actions and outcomes included in any future case plans.

When engaging the sexual perpetrator during the FGM, ensure the Child Safety Officer is clear about Child Safety's concerns (and the outcomes of any risk assessments). The **Child Safety Officer** also explains the 'non-negotiables' of the case plan to the perpetrator. As in other difficult situations, remain impartial during all stages of the FGM process.

It may be appropriate for you to facilitate separate meetings if the child is going to attend. If you have significant concerns about the child's safety and best interests, you could also consider linking the perpetrator into the meeting by phone, or speaking to them separately at the beginning or end of the meeting.

You need to be aware of the dynamics or power differentials between the perpetrator and any other family members participating in the meeting. It may be more appropriate to use structured facilitation, rather than private family time. It is possible that the perpetrator does not agree with the outcomes of the sexual offending risk assessments by Queensland Corrective Services or Child Safety, or Child Safety's assessment of the perpetrator's risk to the child. Acknowledge the perpetrator's viewpoint and advise that it will be noted in the case plan.

Also be aware that the FGM may be emotionally charged. You need to ensure that you acknowledge and manage the participants' emotions accordingly. You also need to ensure that language used during the meeting is respectful towards all.

If, during the preparation phase, you decide (in consultation with the Child Safety Officer and Senior Team Leader) that the attendance of the sexual perpetrator is not in the child's best interests, follow the steps outlined in Chapter 1 about excluding a person from a FGM.

Other practice considerations in circumstances of sexual abuse

Provided that adequate safety strategies and support is planned and implemented, case plans can be effective even in circumstances of sexual abuse, where the perpetrator remains in contact with the child. The role of the FGM is to unpack the best possible action steps to achieve that.

During the preparation stage of the FGM, speak to family members (in conjunction with the Child Safety Officer) to understand the family dynamics. This will help you to be aware of:

- power imbalances
- gender roles (such as men's and women's business in different cultures)
- different cultural lore regarding sexual behaviour and responses to abuse
- behaviour and personality of family members
- hidden dynamics, such as the use of threats.

Be flexible about approaches to private family time. Discuss this with different family members during the FGM preparation stage. For example, the attendance of Elders or other supportive family members (outside of primary relationships and the perpetrator) may help ensure private family time is not dominated by an individual.

Regardless of the legal or criminal status of the abuse (even if criminal prosecution has not been undertaken), Child Safety has the authority to case-plan for the safety of the child and it is the Child Safety Officer's role to make the perpetrator and the family aware of that.

It is important that the child always feels supported in the FGM process, and trusts that you do not doubt their experience of abuse or minimise its impact.

In circumstances of denied abuse, focus the family on planning for solutions to prevent future allegations from occurring (for example, the plan can address the worries expressed by Child Safety about risk of future abuse and the worries the family might have about the concerns held by Child Safety and others).

The case plan is for the child *and* the family. A case plan that keeps a child safe will also create a safe and healthy environment that will benefit the whole family unit. For example, any other areas of concern that are acknowledged by the family in needing assistance (in addition to circumstances of denied abuse), can be useful for increased participation of the family.

Ensure that family members have obtained their own legal advice before the FGM.

Refer to the practice considerations for domestic violence, as many of the approaches are similar to ensure safety of all participants.

If the parent's legal representative focuses on the legal aspects of the case rather than decisions being made at the FGM

Consider using the preparation stage of the FGM to talk to the parent's legal representative to identify any legal issues prior to the FGM. Explain that the FGM is not the forum for resolving legal issues and they may adversely impact on the meeting process. You could suggest a separate meeting with the parent, legal representative, Child Safety Officer, Senior Team Leader and Senior Advisor (OCFOS) prior to the FGM, to discuss the application and any outstanding legal issues.

At the FGM, you could acknowledge the disagreement between Child Safety and the parent and their legal representative regarding the application before the court, and advise that this will be noted in the case plan. You can remind participants of the purpose of the FGM and reiterate that the appropriate forum for discussing the legal aspects of the case is the court-ordered conference or through submissions made to the Childrens Court magistrate.

You can remind participants that decisions made during a FGM are administrative, and the appropriate forum for disputing reviewable administrative decisions is the Queensland Civil and Administrative Tribunal (QCAT). You can advise participants that they will be given written notice of such decisions, including their review rights.

For matters that do not constitute reviewable decisions, you can refer participants to the Child Safety complaints management system. If these strategies do not work, you can consider adjourning the FGM for a short period of time and ask the participants to re-focus on the needs of the child, or end the meeting if the discussion cannot be progressed.

Convening a Family Group Meeting Checklist

- Did you convene or co-convene the meeting in a way that was culturally respectful?
- Did you provide the participants with information about the Child Safety's complaints and review processes, confidentiality provisions and obligations to share certain information with the Queensland Police Service? Were you able to answer participants' questions regarding these issues?
- Did you provide sufficient support to the participants to attend the meeting and, in conjunction with the Child Safety Officer, engage with the family and supportive stakeholders to encourage their participation?
- Did you provide the participants with an opportunity to contribute to the creation of the agenda?
- Did you clearly explain the role of the FGM convenor and co-convenor in the meeting? Did you give all participants an opportunity to introduce themselves and explain their role and relationship to the child?
- Did you set up the room in a safe and comfortable way that encourages participation? Did you offer coffee, tea and water?
- Did you work with the group to develop a shared working agreement about how we would all behave and treat each other in the meeting?
- Were the participants given clear information about the reasons for Child Safety's involvement (harms, complicating factors, worries and 'non-negotiables')?
- Did you incorporate the views and wishes of all participants (and other non-present contributors)?
- Did you ensure that the voice of the child was heard and that their views and wishes were at the centre of the process?
- Did you frame the conversation and structure the meeting in accordance with the CAP framework?
- Did the participants have an opportunity to answer questions about the reasons for Child Safety's involvement with the child?
- Did you encourage discussion and engage all participants in the case planning process during the FGM?
- Did you effectively monitor participant behaviour and intervene appropriately when required?
- Did you appropriately support the child (if they were present) to share their views and wishes? Did you support the child to enter or leave the FGM if they wished?
- Did you ensure that the child was able to participate in the meeting process? Did you

monitor the child's emotional wellbeing throughout the meeting and implement strategies to ensure the child's safety and wellbeing during the meeting?

- Were you able to appropriately convene private family time or structured facilitation (depending on the family's need/ability) to assist the participants to reach agreement about the case plan goal, outcome and actions?
- Did you use strengths-based and solutions-focused approaches to assist participants to reach agreement on goals, outcomes and actions to be included in the case plan?
- Did you effectively confirm the case plan actions, goals and outcomes with the participants to be recorded in the case plan?
- Did you end the meeting in a way that was culturally respectful or appropriate to the family? Did you advise the participants of the process for recording, endorsing and distributing the case plan?

Chapter 3: Endorsing and distributing the case plan

Recording additional information in ICMS

In addition to recording the case plan in ICMS, you will also need to document a record of the FGM in the case notes in ICMS. You will need to include:

- information about the FGM process (venue, special considerations)
- information about whether separate FGMs were held and the reasons for this
- any views and wishes expressed at the meeting by participants that are not able to be documented in the agreed case plan
- specific disagreements with elements of the case plan on the actual case plan form.

As with the case plan form, you must be concise in recording this information and be specific about what was discussed and who raised particular issues.

This information should be recorded by the person who convened the FGM (note: a senior practitioner, Senior Team Leader and Child Safety Officer can also facilitate a FGM in the absence of a FGM convenor and are all required to follow the same process).

Endorsing the case plan

Once you have recorded the case plan in ICMS, it must be sent to the Senior Team Leader for endorsement, within 10 working days of the FGM. You could also consider emailing the Senior Team Leader that you have sent the completed case plan for their endorsement.

The Senior Team Leader may ask for changes to be made to the document (grammatical and spelling errors, or suggest a more appropriate way to word a statement). However, they **cannot** request amendments to the overall goal, goal statements and actions unless the other parties (child, parents and others affected by the changes) have been notified of the proposed changes in writing, and these changes are practicable and in the child's best interests.

It is important that case plan documents are written using statements that are agreed by participants in the FGM meeting. This helps participants to 'own' the document and that it genuinely reflects what they agreed to.

The Senior Practitioner can also endorse a case plan. However, this should only be considered in exceptional circumstances, when the Senior Team Leader is not available within the necessary timeframes (that is, within 10 working days from the completion of the FGM) to endorse the case plan.

Distributing the case plan

In completing the FGM process, you must provide a copy of the case plan to the participants, once it has been endorsed by the Senior Team Leader. The following people **must** receive a copy of the endorsed case plan:

- the child (if appropriate for the child's age and ability to understand)
- the child's parents
- the child's foster or kinship carer, or the licensed care service who will be involved in implementing the case plan for the child
- a suitable person granted with long-term guardianship of the child (where applicable)
- any legal representative of the child or parents
- an elder or other respected person of the child's community who will be involved in implementing the child's case plan
- anyone else impacted by the plan, responsible for actions in the plan, or who the department considers should receive a copy (this can be decided in consultation with the Senior Team Leader and Child Safety Officer).

In most cases, everyone who attends the FGM should receive a copy of the case plan, except if an attendee will **not** be involved in implementing the case plan.

The Independent Person is only given a copy of the case plan if they are involved in implementing the plan.

Where applicable, the case plan (or revised case plan) will also be filed, together with supporting material, with the Childrens Court.

You should inform the Child Safety Officer when the case plan has been completed and endorsed by the Senior Team Leader.

A template of the letter that can be used by FGM convenors to accompany the case plan when sending it to parents and any other relevant person can be found in the Child Safety Practice Manual (Chapter 4, Resources).

You may also consider recording the date of when the FGM process was completed, on a spreadsheet (or other appropriate recording document), including the date that the case plan was sent to the parents and any other person required. This document could include a date of review for the case plan. This information should also be recorded as a case note in ICMS.

Amending the case plan

The *Child Protection Act 1999*, Section 51R(2)(c) also allows the Chief Executive to amend the case plan. The Senior Team Leader can decide to seek the Chief Executive's agreement to amend the case plan without a further FGM (or case planning meeting) taking place. However, this can only occur under certain conditions:

- Within seven working days after the case planning meeting at which the original plan was

developed.

- Only to the extent necessary to ensure the case plan is practicable and in the child's best interests.
- Only after consultation with the convenor, if the FGM was convened by a private convenor.

If a decision is made to amend the case plan, the department **must** provide each person who participated in the FGM with written notice of the amendment and the reasons for the amendment. It is a matter of negotiation between the Senior Team Leader, FGM convenor and Child Safety Officer as to who will undertake this task.

It is the department's role to make decisions about amendments to a case plan. When case plans are submitted to the Childrens Court, it is the role of the Court to ensure the case plan is appropriate for meeting the child's protection and care needs. When making this decision, it is not relevant whether all people who participated in the development or revision of the case plan agreed with the case plan (*Child Protection Act 1999*, section 59 (1)(b)(ii) and (3)).

The case plan cannot be amended once it has been endorsed. If there is a high level of disagreement regarding the content of the case plan that impacts on the implementation of the plan, the Senior Team Leader may decide to revise the case plan that may or may not involve another FGM. If the matter is before the Childrens Court, it is the Court's responsibility to decide whether the case plan meets the child's care and protection needs.

If a case plan needs to be amended

If the Senior Team Leader determines that the case plan (or something contained within the case plan) developed at the FGM is not in the child's best interests, or is impracticable, they cannot endorse it.

The Senior Team Leader should advise you that a case plan is not going to be endorsed as soon as possible following their decision. You could then be asked to undertake the following actions:

- Reconvene the FGM involving the same people from the initial meeting.
- Arrange for a new FGM to be convened with different participants from those involved in the initial meeting.
- Amend the original case plan in ICMS and submit it to the Senior Team Leader for endorsement.
- Arrange for a private convenor to facilitate a subsequent FGM (whether or not they convened the first).
- If it is agreed that a second FGM is required to develop a more appropriate case plan for the child, you should:
 - discuss with the Child Safety Officer or Senior Team Leader who they believe should be invited to attend any subsequent FGM (if applicable), and the reasons why the case plan is considered impracticable or not in the child's best interests.

- ensure that all participants are aware of why a subsequent FGM is being convened.
- provide information to any new participants (who did not attend the first FGM).
- provide any additional information to participants (such as new child protection concerns, information about the child's care and protection needs) since the initial FGM (**note:** you will need to undertake all necessary preparation as outlined in Chapter 1 of this handbook, as required)
- obtain information about any resources or assistance to support the implementation of the new case plan
- consider the strategies used during the first FGM and consider whether different methods or strategies should be employed to assist participants to reach agreement.

Practice considerations

Providing case plan information to children

The department has a responsibility to explain appropriate information in the case plan to the child in a way that will help them to understand it. Providing case plan information to children is another way of including them in the decision making processes that affect their lives.

It is best practice for the Child Safety Officer to discuss case planning information with children face-to-face. The Child Safety Officer should ensure that the child has an understanding of the overall case plan goal, goal statements, and actions included in their case plan. Talking to the child in person may also encourage the child to ask questions about the case plan and clarify anything that they do not understand.

You are responsible for informing the Child Safety Officer when the case plan has been endorsed, and confirming that the Child Safety Officer will discuss it with the child.

If the case plan is required for Childrens Court

The Childrens Court cannot grant a final child protection order unless it is satisfied that there is an endorsed case plan that meets the child's assessed needs. Where possible, the FGM should be held before the department makes a recommendation to DCPL for an application for a child protection order. However, this does not always occur, and an application for a child protection order may be made before the FGM can be convened.

When a FGM has not been held prior to the department making an application for a child protection order, the court can order that a FGM be convened to develop (or revise) the case plan, for the plan to be filed in the court (*Child Protection Act 1999*, section 68(1)(d)(i)). The Child Safety Officer should also ensure that they have organised a referral for a FGM as soon as possible after making the application for the order. You can liaise with OCFOS regularly about upcoming matters before the court requiring a FGM to be convened. This will assist in the planning and prioritising of FGMs.

The case plan is a supporting document to the the application and any subsequent affidavits filed in the Childrens Court. The case plan must meet all of the essential requirements for any child subject to ongoing intervention. The case plan should give the child, their family and the court a clear understanding of the child's history, their current needs and what is going to happen

over the next six months (as a minimum) to meet these needs.

You should ensure that the case plan is developed in a timely way to ensure that it can be endorsed by the Senior Team Leader within 10 working days and attached to any court material filed in the childrens court.

If the parents are no longer together and there is sensitive information about a parent in the case plan that they will both receive

It is best practice to have the goals and actions contained in a case plan. However, if there is specific information about a particular parent (that will be read by both parents) that may be detrimental to their safety, you should consider developing general actions. This should only occur on the condition that the Child Safety Officer will provide more specific information to the respective parents (for example, family contact information) immediately following the case planning process and during the implementation phase.

These actions should still meet the other S.A.F.E.T.Y. principles, but may be more general in context. For example, *'the mother will have contact with her son once a week, supervised by the department at a location agreed by the mother'*. The fact that more specific information will be provided to each parent by the Child Safety Officer, either in writing or in person, should be stated in the case plan. You could consider writing in the case plan that the actions have deliberately been recorded in a general manner due to safety reasons.

The Child Safety Officer or Senior Team Leader will have assessed whether a parent is at risk if information contained in a case plan is shared with the other parent. You should discuss safety issues with the Child Safety Officer and Senior Team Leader during the preparation stage. Developing a case plan in this format should only occur in exceptional circumstances where there is a significant risk to the parent or child.

If the child is subject to a long-term guardianship order to a suitable person

You may convene a FGM but you are **not** required to review and develop a revised case plan for a child who is subject to an order granting long-term guardianship to a suitable person.

If the child is subject to a permanent care order

You may convene a FGM but you are **not** required to review and develop a revised case plan for a child who is subject to a permanent care order.

Checklist for Endorsing and distributing the case plan

- Have you ensured that the child's and parent's strengths and needs have informed the goals and actions to be included in the case plan?
- Have you addressed all worry statements with a corresponding goal statement and associated action steps?
- Did you assist participants to identify goal statements for the case plan that met the S.A.F.E.T.Y principles? (Refer to Chapter 4).
- Have you recorded the case plan on the approved form in ICMS in a clear, concise way using language that is easily understood by the child and the family?
- If the family is Aboriginal, Torres Strait Islander or from a CALD background, did you use culturally respectful language to record the case plan?
- Does the case plan clearly explain why the department is involved, what needs to happen, and what everyone involved needs to do to meet the child's safety, belonging and wellbeing needs?
- Did you follow the correct procedure if the case plan needed to be amended because it was not in the child's best interests or not practicable?
- Have you completed the Record of Family Group Meeting form?
- Did you ensure that the Senior Team Leader or Senior Practitioner endorsed the case plan within 10 working days?
- Have you distributed the case plan to the appropriate people?
- Did you provide information about the case plan to people that was easy to understand?

Chapter 4: Recording the case plan

This section provides convenors with information on how to record the case plan using the case plan template, and in accordance with the Framework for Practice.

Developing the case plan is a process that starts well before the FGM, by Child Safety staff working collaboratively with the family, with support provided by the FGM convenor. This section provides advice on how to frame the case plan elements when discussing them before, and during, the FGM with the family.

At the end of the FGM, a case plan will have been developed subject to endorsement. The examples in this section provide a guide to language and tone when entering the case plan in ICMS. However there must be 'no surprises' when the case plan is distributed. The final document should not differ materially from the discussions held in the FGM. Wherever possible, statements documented in the case plan will have emanated from the FGM and agreed to by all.

Overview of the case plan

The case plan is structured to reflect the CAP domains of inquiry:

- What is going well within the family (acts of protection and belonging, and strengths and resources)?
- What has happened, or is happening, within the family that worries us (past harm and complicating factors)?
- Safety and Wellbeing Scale — on a scale of 0 to 10, how safe is it for the children in the care of the family at this point in time? **Note:** although this domain doesn't appear in the final case plan template, it is an important component of the CAP discussions in the FGM (and prior) to get agreement on the current safety assessment.
- What needs to happen for the children to be safe and well in the future (identifying future worries, collaborative goals, and actions steps to achieve those goals)?

Domains of inquiry are applied to ensure that the collaborative assessment and planning process undertaken prior to, and during the FGM, will result in a 'no surprises' case plan for the family.

The case plan should be clear and stated in behavioural terms. The plan will illustrate what we will see happening when the worries have been addressed. This will be outlined through goal statements, which are documented in plain language.

The case plan is made up of interrelated goals and actions that, if achieved, will meet the overall goal of the case plan.

1. *Record of meeting*

- Who participated in developing the case plan?

2. *Current assessment:*

- Primary Goal of the case plan (to best achieve permanency)
- The alternative goal to achieve permanency
- What are we worried about has happened (Harm)?
- Complicating Factors
- What's working well?

2. Planning for Safety, Belonging and Wellbeing

- What are we worried will happen in the future if nothing changes?
- What needs to happen? (Primary Goals and Alternative Goals)

3. Child Wellbeing and Belonging

- Placement, contact, education, health, cultural support

Recording key items in the case plan

The purpose of the case plan is to provide a clear understanding and sense of the child and their situation — their history, current circumstances and the plan to meet their needs for (as a minimum) the next six months (or 12 months or longer if the child is subject to a child protection order granting long-term guardianship to a suitable person).

The case plan can be considered as a 'story' of the child (in a child protection context) up until that point in time; and a plan for the future. The case plan should be unique for each child, particularly when writing case plans for sibling groups.

The case plan should be written in easy-to-understand language. In recording the case plan, you should accurately capture the key items that were developed by the child, their family and significant others at the FGM, in their own words if at all possible.

The section below outlines what should be recorded in each part of the case plan document in ICMS.

Writing case plans in family-friendly language

The case plan must be written in language that is easy for the child and the family to understand. When writing the case plan you must always keep the audience of the case plan in mind and think '*Will the parents and the child understand this? Does this reflect what the parent's said? Is this what we agreed on in the meeting?*'

The best way to ensure that the case plan is written in family-friendly language is to use the family's own words in the case plan. During the FGM, assist the family to develop their own worry statements, goals statements and action steps and then document these exactly as the family word them.

Case plan section: Record of Meeting

Record the names of who attended, their role and relationship to the child, and whether they

participated in the meeting or were otherwise consulted.

Case plan section: Summary of Current Assessment

Overall case plan goal: rationale for goal

It is important that the child, their family, their network, carers (where applicable) and Child Safety have a clear and shared understanding of the overall goal of the case plan. The overall goal of the case plan is the goal for best achieving permanency for the child and can be dependent on the type of order (or intervention) the child is subject to. You should discuss it with the family prior to the FGM and seek agreement at the meeting. Options for the overall goal are:

- Child to remain safely at home — the child's protection needs can be met by the family without ongoing Child Safety involvement.
- Reunification — where a child has been removed from the care of a parent, the goal of the initial case plan must be to reunify the child with the parents on a long-term basis, unless it is not in the child's best interests, not possible, or not safe to do so.
- Long-term out-of-home-care — if reunification with a parent is not possible or not in a child's best interests, an alternative long-term care arrangement is required, with a member of the child's family group, foster carer or a shared care arrangement for the child involving particular members of the child's family group or cultural community.
- Young person lives independently — if reunification with a parent is not possible, or not in the child's best interests, an older child may transition to independent living.
- Other permanency option — the adoption of an infant or young child.

If the overall goal of the case plan is Reunification, the case plan must also include an alternative goal in the event that timely reunification is not possible.

Permanency/concurrent planning

Planning for long-term care arrangements for a child commences as soon as the the child is placed in care. This means that a goal of 'reunification' is pursued at the same time as a plan for a 'long-term alternative placement' or 'other permanency option' is developed. This allows for the possibility that reunification may not occur within a timeframe appropriate to the child's age and circumstances, and that the child's protection and care needs may not be able to be met by the parents.

When the goal is reunification, the alternative goal (in the event that timely reunification cannot be achieved) must be included in the case plan.

Recording what we are worried has happened

This section of the case plan focusses on the past — the things that have been happening in the family up until this point that have been worrying people, in relation to the safety, belonging and wellbeing of the child.

While harm statements will have been developed initially by the Child Safety Officer, the collaborative assessment and planning prior to the FGM is an opportunity to confirm

understanding and language used in the harm statements.

The harm statements should not be re-litigated in the FGM. However, the discussion in the FGM is an opportunity to remind families why we are here. By the time the FGM has been completed, the family should already understand the harm statements. It doesn't mean that everyone has to agree on what has occurred. Agreement on harm statements is not required in order to develop worry statements. The different views about what happened in the past can be captured in the harm statements so that time and energy can be used to focus on future safety.

Writing harm statements

Harm statements clearly outline the physical, emotional and psychological impacts of abuse and neglect for children. They should assist everyone to understand the actions or inactions of the parent and what has been experienced by the child.

It is important to be specific about the parent's behaviour that resulted in harm to the child (such as hitting the child, hitting and yelling at the other parent in front of the child, leaving the child alone with someone who has harmed a child), as it is this behaviour that we will be asking parents to change.

If the *risk* of harm only is substantiated, then no actual harm has been experienced and the harm box is left blank. The actions or inactions of the parent that form the basis of the future risk of harm are documented as complicating factors, and should have corresponding worry statements.

Harm statements must respond to the three harm types outlined in the *Child Protection Act 1999* (physical, emotional and psychological). Each harm type should have its own harm statement. Be careful not to confuse *abuse* types (what the parent does or doesn't do — physical abuse, emotional abuse, sexual abuse or neglect) with *harm* types (what the child experiences).

A harm statement should include all the following:

- What Child Safety or others know.
- What the parents or caregivers did or didn't do, in clearly stated behavioural terms, and in what circumstances or context this happened.
- The impact of this on the child.

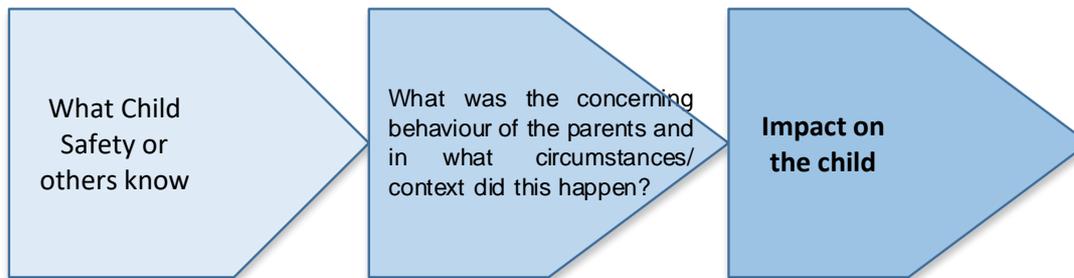
Harm statements should be written in plain language that is easily understood by the family. For example 'domestic violence' may mean very different things to different people, while hitting, spitting and punching are more clearly understood.

The most effective harm statements are jointly developed with the family and reflect the family's language. It is important to ensure, however, that what is known about the past and what has happened to the child does not become lost or watered down in an attempt to engage the family. Children and families are more likely to engage if Child Safety clearly states the impacts for the child in an honest, transparent and respectful way.

Harm statements can be direct but still reflect different views. For example, '*Child Safety is aware that on three occasions over the last year, Simon (Dad) has gone to the casino and lost a lot of money, drunk a lot of alcohol and then touched Selena (his daughter) on the vagina and*

put his finger in her vagina. Selina reports this made her feel scared, sad, bad, unsafe and confused. Simon and Sharon (mum) say that dad never did touch Selena’.

Harm statements must include:



Example of a substantiated investigation and assessment harm statement: Significant harm has been experienced by the child and there is an unacceptable risk of significant harm as the child does not have a parent able and willing to protect them.

Maria told Child Safety that she has been disciplining Aran (age 5) and Asnee (age 4) by pinching them on the forearm and hitting them around the head with her hand. Maria said that on 6 September, she used a cane to whip Aran about the legs. Aran and Asnee both have a number of bruises from the pinching and Aran has a 6 cm long bruise on the back of his right leg from the whip. Both boys say that the hitting about the head gives them a loud noise in their ears and a bad headache. Aran says he is very scared of his mum and does not want to go home from school.

Example of a substantiated ‘unacceptable risk of harm’ investigation and assessment No actual harm has occurred, but there is an unacceptable risk of significant harm as the child (or unborn) does not have a parent able and willing to protect them.

A parent is reported to Child Safety after having been pulled over by police at 2 am while driving with a blood alcohol level of 0.23. Mother was driving erratically and was at risk of an accident. Two infant children are asleep in the vehicle. Grandmother is contacted and will collect the children. This is the mother’s second drink driving offence with children in the car.

In this instance, no actual harm has been experienced by the child. There is likelihood that the child will be significantly harmed in the future (after birth for an unborn for example).

No harm statement will be written in the CAP tool, the harm box will be left blank. Parental actions, inactions, issues, circumstances or conditions that contribute to the future risk of harm will be documented as complicating factors. The complicating factors that contribute to future risk will be reflected in the future risk worry statement. As an example:

The complicating factors are the mother’s alcohol addiction and her repeated driving with the children in the car. These complicating factors would then form the basis of a worry statement in relation to what Child Safety is worried will happen to harm the children in the future if nothing changes.

Example of an ongoing intervention harm statement (open IPA or CPO)

Dave and his doctor told Child Safety that Dave has paranoid schizophrenia and sometimes he gets ‘wobbly’, doesn’t take his medication and can’t get out of bed which means there is no one to feed or take care of Rachel.

While Rachel (age 4) was at Dave’s (dad) house for an unsupervised family contact visit, Dave got angry when the visit was nearing an end and barricaded himself and Rachel into the house. The police were called and they had to negotiate with Dave to open the door, which left Rachel

confused, scared and terrified that someone would get shot.

For children in long-term care, consider and include harm related to past care environments, or which might stem from their own choices and actions. This should be included in addition to the harm that led to Child Safety being involved.

Recording what's working well

This section of the case plan focuses on those things that have been happening in the family in the past, and are happening currently that are positive and contribute to the safety, belonging, and wellbeing of the child. This information is critical as it provides ideas about what future safety, belonging and wellbeing for the child could look like.

'Protection and belonging' describes any time when the child, parent, carer or support network has taken action, or made a decision, that resulted in the child being safe, when they might otherwise have been harmed.

'Strengths and resources' describe attributes, capacities and supports that are present in the child, parent, caregiver or network and are positive, but do not (on their own) create safety for the child.

How to write a protection and belonging or strengths and resources statement for recording what's working well

For in-home and short-term cases with a goal of reunification, statements about actions of protection and belonging taken by child, parents, carers and the network must be specific and describe the behaviours that resulted in increased safety for the child.

Similarly, strengths and resources statements should reflect strengths and resources available to the child, parent carer and network that are improving the situation for the child.

For cases where the goal is long-term care and stability for the child, protection and belonging and strengths and resources statements may relate more broadly to actions undertaken by the parent, carer or network to meet the child's safety, belonging and wellbeing needs. Young people may also demonstrate personal strengths and acts of protection on their own, and these actions and decisions should also be documented as protection and belonging or strengths and resources statements.

Ensure that protection and belonging and strengths and resources statements make clear:

- Who (child, parent, carer or network member)?
- Does what?
- How this improves the situation for the child (safety, belonging, wellbeing).

Protection and belonging and strengths and resources statements should not reflect the absence of something. For example '*no previous child protection history*' is not a strength, whereas '*the family has worked together well enough that they have kept the children safe for the past seven years*' is a reasonable strength statement.

Statements about 'what is working well' should be written in plain language that is easily understood by the family, and relate directly to the documented harms and complicating factors. Do not use jargon or words that don't have clear, shared meanings. Strengths and resources

and protection and belonging statements should be constructed with the child, young person, parents, carer and network.

Example of strengths and resources statement in response to worries about neglect *The school says that Leanne (mum) brings Cara to class every day on time and that Cara is always clean and tidy, and has everything she needs including a healthy lunch.*

Maria's mother-in-law Terry has told Maria that hitting and hurting the children as discipline is not okay. Terry stopped Maria from pinching the boys and hitting them with the cane on 4 or 5 occasions in January. Maria respects Terry and did not pinch or hit the boys for about 5 months after this.

Nathan's mum Colleen and his carer Judy have worked out a plan where they will take Nathan to the Healing Centre classes together so that they can all learn more about his dad's Aboriginal culture and heritage.

Case plan section: Planning for Safety, Belonging and Wellbeing

What needs to happen?

This section of the case plan focuses on the future. Once there has been a balanced and collaborative assessment of what has happened in the past, and is currently happening in the family, this section documents:

- future worries about the children
- future goals to address the worries
- action steps to address the goals.

Recording worry statements in the case plan

What are worries?

The *Child Protection Act 1999*, section 10 refers to an 'unacceptable risk of harm', which is significant harm, which has not yet occurred but is likely in the future, given risk factors identified in the present.

A child is assessed as 'in need of protection' if the level of risk is identified as likely (probable) or not just possible (may occur); the probable harm will have a significant detrimental effect on the child if it does occur; and there is not a parent able and willing to protect the child from future significant harm.

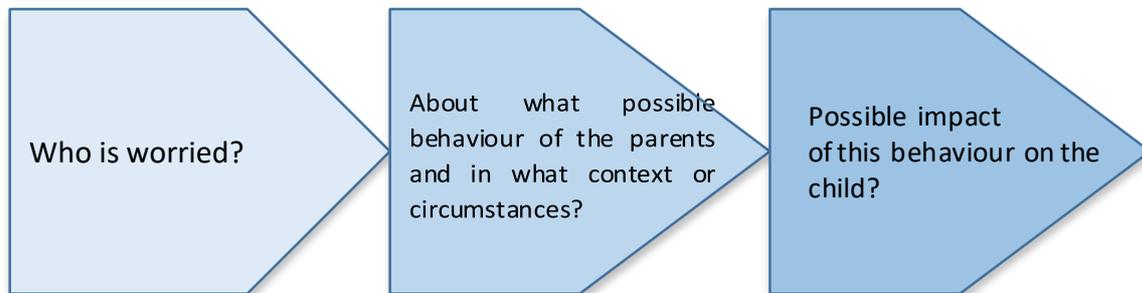
Worry statements document unacceptable risk of significant harm to a child. 'Worries' are actions or inactions that may happen in the future to significantly harm the child if nothing changes.

How to write a worry statement

Each harm statement (physical, emotional, psychological) and complicating factor that is related to a significant risk of harm should have a corresponding worry statement.

A worry statement uses clear, behaviourally focused descriptions of parental action or inaction, and the future danger this poses to a child. Worry statements help everyone (especially the child and their family) to understand what Child Safety is worried might happen to the child in the future, if nothing changes, and why the department Child Safety is involved.

A worry statement is future focused and must include:



While worry statements may be developed initially by Child Safety, it may be possible to construct worry statements together with the family over time (for example, using the parent's or child's language and/or including alternative views).

Agreement about past harm is not necessary to achieve agreement in relation to worries for the future. For example, the harm statement:

Child Safety is aware that on three occasions over the last year, Simon (Dad) has gone to the casino and lost a lot of money, drunk a lot of alcohol and then touched Selina (his daughter) on the vagina and put his finger in her vagina. Selina reports this made her feel scared, sad, bad, unsafe and confused. Simon and Sharon (Mum) say that dad has never touched Selina.

Could have a worry statement:

Child Safety and Selina are worried that if Simon (Dad) is alone with Selina (daughter), that he will touch Selina on the vagina or behave in sexual ways and that Selina will feel sad, bad, unsafe and confused. Simon and Sharon say that dad has never touched Selina but they are also worried that Simon will be accused of touching Selina again in the future.

Other examples of worry statements:

Child Safety is worried that Amy (mother) and Jason (father) will spend money on drugs and inject speed every day and then won't be able to feed, look after, supervise or care for Shanaya (7 years), Jake (5 years) and Poppy (18 months) properly and the children might be hurt while wandering the streets, get sick from not having enough to eat, and feel scared, worried and alone.

Child Safety is worried that Maria (mother) will pinch Aran (age 5) and Asnee (age 4), hit them around the head with her hand and whip them with a cane when they are naughty, and that Aran and Asnee might be badly hurt in the future. Child Safety is also worried that if Maria disciplines the boys by physically hurting them, Aran and Asnee will get more and more scared of her and won't want to live with her.

Child Safety, police, Mary and Rob (carers) and Bronte (mum) are all worried that if Noah smokes weed, misses school and shoplifts he will not finish Year 12 and might end up with criminal convictions and so won't be able to get the job that he wants or be able to travel overseas.

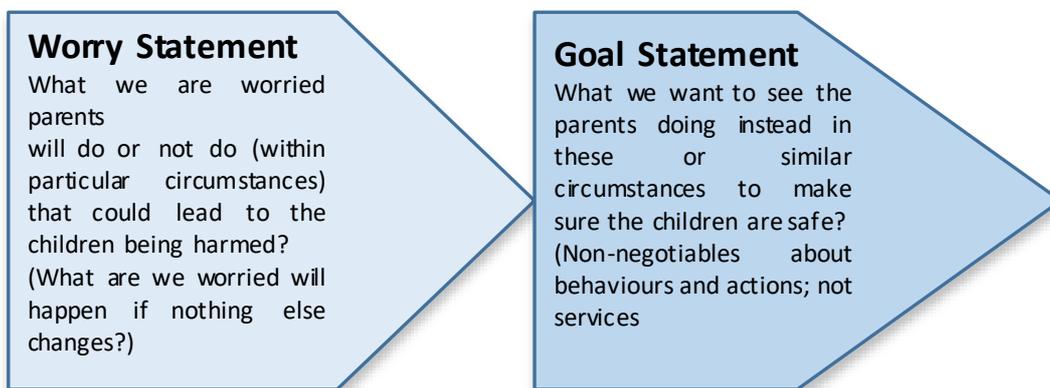
By avoiding words like 'continue' and 'again' in worry statements, you can avoid a dispute about whether or not something happened in the past. This doesn't weaken the worry statement, but remains focused on what we are worried will happen in the future, rather than what we think happened in the past.

Recording goal statements in the case plan

Goal statements are clear, behavioural statements about what the parents will do differently in their care of the child in the future, to address the worry statements, and to protect the child from the identified worries (the identified possible behaviour of the parents, within the identified worrying circumstances).

Goal statements provide a vision for future safety, belonging and wellbeing for the child and provide the focus and direction for the creation of rigorous plans. The primary goal statements will be related to the primary goals of the case plan. There will also be alternate goals

While worry statements identify the potentially dangerous circumstances and behaviours or actions of the parents that could lead to possible harm to the child in the future, goal statements identify the safe and protective behaviour of parents that we would want to see happening within these circumstances in the future to be confident that the child will be safe.



How to write a goal statement

Goal statements describe the future actions or behaviours of the parents that will protect the children from the identified worries. Goal statements provide the broad description of these actions and behaviours. The details of how these behaviours will be achieved on a day to-day and ongoing basis are then contained in the action plan.

As well as the future actions of protection, goal statements contain two other components:

1. An initial umbrella statement that makes it clear that the parents will need to work with a network and with Child Safety to develop a plan with details of how the goal statements will be achieved.
2. A timeframe that identifies how long it may take to achieve the goal statements (or length of time needed for the plan to work effectively), for everyone to be confident that the plan will continue working to achieve the goal statements.

Goal statements state the change in situation or behaviours that need to occur to achieve the primary goal of the case plan. The goal statements must respond to the worry statements. The goal statements must also relate to the child's care and protection needs as determined by the child's strengths and needs assessment, as well as addressing priority needs as identified in the parent's strengths and needs assessment.

The alternative goals relate to what the future should look like if the timely return of the child to a parent is not possible. The goal statements relate to the child's care and protective needs

and how the child will experience legal, relational and physical permanence.

Suggested goal statement template

(Parents) will need to work with Child Safety and with a safety network (family, friends and professionals) to develop and put into place a detailed plan that will show everyone that:

- [Insert Statements (usually one for each worry statement) that describe in broad terms the future...
- ...actions of protection or behaviours of the parents that ensure the children are protected in...
- ...relation to the identified worries]

The department Child Safety will need to see the plan in place and working for a period of at least XX months so that everyone is confident that the plan will keep working once Child Safety withdraws.

Examples of goal statements (examples will vary depending on the protection outcome)

Tanya and David will work with Child Safety and a network (family, friends and professionals) to develop and put into place a plan for Tahlia that will show everyone that:

- *Tahlia is always looked after by an adult who is sober/not affected by drugs and who everyone agrees is a 'safe' adult.*
- *Tahlia will live in a safe and calm house where she is able to sleep well and where people who visit the house consider her best interests at all times.*
- *Tahlia will be given caring attention and helped to learn things through playtime and different activities that help her to grow.*
- *If Tahlia makes mistakes or things mum and dad don't want her to do, Tanya and David will have ways of helping Tahlia to understand how to do the right thing that don't cause fear or hurt for Tahlia.*
- *Tahlia will be supervised at all times and never left alone and will reassure her when she is feeling scared and confused.*
- *Tahlia is able to see her Mum and family regularly while she is living in out of home care so that she is able to continue feel connected to her family and community [i.e. if applicable].*

Child Safety will need to see the plan in place and working for a period of six months so that everyone is confident that the plan will keep working for Tahlia once Child Safety withdraws.

Kristy and Darren and a network for Isabella [the child] made up of Tom, Mary, Lorraine and Karen will agree to work with Child Safety to make a plan for Isabella that will keep her safe and show everyone that:

- *Isabella is taken to all her medical appointments to make sure that she is withdrawing from the drugs in a safe way and she keeps being given the right amount of morphine until the doctor says that she doesn't need it any more.*
- *Isabella is always getting what she needs, is putting on weight, getting all of the love that she needs, like being care and affection, and reaching her developmental milestones [give*

examples in plain language].

Everyone wants to see the plan working well for a period of six months to feel confident that alternative arrangements can be explored.

Just as with the worry statements, goal statements are developed collaboratively with all of the key stakeholders who are involved at that point in the assessment and planning process. Although there may not always be agreement on the goal statements, everyone needs to be involved in the process of planning the care and protection for the child.

Developing goal statements for the case plan

When developing goal statements for the case plan, focus on the needs of the child:

- What needs to be different for this child to be safe in their parent's care?
- What situation or behaviour needs to change for the child to be safe?
- Ask the parents 'What do they think needs to happen for them to have the child returned to their care? What needs to happen for them to achieve their family vision?'
- What needs to happen for the child to remain safe and well cared for on a long-term basis?

Other quality checks:

- Ensure goal statements reflect the needs captured by the Child Strengths and Needs Assessment, and Parental Strengths and Needs Assessment (when it is used). Develop goal statements as positive statements (for example, what positive thing would the parents do *instead* of using drugs or instead of fighting).
- Ask questions from other people's points of view — what would others like to see happening?
- Cover all of the identified worries.
- Distinguish between goal statements and detailed action plan. The goal statements are where we want to get to and the action steps are *how* we are going to get there.

How to write a non-negotiable

When an immediate harm indicator is identified, Child Safety should be clear about what non-negotiables are needed to create a rigorous immediate safety plan. Non-negotiables are written using clear, plain language to describe what Child Safety must see included in the plan. Non-negotiables will change over time as situations and circumstances change and as children, young people, parents, carers and networks develop new strengths and skills.

Example of a non-negotiable

If your goal is: *Child Safety, Sam (step dad), Mum and Zoe (young person) and a safety and support network will work together to create a plan that ensures that Sam is not alone with the girls so that the girls are protected from future touching and Sam is protected from allegations of touching and everyone feels safe at home in the future.*

Non-negotiables could include:

- *Zoe will not be alone with Sam and there will always be a safe adult there when Zoe is around Sam.*
- *At the moment, everyone has agreed that Mum, Grandma, Grandpa and Auntie Tina can be the safe adults.*

How to write action steps

'Action steps' describe what everyone needs to do next to achieve the goal statements.

Once the family and others attending the FGM have discussed and determined what goals need to be included in the case plan, they will decide what actions are required to meet these goals. Actions are the activities that will help the family move from their current situation to a circumstance where they are able to safely meet the child's care and protection needs.

Action steps give everyone involved clearly defined roles and responsibilities, and should be stated in terms of:

- What must be done?
- Who is responsible?
- What is the timeframe for the action to be completed by?

The people responsible for undertaking actions outlined in a case plan are typically:

- participants at the FGM
- other members of the safety and support network that did not attend the FGM.

Responsibility for key actions should not be given to those who are not at the meeting unless this was tentatively arranged before the meeting. If an action involves a person who is not attending the meeting, it should be recorded in the case plan as a proposal to be followed up by a particular date or subject to the agreement by the particular party.

Goal statements and action steps need to capture the following elements:

- S** Specific and measureable, describing the actual behaviours and actions of parents needed to protect the child from each of the identified worries (each of the worry statements).
- A** Achievable. The family and network need to have, or be able to develop, the knowledge, skills, resources and willingness to achieve the goal statements.
- F** Family-owned. Ideally, the goal statements will be based on both the family and Child Safety's vision for future safety. At a minimum, they will be based on the family's ideas of what will satisfy Child Safety.
- E** Endorsed by Child Safety. Child Safety must agree that the goal statements will provide the level of care and protection for the child before it can close the case.
- T** Time-specific. Goal statements need to be set over a specified period of time to build confidence that the child's safety, belonging and wellbeing will be maintained once Child Safety withdraws or closes the case.

- Y** Young people and children have contributed to the goal statements, or can understand the goal statements.

Examples of action steps

1. *Neighbour Paul, Aunt Eugenia, Helen, foster carer Trina and outreach worker Betsy have all agreed to be a part of Cheryl and the girls' safety and support network. Visits for Cheryl and the girls will be three times a week and supervised until everyone agrees this can change. Anna (Cheryl's case worker) will supervise visits on Monday and Wednesday and Aunt Eugenia will supervise on Saturday. Visits will start this Wednesday.*

Everyone will have a copy of the plan and if at any time they are not able to follow the plan or are worried about anything, they will call Anna. Anna and Trina will explain what is happening to Rebecca and Lisa and will go through the plan with them, to make sure that they understand the plan. Anna will help the girls talk about their thoughts and feelings by creating their Three Houses.

Paul, Eugenia and Helen have made a roster with Cheryl and each of them will call or visit Cheryl daily. They will talk to Cheryl, ask how she is doing and also scale the impact of depression on her. When the network visits they will also write in the family safety book.

2. *Kristy and Darren will stay in the hospital with Isabella and they will look after her fulltime for the next four days to show everyone that they know what to do to care for her. The hospital will review her health three times a day and if she continues to be well, they will agree to her being discharged on the fifth day.*

For Isabella to be discharged from hospital into the care of Kristy and Darren, they will need to move in with Tom and Mary and stay there until Child Safety and Kristy and Darren and the network agree that Isabella will be safe with them in their own home.

3. *Heather will call the parenting centre and ask to go to the weekly toddler parenting class.*

Heather will show what she has learnt at these classes by buying healthy food and making healthy meals for breakfast, lunch and dinner for Rosie every day.

The Child Safety Officer will visit with Rosie and Heather once a week to talk to Heather about how she looking after Rosie and to make sure that Rosie is safe. The Child Safety Officer will watch how Heather is playing with Rosie and will see what food she feeds Rosie. The Child Safety Officer will also watch how Heather talks to Rosie when she is doing something that Heather doesn't want her to do.

The Child Safety Officer will ask the parenting centre to contact them every two weeks about whether Heather is going to the parenting classes and whether they think she understands what she is learning and is able to do this at home.

The Family Intervention Service (FIS) worker will come to Heather's home and help her to make some plans about how she is going to get Rosie's meals ready for breakfast, lunch and dinner. The FIS worker and Heather will draw a timetable up with these plans on it.

Case plan section: Child wellbeing and belonging

This section records the placement and living arrangements for the child, and includes information about:

- where and with whom the child is living (the name and address of approved carers), *unless* the provision of this information poses a risk to the child, the child's carers or anyone else

with whom the child lives

- where the child will attend school and arrangements for the child's Education Support Plan (where applicable)
- whether the child requires a child health passport and how the child's medical and therapeutic needs are to be met (when not included as actions in the case plan)
- plans for the child to participate in recreational, sporting and cultural events that meet their developmental needs.

Living details

If there is a safety risk with one parent knowing about the child's placement and a decision has been made by Child Safety to withhold placement information, you must remove this information from the copy of the case plan to be provided to that parent. However, you would still provide a copy of the complete case plan (with the child's placement information) to the parent who needs to know where the child is residing.

Education

Details of where and when the child attends school, child care, kindergarten or preschool should be provided in this section. You also need to include the date of the child's most recent Education Support Plan (ESP), where applicable. An ESP is ~~only~~ required for a child who is subject to a final child protection order granting custody or guardianship to the chief executive, placed in out-of-home care and is of compulsory school age or enrolled at school from Prep to year 12. Child Safety of Education and Training is responsible for developing and recording the ESP. Child Safety and the child's carers will be involved in the development, review and monitoring of the ESP, along with the child's parents (where appropriate).

If the child has significant educational needs that require ongoing intervention and review, this should be included as a goal statement with attached actions to meet these needs. The Child Safety Officer should ensure that education, employment or vocation has been identified as a need on the Child Strengths and Needs Assessment (CSNA).

Child health passport

Collaborative family decision making processes, including FGMs, can be used to gather information, plan, gather and motivate ongoing support for a child's health and wellbeing. Involvement of the family in health assessment and health management planning for physical, developmental and psychosocial health is important so that a complete picture can be developed.

A Child Health Passport (CHP) is commenced when Child Safety makes a request in writing for a health and dental professional to complete an appraisal, or undertake an assessment of a child's health and dental needs, or when confirmation of a medical appointment has been received. It must begin within 30 days, and no later than 60 days, after a child enters out-of-home care.

The CHP process is not to be implemented as an isolated event. It is to be linked to the child's strength and needs assessment and the development and ongoing review of the child's case plan and case work. In relation to the case plan, if the child has a significant health need (for

example, a disability or a chronic or acute medical condition) that requires ongoing intervention and review, these should be included as a goal statements with attached actions to meet these needs. The Child Safety Officer should also ensure that physical health is identified as a need on the CSNA.

The CHP folder is an active document and moves with the child for each new placement. Collaborative family decision making meetings can be used to the CHP when the child's circumstances change.

All people involved in the CHP process must be made aware of their responsibility to maintain the confidentiality of health-related information in accordance with the requirements of the *Child Protection Act 1999*, Sections 187 and 188.

Family, culture and community connection — cultural support plans

The case plan for a child must include actions and arrangements that maintain and support the child's cultural identity, consistent with the statement of standards, the charter of rights and the principles of the *Child Protection Act 1999*. This applies to an Aboriginal or Torres Strait Islander child, or a child from another cultural community. Strategies developed at the FGM to maintain and support the child's cultural identity, relationships and cultural obligations are included in this section of the case plan.

Child Safety is responsible for ensuring that the child's cultural identity and relationships are maintained and providing opportunities for contact between the child and appropriate members of the child's community or language group, as often as is appropriate. This is particularly important when the child is placed with a non-Aboriginal or Torres Strait Islander person or with another Aboriginal or Torres Strait Islander not from their tribe or language group.

When completing the cultural support plan, be specific in detailing the support that the carer requires to ensure that the child is able to participate in culturally appropriate activities, as well as the type and nature of these activities. The Child Safety Practice Manual contains further information and advice, including the [Safe Care and Connection Practice Kit](#).

Consider holding an additional, separate meeting to develop the cultural support plan, to give participants time to seek and invite appropriate people to contribute to the design of the plan. To develop a comprehensive and meaningful plan, involve all cultural support people and obtain their commitment to fulfilling the actions in the plan. The case plan documents the 'who', 'how' and 'when' of cultural support.

Building or establishing cultural connection

You must clearly state in the plan if you do not have information about the name of the mob, community and or island group, clan group, language group and skin group that the child (or their siblings or parents) belongs to. State the strategy for obtaining this information and the timeframes. Also consider including this as a goal statement in the case plan if cultural identity has been assessed as an evolving, significant need for the child. A cultural support plan is a document that will transfer from one case plan to the next, and can be amended as new information becomes available.

Contact plan (Family Connection)

The case plan must state how the child will maintain his or her connections with:

- parents
- siblings
- extended family and community members
- people of cultural or ethnic significance.

The contact arrangements must be consistent with any order made by the Childrens Court, outlining the child's contact with their family or how the contact should happen. Include directions about contact made by the Childrens Court on granting an interim order, the Childrens Court that made this order, the details of the order and when it expires.

Contact decisions are made by the senior team leader and the Child Safety Officer makes the contact arrangements. As FGM convenor, you remain independent of those decisions. Ensure that you have all the information from the Child Safety Officer to be able to complete the case plan.

The contact arrangements in the plan must allow for contact to be regularly monitored and reviewed in line with the case plan goals and the child's safety and best interests. You should provide the following details about contact arrangements:

- Purpose
- Type
- Frequency
- Location
- Supervised or unsupervised contact

Purpose — add description of purpose

Type of contact — the case plan should state the type of contact that is to occur. Contact may entail visits, phone calls, emails, online platforms mail and activities such as attending school events, parent/teacher nights and sporting activities.

Frequency of contact — the frequency of the contact must be recorded in the plan and stated as subject to ongoing monitoring, review and progress towards the case plan goal. A regular review of contact can also be written into the case plan, including details of who will conduct the review and how (for example, contact will be reviewed every eight weeks by the Senior Team Leader and Child Safety Officer, and if a parent is attending and interacting appropriately with child, contact will be increased from once to twice per week). Where it is intended to be increased, this should be stated in the plan and be subject to the child's safety and review of progress.

Location of contact — Contact visits must occur in a location that is safe and culturally appropriate for the child and family. It is ideal if contact visits occur in natural settings that are comfortable for parent, child and family interaction. Provided it is in the child's best interest and consistent with a child's need for safety, visits can occur at different places, such as at the child's home, a family member's home, a park or contact centre. A child safety service centre is only to be used as a location for contact visits where there is a legitimate reason, such as it is necessary to ensure the child's safety.

Monitoring of contact (supervised or unsupervised) — supervised contact provides an opportunity to coach parents and work with them to develop skills in areas that they may need

support. Supervised contact should only occur when we have safety concerns (physical, psychological or emotional) for the child. Supervision must be provided for contact visits when some level of parental control or direction (or for other people in contact with the child) is necessary during contact arrangements.

The case plan must provide for departmental supervision in the following circumstances where:

- there are legitimate concerns about the child's emotional, psychological or physical safety
- there are legitimate concerns that the child may be abducted
- the child or family requests that a Child Safety Officer or Child Safety Support Officer is present
- there is a need to observe interactions between the child and the family to assess progress of case plan goals and actions and assist with court processes
- the Child Safety Officer or Child Safety Support Officer is working in a therapeutic capacity with the child and family in accordance with the case plan
- a qualified professional working with the child and the child's family recommends supervision based on legitimate concerns.

The case plan should detail who is going to supervise the contact visits and the reasons for this supervision. It is the role of the Child Safety Officer to define the contact arrangements for the case plan. Tools such as the 'Establishing Safe Contact Tool' from Sonya Parker Consultancy explains the justification for supervised contact, based on worries, existing safety and the steps that need to be taken for contact to become safe (and unsupervised).

Regular review of the contact arrangements (within the six-month case plan review date) by the Child Safety Officer and Senior Team Leader with information gathered from the contact supervisor, the parent and any other relevant professional working with the family, can also be written into the case plan.

Documenting disagreement about contact

Any disagreements about the proposed contact arrangements should be documented in this section of the case plan. The parent or family member will receive a letter from Child Safety detailing the contact arrangements (or changes to contact) and how they can request a review of this decision by the QCAT.

In addition to documenting contact to be regularly reviewed into the case plan, outlining what has to happen for contact to be changed can sometimes be a successful strategy in shifting a person's mindset off disagreements about the current level or nature of contact.

Transition to adulthood

During the preparation stage of the FGM, the Child Safety Officer will inform you if the young person is old enough to begin planning for their transition to adulthood (from 15 years old). The Child Safety Officer will also identify this need through the completion the Child Strengths and Needs, which you will review when preparing for the meeting.

This will be discussed during the FGM, along with the goals and actions developed for the case plan. Indicate in the relevant section in the case plan that transition to adulthood planning has

commenced. You should also state in the section 'type of ongoing intervention' that the child is eligible for transition from care to independence planning and that dual planning is being undertaken (in the form of a case plan) to meet the child's current and future needs. You should also consider including specific goals that address the child's transition from care to independence needs in the case plan.

For more information and advice about case planning for a young person's transition to adulthood, review the Child Safety Practice Manual, Practice Kit Transition to Adulthood, [case planning section](#).

Case plan review

With the exception of support service cases, permanent care orders and child protection orders granting long-term guardianship to a suitable person, case plans for children subject to ongoing intervention must be reviewed at least every six months.

Case plans can be reviewed more regularly than six months, depending on the child's circumstances, the nature of the ongoing intervention, if Child Safety is waiting on significant information that would impact on the overall case plan goal, goal statements and action steps and whether or not the matter is before the court. The review date decided at the FGM should be recorded in this section of the case plan.

Resources required for the case plan

The Child Safety Officer and Senior Team Leader should seek financial approval from the financial delegate (Child Safety Service Centre Manager), prior to the FGM, for resources or services to support the child or family. The case plan cannot be endorsed by the Senior Team Leader or Senior Practitioner until financial approval has been given by the manager for the resources to be included in the case plan.

When writing the case plan, the action should state '*the Child Safety Officer will submit a Child Related Costs Approval Form and seek approval from Child Safety Service Centre Manager for the resource to be purchased for the child*'. This must be clearly explained to participants during the FGM meeting.

You need to be very specific when completing this section of the case plan. On the FGM referral form, the Child Safety Officer should give clear information about what resources have been approved by the manager.

Application for long-term guardianship to a suitable person or permanent care order

When a decision is made to apply for a child protection order granting long-term guardianship to a suitable person or a permanent care order, the revised case plan submitted to the Children's Court must include all key items.

Goals and actions

The goals will only address the key needs of the child, and not any previously identified priority needs for the parents, as the decision has been made to seek a long-term guardianship order or permanent care order.

Record the following actions in the revised case plan:

- The decision to apply for a child protection order granting long-term guardianship to a suitable person or a permanent care order.
- For child protection order granting long-term guardianship to a suitable person, Child Safety will have contact with the child every 12 months.
- For child protection order granting long-term guardianship to a suitable person, the proposed guardian will allow contact with the child to occur.
- The proposed guardian will keep the child's parents informed about where the child is living and the child's care, *unless* an exception is made by the Childrens Court.
- The child or the proposed guardian may contact Child Safety at any time in the future, to request support.
- The proposed guardian will notify Child Safety **in writing** should the child leave their direct care at any time in the future, including details of the child's current whereabouts if known.
- The proposed guardian will ensure the child is aware of the Charter of rights for a child in care (Schedule 1 of the *Child Protection Act 1999*).
- The proposed guardian will ensure the child is given appropriate help to transition to adulthood.
- The proposed guardian will preserve the child's identity and connection to culture (to the extent it is in their best interests and *unless* an exception is made by the Childrens Court).
- The proposed guardian will help the child maintain relationships with their parents, family and other significant people (to the extent it is in their best interests and *unless* an exception is made by the Childrens Court).

Child information

Record the following details of the child's placement and living arrangements:

- Where there is a significant risk to the safety of the child or anyone else with whom the child is living, Child Safety will make a submission as part of the application to the Childrens Court, about necessary modifications to providing information about where and with whom the child is living.
- That the proposed guardian will assume full responsibility for meeting the child's identified educational, medical and therapeutic needs, unless it is included as an action in the case plan that the child is no longer eligible for an Education Support Plan or a Child Health Passport.
- The ongoing support needs of the child and the proposed guardian, and how these needs will continue to be met.

Family and community

The proposed guardian must legally provide opportunity for contact between the child, parents and appropriate members of the child's family and community as often as is appropriate in the circumstances, *unless* the Childrens Court orders otherwise in response to a submission made

by Child Safety.

Record the views of the child, the parents and the proposed guardians regarding:

- proposed contact arrangements
- any submissions to be made by Child Safety to the Childrens Court about the proposed guardian's ongoing requirement to provide family contact, where there is a significant risk to the safety of the child or anyone else with whom the child is living.

Resources required for the case plan

Record the approved financial supports, including specific details of the service to be provided and any expected costs to be paid, following the making of the long-term guardianship order to a suitable person, as recorded in the Assessment report: Long-term guardianship to a suitable person.

Record the approved financial supports, including specific details of the service to be provided and the duration and the expected costs to be paid, following the making of permanent care order, as recorded in the Permanent Guardian assessment report. This is expected to be short term to provide transitional support for the proposed guardian.

Other key items to be included in the case plan

The goals and actions form the foundation of the case plan and work together to meet the overall goal of the case plan. However, there are other items that are important to a child in ongoing intervention, and must be included in the case plan. These are:

- Child information — details of placement and child's living arrangements (unless this poses a risk to the child, the child's carers or anyone else with whom the child lives), where the child will attend school, details of the most recent Education Support Plan, most recent child health passport and transition to independence plan (if child is aged 15 years and over).
- Family and community — outline contact arrangements for child; how they will maintain connection with their family, significant others and other people with cultural and ethnic significance.
- Key items specific to an application for a long-term guardianship order to a suitable person or permanent care order (where applicable).
- Case plan review date.
- Resources required for the case plan (as above).

The above items are discussed at length in the Child Safety Practice Manual, [Support a child in care, record the case plan](#)—.

References

- Ban, P 1996, 'Implementing and evaluating family group conferences with children and families in Victoria Australia', in Hudson, J, Morris, A, Maxwell, G & Galaway, B (eds.), *Family group conferences: Perspectives on policy & practice*, The Federation Press, Annandale.
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- Secretariat of National Aboriginal and Islander Child Care (SNAICC) 'Aboriginal and Torres Strait Islander Participation in Child Protection Decision making' 2013 (available from SNAICC)
- Secretariat of National Aboriginal and Islander Child Care (SNAICC) 'Understanding and Applying the Aboriginal and Torres Strait Islander Child Placement Principle: A Resource for Legislation, Policy and Program Development'. (available from SNAICC)

Resources

- *Child Protection Act 1999* (sections 4(2), 51L, 51M, 51N, 51O, 51P, 51Q, 51R, 51T, 51YA, 51YB, 80, 80A)
- [Department of Child Safety and Youth and Women website](#)
- Commonwealth Government's Translating and Interpreting Service (TIS) - <https://www.tisnational.gov.au/>

Department of Child Safety and Youth and Women intranet:

- Policy No. CPD598-7, *Child Related Costs — Client Support and Family Contact*
- Child Related Costs Approval Form

Child Safety Practice Manual Resources

[Child Safety Practice Manual](#)

Procedures

- [Case planning](#)
- [Report information to the Queensland Police Service](#)
- [Record the case plan](#)

Practice Resources

- [Framework for Practice](#) tools, including the Collaborative Assessment and Planning (CAP) Framework
- Collaborative Assessment and Planning Framework Tool (Tip Sheets):
 - [Harm Statements](#)
 - [Worry Statements](#)
 - [Protection and Belonging/Strengths and Resources Statements](#)
 - [Goal Statements](#)
 - [Bottom Lines, 'non-negotiables' and Action Steps](#)
 - Practice Kit: Safe Care and Connection: [Developing a cultural support plan for an Aboriginal or Torres Strait Islander child](#)
 - Practice Guide: [Culturally Capable Behaviours](#)
 - Practice resource: [Participation of Children and Young people in decision-making](#)