Appendix 1: Recording the case plan

Purpose

Appendix 1 provides convenors with information on how to record the case plan using the departmental case plan template, and in accordance with the Framework for Practice.

Note: Recording the case plan in ICMS and finalising an agreed document

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 departmental case plan structure as reflected in ICMS and in the case plan template is:

1. Record of meeting
   • Who participated in developing the case plan?

2. Current assessment:
   • What are we worried about?
   • What’s working well?

2. Planning for Safety, Belonging and Wellbeing
   • What needs to happen?

3. Child Wellbeing and Belonging
   • Contact, education, health, cultural support

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.

**Recording 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 child-focused, 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.

**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, carers (where applicable) and the department have a clear and shared understanding of the overall goal of the case plan. The overall goal of the case plan 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 departmental 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.

**Practice considerations**

**Permanency/parallel planning**
Planning for long-term care arrangements for a child commences as soon as the first custody or short-term guardianship order is granted. This means that a goal of ‘reunification’ is pursued at the same time as a plan for a ‘long-term out-of-home 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.

You should include a plan to progress alternative long-term arrangements in the case plan, following each review. This key item will not appear in a child's initial case plan, but is available in subsequent case plans where 'reunification' has been selected.

**Recording what we are worried about**
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 the department 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 the department 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, ‘the department 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 the department 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 the department 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 the department 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 the department 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 out-of-home 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 the department being involved.

**Recording what’s working well**
This sub-section of the ‘Summary of Current Assessment’ 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 out-of-home 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 the department is worried might happen to the child in
the future, if nothing changes, and why the department is involved. A worry statement is future-focused and must include:

Who is worried?

About what possible behaviour of the parents and in what context or circumstances?

Possible impact of this behaviour on the child?

While worry statements may be developed initially by the department, 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:

The department 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:

The department 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:

The department 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.

The department 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. The department 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.

The department, 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.

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 the department 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 overall 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.
Suggested goal statement template

(Parents) will need to work with the department 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 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 the department withdraws.

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

Tanya and David will work with the department 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].

The department 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 the department withdraws.

Kristy and Darren and a network for Isabella [the child] made up of Tom, Mary, Lorraine and Karen will agree to work with the department 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.

Practice considerations

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, the department 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 the department 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: the department, 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 family members, other significant people to the child and service providers 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 measurable, 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 the department’s vision for future safety. At a minimum, they will be based on the family’s ideas of what will satisfy the department.

**E** Endorsed by the department. The department 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 the department 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 the department 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 the department 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. The Department of Education and Training is responsible for developing and recording the ESP. The department 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 the department 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 should be included in this section of the case plan.

The department 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 Recognised Entity may be able to assist in obtaining/providing this information.

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.

**Practice consideration**

**Unknown details in cultural support plan**
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. You should 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**
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. Directions about contact made by the Childrens Court on granting an interim order should also be included. You should clearly state the details of the Childrens Court that made this order, the details of the order and when it expires.

The contact arrangements are specified by the Child Safety Officer. As FGM convenor, you remain independent of those decisions. You should 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, 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 should only 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 ‘Contact Planning 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.

Practice consideration

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 the department 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 from care to independence

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 independence (from 15 years old). The Child Safety Officer should also identify this need through the completion of the SDM assessments, which you will review when preparing for the meeting.

This will be discussed during the FGM, with goals and actions developed for the case plan. You should indicate in the relevant section in the case plan that transition to independence 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.
Case plan review

With the exception of support service cases 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 the department 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. Any proposals A Child Related Costs Approval Form must be completed requesting approval for the department to fund resources or services for the child or family that arise during the FGM, for consideration by the Child Safety Service Centre manager.

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.

Recording key items in the case plan

Application for long-term guardianship to a suitable person

When a decision is made to apply for a child protection order granting long-term guardianship to a suitable person, the revised case plan submitted to the Childrens Court must include all key items unless specified in the key items outlined below.

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.
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.
- The department will have contact with the child every 12 months.
- 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 the department at any time in the future, to request support.
- The proposed guardian will notify the department *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.

**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, the department 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 the department.

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

- proposed contact arrangements
- any submissions to be made by the department 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.
Plan for alternative long-term arrangements if reunification is not achieved

Record the decision to apply for a child protection order granting long-term guardianship to a suitable person.

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.

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 (where applicable).

- Case plan review date.

- Resources required for the case plan.

The above items are discussed at length in the Child Safety Practice Manual, Chapters 4 and 5.

Practice consideration

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 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.