Office of the
Children's Guardian

NSW GOVERNMENT

Specialised Substitute Residential Care Implementation Handbook

Contents

How to use this handbook

This handbook is for organisations providing and supervising specialised substitute residential care (SSRC) placements in NSW. It supports the implementation of the Child Safe Standards set out under section 8C of the *Children's Guardian Act 2019*.

This handbook covers the specific obligations that SSRC providers must comply with. These obligations are set out in the SSRC Code of Practice at Schedule 4 of the Children's Guardian Regulation 2022. Additionally, this handbook clarifies intersections with other relevant Commonwealth and NSW legislation. It also gives more detailed guidance to build organisational capability and promote continuous improvement of child safe practice.

Where there are defined rules and requirements, helpful resources or case studies these are colour-coded as below:

Defined rules and legislative requirements

Helpful resources and practice notes for consideration

Note that these are not real-life examples, but are created from a number of real-life scenarios

The SSRC Code of Practice and the more detailed guidance in this handbook are not intended to be a set of rules or checklists that can be added to a policy and filed away with no real impact on practice. Instead, this handbook contains additional information about service principles and examples that will help SSRC providers meet their obligations under the SSRC Code of Practice.

Clear principles are more effective than prescriptive requirements because they encourage organisations to think about their unique work environments and tailor good practice to their own workplaces and cultures. This makes the expectations around quality service and child safety easier for all staff to understand and implement, because it is integrated across the organisation.

This handbook has been informed by sector feedback and best practices that they have shared. It will continue to evolve over time. Please note that references to children in this handbook includes both children and young people.

This handbook reflects legislative, legal and practice requirements and the OCG will update this handbook as required.

Please email the SSRC team for further details about implementing the SSRC Code of Practice.

Overview of SSRC

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What is SSRC?

The Act defines substitute residential care as care:

(a) involving the provision of accommodation together with food, care and other support, **and**

(b) in the State (NSW) for more than 2 nights in any period of 7 days, **and**

(c) of a type ordinarily provided to children in a home environment, provided by persons other than the child's parents or relatives.

The Act defines *specialised* substitute residential care as **substitute residential care** that is:

(a) funded by the National Disability Insurance Scheme under the *National Disability Insurance Scheme Act 2013* of the Commonwealth, **or**

(b) provided for the purposes of respite services or behaviour support.

In practice, SSRC is a voluntary arrangement between a parent and a service provider to provide care to children or young people under age 18, away from their usual home for 3 or more nights in a week. The care must be for respite or behaviour support or funded by the National Disability Insurance Scheme (NDIS). It is a type of arrangement which may include:

- stays of 3 or more consecutive or non-consecutive nights within a consecutive 7-day period in a group home, respite, hotel or Airbnb environment
- short-term accommodation through the National Disability Insurance Scheme
- overnight stay of 3 or more nights with another family in a 'host family' arrangement
- longer-term residential care
- camps of 3 or more nights that focus on respite or behaviour support.

SSRC can be a one-off arrangement, including arrangements made in an emergency, or it can involve frequent or long-term care.

While SSRC arrangements can include longer-term residential care, longer-term SSRC arrangements should only be considered after other supports such as in-home care have been fully explored.

SSRC arrangements can be funded through the NDIS, they can also be funded from other sources including direct payment by families.

All SSRC providers are subject to the SSRC Code of Practice. SSRC providers are entities, including organisations and sole traders, who deliver SSRC to children. For an entity to be an SSRC provider, it is not a requirement that all SSRC placements they provide be for 3 or more nights. As long as an organisation provides one or more care placements for 3 or more nights in any 7 days, they are considered an SSRC provider for regulatory purposes.

One of the key obligations for SSRC providers is to record SSRC placements on the SSRC Register. This includes all episodes of care that meet the definition of SSRC as well as episodes of care that are for only 1 or 2 nights in any 7-day period that meet the other elements of the definition of SSRC. More details are outlined below in 'The SSRC register'.

SSRC does not include:

- care provided by an individual in a private capacity – that is the individual is not acting on behalf of, or pursuant to an arrangement with, a body or organisation, or as a sole trader
- care provided outside NSW – however if a child in SSRC enters another state or territory for an excursion or holiday as part of their respite package then they remain in SSRC during that time
- statutory out-of-home care such as care provided for a child when the Children's Court has made an order allocating parental responsibility for the child to the Minister for Families and Community Services
- supported out-of-home care such as care the Department of Communities and Justice (DCJ) provides, arranges or otherwise supports when DCJ has assessed the child is in need of care and protection, for example where the Children's Court has made an order giving a relative or kin carer full parental responsibility for the child
- certain arrangements and services, including adoption services under the *Adoption Act 2000*, boarding services provided by an educational institution or affiliate to enable children to attend the institution, juvenile detention centres, health services under the *Health Services Act 1997*, accommodation provided by specialist homelessness services funded by DCJ and bail assistance program placements.

SSRC providers may provide services to children that do not meet the definition of SSRC. Where an SSRC provider provides care to a child that does not meet the definition of SSRC, the placement should not be recorded on the SSRC Register.

This may include providing respite services to children who are under the parental responsibility of the Minister for Family and Community services or the Secretary of DCJ. In these cases, the designated agency that is providing case management to the child is responsible for supervising the child's placement and must make sure the accommodation is suitable for their needs. More details about designated agencies are outlined below in 'Role of other agencies in SSRC' and can be found on the OCG website.

In practice, SSRC is a voluntary arrangement between a parent and a service provider to provide care to children or young people away from their usual home.

Child Safe Scheme

Child Safe Standards

The Child Safe Scheme requires child safe organisations to prevent, detect and respond to child abuse by implementing the Child Safe Standards. Organisations subject to the Child Safe Scheme , including SSRC providers, are required to implement the Child Safe Standards through their systems, policies and processes.

The Child Safe Standards provide a framework for creating child safe organisations. They are designed to drive cultural change to create, maintain and improve child safe practices. When organisations implement the Child Safe Standards they build a culture where abuse of children is prevented, responded to and reported.

The Standards are based on extensive research and consultation by the Royal Commission into Institutional Responses to Child Sexual Abuse. They provide clear guidance for organisations to create cultures, adopt strategies and act to put the interests of children first to keep them safe from harm.

All organisations that work with children are encouraged to implement the Child Safe Standards and continually work to improve their child safe practices.

More information about how to implement the Child Safe Standards can be found on the OCG website and in the Guide to the Child Safe Standards.

The 10 Child Safe Standards		
	1	Child safety is embedded in organisational leadership, governance and culture
	2	Children participate in decisions affecting them and are taken seriously
	3	Families and communities are informed and involved
	4	Equity is upheld and diversity is taken into account
	5	People working with children are suitable and supported
	6	Processes to respond to complaints of child abuse are child focused
	7	Staff are equipped with the knowledge, skills and awareness to keep children safe through continual education and training
	8	Physical and online environments minimise the opportunity for abuse to occur
	9	Implementation of the Child Safe Standards is continuously reviewed and improved
	10	Policies and procedures document how the organisation is child safe

Act, Regulation and SSRC Code of Practice

In addition to the 10 Child Safe Standards, SSRC providers must also comply with certain requirements in the Regulation, including the SSRC Code of Practice.* The Act and the Regulation outline the full requirements of the Child Safe Scheme.

The SSRC Code of Practice does not create new or extend existing obligations under the Child Safe Scheme. The SSRC Code of Practice guides SSRC providers to meet their obligations in providing care to vulnerable children in circumstances where that care is provided away from their home and family. It outlines specific actions SSRC providers must take once they start providing SSRC to meet minimum requirements of the Child Safe Scheme.

The SSRC Code of Practice guides SSRC providers to meet their obligations in providing care to vulnerable children in circumstances where that care is provided away from their home and family.

*Refer to Section 8DA(1) *Children's Guardian Act 2019*.

Role of other agencies in SSRC

Office of the Children's Guardian

The Office of the Children's Guardian (OCG) regulates SSRC providers under the Child Safe Scheme and monitors compliance with the SSRC Code of Practice to ensure high-quality services are provided to children. The OCG is focused on building the capability of SSRC providers and has a range of resources and training available for SSRC providers.

Through the SSRC Register, the OCG also monitors the time children spend in SSRC so opportunities for additional support to the family or formalised planning for longer-term placements can be identified.

The OCG has enforcement powers available under section 8DA and Part 9A of the Act. This means if an SSRC provider fails to comply with the Code, the Children's Guardian can:

- conduct an investigation
- issue a compliance notice
- negotiate an enforceable undertaking
- issue financial penalties.

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Designated agency

A designated agency is an agency accredited by the Children's Guardian under Schedule 3A of the Act to arrange statutory out-of-home care in NSW. Designated agencies have a particular role in SSRC because supervision by a designated agency is a requirement when a child has been in SSRC for more than 90 days in a 12-month period, unless the designated agency is the agency providing SSRC.

A designated agency can provide SSRC as an SSRC provider or supervise a child's placement in SSRC with another, non-designated provider.

In cases where the designated agency is the principal care agency, it is not required to arrange external supervision for any SSRC it provides. However, at the 90-day threshold of care, if the child has received some SSRC from other non-designated SSRC agencies, then the principal care agency must supervise the SSRC provided by those other non-designated agencies involved or arrange for another designated agency to supervise the SSRC provided to the child.

See section 'Supervision and case planning' below for further detail on the requirements and purpose of supervision by a designated agency.

National Disability Insurance Scheme Quality and Safeguards Commission

The NDIS Quality and Safeguards Commission (NDIS Commission) is an independent agency established to improve the quality and safety of NDIS supports and services. The aim of the NDIS Commission is to introduce a nationally consistent approach so participants can access services and supports that promote choice, control and dignity.

The NDIS Commission sets the requirements for monitoring and reporting on the use of restrictive practices within NDIS funded supports and services. It also responds to complaints and allegations of abuse and neglect of NDIS participants. The NDIS Commission can receive complaints from anyone including participants, other service providers and family members. Complaints can be made about service standards or how an NDIS provider has dealt with complaints or incidents. Making complaints helps ensure that service delivery can be improved and that problems can be resolved.

SSRC providers and behaviour support practitioners in NSW who are registered with the NDIS must comply with the requirements set out by the Commission. SSRC providers who are not registered with the NDIS must also comply with the requirements when providing supports to NDIS participants. Further information can be found on the Commission's website.

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Department of Communities and Justice

DCJ is the NSW Government department with statutory responsibility for assessing whether or not a child or young person is in need of care and protection. They are also responsible for the investigation and management of risk of significant harm reports to the Child Protection Helpline and providing support to families where there may be a child protection concern.

For children with disability, DCJ has a role in supporting children in contact with child protection or in out-of-home care to access disability supports to promote family preservation. Additionally, for NDIS participants DCJ has a role to mandate positive behaviour strategies, provide guidance for behaviour support plans and outline policy regarding prohibited practice.

From time to time, SSRC providers may work with children while DCJ is involved or becomes involved. It is important for providers to make sure they understand the legal status of the child and what that means for the child and their family.

If a child is not in statutory out-of-home care, the child's parent/s are responsible for arranging the SSRC placement and for making decisions involving the care and support of their child. The SSRC provider must continue to involve and work with the child's parent, while also involving any relevant caseworkers or support workers who are also assisting the family.

Principles underpinning the SSRC Code of Practice

Five guiding principles underpin the SSRC Code of Practice:

- child-centred decision-making
- keeping parents involved
- collaborative decision-making
- cultural safety
- diversity and inclusion.

The minimum requirements for these principles can be found in the SSRC Code of Practice. Read on for more detail.

Decision-making is child centred

Section 4, subsection (2): Decision-making is child centred

Decision-making, service planning and service delivery for a child in specialised substitute residential care are child centred and take active account of the following —

(a) the child's preferences, likes and dislikes,

(b) the child's strengths, skills and abilities,

(c) the child's personal goals and aspirations.

Children and young people feel safe in organisations where adults value them, and where they know they will be taken seriously, be involved in decision-making and have their concerns responded to.

Children may need preparation, support and encouragement to participate in decision-making in an age and developmentally appropriate manner. It may also be the case that children may choose not to, or are not able to, participate in the planning or review of their care. However, SSRC providers should:

- make sure children have an opportunity to express their views freely, and that their views are given due weight in accordance with their developmental capacity and circumstances
- make sure information provided to children (to the extent of their capacity) is provided in a manner and language they can understand
- facilitate opportunities for communication, including supporting a child's use of an alternative communication system where appropriate or necessary
- make sure children have a say in setting the agenda for case planning or review meetings, and in who will attend those meetings
- make sure children's voices and views are asked for and heard within the decision-making process, both in formal processes such as in service planning and case planning, but also in day-to-day decisions.

Where children under 7 are in SSRC, it may be necessary to use specialised processes to encourage age appropriate engagement. It is also important to remember that SSRC is not preferred for children under 7 (refer to 'Part 4: Intake and assessment' for age related requirements).

Research demonstrates that children progress better when they are participants in, rather than passive recipients of, decisions about their lives.[1] The Office of the NSW Advocate for Children and Young People considered both challenges and solutions for organisations seeking to ensure meaningful participation of children with disabilities in decision making in section 3 of their report The Voices of children and young people with disability. This resource, and others promoting participation of children in decisions affecting them, can be found on the ACYP website.

Some questions SSRC providers can ask when preparing policies and procedures, and when preparing, supporting and encouraging children to participate in decision-making include:

- What opportunities do we offer children so they can give their views?
- How do children develop the skills to understand their feelings so they can describe them to adults?
- Does our organisation discourage children from raising particular subjects?
- Does our organisation actively encourage children to raise issues that concern them?
- How do our staff demonstrate they understand the importance of children's rights?

The OCG has free resources and training on engagement and participation for children and young people, including Empowerment and participation: a guide for organisations working with children and young people.

Parents are supported to remain involved and engaged

Section 4, subsection (3): Role of parents

The parent of a child in specialised substitute residential care have ultimate responsibility for decisions about the child and the services the child receives.

The parent of a child in SSRC need to fully understand and be able to exercise choice regarding services the child receives. Alongside the child themselves, the child's parent are usually the experts in their child's needs, routines, likes and dislikes, and strengths and aspirations. Informed participation and choice, with both children and their parent being partners in decision-making is integral to SSRC.

Families value being informed about the range of services available to them,[2] and being offered emotional support and assistance to access those services.[3] Additionally, children feel more valued when families and community members take an active role in decisions that affect them. Sometimes other engaged family or community members also have important information and perspectives that also need to be taken into account, and parent may choose to involve extended family members where appropriate. SSRC providers should remain flexible to support the involvement of all the important people in the child's life where that supports the child.

When considering the needs of the parents of the child, SSRC providers should consider the NSW Carers Charter, which states:

"The views and needs of carers and the views, needs and best interests of the persons for whom they care must be taken into account in the assessment, planning, delivery and review of services provided to persons who are cared for."

While the NSW Carers Charter does not apply to all SSRC providers or all parents and carers of children in SSRC, the principles reflect quality practice in meeting their needs.

Parents should always be active participants when a child is in SSRC. Not only because they are the legal guardians, but because this tends to provide better outcomes for the child. If a parent chooses not to participate, this may be an indicator of other issues. To facilitate effective participation, SSRC providers should:

- seek to understand the perspective of each parent, such as their challenges, concerns and support needs
- make sure information is provided to parents in a manner and language they can understand
- encourage and facilitate ongoing communication, both between the SSRC provider and parent(s), and the child and their parent(s)
- make sure parents have a say in setting the agenda for case planning or review meetings, and in who will attend those meetings.

Some questions SSRC providers can ask when preparing policies and procedures, and when preparing, supporting and encouraging parents and carers to participate in decision-making include:

- How do we actively involve families and communities in our organisation?
- Are codes of conduct and child safe policies and procedures accessible to families and community members?
- How would we include families when responding to a complaint of child abuse?

Information for parents can be found on the OCG website.

Decision-making is collaborative

Section 4, subsection (4): Decision-making is collaborative

Decision-making, service planning and service delivery for a child in specialised substitute residential care should be collaborative and involve continuous consultation with the following—

(a) the child,

(b) the parents of the child,

(c) other providers of specialised substitute residential care,

(d) providers of supports and services used by the child and the child's family.

Decision-making, service planning and service delivery in SSRC should be collaborative and involve continuous consultation with the child, the child's parent, other SSRC providers, and providers of supports and services used by the child and the child's family.

A collaborative approach to SSRC is one in which SSRC providers coordinate decision-making and the delivery of services for children with other organisations that have responsibilities relating to the children's safety, welfare and wellbeing. This includes sharing important information, which is allowed and sometimes required under the legislation. The basis for information exchange in this context is to support the safety, welfare or wellbeing of a child or group of children in SSRC.

SSRC providers are required to exchange information about children and their families in some circumstances. This includes where the Children's Guardian directs an SSRC provider to provide information to the Children's Guardian under section 180 of the Act and Schedule 4, section 24 of the Regulation, or where DCJ directs an SSRC provider to provide information to DCJ under section 248 of the *Children and Young Persons (Care and Protection) Act 1998*.

Additionally, information may be exchanged by SSRC providers under Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998*. More information is available on the OCG website.

Additionally, the SSRC register allows SSRC agencies to access information about other providers who have previously provided care or developed case plans for children. SSRC agencies must contact those other providers to obtain information relevant to the safety, welfare and wellbeing of children in, or entering, their care. Some questions SSRC providers can ask to promote collaborative decision-making include:

- How do we make sure the child's opinions and preferences are not only heard, but included in planning and day-to-day activities?
- What are our practices around appropriate information sharing with other SSRC providers, and other support providers working with the children we are working with?
- Are our staff well trained and capable of collaborative work with children, parents, and other support providers?

More details are outlined below in 'Part 4: Intake and assessment' and 'Part 5: Supervision and case planning'.

Cultural safety

Section 4, subsection (5): Cultural safety

In decision-making, service planning and service delivery for specialised substitute residential care, the entity must consider the needs of the following—

(a) Aboriginal children and families and Torres Strait Islander children and families,

(b) children and families from culturally and linguistically diverse backgrounds.

SSRC providers need to be sensitive to the needs of children and families from Aboriginal, Torres Strait Islander, and culturally and linguistically diverse (CALD) backgrounds.

Using a person-centred approach to care and developing an understanding of 'family' and 'community' in a cultural context is critical for properly identifying and responding to a child's specific cultural needs while in SSRC.

Additional supports may be required by families from Aboriginal, Torres Strait Islander and CALD backgrounds such as interpreter services or community support workers. Families should be advised that they can bring support people, such as from their extended family or community, or a trusted support worker to important meetings if they choose.

First Nations people with disability

The Disability Royal Commission found that for First Nations (Aboriginal and Torres Strait Islander) people with disability, cultural safety is defined by interactions with services and systems, and as a result, many First Nations people with disability signified the importance of accessing First Nations community-controlled services as their general preference.[4]

However, it is crucial for SSRC providers that are not community-controlled to consider more deeply the needs and experience of First Nations children and families who access SSRC services.

Tips for providers:

The Disability Royal Commission[5] states that cultural safety has many characteristics, however key themes that providers can consider today are:

- Cultural safety must be seen in context, and it is important to recognise and respond to the holistic needs and experiences of First Nations people
- Cultural safety is built around trust and it is important to build relationships, be respectful, and judgement free
- Ultimately, only the First Nations recipient of a service can determine whether it is culturally safe for them, and as such, providers should ensure effective and regular communication with First Nations families in order to determine whether cultural safety is met
- Cultural safety starts with services acknowledging that First Nations' understanding of health and wellbeing is different to that of mainstream Australia as it considers all elements of social and emotional wellbeing, connecting the health of a person to the health of their family, kin, community, connection to Country, culture, spirituality and ancestry.

It is important that SSRC providers consider and adapt to the diverse needs of children so they have equitable opportunities to feel welcome and participate in activities and programs.

Where can we find more information to deliver a culturally safe service?

The delivery of quality outcomes for Aboriginal and Torres Strait Islander people, their families and communities is outlined in DCJ's Aboriginal Outcomes Strategy 2017-2021. It provides a model of accountability for Aboriginal and Torres Strait Islander service delivery, participation in decision-making, and fostering genuine partnerships with Aboriginal and Torres Strait Islander people and communities.

Secretariat of National Aboriginal and Torres Strait Islander Child Care (SNAICC) has developed an Aboriginal and Torres Strait Islander Children's Cultural Needs Tool, a resource developed to help meet the needs of Aboriginal and Torres Strait Islander children. It includes a cultural needs diagram for cultural connection. This is linked to the Early Years Learning Framework for Australia.

The National Workforce Centre for Child Mental Health has published a helpful resource called 'Working with Aboriginal and Torres Strait families and children living with disability'.

The Office of the Children's Guardian has published a video on 'Culture and Care' that is designed for out-of-home care settings, and will be useful for providers of respite and accommodation in SSRC.

The SSRC Register requires SSRC providers to record whether a child identifies as Aboriginal, Torres Strait Islander or both. SSRC providers must make sure they capture this information at a child's intake into an SSRC placement.

Diversity and inclusion

Section 4, subsection (6): Diversity and inclusion

In decision-making, service planning and service delivery for specialised substitute residential care, the entity must take account of the following—

(a) the needs of children with a disability and the needs of families of children with a disability,

(b) the gender identity and sexuality of children in care,

(c) the gender identity and sexuality of the parents of a child in care.

It is important SSRC providers consider and adapt to the diverse needs of children so they have equitable opportunities to feel welcome and participate in activities and programs.

Some reflective questions that can be useful when considering the inclusivity of decision-making, service planning and service delivery include:

- How do we identify children with vulnerabilities and establish their needs?
- How do we adapt and respond to the diverse needs of children and their families?
- How are children provided equitable opportunities to participate in SSRC?

Risks in the SSRC sector

2

Organisations that work with children have a responsibility to keep them safe from harm and abuse. Almost all child-related organisations deal with some element of risk.

Additionally, SSRC providers often work with children with disability, additional needs and vulnerabilities. This means children are more at risk.

The SSRC Code of Practice requires SSRC providers to have a risk management plan, to perform risk assessments when children enter placements, and to regularly revisit risk assessments at certain intervals. More detail on these requirements is given below.

This section will explore risks that SSRC providers should be aware of when developing risk management plans and performing risk assessments. It also gives suggested considerations for addressing those risks. This is not an exhaustive list and providers should consider their organisational context and the specific needs and situations of the children they are providing SSRC to.

Research suggests that risk of harm to children can be broken down into four categories:

- vulnerabilities of children
- physical and online environments
- organisational cultures
- propensity risk of adults working with children.

It is important to note that risks within each category can and do overlap, and when addressing risk factors organisations should be mindful of how different risks may overlap or impact on other risk factors.

Resources to help you plan for and manage risk are available on the OCG website.

Vulnerabilities of children

Complex needs that heighten vulnerability to abuse

SSRC providers play an important role in caring for some of our most vulnerable children and provide much needed respite and support for families. Children with disability often require additional supports and rely on the commitment of skilled adults to meet their needs. Additional supports may include overnight medical and personal hygiene care that requires relative intimacy, often provided in private, that increases the risk of abuse.

Children with disability are at nearly four times greater risk of experiencing violence and abuse than children who do not have a disability.[6] Centre-based or residential care settings where children with disability are isolated have been associated with the highest risk of sexual abuse for children with disability. The structure of disability-specific organisations in the SSRC sector may increase this risk of harm. Risk and vulnerability factors for children with disability that should be considered include:[7]

- **Communication needs**. Children with additional speech and communication needs may have difficulties disclosing abuse or having their disclosure of abuse understood by others. This can include children with intellectual disabilities, or who have speech and language impairments.
- **Dependency on others for support**. Some children with disability rely on adults for personal care and assistance or may otherwise lack independence due to their needs. This increases the vulnerability of children in situations where adults are alone with them or may make children more hesitant to disclose abuse out of concern they may not be believed or that any support being provided to them will cease.
- **Lack of education about appropriate relationships and interactions**. Children with disability may be less likely to receive education that takes into account their cognitive and communication needs about appropriate relationships and may lack understanding of inappropriate sexual and abusive behaviours.

SSRC providers can address these risks by thinking about the following:

- screening, training and monitoring staff appropriately
- regularly asking children and young people how they are going, if they feel safe and if their needs are being met
- using communication aids where needed
- regularly asking parents how their children are faring, or if there are any concerns or changes in behaviour that they can distinguish
- lowering the environmental risks – such as visibility of rooms and having transport and online environment policies
- discussing risks with children and staff and normalising conversations about feeling and being safe
- providing education where appropriate to empower children and to give them the knowledge and the skills to communicate their concerns.

Scenario

Provider A has recently begun offering SSRC, and has been contacted by a parent seeking respite care for their 13-year-old child. The child has autism spectrum disorder, is non-verbal and when distressed has been known to repeatedly clap their hands on their ears and bang their head against walls.

Before providing SSRC, the principal officer undertakes a thorough risk assessment and identifies a number of key mitigation strategies that could be implemented, including:

- providing training for staff on how to best support a child with autism spectrum disorder
- consulting with the child's parent on how the child is sensitive to the environment, and what steps could be taken to reduce the risk of sensory overload and associated stimming behaviours
- discussing with the child's parent to discover if they have developed non-verbal communication methods with the child.

Characteristics of the cohort

There are a range of factors or characteristics that may increase the vulnerability of children to abuse.[8] Children who enter into SSRC may have some or all of the following characteristics that place them at higher risk of harm:

- **Difficulties regulating behaviour or emotions**. Some children who are accessing SSRC have significant challenges regulating their behaviours, and may require behaviour support. A significant risk for this group is that their behaviours may not be understood in context by inexperienced staff. This can lead to the belief that children are 'naughty' or 'manipulative', and therefore in need of 'punishment' or 'discipline', when their behaviours may be part of their disability or a trauma response and need to be managed in a way that provides support or healing.
- **Social disruption including disconnection from community or disruptive home environment**. Social isolation from peers is a risk factor for child sexual abuse, as children who are socially isolated may be easier to manipulate, are less likely to disclose abuse, or others are less likely to believe disclosures of abuse.[9]
- **An existing history of physical or emotional abuse**. Some children may have experienced maltreatment or abuse in previous care settings, and the emotional, cognitive and psychological impacts increase the risk of further maltreatment or abuse.[10]

Some children who are accessing SSRC have significant challenges regulating their behaviours, and part of their SSRC planning will include behaviour support.

When undertaking risk assessments and risk management, it is important to consider the risks that a child may pose to other children in care as well as the risks that other children in care may pose to a child. This includes risks of problematic and harmful sexual behaviour (PHSB).

PHSB are sexual behaviours by children under the age of 18 that fall outside the range of expected activity for a child's age and stage of development that may be developmentally inappropriate, harmful towards themselves or others, or abusive toward another child or adult.

Research indicates that:[11]

- PHSB increases sharply at age 12 and plateaus after age 14
- children with PHSB are more likely to have learning and intellectual disabilities, as well as mental health disorders
- most PHSB occurs in domestic environments, but children in residential care are more vulnerable to being victimised by PHSB.The NSW Government has released the Children First, 2022 – 2031 multiagency public health framework for preventing and responding to PHSB by children. This Framework provides guidance and direction for government and non-government organisations in recognising and preventing PHSB.

SSRC providers can address these risks by thinking about the following:

- ensuring intake and assessment processes gather all relevant information about children to enable proper risk assessment and service planning
- creating an environment that discourages social isolation and encourages children's engagement with peers and community
- empowering children to disclose abuse and harm
- using regular support workers so that children can form trusting relationships with the adults caring for them, and so that those adults can notice changes in behaviour.

Scenario

A 15-year-old female young person has been receiving SSRC on a regular basis over the past 5 years. Recently, the young person and her family moved to a new city, and her parents have enquired with a new SSRC provider, Provider B. During the intake process and over the first few episodes of care, the staff noticed that she has difficulties in regulating her behaviours and emotions, and reacts particularly negatively when approached by any male staff member.

The principal officer suspects that she may have an undisclosed existing history of abuse underpinning her behavioural difficulties, but during intake processes no disclosure was made. The principal officer discusses their observation that she appears anxious around male carers in a sensitive manner with the young person herself, her parents, and the principal officer of her previous SSRC provider. From these seperate discusssions, it is identified that there is no known history of abuse that might be underpinning her behavioural difficulties.

Following the discussions, to create a more positive and supportive environment the initial risk assessment is revisited and her service plan is amended to include:

- provision that the young person should be primarily cared for by female staff members, and where male staff members must interact with her that they must be accompanied by at least one other female staff member
- social activities are encouraged and implemented to increase social connectivity and promote a feeling of safety for the young person
- activities are incorporated into her service plan that promote protective behaviours.

Culture

Aboriginal and Torres Strait Islander children

Aboriginal and Torres Strait Islander children can be at a higher risk of harm and adverse outcomes in SSRC if not supported with culture in mind. Culture is a source of strength, resilience, happiness, identity, and confidence for First Nations people and can have a powerful positive impact on health and wellbeing. First Nations people with disability described to the Disability Royal Commission the importance and centrality of culture to them, and how culture can turn into a source of strength that helps their sense of belonging. On the other hand, a lack of cultural safety intensifies feelings of isolation for First Nations children with disability. Families are stronger when their cultural needs are met and respected, therefore it is important to talk to children and families about their cultural strengths and needs.

The Royal Commission into violence, abuse, neglect and exploitation of people with disability noted the additional advantage that First Nations people face when accessing disability supports, and the need for culturally safe practices that take the impacts of colonisation, intergenerational trauma and institutional racism into account. The Royal Commission's findings noted that many First Nations people with disability prefer a cultural model centred on inclusion. This recognises that inclusive participation in culture and community has a positive impact on social health and wellbeing, and moderates the harm of inequalities experienced in daily life.[12]

When family stress has contributed to the need for respite or behavioural supports, children are also at increased risk of coming into statutory out-of-home care and additional support should be considered for the whole family as part of the planning process. This is of particular importance for Aboriginal and Torres Strait Islander children, who in NSW are 11.2 times more likely to be in out-of-home care.[13]

Not only are First Nations children more likely to be in OOHC, but recent research commissioned by the Disability Royal Commission indicates that parents with disability who interact or are involved with child protection systems are more likely to have their children removed from their care, and often child protection authorities are less likely to work towards reunifying parents and children with disability, or to refer parents with disability to parenting support services. For many parents with disability involved in the child protection system, the removal of their children is permanent and often extended to subsequent children. This is magnified for First Nations parents with disability.[14]

Aboriginal and Torres Strait Islander children, children with disability and children from culturally and linguistically diverse backgrounds are likely to encounter circumstances that put them at greater risk and are less likely to disclose abuse or receive an adequate response if they do.[15]

When conducting risk assessments for Aboriginal and Torres Strait Islander children, it is important that historical and contextual factors around Aboriginal and Torres Strait Islander peoples' engagements with child protection and other care systems are considered, and that children and their families are adequately consulted. It is not enough to simply note 'Aboriginal and/or Torres Strait Islander' as a stand-alone risk factor, but instead it is important to engage in positive and open engagement with communities.[16]

Scenario

Provider C has opened a new care location where there is a large Aboriginal and Torres Strait Islander community. There are no other SSRC providers in this new location, and the principal officer anticipates that there may be a larger proportion of Aboriginal and Torres Strait Islander children accessing care at this new location than in Provider C's previous location.

Provider C's principal officer looks over existing service and risk management policies for the program. While they currently contain general statements about the kinds of consultation that should be undertaken with Aboriginal and Torres Strait Islander children and their families, there is room for improvement. The principal officer makes the following changes:

- each local service is required to develop their cultural competence. Some of the measures considered are: attending training on cultural humility, creating and maintaining contacts with local Aboriginal and Torres Strait Islander community representatives and elders, encouraging staff to develop awareness about the local culture, and an openness to ongoing cultural learning
- it is made standard practice to ask new staff if they are Aboriginal or Torres Strait Islander, and to advertise specifically for culturally matched staff in key positions where the organisation is working with Aboriginal and Torres Strait Islander families
- where possible Aboriginal and Torres Strait Islander staff and children will be matched
- during intake and risk assessment processes for each child, additional consultation with families is required to identify if the child can remain with their family with additional daytime supports
- work to ensure that children are not placed far away from their families, or off-country unless unavoidable.

Children from culturally and linguistically diverse backgrounds

Children and parents from CALD backgrounds may lack the language skills required to report abusive behaviour or the knowledge of the Australian system to report concerns, particularly if they are recent arrivals to Australia. It is essential that SSRC providers consider these risks and how best to ensure equity in service delivery and the maintenance of connection to community and culture.

An intake process that specifically asks about cultural needs, respects a child's culture and aims to provide them a placement that meets those cultural needs is essential to helping the child feel safe and included. Simple measures can make a big difference. For example ensuring appropriate cultural foods are provided, cultural and religious practices are able to be observed, and that interpreters are used if needed during important discussions such as intake.

If your team does not include members of the cultural community you are serving who can share their cultural knowledge, there are many organisations that can assist, such as Migrant Resource Centres, or community cultural and religious associations.

Cultural strengths

Cultural strengths are important in risk planning. The positives that children can take from connection to culture, religion and their community can be powerful protective factors. SSRC providers can build on these strengths by incorporating cultural and religious requirements or preferences and maintaining connections as a way to help children stay safe and feel included and connected. Alongside formal cultural training, the best way to find out about a child's culture or religion is to ask the child and their parents. Extended family and their community (when involved) can also be a great source of information and support for the child. If an SSRC provider works with a lot of children from a particular cultural or religious background, there are also likely to be community or religious organisations who could assist staff to understand their needs.

SSRC providers can address the risks above by thinking about the following:

- making sure children, families and communities are appropriately engaged in service planning and are asked about their cultural and religious needs, strengths and preferences
- making sure children are supported to continue to participate in their usual cultural, social or religious activities
- asking children what culture or religion means to them and how they like to express it, or be involved, and what is important to them
- providing adequate support to ensure that children can understand and be understood
- employ staff who reflect the cultural backgrounds of the children you are supporting, and value their cultural expertise as a skill.

The positives that children can take from connection to culture, religion and their community can be powerful protective factors.

Gender identity and sexual orientation

Research has identified gendered patterns of harm.[17] For example, studies suggest that girls are more likely to be victims of harm than boys, however for boys who were victims of harm a higher proportion of cases were in organisational settings compared to other settings when compared to girls. Additionally, research suggests that while disclosure rates for sexual abuse are low for both boys and girls they may be disproportionately low for boys.

Research also indicates that children with diverse gender expressions and sexual orientations are at a higher risk of physical, sexual and psychological abuse.[18] Same-sex attracted children or children who are questioning their sexual orientation may be specifically targeted for harassment or unwanted sexual contact, particularly where negative views of homosexuality in the home or organisation leads to feelings of shame and isolation that can be exploited by perpetrators. Children with diverse gender expressions are also at a higher risk of harm where their homes or the organisations they interact with are not safe environments to express themselves.

While these risks are not specific to SSRC settings, it is important that they are considered as they may intersect with other risks such as social isolation, diverse cultural backgrounds, relationships with primary carers and relationships with staff members.

SSRC providers can address the risks above by thinking about the following:

- ensuring that the concerns of children and their parents are listened to during intake and ongoing service provision
- providing training to staff on how to respond to a child who expresses concerns around sexuality or gender identity
- creating an environment that discourages social isolation and encourages children's engagement with peers and community.

Children and young people with diverse gender expressions are also at a higher risk of harm where their homes or the organisations they interact with are not safe environments to express themselves.

Many children and young people do not identify as being cisgender or heterosexual. They feel safest when:

- those around them understand what this means to them
- they are referred to in a way that makes them feel comfortable
- organisations create safe spaces for them where they aren't discriminated against, judged or bullied.

Organisations can empower same-sex attracted and gender diverse children and young people by creating an inclusive environment that actively demonstrates that the organisation welcomes and values them and takes a zero-tolerance approach to discrimination.

Find more tips in the Office of the Children's Guardian's 'Empowerment and Participation' Handbook.

Scenario

A 15-year-old young person receiving care from Provider D has disclosed to a staff member that they are questioning their sexual orientation, and that they may be same-sex attracted. The staff member, who has had no previous training on how best to respond, brushes off the concerns of the young person, who then withdraws from group activities and shows greatly reduced interest in socialising with friends.

The young person's changed behaviour is brought to the attention of the principal officer, and the staff member mentions the young person's recent disclosure as a possible reason. They look over their risk management frameworks and note that they do not consider how to manage risks for children and young people with diverse gender expressions and sexual orientations. In response they:

- provide training sessions for all staff on how to respond to a child or young person who discloses that they may be questioning their sexual orientation or gender identity
- conduct some research into how their services can be more inclusive for children with diverse gender expressions and sexual orientations by contacting organisations with expertise in the area such as Twenty10 or The Gender Centre.

Children, parents or families become disengaged

Children, parents or families may for various reasons become disengaged from SSRC. Children may not want to go or may become disengaged from care where they do not feel supported.

In making the decision to seek SSRC, children, parents and families may be experiencing complex and difficult emotions. They may also be managing the needs of others within their household. There is a risk that the process of finding SSRC care can leave them feeling disempowered and disenfranchised. This can increase the risk of harm for children, especially as family conflict or breakdown, a poor relationship with primary carers or a lack of parental supervision and availability are also associated with increased risks of harm.[19]

SSRC providers can address these risks by thinking about the following:

- using a family-centred approach to care, which means the service is responsive to the needs of the child and their parents and family, and supports family functioning in the child's best interests
- ensuring the child and their parents can make informed choices about care
- not placing children in SSRC if appropriate services can be provided to enable them to remain with their families
- ensuring that cultural needs, strengths and preferences are included in planning
- supporting the child to maintain connections with their family, friends and community.

However, if the needs of a child and their parents and family become incompatible, alternative arrangements must be made as the safety, welfare and wellbeing of the child is paramount.

Scenario

A child with a disability has recently received NDIS funding for respite care, and the child's parents have been put in contact with Provider E. During initial discussions, the intake and assessment officer notes that the parents seem reluctant to engage with the provider and express multiple times that they don't need external help as they can manage on their own. After a few discussions, the parents inform the officer that they won't be engaging Provider E for SSRC for their child.

After some reflection, the officer contacts the parents again and asks if they can discuss some alternative strategies not involving respite to begin with, and any fears and concerns they may have about getting this type of help. The parents are able to air their concerns and feel more comfortable asking questions. They agree to work with the officer to support their child with a range of activities that may involve some short term respite.

As part of internal ongoing improvement processes, the principal officer discusses the situation with the intake and assessment officer and they agree on a number of improvements that could be made to the intake processes to help address concerns of parents who may be apprehensive about SSRC. These improvements include:

- updating information packs to include a clear definition of SSRC, including making the distinction between SSRC and out-of-home care more clear
- modifying staff training to ensure that staff view and can explain overnight respite as a last resort, and daytime or in-home supports are considered first
- providing training to all staff on how to notice where parents may be nervous about SSRC or are at risk of disengaging, and on how to pre-emptively address concerns.

Physical and online environments

Design of the care environment

The way that accommodation and services are designed can create risks and can also help to keep children and young people safer.

Standard 8 of the Child Safe Standards is that *physical and online environments minimise the opportunity for abuse or other kinds of harm to occur*.

Child abuse can occur if the physical or online environments create opportunities for an adult to be alone with a child without supervision or oversight. Child-safe organisations adapt their physical and online environments to minimise the opportunities for abuse to occur by striking a balance between visibility and children's privacy.

It may not be possible to alter physical environments by knocking down walls or adding windows, and online environments can be difficult to control. The development of robust policies and procedures which include risk assessments are important in order to identify and control risks, as well as identifying practical adaptations that can be implemented.

When thinking about the risks within your environment, consider starting with the following:

Accommodation and physical spaces

- Is the care environment safe, clean and well maintained? Are there clear lines of sight? Are there areas where adults can be alone with children?
- Do children have privacy in their personal space and are their belongings safe and respected?
- Does the care environment have rooms and spaces that allow for adequate supervision by staff?
- Is the care environment fire-safe, and is there a fully stocked and accessible first aid kit? Do staff have first aid training?
- Where swimming pools are present, do they have a valid certificate of compliance? When were they last inspected? What policies exist around change rooms, assisting children to get changed and interacting with children in and around the water?
- If security cameras are used, how is the child's right to privacy maintained while managing safety concerns?

Online

- What access to online environments do children have, and how is this supervised in an age and developmentally appropriate way?
- Are computer screens and devices used by children or staff visible to supervising staff?
- Where children bring internet connected devices from home, is a device safety plan appropriate based on agreed usage and boundaries between the child, their parents and the SSRC provider?

General risks

- Are adequate numbers of staff rostered on for the number of children in care? What are the lengths of shifts for workers and do staff have adequate training for the needs of children they are providing care for?
- Does the care environment need to be altered or adjusted to fit the specific needs of a child? For example, age-specific, behavioural or mobility needs?

Like with other risk factors, environmental risk must be assessed on an ongoing basis, rather than as a 'tick and flick' activity done once and then forgotten about. Risks change over time, such as when property damage occurs or there is maintenance required. Each new child also comes with their own needs and risks that must be considered, including how children or other residents interact with each other.

Risks when transporting children and young people

When children and young people are provided transport services, such as to school or for activities outside the home, risks must be carefully assessed and monitored, as transport is an inherently high-risk activity for children who are a flight risk, have mobility issues, or behavioural issues.

SSRC providers who provide or assist clients to access transport services should have a safe transport policy in place, and staff must be trained in all related policies. The policy should cover relevant considerations including:

- making sure vehicles are maintained, insured and fitted with appropriate car seats and restraints
- assessing for any additional restraints required to keep children safe and adhering to any restrictive practice protocols required by the NDIS Commission
- consideration of the number of adults in a car to adequately supervise children, considering each child's unique needs and risks
- consideration of whether and under what circumstances adults and children might be safely transported together
- making sure children aren't left unsupervised in vehicles
- making sure staff have adequate training on safety procedures, including during an emergency, and that information about safety and emergency procedures is communicated to children
- making sure when working with third party transport providers adequate information has been provided about the child's unique needs and risks prior to any journey
- making sure information has been sought from children and their parents about the child's behaviours, needs and preferences when using transport services.

Scenario

A family has engaged Provider F for the first time for an urgent respite period of 1 week while the parents attend a funeral in another state. Their child Priya is 8 years old, non-verbal and has stayed in respite occasionally with a different provider when the family needed to travel for purposes other than holidays. At intake, the parents speak to Provider F and advise that they usually use a special seatbelt when taking Priya to school because she has been known to try to get out of the car, even when child safety locks are on.

Provider F takes all the information down, but when the assessment is discussed back at the office, they decide that the seatbelt suggested is a restrictive practice, they are unable to get this signed off immediately, and it should not be required for the week as long as there are 2 staff in the vehicle, one sitting next to Priya and one driving.

The first few days of school there are no incidents and Priya is fairly happy in the car. However, on the fourth day, Priya is agitated when getting into the car. One support worker has called in sick and Priya is temporarily left with just one staff member, who decides that she can take Priya to school in the car on her own as Priya has never been any trouble. As the worker is driving on a busy road, Priya wriggles out of her seatbelt and tries to open both backseat car doors. Finding them locked, she starts climbing into the front seat. The support worker tells her to sit down and begins to pull the car over to the side of the road, but as she is on a busy 2 lane street, she can't do it quickly enough. Priya grabs the steering wheel and pulls it sharply to the side.

The car hits a telegraph pole and is written off, but Priya and the support worker are, miraculously, not injured. Provider F immediately informs Priya's parents, reviews the incident, and ensures all required reporting is completed appropriately. A separate internal review is conducted to understand the causes of the incident and what improvements need to be made. They decide to take the following actions:

- convene an internal working group to discuss how risks are managed within the organisation and barriers experienced by staff in managing risks in the day-to-day environment, with a goal to improve risk management practices
- request advice from the NDIS Commission in relation to their transport policy and restrictive practices
- look into options for third party transport providers the organisation can partner with
- provide additional staff training on the transport policies and procedures.

Risks for children and young people placed in group homes with other children or adults

Where SSRC is provided in a group home or setting, care needs to be paid to risks that may be posed to a child entering care as well as the risks a child entering care may pose to others. These risks could include where children (or adults) receiving care have particular vulnerabilities or difficulties regulating behaviour and could pose a risk of harm to others, or situations where children imitate the behaviours of those around them in ways that pose a risk of harm.

The SSRC Code of Practice provides specific requirements around risk management for placement matching depending on the age of the child or young person and the ages of others receiving care in the same centre, including where:

- a child is less than 7 years of age
- a child who is less than 16 years of age is to be placed in centre-based care with an adult
- a young person who is 16 or 17 years of age is to be placed in centre-based care with adults or other children.

In addition to the above required risk management processes, SSRC providers can address these risks by thinking about the following:

- considering whether centre-based care is appropriate for a child, or whether alternative arrangements may be better
- making sure proper processes and procedures are in place to separate individuals who may otherwise pose a risk to each other
- regularly reviewing placements for ongoing suitability and risk management.

More details on risk management in placement matching, including age-specific requirements, is set out below in ‘Part 4: Intake and assessment’.

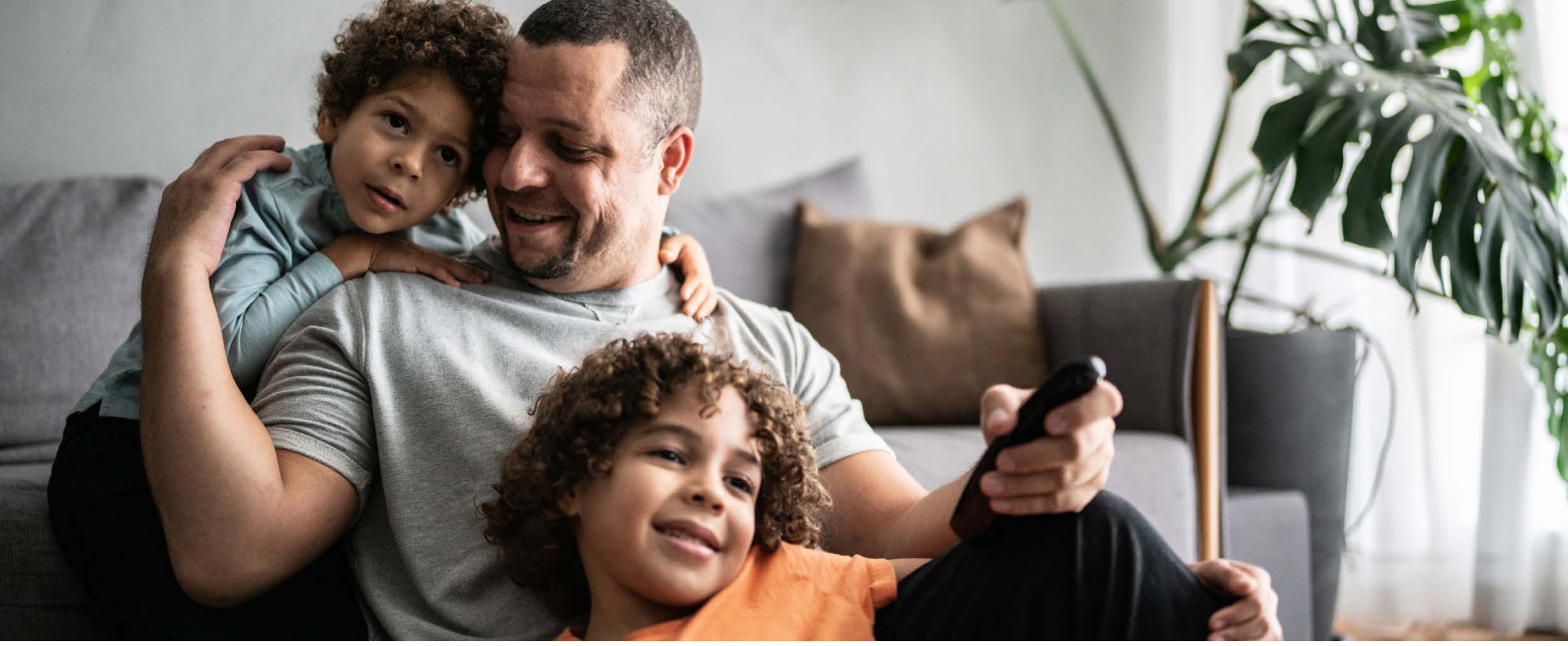
Scenario

Provider G has been providing overnight respite care for adults and children with disabilities for several years now. Over that time they have generally provided separate accommodation for children and adults but sometimes young people who are 15 or 16 years old have been placed in accommodation with adults.

On one occasion, a staff member heard strange noises from a room where a 16-year-old with intellectual disabilities was accommodated. The room had an adjoining door to another room where a 30-year-old man, also with significant intellectual disability, was accommodated. Opening the door, the staff member discovered that the 30-year-old had managed to open the adjoining room door and was masturbating in front of the 16-year-old who appeared confused and distressed. The staff member immediately moved the 16-year-old to a new room and followed the appropriate reporting and incident management protocols.

In response to the incident the principal officer made a number of changes to internal risk management and placement processes, including:

- revising risk management processes for identifying where it is appropriate to provide care for both adults and children in the same centre-based care location
- making sure children and adults are not sharing accommodation and that appropriate measures are in place to prevent movement of individuals that could increase risk of harm to others
- implementing 3-monthly review points for each placement to ensure ongoing suitability and risk management
- making sure parents are aware of the age of other residents, and consent to their child being placed in the setting.



Organisational cultures and factors

Benefits and risks of specialised substitute residential care

Respite is one form of SSRC and it is important that this form of SSRC is used first and foremost to support children and their families and to keep them together. SSRC should always be a last resort, and only after supports that keep the child or young person in their own home have been considered.

Many SSRC placements are arranged to provide parents with respite for short periods. Respite can be used effectively as regular family support and as a response to crises and unforeseen circumstances. Respite has positive effects on family functioning when managed well and as part of a holistic support strategy. It can reduce stress and improve a family's resilience and ability to care for their child on an ongoing basis. Children in respite can benefit from additional support, as well as the opportunity to enjoy experiences outside the home that expand their skills, social experience and wellbeing.

However, the use of SSRC placements can be driven by or contribute to a lack of adequate less-intensive support services for families. Where children and parents are not adequately supported or where children or parents are not actively engaged in placement decision-making, over-reliance on SSRC placements may occur. This poses a risk of unplanned drift into a form of out-of-home care or into the statutory out-of-home care system.

SSRC providers can address these risks by thinking about the following:

- What is the child's perception of the situation and what would help them or their family avoid drift into support or statutory out-of-home care?
- What are the parent/s perceptions of the situation and what would help them or their family?
- Are there day-time activities away from the home that would give the child, their parents or other family members a reasonable break?
- Is there a way of bringing extra support to the home?
- Who else is working with the child, including other agencies or professionals, and how can you work as a team around the child?
- What does the child's NDIS package cover and is it being used appropriately, particularly if the situation has changed recently?
- How could the family be supported over time with the goal that formal respite is no longer required?

Scenario

Provider H has been providing SSRC for a decade, and operates across five care centres. The principal officer regularly travels between each centre to ensure that proper policies and procedures are being followed. On one visit to a care centre, the principal officer is talking to a child's parent as they are dropping their child off for care. The parent mentions that after a new manager started at the care centre, their child and others have been in care far more regularly.

The principal officer investigates, and discovers that the new manager has been encouraging all staff and parents to increase the length and frequency of care episodes for all children, even where unnecessary, as a way to boost profits at the centre. Concerned that this could prompt drifts into out-of-home care, the principal officer steps in and strengthens policies and procedures to reduce this risk, including:

- mandatory steps in intake and risk assessment processes to identify day-time activities away from the home or other in home supports that families could access rather than SSRC
- requiring all centres to regularly consult with children and their families so their perceptions and needs are more accurately reflected in service planning and provision
- implementing regular reviews of placement arrangements, and making sure these placements are focused on reducing the length and frequency of care episodes over time, where possible and appropriate.

Lack of trusted relationships with SSRC staff

While the majority of staff working with SSRC providers provide capable care, high turnover rates and a highly casualised workforce can increase the risk of harm for children in SSRC. High turnover rates can limit the effectiveness of staff training and result in new staff being inadequately equipped to protect children from harm. Additionally, a highly casualised workforce can limit opportunities for children to develop trusted relationships with those providing their care.

Actual or perceived conflicts of interest for SSRC staff can also increase the risk of harm for children in SSRC. These conflicts may include where staff are receiving additional incentives for caring for children, or where an organisational culture exists where staff act to protect other staff over prioritising the needs of children. Where children perceive these conflicts of interest, they may be less likely to disclose instances of harm to others out of fear of reprisal or that they won't be listened to.

SSRC providers can address these risks by thinking about the following:

- What training are we offering all staff members and how do we ensure that new staff are adequately trained?
- Do the children we provide care to have a trusted adult they can talk to for support or to disclose instances of abuse?
- How do we make sure our staff work together as a team and support each other to provide quality care to children?
- Do we have procedures for addressing conflicts of interest?
- What perceived conflicts of interest might exist?
- How do we encourage protective behaviours in children and young people?

Scenario

Provider I has been providing SSRC for several years, and the principal officer has recently noticed that their workforce is increasingly made up of casual staff members. As a result children in care are rarely interacting with the same staff members on a repeated basis. While all staff receive adequate training and provide high standards of care, the principal officer is concerned that children in care may not feel they can trust the range of adults they are interacting with.

After consulting with staff, the principal officer looks to implement a few changes, including:

- conducting a financial and HR review to determine whether more casual staff could be transitioned to permanent part-time or full-time arrangements
- including in risk assessment and placement matching processes considerations to match children with particular staff members so that where possible those staff are rostered on when those children are receiving care
- making sure any part time or full-time staff members are pointed out to children as someone who can be approached at any time, and that these staff make an effort to engage with the children regularly
- revisiting existing training on how to engage with children to ensure that children feel they can trust all staff members.

Where adults abuse children and young people

It is important to properly consider the potential motivations and behaviours of adults who abuse children and young people when conducting thorough risk assessments and when developing required employment, training and supervision processes. Research suggests that while there may be different typologies or broad categories of perpetrators, there is no typical profile of an adult who sexually abuses or otherwise harms a child.

The Royal Commission into Institutional Responses to Child Sexual Abuse identified a number of typologies of male and female perpetrators which can be useful for understanding patterns of abuse.[20] However, perpetrators rarely fit neatly into discrete categories, and these typologies are not sufficiently specific to develop perpetrator profiles or function as diagnostic tools.

Research identified three general types of male perpetrators, including:

1. fixated, persistent perpetrators, who tend to have longstanding sexual attraction to children, are often repeat offenders, and may actively manipulate environments to enable them to abuse a child
2. opportunistic perpetrators, who may not have a greater sexual attraction to children over adults but instead use children for sexual gratification by exploiting situations where they have access to and authority over children. They are less likely to intentionally create situations where children can be abused such as using grooming strategies
3. situational perpetrators, who do not usually have a sexual preference for children but instead are more likely to abuse children in response to stressors in their own lives.

Research identified three general types of female perpetrators, including:

1. predisposed offenders, who may have a history of child sexual abuse themselves
2. 'teacher-lover' offenders, who target adolescents and view themselves as romantically involved or in love with their victim
3. male-coerced offenders, who were initially forced into offending, frequently in the context of an abusive relationship with a male.

Risk factors associated with adult perpetrators within organisations will differ from organisation to organisation, but may include:

- interpersonal, relationship and emotional difficulties
- distorted beliefs and 'thinking errors' supportive of child sexual abuse
- indirect influences, such as preferences or contextual or trigger factors.

SSRC providers can address these risks by thinking about the following:

- making sure adequate pre-employment checks are performed, including the Working with Children Check and checking references for previous employers, particularly previous positions where they worked unsupervised with children
- using external barriers, including physical or policy-based barriers, to reduce the risk of abuse
- making sure child safe policies do not only consider stereotypes about adult perpetrators of abuse but make the assumption that any adult could perpetrate abuse
- providing education where appropriate to empower children and to give them the knowledge and the skills to communicate their concerns.

The OCG's handbook Child Safe Recruitment and the Working with Children Check: a handbook for child-related organisations has a range of relevant information.

Scenario

Provider J works mostly with children in their own homes, and provides overnight respite occasionally in Airbnb settings where necessary. The organisation has significant risk mitigation strategies in place to minimise the risks of this type of accommodation, including a long term agreement with two particular suitable properties, and has the experience to make these short term placements safe and productive.

One day the principal officer receives a notification from the Working with Children Check team at the OCG, advising them that a staff member who has been employed as a casual for 6 months has been barred from working with children. They receive the call because they are a registered employer and ensure their checks are always completed and verified online prior to work with children commencing.

The principal officer is surprised, as the female staff member often receives compliments from parents for her work with families. They know that this means the staff member cannot be rostered to work with children any longer, and works within their HR processes to remove her from child related work immediately and determine next steps. They undertake a review of the work the staff member undertook with families and children, as well as reviewing the recruitment and monitoring processes and practice relating to the staff member. After an investigation the principal officer finds that there were no concerns in her work at their organisation. However, while she was hired with the correct qualifications, no previous employers were actually contacted by the hiring manager, even though she had a CV with many short term jobs.

The principal officer knows that contacting previous employers is an important step in ensuring staff are safe to work with children, and is surprised that the hiring manager did not think it was important. The principal officer develops a new training module for hiring managers in the organisation that covers child safe recruitment and ensures that all managers and HR staff are mandated to attend.

When risks are identified

The NSW Child Protection System comprises a range of safeguarding mechanisms to promote the safety of children. SSRC providers have a range of reporting obligations, that fall under different legislative frameworks. Sometimes an allegation of abuse or neglect may require SSRC providers to make a report to the OCG, NSW Police, the NDIS Commission or DCJ.

When risks to children are identified, there are different internal and external reporting processes and policies to follow.

Risks to children:

- can be identified through a range of sources including disclosures from a child, witness reports, incident reports or complaints from parents or staff
- can occur in a range of settings, including in a service or community setting that the child attends, or in the family home
- may be a single incident of abuse or neglect or may be a pattern of behaviour which causes or is likely to cause harm

Staff need to know how to identify when there are concerns for children and escalate them internally, so that external reporting obligations can be met. In such cases, the SSRC provider has obligations to report and investigate, if required. Please refer to the OCG's Reporting Obligations and Processes handbook for more information.

The Office of the Children's Guardian: The Reportable Conduct Scheme

The OCG manages the NSW Reportable Conduct Scheme, which is an allegations-based scheme. What this means is that the threshold for making a notification to the Children's Guardian is that there has been an allegation that an employee has engaged in conduct towards a child that may be reportable conduct. It is not necessary at the allegation stage to have any information that the alleged conduct has occurred, or that is it likely to have occurred. The obligation to notify the Children's Guardian is based upon the substance of the allegation itself.

For SSRC providers, the term 'employee' includes:

- any salaried staff of the SSRC agency
- any person engaged by the SSRC, directly or through a third-party, as a volunteer to provide services to children
- any contractor engaged by the SSRC to provide services to children if they hold, or are required to hold a WWCC for the purposes of their engagement with the SSRC
- the head of a third-party employer contracted to provide services to children on behalf of the SSRC, if they hold or are required to hold a WWCC.

The head of an SSRC provider must notify the Children's Guardian within 7 days of becoming aware of any information that alleges an employee has engaged in conduct towards a child under the age of 18 that may be:

- a sexual offence
- sexual misconduct
- assault
- ill-treatment
- neglect
- behaviour that causes emotional or psychological harm to a child
- an offence under s43B or s316A Crimes Act 1900

Because SSRC providers are Schedule 1 entities, an employee's conduct in and outside the workplace falls under the reportable conduct scheme.

The definitions and thresholds of these terms (categories of conduct) do vary from other SSRC reporting obligations (i.e. NDIS Quality and Safeguarding Commission, Mandatory Reporting requirements and other reportable conduct schemes). Further information about the NSW Reportable Conduct Scheme's definitions, thresholds and the obligations on SSRC providers and employees is available on the OCG website.

The NDIS Quality and Safeguards Commission: Reportable incidents

SSRC providers who are registered NDIS providers are subject to requirements under the NDIS Quality and Safeguards Rules. This includes reporting of certain acts or events in connection with the provision of NDIS supports or services.

Reportable incidents can involve either adults or children and include:

- the death of a person with disability
- serious injury of a person with disability
- abuse or neglect of a person with disability
- unlawful sexual or physical contact with, or assault of, a person with disability
- sexual misconduct, committed against, or in the presence of, a person with disability, including grooming of the person with disability for sexual activity
- use of a restrictive practice in relation to a person with disability where the use is not in accordance with an authorisation (however described) of a state or territory in relation to the person, or if it is used according to that authorisation but not in accordance with a behaviour support plan for the person with disability.

The NDIS Quality and Safeguards Rules set out different reporting requirements for different types of reportable incidents. For more information, visit the NDIS Commission website.

Please note, if the reportable incident involves a child, other reporting obligations may also apply, including to the Child Protection Helpline or to the OCG under the Reportable Conduct Scheme.

Department of Communities and Justice: Mandatory reporting

If there are concerns for the safety, welfare or wellbeing of a child, or class of children, a report to Child Protection Helpline must be made, as per mandatory reporting legislation. For more information, please see the DCJ website.

SSRC providers who are registered NDIS providers are subject to requirements under the NDIS Quality and Safeguards Rules.

Key Requirements of the SSRC Code of Practice

3

This section describes the requirements of the SSRC Code of Practice in terms of how services must be provided for children and young people. Each section below corresponds with and explains a part of the SSRC Code of Practice, as well as provides implementation advice on how the requirements can be met. As each organisation and service is different you will need to adapt these implementation principles to your own context.

Part 1: Preliminary

Part 1 of the SSRC Code of Practice contains several important preliminary matters, including:

- key definitions
- the application of the SSRC Code of Practice to SSRC providers
- the objects of the SSRC Code of Practice
- the guiding principles for all SSRC providers

The object of the SSRC Code of Practice is to not only facilitate compliance with the Child Safe Standards, but also to improve the quality of services delivered to children by SSRC providers.

More details on the guiding principles are outlined above in 'Principles underpinning the SSRC Code of Practice'.

Section 3 Object of code

The object of this code of practice is to establish the minimum obligations an entity providing specialised substitute residential care must comply with to

(a) facilitate compliance with the Child Safe Standards, and

(b) promote improved child safety, and

(c) promote improved quality and consistency of, and coordination in, the delivery of services to children in specialised substitute residential care, and

(d) reduce the risk of children entering, remaining in or exiting specialised substitute residential care without appropriate planning and care.

Part 2: Compliance

Relevant legislation

Section 5 Compliance with relevant legislation

An entity providing specialised substitute residential care must ensure all staff of the entity are aware of and comply with the relevant legislation.

In addition to the Act and the Regulation, key legislation relevant to SSRC providers includes:

- *Child Protection (Working with Children) Act 2012* and Child Protection (Working with Children) Regulation 2013.
- *Children and Young Persons (Care and Protection) Act 1998* and Children and Young Persons (Care and Protection) Regulation 2022.
- *Carers (Recognition) Act 2010.*
- *Disability Inclusion Act 2014* and Disability Inclusion Regulation 2014.
- *Community Services (Complaints, Review and Monitoring) Act 1993.*
- *National Disability Insurance Scheme Act 2013, and National Disability Insurance Scheme (Incident Management and Reportable Incident) Rules 2018, National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018 and National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018.*
- NSW and Commonwealth privacy legislation.

To ensure that your staff are aware of relevant laws and have the knowledge to adhere to them, you may consider the following:

- note applicable laws within your policies and procedures and make them part of your organisation's 'way of working'
- add particular obligations to role descriptions for key staff, such as those who are considered mandatory reporters
- address legal responsibilities in your induction training and ongoing staff training where relevant.

SSRC providers will usually have other reporting obligations and may need to comply with other policies and procedures set by government and statutory bodies that fund or oversight SSRC services. The OCG will continue to work with funding bodies to ensure their policies and procedures are brought into alignment with SSRC requirements.

Scenario

Provider A is an NDIS registered disability support provider and has a long history of providing great care to adult participants. Its Board has received many requests from the community to provide overnight respite care for children and young people over 12, and it has decided to add this to its service offerings.

Prior to sourcing accommodation and staff for the new service, the provider researched the new legislation that will impact its child-focused services, as this is a completely new participant or client group. It found that a lot of its current procedures are fit for purpose for the new child-focused services, but that there are some essential tasks that need to be introduced in order to orient the service for children and their families. It creates an implementation plan that includes:

- reviewing its general organisational policies and procedures to ensure it is compliant with the Child Safe Standards
- reviewing its recruitment and onboarding processes to make sure that staff have the right qualifications and experience to work with children, and that it complies with Working with Children Check and NDIS worker check legislation
- re-writing position descriptions to make sure that reporting obligations are mentioned for all staff roles
- creating additional policies and procedures for the new service where needed but without duplicating existing ones, including a special intake form for children and their families
- developing a training and induction training package for all staff working in the new child-focused program.

In doing this, the provider checks the OCG website for guidance and training, and requests clarification on any issues it is unsure about.

Completion of Child Safe Self-Assessment

Section 6 Self-assessment of compliance with Child Safe Standards

(1) The principal officer of an entity providing specialised substitute residential care must complete a self-assessment of the entity's compliance with the Child Safe Standards.

In order to provide SSRC to children, the principal officer of an SSRC provider must complete a Child Safe Self-Assessment (CSSA) in a form approved by the Children's Guardian. Under the SSRC Code of Practice, the principal officer must complete a CSSA either:

- within 14 days after they first provide SSRC for a child, or
- before 1 March 2023 if the provider was, immediately before 1 September 2022, a registered voluntary out-of-home care provider.

The Children's Guardian may also direct an entity to complete a CSSA at any time during the entity's provision of SSRC.

The CSSA provides further guidance to agencies on how to implement the Child Safe Standards through an automatically generated action report.

In addition to the above requirements for completing a CSSA, the CSSA is a valuable way to track an organisation's implementation of the Child Safe Standards over time. As such, organisations are encouraged to perform regular CSSAs, and there is no limit on the number of times they can be completed.

Part 3: Systems, policies and procedures

Part 3 of the SSRC Code of Practice requires an SSRC provider to, at a minimum, have in place a:

- publicly available statement of the organisation's commitment to child safety
- document informing staff of the organisation of the organisation's commitment to child safety
- code of conduct
- risk management plan
- documents setting out intake, assessment and service planning procedures
- complaint handling policy.

Details on the requirements for each of the policy documents above, as well as links to useful resources, are set out below.

The principal officer of an SSRC provider must be able to demonstrate that steps have been taken to ensure that the relevant policies and procedures have been understood and implemented by all staff.

SSRC providers should also consider ways to make key policies and procedures that impact the services they deliver accessible to and understandable by chidlren and families who use their services.

The policy documents must be made available to an officer of the OCG on request.

SSRC providers may also need to adhere to NDIS requirements, or the requirements of funding contracts. This might mean some duplication in regulatory requirements.

The SSRC Code of Practice does **not** require an SSRC provider or prospective SSRC provider to develop all new policies and procedures if they already have existing policies and procedures that cover the minimum requirements mentioned above. Existing policies and procedures can be expanded or adapted where necessary to align with the requirements of the Code.

It is best practice to regularly review policies and procedures to ensure they are fit for purpose. This should also occur after critical incidents.

The OCG offers a range of resources to assist organisations with the development of child safe policies and processes on the OCG website.

The OCG also offers regular webinars on a range of topics. Visit the OCG website to see when upcoming webinars are scheduled.

Statements about Child Safety

The principal officer of an SSRC provider must ensure the provider has a publicly available statement of the provider's commitment to child safety and a document informing staff of the provider's commitment to child safety and their obligation to contribute to creating a child safe organisation.

The principal officer of an SSRC provider must also be able to demonstrate to the satisfaction of the Children's Guardian the steps that have been taken to ensure that the documents have been read and understood by all staff, are applied by all staff in their work, and are accessible to children and their families. The Children's Guardian can request to see these documents.

When developing the contents of a Statement of Commitment to Child Safety consider including commitments to:

- the participation and empowerment of children
- treating all allegations and safety concerns seriously and consistently with internal policies and procedures
- creating a safe environment through the careful management of risks
- legal and moral obligations to contact authorities when concerns are raised about a child's safety
- the cultural safety of Aboriginal and Torres Strait Islander children and their families, the cultural safety of children of diverse backgrounds and their families, and to providing a safe environment for children with a disability.

The Child Safe Standards and the principles underpinning SSRC can provide a helpful starting point for inclusions in a Statement of Commitment to Child Safety. The OCG has developed the Understanding and Developing a Child Safe Policy handbook for organisations to use in developing child safe policies.

Code of conduct requirements

The principal officer of an SSRC provider must ensure that the provider has a Child Safe Code of Conduct setting out the standards of behaviour expected of staff interacting with children for whom they provide SSRC. As every organisation and employment situation is different, codes of conduct will also differ between organisations. However, at a minimum, codes of conduct must require staff to report:

- instances of another staff member having engaged in reportable conduct or been involved in a reportable incident
- allegations or concerns that another staff member has engaged in reportable conduct or been involved in a reportable incident
- other concerns about the safety, wellbeing or welfare of a child receiving services.

There is no need for a separate Child Safe Code of Conduct for SSRC services if your organisation already has an existing code of conduct, but it's important to review it to make sure it includes measures that promote the safety of children. The OCG has developed the Codes of Conduct handbook for organisations to use in developing their own codes of conduct.

The Child Safe Standards and the principles underpinning SSRC can provide a helpful starting point for inclusions in a Statement of Commitment to Child Safety.

Child Safe Risk Management Plan

The principal officer of an SSRC provider must ensure that a Child Safe Risk Management Plan is developed and implemented to assist staff to both identify and manage risks of abuse of, or harm to, children, and put mitigation strategies in place. This plan is an organisation or program-wide plan covering all potential and actual risks to children, and should be the result of a thorough, and ongoing, risk analysis. A risk management plan must set out actions to be taken before a child is provided with SSRC and actions to be taken while a child is being provided with care.

A risk management plan will be a useful support document to rely on during intake and assessment processes. It is also important to remember that risks should be considered individually for each child, particularly in higher risk situations such as when considering the placement of:

- children under the age of 7 who have complex health needs that require such care
- young people aged 16-17 with either children or adults
- children under the age of 16 in a centre that also provides support to adults.

Some key risks were explored in the above section 'Risks in the SSRC sector', including:

- complex needs that heighten vulnerability
- Aboriginal and Torres Strait Islander children and children from culturally and linguistically diverse backgrounds
- characteristics of the cohort
- gender identity and sexual orientation
- children, parents or families become disengaged
- the design of the care environment – including accommodation/physical spaces
- risks when transporting children
- risks for children placed in group homes with other children or adults
- benefits and risks of SSRC
- lack of trusted relationships with SSRC staff
- where adults abuse children and young people.

These are key risks that could be considered in an SSRC provider's risk management plan, for example as considerations to be aware of when performing intake and assessment processes for a child. A good risk management plan should then also include examples of strategies or tools that could be utilised to manage or mitigate risk associated with these and other risk factors.

For more information on how to develop a risk management plan and how to identify risks, the OCG has additional resources on risk management, including the Risk management and the Child Safe Standards Part 1: Responding to risk and Risk management and the Child Safe Standards Part 2: Identifying risk.

The OCG also runs regular training sessions on developing a risk management plan and recordings of previous training sessions are also available online. More information about resources and training available is on the OCG website.

Intake, assessment and service planning policies and procedures

The principal officer of an SSRC provider must ensure that the SSRC provider has intake, assessment and service planning policies and procedures. These policies and procedures must set out the actions to be taken both before a child is placed in care and while a child remains in care, including how a provider will obtain information about a child, assess the child's needs, and plan the delivery of services to children.

More detailed guidance on these requirements is set out below in 'Part 4: Intake and assessment'.

Complaint handling

The principal officer of an SSRC provider must ensure that the SSRC provider has a complaint handling policy to respond to complaints made by:

- children in SSRC
- parents of children in SSRC.

The Royal Commission into Institutional Responses to Child Sexual Abuse found that clear, accessible and child-focused complaint handling policies and procedures are crucial for organisations. Strong complaints and dispute resolution systems are also essential for effective SSRC care planning as agencies and children or their parents may sometimes disagree with the services an agency provides or the decisions it makes. Failure to resolve complaints may lead to a breakdown in a family's relationship with an agency or carer or result in the parents becoming disengaged from the care of their child.

Children often face barriers that discourage them from speaking up, including:

- fear they will not be believed
- feeling intimidated
- their own vulnerabilities or experiences
- reporting processes that are not well designed for children
- communication challenges or disability.

An SSRC provider's complaint handling policies and procedures should work to support children who report abuse and to provide guidance to staff about their internal and external mandatory reporting obligations.

Complaint handling policies and procedures should be available in different formats and accessible to all children in their care. Where possible, children should be offered independent support when they are seeking to make a complaint.

SSRC providers must keep records of complaints and their responses to them.

NDIS registered providers may already have complaints handling policies that meet NDIS requirements. There is no need to duplicate resources, however they must also meet the needs of children under the SSRC Code of Practice.

When designing complaint handling policies and when handling complaints, some helpful questions that could be asked include:

- How do we prioritise the safety of all children in our organisation after a complaint is received?
- How do we make our complaint handling process publicly available and accessible?
- How do we embed a culture of reporting?
- How do we support families after a complaint is made?
- What mechanisms ensure the confidentiality of complaints and the investigative process?
- How do we record complaints?

SSRC providers must keep records of complaints and their responses to them.

SSRC providers must also ensure that children in SSRC and their parents are made aware of how to make a complaint about an SSRC provider's services or conduct and how the provider responds to complaints. The information provided must address internal complaint handling arrangements and the rights of clients to refer complaints to an external body such as the NSW Ombudsman and the NDIS Commission. The OCG is not a complaint handling body.

When a complaint is made by a child or their parent(s), DCJ may become involved if the complaint:

- involves a criminal offence
- poses a risk of significant harm to a child or a class of children.

If a complaint involves a criminal offence or risk of significant harm to a child or a class of children, the agency should not proceed with any complaint resolution until it obtains clearance from the police or DCJ, so as not to interfere with their investigation. SSRC agencies should obtain clearance from DCJ or police before proceeding with complaint resolution processes. The OCG has developed the Reporting Obligations and Processes handbook for organisations to use in developing their own codes of conduct.

The SSRC register

Section 35 of Part 5 of the Regulation requires SSRC providers to record certain information on the SSRC Register. SSRC providers must record:

- the date the child enters care
- information about:
  - the child
  - the provider
  - any case plans that have been prepared for the child
- when the child leaves care the date care has ended.

These details must be entered by SSRC providers within five business days of the commencement of the placement. The date care has ended must be entered within five business days of the conclusion of the placement.

Designated agencies supervising SSRC must also enter details about the child, the entity providing the SSRC, designated agency and date supervision commenced within five business days after a child commences SSRC supervised by the designated agency.

The SSRC Register is a secure, online database that keeps record of all children in SSRC.

The SSRC Register includes a child's placement history which calculates the number of nights that a child spends in SSRC across all SSRC providers for the last 12 months.

It is important that SSRC providers use the SSRC Register to update information at all stages of care. Any placement of one or more nights must be recorded so that the total nights a child spends in the care of an SSRC provider remains accurate.

To gain access to the SSRC Register, SSRC providers need to contact the OCG following completion of the Child Safe Self-Assessment. SSRC providers also need to update their contact details with the OCG regularly to maintain access.

The OCG regularly monitors the SSRC Register to identify organisations that have not provided SSRC recently. If an organisation ceases to provide SSRC, they may be taken off the Register and will need to reapply for access. Organisations can also request to be removed from the Register. When re-applying, organisations will need to complete the CSSA regardless of whether they have done this before as their answers to services provided will necessarily have changed.

More information about the SSRC Register, including guidance on how to access and use the SSRC Register, is available on the OCG website.

All overnight stays must be recorded, even those of just 1 or 2 nights, to ensure correct calculation of the child's yearly nights in SSRC.

Part 4: Intake and assessment

Thorough intake and assessment is important for children and young people accessing SSRC. A clear and thorough intake and assessment process that happens before the child enters an SSRC placement helps to:

- match the right services and carer team to the child
- get essential information to manage risks for the individual child
- allay any concerns or anxiety that the child or their parent(s) may have
- meet the organisation's legal obligations according to the SSRC Code of Practice.

The SSRC Code of Practice sets out clear minimum requirements that must be met during the intake and assessment process.

It is important that SSRC providers undertake thorough intake and assessment processes, as the information obtained and used here is crucial for managing risks and ensuring that services match the needs of the child or young person.

Information and planning

Section 12 Information gathering

Intake and assessment involve obtaining and using information about the child and their parents, and other family members where relevant, to understand their strengths and service needs. These requirements must be completed prior to a child commencing an SSRC placement and in collaboration with a child's family and other service providers involved in the child's care.

It is important that SSRC providers undertake thorough intake and assessment processes, as the information obtained and used here is crucial for managing risks and ensuring that services match the needs of the child. Several meetings and sources of information may be necessary to finalise the assessment.

It is still important to undertake proper information gathering even where a provider has provided care for a child before as a child's needs will change over time or new staff may be providing care to that child or young person.

Where a child must enter care in rushed circumstances, such as during an emergency, it may be impracticable to gather all information before the child enters care. In these circumstances, it is still important to collect all relevant information as soon as practicable to ensure that service delivery meets the needs of the child, and to actively manage all potential risks. A failure to gather all relevant information is a breach of the SSRC Code of Practice, and compliance action may be taken where necessary.

While SSRC providers should gather and analyse a range of information when performing intake processes, the SSRC Code of Practice requires SSRC providers to gather the following information:

Section 12 Information gathering

(1) The principal officer of an entity providing specialised substitute residential care for a child must ensure the entity obtains the following information about the child

(a) information recorded on the specialised substitute residential care register, including —

(i) the number of days the child has spent in care over the previous 12 months, and

(ii) the designated agency currently providing or supervising care for the child, and

(iii) a case plan for the child,

(b) relevant information from a designated agency —

(i) currently providing or supervising care for the child, or

(ii) that has recorded on the specialised substitute residential care register the development of a case plan for the child,

(c) relevant information held by other organisations or people who are or have been involved in supporting the safety, welfare and wellbeing of the child,

(d) relevant information about —

(i) the formal and informal supports in place for the child and the child's family, and

(ii) the child's living and socialisation skills and daily routine, and

(iii) specific risks for the child and how the risks will be managed in the specialised substitute residential care environment,

(e) information about the needs of the child, including —

(i) health, medication and disability needs, and

(ii) environmental, risk management and mobility needs, and

(iii) emotional, behavioural, cognitive and developmental needs, and

(iv) nutrition and dietary needs, and

(v) cultural, language and communication needs,

(f) information about the needs of the parents of the child,

(g) emergency contact details for the parents of the child and other relevant family members.

SSRC providers must obtain the above information before a child or young person enters SSRC, or as soon as practicable for an emergency placement.

The information listed in the SSRC Code of Practice is not an exhaustive list of information that may be relevant for an SSRC provider to obtain about a child and their family when completing intake processes. Beyond the minimum information required, it is important to consider questions such as:

- Is SSRC being considered as a last resort?
- What information is necessary for understanding which if any SSRC is appropriate for the child?
- Is additional information required to ensure a person-centred approach to care is followed?
- How does our organisation make it simple for parents and the child's other support providers to communicate the required information, thereby ensuring important detail is not lost? For example, going through a detailed list of questions that would inform all aspects of the risk planning process.
- How might this information be protected by privacy legislation, and how should this information be stored securely?

SSRC providers are prescribed bodies for the purposes of Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998*. This means that they can exchange information with other prescribed bodies relating to the safety, welfare or wellbeing of a child or children. More information is available on the OCG website.

Scenario

8-year-old Jack is diagnosed with ADHD and autism and has been displaying difficult behaviours. Jack and his mother have been working with an NDIS coordinator and a psychologist, and a current behaviour support plan (BSP) is in place to help Jack's mother handle challenging situations, understand triggers and stay calm.

Jack has had respite care before, and his BSP indicates that he needs additional support and ongoing supervision to make sure he is safe due to displaying behaviour such as wandering off and not being able to recognise danger in unfamiliar situations. When in new and unfamiliar environments, he becomes overwhelmed and will often attempt to flee, including climbing out of windows.

Due to a family emergency, Jack's mother contacts his NDIS coordinator to arrange a week of respite urgently. The coordinator calls Provider B who has provided respite for Jack before, but they don't have the capacity to provide care for him. Then they call Provider C, who says that they can take Jack in.

Following the call Provider C emails a Service Agreement to the coordinator, but sends a Referral Form the next day just hours before Jack was due to start respite. The coordinator completes the Service Agreement and provides a copy of Jack's BSP, but misses the Referral Form the next day and no one from Provider C follows up on it or reviews the provided BSP.

Shortly after beginning respite, the employee supervising Jack decides to take a break in the living room, leaving Jack alone in the adjacent bedroom playing on his tablet. The employee goes to check on Jack 30 minutes later and finds that he has gone.

They notice that the bedroom window is wide open, and beyond it is a large driveway with additional flats towards the back and a busy street at the front.

Fortunately, as the employee runs outside to try and find Jack, a neighbour who was out for a walk had found Jack at the mouth of the driveway and assisted the employee to take Jack inside. Jack appeared very distressed, and the employee immediately contacts his mother who comes to take him home.

Following the incident, the principal officer of Provider C examines the organisation's policies and procedures, and makes changes including:

- requiring in person on-site interviews for all new children and their parents to gather information and allow children and their parents to familiarise themselves with the care centre
- combining the existing service agreement and referral form into one document to make sure relevant information is captured
- policies now require review of all BSPs for a child on intake to make sure that all relevant information is captured
- if a new child has received SSRC from another provider before, procedures require that the previous provider is contacted during intake to find out more information about the child's needs
- review of staffing levels to ensure adequate support is provided to children at all times.

Section 13 Information to be given

As well as collecting information, SSRC providers must ensure that before a child is received into care, the following information is given to the child and the child's parents:

Section 13 Information to be given

(1) The principal officer of an entity providing specialised substitute residential care for a child must ensure that, before the entity provides the care, the child and the parents of the child are given information about the following

(a) the services the entity can arrange and provide,

(b) the cost of each service,

(c) the provider of each service,

(d) the role in decision-making about the ongoing care and support of the child of the following —

(i) the entity,

(ii) other service providers,

(iii) the child,

(iv) the parents of the child,

(e) the information that will be recorded on the specialised substitute residential care register,

(f) that the child and the parents of the child may receive information on the specialised substitute residential care register about the child and request that errors in the information are corrected,

(g) complaint handling processes, both internal and external.

When providing information it is important that SSRC providers use language that is readily understood by both children and their parents. SSRC providers should consider the capacity of children when they provide information to them.

The rights of children and their parents to request information on the Register and to request that information on the Register be corrected are set out in sections 37 and 38 of the Regulation.

The information listed in the SSRC Code of Practice is not an exhaustive list of information that can or should be shared with children and parents. When considering what information may be important to share, SSRC providers are encouraged to keep in mind the principle of collaborative decision making in SSRC. Sharing additional information may be an important step towards strengthening collaboration between providers, children and parents.

Section 14 Sharing of information

An SSRC provider must ensure that the child and the child's parents are informed that relevant information about the child may be shared with other agencies before the child enters SSRC. Additionally:

Section 14 Sharing of information

(2) The principal officer

(a) must ask the parents of the child to sign an acknowledgment that they have been informed about the sharing of information with other agencies, and

(b) may ask the child to sign the acknowledgment.

SSRC providers may share information relevant to a child's safety, welfare or wellbeing, and it is important that this is clearly communicated to the child to the extent of their capacity and to the child's parents. Where asking a child to sign an acknowledgement, it is important that their capacity is considered and the acknowledgement is presented in a form they can understand.

While SSRC providers must ask at least the parents of the child to sign an acknowledgement that relevant information may be shared, the consent of both the child and their parents is not necessary for the exchange of information.

Keeping children and their parents informed of specific incidents of information exchange helps to maximise their engagement in SSRC service delivery and is part of best practice case management. Where practicable and appropriate, a child and their parents should be informed when specific information about them is being disclosed to another agency.

It will not be appropriate to inform a child and their parents of specific incidents of information exchange if the agency believes this would jeopardise a child's safety, welfare or wellbeing or place any person at risk of harm.

SSRC providers should also ensure they comply with relevant requirements under the *Privacy and Personal Information Protection Act 1998* (NSW), *Health Records and Information Privacy Act 2002* (NSW) and under the *Privacy Act 1988* (Cth) relating to the collection, use and disclosure of information.

Section 15 Intake meetings

Section 15 Intake meetings

The principal officer of an entity providing specialised substitute residential care for a child must, if practicable, schedule meetings for intake and assessment at places and times convenient for the child and the parents of the child.

In practice, all reasonable steps should be taken to accommodate the child's and family's needs in relation to intake meetings. This might include asking about families' commitments and offering times that do not conflict with their commitments, such as planned activities for the child or work or caring obligations.

Section 16 Service planning

SSRC providers must use the information obtained from intake processes, as well as information obtained from the provider's regular planning and review of services provided, to ensure that the provider meets the child's ongoing care needs. These needs include:

Section 16 Service planning

(2)

(a) health, medical, mobility and behavioural needs,

(b) communication and personal care needs,

(c) maintenance of relationships with family and significant others,

(d) cultural, spiritual and religious needs,

(e) participation in educational, vocational, social and leisure activities.

SSRC providers should also consider more broadly how best to meet the child's care needs beyond the considerations listed in the SSRC Code of Practice. It is important that children and their parents are active participants in care planning. It may be useful for care providers to ask:

- What are the likes and interests of the child?
- How can we promote the child and their family's active involvement in service planning?
- What additional training or staffing may be required to meet the needs of the child?

In some circumstances, for example during short stays, service planning may be appropriately confined to using information collected through the intake process to meet the child's immediate needs.

Where the child stays in care for longer, or receives regular short periods of care, service plans should be adjusted where necessary to address the child's ongoing day-to-day care needs. It is best practice here to continue to consult with the child and their parents to obtain information needed to provide person-centred care on an ongoing basis.

More detail on involving children and parents in care and collaborative practice is above in 'Principles underpinning the Code of Practice'.

Scenario

Provider D has recently begun providing overnight respite care to a 14 year old male who has never received respite care before. After the first few nights, staff report that he won't engage in activities, is reserved around others and is hard to get off his iPad. During initial intake interviews, he rarely spoke up though his parents indicated that he is not non-verbal when at home.

To help him settle in to a new environment and make sure that his needs are being met, the principal officer and staff discuss strategies to overcome the perceived barriers to communicating with him.

Strategies that are considered include:

- adapting communication techniques to better suit him
- alternative feedback approaches that better suit his needs and preferences, such as using an iPad, forms of non-verbal communication and setting up a suggestion box
- appointing one staff member to work closely with him to build trust and confidence
- working with his family to help facilitate feedback from him.

These strategies are implemented, and as he begins to provide more feedback a service plan is developed that includes:

- identifying a place for quiet time
- bringing games from home
- slowly introducing him to other staff and children
- plans for outings to his favourite skateboard park.

Placement

Section 17 Placement matching

When considering the provision of care to a child, an SSRC provider must consider at least the following:

Section 17 Placement matching

(1)

(a) whether the care is appropriate for the needs of the child and the child's family,

(b) the child's culture, age, disability, language, religion, gender and sexuality,

(c) the individual needs and preferences of the child,

(d) the benefits of placing the child with peers of a similar age and developmental stage and who have similar interests,

(e) the current supports available to the child,

(f) additional supports required to meet the child's needs.

In addition to the above considerations, an SSRC provider must not place a child in centre-based care with another person unless an assessment has been undertaken of the following:

Section 17 Placement matching

(2)

(a) risks posed to the child by other persons in the centre-based care,

(b) risks posed by the child to other persons in the centre-based care.

As outlined above, all SSRC providers must have risk management plans in place, but it is particularly important to undertake full risk assessments where multiple persons are placed in centre-based care.

If during intake and assessment, the principal officer is of the opinion that SSRC is not appropriate for the needs of the child and the child's family, they must request that the parents of the child make alternative care arrangements. The principal officer should also request that the parents of the child make alternative care arrangements if at any time during service provision they are of the opinion that SSRC is not appropriate for the needs of the child and the child's family.

As part of intake and assessment, SSRC providers should consider if there are other services that can be provided to children to enable them to remain with their parents outside of SSRC. These could include other family supports, non-SSRC respite arrangements, or a combination of SSRC and other supports.

During intake and assessment, some questions to ask could include:

- What specific needs of the child and the child's family would SSRC meet?
- Are there specific needs that SSRC is not best placed to meet, or cannot meet?
- Would another SSRC provider be in a better position to meet the specific needs of the child and the child's family?

It is also important that SSRC providers are responsive to the needs of Aboriginal and Torres Strait Islander children and families and children and families from CALD backgrounds, in keeping with the principle of cultural safety. These needs must be considered when making arrangements and in the service planning for each placement.

Scenario

Provider E has been providing respite care for several years and provides care out of three different houses. The first house has space for two children in their own bedrooms, the second has space for three children in their own bedrooms, and the third has bunk beds and can sleep up to six children across three bedrooms. They were recently contacted by a new family to provide two nights of respite care per week for a month for David.

The principal officer discusses the respite care arrangements with David's parents, and discusses David's behavioural challenges, including his tendency to play with matches and knives. However, the principal officer does not also discuss the placement with David himself or attempt to find out his needs and preferences directly.

On the nights that David is coming to stay for care, the second house is full but the first and the third house have one bed free each. The principal officer decides that David would be assigned to the third house, because the care location is closer to David's home and because as a larger facility there are more staff available to supervise David's safety. David arrives and spends the first night sharing a room with an 8-year-old girl.

Just after bedtime, staff hear a yelling and crying from David's room. When they reach the room, they discover that David had snuck a packet of matches in with him and was lighting them while threatening to light the 8-year-old girl's hair on fire. The two children are separated, and their sleeping arrangements are changed so that David is sharing a room with a 15-year-old boy.

Staff ask David why he was doing that, and David says that he sometimes has to share his bedroom with his younger sister who he doesn't get on with, and the girl in the room reminded him of her so he started to play with her. The next day David is transferred to the first house where he would have a room to himself.

The principal officer and staff review their risk management policies, and make changes including:

- adding interviews with children and their parents as part of intake processes
- making sure that risks posed by the child to other persons in centre-based care are considered in risk assessments
- adjusting policies around which children share rooms, with a preference for only children of the same age or developmental stage to share rooms, and considering gender and gender identity
- changing decision-making processes for which residence children are placed to prioritise the needs and safety of the child over convenience of location.

Section 18 Age specific placement requirements

The SSRC Code of Practice contains specific requirements around the placement of children and young people of certain ages.

Children under 7

Section 18 Age specific placement requirements

(1) The principal officer of an entity providing specialised substitute residential care must ensure that when considering the provision of care for a child who is less than 7 years of age the following principles are considered —

(a) family care with a focus on individualised care must be the preferred option,

(b) centre-based care must not be used unless the child has complex health needs that can only be met by centre-based care.

(5) In this section —

complex health need means a medical condition or a disability requiring specialist medical, nursing or other health care treatments that are not able to be effectively delivered in a home-like environment.

Children under 7 should only be considered for SSRC placements that are in a host family, or family care setting. Centre-based care must only be considered if there are extremely unusual circumstances due to the complex medical needs of the child that can only be met in centre-based care. Centre-based care is not considered appropriate for the purposes of behaviour support for children under 7 years old.

Children aged under 16 placed in care with an adult

Section 18 Age specific placement requirements

(2) The principal officer must ensure that a child who is less than 16 years of age must not be placed in centre-based care with an adult unless the principal officer —

(a) has conducted a risk assessment and is satisfied —

(i) the placement is appropriate for the child's needs and circumstances, and

(ii) the adult presents no risk to the child because the medical support needed by the adult is high, and

(iii) there is no other suitable option for the child, and

(b) has obtained the written consent of the parent or guardian of the child before the care is provided.

In practice, this means that a child should only be placed in centre-based care with adults who are immobile or incapable of posing any risk to the child. They should not be accommodated in the same room as an adult. Any time a child is placed in a centre that also looks after adults, there should be ongoing risk assessment and efforts to find more suitable accommodation.

Section 18 Age specific placement requirements

(3) The principal officer must ensure that a young person who is 16 or 17 years of age is not placed with adults or other young people in centre-based care unless the principal officer —

(a) is satisfied the care is suitable for the individual needs of the child, and

(b) has conducted a risk assessment, and

(c) has obtained the written consent of the parent or guardian of the child before the care is provided.

Young people aged 16-17

Any child placed with either adults or other children can be at risk or create risk. It is the SSRC provider's responsibility to manage these risks through appropriate risk management planning, supported by robust governance, policies and procedures and staff training.

Section 19 Placement to be confirmed in writing

Section 19 Placement to be confirmed in writing

The principal officer of an entity providing specialised substitute residential care for a child must give written notice to the parents of the child confirming the provision of the care within 5 business days after provision of the care begins.

Providing written notice to parents of children in SSRC is important for making sure that children, parents and families understand the services being provided and for meeting record keeping requirements. Avoiding miscommunications through establishing clear and shared expectations around services being provided helps keep children and young people in SSRC safe.

Providing written notice to parents of children in SSRC is important for making sure that children, parents and families understand the services being provided and for meeting record keeping requirements.

Part 5: Supervision and case planning

Section 8ZA of the Act places limits on the amount of time a child or young person can spend in SSRC over a 12-month period. The 12-month period is a rolling period of the 12 months leading up to the current date.

Firstly, a child must not remain in SSRC for more than a total of 90 days in any 12-month period unless that care is provided or supervised by a designated agency.

Secondly, a child must not remain in SSRC for more than a total of 180 days in any 12-month period unless the designated agency providing or supervising the care, or the Children's Guardian, has ensured the child has a case plan that meets their needs.

The SSRC Code of Practice sets out specific requirements for SSRC providers that must be met when a child or young person is in SSRC beyond these limits.

Across these sections:

- **designated agency** means an agency accredited by the Children's Guardian under Schedule 3A of the Act to provide statutory out-of-home care
- **supervising agency** means a designated agency acting to supervise the placement of a child in SSRC
- **principal care agency** means the agency that is providing most or all of the relevant SSRC services to a child.

In practice, this means that where an SSRC provider is providing care to a child:

- by the time the child reaches 90 days of care they must arrange supervision of the child by a designated agency, unless the SSRC provider is a designated agency, and
- by the time the child reaches 180 days of care they must have already developed, and be implementing, a case plan that is overseen by the supervising agency.

Section 20 Supervision

Section 20 Supervision

(1) The principal officer of an entity providing specialised substitute residential care for a child who has been in specialised substitute residential care for a total of 90 days or more in a 12-month period must —

(a) ensure the care is supervised by a designated agency, and

(b) consult the parents of the child about the supervision and give the parents the name and contact details of the designated agency providing the supervision.

Where a child receives more than 90 days of care within a rolling 12-month period the principal officer must arrange for supervision of the care, unless the care is provided by a designated agency.

Example 1: On 13 September 2022, Liana enters into a 3-day placement. Over the past 6 months she has received 88 days of SSRC. At the time she enters into care, she is under the threshold for supervision. However, on 14 September, she reaches her 90th day of care in a 12-month period and patterns of care indicate she will continue to receive ongoing care which means her SSRC must be supervised by a designated agency.

Example 2: On 13 September 2022, Gerald enters into a 5-day placement. Over the last 12 months, he has received 88 days of care, the first of which was from a 5-day placement that started on 13 September 2021. As a result, he does not reach the 90-day threshold in the new placement due to the rolling 12 month period.

In some cases, a child or young person may be receiving care from multiple SSRC providers. In these cases, the provider responsible for arranging supervision is the principal care agency. The principal care agency may change should a child's patterns of care change.

It is important to know who the principal care agency for a child is. To find out which SSRC provider is the principal care agency, the SSRC Register is a useful starting point to examine previous placements.

If the principal care agency is a designated agency, then it is not required to arrange external supervision for any SSRC it provides. However, if a child also receives some SSRC from other non-designated SSRC providers, then the designated agency must supervise the SSRC provided by those other agencies or arrange for another designated agency to supervise the SSRC provided to that child.

The process for arranging supervision is as follows:

- the OCG will ensure non-designated providers are alerted either directly or via a contracted designated agency that a child or young person is approaching the 90 day threshold. However, SSRC providers must check the Register and keep track of children's nights in SSRC themselves to ensure supervision arrangements are in place by the 90 day threshold
- if patterns of care suggest that the 90 day threshold will be met, supervision arrangements must be made, including regular supervision meetings between the designated agency and SSRC provider or providers (if multiple providers are engaged)
- either the principal care agency or the supervising agency must advise the child's parents when supervision has been arranged and provide them with the name and contact details of the supervising agency, as well as discuss the supervision arrangement with the child and their parents
- designated providers will not be alerted to supervision thresholds as they are able to supervise their own placements they must ensure that children are receiving the appropriate planning and support for placements over these thresholds.

Responsibilities of the supervising agency

A supervising agency must lodge a supervisor notification on the SSRC Register within 5 working days of commencing supervision. They should also provide the principal care agency with a copy of the notification. This notification stays in place either until there is no longer a need for supervision, or when the child's principal care agency changes.

It is not necessary for the supervising agency to lodge notifications every time the child enters a new placement, as long as the principal care agency remains the same. The supervising agency should monitor placements to ensure the principal care agency is updated where required. Supervision is no longer required when a child does not meet the 90-day threshold, for example, where ongoing work with the child and family have reduced the need for SSRC placements. The supervising agency is also responsible for supervising all SSRC provided to the child, including:

- conducting an initial supervision meeting between the principal care agency, supervising agency and any other relevant SSRC providers to discuss supervision arrangements
- developing a supervision plan
- reviewing current service plans that have been developed by SSRC providers
- the supervising agency must arrange supervision meetings with SSRC providers, either in person or remotely, an a monthly basis at minimum under section 40 of the Regulation
- monitoring placements to ascertain if a child is likely to reach the 180-day case plan threshold and start a collaborative and formally constituted case plan accordingly.

Ending supervision

Section 20 Supervision

(2) The principal officer must notify the designated agency if the provision of the care no longer requires supervision.

In addition to notifying the supervising agency if the care no longer requires supervision, the principal officer of the primary care agency should also notify the supervising agency if it ceases to be the principal care agency for the child.

Where supervision is to be ended, the outgoing supervising agency must email the OCG within 5 business days detailing the change of supervision details, and inform the principal care agency and any other relevant SSRC providers that its supervision of the child's SSRC has ended.

Supervision requirements not met

Section 20 Supervision

(3) The principal officer must report a breach by a designated agency of this Regulation, section 40 to the Children's Guardian.

The principal officer of an SSRC provider must report a failure of a designated supervising agency to arrange monthly supervision meetings with the SSRC provider to the Children's Guardian. If a supervising agency reports a lack of engagement by an SSRC provider to the Children's Guardian that results in supervision not being established or ongoing, this may result in a breach for the SSRC provider.

The obligation to notify the Children's Guardian of a breach of section 40 of the Regulation may arise at any time after the 90-day threshold is reached. For example, a non-designated agency may start providing SSRC to a child already over the 90-day threshold who was previously receiving SSRC from a designated agency.

Some breaches may be unavoidable and technical in nature such as where a child enters a non-designated agency's emergency care immediately before or after the 90-day threshold.

When the OCG is notified that supervision requirements have been breached, the OCG will contact the principal care agency, the supervising agency and the child's parents where appropriate to discuss the reasons for the breach and any action being taken to address it.

The OCG will then determine, in accordance with any guidelines issued by the DCJ, whether it will make a risk of significant harm report.

Section 21 Case planning

SSRC providers are required to undertake service planning to address each child's day-to-day needs in a placement. In some circumstances, service planning may just use information collected through the intake process, but where the child stays in care for longer periods or repeatedly, they should address the child's ongoing day to day care needs.

Where a child receives SSRC for more than 180 days in a 12-month period, a case plan must be prepared that builds on existing service planning while also providing an accurate and up-to-date record of the decisions, services, actions, roles, responsibilities and timeframes that are necessary to address the needs of the child.

A case plan is a comprehensive and holistic written plan that addresses the child's needs and circumstances, any aspirations and needs of the child's parents and other family members where relevant, and any risks associated with the child's care.

There is no one 'right way' to complete a case plan, but they should be informed by existing service planning and are a collaborative process that involves the participation of:

- the child, to the extent of their capacity
- the child's parents
- relevant family members of other people who are significant to the child
- any carers or agencies that provide care or other support
- the supervising agency, if relevant.

A case plan should have clear and achievable goals and identify tasks, responsibilities and time frames to address those goals and when the plan will be reviewed. Any subsequent service planning should align with the case plan.

As with the requirements for policies under the SSRC Code of Practice, there is no single template or form that case plans must take.

SSRC providers must plan proactively as it is important that case planning time frames are met. Where children do not have a case plan in place that meets requirements, the OCG will consider this a breach of the SSRC Code of Practice.

Developing a case plan

Where a child or young person receives care from only one SSRC provider, the provider is responsible for developing a case plan.

Where a child receives care from more than one care provider, the case plan is to be prepared by:

Section 20 Case planning

(2)

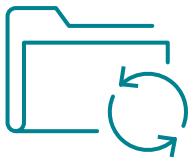
(a) the care provider that provides the majority of the care, or

(b) if no care provider provides the majority of the care — the designated agency supervising the care.

Note that while the case plan is to be prepared by the principal care agency, in practice a case plan should be prepared in collaboration with those who actively provide care for the child such as support coordinators alongside the principal care agency.

Where a case plan is developed in a collaborative effort, those who help develop the case plan are all responsible for ensuring the case plan is written in accordance with the SSRC Code of Practice and any other requirements that might apply, such as from the NDIS.

There is no need to duplicate case plans where they already exist, as long as the case plan also complies with the SSRC Code of Practice.



A case plan should have clear and achievable goals and identify tasks, responsibilities and time frames to address those goals.

Case plan preparation

Case planning works best with preparation. The principal care agency responsible for developing the case plan should, well before a child reaches 180 days of care in a 12 month period, start to prepare by considering:

- who the care professionals providing support for the child are
- how any care professionals should be involved
- how can we best ensure that the child is supported to be actively involved to the extent of their capacity?
- how to best communicate with and involve the child and their parents
- whether a case plan coordinator should be identified to lead case plan preparation
- previous assessments and plans, and what further assessment of the child's needs may be necessary.

To develop the case plan, the principal care agency needs to:

- convene case meetings with, and distribute case meetings minutes to, children (to the extent of their capacity), their parents and others involved in developing the case plan
- develop the case plan from a formal case conference, making sure that the plan has clear and achievable goals, identifies tasks, responsibilities and time frames, and specifies when the plan will be reviewed
- attempt to resolve any disagreements or conflict, including between SSRC providers and the child and their parents about case planning and provide the child (to the extent of their capacity) and their parents with information about complaint handling systems
- if relevant, attempt to ascertain the reason why a child's parents may refuse to participate in case planning.

Case plan contents and review

Section 21 Case planning

(1) The principal officer of an entity providing specialised substitute residential care for a child must ensure a case plan —

(a) addresses the following —

(i) the child's health, medical, mobility, behavioural and personal care needs,

(ii) maintenance of relationships with the child's family and significant others,

(iii) the child's cultural, spiritual and religious needs,

(iv) participation by the child in educational, vocational, social and leisure activities,

(v) risks associated with the child's care and appropriate management strategies,

(vi) age-related considerations, including developmental needs and the child's transition to adulthood,

(vii) long-term care planning, including arrangements for the child to transition out of specialised substitute residential care, and

(b) is reviewed —

(i) when the child's ongoing care and support needs or care arrangements change, and

(ii) at least once every 12 months.

To make sure all the required points are addressed, case plans should include the following information about:

- the child's needs
- the child's parents needs
- impending key transition stages in the child's life
- views expressed by the child and their parents, or records of attempts to obtain such views
- any formal or informal supports the child and their family currently receive
- any other relevant information.

It is important to include clear and achievable goals and identify tasks, responsibilities and timeframes to address those goals and when the plan will be reviewed.

For example, a case plan could include the following goals:

- the child living with their family to the greatest extent that is practical, having regard to the particular needs of the child and their family
- the child maintaining contact with the family while in SSRC
- providing the child with stable and secure SSRC.

SSRC providers must make sure of the provision of culturally safe services for First Nations children and children from culturally and linguistically diverse backgrounds. This must be documented in the case plan.

A review considers the ongoing care and support needs of the child and their family and whether the existing case plan supports those needs. A review should result in the case plan being confirmed or amended.

Case plans must be reviewed at least once every 12 months, and should be reviewed any time the child's ongoing care and support needs or care arrangements change and after critical incidents.

The principal officer of the principal care agency, or case plan coordinator if one has been appointed, must make sure the case plan is reviewed when the child's ongoing care and support needs or arrangements change and at least annually.

The supervising agency or principal care agency must have processes in place to identify these plans and coordinate case plan reviews before the annual date has expired.

Where a case plan does not meet a child's needs

Where a child is in SSRC for more than a total of 180 days in a 12-month period and the child does not have a case plan that meets their needs, the supervising agency (where supervising a placement with a non-designated SSRC provider) must notify the Children's Guardian as soon as is practicable after becoming aware the plan does not meet the child's needs under section 32(b) of the Regulation.

Part 6: Staff recruitment and training

Section 22 Recruitment

Section 22 Recruitment

(1) The principal officer of an entity providing specialised substitute residential care for a child must ensure the entity engages staff with appropriate skills and qualifications for the roles the staff are engaged to fill.

(2) The principal officer must ensure the entity has systems in place to ensure the entity undertakes appropriate pre-employment checks for all staff.

(3) The pre-employment checks must include the following —

(a) checks required under the *Child Protection (Working with Children) Act 2012* and the *National Disability Insurance Scheme (Worker Checks) Act 2018*,

(b) professional reference checks with previous or current employers,

(c) verification of qualifications.

Verifying the WWCC online

Did you know a Working With Children Check must be verified by the employer? Verifying makes the link between the worker and organisation in our continuous monitoring system. If your worker becomes barred in the future, we will let you know immediately and advise you to remove the person from child-related work.

SSRC providers must have clear policies and procedures to make sure that the required checks are completed before a staff member is allowed to work with children.

Providers should make sure that staff have relevant skills, training and qualifications to work with vulnerable children. Making sure that staff have the right skills and training is an important way for SSRC providers to reduce risks of harm for children in SSRC. For example, staff who have only worked with adults in a disability training may not have the relevant experience to understand the needs and behaviours of children without proper training.

SSRC providers must register with the OCG to verify the WWCC details of people they engage in child-related work. Verifying a worker or volunteer lets the OCG know who works for an organisation, and allows the OCG to advise organisations if a person becomes barred from work in the future. Verifying is a legal requirement and there is a fine for not verifying. More information is available on the OCG website.

For more information, see the OCG's handbook Child Safe Recruitment and the Working with Children Check: A handbook for child-related organisations.

Providers should make sure that staff have relevant skills, training and qualifications to work with vulnerable children.

Section 23 Training

Section 23 Training

(1) The principal officer of an entity providing specialised substitute residential care for a child must ensure the entity provides—

(a) child safety awareness training to staff and volunteers, including training in identifying and reporting risks of significant harm to children, and

(b) regular supervision of, and support to, staff caring for children in specialised substitute residential care.

(2) Child safety awareness training must be completed before the staff member or volunteer commences providing care to a child in specialised substitute residential care.

SSRC providers should specify minimum training requirements for their staff, both during induction and ongoing, to make sure that these requirements are met.

Providing support to staff caring for children can include but is not limited to making sure that:

- adequate resources are provided to staff
- work environments are safe for staff to work in
- appropriate numbers of staff are scheduled to work each day.

A range of resources to support child safety awareness are available on the OCG website.

Part 7: Miscellaneous

Section 24 Record keeping

SSRC providers must maintain records of practice relevant to the safety, welfare and well-being of children in the SSRC provider's care. At a minimum, SSRC providers must retain written records, including hard copy and electronic records, that include:

Section 24 Record keeping

(1)

(a) information obtained in the intake, assessment and service planning processes,

(b) details of the services the entity has agreed to provide to the child and the child's parents,

(c) consents given by the parents of the child,

(d) the responsibilities of the parties involved in providing or supporting the provision of specialised substitute residential care to the child,

(e) the child's case plan and each review of the plan,

(f) records about the safety, welfare and wellbeing of children in the specialised substitute residential care provider's care.

SSRC providers must provide to a child's parents hard or electronic copies of the records referred to in (b), (c) and (d) above. See the *State Records Act 1998* for other record keeping obligations.

All of the above records must be made available to the Children's Guardian for inspection upon request.

Record keeping requirements under the SSRC Code of Practice should be carried out in addition to any other record keeping requirements that an SSRC provider may be subject to, such as from a funding body or other regulating agency.

SSRC providers should maintain appropriate records of internal processes, including:

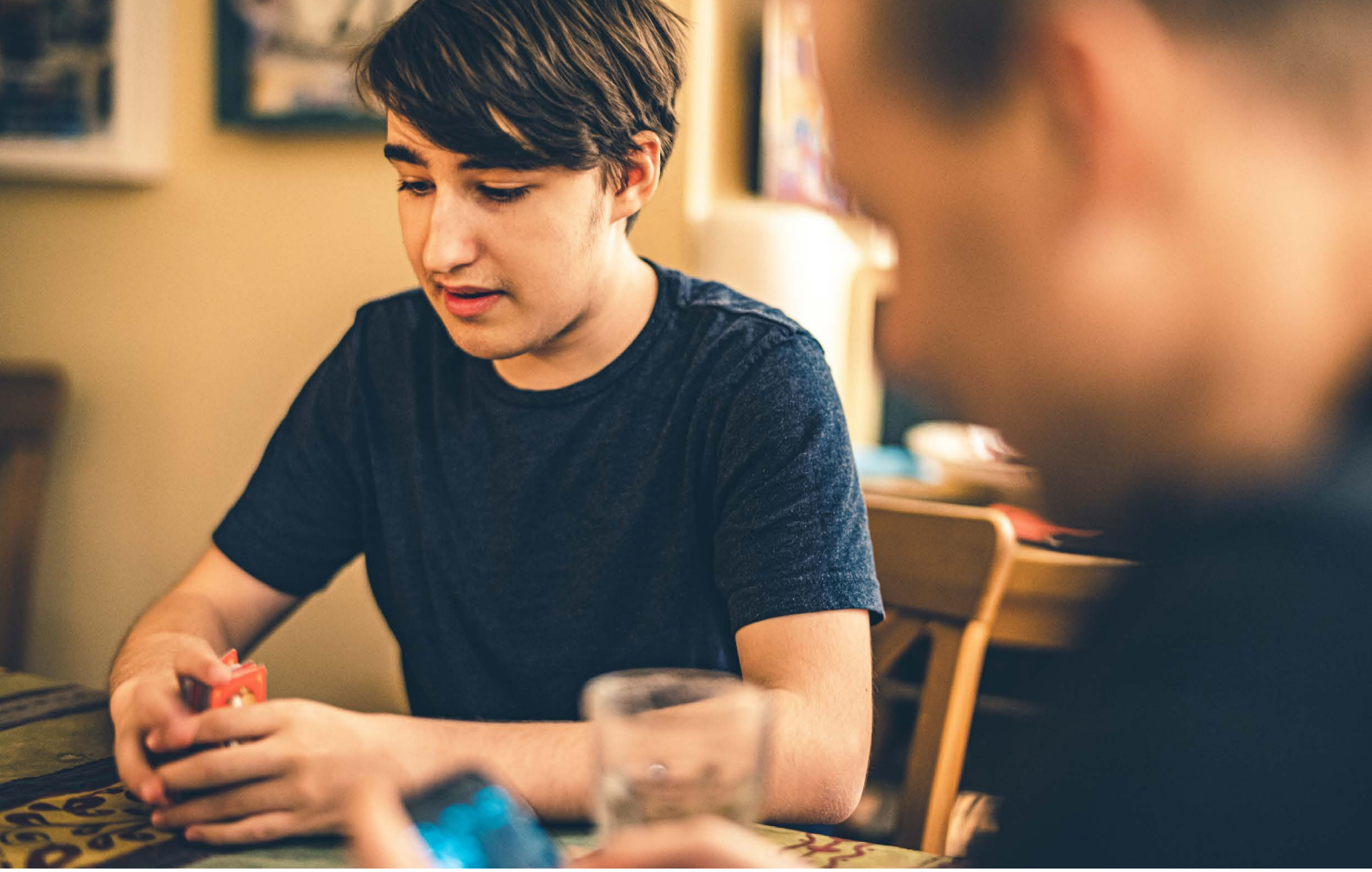
- records of any complaints made and how they have been addressed
- records of which staff have access to the SSRC Register and who is listed as the SSRC Coordinator with the OCG
- signed privacy declarations for all staff members
- Working with Children Check expiry and verification dates.

Due to the sensitive nature of the information that SSRC providers generate and obtain, SSRC providers must ensure that all information is kept securely and in accordance with relevant privacy laws, including the *Privacy and Personal Information Protection Act 1998, Health Records and Information Protection Act 2002* and *Commonwealth Privacy Act 1988*.

Commonwealth privacy legislation recognises that people have a general right to access and correct information that is held about them. Where a person applies to an SSRC provider requesting access to information or corrections to information held by the provider, the SSRC provider should consider any relevant legal obligations, including obligations under privacy laws.

As SSRC providers need to collect and use a range of personal information under the SSRC Code of Practice and to deliver services to children, it is best practice to regularly review the kinds of information collected and used, and ask questions such as:

- What is this information used for? What could this information be used for?
- Do we need to collect this information?
- Who has access to this information, and should they have access to this information?
- What could happen if this information was to be revealed or transmitted without proper authorisation?
- What authorisation do we have to collect this information? Have we obtained consent to collect this information?



Section 25 Child leaving SSRC

Section 25 Child leaving specialised substitute residential care

(1) The principal officer of an entity providing specialised substitute residential care for a child must ensure that at the end of the care the child is released to the care of a parent of the child or a person authorised by a parent of the child.

(2) If the parent of the child refuses to resume the care of the child, the principal officer must —

(a) report the matter to the Child Protection Helpline, and

(b) arrange short-term care or an alternative emergency placement for the child.

(3) The short-term care or alternative emergency placement must, if practicable, be arranged in collaboration with the parents of the child.

(4) The principal officer must ensure the specialised substitute residential care register is updated with information about the end of the provision of the specialised substitute residential care for the child within 5 business days.

If a child's parents are unwilling to resume providing shelter, food and supervision for a child at the conclusion of a SSRC placement, the SSRC provider should either attempt to continue the placement for a short period or assist the parents in accessing an alternative emergency placement while the child's longer-term care arrangements are settled.

An SSRC provider must also urgently notify the DCJ office closest to where the family resides if a child's parents are refusing to resume care. DCJ, in consultation with the child and their parents, will then consider whether there are appropriate additional or alternative services and supports that could be provided to support the child remaining with their family.

When a child in SSRC turns 18 years old, the SSRC provider must update the SSRC register within 5 business days after the child's 18th birthday with the date of the child's 18th birthday as the date on which SSRC ceased to be provided for the child. They may remain in the care of the agency, but for the purposes of the SSRC register, they are no longer in SSRC.

Any current supervision or case plan notification should also be surrendered. The relevant agency must contact the OCG to surrender any such notification.

Section 26 Reporting

Mandatory reporters must report to the Child Protection Helpline where they have reasonable grounds to suspect that a child is at risk of significant harm, and those grounds arise during the course of, or from, their work.

Under section 27 of the *Children and Young Persons (Care and Protection) Act 1998*, a person who delivers respite services or who holds a management position at an SSRC provider are mandatory reporters.

A child is at risk of significant harm where:

- their parents or carers are not meeting or are at risk of not meeting their basic physical or psychological needs – this includes cases where care is relinquished without alternative care arrangements being in place
- their parents or carers are not and are unable or unwilling to arrange necessary medical care
- they are at risk of physical or sexual abuse or ill-treatment
- the behaviour of their parents or carers towards them causes or risks them suffering psychological harm
- there are incidents of domestic violence where the consequence is the child or young person is at risk of serious physical or psychological harm.

It is a crime under the *Crimes Act 1900* section 43B for certain persons to fail to reduce or remove the risk of a child becoming the victim of a child abuse offence.

The principal officer of an entity providing SSRC must:

Section 26 Reporting

(2)

(a) ensure the staff of the entity understand their mandatory reporting obligations, and

(b) notify the Children's Guardian of all reportable allegations and convictions against a person engaged by the entity whether arising from the person's work or otherwise,

(c) report allegations of reportable incidents involving children who are NDIS participants to the NDIS Quality and Safeguards Commission.

The *Children and Young Persons (Care and Protection) Act 1998* protects the identity of anyone who makes a report to the Child Protection Helpline or a Child Wellbeing Unit. A reporter's identity may only be disclosed to a law enforcement agency in very limited circumstances. This makes sure that people who make reports to the Child Protection Helpline or a Child Wellbeing Unity in good faith are protected from any criminal, civil or disciplinary action in connection with that disclosure.

It is a crime under the *Crimes Act 1900* section 43B for certain persons to fail to reduce or remove the risk of a child becoming the victim of a child abuse offence. It is also a crime under section 316A to fail to report child abuse offences. Allegations that a person has failed to reduce or remove the risk of a child becoming the victim of a child abuse offence or has failed to report a child abuse offence are also reportable allegations that are notifiable to the OCG.

More information on mandatory reporting is available on the DCJ website.

If an SSRC provider has concerns about a child or young person's safety in their home environment or elsewhere outside the SSRC location, it is important to liaise with the Child Protection Helpline and the Police if necessary, rather than making decisions about the child's care on the parents' behalf.

Section 27 Behaviour support

Section 27 Behaviour support

The principal officer of an entity providing specialised substitute residential care for a child must ensure behaviour support for children in specialised substitute residential care is delivered consistently with obligations imposed by relevant legislation.

The term 'behaviour support' has both a broad day-to-day definition, and a clinical definition in SSRC.

Generally, the day-to-day supports that SSRC providers plan and provide to assist children to manage their behaviour are a form of behaviour support. This broad definition could include:

- structured timetables
- de-escalation strategies
- proper nutrition
- other strategies a parent could use to provide structure and support.

It is important that all SSRC providers engage in planning with the child and their parents to manage behaviours in this day-to-day sense in order to provide behaviour support as part of service planning.

The clinical form of behaviour support includes those strategies that are recommended by a qualified behaviour support expert as part of a behaviour support plan (BSP).

Behaviour support experts include:

- psychologists
- occupational therapists
- social workers
- other professionals with specialist training and expertise in behaviour support.

These plans are generally designed to address more challenging behaviours. It is particularly important that BSPs including restrictive practices such as psychotropic medications are developed by qualified experts.

SSRC providers must be registered NDIS providers in order to provide behaviour support services or implement restrictive practice, and where a BSP is in place will need to work with the experts who developed it to understand and implement strategies appropriately and to incorporate them into day-to-day support for the child.

Developing and implementing behaviour support plans

Behaviour support is regulated by the NDIS Commission. BSPs must be developed by either NDIS behaviour support practitioners or by qualified staff from DCJ when DCJ is providing support to the child and family. SSRC providers may be registered NDIS behaviour support practitioners or 'implementing providers' when a child has a BSP in place.

Where a BSP is in place, it is the obligation of the SSRC provider to implement it and act in accordance with the BSP.

While the SSRC Code of Practice does not require SSRC providers to cover behaviour support practices in their policies and procedures, SSRC providers who provide behaviour support must be registered with the NDIS Commission and the NDIS Commission may require SSRC providers to have certain policies and procedures as part of registration with them. It is important to contact the NDIS Commission for the most up to date information.

It is best practice even for SSRC providers who do not register with the NDIS Commission to have policies outlining what constitutes a prohibited practice and limitations relating to the use of any restrictive practices.

More information on behaviour support, restrictive practice and BSPs can be found on the NDIS website.

Behaviour support is about creating individualised strategies for people with disability that are responsive to the person's needs, in a way that reduces and eliminates the need for the use of regulated restrictive practices.

Behaviour support focuses on evidence-based strategies and person-centred supports that address the needs of the person with disability and the underlying causes of behaviours of concern, while safeguarding the dignity and quality of life of people with disability who require specialist behaviour support.

Both specialist behaviour support providers (who engage NDIS behaviour support practitioners), and providers who use regulated restrictive practices (implementing providers), must meet the requirements outlined in the *National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018*.

Behaviour support is about creating individualised strategies for people with disability that are responsive to the person's needs, in a way that reduces and eliminates the need for the use of regulated restrictive practices.

Notification of deaths of children

Another important obligation for SSRC providers outside of the SSRC Code of Practice is to notify the OCG and NDIS of the death of a child or young person in SSRC, under section 8ZB of the Act.

Section 8ZB Notification of deaths of children in specialised substitute residential care

If a child dies while in specialised substitute residential care, the principal officer of the entity providing the specialised substitute residential care must immediately give notice of the death to the following persons—

(a) the parents of the child, if the parents can reasonably be located,

(b) the Children's Guardian,

(c) the Coroner.

SSRC providers can notify the OCG by email if outside of business hours with the subject line: **SENSITIVE NOTIFICATION**. In the body of the email please note that the child has passed away and include:

- Child's details
  - Name of child
  - Date of birth
  - Date of death
  - Gender
  - NDIS participant (where relevant)
- Placement details
  - SSRC agency name
  - SSRC Register child reference (CGVP number)
  - SSRC agency contact person and their phone number and email
  - Agency with case management for the child (where relevant)
  - Whether other children are in the same placement as this child, including details such as any relation to the subject child
  - Circumstances of the death
- Reporting requirements
  - Date parents notified
  - Date Coroner notified
  - Date DCJ notified, where DCJ are involved in supporting the child

Alternatively, SSRC providers can call the SSRC team at the OCG on 02 8219 3798 and request a call back about a sensitive notification. Please ensure that you state it is a sensitive notification so that the team prioritises the call.

Additionally, the death of an NDIS participant arising in the context of NDIS funded supports or services must also be reported to the NDIS Commission as a reportable incident. More information about reportable incidents is set out above in 'When risks are identified'.

Non-compliance with the SSRC Code of Practice

4

The OCG is focused on cooperation and capability development for SSRC providers, and will work with SSRC providers to improve the quality and safety of services they provide to children and young people.

The OCG conducts monitoring and compliance activities according to a responsive, risk-based approach to keep children safe by making sure SSRC providers understand and comply with their legal obligations under the Child Safe Scheme, including the SSRC Code of Practice. SSRC providers must participate in any relevant monitoring activities.

These activities can include:

- desktop audits of policies, processes and procedures
- telephone or online interviews with the head of the agency
- site visits
- file audits, including records required under the SSRC Code of Practice
- review of information and records kept.

Where an SSRC provider is not compliant with the Child Safe Scheme or SSRC Code of Practice and their non-compliance may result in serious risk to the safety of children and young people, the OCG may conduct an investigation under section 8DA and part 9A of the Act to determine if an enforcement action is necessary.

An enforcement action can include:

- a compliance notice
- an enforceable undertaking.

Where a compliance notice is issued or an enforceable undertaking is entered into, details will be published on the OCG website.

If an SSRC provider fails to comply with a compliance notice or enforceable undertaking, the Children's Guardian may issue penalty notices.

SSRC providers can request further assistance and advice at any time by emailing the OCG.

The OCG has published a factsheet about monitoring activities for SSRC providers. More information about the OCG's approach to compliance and enforcement is available on the OCG website.

Appendix A: SSRC processes

Time (days)	Tasks	Office of the Children's Guardian (OCG)	SSRC Providers	
0	INTAKE AND ASSESSMENT		**SSRC Provider** Conducts intake and assessment and commences service planning	Assess child or young person and parents and identify services to be provided
				Checks placement history for number of days already in care, supervision arrangements and case plan details if applicable
				Contacts other agencies for information if applicable
				Informs/involves child/young person and parents
				Enters placement information on SSRC Register
60		OCG alerts registered Principal Care Agency that supervision may be required		
90	SUPERVISION	If supervision has not been arranged the OCG may report Risk of Significant Harm	**Principal Care Agency** Arrange supervision of child/young person with a designated agency	Informs child/young person and parents of supervision prior to start
				Notifies OCG if supervision not arranged
			Supervising Agency Responsible for ongoing supervision	Enters supervision information on SSRC Register
				Advises OCG if supervision ceases
150		OCG alerts supervising agency and principal care agency that a case plan may be required	**Principal Care Agency** Develops and implements case plan	Involves child/young person and parents
				Consults with other service providers involved in the child/young person's care or support where applicable
				Reviews case plan at least annually, or where circumstances change
180	CASE PLANNING AND REVIEW	If case plan has not been arranged the OCG may report Risk of Significant Harm	**Supervising Agency** Monitors case plan development and continues to monitor review compliance	Approves case plan
				Enters case plan information on SSRC Register
				Advises OCG if a case plan has not been developed

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