GOOD PRACTICE GUIDELINES FOR WORKING WITH UNACCOMPANIED CHILDREN 12 – 15 YEARS ACCESSING SPECIALIST HOMELESSNESS SERVICES (SHS)

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PREFACE

Yfoundations is the peak body organisation representing youth homelessness in NSW. Yfoundations work collaboratively with members, non-government organisations (NGOs), government departments and community members to provide policy and advocacy, services, health projects, and research and sector development.

Through various discussions and consultations with the membership of Yfoundations and the Specialist Homelessness Services (SHS) sector, a need was identified for greater consistency, transparency and accountability across services working with and supporting unaccompanied children 12 – 15 years of age.

In March 2016, Yfoundations initiated consultations with the SHS sector to gain a broader perspective and understanding of what services required to assist in informing internal policies and procedures, so that best practice could be consistently achieved and shared. The Guidelines recognise the existing high standard of work taking place in the SHS sector and aim to record and publicise this, as well as build on this to ensure consistency and excellence in service provision.

The Guidelines are a companion resource to support the following Family and Community Services (FACS) documents:

- **Draft protocol for responding to unaccompanied children and young people 12– 15 years of age who are homeless or at risk of homelessness**
- **Unaccompanied Children and Young People 12–15 Years Accessing Specialist Homelessness Services Policy**
- **Homeless Youth Assistance Program Service Delivery Framework**
- **Specialist Homelessness Services Practice Guidelines**
- **Specialist Homeless Services Case Management Resource Kit**
- **The Children and Young Persons (Care and Protection) Act 1998 (the Act)**

The Guidelines will continue to be reviewed and updated as required in response to changing legislation, policies and service delivery requirements. Any changes will be carried out in consultation with FACS and SHS supporting unaccompanied children 12 – 15 years.

ACKNOWLEDGEMENTS

Yfoundations developed the Good Practice Guidelines for working with Unaccompanied Children 12 – 15 years accessing Specialist Homelessness Services with funding from the Department of Family and Community Services. Yfoundations would like to acknowledge Family and Community Services for their input in providing feedback on the Guidelines.

Yfoundations would like to recognise the valued time and effort contributed by all the youth Specialist Homelessness Services involved in consultations focussed on developing and guiding this work. In particular, Yfoundations recognises the valuable and significant contribution of the Reference Group who provided expertise and constructive feedback to further refine the Guidelines.

Additionally, Yfoundations would like to acknowledge the support of our industry partners, DVNSW and Homelessness NSW, for their extensive involvement and expertise in providing direction on the Guidelines.

Finally, Yfoundations would like to pay respect to all the children and young people experiencing homelessness or at risk of homelessness, accessing Specialist Homelessness Services. It is the hope of Yfoundations that these Guidelines will positively impact on practice in order to create consistency and contribute to increasing successful outcomes for unaccompanied children 12 – 15 years accessing Specialist Homelessness Services.

This project was funded by NSW Family & Community Services

The development of the good practice guidelines is a project of the Industry Partnership, which is a partnership between Homelessness NSW, DV NSW and Yfoundations.

1. INTRODUCTION

1.1 BACKGROUND

In NSW, 40 youth specific SHS receive funding that includes varying types of support for children 12-15 years. In 2013-14, data from SHS showed that 1,200 children, 12 to 15 years, accessed SHS.

In June 2014 the Minister for FACS announced $27 million over three years under the Homeless Youth Assistance Program (HYAP) to deliver targeted service responses tailored to the specific needs of unaccompanied children 12 – 15 years who are homeless or at risk of homelessness. HYAP funds services to deliver support and accommodation models, with the aim of safely and effectively reconnecting unaccompanied children 12 – 15 years of age with their families or wider support networks; or providing them with the necessary support if they are unable to return home.

These guidelines have been developed to support good practice in HYAP and SHS supporting children 12 – 1 5 years old.

1.2 PURPOSE

The key purpose of the Guidelines is to create consistency in practice and inform policies and procedures for all SHS working with and supporting unaccompanied children 12 – 15 years. The Guidelines aim to provide clarification and support for services working with this group, taking into account that unaccompanied children 12 – 15 years are a unique cohort with distinctive experiences, strengths and developmental needs and therefore require service providers to have specific and relevant skills to provide tailored, holistic and outcomes-focused service responses. Service responses for this cohort will share some of the characteristics of wider homelessness responses but are targeted specifically to the unique developmental needs of children 12 – 15 years.

The Guidelines have been developed for workers who support unaccompanied children 12 – 15 years in Specialist Homelessness Services. This includes, but is not limited to:

- CEOs, operational managers & team leaders
- Case managers
- The clinical lead and/or therapeutic workers
- Youth workers
- Residential staff
- Family mediation workers
- Family support workers

[1] VITIS, L., GRONDA, H. and WARE, V. A. 2010. International Rough Sleeping. Melbourne: Australian Housing and Urban Research Institute (AHURI), Research Synthesis Service for the Australian Government, Melbourne, Australia.

[2] McMurray-Avila, M. (2001). Organising Health Services for Homeless People: A Practical Guide. Nashville, TN: National HCH Council.

[3] Phillips & Parcell (2012). The Role of assertive Outreach in ending 'rough sleeping' https://www.ahuri.edu.au/__data/assets/pdf_file/0010/2062/AHURI_Final_Report_No179_The_role_of_assertive_outreach_in_ending_rough_sleeping.pdf

1.3 DEVELOPING THE GUIDELINES

The Guidelines were developed through a process of consultations with the SHS sector and relevant stakeholders. Yfoundations utilised varying methodologies to inform the Guidelines. These included:

- Conducting forums and individual consultations with SHS providers working with unaccompanied children and young people 12 – 15 years to identify gaps within practice and policy. Consensus was established that guidelines of good practice would be a useful tool to assist in gaining consistency and improvement in practice across the SHS sector.
- Conducting a Literature Review examining and evaluating national and international evidence pertaining to best practice principals and guidelines for working with children and young people who are homeless or at risk of homelessness.
- Consultations with the districts, including follow up calls and emails.
- Conducting an online survey seeking feedback regarding the outcomes, and identification of any further gaps in practice.
- Establishing a Reference Group to further refine and assist in finalising the Guidelines.

1.4 RELATIONSHIP BETWEEN THE GUIDELINES AND THE SHS PRACTICE FRAMEWORK

The Guidelines are intended to complement the SHS Practice Guidelines and the SHS Service Delivery Framework, albeit with a targeted focus on unaccompanied children 12 – 15 years who are homeless or at risk of homelessness. This is achieved by incorporating principles based on connection with family, community, education and employment, service quality, industry and workforce development and person-centred and collaborative practice. Principles are also aligned with the paradigm of the four core service responses:

1. Prevention and early intervention
2. Rapid re-housing
3. Crisis and transitional accommodation
4. Intensive responses for complex needs

SHS are part of the broader service system response for people experiencing or at risk of homelessness. Unaccompanied children 12 – 15 years are not a designated target group of the SHS program, however they do seek assistance from SHS providers. In response, FACS developed the 'Unaccompanied Children and Young People 12 – 15 Years Accessing Specialist Homelessness Services Policy', a subsection of the SHS Practice Guidelines. This policy provides parameters within

which SHS, FACS and the broader service system for young people, work collaboratively to meet the needs of unaccompanied children 12 – 15 years who are homeless or at risk of homelessness.

1.5 DEFINING THE COHORT

The Children and Young Persons (Care and Protection) Act 1998 (the Act) identifies a person under 16 years of age as a child. 'Unaccompanied children' refers to all children and young people aged 12 to 15 years who request assistance from SHS or HYAP services on their own, without a parent or guardian. It includes children who are living in unstable home environments, sleeping rough, in homelessness shelters and those who couch surf at the homes of friends, relatives or acquaintances. In accordance with the Act, a parent retains legal responsibility for a child under 16 years of age unless a court order has allocated parental responsibility to the Minister for FACS or another person. For the purpose of this document the term 'children' will be used herein to describe the target group of unaccompanied children and young people 12 – 15 years accessing SHS.

1.6 THE DISTINCT DEVELOPMENTAL NEEDS OF UNACCOMPANIED CHILDREN

Unaccompanied children are a highly vulnerable client group at risk of becoming disconnected from their families and wider support networks. These children often experience a range of interrelated and compounding risk factors, including disengagement from education, interactions with the criminal justice system, the onset of mental illness and mental health issues, drug and alcohol misuse and the experience of trauma. Most importantly these children have distinctive development needs that differ from young people 16 years and over. This distinction must be acknowledged and accommodated by SHS and FACS so that appropriate support services can be provided to meet the specific developmental needs of this group. Furthermore is it essential that services working with these children and young people have appropriate skill sets, funding and service supports in place to meet this requirement.

1.7 WORKING TOWARDS CREATING STABLE LONG-TERM POSITIVE ACCOMODATION OUTCOMES FOR UNACCOMPANIED CHILDREN 12 – 15 YEARS

The aim of SHS working with unaccompanied children 12 – 15 years is to work towards gaining stable, positive, long-term accommodation outcomes for children, in which family reunification is considered the priority. It is imperative that SHS is seen as a short-term measure for children where family reunification is possible. Children may only stay in SHS for longer than 6 months when it has

been identified that family reunification is possible. When family reunification is not possible, service providers are to advocate for a longer term, more suitable and stable accommodation response that is in the best interests of the child. When a child can no longer return to their family, SHS will work with FACS to ensure the child is provided with stability as soon as practicable. Districts are to develop protocols, which outlines specifically how to support services when this situation arises to ensure the child is not exposed to a drawn out process where no one takes responsibility for their care. Trauma informed practice requires that children are kept informed of accommodation support and timeframes around any movement of accommodation at all times. Creating a predictable environment for children forms an important part of working from a trauma informed care perspective.

1.8 LIMITS AND INTENDED APPLICATION OF THE GUIDELINES

Consultations conducted in the development of the Guidelines, revealed that, despite the provision of the 'Unaccompanied Children and Young People 12 – 15 Years Accessing Specialist Homelessness Services Policy' considerable perplexity and ambiguity remains regarding responsibility of care and most suitable alternative placement options when family reunification is not possible in the short term. The Guidelines attempt to define good practice when working within these undefined parameters. However, it will be imperative that policy continues to be reviewed and refined collaboratively by FACS and SHS/HYAP, so that clarity is achieved regarding the roles and responsibilities of the department and SHS/HYAP service providers when supporting unaccompanied children accessing SHS. Refining policy and providing clarity is imperative so that the overriding objective of ensuring safety and wellbeing of unaccompanied children 12 -15 years who are homeless or at risk of homelessness can be most effectively met.

The Guidelines do not provide an exhaustive list of every aspect of service delivery but are intended to provide a benchmark to enhance or maintain quality and consistency of practice across the SHS sector. The Guidelines are based on evidence obtained from a literature review, examining good practice on a national and international level. They also reflect the exceptional practices that are already effective within the SHS sector.

Establishing if a practice is truly good practice requires assessment in all contexts in order to be deemed appropriate. Therefore, it should be noted, that as services and models of practice differ across the SHS sector, all recommendations prescribed within the Guidelines may not apply in every setting, and should be adapted to suit different models of service delivery.

2. CONCEPTS AND DEFINITIONS

CONCEPTS

The relationship between children's right, social justice and decolonising practice are at the centre of design of the Good Practice Guidelines.

2.1 CHILDREN'S RIGHTS

The underlying principle of the Guidelines is that all children have the right to special protection because of their vulnerability to exploitation and abuse. The Convention on the Rights of the Child (CRC) is the main international human rights treaty, and sets out the civil, political, economic, social, health and cultural rights of children. Australia ratified the CRC in December 1990, and therefore Australia has a duty to ensure that all children in Australia enjoy the rights set out in the treaty.[1]

Children experiencing homelessness or mental health issues, children with a disability, children in immigration detention, and Indigenous children can be particularly at risk of falling through the gaps. It is essential that SHS operate within the Children's Rights Framework and embed these rights into service delivery. For services to adopt this framework it is necessary that they are aware of **The National Framework For Protecting Australia's Children 2009–2020**.

2.2 SOCIAL JUSTICE

A social justice framework that focuses on the principles of access, equity, equality and participation underpins the Guidelines. The Federal Government's **Social Justice Strategy** was developed in recognition of social inequality between groups of people based on inadequate income, disability, race, location, gender, sexual preference and age. The strategy was introduced to ensure that all people, including children, are able to participate fully as citizens in the economic, social and political life of Australia.

The ethnic, racial and religious diversity of contemporary Australia means that there exist barriers of language, culture or prejudice, which can generate inequalities. The Federal Government's Social Justice Strategy seeks to redress such inequities that continue to exist in Australian society. It is important to ensure that all SHS have well-developed and implemented policies which seek to balance inequalities and ensure resources are in place to support minority groups.

2.3 DECOLONISING PRACTICE

Decolonising practice forms part of working within a social justice framework. It recognises the devastating and lasting

[1] Australian Human Right Commission, 'About Children's Rights', viewed on 5 May 2017, <https://www.humanrights.gov.au/our-work/childrens-rights/about-childrens-rights>.

impact of colonisation on the wellbeing of Aboriginal and Torres Strait Islander peoples of Australia and attempts to redress this in current practice and policy by appreciating the key distinctive cultural and social determinants that contribute to Aboriginal health and wellbeing.

Decolonising practice is supported by the United Nations Declaration on the Rights of Indigenous Peoples (2007), and is considered fundamental in improving the health circumstance of Indigenous peoples across the globe and in Australia.[2] Decolonising practice actively confronts racism and discrimination and recognises that Indigenous people's health is inextricably linked not only to their collective rights to land and natural resources, but also to the maintenance and application of traditional knowledge and contemporary cultural practices.[3]

DEFINITIONS

2.4 CULTURALLY AND LINGUISTICALLY DIVERSE (CALD)

Culturally and linguistically diverse is a broad and inclusive descriptor for communities with diverse language, ethnic background, nationality, dress, traditions, food, societal structures, art and religion characteristics. This term is used broadly and often synonymous with the term 'ethnic communities'. CALD is the preferred term for many government and community agencies as a contemporary descriptor for ethnic communities.[4]

2.5 SEX AND GENDER DIVERSE

Yfoundations recognises that not all children ascribe or fall into categories that are outlined in the LGBTIQ (lesbian, gay, bisexual, transgender, intersex and queer) term. The term sex and gender diverse is used to allow children to ascribe their own unique sexualities and genders.

2.6 RISK OF SIGNIFICANT HARM (ROSH)

Significant harm has been defined in the Child Wellbeing and Child Protection Interagency Guidelines as 'sufficiently serious to warrant a response by a statutory authority irrespective of the family's consent. What is significant is not minor or trivial and may be reasonably expected to produce a substantial and demonstrably adverse impact on the child or young person's safety, welfare or wellbeing, or in the case of an unborn child, after the child's birth'.[5]

2.7 DUTY OF CARE WHEN WORKING WITH CHILDREN

Duty of care applies to a range of situations and can be briefly described as an obligation that a sensible person would

[2] Australian Human Rights Commission, 'United Nations Declaration on the Rights of Indigenous Peoples', viewed on 5 May 2017, <https://www.humanrights.gov.au/publications/un-declaration-rights-indigenous-peoples-1>.

[3] P Dudgeon & R Walker, 'Decolonising Australian Psychology: Discourses, Strategies, and Practice', Journal of Social and Political Psychology, vol. 3, no. 1, 2015, pp. 276–297.

[4] Ethnic communities council of VIC, 'ECCV Glossary of Terms', October 2012

[5] NSW Government, Family and Community Services, 'Child Wellbeing and Child Protection – NSW Interagency Guidelines', viewed on 5 May 2017, <http://www.community.nsw.gov.au/kts>.

have in the circumstances when acting toward others and the public. A very high degree of care is owed to children because they have a limited capacity to care for themselves. Failure to discharge this duty is called negligence.

2.8 MANDATORY REPORTING

Mandatory reporting is the legislative requirement for selected classes of people to report suspected child abuse and neglect to government authorities.[6] In NSW, mandatory reporting is regulated by the Children and Young Persons (Care and Protection) Act 1998. Mandatory Reporters include workers from the following professions:

- Welfare (e.g. psychologists, social workers, caseworkers and youth workers)
- Education (e.g. teachers, counsellors, principals)
- Children's services (e.g. child care workers, family day carers and home-based carers)
- Residential services (e.g. refuge workers)
- Law enforcement (e.g. police)

Mandatory reporters in NSW should use the **Mandatory Reporter Guide (MRG)** if they have concerns that a child or young person is at risk of being neglected or physically, sexually or emotionally abused.

The MRG supports mandatory reporters to:

- Determine whether a report to the Child Protection Helpline is needed for concerns about possible abuse or neglect of a child (including unborn) or young person.
- Identify alternative ways to support vulnerable children, young people and their families where a mandatory reporter's response is better served outside the statutory child protection system.

[6] Australian Institute of Family Studies, 'Mandatory reporting of child abuse and neglect CFCA Resource Sheet', May 2016, viewed on 5 May 2017, <https://aifs.gov.au/cfca/publications/mandatory-reporting-child-abuse-and-neglect>.

3. CHILD AND ADOLESCENT DEVELOPMENT IN THE CONTEXT OF HOMELESSNESS

3.1 FOUNDATIONS FOR HEALTHY CHILD AND ADOLESCENT DEVELOPMENT

It is vital that during the formative years of a young person's life that they grow up in an environment that promotes physical, social and emotional wellness. Yfoundations has identified five foundations considered fundamental for the healthy growth and development of all children and young people, and believes each young person should have the opportunity to thrive within each of these domains:

1. Health and Wellness
2. Safety and Stability
3. Home and Place
4. Connections
5. Education and Employment

With access to mechanisms that support the development and attainment of each foundation, a young person is more likely to enter adulthood with the skills, interests, competencies and healthy behaviours necessary to realise and attain their full potential, and build a productive and bright future. These foundations are crucial to young people who are homeless or at risk of homelessness and have been used to direct the Guidelines. They place youth homelessness in a broader context, recognising that it interrelates with a range of issues, and that ending youth homelessness will require coordination across silos. They provide a framework for reaching out to other service areas to explore collaborative and integrated solutions.[7]

3.2 EFFECTS OF TRAUMA ON CHILD AND ADOLESCENT DEVELOPMENT

Research carried out by the Australian Institute of Family Studies has outlined six principles for supporting children in care who have been traumatised:[8]

1. Provide safe environments and rich experiences that stimulate and enrich brain growth.
2. Support children and caregivers to understand the link between traumatic events and cognitive difficulties.
3. Develop and support positive relationships and connections in children's lives.
4. Maintain targeted interventions throughout childhood and adolescence.

[7] Yfoundations, 'The Foundations', viewed on 5 May 2017, <http://yfoundations.org.au/explore-and-learn/publications/the-foundations/>.

[8] S McLean, 'The effect of trauma on the brain development of children: Evidence-based principals for supporting the recovery of children in care', in Australian Institute of Family Studies, June 2016, viewed on 5 May 2017, <https://aifs.gov.au/cfca/publications/effect-trauma-brain-development-children>.

5. Offer all children in care targeted and trauma-specific interventions.
6. Ensure that specific cognitive difficulties are addressed directly.

In understanding brain development, it is important to understand how the effects of trauma, abuse and neglect can result in developmental delays and cognitive difficulties in some children. While children in care or who present to SHS are likely to have been exposed to trauma, they are also likely to have been exposed to a range of other factors that may impact their cognitive development. Early-life adversities for these children may include exposure to alcohol and other substances in utero, domestic and family violence (DFV) and neglect.[9] The potential impact of all these factors must be considered when supporting these children. Children who have been exposed to trauma, neglect or abuse may not be functioning at their chronological age in terms of their physical, social, emotional, and cognitive skills. They may also be displaying unusual and/or difficult coping behaviours.[10]

Research carried out on brain development shows that the environment has a powerful influence on development. Stable, nurturing caregivers and knowledgeable, supportive professionals can have a significant impact on children's development.[11] Focusing on preventing child abuse and neglect, helping to strengthen families through trauma-informed systems and practices, and ensuring that children receive needed services are considered central to best practice.

[9] ibid

[10] Child Welfare Information Gateway, 'Understanding the Effects of Maltreatment on Brain Development', April 2015, viewed 5 May 2017, <https://www.childwelfare.gov/pubPDFs/brain_development.pdf>.

[11] ibid

4. PRACTICE PRINCIPLES & GUIDELINES

The Guidelines are based on 9 practice principles that are considered critical to achieving best practice in supporting unaccompanied children 12 – 15 years. These principles were developed as a result of SHS sector consultations and reviewing the literature. Underpinning all of the principles is an understanding of homelessness and how it specifically relates to the distinctive developmental needs of unaccompanied children 12 – 15 years.

1. TRAUMA INFORMED CARE AND PRACTICE

To provide trauma-informed care to children, young people, and families, professionals must understand the impact of trauma on the child and their development and learn how to effectively minimise its effects without causing additional trauma.[12] Service providers need to understand the client's previous exposure to trauma and how these experiences have shaped their life trajectory. They need to realise the widespread impact of trauma, recognise the signs and symptoms of trauma in children, families, workers, and organisations, understand the potential paths for recovery, and respond by fully integrating knowledge about trauma into policies, procedures and practices.[13]

To reduce the likelihood of re-traumatisation all interactions and engagement with clients should be based on the following core values of trauma informed care:

- Understanding trauma and its impact
- Promoting safety
- Ensuring cultural competence
- Supporting consumer control, choice and autonomy
- Sharing power and governance
- Integrating care
- Supporting healing through relationships
- Believing that recovery is possible.[14]

Practicing trauma informed care requires service providers to appreciate that the vast majority of unaccompanied children 12 – 15 years accessing SHS will have trauma histories. Therefore adopting a systemic approach is imperative to ensure that all children who access SHS will receive services that are sensitive to the impact of trauma. Every part of the service, management and program

[12] Child Welfare Information Gateway, 'Trauma Informed Practice', viewed on 5 May 2017, <https://www.childwelfare.gov/topics/responding/trauma/>.

[13] Substance Abuse and Mental Health Services Administration (SAMHSA), 'Trauma-informed approach and trauma-specific interventions', August 2015, viewed on 5 May 2017, <https://www.samhsa.gov/nctic/trauma-interventions>.

[14] J Bateman, C Henderson & C Kezelman, 'Trauma-Informed Care and Practice: Towards a cultural shift in policy reform across mental health and human services in Australia, A National Strategic Direction, Mental Health Coordinating Council (MHCC), September 2013, viewed on 5 May 2017, <http://www.mhcc.org.au/media/32045/ticp_awg_position_paper__v_44_final___07_11_13.pdf>.

delivery systems need to be assessed and modified to include an understanding of how trauma affects the life of individuals seeking support and the workers delivering the care.[15] An integrated approach to trauma informed care involves having a well developed and consistent organisational culture of non-violence, thoughtfulness and communication and a congruent theoretical framework regarding trauma informed residential care and support for children and young people.[16-17]

Two strategies promote understanding of trauma and its impacts: trauma-informed policies and trauma-related workforce training. Trauma-informed policies formally acknowledge that children have experienced trauma, commit to understanding the impact of trauma, and detail trauma-informed care practices. Additionally, they recognise the impact of vicarious trauma on those who work with the individual, and on the organisation providing the service. Ongoing trauma-related workforce training and support is also essential and should focus on trauma, attachment and resilience.[18] For example, staff members need to learn about how trauma impacts child development and attachment to caregivers.

Youth and DFV

Experiencing and/or witnessing domestic violence is a form of complex trauma. When the traumatic stressors are interpersonally mediated in relationships of care, it is especially damaging and affects early attachment dynamics and brain development and functioning. DFV is a key driver of homelessness among all age groups, but particularly for vulnerable children and young people.

- A system wide coordinated response to DFV that focuses on specific needs of children needs to be developed that is based on trauma informed care and practice.
- Practice should aim to improve access to mental health and trauma specialist services including domestic violence counsellors, family counsellors and psychologists.

[15] Atkinson, 'Trauma informed services and trauma specific care for Indigenous Australian children: Resource sheet no. 21 produced for the Closing the Gap Clearinghouse', Australian Institute of Health and Welfare & Australian Institute of Family Studies, July 2013, viewed on 5 May 2017, <http://www.aihw.gov.au/uploadedFiles/ClosingTheGap/Content/Publications/2013/ctg-rs21.pdf>.

[16] SL Bloom, 'Introduction to Special Section - Creating Sanctuary for Kids: Helping Children to Heal From Violence', Therapeutic Community: The International Journal for Therapeutic and Supportive Organisations, vol. 26, no. 1, 2005, pp. 57–63, viewed on 5 May 2017, <http://sanctuaryweb.com/Portals/0/Bloom%20Pubs/2005%20Bloom%20Intro%20Creating%20Sanctuary%20for%20Children%20TC.pdf>.

[17] P Tomlinson, 'Trauma Informed Care for Homeless Young People: An Integrated Systems Approach', PARITY, vol. 25, no. 7, October 2012, viewed 5 May 2017, <http://lighthouseinstitute.org.au/wp-content/uploads/sites/2/2013/09/gonzalez_tomlinson_klendo_-_an_integrated_systems_approach.pdf>.

[18] K Guarino, P Soares, K Konnath, R Clervil & E Bassuk, 'Trauma-Informed Organizational Toolkit for homeless services', Centre for Mental Health Services, Substance Abuse and Mental Health Services Administration, and the Daniels Fund, the National Child Traumatic Stress Network, and the W.K. Kellogg

PRACTICE GUIDELINES

1.1 SERVICES ARE COMMITTED TO WORKING IN A TRAUMA INFORMED WAY THAT ALIGNS WITH THE CORE VALUES OF TRAUMA INFORMED PRACTICE AND A STRENGTHS-BASED FRAMEWORK

- Safety: The physical and emotional safety of all children in the SHS is ensured. This includes provision of a safe, welcoming environment, where privacy and confidentiality is respected, and clear explanations about the services are provided. Children are asked about what measures make them feel safe, and these measures are consistently, predictably and respectfully implemented. Services are aware of the potential for re-traumatisation through inappropriate work practices and/or any continuing trauma in the person's personal life and therefore implement strategies to protect against this.
- Collaboration: Services maximise collaboration and sharing of power. This involves collaboration with agencies, including expert agencies that can provide specialised advice in trauma care. This also requires comprehensive collaboration with the child and family, to best support and assist the physical, emotional, social, spiritual and cultural wellbeing of the child.
- Trustworthiness: Services maximise trustworthiness through task/role clarity, consistency and interpersonal boundaries. Trustworthiness, quality and safety are imperative in addressing disrupted attachments and relationships.
- Choice: Services maximise the choice and control of the child. Workers involve children in decision making to increase individual control and autonomy and recognise the child's need to be respected, informed, connected and hopeful. In recognising choice, duty of care must also be acknowledged by understanding that the developmental stage and the impact of trauma on a child 12 – 15 years can impact their decision-making abilities. Therefore, workers recognise the important balance between choice, safety, duty of care and legislative responsibilities.
- Empowerment: Services prioritise empowerment and skill building. Workers focus on building therapeutic relationships that promote empowerment and support the strengths and learning of a child. Therapeutic relationships understand past adaptations and coping mechanisms and respectfully support the child in addressing trauma and their journey from victim to survivor.

Foundation, 2009, viewed on 5 May 2017, <http://www.nada.org.au/media/14607/tictoolkitforhomelessservicesusa.pdf>.

1.2 SERVICES INTEGRATE TRAUMA INFORMED CARE INTO ORGANISATIONAL POLICY

- Services have a clear trauma informed care and practice policy, specific to the needs of children 12 – 15 years, that incorporates the core values and best practice principles of trauma informed care.
- Trauma informed care approaches are embedded in policies and workplace practices across the service for consistency at all levels of service provision.
- All workers are informed of the trauma informed care and practice policy.

1.3 SERVICES UNDERTAKE TRAUMA INFORMED CARE TRAINING AND WORKFORCE SUPPORT

- Workers are all adequately trained in trauma informed care and practice. This involves receiving education and training on the prevalence and impact of trauma on children and development, attachment and resilience.
- New workers are briefed in trauma informed care at orientation. Each new employee receives training in trauma informed care within a short time frame, ideally, where possible, within 3 months of commencing employment.
- Services recognise that ongoing trauma-related workforce training and support is essential so there is continuous refreshment of knowledge and practice for all employees operating within a trauma informed care framework.
- Services implement continuous reflective practice evaluating the individual and organisational incorporation of trauma informed care. This may involve developing a checklist that the service can use to ensure they are working within a trauma informed care framework.
- Services have information, for example resource manuals, available for workers to access explaining trauma, trauma informed care and DFV specific to the context of youth homelessness.
- Workers receive training in and have an understanding of trauma related to DFV, and how this specifically impacts the child.

1.4 SERVICES ADDRESS THE IMPACT OF VICARIOUS TRAUMA ON STAFF

- Services have organisational guidelines in place to manage the risk of vicarious trauma as part of the Workplace Health & Safety policy.
- Workers receive regular supervision as part of their work plans to reduce the potential risk of vicarious trauma and to monitor emotional wellbeing and health. Other appropriate support may involve team meetings, debriefing, team leaders/management informally checking in with staff around their emotional wellbeing or providing staff self-care opportunities.

2. CULTURALLY COMPETENT PRACTICE AND CULTURALLY SAFE ORGANISATIONS

Cultural competence requires that organisations have a defined set of values and principles, and demonstrate behaviours, attitudes, policies and structures that enable them to work effectively cross culturally.[19] The intention of culturally competent practice is to create an organisation that is experienced by children as culturally safe. Cultural safety is defined as an environment that is physically, spiritually, socially and emotionally safe, where there is no assault challenge or denial of a person's identity or needs. It is about shared respect, shared meaning, shared knowledge and experience of learning together.[20]

Culturally competent services are respectful of, and specific to, diverse cultural backgrounds. Culture plays an important role in how children who have experienced trauma manage and express their traumatic life experience/s and identify the supports and interventions that are most effective. A lack of awareness about the needs and issues affecting culturally diverse children can result in re-traumatisation and perpetuate damaging stereotypes.

Cultural safety is primarily about examining ones own cultural identity and attitudes, and being open-minded and flexible in attitudes towards people from other cultures. Culturally competent staff are aware of their own cultural attitudes and beliefs, as well as those of the individuals, families and communities they support. They are alert to the legitimacy of inter-cultural difference and able to interact effectively with different cultural groups.[21]

PRACTICE GUIDELINES

2.1 SERVICES PROVIDE A CULTURALLY SENSITIVE AND INCLUSIVE ENVIRONMENT

- Relevant information, symbols, images and objects for specific cultural groups are available and displayed as determined by elders, families and communities from the various cultural backgrounds.
- Children are treated as individuals so that they are not stereotyped according to their cultural background, sexual preference, religious or other affiliation, or individual needs or differences.
- Workers recognise that cultural knowledge, beliefs, values, attitudes and behavior are not equally shared between people of any culture and so avoid making assumptions about the needs of a child.
- Services provide clear information about their service, and have this

[19] National Centre for Cultural Competence, 'Conceptual Frameworks/Models, Guiding Values and Principles', Georgetown University Centre for Child and Human Development, viewed 5 May 2017, <https://nccc.georgetown.edu/foundations/frameworks.html>.

[20] R Williams, 'Cultural safety – what does it mean for our work practice?', Australian and New Zealand Journal of Public Health, vol. 23, no. 2, 2009, pp. 213-214.

[21] Department of Education, Employment and Workplace Relations, 'Belonging, Being and Becoming: The Early Years Learning Framework for Australia', 2009, viewed 5 May 2017, <https://docs.education.gov.au/system/files/doc/other/belonging_being_and_becoming_the_early_years_learning_framework_for_australia.pdf>.

available in relevant community languages and presented in a culturally appropriate way.

- Workers are aware of how culture and their own racial and cultural identities impact on their own values, practice and decision-making.

2.2 THE CULTURAL AND LINGUISTICALLY DIVERSE HERITAGE OF CHILDREN IS RESPECTED

- Organisational policies are implemented that reflect a commitment to providing culturally sensitive services and incorporate cultural knowledge into infrastructure and practice.
- Workers attend training regarding culturally competent practice and how to work with interpreters.
- Workers engage and collaborate with interpreters to best understand and meet the needs of the child.
- Organisational structure and practice allows for children to be able to maintain their dietary customs according to religion or culture. For example, services may offer opportunities for clients to engage in cultural rituals and offer specific foods.
- Services seek and encourage relationships with local community elders and organisations that work with CALD communities.

2.3 A CHILD'S ABORIGINAL CULTURAL AND SPIRITUAL HERITAGE IS RESPECTED

- Services have a written policy that outlines a commitment to providing culturally appropriate services to Aboriginal and Torres Strait Islander children, specific to the region.
- Services create opportunities for Aboriginal voice and presence in an organisation's planning, policies and activities. Services consult with local Aboriginal people, stakeholders and organisations for guidance on policy development and ways in which an organisation can become culturally safe.
- Workers are respectful of Aboriginal culture and recognise how it relates to a child's sense of identity and self-esteem.
- Services develop culturally appropriate ways of working within family and extended family structures and relationships and have a thorough understanding of the complexities of Aboriginal communities and kinship networks.
- Services work in partnership with Aboriginal organisations and provide Aboriginal children with the option of accessing an Aboriginal support service, while respecting that not every Aboriginal child needs or wants to be referred to an Aboriginal practitioner.[22]

[22] NSW Department of Community Services, 'Working with Aboriginal Communities, A Practice Resource', 2009, viewed 8 May 2017,

3. PERSON CENTRED PRACTICE

Person centred practice is about ensuring that the child is at the centre of decision-making processes that affect their life. This ensures each child is supported toward their personal goals, even as they evolve and change, and prevents further traumatisation. Person centred practice has its roots in strength based practice, which focuses on building individual capacities, skills, resilience, and connections to community. The ultimate aim is to understand what each individual child needs to achieve their own personally defined future that is based on individual interests, identity, cultural heritage and aspirations.[23] Person centred practice also recognises and involves other people who make a difference in the child's life, including family, friends and the wider community.

Person centred practices:

- Value a child's role in their family and community;
- Inspire participation and belonging;
- Ensure the child has greater authority over decisions about their lives;
- Promote self advocacy and support children to make positive life choices and informed decisions about their future and reduce reliance on the service system;
- Encourage partnerships between the child, the service, their family and carers, and extended community;
- Ensure support arrangements are personalised to the needs of the child;
- Respect a child's cultural, spiritual, religious, relationship, emotional and physical needs.

PRACTICE GUIDELINES

3.1 SERVICE PROVIDERS IMPLEMENT PERSON CENTRED APPROACHES IN THEIR DAILY PRACTICE

- Workers develop quality relationships with the child that involves listening to and thinking with the child and demonstrating honesty, empathy and open and non-judgemental communication in all interactions.
- Workers respectfully explore a child's circumstances and actively learn what the child wants. This involves asking the child about their personal goals, values and aspirations. Workers respond by providing individualised, flexible and creative supports required for achieving the goals and aspirations identified by the child.
- Workers encourage the active involvement of family, friends, carers, personal supports and community. Workers acknowledge the strengths and skills of parents and families and where appropriate support them to increase their confidence and capacity to respond to the needs of the child.

[23] NSW Department of Ageing, Disability and Home Care, 'Exploring and Implementing Person Centred Approaches: A Guide for NSW Community Participating Program Service Providers', 2009, viewed on 5 May 2017, <https://www.adhc.nsw.gov.au/__data/assets/file/0005/228290/DADHC_PersonCentred201208.pdf>.

- Workers seek feedback from children at all stages and continuously evaluate the support process.

3.2 SERVICES INTEGRATE PERSON CENTRED PRACTICES INTO ORGANISATIONAL POLICY AND PROCEDURES

- Services create a culture that reflects person centre approaches across all levels of the organisation. This requires commitment to change from all service areas so that person centred approaches become embedded into every day practice across the whole organisation.
- Services ensure knowledge and information is available for all staff regarding the implementation of person centred approaches within the service.
- Services develop assessment tools that link client needs to the best service response.
- Services support the training and development of staff to ensure workers have the necessary skills required to develop successful relationships with young people within a person centred practice model.

4. FAMILY, CONNECTION AND ATTACHMENT

Working together with both the child and family to re-establish connection is categorically fundamental to best practice due to the priority for the child to return to family, fostering resilience and attachment.

Connection & resilience

It is vital that all children are given the opportunity to develop and nurture the positive connections in their lives. This may include connections with immediate and extended family, friends, support workers, a mentor, work colleagues, or members of a group (community, cultural or spiritual). Connectedness and belonging promote resilience and social inclusion.[24] The development of positive connections during the formative stages of childhood and adolescence enables a young person to build a strong positive foundation and prepares them for adult life.[25] Feeling connected provides children with the validation and confidence to pursue their goals and is an important factor in overcoming challenges.

Connections between workers and children that are based on consistent and trusting relationships are imperative for best practice. The experience of positive, safe and stable relationships helps children build secure attachments, develop self-confidence, self-esteem and self-reliance and contributes to a strong sense of identity and belonging.[26]

The building of such relationships can

[24] Yfoundations, 'Connections', viewed on 5 May 2017, <http://yfoundations.org.au/explore-and-learn/publications/the-foundations/connections/>.

[25] ibid

[26] K Winter, 'Supporting positive relationships for children and young people who have experience of care', Iriss, February 2015, viewed on 5 May 2017, <https://www.iriss.org.uk/resources/insights/supporting-positive-relationships-children-young-people-experience-care>.

begin to rectify mistrust of services and the trauma of demeaning behaviours and attitudes. This is particularly relevant when children have had previous negative experiences with trusting relationships with adults. Establishing and maintaining trusting relationships between workers and children is essential in assisting the process of working toward family reunification.

Attachment

Attachment is a form of connection important in the development of children and young people. Attachment is described as a long lasting psychological connection with a meaningful person that causes pleasure while interacting and soothes in times of stress. The quality of attachment has a critical effect on development, and has been linked to various aspects of positive functioning, such as psychological well-being. Secure attachment is

associated with less engagement in high-risk behaviours, fewer mental health problems, and enhanced social skills and coping strategies. Confusing, frightening or isolating emotional experiences early in life can create insecure attachments and can result in severe attachment disorders. As most children in care have experienced some form of abuse, neglect and/or trauma, their attachments are inevitably disrupted. Attachment disorders can limit a child's ability to successfully manage their emotions, communicate effectively or build satisfying and meaningful relationships. Therefore, they may need intensive support so that family connection can be re-established, and a return to home is possible.[27]

PRACTICE GUIDELINES

4.1 SERVICE PROVIDERS DEVELOP CONSISTENT AND TRUSTING RELATIONSHIPS WITH CHILDREN

- Workers are available, respectful and honest and engage in positive interactions that include listening, and actively looking for each child's strengths. Workers share an appreciation of those strengths with the child, the child's family and their connections.
- Workers are responsive to a child's interactions and work hard to understand a child's communication (verbal and non-verbal). Workers respond rather than react to challenging behaviours and look behind the behaviour to attempt to understand the stressor or the message it conveys.
- Workers support children to understand and express their feelings appropriately and respect each child's uniqueness, encouraging their choices and feelings.
- Workers encourage independence while communicating that support is available.

[27] M Moretti & M Peled, 'Adolescent-parent attachment: Bonds that support healthy development', Paediatrics & Child Health, vol. 8, no. 8, 2004, pp. 551 – 555, viewed on 5 May 2017, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2724162/>.

- Workers model positive behaviours and positive interactions with everyone within the service.
- Services provide a relaxed atmosphere, demonstrating warmth and welcome.
- Services identify and address commonly cited barriers to developing and sustaining trusting relationships. These may include:
  - Lack of time, training and tools
  - Caseloads that are too high
  - Emphasis on the bureaucratic, form filling aspects of the job
  - A fear of complaints, accusations of over-involvement and adverse emotional impact on workers by forming close relationships with children
  - Management styles that reproduce objective, emotionally detached ways of working

4.2 SERVICE PROVIDERS FOSTER CONNECTIONS

- In collaboration with the child and family, service providers/case managers identify important people in a child's life and actively support and foster these connections where safe to do so.
- Services work towards reconnecting children to their families and wider support networks.
- Services encourage, preserve and support a child's connections to community, culture, stable family, friends and personal networks.
- Services ensure Aboriginal children are supported to maintain connections in a culturally sensitive way.
- Services have the necessary resources and training to support connections relating to CALD children.

4.3 SERVICES RECOGNISE FAMILY RECONCILIATION AND MEDIATION AS AN IMPORTANT FOCUS WHEN WORKING WITH CHILDREN

- Services ensure family reconciliation and mediation occurs when it is identified as safe to do, to enable children to reconnect with their families and wider support networks. This includes working towards opening up lines of communication with the child's family.
- Workers have adequate skills and receive training in effective family mediation and these skills are continually reviewed and updated. Family mediation and reconciliation work is a vital component in creating stability for children and reuniting children and families.
- Services support and encourage family visits/activities.
- Workers incorporate family reconciliation into case plans.

- Family are kept informed of decisions relating to the child when it is identified safe to do so.
- Services collaborate with family services with expertise in family mediation and reconciliation.

4.4 SERVICES PROVIDE THERAPEUTIC SUPPORT TO CHILDREN AND THEIR FAMILIES TO HELP SUPPORT, DEVELOP AND BUILD RELATIONSHIPS IN THE FAMILY

- Services provide clear and consistent communication between children, families and other SHS to help support relationship building.
- Workers receive appropriate training and are knowledgeable about child and adolescent development and the value of adolescent-parent attachment, shifting from a view that assumes adolescence as a period of detachment and rebellion to a view that stresses the importance of staying connected.
- Services provide child and parental interventions that focus on understanding and developing secure attachment and conflict negotiation skills. This includes:
  - Providing parents with solid information on the social and emotional changes that occur during adolescent development and the importance of their continued sensitivity and attunement to their child's needs during this time.
  - Helping parents to reframe the meaning of conflict as an opportunity to build their relationship with their adolescent child by providing in depth support to develop the skills that are necessary to support their children through adolescence.
- Workers provide appropriate referrals, where necessary, to counselling services and/or therapeutic family services.

5. HEALTH, SAFETY AND WELLBEING

It is vital that all young people, particularly during the formative stages of their growth and development, are physically, socially and emotionally well. The World Health Organisation defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".[28] As recognised in the CRC, every young person has the right to make healthy life choices and access health care services when required.[29] To achieve optimum health and wellness children need to feel safe and feel free from harm or risk.[30] Services should have policies in place to adequately address health, safety and

[28] World Health Organization, 'Constitution of the World Health Organization', October 2006, viewed 8 May 2017, <http://www.who.int/governance/eb/who_constitution_en.pdf>.

[29] United Nations, Human Rights, Office of the High Commissioner, 'Convention on the Rights of a Child', 2017, viewed 5 May 2017, <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx>.

[30] Yfoundations, 'Health and Wellness', viewed on 5 May 2017, <http://yfoundations.org.au/explore-and-learn/publications/the-foundations/health-and-wellness/>.

wellbeing concerns, and staff should be aware of the necessary course of action to take in order to address these concerns and enable children to achieve optimal states of health, safety and well being.

Working closely with children, over long periods of time, is common in SHS, especially in residential settings. As a result staff can have significant influence over children's lives. Services working with children should be aware of their increased duty of care, as children are a vulnerable group. Staff should be made aware of current legislation relevant to children and ensure compliance to organisational policies and procedures. It is imperative that all staff are informed about healthy professional boundaries and have the ability to foster healthy positive relationships with children. This acts as both a safeguard for staff and children.

PRACTICE GUIDELINES

5.1 SERVICES SAFELY AND EFFECTIVELY ADDRESS THE HEALTH REQUIREMENTS OF CHILDREN

- All services have health policies and procedures in place. This includes polices and procedures covering the following areas:
  - Safety and security regarding prescribed medications kept on premises.
  - Administration of medication - roles and responsibilities.
  - Children's right in regards to refusing or deciding to stop prescribed psychotropic medication.
  - Parental consent requirement in addressing health needs.
  - There is a member of staff who has completed first aid training on shift at all times in which children have access to. There is a list of all members of staff who have been trained in first aid available to the children. This list is clearly displayed in the service.
  - In the case of an emergency, there is a medical emergency plan in place. All emergency phone numbers are visible and accessible to children and staff.
  - Fire evacuation plans are displayed within the service and all children are aware of protocol regarding emergency exiting.
- Services collaborate between agencies working with children, recognising that information sharing between agencies is an important component of addressing health needs and supporting health plans.
- Services are aware of **Chapter 16A Exchange of Information** relating to health requirements.

5.2 SERVICES EFFECTIVELY SUPPORT CHILDREN WITH A LIVED EXPERIENCE OF MENTAL DISTRESS

- All workers have recognised accredited training in child and adolescent mental health. This training is recorded on each individual staff file.
- Workers are equipped with the necessary skills to recognise possible mental health signs and symptoms.
- Services ensure there is continuous learning, development and refreshment of skills and knowledge amongst workers regarding mental health. This includes regular discussion in supervision, debriefing and team meetings.
- Services have information resources on mental health available to staff.
- Services collaborate with other SHS, health services and other agencies to best support the mental health needs of children.
- Services support and encourage children to engage with mental health support when and where necessary.
- Services have a mental health policy in place that addresses the specific mental health needs of children. (Refer to Resource Manual: 6.1 Mental Health – Model Policy).

5.3 SERVICES ARE CHILD SAFE ORGANISATIONS AND ARE DEDICATED TO PROTECTING CHILDREN

- All workers have mandatory working with children checks. National police checks may also be required where necessary.
- All workers receive recognised accredited training in child protection. This includes but is not limited to knowing when and how to report Risk of Significant Harm (ROSH) and FACS funded SHS Child Protection training.
- All workers are aware that they are mandatory reporters. Mandatory reporters in NSW should use the **MRG** if they have concerns that a child or young person is at risk of being neglected or physically, sexually or emotionally abused. It is recommended that mandatory reporters complete the MRG on each occasion they have risk concerns, regardless of their level of experience or expertise. Each circumstance is different and every child and young person is unique.[31] For all children 12 – 15 years who present unaccompanied at and SHS/HYAP, the MRG must be followed and the child reported to the Child Protection Helpline as soon as possible. The service should keep a copy of their MRG record and document their actions and decisions regarding the child. Where appropriate the reporter should advise the child about the making of a child protection report and explain the process to them in age appropriate language. This will ensure they are included in decision-making about their care.

[31] NSW Government, 'Child Story Reporter', viewed 5 May 2017, <https://reporter.childstory.nsw.gov.au/s/>.

- Services have a clearly written child safeguarding policy, approved by the relevant management body, to which all staff and associates (including partners) are required to adhere, and is easily understood by everyone including children. It should include:
  - A statement setting out the organisation's commitment to protecting all children.
  - What the organisation will do to keep children safe and respond to concerns.
  - Specific supports for children disclosing any form of abuse within the service.
  - Roles and responsibilities relating to curfews in supported accommodation, ensuring all children are accounted for at curfew times. This will include an action plan for when a child cannot be located or contacted at curfew time (for example, contacting family and/or police).
  - A list of the supporting procedures that accompany the policy.
- Everyone supporting children has knowledge of:
  - **Child Wellbeing and Child Protection – NSW Interagency Guidelines**
  - **Keep them Safe:** A shared approach to child wellbeing is the NSW Government's five-year (2009-14) action plan to re-shape the way family and community services are delivered in NSW to improve the safety, welfare, and wellbeing of children and young people.
  - **National Framework for Protecting Australia's Children 2009–2020:** A long-term approach to ensuring the safety and wellbeing of Australia's children and aims to deliver a substantial and sustained reduction in levels of child abuse and neglect over time.
- The service has written guidelines for behaviour (Code of Conduct) that provides guidance on appropriate/expected standards of behaviour of adults towards children, and of children towards other children. This includes guidelines on professional boundaries between staff and children. Where there is any concern or where a staff member is unsure of what constitutes a healthy boundary, this is discussed with manager/team leader. Full reports are drawn up of all observed inappropriate behaviours. (Refer to Resource Manual: 6.2 Professional Boundaries – Model Procedures).
- Services support harm reduction strategies and have harm reduction policies and procedures implemented across the organisation. (Refer to Resource Manual: 6.3 Harm Reduction

– Model Policy).

- Services ensure organisational policies and procedures are inclusive of children of diverse sexualities and genders. This entails policies regarding inclusive language, confidentiality, harassment, housing placements, and bathroom and shower use. Developing and enforcing policies or 'house rules' that reflect these policies can increase the sense of safety and feelings of security for children of diverse sexualities and genders.

5.4 RISK ASSESSMENTS ARE CARRIED OUT ON INTAKE AND SUPPORT PLANS ARE FORMULATED ACCORDINGLY

- Services ensure that there is more than one staff member present at all times where there has been an assessment of risk or unsafe behaviours.
- A behaviour support/risk management plan is developed where a risk is identified that puts the safety of a child or the safety of others at risk. This is also required where a chid is on psychotropic medication.
- Services ensure support plans are person centred and developed collaboratively with all agencies working with the child. Support plans outline the behaviours of concern of a child and what agreed strategies are to be put into place to manage or prevent the behaviour. Plans to de-escalate behaviours are developed using a trauma informed care response.
- All episodes of challenging behaviours are recorded and, where necessary, incident reports are completed.
- Risk assessments and support plans are subject to continuous monitoring and review in collaboration with the child and all agencies supporting the child.

5.5 A SAFE, HOME-LIKE ENVIRONMENT WHERE CHILDREN FEEL SAFE AND RESPECTED IS PROVIDED

- Residential settings reflect a home-like environment as much as is possible. Creating a safe, home-like environment forms part of working from a trauma informed care perspective.
- Children have the right to privacy and to feel safe where they live.
- Policies and procedures are in place regarding entering children's bedrooms and the use of locks on doors so that the environment is predictable for a child.
- Policies and procedures are in place for staff around possible volatile situations for the protection of staff and children.

6. PREVENTION AND EARLY INTERVENTION

SHS working with children need to undertake early intervention approaches that include collaborating with schools and appropriate services that target children at risk of homelessness. Early identification and support can often prevent a situation from escalating and prevent a child disengaging from school. In order to prevent family breakdown, SHS can work with the child and their families to identify risk factors, provide support and open communication pathways before a child leaves the family home.[32] Valuable referral pathways may include school counsellors and children and family services. SHS should also collaborate with local health services, juvenile justice and local police, to identify children who may require extra support and who may be at an increased risk of becoming homeless. This may include working with adolescent mental health teams and alcohol and other drug services supporting families facing addiction issues.

Research has identified that young carers are an extremely vulnerable and disadvantaged group in our community. The average age of young carers is 12 - 13 years.[33] They are often at risk of experiencing poor physical or mental health, impaired psychosocial development, low participation rates in education, training and employment, difficulty and delay in gaining independence and a general lack of choice and opportunity. These factors significantly increase their chances of being economically and socially marginalised, and also place them at higher risk of homelessness.[34] Early intervention work involving accessing specific carer support networks and navigating the service system, is particularly crucial for this group of children.

PRACTICE GUIDELINES

6.1 SERVICES FOCUS ON EDUCATION AS AN IMPORTANT ELEMENT OF PREVENTION AND EARLY INTERVENTION OF HOMELESSNESS

- Service providers work, using strengths based approach, to actively support and encourage children to maintain engagement in education. Children are strongly supported to remain engaged in school and/or training, in a culturally sensitive, trauma informed way. Where this is not possible alternative education pathways are identified that meet the needs of the child.
- Services provide necessary transport and/or financial assistance to and from education/training provider.
- Case plans include a strong focus on engagement in education/training.

[32] NSW Department of Family and Community Services, 'Specialist Homelessness Services – Practice Guidelines', November 2014, viewed on 5 May 2017, <http://www.housing.nsw.gov.au/__data/assets/pdf_file/0009/327996/GHSHPracticeGuidelines.pdf>.

[33] Australian Government, Department of Social Services, 'Disability and Carer. Young Carers Research Project: Final Report', September 2016, viewed on 5 May 2017, <https://www.dss.gov.au/our-responsibilities/disability-and-carers/publications-articles/young-carers-research-project-final-report?HTML>.

[34] ibid

- Services communicate and collaborate with education providers/schools, other agencies and the child's family, where possible, to ensure children are supported in their education/training goals.

7. COLLABORATIVE PRACTICE

Collaborative practice is an ever-emergent process that involves services and organisations working together to achieve common mutual goals. Collaboration relies on openness and knowledge sharing to engender trust, but also some level of focus and accountability from all parties collaborating Working collaboratively provides greater efficiency, access to additional resources and expertise, improved service coordination with better referral pathways, greater innovation and flexibility, and improves positive outcomes and the quality and scope of service provided to children and families that services are working with.[35-36]

Evidence-based assessment of successful collaboration highlights six partnership principles:

1. Recognise and accept the need for partnership
2. Develop clarity and realism of purpose
3. Ensure commitment and ownership
4. Develop and maintain trust
5. Create clear and robust partnership arrangements, and
6. Monitor, measure and learn.[37]

Collaboration with between SHS providers, government and non-government service providers is an important element of working with children and families, and is seen as the cornerstone of best professional practice. It is crucial that SHS workers have a sound understanding of the broader service system, as well as an awareness of gaps, so as to be able to accurately develop an integrated, collaborative, sustainable and holistic service response to a child's individual needs. This is to ensure a safe and dependable experience for clients, particularly important when implementing trauma informed care practices.

SHS supporting unaccompanied children 12 – 15 years will need to liaise and collaborate with the following departments:

- Health
- Education
- Juvenile Justice
- FACS
- Children and Family Services
- Child Protection Services
- External youth and community services
- Broader service system

[35] V Wildridge, S Childs, L Cawthra & B Madge, 'How to create successful partnerships – a review of the literature', Health Information and Libraries Journal, vol. 21, 2004, pp. 3 – 19, viewed on 5 May 2017, <http://onlinelibrary.wiley.com/doi/10.1111/j.1740-3324.2004.00497.x/epdf>.

[36] Centre for Substance Abuse Treatment, 'Chapter 5 – Effective Referrals and Collaborations', Integrating Substance Abuse Treatment and Vocational Services, 2000, viewed on 5 May 2017, <https://www.ncbi.nlm.nih.gov/books/NBK64299/>.

37 Wildridge et al., op.cit.

Collaboration in case planning & coordination

Collaborative practice can involve informal agreements or information sharing such as interagency or network meetings, to more formal collaborative practice regarding case coordination and planning. Case coordination is a fundamental component of the SHS program. It is imperative that case management is delivered in a coordinated and collaborative approach involving multiple service systems so as to provide an integrated and holistic response to the needs of clients.

To support coordination it is essential that each person have 'one case plan' that all collaborators/partners are working from. Individual case plans need to be established based on assessment of the individual needs of the child, and provide a record of the goals and objectives as set out by the child and therefore provide a tool in measuring and tracking positive long-term outcomes for children. Case planning is a participative process that involves the child, their family, carers and other agencies involved with the child. Ensuring active participation of children with disability, Aboriginal and Torres Strait Islander children and children from CALD backgrounds requires specific strategies. The case plan should stipulate timeframes regarding working toward family reunification, and FACS should be informed of the plans in the early stages. As the child's needs change it is necessary to undertake reassessment and the case plan should be reviewed and updated regularly to reflect growth and changing needs.

PRACTICE GUIDELINES

7.1 SERVICES EFFECTIVELY COLLABORATE WITH A NETWORK OF AGENCIES

- Services are committed to working collaboratively, utilising identified partnership principles, to ensure that the child is not subject to fragmented services, that the child does not fall through the cracks between disparate and unconnected agencies, and that the child's needs are addressed holistically.
- Services work to understand the role of the other providers and create an appropriate working relationship with the other providers so the client can most effectively benefit from all.
- Services undertake resource mapping which consists of gathering information about agencies and programs in the community with which linkages can be made to provide collaborative services to clients.
- Services make effective referrals within a network of numerous agencies.

7.2 SERVICES DEVELOP EFFECTIVE AND COLLABORATIVE CASE PLANS

- Case plans are collaboratively established that strongly reflect goals that support safety, according to child protection measures, and stability, in regards to working towards long-term accommodation outcomes and family reconciliation.
- Case plans are person centred and reflect the goals of the child, culturally sensitive, and underpinned by trauma informed care principals.
- Case plans are formed as part of a formal and informal process with the child, case manager, family and broader service network, including FACS.
- Roles and responsibilities are outlined in case plans. This includes defining the roles and responsibilities of the family, SHS and FACS in regards to care for the child, and specifying response timeframes that will determine when/if a child requires FACS intervention.
- Case plans are subject to review continuously. Reviews provide a means to ensure that case plans are being followed, that they remain appropriate and that children can have a say in decision-making about them. Regular review requirements are outlined in services policies and procedures.
- Strategies are implemented to ensure active participation of children with disability, Aboriginal and Torres Strait Islander children and children from CALD backgrounds in their own case planning. These strategies may include:
  - Aboriginal and Torres Strait Islander children having the option of support from an Aboriginal caseworker/service to support and develop case plans
  - Use of Interpreters
  - Resources and information about case plans objectives in a language understood by the child.

8. REFLECTIVE PRACTICE

Reflective practice is the ability to reflect on an action so as to engage in a process of continuous learning. Reflective practice allows for the service provider to develop knowledge and understanding of the practice setting, so as to become truly responsive to the needs, issues and concerns important in shaping practice and helps facilitate insights that might otherwise be missed.[38] By engaging in reflective practice, SHS are more likely to see evidence of an increase in knowledge and skill development, be more open to different ways to think about and understand things, and be more flexible and adaptable in their approaches. When everyone is involved in the process of reflection, it is more likely to result in

[38] JJ Loughran, 'Effective reflective practice: in search of meaning in learning about teaching', 'Journal of Teacher Education', vol. 53, no. 1, January 2002, viewed on 5 May 2017, <http://journals.sagepub.com/doi/abs/10.1177/0022487102053001004>.

an exchange of ideas, shared decision-making and positive partnerships.[39] It also means SHS are more likely to learn, develop and strengthen their capacity as a team. Collectively this will lead to better outcomes for children and families.

Reflective practice is a process where the individual thinks through a series of actions or activities to identify positive and negative elements contributing to any situation in which the individual has been involved or has observed. This includes reflection on ones own reaction, the consequences of that action, and what behaviours could generate a more positive outcome in the future. The process involves problem solving from a point of having knowledge and understanding about something and applying analysis to this knowledge to inform future thinking and actions. It is an ongoing process in which an individual case manager/ support worker can draw on both the current situation and previous experiences to explore possible future action and consider the relative merits of any particular approach.[40]

Elements for reflection can include, but are not confined to:

- Relationships
- Feelings
- Experiences
- Events
- Context
- Actions
- Values and belief system
- Culture

Reflective practice is a critical component of effective case management and supporting children 12 – 15 years. Additionally, it is a vital part of comprehensive supervision in which joint exploration of some of the issues arising in practice should be encouraged in an environment of safety and shared learning. It is in conversation with others that ideas are challenged, new approaches and perspectives can be considered, and notions of what is possible and what is 'best practice' are developed and shared.

PRACTICE GUIDELINES

8.1 SERVICES COMMIT TO REFLECTIVE PRACTICE AT AN INDIVIDUAL AND ORGANISATIONAL LEVEL

- Workers carry out reflective practice on an individual level, reflecting on what has been learned, the impact on practice and ways things can be carried out differently in future practice. Tools that may assist with this reflective practice may include:

- Keeping a journal or diary
  - Using peers and experienced colleagues to assist in discussion reviewing individual practice

- Services carry out reflective practice at an organisational level utilising the

[39] Amulya, 'What is Reflective Practice?', The Centre for Reflective Community Practice, Massachusetts Institute of Technology, 2004, <http://www.itslifejimbutnotasweknowit.org.uk/files/whatisreflectivepractice.pdf>.

[40] Department of Human Services NSW, 'Case Management Practice Guide, 7 Phases of Case Management', March 2010, <http://www.abistafftraining.info/pdf/case_management_practice_guide_7_phases_march2010.pdf>.

following forums:

- Group supervision
- External supervision
- Team meetings
- De-briefing sessions

9. ADVOCACY

Children are a vulnerable group and often have a limited voice in decisions affecting their lives due to the power imbalance common between children and adults. Therefore children rely on adults to speak on their behalf and protect their rights, highlighting the need for advocacy of the interest of all children across agencies and systems.[41] Every child has rights, protected by the United Nations CRC. Child advocacy refers to a range of individuals, professionals and advocacy organisations that speak out on the best interests of children to advance their rights. Children that require support from SHS also require SHS to advocate on their behalf to protect their interests, wellbeing and rights. This is particularly crucial for establishing long-term, safe and stable accommodation options for children when they are unable to safely return to family.

PRACTICE GUIDELINES

9.1 SERVICES AND WORKERS ADVANCE THE RIGHTS AND INTERESTS OF CHILDREN

- Services have a child specific Client Rights or Charter in place. This outlines a child's rights and how they will be treated within a service, what they can expect, and methods for contributing to improvement in service delivery. (Refer to Resource Manual: 6.4 Children's Rights Charter – Checklist Template).
- Services practice person-centred, strength based approaches and consult with children to actively seek their involvement in all decision-making processes.
- Services work with the child to ensure that decisions are made in the best interest of the child.
- Services work to influence policy and legislation to improve the rights and needs of unaccompanied children who are homeless or at risk of homelessness.

[41] Australian Law Reform Commission, '5. Responding to children – advocacy and action: Why do children need advocacy', viewed 8 May 2017, <http://www.alrc.gov.au/publications/5-responding-children-%E2%80%94-advocacy-and-action/why-do-children-need-advocacy>.

5. RESOURCE MANUAL

INTRODUCTION

The resource manual is intended to be user friendly and to be utilised as a guide for services to support implementation of the guidelines. As service models differ across the state, services can adapt these policies to suit their service delivery requirements. Due to changing policies and contractual obligations the resource manual will be a working document with additions made when and where necessary.

5.1 MENTAL HEALTH – MODEL POLICY

Definition

Mental health is defined "as a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community."[42] Mental health includes our emotional, psychological, and social well-being and affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices.

Purpose

The purpose of this policy is to ensure all clients of (insert service here) have the necessary resources and supports in place in order to support clients' mental health needs.

X.1 PROMOTION AND AWARENESS

(Insert service here) will promote and encourage open and non-judgemental communication about mental health disorders, services and interventions and will support young people experiencing any issues or problems to seek help. (Insert service here) will engage in activities that promote mental health awareness and reduce stigma and discrimination.

X.2 MENTAL HEALTH TRAINING

(Insert service here) recognises young people's right to be supported by a competent and fully trained workforce. (Insert service here) will provide employees with access to high quality, accredited training in mental health and will record all staff training on file. Workers will be provided with updates on mental health interventions, service profiles, legislation and better practices.

X.3 EARLY INTERVENTION

(Insert service here) supports young people's right to access help and

[42] World Health Organization, 'Mental health: A state of Wellbeing', August 2104, viewed on 5 May 2017, <http://www.who.int/features/factfiles/mental_health/en/>.

support early at a crucial time in their development to minimise the severity and duration of mental health conditions and reduce its impacts on adolescent and adult outcomes. (Insert service here) will collaborate with the broader service system to develop a support plan and clear referral pathway for young people experiencing mental health issues, including working with:

- Primary and youth health providers
- Mental health services
- GP's
- Family and community based services
- Mental health advocates.

This support plan will consider the young person's life stage, their current situation and their presenting needs and will be client centred and strength based.

X.4 REFERRALS

Clients of (insert service here) will identify appropriate youth mental health services and other appropriate support services for the referral of young people experiencing mental health issues. Young people will be engaged in the referral process and where possible will be offered choice in determining the appropriate referral service.

X.5 PARTICIPATION AND INCLUSION

(Insert service here) will empower young people engage with their own mental health development by:

- Providing opportunities to develop life-skills such as stress management, self-awareness and mental health sector knowledge.
- Supporting clients' development of knowledge and understanding about their own mental health.
- Active participation by clients' in decisions that will affect them.

(Insert service here) will promote positive activity that facilitates participation and inclusion in mental health interventions by providing clinical and service sector information and non-judgmental support.

X.6 QUALITY FRAMEWORKS

(Insert service here) will implement a clearly articulated mental health quality framework to ensure that appropriate mental health information is available for young people and employees, and that this information is used to guide decision-making about service development, delivery and evaluation.

5.2 PROFESSIONAL BOUNDARIES – MODEL POLICY

X.1 DEFINITION

Professional boundaries define effective and appropriate interaction between

professionals and the children they support. Boundaries exist to protect both staff and the child.

X.2 PURPOSE

Implementation of professional boundaries fosters healthy and safe boundaries. This improves interpersonal skills, which in turn, reduces the risks for boundary transgressions. Having an awareness of what constitutes healthy and safe boundaries with children is vital.

The following lists provide examples that will assist staff in establishing and maintaining expected professional boundaries when working with children:

X.3 COMMUNICATION:

- Use of inappropriate "pet" names.
- Giving out personal information e.g. communicating via personal phone numbers, text, emails and social media of all forms.
- Inappropriate conversations or remarks of a sexual nature.
- Excessive flattering comments of a young person.
- Any form of humiliating comments even in-joke context.
- Comments about young persons appearance (many young people are very sensitive about appearance).

X.4 PHYSICAL CONTACT

- Unwarranted and unnecessary touching of a child or young person personally or with objects.
- Any form of physical punishment.
- Initiating, permitting or requesting inappropriate or unnecessary physical contact with a child or young person (e.g. massage, tickling games) or facilitating situations which unnecessarily result in close physical contact with a child or young person.
- Inappropriate use of physical restraint.

X.5 PROFESSIONAL RELATIONSHIP

- Giving or receiving of personal gifts that may be deemed as unprofessional (all gifts received and given should be reported to manager) to ensure no singling out or favouring of a particular child/children.

X.6 SAFETY

- No unauthorised video, visual/audio or photographs of young people.
- Keeping of authorised/unauthorised photos and/or videos on personal non-work related devices.
- All staff should report any behaviour that they view as unhealthy or compromising to the safety of young people or other staff members to manager/ team leader immediately.

5.3 HARM REDUCTION – MODEL POLICY

Definition

Harm reduction (or harm minimisation) is intervention that prevents or reduces negative health consequences associated with certain behaviours. Federal and State governments, SHS funders and youth and health peak body's support harm reduction strategies.

Purpose

The purpose of this policy is to align SHS health policies with NSW Health policy and better practice in relation to harm reduction.

X.1 PRINCIPLE

(Insert service here) acknowledges that young people engaging in potentially risky practices is an inevitable part of life and can contribute to positive adolescent development.[43] (Insert service here) will take a harm reduction approach to health issues experienced by young people who use the service. This includes providing information, referral and support in relation to sexual health, smoking, alcohol and other drugs.

X.2 CLIENT AUTONOMY AND DUTY OF CARE

In addressing the risks associated with young people's behaviours (insert service here) will balance duty of care to all clients, the young person's right to be protected and the young person's right to autonomy and informed choice in relation to health interventions.

X.3 CLIENT RIGHTS

(Insert service here) supports young people's right to receive homelessness and support services whether or not they can abstain from or reduce identified risky behaviours. This may include continuing to provide services or making appropriate referrals.

X.4 CLIENT CENTRED INTERVENTION

(Insert service here) affirms that young people themselves are ultimately the primary agents of their risk-taking behaviours, and commits to giving young people a real voice in the programs directed at changing such behaviours. This necessitates the non-judgemental, non-coercive provision of services, and genuine consultation with young people about their needs, desires and capacities for change.

X.5 LIVED EXPERIENCE

(Insert service here) acknowledges that lived experiences of poverty, class, racism, sexism, homophobia, transphobia and other forms of discrimination and social inequality affect young peoples' vulnerability to harm and ability to assess risky behaviours. (Insert service here) will acknowledge this principle in development of programs and other interventions.

[43] Harm Reduction Coalition, 'Principles of Harm Reduction', 2016, viewed on 5 May 2017, <http://harmreduction.org/about-us/principles-of-harm-reduction>.

X.6 HEALTH PROMOTION RESOURCES

(Insert service here) will ensure young people who use the service will have access to harm reduction information regardless of whether or not they are known to staff as engaging in risky behaviour and will provide support and referral to young people to implement harm reduction strategies.

X.7 EVIDENCE BASED INTERVENTION

(Insert service here) will provide access to resources on the basis of better practice and evidence, including the supply of free condoms, sexual health information including consent and safe disposal boxes for needles and syringes.[44]

5.4 CHILDREN'S RIGHTS CHARTER – CHECKLIST TEMPLATE

All children have rights and are entitled to be informed of their rights. It is our duty of care to provide children 12-15 years with the necessary information informing and advising a child or young person of their rights. All children and young people have a right to participate in decision making about their own life. Children and young people's participation is a right, not an option.

The following provides a checklist of children's rights:

- ☐ You have the right to have contact with your family and community.
- ☐ You have the right to ask for any information that is being kept about you, to read your file and to add any information to your file.
- ☐ You have the right to be treated fairly.
- ☐ You have the right to voice your opinions.
- ☐ You have the right to be treated with respect.
- ☐ You have the right to feel safe and not be abused.
- ☐ You have the right to complain.
- ☐ You have the right to services that promote your health and wellbeing. You have the right to ask for extra help with your education.
- ☐ If you have to go to court, you have the right to be helped and supported.
- ☐ You have the right to do things that you enjoy.
- ☐ You have a right to your own beliefs and way of life.
- ☐ You have the right to make choices about everyday matters.
- ☐ You have the right to say what you are thinking and feeling.
- ☐ You have the right to take part in making important decisions affecting your life.

For more information please visit Charter of Rights

[44] NSW Kids & Families, 'Youth Health Resource Kit: An essential Guide for Worker', 2014, viewed on 8 May 2017, < http://www.health.nsw.gov.au/kidsfamilies/youth/Publications/youth-health-resource-kit.pdf>.

5.5 TRAUMA INFORMED CARE POLICY TEMPLATE

Purpose and Scope

The purpose of this policy is to enable:

- Every part of the organisation, including administration, management and service delivery systems is assessed and modified to incorporate trauma-informed principles into practice
- The provision of safe environments in which re-traumatisation of consumers is minimised and staff health and wellbeing are fostered
- Staff to understand that they must be informed about trauma and its dynamics so as to minimise triggers which may interfere with effective executive functioning in both consumers and other staff members with a lived experience of trauma
- The workforce to be informed about pathways to services which can provide appropriate integrated support and/or referrals for consumers presenting with complex trauma, co-occurring mental health and psycho-social difficulties
- Assistance to [insert organisation name] to establish clear policies and procedures to minimise risks to work health and safety e.g. re-traumatisation of staff and/or clients with past trauma histories, vicarious traumatisation (staff) and self-harming behaviours (clients)
- This policy applies to all consumer services and programs of [insert organisation name] and all staff of [insert organisation name]. It does not prescribe specific treatments, philosophies or counselling techniques. It is based on trauma-informed recovery-oriented practice and the collaborative recovery model for community managed organisations

X1. PRINCIPLES

[Insert organisation name] adheres to five principles of trauma-informed best practice outline:

- **SAFETY:** Ensure physical and emotional safety
- **TRUSTWORTHINESS:** Maximise trustworthiness through task clarity, consistency, and interpersonal boundaries
- **CHOICE:** Maximise consumer choice and control
- **COLLABORATION:** Maximise collaboration and sharing of power
- **EMPOWERMENT:** Prioritise empowerment and skill-building

X2. STRATEGIES

- Recognise the prevalence of trauma in mental health consumers
- Recognise high rates of mental health,

physical health and psycho-social disorders related to trauma exposure in children and adults

- Recognise that mental health treatment environments are often traumatising, both overtly and covertly
- Recognise that coercive interventions cause traumatisation/re-traumatisation and avoid such practices
- Recognise that the majority of mental health staff are uninformed about
- Trauma, do not recognise it and do not know how to manage it
- Review policies and procedures to incorporate trauma-informed principles
- Review education and training to incorporate trauma-informed practice
- Provide training on reducing re-traumatising practices
- Inform regarding where trauma screening is appropriate
- Understand the impacts of trauma, complex need and the importance of
- coordinated care
- Articulate and uphold trauma-informed human rights

To undertake trauma-informed care and practice, [insert organisation] will promote the following as core values of trauma-informed care including the following:

- Understanding trauma and its impact
- Promoting safety
- Ensuring cultural competence
- Supporting consumer control, choice and autonomy
- Sharing power and governance
- Integrating care
- Healing happens in relationships
- Recovery is possible

X3. OUTCOMES

- [Insert organisation name] assess all consumers with the understanding of mental health presentations from a trauma-informed perspective. Co-existing mental health and complex need occur commonly as a consequence of trauma and need to be understood as such.
- They do not constitute criteria for service exclusion or denial. Workers are provided with education, skills and support in trauma-informed mental health assessment, screening where appropriate; support plan development and support coordination.
- [Insert organisation name] develops and maintains partnerships with trauma specific services, mental health and related services to provide integrated support for consumers.
- [Insert organisation name] creates a safe and healthy work environment for

all employees, contractors, consumers and visitors. Support is provided for personnel who may have difficulty addressing trauma-related issues. This may include those with their own trauma history. The high prevalence of pre-existing trauma in workers needs to be recognised and acknowledged.

- [Insert organisation name] fosters a personal, holistic, creative, open and therapeutic culture that supports service providers in moving from a caretaker to a collaborator role using a recovery-oriented approach.

5.6 OTHER SUPPORTING RESOURCES

The Children and Young Persons (Care and Protection) Act 1998 (the Act)
<http://www.legislation.nsw.gov.au/#/view/act/1998/157/id1>

The National Framework For Protecting Australia's Children 2009–2020
<https://www.dss.gov.au/our-responsibilities/families-and-children/publications- articles/protecting-children-is-everyones-business>

Social Justice Strategy
<https://www.dss.gov.au/our-responsibilities/settlement-and-multicultural-affairs/programs-policy/a-multicultural-australia/national-agenda-for-a-multicultural-australia/participation/social-justice>

Chapter 16A Exchange of Information
<http://www.community.nsw.gov.au/kts/guidelines/info-exchange/provide-request>

Child Protection- online mandatory reporter guide
<https://reporter.childstory.nsw.gov.au/s/topiccatalog>

Keep them Safe
<http://www.keepthemsafe.nsw.gov.au/>

UN Convention on the Rights of a Child
<http://www.ohchr.org/en/professionalinterest/pages/crc.aspx>


foundations