Coordinated Responses

Continuing to Strengthen Collaborative Practice

Centre for Excellence in Child and Family Welfare
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No to Violence
Leading the change to end male family violence in Australia

Child and Family Services Practice Example

History

Alexandra (she/her) is a three-year-old child who resides in a kinship placement with her maternal aunt, Kim (she/her), and her uncle, James (he/him). Alexandra's biological mother, Anh, immigrated from Vietnam to Australia 5 years ago, along with her sister Kim. Anh met Alexandra's biological father, Nick, when she moved to Australia, and they married 5 months later. At around the same time. Anh became pregnant and gave birth to Alexandra, and Kim lost contact with her sister.

Nick has used significant family violence against Anh and Alexandra. Nick and Anh have both they both engaged in frequent substance use which impacted upon their ability to provide suitable care to Alexandra. There were concerns about their ability to keep Alexandra safe from harm, and this resulted in a notification being made to Child Protection.

Child Protection became involved when Alexandra was six months of age. When working with Anh, Nick, and Alexandra, Child Protection used the MARAM Intermediate Risk Assessment to assess the level of family violence risk. Using Structured Professional Judgement and Anh's responses from the risk assessment, it was revealed that Nick poses family violence risk to Anh and Alexandra. However, risk management strategies such as Child Protection's involvement and victim survivor support and referral could be used to manage the risk.

A referral was made for Anh and Nick to attend an Alcohol and Other Drugs (AOD) service to address their substance abuse which was considered to be impacting upon their ability to be able to provide adequate care to Alexandra. Anh was also referred to a local family violence service, while Nick was referred to a Men's Behavioural Change Program. Using the Family Violence Information Sharing Scheme (FVISS), Child Protection proactively shared information with both services in order to assess and manage family violence risk to both Anh and Alexandra.

After thorough assessments, it was concluded that Alexandra was not safe, and her needs were not able to be met whilst in the care of her parents. The decision was made for Alexandra to be placed in out of home care. Upon Alexandra's removal from her parent's care, Kim and James were located and assessed as suitable caregivers for Alexandra and she was subsequently placed in their care. After Alex was removed from their care, Anh and Nick were unable to address the concerns identified and gradually ceased contact with their daughter.

After twelve months Child Protection made an application to the court for a permanent care order to be made to Kim and James. During this process, Kim and James had been able to demonstrate that they were committed to providing high quality care to Alexandra and would make efforts to maintain connection with her parents. After a permanent care assessment had been completed, a permanent care order was granted, and guardianship responsibilities of Alexandra were transferred to Kim and James and Child Protection ceased their involvement with the family.

Questions:

- **What wellbeing concerns could be present for Alexandra as a result of her exposure to family violence and substance use?**
- **What must you consider when engaging multicultural children and their families?**

Current Situation

Kim and James had initially expected that it may have taken time for Alexandra to settle in, however after a while they both became concerned when even after having been with them for a significant period of time, she continued to be extremely tentative of them and did not appear to engage with the couple. They noticed that she did not make eye contact and would go out of her way to avoid their attempts to initiate play and affection.

Their concerns were heightened when a few months after the Permanent Care Order was granted, Kim and James discovered that they were pregnant. In preparing for the arrival of their child, they couple became concerned about the impact a new child may have on Alexandra considering her current behaviours. Kim and James spoke to close friends within their community about their concerns, a friend mentioned that their family had previously engaged with services offered by their local council when looking for parenting support.

Following this advice, Kim and James contacted their local council about getting information regarding parenting support. When talking about their options, the council worker shared that because Alexandra was in a kinship care arrangement, the family was eligible for services such as a DFFH Supported Playgroup1, a Phase 2 prescribed service. Interested in the service, Kim and James were referred to a local supported playgroup to assist Kim and James to be able to further develop their confidence and parenting skills.

At the supported playgroup, the facilitator identifies several concerns regarding Alexandra's wellbeing. The facilitator notices that Alexandra shows delays in her language development, is exhibiting anti-social play, and a lack of interest in engaging with others. The facilitator notes that these are observable signs of trauma within MARAM practice guidance.

At the next supported playgroup session, the facilitator discusses her concerns about Alexandra's behaviour with Kim and James. Kim and James explain that Alexandra's biological father used physical violence towards his wife and was believed to have been verbally abusive towards Alexandra. It was also revealed that both Alexandra's mother and father were observed to have misused substances which impacted upon their capacity to parent Alexandra. The facilitator relays this information to her supervisor, who suggests that the facilitator discuss further support options for the family with Kim, James, and Alexandra.

When talking to Kim and James, the worker suggests that Alexandra should be referred to Child FIRST/The Orange Door. After consulting with Kim and James, the family are referred to The Orange Door for the purpose of building strong attachments with the child and a safe and supportive home environment.

Questions:

- **When observing Alexandra's behaviours, how would you record and share this information?**
- **How would you ensure that practice remains child-focused when engaging with families?**
- **What other services might be involved with the family at this stage? Are there opportunities for collaboration and coordination?**

1 DFFH Supported Playgroups deliver an evidence-based program (smalltalk) to families facing complex challenges and support parents/carers to develop the skills and confidence to support their children's safety and development. Families are also supported to connect to their local community including informal supports and specialised services. DFFH Supported Playgroups are delivered by qualified and trained facilitators who also provide 1:1 support to families in their homes focussing on improving parent/child interactions.

Families may be able to access a DFFH Supported Playgroup if they meet one of the following eligible criteria: A family member in the household holds a Health Care Card or equivalent, families in which a family member identifies as Aboriginal and/or Torres Strait Islander, families looking after children in kinship care arrangements (Out of Home Care), families referred from Child FIRST/Child Protection, or families referred from or participating in Enhanced Maternal and Child Health Services.

Information about DFFH Supported Playgroups can be accessed via the service provider in the local government area where a family resides. In most local government areas this is the local council.

Action

At the initial appointment, the Orange Door Practitioner conducts an assessment and asks Kim and James about Alexandra's behaviours. As part of the assessment, the practitioner screens for family violence using the MARAM Screening and Identification Tool, however, no current signs of family violence are identified.

Through the referral process, the supported playgroup provided information about Alexandra's presenting concerns and that Alexandra was placed on a Permanent Care Order with Kim and James. The practitioner explains that they would like to gather some further information from the supported playgroup and Child Protection to further inform the assessment.

The practitioner is prescribed as an Information Sharing Entity (ISE). They can make an information sharing request under the Child Information Sharing Scheme (CISS) for the purpose of promoting the wellbeing and safety of a child. The practitioner informs Kim and James that their consent is not legally required, however, their views will be sought over how and when their information is shared and wherever possible, they will be informed that their information has been shared. As Alexandra is a toddler, the practitioner engages with Alexandra using body language and simplified language.

Using CISS, the practitioner contacts and requests information from Child Protection about:

- Child Protection's involvement with Alexandra and relevant details relating to her biological parents.
- Details of any past family violence behaviours or risk factors.
- Any assessments, safety plans, or case plans that may be relevant to, or indicate signs of trauma.

Using CISS, the practitioner also contacts and requests information for the supported playgroup regarding Alexandra's behaviours, any known developmental delays, patterns of attendance, and previous maladaptive behaviours.

Questions:

- How would you keep the 'child in mind' when seeking information from caregivers and other services?
- How do you document what information is shared and received by your organisation?

Outcome

Information from Child Protection revealed that evidence-based risk factors were present for Alexandra, such as:

- **Alexandra's father often punched walls and had frequent, loud verbal arguments in front of Alexandra with her mother.**
- **Alexandra's father was verbally abusive of Alexandra and was becoming increasingly aggressive towards her when he could not settle Alexandra or when she was crying.**
- **Alexandra's mother misused substances as a way to cope with the violence which impacted on her parenting capacity.**

After receiving the information, the practitioner sets up a meeting with Kim, James, and Alexandra to put a plan into place to support Alexandra's wellbeing. The plan includes arranging care team meetings with the supported playgroup and The Orange Door, connecting Alexandra with specialist Culturally and Linguistically Diverse supports, and referring Alexandra to a children's counselling service. Kim and James are also provided with specialised supports to enhance their parenting skills.

The services have agreed to maintain contact and, where services are prescribed, proactively share information to support Alexandra's wellbeing and safety.

Questions:

- **What strategies might assist to develop coordinated and collaborative information sharing?**
- **What culturally appropriate supports could be provided to Alexandra and her permanent carer's?**

Practice Considerations:

Approaches to Cross-Sector Collaboration and Coordination

MARAM and the Information Sharing Schemes seek to promote collaboration and change the culture of organisational cooperation to promote the safety and wellbeing of victim survivors. It is important to understand that information sharing is a key enabler of collaborative practice required under MARAM, and that working collaboratively with other services leads to more informed decision making.

No single institution collects all necessary information or has all the appropriate tools to adequately protect children, young people and their families from harm as well as actively promoting their safety and wellbeing, in isolation. Working collaboratively with other services requires clear and purposeful communication.

A focus on building and maintaining trust in relationships with other services as well as clients is also essential. Professionals should become familiar with the work of other organisation and their practitioners in order to build trust. This could be undertaken through participation in collaborative forums, staff presentations, secondments, and collective policy development. Additionally, undertaking secondary consultations with other organisations can help to build partnerships and strengthen collaboration to enhance engagement with children, young people, and families.

Keeping Children in View and Heard

Children impacted by adverse experiences are often the most vulnerable and unheard. Children have a right to be heard but we cannot assume that the adults in their life are able or willing to provide these opportunities. Keeping children in view and heard can help support greater long-term health and wellbeing outcomes.

There are many ways to keep children in view when accessing services, this may involve: Undertaking an individualised child needs assessment such as the MARAM Child Assessment Tool, seeking the child's views and wishes, and engaging directly with children rather than through the caregiver. It is crucial that professionals keep the 'child in mind' throughout their practice.

Supporting Children's Wellbeing

Effective implementation of the Child Information Sharing Scheme (CISS) helps promote child wellbeing and safety. The promotion of wellbeing enhances the rights and quality of life for children and young people and supports safety and development.

Different frameworks use different indicators to contextualize children's wellbeing, for example: the CISS Ministerial Guidelines highlight wellbeing indicators that encompass the different dimensions to help consider a child's wellbeing.

It is important to understand children's wellbeing indicators in different contexts in order to be able to provide appropriate supports for children. There are various resources to help you understand children's wellbeing such as, the Children's Wellbeing Case Management Reflection Tool (SCRP), a tip sheet on Understanding Wellbeing (CFECFW), and the Centre's webinar series on Children's Wellbeing.

Resources:

MARAM provides the 'how to' for professionals to identify, assess and manage family violence risk. The FVISS and CISS are key enablers to the MARAM Framework – this means that relevant information can now be shared using FVISS or CISS to support the identification, assessment or management of family violence risk (or in the case of CISS to promote the wellbeing and safety of children). The resources, tools, and guides provided below can be used to support professionals in their roles and with their aligned MARAM responsibilities.

Multi-Agency Risk Assessment Management Framework (MARAM):

- Family Violence Multi-Agency Risk Assessment and Management Framework
- MARAM Framework on A Page
- MARAM Responsibilities Decision Guide
- Foundation Knowledge Guide
- Victim Survivor-Focused Practice Guides
- Perpetrator-Focused Practice Guides

Information Sharing Schemes:

- Child Information Sharing Scheme and Family Violence Information Sharing Scheme Fact Sheet
- Information Sharing Entities (ISE) Online List
- Tips for Information Sharing Record Keeping
- Information Sheet: Working collaboratively with other professionals to improve the wellbeing and safety of common clients, especially children, young people and their families (CFECFW)

Child Information Sharing Scheme (CISS):

- Child Information Sharing Scheme Ministerial Guidelines
- Child Information Sharing Scheme Summary
- CISS Example Record Keeping Form

Family Violence Information Sharing Schemes (FVISS):

- Family Violence Information Sharing Guidelines
- Family Violence Information Sharing Scheme Overview Diagram
- FVISS Example Record Keeping Form

Working with culturally and linguistically diverse (CALD) children and families:

- Culture Matters Video
- Understanding intersectionality
- Everybody Matters: Inclusion and Equity Statement
- Intersectionality: A snapshot of theory and practice (CFECFW)

Specialist Family Violence Victim-Survivor Services Practice Example

Part 1

Carmel is a 73-year-old woman living alone in metropolitan Melbourne. She has a daughter, Melissa, who is mother to 27-year-old Brayden. Brayden moved in with Carmel 3 months ago following a Police-issued final Family Violence Intervention Order (FVIO) protecting Melissa and excluding him from the home.

You are a case manager at a local family violence support service. The local Hospital Admission Risk Program (HARP) send your service a referral including a completed MARAM Screening and Identification Tool. HARP commenced supporting Carmel about a month ago for poorly controlled Type 2 Diabetes. They became involved after Carmel attended the Emergency Department several times via ambulance due to hypoglycemia (low blood sugar). Carmel's health has been deteriorating for a few months now. HARP are concerned the family violence may be contributing to this, particularly Brayden's financial abuse.

Collaborative practice is an essential component of the MARAM framework. A range of health services were prescribed to MARAM and/or FVISS and CISS during phase two of the reforms. You can view which areas of health this includes here. HARP are prescribed to MARAM, FVISS and CISS and provide short term specialist support to people with chronic disease and/or complex needs who are at risk of hospital admissions.

The referral from HARP advises that Brayden has been verbally abusive towards Carmel, and often steals money and valuable belongings. Carmel struggles to afford diabetic-friendly food, and recently has been skipping meals due to having insufficient money. She does not want Brayden to be removed from the home as he has nowhere else to go. Carmel says Brayden's verbal and financial abuse is getting worse in the lead up to a hearing for breaching the FVIO protecting his mother. Carmel tells HARP he has previously been to Court for criminal charges and often escalates in the lead up to hearings. She is open to receiving specialist family violence support to enhance her safety.

Five health services are trialling an 'integrated model of care for responding to suspected elder abuse'. Participating regions have a Liaison Officer who undertake clinical advice and consultancy regarding complex discharge decisions and secondary consultations for their health service. If you are working in one of the trial catchments, you may also work collaboratively with this Liaison Officer. See 'further reading' for more information including catchments.

Questions:

- Where would you seek family violence risk relevant information about Brayden?
- What would supporting Carmel look like, using an intersectional analysis? What do you need to consider?

Part 2

Given involvement with both Victoria Police and the Magistrates Courts, you make information sharing requests to each agency. The Magistrates Court share that there is an upcoming hearing for breaches of an FVIO in three weeks. Police share that there is one current and two past FVIOs, convictions for five FVIO breaches, and two assault convictions. They also provide some of the Family Violence Reports (L17s) narratives. Two FVIO breaches included Brayden attending the excluded property and behaving aggressively. One assault included multiple punches. Police information relates to two separate AFMs, and their information is de-identified. Upon receiving the L17 narratives you make an information sharing request to the Orange Door where the L17s were originally referred.

You commence a comprehensive risk assessment incorporating information from the MARAM Screening and Identification Tool and referral form that HARP completed. Carmel discloses that Brayden is also frequently physically intimidating and has made threats to hit her. As Carmel is older and has Type 2 Diabetes you ask her the relevant additional considerations questions in the MARAM comprehensive risk assessment. You learn that Carmel cannot drive and has limited mobility due to diabetic foot ulcers. She is confident in catching public transport locally to go shopping and get to appointments when required. Brayden does not prevent her from attending appointments. Carmel's level of fear has increased in the last month. She did not think he would physically assault her previously, but now believes this is likely to occur. She is worried that she cannot easily leave or call for help if serious incidents occur and wants help with what to do if this occurs.

When undertaking comprehensive risk assessment MARAM asks practitioners to build on screening, brief or intermediate assessments already completed, including from external services. You may need to undertake risk assessment over several sessions, going at the victim survivor's pace and taking time to gather information. For further information on see Responsibility 7 in the MARAM Victim Survivor Practice Guides.

You commence safety planning with Carmel and discuss the option of a limited condition FVIO. Carmel tells you Brayden's violence worsened after the FVIO protecting his mother. You both agree this may increase her risk, especially as Brayden will remain in the home, and based on his reactions is unlikely to make him reduce or cease his use of family violence. Carmel also tells you she does not want 'to get Brayden into more trouble' and would be reluctant to report breaches. She is mainly focused on being safer, and on how Brayden might stop using violence against her and her daughter.

Questions:

- How would you work collaboratively with the HARP clinician? What information can you share to enhance Carmel's safety?
- What information might you seek from the HARP clinician about the health impacts of Brayden's use of family violence?
- How would you work collaboratively with Carmel to safety plan while Brayden remains in the home?

PART 3

With Carmel's consent you speak with her HARP clinician, Emma, and you provide the current comprehensive risk assessment and safety plan. Instead of attending the home, Emma has arranged to attend Carmel's high risk foot clinic appointments so they can safely speak about the family violence without Brayden present.

You discuss with Emma ways to support Carmel to be safer if a serious incident occurs, given her health condition, limited mobility and reliance on public transport. You discuss the option of a personal safety device, which would be suitable for both health and family violence risk. You discuss this option with Carmel, who agrees and says she would feel more at ease knowing she can call for emergency support if needed. She says she will tell Brayden it is for her health, and as he is aware of HARP involvement and her recent emergency department presentations, she believes he won't have a problem with this or suspect anything. You are able to use the Personal Safety Initiative (PSI) to arrange this.

When undertaking comprehensive risk assessment MARAM asks practitioners to build on screening, brief or intermediate assessments already completed, including from external services. You may need to undertake risk assessment over several sessions, going at the victim survivor's pace and taking time to gather information. For further information on see Responsibility 7 in the MARAM Victim Survivor Practice Guides.

In the lead up to Brayden's hearing Carmel tells you his verbal abuse and physical intimidation becomes more frequent, and her fear has further increased. On the day of the hearing, you request an outcome from the Magistrates Courts. They advise you Brayden has received a Community Corrections Order. You request information from Corrections. Once allocated, a case manager named Alice gets in contact with you. The Orange Door respond to your FVISS request. They advise they have not been able to make contact with Brayden after receipt of each L17 referral. However, they are aware he is on the wait list to attend a local Men's Behaviour Change Program which was Court ordered when the FVIO was made final 3 weeks ago.

Questions:

- How might you keep Brayden in view and accountable for his use of family violence?
- As a specialist family violence practitioner, how would you lead coordinated risk management? Who would you include, and how?

FINAL TIPS

Keeping Brayden in view and accountable

There are now two services involved that will work directly with Brayden, including a behaviour change program intended to address his use of violence. This provides increased opportunities to share family violence risk relevant information, coordinate risk management, and provide opportunity to Brayden to take accountability for his use of violence and change his behaviour. These services may also be able to address other needs, such as his lack of alternative housing, which may enhance Carmel's safety.

It is important that practitioners work collaboratively with services involved with both victim survivors and perpetrators. In this example, in addition to services supporting Carmel and Brayden it may be appropriate to work with any services supporting Melissa provided that the applicable consent thresholds are met.

Coordinated risk management

Under MARAM Responsibility 9 'Contribute to Coordinated Risk Management', specialist family violence practitioners should provide leadership of coordinated risk management, monitoring of risk and collaborative action planning. This may include coordinating when and how services collaborate to manage family violence risk, leading risk assessment and management, and receiving and incorporating risk relevant information.

A number of activities can support this coordination and will depend on each unique situation. You might establish type and frequency of communications, receive and analyse risk relevant information, collaboratively explore and enact risk management strategies, share comprehensive risk assessment and safety planning, or share and receive information about changes to the level of risk. In coordinating risk management, it is essential to continue to centre and collaborate with the victim survivor.

In this example, the practitioner should also continue to work closely with the HARP clinician to address the health risks of Brayden's use of violence. Notably, the impacts of the financial abuse are carrying significant risk to Carmel's health and resulting in her needing to attend the Emergency Department. Risk management and safety planning strategies should be collaboratively explored including access to finances, food and medication (if applicable).

FURTHER READING

- **For foundational MARAM guidance on working with older victim survivors see the MARAM Foundation Knowledge Guide, '12.1.5 Family violence against older people (elder abuse)',** https://www.vic.gov.au/maram-practice-guides-foundation-knowledge-guide/presentations-family-violence-different
- **For more information about the 'Integrated Model of Care for Responding to Suspected Elder Abuse' see** https://www.health.vic.gov.au/wellbeing-and-participation/integrated-model-of-care-for-responding-to-suspected-elder-abuse**.**
- **For a range of information and resources about elder abuse see 'Seniors Rights Resources and Education',** https://seniorsrights.org.au/resources-education/

Perpetrator Services Practice Example

Part 1 - Background:

Binh, a 43-year-old male attends The Orange Door (TOD) reception at 4:55pm, just before closing time on a Thursday evening. Binh's five children (5, 7, 9 and 13-year-old twins) attend along with Binh. The men's self-referral team practitioner Oscar, who is on duty, shares the limited confidentiality statement with the client and Binh provides consent to proceed with the assessment.

Binh states that he is suddenly left with the care of his five children. Binh mentions that the children's mother Hang dropped off all the children at school that morning and her current whereabouts are unknown. Binh adds all children had been residing with Hang for the past seven years since Binh moved out of their family home. Binh says he used to see the children once a fortnight only and was not prepared for the full-time care of his children. Binh advises Oscar he is unemployed and is currently residing in shared accommodation with no space or resources to provide for the children. Binh advises that he has a 7-seater vehicle to travel, but he has no money for fuel or groceries.

TOD practitioner Oscar identifies the family's immediate needs and supports Binh and the children with crisis accommodation for four nights, informing Binh that he will be contacted the next day for further support. Oscar also arranges fuel, grocery, and meal vouchers for the family via brokerage funding. Oscar provides the Men's Referral Service (MRS) and Haven Home Safe contact details to Binh in case his circumstances change overnight, and if he requires after-hours support.

Oscar confirms that Binh would be contacted by TOD the following day for a detailed conversation to further assess his and his family's support needs and create a service plan. Binh thanks Oscar for providing him and the children with a place to sleep and vouchers to feed his family.

Right after this conversation, Oscar completes a full history check on the Client Record Management (CRM) system and L17 portal but finds no records. Seeing the complexity of the case, Oscar consults with the Team Leader and Practice Leader for further service planning. The Practice Leader weighs the option of completing a wellbeing check on the children's mother but does not have enough information available to warrant this check. TOD decides to contact the children's school the following morning and request information as per Child Information Sharing Scheme (CISS) guidelines.

Due to limited information available, Oscar also seeks approval for an urgent Central Information Point (CIP) report and submits the CIP request before finishing his work for the day. Oscar also gets approval for a risk-based consultation with Community-Based Child Protection (CBCP) for information sharing and risk assessment purposes.

Questions:

- **Considering the timing of Binh's attendance at TOD with five children, what other actions could Oscar take before finishing work for the day?**
- **What risk factors are identified in Binh's first contact with TOD?**
- **What is your understanding around why TOD did not go ahead with the wellbeing check for the children's mother, Hang?**

Practice Tip:

Safety of victim survivors is the priority. When the mother is not present and the children are suddenly in their father's care, professionals should have regular interaction with the father to provide support and continue to inform and update the risk assessment and risk management. This keeps the whole family in view and monitors the changing risks. Support is provided to ensure the children's safety, stability, and development by using the Best Interests Case Practice Model by identifying and addressing their immediate needs.

Part 2 - Current situation:

The following morning, Oscar calls the children's schools for their child wellbeing checks under CISS guidelines. The school confirms that the children's mother Hang dropped the children on Thursday morning, informing school staff that she is going to see her mother, and they do not have clarity around Hang's current whereabouts or whether she is planning to return.

Oscar informs the school Principal about Binh's attendance at TOD with the children, and that the children are currently residing with their father in crisis accommodation. TOD practitioner requests a child wellbeing check to ensure children have been doing well noting that none of the children attended school on Friday. The School Principal shares that they had no concerns for the children and their wellbeing until the day before as their mother was very proactive and always working towards caring for children as a single parent, but they have high concerns for children since their mother left and due to recent changes in children's stable environment.

The school confirms that the children had been residing with their mother in stable accommodation for the past seven years and are surprised to know that they are currently in crisis accommodation with their father. Feedback from school staff indicates that Binh rarely spent time with them. The principal shares that this is concerning considering the 13-year-old daughter had recently refused to see her father when he recently visited the school unannounced to meet the children.

Based on the evidence-based risk factors, TOD and the school create a safety plan and agree to share relevant information to ensure the children's safety. The school confirms that they will check on the children regularly to ensure they are doing fine and will update TOD. Oscar shares his contact details with the school principal to facilitate this information sharing strategy. The school principal agrees to also contact the children's emergency contact (Hang's sister) to check when Hang is returning, without sharing any further details with the emergency contact.

After this initial safety planning through the school, Oscar then contacts Binh to keep him, and the family engaged and reassess the family's support needs. Binh mentions the children have been fine but have not attended school as he needed to get their school uniform from their mother's house. This is a changed narrative than the prior day as Binh mentioned children had no place to live. Oscar tries to ascertain further information regarding Binh and Hang's relationship to inform the risk assessment, but Binh changes the subject after each attempt and is reluctant to provide information. Oscar case notes all details in the CRM. Oscar ensures the children are safe and well with Binh at that time and has a detailed conversation with Binh for further risk assessment and service planning.

Questions:

- What is Oscar prioritizing as a practitioner?
- If you were the men's services practitioner supporting Binh and his children, what approach would you take?
- What information is relevant to be shared under FVISS and CISS guidelines?

Practice Tip:

Risk is fluid and changes with time and circumstances – particularly where the narrative changes over time. Risk should always be assessed as per the current circumstances. Regular check-ins with the client should occur for assessment purposes in a reasonable frequency throughout the open case as things may have changed since the client last spoke to the service. A Central Information Point (CIP) report can be useful to source historical information when there is limited information available through information sharing or other resources which can inform the risk assessment and management.

Part 3 - Service Involvement and Information Sharing:

TOD extends crisis accommodation for Binh and the children for another six days as Binh states that Hang sold the property where children used to reside for the past seven years. This is a different narrative than the first day of conversation when Binh previously stated he visited Hang's home to bring back the school uniforms. Binh also informs the school principal that he went home and took photos of the property, using the language "the house was very filthy, and I have taken photos of all rooms" and that he is planning to report their mother to Child Protection.

As per his changed narrative, Binh states that Hang's house is very dirty, and he does not want the children to live there. He mentions that he has reported Hang to Child Protection and uses degrading language towards her. Binh adds he has filed a case in Family Law Court against Hang to get full custody of his children. He tells Oscar he has contacted Centrelink to get benefits as a single parent as Hang will lose custody of the children. Binh's timeline for all the above actions does not match his presentation at TOD. Binh mentions he has contingency plans in mind but does not share any details about these plans.

Binh is difficult to communicate with and only responds well to queries related to funding and brokerage. Binh is not willing to talk about what led to Hang leaving and is not interested in sharing details about his relationship with the children.

Binh is offered parenting support, but Binh refuses to get involved with a parenting program and blames Hang throughout his interaction with all professionals.

TOD offers him Family services and brokerage to get Hang's house professionally cleaned for children to resume residing in their stable house. Binh declines this, stating he wants a separate house to be arranged for him and the children.

Oscar case notes every conversation with Binh and shares relevant information with the school principal who is the main contact for the children's wellbeing.

Questions:

- What information is risk relevant in Binh's changed narrative?
- What next steps can inform the safety planning for the children and family?
- Who else can you seek information from to inform your safety planning?

Practice Tip:

Family services and children's services should be included for collaborative risk assessment and safety planning. Schools are prescribed Information Sharing Entities (ISE) under MARAM (Multi Agency Risk Assessment and Management) Phase 2. In this case, relevant information is being shared with the school and Community-Based Child Protection, keeping the children's best interests and safety in mind. Any observation, update and client narrative including victim-blaming should be recorded. Any information should always be recorded as based on MARAM, Family Violence Information Sharing Scheme (FVISS) and CISS (Child Information Sharing Scheme) when sharing with an ISE or Risk Assessment Entity (RAE) and the purpose of information sharing must be included.

In this case study, Community-Based Child Protection is both an ISE and RAE, whereas the school is a prescribed ISE under MARAM Phase 2. Information sharing helps keep the family in view beyond the current service's involvement by ensuring there are no safety and wellbeing concerns. On this occasion, TOD is providing one-off support on a voluntary basis due to a self-referral whereas the school is now aware of the changed circumstances and will now be able to continue monitoring for any concerns and report as required, even after the case is closed at TOD.