

OzChild's Submission to the Commission into the Queensland Child Safety System

“Corporate parenting and the links between the child safety and youth justice systems”

23 January 2026

Acknowledgement of Country

OzChild acknowledges the First Peoples of Australia as the traditional custodians of the land on which we work. We acknowledge their cultures are living ones, which relate to their ongoing connection to all things living and non-living on land, sea, and sky. We pay our respects to their Elders past and present.

May the children of today lead us to a brighter tomorrow.

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About OzChild

OzChild is a not-for-profit community service organisation committed to improving the lives of at-risk children, young people and their families, and supporting foster and kinship carers.

OzChild’s vision is that all children and young people are safe, respected, nurtured, and able to reach their full potential. OzChild achieves its vision by striving to give every child and young person what they need and what the evidence says works.

OzChild has a proven record of working collaboratively with state and territory governments to allocate investments to achieve better outcomes for vulnerable children and young people by delivering evidence-based programs that are specifically adapted to succeed in the local context.

Evidence-based programs use research evidence, undergo rigorous evaluation, and are proven to be effective with the specific populations they are designed for.

There are clear links between the core components of each evidence-based program and the intended improved outcomes for cohorts of vulnerable children, young people, and their families.

OzChild has over eight hundred staff, carers, and volunteers, across Queensland, Victoria, New South Wales, and the Australian Capital Territory, who deliver 23 programs and services to over 10,000 children and young people and their families, guardians, and carers annually.

“It is no longer good enough for a child to only get what is available. We strive to give a child what is needed and what the evidence says works.”

Dr Lisa J. Griffiths, Chief Executive Officer, OzChild

The Commission of the Inquiry into Queensland Child Safety System Call for Submissions

In December 2025, the Commission of the Inquiry into Queensland Child Safety System (**Child Safety Inquiry**) made a Call for Submissions in respect of “*corporate parenting and the links between the child safety and youth justice systems*” (**Call for Submissions at Annexure A**).

The Call for Submissions asks specific questions as to the effectiveness of the Child Safety department as a corporate parent of children and young people who are: in statutory residential care; known to the Child Safety and Youth Justice systems; and/or transitioning out of detention into care and from care into adulthood.

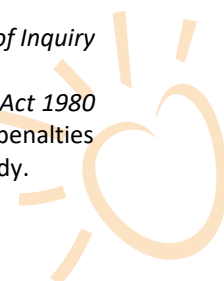
The Call for Submissions also asks whether there is a link between the Child Safety and the Youth Justice systems, and if residential care is operating as a ‘*feeder system*’ to the Youth Justice system.

The Call for Submissions aligns with the Child Safety Inquiry’s Terms of Reference that include evaluating the effectiveness of the Child Safety department as a corporate parent and whether it can meet community expectations around parenting.¹

The Terms of Reference direct the Child Safety Inquiry to undertake its investigations and evaluations through case studies of children and young people who are subject to dual orders under the *Child Protection Act 1999* (**Child Protection Act**) and the *Youth Justice Act 1992* (Qld) (**Youth Justice Act**) and/or under the guardianship of the department of Child Safety and who have committed crimes under the *Making Queensland Safer Act 2024* (Qld) (**Making Queensland Safer Act**).²

¹ Queensland Government Gazette Extraordinary, Vol. 399, Friday 23 May 2025, No.16, *Commissions of Inquiry Act 1950*, Commissions of Inquiry Order (No. 1) 2025, at paragraph 3(d).

² The *Making Queensland Safer Act 2024* (Qld) amended the *Youth Justice Act 1992* (Qld) and the *Bail Act 1980* (Qld), amendment included prescribing certain offences that children could be sentenced to the same penalties as adults and increasing the likelihood that children charged with such offences would remain in custody.



OzChild's Submissions

OzChild's November 2025 Submission

In November 2025, OzChild made a submission to the Child Safety Inquiry (**OzChild November 2025 Submission, at Annexure B**).³

The OzChild November 2025 Submission is directly relevant to the Child Safety Inquiry's December 2025 Call for Submissions. It outlines the opportunity for the Child Safety department to scale up delivery of a program that works, Treatment Foster Care Australia (**TFCA**).

OzChild has successfully customised TFCA to the local context, known as Treatment Foster Care Australia – Queensland (**TFCA-QLD**). OzChild delivers TFCA-QLD in Toowoomba, Ipswich and Ormeau. It is successfully exiting children 12 years and under out of residential care and avoiding new entries.

TFCA-QLD is an intervention that improves the effectiveness of the Child Safety department as a corporate parent. It reduces a child's anti-social behaviours, delivers therapeutic treatment enabling healing from trauma, and re-engages a child in education. TFCA-QLD also works concurrently with the child's parents or planned home-based foster or kinship placement, building their capacity to support the child and maintain a stable placement.

TFCA-QLD is reducing reliance by the Department of Families, Seniors, Disability Services and Child Safety (**Child Safety department**) on residential care, a system designed for children 12 years and over, for Queensland's children who are 12 years and under.⁴ It is improving the outcomes for these children by removing them from a residential care setting, which also reduces their likelihood of engagement in the youth justice system.

The OzChild November 2025 Submission outlined that the evidence-based program TFCA-QLD is scalable for delivery in regional Queensland. Further, the expansion of TFCA-QLD is a practical and tangible measure to reduce the number of children in, and the reliance on, residential care in Queensland.

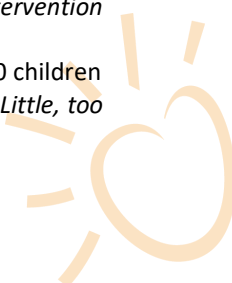
This Submission

OzChild welcomes the opportunity to continue to contribute to the Child Safety Inquiry's important work.

This submission responds to the Child Safety Inquiry's December 2025 Call for Submissions in respect of *“corporate parenting and the links between the child safety and youth justice systems”*. This submission builds and expands on the OzChild November 2025 Submission.

³ See OzChild's Submission to the Child Safety Inquiry, *“Treatment Foster Care Oregon (TFCO) OzChild's Model of Care Treatment Foster Care Australia – Queensland (TFCA – QLD) – A behavioural and treatment intervention that is exiting children 12 years and under out of residential care in Queensland”*, 5 November 2025.

⁴ In Queensland, residential care was designed for children over 12 years of age, but of the over 2,000 children in residential care, one in three is under the age of 12. Queensland Family & Child Commission *“Too Little, too late, The progress made against the Queensland Residential Care Roadmap”*, December 2024, pg 20.



This submission outlines:

- The role and responsibilities of the Child Safety department as a '*corporate parent*' for children and young people in care, engaged in the youth justice system, or in youth detention.
- The need for a whole of Queensland Government approach to reduce the multiple challenges experienced by families and prevent child maltreatment.
- The greater prevalence of child maltreatment and cumulative harm for children and young people in care, known to the youth justice system, or in youth detention.
- The Child Safety department as a corporate parent is not providing consistent, protective, trauma-informed care to children and young people in care, known to the youth justice system, or in youth detention.
- The opportunity for new whole of Queensland Government approach to corporate parenting that mandates priority services across areas such as health and education to support children and young people in care and youth detention to be safe, healthy, well, and successfully transition to adulthood.
- The need for trauma informed care and interventions that address the impacts of chronic child maltreatment and cumulative harm to children and young people prior their entry into care or youth detention.
- Implementing interventions and programs that have been demonstrated to work to reduce anti-social and offending behaviours in children and young people and improve the capacity of their families to manage and care for them. Two exemplars of evidence-based programs are outlined, Multisystemic Therapy (**MST**) and Functional Family Therapy (**FFT**).



Executive Summary

Queensland's children and young people are early in their lives. For children and young people in families experiencing disadvantage they are both early in their lives and early in need.

The largest cohort of children and young people known to the Child Safety system are born into families experiencing multiple challenges - such as domestic and family violence, substance misuse, mental health concerns, and housing insecurity. These family challenges increase the risk of child maltreatment and harm.⁵

Child maltreatment can be physical abuse, sexual abuse, emotional abuse, neglect, and/or exposure to family and domestic violence.

Child maltreatment leads to poor outcomes for children and young people, Child Safety and Youth Justice service utilisation and perpetuates an intergenerational cycle.

Reducing family challenges and child maltreatment requires a whole of Queensland Government approach across portfolio areas, such as health, mental health, education and housing.

For children and young people in care, under a Child Protection and Youth Justice order, or in youth detention, improving the effectiveness of the Child Safety department as their corporate parent also requires a whole of Queensland Government approach. Mandating services and outcomes for these children and young people will support them to heal, be healthy, meaningfully engage in learning, and successfully transition to independent adulthood.

As a corporate parent, the Child Safety department and service providers must provide trauma informed care and interventions that addresses the impacts of chronic maltreatment and cumulative harm experienced by children and young people before entering care or youth detention.

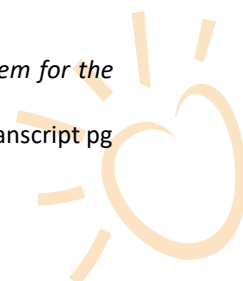
To reduce the number of children entering care or in youth detention and better support the transition out, the Child Safety department can also deliver evidence-based whole of family interventions. Evidence-based interventions are structured and proven to deliver consistent outcomes. They enhance family functioning and reduce a child or young person's emotional issues, offending, re-offending and/or anti-social behaviours. Examples of evidence-based interventions proven to work are Multisystemic Therapy (**MST**) and Functional Family Therapy (**FFT**).

The Honourable Paul Anastassiou KC, Commissioner of the Child Safety Inquiry, has called for real and practical assistance to prevent entries into care and deliver better services to children and young people in care.⁶ This submission calls for:

- A whole of Queensland Government approach to reduce family adversity and prevent child maltreatment and entries into care.
- A whole of Queensland Government approach to deliver services to children and young people in care, which are beyond the remit and funding to the Child Safety department as a corporate parent.
- The importance of the Child Safety department's care and interventions being trauma informed.
- Implementing whole of family interventions grounded in evidence that have been proven to work to reduce anti-social behaviours, offending by children and young people, promote pro-social behaviours, and improve family functioning. Examples of such interventions include MST and FFT.

⁵ Higgins, D.J., Herrenkohl, T. I., Lonne B., Scott, D., "Advancing a prevention-oriented support system for the health and safety of children", Children and Youth Services Review 159 (2024) 107521, pg 1.

⁶ See Commission of the Inquiry into Queensland Child Safety System, Public Hearing 23 July 2025, transcript pg 13.



Queensland has successfully implemented TFCA-QLD, demonstrating its agility to implement rigorous evidence-based models and exit child from residential care. MST and FFT are evidence-based that can also be implemented successfully in Queensland.

The Child Safety Department's role and responsibilities as a 'corporate parent'

The purpose of the Child Protection Act is to provide for the protection of children, to promote the safety of children, and to the extent that it is appropriate, support families caring for children.⁷

Parental responsibility for a child in care and engaged in youth justice

The Child Safety department is legally responsible and exercises parental responsibilities for:

- a child or young person in care under a Child Protection Act order;
- a child or young person in care and subject to a youth justice order under the Youth Justice Act (sometimes referred to as a child under 'dual orders'); and
- a child or young person in care and in youth detention.

For a child or young person under a youth justice order or in youth detention, the Child Safety department remains the child's legal parent and exercises parental responsibilities under the Child Protection Act and the Youth Justice Act.

While a child or young person in care is in youth detention, the Department of Youth Justice and Victim Support's (**the Youth Justice department**) responsibilities are for the child's day-to-day supervision and support needs.

The Child Safety department's role as a 'corporate parent'

As a system administrator, the Child Safety department funds, regulates and manages care placements. However, its parental responsibilities for a child or young person in care extend beyond legal guardianship, custody, and the provision of a kinship, foster or residential care placement.

The Child Safety department steps into the parental role and assumes responsibility for the child or young person's safety, wellbeing and development needs. The Child Safety department must proactively work with other government departments, who provide services outside its scope and funding, to identify and meet the individual needs of each child and young person in care, such as health, mental health, education, housing and transition to adulthood support.

For a child or young person in or transitioning from youth detention, the parental role of the Child Safety department is critical. It is responsible for working with the Youth Justice department to ensure the child or young person's needs continue to be met while in detention. The Child Safety department must also support the child or young person's successful reintegration into the community.

The Child Safety department must coordinate decisions, supports, services, and plans for a child's current and future needs across several government departments. Given these parental responsibilities for a child or young person in care, and who may also be under a Youth Justice order or in youth detention, the Child Safety department can be referred to as a "corporate parent".

⁷ Child Protection Act 1999 (Qld).



The Child Safety department's responsibilities as a 'corporate parent'

The Child Protection Act does not explicitly refer to or define the role or the responsibilities of a "corporate parent" of a child or young person in care and who may also be under a Youth Justice order or in youth detention.

It is generally understood that the Child Safety department should act 'as a good parent would'. The Child Protection Act sets principles relevant to making decisions relating to safety, wellbeing and best interests of a child or young person.

The principles in the Child Protection Act are based on those articulated in the *United Nations Convention on the Rights of the Child (the Convention on the Rights of the Child)*. Australia ratified the Convention on the Rights of the Child in 1990, and it became legally binding in 1991. States and territories are responsible for child protection in Australia and must ensure their laws and policies comply with the Convention on the Rights of the Child.

The Convention on the Rights of the Child has four guiding principles that underpin the specific rights of the child:

- the best interest of the child must be a primary consideration for all decisions affecting them (Article 3);
- all children have the same rights (Article 2);
- children must be supported to develop physical, emotionally, socially and mentally (Article 6); and
- children have the right to express their views and have those views taken seriously (Article 12).

The rights of the child include:

- protection from abuse, neglect, exploitation, inhuman or degrading treatment;
- health care, education, and disability support;
- to express views, access information, and have freedom of thought;
- detention only as a last resort and for the shortest appropriate time;
- to legal assistance, treatment that promotes dignity, rehabilitation and reintegration when engaged in youth justice.

The Convention on the Rights of the Child defines a child as anyone under 18 years of age. It recognises specific rights that all children have because of their vulnerability and development needs. Governments have responsibilities to children as right holders; systems and services involving children must focus on their care and future wellbeing.

The child rights set out in the Convention on the Rights of the Child are reflected in the Child Protection Act. Acting in the best interests of the child throughout their childhood and for the rest of their life is reflected in the paramount principle in the Child Protection Act.⁸ Acting in the best interests of a child or young person includes keeping them safe, supporting their connection to culture, community, and family, ensuring access to educational and health services, and upholding their human rights.

⁸ *Child Protection Act 1999* (Qld), Paramount principals. 5A.



The Making Queensland Safer Act 2024 (Qld)

The objectives of *Making Queensland Safer Act Qld (2024) (Making Queensland Safer Act)* include strengthening community safety and increasing accountability for serious repeat offenders. It amended the Youth Justice Act to shift the focus from rehabilitation and diversion to a more punitive approach to children who offend.

The key amendments to Youth Justice Act in the Making Queensland Safer Act are inconsistent with the Convention on the Rights of the Child, specifically:

- the principle that youth detention should be a last resort for children has been weakened; and
- the likelihood of children being remanded into custody and detained in youth detention has increased, particularly for certain offences and repeat offenders; and
- children can be sentenced for certain offences as adults.

Child maltreatment

Child maltreatment refers to acts or omissions by a parent, care giver or person with parental responsibility for a child that results in harm or the risk of harm to a child.

The Australian Child Maltreatment Study (**ACM Study**) defines child maltreatment as physical abuse, sexual abuse, emotional abuse, neglect, and exposure to family and domestic violence.⁹

Child maltreatment includes single events, multiple events and chronic patterns. It can cause significant lifelong impacts on the health and wellbeing of a child or young person and entrench intergenerational experiences of maltreatment.

The prevalence of childhood maltreatment is known from the ACM Study.¹⁰ The ACM Study found that 61 per cent of Australians had experienced one type of child maltreatment and one in four had experienced three to four types.¹¹

Preventing child maltreatment

Children, young people and their families are supported by a continuum of services across universal, secondary, and tertiary platforms. Services aim to promote child safety, wellbeing, development and support families care for their children. In summary:

- **Universal services** promote wellbeing and development (e.g. education and primary health care). They build resilience and protective factors for children, young people and their families.
- **Secondary services** aim to reduce risk and escalation into crisis (e.g. family support services).

⁹ Haslam, D., Mathews, B., Pacella, R., Scott, J. G., Finkelhor, D., Higgins, D. J., Meinck, F., Erskine, H. E., Thomas, H. J., Lawrence, D., & Malacova, E. (2023). *The prevalence and impact of child maltreatment in Australia: Findings from the Australian Child Maltreatment Study: Brief Report*. Australian Child Maltreatment Study, Queensland University of Technology. <http://doi.org/10.5204/rep.eprints.239397>

¹⁰ The Australian Child Maltreatment Study found prevalence rates of maltreatment among people aged 16 to 24 included: 28.2 per cent experienced physical abuse; 25.7 per cent experienced sexual abuse; 34.6 per cent experienced emotional abuse; 10.3 per cent experienced neglect; and 43.8 per cent experienced exposure to domestic violence.

¹¹ Haslam, D., Mathews, B., Pacella, R., Scott, J. G., Finkelhor, D., Higgins, D. J., Meinck, F., Erskine, H. E., Thomas, H. J., Lawrence, D., & Malacova, E. (2023). *The prevalence and impact of child maltreatment in Australia: Findings from the Australian Child Maltreatment Study: Brief Report*. Australian Child Maltreatment Study, Queensland University of Technology. <http://doi.org/10.5204/rep.eprints.239397>, pg 3.



- **Tertiary services** respond after significant harm has occurred, they are reactive, operate under statutory and coercive powers, and are resource-intensive.

Universal and secondary service platforms can reduce family challenges, build protective factors for children, young people and their families, and reduce child maltreatment. Universal and secondary service platforms should be complementary. Secondary services rely on universal service to identify and engage children, young people and their families in a non-stigmatising way when emerging needs are identified.

Families, guardians and carers supporting the journey of children to adulthood require multiple supports and services that are provided by government and non-government organisations across the universal and secondary service platform. They must identify and navigate services available to the children and young people in their care.

Universal and secondary services can be unconnected and siloed, and become standalone systems in themselves e.g. the *child and maternal health system, the education system, the health system, the mental health system*.

For families with multiple challenges, universal and secondary services can be difficult to navigate particularly when they make multiple referrals, fragmented, and not focused on assisting supporting family functioning, addressing the root causes of their challenges, or supporting the improvement of their child’s wellbeing.

For vulnerable children, young people and families, the former National Children’s Commissioner, Ms Anne Hollonds, described the fragmentation of services systems that are meant to help, such as health, education and social services as *“fragmented, piecemeal and uncoordinated, described by some as ‘mid-last century’ in their design and ‘not fit for purpose’ for an ‘epidemic’ of unmet needs today.”*¹²

The role of the Child Safety system

If universal and secondary services are unable to identify and support families to reduce or alleviate the challenges they experience, the risk of child maltreatment increases and children and young people come to the attention of the Child Safety system.

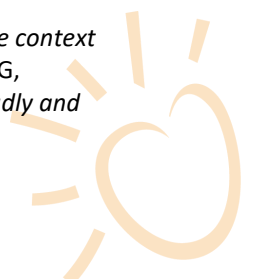
The Child Safety system is a tertiary service system. It investigates discrete events of harm that have already been perpetrated, focuses on intervention after harm has occurred, and on managing the risk of future harm.

Child maltreatment and harm to children and young people is the key driver of demand in the Child Safety system.¹³ However, as a tertiary service, the Child Safety system focuses on incidents of harm. Its remit and resources are not directed at identifying or addressing the root causes of child maltreatment (such as parental mental ill-health and/or substance misuse, socio-economic stress, or housing insecurity etc) or the impacts of cumulative harm to children.¹⁴

¹² Anne Hollonds speech at the National Press Club, 2 August 2024, on the report, *“Help way earlier! How Australia can transform child justice to improve safety and wellbeing”* August 2024, Australian Human Rights Commission.

¹³ Jones, L., Harris, J., Abdelgawad, M., Booth-Rosamond, A., Smith, E., McCoy, E., Ashworth, E., Quigg, Z, *“A mixed-method systemic review. Parenting and whole-of family interventions for families with multiple & complex needs with children & young people 11 to 19”*, Foundations, What Works Centre for Children and Families, December 2025, foundations.org.uk, pg 14.

¹⁴ Collier, S. and I. Bryce, *Addressing cumulative harm: responding to chronic child maltreatment in the context of an intensive family support service*. Journal of Children’s Services, 2021. **16**(3): p. 249–266. Harris LG, Rattambige D, Hunt GR, Higgins DJ, *“Accumulation of violence and victimisation: Why measuring broadly and accounting for different harm types matters”*, Current Opinion in Psychology, <https://doi.org/10.1016/j.copsyc.2025.102260>.



By way of example, in responding to reports about the safety of an unborn child, the Child Safety department was found to be focused on collecting evidence for future statutory child protection interventions and not on prioritising health and wellbeing outcomes for the unborn child, new infant, and their parents.¹⁵

For children and young people in care, the effectiveness of the Child Safety department as a corporate parent is adversely impacted by:

- the high prevalence of child maltreatment driving demand and consuming resources;
- its operation as a tertiary service system, focused on incidents of harm and making referrals to other services;
- its scope and funding, meaning it cannot guarantee the provision of services that are required to promote the safety, health, wellbeing and development of children and young people; and
- the overreliance on and the model of residential care, which is not a therapeutic care model and can cause further trauma to children and young people who have experienced cumulative harm prior to their entry into care.

The impact of adversity and child maltreatment

The pathways of children and young people into Child Safety and Youth Justice systems are rarely unconnected or episodic. Instead, they reflect the impact of adversity, child maltreatment and cumulative harm from factors such as family and domestic violence, parental mental ill-health and/or substance misuse, socio-economic stress, parental engagement in the criminal justice system, and/or repeated exposure to fragmented service systems.¹⁶

The accumulation of adversity in families is linked with a higher prevalence of child maltreatment.¹⁷ Child maltreatment contributes to mental health conditions,¹⁸ causes cumulative harm¹⁹ and a substantial economic burden annually from increased health costs and lost productivity.²⁰

The prevention and reduction of child maltreatment requires a whole of Queensland Government approach to alleviating disadvantage. This approach would prioritise child wellbeing, with Queensland Government departments responsible for universal and secondary services delivering early, coordinated, culturally safe, proactive services and support that actively encourage help seeking by families experiencing adversity. Such a primary prevention approach across universal and secondary services would reduce the risk factors for child maltreatment and enhance protective factors.²¹

¹⁵ Queensland Family & Child Commission. *“Child Death Review Board Annual Report, 2024-2025 – Systemic findings, insights and recommendations of the Queensland Child Death Review Board”*, pg 7 and Chapter 2.

¹⁶ Bromfield, L., Australian Centre for Child Protection, University of South Australia, ACWA Strategy to Action Symposium, *Preventing and Responding to Child Abuse and Neglect – Where are there opportunities for action?* March 2025.

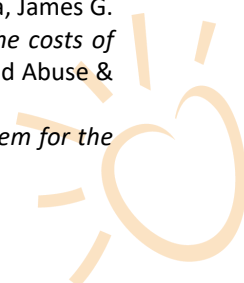
¹⁷ Higgins, D.J., Herrenkohl, T. I., Lonne B., Scott, D., *“Advancing a prevention-oriented support system for the health and safety of children”*, Children and Youth Services Review 159 (2024) 107521, pages 1-2.

¹⁸ Grummitt, L., Baldwin, J. R., Lafoa’l J., Keyes, K. M., Barrett, E, *“Burden of Mental Disorders and Suicide Attributable to Childhood Maltreatment”*, JAMA Psychiatry, 2024;81(8):782-788. doi:10.1001/jamapsychiatry.2024.0804, published online May 8, 2024.

¹⁹ Harris LG, Rattambige D, Hunt GR, Higgins DJ, *“Accumulation of violence and victimisation: Why measuring broadly and accounting for different harm types matters”*, Current Opinion in Psychology, <https://doi.org/10.1016/j.copsyc.2025.102260>.

²⁰ Dai Quy Le, Long Khanh-Dao Le, Marie Bee Hui Yap, Divna M. Haslam, Daryl J. Higgin, Eva Malacova, James G. Scott, David Lawrence, Ben Mathews, Cathrine Mihalopoulos, *“Impact of child maltreatment on the costs of health service use and productivity loss: Findings from the Australian child maltreatment study”*, Child Abuse & Neglect 171 (2026) 107818.

²¹ Higgins, D.J., Herrenkohl, T. I., Lonne B., Scott, D., *“Advancing a prevention-oriented support system for the health and safety of children”*, Children and Youth Services Review 159 (2024) 107521, pg 4.



A prevention approach cannot be limited to the period of early childhood but must be across the life course of children and young people and well before an immediate safety concern arises.²²

A whole of Queensland Government commitment to alleviating adversity and preventing child maltreatment could be informed by the Scottish approach, “*Getting it Right For Every Child*” (GIRFEC). GIRFEC is a long-standing and bipartisan commitment and framework for improving outcomes and wellbeing of children through a coordinated services approach focused on early intervention and the rights of the child. GIRFEC is legislated in the *Children and Young People (Scotland) Act 2014*. It is a universal framework for all Scottish children and young people that aims to provide the right support at the right time for all children and their families.

The effectiveness of the Child Safety department as a corporate parent of children and young people in care

Child maltreatment and cumulative harm

For children and young people in care, the ACM Study found that the prevalence of child maltreatment was significantly higher and more intense than in the general population. Children and young people in care reported more types of maltreatment, more frequent exposure, earlier onset, longer duration, and more perpetrators than their peers.²³

Cumulative harm is caused by the compounding impact of ongoing and/or multiple experiences of child maltreatment. Cumulative harm can significantly impair a child or young person’s safety, wellbeing and development over time. It is often associated with chronic neglect.²⁴

Children and young people who enter care with cumulative harm may experience additional challenges in care due to their impaired emotional, behavioral, relational and development functioning.

Trauma Informed Care

Treating cumulative harm requires trauma-informed care. Trauma-informed care includes understanding that a child or young person’s behaviours, emotions, relationships, and development may be a response to trauma. Trauma-informed care recognises the impact of trauma on a child or young person and responds by integrating that understanding into how care and other services

(such as education and health care) are delivered to ensure that they promote safety, trust, empowerment, avoid re-traumatisation and build protective factors and resilience.²⁵

If the cumulative harm of a child or young person is not treated in care, it can lead to placement instability, disrupted relationships and education, and further trauma.²⁶

This can result in a residential care placement. Residential care in Queensland is not a therapeutic model of care. Therefore, a placement in residential care can cause further harm. It can also lead to children and young people becoming known to the Youth Justice system.

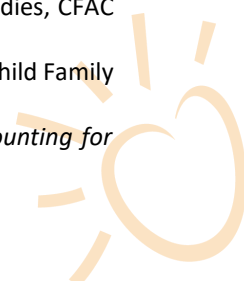
²² Higgins, D.J., Herrenkohl, T. I., Lonne B., Scott, D., “*Advancing a prevention-oriented support system for the health and safety of children*”, *Children and Youth Services Review* 159 (2024) 107521, pg 2.

²³ Harris LG, Higgins DJ, Willis ML, Lawrence D, Meinck F, Thomas HJ, Malacova E, Scott JG, Pacella R, Haslam DM, “*Dimensions of child maltreatment in Australians with a history of out-of-home care. Child Maltreatment*” 2025 August, 30(3):525-39.

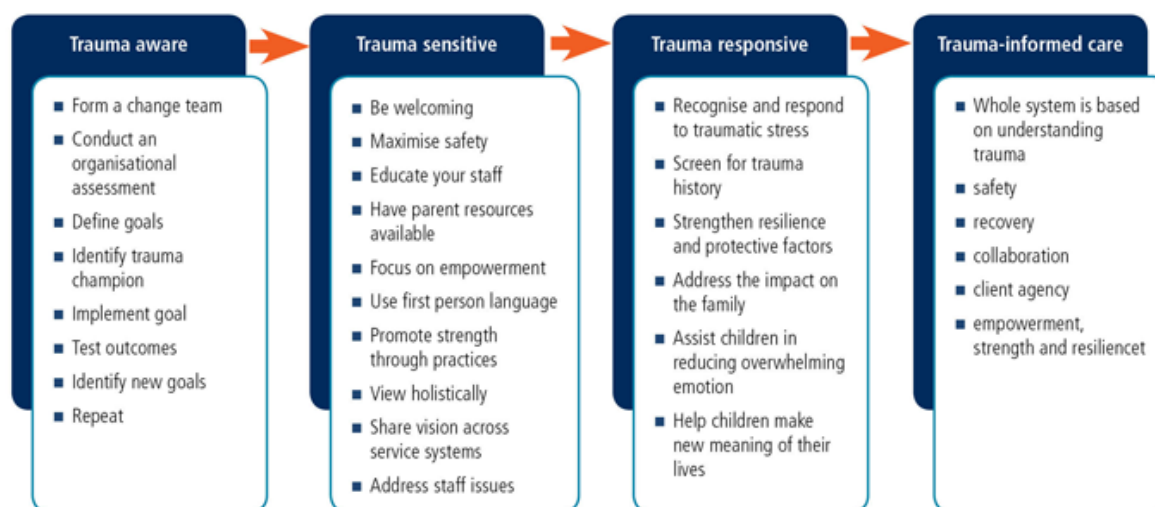
²⁴ Price-Robertson. P., Rush., P., Wall., L., Higgins, D., “*Raley an isolated incident. Acknowledging the interrelatedness of child maltreatment, victimisation and trauma*”, Australian Institute of Family Studies, CFAC Paper No. 15 2013.

²⁵ Wall, L., Higgins, D., & Hunter, C. (2016). “*Trauma-informed care in child/family welfare services.*” Child Family Community Australia information exchange, Australian Institute of Family Studies, Melbourne

²⁶ Harris, L.G., et al., *Accumulation of violence and victimisation: Why measuring broadly and accounting for different harm types matters.* *Current Opinion in Psychology*, 2026: p. 102260.



The Australian Institute of Family Studies has set out practical steps to support services and workers move from being aware of trauma to providing trauma informed care, outlined in the table **below**.²⁷



The Outcomes and Experiences of Children and Young People in Care

The experiences and outcomes of children and young people in care are consistently poorer than those of their peers. The numerous challenges for children and young people in care include difficulties in accessing mental health services (despite high levels of mental health issues), exclusions from education, and insufficient supports to successfully transition from care to independent living and adulthood (such as the provision of housing). These challenges are evident in the Child Safety department’s “*Children in Care Census 2024*”.²⁸

The Queensland Families and Child Commission’s (QFCC) annual performance report of Queensland’s Child Protection system in 2024-25²⁹ reports on the experience and outcomes for children and young people in care. The QFCC report outlines safety risks, limited disability and mental health supports, and poor educational engagement of children and young people in care.³⁰

The report identifies that young people exiting care or youth detention also face higher risks of homelessness, poor mental health, and early death without sustained supports.³¹

The effectiveness of the Child Safety department as a corporate parent – residential care

Children and young people in residential care have significantly higher levels of complexity compared to children in home-based care (kin or foster)³² and are more likely to have a diagnosed or suspected mental illness.³³

Whilst children and young people in residential care live in a house, it is also a workplace, and multiple staff are required to fill a 24/7 roster. In this accommodation model of care, the Child Safety

²⁷ [Trauma-informed care in child/family welfare services | Australian Institute of Family Studies](#)

²⁸ Department of Families, Seniors, Disability and Child Safety, “*Children in Care Census*”, 2024.

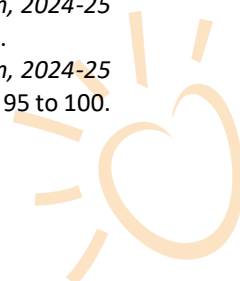
²⁹ Queensland Family and Child Commission, “*Performance of the Queensland child protection system, 2024-25 Annual Report*”.

³⁰ Queensland Family and Child Commission, “*Performance of the Queensland child protection system, 2024-25 Annual Report*”, pages 3, and set out in “*Experiences of Children and Young People*” at pages 71 to 92.

³¹ Queensland Family and Child Commission, “*Performance of the Queensland child protection system, 2024-25 Annual Report*”, pages 3, and set out in “*Outcomes after involvement with statutory services*” at pages 95 to 100.

³² Department of Families, Seniors, Disability and Child Safety, “*Children in Care Census*”, 2024 pg 4.

³³ Department of Families, Seniors, Disability and Child Safety, “*Children in Care Census*”, 2024 pg 15.



department as a corporate parent is reliant on other government departments to provide services such as health and education. These services must understand the impacts of cumulative harm, be trauma informed and tailored to engage and promote participation by children and young people.³⁴

The Child Safety Inquiry heard evidence from medical professionals at its September 2025 Far North Queensland public hearings in Cairns that children and young people in residential care do not receive preliminary or comprehensive health and development checks and assessments in accordance with the *National Clinical Assessment Framework for Children and Young People in Out-of-Home Care*.³⁵ Further, trauma-informed supports and services for children and young people in residential care are often not available.

The workforce environment and limited capacity of residential care workers can also exacerbate the challenges experienced by children and young people in their care. The placement of up to four unrelated children and young people with multiple challenges in a house can compound complex behaviours. Highly skilled and experienced workers trained in delivering trauma informed care and with the capacity to support children and young people to understand and manage their own behaviours is essential.

Residential care workers in Queensland must have, or be working towards, a Certificate IV qualification and undertake five hours of mandatory online training. Arguably, neither credential prepares residential care workers to manage the complex and multiple needs of children and young people in their care.

Children and young people can also be exposed to, and encouraged to participate in, anti-social behaviours by other children and young people in their residential care home.

Consequently, residential care workers may contact the Police to assist in managing behaviours of children and young people in residential care, which often criminalises such behaviours.

There have been numerous studies and reports into the links between the residential care and youth justice systems. In New South Wales, longitudinal studies have shown that children with residential care experience are more likely to be engaged in the justice system.³⁶

In Victoria, the Sentencing Advisory Council examined the intersection of child protection and youth justice systems. Their report, *'Crossover Kids': Vulnerable Children in the Youth Justice System*, identified that children and young people with a care experience, particularly a residential care experience, are vulnerable and overrepresented in the youth justice system.³⁷

The report of the Australian Senate's Legal and Constitutional Affairs Reference Committee, *"Australia's youth justice and incarceration system"* considered the *'social determinants of justice'* and highlighted care as a key risk factor for engagement in the youth justice system.³⁸

³⁴ In Queensland residential care is not a therapeutic model of care. Instead, it is an accommodation model, with 24/7-hour shift workers, and reliant on service provision by government departments and agencies other than the Child Safety department, such as health, mental health and education.

³⁵ National Clinical Assessment Framework for Children and Young People in Out-of-Home Care, March 2011.

³⁶ The New South Wales Government funded *"Pathways of Care Longitudinal Study – Improving the long-term outcomes of children in Out-of-Home Care"*. It commenced in 2011 and is a large-scale longitudinal study of children and young people care and focuses on child development domains of physical health, socio-economic wellbeing and cognitive/learning ability. This study shows that children and young people with a residential care experience have lower school engagement, attendance and achievement, are more likely to be suspended or excluded, are less likely to meet national literacy and numeracy benchmarks and are more frequently involved in the justice system.

³⁷ Sentencing Advisory Council, *"Crossover Kids': Vulnerable Children in the Youth Justice System. Report 1: Children Who Are Known to Child Protection among Sentenced and Diverted Children in the Victorian Children's Court"*, June 2019.

³⁸ The Senate, Legal and Constitutional Affairs Reference Committee, *"Australia's youth justice and incarceration system"*, February 2025, pages 11 to 14.



The effectiveness of the Child Safety department as a corporate parent – youth detention

The effectiveness of the Child Safety department as a corporate parent and in upholding the rights of children in care and in youth detention are impacted by the Making Queensland Safer Act. It shifts the focus away from rehabilitation and reintegration to primarily seeing children and young people as offenders. It is also likely to fail to make the community safer.

The Making Queensland Safer Act is likely to disproportionately impact groups already overrepresented in the Child Safety and Youth Justice systems, including First Nations children, children in care (particularly residential care) and children with unmet mental ill health and/or disability.

Extensive research and evidence demonstrate that early and increased contact with the justice system and youth detention is associated with higher rates of recidivism, poorer educational outcomes, and increased transition into the adult criminal justice system. Engagement in the adult criminal justice system drives intergenerational engagement in the Child Safety system.

The QFCC has also found youth detention facilities to consistently fail to meet standards relating to safety, dignity, education, health, cultural connection, and freedom from isolation and restraint for children and young people.³⁹

Consequently, the Making Queensland Safer Act and the conditions in youth detention adversely impact the Child Safety department's ability to be an effective corporate parent. In this respect, detention is no longer the last resort and for the shortest period of time, children and young people are not considered vulnerable by reason of their age and instead can be sentenced as adults, and they may experience inhuman or degrading treatment in youth detention centers.

The transition supports for children and young people from detention to care, family, or independent adulthood have been found to be insufficient and not based in evidence.⁴⁰

However, to address this, transition support has been funded by the Queensland Government ("Staying on Track") in the 2025-26 state budget.

"...too many Queensland children remain in residential care, too many young people are in detention, and too many families are facing trauma from suicide, violence, and addiction"

Principal Commissioner Mr Luke Twyford, QFCC 2024-2025 Annual Report, page 5.

A new approach to corporate parenting

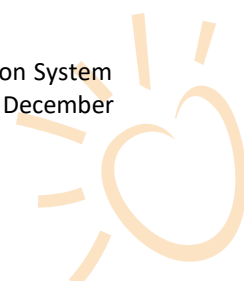
Children and young people in care need support and interventions to address the reasons for their entry into care and the cumulative harm caused by maltreatment. They need services that proactively identify and address their individual needs to be healthy, engaging in learning, and pro-social behaviours.

The effectiveness of the Child Safety department as a corporate parent could be improved by mandating provision of support and accountability by all Queensland Government departments for children and young people in care and youth detention.

A new Corporate Parenting Model could require the State of Queensland, and all its ministers, agencies and departments, to be responsible and accountable for upholding the rights of children and

³⁹ Queensland Family and Children Commission, Inquiry into Australia's Youth Justice and Incarceration System "Submission to the Australian Federal Senate Legal and Constitutional Affairs Reference Committee", December 2025, pg 4.

⁴⁰ Queensland Audit Office, "Reducing serious youth crime (Report 15: 2023-24)", pages 3, 33, 34.



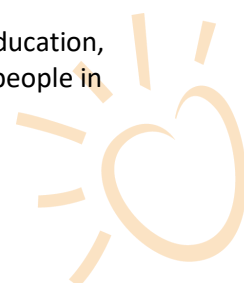
young people in care in their specific service-delivery roles. This would promote the health and wellbeing of children and young people in, at risk of entering, or transitioning from care or youth detention.

The elements of an effective corporate parenting model

An effective corporate parenting model goes beyond statutory parental responsibilities. It ensures that children in care and young people in care receive the same level of commitment, care, services, and opportunities that a good parent would provide for their child.

The elements of an effective corporate parenting model and practical examples for the Queensland context include:

- **Legislating a corporate parenting model:** conferring corporate parenting responsibilities onto a broad range of departments responsible for delivering services such as health, mental health, education, housing.
- **A shared vision and leadership across government departments providing services to children and young people in care:** that places children and young people at the center of decision-making, strong leadership and culture of ensuring provision of services to children and young people in care.
 - For example, the health department would proactively engage and coordinate with the Child Safety department in respect of new care placements and make appropriate arrangements for assessments and health and mental health care.
- **Governance and accountability:** a corporate parenting framework that clearly defines what government departments are corporate parents, their roles, responsibilities, and performance monitoring requirements to ensure that timely and quality services are provided and that they deliver specific and measurable outcomes to children and young people in care. For example:
 - The health department as a corporate parent would meet the requirements of the “*National Clinical Assessment Framework for Children and Young People in Out-of-Home Care*”, such as Preliminary Health Checks no later than 30 days after a child or young person enters care (to identify immediate health concerns); and a Comprehensive Health and Developmental Assessment within three months of a care placement.
 - The education department as a corporate parent would proactively promote engagement in education for children and young people in care, and arrange supports to assist with learning and enable meaningful engagement. School exclusions for children and young people in care could have clear conditions, such as being undertaken in the school environment, requiring immediate alternative arrangements for learning, addressing behavioural concerns that caused the exclusion, and a timely plan to transition to return to school being in place and monitored for compliance.
- **Child-centred decision making:** policies, guidance and actions are informed by children’s needs and wishes, ensuring their voices are heard and respected.
 - For example, a known and trusted person to the child or young person is identified who they feel comfortable to freely express their views to. Complemented by annual surveys undertaken by the Child Safety department of children and young people in care.
- **Cross department coordination:** effective coordination between services such as education, health, housing, and Child Safety to ensure holistic support for children and young people in care.



For example:

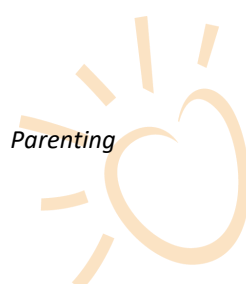
- The health and Child Safety departments proactively coordinating applications to the National Disability Insurance Scheme (**NDIS**) for children and young people assessed as having a disability.
- The housing department coordinating with the Child Safety department to know and plan well in advance of young people transitioning from care to adulthood and ensure housing is immediately available on exit from care.
- **Stable and supportive relationships:** prioritising placement stability and trauma informed care, with consistent carers and workers, to support children and young people feel secure and valued and enable them to heal from cumulative harm prior to entry to care.
 - For example, the provision of trauma informed and therapeutic supports to enable children and young people to heal from the harm that resulted in their entry to care.
 - A commitment and investment in ongoing training and development for workers across services such as health, education, and residential care to understand and provide trauma informed care.
- **Outcomes, measurement, reporting and high aspirations:** identifying specific, evidence-based and measurable outcomes for children and young people and collecting and reporting on consistent data against these outcomes. In conjunction with having high aspirations for the children and young people in care in education, health, emotional wellbeing, and future independence.

Effective corporate parenting model elements have also been considered in the United Kingdom by the All-Party Parliamentary Group for Care-Experienced Children and Young People (**APPG Care Group**), with their report making several recommendations.⁴¹

Jurisdictional approaches to corporate parenting

A Queensland legislative mandate for providing support and associated policies and operational frameworks could be informed by the Scottish approach “*The Promise*” as well as by the Bill introduced to the Victorian Parliament on 2 December 2025, “*Children, Youth and Families Amendment (Supporting Stable and Strong Families)*”.

⁴¹ APPG for Care-Experienced Children and Young People, “*Inquiry on Extending Corporate Parenting Responsibility across the Public Sector Final Report*”, March 2024.



Scotland - “The Promise”

“The Promise” responded to the independent review into the legislative underpinnings, practices, culture and ethos of the Scottish care system. It was conducted in consultation with over 5,500 individuals including those with a care experience and their families.

The “Independent Care Review” found that the Scottish care system:

- failed to provide consistent love, safety and respect for children and young people; and
- experiences of children and adults in care revealed trauma, instability and poor outcomes.

The “Independent Care Review” called for:

- The balance of power to be upended so that listening to children and young people is always the basis of all decisions made about their lives.
- A focus on building and maintaining life-long relationships, including a broader understanding of the risk of not having long term, loving relationships.
- Scotland must parent, not process, children and young people. There must be no difference between the lives of children and young people in care and their peers. Children and young people in care must not miss out on the kind of childhood that many take for granted and the future that all young people deserve.
- Families must be kept together wherever it is safe to do so. Families must get the support that is right for them at the earliest opportunity. Support to families must be flexible, consistent, patient and free from stigma. This will mean children and young people can live safely and happily with their families.⁴²

“The Promise” is a pledge to Scottish children and young people with a care experience to grow up loved, safe and respected by 2030. It requires immediate action to improve experiences and outcomes for children, young people, adults and their families who are currently in or on the edge of care; young people who are moving on from children’s care services. The Promise also requires action over the longer term to improve the level of support for families from birth through to adulthood to significantly reduce the numbers of families coming into the care system.

“The Promise” has five foundations:

- voice of the children must be heard at all stages;
- what all families need to thrive;
- care, that builds childhoods for children who Scotland has responsibility for;
- people, with a relentless focus on the importance of relationships; and
- scaffolding, so that the structure is there to support children and families when needed

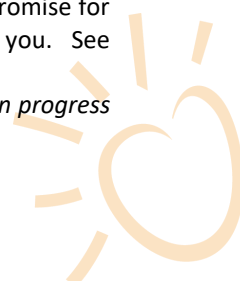
To keep its “The Promise” Scotland has recognised the interdependences across portfolio areas and the requirement for a commitment to prioritise decision making to improve outcomes for children, young people, adults and families with a care experience.⁴³

The Scottish Government developed the “Keeping the Promise implementation plan” to deliver on the “The Promise”.⁴⁴ The implementation plan sets out actions and requirements across government departments, including:

⁴² On 5 February 2020, the Scottish Care Review published seven reports: The Promise and a Pinky Promise for younger readers; The Plan; The Money and Follow the Money; The Rules; and Thank you. See <https://www.carereview.scot/conclusions/independent-care-review-reports>.

⁴³ Scottish Government, “Keeping The Promise to our children, young people and families – Update on progress 2024”, pg 7.

⁴⁴ See <http://www.gov.scot/publications/keeping-the-promise-implementation-plan>.



- coordination by a lead government agency;
- dedicated funding for prevention including family supports;
- re-imagined codes of practice and service standards;
- better access for care-experienced children to universal education and health services; and
- revised workforce development frameworks.

“We grow up loved, safe, and respected so that we realise our full potential.”

Scotland’s Ambition for children and young people

Victoria - Supporting Stable and Strong Families

The Victorian Bill, *“Children, Youth and Families Amendment (Supporting Stable and Strong Families)”* introduced into parliament on 2 December 2025 is based on *“The Promise”*.

The Victorian Bill’s objective is to achieve a fundamental shift in how government cares for the most vulnerable children and young people. The aim is to move away from a reactive referral model to a proactive model of collective government responsibility.

The aim of the Victorian Bill is to provide comprehensive supports that promote earlier interventions and support families to stay together and to address the diverse needs of children in care.

Evidence-based models reducing engagement in the child safety and youth justice systems

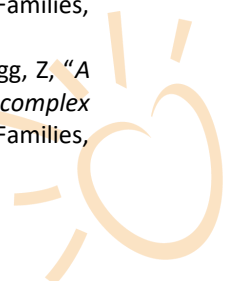
Structured interventions have set components that conceptualise behavioural problems as embedded within broader family and social systems. They aim to shift dysfunctional interactions, enhance parenting and improve problem-solving within the family unit. These interventions include therapy and coaching sessions with parents, children and young people, focused on restructuring family dynamics, goal setting, and family led change.⁴⁵ They aim to reduce maltreatment, enhance the child-parent relationship, and reduce behavioural problems.

Structured interventions are delivered by qualified therapists, psychologists and social workers, with specialist family therapy expertise and often postgraduate qualifications and training. They are supported by ongoing training, supervision and support to deliver evidence-based interventions as intended to achieve consistent outcomes.

Structured whole-of family interventions that reduce parenting stress and offending and anti-social behaviours are proven to improve family functioning and child wellbeing.⁴⁶

⁴⁵ Jones, L., Harris, J., Abdelgaward, M., Booth-Rosamond, A., Smith, E., McCoy, E., Ashworth, E., Quigg, Z, *“A mixed-method systemic review. Parenting and whole-of family interventions for families with multiple & complex needs with children & young people 11 to 19”*, Foundations, What Works Centre for Children and Families, December 2025, foundations.org.uk, pg 30.

⁴⁶ Jones, L., Harris, J., Abdelgaward, M., Booth-Rosamond, A., Smith, E., McCoy, E., Ashworth, E., Quigg, Z, *“A mixed-method systemic review. Parenting and whole-of family interventions for families with multiple & complex needs with children & young people 11 to 19”*, Foundations, What Works Centre for Children and Families, December 2025, foundations.org.uk.



MST and FFT are evidence-based interventions that deliver structured intensive interventions in the home. They are designed for children and young people engaged in offending and/or anti-social behaviour.

MST and FFT work with the child or young person and their family to understand and address their individual and root causes of offending and anti-social behaviour. Concurrently, MST and FFT interventions work with parents or guardians to improve the overall quality of their parenting and enhance the relationship with their children.

OzChild collaborates with the Child Safety and Youth Justice system to deliver MST and FFT across Australian jurisdictions. OzChild's experience and expertise in the delivery of evidence-based models, with high fidelity, is demonstrated to consistently achieve outcomes for children, young people, and their families.

The evidence-based models MST and FFT are considered in detail in **Annexures C and D**.

"The other services hadn't worked. I think they refer because they can, but it doesn't really meet our needs.... You name it, I've done it. I wasn't sitting on my arse at home. We were always trying to find help for my son. I thought he was going to be locked up".

Parent in New South Wales on services provided prior to FFT



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Supporting Documentation

- **Annexure A** - Commission of the Inquiry into Queensland Child Safety System, December 2025 Call for Submissions
- **Annexure B** - OzChild November 2025 Submission
- **Annexure C** - Multisystemic Therapy (MST)
- **Annexure D** - Functional Family Therapy (FFT)



Child Safety Commission of Inquiry



Call for submissions

Corporate parenting and the link between the child safety and youth justice systems

The Commission of Inquiry into the Child Safety System invites submissions from the public in respect of the Department's role as a corporate parent and the link between the child safety and youth justice systems.

- Is the Department an effective corporate parent and is it meeting community expectations in relation to parenting, particularly in respect of:
 - children and young people who are placed in non-family-based (residential) care;
 - young people in care who are known to both the child safety system and the youth justice system;
 - young people who are transitioning out of detention into care and care into adulthood?
- What is the link, if any, between the child safety system and the youth justice system? For instance, do elements of the child safety system operate as a 'feeder system' to the youth justice? What are the factors contributing to children in care entering the youth justice system?
- Experiences of information sharing, communication and engagement between government agencies in relation to 'dual order' youth offenders.
- The experiences of non-family based (residential) care workers, foster carers and kinship carers in dealing with children in care who are known to the youth justice system and/or youth offenders.
- The experiences of children in family-based and non-family-based (residential) care who have also been in the youth justice system.
- The experiences of children in family-based and non-family-based (residential) care of contact with other children in care who have also been in the youth justice system and the impact of that contact upon their experiences in care.
- The experiences of community members who have been:
 - victims of crime at the hands of young people who were in care at the time of the offending;
 - negatively affected by the conduct of children and young people housed in non-family based (residential) care facilities in their neighbourhoods.

To make a submission, visit the Commission website at www.childsafetyinquiry.qld.gov.au/submissions.

Due date for submissions: Friday 23 January 2026

Annexure B

Submission to the Queensland Child Safety Commission of Inquiry

Treatment Foster Care Oregon (TFCO)

OzChild's Model of Care

Treatment Foster Care Australia - Queensland (TFCA-QLD)

A behavioural and treatment intervention that is exiting children 12 years and under out of residential care in Queensland

Date: 5 November 2025

Acknowledgement of Country

OzChild acknowledges the First Peoples of Australia as the traditional custodians of the land on which we work. We acknowledge their cultures are living ones, which relate to their ongoing connection to all things living and non-living on land, sea and sky. We pay our respects to their Elders past and present.

May the children of today lead us to a brighter tomorrow.

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About OzChild

OzChild is a not-for-profit community service organisation committed to improving the lives of a-risk children, young people and their families, and supporting foster and kinship carers. OzChild's purpose is to strive to give every child what is needed and what the evidence says works. OzChild achieves its purpose through long-standing expertise in the delivery of evidence-based models, which are specifically adapted to the local context.

OzChild employs over 800 staff, carers and volunteers in Queensland, Victoria, New South Wales and the Australian Capital Territory, delivering 23 programs and services to over 10,000 children, young people and family members annually.

OzChild has successfully trialled and implemented the Treatment Foster Care Oregon (**TFCO**) evidence-based model in Australia since 2016, adapted to the local context in Australia and now known as Treatment Foster Care Australia (**TFCA**).

This submission focuses on OzChild's delivery of TFCA - Queensland (**TFCA-QLD**) in Toowoomba and Ipswich since 2018, which has more recently been expanded to Ormeau.

OzChild delivers TFCA in Victoria (**TFCA-VIC**) and New South Wales (**TFCA-NSW**). OzChild also delivers evidence-based models, Multisystemic Therapy (**MST**)¹ and Functional Family Therapy – Child Welfare (**FFT-CW**)², in Victoria and New South Wales. OzChild would welcome the opportunity to discuss these models with the Inquiry.³

¹ MST is an evidence-based model designed to reduce anti-social behaviours (such as drug use) and youth offending and re-offending. Its objective is to reduce young people being placed in custody and/or statutory care.

² FFT-CW designed for families involved with Child Safety where children are at risk of abuse, neglect or removal into care

³ OzChild delivers evidence-based models in New South Wales, Victoria and the Australian Capital Territory. Please refer to our website for more details: <https://www.ozchild.org.au/our-work/prevention-strengthening-families>.



1. Executive Summary

Residential care harms children more than it helps them. It dislocates children from their family, friends and culture, and for many, that dislocation never heals.

In Queensland, residential care was designed for children over 12 years of age, but of the over 2,000 children in residential care, one in three is under the age of 12.⁴

Residential care is an accommodation service with 24/7 rostered staff. It is “widely acknowledged as the most expensive and least preferable form of placement, especially for younger children or those requiring more stable environments.”⁵ Moreover, the average cost of residential care in Queensland is 13.77 times higher than for a child in home-based care (kinship and foster care).⁶

The underlying reasons for a child’s removal from their birth family and placement into residential care, instead of kinship or foster care, are not addressed in residential care. Children do not receive treatment for the trauma they have experienced nor support to manage their behavioural and emotional issues, which are exacerbated in a residential care setting.

In Queensland, residential care is also a billion-dollar industry, consuming 51 per cent of total state Child Protection expenditure, for services to approximately 2,000 children. An additional 4,000 Queensland children are predicted to enter residential care by 2030⁷. The growth of residential care and associated costs is a phenomenon unique to Queensland among Australian states and territories⁸.

For Queensland, exiting children currently in residential care and significantly reducing future placements is vital and urgent work. It requires the implementation of models of care that the evidence tells us work, having regard to “*all of the exigencies that bear upon the State as the notional parent to many children throughout Queensland*”.⁹

Successfully and sustainably reducing residential care placements and preventing entries is only possible when children receive the treatment they need to heal and manage their behaviours; support and coaching to engage in pro-social activities such as education; and enforced distance to help children disengage from problematic peers.

It is in this context that OzChild makes this submission to the Commission of Inquiry into Queensland’s Child Safety System (**Inquiry**). This submission details the only model of care in Queensland (Treatment Foster Care Australia – Queensland, known as **TFCA-QLD**), that has proven success at exiting children from, and preventing entry into, residential care of children aged 7 to 12 years old. Almost half of these children are Aboriginal or Torres Strait Islanders.

Indeed, in his evidence at the Inquiry’s Carins Public Hearings, Mr Tom Allsop, the Chief Executive Officer of PeakCare Queensland Inc¹⁰, raised the evidence-based model Treatment Foster Care Oregon (**TFCO**), adapted to the local context in Australia and now known as Treatment Foster Care Australia (TFCA).

⁴ “*Too Little, too late, The progress made against the Queensland Residential Care Roadmap*”, Queensland Family & Child Commission, December 2024, pg 20.

⁵ Queensland Family & Child Commission. *Buyer Beware, How economic forces are shaping Queensland’s residential care market*, Queensland Family & Child Commission. August 2025. pg 13.

⁶ *Buyer Beware, How economic forces are shaping Queensland’s residential care market*, Queensland Family & Child Commission, pg 14.

⁷ Queensland Family & Child Commission. *Buyer Beware, How economic forces are shaping Queensland’s residential care market*, Queensland Family & Child Commission. August 2025. pg 1 and 20.

⁸ Child Safety Commission of Inquiry, 23 July 2025, at transcript pg 18.

⁹ Child Safety Commission of Inquiry, 23 July 2025, at transcript pg 13.

¹⁰ PeakCare is a not-for-profit peak body for the child and family services sector in Queensland.



TFCA-QLD is being implemented in the south-east of Queensland, in Toowoomba, Ipswich and more recently Ormeau. Mr Allsop gave evidence that models such as TFCO (TFCA-QLD), and a professional foster care model (currently being commissioned), would support Queensland to reduce its reliance on residential care. Moreover, TFCA-QLD supported children to achieve better outcomes, compared to children in residential care, by providing healing and treatment and enabling them to succeed in home-based care placements or be reunited with family.

TFCA, and its adaptations for the local context (TFCA-NSW and TFCA-VIC), is a time-limited treatment model that addresses significant behavioural and emotional issues in children through a specialist foster care placement. Every child in the model has an individualised behaviour modification plan to suit their needs and circumstances. Specialist foster carers are supported by daily engagement with OzChild’s multi-disciplinary team to implement the child’s plan. Carers report that the OzChild team provides critical “*support around rules and boundaries*” and that “*TFCA-QLD allows us to follow through and implement plans 100% and be able to monitor progress through charts and graphs*”.¹¹ OzChild’s model recognises the critical role of foster carers, with the carer receiving \$75,000 per annum pro-rata tax-free, specialist training and 24/7 support.

Every child in TFCA-QLD has an individualised behaviour modification plan to suit their needs and circumstances. The specialist TFCA-QLD foster carers receive daily support from OzChild’s multi-disciplinary team to implement the child’s plan.

Concurrently, the child receives therapy and educational skills coaching, supporting them to disengage from problematic peers, re-engage in education, and positively participate in their community.

Since TFCA-QLD model commenced in Queensland in 2018, initially with one team, 36 Queensland children have graduated from TFCA-QLD and either exited residential care or avoided entry into it.

OzChild’s TFCA-QLD model has had significant positive benefits beyond reducing residential care for children, including reducing the risks of children engaging in criminal behaviour and the future involvement of these children as parents in the Child Protection system.¹² Importantly, OzChild’s TFCA-QLD model has and continues to enable children to significantly improve school engagement, attendance and educational proficiency.

For the Queensland budget, the financial impact of 36 children completing the TFCA-QLD intervention and exiting residential care, or avoiding entry, is compelling. For example, one 8-year-old child successfully completing the TFCA-QLD intervention and exiting residential care can save over \$4 million in care services over their childhood alone. For a 12-year-old child, the saving can be over \$2 million in care services.

The Principal Commissioner for Children and Families (**QCCF**) called for the rapid pursuit of alternatives to residential care in his August 2025 report¹³.

¹¹ TFCA-QLD Foster Carer, Toowoomba, 2025.

¹² Saldana, Campbell, Leave, Chamberlian, 2019.

¹³ Queensland Family & Child Commission. *Buyer Beware, How economic forces are shaping Queensland’s residential care market*, Queensland Family & Child Commission.



The QCCF report called for short-term actions to be taken during the Inquiry as “*steps of no regret*” and to mobilise pilot programs to remove vulnerable children currently in residential care.¹⁴

OzChild’s TFCA-QLD model of care is the only demonstrated alternative model to residential care that enables children to successfully reunite with their families or be placed in home-based care (kin or foster). While there are currently only three TFCA-QLD teams in Queensland, the model is scalable for implementation in regional Queensland to reduce the severity and immediacy of harm being experienced by children currently in residential care.

OzChild gives prominence in this submission to hearing from the ground in Queensland, setting out in detail carer and worker feedback on their practical experiences of TFCA-QLD and its impacts on children and young people. The submission sets out “*Frequently Asked Questions*” about TFCA-QLD in **Appendix 1**. OzChild also invites the Inquiry to its Queensland offices to meet its frontline TFCA-QLD workers and carers and hear first-hand about the only model of care in Queensland that successfully and permanently exits children aged 12 years and under from residential care.

OzChild’s TFCA-QLD model is ready to be rolled out, and the cost savings to the Queensland community now and into the future are substantial, as outlined in this submission. OzChild commends its model of TFCA-QLD customised specifically for Queensland to the Inquiry. In summary, scaling TFCA-QLD is a step of no regret to remove vulnerable children from residential care placements in Queensland.

¹⁴ Queensland Family & Child Commission. *Buyer Beware, How economic forces are shaping Queensland’s residential care market*, Queensland Family & Child Commission. August 2025, pg 36.



2. Growth of Residential Care in Queensland – the Case for Urgent Action

On 18 May 2025, the Queensland Government announced the Inquiry.¹⁵ On 23 July 2025, the Inquiry formally commenced with the Commissioner providing a succinct overview of the growth and associated costs of the residential care system in Queensland.

Growth in residential care in Queensland

Over 2,000 Queensland children are in a statutory residential care placement. The number of children in residential care in Queensland grew by 85 per cent between 2018 to 2023. One in three children are under 12 years of age,¹⁶ despite Queensland's residential care system being designed for children over 12 years of age.

The growth in the number of children in residential care is a phenomenon unique to Queensland. Between 2018 to 2023, Queensland had 40 per cent of Australia's residential care placements, despite only having 21 per cent of the nation's children in care.¹⁷ In Queensland, the proportion of children in residential care as a percentage of all children in statutory care increased from 8% in 2011/12 to 20% in 2023/24.

Growth in residential care in Queensland is forecast to continue, with modelling suggesting that 1,000 children will enter residential care during the tenure of the Inquiry¹⁸ and by 2030, an additional 4,000 children will enter residential care.¹⁹

Cost of residential care in Queensland

The growth in residential care has a tangible impact on the Queensland budget. Queensland spends \$1.1 billion annually (51 per cent of total Child Protection expenditure) on residential care services for the 2,000 children in residential care.²⁰ The average cost to the Queensland taxpayer per day of residential care is approximately \$2.8 million.²¹

However, the cost of residential care is not limited to the direct costs of \$2.8 million per day for a 24/7 rostered staff model and the bricks and mortar cost of residential care homes.

Adverse impact of residential care on outcomes for children

Children in residential care are often born into families with complex intergenerational issues. Their families experience domestic violence, misuse of alcohol or other drugs, mental health conditions and engagement in the criminal justice system.²²

¹⁵ The Terms of Reference for the Commission of Inquiry into Queensland's Child Safety System are published in an Extraordinary Queensland Government Gazette on 23 May 2025, Vol. 399, No.16.

¹⁶ "Too Little, too late, The progress made against the Queensland Residential Care Roadmap", Queensland Family & Child Commission, December 2024, pg 20.

¹⁷ Child Safety Commission of Inquiry, 23 July 2025, at transcript pg 18.

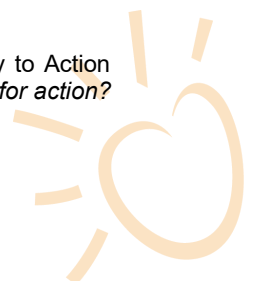
¹⁸ Queensland Family & Child Commission. *Buyer Beware, How economic forces are shaping Queensland's residential care market*, Queensland Family & Child Commission. August 2025,

¹⁹ Queensland Family & Child Commission. *Buyer Beware, How economic forces are shaping Queensland's residential care market*, Queensland Family & Child Commission. August 2025, pg 21.

²⁰ Buyer Beware, How economic forces are shaping Queensland's residential care market, Queensland Family & Child Commission, August 2025, pg 1.

²¹ Child Safety Commission of Inquiry, 23 July 2025, at transcript page 18.

²² Bromfield, L., Australian Centre for Child Protection, University of South Australia, ACWA Strategy to Action Symposium, *Preventing and Responding to Child Abuse and Neglect – Where are there opportunities for action?* March 2025.



Children in residential care have significantly higher levels of complexity compared to children in home-based care (kin or foster)²³ and are more likely to have a diagnosed or suspected mental illness.²⁴

Residential care also has a legacy that is life-long and intergenerational. Children experience significantly poorer health, educational and employment outcomes, are more likely to engage with the mental health and justice systems, and their children are more likely to be known to Child Protection and experience statutory care.

Work-related violence and aggression on residential care workers

Residential care workers are at increased risk of work-related violence or aggression (**WVA**). They encounter complex and potentially volatile situations in residential care homes²⁵, and experience WVA directly and/or as witnesses, particularly from children with behavioural, emotional, mental health and substance abuse issues that can escalate into physical assaults.²⁶

Residential care workers in Queensland have, or are working towards, a Certificate IV qualification and undertake 5 hours of mandatory online training (known as Hope & Healing). Arguably, neither prepares them for managing the complexity and multiple needs of children in their care.

Frequent exposure to WVA can have long-term impacts on workers' psychological health, as well as economic and social costs for them, their families, and the community. Workplace Health and Safety Queensland reported that there was an increase of 93 per cent in WVA claims in the residential care service sector in the five years to 31 January 2021, with 25 per cent of claimants not returning to work in the sector.²⁷

Granular WVA data for statutory residential care workers is not publicly available in Queensland. However, comparison data from Victoria showed that residential care worker compensation claims increased by 24 per cent in 2020 compared to 4 per cent across the social services sector, with the residential care sector accounting for 9 per cent of all mental injury claims in the five years to 2020.²⁸

²³ Department of Families, Seniors, Disability and Child Safety, "Children in Care Census", 2024 pg 4.

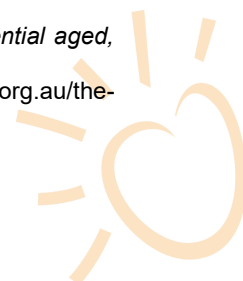
²⁴ Department of Families, Seniors, Disability and Child Safety, "Children in Care Census", 2024 pg 15.

²⁵ PeakCare, "Insights and Opportunities – Queensland Residential Care Workforce", March 2025, pg 20.

²⁶ Workplace Health and Safety Queensland (2021). *Work-related violence and aggression in residential aged, disability and youth care.*

²⁷ Workplace Health and Safety Queensland (2021). *Work-related violence and aggression in residential aged, disability and youth care.*

²⁸ The Residential Care Sector Occupational Health and Safety Capability Program <https://www.cfecfw.org.au/the-residential-care-sector-occupational-health-and-safety-capability-program/>



3. TFCA-QLD – Feedback from Carers, Workers, and Children

The Inquiry’s approach is to gather evidence on the ground and from the ground up. In opening the Inquiry, the Commissioner stated that this ground-up approach will ensure *“that any suggested reforms may be ‘stress tested’ in the course of the Inquiry against the measure of what is real and practical, having regard to all of the exigencies that bear upon the State as the notional parent of many children and young people dispersed throughout Queensland.”*²⁹

OzChild champions the dedication of Queensland’s carers and workers, who are committed to improving the care experience and outcomes of vulnerable children regardless of the risks they face. OzChild is committed to hearing the voice of children and delivering services that meet their needs.

To prepare this submission, OzChild started with the carers and workers who implement the TFCA-QLD model adapted for Queensland and sought their feedback. This feedback consistently refers to the benefits of the model’s structured approach, clear boundary setting for children and support for the carer to enforce boundaries, and the OzChild team’s work to develop children’s pro-social behaviours. OzChild has also undertaken a TFCA-QLD Renewal Assessment in September 2025 that surveyed both carers and children in TFCA-QLD.

Carers and workers feedback

Feedback from these Queensland carers and workers is detailed below. OzChild invites the Inquiry to visit its offices, meet its workers and carers and hear more about its model firsthand from the frontline.

TFCA-QLD carers value being actively engaged with the OzChild care team, with 77% responding that the OzChild care team values their opinions and includes them when making decisions that impact the children in their care. Feedback on components of TFCA-QLD are set out below.

Behaviour management plan

An OzChild TFCA-QLD worker in Toowoomba described the behaviour management plan as critical for children as it *“communicates, then positively reinforces target behaviours at the personal level, like emotional regulation, and the social level, like following directions, using respectful language, cooperating with others.”*

TFCA-QLD carers provided feedback on the benefits of the behaviour management plan, including *“clear structures, plans and daily checklists help to ensure we are on the right path”*. Further, the *“behavioural charts that are developed by the team are great as the child has a clear idea of what they are expected to do, which leaves the carer to guide the child in positive ways. This also allows you to develop more meaningful relationships with the child, which in turn leads to greater learning opportunities at home and school.”*

Feedback from carers emphasised the importance of the model providing routine, structure, and an understanding of consequences to children, including *“the behavioural charts are good as children thrive on set routines and structure, but as they are set by the team, the carer avoids being the instigator of things that the child dislikes. The child I have enjoys the fact that we both have the same boss and have to follow the rules together”*.

Moreover, *“TFCA-QLD uses structured, appropriate consequences so children learn how their behaviour influences their own future in positive or negative ways.”*

²⁹ Child Safety Commission of Inquiry, 23 July 2025, at transcript pg 13.



Formal training and support for carers

Before the child commences the model in the home of their carer, the carer receive a formal introduction and training and is provided with a detailed history of the child, the child's behaviours and effective responses. The carer also has daily support from the OzChild care team, and a peer support group that meets once a week. A TFCA-QLD worker in Toowoomba describes this process as follows:

"TFCA-QLD has a formal induction program, so carers learn about the program before they begin to care for children and young people. Once carers are inducted, there are meetings to introduce the carer to the child and to understand their history before the child moves in. the carer receives a daily call from TFCA-QLD staff to check in and discuss any behaviours over the past day. The carer attends a meeting with other carers in the program for peer support, as well as coaching and education from the TFCA-QLD staff once a week."

100% of TFCA-QLD foster carers agreed that the training they received effectively prepared them for being a carer.

The TFCA-QLD team contacts the carer daily to monitor the child's behaviour, complete the Parent Daily Report, and monitor and address any carer's stress. The carer meets weekly the TFCA-QLD team. Further, 24/7 support is available to carers whenever they need it from the TFCA-QLD team. Queensland's TFCA-QLD carers consistently identify this contact, support and engagement as critical in implementing the behaviour plans and addressing any issues, carer feedback includes:

"Daily check ins, which include problem solving ways to address/change behavioural issues"

"Always feel supported 100% listened to and problem solving together"

Carers reported that the weekly carer meeting allows them to build solid relationships with other TFCA-QLD carer peers who understand their struggles and allows them to debrief and relate with one another.

Further, carers reported that the OzChild team engages with Child Safety on their behalf and provides advocacy and follow-up. This allows carers to focus solely on their parenting role with the child. Feedback on the level of support provided by the TFCA-QLD model by a Queensland carer included:

"The daily check ins are a great way of being able to express any concerns or achievements of the child. The weekly meetings put you in touch with others who are supportive and that may have ideas on other strategies that they are using. It is good to know that the 24/7 support is there should you require it. It is good to know that any concerns about the child that I address during the daily check ins are taken to the team members and dealt with quickly "

91% of TFCA-QLD carers felt that their OzChild workers listens to what they have to say either all the time or most of the time (September 2025)



Re-engagement with education

A key component of TFCA-QLD is the requirement and support given to the child to re-engage in education and learning. A dedicated role for a teacher is included in the OzChild multi-disciplinary team. A TFCA-QLD worker in Toowoomba described the teacher as taking:

“... the lead role in engaging with schools to explain the TFCA-QLD program and provide additional support and coaching to school teachers and staff for managing the child in classroom environments. The teacher’s role also includes academic testing with children when they enter and leave the program to monitor their progress.”

A TFCA-QLD worker in Ormeau described the dedicated teacher as working with:

“... both the school and one-on-one with the child. This provides the teacher and wider school environment with strategies being utilised in the program, to support and encourage positive behaviours within the school. Furthermore, many of our children in the program are on reduced hours due to behavioural needs; therefore, having a dedicated TFCA-QLD teacher allows us to give that one-on-one educational support to ensure they remain at the appropriate educational level.”

Monitoring and measuring progress

TFCA-QLD is an evidence-based and data-driven intervention. Data is collected from carers through the Parent Daily Report and accepted tools for measuring progress at various intervals.

Carers provided feedback that this monitoring and measurement of a child’s progress throughout the program supports the carers, workers and children to work together, address any concerns promptly, and celebrate progress.

Carer feedback on the child’s progress being monitored and measured daily included:

“Daily check ins and data collection allows us to measure the progress in the child’s behaviour”

“Being part of a team who support both you and child’s needs in real time”

“seeing hard work making a difference”

“seeing positive results in behavioural changes”

“The most enjoyable part is seeing the progress that the children make in changing their behaviour and enabling them to go to a forever home”

Exiting children from residential care

The TFCA-QLD model is designed to exit children permanently from residential care. A TFCA-QLD worker in Toowoomba described how the model acts as an intervention to exit children from residential care as follows:

“A key challenge for children and young people in residential care, is that they live with other children who are typically also survivors of complex trauma.....many children in residential care display regular, high level anti-social behaviours (violence, aggression, defiance etc). It is extremely difficult for a child to develop positive social skills in that environment.

However, TFCA-QLD provides a safe and stable living environment for the child, where their own negative behaviours can be respectfully and firmly, but gently, addressed. In this space, children have the time and space to relearn positive behaviours without regular disruption and antithetical influences from other children, who are themselves struggling to cope....



TFCA-QLD placements create a positive reinforcement cycle in which positive behaviours are recognised and reinforced, developing new expectations and habits.”

TFCA-QLD engages and supports care workers

Workers also report that implementing TFCA-QLD, a structured and intentional intervention, is more rewarding than working in residential care as they are able help children learn life and social skills. A TFCA-QLD worker in Toowoomba who has also worked in residential care stated:

“Having worked in both residential care placements and in the TFCA-QLD program, TFCA-QLD is notably more structured, with a focus on teaching children to behave in prosocial ways, compared with residential care. TFCA-QLD takes a more intentional approach to develop expectations for how children should behave, and interact with others, then it builds a cohesive network of adults who work together to reinforce consistent messages for the child. It is a more rewarding experience as a worker to feel I am working cooperatively with a team of adults to help children learn basic life and social skills which they were not taught when they were young.”

TFCA-QLD reduces children’s engagement with the criminal justice system

The TFCA-QLD model is shown to reduce children’s engagement in the criminal justice system. TFCA-QLD workers in Toowoomba and Ormeau provided their reflections on how removing children from residential care and placing them in a TFCA-QLD intervention supports this outcome being achieved as follows:

“Children become engaged with the Youth Justice system when they have not learned to meet social norms and expectations. ...Children in residential care are often exposed to other children who have not learned these life skills. Consequently, a collective drive can develop to test boundaries and defy social expectations. TFCA-QLD removes children from situations where they experience this negative cycle of behaviour, and places them in situations where they experience positive behaviour reinforcement.”

“By offering the chance for a child to learn new ways of managing their emotions and reactions to authority, TFCA-QLD can support the child to find a new trajectory in life and be supported along the way. Being engaged with TFCA-QLD offers the child new pathways for support and access to this being ongoing while required.”

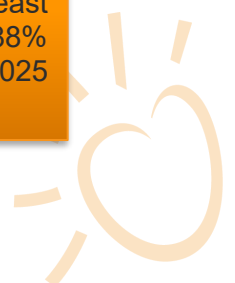
Feedback from children in TFCA-QLD

OzChild’s TFCA-QLD Renewal Assessment in September 2025 included a survey of children in the intervention in the last 12 months. The survey results show that TFCA-QLD provides children with a consistent adult in their life, support to connect with family and to engage in activities of their choosing.

Key survey results from children included:

- 91% of children felt either completely or mostly settled in their TFCA-QLD foster care home;
- 80% of children felt like they had someone to talk to always or most of the time when it comes to their feelings and emotions; and
- 80% of children participate in social and/or recreational activities of their choice;

100% of children in TFCA-QLD over the last 12 month reported that they had at least one adult that cares about what happened to them now and in the future; and 88% responded that they saw this adult all the time or most of the time (September 2025 survey).



4. TFCO & OzChild's TFCA-QLD Model Customised for Queensland

History of TFCO

TFCO (formerly known as Multidimensional Treatment Foster Care) was developed by the Oregon Social Learning Centre, a non-profit research centre dedicated to strengthening children, families and the community.

TFCO was specifically designed to address significant behavioural and emotional problems that prevent children and young people exiting residential care or cause them to be at high risk of entry into residential care. The aims of TFCO include:

- improving daily school attendance and engagement;
- developing children's positive attachment to adults;
- reducing teenage pregnancies;
- increasing reunification with family;
- developing children's positive attachment to adults; and
- reducing intergenerational contact with the Child Protection system.

TFCO is a short-term, intensive intervention (usually 9–12 months) with the goal of transitioning children and young people back to family, kin, or longer-term foster placements with improved stability and functioning.

TFCO is backed by multiple randomised control trials with different cohorts of children and young people in different contexts and jurisdictions. It has demonstrated effectiveness in reducing a range of issues, including recidivism, delinquency, unplanned pregnancies, deviant peer relations, and psychotic symptoms.³⁰

Refer **Appendix 3** for an evidence summary of TFCO.

TFCO has been successfully implemented internationally in the United States, United Kingdom, Denmark, Sweden, and New Zealand. TFCO is also included in the registry of evidence-based positive programs for the Blueprint Program for Healthy Development.³¹

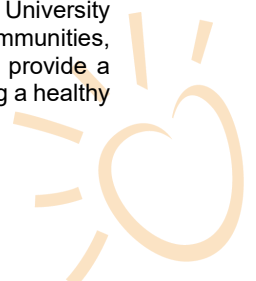
TFCO in Australia localised and adapted as TFCA

Commencing in Victoria, OzChild has successfully trialled TFCO in Australia since 2016, now known as Treatment Foster Care Australia (**TFCA**).

OzChild is mindful of different cultures and practices across Australian jurisdictions and the need to ensure TFCA is fit for purpose and scalable. To understand and adapt to these differences, OzChild first seeks to understand each Child Safety systems and their requirements (such as referral pathways and regulations). Recognising the significant overrepresentation of First Nations children and young people in care, OzChild actively seeks to listen to, and consult with, local First Nations communities and organisations.

³⁰ Chamberlain, Leve, & DeGarmo, 2007; Leve & Chamberlain, 2005; Leve & Chamberlain, 2007; Kerr, Leve, & Chamberlain, 2009; Harold, Kerr, Leve et al., 2013.

³¹ Blueprints for Healthy Youth Development is a project within the Institute of Behavioral Science at the University of Colorado Boulder, that identifies, recommends, and disseminates programs for youth, families and communities, based on scientific evaluations, have strong evidence of effectiveness. The Blueprints mission is to provide a registry of evidence-based interventions that are effective in reducing antisocial behaviour and promoting a healthy course of youth development and adult maturity. See <https://bleprintsprograms.org>.



OzChild trials TFCA first, continually gathers feedback and establishes the conditions for its successful implementation in each jurisdiction. For example, in Queensland, OzChild has a dedicated Aboriginal and Torres Strait Islander Practice Lead as an identified position that is as an integral part of its TFCA teams on the ground.

OzChild's deep and extensive experience in delivering evidence-based models allows for adaptations to TFCA that meet the local environment whilst maintaining model fidelity.³² Maintaining the model fidelity means that TFCA is delivered in accordance with its core components, protocols and methods (essentially the component of the TFCO model that the evidence proves work to deliver outcomes for children and young people). Maintaining TFCA model fidelity is crucial to ensuring that TFCA achieves its objectives and outcomes in real-world practice and can be consistently scaled and replicated.

OzChild has successfully adapted the TFCO model to match each local context, known as in Victoria, New South Wales and Queensland as TFCA-VIC, TFCA-NSW, and TFCO-Q respectively.

Refer **Appendix 4** for a summary of OzChild's national program data for TFCA.

Targeted Age Cohorts in TFCA

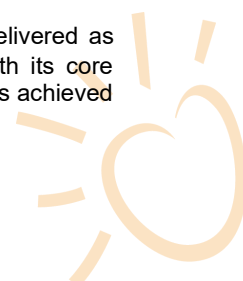
The TFCA evidence-based model is tailored specifically for three age groups, children aged 3 to 7 years old, children aged 7 to 11 years old, and young people aged 12 to 17 years old.

TFCA is suitable for children and young people engaged with Child Safety and Youth Justice who:

- are in residential care;
- at high risk of placement breakdown and entry into residential care or a custodial setting;
- have experienced significant trauma;
- present with complex emotional, behavioural, and relational difficulties;
- display high-risk behaviours such as aggression, truancy, offending, or substance use;
- have had multiple care placement disruptions; and/or
- require a structured and therapeutic environment to support healing and behaviour change.

TFCA provides these children and young people with an intensive treatment intervention. On commencing in TFCA, children and young people have a case plan goal clearly identified, specifically to reunify with their family or transition to an identified kinship or foster carer placement. TFCA first stabilises a child or young person's behaviour and then supports their re-engagement with education and pro-social activities. Concurrently, the TFCA model works with the child or young person's family or identified home-based carer in the Case Plan to prepare and support a successful placement on completion of the TFCA model. Through this intervention and support, children and young people can successfully reunite with family or a home-based carer.

³² Model fidelity refers to the degree to which a program or intervention, such as TFCA-QLD, is delivered as intended by its original design. High fidelity means the program is implemented in accordance with its core components, protocols, and methods. Maintaining model fidelity is crucial to ensuring that the outcomes achieved in research settings can be replicated in real-world practice.



TFCA-QLD model of care

TFCA-QLD is delivered in the home of foster carers who are supported by a multidisciplinary treatment team. TFCA-QLD foster carers receive specialist training and have daily contact with the TFCA-QLD team, and 24/7 support.

The TFCA-QLD intervention model:

- places children and young people in home-based care with close monitoring, which provides stability and allows for consistent feedback and encouragement of positive behaviour and skills development;
- trains carers to use a behaviour modification plan, developed for the individual child or young person, which enables consistent reinforcement of positive behaviours and consequences for problem behaviours, and over the course of the intervention results in an expectation and frequency of positive behaviours;
- separates children and young people from problematic peers, which reduces reinforcement of negative behaviours by problematic peers; and
- addresses behavioural and emotional symptoms, through mandated therapy and re-engagement (with dedicated support) in education and learning.

There are three customised TFCA-QLD interventions models to meet specific age-related needs of children and young people set out below. TFCA-QLD-C is the model currently implemented in Queensland.

a. TFCA-QLD-C

<u>Age cohort:</u>	7 to 12 years old (OzChild is also able to deliver TFCA-QLD flexibly and accepts children aged 6 and 13 when appropriate)
<u>Target group:</u>	Children with chronic behavioural difficulties, often related to trauma, neglect, or early adversity
<u>Objectives:</u>	Building social skills, academic engagement, and emotional coping strategies, the carer implements a structured behaviour management program and children receive skills coaching and therapy
<u>Parent support:</u>	Where family reunification is the goal, families are trained in consistent parenting strategies
<u>Key outcomes:</u>	Reductions in oppositional and aggressive behaviour; improved school attendance and performance; improved placement stability ³³ .
<u>Delivery locations:</u>	Queensland (Toowoomba, Ipswich and Ormeau) Victoria (Dandenong). New South Wales (Campbelltown).

b. TFCA-QLD-A:

<u>Age cohort:</u>	12 to 17 years old
<u>Target group:</u>	Serious behavioural challenges, including engagement in criminal activity, absenteeism from school, and substance misuse

³³ Chamberlain et al., 2006; Price et al., 2008.



<u>Objectives:</u>	Structured home environment with daily supervision, strong behavioural reinforcement systems, and pro-social mentoring. Young person receives individual therapy, skills training, and education support
<u>Parent support:</u>	Where family reunification is the goal, families receive therapy and parent training to prepare for reunification
<u>Key outcomes:</u>	Significant reductions in criminal activity, arrests, and time in detention; improved school attendance; decreased substance use, reduced association with problematic peers ³⁴ .
<u>Delivery locations:</u>	New South Wales (Blacktown).

c. TFCA-QLD-P

<u>Age cohort:</u>	Pre-school aged children aged 3 to 6 years
<u>Target group:</u>	Very young children displaying severe externalising behaviours such as aggression, defiance, and poor emotional regulation
<u>Objectives:</u>	Structured home environment providing consistent parenting practices, positive reinforcement, and early developmental support, with carers providing nurturing interactions, and immediate feedback to help children develop emotional regulation and social skills
<u>Parent support:</u>	Where reunification is the goal, parents receive parallel training to ensure continuity when their child returns home
<u>Key outcomes:</u>	Improvement in attachment security, emotional regulation, reduction in disruptive behaviours and dysregulation, increased likelihood of successful reunification with families. ³⁵
<u>Delivery locations:</u>	Currently no programs in Australia.

TFCA referral criteria

Achieving a reduction in the number of Queensland children and young people in residential care and significantly reducing future entries requires a multi-faceted approach. It will require dedicated focus, funding and scaling of models that are based in evidence and proven to be successful at exiting children and young people from residential care and preventing entries. TFCA-QLD is currently the only proven model being delivered in Queensland achieving this objective.

TFCA-QLD will not be suitable for every child and young person in residential care in Queensland. For example, TFCA-QLD is not suitable for children and young people with significant and active suicidal or homicidal behaviour, or with a disability that impacts on their ability to develop skills in consequential thinking and self-regulation. The TFCA Referral Criterion are detailed at **Appendix 2**.

³⁴ Chamberlian & Reid, 1988; Eddy et al., 2004; Astrom et al. 2020; Ding et al., 2023; Leve et al. 2020.

³⁵ Leve, Fisher & Chamberlian, 2009.



5. OzChild's Delivery of TFCA-QLD

OzChild now has three TFCA-QLD teams operating in Queensland since commencement in 2018, located in Toowoomba, Ipswich and most recently in Ormeau.

OzChild works collaboratively with local communities, carers, and government to specifically adapt TFCA for Queensland and to ensure fit within the local environment.

This approach includes dedicated Aboriginal and Torres Strait Islander Practice Leads, who undertake culturally safe assessments of children, ensure children maintain connection to culture. The leads also provide cultural advice on practice matters to ensure culturally appropriate decision making, including through liaising with Community Elders, Traditional Custodians and Aboriginal and Torres Strait Islander organisations.

The model is driven by data and monitoring, using Queensland endorsed measurement tools, and child and carer feedback. These include:

- The Strengths and Difficulties Questionnaire (**SDQ**).³⁶
- The Child Behaviour Checklist (**CBC**).³⁷
- The Parent Daily Report (**PDR**).
- PAT-R assessments (Progressive Achievement Tests in Reading)³⁸.
- North Carolina Family Assessment Scale (**NCFAS**)³⁹ pre and post completion.

TFCA-QLD team structure

TFCA-QLD adapted for Queensland is delivered by a multidisciplinary team. Each team supports seven children aged between 7 and 12 with chronic behavioural difficulties, trauma, neglect, and/or adverse childhood experiences.

Every member of the TFCA-QLD team understands the challenges experienced by children and young people who experience abuse and neglect. The TFCA-QLD multidisciplinary team consists of the following:

1. Program Supervisor:

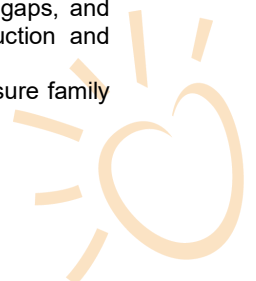
- Responsible for the operational and clinical oversight of the TFCA-QLD team and works with the model developer to ensure fidelity and works closely with the responsible departmental staff to identify referrals.
- Qualifications and experience: masters qualification in Social Work, Psychology or equivalent preferred, experience in management roles in Child Protection or out-of-home care and with clinical experience working with children.

³⁶ The Strengths and Difficulties Questionnaire is a 25 item questionnaire used to screen for and assess emotional and behavioural problems in children and young people aged 4-17, as well as to measure pro-social behaviour. It was developed by Robert Goodman in 1997 to screen for emotional and behavioral problems in children and adolescents through five areas: emotional symptoms; conduct problems; hyperactivity; peer relationships problems; and pro-social behaviour (strengths).

³⁷ The Child Behavior Checklist is a standardised questioner for assessing children's social and emotional problems, social competence and academic skill. Achenbach T, Rescorla L. Child Behavior Checklist for Ages 11/2-5. Burlington: University of Vermont; 2000.

³⁸ The PAT-R assessments (Progressive Achievement Tests in Reading) are a suite of standardised reading comprehension tests developed by the Australian Council for Educational Research (**ACER**) and used in schools across Australia, including Queensland, to measure student reading achievement, identify learning gaps, and monitor progress. The assessments provide diagnostic information for teachers to inform instruction and assistance for students to achieve their learning goals in reading.

³⁹ The North Carolina Family Assessment Scale is a child welfare assessment tool designed to measure family functioning, particularly in high-risk families facing potential child removal or reunification.



2. Case Coordinator:

- Responsible for the case plans and case management for children, assists with the behavioural charts and collaboration with stakeholders (education, health, and recreational providers).
- Qualifications and experience: tertiary qualification in Social Work, Psychology or equivalent.

3. Family Therapist:

- Responsible for weekly family therapy to the child or young person's family and for introducing behavioural, coping, and parenting skills using strategic reinforcement and coaching interventions.
- Qualifications and experience: tertiary qualification in Social Work, Psychology or equivalent and knowledge of social learning theory.

4. Child Therapist:

- Responsible for supporting the development of individualised treatment plans, weekly individual therapy, and working with the child or young person to develop pro-social skills and regulate emotions.
- Qualifications and experience: tertiary qualification in Social Work, Psychology or equivalent, experience in treating children and young people.

5. Skills coach:

- Responsible for providing weekly skills coaching to the child or young person, which directly relates to the goals of their individual treatment plan.
- Qualifications and experience: Certificate IV in Youth Work or demonstrated experience in the human service delivery system, ability to establish relationships with children and young people and assist them acquire new skills.

6. Teacher:

- Responsible for educational support and individual tutoring, implementing and reviewing education plans, teaching, and assessment of outcomes.
- Qualifications and experience: tertiary qualification in Education, classroom teaching experience and of the education system, and with supporting children and young people at risk of poor learning outcomes.

7. Carer Recruiter and Trainer:

- Responsible for recruiting, training and supporting TFCA-QLD carers and conducting the Parent Daily Report with TFCA-QLD carers for children and young people.
- Qualifications: tertiary qualification in Social Work, Psychology or equivalent, Certificate IV in Training and Assessment, experience and familiarity with recruiting foster carers and conducting assessments of foster carers.

8. Aboriginal and Torres Strait Islander Practice Lead (identified position):

- Responsible for ensuring assessment, planning and program delivery are culturally responsive, providing comprehensive cultural advice on practice matters to ensure culturally appropriate decision making, liaising with Community Elders, Traditional Custodians, community-controlled organisations to facilitate culturally appropriate services.



- Qualifications: tertiary qualifications in social/human services, community welfare, youth work or experience in Aboriginal health, community-controlled organisations, experience working in the Child Protection context desirable.

9. TFCA-QLD Carer:

- Responsible for providing supervision, structured care and daily structured feedback on the child's behaviour through the Parent Daily Report.
- Qualifications: enhanced recruitment and training, in addition to the Hope and Healing foster care training requirements in Queensland.
- Support: 24/7 on-call support from the TFCA-QLD team; coaching throughout the child's placement; and \$75,000 per annum (pro rata) tax free in Queensland.

TFCA-QLD commitment to cultural responsiveness and safety

To maintain strong cultural connections, OzChild convenes First Nations Cultural Connection Panels twice a year. These panels are chaired by the Director of Services, Queensland, and the Director – Aboriginal Practice and Partnerships. Attendance includes a community elders, an Aboriginal agency representative, the OzChild Team Leader, and the Case Worker. Carers and children are assessed against the SNAICC Outcomes Measures to ensure cultural needs and aspirations are being met.

OzChild also holds *Yarning Circles* with carers twice a year, providing a culturally safe space for reflection, feedback, and shared learning. All First Nations cases are guided by the QLD-based Senior Aboriginal Practice Leader,

In TFCA-QLD Renewal Assessment, September 2025, found that in the 80% of Aboriginal and Torres Strait Island children in TFCA-QLD were in contact with their family members.

TFCA-QLD Carers

TFCA-QLD carers implement the child's behaviour plan, provide the Parent Daily Report to the treatment team, attend weekly meetings and actively support the child to re-engage in education, attend coaching and therapy, and achieve their treatment goals.

Carers must be over the age of 21. Carers with experience in dealing with children or young people with complex behaviours is preferred but not mandatory. TFCA-QLD carers are compensated with a tax-free allowance of \$75,000 per annum, pro rata.

TFCA-QLD carers complete the mandatory foster care training in Queensland, the Hope and Healing foster care training that is self-paced and online. In addition, OzChild conducts two-days of carer training prior to a placement. Attendance is mandatory prior to the carer's first TFCA-QLD placement. They are then invited to future sessions as a refresher.

Throughout the TFCA-QLD intervention, carers receive:

- A daily telephone call to provide the treatment team with their Parent Daily Report on the child's behaviour and progress.
- Coaching on program implementation & strategies (daily/as needed).
- Weekly Carer Meeting for social and program support.
- Weekly Sessions with Clinical Team – Child Therapist, Skills Coach, Teacher & contact with Program Supervisor as needed.
- Support in liaising with Child Protection.
- On-Call Support provided over weekends, after hours and holiday periods.
- As needed TFCA-QLD respite support. Generally, children have built in respite with a TFCA-QLD Trained respite carer to support placement longevity.



- Monthly formal home visits, with additional visits to the home scheduled as required.
- Training both pre-placement and ongoing (as detailed above).

TFCA-QLD carers receive a significant level of support, in recognition of the role and its requirements, which reduces carer stress levels and allows constant communication with the care team. The daily phone call allows for a minimum daily debrief, and ensures carers are able to work closely with the clinical team each day.

TFCA-QLD is encouraging new foster carers into the statutory care system. OzChild's TFCA-QLD carers are usually first-time carers, never having been a statutory carer in Queensland or another state. Indeed, OzChild's TFCA-QLD carers in Ormeau are all first-time foster carers.

Family therapy within TFCA-QLD

The role of the family therapist in TFCA-QLD is pivotal to achieving successful reunification and long-term stability for children and young people graduating from the program. The therapist engages in intensive family finding and therapeutic work to identify and support viable aftercare options and build the parenting capacity. This includes re-engaging biological parents or kin, and equipping them with the skills and confidence needed to support their child's emotional regulation, daily functioning, and social development. Through structured interventions and transition planning, the family therapist works to ensure that the child's progress in TFCA-QLD is sustained post-placement, enabling reunification with parents or kin and reducing the risk of returning to residential care.

Average time for children to complete TFCA-QLD

TFCA-QLD is an intervention, not an ongoing placement for a child. There is no set time limit for a child to complete the TFCA-QLD program, providing flexibility for children to complete the program. On average Queensland children are graduating from the TFCA-QLD program in 10 months.

Frequently Asked Questions on the TFCA-QLD model are set out in **Appendix 1**.



6. Measuring Success of TFCA-QLD

The Hon. Mr David Janetzki MP, the current Treasurer of Queensland and Member for Toowoomba South, has called for more investment in fostering and prevention programs rather than expensive residential care. He has described residential care as *“an institution, it is not a stable, loving family home”*, as *“failing our children, and it is outrageously expensive”* and *“It is certainly not the place for traumatised children, including babies, to live where they are supervised by paid shift workers.”*⁴⁰

Further, Mr Janetzki described OzChild’s TFCA-QLD team in Toowoomba and its TFCA-QLD foster carers as *“achieving life-changing results for these children who everyone else has given up on”*.⁴¹

Queensland children who have graduated from OzChild’s TFCA-QLD model have demonstrated:

- improved emotional, behavioural and social health, measured by the SDQ and CBC;
- decreased problematic behaviours, as measured by the PDR, at 4 weeks, the midpoint and end of the TFCA-QLD placement;
- increased school engagement, measured by term attendance rate at pre and post and two terms prior;
- improved academic functioning measured by pre and post PAT-R assessments;
- improved family functioning for families where reunification is the goal, measured by the NCFAS at pre and post;
- placement outcome, the percentage of children able to successfully transition into home-base care or be reunified with family; and/or
- children, carers and families experience of the TFCA-QLD program as measured by feedback surveys.

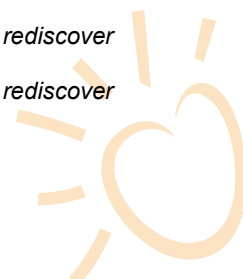
Thirty-six children aged between 7 and 12 have successfully completed the TFCA-QLD program with the Toowoomba and Ipswich TFCA-QLD teams. Almost half of these children (47 per cent) are Aboriginal or Torres Strait Islander children.

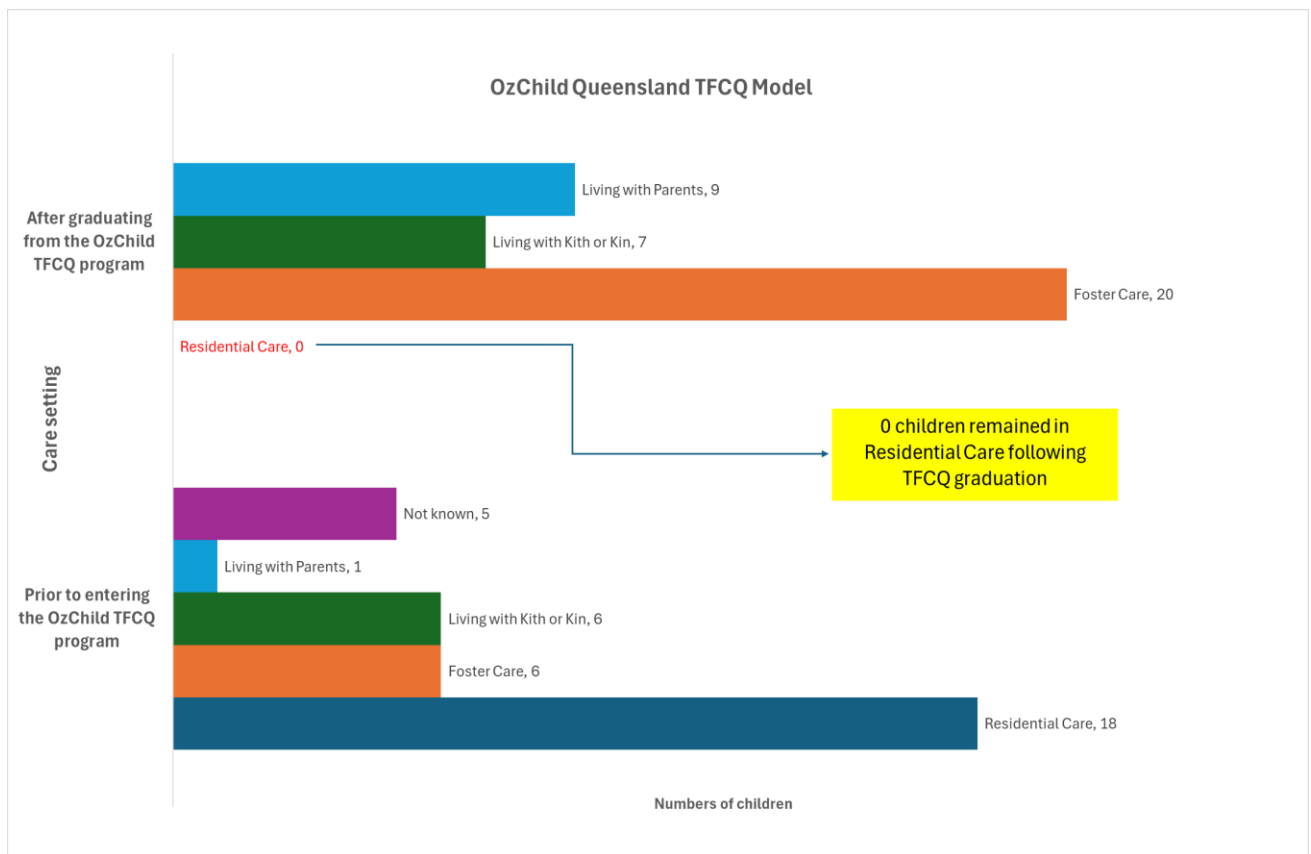
Eighteen of these children who had been in residential care exited to home-based care (foster or kin) or were reunified with their family (see graph below). Completion of the TFCA-QLD program also prevented children at high risk of entering residential care, due to their significant behavioural issues, from entering residential care.

TFCA-QLD foster carers are *“achieving life-changing results for these children who everyone else has given up on”*. Hon Mr Janetzki MP on OzChild’s TFCA-QLD team in Toowoomba.

⁴⁰ The Toowoomba Minute, *“Specialist foster carers help “las chance” children heal from trauma and rediscover childhood”*, 15 September 2024.

⁴¹ The Toowoomba Minute, *“Specialist foster carers help “las chance” children heal from trauma and rediscover childhood”*, 15 September 2024.





TFCA-QLD is cost-effective

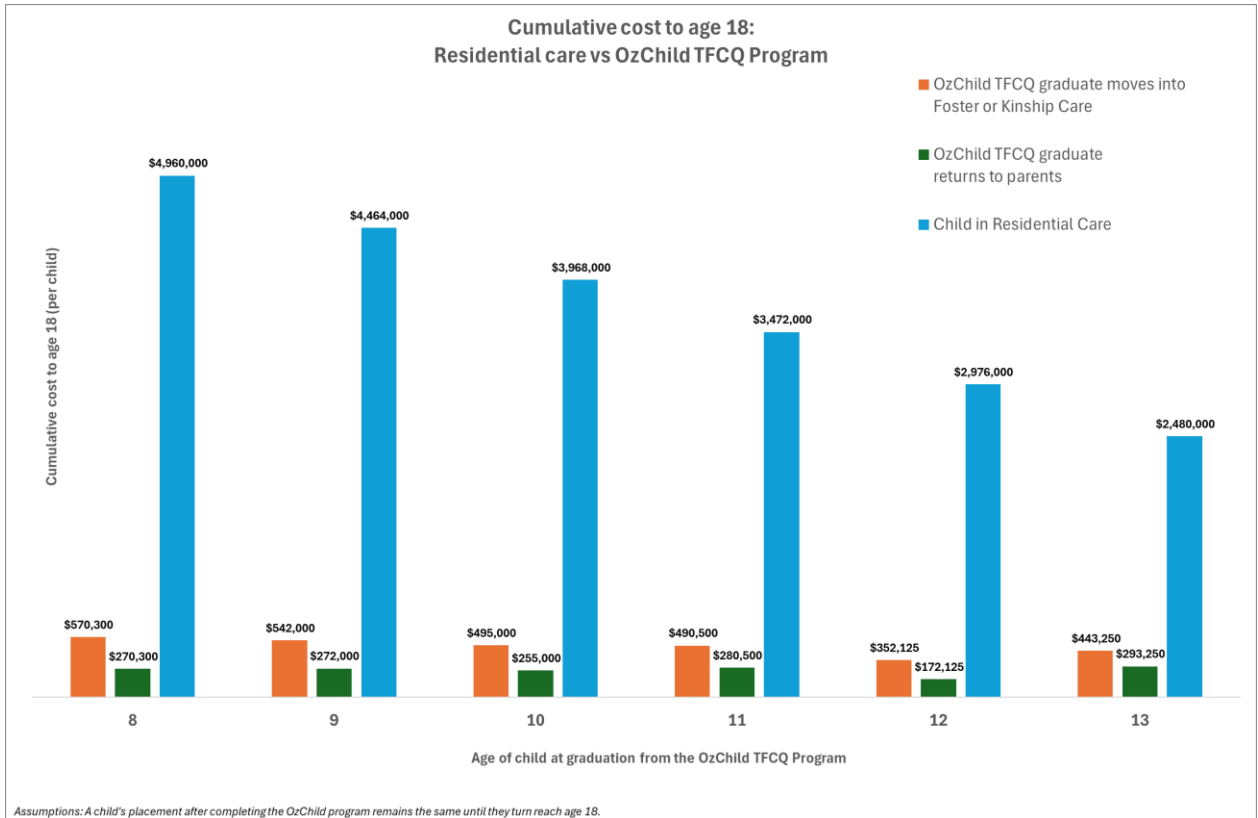
TFCA-QLD is demonstrably more cost-effective than residential care, the only alternative for many high-needs children. Unlike residential care, TFCA-QLD has throughput as it is a treatment intervention that addresses significant problem behaviours and thereby enables children to be placed successfully in home-based care (foster or kinship) or be reunified with their families (at a significant cost reduction).

On successful completion of the TFCA-QLD program, children exit residential care or are prevented from entering residential care, resulting in significant cost savings for the Queensland budget.

The projected cost saving to the Queensland budget of the successful completion by 36 children of the TFCA-QLD model is compelling. The graph below outlines the cost for a child to complete the TFCA-QLD program and then transition into home-based care (kin or foster) (orange) or return to living with parents (green), compared with the cost of residential care (blue) until the age of 18.

Significant cost savings are achievable per child on completion of the TFCA-QLD intervention when compared with the costs of a residential care placement for the child.





7. Conclusion

Senior Counsel Assisting the Inquiry, Ms Robyn Sweet KC, addressed its opening hearing on 23 July 2025. Ms Sweet described the work of the Inquiry as vital, urgent and wide-ranging.⁴² The Inquiry also highlighted the tangible impact of residential care on the Queensland budget.

The most significant, long-lasting, and positive impact on outcomes for children and the Queensland budget will come from successfully exiting children from residential care and turning off the entry pipeline into residential care. Without such immediate action, the Principal Commissioner, QCCF, Mr Luke Twyford has warned Queensland faces “a *multi-generational crisis of cost, harm and lost potential*”.⁴³

OzChild’s TFCA-QLD is a proven, evidence-based, and cost-effective intervention to reduce reliance on residential care. Scaling TFCA-QLD across Queensland can significantly improve outcomes for vulnerable children, especially Aboriginal and Torres Strait Islander children who remain overrepresented in the statutory care system.

OzChild commends the TFCA-QLD model to the Inquiry for broader implementation to address the harm and cost of Queensland’s increasing residential care placements for children.

⁴² Child Safety Commission of Inquiry, 23 July 2025, at transcript page 17.

⁴³ ABC News Brisbane, “Cost of residential care in Queensland to blow out to \$7 billion, report warns”, 22 August 2025.



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Appendix 1 – TFCA-QLD Frequently Asked Questions

1. How does TFCA-QLD support the children?

TFCA-QLD provides children with a highly structured, therapeutic family environment, often as an alternative to residential care. It offers:

- **One-on-one attention** from model specific trained foster carers.
- **Consistent routines and boundaries** to create stability and predictability.
- **Tailored behaviour management plans** developed with mental health professionals.
- **Therapeutic support** including counselling, skills development, and emotional regulation strategies.
- **Regular monitoring** and review to ensure progress and address emerging needs.

2. How does TFCA-QLD act as an intervention to exit children out of residential care and prevent entries into residential care?

- **Short-term, intensive program** (typically 6–9 months) designed to stabilise behaviour and build skills for successful family or long-term foster placements.
- **Specialist team support** addresses trauma-related behaviours and psychoeducation to stabilise placements.
- **Transition planning** ensures children move into permanent family-based care (return to family, kinship care, or long-term foster care) slowly with full therapeutic support for both child and carer.
- **Early intervention** for carer and child, reducing the likelihood of future placement breakdown.

3. What are the critical elements that make TFCA-QLD different and successful?

- **24/7 support for carers** so they are never managing crises alone.
- **Intensive, team-based approach**—therapists, skills coaches, teachers, and case managers work together daily.
- **Highly structured behaviour support plan** for each child
- **Daily feedback loops** (carers report progress and challenges daily to the program team).
- **Clear timeframes** - the program is short-term and goal-focused, which maintains momentum and direction ensuring success
- **Proven evidence base** - decades of international research demonstrating reduced behavioural incidents, improved school attendance, and fewer justice system contacts.



4. How is TFCA-QLD different/rewarding/satisfying (from a worker's perspective)?

- Workers see **tangible, measurable progress** in a relatively short time.
 - **Close teamwork** creates a strong sense of shared purpose and professional support.
 - The **structured model** reduces ambiguity
 - Workers can see children successfully step down into family placements, which is deeply rewarding.
 - Opportunities for **professional growth** in trauma-informed care and evidence-based practice.
-

5. How does TFCA-QLD give carers the authority and clarity to care for children?

- **Training before placement** gives carers specific tools and strategies for managing behaviours.
 - **Daily contact** with program staff provides guidance, affirmation, and problem-solving support.
 - **Written behaviour support plans** outline clear expectations, routines, and consequences.
 - **Team backing** - carers know they have the program's full support in decisions.
 - **Crisis support available 24/7**, empowering carers to act decisively without fear of being "left alone" in high-stress situations.
-

6. How does TFCA-QLD ensure meaningful engagement with education for children?

- **Teacher roles** work directly with schools to support attendance, behaviour, and learning plans.
 - **Daily school check-ins** ensure issues are addressed before they escalate.
 - **Teacher roles** help children with homework, organisation, and classroom behaviour.
 - **Positive reinforcement** for attendance and school achievements.
 - **Collaborative planning** with teachers to adapt learning strategies to each child's needs.
-

7. How does TFCA-QLD prevent and/or reduce children's involvement with the Youth Justice system?

- **Focusing pro-social skills and team sport engagement** assists with emotional regulation reduces offending behaviour by way of a sense of belonging and control.
- **Close supervision and structure** limits opportunities for high-risk activities.
- **Immediate, consistent consequences** teach accountability without escalating into legal consequences.
- **Therapeutic intervention** addresses underlying trauma and mental health challenges driving behaviours.
- **Family engagement** ensures children have stable, supportive environments post-program, reducing reoffending risk.



Referral Criteria

Treatment Foster Care Australia

General criteria



- Child's age between 7-11 years (TFCA-C Program)
- Adolescent's age between 12-17 years (TFCA-A Program)
- Referred from residential care, foster/kinship care or family care
- The child or young person expresses willingness to engage in the TFCA program and transition planning.

There is some flexibility with age ranges on a case-by-case basis. Unresolved parental refusal to consent to prescribed medication may impact TFCA goals and may require child protection intervention or legal pathways.

Community safety

The child or young person can be safely managed in the community.

Identified aftercare placement

There is a potential placement after TFCA (e.g. reunification with birth family, return to a previous kinship placement, long-term foster care, or an independent living plan).

The identified after-carer is **willing to actively participate** in the TFCA program (including weekly training, support meetings, and transition planning). Any reimbursements need to be discussed with child protection/child safety.

Example: *A foster family is prepared to take the child after TFCA and engages in the program simultaneously with the child or young person.*

Education

The child is currently attending, or able to attend (with support) an educational program. While TFCA does not mandate a minimum, the goal is to work towards full-time engagement. Individual plans will be developed for disengaged youth.

Example: *The young person is enrolled in a mainstream school or an alternative education setting with behavioural support.*

Siblings

TFCA places only one child per treatment home but can take siblings in separate placements with the view of being reunified or strengthening family and sibling connection throughout the program.

Exclusion criteria - not suitable for the program

Children and young people would generally **not** be suitable for TFCA if they have:

Severe developmental or cognitive disability

A disability that significantly limits their ability to develop skills in consequential thinking and self-regulation.

Example: A child with significant intellectual disability and very limited verbal skills.

Current high-level risk to self or others

Demonstrated **danger to self or others**, including acute suicidal or homicidal intent.

Example: A young person with an active plan to harm themselves or another person that cannot be safely managed in the community.

Example: Problematic sexual behaviour and significant physical violence towards caregivers.

Example: Cruelty to animals or fire lighting – these behaviours potentially impact on the safety of the members of the TFCA placement household.

Significant and active mental illness

Severe psychiatric conditions that are currently untreated or unstable.

Example: A young person experiencing uncontrolled mental health issues requiring hospital-based care.

Persistent and protracted absconding

A pattern of frequent running away that cannot be mitigated through intensive support.

Example: Leaving placements multiple times per week and remaining missing for extended periods.

No identified aftercare placement

The absence of a clear plan for a stable aftercare placement at referral.

While a clear aftercare plan is preferred, TFCA teams may work collaboratively to identify aftercare placement options within the first 2–3 months.

Disclaimer: Criteria may be adapted to align with state-specific TFCA practices and policies.

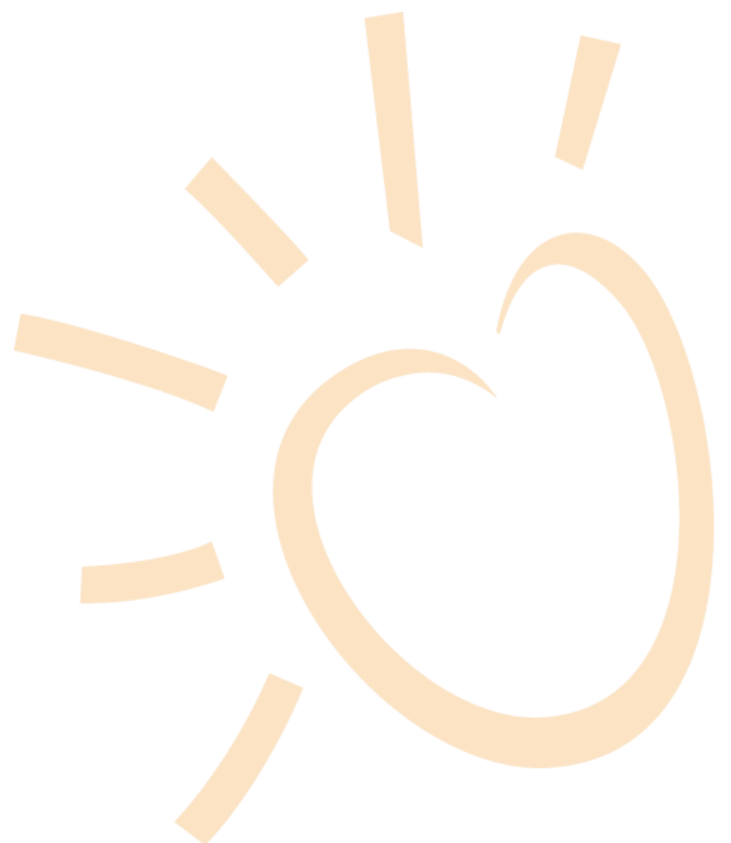


ozchild.org.au

Treatment Foster care Oregon (TFCO)

Evidence summary

Monday 25 August 2025



How Effective is TFCO at Improving Outcomes?

TFCO is moderately to highly effective in improving behavioural, criminal, and psychosocial outcomes for youth with serious behavioural problems, especially compared to group or residential care.

Introduction

Treatment Foster Care Oregon (TFCO), formerly known as Multidimensional Treatment Foster Care (MTFC), is an evidence-based intervention designed for youth with serious behavioural and emotional problems, particularly those at risk of placement in restrictive settings.

The literature consistently demonstrates that TFCO is more effective than traditional group or residential care in reducing criminal behaviour, improving behavioural and emotional outcomes, and achieving greater placement stability (Åström et al., 2020; Ding et al., 2023; Gutterswijk et al., 2020; Hukkelberg & Ervik-Jeannin, 2022; Farmer et al., 2010; Daniels et al., 2024; Haggerty et al., 2022).

Meta-analyses and systematic reviews show moderate certainty that TFCO reduces future criminal activity and days spent in locked settings, with additional—though less robust—evidence for improvements in peer associations, drug use, and depression (Åström et al., 2020; Ding et al., 2023; Chor & Oltmans, 2023; Gutterswijk et al., 2020; Hukkelberg & Ervik-Jeannin, 2022).

Cost-benefit analyses also indicate that TFCO is less expensive and yields substantial long-term savings compared to residential care (Vimefall et al., 2022; Chamberlain, 2020; Shimshock et al., 2022).

However, the effectiveness of TFCO is most pronounced among youth with high levels of antisocial behaviour, and its implementation in different contexts (e.g., outside the US) can present challenges (Hukkelberg & Ervik-Jeannin, 2022; Greenberg & Lippold, 2013).

Overall, TFCO is a preferred intervention for youth requiring out-of-home placement due to severe behavioural issues (Åström et al., 2020; Gutterswijk et al., 2020; Hukkelberg & Ervik-Jeannin, 2022; Farmer et al., 2010; Daniels et al., 2024; Haggerty et al., 2022).

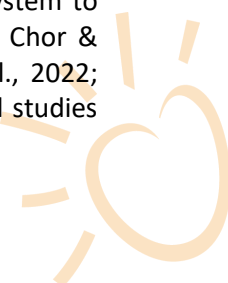
Methods

A comprehensive search was conducted across over 170 million research papers in Consensus, including sources such as Semantic Scholar and PubMed. In total, 1,037 papers were identified, 712 were screened, 307 were deemed eligible, and 50 were included in this review. The search strategy involved multiple targeted queries on TFCO effectiveness, outcome-specific impacts, cost-benefit analyses, and implementation challenges. Seven unique search groups were used, focusing on TFCO outcomes, foundational research, cost-effectiveness, and implementation across contexts.

Results

Study Designs and Populations

The included studies comprise randomized controlled trials, meta-analyses, systematic reviews, and cost-benefit analyses, with populations ranging from adolescents in the juvenile justice system to children in child welfare and foster care settings (Åström et al., 2020; Ding et al., 2023; Chor & Oltmans, 2023; Gutterswijk et al., 2020; Hukkelberg & Ervik-Jeannin, 2022; Vimefall et al., 2022; Chamberlain, 2020; Farmer et al., 2010; Daniels et al., 2024; Haggerty et al., 2022). Several studies



also examined international implementations, such as in Norway and the UK (Chor & Oltmans, 2023; Hukkelberg & Ervik-Jeannin, 2022; Greenberg & Lippold, 2013).

Main Outcomes: Behavioural, Criminal, and Emotional

TFCO consistently outperforms group or residential care in reducing criminal recidivism and days spent in locked settings, with moderate certainty of evidence (Åström et al., 2020; Ding et al., 2023; Gutterswijk et al., 2020; Hukkelberg & Ervik-Jeannin, 2022). There are also significant reductions in both externalizing (e.g., aggression) and internalizing (e.g., depression) symptoms, as well as improvements in placement permanency and social skills (Chor & Oltmans, 2023; Gutterswijk et al., 2020; Daniels et al., 2024; Haggerty et al., 2022). However, evidence for reductions in delinquent peer associations, drug use, and depression is less robust (Åström et al., 2020; Chor & Oltmans, 2023; Shi, 2020).

Cost-Effectiveness and Long-Term Impact

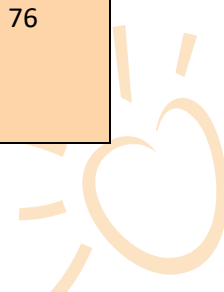
Cost-benefit analyses show that TFCO is less expensive than residential care, with substantial net benefits per participant and ongoing economic advantages up to 10 years post-intervention (Vimefall et al., 2022; Chamberlain, 2020; Shimshock et al., 2022). Long-term follow-up studies indicate sustained reductions in criminal charges and improved functioning (Ding et al., 2023; Chamberlain, 2020).

Moderators and Implementation Challenges

TFCO is most effective for youth with high levels of antisocial behaviour; benefits are less clear for those with lower levels of such behaviour (Hukkelberg & Ervik-Jeannin, 2022). Implementation in different countries can be challenging due to contextual differences, but fidelity to the core model is key to maintaining effectiveness (Greenberg & Lippold, 2013).

Key Papers

Title	Author(s) & Date	Study Design	Population Sample	Key Result	Size
Treatment Foster Care Oregon for Delinquent Adolescents: A Systematic Review and Meta-Analysis	(Åström et al., 2020)	Systematic Review	Youth with serious behaviour	Reduced criminal behaviour. Moderate certainty	633
Criminal offense charges in women: A 10-year follow-up of an RCT of TFCO	(Ding et al., 2023) L. Leve et al. (2022)	RCT	10-year follow-up Adolescent females in JJ	Sustained reduction in criminal charges	166
TFCO: Preliminary Results from a Study among	(Chor & Oltmans, 2023) S.	Observational	Norwegian youth	Severe behaviour Significant reduction in	76



Norwegian Youths	Hukkelberg et al. (2022)			behavioural/emotional problems	
The outcome of non-residential youth care compared to residential youth care	(Gutterswijk et al., 2020) R. Gutterswijk et al. (2020)	Meta-analysis	Youth in out-of-home care	TFCO more effective than residential care	16,943
Cost-Benefit of TFCO Versus Residential Care in Illinois	(Vimefall et al., 2022) K. H. B. Chor et al. (2023)	Cost-benefit analysis	Child welfare system	TFCO less expensive, higher net benefit	119

Top Contributors

Discussion

The research base for TFCO is robust, with multiple high-quality randomised controlled trials, meta-analyses, and cost-effectiveness studies supporting its use for youth with serious behavioural problems (Åström et al., 2020; Ding et al., 2023; Gutterswijk et al., 2020; Hukkelberg & Ervik-Jeannin, 2022; Vimefall et al., 2022; Chamberlain, 2020; Farmer et al., 2010; Daniels et al., 2024; Haggerty et al., 2022). The strongest evidence is for reductions in criminal behaviour and improvements in behavioural and emotional functioning, especially among youth with high levels of antisocial behaviour (Åström et al., 2020; Ding et al., 2023; Gutterswijk et al., 2020; Hukkelberg & Ervik-Jeannin, 2022). Cost-benefit analyses further support TFCO as a financially sound alternative to residential care (Vimefall et al., 2022; Chamberlain, 2020; Shimshock et al., 2022). However, the evidence for improvements in peer associations, drug use, and depression is less certain, and the effectiveness of TFCO may be context-dependent, with challenges in implementation outside the US (Hukkelberg & Ervik-Jeannin, 2022; Greenberg & Lippold, 2013).

Despite these limitations, TFCO remains a preferred intervention for youth requiring out-of-home placement due to severe behavioural issues. The evidence base is less robust for youth with lower levels of antisocial behaviour and for long-term outcomes beyond 10 years (Hukkelberg & Ervik-Jeannin, 2022; Greenberg & Lippold, 2013; Haggerty et al., 2022). More research is needed to clarify these areas and to optimize implementation in diverse service contexts.

Claims and Evidence Table

Claim- Evidence Strength – Reasoning - Papers

- TFCO reduces criminal behaviour and days in locked settings Multiple RCTs and meta-analyses show moderate to strong effects vs. group care (Åström et al., 2020; Ding et al., 2023; Gutterswijk et al., 2020; Hukkelberg & Ervik-Jeannin, 2022; Chamberlain, 2020)
- TFCO improves behavioural and emotional outcomes Consistent findings in RCTs and observational studies, especially for high-risk youth (Chor & Oltmans, 2023; Gutterswijk et al., 2020; Daniels et al., 2024; Haggerty et al., 2022)
- TFCO is more cost-effective than residential care Cost-benefit analyses show substantial savings and net benefits (Vimefall et al., 2022; Chamberlain, 2020; Shimshock et al., 2022)



- TFCO is most effective for youth with high antisocial behaviour Subgroup analyses and moderator studies support differential effects (Hukkelberg & Ervik-Jeannin, 2022)
- TFCO reduces delinquent peer associations, drug use, and depression Some evidence, but lower certainty and fewer studies (Åström et al., 2020; Chor & Oltmans, 2023; Shi, 2020)
- TFCO effectiveness is context-dependent and may face implementation challenges UK and international studies highlight barriers and mixed results outside US (Hukkelberg & Ervik-Jeannin, 2022; Greenberg & Lippold, 2013)

Conclusion

TFCO is a moderately to highly effective intervention for improving behavioural, criminal, and psychosocial outcomes among youth with serious behavioural problems, especially when compared to group or residential care. Its benefits are most pronounced for those with high levels of antisocial behaviour, and it is also a cost-effective alternative. However, more research is needed on its long-term effects, effectiveness for lower-risk youth, and implementation in diverse contexts.

In summary, TFCO is a well-supported, cost-effective intervention for high-risk youth, but further research is needed to address gaps in long-term outcomes, broader populations, and international implementation.

Research Gaps

Despite strong evidence for TFCO's effectiveness in certain populations and outcomes, gaps remain in understanding its long-term impact, effectiveness for lower-risk youth, and optimal implementation strategies in non-US contexts.

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TFCA – National Program Data 30 September 2025

123 graduates from the TFCO program

41 per cent are First Nations CYP

79 accredited carer households

35 CYP currently in the program



11 months average length of time in the program

CYP living arrangements after graduation

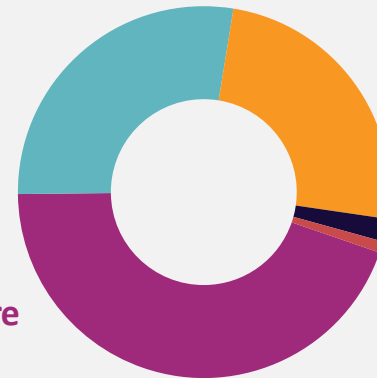
26% Birth Parents

28% Kith or Kin

3% Semi-independent living

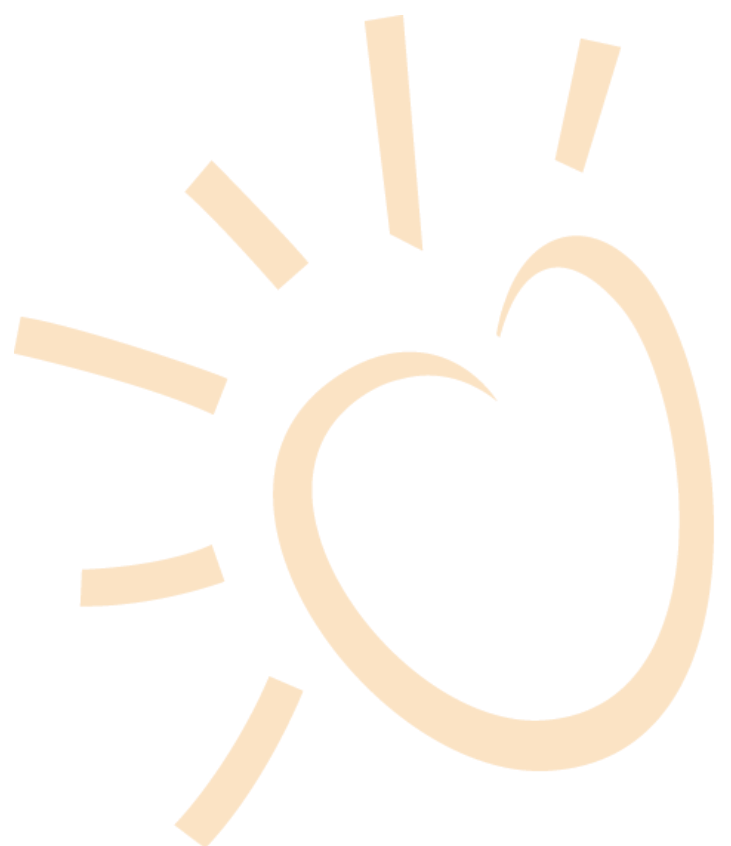
42% Foster Care

1% Residential Care



Annexure C - Multisystemic Therapy (MST)

Annexure D - Functional Family Therapy (FFT)



Annexure C - Multisystemic Therapy (MST)

MST Model

MST works with children and young people with persistent anti-social and delinquent behaviours, offending behaviours, and/or substance misuse. MST is targeted at children and young people considered to be the most complex and challenging, often with histories of re-offending and repeated arrests.

MST is an intensive intervention delivered in the child or young person's home and community, with the therapist working intensively to build the capability of parents or guardians and support sustainable behavioural change.

Families with multiple and complex needs are heterogeneous and require flexible approaches that are tailored to their individual needs. MST is grounded in systems theory, viewing and working with the child or young person within the context of their individual eco-system – family, peers, school, and community.

The elements of the MST intervention are:

- **Home and community-based delivery:** Sessions are tailored to each family's needs and may occur in the home, school, or community. Families co-design the intervention plan, with therapists available 24/7.
- **Therapist engagement:** MST therapists adopt a “*whatever it takes*” approach to engage families and stakeholders. Weekly case reviews ensure alignment with MST principles.
- **Treatment techniques:** Interventions focus on improving parenting practices, strengthening family relationships, promoting pro-social peer connections, and enhancing school performance.
- **Model fidelity:** High fidelity to the component of the MST model is critical to deliver the intended outcomes. MST therapists receive intensive training, including a week-long induction, weekly supervision and consultation, and quarterly booster sessions to endure the fidelity of MST delivery.

"The MST worker kept coming back and was persistent. I knew that she would stick around and I could trust her. I could then let down my walls and let her in"

-Mother in MST



The key features of the MST model are set out below.

Age cohort:	Children and young people aged 12 to 17 years.
Target group:	Children and young people with severe and persistent behavioral problems, serious offending and re-offending behaviours, and/or substance misuse.
Objectives:	Eliminate or reduce criminal behaviour. Decrease anti-social behaviours such as substance misuse. Avoid entry into care and/or youth detention.
Duration:	Three to five months.
Outcomes:	Eliminates and/or reduces offending and anti-social behaviours. Meaningfully reengagement in education and/or employment. Avoids entering care and contact with the youth justice system. Empowers parents and guardians to manage a child or young person's behaviour.
Implementation locations:	Victoria, New South Wales.

"I learnt to listen to what my son was saying rather than keep losing my temper with him. We are able to communicate much better and I could understand how he was feeling"

- Father in MST

Every member of the MST team understands the child safety and youth justice systems, the challenges for vulnerable families and the potential impacts on the behaviours of children and young people.

Each MST team consists of five professionals who provide support to 20 children and young people over a 12-month period. The responsibilities, qualifications, and experience required for each team member are detailed in the table below.



Role	Function	Qualifications & Experience
Supervisor	<ul style="list-style-type: none"> • Clinical and supervisory responsibilities for the MST team. • Manage and monitor complex cases to maintain the highest standard of clinical care and effective risk management. • Oversee the development of comprehensive and systemic management plans for all clients of the MST program. • Conduct weekly group supervision and training for the MST team. • Assure clinician competency in implementation of interventions. • Collaborations with stakeholders. 	<ul style="list-style-type: none"> • Degree psychology, social work, or a related area. • Considerable experience in therapeutic settings and clinical supervising. • Expertise in behavioural and cognitive therapies and their application to the treatment of antisocial youth. • Demonstrated knowledge of cultural sensitivities and proven capability to engage and collaborate effectively with First Nations children, young people, and families.
MST Therapists	<ul style="list-style-type: none"> • Conduct MST assessments including review of referral information, identifying, and engaging key participants, identifying systemic strengths and weaknesses, and developing an analysis of the problem behaviours. • Engage primary caregiver and other key participants and overcoming barriers to engagement. • Maintain clear and concise documentation of treatment and demonstrate compliance with MST Principles. 	<ul style="list-style-type: none"> • Master's degree or four-year bachelor's degree in psychology, social work, counselling, or related area. • Demonstrated experience in interventions and behavioural cognitive therapies and their application to anti-social youth. • Skilled in conducting systemic assessments and analysing client behaviour, with expertise in problem solving and hypothesis development to explain behaviour. • Demonstrated knowledge of cultural sensitivities and proven capability to engage and collaborate effectively with First Nations children, young people, and families.



<p>Aboriginal Practice Lead</p>	<ul style="list-style-type: none"> • Support and collaboration with MST teams and clients to ensure care plans and practices are culturally responsive to each family. • Provide comprehensive cultural advice on casework matters to ensure culturally appropriate decision making. • Lead respectful approaches to engagement with Aboriginal families. • Liaise and collaborate with local community controlled-organisations and communities to facilitate connection and access to culturally responsive services. 	<ul style="list-style-type: none"> • Experience in social work, community welfare, youth work with experience working in Youth Justice, Child Protection or similar areas. • Extensive knowledge of issues impacting First Nations children, young people, families and communities. • Ability to communicate effectively and sensitively. • Demonstrated ability to work with families and communities from a strength-based, culturally appropriate perspective. • Ability to liaise with First Nations stakeholders and community members, to help ensure effective processes of engagement and participation in support services.
<p>Case Manager</p>	<ul style="list-style-type: none"> • Case management. • Ongoing assessment of risk, whilst taking steps to reduce risk and increase children’s safety and wellbeing. • In-home family casework, working in partnership with families to identify and achieve goals, aimed at enhancing the child’s safety, stability, and development. • Work collaboratively with Youth Justice, Child Protection, other professionals, and families. • Promote positive parenting skills and provide modelling and practical support. • Complete comprehensive assessments and present these reports to Youth Justice, Child Protection, the Children’s Court and other professionals as required. 	<ul style="list-style-type: none"> • Tertiary qualification in social work, psychology, community services or a related discipline. • Comprehensive experience and understanding of Youth Justice, the Child Protection system and court orders. • Experience in developing strengths-based risk and needs assessments with families and holding risk. • Understanding of issues impacting First Nations children, young people, families, and communities.



MST – Measuring and Monitoring Outcomes

MST utilises validated tools to measure and monitor outcomes which are outlined in the table below.

Measurement Tool	Description
Strengths and Difficulties Questionnaire (SDQ)	A 25-item questionnaire used to screen for and assess emotional and behavioural problems in children and young people, as well as to measure pro-social behaviour. It screens for emotional and behavioural problems in children and adolescents through five areas: emotional symptoms; conduct problems; hyperactivity; peer relationships problems; and pro-social behaviour (strengths).
Consultative Adherence Measure (CAM)	A 23-item measure in three domains that evaluates adherence to the MST model. It is used to assess the quality of MST consultation and its impact on child behaviour.
Therapeutic Adherence Measure (TAM)	a quality-assurance tool with 28 items that align with the nine treatment principles of MST. The measure has been validated in studies to predict reductions in anti-social behaviours in adolescents. It assesses the fidelity of therapist to the MST treatment principles and is completed by parents, guardians and young people in the MST intervention.
Supervisor Adherence Measure (SAM)	A 36-item measure that evaluates the MST Supervisor's adherence to the MST model of supervision as reported by MST Therapists. It is administered every two months.



MST Case Studies

The success of MST is best captured in case studies.

Edgar*, 16 yr old male.

Family details: Divorced caregivers. Edgar and his younger sister live at Mum and Dad's house on a 50/50 weekly arrangement.

Engagement agreements: MST engaged with caregivers across households (two sessions per week each and when appropriate one joint caregiver meeting).

Referral Behaviours:

- Verbally aggressive or threatening behaviour (in the home towards caregivers and sibling)
- Vandalism, destruction of property (at home)
- Excessive time spent online gaming
- Low affiliation with prosocial peers (none identified)
- Poor relationships with school staff
- At risk of academic failure (due to low achievement and non-attendance).

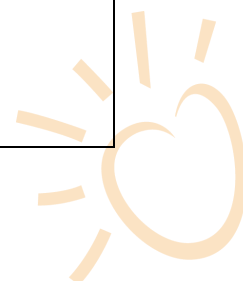
Referred MST to address the above behaviours as well as overall improving family communication and cohesion.

Engagement:

Dad disengaged from treatment after six weeks; stating he wouldn't be putting any more time into attending sessions until Edgar changed his behaviours. He initially threatened out of home placement.

Treatment involved:

- Developed and implemented a reactive safety plan: Tailoring a safety plan for Edgar's violence used in the home.
- Developed and implemented a preventative safety plan: Identifying helpful ways mum could implement consequences for problem behaviours and and put healthy limits around Xbox use in the home that didn't lead to increased conflict or risk.
- Supported Mum in removing the Xbox from the house.
- Explored school-reengagement interventions and engaged with school. Facilitated child-parent decision making around school/vocational options.
- Coached Mum on parent-child collaboration around employment seeking; had Mum prep Edgar for interviews and use strength-based approach to writing his resume.
- Supported Mum in proactively scheduling planned activities for the siblings on weekends to increased shared positive experience and warmth.
- Increased Mums' confidence in influencing peer associations (e.g. incentivising prosocial peers for positive behaviour through inviting them to go-karting on weekends; movie vouchers; pizza night at home).
- Supported Mum in effective monitoring of Edgar's income and purchases;
- Facilitated Mums' efforts to generalise successful interventions to Dad's house; role playing with scripts and providing worksheets.
- Explored and enlisted the help of informal supports to sustain placement (e.g. options for respite; older cousins who could encourage weekend outings and provide positive peer influence).



Outcomes:

- Mum completed full treatment.
- Mum was also actively encouraging the generalisation of successful interventions in Dad's home.
- Edgar had disengaged from school; however, was working two part-time jobs (shifts across five days a week, consistently) for 4+ weeks at closure.
- No further incidences of verbal aggression, threats, or name calling sustained for eight weeks at closure.
- No further incidences of physical violence or property destruction for eight weeks at closure.
- Increased time spent between Edgar and his mother/sister.
- Edgar had a prosocial girlfriend who came over with permission from Mum and participated in cooking meals and movie nights with the whole family.
- Mum and Edgar collaborated well on practical things (e.g. CV writing; job applications) and interpersonal (e.g. problem-solving difficulties he was having with peers).
- Edgar had established positive peer relationships with co-workers at his respective part-time jobs and spent time during the day on weekends socialising with them.
- Overall, improved family functioning and cohesion established.
- Mum reported that there had been no incidents of concern (i.e. physical conflict or threats of out-of-home placement) at Dad's house as well for the eight weeks prior to closure).

Improvements across 100% of the instrumental outcome measures observed:

- The therapist and supervisor have evidence that the primary caregiver(s) has improved the parenting skills necessary for handling subsequent problems
- There is evidence of improved family relations specific to the instrumental and affective domains in that family's subsystems that were drivers of the youth referral behavior.
- The family has improved their network of informal social supports in the community and has demonstrated skill at successfully accessing a range of supports (informal to formal) as needed
- Young person is showing evidence of success in an educational or vocational setting
- The young person is involved with prosocial peers and activities and is minimally involved with problem peers.
- Changes in behaviour of the young person and in the systems contributing to the referral problems have been sustained for 3-4 weeks

Ultimate outcomes:

- At closure placement was secure at both caregiver's homes and Edgar was attending paid-work more than half time.
- Furthermore, Edgar had not been arrested since the beginning of MST treatment.

**names have been changed to protect the identity of our clients*



MST - Evidence of effectiveness

MST has the most extensive body of research supporting its effectiveness with high-risk youth, including those with persistent criminal activity and substance misuse.

Over 90 published studies involving more than 57,000 families have demonstrated strong outcomes at the conclusion of treatment:

- 91 per cent of young people living at home.
- 86 per cent engaged in education or employment.
- 87 per cent with no youth arrests.¹

MST is internationally recognised for its success in reducing offending and improving outcomes for young people and families. It has also shown effectiveness in addressing problem sexual behaviours, child abuse and neglect, substance misuse, serious emotional disturbances, and chronic health conditions.

Extensive international research highlights MST's long-term impact, with sustained improvements well beyond the treatment period. Key findings include:

- Median 42 per cent reduction in re-arrest rates among serious youth offenders.
- Median 54 per cent reduction in out-of-home care placements.
- Improved family functioning and parenting capacity.
- Decreased substance use and mental health difficulties.
- Higher levels of client satisfaction.
- Significant cost savings to government and service systems.²

MST is also proven to be effective in reducing long-term criminality and violence.³

OzChild has successfully supported children, young people and families since launching MST in Victoria in 2019.

OzChild's MST program achieved the following outcomes at the completion of treatment in the 2024–25 financial year:

- 92 per cent of young people remained out of kinship, foster, or residential care.
- 100 per cent of families demonstrated improved family functioning.
- 82 per cent reduced substance use or prevented escalation.
- 53 per cent of young people were engaged in education or employment.
- 85 per cent had no arrests in the final month of treatment.
- 80 per cent reported improved peer associations.⁴

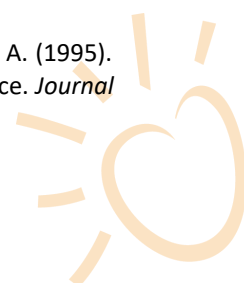
These results demonstrate MST's effectiveness in reducing anti-social and offending behaviours and re-engaging young people in education and employment pathways.

¹ MST Services – Fact Sheet: <https://www.mstservices.com/>

² Multisystem Therapy Research at a glance (January 2025): Published MST outcome, implementation and benchmarking studies.

³ Borduin, C. M., Mann, B. J., Cone, L. T., Henggeler, S. W., Fucci, B. R., Blaske, D. M., & Williams, R. A. (1995). Multisystemic treatment of serious juvenile offenders: Long-term prevention of criminality and violence. *Journal of Consulting and Clinical Psychology*, 63(4), 569–578.

⁴ OzChild 2024-25 Prevention & Strengthening Families Outcomes Report.



The return on investment of MST has been shown. For example, Social Ventures Australia Limited (**SVA**) found that there would be a \$202 million saving to the Victorian child protection and statutory care systems if MST was implemented for 420 children and young people over a 10-year period.⁵

These savings are likely an underrepresentation of total savings to government given the significant cross over of children and young people in the child safety and youth justice systems.

⁵ Social Ventures Australia, *“Keeping families together through COVID-19: the strengthened case for early intervention in Victoria’s child protection and out-of-home care system”*, Research Paper, August 2020.



Annexure D - Functional Family Therapy (FFT)

FFT-YJ Model

Functional Family Therapy – Youth Justice (**FFT-YJ**) is a short-term, evidence-based therapeutic intervention designed to support children and young people aged 11–18 years who exhibit challenging behaviours, offending, or reoffending. FFT-YJ is delivered over 8-30 sessions using a structured, phased model that supports families from initial engagement to long-term change.

The program targets families experiencing socio-economic disadvantage and aims to improve family dynamics, communication, and emotional wellbeing.

FFT-YJ helps families identify positive and negative functions of their behaviours and develop effective strategies for change. The model assumes every family member’s behaviour serves a purpose within the family dynamic. In the short term, families often experience reduced conflict, improved communication, and better behavioural regulation from the child or young person, including less family violence.

In the long term, the child or young person is less likely to reoffend, misuse substances, disengage from their family, or be absent from school.

The following five phases help families understand the function of behaviours, develop new skills, and sustain positive outcomes beyond the intervention:

1. **Engagement:** Builds trust and rapport, especially with families who may be resistant or have had negative service experiences.
2. **Motivation:** Reduces blame and negativity, increases hope to create a context for change.
3. **Relational Assessment:** Contributing to risk factors/ referral concerns.
4. **Behaviour Change:** Teaches a variety of skills that addresses the referral concerns to reduce risk including communication, problem-solving, and conflict resolution skills.
5. **Generalisation:** Ensures changes are sustainable and applicable across settings.

The key design features of the FFT are set out below.

Age cohort:	Children and young people aged 11 to 17 years.
Target group:	Children and young people with behavioural problems, including offending, anti-social behaviours, substance misuse, and violence.
Objectives:	Understand and address the root causes of offending and anti-social behaviours. Empowering parents / guardians to manage a child or young person’s behaviour.
Duration:	Three to five months.
Key outcomes:	Eliminate and/or reduce children and people engaging in anti-social or offending behaviours, and substance misuse. Improved school engagement and increased pro-social behaviours. Parents / guardians improved communication and management of a child or young person’s behaviour
Implementation locations:	Victoria, New South Wales, Australian Capital Territory.



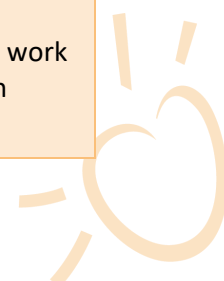
OzChild's FFT Teams

Every member of the FFT team understands the child safety and youth justice systems, the challenges for vulnerable families and the potential impacts on the behaviours of children and young people.

The FFT team consists of three to four practitioners with caseloads of 8 to 12 families and one team leader for clinical oversight and fidelity monitoring to ensure the intended outcomes are consistently achieved.

The responsibilities, qualifications, and experience required for each team member are detailed in the table below.

Role	Function	Qualifications & Experience
Team Leader	<ul style="list-style-type: none"> Works with the FFT program developers and supports adherence to the model requirements. Leads and works with the FFT team to identify and overcome barriers to engagement/motivation in children, young people and families referred. Proactive stakeholder management. Manages a case load of families and conducts assessments including review of referral information. 	<ul style="list-style-type: none"> Master's degree in psychology, social work, or a related area. Experience in leading workers delivering services supporting complex families. Knowledge of child protection, statutory care, and youth justice systems. Knowledge of cultural sensitivities and capability to engage with First Nations children, young people, and families.
FFT Practitioner	<ul style="list-style-type: none"> Provides home-based interventions adhering to FFT model. Develops the treatment plans and the schedule with the child or young person, and their family. Address the needs of children, young people, and families through model adherence and monitoring. Conducts assessments and referrals to community partners. 	<ul style="list-style-type: none"> Bachelor's degree in psychology, social work or related area. Knowledge of child protection, statutory care, youth justice systems and understanding of family violence. In-depth knowledge and understanding of the principles and challenges of supporting vulnerable families. Knowledge of cultural sensitivities and capability to engage with First Nations children, young people, and families.
Aboriginal Practice Lead	<ul style="list-style-type: none"> Support and collaboration with FFT team and clients to ensure care plans and practices are culturally responsive to each family. 	<ul style="list-style-type: none"> Experience in social work, community welfare, youth work with experience working in



	<ul style="list-style-type: none"> • Provide comprehensive cultural advice on casework matters to ensure culturally appropriate decision making. • Lead respectful approaches to engagement with Aboriginal families. • Liaise and collaborate with local community controlled-organisations and communities to facilitate connection and access to culturally responsive services. 	<p>Youth Justice, Child Protection or similar areas.</p> <ul style="list-style-type: none"> • Extensive knowledge of issues impacting First Nations children, young people, families and communities. • Ability to communicate effectively and sensitively. • Demonstrated ability to work with families and communities from a strength-based, culturally appropriate perspective. • Ability to liaise with First Nations stakeholders and community members, to help ensure effective processes of engagement and participation in support services.
<p>Case Manager</p>	<ul style="list-style-type: none"> • Case management. • Ongoing assessment of risk, whilst taking steps to reduce risk and increase children’s safety and wellbeing. • In-home family casework, working in partnership with families to identify and achieve goals, aimed at enhancing the child’s safety, stability, and development. • Work collaboratively with Youth Justice, Child Protection, other professionals, and families. • Promote positive parenting skills and provide modelling and practical support. • Complete comprehensive assessments and present these reports to Youth Justice, Child Protection, the Children’s Court, and other professionals as required. 	<ul style="list-style-type: none"> • Tertiary qualifications in social work, psychology, community services, or a related discipline. • Comprehensive experience and understanding of Youth Justice, the Child Protection system and court orders. • Experience in developing strengths-based risk and needs assessments with families and holding risk. • Understanding of issues impacting First Nations children, young people, families, and communities.

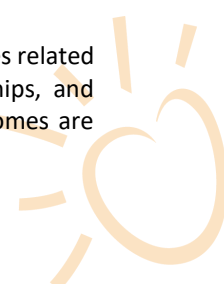


FFT – Measuring and monitoring outcomes

FFT tracks improvement in family functioning, communication, emotional wellbeing, and behavioural regulation using validated tools as outlined in the table below.

Measurement Tool	Description
Client Outcomes Measure Parent & Adolescent (COM-P, COM-A)⁶	A six-point Likert scale that is used to assess the parent or guardians perspective of family functioning and youth behaviour change at the end of the FFT intervention
Therapist Outcome Measure (TOM)	A six item self-report inventory completed by the Therapist that provides for feedback on alliance, matching and resistance and focuses on understanding the family on their terms while supporting the relational perspective of the model.
Outcome Questionnaire (OQ)	An assessment of the parents or guardians against how they feel, how they are getting along with significant others, and how they are doing with important life tasks.
Child and Young Person Outcome Questionnaire (YOQ)	A 64-item questionnaire that tracks treatment progress. It is a self-report measure designed to assess the emotional and behavioural wellbeing of children and adolescents receiving interventions.
Strengths and Difficulties Questionnaire (SDQ)	A 25-item questionnaire used to screen for and assess emotional and behavioural problems in children and young people, as well as to measure pro-social behaviour. It was screens for emotional and behavioral problems in children and adolescents through five areas: emotional symptoms; conduct problems; hyperactivity; peer relationships problems; and pro-social behaviour (strengths).
Family Self-Report	A seven- item self-report inventory that presents family members’ perspectives of the counselling process and the therapist. It provides independent views on alliance, matching, and resistance and supports the relational perspective of the model.

⁶ Client Outcomes Measure Parent & Adolescent (**COM-P, COM-A**), designed to assess various outcomes related to children and young people. Measures domains such as safety, wellbeing, functional relationships, and empowerment, this tool supports workers evaluate the effectiveness of FFT and ensures that outcomes are measurable.



FFT Case Studies

Bailey* and Joy* rebuild after the sudden death of a loved one

OzChild's FFT program aims to change the course for individuals like Bailey, who was at high risk of perpetrating violence and to stop the escalation of violence and protect victim survivors from both immediate and long-term harm.

Bailey was living with his grandmother following the sudden loss of his mum. Bailey and Nana Joy* needed help to connect to each other and prepare them for linking with services to help them move forward and sustain their living arrangement.

Their disconnection was profound... while they were connected in their grief for their daughter and mother Bailey's behaviour was concerning. Bailey was smoking marijuana, skipping school, running away and would often lash out at his nan yelling and swearing, which would escalate to pushing and shoving her. Joy was struggling to cope with her grandson's destructive behaviour and the volatility and growing disconnection were too much for her to handle. Joy knew if things didn't change Bailey would end up leaving for good, or find himself in trouble with the police, and his violent outbursts would only get worse.

Working with OzChild's FFT Therapist Joy and Bailey identified that the risk taking and running away was a sign that he felt like he didn't belong. Bailey was finding it hard to find his place without his mum, not to mention managing his grief. Belonging, connecting to family, and strengthening their relationship were shared goals which became the focus on treatment.

The FFT Therapist used experiences of grief to bring about understanding of each other, rather than being against each other and worked with them to develop skills of conflict resolution, emotional regulation, and effective communication, which were practiced during each session.

Engaging with the family during COVID lockdowns was vital as the isolation they were suffering along with other presenting concerns was intensifying their issues. Over six months, Joy and Bailey achieved their goals of reconnection. With the tools and skills learned through the program, Bailey and Joy were able to live more harmoniously together, setting a foundation for long-term stability.

Both were committed to their relationship and wanted to make it work, they know how precious family is and how quickly things can be taken away. Bailey told his grandmother *"you can't die until you are 100 as I want to stay here"*.



Sarah* learns new skills to break the cycle of violence

For most of their lives, Sarah's kids witnessed violence perpetrated by their father. Influenced by alcohol, arguments would result in physical violence. Fighting between Sarah and her children's father David* was frequent and Sarah's eldest child, Emma* (aged 13) would often step in to protect her mum, calling the police to put an end to the attacks.

Finally, Sarah broke free of David, and Emma and her brother Toby* (aged 11) were no longer live in fear of what their dad might do to their mum, but Emma's behaviours were beginning to mimic those of her father's. The anger Emma felt influenced by what she had seen and heard was now driving her own violent outbursts. Emma was aggressive and violent towards her mum Sarah and little brother Toby. Mum was afraid to put any limits on Emma's behaviour for fear of her response. Sarah was exhausted and was using alcohol to help her relax and sleep at night. She was on edge and unable to cope. *"When we met Sarah and the kids, she was ready to give up, she was so desperate, tired and at her wits end, she even asked me what the process was to surrender the kids to child protection. There was no way I was going to let that happen, not before we gave them a chance to work on changing things,"* said FFT Therapist Nathaniel.

Emma had been diagnosed with Attention-Deficit Hyperactivity Disorder and Oppositional Defiant Disorder, which contributed to difficulty in concentrating, impulsive, defiant and disobedient behaviour.

When Nathaniel began working with Sarah and her kids it was obvious there was a lot of blame and negativity in the family, and so sessions were targeted at reducing these using strength based relational statements and reframing behaviours. This led to increased empathy for each other and increased vulnerability with each other which allowed them to be sad rather than mad, drawing the family closer together.

For the family to change their functioning, they developed new ways of interacting positively. Together they worked on problem solving and negotiating and developing some house rules. Sarah's parenting skills were strengthened as she learnt to listen to her children in a way that they felt heard rather than judged, which helped to restore trust. And Sarah began to focus on improving her own mental health, she started exercising again, reading and reducing her alcohol intake.

She also learnt to walk away when she was feeling triggered, she was able to step aside, calm down and then come back to parent them more effectively without nagging, screaming, criticising, rejecting or blaming. The children then began listening to her more, co-operating and following her instructions.

Sarah, Emma and Toby learnt to be more assertive rather than either aggressive or passive, state how they were feeling and what they needed or wanted more effectively, this resulted in more harmonious interactions and conversations and helped Emma to remain calm and focus rather than lashing out.

The FFT Therapist Nathaniel supported Emma's return to her own therapy.

Recently Nathaniel spoke to Emma's psychologist who told him she had heard from the family about this *"miracle worker"* who had helped them work as a team rather than be in competition with each other, and that they were now much happier because there was so much less fighting and 'agro' in the house.

**names have been changed to protect the identity of our clients*



FFT – Evidence of effectiveness

FFT has been shown to be effective in improving relational dynamics and reducing problem behaviours within families.

More than 40 peer-reviewed research studies, including randomised controlled trials, have consistently demonstrated the efficacy of FFT in addressing substance abuse, delinquency, and mental health issues among adolescents and their families.

Over 50 studies from the past four decades demonstrate greatly improved outcomes after the successful completion of the FFT program:

- 77 per cent of children and young people have no new offences 18 months post-referral
- 89 per cent of children and young people have no drug charges 18 months post-referral; and
- 95 per cent of children and young people attend school or work at the end of the FFT intervention.⁷

FFT has successfully demonstrated how to reduce recidivism, improve family functioning, and prevent out-of-home placements. This makes the FFT an effective tool for professionals in child welfare, mental health, youth justice, and education.

FFT research demonstrates:

- Consistent improvement in family functioning, youth behaviour, and reductions in externalising symptoms.
- Decreased substance use among youth.
- Fewer mental health problems for youth.
- Lower rates of recidivism, even among high-risk delinquent and substance-abusing youth.
- Higher treatment retention rates compared to non-family therapy models.⁸

OzChild's FFT experience and outcomes

OzChild has successfully supported over 174 young people and families since launching FFT in Victoria in 2019. OzChild's FFT program achieved the following outcomes at the completion of treatment in 2024-25:

- 94 per cent of youth experienced no further law violations.
- 91 per cent experienced no safety incidents from family members.
- 85 per cent of youth were attending school and/or work at the time of program closure.
- 67 per cent of parents reported significant positive changes in their child's emotional and behavioural difficulties post-treatment.⁹

⁷ See FFT LLC at <https://www.ftllc.com/evidence-based-research>.

⁸ FFT LLC Functional Family Therapy Research Summary: Summary of FFT Research: Basic, Process, Efficacy, Effectiveness, Meta-Analysis, and Dissemination/Implementation 2024.

⁹ OzChild 2024-25 outcomes report.



OzChild’s commitment to cultural responsiveness and safety

First Nations children and young people are over-represented at all stages in child safety and youth justice systems. Cultural Advisors are an integral member of OzChild’s FFT and MST teams for this reason.

In delivering evidence-based models, OzChild works in partnerships with Aboriginal Community Controlled Organisations.

For example, in the Australian Capital Territory (**ACT**), OzChild delivers Functional Family Therapy – Child Welfare (FFT-CW) in partnership with Gugan Gulwan Youth Aboriginal Corporation.¹⁰ FFT-CW’s aim is to support families with children aged between 0 and 17 years who are at risk of statutory removal. None of the 82 children from the 25 families who have successfully completed the FFT-CW program has entered care.

OzChild also:

- convenes First Nations Cultural Connection Panels for all First Nations children and young people in our foster care programs
- assesses against the SNAICC Outcomes Measures to ensure cultural needs and aspirations are being met
- holds *Yarning Circles* for carers, providing a culturally safe space for reflection, feedback, and shared learning, guided by the Senior Aboriginal Practice Leaders.

“She [FFT therapist] was from the same culture as me. She got me. I didn’t have to explain everything to her. I could be myself with her. Definitely it was the fact that she came from the same culture as me that helped me open up to her and trust her”.

Parent, New South Wales

¹⁰ Gugan Gulwan is an Aboriginal Community Controlled Organisation based in Wanniasa, ACT. It was established in 1992.

