Redesigning Family Preservation in NSW- Fams submission responses

May 2024

The submitted response reflects the collective perspective of more than 80 senior leaders in Family Preservation, each a member of the Fams Family Preservation Sector Network. Input was gathered through three separate two-hour consultations. This submission underwent final review by 15 sector leaders from different organisations, collaborating as the Fams review team. The final responses were also reviewed and endorsed by our fellow peak, ACWA. The key focus of the Fams feedback is to privilege the voice of the sector to ensure that any proposed changes support the best possible outcomes for children and families, with a keen eye to the practical aspects of implementation.

The sector is deeply committed to ensuring the success of the redesign, aiming for exceptional outcomes for children, young people, families, and communities, with the ultimate vison of keeping more children with family. The sector is pleased to see previous recommendations included in the proposed redesign, particularly the increased flexibility to adjust support intensity as needed, support families earlier, bring innovation into service delivery alongside efforts to establish a strong evidence base, holding cases open to foster collaboration and engagement between families, DCJ and NGO's, and the initiation of "Communities of Practice". They see immense potential in the redesign but emphasise the need for adequate resources and support through streamlined systems and processes. Improving communication and clarifying roles between DCJ and NGO services presents a key avenue for maximising the redesign's impact.

Discussion question 1: *Are there any additional primary objectives and/or principles that should be considered for Family Preservation?*

Inclusion of "Community-centred" as a guiding principle

Multiple commissions of enquiry into state-based child protection services have emphasised the importance of collective responsibility in raising children, often expressed through the adage "it takes a village to raise a child."

The inclusion of *community-centred* as a guiding principle would ensure service delivery is rooted in the community, Place-Based, guided by community needs and underscores the fundamental importance of families being supported within their connections to community and cultural groups. This clarifies the role of Family Preservation, clearly identifying it as a system driven to prevent entry into the statutory system by keeping families connected and within community.

To effectively achieve the goals of Family Preservation, being to keep children safe, at home with their families and prevent removal, while also addressing wider health and wellbeing concerns, the principle of *community-centred* is crucial to integrate into as a key component of a responsive Family Preservation system.

Inclusion of "Upholding dignity, safety and honouring resistance" as a guiding principle

Family Preservation services should be grounded in a deep understanding of the pervasive and ongoing effects of interpersonal and systemic violence on individuals, families, and communities. People actively respond to their circumstances, including resistance towards systems that have inflicted harm on their family or within their family's history. The service system must, therefore, in recognition of these injustices, accept a foundational responsibility to cultivate practices that prioritise dignity, cultural humility and self-determination, by understanding people's context and building upon their innate strength, abilities and resilience, starting from the first contact with a family.

Including this principle gives guidance to what is needed to prioritise to get tailored outcomes; focusing on the broader context of persons lived experience, their voice and agency, prioritising reflective practice, transparency and family-led decision making and investing in strong relationships to ensure holistic service provision. Establishing services that are safe and uphold a persons' dignity creates an environment where parents, as leaders and change agents within their families, engage with Family Preservation support meaningfully and effectively, resulting in the breakdown of barriers and lasting change for their children and family.

Discussion question 2: Does the proposed suite of Family Preservation provide the right mix of responsive and culturally safe supports to children, young people, and families?

Overall, the Family Preservation sector commends many aspects of the proposed suite of service options. Introducing a core components framework will enable services to develop and execute responsive service delivery that aligns with local community needs. This flexibility will permit the adjustment of service intensity according to the needs of families, alleviating pressure on families and reducing the need for formal reporting to access services, especially for reduced intensity service provision.

Despite divided opinions regarding the value of continuing MST-CAN and FFT-CW, there's concern about the persistent challenges in accessing training and recruiting staff for these specialised programs, particularly in rural and regional areas. There is a concern that these current issues will persist, potentially resulting in Families Together being overwhelmed with families with more complexities and ineligible for these programs. One service identified that they have used the eligibility criteria as a suitability guide for MST-CAN, and that this change has been approved by the program developers with good outcomes for these families, and may provide a way to work with this challenge.

The consultation raised questions around the evidence supporting the continuation of MST-CAN and FFT-CW due to the high cost of implementation, noting that prior evaluations have found, "these findings reflect the hypothesised outcomes: that the early stage of this outcome analysis means that the costs of establishing and building the programs currently outweighs their benefits" (Shakeshaft, Economidis, D'Este, Oldmeadow, Tran, Naluwago, Jopson, Farnbach, & Doran, 2020, p20).

SafeCare® and Voices and Choices have been trialled in NSW and demonstrated positive benefits to families engaged in these programs. The sector has raised concerns that these two programs do not seem part of the design conversations and would like them to be considered. While it is understood that services could choose to implement SafeCare® under Families Together, Voices and Choices requires DCJ and NGO collaboration for implementation. Sector experience in delivery is that the warm referral, centring the voice of the child and the family autonomy components of Voices and Choices were particularly impactful to initial and sustained engagement with families, and that "DCJ walked with NGOs to ensure family engagement".

The sector would like to further explore other innovative models that could be trialled as alternatives to MST-CAN and FFT-CW due to the variability of success of these two programs across the state.

The sector is firmly supportive of the continuation of Nabu.

Discussion question 3: *How do we ensure that Aboriginal children, young people, and families are provided with culturally safe and responsive supports when working with a Family Preservation service?*

Aboriginal staff working in Family Preservation express concern that the viewpoints of Aboriginal people outside of ACCOs have not been given sufficient attention during the redesign process. They fully support the development of the Aboriginal Family Preservation Framework and are wholeheartedly supportive of the move to increasing the number of ACCOs in the service system but believe this has sidelined the input of Aboriginal people in non-ACCO services. They emphasise that the perspectives and expertise of Aboriginal people working in non-ACCO services are vital in shaping the Families Together and Aboriginal Family Preservation programs. Ensuring safety for Aboriginal families in any program they engage with is paramount, and maintaining choice, autonomy, and agency is crucial for Aboriginal self-determination, including the option to attend non-ACCO services. Fams is endeavouring to host consultations led by Aboriginal staff within non-ACCO services to actively explore these complexities. Fams looks forward to discussing the results of these consultations with DCJ.

The sector noted that for cultural safety to occur for Aboriginal families receiving service in non-ACCOs, the same access to process occurring in Aboriginal Families Preservation need to occur in Families Together. For instance, if DCJ is to "support engagement by attending a yarning session at the outset to establish what engagement looks like, and ensuring they attend monthly FAP-C and risk re-assessments (and/or letting ACCOs lead these) within Aboriginal Family Preservation", a version of this needs

to be accessible to Aboriginal Families in Families Together. Ideally, this process should be accessible to all families engaged in Family Preservation.

Discussion question 4: *How do we ensure children, young people, and families from Culturally and Linguistically Diverse (CALD) backgrounds are provided with culturally safe and responsive supports when working with a Family Preservation service?*

Effective support for children, young people, and families from Culturally and Linguistically Diverse (CALD) backgrounds requires nuanced and resource-intensive practices.

Practical resourcing needed includes cultural consultants to ensure culturally safe support, especially in areas with diverse CALD populations, along with interpreter support and brokerage, particularly for refugee families. Clinical supervision and cultural capability training is critical to ensure staff reflect on and identify their own cultural biases and build skills to ensure culturally safe service provision.

Securing additional funding for translators and interpreters is critical to providing services to CALD families, as current costs often strain agencies' limited resources.

The sector notes that CALD families require greater support hours when compared to non-CALD families. Essential time-intensive tasks include spending time building trust and rapport, educating families about Australian service systems, visa complications, and necessary service flexibility. Investing in relationships with community leaders and attending community events is also pivotal in building trust with communities.

Rural Family Preservation services are reporting increasing numbers of CALD families moving to their communities. Supporting CALD families in rural areas poses a significant challenge, as there is a scarcity of culturally specific resources and opportunities for consultation and collaboration with CALD services, as well as limited access to training.

Wesley Mission's collaboration with the Community Migrant Resource Centre (CMRC) in the Collective Impact project demonstrates an innovative strategy for enhancing support for CALD families. Through this partnership, CMRC provided language and cultural assistance to caseworkers working with CALD families. Evaluated by Western Sydney University (Hawkey, Ussher & Perz, 2019), the program found that families engaged in the program had higher levels of trust, comfort and support, were provided with culturally tailored support (beyond language translation), increased family engagement, increased worker cultural capability, increased positive parenting strategies, increased understanding of Australian child protection laws by CALD families, and improved communication between CALD families and Wesley staff through the avoidance of external interpreters. This approach could be replicated across NSW and would vastly improve outcomes for individual families alongside improving sector skills and capabilities.

The sector suggests that DCJ, in partnership with cultural representatives from the community, create cultural support practice guidelines and principles tailored to aid Family Preservation services responses to CALD families.

Discussion question 5: *Does the eligibility, suitability, and prioritisation approach strike the right balance between providing access to families who could benefit from Family Preservation and targeting a finite resource? If not, what do you think needs to shift so it is striking the right balance?*

Support for eligibility criteria and the assumption of complexity are integral components of a functional Family Preservation program. By establishing clear eligibility criteria, we ensure that families who are most in need of support are identified and prioritised. Additionally, the assumption of complexity acknowledges the multifaceted challenges many families face, allowing for a nuanced understanding of their needs.

However, to ensure that this approach strikes the right balance, continuous evaluation and adjustment are necessary. While guidelines provide essential structure, allowing for some adaptability based on specific circumstances could enhance the effectiveness of the approach.

To date, DCJ's under-resourcing has delayed referrals, leaving services waiting with available capacity. Further increasing pressure on DCJ, for whom the sector holds great empathy, is unlikely to lead to improved outcomes for families. Changing the system to allocate the majority of responsibility for family allocation to community-based organisations, rather than DCJ, could significantly improve outcomes. Having DCJ identified priority cohorts, but managed within community, would adhere to the sector proposed principle of *community-centred*.

By maintaining a commitment to both accessibility and resource efficiency, we can continue to refine this approach to better serve families.

Discussion question 6: *Do the proportions of 60 per cent, 30 per cent, 10 per cent between DCJ allocated, triage, and community referrals strike the right balance? If not, why not?*

The proportions of 60 per cent, 30 per cent, and 10 per cent do not align with what the sector perceives as the right balance and stress the importance of incorporating *community- centred* into Family Preservation as a fundamental principle. They highlight the critical role of community referrals, including self-referrals, in keeping families connected to their communities and reducing involvement in the statutory system.

The sector acknowledges and supports the prioritisation of the most at-risk families for referral. However, they note that current pressures on DCJ have resulted in lengthy waitlists for community referrals while DCJ referral positions remain unfilled. To address this issue, the sector proposes granting more autonomy and responsibility to NGO services and implementing a prioritisation approach and removing fixed percentages for referrals.

Under this proposed model, DCJ referrals would receive primary consideration, followed by triage and community referrals, including internal referrals within agencies across differing programs, particularly Domestic and Family Violence programs. The Anrows report, NSW Human Services Dataset to analyse child protection involvement for families experiencing domestic and family violence, alcohol and other drug and mental health issues (2024), found missed opportunity in the use of the early intervention service Brighter Futures for families experiencing DFV, MH issues, and AOD use. Using internal referral capabilities to holistically respond to identified family need would increase safety and maximise service impact.

Using the proposed prioritisation approach aims to optimise resource utilisation while ensuring that high-priority DCJ referrals are promptly accepted by NGOs. Further, experience has identified in times of community crisis, like environmental disasters, having flexibility to prioritise while also meeting the immediate needs of a community can enhance service access and reduce system pressure.

"During the March 2022 floods there was significant disruption to all services in our local area, many of whom had their office flooded and staff that were directly impacted by the floods. The loss of offices and staff to other areas have had an ongoing impact on services, including DCJ. We have good relationships with the CSCs in our area and Commissioning and Planning and there have been instances where we have been able to accept a greater quota of Community Referrals in response to the community's needs and take pressure off DCJ following the floods.

I think if were worked on a prioritisation approach to all referrals rather than percentages for Community, Triage and ongoing referrals we would be well placed to manage referrals in times of challenge, e.g. natural disasters, low staffing in DCJ etc. If we have good relationships with our CSCs and Commissioning and Planning, we are well positioned to implement a prioritisation approach based on local supply and demand."

The sector is concerned about the absence of opportunities for families to self-refer to family preservation services in the proposed redesign, and the impact on public perception of Family Preservation if self-referral is removed. Providing self-referral options offers families a route to exercise agency and self-determination, particularly crucial for those families who have experienced current and historical trauma from system involvement.

Practice experience indicates that families frequently reach out for support when they are ready and motivated to make meaningful change. This is often after a prior unsuccessful referral attempt and when they are aware a new ROSH report has been made leading to extremely high motivation.

"We get a number of families who self-refer, who maybe haven't engaged in a previous referral but hit a bump in the road and come back. So, for them to have to be turned away, asked to go to another service to get a referral and have a ROSH report made, it seems punitive and counter to the ideas of self-determination. This would be even more detrimental to our Aboriginal families. We need to be listening to the voices of families. If

they are saying "we need a service of that intensity" it's because families often know they are in crisis and heading towards being involved in the child protection system."

Requiring a ROSH report for a community referral is seen as a hurdle to engaging with services and will likely escalate reporting figures. While understanding the potential necessity of concurrent ROSH reports, mandating them as a requirement for accessing services contradicts efforts to reduce reporting, and may impede a families' ability to choose whether to engage with the program. Sector expertise suggests that many community referrals are made to increase safety and support to avoid further ROSH reports, particularly for Aboriginal families. There is serious concern that this condition would disproportionately affect Aboriginal and CALD children and families, exacerbating existing mistrust in the system and increasing the overrepresentation of Aboriginal children in the child protection and out-of-home care system.

The sector rejects the notion that DCJ's possession of ChildStory information inherently results in better assessment of service appropriateness. While acknowledging the usefulness of such data, services often maintain longstanding relationships with families through participation in other programs or community interactions. Consequently, the sector asserts that services should be afforded more autonomy in conducting these assessments of appropriateness for Family Preservation service.

The sector highlights that Family Connect and Support services are dealing with exceptionally high-risk families who are not suitable for Targeted Early Intervention (TEI) services and encountering difficulties in referring them to Family Preservation under the current 10% community referral allocation. There is apprehension that failing to increase the proportion of community referrals could leave these families without adequate support avenues.

It appears there are divided views on the implementation of triage as a point of referral. For services delivering IFP and IFBS, concerns surrounding the priority 2 triage referrals include-

- fear that the NGO system's response might be seen as conducting a statutory response to ROSH reports. This raises significant worries about how this perception will affect family engagement, especially for families without an open case with DCJ, potentially leading to families being reported again due to systemic barriers to genuine engagement.
- concern regarding the absence of warm referrals from triage, which is considered crucial for families previously eligible for more intensive programs.
- concern that genuine consent for referral might not be obtained through triage.
- concern that DCJ's lack of resourcing to allocate cases will lead to higher numbers of referrals at triage without the support provided by DCJ if the case had been allocated.

However, Brighter Futures and Youth Hope providers have identified referrals at triage to be successful overall, particularly when;

- the referral is timely (shortly after the helpline report is made when motivation is greater)
- there is a strong relationship between the NGO service and the triage team
- the triage team can keep the case "open" for a period during assessment for suitability and engagement
- the family has had direct contact with DCJ triage to understand the reason for referral and the program being referred to
- that adequate referral information has been shared via the URF and other relevant documents.

Triage referrals are recognised by the sector as an opportunity to initiate earlier engagement with families. They propose that a referral made during triage should not automatically lead to case closure; rather, conducted alongside an investigation allowing for earlier intervention and support. Maintaining the referral open for a set duration, e.g. a minimum of three weeks upon referral to a service provider, provides families with time to accept the referral. This approach allows for triage and the service provider to reassess if families decline the referral or if additional child protection concerns emerge during the initial assessment.

Overall, there's serious concern from the sector that implementing fixed ratios will hinder service access, escalate system pressure and skew the system towards offering support when risk is highest and readiness to change is diminished. Conversely, delegating the responsibility of family allocation to NGOs, using prioritisation as guidance, is considered an effective strategy to enhance service accessibility, alleviate system pressure, and ensure that families experiencing higher risks receive the necessary priority.

Discussion question 7: *What is your view on which families are more or less suitable for the various Family Preservation models? What factors contribute to this?*

Readiness for change is considered a pivotal factor in determining the suitability of families. Families demonstrating a high level of readiness, motivation and engagement are often considered ideal candidates for referral into Family Preservation.

"Programs sow the seeds of their own failure when they do not accommodate clients' readiness for change or motivational level… the research shows that failure to accommodate the client's state of readiness can spell the failure of the most expensive, thoughtful, extensive programs" (Miller, Duncan & Hubble, 2004).

However, it is recognised that readiness is dynamic. The sector acknowledges they hold a responsibility to articulate the benefits of program involvement and foster a shared understanding of child protection concerns, while dually holding the proposed principle of "*Upholding dignity, safety and honouring resistance*". This process relies on caseworkers' ability to establish and maintain strong rapport with families while engaging with practices that cultivate dignity, cultural humility and self-determination, seeking to understand people's context and building upon their innate strength, abilities and resilience. This ensures that families can make informed decisions about

participation, and that the necessary conditions for successful engagement are established.

'Our service supported a family that upon initial engagement were clear they did not want service intervention but felt forced to accept out of fear that DCJ would re-intervene. No readiness (or motivation) for change was demonstrated at this time.

However, with positive relational and client centred case management, a strong rapport was built with the client, that led to the development and continuation of client readiness and motivation for change. This resulted in the client achieving positive child and family outcomes and exiting our program after a full term of active engagement and achieving their identified goals.

This client has since self-referred back to our service 18 months after exiting, after recognising a need for support to leave a violent relationship and has clearly expressed eager readiness and commitment to active engagement at the outset of engagement."

Assessment and motivational theories like Readiness to Change (Prochaska & DiClemente, 1992) and engagement with Motivational Interviewing (Miller & Rollnick, 2013) are considered crucial for understanding and engaging families' readiness and appropriateness for service. Caseworkers adjust support according to parental readiness levels, maintaining alignment throughout engagement. If parents return to a precontemplative stage, it's an opportunity for caseworkers to evaluate if the support provided is meeting the family's needs and goals, seek to gain understanding and explore motivation.

Assessment of suitability would need to consider a family's readiness for change with cases kept open when referred during this period, but not in isolation to other crucial information. This would ensure services are working at full capacity and responding to need, rather having families getting caught in system "bottlenecks".

Services have noted a surge in referrals for parents with intellectual disabilities. Although these families generally thrive in Family Preservation programs, sustaining change post-support remains a challenge resulting in re-referral when risk resurfaces. To effectively facilitate lasting change, it is crucial to ensure that all necessary supports are in place, including both Family Preservation and disability support concurrently, tailored to the specific needs of each family. This requires a balanced approach with the right level of flexibility, intensity, and sustained service engagement. Services must collaborate cohesively, aligning with the family's goals, leveraging each service's expertise to avoid adding unnecessary burden to the family.

It's critical to emphasise the importance of offering appropriate support that is adaptable and responsive to evolving family needs throughout service provision. This includes implementing a clear plan post Family Preservation case closure to ensure children stay with their families and thrive. This is crucial to preventing the misattribution of system and service constraints to parents, reducing the risk of unnecessary child removal and the ensuing legacy of harm for both parent and child.

Services noted some cases of families of young people being inappropriately referred to Family Preservation. Young people's experiences, needs and input are critical to informing a family's goals and decisions. However, there are circumstances where a referral to a specialised youth and family program would suit meeting the young person's needs than a Family Preservation, e.g. a young person whose family relationships have significantly deteriorated and is referred to Family Preservation due to involvement with Youth Justice.

Discussion question 8: *What practices tools or processes do you currently use, or have you seen used in other services, to determine suitability?*

Due to the wide variability in responses to this question, individual organisations will respond in their own submission to this question.

Discussion question 9: *Do you foresee any unintended consequences in linking DCJ allocated referrals to the Family Action Plan for Change? If so, how can these be mitigated?*

The sector recognises the benefits of integrating Family Action Plan for Change (FAPC) with Family Preservation referrals as an effective strategy for family engagement, especially if the plan is tied to brokerage to implement the plan upon referral (see brokerage comments below). However, there is concern regarding DCJ's capacity to undertake this work, given that plan development relies heavily on the time investment needed to establish strong rapport and relationships with families. There's apprehension that initiating this process before referral, particularly given current DCJ staffing issues, may lead to an increase in procedural bottlenecks, limiting services timeliness and access.

Discussion question 10: *Should service providers be involved in the Family Action Plan for Change? If so, what level of information do service providers need about the family to best support the process?*

Service providers generally express eagerness to participate in the development of the Family Action Plan for Change (FAPC) alongside families and DCJ.

The sector has raised concerns about the lack of family-led development in FAPCs, noting significant discrepancies in how involved families are in plan development. Plans also frequently overlook local resources and availability. They raised concerns about families often agreeing to goals out of fear or compliance rather than genuine engagement and collaboration. Through the engagement of Family Preservation services in the planning process and the establishment of solid rapport and trust with families, there's potential for FAPC to be developed in a way that better respects the family's voice and aspirations and is more closely aligned with the resources and assets within the community.

One proposed solution to address the challenges highlighted in question 9 is to designate the initial three months of an open case for suitability assessment. During this period, the referral agreement could be established prior to FAPC development.

Following this, the FAPC could be collaboratively developed with input from the family, DCJ, and the Family Preservation service, serving as an engagement strategy. Brokerage provided by DCJ would then be tied to the plan's implementation. This approach, implemented after the service has established rapport and understanding with the family, could relieve DCJ of some relational work burden and lead to more comprehensive plans with heightened family commitment.

Discussion question 11: *Will the new referral decline reasons support better referral practices and collaboration between DCJ and service providers? If not, why not?*

The sector is uncertain about whether the new referral decline reasons will improve referral practices and collaboration between DCJ and service providers, given that details of what constitutes a suitable reason for decline have not yet been developed. There is concern of an expectation to handle much higher-risk cases, further amplifying what is the current experience of many services, with DCJ challenging the service when they assess the referral is inappropriate or when escalated risks moves a family to no longer be suitable for the service.

"At the moment you just have to accept anything that comes through the door. A family in our service had been a siege with the dad holding the family captive for 24 hours leading to police involvement. And even with this level of violence, the family was assessed to meet criteria for Family Preservation."

The sector is prepared and eager to support families navigating complex situations. However, to effectively do so, they must ensure their staff receive adequate training and support, especially considering the likelihood of handling more complex cases overall.

Services have highlighted the importance of being able to decline cases at times, particularly when considering their staff's current caseload, capacity and ability to ensure staff safety. This is crucial for maintaining a diverse caseload that includes varying risk profiles and complexities, as it contributes to staff wellbeing and prevents burnout.

Decline reasons to consider-

- The family identifies the service is not a good match for their needs
- The service identifies they are not able to support the family's needs, inclusive of readiness to change assessment
- A service being at capacity
- Risk/ safety issues- child and staff
- Family moved out of area
- DCJ withdrew the referral due to escalation

It is then suggested a referral not being accepted by a service may result in one of three outcomes:

1. The Family Preservation service, during assessment, may identify the level of support required is not high intensity or not the best match for the family's risk level, leading to a decline of service.

2. If the issue is service capacity, the referral is declined to ensure the family can receive a timely support from another service provider.

3. In some cases, the family could be referred to an external service deemed more suitable based on the assessment, such as youth specific individual support.

The sector highlighted while recognising the importance of capturing information about URF form completion, they would not decline a family service because of an incomplete URF, understanding the direct impact it would have on the family. Currently, services accept families with incomplete URFs due to ethical obligations felt by providers. They suggested the need for an alternative process to capture this information for use in contract meetings to better address this challenge.

The current text word limit in the URF affects how much information DCJ can share. Removing the limit could prove an easy solution to the challenge of inadequate information.

Discussion question 12: *If referral practices are effective, what would be a reasonable decline rate for DCJ referrals?*

Insufficient detail has been provided at this stage regarding acceptable reasons for declining referrals makes it difficult for the sector to determine what would constitute a reasonable decline rate for DCJ referrals.

Discussion question 13: *Will keeping cases open for up to three months help service providers improve engagement with families? If not, why not?*

Keeping cases open for up to three months has the potential to enhance service providers' engagement with families, but there are concerns to address. This approach might inadvertently increase stigma and hinder genuine engagement by impacting the family's sense of autonomy, choice and agency. This could be overcome in part by service providers working collaboratively with families to advocate for closure if it's determined that being opened with DCJ is not necessary. An alternative suggestion is to use the 3-month open period for assessing family suitability and readiness to change, with the option to keep the case open with DCJ only if necessary. This period could be utilised for case consultation, warm referrals, assessing suitability (by family and service) and developing the Family Action Plan for Change (FAPC).

This aspect of the redesign requires evaluation to understand if keeping cases open facilitates better family engagement and service communication, or if keeping the case open creates a level of threat for families that impacts genuine program engagement.

Discussion question 14: *Will keeping cases open for up to three months improve collaboration, information sharing, and transparency between families, DCJ, and service providers? If not, why not?*

Theoretically the sector sees, on balance, the benefit in keeping cases open for up to three months to improve collaboration, information sharing, and transparency between families, DCJ, and service providers. Clear guidelines outlining activities during this three-month period are essential for DCJ and NGO service providers to ensure effectiveness. This includes defining roles, responsibilities, and accountability processes.

Doubts are present from the sector in relation to the practical implementation of this change given DCJ's current operational challenges and DCJ staffs capacity to engage with NGO services during the 3-month period.

Discussion question 15: *Will keeping cases open for up to three months result in unintended consequences?*

Keeping cases open for up to three months could potentially lead to unintended consequences, such as:

- increased stigma for families
- negative impact on genuine engagement
- diminished perception of the program being voluntary
- impacts on families' sense of choice and agency.

If the decision is made to maintain open cases, it's crucial that the system takes steps to ensure that the benefits outweigh the risks. If one of the primary reasons for keeping cases open is to alleviate helpline pressure, the sector advocates for the establishment of clear guidelines outlining the expected actions by DCJ when a risk report is submitted by a service.

These guidelines should specify timeframes for receiving confirmation of report receipt and detail the subsequent steps and actions taken by DCJ. Clarity in these areas would enable NGO services to adjust their responses accordingly and assess the need for further escalation.

Discussion question 16: *Do the respective roles and responsibilities of DCJ and service providers regarding managing ongoing and escalating risk provide clarity? Are there any other gaps in understanding?*

The sector is not yet clear about the respective roles and responsibilities in terms of managing risk. While it is understood that if the case is open with DCJ that a service can go directly to the case workers, what steps, actions and accountabilities are the responsibility of DCJ following the direct report are unclear.

Despite not being legally bound by the Care Act, the sector carries significant risks, possesses invaluable knowledge and expertise, and upholds moral and ethical obligations to families. Given the sector's relational and ethical obligations to ensure

child safety, mere compliance with mandatory duties doesn't suffice to ease concerns. Understanding the actions DCJ will take in response becomes essential. Nonetheless, it is viewed that being able to report directly to caseworkers will be of benefit and alleviate systemic stress at the helpline.

For those families without an open case, the sector continues to hold concern that reports of escalated risk will continue to be closed at helpline due to Family Preservation services being involved. They would like assurance that under the redesign service involvement will not lead to an automatic closure.

Broadly speaking there's a consensus held by the sector that DCJ should acknowledge and appreciate the extensive professional training and skills possessed by NGO service staff to a greater extent. This lack of trust in the NGO sector became apparent in the "What We Heard" paper, highlighting DCJ's perception of the NGO sector as being "less skilled and qualified" (p13). The sector is comprised of professionals who are highly qualified and exceptionally skilled. They firmly believe in their ability to assess ROSH. When a service raises concerns regarding a family, these concerns stem from thorough risk assessments informed by their expertise, experience, and ongoing relationships with families. NGOs maintain robust and enduring connections with families, enabling them to detect changes in behaviour effectively.

Training opportunities and communities of practice with DCJ's and NGO services together are viewed as a potential mechanism to enhance trust between the two arms of the child protection system. This would support DCJ to see in practice expertise and clinical skills the NGO sector use to assess risk, increasing trust in the NGO sectors clinical judgement. It has been observed that risk assessment practices by DCJ fluctuate, particularly when DCJ faces resource constraints, possibly leading to reduced risk scrutiny to streamline case closure and service referrals.

"We made 4 reports regarding a family we were working with over a 3-month period, all of which were downgraded to ROSH due to our involvement. We know reports were also made by other services concurrently that were also downgraded due to services involved. Eventually a report was made which resulted in a ROSH. DCJ allocated the case, and the children were removed following one of the children being interviewed and other information being collected. Earlier statutory intervention could have assisted in putting things in place and potentially kept the children with their mother. There are times that good short-term collaboration between service providers and DCJ during service provision can stabilise families and ensure that the children stay in the home and that service providers are able to keep working with the family."

Combining assessments from both DCJ and NGOs offers a holistic approach to risk assessment, leveraging all available resources to safeguard children.

Discussion question 17: *Can you envisage developing a Family Preservation model using the Families Together core components and service activities? What further information would you require about core components and the service activities to develop your model of service delivery?*

Yes, the sector can envisage developing a model of service delivery using the Families Together core components. Having opportunity to recruit and organise teams based on community need would allow for greater flexibility, innovation, and responsiveness.

Ideas shared in sector consultation sessions include employing child specialist workers to assist children affected by trauma, providing staff training for implementing "Safe and Together" in their service delivery, collaborating with other organisations to deliver core components or aid in assessments for more tailored support plans, or hiring in-house family therapists.

To proceed with model development, the sector requires:

- Program logic
- Evidence portal
- Unit costing to determine the feasible options within funding constraints.

Discussion question 18: *Are there any key service activities that have not been captured in the Families Together core components?*

Identified activities not captured in the Families Together core components include-

- Crisis management and stabilisation of the family system
- Implementation of SafeCare®
- Family Group conferencing
- Environmental disaster response

Discussion question 19: *Do you agree with the proposed service duration and service hours per family for Families Together? If not, why not? What would you propose as an alternative?*

The sector believes the ideal duration of service is a minimum of 12 months, with the assumption that the majority of families will require 18 months of service.

The sector does not believe the proposed 200 hours would adequately cover service provision for the reasons provided below, and that contracting based on hours will have unintended negative consequences.

1. Family finding requires a significant time. For Aboriginal families, family finding is critical to ensuring a culturally safe service response, for keeping children with family and kin, preventing child removal, and in keeping with active efforts legislation.
2. Advocacy is essential for ensuring culturally safe support for Aboriginal families, but often requires a significant time commitment. Despite being time-intensive, it plays a critical role in reducing the entry of Aboriginal children into out-of-home care.

3. Increased risk and safety concerns for rural staff stem from the isolation and availability of firearms in rural areas. Adopting an hours-based allocation model would significantly impact the service's ability to enhance safety in these contexts. For instance, a family residing two hours away from the service may require the presence of two staff members for a family visit, consuming a total of eight service hours before any work with the family commences. Data from Australian Government Institute of Health and Welfare child protection reports (AIHW, 2024) highlight a correlation between remoteness and heightened risk. Under an hours-based model, these families would deplete their allocated hours more rapidly, while also facing obstacles in accessing telehealth services due to limited telecommunications infrastructure, digital poverty, and possible low digital literacy.
4. A standardised allocation of hours per family wouldn't accommodate the needs of larger family groups. For instance, a family with 7 children, even if requiring lower intensity service, would necessitate more hours than a family with 2 children due to the complexity of case coordination.
5. On average, CALD families require more service hours as they:
    a. frequently have larger families necessitating more complex case coordination
    b. require the use of interpreters
    c. require cultural consultation and supervision for staff
    d. need greater time to build trust with services
    e. require additional support in understanding and navigating complex Australian service systems particularly for those newly arrived or from refugee backgrounds.
6. Hours can be lost if clients are not present for scheduled appointments, particularly during early engagement stages. Considering the substantial travel times in both metro and rural areas, relying on an hours-based approach could result in detrimental outcomes.
7. Family preservation work is relational work; when violence and harm (including systemic) has occurred in relationships, entering into a relationship has the potential to feel threatening. Imposing time restrictions on this crucial aspect would create stress dynamics that impede the necessary conditions for healing and change, running counter to the person-centred principles of Family Preservation.
8. The hour scoping overlooks the time spent before family allocation, which includes tasks like following up on referral information, assessing risk levels, and determining the suitability of a family for service.
9. Most tasks in Family Preservation require face-to-face interaction. In-person engagement is essential for delivering trauma-informed relational support as it enables co-regulation between the worker and parent, provides opportunities for vital role modelling, and fosters the development of strong rapport through use of body-based nonverbal communication, which telehealth cannot replicate.

Depending on reducing hours by eliminating travel time and relying on telehealth is not viable.

The sector is aware of the discrepancy between DCJ Face to Face targets which focus on the number of children in a family, and NGO service agreement contracts which are based on number of families. Proposing contracting based on duration and considering the number of children within families would provide services with a more suitable approach to allocate resources according to families' needs. For instance, families with 5 children often require more comprehensive support than those with only 1 child.

The sector estimates families at medium to high risk typically need around 350-400 hours of service. Given the potential shift towards higher-risk families with proposed referral changes, it's suggested that this range better reflects the time required to complete services. Nonetheless, the sector does not endorse a funding model based on hours allocated per family.

Discussion question 20: *Does the proposed service duration and service hours per family for Families Together provide enough discretion for practitioners and service providers to be responsive to the changing needs of families through service duration?*

The duration of service and hours allocated per family in Families Together prompt concerns about practitioners' and service providers' capability to meet the evolving needs of families effectively. Flexibility in support is vital, allowing for the adjustment of hours towards the conclusion of service to strengthen learning outcomes and community ties or respond to increased need following a crisis to stabilise the family systems. Allocating additional hours for safety considerations, such as when two staff members need to attend a visit, can quickly deplete allocated hours, impacting families with the greatest needs. Challenges also exist in managing hours when clients are not at home during scheduled visits. A potential unintended consequence could be that services begin to decline clients at greater distances to manage hour allocation.

Discussion question 21: *How would you apportion time across the following functions: face-to-face service delivery, travel time, calls with clients, case preparation and planning, and professional supervision?*

Due to the wide variability in responses to this question, individual organisations will respond in their own submission to this question.

Discussion question 22: *Does Families Together allow you to apply and utilise your current best practice approaches?*

Due to the wide variability in responses to this question, individual organisations will respond in their own submission to this question.

Discussion question 23: *How would use the flexibility under the Families Together framework to drive innovative approaches?*

Due to the wide variability in responses to this question, individual organisations will respond in their own submission to this question. However, there's concern that the

proposed distribution of hours could hamper services capacity to uphold the current high-quality service. This could result in services resorting to telehealth to meet contractual obligations, potentially risking the safety of children and young people. Best practice underscores the importance of dosage, flexibility, and responsiveness in achieving enduring family change. There's significant apprehension that the suggested changes could greatly compromise outcomes.

"In COVID we saw that when services had to provide telehealth services, children and young people's risk increased significantly due to staff not being able to assess safety the home."

Discussion question 24: *How could you leverage skills and capabilities across your organisation or the wider service system to deliver and innovative approach to Families Together?*

Due to the wide variability in responses to this question, individual organisations will respond in their own submission to this question.

Discussion question 25: *What rules and discretion would you like to be reflected in a new brokerage policy?*

Brokerage needs to allow investment in a family for both immediate and foundational needs. The sector would like to see Families Together include an increased brokerage component for costs associated with assessments needed to access other support systems, particularly mental health, and disability.

For those families with an open DCJ case, the sector would like any FAPC to have an associated brokerage allocation, managed by DCJ, to ensure coverage of NDIS assessments, paediatric assessments, and provision of essential safety costs.

Discussion question 26: *What implementation support would new and existing non-ACCO service providers need to deliver Families Together?*

The implementation of redesign of Family Preservation will require substantial support for service providers. It is crucial to boost service funding during the transitional period to support the adoption of the redesign, allowing for the establishment of temporary roles dedicated to oversight, implementation, and change management. This phased approach will ensure transparent communication and the development of necessary backend resources, preventing caseworkers from being burdened with ambiguity and enabling them to focus on frontline work.

As funding increases are necessary to sustain the current model, making additional investment is essential to ensure success. Some services currently offer only medium service intensity, raising concerns about their ability to handle families requiring high service intensity with existing staffing arrangements. There is apprehension that opening services to all referrals, including more complex and families with higher-risk profiles, might lead to staff turnover in the Family Preservation workforce without adequate support. Regional and rural areas face increased implementation challenges

such as limited access to therapeutic services for referrals and small local recruitment pools. To address this access to training, capacity building and development opportunities are essential to prepare staff and services to confidently manage the change in referred family's support needs.

Similarly, clear guidelines are essential for DCJ CSCs to maintain consistency in implementing the redesign, including succession planning to retain corporate knowledge in the face of staff turnover to prevent the burden of supporting and educating local CSCs from falling on NGOs.

"When the URF was introduced none of the case workers in the CSCs that we cover knew about the changes. It was left to service providers to educate the DCJ case workers/managers. This was extremely difficult as we did not have access to ChildStory or a copy of the referral form."

Consultation with the sector revealed significant disparities between regions concerning communication, relationships, and contract implementation. These discrepancies were evident in both in areas with allocation hubs and those relying on local CSC referrals. Consistency is essential for successful implementation. There's a considerable opportunity to incorporate and formalise lessons learned from regions where practices like triage referrals, adaptable service responses, and the involvement of sector in DCJ in allocation meetings had exceptional outcomes. These insights have the potential to contribute to a thriving Family Preservation service system.

Building strong relationships and providing clear guidance are paramount to success. The NGO sector advocates for collaborative training initiatives involving DCJ and NGOs to foster deeper understanding and support, strengthening these pivotal relationships. The introduction of "Communities of Practice" is strongly welcomed as it offers a practical strategy for promoting collaboration and knowledge exchange, ultimately facilitating the development of relationships throughout the child protection landscape.

By reaffirming the Family Preservation principles within the redesign as shared foundational values across DCJ and NGOs, we can establish a common language, clarify roles and responsibilities, highlight the value of each service system component, and ensure the practical implementation aligns with our shared vision for Family Preservation.