SNAICC

National Voice for our Children

Report on Aboriginal and Torres Strait Islander Family-led Decision Making Trials, Queensland January 2016 to June 2017

SEPTEMBER 2017

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Frequently used acronyms

ATSICCOs: Aboriginal and Torres Strait Islander Community-Controlled Organisations

ATSIFLDM: Aboriginal and Torres Strait Islander Family-Led Decision Making

DCCSDS, or the Department: Queensland Government Department of Communities, Child Safety and Disability Services

QATSICPP: Queensland Aboriginal and Torres Strait Islander Child Protection Peak

SNAICC: SNAICC – National Voice for our Children (Aboriginal and Torres Strait Islander Corporation)

VACCA: Victorian Aboriginal Child Care Agency

Recommendations

Recommendation 1: Aboriginal and Torres Strait Islander Family-Led Decision Making (ATSIFLDM) always be led by Aboriginal and Torres Strait Islander staff working for Aboriginal and Torres Strait Islander community-controlled organisations (ATSICCOs).
(Note: there may also be circumstances where a non-formal and non-organisation based local process supported by the community and led by Aboriginal and Torres Strait Islander community members independently of the Department is most appropriate)

Recommendation 2: Rather than co-convening with the Department, co-convening should be undertaken by two convenors within an Aboriginal and Torres Strait Islander organisation to uphold the process as Aboriginal and Torres Strait Islander led, with Department roles undertaken by Child Safety Officers (CSOs) and Team Leaders where there is statutory involvement.

Recommendation 3: Develop locally tailored cultural protocols for engaging with family, community, and ATSICCOs and incorporate into DCCSDS staff training to embed ATSIFLDM processes across service areas and communities rather than as a single program approach.

Recommendation 4: Resource and empower Aboriginal and Torres Strait Islander organisations to design and lead their own processes of community consultation to inform the approach to ATSIFLDM.

Recommendation 5: Allow flexibility for local design of ATSIFLDM processes so that ATSICCOs can work with their communities to harness existing local level leadership and decision making processes and reflect the strengths of each community's and each family's way of working to resolve issues.

Recommendation 6: ATSIFLDM should be defined in legislation, policy and program deign as a community-led process to empower families, not as a service to the Department or a service tied only to child protection systems processes.

Recommendation 7: Access to ATSIFLDM be made available at key decision making points across the care and protection continuum, including wherever possible before decisions about removal and alternate care are made (mandatory referral points that are legislated), as well as through self-referral and flexibility for service providers to identify points when the process would be beneficial for families.

Recommendation 8: Ensure processes and resourcing enable a strong early intervention capability for utilising ATSIFLDM in communities, for example within Family Wellbeing Services, or through existing community-led family decision making processes.

Recommendation 9: Include in training for Department practitioners a focus on understanding the central importance of family and community empowerment at each and every stage of work with a family. This would include building the knowledge, understanding and capability to transfer responsibility from the Department to enable community-led ATSIFLDM processes.

Recommendation 10: ATSIFLDM services in any location have a minimum of 3 and preferably more frontline staff to enable a collaborative and supportive staff team environment, co-convening within organisations, and appropriate backfill. It is suggested that service providers have attention to the importance of gender balance and diversity of clan/ language representation in the recruitment of staff teams.

Recommendation 11: Include within contract delivery requirements and consideration of caseloads the role of ATSICCOs to implement ATSIFLDM using a community development approach with elements including community engagement and collaboration with other providers, ensuring stronger alignment with Human Services Quality Framework (HSQF) standards and community and cultural obligations for organisations and workers.

Recommendation 12: Ensure equitable resourcing of community-controlled organisations in relation to Departmental Collaborative Family Decision Making (CFDM) teams, taking account of frontline workers, management support, professional development and logistical resources. Given significant resources and Aboriginal and Torres Strait Islander identified positions currently in CFDM, it will likely be necessary to transition resources from the Department to community organisations.

Recommendation 13: DCCSDS draw on trial findings to inform a full assessment of the resourcing requirements for undertaking a thorough preparation phase for ATSIFLDM. The assessment must have regard to greater resourcing needs related to travel costs in remote and isolated locations such as the Torres Strait Islands. Resourcing should recognise that families commonly require three or more preparation meetings prior to an ATSIFLDM meeting to be ready to participate.

Recommendation 14: DCCSDS review processes, resourcing and timing of cultural support planning to utilise the strengths of the ATSIFLDM process and convenors and to elevate the status of cultural support for children and young people.

Recommendation 15: Local implementation teams are established that include ATSIFLDM convenors / managers and key child safety staff to promote a consistent and collaborative working relationship between the Department and ATSIFLDM service providers. Local implementation teams should establish consistent agendas, and shared accountability to follow-through on agreed actions.

Recommendation 16: The importance of collaboration between ATSIFLDM and Family Wellbeing Services is recognised and incorporated into the design of future models of practice to promote consistent support and family-led practice.

Recommendation 17: Resourcing of ATSIFLDM recognises functions in building networks and collaboration with a broad range of services that support families to implement their decisions and plans.

Recommendation 18: Information about ATSIFLDM be shared broadly in communities so that all services and stakeholders are aware of the role that they can play to support families to make decisions and implement plans.

Recommendation 19: The processes needed to establish an effective follow-up support mechanism for families be given strong consideration in future ATSIFLDM model design. At least one follow-up meeting coordinated by the ATSIFLDM convenor is recommended to support families to implement their plans.

Recommendation 20: Information sharing protocols and processes are established between ATSICCOs undertaking family decision making to enable appropriate information sharing about families who are transient and spread across broad geographic areas.

Recommendation 21: DCCSDS ensure that appropriate training and capacity development supports are scoped and included in future ATSIFLDM model development in close consultation with QATSICPP.

Recommendation 22: DCCSDS has significant attention to internal training needs to shift culture and practice and develop readiness for its staff to support and enable ATSIFLDM.

Recommendation 23: An independent implementation support role is provided for in any future ATSIFLDM model. This may include elements of intensive implementation support for the establishment phase and ongoing support to promote practice excellence, including through the role of QATSICPP.

Recommendation 24: DCCSDS resource annual service forums in regional centres across the state to support practice sharing and the development of practice excellence for ATSICCOs and ATSIFLDM convenors.

1. Background

This report is based on SNAICC's implementation and practice support to the trials of Aboriginal and Torres Strait Islander Family-led Decision Making in Queensland from January 2016 to June 2017. It reflects the observations of SNAICC as well as input from frontline staff delivering the trials and expert advisors engaged to support the trials.

1.1 Introduction and context

In January 2016, SNAICC – National Voice for our children was contracted by Department of Communities, Child Safety and Disability Services (DCCSDS) to:

> *contribute to the implementation of trials that provide clear learning and direction to inform an ongoing process to empower Aboriginal and Torres Strait Islander families in child protection decision-making in Queensland, and as a result, ensure that more children stay safely connected to their families, communities and cultures* (SNAICC Implementation Plan, revised 2017).

Aboriginal and Torres Strait Islander family-led decision making trials were introduced in response to recommendations for reform to the child protection system proposed in *Taking Responsibility: A Roadmap for Queensland Child Protection*, the final report of the Queensland Child Protection Commission of Inquiry (2012).

In particular, the trials respond to three key recommendations of the inquiry to improve the system for Aboriginal and Torres Strait Islander families:

- Recommendation 7.3 – the development and implementation of a pilot project to trial the Aboriginal and Torres Strait Islander Family-Led Decision Making (ATSIFLDM) model, based upon the Victorian Aboriginal Family Decision Making Model.
- Recommendation 7.5 – the development of cultural support plans for Aboriginal and Torres Strait Islander children that include arrangements for regular contact with at least one person who shares the child's cultural background.
- Recommendation 11.3 – the development of a 'shared practice' model to facilitate close working relationships between Recognised Entities and departmental officers to:
    - coordinate and facilitate family group meetings;
    - identify and assess potential carers;
    - develop and implement cultural support plans; and
    - prepare transition from care plans.

These recommendations seek to promote self-determination and to reduce the overrepresentation of Aboriginal and Torres Strait Islander children in the child protection system. Importantly, they promote government and community services upholding Australia's obligations to support children to be cared for and connected to family, culture and community in accordance with international human rights and national and state based policy and legislation including:

- *United Nations Convention on the Rights of the Child (1989)*

- National Family Matters campaign and Statement of Commitment
- *National Framework for Protecting Australia's Children* 2009-2020
- *Supporting Families Changing Futures: Advancing Queensland's child protection and family support reforms* (2014)
- *Our Way: A generational strategy for Aboriginal and Torres Strait Islander children and families* (2017, Queensland Government)
- *Changing Tracks: An action plan for Aboriginal and Torres Strait Islander children and families* 2017-2019 (Queensland Government).

Aboriginal and Torres Strait Islander family led decision making is endorsed in the above-mentioned Queensland Government *Changing tracks* action plan to address the following two building blocks:

- Aboriginal and Torres Strait Islander people and organisations participate in and have control over decisions that affect their children
- Governments and community services are accountable to Aboriginal and Torres Strait Islander peoples.

The commitment to resource a state-wide approach to including ATSIFLDM within the redesign of the Recognised Entity service in 2018 was made in the latter stages of the trials. SNAICC considers that the learnings, interim evaluation findings and the commitment of ATSICCOS influenced the direction of Department to further pursue the initiative.

1.2 Report structure

This report presents an overview of the trials including trial design, the roles of different stakeholders, and limitations to implementing the Aboriginal and Torres Strait Islander Family-Led Decision Making model.

Key findings and recommendations are outlined based on learnings and themes that recurred throughout trial implementation and were observed by SNAICC directly as implementation partner or that were raised through formal and informal discussion with stakeholders, including service provider staff, department staff and the Expert Advisory Group. The findings and recommendations are intended to provide guidance to the planning and implementation of future service delivery state-wide.

There are also three annexures to this report. Annexure A presents draft guidelines prepared for trial site two that focused on the investigation and assessment stage of statutory child protection. Guidelines were drafted for each trial site and used as a starting point for model and practice development. Annexure B is a family plan template that was developed to support the family planning process for the trials in consultation with the community organisations and DCCSDS staff. Annexure C provides detailed implementation observations that support the key findings and recommendations presented in Section 3 of the report.

2. Trials overview

The following sections provide an overview of the trial design, the role of different stakeholders and limitations to implementing the Aboriginal and Torres Strait Islander Family-Led Decision Making model.

2.1 Trials description and purpose

From April 2016 to 30 June 2017, the trials were conducted across different locations in Queensland and different phases of the child protection continuum as described in the table below.

Table 1 Descriptions of trial sites by location and phase of the child protection continuum

	Trial 1 – Ipswich (South West Qld Region)	Trial 2 – Mt Isa (North Qld Region)	Trial 3 – Cairns and Torres Strait (Far North Qld Region)
Phase of child protection system	Early intervention where there is no requirement for ongoing departmental contact / intervention	Department has the investigation and assessment process open and statutory protection is likely or being considered	Child Protection Orders or Open Intervention with Parental Agreement is in place (ATSIFLDM is both for initial case plan development, as well as case plan review)
Responsible for implementation	Implemented by Kummara Association Inc. (Family Support Service)	Implemented by AIDRWA Inc. (Recognised Entity) in collaboration with Child Safety	Implemeneted by Port Kennedy Association & Wuchopperen (Recognised Entities) and co-convened with Child Safety
Primary outcomes sought	▪ Divert families from future departmental intervention ▪ Keep children connected to family, community & culture	▪ Reduce entry to out-of-home care ▪ Promote timely re-unification ▪ Keep children connected to family, community & culture ▪ Increased role of the Recognised Entity	▪ Reduce intrusiveness and length of intervention ▪ Identify alternatives to OOHC & culturally appropriate placement options in line with ATSICPP ▪ Improve quality of case plans, cultural support plans, and transition from care plans ▪ Increased role of the Recognised Entity

The Aboriginal and Torres Strait Islander family-led decision making trials aimed to:

- Promote self-determination and shared decision making at different phases of the child protection continuum;
- Empower families to make informed choices and decisions about what's best for their children, while the department ensures safety concerns are addressed by the process;
- Develop and trial the capacity of the Aboriginal and Torres Strait Islander community controlled organisations to lead decision making and case planning in a culturally sensitive way;
- Test the practice implications and effect on existing legislative arrangements and delegations;
- Assess the time and resources taken to undertake a full family-led process; and
- Review the efficiency of ATSIFLDM at different phases of the child protection continuum.

Of relevance is the distinction that at the time of the trial Recognised Entities were funded to **provide independent advice to inform the decisions** of the department and the Children's Court when child protection concerns are reported for an Aboriginal or Torres Strait Islander child or young person. In this trial new and additional functions were resourced, whereby the trial convenors sought to **empower families to make decisions and create a family plan** to keep children safe and connected to family, culture and community. This sought a shift from a consultative service to DCCSDS, to a supportive and strengths-based service to families.

2.2 Role of the implementation consultant

SNAICC worked collaboratively to lead the design and implementation for the trials with the Department of Communities, Child Safety and Disability Services, and in partnership with the Victorian Aboriginal Child Care Agency (VACCA) who contributed their expertise developed from over 10 years of delivering Aboriginal Family Led Decision Making services in Victoria. SNAICC's role as the implementation consultant for the trials was to:

- Consult at each trial site to ensure Aboriginal and Torres Strait Islander communities (including Local Reference Groups), their organisations, and Departmental stakeholders inform the design and implementation based on local cultural and service needs;
- Support the design and implementation of an evidence-based family-led decision making process that empowers Aboriginal and Torres Strait Islander families in decision making;
- Provide training and ongoing support to departmental and community controlled service provider staff; and
- Analyse and provide reports on implementation of the trials to inform the evaluation process.

VACCA's role in the trials as an implementation support partner with SNAICC included to co-develop and deliver the initial training, attend subsequent trial site support sessions with local implementation teams, provide ad-hoc phone support to

convenors, particularly during the first 9 months of the trial, and as an ongoing member of the trial Expert Advisory Group.

2.2.1 Trial design support

An important limitation of SNAICC's role in trial design was that a significant range of trial design decisions and actions had been taken before SNAICC was engaged. Early design decisions that SNAICC did not have input to included:

- selection of sites for implementation;
- selection of stages of the child protection continuum at which to trial the process;
- definition of desired trials outcomes;
- selection of services providers;
- allocation of resources;
- adoption of individual or co-convenor models; and
- recruitment of trial and department convenors.

SNAICC did provide input to influence some of the above matters where possible as the trial progressed.

SNAICC worked to ensure that within the scope available to contribute to design, the trial was informed by Aboriginal and Torres Strait Islander perspectives, evidence of best practice internationally, local community knowledge, and child protection systems knowledge within DCCSDS. Processes supporting this design process included:

- A design consultation workshop at each trial site (February 2016);
- Review of literature and completion of aligned draft guidelines for each trial (February – March 2016) (Annexure A – Sampled Draft Guidelines for Mt Isa trial);
- Consultation on guidelines with local stakeholders, and practice and program leaders in DCCSDS (March – April 2016);
- Drafting of family plan document in consultation with local stakeholders and DCCSDS Practice Leadership (included within Annexure A – ATSIFLDM Family Plan);
- Training design aligned with good practice and the draft guidelines and informed by VACCA expertise in delivery.

2.2.2 Trial practice implementation support

SNAICC's implementation support role focused on building support around community organisations and government staff to feel culturally safe, confident and capable to deliver ATSIFLDM. The different types of support provided by SNAICC are depicted in Figure 1 below.

Table 2 Types of Implementation Support provided by SNAICC

Figure 1 Model of Implementation Support for Aboriginal and Torres Strait Islander Family-Led Decision Making

Details of each type of support included:

- 6 meetings of the Expert Advisory Group to enhance the quality of service provision through input on design, service delivery and cultural considerations;
- 2 training workshops (two days each at commencement and mid-trial) for convenors, DCCSDS convenors and ATSICCO support staff on ATSIFLDM model and putting principles into practice;
- Information sessions for local organisations, DCCSDS staff and local reference groups at each trial site to build understanding of the model of practice;
- Implementation tools and templates created or shared by VACCA for each stage of service delivery (for example: referral form, consent form, client information pack, genogram template, meeting agreement, meeting agenda, family plan template, family feedback form, flow charts for engagement and referral processes);
- 5 face to face collaborative practice sessions facilitated with each local implementation team;
- 6 support meetings with ATSICCOs and DCCSDS staff separately prior to group collaborative practice sessions;

- 6 site visits to each trial site to discuss implementation, address concerns or uncertainties, and seek solutions in line with trial guidelines and principles;
- 10 circle of practice teleconferences attended by convenors and hosted by SNAICC using an action learning and reflective practice approach.
- Quarterly local reference group meetings to provide cultural knowledge and expertise which SNAICC supported with developing Terms of Reference, guidance on agendas, and participation including providing trial updates (Note: local reference group meetings were inconsistent at some trial locations as discussed in section 3 below.)

Face to face support was highly regarded by stakeholders as essential to forging positive working relationships for a range of reasons including communication, efficiency and enhanced understanding of community environment and local needs. Outside of the site visits (6 per site), contact and support was maintained frequently via phone and email with convenors. In addition to SNAICC's phone support, VACCA's lead practitioner conducted a number of one on one mentoring sessions with convenors on request.

2.2.3 Convenor training

SNAICC provided two two-day convenor training programs throughout the course of the trials. The first program focused on induction and skill building for new trial convenors, while the second was focused on action learning and practice sharing.

The topics addressed in the initial convenor training in March 2016 included:

- Orientation to and understanding the model of practice described in the draft trials guidelines;
- Scenario based skills for facilitating a family meeting, including case studies and role plays;
- Tools and skills for identifying family support networks and completing genograms;
- Strategies for working collaboratively with DCCSDS; and
- Strategies for including children's voices.

The second two-day workshop with convenors in Decemeber 2016 included:

- Reflecting on progress and envisioning and planning for future improvements;
- Sharing of practice examples and learning by convenors;
- Activity based engagement with families;
- Case study discussions and learning; and
- Trials evaluation.

Other training, advice and mentoring was provided on an ongoing basis throughout the trials by SNAICC and VACCA, including in the ways described in section 2.2.2 above.

2.2.4 Support for, and participation in, ATSIFLDM trials evaluation

SNAICC provided support to the trial evaluators, including through the provision of end of trial information collated through our support role; participating in interviews to inform the evaluation from our perspective; providing feedback to evaluation documentation on request and facilitating connections between trial stakeholders and the evaluators. SNAICC also assisted the evaluation process throughout the trial by incorporating evaluation sessions to discuss program logic and evaluation methodologies at group gatherings and trainings; supporting convenors to work effectively with evaluators on site visits and to seek and gain participant consent; and supporting qualitative interview processes.

SNAICC maintained a clear delineation of reporting from the evaluation team to avoid duplication and to ensure that performance and data analysis was led by an unbiased, external party. SNAICC's report differs from the evaluation report for the trials in that it is based on SNAICC's observations and expertise and implementation stakeholder feedback rather than comprehensive data review or consultation with service users. SNAICC access to data was somewhat limited, whereas the evaluation team was able to access performance reports and case files for auditing purposes, which are reflected in the evaluation report. Evaluators also conducted in-depth interviews with 18 families, as well as a large number of staff and stakeholders for the trials, which provide a further evidence base reflected in the evaluation report.

2.3 Trials principles

Principles for Aboriginal and Torres Strait Islander family-led decision making were established at trial commencement based on best practice, the Queensland Aboriginal and Torres Strait Islander Child Protection Standards and consultation with trial stakeholders.

These principles, outlined below, were adopted as guidance to promote consistent application across all trial sites. Notably, there was a high level of consistent support for the trial principles with a pre-trial survey finding that 100% of trial stakeholders that attended consultations agreed with these proposed principles.

Table 3 Principles of Aboriginal and Torres Strait Islander Family-Led Decision Making

1. Participation of Aboriginal and Torres Strait Islander families, children and communities in decision making
▪ Aboriginal and Torres Strait Islander peoples have the right to participate in decisions that affect their children and families ▪ Aboriginal and Torres Strait Islander children are best cared for in their family, kin and cultural networks – supporting families and communities to stay together promotes healing and the protection of future generations ▪ Children have a right to participate in decisions made about their own care, in accordance with their age and maturity ▪ Family is a culturally defined concept - participants in the decision making process should be defined by the Aboriginal and Torres Strait Islander families, children and communities ▪ Families should be given the opportunity to make decisions without

coercion, including having time to meet on their own without professionals present

2. Supporting the outcomes of family-led decision making
▪ Plans are more likely to be followed through when they are made and owned by the child's family and community ▪ When a plan developed by the family group meets safety needs of the child then all professionals should give preference to the family group's plan over other identified plans and provide resources to progress it

3. The role of Aboriginal and Torres Strait Islander Community Controlled Organisations
▪ Aboriginal and Torres Strait Islander community-controlled organisations have cultural and community knowledge that strongly assists the facilitation of family-led decision making. The independent leadership role of Aboriginal and Torres Strait Islander community controlled organisations needs to be recognised, respected and acknowledged ▪ Child Safety has statutory obligations to ensure safety for children – these obligations need to include collaboration with Aboriginal and Torres Strait Islander community-controlled organisations and families to ensure safety concerns are clearly identified and addressed in decision-making

The guidelines and principles were shared across both government and ATSICCO stakeholders. They formed a common understanding and reference point for the continuous improvement of collaborative practice. Enablers and barriers to putting these principles into practice are noted throughout this report.

2.4 Limitations

It is important to note that from SNAICC's perspective, a number of factors served to limit implementation of the full intended model of Aboriginal and Torres Strait Islander Family-led Decision Making. There were also significant differences and inconsistencies between trial sites that limit their comparability. An awareness of these limitations is important when reading and considering this report.

The most notable limitations to full implementation that SNAICC identifies included:

- *Limited staffing:* Staff allocation ranged from .5 to 1 full-time equivalent (FTE) for the majority of the trial, with one site receiving additional funds in 2017 to increase to 2 FTE staff. Low staffing created challenges to maintaining quality practice, backfill, convenor support and consistency, as discussed in section 3.
- *Limited other resources:* Funding failed to fully cover additional needs such as transport costs, which was particularly evident for smaller organisations that couldn't draw on existing resources such as vehicles, and in the Torres Strait where travel costs between islands are very high.
- *Expedited trial establishment*: SNAICC was contracted approximately three months prior to the commencement of trial referrals and case management, creating a very rushed process of consultation, guideline development and

training. SNAICC would recommend a minimum six month establishment phase for similar trial processes. Further, trial delivery organisations were contracted before SNAICC was contracted to provide implementation support and had little guidance on the service they had been contracted to deliver.

- *Trials variability*: Trials took place at different points on the child protection continuum, with individual and co-convenor models, in differing urban, regional and remote contexts, and with a variety of Aboriginal and Torres Strait Islander cultural groups. However, significant commonalities could still be identified because the objectives and model of practice were very similar for all sites.

A number of these limitations are addressed more fully in the key findings section of this report.

3. Key findings and recommendations

This section reflects SNAICC's perspective on and analysis of the most common enablers and barriers to success identified throughout the trials. Identifying common themes and issues was particularly challenging due to the wide diversity across the trials, including key differences in:

- the stage of the child protection continuum the trial focused on;
- resourcing levels;
- organisational and community relationships;
- single and co-convenor models; and
- remoteness.

Nonetheless, significant common learnings were able to be identified and are detailed below. A detailed set of observations and perspectives is provided in Annexure C to reflect more of the specific practice issues identified at particular trial sites.

SNAICC's sources of information for identifying common key enablers and barriers included:

- Issues identified by stakeholders during six trial site support visits at each site that included issues identification by individual stakeholders, and collaborative practice development sessions with local implementation teams;
- Discussion of trial convenors during monthly circle of practice teleconferences;
- Issues identified by trial stakeholders as requiring additional support from SNAICC and VACCA by phone and email throughout the trials;
- Feedback and advice on identified issues from the trial Expert Advisory Group;
- Perspectives and feedback from local community reference groups; and
- Workshops with trial convenors to contribute their reflections on trial progress and outcomes.

Though SNAICC tracked some quantitative data throughout the course of the trials as part of our implementation support role, more detailed quantitative output and outcome data collection and analysis was undertaken by the evaluators, and is reflected in the evaluation report prepared by Winangali and Ipsos.

As an overview, the evaluation report identifies the following statistical information regarding trial outputs and outcomes:

Trial 1:

- 28 referrals received
- 20 families provided with a service;
- 16 families benefited from improvements in safety, protection from harm and life skills
- 16 case plans addressed safety needs for the family
- 1 family exited due to child protection notification
- 616 hours applied to the service

Trial 2:

- 20 referrals received
- 20 families provided with a service
- 16 families benefited from improvements in safety and protection from harm
- 13 families benefited from improved life skills
- 16 families increased their cultural connectedness
- 16 case plans addressed safety needs for the family
- 4 families exited due to ongoing child protection intervention by DCCSDS
- 641 hours applied to the service

Trial 3 (Cairns site):

- 63 referrals received
- 32 families provided with a service
- 30 meeting convened
- 4 case plan reviews
- 22 families increased their cultural connectedness
- 576 hours applied to the service

Trial 3 (Torres Strait Islands site) ***(note: staffing resources were half FTE of the Cairns site):***

- 18 referral received
- 16 families provided with a service
- 12 meetings convened
- 11 case plans develop
- 11 families increased their cultural connectedness
- 360 hours applied to the service

3.1 Cultural authority and leadership

The trials highlighted the strengths of community-controlled organisations and Aboriginal and Torres Strait Islander practitioners to engage with and support Aboriginal and Torres Strait Islander families. Convenors consistently described the importance of distinguishing the ATSIFLDM approach from existing mainstream and departmental approaches in order to promote family engagement and overcome the distrust of families and communities of the child protection system. Particularly trials 2 and 3 were described as being essentially about reframing the relationship between DCCSDS and Aboriginal and Torres Strait Islander communities to establish a new paradigm of family empowerment and cultural leadership – though, the extent to which this was achieved varied significantly.

Convenors described the strengths of unique cultural engagement practices, including that:

- Families felt more comfortable to engage with them because they were Aboriginal or Torres Strait Islander and working for a community organisation; and
- Families opened up more and worked on solutions when given the opportunity to speak in language and to meet without the Department present.

Some convenors described that their engagement practice was strongest when they were able to meet with families and work in different cultural ways during preparations without Department staff present. In some cases this meant that families most successful participation occurred through 'yarns' in preparation meetings and that they were 'quieter' during the actual meeting when Department staff were present. In other cases convenors believed that families spoke up a lot more than they otherwise would have in meetings with Department staff because they had the opportunity to yarn and prepare beforehand. In some cases, it was identified that extended family were more likely to attend preparation visits than meetings with Department staff.

Various stakeholders, both Aboriginal and Torres Strait Islander and non-Indigenous, observed varied levels of cultural competence of non-Indigenous Department staff and the way that this impacted both positively and negatively on the success of process. In particular, it was apparent that some staff had limited belief in the capacity of Aboriginal and Torres Strait Islander convenors to perform the role and that this undermined collaborative work. It was noted by some that Department staff had varied interpretations of how family-led decision making functioned in practice, with some respecting the role of the convenor to lead family engagement during preparation or "family time" but then retaining control over the meeting process, timing and decision making.

However, other Department staff demonstrated high belief and cultural competence, and as such were able to build strong collaborations and create space for the trial convenors to succeed. This collaborative team approach included practices such as having an 'open door' policy for ATSIFLDM convenors to drop into child safety offices to discuss case progression, and agreeing to uphold the family's preferred meeting time. Characteristics of respectful working relationships included a non-judgmental attitude and two-way learning and open information sharing.

Cultural authority and leadership of trial convenors and organisations was respected when ATSICCOs were enabled to:

- prepare families without a department presence;
- lead meeting facilitation;
- conduct meetings at a time and place of the family's choosing;
- elevate cultural knowledge and protocol to being of equal importance to child protection authority; and
- develop a reciprocal relationship with a local community reference group where cultural advice and connection were shared in conjunction with updates on trial progress and policy change in the child protection system.

Cultural authority and leadership of trial convenors and organisations was undermined when department staff:

- misinterpreted family dynamics, communication styles or lifestyles without deferring to the cultural authority of the ATSIFLDM convenor;
- directed family meeting time, place and structure of meetings;
- placed pressure on convenors to conduct preparation and meetings in set timeframes rather than at a family's pace;
- remained present at preparation visits or didn't allow any time for the convenor to work independently with the family;

- arrived at family meetings or homes with the convenor impacting family perception of the independence of the role;
- focused only on past behaviours rather than caring strengths and future planning;
- dominated conversation or process with the use of department jargon and protocol, effectively excluding cultural protocol and language
- expected and enforced a linear process rather than working alongside family dealing with intergenerational issues and cyclical behaviour patterns that require support for family readiness to address.

Local Aboriginal and Torres Strait Islander community reference groups brought local knowledge and cultural expertise to the trials, and also assisted to support community ownership. In some cases they provided invaluable supports to trial convenors. However, there were a range of limitations to the engagement of reference groups, including:

- The limited size of the trials and the fact that they were 'trials' meant that community members did not always view them as sufficient in scope or sustainability to warrant community buy-in;
- Trial convenors did not have sufficient time allocated to develop and nurture relationships outside of quarterly meetings; and
- Community organisations sometimes viewed them as Department directed processes for engaging their own communities, displacing or duplicating their existing community representative roles.

Some convenors required support and training to facilitate reference groups and some were unfairly burdened with a sense of responsibility for achieving community support and buy-in, which depends strongly on the level of commitment of the Department to new practice and on the support of their organisation to manage community engagement processes.

Convenors suggested that cultural authority and leadership could emerge, be recognised and support a funded process if Elders and community leaders were engaged in service design and establishment phases as well as from referral point and first engagement of a family. A strength of ATSIFLDM was that in theory it is a process that reflects long-held traditions of many Aboriginal and Torres Strait Islander peoples in resolving issues and reaching consensus based decisions with the involvement of the appropriate community people. In practice, the trials highlighted the need for services and processes to be flexible to work alongside these existing local processes and reflect the strengths of each community's and each family's way of working to resolve issues. As one convenor stated *"the first point of call is understanding that it is the way it was always done. Create a space for defining cultural leadership and they will then determine the approach to take."*

As an example of what can occur with adequate support and resourcing, at one trial site the RE manager and ATSIFLDM Convenor presented the trial model and practice to a group of nearly 20 male Elders, who represented all groups within this area. The Elders then understood how the process differed to that of child safety and stated that they would like to see this continue and grow because *"it is what we used to do years ago, old ways with Elders".*

Another process that impacted significantly on cultural authority in trial 3 was the arrangement of co-convening between the Department and community

organisations. In many cases Department co-convenors developed supportive and effective relationships with community organisation convenors. However, tensions arose surrounding role delineation, the concept of one convenor leading in a partnership, and differing cultural perspectives on how the process should be conducted. In contrast, in instances where two community organisation convenors worked together in other trial locations the co-convening relationship appeared to reinforce and support the cultural authority of the organisations and convenors.

Table 4 Recommendations 1 to 6

Recommendation 1: ATSIFLDM always be led by Aboriginal and Torres Strait Islander staff working for Aboriginal and Torres Strait Islander community-controlled organisations. (*Note: there may also be circumstances where a non-formal and non-organisation based local process supported by the community and led by Aboriginal and Torres Strait Islander community members independently of the Department is most appropriate)*
Recommendation 2: Rather than co-convening with the Department, co-convening should be undertaken by two convenors within an Aboriginal and Torres Strait Islander organisation to uphold the process as Aboriginal and Torres Strait Islander led, with Department roles undertaken by CSOs and Team Leaders where there is statutory involvement.
Recommendation 3: Develop locally tailored cultural protocols for engaging with family, community, and ATSICCOs and incorporate into DCCSDS staff training to embed ATSIFLDM processes across service areas and communities rather than as a single program approach.
Recommendation 4: Resource and empower Aboriginal and Torres Strait Islander organisations to design and lead their own processes of community consultation to inform the approach to ATSIFLDM.
Recommendation 5: Allow flexibility for local design of ATSIFLDM processes so that ATSICCOs can work with their communities to harness existing local level leadership and decision making processes and reflect the strengths of each community's and each family's way of working to resolve issues.
Recommendation 6: ATSIFLDM should be defined in legislation, policy and program deign as a community-led process to empower families, not as a service to the Department or a service tied only to child protection systems processes.

3.2 Support across the continuum

Locating the trial at specific points on the continuum created a range of inflexibilities and concerns for trial organisations. Challenges appeared to relate to the current child protection system creating a continuum of disempowerment for families. Organisations identified that the greater contact families had previously had with the system and the further that children were advanced through the system, the less likely they would feel motivated and capable of change or believe that they could be decision makers. Reinforcing this, particularly for trial 3, decisions already made for a child's care and protection significantly limited the scope for families to make their own decisions.

A number of observations were made about the success of engaging families earlier before key decisions had been made, including that the process:

- engaged family supports to address concerns, rather than relying on service supports solely or primarily;
- enhanced family motivation and self-belief in change (evidenced in part by their voluntary engagement with the service);
- reconnected family that were not aware of issues and concerns; and
- supported parents to own issues and concerns and seek family support.

A challenge in the early intervention space was that the motivation of families to engage varied significantly and often dropped off as a case proceeded. This was not always negative and presented learnings about how success is defined – in some cases it was not necessary to hold a meeting because family had been connected and empowered in the preparation and took over responsibility for supporting change. A higher level of risk for worker safety was sometimes identified because family environments and dynamics were not yet known or fully described in a referral. As a result, the importance of engaging with family in pairs was recognised. In many cases a lengthier preparation phase was needed to engage and learn about the family story in the early intervention phase or in other phases where family circumstances had changed significantly.

Use of family-led decision making for families already engaged in the child protection system faced the challenges of learned helplessness, service dependency, lack of confidence in speaking up to department staff, hesitancy of extended family to engage in process due to department involvement and a sense of hopelessness. Throughout the trial practitioners highlighted that trust and rapport building often took longer with these families, or could not be achieved effectively within the constraints of statutory timeframes and processes in trial 3.

Another common experience of participating organisations was the desire to respond to and involve families who were outside the referral criteria because of their stage of engagement with the system. Some providers experimented with delivery at different stages with endorsement of DCCSDS, or attempted to establish processes that would enable this.

From SNAICC's perspective, the limiting effect of tying ATSIFLDM to particular points of on the continuum would be best addressed by making ATSIFLDM flexibly available across the child protection continuum and where any support is provided to an Aboriginal or Torres Strait Islander family, such as by Family Wellbeing services. Such a move would seek to replace the identified 'continuum of disempowerment'

with a ‘continuum of empowerment’ where families are invited to be decision makers at the earliest possible opportunity and are encouraged and supported in culturally appropriate ways to take ownership at each stage of the system. Such a system would empower service providers to identity families who would benefit from the service and families themselves to self-refer, while also creating mandatory referral points, such as when harm is substantiated, to ensure no family is left out of decision-making. Critically, the process should be engaged wherever possible **before key decisions are made *for* the family**, including particularly the decision to remove a child to alternate care. For example, if the process is offered at the point of substantiation it will be essential to support changes to any existing departmental practice of making substantiation and removal / order related decisions concurrently so that the opportunity is left for families to develop and propose solutions that don’t require removal or particular orders.

Table 5 Recommendations 7 to 9

Recommendation 7: Access to ATSIFLDM be made available at key decision making points across the care and protection continuum, including wherever possible before decisions about removal and alternate care are made (mandatory referral points that are legislated), as well as through self-referral and flexibility for service providers to identify points when the process would be beneficial for families. **Recommendation 8:** Ensure processes and resourcing enable a strong early intervention capability for utilising ATSIFLDM in communities, for example within Family Wellbeing Services, or through existing community-led family decision making processes. **Recommendation 9:** Include in training for Department practitioners a focus on understanding the central importance of family and community empowerment at each and every stage of work with a family. This would include building the knowledge, understanding and capability to transfer responsibility from the Department to enable community-led ATSIFLDM processes.

3.3 Limitations of resourcing and single convenors

As discussed in section 2.4, resourcing limitations impacted significantly on trial delivery. Resources for the trials appeared limiting across a range of areas including staffing; expenses, particularly transport and travel; and capacity for engagement with community reference groups, stakeholders and referral agencies.

Having for the majority of the trial and in most sites, allocation for only 0.5 to 1 full-time equivalent (FTE) for the convenor role resulted in a broad range of challenges that were perhaps the most starkly evident limitation of the trial to implement the intended ATSIFLDM model. Limitations of the single convenor model included:

- A lack of contingency and backfill arrangements that interrupted delivery in cases of leave, illness, sorry business and staff changeover;
- A lack of local peer support to develop practice and complete cases;
- Lone worker engagement with families in community that was identified as ‘unsafe’;

- Limited capacity to match worker and family, which excluded some families due to conflict of interest resulting from pre-existing family and cultural relationships with the workers and in some cases disempowered families due to an inability to service families in their first or preferred language; and
- Limited community buy-in to the trial that was viewed as small and insignificant alongside more strongly resourced services and programs.

The inadequacy of staffing was apparent in a number of creative strategies employed by organisations to address the resource gap, such as:

- Supplementing Department resources to enable two staff members to work as a co-convening team;
- Drawing on other Recognised Entity staff to provide support and back-up convening; and
- The Department resourcing a second convenor for trial 2 in the last six months of the trial.

It is important to note that the first two of these strategies were not viewed as sustainable as they created resource drains in other areas of organisations which reported that they consequently reduced performance outputs in other program areas. SNAICC is of the view that the pressures of convening alone contributed significantly to the resignations of at least two convenors during the course of the trial and resultant challenges for providers to re-staff and develop capacity. At points during the trial, Department representatives suggested that organisations draw more significantly on their local reference groups to work with families and conduct meetings. This was not viewed as a viable strategy by service providers, citing that many reference group members had employment and other commitments and that they were not remunerated for participation in the trials.

Where two convenors did work together, it was commonly described as effective to engage a male and female working together to overcome gender related engagement challenges. Working in tandem was also reported to provide an enhanced ability to engage children in decision-making and to gain children's voices on their safety and wellbeing. It also allowed convenors to prepare family members individually or separately during a single home visit. This was identified as particularly important where family violence may be occurring or a person may be hesitant to voice their concerns in the presence of other family members.

Another significant resource limitation was in relation to travel and transport. The impacts of travel costs and limitations in the Torres Strait are discussed in detail in section 3.4 below where the lack of and importance to provide resources for independent travel of the provider to outer islands was identified. A lack of available vehicles impacted delivery at some sites, particularly for small organisations with limited existing organisational resources that could be drawn on to support the trial.

At different points during the trials convenors reported limited capacity to engage effectively in activities such as promoting the trial to community stakeholders and support services and engage with local reference groups. Limited capacity for convenors to attend interagency or networking events to raise awareness of the trial resulted in low uptake of the family plan as a single case plan and service providers at times being unaware that shared clients had received the service. This may have related to a lack of clarity around contract delivery requirements, and that those requirements need to include resourcing for community and stakeholder

engagement. For example, in trial 3 some stakeholders seemed to expect that trial convenors would hold the same caseload as department convenors, without allowance for community engagement activities, the lower level of management and peer support, and activities associated with developing and promoting a new model of practice.

Table 6 Recommendations 10 to 12

Recommendation 10: ATSIFLDM services in any location have a minimum of 3 and preferably more frontline staff to enable a collaborative and supportive staff team environment, co-convening within organisations, and appropriate backfill. It is suggested that service providers have attention to the importance of gender balance and diversity of clan/ language representation in the recruitment of staff teams.

Recommendation 11: Include within contract delivery requirements and consideration of caseloads the role of ATSICCOs to implement ATSIFLDM using a community development approach with elements including community engagement and collaboration with other providers, ensuring stronger alignment with HSQF standards and community and cultural obligations for organisations and workers.

Recommendation 12: Ensure equitable resourcing of community-controlled organisations in relation to Departmental CFDM teams, taking account of frontline workers, management support, professional development and logistical resources. Given significant resources and Aboriginal and Torres Strait Islander identified positions currently in CFDM, it will likely be necessary to transition resources from the Department to community organisations.

3.4 Preparation with families

Reflecting the evidence base for effective family-led decision-making, the trial guidelines and training prepared by SNAICC stressed the importance of the preparation phase to a successful process and included significant guidance on preparation practice for convenors. Practitioners confirmed throughout the trial that the quality and quantity of preparation with families both impacted significantly upon whether the family was engaged and empowered to lead decision-making. Preparation also impacted on who participated and whether the 'right' people were involved to provide support. One convenor described that at preparation *"everyone talks up about the worry statement and what they've done to address that already*". Confidence was built by practicing speaking up about changes in the family with the ATSIFLDM convenor whom they trusted and could relate to due to shared culture and lived experiences. Families were said to be more confident to speak to the department or in the presence of department staff at family meetings following a quality preparation, rather than "sitting with heads down and nodding" to the department staff statements, and extended family were more likely to participate in meetings. On more than one occasion participants expressed gratitude to convenors for "changing their lives" (particularly in reference to enabling the family to develop safe alternative solutions to the feared outcome of having children removed from the family home). Whilst being of Aboriginal and/ or Torres Strait Islander descent is imperative for building such trust and connection, the trials also indicated that being

independent or outside of the department was a significant change factor impacting on family empowerment during the preparation phase.

A number of the essential elements of effective preparation identified by convenors throughout the trials included:

- Meeting with family members on multiple occasions and in a space chosen by them using a yarning style to create opportunities to talk through the concerns, allowing them time to process and reach a stage of readiness to identify solutions;
- Adopting a purposive family engagement framework such as Kummara's Model of Change process to work through the family story and plan for change;
- Completing family genograms and eco-mapping to identify potential networks of care and support for children – more time was needed where this hadn't been done before through previous contact with the Department;
- Undertaking separate preparation meetings with different family members and support people so that everyone understood their roles and could speak openly and share different perspectives;
- Reflecting back children's own words to their parents (where appropriate and with their permission) who may not have heard their voices or considered their worries and wishes previously; and
- Completing meetings with family members with no department staff present so that preparation could take place in different cultural ways or in language and family members felt more comfortable to share their story.

For some convenors there were significant challenges to distinguish between what was required for preparing for an ATIFLDM meeting and drift towards a desire and practice of providing case management support to a family. This drift caused concern for DCCSDS staff as they sought to make decisions around managing risk or closing cases while the ATSIFLDM process drew out. Convenors in some communities highlighted that this drift was contributed to by a lack of culturally safe family services that families could be referred to for ongoing support. For example, one convenor explained that *"the family plan gave hope and optimism but if it didn't give a way forward [connect family with accessible support], they didn't own the plan or feel they could make changes and achieve hopes and dreams for their child."*

SNAICC worked with convenors to implement strategies to address drift towards drawn out family support practice, such as setting the meeting dates with family early in the process so that the family and professionals had a clear goal to work towards in terms of timing to reach decisions. SNAICC also encouraged convenors to work increasingly with other support services to identify where the family could seek ongoing support for particular needs following the decision-making meeting. Practitioners built collaboration and referral networks throughout the trial, though their level of success was limited by the single convenor model and a lack of resourcing dedicated to building community knowledge and collaboration for the trials.

A range of constraints operated to limit effective preparation through the course of the trials. These were particularly evident in trial 3 where many processes appeared to be significantly constrained by the Department's existing Family Group Meeting processes. The co-convening model saw community organisation convenors

struggling to distinguish their role and practice from the existing model of practice. ATSIFLDM appeared constrained by statutory timelines (necessarily), department directed processes, and high caseloads of Department co-convenors. Some convenors commented that they did not have time or opportunity to conduct more than one or two preparation meetings, and struggled to align their preparation practice with the intended model. Dates and times for meetings were sometimes set inflexibly to match the travel and work schedules of Department staff rather than the timing that worked for the family.

While it was apparent that many Department Family Group Meeting staff members were advocates for a stronger participatory family preparation process, they were also constrained by different levels of commitment internally including amongst some Child Safety Service Centre staff. An example of this is when team leaders or other departmental staff would mandate where and when meetings would be held often after family already expressed a preference. Convenors would then need to return to family to advise that their preference would not be met. There were examples of cases where department caseworkers or Team Leaders introduced new concerns or expectations of a family at the meeting and this undermined the preparation that had taken place. On other occasions, meetings would progress without team leaders and in follow-up after the meeting when presenting the family plan to the team leader for endorsement the family plan would be changed (changes included language used and decisions for action). Again, this would place the convenor in the position of returning to the family to explain the actions of the department which undermined the family-led process and intention.

Referral issues also impacted negatively on preparation and included:

- Referrals that had little background information or didn't clearly specify the Department's worries framed in the context of present and future risks to children; and
- Inability of community organisation convenor to access a range of case information that was available to Department staff in their internal case management system but not included in referrals.

There were particularly significant limitations on effective preparation practice in the Torres Strait where the cost of travel to outer islands restricted the capacity of the organisation to undertake independent preparation with families. Preparation time was facilitated through shared helicopter flights with the Department, but meant that the convenor was associated with the Department in the community, and visits were often very short as the Department travel schedule hopped quickly from island to island to save on cost. The provider consistently stressed the need for resources for independent travel and work with families. Some strategies to improve preparation in the Torres Strait were developed throughout the trial including more shared travel to allow preparation meetings, requesting that the Department allow the convenor space to meet with the family alone, and having additional preparation meetings on the day of the ATSIFLDM meeting. Preparation was then further impacted by the fact that Department co-convenors were travelling from Cairns and were involved in facilitating the meeting but not in the preparation with family (except on the meeting day) – this appeared to be disempowering and create confusion for both the Department convenors and the community organisation convenors.

Preparation with families was also impacted by motivation for families to participate. For example, families were observed to be cycling between engaging and disengaging due to denial and lack of perceived seriousness of concerns. In trial 1 families also sometimes took control of solutions following initial preparation supports and no longer needed a meeting. External community and family issues, such as sorry business and family relocation, also impacted engagement and timely completion of ATSIFLDM processes.

It was also identified that there could be improvements in carrying forward the cultural lens and approach from preparation into the meeting space, such as starting with cultural support planning and raising its status as a key component integrated throughout the family plan rather than a separate document or "add on". Cultural support planning is best understood as an active process that grows with the child as they grow and enter different life stages. Promoting its importance was seen to be a sign of respect to the child, the community and the Elders.

Despite the significant challenges, convenors reflected that there had been many positive outcomes of their preparation practice with families, including families opening up and sharing their stories, families being empowered to find solutions and becoming more unified, and more and new support people becoming involved.

Table 7 Recommendations 13 and 14

Recommendation 13: DCCSDS draw on trial findings to inform a full assessment of the resourcing requirements for undertaking a thorough preparation phase for ATSIFLDM. The assessment must have regard to greater resourcing needs related to travel costs in remote and isolated locations such as the Torres Strait Islands. Resourcing should recognise that families commonly require three or more preparation meetings prior to an ATSIFLDM meeting to be ready to participate. **Recommendation 14:** DCCSDS review processes, resourcing and timing of cultural support planning to utilise the strengths of the ATSIFLDM process and convenors and to elevate the status of cultural support for children and young people.

3.5 Collaborative practice development

Trials 2 and 3 included a significant aim to improve collaborative practice between Recognised Entities and the Department. Collaborative practice development requires time and resources to see significant shifts in working culture and relationships between frontline child safety service teams and ATSICCOs and to embed processes where both organisations can work collaboratively to empower families.

During the trials there were observable shifts in the understanding of some department representatives from seeing the relationship as one of purchasing a service (cultural expertise) from a provider for the department, to providing funding for a community service to empower families. There were examples of contract managers shifting focus to outcomes for families instead of strict compliance with outputs or performance measures set out in service agreements.

In practice, this provided ATSICCOs with the flexibility required to facilitate the development of many family plans that responded to the holistic needs of the family and often addressed issues families identified that were additional to the concerns of the Department. Many examples emerged where, as a result, families owned the plan created and were eager to have their own copy to assist their follow through on identified actions. Through observing the process of family identifying issues and supports needed to address them, Department staff began to demonstrate increased understanding of why cases may take longer to complete and that the length of time may indicate positive change occurring rather than a lack of progress.

Collaborative practice in relation to the co-convenor model for trial 3 is discussed significantly in relation to its impacts on preparation in section 3.4 and briefly in a number of other key findings sections. There were a range of positive experiences of co-convenor collaboration throughout the trial, including positive inputs of experienced Department convenors who supported capacity development for new community organisation convenors. Overall, however, the co-convenor model appeared to contribute to significant confusion and disempowerment.

VACCA representatives observed significant differences between the co-convenor model used for trial 3 and the model in Victoria that it was intended to be based on. In Victoria, department co-convenors have delegated child protection decision-making authority and their role to carry through the statutory protective mandate of the department is clear. In contrast, in Queensland both the department and community convenors viewed themselves as independent facilitators of family participation, meaning that there was no clear distinction between the roles. The result was that in some cases department convenors seemed disempowered by the call to defer to cultural leadership and authority of community convenors, while community convenors seemed disempowered by the leadership of department convenors who had strong experience in the Department's Family Group Meeting process and carried significant departmental authority. A secondary finding was that the number of Department staff attending a family meeting could include up to four, which limited the shift in practice change and empowerment of families as decision makers.

This size and scope of internal departmental practice often dwarfed efforts of convenors to promote a new model of practice, particularly for trial 3. Inequities in resourcing between government and ATSICCOs prevailed throughout the trial, as while providers recognised the significant limits of their 0.5 – 1 FTE funding, they also witnessed Department investment to grow the internal Collaborative Family Decision Making teams during the course of the trial. Individual community convenors struggled to create an independent space and leadership alongside much more strongly resourced department teams.

Factors that enabled collaborative practice development included weekly meetings between department staff and trial convenors, shared training and professional development opportunities, facilitated collaborative practice sessions supported by SNAICC and transparent and regular communication between department and community organisation staff, including impromptu and informal discussions. SNAICC encouraged weekly cross-organisation implementation team meetings for trials 2 and 3, but these were inconsistent due to workload pressures or lack of prioritisation. SNAICC observed that follow-up on actions agreed in collaborative

practice meetings facilitated by SNAICC were sometimes not prioritised by Department stakeholders and remained unresolved at subsequent SNAICC site visits.

A good practice example was apparent in Mt Isa, where meetings between the Investigation and Assessment Team Leader and the community convenor seemed to occur regularly. At this site, though there were significant concerns regarding throughput and communication for the first half of the trial, dedication to collaborative practice saw the collaboration mature and processes appeared to be clearer and leading to more successful ATSIFLDM processes in the latter stages of the trial.

Table 8 Recommendation 15

Recommendation 15: Local implementation teams are established that include ATSIFLDM convenors / managers and key child safety staff to promote a consistent and collaborative working relationship between the Department and ATSIFLDM service providers. Local implementation teams should establish consistent agendas, and shared accountability to follow-through on agreed actions. (See recommendation 2 above regarding recommended changes to the co-convenor role)

3.6 Holistic responses and integration with other family supports

Family-led decision making is a point in time process and its success is significantly dependent on support for families as required to reach goals and take actions set in family plans. The level of support required is usually outside the convenor role and dependent on community and family support networks and/or programs and funding available in a geographic location. As discussed in section 3.4 above, in some circumstances, convenors experienced difficulties establishing boundaries between ATSIFLDM and a family support role because they had identified a lack of available and culturally safe service supports to refer families to. Also, families indicated a preference for maintaining contact with the convenor due to the trust and rapport established through the ATSIFLDM process.

Throughout the trial a number of convenors increasingly recognised the importance of establishing collaborative working relationships with a broad range of local service providers to understand service offerings available and support families to identify needed supports. Convenors also identified that they had limited time and opportunity to collaborate with other services, and that this needed to be factored into their roles more clearly and enabled by broader staff teams with appropriate management resources to lead inter-agency relationships.

Integrating ATSIFLDM with culturally appropriate ongoing informal and formal family supports will likely be critical to the success of future models of practice. In particular, attention will be needed to ensuring strong collaborative links between ATSIFLDM services and Aboriginal and Torres Strait Islander Family Wellbeing services that are currently in development and will likely be key sites for ongoing support for families that develop ATSIFLDM family plans. Community-wide network building is essential to provide holistic support that aligns with the range of needs

identified in family plans. This requires networking broader than human services professionals and engaging with, for example, schools, early childhood education and care providers, housing and health services, Elders and sporting groups.

One further process that was integrated into the trial model to enable follow-up support was that there would be a follow-up meeting with the family approximately three months after the ATSIFLDM meeting to discuss progress and ensure that they were receiving supports needed to implement their family plans. These follow-up meetings were implemented to a limited extent throughout the trials. Notably, in trial 3 it was discussed that a process would need to be negotiated with Child Safety Service Centres to integrate the follow-up process with care team meetings, however this process was never established by the Department and as such very few follow-up meetings proceeded.

Integration across ATSICCOs was also noted as being limited due to not having an established process and platform for information exchange. The potential benefits of greater sharing of information between organisations about family groups that were transient or spread across the state and country were recognised.

Table 9 Recommendations 16 to 20

Recommendation 16: The importance of collaboration between ATSIFLDM and Family Wellbeing Services is recognised and incorporated into the design of future models of practice to promote consistent support and family-led practice.
Recommendation 17: Resourcing of ATSIFLDM recognises functions in building networks and collaboration with a broad range of services that support families to implement their decisions and plans.
Recommendation 18: Information about ATSIFLDM be shared broadly in communities so that all services and stakeholders are aware of the role that they can play to support families to make decisions and implement plans.
Recommendation 19: The processes needed to establish an effective follow-up support mechanism for families be given strong consideration in future ATSIFLDM model design. At least one follow-up meeting coordinated by the ATSIFLDM convenor is recommended to support families to implement their plans.
Recommendation 20: Information sharing protocols and processes are established between ATSICCOs undertaking family decision making to enable appropriate information sharing about families who are transient and spread across broad geographic areas.

3.7 Supporting practice excellence

Enabling quality practice through the trials was supported by training and development opportunities and implementation support, but also highly dependent on a range of trial design and environmental factors, many of which have been discussed in other sections of this report. The range of supports available to

organisations and convenors through the implementation support role are addressed in detail in Section 2.4 above.

As noted in Section 2.4, a longer establishment phase could enable community organisations and the communities they work with to contribute to program design and develop the requisite knowledge, understanding and readiness to implement new ways of working. Views were commonly shared that the service development phase was rushed and allowed insufficient time to support department, service, practitioner and community readiness to undertake the trials. Some service providers identified that they were aware that timeframes and resources were insufficient at the beginning of the trials, but they proceeeded nonetheless with the objective to ensure their communities did not miss the oportunity to participate in an empowering family-led model shown to be effective internationally and in Victoria.

As noted in Section 3.2 above, resourcing limitations impacted significantly on the supportive environment for developing effective ATSIFLDM practice. There were clear gaps in adequate resourcing to enable supportive staff team environments with appropriate peer support, management support, professional development and external relationship development. As has been noted, these resources appeared vastly inequitable to resourcing that supported aspects of comparable practice development within the Department's internal collaborative family decision making (CFDM) teams.

Some of the specific training needs that were identified by service providers as important to support their ATSIFLDM practice included:

- Shadowing experienced convenors;
- Community enagement and community development skills;
- Incorporating children's voices and choices;
- Addressing cultural connections in all plans;
- Mediation and conflict resolution skills;
- Group faciltiation skills;
- Understanding of child protection systems and langauge;
- Developing ecomaps and genograms to support identification of family and community support networks; and
- Skills in promoting services to other professionals (including public speaking).

The development support needs of organisations varied significantly across the trials, with identified needs of some organisations including:

- Advocacy and facilitation to address power imbalances or promote shifts in departmental practice, for instance ATSICCOs having input on referrals into the trial to prevent case filtering and to gain access to important information recorded in the Department case management system but omitted from referrals;
- Speaking up and speaking government langauge required to work effectively with Department staff; and
- Report writing (particularly for smaller ATSICCOs without significant internal support for this) where new funding specifications and deliverables not previously reported on with new definitions are introduced.

Many of these needs were addressed throughout the trials through the implementation support roles of SNAICC and VACCA, and through other training

inputs from QATSICPP and the Department, though demand for supports exceeded capacity. Capacity development and training support needs will require significant attention in the design of future models. Attention is needed to providing appropriate training, organisational support, and implementation support to enable genuine shifts in organisational cultures, models of practice and local service, government and community relationships. Recognised Entities expressed a keen interest to share skills and knowledge and participate in forums collectively, which they recognised as effective to support their practice development when facilitated by SNAICC during the course of the trials.

Importantly, many training and support needs to enable the trials were specific to Department staff. As noted in other sections there was significant variability identified in department staff capacity across areas of cultural competence and readiness to change existing practice and to relinqush leadership of practice to non-government providers. A lack of knowledge, understanding and commitment to the trials amongst some local department staff also impacted practice change. This occurred for example, in a location where a small team of staff working on the trials participated in training and information sessions, but there was limited representation of service centres, CSOs and team leaders whose practice directly impacted the success of the process.

Table 10 Recommendations 21 to 24

Recommendation 21: DCCSDS ensure that appropriate training and capacity development supports are scoped and included in future ATSIFLDM model development in close consultation with QATSICPP. **Recommendation 22:** DCCSDS has significant attention to internal training needs to shift culture and practice and develop readiness for its staff to support and enable ATSIFLDM. **Recommendation 23:** An independent implementation support role is provided for in any future ATSIFLDM model. This may include elements of intensive implementation support for the establishment phase and ongoing support to promote practice excellence, including through the role of QATSICPP. **Recommendation 24:** DCCSDS resource annual service forums in regional centres across the state to support practice sharing and the development of practice excellence for ATSICCOs and ATSIFLDM convenors.