NSW GOVERNMENT Family & Community Services

Permanency Support Program (PSP) Family Preservation Package Program Framework

The Family Preservation Package is intended to deliver wrap-around supports to children and families to prevent unnecessary entry into out-of-home care (OOHC). Clearly articulating the core program components will promote effective implementation by service providers and improved outcomes for children and families.

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1 Introduction

The Permanency Support Program (PSP) Family Preservation Package is intended to deliver wrap-around supports to children and families to prevent unnecessary entry into out-of-home care (OOHC). Participation in the program will be voluntary for families.

Unlike other PSP Case Plan Goal Packages, the Family Preservation Package will be paid on a per family basis, rather than per child. This reflects the fact that the value of services provided to support parents and families is unlikely to increase with each additional child.

Consistent with reform directions outlined in Their Futures Matter, the Family Preservation Package will apply the enablers of an investment approach to service delivery and a shift to investment in evidence based services and interventions.[1] By placing an emphasis on early intervention, the Family Preservation Package will aim to keep children and young people[2] at home safely, while supporting financial sustainability of the NSW Child Protection system into the future.

The purpose of this background paper and the Family Preservation Package Program Logic (**Appendix 1**) is to provide a rationale for the services and activities expected for delivery by PSP funded service providers. Understanding and defining the problem, program goals, and evidence around what works, are critical to ensuring the final program design is well placed to achieve desired outcomes. While the program logic will also outline measures to evaluate program success and provide opportunities for continuous improvement, discussion regarding the role of implementation will be limited to this background paper.

2 Why Family Preservation?

2.1 The problem

In 2006 there were 10,623 children in OOHC and this rose to 18,659 in 2016, representing a 76% increase. The number of young people in residential care was also found to have increased by 23% in the single year between 30 June 2015 and 30 June 2016[3]. Among the many problems associated with these figures is the concern that children in care consistently demonstrate poorer outcomes than those who live with their families.

Compared to non-Aboriginal people, Aboriginal children, families and communities disproportionately experience the stress of involvement with the child protection and OOHC systems. While making up only 5.45% of all

[1] Their Futures Matter, 2016, pp. 10-11
[2] Throughout this document, 'children and young people' is shortened to 'children' and 'child and young person' is shorted to 'child'
[3] FACS Annual Statistics Report, 2016

children in the state, Aboriginal children constituted 37% of those in OOHC in 2016.[4] Compounding this problem is the fact that Aboriginal children are also less likely to be restored to their families than non-Aboriginal children[5].

The Independent Review into OOHC conducted by David Tune AO PSM was commissioned to investigate the drivers of entries into OOHC and reasons for the over-representation of Aboriginal children. It was also tasked with proposing solutions to address these concerns. The PSP is one of the FACS responses to the Tune Report findings and recommendations.

Primary aims of the PSP are to preserve more children and young people with their families, reduce entries into care and increase exits via appropriate permanency pathways. The PSP will shift child protection in NSW from a placement-based service system to one focused on outcomes, and centred on safety, permanency and wellbeing for children and families.

There are a number of issues that can be understood as contributing to the higher numbers of Aboriginal and non-Aboriginal children in care. Some of these relate to the way in which the child protection system has been funded. Historically, the bulk of funding has been allocated to the OOHC end of the care continuum, meaning resources available for supporting families to change when risk is first identified, has been minimal. In addition to this, there has been the absence of a system that incentivises work aimed at exiting children out of OOHC.

Families of children who are at risk of entering care often experience multiple risk factors that increase the likelihood of child abuse/neglect, including:

- parent/carer alcohol and other drug (AOD) abuse
- parent/carer mental health issues
- parent/carer cognitive ability
- domestic and Family Violence (DFV) issues
- child disability/behavioural problems.

Insufficient funding to help parents and children address risk factors when they are first identified can result in issues becoming more deeply entrenched and interventions imposed when families are already at crisis point.

For children removed, the impact of separation from family further compounds trauma already experienced. It is well documented that children in care continue to demonstrate poor outcomes on a range of health and wellbeing indicators. Attempting to heal and restore children and families under these

[4] FACS, 2017, *PSP Resources.* http://www.community.nsw.gov.au/__data/assets/file/0010/415882/FAM068_Posters_All_A3_v1_Tagged.pdf

[5] FACS Statistics, 2018, *Improving the lives of children and young people.* https://public.tableau.com/profile/facs.statistics#!/vizhome/Improvingthelivesofchildrenandyoungpeople/Dashboard1?:embed=y&:loadOrderID=0&:display_count=yes

circumstances is likely to be more difficult than working to prevent removal in the first instance.
While the value of keeping families together has been understood for some time and work has been carried out by both government and non-government service providers to support this, the capacity to do so has been limited. This has lead to a lack of coherence in the preservation system. There are limited preservation services available and what is delivered to support preservation is inconsistent across service providers.

2.2 Aboriginal children and families

The reasons behind the over-representation of Aboriginal children in the OOHC system are varied and complex. Among these, and of particular significance, are the impact of colonisation on Aboriginal people and the systemic dispossession of Aboriginal people of their land, children, identity and culture by past government policies.

The over representation of Aboriginal children in OOHC can only be understood in this historical context, with full acknowledgement of the intergenerational trauma that continues to impact many Aboriginal people today. This intergenerational trauma and associated cycle of abuse and neglect is of particular concern. For current children in OOHC:

- 20% of females and 12% of males will have a child in OOHC at some point in the 20 years after exit; and
- OOHC leavers are more than 10 times more likely to need OOHC for their child compared to the general population[6].

Aboriginal people often experience risk factors for child removal to a greater extent than non-Aboriginal people. Indigenous women are 35 times more likely to be hospitalised due to domestic violence than non-Indigenous women[7]; in 2012–13, Indigenous Australians were 3.6 times more likely to report a stressor relating to alcohol or drug-related problems than non-Indigenous Australians[8]; and in 2015, the Indigenous suicide rate was twice that of non-Indigenous Australians[9].

However, disparities in the experience of risk factors are not the only cause of higher rates of entry into care. The Independent Review of Aboriginal Children and Young People in OOHC currently being undertaken will examine the reasons behind the disproportionate number of Aboriginal children in

[6] FACS, n.d., *Their Futures Matter: a new approach, Reform directions from the Independent Review of Out of Home Care in New South Wales*. https://www.theirfuturesmatter.nsw.gov.au
[7] Australia's National Research Organisation for Women's Safety (ANROWS), n.d. *Fast Facts: Indigenous family violence.* https://anrows.org.au/sites/default/files/Fast-Facts---Indigenous-family-violence.pdf
[8] Department of Prime Minister and Cabinet, 2014, *Aboriginal and Torres Strait Islander Health Performance Framework 2014 Report.* https://www.pmc.gov.au/sites/default/files/publications/indigenous/Health-Performance-Framework-2014/tier-2-determinants-health/216-risky-alcohol-consumption.html
[9] Australians Together, n.d. *Indigenous Disadvantage in Australia.* https://www.australianstogether.org.au/discover/the-wound/indigenous-disadvantage-in-australia/

care.[10] The review will look at the way in which services to protect children are delivered and offer recommendations for improvements.

While findings of the review are yet to come, there are issues that we are aware of now and that we can take into consideration in developing the Family Preservation Package. These issues include lack of understanding of Aboriginal culture across the child protection service system, a lack of Aboriginal evidence-based policies and service interventions, inadequate attempts to involve relevant family and community members in decision making to protect the child, and limited access to culturally safe services.

In discussing the limitations of a cultural competence framework, Herring, Spangaro, Lauw and McNamara also suggest the impact of trauma and racism create significant challenges for work with Aboriginal people. Consequences of trauma and racism include the isolation of Aboriginal communities as Aboriginal people 'retreat into community' to avoid racism. Along with this, under-use of services due to past negative experiences, including racism, may occur. This can lead to help-seeking being delayed until situations become severe, exacerbating past traumas, and maintaining Aboriginal families in a 'perpetual state of crisis'.[11]

2.3 Culturally and linguistically diverse (CALD) families

There are numerous barriers to accessing services for CALD families, including language barriers, cultural norms, fear of authorities, and culturally inappropriate service delivery[12].

Data from the 2016 Census indicates that, in NSW, 27.6% of people were born overseas, with 21% of these being from a non-English speaking background. Also, 37% of the population had both parents born overseas, and 25.5% speak a language other than English at home, an increase from 22.4% in 2011. The top five languages, other than English, were Mandarin, Arabic, Cantonese, Vietnamese and Greek.[13]

The *Multicultural Act 2000*, actioned through the NSW Government 2016 Multicultural Policies and Services Program (MPSP) Framework, requires that 'all organisational processes include effective consideration of culturally diverse communities'. With over 200 different languages spoken in NSW, there is a clear challenge in delivering services capable of overcoming language and cultural barriers for all children and families, who come into contact with FACS.

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[10] NSW Government, n.d. *Family is Culture: Independent Review of Aboriginal Children and Young People in OOHC in NSW.* http://www.familyisculture.nsw.gov.au/

[11] Herring, Spangaro, Lauw & McNamara, 2013, *The Intersection of Trauma, Racism and Cultural Competence in Effective Work with Aboriginal People: Waiting for Trust.* pp. 109-110

[12] Sawrikar & Katz, 2008, *Enhancing family and relationship service accessibility and delivery to culturally and linguistically diverse families in Australia.* p. 6

[13] ABS, 2016 Census, Retrieved from: http://www.censusdata.abs.gov.au/census_services/getproduct/census/2016/quickstat/1

2.4 Refugee and newly arrived migrant communities

Between June 2016 and July 2017, there were 10,353 new refugee arrivals in NSW, with the majority settling in South West Sydney and Western Sydney. Syrian and Iraqi refugees make up close to 80% of new arrivals and, of these, most are from persecuted minorities including Assyrians, Chaldeans, Mandaeans and Yazidis. Approximately 40% of new arrivals are children and young people.[14] New data from September 2017 to April 2018 shows there were a further 2,128 humanitarian arrivals in NSW, predominantly from Syria and Iraq[15].

In relation to refugee families, some may have experienced highly traumatic events[16] and some may face settlement-related issues, particularly once eligibility for support services ceases. Along with a lack of family connections and community support, due to displacement, these factors could increase their risk of coming into contact with the child protection system.

Recently, changes were made by the Commonwealth, under the Status Resolution Support Services, to the criteria for support assistance for asylum seekers. In their fact sheet and policy briefing, St Vincent de Paul Society raise the point that "very few people will fit the new restrictive criteria", increasing the likelihood of destitution for many asylum seekers.[17] Further exacerbating this issue is the fact that many asylum seekers reside in areas, which are among the lowest in socio-economic status, experiencing unemployment rates higher than the national average.

3 Program Goals

Giving regard to the problems outlined previously, the primary goal of the PSP Family Preservation Package can be defined as a reduction in the number of children entering OOHC, with particular emphasis on the proportion of Aboriginal children.

There are a number of secondary goals, which will collectively contribute to the achievement of the primary goal. These goals relate to the outcomes sought for children and families through the program, and include:

- ensuring all Aboriginal, CALD, refugee and newly arrived migrant families have been able to access culturally safe and responsive services

[14] Humanitarian Service Providers through the Refugee Settlement Network, 2017
[15] http:/www.censusdata.abs.gov.au/census_services/getproduct/census/2016/quickstat/1
[16] NSW Service for the Treatment and Rehabilitation of Trauma and Torture Survivors, 2016, *Learn more about trauma and torture*. http://www.startts.org.au/resources/refugees-asylum-seekers-and-trauma/learn-about-torture-and-trauma/
[17] St Vincent de Paul Society, 13 August 2018, *Status Resolution Support Services Payments: Fact sheet and policy briefing,* https://www.vinnies.org.au/page/Publications/National/Factsheets_and_policy_briefings/Status_Resolution_Support_Service_Payments/

- achievement of the initial case plan goal of family preservation
- parents make significant progress towards addressing risk factors, such as AOD misuse, mental health, and domestic and family violence
- parents demonstrate improved parenting skills
- children and young people have received support and addressed their health needs, including those relating to trauma and disability
- children and parents report improved wellbeing
- children demonstrate improved educational outcomes
- parents are utilising improved support networks
- children and parents report a feeling of greater empowerment to cope with challenges and affect change in their lives.

4 What works to keep families together?

While some research has been conducted on family preservation interventions, most has focused on programs as a whole, such as Multi Systemic Therapy – Child Abuse and Neglect® (MST-CAN®) and Family Functioning Therapy – Child Welfare® (FFT-CW®), which are evidence based family preservation programs, rather than the specific components that work to achieve outcomes. There is also limited evidence around what works with Aboriginal and CALD families.

As one of the core goals of the PSP Family Preservation Package is to decrease the over-representation of Aboriginal children in OOHC, use of an Aboriginal evidence base is most appropriate. In the absence of such evidence, the applicability of available evidence must be critically reviewed for relevance to Aboriginal people.

Despite the limitations, identifying what evidence is available will support the development of a family preservation model with the best possible chance of success.

4.1 Risk factors for entry into OOHC

In developing a family preservation model, it is highly valuable to understand the factors that contribute to children entering OOHC. For children, individual factors can be summarised as follows:

- low birth weight
- pregnancy or birth complications
- child temperament or behaviour
- child disability.[18]

[18] Black, Smith Slep & Heyman, 2001; Brown, Cohen, Johnson, & Salzinger, 1998; Clément, Bérubé & Chamberland, 2016; Dubowitz et al., 2011; Forston, Klevens, Merrick, Gilbert & Alexander, 2016; Freisthler, Merrit & LaScala 2006; Li et al., 2011; Palusci, 2011; Putnam-Hornstein & Needell, 2011; Shook Slack et al., 2011; Stith et al., 2009 Wu et al., 2004, cited by Australian Institute of Family Studies (AIFS), 2017, *Risk and protective factors for child abuse and neglect.* https://aifs.gov.au/cfca/publications/risk-and-protective-factors-child-abuse-and-neglect

In relation to parents, the experience of childhood trauma has been found to have a significant impact on parenting, influencing the likelihood of psychiatric disorders, such as depression; ability to form healthy attachments with children; and more punitive parenting styles[19].

Family/parental risk factors also include:

- parental alcohol and other drug abuse
- involvement in criminal behaviour
- domestic and family violence and family conflict
- mental health problems
- child perceived as problem by parents
- history of child abuse and neglect
- exposure to stress
- parental temperament
- teenage/young parent/s
- low level of parental education
- use of corporal punishment
- unplanned pregnancy
- physical health problems
- low self-esteem
- social isolation[20]
- parenting skills/role models
- household instability.

4.2 Protective factors

Conversely, there are many factors that serve to protect against the entry of children into care. These include:

Individual/child factors:

- social and emotional competence
- supportive and responsive care giver relationship.

Family/parental factors:

- strong parent/child relationship
- parental self-esteem
- family cohesion
- high level of parental education
- self-efficacy

[19] Ammerman, Shenk, Teeters, Noll, Putnam & Van Ginkelet, 2011, *Impact of Depression and Childhood Trauma in Mothers Receiving Home Visitation.* p. 614

[20] Black, Smith Slep & Heyman, 2001; Brown, Cohen, Johnson, & Salzinger, 1998; Clément, Bérubé & Chamberland, 2016; Dubowitz et al., 2011; Forston, Klevens, Merrick, Gilbert & Alexander, 2016; Freisthler, Merrit & LaScala 2006; Li et al., 2011; Palusci, 2011; Putnam-Hornstein & Needell, 2011; Shook Slack et al., 2011; Stith et al., 2009 Wu et al., 2004, cited by Australian Institute of Family Studies (AIFS), 2017, *Risk and protective factors for child abuse and neglect.* https://aifs.gov.au/cfca/publications/risk-and-protective-factors-child-abuse-and-neglect

- family functioning
- knowledge of parenting and child development
- parental resilience
- concrete support for parents[21]
- a stable household.

Social/environmental factors:

- positive social connection and support
- employment
- neighbourhood social capital
- adequate housing
- socio-economically advantaged neighbourhood
- access to health and social services[22]
- positive connection to culture.

4.3 Systematic review of interventions designed to decrease child abuse

A systematic review of randomised controlled trials (RCT) of interventions designed to decrease child abuse in high-risk families found that home visitation was the only intervention with a "significant evidence base for reducing child abuse".[23] In addition, the study observed the effects of a psychotherapy intervention, which suggested cognitive interventions could also be valuable.

Further factors relating to increased intervention effectiveness included:

- commencement of work during pregnancy, extending for a minimum of two years
- weekly visits immediately following the birth
- longer follow-up post-intervention
- specificity of intervention content.

Participant experiences also impacted intervention effectiveness. While maternal depression was found to support effectiveness, intimate partner violence and a lack of social support reduced positive outcomes.[24]

[21] Black et al., 2001; Brown et al., 1998; Clément et al., 2016; Dubowitz et al., 2011; Forston, Klevens, Merrick, Gilbert & Alexander, 2016; Freisthler et al., 2006; Li et al., 2011; Palusci, 2011; Shook Slack et al., 2011; Stith et al., 2009, cited by AIFS, 2017, *Risk and protective factors for child abuse and neglect*. https://aifs.gov.au/cfca/publications/risk-and-protective-factors-child-abuse-and-neglect

[22] *Ibid*

[23] Levey, Gelaye, Bain, Rondon, Borba, Henderson & Williams. 2017 *A systematic review of randomized controlled trials of interventions designed to decrease child abuse in high-risk families.*

[24] *Ibid*

4.4 Review of evidence for intensive family service models

This review, conducted for FACS, identifies the extent of evidence for programs seeking to address child abuse and neglect. Programs targeted one or more of the following outcomes:

- child development
- child behaviour
- safety and physical well-being
- maltreatment prevention
- family functioning
- support networks
- systems outcomes.

Aspects of interventions relevant to delivery were also identified, including:

- delivery mode and duration
- training and supervision of staff
- intensity of intervention.

The delivery approach applied across more than half of the 45 interventions examined was that of structured sessions.

With regard to content, the four components comprised:

1. parenting skills, education or training
2. child and youth behaviour and behaviour management
3. parent-child interactions
4. communication and relationships.

In identifying the degree of evidence available for programs, the review gave regard to those found to be Well Supported, Supported, Promising and Emerging.

Well Supported and Supported

In doing so, it found that a higher proportion of Well Supported and Supported interventions compared to Promising and Emerging, involved the use of modelling as a delivery technique; and content related to:

- parent stress management
- positive peer relationships
- using praise with children
- having quality time with, and giving positive attention to, children.

Promising and Emerging

When compared to the components of Well Supported and Supported interventions, Promising and Emerging involved a higher proportion of:

- intake and family assessments,

- individualised family plans,
- working in collaboration with families, and
- content related to:
    - child and home safety
    - parent conflict management
    - child development
    - parent life course
    - meeting the families' basic needs.[25]

4.5 Evidence for Aboriginal family preservation models

There is a gap in relation to evidence-based family preservation programs that have been shown to work specifically with Aboriginal families. However, research does exist to suggest what could be included in a family preservation program to achieve the best possible outcomes for Aboriginal children and families.

Research demonstrates the value of Aboriginal culture as a protective factor and in examining Aboriginal cultural practices associated with raising children, Lohoar, Butera and Kennedy identified four main themes:

1. a collective community focus on child rearing
2. skill development provided through opportunities to explore
3. importance of elders and family members' involvement to family functioning
4. significance of spirituality in helping families cope with challenges.

There is emerging evidence, which supports these aspects of Aboriginal culture as key strengths capable of providing Aboriginal children with a strong base for positive health and wellbeing.[26]

During 2013 and 2014, Griffith University and the Secretariat of National Aboriginal and Islander Child Care (SNAICC) conducted research to identify factors contributing to positive outcomes for Aboriginal and Torres Strait Islander families who have come into contact with the child protection system. The research focused on a number of intensive family support services delivered by Aboriginal and/or community controlled organisations. In summary, the report noted the following elements of best practice:

1. Matching services to child and family needs
2. Working with the statutory agency
3. Building partnerships with family members
4. Providing a mix of practical, educational, therapeutic and advocacy supports to children and families
5. Intensity and duration of service delivery
6. Family participation in decision making and case planning
7. Providing services in culturally competent and respectful ways.[27]

[25] Parenting Research Centre & University of Melbourne, 2015, *Review of the evidence for intensive family service models.* FACS

[26] Lohoar, Butera & Kennedy, 2014, *Strengths of Australian Aboriginal cultural practices in family life and child rearing*, pp. 16-17, https://aifs.gov.au/cfca/sites/default/files/publication-documents/cfca25.pdf

A review of studies, relating to cultural competency in health service delivery for Indigenous people, found that from a total of 28 studies, 15 demonstrated a positive relationship between cultural competence and healthcare outcomes, with ten of these finding significant improvements. Of these ten studies, three were considered to be of 'moderately robust research design'. Outcomes were identified at the four levels of service, practitioner, training and education, and patient level. Though the strength of evidence for Indigenous populations was lacking, the review suggests that 'promising, evidence-based strategies and initiatives could be combined into a coherent multi-dimensional approach'.[28]

Herring, et al. (2013) argue the importance of a cultural competence framework that takes into account the significant impacts of trauma and racism. In doing so, it is suggested that work be undertaken at the practice, organisation and policy levels, over a three-stage process. This process involves 'becoming informed' about Aboriginal history and trauma; 'taking a stance' and acknowledging discrimination in service delivery; and 'reaching out to the local Aboriginal community'.[29]

International evidence exists supporting the significance of self-determination for indigenous communities. Chandler and colleagues conducted studies to understand why suicide rates on some Indian reserves in Canada were 800 times higher than the national average, while on others suicide was almost unknown. This research found that in communities where language had been maintained, suicide rates were lower. It also found higher youth suicide rates existed among nations lacking in 'measures of self-government over areas such as health, education, child protection, policing, access to traditional lands, and the construction of facilities for preserving cultural artefacts and traditions'.[30]

In economic terms, The Harvard Project on American Indian Economic Development identified that United States reservations with self-government powers experienced an increased rate of reduction in poverty levels compared to the general population. Leaders were also more accountable to their communities and decisions considered more consistent with cultural values.[31]

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[27] Tilbury, 2015, *Moving to Prevention Research Report*. p. 8. Griffith University and Secretariat of National Aboriginal and Islander Child Care (SNAICC)
[28] Bainbridge, McCalman, Clifford & Tsey, 2015, *Cultural competency in the delivery of health services for Indigenous people*. pp. 16-18
[29] Herring, Spangaro, Lauw & McNamara, 2013, *The Intersection of Trauma, Racism, and Cultural Competence in Effective Work with Aboriginal People: Waiting for Trust,* pp. 111-113
[30] Hallet, D., Chandler, M. J. & Lalonde, C. E., 2007, as cited in Imai, S. *Indigenous Self-Determination and the State*, 2008, Comparative Research in Law and Political Economy. Research Paper No. 25/2008. p. 7
[31] Nettheim, G., Meyers, G. D., Craig, D. 2002, as cited in Imai, S. *Indigenous Self-Determination and the State*, 2008, Comparative Research in Law and Political Economy. Research Paper No. 25/2008. p. 6

In the paper “Our families, our way: Strengthening Aboriginal families so their children can thrive”, the Aboriginal Child, Family and Community Care State Secretariat (NSW) (AbSec) propose the ‘Strengthening Aboriginal Families Model’. Rather than prescribing a specific service approach, an ‘enabling framework’ is suggested, ‘empower[ing] local communities and Aboriginal community-controlled organisations to develop and adapt responses based on available evidence, practitioner experience and community values’. [32]

FACS is committed to working with Aboriginal agencies, including AbSec, to build the evidence base around what works to prevent the entry of Aboriginal children into OOHC. The Their Futures Matter (TFM) unit is currently working with five NSW Aboriginal Community Controlled Organisations (ACCOs) to progress this work.

4.6 CALD, refugee and newly arrived migrant families

Culture is also a protective factor for CALD families, therefore it follows, that working to support families in this context is critical. It is also important to highlight CALD, refugee and newly arrived migrant families in family preservation services to understand possible differences in parenting and family functioning and ensure provision of culturally safe and inclusive services. The significance of this work is highlighted in other FACS programs and frameworks including OOHC Cultural Care planning; the sub-domain of Cultural and Spiritual Identity in the Quality Assurance Framework (QAF) for children in OOHC; and the Multicultural Casework Program.

Service delivery to CALD families can be improved by addressing factors at the practitioner, service and policy levels. At the practitioner level, cultural capability and skills are required, such as those that facilitate working with interpreters and reassuring families about confidentiality. At the service level, addressing language barriers through provision of translated information and promoting services through community publications may assist. Partnering with services with a particular focus on CALD and/or refugee communities can also be beneficial, as can engagement with local community leaders.[33]

4.7 Evidence for delivery

There are a range of factors that may impact the outcomes achieved by a program. Some of these factors relate to the model’s initial design, while others relate to the way the model is implemented. Evidence exists indicating treatment intensity can support improved treatment effects.[34] Staff training and support for implementation is also an important driver of program outcomes.[35] It will be important that services demonstrate fidelity to the PSP

[32] AbSec, 2017, *Our families, our way: Strengthening Aboriginal families so their children can thrive*, pp. 13-14
[33] Sawrikar & Katz, 2008, *Enhancing family and relationship service accessibility and delivery for culturally and linguistically diverse families in Australia.* pp. 12-16
[34] Polanin & Espelage, 2014, *Using a Meta-analytic Technique to Assess the Relationship between Treatment Intensity and Program Effects in a Cluster-Randomized Trial,* p. 1
[35] National Implementation Research Nework (NIRN), 2015

Family Preservation Package model by delivering on the core components identified in the final program logic (**Appendix 1**).

4.8 Examples of relevant evidence-based programs

Details of evidence-based programs relating to the protection of children can be found on the California Evidence-Based Clearinghouse for Child Welfare website.

Evidence-based programs focusing on specific issues or cohorts also exist, including the Families in Cultural Transition (FICT) Program for newly arrived families.

4.9 Approaches

4.9.1 Trauma-informed

The concept of trauma is broad, with the range of people affected extending beyond those coming into contact with the child protection system. The impacts of trauma can also vary, across the short and long term.

Many children and adults, who FACS works with, will have experienced some form of trauma. Child outcomes can be significantly affected by trauma, which may arise as a result of their own, and often their parents', experiences. As such, parents also need to be supported to deal with trauma and the subsequent behaviours that can impact parenting capacity.

Trauma requires a particular way of working with a family at both the practice and broader systems level. Trauma-informed care can be described as 'a framework for human service delivery that is based on knowledge and understanding of how trauma affects people's lives, their service needs and service usage'. Evidence has been found supporting the effectiveness of trauma-informed approaches.[36] Trauma-informed care is one of the nine themes underpinning the PSP.

Aboriginal children and families will be particularly vulnerable to the experience of trauma due to the endemic marginalisation and disadvantage borne since colonisation. Program design will need to take into account the unique intergenerational trauma profile, which is widespread among Aboriginal communities. Refugee families, including children and young people, are also likely to be impacted by trauma, having frequently left situations of violence and oppression in their country of origin.

4.9.2 Strengths-based

A strengths-based approach to preservation practice focuses on the existing capabilities and resources of children and parents, rather than on those areas in which they may be lacking. In relation to parent education programs for the prevention of child maltreatment, research has found that strengths-based

[36] Wall, Higgins & Hunter, 2016, *Trauma-informed care in child/family welfare settings*. CFCA. pp. 2-6

approaches are more likely to achieve positive outcomes than those focusing on deficits.[37] In relation to Aboriginal and CALD families, culture will be a key consideration when applying a strengths-based approach to family preservation.

4.9.3 Ecological theory

As reflected in the Australian Institute of Family Studies (AIFS) categories of risk and protective factors, it is important to recognise that individuals exist within, and interact with, complex layers of systems. Based on the work of Bronfenbrenner (1979), this ecological approach to development is supported by research suggesting factors at the child, school, peer, family, and broader community and societal levels, are known to influence the course of child development.[38]

4.9.4 Practice frameworks

There are a range of practice frameworks and models that service providers may draw from to support safe and effective preservation service delivery. The NSW Practice Framework is a model designed to reflect the diverse range of work that occurs across FACS with the aim of protecting children. The Framework aims to improve the quality of FACS practice to protect children and provide the best possible outcomes for them and their families in NSW. Organisations may also seek to develop their own frameworks, particularly where such work would enhance service delivery to children and families with diverse needs.

5 What does this mean for the PSP Family Preservation Package?

Based on the evidence outlined, there are aspects of program content and delivery style, which can be understood as core to helping children and families work towards change. Overlaying these core components, there are also approaches to practice with Aboriginal and CALD families that will seek to improve trust and meaningful engagement.

The Preservation Service Overview outlines that services will include, but are not limited to, family and parenting support; child focused support; safety monitoring; and risk mitigation.[39] These services are proposed as the core components of the PSP Family Preservation Package.

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[37] AIFS, 2014, *The good practice guide to Child Aware Approaches: Keeping children safe and well*

[38] Fox, S., Southwell, A., Stafford, N., Goodhue, R., Jackson, D. and Smith, C. (2015). *Better Systems, Better Chances: A Review of Research and Practice for Prevention and Early Intervention.* Canberra: Australian Research Alliance for Children and Youth (ARACY). pp. 32-33

[39] Preservation Service Overview, 2017

In delivering these core components, a number of mandatory and non-mandatory activities will be identified, with mandatory activities being those considered critical to program success. While service providers must deliver on mandatory activities, flexibility exists around non-mandatory activities.

The processes through which these core components assist in achieving outcomes for children and families can be described as the 'mechanisms of change'.

5.1 Delivery approach

Defining aspects of delivery will be important to ensuring children and families receive an adequate level of support to help them create change.

Mandatory activities
When designing a delivery approach for Family Preservation, services must make certain the model:

- includes home-based visiting in delivering family and parenting support
- includes availability of caseworkers outside of normal business hours
- reflects the required level of intensity, identified and adapted throughout the course of the program through regular review and consideration of the family's needs. This may include a higher level of intensity in the early stages of the program, gradually stepping down to help children and families utilise newly built resilience, and social and community supports
- will be implemented by staff with appropriate qualification levels as required under Schedule One (Service Requirements) of the Program Level Agreement
- is implemented by caseworkers with an appropriate caseload, commensurate with the intensity of service delivery
- reflects the following approaches:
    - Trauma-informed
    - Strengths-based
    - Cultural safety
    - Ecological theory
- gives due consideration to, and caters for, the literacy and numeracy levels of family members
- properly utilises the two-year funding timeframe to maximise chances of success for children and families.

These aspects of program design will work to achieve goals by incorporating evidence of what works best to achieve outcomes. The requirement for practice to be trauma-informed, strengths-based and culturally safe is also outlined in the PSP Service Requirements.

The potential value of making the NSW Practice Framework and other FACS resources available to PSP providers is recognised by FACS. Work is being undertaken to facilitate access to relevant resources for PSP providers to support practice improvements.

5.1.1 Aboriginal children and families

The following principles and activities must be reflected in the model's approach to working with Aboriginal children and families:

- non-Aboriginal organisations without an available Aboriginal case worker must investigate the viability of brokering in an Aboriginal family worker to coordinate work with an Aboriginal family in receipt of a package
- acknowledgement of historical trauma and its impact on Aboriginal people today
- recognition of the importance of culture and its impact
- delivery of culturally safe services to support meaningful engagement and achievement of outcomes
- use of Family Finding to enable early engagement of, and ongoing support from, family, kin and community
- participation of kin and family support networks in Aboriginal family-led decision making processes, which may include Family Group Conferencing (FGC), where considered appropriate
- investigation into and involvement of services and community groups, such as men's services, groups and cultural activities
- support to participate in cultural and social activities
- acknowledgement and celebration of successful outcomes, involving the wider family and community network such as local Aboriginal community controlled organisations, specialist men's and women's services and local groups involved in decision making to protect children (e.g. Local Advisory Groups)
- application of a gendered approach to service delivery, where appropriate, including a respectful and culturally responsive approach to addressing what is traditionally men's and women's business'.

Caseworkers should look to identify the relevant cultural needs of the child within their familial and community context, with particular focus on the potential protective nature of culture for that child. Implementation of these aspects of program design will work to achieve program goals through culturally safe service delivery. They will help increase accessibility of services for Aboriginal children and families, and improve the likelihood of meaningful engagement.

Guiding Principle five of the OOHC Transition Plan and Implementation Framework, states that "All Aboriginal children and young people in OOHC must be placed in a culturally appropriate setting with a strong preference for placements in Aboriginal community controlled organisations (ACCOs) or in non-Aboriginal agencies working in partnership with a local Aboriginal agency, with a view to developing capacity and independence." This transition has been timed to take place over 2012-2021 to align with the growth and capacity of the ACCO sector. Work is currently underway with ACCOs to progress this transition to ensure culturally safe service delivery and ultimately improved outcomes for Aboriginal children and families.

Ongoing collaboration with Aboriginal staff and organisations will occur to continuously work towards improving design and implementation to support culturally safe service delivery.

5.1.2 CALD, newly arrived migrant and refugee children and families

The following principles and activities must be reflected in the model's approach to working with CALD children and families:

- mainstream services and programs should develop a culturally diverse workforce reflective of the local population demographics to provide culturally safe packages to CALD families. Where a specific CALD worker is not available, organisations must investigate the viability of brokering in a CALD family worker to coordinate work with CALD families in receipt of a package
- recognition of the strength and importance of culture and understanding of the impact migration and settlement experiences may have on a family.
- delivery of culturally safe services is critical to support successful engagement and achievement of outcomes.
- use of Family Finding to enable early engagement of, and ongoing support from, extended family and community networks
- participation of family and community support networks in activities including Family Group Conferencing (FGC), where considered appropriate
- application of a gendered approach to service delivery, where appropriate
- use of professional interpreters to communicate with parents and families, who speak a language other than English.
- investigation into and involvement of services and community groups, such as men's services, groups and cultural activities.

As with Aboriginal children and families, these aspects of program design will work to achieve program goals by increasing the accessibility of services to CALD children and families through culturally safe service delivery.

5.2 Core components

5.2.1 Core Component 1: Family and parenting support

Mandatory content

- parenting skills
- parent/child interaction
- child development, health and safety.

Mandatory activities:

- attempt to build networks of support around the family, including the use of Family Finding and FGC, where possible and appropriate

- engage with extended family and develop their understanding of risk and any traumas experienced by the children and parents[40]
- engagement with social system supports, such as teachers
- in terms of providing support for the care of children, the use of family and social support networks is to be given preference over the use of respite[41]
- family relationship counselling
- work to create an environment and foundation conducive to successful preservation work, including identification of housing and income needs, and advocacy work with relevant services
- in-home practical support and brokerage
- mentoring services for families with structured strategies for improving parenting skills (managing sibling rivalry, playing with children, setting boundaries), home management (cooking, cleaning) outcomes.

Non-mandatory activities

- respite

Family and parenting support will help create change by:

- improving and expanding networks of support and social support for families; improving parenting capacity and family functioning
- strengthening family bonds
- reducing conflict and improving safety
- improving parenting skills
- developing better household living conditions
- developing sustainable household routines
- enhancing problem solving and budgeting skills.[42]

5.2.2 Core Component 2: Child focused support

Mandatory activities:

- identification of child's emotional and psychological needs, including those related to trauma
- psychological services commensurate to the level of identified need (where required), with counselling services a minimum requirement
- educational and learning assistance
- identification of any additional health needs, including those relating to dental, allied health or disability
- services to address identified health needs
- referral and assistance to engage with the National Disability Insurance Scheme (NDIS), where required.

[40] This will help build the extended family's capacity to support children and parents following withdrawal of services

[41] The respite entitlement set by FACS and included in costing of PSP funding packages is the equivalent of up to 24 nights respite per year – PCMP July 2018 p. 20

[42] Preservation Service Overview

Non-mandatory activities

- Child care

The provision of child focused support will help create change for children by improving their health, behavioural problems and overall wellbeing. These factors will also help reduce stress on families, improving family functioning and overall outcomes.

5.2.3 Core Component 3: Safety monitoring

Mandatory activities:

- service support and assistance to decrease potential risk through case review
- contacts and monitoring visits.

Safety monitoring, including three monthly FACS Child Protection reviews, will promote continued child safety and ensure the goal of family preservation remains appropriate.

5.2.4 Core Component 4: Risk mitigation

Mandatory activities:

- identification of major risk factors for parents such as AOD, mental health or DFV
- ongoing identification and addressing of risk factors present in the family
- warm referral[43] to services to address risk factors
- provision of any support required to engage successfully with services, such as assistance with transport or attendance at appointments
- support to maintain engagement with services.

Risk mitigation activities will work towards creating change by assisting in the reduction of major risk factors for child abuse and neglect.

6 Outcomes and measurement

Historically, FACS has sought to assess the performance of programs through the measurement of outputs, such as the number of families that participated in a program. While this conveys some indication of what the program has achieved, it does not specify what, if any, benefits were received by the children or families involved. FACS is shifting to a commissioning approach, which seeks to emphasise anticipated outcomes for children and families. The program logic reflects the outcomes expected from the preservation package (**Appendix 1**).

Overarching outcomes are defined according to the NSW Human Services Outcome Framework (HSOF) Domains of Home, Safety, Health, Education,

[43] A warm referral involves a caseworker introducing a child and/or family member to another agency who will be providing services

Social and Community, and Empowerment. Where required, these domains are also described using PSP language. More specific outcomes are outlined under each domain to reflect the particular focus of the program.

Measurement of outcomes will be a critical aspect of preservation package delivery. Measures have been proposed for each outcome identified in the program logic (**appendix 1**), and these will be developed and refined through further consultation.

The Quality Assurance Framework (QAF), currently being trialled for children in OOHC, covers the three primary domains of safety, permanency and wellbeing, with the wellbeing domain made up of a further five sub-domains. Wellbeing is made up of a further five sub-domains: Physical Health, Emotional and Psychological Wellbeing, Intellectual Potential, Social Functioning, and Cultural and Spiritual Identity. Due to the similarities between outcomes sought for children living with, or apart from, their families, the preservation package may use some of the same measures and tools used by the QAF.

To provide markers for progress for children and families over time, outcomes will be measured in the initial engagement period, intermediate and long term. Proposed timeframes for each assessment period are as follows:

- initial engagement: 0 to 3 months
- intermediate term: 4-18 months
- long term: 19-24 months.

When a service first starts working with a family in the initial engagement period, they will be expected to gather baseline data using validated tools. This will allow service providers to progressively monitor outcomes being achieved and make case plan changes where required. To support program evaluation, child and family outcomes will also be assessed following completion of the program.

6.1 Home (Permanency Goal: Family Preservation)

Child and family safety will be key markers that the permanency goal of Preservation has been successfully achieved. In the initial engagement period the key outcome will be that the child is assessed as eligible for preservation, described in terms of the SDM Safety and Risk Assessment (SARA) outcome of “Safe” or “Safe with plan” and “High” or “Very high” risk. In the initial engagement period, baseline data will also be gathered for additional measures of safety. These may include the Composite Abuse Scale (Revised Short Form) and the Parenting Styles and Dimensions Questionnaire.

In the intermediate term, an outcome of “increased child safety in the home” will be sought, and measured through activities including the first 90 day risk reassessment and safety monitoring reports. Improved family

functioning/parental behaviour will also be expected, measured with the Parenting Styles and Dimensions Questionnaire.

In the long term it is anticipated that families will maintain or surpass improvements already demonstrated in the intermediate phase. In addition to the measures already identified, service data may be sought on factors including:

- helpline reports
- participation rates in mental health/substance use treatment
- criminal justice system contact.

Any outcomes measured through involvement in evidence-based programs will also be taken into account.

Ensuring children and families continue to maintain the outcomes achieved, beyond the maximum two years of support, will be critical to the sustainability of the program. In terms of the program and outcomes for FACS, increased numbers of children remaining safe at home with their families is desired. This may be measured using FACS data on:

- number/percentage of children and young people who achieve their case plan goal within two years
- number/percentage of children and young people who do not receive a ROSH report while receiving a Family Preservation package
- number/percentage of children and young people who did not enter OOHC during the two year period
- number/percentage of children and young people who did not enter OOHC 12 months after the package had ended.

6.2 Safety

As safety is a key indicator of whether or not children are able to remain with their families, outcomes in the domain are consistent with those identified with the goal of preservation. A number of other outcomes and measures are suggested for inclusion.

In the initial engagement period, initial parental engagement with services to address risk factors will also be included, supported by reports from service providers.

In the intermediate term, outcomes will be expected to progress to demonstrate increased child and family safety; improved family functioning and parental behaviour; and meaningful parental engagement with services.

Again, FACS assessment data and reports will be utilised, with the option of additional measures including the Composite Abuse Scale and Parenting Styles and Dimensions Questionnaire. Service provider data on safety and maltreatment outcomes will be reviewed to determine changes in relation to risk factors. In cases where DFV is a factor, this may be demonstrated by the

affected parent reporting an improved sense of control, safety and independence; and where AOD misuse has been present, evidence of work towards harm minimisation or abstinence.

In the long term, improvements would be expected to be maintained or surpassed.

6.3 Health (Wellbeing – Child)

In the initial engagement period, outcomes will be focused on ensuring all child needs relating to culture, physical and mental health, have been identified and engagement with relevant service providers has commenced. This will be measured through self-reporting and service provider data. Baseline data will also be gathered in the initial engagement period, utilising measures including the Personal Wellbeing Index - School Children (PWI-SC) (for children 12 years and over), Personal Wellbeing Index – Intellectual Disability (PWI-ID), Kessler 10 psychological distress scale, Strengths and Difficulties Questionnaire (parent and self report versions). Across all phases of measurement, expression of feelings of cultural safety will be a key outcome for children.

Along with the child's continued access of support services, improved child wellbeing outcomes will be expected in the intermediate phase. These will be measured with self reports, service provider reports, and measurement tools identified in the initial engagement period. Specific data may be sought on factors including:

- sleep
- relationships with others
- self-esteem
- connection to culture.

In the long term, outcomes will focus on maintaining or surpassing those already achieved, again using the same measures. Reduced reliance on support services is also anticipated.

6.4 Health (Wellbeing – Parent)

Given the impact of parental wellbeing on overall family functioning, outcomes for parents are also highly significant and similar to those required for children. In the initial engagement period, outcomes will be focused on ensuring parent needs relating to culture, physical and mental health, have been identified and engagement with relevant service providers has commenced. This will be measured through self-reporting and service provider data.

Baseline data will also be gathered and then follow up data using the same instruments. , Potential tools included the Personal Wellbeing Index – Adult (PWI-A), PWI-ID, Strengths and Difficulties Questionnaire (parent and self

report versions), and Kessler 10 psychological distress scale. As with children, expression of feelings of cultural safety will be a key outcome.

In the intermediate phase, evidence of parents' continuing access to support services is expected, along with improved subjective wellbeing outcomes. These outcomes will be measured through self reports, service provider reports, and previously identified measurement tools. Specific service data may be sought on factors including:

- sleep
- relationships with others
- self-esteem
- connection to culture.

In the long term, outcomes will focus on maintaining or surpassing those already achieved, along with reduced reliance on support services.

6.5 Education

In the initial engagement period, it is expected that service providers will work with parents to ensure they understand the importance of education and the value of parent engagement in education. Evidence of this work may be determined through self reports and service provider records.

During the intermediate phase, educational improvements will be desired. These may be measured using preschool/school attendance data; preschool/school reports; data on engagement and participation in school provided supports; and data on family involvement in the child's educational needs.

In the long-term, the program will seek to achieve maintained or further improved educational outcomes, utilising those measures previously identified.

6.6 Social and Community

Improving meaningful connections with family, friends and groups, will be key to affecting better social and community outcomes. In the initial engagement period, this may simply be reflected by the identification of family, friends and groups with whom parents are interested in connecting. Tools and approaches that may support this work include Family Group Conferencing, Aboriginal family-led decision making and Family Finding, with service provider records and self reports providing useful data for measurement.

Over time, increased connectedness with social support networks will be expected, with regular contact again being demonstrated through self reports and service provider information. In the long-term, maintenance of these connections will represent a critical outcome, coupled with a reduced reliance on service providers for support.

6.7 Empowerment

For both children and parents, a sense of empowerment and resilience will be important to their capacity to cope with future life challenges effectively. Service providers will be expected to convey understanding of the significance of these concepts in an appropriate way. Self reports and service provider reports would provide this information.

Possible measures to assess an improved sense of empowerment include the Connor-Davidson Resilience Scale (For use with 10-18 year olds and adults only) and the Growth and Empowerment Measure. In the initial engagement period, baseline data, only, would be sought.

In the intermediate and long-term, improvement and maintenance of resilience will be measured with the tools previously used to collect baseline data.

7 Roles and responsibilities

FACS

Staff across various FACS divisions and districts will have roles to play in the effective delivery of PSP Family Preservation Packages. More detailed information regarding the roles and responsibilities of FACS and service providers is outlined in the *PSP Family Preservation Package Business Rules*.

At the district level, FACS will be responsible for conducting the initial SARA, identifying the most appropriate case plan goal and referring to a suitable service provider. FACS will work collaboratively with service providers to ensure children and families receive high quality, evidence informed services that meet their needs. FACS will also assist with safety monitoring, providing advice regarding risk and concerns raised, and conducting 90 day risk reassessments. These processes will be facilitated by keeping cases open until such time as criteria for case closure has been met.

Permanency Coordinators will support both FACS and service provider staff to ensure children and young people remain safe and their permanency needs are met. Commissioning and Planning officers will assist service providers with monitoring client and program outcomes, and provide support to improve service delivery. Central office staff will provide information in relation to PSP Family Preservation Package service requirements and manage overall implementation of the PSP. An evaluation framework will also be established to build evidence, where required, and central office will work with districts, service providers and peaks to identify issues and continuously improve the requirements and delivery of the packages.

Service providers
Service providers will ensure that they meet requirements outlined in the PSP Family Preservation Package Program Framework, Business Rules and Program Level Agreement, and that practice and models used are, at a minimum, evidence-informed. Services will be responsible for case management, provided for through the PSP Case Coordination Package, and for identifying appropriate services for referral and brokerage. Recording and reporting on outcomes will be required and monitoring of activities by brokered providers will be the responsibility of service providers.

FACS and service providers must ensure engagement with children and families is respectful, culturally safe and strengths-based, promoting meaningful participation in case planning and activities.

8 The importance of implementation

Without a robust implementation strategy, even programs with a strong evidence base can end up delivering poor outcomes. The PSP will utilise an Implementation Science approach to ensure program delivery is supported by an effective implementation strategy. Implementation Science considers that factors that influence the "full and effective use of innovations in practice."[44]

In relation to the Family Preservation Package, implementation will focus on delivering the key outcomes of fidelity, reach and sustainability. Close monitoring of implementation outcomes and the use of practice-policy feedback loops will assist in addressing implementation issues as they arise, and facilitate amendments to the design, where required.

8.1 Contextual facilitators and barriers to program implementation

There are many factors that can help or hinder program implementation and success. In relation to the Family Preservation Package, factors that may impact the take up of packages include the availability of other FACS funded preservation services in the local area and the cultural safety of these services. The number of packages purchased from providers may also be influenced by the decision making processes of FACS staff.

Factors can be referred to in terms of their likelihood to facilitate or act as a barrier to implementation. Facilitators of package implementation include:

- FACS staff and sector support for the change and belief that it will ultimately benefit children and families
- provision of significant government funding
- engagement with Aboriginal organisations and representatives, including AbSec, to promote culturally safe design and delivery

[44] NIRN, 2015, http://nirn.fpg.unc.edu/learn-implementation/implementation-science-defined

- engagement with CALD organisations and representatives, such as the FACS Multicultural Consultative Group, to promote culturally safe design and delivery.

Barriers to implementation may include:

- time constraints on the design process and preparation for delivery
- inexperience of the sector in preservation, including comfort sitting with risk
- change fatigue.

8.2 Implementation outcomes

8.2.1 Fidelity

Fidelity involves ensuring that the chosen program model is properly adhered to and delivered with competency. Fidelity to the final model can be supported through training and providing resources, such as manuals. In relation to family preservation, fidelity will be reflected through delivery of the core components and mandatory activities outlined in the Program Framework.

8.2.2 Program reach, including Aboriginal, CALD, newly arrived migrant and refugee families

Outcomes that will indicate successful implementation of the package across all targeted families, including Aboriginal and CALD families include:

- children and parents have successfully engaged with services they have been referred to, including participation in case management activities
- family preservation is identified as a case plan goal for an optimal number of children and young people
- optimal rate of uptake by families including Aboriginal and CALD families
- preservation packages are purchased from service providers at a rate commensurate with the number of preservation case plan goals.

8.2.3 Sustainability

Sustainability relates to the continuation of the program and its outcomes for children and families over the long term. Sustainability of the Family Preservation Package will be demonstrated through:

- maintenance of optimal referral rates
- continued delivery of evidence based programs with fidelity
- continued funding.

8.3 Program outputs

Implementation of the PSP is being monitored and evaluated at both state and district levels. Independent process and outcome evaluations will also be conducted. PSP Family Preservation Package outputs will contribute to these broader pieces of work.

Historically, the monitoring of program success has focused on the achievement of program outputs. However, this does not necessarily translate to improved outcomes for children and families.

Delivery of outputs reflects program implementation and, as such, assists in determining how effective the implementation process has been. The outputs identified to assess implementation include:

- number of children and young people with a case plan goal of family preservation
- list of approved service providers with family preservation capability
- number of service providers receiving a preservation package
- number/type of specific services and activities delivered in each program component
- number/type of sessions of each service/activity delivered
- number of trained/certified staff
- number of children and family members participating in activities provided
- SARA reports
- Family Action Plans
- appropriate health plans
- NDIS plans (where relevant)
- relevant service provider documentation.