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Peer-reviewed papers from the FRSA 2017 National Conference, 22–24 November 2017, Melbourne Convention and Exhibition Centre (MCEC)

Connecting the Dots: Creating Wellbeing for All.

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INTRODUCTION

FRSA is proud to launch this second e-journal of peer-reviewed papers from the annual FRSA National Conference.

This e-Journal expands on the FRSA 2017 National Conference theme *Connecting the dots, creating wellbeing for all*. Collectively, the following six papers explore creative ways we can strengthen wellbeing across the family life course by connecting sectors and disciplines as well as formal and informal services and supports.

Given the makeup of delegates at FRSA events, including practitioners, senior managers, CEOs, policy makers and researchers, the conference provides a rich environment in which to hold these conversations.

Following a call for abstracts and the receipt of many high-level submissions, 61 abstracts were selected for inclusion in the 2017 FRSA National Conference program. As well as following the overarching theme of connecting the dots and wellbeing, authors positioned their abstracts within a particular concurrent session stream that was specifically suited to one of five stages in the family life course:

- the first 1000 days
- key transition points in the schooling years
- partnering and cohabitation
- relationship breakdown and re-partnering
- ageing.

Authors of the 61 successful abstracts were then invited to expand on their ideas in a longer paper for peer review. Again, numerous high-level papers were submitted before each paper underwent two rounds of ‘blind’ peer review by two reviewers.

The end result is six highly valuable papers that explore how our sector can better connect the dots.

We would like to express our gratitude to all authors and reviewers for their dedication and professionalism, which has resulted in this final collection of meaningful papers. Anyone who has participated in a peer-review process will understand that the process is iterative and intensive.

We look forward to publishing future e-journals to align with FRSA conferences in the years to come.

With kind regards,

Jackie Brady
FRSA Executive Director
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The overuse of digital media in youth is an emerging public health concern. There is significant controversy in the literature as to what problematic use is and whether or not it constitutes a bona fide clinical disorder. This article reports on the findings of an action-research project which aimed to connect with excessive users and their families, to explore the relationship between digital media use and wellbeing.

The pilot project was undertaken by personnel at EACH, a national health and social services organisation in Melbourne, Australia. Cost-free community seminars and a counselling service were offered to members of the community. Tools used to evaluate the project outcomes included the American Psychiatric Association’s Internet Gaming Disorder (IGD) diagnostic tool, a validated client satisfaction survey, and de-identified client case notes.

The findings from this project do not align with the notion that problematic use is an addictive disorder, but more a symptom of multifaceted psycho-social issues. Clients who accessed the service presented with a constellation of complex life issues, particularly family separation and illness.

This research project had limited funding. Despite this the qualitative design and data collected revealed context rich data which demonstrate significant findings. Pending more research this project recommends a strengths-based approach for building healthy and respectful relationships in a digital age. Enquiring with authentic interest about a person’s use build rapport. By comparison, a dismissive approach may serve to reinforce a maladaptive cycle of family breakdown, poor relationships, complex life issues and continued problematic use.
**Introduction**

Technology has brought about a multitude of documented positive public health outcomes, facilitating pro-social behaviour and education, (World Health Organization, 2015) and in turn enhancing psychosocial wellbeing (Yau, Potenza, & White, 2013). Despite this, the increasing popularity of the internet has also triggered media concern and academic focus on the negative health outcomes related to excessive use (World Health Organization, 2015, p. 7).

This paper reports on the findings of an exploratory pilot project undertaken by personnel at a national health and social services organisation called EACH. Therapeutic workers at EACH identified an increasing frequency of clients concerned about problematic online behaviour. A project was set up to understand more about the relationship between problematic internet use and reduced wellbeing in order to inform the development of an effective intervention framework. Cost-free counselling and community seminars were offered to community members affected by immersive use of the internet. A single project worker was employed for a period of 12 months and this role was developed and supported throughout by a steering committee. This article will focus on the counselling stream only as the key findings came from the direct contact with young people.

The research questions were: What are the risk factors behind problematic use of the internet? Can motivation for use inform harm minimisation?

Many studies in the literature apply this diagnostic nosology and look at excessive use as an addiction. They set out to measure behaviour and develop instruments to diagnose.

An alternative theory in the literature highlights that like many other maladaptive behaviours, problematic technology use is nothing more than a coping mechanism which serves to mask an underlying issue or stressful life event (Wang, Wang, Gaskin, & Wang, 2015; Yan, Li, & Sui, 2014).

**What are the risk factors?**

The literature identified the relevance and prevalence of risk factors in moderating the relationship between problematic use and reduced wellbeing (Kuss, van Rooij, Shorter, Griffiths, & van de Mheen, 2013; Snodgrass, Dengah, & Lacy, 2014; Wang et al., 2015). Table 1 lists the main themes that emerged from the review. An analysis of the risk factors in the literature revealed that stressful life situations result in a higher likelihood of using devices compulsively (Harwood, Dooley, Scott, & Joiner, 2014; Kuss et al., 2013; Wang et al., 2015). The risk factors identified in the review appear to sit across three contexts. Firstly the user’s physical context or make up (age, gender, personality). Secondly the user’s psycho-social context (poor relationships or parenting, pre-existing mental health issues, low self-esteem) and finally environmental context (access, game design, socio-economic status). The literature reviewed suggests that poor mental health and poor relationships are two of the strongest predictive factors of excessive use.

<table>
<thead>
<tr>
<th>Risk factors</th>
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<tbody>
<tr>
<td>Gender</td>
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<tr>
<td>Age</td>
</tr>
<tr>
<td>Genetic/neurological make up</td>
</tr>
<tr>
<td>Personality type (introversion)</td>
</tr>
<tr>
<td>Poor relationships/parenting</td>
</tr>
<tr>
<td>Allure of online relationships</td>
</tr>
<tr>
<td>Mental health issues</td>
</tr>
<tr>
<td>Low self-esteem</td>
</tr>
<tr>
<td>Social isolation</td>
</tr>
<tr>
<td>Access</td>
</tr>
<tr>
<td>Game design</td>
</tr>
<tr>
<td>Socio-economic status</td>
</tr>
<tr>
<td>Low life satisfaction</td>
</tr>
</tbody>
</table>
Social compensatory hypothesis

Several of the articles in the literature align their work with social compensatory hypothesis. In the context of excessive internet use, this theory looks at the reasons behind over-engaging with technology, (Wang et al., 2015) and suggests that motivation to use digital technology is compensatory and a manifestation of underlying low psycho-social wellbeing or risk factors (Haagsma, Pieterse, Peters, & King, 2013; Kirby, Jones, & Copello, 2014; Kross et al., 2013; Van Rooij et al., 2014; Wang et al., 2015; Weinstein et al., 2015).

Method

The counselling stream of the project involved working with adolescents and or their parents and carers to offer therapeutic support. Participants of the counselling stream of the project were adults (often with the young person present) who had heard about the service through the community seminar stream of the project, or through a local school, school wellbeing officer or community worker who had attended a seminar from the community seminar stream.

Data collection measures and analysis

This was an exploratory project, therefore the research agenda and activities were shared by researchers and steering committee members (Lingard, Albert, & Levinson, 2008). The project used mixed methods in order to capture multidimensional insights of the challenges as well as potential local solutions (Lingard et al., 2008). There were four methods of data collection for the counselling stream part of the project. Two quantitative methods in the form of surveys and two qualitative methods in the form of de-identified counselling case notes and a transcription of the interview with the project worker.

The first survey used was the DSM-5 proposed APA diagnostic tool for IGD. In order to test the feasibility of the tool, clients were asked to complete the nine question survey pre-counselling on intake and post-counselling on being discharged.

The second survey used was the Working Alliance Inventory, a validated evaluation tool which measures three key aspects of therapeutic alliance. It measures the tasks of therapy, the agreement on the goals of therapy and the development of an affective bond (Munder, Wilmers, Leonhart, Linster, & Barth, 2010).

Framework analysis was used to analyse the data as it moves from thematic analysis to associations between the concepts (McNiff & Whitehead, 2009), and is geared towards practise-orientated findings (Green & Thorogood, 2004, p. 208).

Program logic

The evaluation of the project was conducted by two staff members from the health promotion team at EACH. Figure 1 is the program logic, which was drawn up by the principal researcher.
during planning stage. It allowed the steering committee to build and articulate the logic of the project, which outcomes it expected to achieve, how it expected to achieve them, as well as how the outcomes would be measured.

**Results and discussion—counselling stream**

This project invited young people into a conversation about the overuse of digital media. It was about comprehending a phenomenon, rather than measuring it (Green & Thorogood, 2014). As the project developed it became apparent to the steering committee that the use itself was just the tip of the iceberg and that comprehending the life story and context behind the use was very important. The strongest findings in this project came from the counselling case notes, the part which gave maximum voice to the young people.

**Reach and demographics**

Over the course of 12 months, the project worker offered counselling services to a total of 17 participants. The tables in Table 2 summarise the demographics of clients:

<table>
<thead>
<tr>
<th>Participant type</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents/carer (one or more attendance from adolescent)</td>
<td>94%</td>
</tr>
<tr>
<td>Parents/carer (no single attendance from adolescent)</td>
<td>6%</td>
</tr>
</tbody>
</table>

**Demographic of parent or carer**

<p>| | |</p>
<table>
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<tr>
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<tbody>
<tr>
<td>Mother</td>
<td>64%</td>
</tr>
<tr>
<td>Father</td>
<td>12%</td>
</tr>
<tr>
<td>Grandparents</td>
<td>12%</td>
</tr>
<tr>
<td>Foster parents</td>
<td>12%</td>
</tr>
</tbody>
</table>

**Gender of adolescent with immersive/problematic use**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>92%</td>
</tr>
<tr>
<td>Female</td>
<td>8%</td>
</tr>
</tbody>
</table>

Care episodes included outreach in 42 per cent of cases. This was due to the young person not being able or not willing to travel to the service.

Of the 17 cases of young people, 15 were identified by the counsellor as presenting with problematic use, with some of these young people gaming for up to 16 hours a day. The counsellor made this identification using the DSM-5 tool combined with his own professional judgement of the impact the use was having on the young person. These 15 adolescents were also assessed as being highly vulnerable young people presenting with a multifactorial range of psycho-social issues.

In the remaining two cases the young people had a negative diagnosis according to the DSM-5 tool. The project worker assessed their use and also found it to be ‘normal’. The counselling sessions in these two cases centred on educating parents and carers about what healthy or balanced digital use looks like in modern day Australia. In these two cases the key underlying issue was addressing cultural or generational disparity between the young person and their parents/carers.

**Client case study**

In one case there was a single parent from a migrant background. The parent felt the young person was gaming excessively. The young person’s use was deemed high but not abnormal by the project worker. The parent’s parenting style was somewhat authoritarian. The parent wanted significant academic outcomes from the child, as well as more connection with them. The worker gave the parent strategies to connect with the child at home, both online and offline. The parent was encouraged to use less force and more acceptance. The parent reported that they had found it very reassuring to be able to speak to the project worker and learn about what constitutes healthy use and how to foster a stronger connection with the child.

**Quantitative data**

**IGD classification tool—Diagnostic and Statistical Manual of Mental Disorders 5th edition (DSM-5)**

The DSM-5 tool is a tool to collect categorical data, assess and diagnose behaviour. This disorder is listed in the appendix of the DSM-5 as a disorder warranting further study. The American Psychological Society have requested more research into the feasibility of the tool (World Health Organization, 2015). This study aimed to test the feasibility of the tool, as well as to evaluate the influence of the counselling sessions on wellbeing.

The project design was to give the DSM-5 diagnostic tool to each client to complete, both pre- and post-care episode. As the project unfolded it became clear that there were two challenges with this process. Firstly it was not always possible to know when a client’s final session was, which made it difficult to request post-care...
data. Secondly the average number of sessions which clients attended was only small and ranged on average from two to three, making a chance in behaviour unlikely. Moreover, only four clients completed both the pre and post tool as well as their consent form for us to use the responses given for research purposes, making the results unlikely to be representative of the population. The DSM-5 tool collects categorical data to track behaviour change only. Working with a small sample, a convenience sampling technique and minimal care sessions meant that this project was not able demonstrate improvement in online behaviour through this tool alone.

**Qualitative data/Case notes**

The data provided by this community pilot project was inevitably small, however non-probability samples may use a small size more effectively, particularly if the aim of the research is the value of the information, not the quantity (Hek & Moule, 2006). The strength of qualitative data is that it allows for understanding the human condition through story. The case notes in this project allowed for considerable insight into the context behind the use and importantly, the motivation for use.

**Motivation for use**

When asked why digital media was compelling, young people’s reasons included: to be entertained; to meet friends; to escape home life; to escape emotions; to distract from dynamics in the house; to escape feelings of neglect. The most common theme throughout was to regulate emotion and escape family tension. The project worker reported that early on in the role he loosened the emphasis on transforming the young person’s use and looked towards establishing the motivation for use and examining underlying issues. This was the new starting point for therapeutic intervention.

Project worker’s comments on working with a client (male, 20):

*It is with this client that I worked out that the surface level manifestation is actually not the issue, it’s the fracture underneath which requires therapeutic intervention. The young person was playing World of Warcraft and League of Legends for up to 16 hours a day. His sister was diagnosed with anorexia and he had the awareness of linking the gaming disorder to the anorexia and his sister having suicidal attempts. He said I do this because of that. He said he felt neglected. The parents have a dysfunctional relationship and the client said he was gaming to escape the emotional overload.*

**Identified risk factors**

The risk factors which were identified in therapeutic work with young people and their affected other family members were complex, broad, co-occurring and relatively severe in nature. They ranged from family conflict or separation, chronic illness or death in the family, sexual, gender and cultural diversity, truancy, pre-existing mental health issues, Attention Deficit Hyperactivity Disorder (ADHD), Autism Spectrum Disorder (ASD), social isolation, low self-esteem, drug and alcohol or mental health issues including torture and trauma. Death or illness of a parent or sibling appeared strongly as a co-occurring predictive risk factor.

*The death of a parent is high among my clients. A disproportionate number of my clients have experienced that. Often drug use and trauma too (Project worker).*

Relationship issues and low psycho-social wellbeing appeared to underpin most risk factors. Most cases had at least three to four complex and co-occurring risk factors. The project worker felt that the immersive use of technology was a coping mechanism. In the same vein, several young people in the counselling sessions spoke about what the positives of gaming were for them. They spoke of feeling a greater sense of self-esteem online, a connection with like-minded youth and a sense of protection from real-life issues, which felt threatening. However after working with young people experiencing problematic use, the project worker commented that:

*The benefits of gaming are that it is task orientated and requires complex thinking. It’s entertaining and social and becomes a support network for many, but it cannot replace the meaningful experience and developmental benefits of face-to-face communication.*

The project worker identified that the social haven of the internet and games was a risk factor of compulsive use. Several clients were using online communication or gaming to cope with social anxiety. One client described how gaming helps distract from anxiety and how he didn’t have the motivation to do anything else. Several clients were immersed in playing Massive Multiplayer Online Role-Playing Games (MMORPGs) like *World of Warcraft*, a game which operates alongside other gamers 24 hours a day. Other clients played First Person Shooter Games (*Counterstrike* and *Halo*), which also involve huge time commitment if the player joins a clan.
Identified impacts/Influence of problematic use
This small project does not make any claim to demonstrate cause and effect and simply notes the commonly perceived negative influences of problematic use, some of which may indeed be risk factors. There is no evidence base to suggest direction of association between excessive technology use and reduced wellbeing (World Health Organization, 2015).

The public health issues linked to excessive use of technology fall into several domains of health (World Health Organization 2015), and will be examined separately below.

The physical impacts of excessive use of devices include a sedentary lifestyle, overweight and obesity issues, musculoskeletal issues like back pain, hearing and vision issues due to over use, and injuries and accidents due to using devices while doing other tasks (World Health Organization, 2015, p. 14). This project identified several negative biomedical issues co-occurring alongside excessive use and they include sleep deprivation and disturbances (gaming for up to 16 hours a day), poor diet (storing processed foods in the bedroom), sedentary lifestyle (barely leaving bedroom), poor hygiene (urinating in bottles in the bedroom), and self-harm (cutting, suicidal ideation and threats).

A common co-occurring impact of problematic use in the young gaming clients seen by the project worker was relationship harm, including aggression to family members, isolating from peers, refusing school and or work and lying about use. Eight of the 17 young people seen at the service were using First-Person Shooter Games, which include significant levels of violence. Additionally there were two clients who experienced bullying both on and offline and two cases of young people having inappropriate relationships online.

The project worker saw many clients using digital media to regulate emotions. On analysing the project case notes it would appear that 15 of the 17 cases were using technology to self-soothe. One client was quoted by the project worker as saying:

I am addicted to gaming, I use it to escape my home life.

This is in line with the literature which found cognitive drivers behind overuse include using technology to regulate feelings of anger, anxiety, dependency, irritation, tension or depression (Haagsma et al., 2013; World Health Organization, 2015; Weinstein et al., 2015).

One of the aims of this project was to highlight to young people the infiltration of the gambling industry into gaming. The convergence of social media, apps and online video games and simulated gambling is putting young people at long-term risk of pathological gambling and is an emerging public health issue (King, Delfabbro, Kaptsis, & Zwaans, 2014). The project worker did not come into contact with any young people with signs of pre-existing gambling harm or problematic spending per se, with the exception of two clients who had spent money on their parent’s credit card without consent on in-app purchases. Although there was no significant mention of exposure to gambling content by clients to the counsellor, it is likely that they were being exposed to online gambling content or simulated gambling.

**Synthesis**

Overall, the project findings suggest that this kind of intervention may be able to achieve some improvements for families experiencing problematic use of digital media. A framework analysis of the case notes revealed repeated examples of improved insight and personal growth, and a greater understanding for the motivations behind the use in both clients and their parents and carers. Despite these improvements, the counselling stream of the project was unable to meet the goals which were mapped out during the planning phase of the project, which are depicted below in Table 3:

<table>
<thead>
<tr>
<th>Goals</th>
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<tbody>
<tr>
<td>Reduced technology use</td>
</tr>
<tr>
<td>Improved family communication</td>
</tr>
<tr>
<td>Improved relationships with peers and family</td>
</tr>
<tr>
<td>Increased in non-screen activities</td>
</tr>
</tbody>
</table>

Failing to meet these outcome goals does not indicate that the counselling stream of the project was ineffective. The reason for not meeting the outcomes is likely to be a combination of the fact that the outcome goals which were set were not realistic, coupled and amplified by the fact that the client portfolio was far more complex than the steering committee had envisaged. A small 12-month project is unlikely to be able to demonstrate medium term cause and effect. The project goals should have been the short-term outcomes, taken from the program logic. For example, rather than aiming to see reduced technology use, the project should have aimed to demonstrate improved knowledge of the motivation for use. This might have been a more realistic starting point towards behaviour change in the long term.
Summary, conclusions and implications

This project set out to discover more about the relationship between problematic use of digital media and wellbeing. The aim of the research was to find out what the risk factors of problematic use are and whether or not the motivation for use can assist harm minimisation. The scope of this project was small and exploratory in nature therefore the conclusions and recommendations for practice, policy and further research are naturally limited.

In the absence of a definition or clinical classification for problematic use, this project would suggest that overuse is on a large spectrum, but that it might be considered problematic when it is deemed as such by either the user themselves and or their affected others.

The findings provide some anecdotal support for the idea of problematic use as a symptom of an underlying social or emotional fracture and unlikely to be a disorder in its own right. The use is merely a vector for a wide range of other psycho-social issues (World Health Organization, 2015).

Overall the project findings align with the social compensatory theory which is the idea that the use psychologically compensates for the social and emotional wellbeing a young person may feel eludes them in their offline life (Snodgrass et al., 2014, p. 481). This project found that if immersive use itself is not the issue and merely a coping mechanism, then an approach which is disciplinary and dismissive of the young person’s use may serve to reinforce a maladaptive cycle of relationship and life issues and problematic use.

In short, in a high-tech world the starting point for prevention and harm minimisation of problematic use would appear to be through focusing on the motivation for use. It would appear that in excessive use, behind the motivation lies several complex and co-occurring risk factors (Boniel-Nissim et al., 2015; Chang et al., 2015; Haagsma et al., 2013; Kuss et al., 2013; Van Rooij et al., 2014; Weinstein et al., 2015). Figure 5 depicts motivation for use as a starting point.

Recommendations

Pending more research this project recommends a strengths-based approach to problematic use. In the case of this study authentic positive enquiring into what a young person was doing online meant that the project worker was able to make clients feel valued and respected. This strengths-based approach appeared to improve the likelihood of a positive professional relationship that was strong enough to explore the motivations behind the use, and ultimately insight to the key driver, of the problematic use.

![Figure 5](image-url)
Professionals/practitioners

Behavioural therapy for maladaptive use should view problematic use as an indication of an underlying life issue and or low psycho-social wellbeing and take a strengths-based approach. This project found that acknowledging that each young person has a unique set of personal and family strengths and challenges appears to engage the family as a partner in developing and implementing more protective factors for the young person who is using technology in an immersive way.

Future projects should include funding for therapeutic sessions, some of which may need to be outreach. Therapeutic staff would benefit from training to work effectively with clients who are compulsively using their devices.

Future practitioners should be familiar with the DSM-5 diagnostic criteria for IGD for reference, but then look beyond classifying use according to a diagnostic criteria and towards investigating problematic use broadly and in context.

Parents/carers

This project would seem to show that parents or carers should engage in digital entertainment time with the young person. It appears helpful to the relationship to be mentored by young people online and to take the time to understand the young person’s online world. It may be helpful to be interested and curious about what the young person is playing or doing as in turn it can open up honest and mutually respectful conversations about healthy use, including conversations about planning offline activities together.

Research

Future research should be longitudinal and explore risk factors of immersive use and their interaction. This may lead to a demonstration of the direction of causation. Qualitative study methodology is recommended. Motivational interviewing could be used to map reasons behind behaviours and context behind individual and sometimes episodic behaviours. Given the significance of the online space in contemporary society, future study might also examine average use, its impact on face-to-face conversation, relationships (Rasmussen et al., 2015; Smahel, Wright, & Cernikova, 2015), and wellbeing.

References


Australian students have been identified as having a lower reported sense of belonging than the average student in other OECD countries, with 23% having reported feeling like outsiders at school (OECD, 2017). Waters, Cross and Shaw (2010) found connectedness to high school was a significant predictor of academic and health outcomes for Australian students. Higher connectedness to school was related to fewer classroom and peer problems, fewer emotional problems and greater pro-social skills. Students who identified as being connected to their school also had less difficulty with the actual transition to high school.

Students who feel part of a school community and have a sense of belonging are more motivated to learn and perform better academically (Battistich, Solomon, Watson, & Schaps, 1997; Goodenow, 1993); which in turn is found to lead to greater social acceptance and sense of belonging (Wentzel, 1998). Within the school environment, a sense of belonging gives students feelings of security, identity and community, which support academic, psychological and social development (Jethwani-Keyser, 2008). A sense of belonging and acceptance at school is important for adolescents’ sense of self-worth and overall satisfaction with life (Juvonen, 2006).

Given the links between student connectedness, their wellbeing and academic performance; target strategies were developed within the School Student and Family Program (SSFP) to build student connectedness. One such target strategy is the Transition to High School Program (TTHS), an early intervention initiative that fosters student connection in Year 6 students with their new high school and peers. TTHS has been delivered, reviewed and amended based on feedback from attendees for 14 years to ensure it continues to meet the needs of students and aligns with current best practice. In 2016, a preliminary review occurred on this feedback informed process with a view to align with the sector’s movement toward more stringent outcome measures. Following this preliminary review, 90% of students reported feeling more prepared for high school after attending TTHS in 2016. Moving into the future, SSFP is continuing to explore evidence-based outcome measures of wellbeing for the TTHS program.
**Introduction**

The transition from primary to high school is an important milestone for both a child and their family; it is identified as one of the five main life stage transitions for young people (Rice et al., n.d.). Coffey (2013) acknowledges that while this transition is considered a regular part of the formal school experience, it can represent a significant challenge to all stakeholders, which is particularly evident when considering the changes experienced by students.

When students enter high school they are faced with significant changes which can impact their wellbeing, for example, being forced to leave their known primary school environment, to attend a new, often unknown and larger high school; with new teachers, new peers and new systems and processes. They are no longer the oldest, but the youngest (and often physically the smallest) within the school community. Instead of one teacher, they have multiple teachers and classes, in addition to an increased workload across school and home environments (homework). Often, students also face increased responsibilities in the move toward self-directed learning and travel arrangements. Additionally, due to the concurrent move to adolescence, a developmental period characterised by strong needs to belong and to make meaningful contributions to the group (Battistich et al., 1997), students’ levels of anxiety are at risk of increasing (Lester, Waters, & Cross, 2013).

Due to this school transition occurring alongside the developmental and socio-emotional changes of adolescence, the term ‘transition’ can often feel inadequate in addressing the level of complexity these simultaneous processes of change and adjustment entail. While most students eventually adjust to high school, this is a key period that impacts on academic performance and the social and emotional wellbeing of students. Collaboration within and across schools and systems is integral to improving the transition of students, particularly students at risk (Towns, 2017).

**Outcomes of an unsuccessful transition**

A reduced sense of connectedness in students during the transition from primary to high school has been associated with poor mental health outcomes, including the existence of symptoms of depression and anxiety (Lester, Waters, & Cross, 2013). Over the past three years, SSFP school counselling data identifies anxiety as one of the most prevalent presenting issues and developmental transition points exacerbate anxiety. Therefore, unsupported transitions place students at further risk of experiencing anxiety.

Even more concerning is the link between an unsuccessful transition from primary to high school and post-school outcomes. Poor transitions have been found to be associated with school disengagement, non-completion of schooling and poor health and education outcomes later in life, including limited employment opportunities and reduced health and wellbeing (Maguire & Yu, 2014; Towns, 2017).

The significant impact of unsuccessful transitions from primary to high school highlight the need for intervention programs which take a proactive approach to supporting the elements of transition in order to increase a student’s likelihood of experiencing a successful transition and subsequently, positive educational and wellbeing outcomes.

**Outcomes of a successful transition**

When students feel part of a school community and have a sense of belonging during and after their transition to high school, they are more likely to perform better academically and are more motivated to learn (Battistich et al., 1997; Goodenow, 1993); which in turn is found to lead to an even greater sense of belonging and social acceptance (Wentzel, 1998). The literature review by Hanewald (2013) identified that transition programs support students to have higher outcomes with academic effort than their peers who did not participate.

Evangelou et al. (2008) found children with special educational needs or those from other vulnerable groups did not experience a less successful transition than other children, however they were approximately 20% more likely to be bullied, which is a key inhibitor of a successful transition. This indicates the need to give special consideration to vulnerable students and their risk of experiencing bullying through transition programs for the achievement of positive outcomes, a population of students that is prioritised by the TTHS program.

**The current TTHS program**

The Transition to High School program (TTHS) is an early intervention initiative that fosters student connection in Year 6 students with their new high school and peers, prior to commencement at the school. The TTHS program aims to alleviate fear in Year 6 students associated with this transition by giving insight into this new life stage and by providing strategies to support student wellbeing. Strategies include making friends (which students
consequently identify each year as their greatest concern, dealing with bullying, identifying support persons and cyber safety, as can be seen in further detail in Appendix 1.

TTHS is currently delivered over a school day, at four different locations, each catering to 120–200 students in Year 6 from 12 primary schools. Whole cohort and small group activities are facilitated, with small groups assisting students to make initial connections with peers attending the same high school and which, according to feedback, students highly value. Secondary students are invited from the main feeder Catholic high schools to help facilitate the program as group leaders. This peer-support is vital for fostering relationships, equipping Year 6 students with knowledge and providing an opportunity to ask questions and share in a safe space.

**Elements of the TTHS program**

Consistent with research findings and relevant literature, the TTHS program directly addresses multiple factors linked with a successful transition experience for students as they move from primary school to high school: connection and belonging; support; information provision and realistic expectations; an understanding of a ‘zero tolerance’ culture towards bullying. By addressing these factors, TTHS takes a preventative approach and is designed to intervene prior to the transition period, as well as during students’ first year of high school, to support a successful transition experience and increase the likelihood of positive educational and wellbeing outcomes.

**Connection**

Given the increased significance of relationships and the role they play at this developmental stage, the literature identifies that the key to ensuring a successful transition period is to focus on relationship building. Positive outcomes stem from building links between the primary school and high school, with transition events and orientation days (Evangelou et al., 2008).

Australian students have been identified as having a lower reported sense of belonging than the average student in other OECD countries, with 23% reporting feeling like outsiders at school (OECD, 2017), it is particularly important to address a student’s sense of belonging and connectedness in transition programs in Australian schools. Prior to the delivery of the TTHS program, the Year 6 teachers place students into small groups containing a mix of students from different primary schools who will be attending the same high school. This provides an opportunity for students to make connections with other students from different primary schools who will attend the same high school and commence building relationships, thereby developing a sense of belonging and connectedness.

Waters, Cross and Shaw (2010) found that connectedness to high school was a significant predictor of academic and health outcomes for Australian students. Higher connectedness to school was related to fewer classroom and peer problems, fewer emotional problems and greater pro-social skills. Students who identified as connected to their school also had less difficulty with the actual transition to high school. Students and staff from the main feeder Catholic high schools attend the TTHS program to facilitate Q&A sessions to further build connectedness to the high school.

Lester, Waters and Cross (2013) found that peer support was a protective factor over the transition period for students who are both a bully and a victim. Consistent with this, Gini, Pozzoli, Borghi and Franzoni (2008) and Menesini et al. (1997) have shown that intervention programs based on increasing peer support were successful in reducing the incidence of bullying at school and reducing the negative effects of bullying for students who are victimised. Given the importance of peer relationships as identified by Hanewald (2013), the TTHS program coordinates a peer support element with students from main feeder Catholic high schools to help facilitate the program as small group leaders. These students are vital for providing the Year 6 students with recent knowledge about high school and the transition. Perceived support from peers was found to be significantly related to students displaying prosocial forms of behaviour and prosocial goal pursuit, pointing to the positive role peer support plays in student social adjustment to school (Wentzel, 1998). Within the school environment, a sense of belonging gives students feelings of security, identity and community, which supports academic, psychological and social development (Jethwani-Keyser, 2008). A sense of belonging and acceptance at school is important for adolescents’ sense of self-worth and overall satisfaction with life (Juvonen, 2006). In addition, students in schools who are aware of the existence of peer support systems worry significantly less about being bullied (Cowie, Hutson, Oztug, & Myers, 2008).

A role of the TTHS program is to foster student connectedness with their new high school, relevant supports, peers and older students. In addition to the abovementioned activities, this is achieved by facilitating icebreaker activities: ‘Mingle Mingle’ and ‘The Human Knot’. During
'Mingle Mingle', the facilitator plays music while the students move around. When the music stops, students form small groups and share their responses to the question posed, e.g. favourite colour, food, movie/TV show. Small groups feed back through a roving mike to facilitate connection with the larger group. In cooperative group game, ‘The Human Knot’, students stand in a circle and put their left hands in the centre and grab hold of another team member that is not next to them. Then, students put their right hand in the centre and grab hold of a different team member. Students then attempt to untangle themselves.

To highlight elements of effective teamwork following from their success in this game, students discuss answers to reflection questions (e.g. what made achieving your goal easier? How did you work together as a team?). This activity is then linked to the transition to high school by identifying they are joining a new team where working together as a team will lead to the goal attainment, learning and fun.

To foster the skills associated with building further connections once at high school, a brainstorming activity is undertaken where students identify ways of making friends in their small groups. Ideas from the small group discussions are built upon by looking at strategies for how to make friends, grow friendships and maintain them as a whole cohort. A section on strategies for making friends is also included in the take home resource booklet.

Support network
When students feel part of a school community and have a sense of belonging, they are more likely to perform better academically and are more motivated to learn (Battistich et al., 1997; Goodenow, 1993). More specifically, Battistich et al. (1997) point to a sense of community being significantly related to students’ prosocial attitudes, motives and behaviour. In addition, a sense of community was also significantly related to the school variables including enjoyment of school, achievement motivation, intrinsic motivation for learning, reading comprehension and student achievement amongst others.

Waters, Cross and Shaw (2010) suggested that interventions to improve students’ school connectedness at the beginning of high school should focus on the school culture. Evangelou et al. (2008) found building student understanding of new routines and the expectations which will be placed on them in high school as two important elements of a successful transition. The most successful schools, as identified from the case studies following positive survey responses, were those with very close links and coordination between primary and high schools.

Exploring the students support network is a key part of the TTHS program and the part which has received the strongest positive feedback from attending teachers and staff. The TTHS program functions to identify relevant support persons for students within their new high school community and externally. This is achieved by the activity entitled ‘My Network Hands’. Students are given an outline of two hands and asked to identify the names of five trusted adults outside of school on one hand and five support people in high school on the other hand. Students are also given a sheet of ‘Support Hands’ identifying the potential for support from the following people: family, friends, teachers, counsellors and other services (e.g. Kids Helpline). During the delivery of the TTHS program, a high school counsellor will often explain their role, how they can help and what actions they would take if a student sought their support; as well as other support roles within the school such as the Year Coordinator.

The value of this element of the TTHS program is evidenced by feedback received from a school principal in 2016:

*By providing our students with the structures that could be available for them at high school, it facilitates an easy transition between the two schools. The variety of workshops supports this on our transition to school day. I find that it has enormous benefits for all students but especially those who are not the ‘outgoing type’; at least they know who to go to when having difficulty. One of the workshop outlines this very well, and helps the students identify who all the different people they have around and where to go to. If I have trouble with school work, I can talk to this person, or [if I have trouble] at home, I could talk to this person or that person, and it may open more than one person they can lean on for support [which they had not thought of before]. I have been able to see this program develop firstly as a grade teacher, and now in my administration role, and I recommend we continue with it every year (Attending School Principal, 2016).*

Myth busting
Research identifies positive expectations and excitement about attending high school as a protective factor through the transition process to prevent an unsuccessful experience and the associated poor outcomes. Evangelou et al., (2008) found enthusiasm for high school and the friendliness of peers and older children at the high
school promoted a positive transition experience for students. Worry about the transition and the new experiences associated with high school, as well as concerns around making friends, were associated with a poor experience of transition for the students surveyed.

These factors are addressed by the TTHS program element of students exploring in small groups what they are looking forward to and what they are worried about in relation to transitioning to high school. Students are asked to finish the following sentences in their small groups: ‘At high school I’m looking forward to …’; and ‘At high school I’m worried about …’. By sharing their feelings with both peers and current high school students, students can become more informed and subsequently have their concerns allayed. Answers are fed back to the whole group, which further serves to validate and normalise student concerns. In addition, the take-home resources provided to students include items to assist with the management of worry and anxiety, e.g. stress balls.

The TTHS resource booklet provided to all participants as a take-home resource includes sections with strategies to deal with worry and anxiety, tips for talking to parents and tips for studying in high school. The TTHS program also uses Department of Education and Communities multimedia and Q&A panels made up of current high school students to dispel any myths and arm the primary students with accurate information. Multimedia clips including ‘Starting High School’ and ‘How to have a great year at high school’ are shown and the current high school students explain any potentially unfamiliar terms, e.g. homeroom and what they like about the change from primary school to high school.

The TTHS program provides space for students to be divided into groups of those attending the same high school the following year. Students who are not attending the represented Catholic systemic schools form a group and a facilitator answers their general questions. Current high school students talk to their respective groups and provide an opportunity for the primary students to ask specific questions about the school.

Bullying

Bradshaw, O’Brennan and Sawyer (2008) found that students involved in bullying are less likely to feel connected to school compared to those students who are not involved, which, as outlined above has been linked with successful transitions to high school and positive outcomes (Evangelou et al., 2008; Lester, Waters & Cross, 2012; Waters, Cross, & Shaw, 2010; Wentzel, 1998).

Lester, Cross, Shaw and Dooley (2012) found an association between peer support, connectedness to school, pro-victim attitudes, outcome expectancies and level of bullying involvement. Given the research into the impact of bullying and our strong collaboration with the Catholic Education Office for the Diocese of Wollongong, an element of the TTHS program involves the Youth Leadership and Development Officer addressing the whole cohort on bullying, with a particular focus on the students’ online presence, leading by example, and not being a bystander.

Current high school students assisting to facilitate the TTHS program are asked to share some advice on what to do if students find themselves being bullied at school or online. The TTHS resource booklet incorporates information on peer pressure, choices, bullying, cyberbullying and where to find more help for students and parents alike.

The literature identifies specific aspects of bullying interventions as key to reducing bullying behaviours and thereby improving academic outcomes and students’ wellbeing. Lester et al. (2012) suggests programs which focus on empathy and positive bystander behaviour, responsiveness with victimised peers and which encourage student self-reflection and a perception of all cases of bullying as unjust are critical in reducing bullying prevalence rates. As we move forward with the delivery of the TTHS program, we are working to focus upon all factors identified in the literature more directly and explicitly.

History and development of the TTHS program

While there are no clear records of when the TTHS program was first delivered, it is known anecdotally to have always been a high priority within the School Student and Family Program at CatholicCare Wollongong for the best part of two decades. Over this time, numerous changes have occurred to the TTHS program to ensure that it was continuing to meet the needs of the students in the local area. In 2012, the TTHS program underwent a major review, which included the following:

- Support materials were updated to be more relevant to the generation of the student participants, i.e. relevant music, increased use of multimedia clips, and scenarios used in problem solving and support needs scenarios. This was based on anecdotal feedback from facilitators, and decreasing engagement of students.
- A booklet was introduced as a resource for students to share with their parents, which
provided continuity of support in the student’s home environment, extended learning beyond the day of program delivery by providing additional resources and references and additionally provided support to parents who often have anxiety associated with the transition process as well.

- Over time, peer support provided through Year 7 or 8 students has been identified as preferable over older high school students, given their recent experience of transition (as compared to senior students) and their subsequent ability to provide detailed information to Year 6 students to address their questions and concerns.
- Group worksheets filled in by students on the day regarding what they are looking forward to or concerned about with the transition were provided randomly and confidentially to teachers to put around their classrooms and schools to normalise and validate fears and extend the impact of learnings from the program beyond the day of delivery.
- Feedback forms for each student to complete at the end of the day were introduced to support program adjustment if required for the following year.

**Insights gained from student feedback on the 2016 TTHS program**

To ensure that the program is continuing to meet the needs of students in this transition process, each year feedback is collected via survey from students and teachers at the end of the program, to aid in any adjustments required to the program for the following year. As the sector moves towards outcome measurement, the TTHS program undertook a preliminary review of the feedback methodology; adjustments were made to the data collection with a view to improve the comparison of data over time.

The current method for evaluating the TTHS program incorporates a survey at the conclusion of the session asking students to answer the following questions:

1. I thought today’s sessions were: mostly fun, mostly ok, mostly boring.
2. Before today, what worried you about going to high school? Teachers, changes in friendships, bullying, school work or homework, getting lost or not understanding the timetable, other (comment) or nothing.
3. Do you feel more prepared going to high school after our session today? Yes, kind of, unsure, not really, not at all.
4. Two things I liked about today’s sessions were:
5. Was there anything you didn’t like about the session?

In 2016, feedback was sought from the 122 students who attended one of the Illawarra sites to complete the transition to high school program in 2016.

**Identified concerns about high school**

The worries identified by TTHS students were similar to identified difficulties measured in an Australian study by Maguire and Yu (2014). Of the 2299 students surveyed across all Australian states, the top five identified difficulties in order of greatest concern included:

- making new friends
- missing friends from their previous school
- being required to do more homework
- dealing with more school subjects, with different teachers
- coping with a larger school with more students.

Due to the employment of different methodologies, the Maguire and Yu (2014) sample and the smaller TTHS sample cannot be directly compared. However, similar themes emerged between the two samples, for example, friendships and changed processes. Table 1 outlines the breakdown of identified worries shared by TTHS students in 2016.

<table>
<thead>
<tr>
<th>Self identified worry</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in processes</td>
<td>62.3%</td>
</tr>
<tr>
<td>Increased workload</td>
<td>57%</td>
</tr>
<tr>
<td>Changes in friendships</td>
<td>44%</td>
</tr>
<tr>
<td>Bullying</td>
<td>31%</td>
</tr>
<tr>
<td>Not getting along with new teachers</td>
<td>22%</td>
</tr>
<tr>
<td>No worries about entering high school</td>
<td>12.3%</td>
</tr>
</tbody>
</table>

**Impact of the TTHS program**

Despite these high levels of concern, it was shown that overall, 90.1% of students who attended the TTHS program felt more prepared for high school having attended the day. One Year 6 student reported that they had found it helpful ‘getting to meet new people going to my high school and realising we are all in the same boat’.
The key themes identified by students about what was of most help on the day included:

- getting to meet new people going to their high school
- getting to meet students whom currently attend their future high school
- getting to hear the high school students share what they most liked about their school
- gaining specific information about their new high school
- hearing other people’s concerns and worries for high school, and being able to problem solve them.

Feedback received from students and teachers included improvement recommendations for the future, such as doing some activities outside rather than being in a hall all day, facilitating different ice breakers at the beginning of the day, and continuing to work on collaboration with high schools to prevent double up of information presented between the transition program and the orientation day.

The TTHS program – One part of systematic wrap-around support

Within the Diocese of Wollongong, the funding arrangement between the Catholic Education Office and CatholicCare Wollongong supports the collaboration between the two entities, as well as the individual school communities. For this reason, support for students transitioning to high school is not done in isolated cases, but is embedded into the larger system to provide appropriate support in a number of ways, dependent on the student’s needs.

Firstly, at a high school level, each high school holds an orientation day in which students receive a tour of the school, meet key contacts within the school and spend some time in classes and ‘experiencing high school’. Generally this occurs after the TTHS event, so any questions that arise on that day can be addressed by the high school.

At a primary school level, students attending the Catholic systemic schools we serve are provided support and opportunities to practise skills such as research, time management and moving classrooms. School teachers also provide information to school counsellors and Catholic Education Office Learning Support Officers about students with a disability who may have additional emotional and physical needs to be addressed as part of this transition process. These identified students are provided with the opportunity to attend a longer orientation process at their new school, attending the high school for a few hours over a number of weeks to build those key relationships with relevant staff further, and address any adjustments that need to take place.

Finally, the school counsellor’s role in this transition is multi-faceted. Where there is a need for continued support for students engaged in primary school counselling, the current school counsellor will arrange a handover with the high school counsellor, and where possible arrange a meeting with the student and high school counsellor. Secondly, for students who are identified by primary teachers as needing additional support, but not to the level noted above, short-term counselling is offered to build strategies around worries for high school. This link to the school counsellor would include the engagement of parental support for students as well. The school counsellors run the TTHS program, which can be a final place to identify students whom may need additional support with this transition. Parents are included in the wrap-around support for a student by tailoring sections of the resource booklet, including the provision of strategies, towards parents specifically. In addition, a holistic approach is taken to the provision of support and external referrals are made where necessary to further support a successful transition for students.

Limitations of current TTHS program and future direction

During the TTHS program’s 14-year history in supporting students during this transition phase, it has seen numerous reviews focused on content and delivery. The most recent review in 2016 focused on capturing feedback more systematically, however further development is needed in this area. As the sector continues to move toward outcome measurement, exploration is occurring into how we can determine if anyone (in this case students) are better off, in accordance with the third part of the results based accountability framework.

This exploration includes identifying suitable evidence-based measure of student wellbeing and connectedness. Administration of these measures pre and post the TTHS program, as well as around larger transition period, will enable us to determine if improvement occurred to student wellbeing and connection, and how much (indicative of a successful transition). Comparing these results to a control group who do not participate in the TTHS program will enable us to further clarify whether any improvement in student wellbeing and connectedness was due to participation in the TTHS program.
At a program delivery level, given the link between bullying and connectedness and the impact of these on student mental health and wellbeing, the TTHS program will intentionally focus on addressing these specific elements. Transition programs can proactively and effectively minimise this negative impact. Transition programs can achieve this by addressing the contributing factors of bullying and positive pro-social behaviours. In accordance with this link within the literature, the future direction of the TTHS program will be to amend the current component addressing bullying to allow for an intentional focus on these specific elements (Bradshaw, O’Brennan, & Sawyer, 2008; Lester et al., 2012).

Implications for the sector

Lester, Waters and Cross (2013) identified the time prior to the transition and within the first year of high school as critical to implementing intervention programs to reduce the negative impact of bullying and lead to an increase in positive educational and wellbeing outcomes. In line with this and ongoing evaluation of this TTHS program, primary to high school transition programs seem most effective when they adopt a systemic approach where the program is embedded within the school systems already in place to support student transition from primary to high school. As such, it is recommended that the establishment of any THHS program ideally should also take this systematic approach.

We recommend transition programs incorporate research findings in conjunction with their own program evaluation, relying on student and community feedback to heavily inform program content. As noted by Battistich et al. (1997), ‘the findings from research on schools as communities certainly provide valuable guidance, but they are not a panacea for improving schools’ (p. 11). Diversity across students, schools and communities will impact on the relevance of content in addressing student needs. Undertaking regular reviews of the program, seeking feedback from all relevant stakeholders and undertaking continued quality improvement will best support a successful transition experience and enable positive educational and health outcomes to transpire for students.

Due to the limited research to date, particularly in Australia, we recommend further research occur on the impact of transition to high school programs on students, including a focus on the systemic approach. Another recommended research area is how providers and school communities are better able to support parents/caregivers through the transition process. We would also recommend longitudinal research into the impact of successful transitions on student wellbeing across high school years and post-school.

Conclusion

The transition from primary school to high school is a major milestone for a child and their family, often coinciding with the move to the adolescent developmental stage. An unsuccessful transition process is linked with poor educational and health outcomes, whereas a successful transition experience is associated with positive academic outcomes and student wellbeing. The TTHS program addresses student connectedness, support networks, myth busting and bullying to support a successful transition process. The TTHS program uses a systemic approach within school communities to support the transition of students to high school and therefore, we recommend further research on the impact of this approach. Communities would also benefit from further exploration on parent/caregiver transition needs and the long-term impact of successful transitions.

About CatholicCare Wollongong

The School, Student & Family Program (SSFP) of CatholicCare Wollongong promotes and supports the wellbeing and development of students attending 38 Catholic schools in the Wollongong Diocese. SSFP operates within a holistic framework supporting students, families and school staff via individual counselling, case management, psycho-education, referral and advocacy. Priority is given to the delivery of early intervention and preventative programs, and supporting vulnerable students to feel part of their school community. The transition to high school period as such is a key initiative within SSFP. SSFP is funded by the Catholic Education Office of the Diocese of Wollongong and works collaboratively with them to support students, families and school communities in the Catholic primary and high schools in the Diocese, which covers the Macarthur, Southern Highlands, Illawarra and Shoalhaven regions.
References


Appendix 1: The TTHS program outline

| Morning session: | Official welcome, housekeeping and outline of the day |
| | Mingle Mingle game |
| | Human Knots activity |
| | Video – Starting high school |
| | Small group activity – At high school I’m looking forward to … |

| Middle session: | Individual activity – My Network Hands |
| | Provide take-home resource |
| | High school counsellor explain their role, and other support roles within the high school setting (i.e. Year coordinator) |
| | Small group activity – How to make friends |
| | Whole cohort activity – Build upon strategies in previous activity |
| | Video – How to have a great year at high school |
| | Question and answer panel with current high school students |

*** Extended break to encourage informal connection ***

| Afternoon session: | Guest speaker – Catholic Education Office – Bullying & cyber safety |
| | Review learnings |
| | Student feedback & evaluation |
| | Close |
Windermere Child and Family Services offers a range of programs to residents of Melbourne’s outer south-eastern suburbs including housing support, disability services, counselling, family services, and victims’ assistance. Rather than delivering these programs in a disjointed and siloed way, Windermere brings highly skilled and well-informed representatives from each program area together to form a consultative panel called the Integrated Care Team (ICT). This multidisciplinary panel provides keyworkers with easy access to contacts, knowledge, resources and brokerage from the various program areas and is particularly helpful when working with families and individuals facing a range of complex challenges. Keyworkers liaise with the panel on behalf of service users to reduce bureaucratic strain and the number of professionals directly involved in peoples’ lives.

The Integrated Care Team has enabled solutions for service users with results that could not be so efficiently achieved through standard practice. Service users and their workers have found that the Integrated Care Team facilitates faster, easier, and more streamlined outcomes than were achieved prior to its conception. Adoption of this collaborative approach highlights the necessity of connecting the dots to improve seamlessness of service, transparency, knowledge transfer, and wellbeing for all.

Introduction

Windermere Child and Family Services is a medium-sized community services organisation operating in outer south-eastern Melbourne. The organisation consists of a number of program areas aimed at supporting local children and families including integrated family services, disability, counselling, victims’ assistance, early childhood development, housing, special projects and groups. While these programs are all run by Windermere, they have previously operated like separate organisations.

The Integrated Care Team (ICT) is an intra-organisational model developed by Windermere Child and Family Services to enhance coordination and seamlessness of service delivery. The model consists of a multidisciplinary panel (the ICT) which is comprised of experienced and highly skilled representatives from each of Windermere’s program areas. This panel brings skilled workers from a range of disciplines together to create a super team of complementary knowledge and broad experience which workers across Windermere can utilise for accessible and efficient secondary consult and practical assistance. While families and individuals continue to work with one
keyworker from the program area most applicable to their current situation; the Integrated Care Team is available to provide the keyworker with specialist advice and resources to more effectively and expediently address needs and goals.

This paper discusses the model and its theoretical underpinnings before augmenting its theoretical value with case studies and interview data from panel members and keyworkers accessing the panel. While this is not an evaluation of the ICT, rather an initial overview of the concept, this paper does suggest that the model could be replicated either intra-organisationally or inter-organisationally to provide people experiencing complex life challenges with increased expertise and resources and decreased bureaucracy and navigational burden.

**Background**

Demand for community services exceeds supply in the outer south-eastern growth corridor where Windermere is located. This over-demand increases Windermere’s need for efficiency as any duplication or waste that can be eliminated or refined needs to be addressed with urgency. While the drive for efficiency is strong, the organisation recognises that effectiveness cannot be achieved without sustainable empowerment of families and individuals. This means that the focus on streamlining and coordinating program delivery needs to be balanced with and underpinned by a commitment to a strengths-based and holistic approach.

Windermere began to discuss the implications of the organisation’s siloed program areas in 2011; recognising that divisions and disconnect hindered the experience for people requiring assistance from multiple programs. The organisation acknowledged that many of the processes, such as procedures around referral pathways, were difficult to change due to funding restrictions. However, monitoring data confirmed that many families and individuals accessing the organisation were utilising multiple programs and were finding juggling several workers and understanding varying procedures individualised to each area difficult to manage. While managing a multitude of workers and their accompanying appointments would be cumbersome for anyone, this overburdening most significantly affects families and individuals experiencing highly complex and co-occurring challenges. The extra strain of bureaucracy adds pressure to people who are already struggling through a vulnerable time of their lives. Additional aspects of disjointedness include a common requirement for families and individuals to retell their story to each new worker and a lack of clear communication channels between workers from different areas working with the same people.

Windermere recognised that the disconnection between its varying program areas was not beneficial to people needing to access multiple services. This has been further highlighted by sector-wide acknowledgement that changes need to occur to better integrate and provide people with easy to navigate, streamlined services (DHS, 2011; 2013; 2014; Kennedy, McLoughlin, Moore, Gavidia-Payne, & Forster, 2011). While the current prevailing model continues to be complex and overly bureaucratic, this paper discusses a step Windermere has taken to address this call for change at an intra-organisational level within its own multiple program areas. While the Integrated Care Team was developed to address this fragmentation and improve connectedness between the organisation’s program areas, its design is transferrable and could be used to connect multiple organisations.

**Communities of practice**

The Integrated Care Team is underpinned by Wenger’s (1998) communities of practice theory which demonstrates the potential for multidisciplinary collaboration to improve practice, operating systems, and knowledge transfer mechanisms. A community of practice is defined as a group of people who engage in collective learning to achieve common objectives (Wenger, 1998). Members from within these communities of practice give and receive information and wisdom from other members; seek collaborative solutions, share assets and resources, and improve effectiveness and accessibility (Fenton O’Creery, Hutchinson, Kubiak, Wenger-Trayner, & Wenger-Trayner, 2015; Sterrett, 2010; Wenger, 1998). A successful community of practice is more than the sum of its parts with holistic, big picture solutions enabling more positive results for the people the community of practice is aiming to assist (Fenton O’Creery et al., 2015; Sterrett, 2010). In addition to improving outcomes for people accessing a program or service, communities of practice enhance the experience and knowledge of their own group members and of other workers who access the group (Staempfli, Tov, Kunz, Tschopp, & Stamm, 2016; Sterrett, 2010).

Communities of practice theory has been used in a variety of disciplinary fields from health and medicine to social services and education. Common themes running through the literature on communities of practice report that workers benefit from increased capacity, professional development, and networking while families and
individuals seeking assistance benefit from ease of access and a streamlined, coordinated response (Kelly & Knowles, 2015; King, Strachan, Tucker, Duvyn, & Shillington, 2009; Lee, Hillier, & Weston, 2014; Robinson and Cottrell, 2005; Sterrett, 2010). The communities of practice highlighted in the literature are most often multidisciplinary but can have transdisciplinary elements. The panellists on Windermere’s Integrated Care Team form a multidisciplinary group as this community of practice involves input from workers from a variety of specialist fields or disciplines. The Integrated Care Team also has a developing transdisciplinary element embodied in the role of the keyworker. A transdisciplinary approach involves people working beyond the traditional boundaries of their profession. While transdisciplinary approaches often utilise guidance from professionals in other disciplines, the aim is that these transdisciplinary workers will be gathering and retaining knowledge that allows them to work across disciplines rather than being narrowly confined only to their own specification. The keyworker role in the Integrated Care Team is beginning to take on this additional multidisciplinary knowledge to move towards working in a more transdisciplinary manner. Windermere envisages that workers will continue to deepen their specialist knowledge in their chosen discipline but that they will be provided with increased opportunities to learn beyond their traditional professional boundaries. This is underpinned by the theory that workers with an augmented understanding of different discipline areas will be better able to recognise subtle signs and know how, when, and where to seek specialist knowledge (Kelly & Knowles, 2015).

Enhancing multidisciplinary and transdisciplinary collaboration combats many of the concerns identified in siloed standard practice. If people consent to working with the Integrated Care Team, it provides their keyworker with a clear communication channel between other workers who might be supporting them concurrently. This provides workers with the ability to stay informed about what other program areas are doing and can avoid families and individuals being presented with contradictory information or duplication. This clear communication channel provides workers with a platform to think of potential solutions to take back to families and individuals and increases the effectiveness of each other’s interventions. The importance of including a transdisciplinary element in a community of practice is most clear in its utilisation of the keyworker model. Developing a multidisciplinary panel enables valuable input from experienced and skilled representatives from a variety of disciplines but may still leave people burdened with numerous workers and appointments (Sloper, 1999). Including an emerging transdisciplinary role through the keyworker model can help remedy these inefficiencies by giving families and individuals a sole point of contact; a method of practice that service users have said is preferential (Kelly & Knowles, 2015; Kennedy et al., 2011; Sloper, 1999).

**The keyworker model**

Keyworkers simplify and streamline program delivery and accessibility by coordinating input across program areas. This role requires broader understanding of the needs of families and individuals rather than the more narrow knowledge of a particular issue necessary for non-keyworker specialist workers. This holistic understanding of the context and challenges facing families and individuals helps keyworkers more effectively pinpoint gaps and ensure individuals and families are receiving all appropriate services for which they are eligible. Additionally, keyworkers can reduce bureaucracy and save time by liaising with necessary specialists to reduce the need for referrals in some cases. When a referral to a specialist is warranted, the keyworker can get the specialist up to date on the person’s situation to save them from retelling their story. They can also coordinate appointments to coincide with other appointments at opportune locations to diminish travel time and inconvenience for people accessing multiple programs. Valuably, keyworkers provide continuity of care and give families and individuals a key point of contact to enable a strong sense of rapport and support.

The keyworker model has been successfully implemented in a range of other program areas including early childhood intervention services and disability support (Drennan, Wagner, & Rosenbaum, 2006; Kennedy et al., 2011; Liabo, Newman, Stephens, & Lowe, 2001; Wilson, Aubeeluck, & Pollock, 2014). The model’s success is due to its person-centred approach that puts families and individuals and their needs, opinions, and feelings at the heart of program delivery. This person-centred focus enables better accessibility to, and coordination of, supports. Kennedy et al. (2011) suggest that the model should be expanded and implemented throughout sectors that deliver social services and programs for human betterment and wellbeing.

The keyworker role works most effectively when operating within, or with access to, a multidisciplinary panel such as the Integrated Care Team. This mode of operation provides benefit to families and individuals as they receive the wisdom of a panel of specialists through a single interface
embodied in the keyworker (Wilson et al., 2014). This enables a communication channel which is augmented with knowledge from multiple skilled and experienced workers while simultaneously being simplified through delivery via a single source (Lee et al., 2014; Bruder, 2000).

This integration of the keyworker model into the communities of practice model diminishes siloed program delivery, reduces duplication, and enhances consistency (Drennan et al., 2005; Harbin, McWilliam, & Gallagher, 2000, King et al., 2009; Liabo et al., 2001). Evaluations of similar models demonstrate that the joining up of keyworker and community of practice approaches is holistic, user-friendly, person-centred, efficient, and effective (Kennedy et al., 2011; King et al., 2009; Sloper, 1999). It not only saves time and confusion for workers, but individuals and families utilising the model reduce the number of appointments they need to attend and enhance the value of the appointments that continue to be necessary.

Recognising the potential for improved functionality, the Integrated Care Team, a community of practice using both a multidisciplinary support panel and a transdisciplinary program delivery keyworker, was implemented at Windermere. The Integrated Care Team serves as a link to connect disparate program areas and a repository for collective knowledge and resources. A central value of this model is how the keyworker acts as a funnel, drawing in the breadth of knowledge and experience from the panel through a single worker and bringing it to families and individuals through a simple and streamlined interface; negating the need for an intricate and complex multi-contact point system.

An implementation challenge of the transdisciplinary keyworker role is the need to clearly define the boundaries and limitations of a keyworker’s role. As being transdisciplinary involves moving outside of and blurring traditional roles, there is ambiguity regarding where workers draw the line between tasks that are in or out of scope. Practitioners such as Evans (2017, p. 501) have noted the potential for the transdisciplinary keyworker role to cause an ‘acute sense of role uncertainty’ which can leave workers feeling unsupported and unsure of their professional standing. Recognising this potential, Windermere has addressed the need for role clarity with clear worker key performance indicators and development of role expectation guidelines that highlight what a worker in each program area is responsible for, and what they are not.

Methods

While this paper is designed to present a model rather than to be an empirical evaluation of the model, it is informed and enriched through inclusion of two family case studies and interview data from keyworkers and panel members. A case study approach is chosen to demonstrate the utility of the Integrated Care Team in this study as thick, qualitative description provides the clearest and most informative data to examine how an intra-organisational community of practice and keyworker approach can be used to effectively support complex families and individuals. This is particularly appropriate as this is a very small-scale intervention. The case studies chosen are representative of different types of cases bought to the Integrated Care Team in 2017 and focus on what the ICT was able to do rather than on the long-term outcomes from these families. These specific case studies were recommended and described by panellists and keyworkers who attend the panel. Families were asked for their consent to include their de-identified stories in this publication in addition to Windermere’s usual consent process, which explains that de-identified data may be used and disseminated for research and evaluation.

The data was primarily collected through interviews with keyworkers, although additional information was provided by panellists, documentation, and families or individuals accessing services. After data was synthesised and case studies composed, they were sent to keyworkers for checking and for discussing with the families who are the subjects of the stories. The families who are discussed in the case studies are completely anonymous and some facts have been altered slightly to further protect their privacy.

Windermere’s Integrated Care Team

The Integrated Care Team is comprised of a skilled and experienced representative from each of the following program areas: disability services, the victims’ assistance program, early childhood development, counselling, integrated family services and housing support. The panel’s operating paradigm is underpinned by a person-centred, strengths-based, appreciative inquiry and solution-focused framework which views families and individuals as the experts in their own lives and respects the expertise of their keyworkers. The Integrated Care Team was developed in early 2012 and is a one-stop-shop for workers to easily access resources and expertise from across Windermere’s multiple program areas; resulting
in a smooth and seamless experience for workers and for the families and individuals with whom they work. The Integrated Care Team congregates once per month and keyworkers can present to the panel at this meeting. As this model has been devised to meet the needs of the most complex families and individuals accessing Windermere’s programs, there is an average of two cases discussed at each meeting to enable sufficient time to unpack issues and discuss solutions. The general process is highlighted in the flowchart in Figure One below.

The keyworker presents the story of the person or family that they are working with to the panel and highlights areas where they are feeling stuck or would appreciate ideas, specialist knowledge, brokerage, or other resources. An additional strength of the model is that, once the keyworker has presented to the panel, the individual panel members can be contacted outside of the organised Integrated Care Team meeting for further support and advice. When warranted, an ICT panel member is able to work alongside the keyworker to provide ongoing specialised knowledge, attend meetings, or meet with families and individuals. Keyworkers are encouraged to attend the next panel meeting for case follow-up.

Managers or supervisors of each keyworker are updated on case progress during supervision as is usual practice. However, supervisors are supportive and aware of input from ICT panel members which might result in keyworkers undertaking tasks or following advice that is outside of the realm of their usual role or program area. The families and individuals who are the subjects of Integrated Care Team discussions are typically not present at these meetings. They are able to attend if they wish although this undermines one of the main reasons for the panel’s inception, which was to reduce the number of meetings people were expected to attend and to reduce the number of workers with whom they had to interact. The Integrated Care Team is more of a multi-actor secondary consult rather than a traditional care team. People whose cases are taken to the panel are briefed on how the panel operates to gain their consent for the keyworker to present, but they rarely wish to attend themselves. In lieu of physical attendance, keyworkers discuss the outcome of the ICT meetings with the families and individuals whose cases were presented to the panel to maintain a strong communication loop. When appropriate, this feedback mechanism could be enhanced by providing people with the meeting minutes for the section of the panel meeting relevant to them.

Initial implementation of the Integrated Care Team involved deliberations regarding the terms of reference and composition of the panel. Despite this being a little time-consuming, development of the model was smooth as it was driven from the top with strong support at the executive and management level.
The main challenges with the ICT have been in maintaining the model, particularly in reference to receiving an adequate number of referrals. In late 2014, an internal survey of staff knowledge of the ICT found that Windermere staff had a good understanding of the ICT’s purpose and of incidences where a referral to the ICT would be worthwhile. The survey did show that a minority of workers were unsure of the resources available at the ICT and of how to refer. In response to this survey, ICT panel members held an all-of-agency training session. Referrals after this point were steady for a few months and then began to reduce again despite highly positive results achieved for families and individuals whose keyworkers were accessing the panel. It appears that now, nearly six years after the ICT’s inception, many keyworkers have utilised the ICT to build their networks within the organisation. This provides them with a strong understanding of expertise within different program areas, which means they can access this specialist knowledge directly rather than waiting for the monthly ICT meeting. This organic and impromptu secondary consult is a useful outcome of the Integrated Care Team. While it potentially reduces the number of cases referred to the ICT, it enhances the ability for a higher number of families and individuals to access specialist knowledge in a streamlined manner through their keyworker. The ICT remains a useful model for keyworkers who have not yet brought a case to the panel and for extremely complex families and individuals whose challenges span many program areas.

Results

To explicate the model through practical examples, this section provides two case studies from families who were supported by the Integrated Care Team. These provide the basis for drawing conclusions about the model, which are augmented through feedback with keyworkers and panel members.

Struggling with disability in a new country

A mother and her four children were referred to Windermere’s integrated family services. They were also linked with Windermere’s early childhood development service as her two youngest children have profound disabilities. As refugees to Australia, the family was struggling with social isolation due to a lack of English, not being able to drive, and having no support network of family or friends. In addition to these burdens the family was experiencing severe mental health issues including post-traumatic stress syndrome, grief and loss, depression, anxiety, and complex trauma. The impact of a violent and unstable home country situation had been exacerbated by a violent and unstable husband who ensured the family had no locus of safety. The husband continues to come in and out of the family’s life. As it is identified that he does not provide physical or emotional support, his sporadic presence serves to further unsettle the family and disrupt chances to heal. While the older children are physically well, they struggle with mental health concerns and have subsequently disengaged from school.

Comprehensive assessment procedures highlighted that this was a highly complex family facing a number of challenges that cut across program areas. The keyworker identified that this family would likely benefit from the collaborative approach of the Integrated Care Team due to previous positive experiences utilising the panel with other families. The keyworker discussed the Integrated Care Team with the family and then presented their case to the panel.

The Integrated Care Team were able to support the family in a number of ways. Disability services provided respite for the family offering four weeks of in-home care and assistance with completing and submitting paperwork for the National Disability Insurance Scheme. Early childhood development services started co-working the case offering physiotherapy to the two younger children and sharing the workload with family services. Two of the family members were referred to Windermere’s counselling team and it helped that the representative from counselling was already aware of the family’s story which saved the family spending the first few sessions of their counselling allocation on re-telling their history. The Integrated Care Team assisted the keyworker’s application for family violence funding by providing advice on wording and pathways for submission. They also pooled their funding to provide brokerage for a car seat, safety items for the home, English classes, and driving lessons. Another benefit of the Integrated Care Team is this ability to provide keyworkers with immediate access to funding.

The keyworker model was particularly important for this family as they have no experience navigating Australian bureaucratic structures and have low English and literacy levels. The family requested the keyworker engage the same translator every time she worked with this family, which helped enhance the rapport and mutual trust needed for progression. Due to close connections with the Integrated Care Team, other program areas working with the family knew to use the same translator as well. An additional benefit of this arrangement was that the translator has a better understanding of the work that Windermere does due to longer engagement and was therefore better able to explain Windermere’s paperwork and procedures.
Further, as transport is difficult for this family, the keyworker’s ability to schedule appointments with different program areas at Windermere at the same or concurrent times has helped relieve the burden of having to attend multiple appointments in different locations.

**Getting down to business**

The second family highlighted as an Integrated Care Team example requires Windermere’s support on a cyclical basis in line with the father’s episodic mental health issues. While the mother is capable and usually able to manage a difficult situation of family violence, finance concerns, mental health issues and trauma, this becomes untenable during her husband’s episodes. These episodes are dangerous and pose a serious threat to the family’s lives.

The keyworker and community of practice model unified in the Integrated Care Team help this family get straight to work and implement solutions quickly and effectively. During an episode of care the family is always referred back to the same keyworker who already knows their history and what actions will likely be required. The family’s background has been presented and discussed by the Integrated Care Team before so the panel is also aware of the family’s history and what may or may not be helpful. The family, keyworker, and panel each know their part and have existing rapport, which facilitates speedy implementation of safety measures.

The keyworker and panel function like clockwork on this case. The keyworker collaborates with the victims’ assistance programs to complete statements. Counselling offer sessions and launch straight into therapy as they are already aware of the backstory and are able to quickly allocate an appropriate counsellor. During the family’s last episode of care at Windermere, the Integrated Care Team pooled their resources to provide brokerage for emergency accommodation, installation of security cameras, and petrol vouchers. The panel provided advice on applying for family violence funding and gave ideas for putting other safety measures in place to protect the family. The keyworker comments that the Integrated Care Team acts as a form of peer review and helps workers know that they are on track and that they have not missed a vital element. This is particularly important in a case like this where the family is at high risk of harm.

As the Integrated Care Team panellists have an understanding of this family’s case, this saves the keyworker from visiting each program area individually and making a request for assistance.

Instead, the relevant program areas approach the keyworker with ideas on how they might be able to help. When the family needs appointments with different Windermere programs, including the victims’ assistance program and counselling, coordination through the Integrated Care Team enables a smooth, time efficient process with appointments scheduled into concurrent time blocks to save the family excess travel time. The family arranges appointments with other program areas through their keyworker meaning they only need to contact one person to organise their schedule.

**Keyworkers’ feedback**

This section presents interview findings provided by four Windermere keyworkers who have taken cases to the Integrated Care Team. They agree that the panel provides a useful and beneficial opportunity to critically reflect on the most complex cases and receive feedback and support from experts in a range of specialisations. Additionally, keyworkers highlight that the Integrated Care Team provides a platform for knowledge transfer both to and from keyworkers and between panellists. It is a symbiotic relationship that enhances practice for families and individuals and develops skills and knowledge for keyworkers and panellists.

One keyworker feels that Windermere’s Integrated Care Team is a particularly beneficial model due to its intra-organisational nature:

*While there are other keyworker models in the sector, they work most effectively when run within one organisation like our Windermere one. They do not work as well when they are comprised of multidisciplinary teams across a number of external organisations unless the organisations are in an alliance where they are all under the same understanding. There is a concern that inter-organisational keyworker models could be subject to sector hierarchies where certain organisations command authority and undermine the role of the keyworker. There is also more chance of funding affecting the ability for inter-organisational models to function seamlessly and of a lack of trust and rapport limiting the easy availability of resource exchange between organisations. Benefits of the intra-organisational model run at Windermere is that keyworkers can build strong and ongoing relationships between program areas, they can have access to different program areas’ resources, and workers from the different areas are on hand to talk to whenever you have a question or need some advice or strategies.*
In Windermere’s Integrated Care Team the keyworker is respected and encouraged to do their job with support from all levels of management. This helps strengthen the keyworker’s practice and self-development as well as helping achieve better outcomes for families.

Keyworkers mention that the Integrated Care Team usefully clarifies case direction. While this is partly due to the input of panelists, keyworkers also find it useful to have a sounding board to consolidate, unpack, and reflect on the situations facing service users. Keyworkers recognise the value of their role as the central interface, identifying that this helps prioritise tasks and avoids the confusion that can occur when there is uncoordinated input from multiple program areas. This approach is far more streamlined than if multiple workers are giving families and individuals different and sometimes contradictory support.

Using the Integrated Care Team helps keyworkers manage their time more effectively as they can ask all their questions to a panel of specialists rather than investigating each question and locating each solution individually. One keyworker highlights that, ‘It’s a valuable resource for collaboration between the different departments which has given better knowledge of the organisation to staff and great outcomes for families.’

Feedback from Integrated Care Team panellists

Six representatives from Windermere’s various program areas who sit on the Integrated Care Team were interviewed about their experience on the panel. They feel that it is a constructive and valuable model and that it should be expanded and become embedded in operation. The panellists believe that service users whose complex cases are heard by the Integrated Care Team have better outcomes than they would in standard practice and that these are achieved with an improved process that limit intrusion into people’s lives. They recognise that presenting to the panel provides keyworkers with momentum and helps them overcome obstacles and uncertainty. Panellists comment that the Integrated Care Team is a platform for critical reflection and that it helps the organisation identify gaps in the sector and search for solutions to ameliorate them.

One Integrated Care Team member provides an overview of the panel’s place in program delivery:  

For me, the thing about the ICT is that it promotes a multidisciplinary approach. This ensures that professional development is occurring so staff and the families are able to access information and pathways in all areas that Windermere cover. As Windermere has such a large range of services, it is important we are collaborating and sharing information for our consumers’ benefit. The ICT provides a safe, reflective space with experienced staff from each department to provide direction, reflective practice and action planning to the worker who is engaged with the family. There are still barriers to smooth and [potential to improve] integrated access to services, however, the benefit of the ICT is reducing the need for families to have multiple contacts and multiple workers all working in siloes.

While the Integrated Care Team has been hailed a success by workers and service users at Windermere, one panelist recognises that, ‘some barriers do still exist based on funding arrangements and service provision like how we have certain referral pathways that are fairly unchangeable’. However, she highlights that the Integrated Care Team’s ability to directly, ‘get the expertise to the worker’ is ‘the main value’ as it results in worker and administrative efficiencies, which lead to positive outcomes and enhanced wellbeing for families and individuals. Panellists identify that increased efficiency is of additional benefit in this high demand growth corridor of outer Melbourne as faster throughput enables Windermere to work with more people seeking support in the community.

Conclusion

The Integrated Care Team demonstrates the benefits of coupling an intra-organisational multidisciplinary community of practice approach with a transdisciplinary keyworker model. This innovative but simple initiative is providing families and individuals with an opportunity to receive specialist feedback from a range of program areas without having to retell their story, navigate referral pathways, complete extra paperwork, or attend multiple appointments in various locations. It represents a significant cost and time saving as workers can easily access secondary consult and additional resources without having to research contacts, schedule suitable consult times, and ask questions to workers in different program areas individually – retelling the family’s story on each occasion. This improved cost and time efficiency is particularly important in Windermere’s high demand region as it releases resources to provide support to additional people in the community.

The Integrated Care Team has been hailed a success by panel representatives, keyworkers, and service users who are benefitting from the quicker, co-ordinated, collaborative approach. In the years since the ICT’s inception it has become an integral part of
how Windermere supports families and individuals in complex and difficult circumstances. This model has low operational and organisational costs and would be easily replicable within similar organisations or to be reconfigured as a hub comprised of panelists from multiple organisations. While the Integrated Care Team is a step in the right direction towards providing streamlined and connected support to improve the wellbeing for families and individuals, there is still more work to be done. A particular focus for future improvements should be on reducing bureaucracy within non-government organisations by limiting administrative burden and simplifying referral and intake procedures. Additionally, continued exploration and pilot implementations of keyworker and person-centred approaches in community services show exciting potential to further enhance sustainable and empowering outcomes for community members and the workers who seek to support them.

References


Devices like computers, laptops, tablets and smartphones are in the offices of nearly all small and medium organisations (Office of the Chief Economist, 2016). People use these devices on a daily basis to handle personal and sensitive information. For example, in 2014, over 75% of Australian GPs used devices and technologies for things such as electronic patient notes or printing prescriptions (Henderson, Pollack, Gordon, & Miller, 2014). And unless they actively opt out by the end of 2018, the health records of every Australian will be digitised and available for all health professionals to see, not just a patient’s usual GP or practice (Department of Health, 2017). In early pilot test sites, only about 1 in 50 chose to opt out, demonstrating that most Australians overwhelmingly accept the electronic storage and use of their personal, sensitive information.

However, practitioners in Australian family and relationships services (FARS) use devices less frequently and less widely than in medicine and general healthcare. Some examples exist showing how the sector has overcome the ‘bumps in the road’ and put new technologies into practice (Knight & Hunter, 2013). However, just 42% of FARS practitioners said in a recent survey that they used digital technology every day to share information with clients or colleagues (Smart, 2017). This means that the FARS sector may be missing an opportunity through technology to make information capture and sharing more efficient. This is important because using a common framework for intake and assessment was recommended both in a recent review commissioned by Family and Relationship Services Australia (Toumbourou et al., 2017) and in its recent government submission (Family Relationship Services Australia, 2017). Technology could have a role in enabling a common framework because it significantly enhances the capture, storage, and sharing of information. Greater efficiency in these areas will help otherwise ‘silode’ services coordinate their efforts and provide earlier and more effective responses to families (Family Relationship Services Australia, 2010; Toumbourou et al., 2017).

This article asks key questions about adopting devices and technologies in the FARS sector. It reviews sector-relevant research into devices and new technologies, filling in gaps with learnings from related fields as necessary. It shows how a new app, the Family DOORS app, could potentially provide the known benefits of the DOORS framework (McIntosh & Ralfs, 2012a) with new efficiencies of information collection,
storage and sharing. The DOORS provides a holistic approach to screening, elaborating and assessing risks in families using FARS services. The Family DOORS app provides an electronic alternative to doing paper-based screening on forms like DOOR 1 (McIntosh, 2011), meaning clients can complete screening on iPads, tablets or laptops – or even on the smartphones they typically have in their pockets. Once completed, the e-screening then becomes a secure pdf for practitioners to review, respond to, store, and share as needed.

So, can devices and new technologies bring greater ‘digital maturity’ (Office of the Chief Economist, 2016) to assist the sector to connect the dots with families? Specifically, could e-screening with the Family DOORS help FARS practitioners connect the dots of family wellbeing?

**Are devices and technology generally available and acceptable?**

The first question to answer is about the general availability of devices and their acceptability in Australia. Surveys show that devices and technology already exist in offices across Australia, with 98% of the small and medium enterprises – where most FARS practitioners work – having internet-connected devices (Office of the Chief Economist, 2016). Furthermore, there are likely to be mobile devices in the pockets and bags of most clients in the waiting rooms. In 2014, 74% of Australians had a smartphone and 68% had used three or more devices in the previous six months, suggesting that many people use devices both at and outside work (Australian Communications and Media Authority, 2015). These devices are therefore widely available. It seems also broadly acceptable to use devices for personal and sensitive matters. For example, 75% of banking interactions in Australia in 2014 were online or through a smartphone, with fewer than 10% being face-to-face in a branch (Bain and Company, 2014). This shows that clients readily share the same sensitive information by devices that they previously did face-to-face. And in terms of acceptability for the DOORS app, information provided by clients would be the same as that provided on the paper versions of DOORS.

People are also frequently relaxed about sharing personal information – even if it’s on unknown or unclear terms or outside of trusted organisations like GPs or banks. A large-scale survey of internet users globally revealed 84% don’t always read privacy policies before sharing personal information and 12% say they never read them (The Internet Society, 2014). This trend seems unlikely to change given that policies continue to be lengthy and acceptance is a necessary pre-condition of us. (For example, if you are reading this article with Google Chrome, then you clicked ‘Accept’ to confirm that you really read and understood the 6,552 word ‘Terms of Use’.)

FARS clients will already have acknowledged the policies about privacy and confidentiality when first engaging with services, as required by Australian Privacy Principles. These same privacy and confidentiality principles cover sensitive information collected by paper or electronically through the DOORS (or similar tools). Clients are highly likely to see FARS services as trustworthy anyway, as was shown in a 2016 anonymous survey of 973 clients at Relationships Australia SA which found over 89.1% of clients agreed with the statement that, ‘Overall I trust the way Relationships Australia SA handles my private information’. It’s likely that using devices for electronic collection of sensitive information will be as acceptable as pen-and-paper collection. Certainly the high acceptability of asking the DOORS screening questions has been confirmed by anonymous surveys of ‘just screened’ clients (Lee & Ralfs, 2015) and tracking client satisfaction surveys over time after the launch of the paper DOORS (McIntosh, Lee, & Ralfs, 2016).

**Do practitioners see devices as acceptable tools for their work?**

Turning to practitioner attitudes to devices and acceptability, Zwaanswijk, Verheij, Wiesman, and Friele (2011) found that health professionals used similar deliberative processes as their clients and patients before using devices in practice. Specifically, GPs consciously traded off benefits and risks of devices such as privacy and security versus convenience and efficiency (Zwaanswijk et al., 2011). Health professionals do this knowing that the dynamics of doctor–patient consultations have significantly changed since computers were introduced into consulting rooms many years ago (Frankel et al., 2005). A large systematic review showed health practitioners are concerned that using electronic records will interrupt the flow of conversation while they read electronic notes (Alkureishi et al., 2016); intriguingly, though, patients...
overall either didn’t notice or didn’t care because satisfaction, communications and relationships were unchanged or – if anything – slightly better after using electronic notes. From the other side of the computer screen, patients also confirmed that practitioners’ skills improved over time when using electronic health notes (Rose, Richter, & Kapustin, 2014). In fact, using notes fluently in sessions without losing rapport was a teachable skill, according to Lanier, Dominicer Dao, Hudelson, Cerutti, and Junod Perron (2017), meaning that if practitioners’ concerns are a barrier then it can be addressed. A rigorous change management perspective is helpful to address other barriers to adoption, according to Boonstra and Broekhuis (2010). And it’s not just an attitude of acceptability: a 2013–14 survey of Canadian GPs found 97.5% were using computers and 65.7% were using them for electronic records (Anisimowicz et al., 2017).

In the parenting and child and adolescent mental health settings, online delivery of manualised parenting programs helps families by improving parent competencies (Nieuwboer, Fukkink, & Hermans, 2013) and reducing child problem behaviours (Kirkman, Hawes, & Dadds, 2016b). Clients doing therapy online benefit similarly to those doing face-to-face sessions, based on systematic reviews of adult, child, and adolescent Cognitive-Behavioural Therapy programs (Andersson, Cuijpers, Carlbring, Riper, & Hedman, 2014; Vigerland et al., 2016). These reviews also confirmed that therapists had significant savings in time and administrative burden by online delivery, showing that online programs are helpful adjuncts to conventional therapy. Elsewhere, Kirkman, Hawes, and Dadds (2016a) compared online delivery of a standardised parent training to conventional face-to-face delivery. Even though practitioners thought their therapeutic alliance was stronger in the face-to-face format, clients rated the alliance in the two formats as equally strong. And while practitioners also thought they were more effective at face-to-face therapy, the outcomes for parents and their children were similar across formats (Kirkman et al., 2016b). Andrews (2014) and Orman et al. (2014) have both described Australia as a ‘world leader’ in developing and using CBT online, with devices extending the reach of mental health programs outside of a traditional setting, but also enhancing their outcomes. Devices are also cost-effective and may be cheaper as an additional option for mental health care (Musiat & Tarrier, 2014).

With support and reassurance, practitioners seem to accept devices and technology. What do these findings mean for the Family DOORS app? It’s highly likely that FARS practitioners who are potential Family DOORS app users will already have the necessary infrastructure for doing online DOORS administration – otherwise it’s highly unlikely they wouldn’t be interested or even able to sign into the app. But even for those FARS practitioners who don’t have devices or don’t wish to use their own devices, there is another option. The Family DOORS app can send a one-time code to clients so they can securely complete the client self-report DOOR 1 part of DOORS on their own device in the waiting room before the practitioner then securely accesses a back-end practitioner-only DOOR 2 report.

Are devices as good as paper-based screening and assessment?

The previous section suggested that in addition to benefits of cost and reach, the ‘treatment’ component of mental health delivery could be on par with its face-to-face equivalent. These studies of treatment outcomes presume that clients have fully engaged with the device and completed the online service. In other words, the clients in these analyses may be more accepting of devices and technology otherwise they would not have completed the treatment ‘per protocol’. This raises the question about the experience of first session clients at the intake, screening, or initial assessment phase.

This question can be answered by studies comparing devices and technology versus paper forms head-to-head for initial clients. A systematic review did this for key adult standardised mental health questionnaires and found mostly no difference and ‘adequate’ psychometric properties (Wouter van, Riper, Cuijpers, Patricia van, & Smit, 2016). However, there were a few exceptions to the trend such as Patalay, Hayes, Deighton, and Wopert (2016) finding differences between matched pairs of young people who had either completed paper or online versions of the Strengths and Difficulties Questionnaire (Goodman, 1997). The differences found by Patalay et al. (2016) were attributed to the ‘online disinhibition effect’ (Suler, 2004), namely that young people were more likely to reveal sensitive or risky information with the anonymity of electronic forms. However, young people reported some risks less often electronically and both formats were anonymous, so this explanation probably is not definitive, and Patalay et al. (2016) concluded that more research would be needed to decipher why.

Another systematic review, by Rutherford et al. (2016), compared studies of preferences for either paper or computer formats in randomised trials. They found no overwhelming preference for one format over the other across the studies, and in
fact there was no clear and consistent trend in preference. This suggests the value in keeping both modes of administration open for clients. A systematic review of self-reported client or patient outcomes showed it didn’t matter whether health care patients use paper forms or computer interfaces when they disclose psychological wellbeing or rate their quality of life (Rutherford et al., 2016). The authors concluded that validated paper-based measures could be transferred if wording, format and response options can be as similar as possible. This is important because Marcano-Belisario et al. (2017) found that people navigated and completed mental health screening differently depending on the layout of web forms.

Another large trial randomised pregnant women to computer-based or paper-based mental health screening questions (Kingston et al., 2017). No significant difference was found in the levels of mental health risks disclosed, meaning each format was equally sensitive. They also found that women who used computers were more satisfied by their experience and saw more benefit to computer screening generally. In other words, it seems the experience of doing e-screening creates subsequent e-screening converts. This is important when clients are re-screened, as will happen for women being screened for post-natal mental health risks. This finding is consistent with the previous section summarising doctor and patient feedback of adopting electronic health records: things get better with practice and experience.

So overall, people will probably be typically as honest and comfortable with electronic versions of forms as they are with paper versions. The studies named above broadly suggest that devices are as good as paper-based formats for screening and assessment for new clients at intake, possibly even getting better with time as familiarity increases. A survey of 247 ‘just screened’ clients at Relationships Australia SA in 2016 echoes this, finding that only 14.2% disagreed with the statement ‘I’d be ok completing DOOR 1 at this office with an iPad or tablet in a private room’. And in early testing of the Family DOORS app prototype, only one person (from the first 30 offered the choice) insisted on a paper version instead of the Family DOORS app. This suggests electronic screening could be unacceptable to around 1 in 7 clients, so keeping a paper copy of screening tools will still occasionally be needed as an alternative. The design brief for the Family DOORS app has followed the paper-based formatting and layout as closely as possible to minimise any error being introduced.

Are there situations where devices are better than paper versions? Or worse?

Some studies suggest there may even be advantages to using devices over paper. Better visual aids made computer-based multimedia formats easier to use than paper-based formats in a test of the Taipei II child development screening tool by Cheng et al. (2017). They found only 0.8% of clients preferred the paper-based format (Cheng et al., 2016) and only 2% of professionals preferred paper-based (Cheng et al., 2017). Given the good psychometrics and comparability of these two different formats, the authors recommended using the new computer-based format.

Wood, Nosko, Desmarais, Ross, and Irvine (2006) found that people using online formats disclosed more differences in sexuality when compared to people using paper versions. They paradoxically found people skipped more questions, giving more ‘missing data’, when they had a well-intentioned research administrator available to help them. Also Wood et al. (2006) suggested that online was more enjoyable than paper and was less fatiguing to complete. Women screened for Domestic Violence (DV) preferred computer-based screening over paper-based or face-to-face questions, adding they would be comfortable answering these sensitive questions honestly on computer (Renker & Tonkin, 2007). Elsewhere, Renker and Tonkin (2006) found 97% of women screened for DV said they were not embarrassed, angry, or offended by the experience. Nevertheless, they found lower disclosures of DV due to fears of being reported to statutory authorities, with higher disclosures found after women were reassured that this would not happen. This reassurance about non-reporting may not always be the case in all jurisdictions or organisations and it reminds practitioners and researchers to keep the client and the therapeutic frame in mind, not just the questions or the format of the device. It also reminds us that screening should not be totalised as ‘the truth’ and the only way clinicians can detect violence – practitioner elaboration and practice wisdom will always have a role in keeping families safe (McIntosh & Ralfs, 2012b).

In a young people’s mental health setting, a systematic review supported the framework of doing a ‘holistic self-complete screen then elaborate by practitioner’, though there was no clear preference for paper or computer formats (Bradford & Rickwood, 2012). In a large qualitative study, most young people aged 15–29 said they would prefer using devices to open up about sensitive topics compared to face-to-face questions (Bradford & Rickwood, 2015). But, again,
not all young people expressed this preference for devices, citing worries about non-verbal cues, therefore flexibility and responsiveness are helpful to increase disclosure rates.

Finally, the ‘Gottman method’ of relationship counselling is built on highly detailed and structured assessments completed by clients at intake, which then enable practitioners to plan their interventions (Gottman & Gottman, 2015). Online versions are now available and have been described as ‘The future of assessments’ and ‘Relationship assessment made simple’ (https://checkup.gottman.com), naming the benefits of efficiency from automatic scoring and faster turnaround in intervention planning. If practitioners can send online assessments to couples to complete at home online on their own devices before their appointments then this is said to have equivalent psychometrics compared to paper-based assessments (www.johngottman.net).

While there are many situations where devices may be better, there are some situations where devices and technology are unhelpful, misleading, or even unethical. Many mental health apps are available to download at low or no cost from online sources, but – worryingly – few appear to take seriously their duty of care (BinDhim et al., 2016). Specifically, BinDhim et al. (2016) found few apps made robust, appropriate recommendation to ‘seek further assistance’ for any significant risks. This contrasts with the hype of many of the apps available, some of which offer, for example, ‘a fast and efficient remedy from emotional stress’ or ‘… fast and simple method to be liberated from … Post Traumatic Stress Disorder’ (based on an iTunes store search in September 2017).

By contrast, we know that clients readily disclose family safety and wellbeing risks on paper forms during universal risk screening with the DOORS, with these disclosures linking strongly to subsequent practitioner actions, such as planning their response or intervention (McIntosh, Wells, & Lee, 2016). Practitioners are under pressure to respond to these risks quickly and efficiently, so they are likely to appreciate the app’s freedom from ‘data entry’ or physical handling of paper such as scanning and uploading of forms. This provides potential cost savings to FARS practitioners and organisations. For these reasons, we believe practitioners will see the benefits of technology like the Family DOORS app on devices in their practice. As an aside, there would have been immense savings from doing 12,000 paper versions of DOOR 1 over four years (at the time of writing) at Relationships Australia SA.

Conclusion: devices and technology usable in the family and relationships sector

The family and relationships sector in Australia has already seen attempts to use devices and new technology to enhance, extend, or replace interactions with clients (Knight & Hunter, 2013; Robinson, 2009). Yet Smart (2017) has shown that overall, our sector uses technology far less frequently and widely than in medicine and general health care, where electronic capture, storage and sharing of information is commonplace and well evaluated (Ross, Stevenson, Lau, & Murray, 2016). This is a lost opportunity. The research reviewed in this article suggests that devices are widely available, acceptable, and offer at least equivalent clinical utility for our sector. Additionally, new technologies have potential benefits for practitioners from efficiencies and may be preferred by many clients for disclosing risks.

Our sector peak body, Family and Relationships Services Australia, has concluded we need a common framework for screening for complex multiple risks (Toubourou et al., 2017) and has begun lobbying for this to happen (Family Relationship Services Australia, 2017). Elsewhere, we have a framework calling for all of us to notice and respond to the effects of gender inequality during key transitions such as separation and divorce (Our Watch, 2015). We know that effective coordinated screening across multiple risks is more effective in health care than single issue screens (Hale, Fitzgerald-Yau, & Viner, 2014) and that screening for risks makes a difference to practitioner decisions in health (Webb, Kauer, Ozer, Haller, & Sanci, 2016).

We conclude that the Family DOORS app could provide an acceptable and useful innovation which can help our sector with a common tool to notice and respond to risks of people using FARS services. It is based on the DOORS framework, a holistic approach to detecting, responding and assessing a range of victimisation and perpetration risks across the family (McIntosh & Ralfs, 2012a). Successful launches of e-health innovations have addressed the key issues of adaptability, complexity, and cost, according to a systematic review of implementation evaluations (Ross et al., 2016). We believe that the Family DOORS app should meet these needs. Specifically, if adaptability is ‘the ability of the technology to be adapted to fit local contexts’ (p. 145) then Family DOORS offers adaptability because it has been tested across browsers (Google Chrome, Internet Explorer, and Apple Safari); smartphone and tablet operating systems (Windows Mobile, iOS, and Android); and devices (Windows desktops and Surfaces, and Apple devices). If complexity refers to the overall...
‘demandingness’ for clients, practitioners, and back office staff to learn how to use an innovation, then the Family DOORS app is only as complex as existing electronic client diary or management systems, or even Microsoft Outlook. Because the app uses already-installed internet browsers, users will have an easier learning curve because they are already familiar with many features. For example, printing from the app is via the browser’s drop-down menus and the browser’s ‘padlock’ will show that the connection to the DOORS App Server is via secure 256 bit SSL encryption. And in terms of cost, the Family DOORS is available at very low or no cost using existing ‘IT infrastructure’ through already-installed internet browsers. Because the Family DOORS app is not network-heavy, it will not require acquisition of an especially fast internet and can run on 3G wireless speed.

In this way, we hope the Family DOORS app can have a role in detecting and responding to the multiple risks that many – but not all – FARS clients may face. The app may also have a role in coordinating and organising our responses to clients.

Endnotes

1 This article provides background information to the Family DOORS app and complements a presentation at the FRSA 2017 Conference on Connecting the dots. The article reviews literature and research on e-screening and shows its relevance to the app. The actual presentation contains more description of the app itself and a live demonstration.

2 We are grateful to the input and suggestions from two anonymous peer reviewers coordinated by Dr Adam Heaton, Senior Policy Officer at FRSA.

References


This paper explores how and why the complex needs of parents and families in dispute after separation and accessing Family Relationship Centres (FRC) require more than mediation. At FRC Logan, SE Queensland we have evidenced how partnering for professional development during action research in the period 2014 to 2015 has informed change shaping for innovation in service delivery. Current funding guidelines actively encourage FRCs to pursue ideas of innovation, either practical or theoretical, to enhance service delivery outcomes. A family system approach to FDR has emerged in case management design along with diversification in practitioner roles and partnering for direct referral activity with other service providers. This has been supported by taking a strength-based approach in client engagement and advancing the professional identity of family dispute resolution practitioners.

Integrated and coordinated service provision in the context of the FRC uses assessment and direct referral action in supporting clients, with ready access to capacity building interventions, in addition to family mediation. Helping people to address the underlying complex issues underpinning extreme distress and conflict around post-separation parenting and family relationships contributes longitudinally to the sustainability of parenting plans, quality parenting relationships and productive society.

The paper also describes strength-based practice and outcomes for children and parents from their engagement in child-focused and inclusive FDR. Established in 2008, the FRC is located in South East Queensland and services the catchment areas of Logan City (Population 313,785 [The Census usual resident population of Logan City in 2016]) and Redland City (population 151,987, [June 2016]), Moreton Bay Islands, and North Gold Coast.
Reforming the Australian family law system and motivating social change

In reforming the Australian family law system in 2006, an initiative of the federal government was to place the best interests of children at the forefront by providing a safe alternative to formal legal procedures for families who are separated, separating and in dispute. Sixty-five Family Relationship Centres (FRCs) were established nationally between 2006 and 2008 and the intentions of service delivery as stated in the operational guidelines are:

- helping families stay together
- supporting people through separation
- strengthening family relationships.

Activities include intake for referral and advice and intake for Family Dispute Resolution (FDR). In some locations an FRC is co-located with other federally and state-funded family and relationship support programs. FRC client intake and assessment activity currently demonstrates the prevalence of circumstances characterised as placing individuals at risk of primary health and social problems. Having impacted on the breakdown of partner and family relationships the complex needs wanting support, restorative and healing intervention remain largely unidentified and unaddressed after separation. This carries significant social, health and economic costs to families, especially children, and it is evident there is an increasing role for family relationship services to place a focus on activity towards strengthening protective factors within family relationships, as a high priority.

There has been a trend for service provision design in the human services sector to be targeted as intervention for capacity building. This could be depicted as a recovery and repair response to a realisation that the fabric of something fundamentally important has been extensively damaged or broken. Clearly, as the damage and breakdown in family relationships and consequently the health and wellbeing of our society is continuing, perhaps what could help is partnership between prevention and restorative intervention that bridges social capital capacity building. During a recent conference the author attended, an audience participant directed a question to a panel and his genuine concern and frustration was tangible:

*I have been working in the community services sector now for over 30 years in intervention; clearly the prevalence of social problems has significantly increased in that time. Why is that, in view of the increase in resources and services? What will it take to change this trend? (not verbatim).*

The question resonated strongly intellectually and emotionally with the panel and audience responses varied. The discussion pointed to recognition of the need for a new approach to child and family service provision and questions and suggestions emerged about how we could do this a little differently. The ‘what will it take’ question also brought forth acknowledgements of what we can do, have done, and what else is possible. How we could get there in a coordinated way was identified as a much wider discussion for the future. This reflects a readiness for change and a willingness to make way for and be a part of further contemporary reform; transitioning from siloing of service types towards a more inclusively rich and diverse model of service provision.

Deakin University and Family and Relationship Services Australia (FRSA) recently released a research report: *Strengthening prevention and early intervention services for families in the future.* The report discusses the notion of taking a public health approach in response to moving toward a service provision model of prevention and intervention for collective impact at a whole population level. The report takes a comprehensive look at the progress, achievements and diversities of the family relationship services sector and asserts that most of the health and social problems that bring high health and social costs to family and society are preventable. They are categorised in government policy as follows:

1. substance abuse, alcohol misuse, tobacco use, substance use disorders
2. anti-social behaviour including family violence and other crime
3. mental illness (preventable distress due to depression, anxiety, suicidal behaviour and less common mental disorders)
4. obesity (identified as amongst the top prevention priorities by The Australian National Preventive Health Agency, 2011)
5. developmental injury (leading to preventable disability)
6. chronic illness including preventable Type 2 diabetes, cancer, cardiovascular disease, asthma, allergies (Vos et al., 2010)
7. school failure (including leaving school and not participating in further education)
8. social exclusion (lack of meaningful and constructive social and economic participation). (AIHVV, 2014a.)

Three of the eight health and social problems identified above at 1, 2 and 3 as preventable are identified by clients and practitioners at FRC Logan during intake and assessment as impacting on...
parenting and family relationships after separation. The remaining five points 4, 5, 6, 7, and 8 are not assessed for impact on the family relationship as possible risk factors. However, this serves to highlight the trend of separating of social and health determinants in assessment practices.

Separation of the parent relationship and living arrangements for the family is often seen as the only immediate option for bringing peace and protection from harmful behaviour, when parents and children are experiencing extreme distress. However, it does not take long for the hope for peace and protection to be impeded by the additional social, emotional and economic challenges the separation brings, including the stress of legal proceedings. This often leads to further escalation of high conflict and deepening of acrimony about shared parenting responsibilities, time spent arrangements and other child-related matters.

Consequently, children and young people find themselves burdened at the centre of a new story about adults in dispute and despair. It is very important that protecting the human rights of children, including safety and security in family relationships, remains a high priority in any proposed structural reforms in the family relationship sector in support of strengthening intervention for a public health purpose. Restoring capacity for personal peace is as important as attending to the health and social needs of people in the interest of sustainable societies, communities and family life. According to the Global Peace Index 2016, the cost of conflict in its various forms has a cost of 13.6 trillion dollars to the world economy and a 2 per cent reduction could pay for the entire UN development goals (Institute for Economics and Peace, 2016).

FRCs have the capacity by design, and with additional resources, to take a significant role in the family relationship sector to support the four recommendations for structural and funding reform included in the recently released research report. This is with a view to achieving a more coordinated, sector-wide approach in responding to the complex needs of clients and towards the best possible life experience for the families and communities we serve. FRCs have been established for approximately 11 years now and have reputation, extensive community links and are central to the recently reformed family law system as a point of first contact for separated families for access to free or affordable family dispute resolution intervention. Positioning FRCs for playing a stronger role to better coordinate at local and national levels, active intervention to reduce priority health and social problems, in addition to provision of family dispute resolution, may require some re-positioning and re-modelling of operational structures. The development and trialling of an advanced common intake and risk assessment framework or guidelines, as suggested in the Deakin University and FRSA research report, would greatly assist the endeavour for a more coordinated approach to targeting sustainability and intervention resources for clients engaged in FDR and other family relationship programs.

In The idea of family relationship centres in Australia (2013) Patrick Parkinson gives a comprehensive overview of the political circumstances, history, intentions and hopes for the future behind the establishment of FRCs during the period 2006–2008. According to Parkinson, there was an intention that FRCs would not only have a role in helping parents after separation; they would also play a role in strengthening intact relationships by offering an accessible source for information and a referral gateway to other government and non-government services to support families. This highlights the value of FDR in FRCs also being positioned and promoted as a preventative intervention for families at risk as well as to assist parents, grandparents and significant other family members to manage and resolve conflicts and disputes during and after separation and family reformation.

The focus of many FRCs to date has been on post-separation mediation with referral to other service providers for various forms of intervention and support. The attraction of people in intact families experiencing relationship breakdown and at risk of separation has not been strong. Diversifying from a post-separation mediation model of practice to a family relationship restorative model of practice enables case management activity to bring greater support for families at risk of relationship breakdown, separation and post-separation dispute. A restorative family system approach would include post FDR reconciliation and reunification support for children and young people who have been estranged from a parent or family members during unresolved conflicts and are moving towards repair: helping families stay together; supporting people through separation; strengthening family relationships.

**Bringing a strength-based case management approach into screening and assessment activity**

FDR practice is informed by theories of conflict resolution: family systems, human development, relationship attachment, the Family Law Act 1975, accompanying regulations and other legislation
applying to family and domestic violence and child safety. In addition, Child Aware Principles and national frameworks, such as The National Framework for Protecting Australia’s Children 2009–2020 (DSS, 2009) and the National Plan to Reduce Violence against Women and their Children 2010–2020 (DSS, 2010). Practitioners undertaking assessment activity form professional judgement for ‘suitability’ for FDR or other forms of interventions in the family law system. Screening and assessment prior to the provision of FDR is required under Family Law (Family Dispute Resolution) Regulations 2008 and informed by Framework for Screening, Assessment and Referrals in Family Relationship Centres and the Family Relationship Advice Line Guidelines (Attorney-General’s Department, 2008) and DOORS.

The activity of pre-FDR screening and assessment has been strongly linked to screening out of complex cases including a history of domestic and family violence. Given statistical data tells us that the majority of cases presenting for FDR have complex needs and medium to moderate presence of psychological, emotional and other forms of relationship abuse during and post separation, screening out is not productive, except where a safety intervention is a concrete alternative. Screening out leaves many vulnerable parents and children with no hope of help and whilst court orders impose an important structural forms of relationship abuse during and post separation, screening out is not productive, except where a safety intervention is a concrete alternative. Screening out leaves many vulnerable parents and children with no hope of help and whilst court orders impose an important structural intervention, they do nothing to improve or transform the predicament of distress and entrenched conflict impacting on relationships, health and wellbeing. At FRC Logan, our internally customised narrative-based Assessment for Parental Capacity Building and related FDR Case Management Plan Tool, is linked to the FDR Intake Screening and Assessment document and has evolved over some years. More recently, informed by professional development in narrative practice and action research activity to build capacity for effectiveness in family dispute resolution and child inclusive practice. This supports clients and practitioners in having conversations about the effect the unchanged conditions of the parent relationship after separation is having on hopes for a safer and less stressful future and what action this would really take.

Ongoing service evaluation activity and regular review of the case management and assessment tools serves to capture practical outcomes for parents and children, advancing professional development and efficacy of practitioners and service level management, including administration coordination. To assess the effectiveness of FDR case management and direct referral action to inform evaluation of the effectiveness of the integrated case management process, we are now collating data on the frequency of parents returning to review parenting plans. Direct referral action has been identified as a potential catalyst for client follow up and engagement with other services for support in addressing complex needs impacting on the quality of the parenting relationship. (see Appendix 1 tables).

Having identified and acknowledged that attention to the practical needs of parents in distress is as important as attention to their emotional, psychological and conflict resolution needs, and likely to increase the workability and sustainability of a parenting plan, how can we attend to all needs in a short, timely 8–10 weeks? Person-centred client engagement is concerned with the quality of the client and professional relationship towards supporting self-agency and access to resources. Taking this approach supports parents to have the personal support they need right now and getting to the right place in themselves, by harnessing their own strength and knowledge and regaining or uncovering their parental capacity for care and protection of their children from an attachment perspective.

Strength-based practice in therapeutic and non-therapeutic intervention aims to support children, young people and adults in solution-focused activity and envisioning their preferred life experience and hopes for the future. Discovering and identifying the skills and knowledge they have used so far for coping in the dominant story of trauma and high conflict can be a motivator for initiating and driving future change. The individual must have the capacity to envision the change they want if they can describe in such detail what they don’t want. Narrative practice is a methodology used in counselling created by Michael White in 1990, and in Maps of narrative practice he shows how engaging with clients, as the experts of their own lives, and using questioning techniques that elicits client’s knowledge and skill, rather than the practitioner’s own, is empowering for the client. A narrative approach to client engagement can be applied effectively in non-therapeutic contexts where inviting feedback from clients and discussing impacts and obstacles getting in the way of the life experience they want and what can change is the focus. At FRC Logan we have demonstrated this skill can be learned and developed through partnering inside and outside of the team for specifically targeted practice development and supervision post tertiary training.
Beyond risk assessment
Risk assessment is concerned with threat, probability of and possible exposure to harm. In reality, families currently presenting at FRCs for FDR are often beyond risk. According to our case management statistical data collection, the effects of complex issues identified as primary health and social problems are impacting on a significant number of adult clients and consequently children and young people accessing the services (see Appendix 1 tables). In response to this, the intake and assessment process at FRC Logan has taken a ‘universal’ approach to gathering information to inform case management for active referral for intervention and support and FDR planning. Screening out of cases, where family violence has had presence assessed as moderate or medium and complex needs are impacting on individuals coping capacity, has reduced significantly as a result of this approach (see Appendix 1, tables E and F).

A parenting plan or a parenting order can be a significant achievement from FDR or family court intervention; however the parenting arrangements are not sustainable whilst the underpinning critical issues remain unaddressed and unresolved. When parent resilience is low and daily life is consumed by juggling the survival needs of the separated family, the likelihood of the most vulnerable clients making their own connections with various services for further intervention and support to address complex needs has shown to be limited. In recognition of this, our case management activity in FDR at the post assessment phase now involves referral to the FRC Family Advisor/Counsellor for direct referral action and social work support. In addition to dispute resolution support, this activity aims to further focus on individual and family needs assessment for referral coordination, in consultation with parents/grandparents. The systems approach enables the FDR practitioner to remain within the boundaries of their role whilst also actively engaging clients with local services and agencies.

Case management for active intervention and provention in a FDR context
Effective person-centred family relationship intervention begins at first point of contact in conversations with clients and continues throughout every phase of their engagement with the service. Through leadership in the creation of a collective ‘person-centred culture’, clarity of vision and purpose in the service provision framework and coordinated administration, all staff in the team can know and seamlessly play their part in a systems approach. A systems approach designed to inform and support action planning through the intake and assessment and intervention process ensures the particular circumstances of each family and the individual support needs of parents and children in family dispute resolution are taken into account. Actively coordinating access to support and active intervention for parents and caregivers will enhance the sustainability of a parenting plan, or achieving relationship repair or reconciliation post separation and the likelihood of going to court (see Appendix 2).

Provention is a term that could be used to describe a process where individual practitioners take a ‘family systems’ approach in FDR work and take on greater responsibility for managing resources, sourcing supports and coordinating services for individual clients and families. Despite the modern argument that the term ‘case management’ is out-dated and implies that clients are ‘cases’ to be ‘managed’ the term continues to be an acceptable description of a function designed to coordinate client-centred or person-focused activities when multiple interventions and supports arise from one point of a service intervention. Case management is a comprehensive and detailed process and is most effective when supported by resources, assessment and evaluation tools. This provides the practitioner, and/or service provider with a robust understanding of standards and guiding principles for phases of the case management process and assessing individual and collective professional performance. The Case Management Society of Australia and New Zealand has National Standards of Practice for Case Management (3rd revised edition, 2013) that specify the minimum national level of practice (benchmark of excellence) to be attained by a practitioner throughout the case management process and provides the foundation for a best practice framework.

Professional development and child inclusive practice in FDR: From evolution to revolution

FDR activity at FRC Logan is child focused by conversations beginning at the intake and assessment phase that centre on attachment experience and the importance of safety and quality of the parent–child relationship. We honour the UN Convention on the Rights of the Child and support Child Aware Philosophy and Principles (Australian Institute of Family Studies, 2014) by raising awareness in parents and including all children from school age in the opportunity to participate in family dispute resolution. Also by supporting parents through our process, to seek professional assistance where needed and achieve readiness to look beyond their own needs and seriously
consider the needs and interests of their children (see Appendix 4). Advanced FDR practitioners with training in child inclusive mediation, a sound knowledge of attachment development and family systems theories, can participate in in-house supervision and coaching that positions them to skilfully engage with both children and parents. We place a high priority on the value of professional development and strengths-based supervision by creating time and space. This is with a view to fostering authenticity in practitioner critical thinking for advancing contemporary practice in FDR; marrying structural and post-structural paradigms and acting to break down barriers to inclusion.

The intention of ongoing professional development post tertiary training is to equip practitioners with advanced knowledge and skills, in addition to mediation, that equip them in supporting parents to engage in conversations that address behavioural factors getting in the way of safety and security in relationships. This approach transforms the customary separated roles of child consultant and mediator and brings them together in the FDR practitioner, and consequently dispute resolution, practice. This new practice at FRC Logan has seen a 450 per cent increase in the participation of children and young people since 2014 and remains steady. Parent feedback collated from three-month post FDR follow up shows this has contributed significantly to the sustainability of parenting plans and parent responsiveness to the emotional and secure attachment needs of children and young people (see Appendix 3, tables A and B). The stance in child-inclusive FDR is one of respectful curiosity about the child and the effects of their experience of family relationships prior to and post-separation. Partnering collaboratively with parents to bring the child’s voice into view helps re-author their future family relationship story after separation (see Appendix 4). Collaborating is also important for bringing insight and realistic understanding to what has happened, how and why and what the possibilities are for the future in parent and child relationships, as described in Jane D’Arcy Pope’s publication Staying connected and holding onto hope (2007). Knowing that it is in their capacity as parents to make the changes in their thinking and actions necessary to bring the stability and peace they say they want.

Conversations with parents in the assessment phase of FDR demonstrate that peace is what the majority of parents in dispute ultimately want for themselves and their children, although they may characterise and expect this in different ways. How is peace achieved even incrementally, in the midst of what may seem like intractable disputes and legal battles? Partnering with parents in this strengths-based and child-focused way can influence a cognitive and emotional shift for the individual, irrespective of their unique circumstances and experience of suffering. This person-centred intervention also has the power to draw emotionally violent persons away from the belief that ‘power-over’ and denigration of partners and consequently children is the only means available to them for control and their own survival, when not coping. Safety for children and young people is not achieved by excluding their involvement in conflict resolution in child-related matters – it is achieved by the professional skilfully participating in a feedback loop and having conversations with parents and children, with emotional and cognitive resonance.

To externalise and scrutinise the problem story and behaviours and actions getting in the way of safety and security in the parenting relationship whilst focusing on how this can change.

Eminent conflict resolution theorist John Burton (1992) asserts:

Empirical evidence suggests, in short, that aggression is not used for its own sake. It is not part of human nature, as has been assumed all along. Indeed, we perceive the possibility that violence exists not as the preferred means by which to remedy unacceptable conditions, but as the only means available within social institutions and frameworks that are irredeemably based on power (cited in Williams, 2002, p. 1).

Adults must take the responsibility for making peace by creating communities that value and promote equity and function to preserve the innately loving nature of children and their human rights. Through education and example we can foster in children the skills and attitudes that will empower them to approach problems confidently, collaboratively and constructively; living together compassionately in a complex world.

An argument for the benefits for children/young people, parents and practitioner working together in family relationship services

Demonstration of our own capacity as practitioners, to attune to the emotional and psychological needs of clients, coupled with empathy and sensitive response for their predicament at a point in time of high stress and diminished parenting capacity, is crucial when inviting parents to participate in their own self-assessment. Participation in self-assessment of parental capacity and responsiveness to the
practical, social and emotional needs of their children brings forth openness to the concept of hearing feedback about their children’s lived experience. This rapport builds trust in the parent and practitioner relationship and facilitates hard to have conversations, about how a parent sees their own behaviour contributing to the high conflict, parental acrimony and psychological stress in the now separated family. When the same practitioner, with the benefit of the established rapport, brings the parent story and the child’s story together in the joint parent session in a psychologically safe way, this brings authenticity to the feedback loop.

The methodology described in this paper has shown to be a resourceful way of achieving inclusive practice in a coordinated and timely way in the context of an FRC. Appealing to the fundamental human characteristic of empathy as a motivator for behavioural change cannot be achieved through a brief mediation encounter as this development takes more time. However, we can demonstrate that all the steps in the systems process can be achieved in 8–10 weeks, given there are no delaying circumstances. Capacity for hearing the ‘voice of the child’ in FDR with empathy and resonance may seem unpredictable for parents who are struggling with and immersed in so far intractable conflict, acrimony or fearful partner relationships. Bringing the essence of the child’s experience of the effects of separation and harmful behaviours in the parent relationship prior and post separation may be considered risky by some practitioners, however, when and how to do this safely and skilfully in a timely way can be learnt through appropriate professional development and coaching.

**Strengthening the voices of children and honouring their rights**

The right of children to be free from all forms of violence, abuse and neglect and the responsibility of governments and parents to protect children is outlined in article 19 of the UN *Convention on the Rights of the Child* (1990), which states that:

**States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child (Page 5, Article 19).**

Megan Mitchell, National Commissioner for Children, in her *Children’s Rights Report (2015)* points to self-harm and suicidal behaviour in children and young people and this is a growing concern. In the report the Commissioner highlights the ways in which Aboriginal and Torres Strait Islander children and young people are disproportionately affected by intentional self-harm and suicidal behaviour and data from the Australian Bureau of Statistics (ABS) in 2014 that shows Aboriginal and Torres Strait Islander children and young people accounted for 28.1 per cent of all the recorded deaths of children and young people under 18 years of age due to intentional self-harm. According to Homelessness Australia, on Census Night 2011 rates for children less than 12 years experiencing homelessness were counted at 17,845 and rates for children less than 12 years counted as ‘sleeping rough’ were counted as 402. Children under the age of 18 years of age were counted as making up 27 per cent of people experiencing homelessness and this is considered to be an undercount due to limitations of the Census as a vehicle for capturing people aged 12–18 staying temporarily with friends and relatives or ‘couch surfing’ (Homelessness Australia, 2016).

More than 70,000 people supported by homelessness services in 2014–15 were children aged birth to 0-17. The current rate of family relationship harm and breakdown contributes significantly to this predicament for children and young people. There were 113,595 marriages registered and 48,517 divorces granted in Australia in 2015. Over the past five years there has been a gradual increase in the median age at separation and divorce. In 2015, divorces involving children represented 47.5% of all divorces granted compared with 47.0% in 2014. The number of children involved in divorces totalled 42,303 in 2015, an increase from the 40,152 reported in 2014. The average number of children per divorce involving children in 2015 was 1.8 (ABS, 2015). The information is collated on the number of marriages and divorces registered in Australia and this does not take into account separation rates in de-facto relationships.

One of the major recommendations in the Commissioner’s report was the need for focused national research in a range of areas that would inform the development of an effective suite of interventions for children and young people, in particular for Aboriginal and Torres Strait Islander children and young people, including universal resilience building through to clinical treatments. The recommendation has synergy with recommendations in the Deakin University and Family Relationships Australia (FRSA) 2017 research report in support of taking a
whole population and public health approach to prevention and early intervention. Whilst resilience building is important for healthy development, it is also important to address the structural conditions in society that create inequity and inadequate resourcing to communities and consequently families, if sustainable change is to be achieved through intervention.

Intervention and support for family relationship breakdown and domestic and family violence matters in Aboriginal and Torres Strait Islander communities is traditionally the unpaid work of community elders and leaders. Some mainstream community organisations have ‘elders in residence’ to link families and individuals with services and this initiative seems to be rare. There is a place in future planning for FRCs and family support services to include recruitment of community leaders and elders in a paid consultancy role, and as a first point of contact for local Aboriginal families. Working together to increase the engagement of parents and children in a culturally appropriate and sensitive way, as their involvement is currently not high nationally. At a local level, feedback indicates some concerns about mediation and bringing together parents where domestic violence has caused significant harm. This is unfortunate, and the activity of FRCs and family dispute resolution has traditionally been widely characterised as ‘mediation’, although an FRC has a much broader scope of service delivery to offer parents and children experiencing harm.

Partnering for community engagement in building capacity for self-agency

Systems change at FRC Logan has brought an approach to client engagement and coordination of the administration of FDR and direct referral action. Within the security of that system a framework of principles and intentions to provide direction for practice has also emerged. We have named this FRC Logan SEER Framework for Client and Practitioner Engagement in Child Informed Family Dispute Resolution: Support, Encourage, Empower, and Repair (see Appendix 4).

A flexible and responsive model of child-focused and inclusive service delivery has also enabled us to accommodate the opportunity to partner with two primary schools located in densely low socio-economic communities through outreach activity. Family violence and moderate to high levels of family breakdown affects a high proportion of primary aged children assessed by teachers and guidance officers as at risk, with many already experiencing social isolation and family trauma related behavioural difficulties. This has placed a heavy and at times unmanageable load of social work activity on staff. Bringing child and family relationship support to the schools through FRC outreach has enabled the FRC to overcome a barrier to access, due to isolation, for families.

Linking social and health determinants

The COAG National Summit on Reducing Violence against Women and their Children was held in Brisbane, Australia on 27 and 28 October 2016. The purpose of the Summit was for governments to review progress and profile best practice in our collective efforts to make Australia safer for women and their children and considered the following:

- Behavioural insights challenge the conventional economic paradigm that people are rational and act with self-interest. It gives us an opportunity to rethink our approach to complex social policy issues, like domestic violence.
- Behavioural insights emphasise that, to be effective, interventions to change behaviour need to be easy, attractive, social and timely (EAST).
- Using randomised controlled trials, wherever possible, when implementing interventions helps provide robust evidence of impacts on behaviour.
- In New South Wales, a trial is underway which aims to increase court attendance by perpetrators. Perpetrators are sent a text message as a reminder (some are worded more positively, others more formally). Interim results are showing an 11 per cent increase in court attendance overall.
- Collaboration across jurisdictions could help to increase sample sizes for tests of interventions, which would improve the basis for randomised controlled trials.
- Jurisdictions working together will also help to build the understanding of the merits of behavioural insights among the women’s safety sector.
- Behavioural insights can have many applications to reduce violence against women and their children, including by:
  - exploring what works in shifting behaviours, aspirations and expectations
  - teaching respectful communication skills
  - targeting and preventing alcohol abuse.
- Behavioural insights interventions should draw on the expertise of specialist services in devising interventions for women and children.
In recent years, the Commonwealth Government, New South Wales and Victoria have established behavioural insights units (BIU’s) and have run successful behavioural interventions in a range of areas. Many of these interventions have been relatively simple and cheap to implement and provide new ways of looking at existing challenges, including complex social problems like domestic violence. Evidence-based initiatives such as this and initiatives for collective impact such as Logan Together in SE Queensland, and other progressive social capacity building programs, can inform future planning for a more coordinated approach to service delivery and a strength-based approach to case management in the child and family relationships sector.

What will the future hold for strengthening prevention and early intervention service provision for families?

In a period of approximately 11 years the FRCs and related family relationship programs have made considerable achievements in realising the Federal Government’s agenda for influencing cultural change in the Australian family law system. Access to family dispute resolution through FRCs has influenced the way many parents think about and go about resolving disputes relating to children’s matters after separation. Increasingly keeping family relationship disputes out of the court system to be addressed in regulated family dispute resolution has also enabled important conversations to be had in a safe, non-threatening and non-punitive context about behaviour that constitutes domestic and family violence, why that needs to change and what can bring change. This is where significant cultural change has been achieved and must continue to be a priority. Child inclusion in family dispute resolution has brought progress towards honouring the rights of the child, as expressed in Article 12 of the UN Convention on the Rights of the Child.

When supported by internal organisational policies, supervision and strength-based frameworks, professional development can support practitioners and teams in accelerated learning and advancing practice. The strength-based positioning of practitioners and development of narrative practice and communication skills for client engagement in assessment conversations with children, young people and parents has been supported through partnering with the professional development program and coaching support of SKATTLE Ltd, Brisbane Queensland. The willpower to build momentum for change and breaking through prevailing political, structural and polemic barriers is an essential participatory leadership characteristic for influencing systemic and structural reform. In Centering ethics in group supervision: Fostering culture of critique and structuring safety (2014) Reynolds explains the importance of: ‘understandings of ethics, ethical stances, collective ethics; understandings of critique, fostering cultures of critique, promoting and dignifying supervisory relationships’ (p. 2). Reynolds draws attention to the importance of structuring safety into supervision groups when addressing power, the role of collaboration, resisting innocent positions, and problematising the politics of politeness. This is particularly important when an intention of practitioner supervision and associated professional development is to inform a paradigm shift and influence cultural change.

Behavioural insights evidence-based intervention brings the opportunity to rethink our approach to addressing complex social issues like domestic violence in family relationship work. Strength-based post separation psycho-educational programs designed to inform, motivate and influence behaviour change towards less harmful and punitive ways of relating and meeting needs for power and control can contribute significantly to influencing socio-cultural change. Family violence is currently the most prevalent contributor to relationship breakdown and negative impacts on children, young people, health and wellbeing. Coordinating access to family relationship services for non-therapeutic and therapeutic interventions such as family dispute resolution, counselling, psychoeducational programs, intensive family support, children’s contact services and community legal services is a very important yet complex and time consuming activity. Broadening the lens of service delivery to include family breakdown prevention and family relationship sustainability intervention, a prevention, would further enhance the demonstrated capacity of FRCs for working together with child and family, health and legal services for the best interests of children and families. Working for the best interests of children must include attending to the needs of parents and families as a community and reaching for the ideal of equal opportunity and the best possible life experience for every child and family in Australia.
Appendices

Appendix 1. Case management: Screening and assessment and FDR activity statistics, January to September 2017 (9 months)

Table A. Assessment of impact on adult safety and wellbeing — FDR Case Management

<table>
<thead>
<tr>
<th>Impact</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gambling</td>
<td>8</td>
</tr>
<tr>
<td>Pornography</td>
<td>6</td>
</tr>
<tr>
<td>Illicit Drug Use</td>
<td>67</td>
</tr>
<tr>
<td>Alcoholism</td>
<td>53</td>
</tr>
<tr>
<td>Financial crisis</td>
<td>16</td>
</tr>
<tr>
<td>Homeless</td>
<td>1</td>
</tr>
<tr>
<td>Disability</td>
<td>12</td>
</tr>
<tr>
<td>Current DVO</td>
<td>54</td>
</tr>
<tr>
<td>Children included in the DVO</td>
<td>69</td>
</tr>
<tr>
<td>Parental Acrimony</td>
<td>154</td>
</tr>
<tr>
<td>FV &amp; DV included cultural abuse</td>
<td>189</td>
</tr>
</tbody>
</table>

Table B. Current child safety concerns

<table>
<thead>
<tr>
<th>Concern</th>
<th>Count</th>
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</thead>
<tbody>
<tr>
<td>DV</td>
<td>139</td>
</tr>
<tr>
<td>FV</td>
<td>18</td>
</tr>
<tr>
<td>Direct Physical Abuse</td>
<td>10</td>
</tr>
<tr>
<td>Direct emotional abuse</td>
<td>35</td>
</tr>
<tr>
<td>Direct psychological abuse</td>
<td>15</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>2</td>
</tr>
<tr>
<td>Parent with addiction</td>
<td>49</td>
</tr>
<tr>
<td>Exposure to pornography</td>
<td>2</td>
</tr>
<tr>
<td>Homeless</td>
<td>0</td>
</tr>
<tr>
<td>Self Harm</td>
<td>1</td>
</tr>
<tr>
<td>Depression</td>
<td>5</td>
</tr>
<tr>
<td>Parent with mental illness</td>
<td>12</td>
</tr>
<tr>
<td>Cultural abuse</td>
<td>0</td>
</tr>
<tr>
<td>Social isolation</td>
<td>0</td>
</tr>
<tr>
<td>Child protection service</td>
<td>17</td>
</tr>
<tr>
<td>Neglect</td>
<td>3</td>
</tr>
<tr>
<td>Peer/step sibling bullying</td>
<td>0</td>
</tr>
<tr>
<td>Parent with clinical depression</td>
<td>27</td>
</tr>
<tr>
<td>Parental high acrimony</td>
<td>41</td>
</tr>
<tr>
<td>Parent with disability</td>
<td>2</td>
</tr>
</tbody>
</table>

Table C. Adult client gender and family origin

<table>
<thead>
<tr>
<th>Gender</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male Gender</td>
<td>281</td>
</tr>
<tr>
<td>Female Gender</td>
<td>277</td>
</tr>
<tr>
<td>LGBTI Gender</td>
<td>2</td>
</tr>
<tr>
<td>ATSI Family Origin</td>
<td>12</td>
</tr>
<tr>
<td>English 2nd Language Family Origin</td>
<td>56</td>
</tr>
<tr>
<td>Other Family Origin</td>
<td>461</td>
</tr>
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Table D. Mental illness

<table>
<thead>
<tr>
<th>Mental Illness</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bi-Polar</td>
<td>15</td>
</tr>
<tr>
<td>PTSD</td>
<td>17</td>
</tr>
<tr>
<td>Anxiety / Depression</td>
<td>124</td>
</tr>
<tr>
<td>Suicide attempt during past three months</td>
<td>2</td>
</tr>
</tbody>
</table>

Table E. FDR case management outcomes – Comparison of 3 year period

<table>
<thead>
<tr>
<th>Year</th>
<th>No. of S&amp;As</th>
<th>601 (b) Certificate Issued</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>1317</td>
<td>7</td>
</tr>
<tr>
<td>Jan – Sept 2017 (9 mths)</td>
<td>726</td>
<td>11</td>
</tr>
</tbody>
</table>
Appendix 2. Partnering for community engagement

Figure A. Family Relationship Centre (FRC) Logan – Services and Local Alliances direct referral pathways 2017 (Sample)
### Table A. Three months post FDR at March 2017

<table>
<thead>
<tr>
<th>Q1. If your children participated in pre family dispute resolution do you think your children benefited from participating at the Family Relationship Centre?</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Disagree nor Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>2</td>
<td>4</td>
<td>1</td>
<td>8</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q2. Has your recent attendance at family dispute resolution helped your co-parenting relationship?</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Disagree nor Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>6</td>
<td>2</td>
<td>7</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q3. Since family dispute resolution are you more able to put your children’s interests above unresolved issues or conflicts with the other parent?</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Disagree nor Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>11</td>
<td>4</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q4. Has the parenting plan been sustainable since family dispute resolution (even if you have made mutually agreed changes)?</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Disagree nor Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>5</td>
<td>3</td>
<td>6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q5. Since participating in family dispute resolution has the quality of your relationship with the child/ren improved?</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Disagree nor Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>7</td>
<td>8</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q6. Has family dispute resolution helped you to prioritise the emotional security of your child/ren?</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Disagree nor Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>12</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

Total No of Responses: 17
The number of people attempted to contact in the random survey was 30

### Table B. Three months post FDR at August 2017

<table>
<thead>
<tr>
<th>Q1. If your children participated in pre family dispute resolution do you think your children benefited from participating at the Family Relationship Centre?</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Disagree nor Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>7</td>
<td>2</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q2. Has your recent attendance at family dispute resolution helped your co-parenting relationship?</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Disagree nor Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>5</td>
<td>4</td>
<td>6</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q3. Since family dispute resolution are you more able to put your children’s interests above unresolved issues or conflicts with the other parent?</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Disagree nor Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>11</td>
<td>5</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q4. Has the parenting plan been sustainable since family dispute resolution (even if you have made mutually agreed changes)?</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Disagree nor Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>8</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q5. Since participating in family dispute resolution has the quality of your relationship with the child/ren improved?</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Disagree nor Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>7</td>
<td>7</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q6. Has family dispute resolution helped you to prioritise the emotional security of your child/ren?</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither Disagree nor Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>5</td>
<td>9</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

Total No of Responses: 17
The number of people attempted to contact in the random survey was 27
Appendix 4. FRC Logan SEER Framework for Client and Practitioner Engagement in Child Informed Family Dispute Resolution

Table A. Practitioner strength-based approach to screening and assessment and FDR activity

<table>
<thead>
<tr>
<th>Support</th>
<th>Encourage</th>
<th>Empower</th>
<th>Repair</th>
</tr>
</thead>
<tbody>
<tr>
<td>P.1. Identify and respond to the needs of adults who are parents.</td>
<td>P.4. Recognise and be sensitive to each child’s unique perspective and experience.</td>
<td>P.6. Promote child-safe environments.</td>
<td>Self agency, solutions focus for behavioural change.</td>
</tr>
<tr>
<td>Take the child’s perspective and make space for parents to consider this.</td>
<td>Building parent capacity for reflection, and empathy.</td>
<td>Position as parents focusing on the child, their best interests, what they need and how they see things.</td>
<td>Commitment to action the parents will take to maintain the child focus and the parenting relationship.</td>
</tr>
<tr>
<td>Help parents to hear and accept the impact of trauma and unresolved conflict on children.</td>
<td>Acknowledge advances parents make in the child focus and strengthening the parenting alliance.</td>
<td>Honour the client’s right to safety, and their children’s need for a safe, secure and stable relationship with both parents.</td>
<td>Creating a sustainable and workable parenting plan.</td>
</tr>
<tr>
<td>P.3. Understand and apply knowledge of children’s needs at each stage of their physical, cognitive, emotional and social development.</td>
<td>Acknowledge intentions to act in the best interests of the child.</td>
<td>Value parents knowledge and skills.</td>
<td>P.9. Develop and maintain connections between adult-focused services and child and family focused services.</td>
</tr>
</tbody>
</table>
| P.10. Understand cultural influences on family and parenting practices and respond in a culturally sensitive way. | | P.7. Enable parents by promoting their parenting role as a motivator for positive change. | |}

Incorporates 10 Child Aware Principles: The SEER Practice Framework was developed collectively during action research and professional practice development activity at FRC Logan led by Norma Williams during 2014 and 2015. Acknowledgements to Margaret Cameron and Kristal Kinnane in assisting in the development of the SEER Framework to support practitioner strength-based positioning.

References


This paper will describe three programs that Child & Family Services (CAFS) Family Services have developed to provide a greater level of safety for children within families where they were/are being exposed to family violence. From identifying the initial needs of these families to developing targeted, child-focused, collaborative, inclusive and wrap-around interventions. The focus is to address the harm of family violence and support families in eradicating these destructive behaviours and begin the process of healing, by implementing programs such as the Family Services Family Violence Practitioner, create-respect primary school program and Dad’s Tool Kit.

In this paper we will describe the origins of three individual, flexible and unique programs that have been developed to address the needs of vulnerable children and their families. Our aim was to do this within the Victorian Government’s plan to provide one-stop, wrap-around programs and services. The benefits that the collaborative learning has provided to both Family Services family violence practitioners and Family Services case managers will be discussed in addition to the exciting outcomes that have been achieved for vulnerable children and their families.

Managing the requirements of the intensive family services and family violence sectors, and blending two frameworks/models, which have different focuses, has been challenging. The Best Interest Case Practice Model focuses on trauma and attachment while family violence models have historically focused on the adult perpetrator and victim. This challenge will be considered and explored.

**Background**

CAFS, Ballarat provides over 50 different programs to support individuals, families and children within the Ballarat and greater Central Highlands area. The Family Services program at CAFS has a team of 18 staff that operate from five sites to service families across five local government areas in Central Highlands Victoria (www.cafs.org.au).

In recent years there has been a substantial rise in family violence related issues for families referred to Family Services. Considering the handing down of the 227 recommendations from the 2016 Victorian Royal Commission’s Report into Family Violence, together with other initiatives and community collaborations such as the Van Go pilot project in Bacchus Marsh, increased funding to Men’s Behaviour Change programs...
and community forums to assist with planning and implementation of the Department of Education respectful relationship program that have been developed since the release of that report. This has led to more people identifying family violence.

**Intended aims of the programs**

The domestic violence perpetrator and his behaviour are the foundational source of the risk and safety concerns for children (David Mandel, 2013).

Many families presenting with family violence issues often do not fit the sometimes inflexible criteria of traditional family violence services. There is a changing landscape with perpetrators remaining in the home and therefore families are staying together where family violence presents as an issue. Those families don’t just want crisis support — they need holistic, one-stop-shop, co-designed programs to assist them. Generally, families want to understand ‘how they got here’ and ‘how to move forward.’ This goes hand-in-hand with Family Services seeking to give more children in the program a voice so as to reduce/eradicate the violence that children are being exposed to.

In particular, families are looking for other types of support, during and after the violence has ceased. To do this, the support needs to be inclusive of all of the family, especially in understanding the impact of family violence on the children.

**Challenges**

During the 2016–2017 financial year, Family Services engaged with 261 families. Of these families, 71% had experienced or were currently experiencing family violence, including physical, emotional and psychological violence. The challenge was to prioritise the greatest needs based on our data, within our funding restraints, to reach as many families as we could, to improve the lives of children experiencing family violence. The biggest challenge was to develop programs that address family violence holistically but remain child focused at all times. There is also a need for such programs to be flexible enough to respond to each family’s individual needs.

**Family Services Family Violence Practitioner**

To paraphrase Tolstoy: Happy families are pretty much alike but unhappy families are unhappy in their own – and often complex – way (Anna Karenina, Leo Tolstoy, 1873).
enthusiastic about being involved, to the point of visiting families and letting the affected family member and the children know, that they are there for them, a phone call away.

This police presence in the family’s life can be of enormous benefit in re-establishing in the family a sense of safety, stability and wider community support. The connection with the police is also helpful with obtaining IVOs and addressing breaches. The sense of community that bounces back and forth between the family, the police and the Family Services team, by all accounts, is inspiring. The police members have remarked that they appreciate the collaboration as it deepens their understanding of family violence and the way other services operate. It also widens their support network.

The African proverb ‘it takes a village to raise a child’ we might paraphrase to ‘it takes a community to heal a family’. Early in the work, the Family Services Family Violence Practitioner and the Family Services Case Manager help families understand that their experiences of abuse are in no way their fault and that nobody deserves to be treated with any form of violence. We are particular in giving children opportunities to talk about their experiences in a safe environment. It is quietly reiterated in the work that the perpetrator must accept full responsibility for their choices to use ongoing abusive behaviour. But we are mindful not to paint the perpetrator as the enemy. We are clear in acknowledging that the perpetrator is also a father/mother/partner/ex-partner and while this person may have redeeming qualities, it is his/her choice of violent behaviour that is unacceptable.

We use the term ‘family violence trauma’ to help the family understand and process their experiences. Family violence trauma has unique characteristics as the trauma is a result of ongoing violence from a trusted care-giver/family member who is connected to the family via complex psychological, emotional and physical bonds. Too often the abused family members feel more responsibility and guilt for the abuse than the perpetrator, who frequently takes little or no responsibility.

To help families understand their experiences, we employ a variety of strategies and interventions. We might ask them to visualise/imagine a future where they are living free of violence, we may also ask them to explore their anger and sense of betrayal and other emotions they may have experienced or that may arise as their healing proceeds. We are mindful that healing needs to be a gentle process geared to the individual family member’s pace. We use elements of grief and loss counselling such as letter writing addressed to the perpetrator, although not necessarily posted, and strength-based strategies such as listing and discussing the family member’s strengths and how they are demonstrated in their daily life.

Much time is spent unpacking and reframing how the family actively resisted the violence as best they could. Words such as ‘courage’ and ‘resilience’ are used to help clients understand that any guilt they may feel about not protecting themselves and/or their children from the violence is more than likely unfounded given the precarious position they were in. For example, the affected parent was more than likely overwhelmed in attempting to placate a violent and potentially dangerous partner, repair the relationship, care for the children and keep their own sanity and wellbeing intact.

In tandem, with the above work we also help the family develop and learn specific techniques to deal with anxiety and unhelpful behavioural loops with the aim of assisting the ‘whole’ family to reinstate healthy family dynamics.

Whole of family approaches that engage each member of the family where there is family violence and focus on parenting represent emerging practice … they explicitly focus on work with both parents and children (Humphreys & Campo, 2017).

We like to guide families in reconstructing their lives, encouraging them to re-socialise, as many families affected by family violence become isolated from friends and family. We also advise circumspection when sharing their stories, as some conversations with friends and family members are not helpful in moving forward and these conversations can taint what might have been a healing and uplifting family/friend interaction.

Most sessions with the family begin with a review of the safety plan/progress of IVO or other legal matters/breaches and the impact of these on the family. We work with the family to address any new issues that may have arisen. This is important work because often, the violence is continuing by various means: texts, phone-calls, change-over on access visits and the family can feel they are not healing and moving forward because the perpetrator is still having a toxic influence on their lives.

We need to be patient with these types of families as it is not always easy to stand up to the violence and say ‘no’ to harassment. It is important to be mindful of where family members are situated in the process of regaining their power and safety, and their sense of self. It is not a linear process. There are many backward and sideways steps along the way, which need to be met by workers with generous understanding and encouragement.
The numbers

Since its commencement in April 2016, the Family Services Family Violence Practitioner has supported Family Services case managers with 56 families. Of these, 31 families received individual or family counselling, whilst a further 25 families were consulted in the program leading to better informed, targeted practice to address family violence. During the 2016–2017 financial year, the Family Services Family Violence Practitioner completed 711 direct and supported hours to families, equating to providing an extra five hours per day of professional support to both our Family Services case managers and vulnerable families. During this time, 49 families received some type of support. Of these families referred to Family Services, 36% were currently experiencing some form of family violence and 47% experienced family violence at some point in their lives. Of the families referred to the Family Services Family Violence Practitioner, 53% had not been identified as having experienced (currently or historically), family violence during their assessment in Child FIRST (Family Information, Referral and Support Team). Child FIRST is the intake point for Family Services and other support services in Victoria. These families were identified by the Family Services case managers once allocated to the program. The position was originally funded internally by the Family Services program, but with the handing down of the recommendations by the Royal Commission into Family Violence – more specifically Recommendation 221: In the 2016–17 State Budget the Victorian Government give priority to: providing an immediate funding boost to increase the capacity of specialist family violence services and integrated family services to respond to existing demand – the Department of Health and Human Services now provide funding for this position and we are into the second financial year of that funding being provided (Royal Commission into Family Violence – Victoria, 2016).

Outcomes

Since its implementation, the Family Services Family Violence Practitioner role has provided a number of positive outcomes. The base of such outcomes is the ‘one-stop-shop’ model where the family’s needs and support generally sits within one program and where two workers support the family for the duration of the case. This allows for continuity of care, which supports families to remain engaged and creates trusting working partnerships that give families the time and space to address issues and heal together. Using a child-focused, strength-based/solution-focused approach (broadly speaking) with an underlying family violence/trauma lens, helps increase the consistency of engagement with families and works to assist Family Services case managers to feel better equipped to journey with the family as they identify where they’d like to be as a family. Most importantly the level of risk is held by two frameworks – the Best Interest Practice Case Model and the Family Violence model – which allows for better assessment, planning and outcomes for families whilst building safety and stability for the children.

Family Services case managers have also benefited from the model with increased knowledge and understanding of family violence. Case managers have gained more confidence in having discussions about family violence with families and providing psycho-education regarding the causes and effects of family violence within their case work. Case managers have also reported greater confidence in conducting assessments with families where family violence is an issue and implementing fitting interventions and where necessary, also providing appropriate referrals. The outcomes for clients (we refrain from calling family violence clients ‘victims’) have been many and varied. To again paraphrase Tolstoy: families also heal in their own way. Themes from client feedback focus on liberation, social reconnection, a renewed sense of personal power, hope and gratitude.

Each family has a Common Risk Assessment Framework (CRAF) assessment completed and outcomes are clearly recorded. During this process of the intervention, parents gain an increased awareness of the cause and effects of family violence, in particular the effects on children. This enables them to make informed decisions into the future regarding the safety and wellbeing of the family. Case managers have also reported greater confidence in conducting assessments with families where family violence is an issue and implementing fitting interventions and where necessary, also providing appropriate referrals. The outcomes for clients (we refrain from calling family violence clients ‘victims’) have been many and varied. To again paraphrase Tolstoy: families also heal in their own way. Themes from client feedback focus on liberation, social reconnection, a renewed sense of personal power, hope and gratitude.

Clients are assisted to navigate their way through relevant legal and government processes including: police involvement, intervention orders, court hearings, child protection involvement, Centrelink and so forth. Clients frequently become quite adept at dealing with these organisations, which we encourage as part of the family’s re-empowerment. Often families have had unhelpful experiences in dealing with welfare organisations and support workers. However, we have found that from having a positive experience with the Family Services team, families seem more willing to engage in support services relating to family violence for ongoing work.
When it has been assessed that the perpetrator residing in the family home continues to place the children at unacceptable risk, outcomes have been achieved by removing the perpetrator from the home in the safest way possible. The removal is generally planned with the Family Services Family Violence Practitioner/Family Services Case Manager and affected family member, and often in consultation with police, to minimise the children being exposed to further traumatic events. The plan prioritises the safety of the children and the protective parent.

Those who perpetrate violence, in any form, are held accountable for their actions and choices. In doing so they are made accountable in their role as a parent, and also for the impact that their behaviour has on their children.

Case study

The violence/abuse has not returned to the level that it was … my partner accepts that our children’s behaviour is a reflection of his abusive behaviour … the children feel safe to push back at their father because he doesn’t respond with violence as he once did … he is still engaged in part-time employment … overall the family’s engagement with the service has had a positive and lasting effect (anonymous parent).

Engagement began with the family during a relationship breakdown between the parents, which culminated in the subsequent removal of the male parent from the home. It was identified by workers, and via testimony of the children and the female parent, that the male parent had engaged in sustained emotional abuse of the family over a number of years.

We worked with the family on two fronts. Intensive weekly sessions between the female parent and the Family Services Family Violence Practitioner and concurrent sessions between the two children and the Family Services Case Manager.

The Family Services Case Manager began by ensuring the children felt safe to explore their feelings. He spent time instilling the concept of a ‘safe space’. Initial activities were focused using an activity booklet given to the children at an earlier session. The booklet Through your eyes promotes activities that aid in recognising stresses, successes, concerns and protective factors of the individual using it. As both children had already engaged in the various activities from the booklets, it provided a gateway to discussing issues around what has been occurring domestically and emotionally for them.

The second visit focused on assuaging fears the children held for the return of the male caregiver. As this work was concurrent with a family violence counselling session, the author was able to employ the knowledge of current events (such as the male family violence perpetrator’s living situation, police contact etc.) to aid in the direction of the interventions with the children. The Family Services Case Manager focused the children on anti-anxiety activities, which included exploring concepts of ‘practicing what works for us’. Tools used included flash cards, relaxation activities and writing a list based on things that ‘we are better at now than we used to be’. (This was used as a comparative tool to demonstrate the ability to ‘practise’ relaxation in an individualised sense.) Throughout the sessions, the Family Services Case Manager was able to evolve the process of choosing discussion points and activities by reflecting upon engagement successes. It’s been identified that activities around personal strengths and methods of relaxation are both successful in ascertaining the direction of a session. The Family Services Case Manager concluded each session by asking the children to think of ‘one thing’ such as, ‘what’s one way you relax if you feel upset by something?’ and asking them to provide an answer at the beginning of the next session. This has been a useful tool in both informing the worker of their understanding of a given topic, but also as a signifier of their engagement and interest in that particular line of activity.

This has informed a parallel commitment between the Family Services Case Manager and the Family Services Family Violence Practitioner to bring a focused approach of intervention throughout an unstable period for the family as a whole. The Family Services Case Manager was able to see a follow through on concepts discussed by the Family Services Family Violence Practitioner with the female parent. An example is the sharing of information regarding police involvement (IVO, police visiting the residence) that was used in regards to strength building engagement with both children. This has played a part in continuing to reiterate protective factors and disseminating what is appropriate to share with the children in regards to the separation process.

The Family Services Case Manager holds the case during the intervention. The Family Services Family Violence Practitioner can assist the family with referrals to other family violence services, detailing and updating safety plans, and supporting the family with family court processes. The intervention is generally short to medium term, but can be of long-term duration if deemed necessary.
create-respect

create-respect came about from Family Services case managers identifying a significant service gap for children aged between eight and twelve, who were presenting with behaviours consistent with exposure to ongoing family violence, and who did not fit the moulds of support services (too old, too young, still living at home).

A pilot after-school group was initiated which demonstrated many positives in engaging this high-risk group. However, there were a few notable issues with the format – being after school was the wrong time of the day for children to engage and the inconsistency of the parents in getting the children to group. Parents, with their own complex issues, including family violence, were unreliable in prioritising their child’s attendance at the group. Hence, a decision was made to offer the program to primary schools based on the fact that we could access greater numbers of children and the structure and consistency of the education setting offered a highly suitable ‘space’ for engaging these children. On this basis, Family Services developed an eight-hour program to be delivered to primary schools over a two-hour x four-week period.

Overall, create-respect is an identified needs-based concept that has grown from working with families and children in Family Services, Family Relationship and Family Violence Counselling and Respectful Relationships School Forums. The therapeutic approaches include child focused, mindfulness, strength based, solution focused and cognitive behaviour therapy. create-respect also uses an art-based, forum-style approach to engage students.

Research reveals that young people are struggling to work out what healthy, respectful relationships look like. About 25% of young people don’t think it’s serious when boys/young men insult or verbally harass girls in the street and they think it’s pretty normal for boys/young men to pressure girls into sex and they don’t think it’s serious if a boy/young man sometimes slaps his girlfriend when he’s drunk and they’re arguing. About the same percentage of young people think it’s important for men to be tough and strong (Our Watch, 2016).

Encouragingly, the research reveals that young people universally agree that behaviours that make a girl or woman feel frightened, diminished or intimidated ‘cross the line’ and are unacceptable. However, the research shows there is a group of young men who are more likely to justify and potentially perpetrate violence against girls and women in the future (Our Watch, 2016).

create-respect adds to the conversation with a curriculum focus that supports the development of healthy, equal and respectful relationships and helps develop emotional intelligence – using guided discussions and role-plays to share the students’ views and beliefs to the broader class. These approaches also help students in defining personal boundaries and develop strategies to keep them safe (see Figure 1).

CAFS Family Services

create—respect forums

Primary School 5 & 6

create—respect session plans

Session 1: Drawing Our Selves (Emotional Literacy)
Session 2: Super-hero (Personal Strengths — Positive Coping)
Session 3: Be Careful Out There (Bullying — Safety Plans)
Session 4: Walking In Sunshine (Respect — Communication)

Helping young people draw the line

According to Our Watch, gender stereotypes appear to be having a significant negative impact on young people’s expectations and behaviours when it comes to intimate relationships. Parents aren’t talking to their children about the issues, it’s not being adequately covered in the education system, and community leaders are not addressing it. As a result, young people are left in a vacuum and require information and guidance from parents and teachers.

Young people are left to figure it all out for themselves from other sources: their friends, their ‘heroes’, the media’s portrayal of women, pornography, and porn-inspired popular culture (Our Watch, 2016).
Learning happens best when driven by wonder, curiosity … (Carey, 2014, p. 1). (and one might add – an appropriate measure of humour and a license to be creative.)

Vakos (2003) states in her paper, Why the blank stare? Strategies for visual learners: ‘Children have different ways of learning; in fact, 65 per cent of the population consists of visual learners’. As such, create-respect uses conversation, white board diagrams, role-plays and art-based exploration to help engage students.

create-respect is predominantly a forum to give students an opportunity to talk about their feelings, their concerns, their strengths and resilience. At the same time, students learn practical coping strategies and get to practise respectful behaviour, active listening and engage in supportive friendship scenarios.

The benefit of the sessions being delivered by workers from the CAFS Family Services team is that the facilitators bring to the schools a wealth of experience working with families, youth and children with family violence, trauma and attachment issues.

During the sessions, facilitators are attuned to children’s behaviours and interactions as they need to assess children who may be at risk. The facilitators also consult with school staff to devise a plan for additional work with a student, which may involve referrals to Child FIRST for further assessment or other services to assist schools to support the individual student.

There have been many occasions where teachers have benefited from our insights of certain children and there have been instances where children have approached our workers to discuss various personal issues. These outcomes were what we had envisaged when we were designing the program and it is gratifying to see them play out in positive ways.

The class teacher initiated a project after the second create-respect forum – students chose a fellow class member to write and illustrate their positive qualities on a poster. Twenty-two such posters were suspended from the ceiling to greet the facilitators at the beginning of the third session.

create-respect review and outcomes

The create-respect primary schools program began in May 2017. To date, 160 primary school students have gone through the program. Family Services facilitators have noted a consistent and engaged response to the content of create-respect.

Feedback from teachers and students reiterated the necessity for sustained engagement of school children in ‘personal strength based’ activity work. The children responded with enthusiasm to working week to week on abstract self-portraits. The portraits evolved during each session and were informed by the students’ connection to the program’s content.

It was interesting to observe the children using different colours, texts and shapes in their portraits to convey their understanding of the program – i.e. picking strength words, changing facial
expressions, colours and mediums on the portraits. It also worked well to utilise the artwork as a final discussion point from each session. This illuminated the facilitators on the children’s ability to verbalise the content that they had been discussing.

Having an ‘elastic’ nature to the program allowed room for the children to inform a self-directed nature during the sessions. This was evidenced by utilising role-plays, which the children were consistently keen to do, as a means of challenging their understanding of complex concepts around bullying, self-care and empowerment.

For example, a larger group at Ararat North Primary School allowed a good ‘testing pool’ of the material against different children’s personality types. If some of the participants were too shy to engage in role-plays, or group discussions they had the option of engaging in a discussion with a facilitator while working alone on their art projects.

By taking this valuable program into the primary schools has allowed Family Services to access many more children than would be normally possible, as well as accessing children that may not have contact with professional services.

**Figure 4. Student illustrates her understanding of emotional states**

**Teacher’s feedback (Ararat North Primary School, Trawalla Primary School & Clunes Primary School)**

Useful strategies … smile-breathe-scan and shake … students enjoyed and benefited from the role-plays and they appreciated the chance to talk about themselves and their personality traits … their feelings and their relationships.

We will incorporate ‘smile-breathe-scan and shake’ as a tool to use when we are upset or angry … the school is also going to explore other techniques of self-regulation … the students really enjoyed the create-respect program it helped them extend their understanding of themselves/ others and how they communicate. I will continue to use role-plays and the music in the future (classical relaxation) and I will further develop student’s ability to identify feelings.

The role-play activities were helpful as they allowed the students to create a scene relevant to them. The circle talk at the beginning was well organised and helped the students to remember and consolidate their learning. To be honest the program really supported the work we do here in school around values, respect and positive behaviours. We already have in place many of the key understandings that were presented.

So far the only suggestions for what we might do differently is perhaps the sessions were too long. Possibly an hour would be better with short, sharp activities … less role-plays, preparation perhaps.

**Figure 5. Student evaluation form**
Student observer feedback (Clunes Primary School)

…the facilitators joking with students encouraged fun behaviour (dancing) and helped keep the students engaged… children were made aware of each other’s needs to be heard and treated fairly by their peers … the facilitators reflected and paraphrased the child’s statements to invite more thought and comments around their statements … the facilitators allowed students to speak freely and showed genuine interest in the student’s views of themselves and their world … this gave me a glimpse of the child’s personality that I might not otherwise see.

Dad’s Tool-Kit is a two-hour x eight-week forum for men to explore and challenge their beliefs and understanding of healthy parenting and to educate dads on the impact that violence and controlling behaviour has on their children, from the perspective of the child.

The development of this program came about from the steep increase in Family Services that had family violence as an issue and the number of dads who were single parents or were remaining within the family unit. A new theme had emerged in Family Services referrals; dads who were the primary carers of their children had been assessed by Child Protection to have the care of their children even though they had perpetrated family violence.

The program strives to help men gain insight into their child’s need for safety, stability, identity and wellbeing and to take responsibility in becoming a dad who helps make sure these needs are met.

Using diagrammatical conversations and role-plays, men are encouraged to reflect upon their actions ‘through the eyes of their children’. They are invited to take ownership of their behaviour whilst developing and practising healthy parenting styles that assist in repairing their relationships with their children and others.

Practice skills in assisting men to re-author preferred, richer accounts of identities as men, partners, and fathers … (Jenkins, 2009).

Topics discussed include:

- Understanding the effects of parental capacity and family dynamics on children’s development
- Equality and respect in the home
- Responding versus reacting
- Strategies to enhance parenting practice

Figure 7. Brainstorming the quality of our relationships with our children

Whilst Men’s Behaviour Change groups address the impact of family violence on children as well as healthy parenting strategies, Dad’s Tool Kit’s consistent focus on the impact of the father’s actions and behaviours upon their children has undoubtedly been where the most powerful revelations have occurred and the fathers’ genuine insight has developed. This is fundamentally a dad’s parenting group that delivers a child-centred approach to family violence.

Facilitators have noted an apparent growth and development of the father’s insight and capacity to empathise and understand the needs of their families. Many participants have also showed their desire to want to change and grow as men, change their current path in life and have reflected the desire to be better fathers, better partners and good role models for their children.

Figure 7. The three basic positions we communicate from
Often men enter parenthood with unrealistic expectations of their role, when reality sets in they don’t have the skills or capacity to meet these demands adequately. The Dads Tool-Kit Program allows fathers to learn and become aware of their ‘child’s voice’, through a myriad of activities, group discussions and role plays that challenge the fathers knowledge and belief systems regarding their child. The setting allows men to voice and hear the opinions and advice from the group. It becomes very raw and emotional at times as these men describe their situations (often for the first time) and are supported to talk about their situations but are challenged when their opinions and statements are identified as disrespectful, appear to be family violence or are unhealthy in promoting positive relationships. However, the men often have unhealthy belief systems about family violence and the group challenges these beliefs to restructure them into strategies that become positive and achievable.

A group member stated that he had been able to connect and have a deep and meaningful conversation with a friend whom is also a single father, he was very pleased with this development as the facilitator had a sense that he was limited in his opportunities to connect with other fathers. The group member stated that the conversation was a great experience for him.

The bigger picture

The Dads Tool Kit program is well integrated in our local community. Our most common collaborations include: Department of Health and Human Services, Ballarat and District Aboriginal Co-operative, local services (Uniting Care, Centacare, Early Childhood Parenting Centre CAFS), local medical services, schools and childcare services, as well as internally from other CAFS programs. The program also offers the extra support of case management during the duration of the program. This can lead to referrals for further support and ongoing work if required. Before commencing the group, men attend individual intake sessions where a CRAF risk assessment is completed and goals are discussed and set to achieve during the group.

Having a greater understanding of each participant’s situation can lead to more opportunities to challenge and change beliefs and behaviours. The case management aspect of the program allows for follow-up of high-risk safety concerns for men or their families after group.

Referral and participant numbers

Since the commencement of the group program in April 2017, 26 referrals have been received. The group structure allows for eight participants. In our previous group, six intake sessions were completed from eight referrals. Six dads completed this group. Our current group has five participants and we have a further 19 referrals to work through. We are considering an after-hours group and a special needs revised group. The community and professional sectors have welcomed our group program and the demand continues to grow. January 2018 sees Dad’s Tool Kit going to Ararat to facilitate its first group due to the demand from other services.

Conclusion

The Family Services team at CAFS is continually exploring for tools, strategies and supports to better address the impact of family violence on children. Our case managers are feeling more confident to address family violence with their families and are seeing the benefits of having extra programs to engage families. We also feel that these programs sit well within the broader planned Support and Safety Hubs.
Families need to be able to access ‘services or practical supports they need to be safe and address underlying challenges to their recovery, stability and wellbeing’ (Lucas, Winter, Hughes, & Walsh, 2016).

The responses from regional primary schools regarding the create-respect program have been beyond our expectations. The demand for the program has been strong and we are currently booked until primary school term two 2018.

We have been fortunate to receive funding from the Department of Human and Health Services (DHHS) for the Family Services Family Violence Practitioner position based on the outcomes we have achieved. The Family Services program is seeking ongoing DHHS funding for Dad’s Tool Kit, which is servicing a significant gap in our region.

Our next step will be obtaining ongoing funding for create-respect. We are currently funding this program from our existing Family Services funding from DHHS. The plan for these services is to have them accessible across all our regional sites so all families that engage with Family Services can have support to address family violence and protect their children.

In the near future, we hope to obtain funding to evaluate all three programs to assist with future development and direction of these support services and to refine them. The final stage will be to share our experiences with other agencies across the sector.

We are proud of the innovative services we have developed, that enable our team to achieve better outcomes for vulnerable children and families.

**Bibliography**


