

Practice First Evaluation Report

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Community Services

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This document is the report of the evaluation of *Practice First* across 24 sites in NSW. The evaluation was conducted as a collaborative project by the Parenting Research Centre in partnership with the Social Policy Research Centre and the University of Melbourne with funding from the New South Wales Government Department of Family and Community Services (FACS).

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Abbreviations

CSC	Community Service Centre
FACS	FACS NSW Department of Family and Community Services
JIRT	Joint Investigation Response Teams
KiDS	Key Information Directory System (KiDS) – Community Services information management system and the database from which the administrative data for this analysis was recorded
NGO	Non-Government Organisation
OOHC	Out of Home Care
OSP	Office of the Senior Practitioner
PRC	Parenting Research Centre
ROSH	Risk of Significant Harm
SARA	Part of the SAS2/SARA. Safety Assessment, Risk Assessment (and Risk Reassessment)
SAS1	Secondary assessment 1, the preliminary investigation associated with a ROSH report
SARA/SAS2	Secondary assessment 2, also known as a face-to-face investigation
SDM	Structured Decision Making
SPRC	Social Policy Research Centre

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1. Executive summary

The NSW Government has invested heavily in reforms to the child protection system in response to the rising number of children entering out of home care (OOHC) and high re-reporting rates for children known to child protective services, as highlighted by the 'Wood Inquiry' in 2008.

As part of these reforms, *Practice First* was introduced into 17 Community Services Centres (CSCs) in 2012 and a further seven CSCs in 2013. *Practice First* is a child protection service delivery model that aims to improve systems, practices and culture relating to the assessment, decision making and support for children and young people identified as at risk of significant harm (ROSH). The model incorporates strategies to strengthen caseworker skills and capability and reduce administrative burden so caseworkers can spend more time on direct client contact, increasing family and partner agencies' participation in decision making and improving caseworker satisfaction and retention. Developed by the Office of the Senior Practitioner (OSP) within NSW Department of Family and Community Services (FACS), the design of *Practice First* has a strong emphasis on principles aligned with strengths-based and solution-focused work.

This report describes the evaluation of the implementation and service system outcomes of *Practice First* across 24 CSCs in NSW. The evaluation used four methodologies, with findings from each triangulated to strengthen conclusions.

Key Findings

The evaluation has found that for many staff, the shift to *Practice First* has made a significant difference to their work. Caseworkers report spending more time with families, which was perceived to improve caseworkers' understanding of and engagement with families, making assessments more accurate and comprehensive, and providing more information with which to make decisions. Improved family-caseworker relationships were also seen as beneficial in helping families to make changes, and even when children had to be removed, caseworkers felt more confident and were better able to maintain family engagement over that challenging time. Working in this way was more professionally satisfying for staff, and perceived to ultimately lead to better outcomes for children.

Group supervision was widely endorsed by staff. The shift in individual responsibility to shared decision making and the shared management of risk through the group supervision process was highly valued. Group supervision was perceived to be working best where supervisor skills were strongest.

There was evidence that some of the principles behind *Practice First* have started to influence practice in non-*Practice First* sites.

It is important to note that *Practice First* is not the only reform initiative occurring in NSW at this time. While it is difficult to separate out the effects of *Practice First* independently within this context of reform, it is apparent that in combination these different initiatives seem to be complimentary and reinforce good practice.

Implementation of *Practice First*

Practice First has generally been implemented as intended. Overall the group supervision is working well, caseworkers are spending more time with families, casework practice has improved and organisational culture has changed considerably.

Most staff felt well supported in the early stages of implementation of *Practice First*, including support received from the Office of the Senior Practitioner, mentors and managers.

Despite positive views of the implementation of *Practice First*, there has been little reduction in the administrative burden on caseworkers in *Practice First* sites and many stakeholders have reported that this has compromised the implementation of *Practice First*.

The analysis of administrative data showed no differences between *Practice First* and non-*Practice First* sites with respect to either the duration of secondary assessments or the timing of court applications – two proxy indicators of time spent in direct client contact. In the absence of administrative data regarding time spent with families or the quality or content of the work done with children and families, these proxies were used as indicators of a core component of the *Practice First* model - reducing administrative burden so caseworkers can spend more time on direct client contact.

While *Practice First* does not appear to have had an impact on the administrative burden of staff, many of the factors driving administrative time are beyond the purview of *Practice First*, and include staff vacancies, the structure of the KiDS database and directives from managers. In addition, continuing risk aversion in child protection practice and the paradoxical effect that more client visits requires more recording, inhibit the easing of administrative burden. Nevertheless, there are pockets of more effective and efficient recording practices across *Practice First* sites, which may be extended upon in future implementation of the model.

The fidelity of implementation of *Practice First* appears to be highly dependent on leadership in each site. That is, where managers are committed to the model and are proactive in implementing it, *Practice First* appears to be better implemented and existing challenges are better addressed. In contrast, where local managers are reported to be resistant or sceptical, this tends to affect the culture across the site. Despite general endorsement of *Practice First*, staff identified several barriers to effective implementation, including: caseworkers' administrative burdens; insufficient resources; poor group supervision facilitation in some sites; inadequate training; uncertainty with respect to *Practice First* model fidelity; the timing of *Practice First* implementation; and the KiDS system. It may be that organisational pressures have limited some caseworkers fully embracing the *Practice First* model, raising concerns about the fidelity of implementation.

The impact of *Practice First* on broad, system-level outcomes

The administrative analysis did not find any significant differences between *Practice First* sites and non-*Practice First* sites on a range of high-level outcomes. This is almost certainly because the major drivers of child protection risk decisions (e.g., family circumstances; policy-driven risk thresholds) and their associated system-level outcomes (e.g., subsequent ROSH; placement in OOHC) are overwhelming the effects of service reforms introduced by *Practice First*. That is, both *Practice First* and non-*Practice First* sites are responding to the same set of risks and problems, and

both types of sites are receiving far more reports from the Helpline than they can respond to with a face-to-face visit.

Therefore, the large number of children reported to the system likely dictates a risk dependent, triage approach. Child age, Aboriginality, and prior history are still the major predictors of whether children come back into the system with a new ROSH report and/or an entry into OOHC. Given that the same client population is being selected for face-to-face assessment, which is dictated by the overall mission, policies and culture of the child protection service, it is not surprising that the major predictors of system-level outcomes are overwhelming any 'treatment' effect that may be present in *Practice First* sites.

Crude but powerful proxies for risk continue to predict systems-level outcomes. Specifically, young and very young children, Aboriginal children, children with a prior ROSH report, and children with a history of OOHC are all more likely to be seen in a face-to-face assessment and to be involved in court proceedings, have a subsequent ROSH report, and experience a placement in OOHC, irrespective of whether they are clients in a *Practice First* site or a non-*Practice First* site.

Consequently, there is no clear evidence that *Practice First* works better in terms of engagement, outcomes and safety for any particular group of children or families (e.g., Aboriginal children, different child age groups, children classified into different ROSH risk categories). Some staff reported that the model is particularly effective for Aboriginal children, but this is not a widely held view and the quantitative data analyses do not indicate additional benefits for any specific group of children.

Involving children, families and other agencies in decision making

Children and families

Practice First has made some improvements in increasing the involvement of children and families in decision making, although in the absence of formal mechanisms to foster increased family involvement, this finding was limited to a small number of caseworkers and managers who strongly believed that children and families were more involved. The level of involvement of families is still for the most part at the discretion of caseworkers. Thus, there is still some way to go in relation to the routine and mutually beneficial involvement of families in decision-making as part of the *Practice First* model.

Other agencies

With regard to other agencies there is evidence that they are more involved in various aspects of the work, including during group supervision and in contributing to thorough family assessments. FACS staff reported that *Practice First* was associated with greater understanding by other agencies of the shared responsibility for decision making about families. Sharing the workload of supporting families across agencies, and better post-FACS support options for families upon case closure were also seen as benefits of increased collaboration with other agencies. However, any trends toward more involvement by other agencies is not limited to *Practice First* sites and is evident in many CSCs across the state, so this cannot be attributed solely to *Practice First*.

The capacity and efficiency of the system

Practice First has led to some improvements in the capacity and efficiency of service delivery across child protection in NSW. Caseworkers report improvements in their capacity to make decisions

about child placement and referral, resulting from the more comprehensive assessments and clinical supervision found in *Practice First*. Staff felt that the group supervision approach had increased efficiency by sharing decision making. Staff report that *Practice First* has allowed them to work more effectively with clients, and *Practice First* staff reported higher levels of satisfaction with opportunities to make a difference to families and with the quality of services delivered, compared with staff at non-*Practice First* sites.

The improvements in capacity and efficiency reported by *Practice First* staff were not echoed in analyses of data collected about children reported to the NSW Child Protection Helpline. When characteristics of the children in *Practice First* and non-*Practice First* sites are taken into account, *Practice First* has not, overall, resulted in longer duration of cases, nor has it resulted in fewer re-reports. There are opportunities to improve measurement of capacity and efficiency within the NSW child protection system. Gaps in the availability of administrative data regarding time spent with families or the quality or content of the work done with children and families, limit the extent to which this data can be used to assess the efficiency and capacity of the service system.

Furthermore, in the context of broader service reform it can be difficult to attribute any changes to a particular action. Considering this, it can be concluded that in conjunction with other FACS reforms it appears that *Practice First* has resulted in improved collaboration, more comprehensive assessments and interventions, and more efficient service provision.

Staff satisfaction and retention

There is clear evidence that *Practice First* has resulted in greater work satisfaction and some indication that *Practice First* has improved staff retention. Four out of five staff surveyed reported *Practice First* had improved workplace culture, and over a third believed it had improved to a great extent. Almost three quarters of respondents believed *Practice First* had improved their job satisfaction. There was evidence that increased staff satisfaction could be attributed to staff being given 'permission' to work in a way that matched their view of appropriate and effective casework.

Staff mix and support processes

In general, the staff mix and support processes in place in *Practice First* sites are appropriate and the group supervision format is highly valued by most staff. Collaborative decision making through group supervision allows staff to feel confident that when a decision is made to remove a child, that the team had considered and exhausted all other options.

Nevertheless, a number of staff expressed the view that group supervision is not a substitute for individual supervision and should sit alongside it, but there are also potential pitfalls in reintroducing individual clinical supervision, in particular, undermining shared decision making which is a core component of *Practice First*. There is also a strong indication that the quality of the group supervisors is variable and that some of the group supervision sessions are not being conducted optimally. Where a manager's supervision skills were strong and where there was enthusiasm for *Practice First* by leaders at the site, the *Practice First* model was viewed positively by staff.

Improving the *Practice First* service delivery model

Practice First provides a solid platform for future improvements in the quality of service provision and practice in NSW's child protection system. Table 1 outlines opportunities moving forward to improve the model and its implementation in order to better achieve the aims of *Practice First*.

Table 1. Recommendations for improvements in Practice First implementation.

Finding	Recommendation we can confidently make	Next steps/forward agenda
<p><i>Practice First</i> has generally been implemented as intended. Group supervision is generally working well, and casework practice and organisational culture have improved. Caseworkers spend more time with families and report increased work satisfaction and intention to stay.</p> <p>It is unclear whether the changes identified above have resulted in improved capacity and efficiency across the system. Reports from staff indicate improvements, but this is not supported by the administrative data collected from the KiDS system which were sometimes incomplete, unreliable or invalid and therefore unhelpful in answering questions related to the frequency, duration and content of client contacts.</p>	<p>There is an opportunity to build on the positive findings associated with <i>Practice First</i> implementation, including areas of practice to strengthen and changes to install. The consequences of de-funding <i>Practice First</i> may be more harmful than moving ahead with it as a framework in which to embed best practice child protection service delivery.</p>	<ul style="list-style-type: none"> ➤ Consider the increased adoption and implementation of evidence-informed programs and practices that have been shown to improve practice and outcomes for families in the system. A current example of where efforts are being made now is the pilot implementation of <i>SafeCare</i>¹ in two <i>Practice First</i> sites.
<p>There has been little reduction in the administrative burden on caseworkers in <i>Practice First</i> sites and this has likely</p>	<p>The major system level barriers to achieving effective implementation are external to <i>Practice First</i>. These include the administrative burden</p>	<ul style="list-style-type: none"> ➤ Improve the reliability, range and quality of the data collected. Balance this against the finding that the administrative burden on caseworkers is still too high. Support managers to address the tension between administrative requirements and face-to-face work with clients.

¹ SafeCare is a highly structured, empirically supported parenting program developed in the United States for parents of children where safety and risks have been identified. The Office of the Senior Practitioner is currently overseeing a pilot of SafeCare in two CSCs and one FACS funded Brighter Futures agency in NSW.

<p>compromised the implementation of <i>Practice First</i>.</p>	<p>on staff and the legal advice provided to caseworkers around recording. These barriers would need to be addressed for the model to be effectively implemented across all <i>Practice First</i> sites.</p>	<ul style="list-style-type: none"> ➤ Build on examples of more effective and efficient recording practices across <i>Practice First</i> sites, which may be extended upon in future implementation of the model. ➤ Develop and put in place a research-informed implementation plan that specifically addresses the identified barriers to effective and high quality implementation. ➤ Build and use implementation teams to actively drive improved implementation efforts. Implementation teams are groups of individuals who have the task of intentionally monitoring and supporting implementation. These teams are accountable for achieving the objectives of <i>Practice First</i>. Team members should have adequate knowledge and skill in a number of areas in order to support those who are doing the actual implementation of <i>Practice First</i>. ➤ Use data and feedback loops to drive decision-making and promote continuous quality improvement. This means the right data is continuously collected and used to systematically assess and feedback information related to planning for new <i>Practice First</i> sites, improving implementation at the site level and achieving the intended outcomes of <i>Practice First</i>.
<p>There is some evidence for improvements in involving other agencies in decision making, but this may not be due to <i>Practice First</i> alone.</p>	<p>There is an opportunity to build upon developing examples of good practice in relation to the involvement of other agencies in decisions made about families in the system.</p>	<ul style="list-style-type: none"> ➤ Incorporate formal mechanisms for involving other agencies. Build on examples of good practice in relation to this.
<p>The practitioner training associated with the implementation of <i>Practice First</i> is delivered in low doses, with little post-training coaching and consultation in the field. This does not adhere to best practice implementation in the human service sector.</p>	<p>Adopt strategies to enhance the competencies of staff through the provision of best-practice training and post-training support.</p>	<ul style="list-style-type: none"> ➤ Enhance and extend training procedures that map on to the competencies required to deliver the practice model at a very high quality. ➤ Develop and follow protocols establishing minimum requirements for participation in training (e.g., that training is delivered as a standard induction procedure for all practitioners), enhanced in-field support such as coaching and supervision.

		<ul style="list-style-type: none"> ➤ Provide structured post-training, in field, coaching to develop skills and take actions consistent with the <i>Practice First</i> approach, and to ensure these are sustained over time.
Absence of clear program logic was a limitation to the current evaluation.	Program logic needed to guide implementation and any future evaluation.	<ul style="list-style-type: none"> ➤ Develop a clear and realistic program logic and theory of change for <i>Practice First</i> which contextualises <i>Practice First</i> in relation to other policies and programs within FACS and NSW.
Group supervision was widely endorsed, but appears to be best when supervisors' skills are high.	The quality of supervision and training should be more consistent. This can be achieved by developing a documented implementation plan which includes enhanced strategies for workforce training and coaching.	<ul style="list-style-type: none"> ➤ Clearly articulate competencies required for delivery of supervision, training and coaching. Ensure those delivering supervision, training and coaching are delivering at these standards and provide additional training where that is not occurring. ➤ Routinely monitor quality against competencies and put implementation plans in place to overcome any issues with consistency or quality of delivery.
Strong leadership is important. The fidelity of implementation is dependent on leadership - where managers are committed to the model and proactive in implementing it, <i>Practice First</i> is better implemented and existing challenges better addressed.	Improve knowledge and understanding of the purpose and objectives of <i>Practice First</i> and accountability to support effective implementation at all levels of the system, particularly at a senior leadership level (practitioner, manager and senior leadership).	<ul style="list-style-type: none"> ➤ Attention to the leadership driver to be built into future implementation planning in order to ensure ongoing gains are maintained.
No evidence that <i>Practice First</i> is more or less effective for particular families (e.g., Aboriginal families).	Administrative data was sometimes incomplete, unreliable or invalid in relation to the frequency, duration and content of client contacts. Improve the routine and continuous use of more reliable and valid data to allow a continual quality improvement process to be introduced into <i>Practice First</i> .	<ul style="list-style-type: none"> ➤ Further enhance and improve the program logic of <i>Practice First</i> and include more reliable and valid measurement variables that are better able to monitor both implementation and progress against relevant child and family outcomes.

Conclusion

Practice First has been successful in changing organisational culture but could not be expected, in and of itself, to change child protection outcomes. That would require service reform in areas of FACS external to *Practice First*.

Overall, the evaluation has found that *Practice First* has facilitated a shift in organisational culture within FACS towards a focus on child-centred practice and increased engagement with children, carers and other agencies. *Practice First* is part of a range of reforms which are intended to transform child protection in NSW and it is working alongside other processes to improve the efficiency and effectiveness of the child protection service. The *Practice First* approach establishes a solid foundation for the types of continuing reforms needed to improve outcomes for children and families reported at risk of significant harm.

2. Introduction

In July 2014, the NSW Department of Family and Community Services (FACS) engaged the Parenting Research Centre (PRC) and project partners at the University of Melbourne and the Social Policy Research Centre (SPRC) to evaluate the *Practice First* service delivery model within the statutory child protection authority in NSW. The aim of the evaluation was to assess how well *Practice First* is being delivered at implementation sites, and the outcomes for children, families and FACS staff associated with *Practice First*.

This document reports the findings of that evaluation, conducted over eight months from November 2014 to June 2015. Section 2 outlines the background and rationale for the evaluation including aims and research questions. Section 3 provides a brief overview of the design and method for the evaluation (see Appendix A for a more detailed description). Section 4 presents detailed information gathered using four methods addressing each of the evaluation questions, along with a discussion of findings and recommendations for future improvements in the implementation of *Practice First*, and a discussion of the major conclusions drawn from the evaluation.

2.1 Background

FACS is the statutory child protection authority in NSW. FACS exists to build stronger communities by supporting vulnerable people and families to participate in social and economic life. FACS provides direct service delivery as well as funding for non-government organisations (NGOs) across New South Wales to deliver specialist support services aimed at protecting children and young people from abuse and neglect.

Worldwide, child protection systems face a range of challenges to quality service delivery. For instance, challenges in resourcing (e.g., staff recruitment, training, and retention) are commonly cited. Further, systems and practices are often forensic and adversarial in nature, with a reliance on risk assessment and child removal rather than safety and permanency planning, skill development and family support. As a consequence, caseworkers have tended to be preoccupied with administrative tasks and reporting rather than developing skilful practice. Internationally, a range of solutions have been posed, trialled and evaluated, with varying success. For example, *Victoria's Vulnerable Children – Our Shared Responsibility Strategy*² involved a reform to that state's child protection system over four years from 2012.

In November 2008, James Wood, QC, delivered his report from the *Special Commission of Inquiry into Child Protection Services in New South Wales*.³ This report noted that “The contemporary challenge facing all child protection systems in Australia, and in particular NSW as the largest, is sufficiently resourcing flexible prevention and early intervention services so as to reduce the numbers of children and young people who require the state to step in to keep them safe” (p. i).

² Victorian Government (May 2013). *Victoria's Vulnerable Children – Our Shared Responsibility (Strategy 2013-2022)*. Melbourne: Victorian Government.

³ Widely referred to as the “Wood Inquiry”. Wood, J. (November 2008). *Report of the Special Commission of Inquiry into Child Protection Services in NSW*. State of New South Wales.

Wood highlighted a range of challenges that were faced by the NSW child protection system at the time, many of which were not unique to NSW, but which included:

- increasing rates of reports of harm to children and young people,
- frequent re-reports,
- over-representation of aboriginal children in the system,
- increasing number of children in out of home care (OOHC) for increasingly longer periods and at increasing cost,
- a decreasing pool of foster carers,
- lower than anticipated rates of follow-up of cases reported via the Helpline⁴,
- high rates of inappropriate reports that could have been better managed in other family support services,
- poor information management systems,
- poor implementation of evidence-base policies and practices across the system,
- poor rates of skilled and diverse staff recruitment and retention,
- insufficient early intervention, prevention and targeted services,
- limited collaboration with other agencies,
- lack of sufficient data to assist understanding, assessment and monitoring of the system, and
- poorer than anticipated medical, dental and allied health care for children in out of home care and leaving out of home care.

Added to the conclusions of the Wood Inquiry, and highlighted in a recent NSW Auditor General's report,⁵ FACS faces a current challenge in meeting resource demands associated with the recruitment and retention of caseworkers. Despite an increase in caseworker numbers in recent years, FACS caseworker numbers are approximately five per cent less than funded positions. Furthermore, there was a reported 20 per cent increase in the number of risk of significant harm/referred reports from 2012-13 to 2013-14 (see Table 2). The impact of this is that while caseworker-to-child ratios have improved since 2012 from 1:25 to 1:21, this remains well behind the ratio of 1:12 recommended by the NSW Ombudsman. Furthermore, the Auditor-General's report noted that 46 per cent of all children in care in NSW had not had their required annual placement reviews in the previous year. Thus, the report of the Auditor-General (2014), along with

⁴ Examination of reports to the NSW Department of Community Services in 2007/08 indicated that 21 per cent of reports were assessed by the Helpline as requiring further assessment, but received none from the Community Services Centre to which they were referred and 33 per cent received some attention but did not get a face to face visit (Wood, November 2008).

⁵ Audit Office of New South Wales. (2014). *New South Wales Auditor-General's Report: Financial Audit (Vol. 9)*. Sydney: author.

previous reports from NSW, raises concerns that FACS is ill-equipped to ensure the safety of children at risk.

Table 2. NSW child protection statistics 2012-2014

	2012*	2013*	2014*
Total child and young person concern/child protection reports	228,821	246,173	265,071
Rate per 1,000 children and young people 0-17 years who were subject of risk of significant harm/referred report	38	39	44
Number of risk of significant harm/referred reports	99,283	104,817	125,994
Volume of Helpline calls entered	145,425	134,486	136,567
Volume of Helpline calls answered by a caseworker	114,020	111,834	111,949
Average waiting time (minutes:seconds)	4:46	4:04	5:21

Source: Audit Office of New South Wales (2014). * year ended 30 June

Responding to the Wood Inquiry (November 2008), and a range of subsequent reports, recommendations and plans (e.g., the NSW Government Plan, *NSW 2021: A Plan to Make NSW Number One*⁶), the NSW Government has invested heavily in a range of reforms to the child protection system aimed at improving service delivery and child and family outcomes for vulnerable families. For example, the five-year plan associated with the *Keep Them Safe*⁷ initiative involved investment of \$750 million to promote early intervention for vulnerable children; early responding aimed at reducing entry into OOHC; greater support for Aboriginal children, families and communities to address Aboriginal over-representation in child protection; and improvements to child protection practices and systems, including improving interagency collaboration and information exchange across services. These activities are largely focused on early intervention as a critical factor in reducing later risk. Early intervention for children and young people at risk of significant harm (ROSH) has consistently been demonstrated to have positive long-term social and economic benefits⁸. These benefits can be seen in reductions in costs associated with OOHC and re-notifications, as well as improvements in long-term outcomes associated with child abuse and neglect, including mental illness, drug and alcohol addiction and unemployment.

Another service improvement strategy adopted by FACS in NSW is *Practice First*.

⁶ NSW Government (September 2011). *NSW 2021: A Plan to Make NSW Number One*. Retrieved 16th September 2014. Available at www.2021.nsw.gov.au.

⁷ Cassells R, Cortis N, Duncan A, Eastman C, Gao G, Giuntoli, G, Katz I, Keegan M, Macvean M, Mavisakalyan A, Shlonsky A, Skattebol, J, Smyth C and valentine k (2014), *Keep Them Safe Outcomes Evaluation Final Report*, Sydney: NSW Department of Premier and Cabinet.

⁸ Segal, L, Dalziel, K., Papandrea, K. (2013). *Where to Invest to Reduce Child Maltreatment – A Decision Framework and Evidence from the International Literature*. University of South Australia.

2.2 What is *Practice First*?

Practice First is a model for child protection service delivery first developed in 2011 by the Office of the Senior Practitioner (OSP) within FACS, in response to the identified need to better protect the most vulnerable members of our community and break the cycle of disadvantage.

Practice First was developed as a service delivery model to improve systems, practices and culture relating to the assessment, decision making and support for children and young people identified as at ROSH. *Practice First* focuses on strengthening caseworker skills and capability and reducing administration so caseworkers are able to spend more time on direct client contact; increasing family and partner agencies' participation in decision making; and improving caseworker satisfaction and retention.

2.2.1 The *Practice First* Model

Practice First was developed to address all aspects of statutory child protection work, including preservation casework, the removal of children and subsequent court work, restoration of children and children in OOHC. The design of *Practice First* has been influenced by a broad range of practitioners, researchers, practice frameworks and existing systems (e.g., Structured Decision Making, Motivational Interviewing, Minnesota's Differential Response Model⁹, the Munro Report¹⁰, Kari Killen's (Norway) work on neglect, relationship-based practice, and the Three Houses Tool), with an emphasis on principles aligned with strengths-based and solution-focused work.

Practice First aims to change existing practice culture to achieve improved outcomes for children identified as at ROSH. Stated aims of *Practice First* include¹¹:

1. Increasing the number of families receiving a service by reducing caseworker time spent on administrative tasks to free caseworkers to spend more time on direct client contact
2. Engaging children, families and other agencies better in decision making and processes to increase families' motivation to change
3. Ensuring children only come into care after thorough assessment and intervention reveal that parental change and safety cannot be achieved
4. Improving risk management through more support for critical reasoning
5. Reducing re-reporting rates
6. Increasing caseworkers' skills and confidence in helping families tackle their problems, thereby supporting more children to remain safely with their families and increasing caseworker satisfaction and retention.

⁹ In particular the work of Suzanne Lohrbach and Rob Sawyer, American Humane Society.

¹⁰ The Munro Review of Child Protection (May 2011). Final Report. A child-centred system. Department for Education UK.

¹¹ Based on information from *Practice First Operating Manual* (FACS, April 2014).

The key components of the *Practice First* model include:

- **Culture:** principles of practice form the basis of practice culture, rather than a culture that seeks compliance with tools and adherence to structure.
- **People:** casework is delivered by teams, not individuals. Skill development is ongoing and requires practitioners to have insight into the impact of practice on families, and to strengthen their skills in working with families to sustain change. It relies on clear role definition and makes practice leadership the most important aspect of management.
- **Systems:** built on a clear mandate giving legitimacy to family work, freeing casework time from administration, and sharing risk and decision making across teams.

Practice First incorporates a set of ten *Principles to guide practice*, grouped here under the four principles of the NSW Community Services Care and Protection Practice Framework:

1. Children are at the centre of practice with families

Principle 1: Ethics and values are integral to good practice.

Principle 2: Families have a right to respect.

2. Respect for culture and context

Principle 3: An appreciation of context strengthens practice.

Principle 4: Language impacts on practice.

3. Contemporary skills and knowledge in a work culture that shares risk

Principle 5: Good practice is built on both knowledge and skills.

Principle 6: Practitioners do best in a culture that fosters learning, hope and curiosity.

Principle 7: Reflection leads to better outcomes.

Principle 8: Sharing of risk leads to better decision making.

4. Build relationships to create change

Principle 9: The quality of the relationships makes a significant impact on effectiveness.

Principle 10: Relationships have a cascade effect.

Increasing time spent with families

Within a *Practice First* approach to service delivery caseworkers are supported to prioritise direct work with families over administration (e.g., writing case notes). The adoption of this approach is based on the proposition that the pull of administrative compliance is de-skilling for caseworkers and occupies as much as 80 per cent of their time. Within *Practice First* caseworkers are given permission to prioritise family work, and are taught to write case notes differently. Administration staff are viewed as integral participants in service delivery to clients. They assist with client-related

administrative work such as data entry and are considered as integral participants in group supervision. As a consequence, caseworkers have greater capacity to develop their skills in family work and analysis through increased time spent with families. This is subsequently proposed to influence child and family outcomes by increasing the number of families receiving a service, and seeing each family more often.

Building relationships to create change

Practice First prioritises building relationships between families and caseworkers to foster open communication, information sharing, shared decision making and increased family motivation to change over sustained periods. *Practice First* training and supervision emphasises the importance of relationship-based practice.

Caseworker skills and knowledge

Practice First incorporates a range of strategies to increase the professional skills of caseworkers, with the intention of increasing their satisfaction in their job and improving their confidence in family support. Key caseworker skills include: individual practice styles that are consistent with a strengths-based framework; motivational interviewing; and the appropriate use of assessment and recording materials. These skills are fostered within a supervision model that promotes reflective practice, which is modelled from the top down has an emphasis on continuous learning in a group setting; and through mixed caseloads and teams. The culture of the workplace is informed by theory and research, as well as shared experience, and is united by principles (rather than rules) which are designed to promote respectful, compassionate and helping responses. The roles of all staff (including specialists, managers and administrative staff) are clearly described.

Sharing risk

The approach to risk management is to allocate a primary worker to a family but for significant decision making to require team endorsement and senior staff consultation. Specialist input, Aboriginal consultation and legal advice are available to caseworkers in 'real time' through group supervision, as is the involvement of external agencies that are involved with a family. There is a shared understanding among all stakeholders that the aim of casework is to decrease the number of children entering long-term OOHC and increase the number of children who remain with or are successfully restored to their families. The safety of children is assessed continuously through appropriate and consistent use of common assessment tools and adherence to legislation.

2.3 Evaluation of *Practice First*

The current evaluation of *Practice First* was conducted by a consortium led by the PRC, involving the University of Melbourne and the SPRC at the University of New South Wales. Broadly, the evaluation explores the degree to which the *Practice First* model is being implemented across 24¹² sites as at September 2014, along with associated improvements in workforce and child/family

¹² Note that one of the *Practice First* CSCs was a specialist adolescent unit, which was not included for the analysis of administrative data as it is difficult to compare with other CSCs.

outcomes. Specifically, the evaluation uses both formative and summative methods to determine the extent to which *Practice First* has been implemented as intended, whether this has resulted in a shift in practices and agency culture, whether these changes have resulted in improved agency capacity and caseworker skill, and whether such improvements have led to better outcomes for children and families. As such, the evaluation incorporates both process and outcomes components that draw on a mix of quantitative and qualitative data sources, with findings from each method triangulated to strengthen conclusions.

2.3.1 Evaluation questions

The aims of the current evaluation were to:

- A. Assess the extent to which *Practice First* is delivered as intended by its developers and in line with the service model (implementation fidelity).
- B. Identify differences in outcomes between children who received *Practice First* supported services and those who did not.

Specific questions to guide the evaluation, as stipulated by FACS, were as follows:

1. Has the *Practice First* service model been implemented as intended?
2. Have the system, practice and culture changes led to increased capacity and efficiency?
3. Does the *Practice First* model work better for some groups of children (e.g., Aboriginal children, different child age groups, children classified into different ROSH risk categories) and families than others in terms of engagement, outcomes and safety?
4. Are children, families and other agencies more involved in decision making at *Practice First* sites, and does this involvement result in improved quality services?
5. Are the *Practice First* staff mix and support processes appropriate in providing greater support in decision making for staff and confidence to undertake their role?
6. Do practitioners in *Practice First* sites have greater work satisfaction and staff retention?
7. Are there opportunities to improve the *Practice First* service delivery model to better achieve the program objectives?

3. Methodology

This evaluation employed multiple methods to address these evaluation questions in a mixed method design involving the collection and analysis of qualitative and quantitative data from managers, caseworkers, administrative and specialist staff, and from families of children who were FACS clients.

A detailed description of each method is in [Appendix A](#).

3.1 Administrative data

The administrative data component of the *Practice First* evaluation describes activities in a child protection system, as recorded in the KiDS database, and uses a retrospective cohort design to examine whether *Practice First* has an independent influence on certain key outcomes.

The data used for this component are sourced from the Community Services annual 'reports' files, which contain historical information on all child protection reports and assessments made between the financial year 2003/2004 and financial year 2013/2014, and the Community Services 'Out of Home Care (OOHC) file' that contains placement information for every child placed by Community Services (and non-government organisations) dating back to at least the financial year 2000. Using this information, the evaluators constructed an analysis database that included the child protective service history of children and families reported to the State's CSCs covering the period of time that *Practice First* has been delivered in NSW.

3.2 Survey of caregivers

Caregivers of children currently receiving services from 12 FACS-selected *Practice First* sites were recruited to participate in brief phone surveys with the researchers. The purpose of these surveys was to assess the dynamic fidelity¹³ associated with delivery of *Practice First*.

Fifty-eight caregivers consented to participate, and 38 caregivers were contacted by phone by the PRC.

3.3 Workforce survey

All managers, caseworkers, specialists (e.g., Psychologists, Aboriginal liaison workers) and administrative staff from every CSC in NSW were invited by email to take part in an anonymous online survey addressing aspects of the structural¹⁴ and dynamic fidelity associated with implementation of *Practice First* across sites, as well as some of the workforce and child/family outcomes deemed important to the delivery of services in CSCs. The email invitation contained a

¹³ Dynamic fidelity refers to the quality and content of service delivery setting, including the relationship between caseworker and client, the methods and practices used during home visits, and the demonstration of key practices during the session (see Appendix A for further description)

¹⁴ Structural fidelity refers to practitioner, service, and organisational characteristics associated with high quality implementation (e.g., quality of casework and supervisory staff, service reach, dosage and duration, frequency of supervision, rates of completion of assessments and case plans, length of engagement with clients (see Appendix A for further description).

link to the online survey, which was preceded by a plain language information statement. Consent was implied by survey completion.

The online survey was undertaken over a two-week period in February 2015. In total, 728 valid responses were received. According to the Community Services Caseworker dashboard for the September 2014 quarter, there were 2047 FTE caseworkers in NSW. Based on this figure, we estimate the response rate was 35.6 per cent.

3.4 Interviews and focus groups with FACS staff

Focus groups were conducted with caseworkers, specialists (e.g., Psychologists, Aboriginal liaison workers) and administrative staff at six *Practice First* CSCs and two non-*Practice First* CSCs. Interviews were also conducted with managers at seven of the selected CSCs, six *Practice First* and one non-*Practice First* CSC.

4. Findings

Findings from the different methods are presented below under headings relating to each of the seven evaluation questions:

1. Has the *Practice First* service model been implemented as intended?
2. Have the system, practice and culture changes led to increased capacity and efficiency?
3. Does the *Practice First* model work better for some groups of children (e.g., Aboriginal children, different child age groups, children classified into different ROSH risk categories) and families than others in terms of engagement, outcomes and safety?
4. Are children, families and other agencies more involved in decision making at *Practice First* sites, and does this involvement result in improved quality services?
5. Are the *Practice First* staff mix and support processes appropriate in providing greater support in decision making for staff and confidence to undertake their role?
6. Do practitioners in *Practice First* sites have greater work satisfaction and staff retention?
7. Are there opportunities to improve the *Practice First* service delivery model to better achieve the program objectives?

4.1 Was *Practice First* implemented as intended?

Summary of main findings

- It was widely reported by staff that *Practice First* had been successful in changing practice and organisational culture. Nevertheless, ongoing administrative requirements and training gaps were viewed as barriers to the successful implementation of *Practice First*, as were insufficient resources, poor group supervision facilitation, uncertainty with respect to *Practice First* model fidelity, the timing of *Practice First* implementation, and the KiDS system.
- *Practice First* is not the only initiative that has led to practice changes across FACS and there was some debate about which reform was responsible for changes in practice (e.g., the requirement to do SARA assessment). However, ultimately these two approaches appear to be complementary and reinforce good practice.

Regarding time spent with families and time spent on administrative tasks:

- Staff reported increases in time spent with families under *Practice First* and this was perceived to improve the caseworkers' understanding of and engagement with families. However, there were no apparent differences between *Practice First* and non-*Practice First* sites on indicators of time spent with families (duration of secondary assessments and timing of court applications). In the absence of more accurate measures of frequency and duration of client visits, KiDS data did not reveal any differences in caseworker time spent with families. On the positive side, *Practice First* is able to operate within current organisational and legislative constraints in this respect. That is, the use of *Practice First* as a strategy does not appear to decrease the number of clients seen in a face-to-face visit, nor does it affect the length of time clients may be seen during secondary assessment. On the other hand, it may be that organisational pressures do not allow for caseworkers to fully embrace the *Practice First* model, raising concerns about the fidelity of implementation.

- While some *Practice First* sites reported an initial reduction in administrative burden, for a number of reasons not connected to *Practice First*, the administrative load on *Practice First* staff remains high. There appears to be little difference between *Practice First* and non-*Practice First* sites in terms of administrative burden, time spent with clients or likelihood that children will receive a face-to-face assessment. Initial positive shifts may be compromised by a lack of ongoing fulfilment of promises about *Practice First*.

Regarding building relationships that create change:

- Caregivers and staff reported relationships between caseworkers and families are generally positive, and most staff attributed improvements in relationships to *Practice First*.
- For many staff, the emphasis on building relationships with parents and children was leading to a better understanding of families and more meaningful client engagement. Working in this way was professionally satisfying for staff, who felt their practices were more respectful, less adversarial, more likely to effect change and ultimately led to better outcomes for children.
- Staff believed that better relationships with families helped the families to change and even when children had to be removed, caseworkers felt more confident and were able to continue to engage with parents.

Regarding caseworker skills and knowledge:

- Group supervision is regarded highly by most staff, although areas for improvement were identified. Quality of group supervision is viewed as being dependent on supervisor skills. There were also questions raised around the appropriateness of group supervision in all circumstances as some felt that some issues were best explored through individual supervision.
- Staff gave mixed responses to questions about the quality of service delivery under *Practice First*. Responses reflected views that the quality of service delivery was as good as it could be given resource constraints, that things were improving under *Practice First*, and that things could always be better. Nevertheless, nearly 8 in 10 respondents to the workforce survey reported that *Practice First* had helped them work more effectively with clients.
- There is room for improvement in staff knowledge of the key practice elements (as articulated within the Practice Standards, Practice Framework and i-Practice).

Regarding sharing risk

- *Practice First* allows caseworkers to ‘sit with risk’, which staff felt has enabled them to focus on creative approaches to building families’ capacity to meet children’s needs. Sitting with risk made staff feel more confident in the event that a child had to be removed, because they knew that all options had been exhausted.
- Staff widely valued the shift in emphasis from individual responsibility to shared decision making and the shared management of risk that was promoted through group supervision.

Practice First aims to change practice culture within CSCs to achieve improved outcomes for children identified as at ROSH. The *Practice First* model suggests that four key components are critical to successful implementation. These are:

- Increasing time spent with families (structural fidelity)
- Building relationships to create change (dynamic fidelity)
- Caseworker skills and knowledge (structural and dynamic fidelity)
- Sharing risk (structural fidelity)

To analyse the extent to which *Practice First* was implemented as intended we drew on information collected from staff interviews and focus groups (dynamic and structural fidelity), administrative data (assessing aspects of structural fidelity), and phone interviews with caregivers (assessing dynamic fidelity). Findings from each of these methods are presented under headings below that reflect the four components of the *Practice First* model outlined above. Then, information regarding the implementation process associated with *Practice First*, and barriers and facilitators is presented.

4.1.1 Increasing time spent with families

Staff interviews and focus groups

Staff indicated a number of improvements to their practice since the implementation of *Practice First*. Key to the changes was the increase in time spent with families under *Practice First*. This was perceived to improve the caseworkers' understanding of the family issues and engagement with the family, making assessments more accurate and comprehensive, and providing more information with which to make decisions. In addition, the relationships with the families helped the families to change and even when children had to be removed, the caseworkers felt more confident and were able to continue to engage with parents. It is important to note that *Practice First* is not the only initiative that has led to practice changes and there was some debate about whether the requirement to do SARA assessments or *Practice First* was more influential in changing the nature of direct work with families. However, ultimately these two approaches appear to be complementary and reinforce good practice.

It is clear, however, that *Practice First* has not removed all of the obstacles to good practice. Its introduction has created significant tensions for many staff with respect to managing administrative tasks, including recording and inputting information into KiDS, while also spending more time in face-to-face contact with families.

There are substantial inconsistencies in data recording practices across CSCs. Some CSCs seem able to shift to more succinct record-keeping and introduce measures to reduce time spent on administration, while others believe they have to record more detailed case notes. This is primarily driven by a fear of legal proceedings and represents the risk-averse practice that *Practice First* is trying to reduce. There could be a number of different reasons for these differences between CSCs, including management attitudes, staff turnover, overall organisational culture and experiences in court situations.

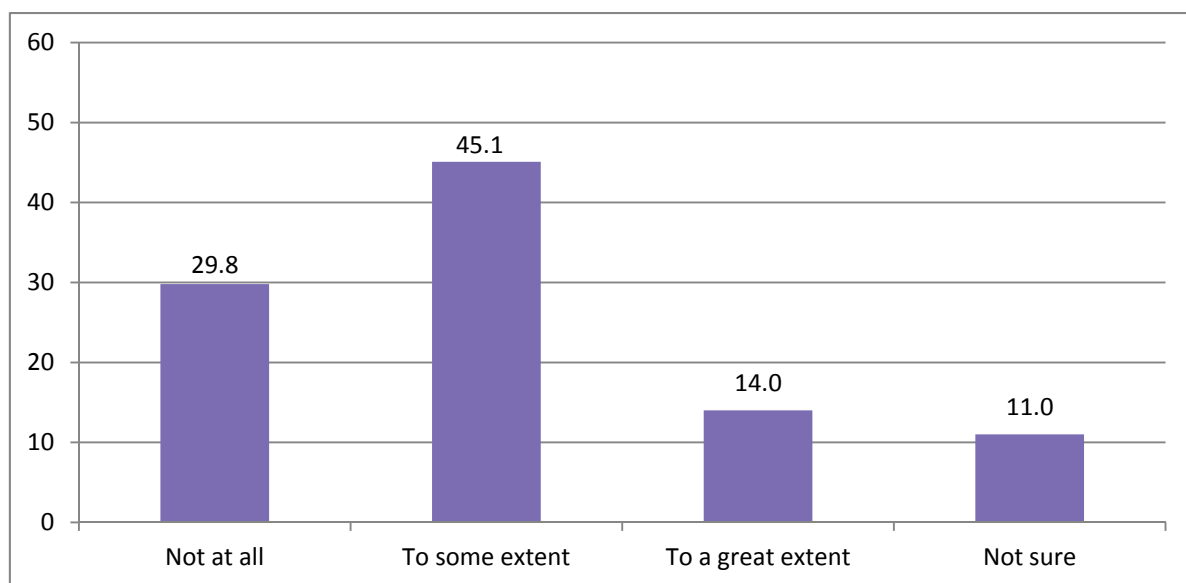
Online workforce survey

The findings from the qualitative interviews were reflected in the responses to the workforce survey.

The 400 respondents who said they had ever worked in a *Practice First* site were asked a series of questions about the extent to which they felt the *Practice First* model had helped improve various aspects of their work.

Figure 1 shows that around 60 per cent of these respondents felt that *Practice First* had, at least to some extent, helped them to spend more face-to-face time with clients, although most of this group said ‘to some extent’ (45.1 per cent) rather than ‘to a great extent’ (14.0 per cent). However, it should be noted that a relatively large proportion (29.8 per cent) reported that *Practice First* had not enabled them to spend more face-to-face time with clients, and a further 11 per cent were unsure.

Figure 1. Extent to which *Practice First* enabled you to spend more face-to-face time with clients (n=400) (%)



Comparison between Practice First sites and others

All respondents who worked directly with children or families were asked a series of questions about the appropriateness of the time they spent in face-to-face practice. The distribution of practitioners’ responses was then compared for *Practice First* CSCs and other sites, as a way to assess the impact of the initiative. Perspectives could also be compared among the *Practice First* sites, to identify any differences according to phase of implementation. Statistical significance was tested using chi-square tests.

Table 3 shows that a higher proportion of respondents from *Practice First* CSCs felt time spent on face-to-face work with children and families was about right: 27.4 per cent compared with 19.9 per cent of practitioners who were not in a *Practice First* CSC. Those in a *Practice First* site were also less likely to report that time with clients was too little (69.8 per cent compared with 76.0 per cent; $p=.09$). However, it should be noted that a high proportion of respondents overall reported that face-to-face time was too little (72.8 per cent). While the numbers reported suggest more appropriate amounts of time may be spent with clients in *Practice First* sites compared to non-*Practice First* sites, the differences are not statistically significant. The major finding is that most respondents perceive that they are not able to spend as much time as they feel is needed with

children and families. That is, structural barriers to spending more time with clients are still present for both *Practice First* and non-*Practice First* caseworkers.

Table 3. Perceptions of time spent on face-to-face work with children and families (n=610)

	<i>Practice First</i>	Non- <i>Practice First</i>	All
	%	%	%
Too much	0.3	1.4	0.8
About right	27.4	19.9	23.8
Too little	69.8 [^]	76.0 [^]	72.8
Not sure / NA	2.5	2.7	2.6

[^] $p=.09$ (for difference between respondents in a *Practice First* site (any phase) and those not in a *Practice First* site). Differences between phases of implementation were non-significant.

Practitioners were also asked about their perceptions of the amount of time they spent on administration. As Table 4 shows, *Practice First* sites were no more likely to feel time on administration was about right than those who were not in a *Practice First* site.

Table 4. Perceptions of time spent on administration (n=604)

	Any <i>Practice First</i> phase	Not in a <i>Practice First</i> CSC	All
	%	%	%
Too much	81.8	83.5	82.6
About right	16.6	14.4	15.6
Too little	1.3	0.3	0.8
Not sure / NA	0.3	1.7	1.0

To explore the extent to which administration may be interfering with practice, the survey also asked respondents to report how strongly they agreed or disagreed with the following statements:

‘Rules and regulations often get in the way of getting things done’; and

‘The interests of the children are often replaced by administrative tasks (e.g., paperwork)’.

Differences between *Practice First* and other sites were small and not statistically significant, suggesting *Practice First* has not changed these indicators. Again, this supports the view that the lack of change in administrative burden with *Practice First* limits the benefits anticipated by the service model.

The limited effect of *Practice First* on administration time was also reflected in the open-ended responses. Many respondents pointed out that practitioners’ administration time hadn’t been reduced, that they continued to find it difficult to deal with the administrative load, and that their

administrative workload impeded their service delivery. When asked how *Practice First* could be improved, respondents often called for better support with administration.

As such, data from the open-ended responses corroborated the quantitative responses, indicating that practitioners did not feel that *Practice First* had sufficiently reduced practitioners' administrative load.

Administrative data

At the outset, it is important to understand the differences between the sample used to evaluate *Practice First* and the sample of all children reported as at ROSH within the current observation window. The analysis of administrative data was complex due to the fact that *Practice First* operates at the family or household level while data are stored at the individual child level as well as at the case plan level, which in this analysis is equivalent to a household. This was accounted for by aggregating child-level information to the plan for the household (households and plans overlap completely; that is, there is one plan per household). In addition, some cases are handled by different streams of services based on the type of maltreatment and maltreatment severity. In particular, Joint Investigation Response Teams (JIRT) cases and cases seen in specialist sites are not representative of standard cases seen in either *Practice First* or non-*Practice First* CSCs, so were not included in the analysis sample. Taken together, the aggregation to plan (household) and the removal of JIRT and other cases seen in specialist sites result in a unique sample that is quite different from the overall population of children reported as at ROSH, resulting in rates of secondary (SARA/SAS2) assessments that are markedly different from what would be seen in a more inclusive sample (**Table 5**; see Detailed Methods in [Appendix A](#) for methodological rationale and explanation). Taken at an individual level, *Practice First* and non-*Practice First* sites provide a face-to-face assessment about 26 per cent of the time, while JIRT and other specialist sites, in line with the types and/or severity of the Helpline reports they receive, have face-to-face assessments far more often (42.9%). At a household level, *Practice First* and non-*Practice First* sites are still similar at about 19 per cent, while JIRT and other specialist units see a much higher proportion (52.6%).

Households/plans receiving face-to-face assessments (SARA/SAS2)

Overall, the proportion of plans (potentially involving multiple children) that include a secondary (SARA/SAS2) assessment are virtually the same for *Practice First* (19.0%) and non-*Practice First* (19.4%) sites. In addition, the demographic and case-level makeup of populations receiving a secondary assessment appears to be largely similar between *Practice First* and non-*Practice First* sites, including months since implementation (i.e., there were no detectable differences when accounting for time since implementation, though it should be noted that our observations ended June 30, 2014 and there may be differences since that time). Initial assessments (SAS1's) involving younger children and children with a child protection history of prior reports and placements into OOHC were more often provided with a secondary (SARA/SAS2) assessment.

Table 5. Rate of face-to-face assessments by level of aggregation, *Practice First*, and JIRT and other specialist sites

	<i>Practice First</i> Sites (average)	Non- <i>Practice First</i> Sites (average)	JIRT and other specialist sites (average)
% individual children in all ROSH reports with any secondary investigation associated with report ¹⁵ (N = 313,707)	26.0	26.2	42.9
% unique households / plans with any secondary investigation associated with the first plan in observation period (this analysis) ¹⁶ (N = 50,979)	19.0	19.4	52.6

Note: This is a high-level description of the data to demonstrate the differences in level of analysis and type of report. Additional selections that were made to perform subsequent analyses have not been included here. Please see detailed methods section for further information.

Summary

In summary, the findings indicate that in some *Practice First* sites there was an initial reduction in administrative burden but that for a number of reasons **not connected to *Practice First*** the administrative load on *Practice First* staff remains high, and that currently there appears to be little difference between *Practice First* and non-*Practice First* sites in terms of administrative burden, time spent with clients or likelihood that children and their corresponding households will receive a face-to-face assessment. A number of reasons were given for this including the continuing risk aversion of the agency and the paradoxical effect that more visits to clients require more recording. In some *Practice First* sites this issue has been mitigated by more effective and efficient recording practices but this is not the case across the whole of *Practice First*.

4.1.2 Building relationships to create change

Practice First prioritises building relationships between families and caseworkers to foster open communication, information sharing, shared decision making and increased family motivation to change over sustained periods.

Caregiver phone survey

Items on the *Practice First* Dynamic Fidelity Checklist that relate to building relationships to create change included statements such as, ‘Before the session I knew that the worker was going to come’, ‘During the session the worker listened to me’, and ‘During the session the worker talked

¹⁵ That is, out of every report received for every child, including multiple reports for the same child, what percentages were associated with a face-to-face investigation?

¹⁶ That is, the first time we saw each household, did they receive a face-to-face investigation at any point after any report?

about the good things I am doing for my child', to which caregivers gave a yes, no, a little, or not sure/no response (see [Appendix E](#)).

In general, caregivers rated their caseworkers highly on adherence to aspects of *Practice First* service delivery that are aimed at building relationships to create change. This suggests that according to caregivers, caseworkers were demonstrating behaviours, practices and principles consistent with the *Practice First* Practice model.

Across all sites at least three quarters of respondents indicated that their caseworker demonstrated actions reflecting the family having a right to respect. The use of positive language when talking about the family was particularly common, with over 9 in 10 caregivers reporting that their caseworker had demonstrated this in the previous session.

Caseworkers reportedly demonstrated an appreciation of families' contexts, although there was a difference between pilot/phase 1 sites (63 per cent of respondents reported that during the session they felt that the caseworker was being honest about their concerns) and phase 2 sites (95 per cent).

Regarding the principle that relationships are key, 81 to 91 per cent of caregivers reported that their relationship with their caseworker was strong and positive. There were mixed views about caseworker's actions to praise family progress while still feeling comfortable enough with the relationship to challenge caregivers. For pilot/phase 1 sites, the vast majority of respondents indicated their caseworker did praise and challenge them, however for phase 2 sites, less than 60 per cent responded 'yes', and a large proportion of respondents were either not sure or declined to answer this item.

Open-ended survey responses

Although not specifically elicited as part of the survey, the phone discussions did provide caregivers an opportunity to express their views about the services they received from their caseworkers and their experiences with the child protection system. Comments that were relevant to this evaluation were collated. They reveal additional insights from the end-user point of view about the value (or otherwise) of *Practice First*. For instance, several participants explained that they had previously had negative experiences with FACS or "DoCS" or in other areas of Australia (e.g., saying their previous caseworkers were suspicious, disrespectful and antagonistic), yet their more recent experiences with FACS was described as a dramatic change.

The majority of respondents to the phone survey shared positive reflections about the way their caseworker related to them, describing caseworkers as "*an excellent source of support...to the whole family*", "*a very soft, caring, gentle lady...she is also caring and supporting us*", "*easy to talk to*" and that "*I really appreciate the one-to-one positive female relationship with my caseworker*". Other positive reflections are presented below.

I feel very positive about my experiences with DoCS. My granddaughter had to be removed from an abusive situation and they really helped us. In the past they didn't help, but eventually they made the decision for her to stay here with us (grandmother and father) and now she is in a loving environment.

I'm very happy with my caseworker, he is a good male role model for my grandson. They spend time together and they have a good relationship.

My caseworker was respectful, friendly, and professional and we had good rapport. This was very different to my previous experiences in Queensland. My previous experiences were terrible and very destructive to my family.

My caseworker now is solution focused and knows when to bring-up issues. He is just trying to do his job. I'm relieved because as a foster carer I have had some very bad experiences with FACS over the last 10 years.

I've known my caseworker for a long time. I previously had my older children removed and now I have a case with my youngest. But because I've maintained a relationship across time I feel like I trust her. I really like my caseworker.

Despite generally positive views about caseworkers under the *Practice First* model, caregivers did also express some concerns that reflect poor adherence to the *Practice First* way of working with families. For instance, some expressed concern that their caseworker was not being open and honest with them about concerns, or that the tenet of respect for the family had been breached:

I had an issue with confidentiality. I needed to complain about how my caseworker handled our situation. But every time I complained things got worse, so I think they talked to each other in the office. There was no confidentiality.

Sometimes I felt like my caseworker listened to referrers more than me. I also felt like sometimes they were being two-faced and weren't honest with me.

A couple of participants commented that they did not understand why they were involved with FACS:

My caseworker is unreliable now. I'm unsure where I stand and where I'm up to. I don't know why the case is still open.

I didn't understand why FACS was being involved.

Staff interviews and focus groups

Participants in focus groups and interviews indicated that operating under a *Practice First* framework was associated with the development of more meaningful/purposeful relationships with clients. Staff felt that these relationships could contribute to better outcomes for children and families and lead to lasting change, by reducing re-entry into the child protection system. Staff felt that *Practice First* allowed them to work in a more respectful manner; that their practices were less adversarial; that they were more conscious of communicating in terms that were meaningful to families; that *Practice First* was a better way to engage Aboriginal families; and that working within a *Practice First* framework was leading to improved outcomes for children, young people and their families.

The *Practice First* emphasis on relationship-building resonated with staff who found the approach more respectful of clients, which they felt was critical if they hoped to effect change.

I mean we can't go out there and tell families this is what you've got to do and everything will be all right. It's more around working with them to develop an understanding of why things need to change. And I think Practice First allows us to build those relationships to then have those conversations with families.

Staff reported that pre-*Practice First* their focus had been on assessing risk and then making a decision to close the case, take it to court or give it to another agency to address, whereas under *Practice First*: “we’ve started to see that we have a role in fixing the problem.”

Staff felt that working under *Practice First* allowed them to work more purposefully and intensively with families, with more face-to-face contact and fewer phone calls. They contrasted this to their pre-*Practice First* practices where they would often fail to grasp the multi-layered complexities of a family’s situation.

Gaining a more in-depth understanding of clients’ context was viewed as critical for developing empathy, being less judgemental and working towards better outcomes for families. The emphasis on strengths rather than deficits was also regarded as a notable positive shift in practice. One caseworker, who had only worked at Community Services under *Practice First*, reported that clients had commented that they felt that their relationship with Community Services was much improved in recent times and that they were now getting the help they needed. For another caseworker, as a consequence of *Practice First*, staff now have the opportunity to develop meaningful relationships through more frequent home visits with both parents and children, something that did not happen pre-*Practice First*:

Somebody asked me what was the difference between working in a Practice First site and working not in a Practice First site and I said “Well the kids know my name.” When I walk into the house they see me enough that they know my name and that was a really significant...

As a consequence of the practice changes associated with *Practice First*, some staff felt that clients had changed their perceptions of the work of Community Services. Staff reported that clients’ view that the Department’s core business was child removal appeared to be shifting. An office support staff member (*Practice First* implemented at CSC in December 2012) described making the mistake of introducing herself to a client as being from DoCs, to which the client replied:

“Well, no, you’re not from DoCs.” She said, “You’re from FACS. You’re very different from DoCs. You’re not here to take my kids.” I said, “Oh, look, totally agree. Don’t know why I said that, it was just habit.” But, yeah, she was, like, “You’re not those people anymore.”

While applauding the emphasis on relationship building under *Practice First*, a manager (*Practice First* implemented December 2013), struggled with the emphasis on relationship building when a statutory response may be necessary if there is risk of significant harm. Yet despite this tension, they were keen to emphasise that the *Practice First* principles “are almost like this constant backdrop or canvas which we build our relationships with.” Even in the event that a child had to be removed, the manager emphasised that the influence of the *Practice First* principles were evident in staff’s engagement with the family, through respectful communication, listening, and engaging the wider family where appropriate. An additional tension they identified was the emphasis on spending more time with families, but also trying to see a higher volume of cases.

The emphasis on building better relationships with clients was perceived as having two contrasting results in the context of child removal.

On the one hand, several staff felt that the decision to remove a child was easier because they had had the opportunity to develop a relationship with the parents and they felt that parents were more likely to understand why their child was being removed. Staff were more comfortable in the

event that a decision was made to remove a child, because they were confident that all options to keep the child safe in the family home had been exhausted. Some staff also commented that even when a situation ended up in Court, the time spent building a relationship with the family allowed them to offer some balance to proceedings by focussing on the positives as well as the negatives.

On the other hand, one manager reported that child removal was even more difficult under *Practice First* because staff invested so much time in developing relationships with clients, and because families felt betrayed, which was difficult for staff.

A minority of staff felt that they had always worked according to many of the *Practice First* principles before *Practice First* implementation and therefore did not feel that the implementation of *Practice First* at their CSC had any influence on their work practices.

Less adversarial

As a consequence of the emphasis on building positive relationships with clients, staff felt that their work practices were less adversarial and confrontational under *Practice First* than before. All were aware that confrontation was inevitable in their work, but *Practice First* appeared to have made staff more mindful about how to manage confrontation and to be more respectful in their interactions with clients. Pre-*Practice First*, staff referred to the habit of showing up at clients' homes unannounced, whereas under *Practice First* efforts were made to make appointments to visit clients at times that were convenient for them. Even in situations where a report required a response within 24 hours, one manager spoke of how working under a *Practice First* framework had raised their awareness of trauma and has encouraged her to try to help staff manage potentially confrontational encounters:

So in my role I can help a caseworker or a manager casework understand that trauma, so that when they go out into a confrontational situation, with a 24 hour report, the approach to that could be quite different [from past practice].

For some staff, the emphasis on relationship-building under *Practice First* also served to reduce the level of confrontation in court situations, because they felt that families and children had a better understanding of what was happening and why.

Language

Staff from all of the *Practice First* CSCs involved in the evaluation spoke about how *Practice First* had raised their awareness of the impact of language, which influenced the way they spoke to clients and to each other. Staff reported making efforts to speak respectfully to clients, using terms that were meaningful to them and reducing reliance on the formal terminology that was more prevalent pre-*Practice First*.

Going back before it was very jargonistic, you know, "We've got a report about this, this, this." Now [we use] simple language, "We're worried about such and such," in terms that everyone's clear about.

A manager in one CSC (*Practice First* implemented December 2012) reported they were attempting to simplify the language they used in formal documents often used in the Children's Court and care plans to ensure that families could understand what was happening. She referred to "some

resistance from legal about some of those changes” and the need to educate them as to why these changes were important.

Staff spoke of how the *Practice First* principles imbued their everyday work practices, with staff challenging each other about the language they used when referring to clients. The catchcry ‘That’s not very *Practice First!*’ was reported by staff in a number of CSCs as a playful way of taking staff to task for using inappropriate or disrespectful language.

I can hear it from my office, just people saying ‘That’s not very Practice First!’ in a joking way but it carries the message.

Staff spoke of trying to be mindful to speak about clients as if they were present in the room and some managers spoke of growing awareness of how language impacts on thinking:

So rather than saying that someone really can’t get their shit together, it’s around that they’re not able to cope due to their anxieties or something like that. So it’s about how we express what their experiences are to each other.

Some staff also referred to the frustrations they experienced when working with external agencies that did not uphold *Practice First* principles.

In a joint interview with two managers (*Practice First* implemented December 2012), they shared the view that while *Practice First* had raised staff’s awareness of language in the early months after implementation, there had been some reversion to old ways of speaking in some pockets of the CSC and fewer instances of staff calling each other to task. They attributed this to the fact that some staff at their CSC felt disillusioned with the mismatch between the promise of *Practice First* and their experience of trying to work within a *Practice First* framework:

Certain things haven’t been delivered, you’re still trying to keep up with all the work that’s not been alleviated and so you’ve let things go in general.

Aboriginal families and Practice First

An Aboriginal caseworker felt that under *Practice First* she had greater opportunity to provide cultural advice to her colleagues through group supervision. She also felt that operating under a *Practice First* framework was “a lot better for Aboriginal families”, because they were afforded more respect. The emphasis on exhausting all options in the best interests of the child under *Practice First* also allowed this caseworker to go to greater efforts than she might have pre-*Practice First*:

“We’ve got an [Aboriginal] child and we’ve just found out that [...] his birth’s not registered. We find it really hard to contact dad because I need dad to come in now and sign the papers and ID himself. But I think in the past we would have just sent those forms off. Don’t worry about dad. If he doesn’t want to be there that’s his issue. But now, myself, I’m saying, “Well, this little boy’s Aboriginal and this comes from dad’s side. So I think it’s really important that we do everything in our power now to contact dad.” And I think I’ve changed in that way as well.”

A manager at another CSC felt that clients’ perceptions of Community Services were far less negative than in the past, something that they felt was particularly apparent among Aboriginal

families. They gave two examples to illustrate the dramatic shift in attitude towards Community Services among Aboriginal parents.

In the first example, an Aboriginal mother initially refused to engage with the CSC, because she thought her children would be removed, but caseworkers managed to work with her intensively over several months before closing the case. About a year later, the mother put in a request for assistance through the Helpline and requested particular caseworkers within the CSC who had supported her previously.

In the second example, an Aboriginal grandmother whose own children had been removed by Community Services many years earlier was now caring for her grandchildren. The grandmother contacted the CSC to request food assistance support, and in doing so acknowledged that *“it took a lot of her energy and strength to actually come into the office and talk to us and ask for support.”* The manager felt that the grandmother had been able to make this shift because since taking on the care of her children *“she had a good relationship with the workers in the office, and felt that she’d been heard.”*

The perception that *Practice First* is a more respectful way to work with Aboriginal families was echoed by another manager:

If you’re going to work with Community Services in an Aboriginal family then Practice First is the way to do that.

Improved outcomes for children, young people and their families

Compared to their pre-*Practice First* practices, staff generally felt that working within a *Practice First* framework was leading to improved outcomes for children, young people and their families. Factors identified as contributing to improved outcomes included:

- Undertaking comprehensive assessments and adopting a more holistic approach to addressing families’ needs
- Collaborating with other agencies that could take some of the pressure off Community Services by supporting clients and allow Community Services to *“get back to our core business and focus on the families that really need us in their life at that period of time.”*
- Being more responsive to client needs because staff have a better understanding of other cases and can step in when a caseworker is on leave: *“Because I was off sick and [caseworker] just picked it up. She knew where it was so she picked it up and just ran with it.”*
- Giving clients the chance to gain a better understanding of what is concerning Community Services so that they will want to make changes to keep their children safe
- Being more child-focussed and improving engagement with children *“so we actually know what they need better and we make better decisions for them”*
- Being less adversarial
- Being willing to be flexible and think creatively: *“I think this model gives permission to do that.”*
- Being more considered in interactions with and decision making about families:

Summary

In summary, both caregivers and staff reported that relationships between caseworkers and families are generally good, and most staff attributed improvements in relationships to *Practice First*.

For many staff, the shift to *Practice First* was transformative. Staff felt that the emphasis on building relationships with parents and children was leading to a better understanding of their lives and allowing for more meaningful engagement. Working in this way was more professionally satisfying for staff, who recognised that it was more likely to effect change. Staff felt that their practices were more respectful, less adversarial, more likely to effect change and ultimately lead to better outcomes for children. For many staff, their work practices under *Practice First* stood in marked contrast to their pre-*Practice First* practices.

However, staff in one CSC reported an initial positive shift in practice in the early stages of *Practice First*, but subsequent disillusionment has resulted in some slippage from some *Practice First* principles. The disillusionment is particularly related to the fact that the administrative burden had not reduced and some caseworkers felt very pressurised because they were required to continue with excessive administration and recording tasks while trying to spend more time face-to-face with clients.

It is also important to note that while many felt the shift to *Practice First* had ushered in a fresh approach to the way they worked with clients, others were quite adamant they had always worked according to the principles enshrined within the *Practice First* framework and to work any differently was unthinkable. Nevertheless it is clear that *Practice First* has facilitated an overall cultural shift in most CSCs, albeit that the change appears to be rather fragile. There is a risk that factors such as work pressures or staff turnover could relatively easily reverse some of the progress made by *Practice First*.

4.1.3 Caseworker skills and knowledge

Practice First incorporates a range of strategies to increase the professional skills of caseworkers, with the intention of increasing their satisfaction in their job and improving their confidence in family support. Key caseworker skills relate to strengths-based practice, motivational interviewing, and the appropriate use of assessment and recording materials. These skills are fostered within a model of group supervision that promotes reflective practice.

Caregiver phone survey

Items on the *Practice First* Dynamic Fidelity Checklist that related to caseworker skills and knowledge, and the percentages of caregivers who responded yes, no, a little, and not sure/no response for each item are listed in **Table 6**. In general, caregivers rated their caseworkers highly on adherence to aspects of *Practice First* service delivery that reflected on caseworkers' knowledge and skills. This suggests that according to caregivers, caseworkers were demonstrating behaviours consistent with the *Practice First* Practice model. Specifically, over three quarters of respondents across all phases indicated their caseworker had used language they could understand and checked for understanding.

Table 6. Percentage of respondents in each response category across dynamic fidelity indicators

	Pilot (n=1) and Phase 1 (n=15)				Phase 2 (n=22)			
	Not sure/ no response	Yes	No	A little	Not sure/ no response	Yes	No	A Little
<i>Principal 4: Language impacts on practice</i>								
*During the session the worker always used words that I could easily understand	0	81	0	19	0	91	5	0
<i>Principal 7: Reflective practice</i>								
*During the session the worker checked that he/she had understood me correctly	0	75	25	0	0	82	14	0

*There was missing data for one respondent from Phase 2 on items marked with an asterisk. The survey was discontinued early at the respondent's request. There was no other missing data across participants.

Note. Percentage values are rounded up to whole numbers, therefore in some cases rows do not total to 100 per cent.

Staff interviews and focus groups

Caseworker skills and knowledge through group supervision

Group supervision was identified as an important opportunity for skill development and learning for staff because it gave them the opportunity to hear from a mix of staff and specialists. Group supervision was recognised as the forum in which staff could “*practice our practice*”. Staff spoke of using group supervision to role play a visit to a client or get feedback on a family interview concerning the questions they might ask, or how they might prepare a case. Staff also spoke of going over Motivational Interviewing skills in group supervision. One Aboriginal caseworker felt that she was able to contribute to her colleagues’ cultural awareness and understanding through the group supervision process. One of her colleagues found this particularly valuable “*because it’s really hard to get a consultation from our Aboriginal consult person*”. A manager also felt that group supervision was an important venue for identifying skill gaps that might have been less apparent under the pre-*Practice First* individual supervision model. The benefit of group supervision was that:

As an individual worker you could possibly – if you’re just having conversations with your manager about your practice you can wangle that a little bit differently to being exposed by your colleagues who make you – you’re accountable to more than one person.

Several specialist staff felt that the group supervision model gave them the opportunity to make a greater contribution to caseworkers at their CSC. For casework specialists, group supervision was important for engaging with staff and identifying support needs. By being present at group supervision, psychologists felt they could make a bigger difference to caseworkers because they could give advice “*in real time*”. These points were raised in a second focus group where casework specialists and psychologists were regarded as having more purposeful engagement with staff through the group supervision model:

Instead of having haphazard consults or willy nilly things like people talked about, I guess we get to sit with a team kind of in real time and follow cases right through. So I think a lot of it – like certainly in this position it’s definitely improved. And I would say to that, it enables like psychs and specialists to have better ongoing relationships with the teams to feel like they’re more part of the teamwork, rather than just to come along for a minute, say, ‘Hey, why don’t you try this?’ and then kind of go away.

Staff reported that with the introduction of group supervision, individual supervision became optional, with caseworkers or managers initiating it if they felt the need. While both are available, there was a sense that individual supervision happens less frequently than it did in the past and that group supervision can often be the appropriate forum to discuss issues that previously would have been discussed between manager and caseworker in individual supervision.

Some staff, however, felt that there were certain issues that were best addressed through individual supervision such as performance issues, workload planning and career development opportunities (although it was acknowledged that the Professional Development Plan framework, which sits outside *Practice First*, is intended to address the latter).

Although group supervision was widely endorsed and regarded as a very positive practice change, a few participants expressed concern that some staff might be reluctant to raise particular issues in a group forum.

And if you’re not forthright enough to go up and say, “Hey, I really need to talk to you because there’s some issues happening for me,” then you’re not going to get that. That could then impact on your work.

One of the CSCs (*Practice First* implemented December 2012) reported that several teams have reinstated individual supervision, because they found that they could not incorporate workload planning into the time available for group supervision.

There was no - Practice First is - didn’t come with a workload planning tool. They said that the group supervision would replace the workload planning. Rightly so teams right across the state have said, “We need workload planning still. Yes, group supervision’s great. We love it. We only get to X number of cases. We still need that individual supervision.”

Conversely, one CSC (*Practice First* implemented December 2012) identified the shift away from individual supervision as a positive practice change coming out of *Practice First*. The managers at this CSC reported that staff found individual supervision and individual case reviews to be boring and un-motivating in contrast to group supervision.

Open-ended responses to the workforce survey also provided detailed insight into perspectives on the impact of *Practice First* on supervision. When asked what was working well, many respondents pointed to group supervision, for example:

The group supervision process is valued and has become an integral part of our work. At times it is a bit formulaic, but in general it is a great as promotes critical reflective thinking in a shared forum.

However, although supervision was generally seen as a supportive element of the *Practice First* model and helpful for case review, many respondents felt supervision was an aspect of *Practice First* that needed improvement. Several felt managers did not necessarily have the necessary skills to conduct group supervision, and caseworkers still required individual supervision, for example:

Group supervision has resulted in supervision between caseworker and manager casework being discontinued. This is a negative impact. Some managers do not have the skills to conduct group supervision.

Group think in group supervision can be problematic. No individual supervision is offered.

Group supervision needs to be used more effectively to create a culture of reflective practice. Instead of just a group of people sitting around judging our families and agreeing with whatever the caseworker has decided. People need education and training on what is involved in critical reflection - how to think analytically about cases and question our own judgements of cases.

Others pointed out that group supervision had had unintended consequences of increasing workloads and reducing support and guidance for caseworkers:

The introduction of group supervision worked well with my team. For me as a MCW, my workload re time spent in supervision/case review dropped, thus providing me increased opportunities for more face-to-face time with my team members to support them, however for the caseworkers their time spent in supervision increased, everyone's paperwork load increased and therefore there was no increase in face-to-face time with the families yet.

Quality of service delivery

Staff were asked to comment on whether they felt that working under *Practice First* had influenced the quality of service delivery at their CSC. Comments ranged from the quality of service delivery being as good as it could be given resource constraints, to a sense that things were improving under *Practice First*, and a sense that things could always be better.

Some felt that working under *Practice First* had improved the quality of service delivery because:

- caseworkers had more face-to-face contact with clients
- interactions with and discussions about clients were more respectful
- interactions were less adversarial than before
- there was a perceived drop in re-reports, which the manager felt was reflective of improved service delivery, although she did not know the actual figures

- comments from long-term clients concerning improvements in the support they have received since *Practice First* implementation improved skills among caseworkers
- there was greater collaboration and improved decision making
- there was greater awareness of clients and their situations among front desk staff, thereby improving their ability to respond or refer appropriately

One interview participant reported feeling pleasantly surprised by the energy and commitment to *Practice First* that she witnessed when starting work at a *Practice First* CSC:

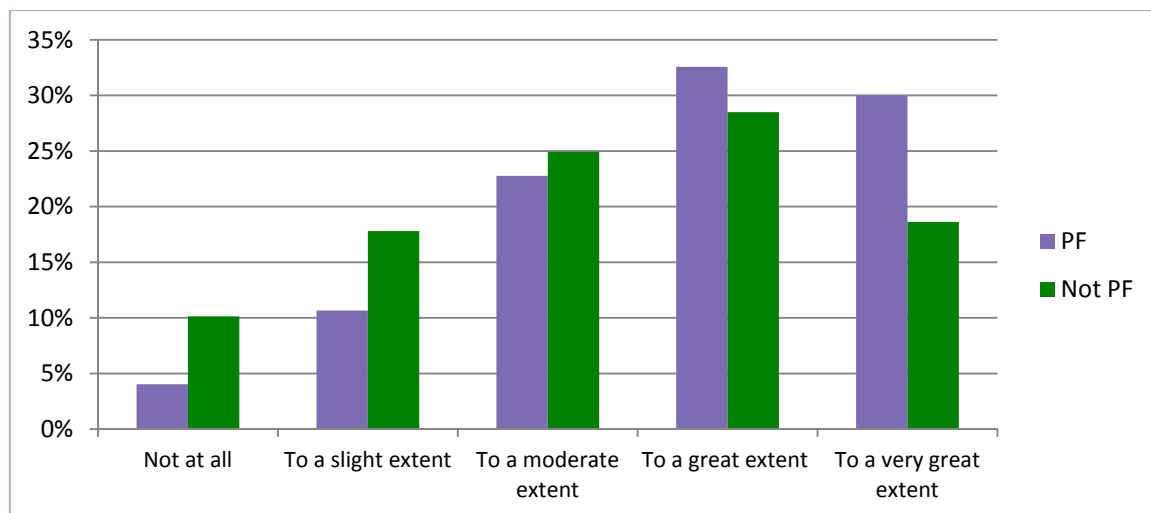
They're very practice focused and considerate and I think that people feel more comfortable about expressing empathy for families and for different members of the family. Whereas before, there was this real feeling that we have to be neutral and that's about showing a bias and we've got to hide all that somewhere. Yeah and I think people actually feel comfortable to talk about personal values and how [Practice First] exposes some of that in those conversations in group supervision.

Some felt that *Practice First* and the structured decision-making tool (SARA) were mutually reinforcing and had contributed to a better quality of service delivery at their CSC through improved and more timely decision making.

Online workforce survey

The survey results provide mixed evidence about the impact of *Practice First* on caseworkers' experiences of supervision. First, respondents were asked to state how strongly they agreed with the statement "*There are regular opportunities to reflect on cases with my supervisor, or in my supervision group*". Those in a *Practice First* site were less likely than others to say they agreed with this 'not at all' or 'to a slight extent', and more likely to agree to a 'great' or 'very great extent' (see **Figure 2** and **Table 7**). Differences were statistically significant ($p < .001$).¹⁷

Figure 2. Level of agreement that there are regular opportunities for supervision (n=712)



¹⁷ As a check, we restricted analysis to those who said their role involved working directly with children and families. The results were consistent with those in **Figure 2** and **Table 7** in that more practitioners from *Practice First* sites were more likely to agree that they had regular supervision opportunities to a great or very great extent, and less likely than those outside *Practice First* sites to agree not at all or only to a slight extent.

Table 7. Level of agreement that there are regular opportunities for supervision (n=712) (%)

	Pilot/Phase 1 sites	Phase 2 sites	Phase 3 sites	Any <i>Practice First</i> phase	Not in a <i>Practice First</i> CSC	All
Not at all	4.4	1.6	4.8	4.0***	10.1***	7.2
To a slight extent	8.8	13.1	11.9	10.7***	17.8***	14.3
To a moderate extent	25.6	27.9	16.7	22.8	24.9	23.9
To a great extent	31.9	27.9	35.7	32.6***	28.5***	30.5
To a very great extent	29.4	29.5	31.0	30.0***	18.6***	24.2

*** $p < .001$ (difference between respondents in a *Practice First* site and those not).

However, while *Practice First* appears to have made a difference based on respondents' perspectives on the extent to which there were regular opportunities for supervision, other measures did not indicate a positive impact. **Table 8** shows that overall, there were no significant differences in caseworkers' perspectives of the amount of time spent in supervision between *Practice First* and non-*Practice First* sites ($p > .05$). However, those in Phase 3 sites were more likely than other *Practice First* sites to report that supervision time was too much, and less likely to report it was too little ($p = .005$). There was no difference across sites in caseworkers' levels of confidence in their supervision (data contained in **Table 10**) or satisfaction with supervision (see **Table 14**).

Table 8. Perceptions of time spent in supervision (n=609) (%)

	Pilot/Phase 1 sites	Phase 2 sites	Phase 3 sites	Any <i>Practice First</i> phase	Not in a <i>Practice First</i> CSC	All
Too much	4.3**	3.4**	16.2**	8.5	5.1	6.9
About right	54.6	56.9	57.3	56.0	54.9	55.5
Too little	32.6**	31.0**	20.5**	27.8	31.7	29.7
Not sure / NA	8.5	8.6	6.0	7.6	8.2	7.9

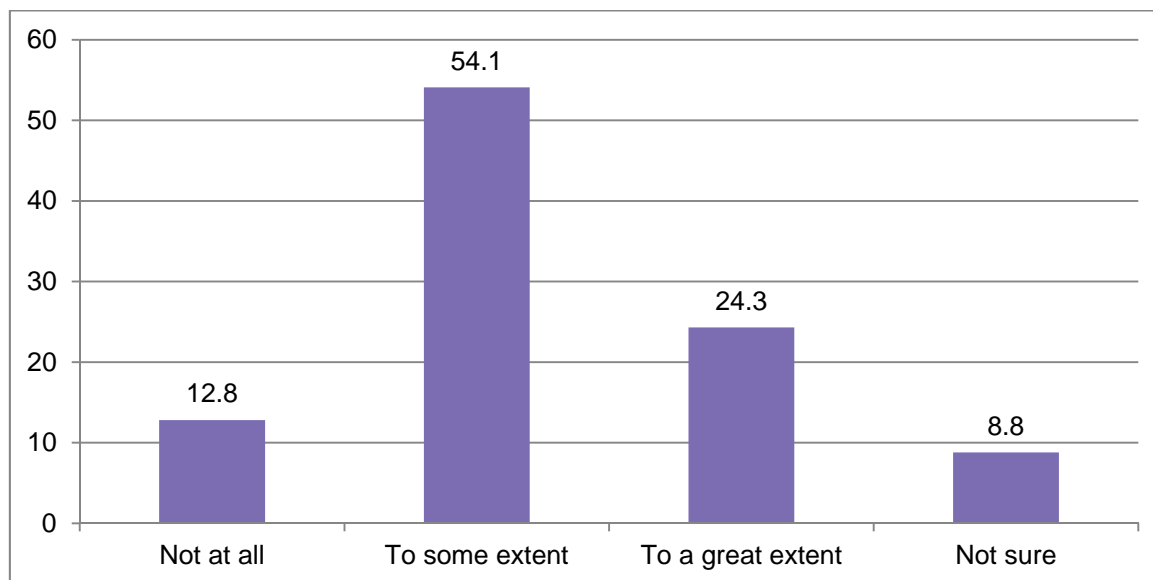
** $p < .01$ (difference between respondents in Phase 3 *Practice First* sites and other *Practice First* sites).

Work with clients

Respondents who were currently working or had ever worked in a *Practice First* site were asked the extent to which they felt *Practice First* had helped them to work more effectively with clients.

Of the 400 respondents to this question, 78.4 per cent felt the initiative had helped them work more effectively with clients, with nearly a quarter (24.3 per cent) reporting this was the case ‘to a great extent’ (see Figure 3).

Figure 3. Extent to which respondents’ felt *Practice First* enabled them to work more effectively with clients (n=400) (%)



Understanding of the Practice Framework and Standards

Participants were also asked to rate their understanding of key practice elements. Overall, less than half of respondents felt they understood the Practice Standards or the Practice Framework, and only a small proportion of respondents felt they understood i-Practice to a great or very great extent. However, as Table 9 shows, those in *Practice First* sites were more likely to agree that they understood the Practice Standards, Practice Framework, and i-Practice, to a ‘great’ or ‘very great’ extent. While the proportion who understood the Practice Standards to a great or very great extent was highest for Phase 2 sites, understanding of i-Practice and the Practice Framework was highest in Phase 3 sites. For all measures, both differences between *Practice First* and non-*Practice First* sites, and differences across phases, were statistically significant ($p < .05$).

Table 9. Percentage of respondents who agreed they understood aspects of *Practice First* to a ‘great’ or ‘very great’ extent

	Pilot/ Phase 1 sites	Phase 2 sites	Phase 3 sites	Any <i>Practice First</i> phase	Not in a <i>Practice First</i> CSC	All
Practice Standards (n=727)	54.9	60.3	51.9	54.8	42.9	48.7
Practice Framework (n=726)	49.4	49.2	55.8	51.7	38.9	45.2
i-Practice (n=722)	13.5	14.3	24.8	17.8	10.1	13.9

Practitioners' confidence in their work

As **Table 10** shows, respondents in Pilot/Phase 1 and Phase 2 sites were slightly more likely than others to say they felt confident or very confident in their face-to-face work, but less likely to feel confident with administration, perhaps reflecting the reduced emphasis on administration in *Practice First* sites. While the differences in confidence in face-to-face work were not statistically significant, there were significant differences in caseworkers' confidence in performing administration both between *Practice First* and non-*Practice First* sites, and across *Practice First* phases, because of lower confidence in pilot/phase 1 sites ($p < .07$). It is also notable that caseworkers' perceptions of their confidence in supervision did not differ across the sites, despite those in *Practice First* sites being more likely to agree they had regular opportunities for supervision (see **Table 7**). Confidence in involving children and families in decision making was also slightly higher outside the *Practice First* sites, although the difference was small and not statistically significant.

Table 10. Percentage of respondents who felt 'confident' or 'very confident'

	Pilot/Phase 1 sites	Phase 2 sites	Phase 3 sites	Any phase <i>Practice First</i>	Not in a <i>Practice First</i> CSC	All
Administration [^] (n=612)	74.5	83.1	81.4	78.6 [^]	84.0 [^]	81.2
Face to Face work (n=612)	95.1	96.6	91.5	94.0	91.8	93.0
Working with other agencies (n=611)	86.6	94.9	90.7	89.7	87.3	88.6
Court work (n=608)	56.0	56.9	56.8	56.5	55.3	55.9
Supervision (n=604)	64.0	67.2	69.8	66.8	66.3	66.6
Involving children and families in decision making (n=608)	82.9	81.0	85.5	83.5	87.0	85.2

[^] $p = .051$ (difference between *Practice First* and non-*Practice First*), $p = .063$ (difference by phase).

Summary

Caregivers rated their caseworkers highly on adherence to aspects of *Practice First* service delivery that reflected on caseworkers' knowledge and skills. The aspect of *Practice First* that was seen to most closely relate to caseworker skills is group supervision, which was regarded highly by staff although areas for improvement were also identified.

The group supervision process was identified as a critical forum for building caseworker skills and knowledge. It gives caseworkers the opportunity to discuss challenging cases, role play encounters

and get feedback from colleagues (including caseworker specialists and psychologists) who can offer a range of perspectives and insights into how to tackle a particularly challenging case.

However, the quality of group supervision is dependent on the skills of the supervisor, and there were indications that this needs improving in some areas. There were also questions raised around the appropriateness of group supervision in all circumstances as some felt that some issues were best explored through individual supervision.

4.1.4 Sharing risk

Practice First is intended to change the way risk is managed. The approach is to allocate a primary worker to a family but for significant decision making to require team endorsement and senior staff consultation. Specialist input, Aboriginal consultation and legal advice are available to caseworkers in ‘real time’ through group supervision, as is the involvement of external agencies who are also involved with a family. There is a shared understanding among all stakeholders that the aim of casework is to decrease the number of children entering long-term OOHC and increase the number of children who remain with, or are successfully restored to, their families. The safety of children is assessed continuously through appropriate and consistent use of common assessment tools and adherence to legislation.

Caregiver phone survey

The item on the *Practice First* Dynamic Fidelity Checklist that related to sharing risk and the percentages of caregivers who responded yes, no, a little, and not sure/no response is listed in **Table 11**.

Despite generally high ratings of dynamic fidelity across other items on the survey, the item ‘During the session I was involved as much as I wanted to be in decisions about my child or family’ received higher prevalence of ‘no’ responses relative to other items (25 per cent for Pilot/Phase 1 respondents and 14 per cent for Phase 2 respondents).

Table 11. Percentage of respondents in each response category across dynamic fidelity indicators

	Pilot (n=1) & Phase 1 (n=15)				Phase 2 (n=22)			
	Not sure/ no response	Yes	No	A little	Not sure/ no response	Yes	No	A little
<i>Principal 8: Sharing decision making & risk</i>								
*During the session I was involved as much as I wanted to be in decisions about my child or family	0	56	25	19	5	73	14	5

*There was missing data for one respondent from Phase 2 on items marked with an asterisk. The survey was discontinued early at the respondent’s request. There was no other missing data across participants.

Note. Percentage values are rounded up to whole numbers, therefore in some cases rows do not total to 100 per cent.

Staff interviews and focus groups

For staff, sitting with risk was about being less reactive, working more closely with families and exploring all options whilst trying to keep children safe at home. Staff felt that the *Practice First* approach of 'sitting with risk' has enabled them to focus on how to “keep the family functioning and together at home” and the encouragement to think creatively about how to address a family's needs was welcomed.

We are encouraged to think of different ways to manage that risk, and you know, you as a caseworker, invest a lot of effort into that family like so you invested your skills and you know your time, so you build that relationship with them

Building relationships was recognised as a critical part of sitting with risk and staff were conscious of the need to invest time and energy with the family and to be available when needed. One staff member contrasted this to pre-*Practice First* where child removal happened before any relationship building:

It was more that I would go out and remove children and then I would build relationships with them following that, as opposed to now like we sit with a lot more risk.

Group supervision was recognised as a critical component of sitting with risk, because it enabled staff to sit together and collectively determine whether the available evidence pointed towards removal or highlighted the opportunity to sit with risk. Sitting with risk made staff feel more confident in the event that a child had to be removed, because they knew that all options had been exhausted. It was also seen as less adversarial, with a caseworker describing a situation that they felt would have played out very differently pre-*Practice First*.

The risk is mum can go to that house at any time and get her son. That's the risk. But we sit with that because she's not going to do that; I'm 100 per cent confident. She's told me that the other day and I've no reason to distrust her and she hasn't done it for, like, eight months. But I guess historically we would have just gone, "Well, mum's not coming to the party. We'll go to court. We'll get PR to 18," away we go.

There was a sense among staff in all the CSCs that because they were working more closely with families and therefore had more knowledge of the families' strengths and vulnerabilities, *Practice First* has given them permission to be flexible in how they work with families, while still addressing areas of concern. Staff at one CSC reported adopting a more flexible approach in their work with families and challenging old ways of thinking. In one CSC, a manager said that *Practice First* facilitated greater decision making by caseworkers, rather than rigid adherence to policies.

On the whole, the shift from a risk-averse culture to one where sitting with risk is permissible was regarded as a positive change for the Department. However, managers in three CSCs described this in terms of an over-emphasis on strengths and relationships at the expense of assessing safety. Determining risk is obviously a critical task for caseworkers, so the fact that these concerns are being expressed indicates work is still to be done.

A caseworker on my team, that because they're so strength-based, and wanting to work with the family and stuff, that they actually lost their analytical skills in relation

to assessing risk to the children ... So to marry the two together is for some caseworkers can be quite difficult, because you want to do all that lovely fluffy stuff which is fantastic, but you also have got to keep the child in the centre around what are the risks, what is the safety, and marry the two beautifully together.

One manager even reported that other offices were saying that they were not removing children after *Practice First* implementation because they believed that “*You don’t remove children under Practice First.*” Whilst they were aware that this was not the intended message:

A lot of children have remained in very unsafe circumstances as a consequence of misinterpretation of what you’re trying to achieve and what threshold is acceptable and what threshold isn’t acceptable.

In acknowledging the tensions that often existed for caseworkers, managers were conscious that they played a critical role in encouraging caseworkers to sit with risk, but making them aware that “*there’s also a threshold that it’s not acceptable anymore for children*”:

So for me to keep saying that and to keep them thinking that way, you go out there and you do every single thing possible you can to make it safe enough for that child to be with their family, because the other decision is just way too painful and too traumatic. And the problem with that is though; you have to keep the balance. Our role is around keeping children safe, so it’s not that children don’t enter care, it’s just that the right children enter care. And you have to keep living and breathing that.

For another manager, learning to sit with risk through *Practice First* was also an acknowledgement that there may be times when the organisation gets things wrong, but that it was important to learn from those situations and reflect on the process.

Sharing risk

The group supervision model within *Practice First* was widely endorsed, with staff at all CSCs emphasising the benefits of the model over pre-*Practice First* work practices. Staff valued the shift in emphasis from individual responsibility to shared decision making and the shared management of risk that was promoted through group supervision. Staff welcomed the opportunity to discuss complex cases, talk through issues and work out solutions with their colleagues and the external agencies that were often invited to group supervision meetings. Having a range of perspectives and experiences to draw on was considered vital for sound decision making:

In the old system, a caseworker, if they hit a brick wall and felt like an idiot and were relying only on their one-to-one supervision which sometimes would be six months apart that person would simply sit there and rot and get nowhere. Now cases are regularly scheduled to come up in group supervision and people are given clear directions.

Sometimes you might be thinking this is the path I have to go down to so everything’s channelled there. Then in group supervision you start talking and someone throws up something and you go, “Oh, I hadn’t thought of that.”

Through group supervision, staff had the opportunity to hear about their colleagues’ cases which many felt has contributed to a more open, collegial and supportive work environment, whereby

caseworkers were more inclined to discuss their cases and seek advice and feedback outside group supervision.

Staff appreciated the shift from individual to shared responsibility that came out of group supervision. They were relieved to know that if they took a day off sick or went on holiday, someone else would be able to address an issue if it arose:

You know [that] within the team, everybody knows where that family's up to, to a certain degree, and it's about keeping that momentum going.

On the downside, however, other staff commented that working collaboratively and helping others can reduce the time a caseworker can spend on their own casework:

I think for a week and a half I haven't touched any of my cases because we've just had a – ... and I love helping my team. It's almost like you're robbing from Peter to give to Paul in some cases.

This was reiterated by another caseworker who struggled to find enough time to manage her own casework when she needed to help out other caseworkers.

Summary

The shift from individual responsibility to collective decision making and sharing the risk under *Practice First* was universally endorsed. The only reported downside was staff not having enough time to work on their own cases because they were helping colleagues.

4.1.5 Differences between working under *Practice First* and non-*Practice First*

Comparison of information from staff focus groups and interviews in *Practice First* and non-*Practice First* CSCs revealed some interesting insights about the perceived differences of working in a *Practice First* versus non-*Practice First* site.

Some participants interviewed had worked in both *Practice First* and non-*Practice First* CSCs since the introduction of *Practice First*. The view of these participants was that operating under *Practice First* yielded many benefits. These included many of the benefits reported elsewhere in this report including:

- developing better relationships with families
- greater collaboration and relationship building with services
- collaborative decision making and shared responsibility
- More concise note-taking - decline in verbatim reports
- Improved outcomes for children and families

A key difference between *Practice First* and non-*Practice First* CSCs was the time caseworkers spent recording case notes. The participants believed that caseworkers in the non-*Practice First* CSC spent excessive amounts of time recording case notes that were more detailed than necessary and that they were reluctant to change their habits:

I'm not to say how they do their casework, but even the conversations that the Court don't require, the Court doesn't need you to have these notes, which is what we

found in Practice First, the Court doesn't need it, so yeah, I try and help them save some time but they're not interested at this point in time in changing that.

It was suggested that this was because staff had become accustomed to working in that way and were therefore reluctant to change. Also the manager-caseworker decision-making model that existed in non-*Practice First* sites contrasted to the shared decision-making model under *Practice First*.

Another key difference concerned visiting clients in their homes. Over time, there appears to have been an increase in home visits at the non-*Practice First* CSC, but not to the level that might be observed at a *Practice First* site:

I think that's changing, I think that that's picked up, but yeah, not a problem to go a month without seeing a child protection family (in the non-Practice First CSC).

Other differences between *Practice First* and non-*Practice First* sites were that in the non-*Practice First* CSCs there were lower levels of engagement with families and other services.

Some participants reported that it was possible to hold on to some elements of the *Practice First* approach in non-*Practice First* sites even without many of the accompanying practice changes, such as group supervision. Once staff had started working in a *Practice First* way, it was reportedly very difficult to revert to working in a pre-*Practice First* fashion.

However, as [Appendix D](#) shows, there were also significant differences between non-*Practice First* CSCs. One of the two sites had reported practices that are similar to those in *Practice First* CSCs, including changes over time in meaningful engagement of families; increased collaboration with other agencies; and more teamwork and discussion. Staff at the other CSC reported high staff turnover, low levels of shared responsibility and confidence in their engagement with families. This finding is not surprising, as CSCs have local cultures and practices and the presence or absence of *Practice First* is only one component of that. However, it does speak to the challenges facing initiatives like *Practice First* that attempt to change practice at an organisational level across all CSCs, in a context where increased local decision making and practices are also being encouraged.

4.1.6 Practice First implementation

Building on information presented in the section above regarding the four core elements of practice under *Practice First*, this next section describes additional evidence captured through staff focus groups and interviews regarding implementation of *Practice First* in general. Key themes emerging from this evidence include: staff experienced variable levels of support for implementation of *Practice First*, although generally they rated this support favourably; and administrative burden and training gaps were viewed as a barrier to the successful implementation of *Practice First*.

Staff interviews and focus groups

Managers' perspectives on the level of support they received when implementing *Practice First* differed somewhat, with most feeling they could tap into all the support they needed, while one felt the support they received was less than adequate. For another CSC, the timing of the *Practice First* implementation was particularly challenging, occurring at the same time as a significant restructure of the management and teams at the CSC.

Four of the six CSCs felt adequately supported to implement *Practice First* effectively. All found the support of their *Practice First* mentors to be valuable, particularly in the early stages of implementation. Support from the Office of the Senior Practitioner (OSP) was also highly valued and acknowledged as an important resource they could tap into if need be. The weekly managers' teleconference was also noted as an important forum for discussing a range of issues.

For one of the CSCs (*Practice First* implemented November 2013), the implementation of *Practice First* was a significant challenge, coinciding as it did with a restructuring of the management and teams at the CSC and also with the Christmas holiday period. The manager did not find the mentor to be particularly helpful largely due to the fact that the mentor was based a long distance from the CSC and the manager felt that the support would have worked better if it were face-to-face rather than over the phone. Nevertheless, the manager reported that they received adequate support from the OSP in particular and developed good relationships with staff there. They also found the weekly teleconference to be a valuable source of support and in spite of the challenges, felt that:

Looking back it worked, that approach worked, but for me as a manager, steady as we go kind of thing, it was really unsettling...

In a joint interview with two managers at one of the CSCs (*Practice First* implemented December 2012) both expressed disappointment/frustration about a perceived lack of support from their own district office who they felt appeared to be supportive of *Practice First* but placed additional demands on the CSC that limited their capacity to work in a *Practice First* manner. This perceived lack of support, they felt, prevented them from successfully implementing *Practice First*:

So I think there hasn't been good buy in from – at that level and I think that that is really critical. I think if CSCs are going to be supported or units are going to be supported to work in a Practice First way you expect some of that support to come from your own supervisor but as I said, they're the ones actually pushing the other priorities.

These managers also did not find their mentor to be a particularly useful support, because they felt the mentors were inexperienced in frontline case management, and that the mentors benefitted more from their exposure to the realities of casework than the CSCs benefitted from their input:

Only because that person hasn't worked on the frontline and I think most of the mentors haven't. So I think for their learning they were able to see firsthand how things worked, were able to run things past us.

Barriers to effective implementation of Practice First

Staff were asked what they perceived were the barriers to good quality implementation of *Practice First* at their CSC. Without exception, all CSCs reported that caseworkers' administrative burdens negatively impacted on their ability to perform their work in the way *Practice First* was designed to achieve. Other issues that were seen to mitigate CSCs' ability to operate in accordance with *Practice First* principles included: insufficient resources; poor group supervision facilitation; inadequate training; uncertainty with respect to *Practice First* model fidelity; the timing of *Practice First* implementation; and the KiDS system.

In one CSC (*Practice First* implemented March 2012), a manager spoke of the need for a casework support position in every CSC “that does all the time consuming jobs that take away from our families, our time with our families.” Among the tasks they felt could be delegated were organising birth certificates, Medicare cards, and the documentation for information sharing requests:

I had one family and people have had this, lots of people. You send for six birth certificates. You send for six Medicare cards. You organise six paediatric referrals. Six dental referrals. You could not even conceive of how much time that takes away from children and families.

A manager at another CSC was aware that some CSCs were starting to employ caseworker support workers and felt that this was a move in the right direction to reduce caseworkers’ administrative loads.

Staff in five of the CSCs felt that a barrier to good implementation of the *Practice First* model was the lack of ongoing training. Some felt that the training was inadequate or too far in the past for staff to retain the benefits.

I think some of the things we’ve probably learnt in that first training would have more meaning now that we’ve actually had a chance to go through them in practice.

Among the areas that staff expressed a need for further or refresher training were: motivational interviewing, the *Practice First* principles, and group facilitation. Further, although staff were expected to reduce their case note recording by focussing less on verbatim accounts and more on being more concise and analytical, one staff member spoke of the lack of training to facilitate this shift in their documenting practices.

Another barrier to effective implementation of the *Practice First* framework, as noted above, was the time and resources taken in data entry into KiDS:

I think it’s eroding that process, I’ll be very honest about that. So our KiDS system as far as I’m concerned is over-engineered. It’s not a good system for the work we do, and they’re relying on it for all their reporting. And if we don’t have the information in there accurately then there’s a problem. I understand all that but it’s extremely time-consuming to get it all in there and get it all in there properly.

While a manager at one of the CSCs felt the Department was aware of the issues and working towards making changes, there was a sense of disappointment that nothing had yet happened. This point was also made in a joint interview with two managers at a CSC where *Practice First* had been implemented in December 2012, one of whom summed up the situation as: “essentially we’re working in a new way but still in the old system.” Both spoke of the enthusiasm and motivation among staff at their CSC about the promise of *Practice First* and increasing home visits and spending less time in front of their computers. However, as time went on:

Everyone became very disillusioned because nothing – and I have to say; nothing, zero has changed around policy, procedure to make our life easier that we do not have to be behind our desk... So we’re in exactly the same spot that we were in before Practice First, just with the principles.

Both reported an increase in home visits in the early months after implementation, but a subsequent decline as caseworkers found their administrative load had not been reduced. Among the factors identified as contributing to caseworkers’ increased administrative load were: the

requirement to read and respond to all emails, keeping abreast of updates within the Department, accountability for maintaining complete records in KiDS, and the requirement to read and digest all policy and procedures in place. Both felt extremely frustrated by what they perceived as an inability or unwillingness to address the issues they felt the Department was aware of:

There's been absolutely no communication apart from selling the product. Practice First, Practice First, culture change. That's great. Do that but also do the other aspect. We've been trying to change this. This is our communication to you but I have to say I don't think I've heard one thing that they've tried to change and have been unsuccessful at or successful at. So that tells me either they're not doing anything at all or they've got a huge issue ...

Summary

Five out of six CSCs felt well supported in the early stages of implementation – this included support from OSP, mentors and the weekly managers' teleconference. Implementation was a challenge for one CSC, however, due to it coinciding with a restructuring of teams at the CSC and the Christmas period.

One of the CSCs felt very frustrated by a perceived lack of support from their district office that they felt prevented them from implementing *Practice First* effectively.

Despite the general endorsement of *Practice First*, staff in all CSCs were able to identify several barriers to effective implementation. These included: caseworkers' administrative burdens; insufficient resources; poor group supervision facilitation; inadequate training; uncertainty with respect to *Practice First* model fidelity; the timing of *Practice First* implementation; and the KiDS system.

4.1.7 Summary of main findings related to Question 1

Based on findings from the focus groups and interviews with FACS staff, there was a general consensus that *Practice First* had been successful in changing practice and organisational culture within the CSCs in which it had been implemented. There was also some evidence that the impact of *Practice First* had extended beyond these CSCs to some other CSCs. However the changes appear to be somewhat fragile and have been undermined in some respects, particularly by the perceived continuing administrative burden. This has caused tensions for staff in *Practice First* CSCs and appears to have undermined confidence in aspects of *Practice First* in a small number of sites, where disillusionment with the promise of *Practice First* has become apparent.

These concerns are reflected, if imperfectly, in the administrative data findings pertaining to structural fidelity. From these data, there do not appear to be any substantial differences between *Practice First* and non-*Practice First* sites with respect to either the duration of secondary assessments or the timing of court applications (see section 4.2 below and Appendix C). It may well be that clients are seen more often, or for longer individual visits during these periods of engagement, but the overall period of engagement, as a whole, conforms to standard operating procedure at the agency. On the positive side, *Practice First* is able to operate within current organisational and legislative constraints in this respect. That is, the use of *Practice First* as a strategy does not appear to decrease the number of clients seen in a face-to-face visit, nor does it affect the length of time clients may be seen during secondary assessment. On the other hand, it may be that organisational pressures do not allow for caseworkers to fully embrace the *Practice First* model, raising concerns about the fidelity of implementation.

The two components of *Practice First* that were cited by focus group and interview participants as having the most important impact on the work were group supervision and the 'permission' for staff to spend more time in face-to-face work with families.

It was felt that group supervision encouraged sharing of risk as well as improving knowledge and skill, and also resulted in closer collaboration with other team members and with agencies outside FACS. There were strong indications that the effectiveness of group supervision was greatly influenced by the skills of the group supervisor, and some participants felt that supervisors should be given more training and support. A minority of focus group and interview participants believed that group supervision was not a substitute for one-to-one supervision, and that both forms of supervision should be regularly provided as they serve different purposes.

Focus group and interview participants felt that face-to-face work improved engagement with families, facilitated more informed assessments and decisions and ultimately was perceived to lead to better outcomes for children and families. In particular there was a strong perception that this way of working was responsible for children remaining with their birth families who would have been removed under pre-*Practice First* working practices.

Based on findings from the online workforce survey, *Practice First* appears to have had a generally positive impact. Among respondents who had ever worked in a *Practice First* CSC:

- 79 per cent said the initiative had improved the culture of their CSC
- 78 per cent said *Practice First* had helped them work more effectively with clients
- Around 60 per cent felt the initiative had helped them spend more face-to-face time with clients.

Open-ended responses to the online survey also showed practitioners were generally very positive about the impact of *Practice First* on the culture of their CSC, and their face-to-face time with clients.

Compared with respondents who were not working in *Practice First* sites, those currently working in *Practice First* CSCs were:

- more likely to feel they had a good understanding of Practice Standards, the Practice Framework, and i-Practice
- more positive about cultures of practice in their CSC
- more satisfied with their opportunities to make a difference
- more satisfied with the quality of service they were able to deliver, and
- more likely to feel the amount of face-to-face time with clients was 'about right', although high numbers overall (more than 7 in 10) still felt it was 'too little'.

Perspectives on supervision from respondents to the online survey were mixed. Respondents from *Practice First* sites were more likely to agree that they had regular opportunities to reflect on cases with their supervisor or in group supervision than those in non-*Practice First* sites. However, they were no more likely to feel either satisfied with the supervision received, or confident about participating in supervision. Many respondents identified supervision as an area that could be improved.

Respondents to the online workforce survey who were working in *Practice First* sites were no more likely than others to feel they were spending an appropriate amount of time on administration. The open-ended responses showed that many practitioners felt *Practice First* had not sufficiently reduced their administration time, and that caseworkers still struggled to meet their workload demands. Notwithstanding, respondents were positive about *Practice First* on the whole, and several commented that implementation should be expanded.

Findings from the phone surveys with caregivers suggest generally high levels of fidelity to the caregiver-caseworker interaction aspects of *Practice First*. This is particularly true for more recent adopters of *Practice First*. Thus, fidelity to the core principles of practice of *Practice First* are generally met, including principles that families have a right to respect, caseworkers must demonstrate an appreciation of family context, relationships are of key importance, language impacts on practice, and caseworkers use reflective practice.

4.2 Did system, practice and culture changes lead to increased capacity and efficiency?

Summary of main findings

- There were no differences in duration of secondary assessments that could be attributed to *Practice First*. The big drivers of longer assessment periods were prior placements in OOHC, multiple prior reports, domestic violence as a reported issue, and the involvement of an Aboriginal child. These factors were the major drivers regardless of whether the case was in a *Practice First* CSC or not.
- Staff reported that *Practice First* has allowed them to work more effectively with clients and that group supervision in particular has facilitated a more efficient approach to decision making.
- In line with findings from other methodologies employed for the current evaluation, focus group and interview participants felt that the continued administrative burden and recording requirements had hampered the efficiencies under *Practice First*.
- *Practice First* was seen as complementing other FACS reforms, such as the provisions of Chapter 16A and the introduction of SARA, all of which have led to improved collaboration, more holistic assessments and interventions, and more efficient service provision.

Changes to the capacity or efficiency of service delivery within Community Services was examined using information collated from KiDS administrative data (in relation to structural fidelity) staff interviews and focus groups, and the online workforce survey.

4.2.1 Administrative data

As discussed earlier, in response to Question 1, the availability of reliable and valid administrative data that could be used to establish structural fidelity to the *Practice First* model was limited. This therefore impacts on our ability to identify capacity or efficiency changes that may be a consequence of *Practice First*. While ideally our analyses intended to ascertain the frequency and duration of individual face-to-face visits and other indications of active service, communication with FACS personnel indicated that these were not recorded reliably and validly in KiDS. In particular, contact data were less likely to be entered into KiDS by *Practice First* staff, despite the suggestion that *Practice First* caseworkers would visit clients more often. As such, the administrative data analysis described here was limited to examining the duration of services for two constructs: duration of time between SAS2/SARA start and plan closure; and, for cases that were referred for court supervision, the duration of time between SAS2/SARA and judgement and decision (see also [Appendix C](#) Detailed Analyses).

Duration of plan – SARA/SAS2 to plan closure

The length of time spent in the plan from the start of the SAS2/SARA until plan end was somewhat shorter for *Practice First* (median=58 days) and non-*Practice First* (median=63 days) cases when considered in isolation (Table C1, Appendix C). Cases involving Aboriginal children,

history of reports, prior OOHC, and at least one primary report type of domestic violence within plan tended to also have longer secondary assessment periods for both *Practice First* and non-*Practice First* cases when considered in isolation. There was no clear pattern of differences between *Practice First* and non-*Practice First* with respect to how long the individual sites had been running *Practice First*.

In order to further explore any potential differences in duration of plan between families that received *Practice First* and those that did not, we used Cox Proportional Hazards regression to account for the impact that demographic and case characteristics have on duration (Table C2, Appendix C). Over time, *Practice First* plans were slightly more likely to close sooner than non-*Practice First* (HR=1.07)¹⁸ plans. However, it seems that the big drivers of longer plan length were prior placements in OOHC, five or more prior reports, and the presence of at least one child who was aged one year or younger.

Taken together, these findings indicate that secondary assessments at *Practice First* sites tend to have the same duration as secondary assessments at non-*Practice First* sites. It is not known whether more visits are conducted within the same period of time (frequency), nor whether *Practice First* visits last longer (dose) or are more engaging to clients (quality) than non-*Practice First* visits.

Duration SARA/SAS2 to ‘judgment and decision’ for Court Supervision Applications Only

We also examined the timing of a caseworker/supervisor decision to make an application to the Children’s Court (as reflected in the judgment and decision field in KiDS) in order to observe any differences in how long this decision took between *Practice First* and non-*Practice First* sites.

When considered in isolation, the median number of days from SARA/SAS2 start until the application to Children’s Court was longer in *Practice First* (median=33) than non-*Practice First* (median=28) sites (Table C3, Appendix C). While the median number of days from SARA/SAS2 start to court supervision request varied across the three-month intervals since *Practice First* implementation, and across the waves of implementation, there was no clear pattern within *Practice First* or between *Practice First* and non-*Practice First* sites. This means that length of time since implementation of *Practice First* did not appear to affect the timing of Court application.

Taking into account a range of important demographic and child-level factors, there was no statistically significant difference in the timing of Court applications between households receiving services at *Practice First* and non-*Practice First* sites (Table C3, Appendix C). The biggest drivers of longer periods of time between SARA/SAS2 and court supervision request were related to having at least one child in the plan age less than one year, having a prior history within the household of frequent ROSH reports, and one of the children in the household having at least one prior placement in OOHC.

¹⁸ HR=Hazard Ratio, which describes the comparative rate of occurrence, over time, for a given outcome (in this case, plan closure). Although 1.07 is significant, it is a very small effect. In other words, households receiving *Practice First* were statistically more likely to close sooner than non- *Practice First* sites, but the size of the effect is small especially compared to the large historical and age effects that were also observed in the statistical model.

4.2.2 Online workforce survey

As discussed earlier, findings from the online workforce survey indicate that staff perceive that *Practice First* has allowed them to work more effectively with clients, which may reflect an aspect of efficiency. Furthermore, compared with respondents who were not working in *Practice First* sites, those currently working in *Practice First* CSCs were more satisfied with their opportunities to make a difference and with the quality of service they were able to deliver to families.

Nevertheless, survey participants working in *Practice First* sites were no more likely than others to feel they were spending an appropriate amount of time on administration. So, in the client-time to admin-time ratio, *Practice First* does not seem to have made an impact. The open-ended responses showed that many participants felt *Practice First* hadn't sufficiently reduced their administration time, and caseworkers still struggled to meet their workload demands. It should be noted that although it was anticipated that *Practice First* would reduce administration, many of the factors driving administration time are external to *Practice First*, such as the structure of KiDS and local directives to staff.

Despite these perceived problems, the popularity of *Practice First* among CSC staff is evident. When asked an open-ended question about how *Practice First* could be improved, several respondents to the online workforce survey recommended expanding *Practice First*, including to NGOs and to OOH sites, and to the JIRT. For example:

Practice First needs to be implemented in all CSCs so we are all on the same page.

The roll out of Practice First should be reconsidered for additional sites.

It needs to be rolled out to all CSCs because as CWS I work across CSCs and have observed and 'us and them' culture; where the Practice First sites feel superior (at times) in their culture and practice and those that are not (at times) feel that they are 'Practice Second' or 'Practice Last'.

Practice First can be better improved by ensuring that NGOs funded by FACS incorporate facets of Practice First in their service delivery.

The extension of the Practice First principles into other agencies (education, health, police, etc.) would be beneficial for clients and staff.

4.2.3 Staff focus groups and interviews

Staff were asked whether they felt their capacity to see clients had improved or reduced since implementing *Practice First*. Views differed between CSCs, with some feeling that capacity to see clients had improved, whilst others felt that nothing had changed under *Practice First*. Some staff felt that it was difficult to determine whether *Practice First* had influenced their capacity to see clients due to natural fluctuations in their caseloads over time, whether they had cases going through the courts and that comparisons with the past were meaningless because "*the type of work we do now (under Practice First) is different*".

In one CSC (*Practice First* implemented December 2012), the consensus view was that capacity to see clients has improved under *Practice First* because "*we're encouraged to*", but administrative tasks were preventing staff from getting out as often as they would like. At the same time, however, staff felt the administrative tasks were essential.

In another CSC (*Practice First* implemented December 2012), staff felt their caseloads had reduced under *Practice First*. However, participants were quick to stress the quality of their interactions over the quantity of their visits, with the emphasis on building quality relationships and intensive casework under *Practice First* reducing their capacity to undertake a greater volume of visits.

A manager in one CSC (*Practice First* implemented December 2013) felt the capacity to see clients at her CSC had improved as a consequence of reduced administrative burdens, but also as a consequence of the way caseworkers engage with families under *Practice First*:

So for example where we might have called someone in for an interview, or asked them in for a meeting or something, now I think the caseworkers are more inclined to actually go out, take them to an appointment, but have that discussion while they're driving there.

The consensus view in one CSC (*Practice First* implemented December 2012) was that capacity to see clients has remained the same as it has always been, however, under *Practice First*, “the focus has changed”. With no perceived change in capacity and a greater emphasis on spending more time with families, there was a view that the only way that staff could keep up with the associated administrative tasks was by putting in longer hours:

That's the thing, the people that feel that recording should happen end up staying back or taking it home with them to make sure it happens.

On the whole, the group supervision model was considered to have led to increased capacity and efficiency, however, as noted earlier this assessment is not without qualification.

Efficiencies of the *Practice First* approach

Staff identified a number of efficiencies they felt resulted from working within a *Practice First* framework, with group supervision being the key mechanism through which these efficiencies were realised. The efficiencies identified as arising from group supervision included:

- More thorough assessment of child and family needs
- Having a weekly opportunity to discuss challenging cases
- Coming up with a range of possible responses/options to address a family's needs through collaborative brainstorming
- Caseworker skill development and knowledge sharing happening at a faster rate
- Shared responsibility and knowledge of other caseworkers' caseloads meaning that other caseworkers can respond to issues if a caseworker is on leave

Staff also felt that the *Practice First* emphasis on relationship building also had the potential to lead to greater efficiencies in the long run by reducing re-entry to the child protection system.

4.2.4 Summary of main findings related to Question 2

Staff participating in the online workforce survey reported that *Practice First* has allowed them to work more effectively with clients. *Practice First* staff also expressed higher levels of satisfaction with their opportunities to make a difference for families, and with the quality of services delivered. Yet, *Practice First* staff did not perceive that their administration time had been decreased as a result of *Practice First*.

Results of the focus groups and interviews echoed the above sentiments, with participants reporting that *Practice First* has facilitated a more efficient approach to the work. They reported that group supervision in particular has facilitated decision making. *Practice First* was seen as complementing other reforms, such as the provisions of Chapter 16A and the introduction of SARA across FACS, all of which have led to improved collaboration, more holistic assessments and interventions, and more efficient service provision. Nevertheless, and again in line with findings from other methodologies employed for the current evaluation, focus group and interview participants felt that the continued administrative burden and recording requirements had hampered the efficiencies under *Practice First*.

Administrative data on efficiency and capacity changes is limited. Analysis of available administrative data indicated no differences between *Practice First* and non-*Practice First* CSCs in the time cases spent in secondary assessment. While the median number of days from the start of a secondary assessment until plan end or to application to Children's Court was somewhat longer in *Practice First* than non-*Practice First* sites, and the longest median times in secondary assessment were for non-*Practice First* cases, these differences did not end up influencing duration once other important demographic and case-level factors were considered. Cases involving Aboriginal children, young children, prior history of reports or OOHC, or at least one primary report type of domestic violence tended to have longer secondary assessment periods for both *Practice First* and non-*Practice First* sites.

4.3 Did *Practice First* work better for some groups than others?

Summary of main findings

- The major drivers of whether children receive a face-to-face assessment, become involved with Children’s Court, have a new ROSH report, or enter OOHC were child age, Aboriginality, type of maltreatment allegation, and child protection history.
- Children were just as likely to be seen for a face-to-face visit in *Practice First* sites as they were to be seen for a face-to-face visit in non-*Practice First* sites.
- Children receiving services at *Practice First* sites had a similar chance of being involved with the Children’s Court as children in non-*Practice First* sites
- Children receiving face-to-face assessments in *Practice First* sites had similar chances of having a subsequent ROSH report as children receiving face-to-face visits in non-*Practice First* sites
- Children receiving face-to-face assessments in *Practice First* sites had similar chances of entering OOHC as children receiving face-to-face visits in non-*Practice First* sites
- Around two thirds of respondents to the workforce survey viewed *Practice First* as effective at engaging with, achieving safety for, and achieving outcomes for ROSH children. Only 40 to 50 per cent of respondents felt this to be true for Aboriginal children.

In examining whether *Practice First* appears to work better for some groups of children and families than others we examined available administrative data and information collected through the online workforce survey.

4.3.1 Administrative data

KiDS administrative data were used to see whether similar cases were seen for a face-to-face assessment in *Practice First* sites and non-*Practice First* sites and to analyse three specific outcomes: (1) Whether an application was made for Children’s Court; (2) Whether any child who received a secondary assessment had a new ROSH report; (3) Whether any child who experienced a ROSH report during the period of analysis had a concurrent or subsequent placement into OOHC. It is important to note that these outcomes are limited both in their scope and their capacity to tell us, specifically, how families were functioning as a result of services. Nonetheless, they allow us to find out whether receiving services at *Practice First* sites is associated with any differences in these areas, while accounting for the major demographic and case-level characteristics that are usually associated with these particular outcomes in such analyses.¹⁹

As highlighted in Table 12 (and also in Appendix C: Detailed Tables and Analyses) there was no statistically significant difference in the likelihood of a Court application among families receiving *Practice First* compared with those receiving standard services ($p=0.73$)²⁰ and there are no

¹⁹ See, for example, Keep Them Safe Evaluation http://www.keepthemsafe.nsw.gov.au/kts_evaluation/outcomes_evaluation

²⁰ Logistic regression predicting court filing versus no court filing (not shown)

differences between *Practice First* and *Non-Practice First* in the time it takes to make a Court Application when one is actually made ($p=0.87$, Table C.4) . This indicates that, when controlling for important case-level and demographic characteristics, *Practice First* sites were no more or less likely than non-*Practice First* sites to make a Children’s Court application.

When controlling for demographic and case-level factors, there was no statistically significant difference in the likelihood of a new report for children involved in secondary (SARA/SAS2) assessment among those assessed at *Practice First* sites compared with those assessed at non-*Practice First* sites ($p=.515$).

Overall, there appears to be no substantial difference in entry to OOHC between *Practice First* and non-*Practice First* sites. While there is variability in the proportion of children entering care by their case and demographic characteristics, these do not seem to vary much by whether children received services at *Practice First* or non-*Practice First* sites ($p=.187$).

Table 12. Differences in outcomes between *Practice First* and non-*Practice First* sites

Practice First Outcomes Summary ^{a, b, c}	<i>Practice First</i>		Non- <i>Practice First</i>		Adjusted <i>p</i> -value
	<i>N</i>	%	<i>N</i>	%	
Face-to-face visit ^d	1839	18.0	3842	17.9	0.11
Children’s Court involvement	257	10.7	592	11.5	0.73
New ROSH	937	39.1	2182	42.4	0.52
Placement in OOHC	435	2.9	932	3.0	0.19

NOTES:

a. None of the outcomes listed here were statistically significant ($p<0.05$) in statistical modeling.

b. More detailed analysis available in Appendix C.

c. Statistical tests for all outcomes were adjusted for age, Aboriginality, prior ROSH reports, prior episode in OOHC, associated maltreatment type, and time (i.e., logistic regression using same length of follow-up for all children; Cox Proportional Hazards Regression for observations with different follow-up).

d. The percentage of face-to-face visits differs from the rate of face-to-face visits for the entire population of children at ROSH reported to CSCs. The figures here are reflective of the sample selection criteria used for the evaluation (i.e., JIRT reports are not included). See methods section in Appendix A for further detail.

4.3.2 Online workforce survey

All respondents who had worked in a *Practice First* site ($n=400$), or who were familiar with the model ($n=161$), were asked about their perceptions of how the initiative had achieved improvements to practice and outcomes for Aboriginal children and families, and for children and families at ROSH. Results are shown in **Figure 4** and **Figure 5** respectively. More than half of respondents thought that *Practice First* had no effect for Aboriginal families, although more than two in five considered it to be effective. More than 60 per cent of respondents reported that *Practice First* was effective or very effective with respect to children at ROSH, but again, a large proportion were neutral (**Figure 5**).

Figure 4. Perceptions of *Practice First* effectiveness with respect to Aboriginal children and families (n=547) (%)

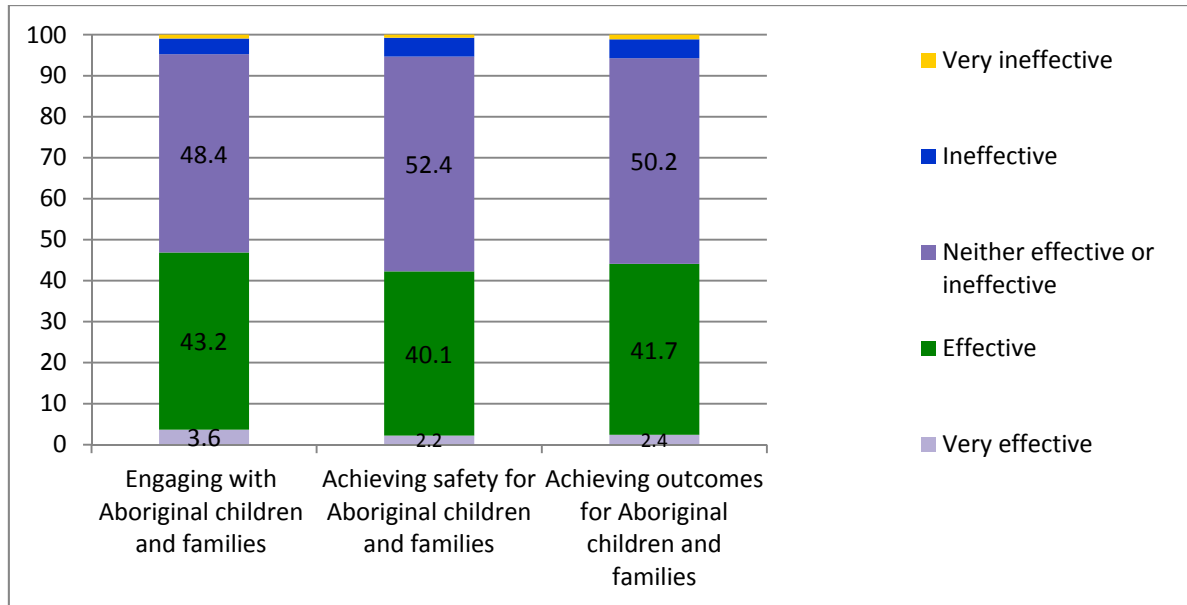
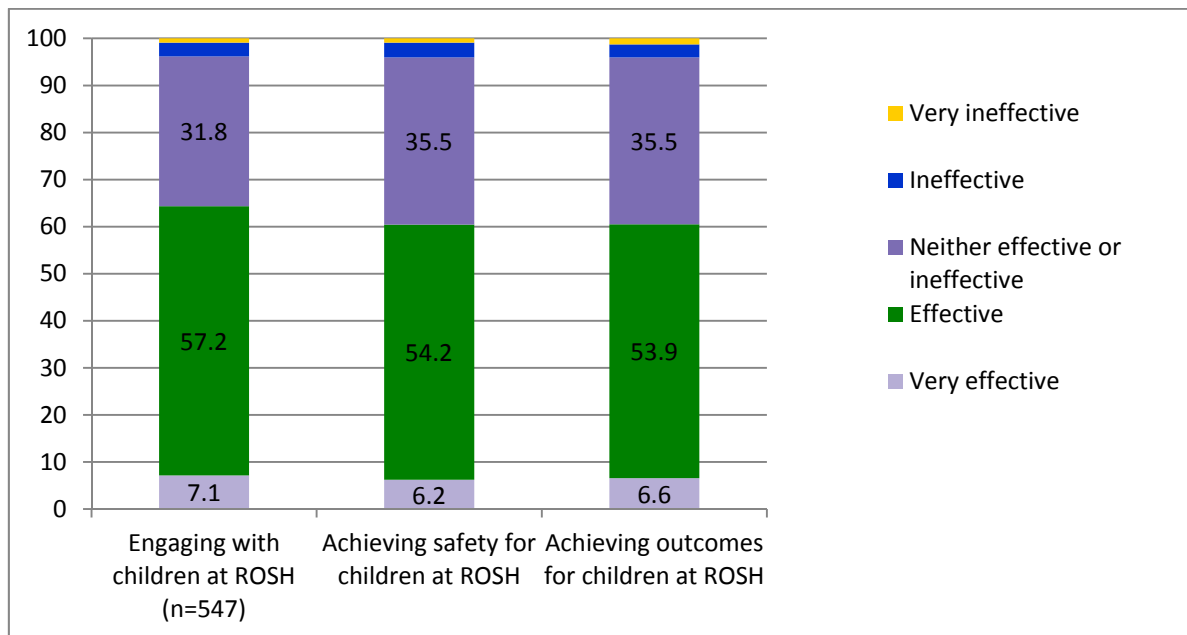


Figure 5. Perceptions of *Practice First* effectiveness with respect to risk of significant harm (n=547) (%)



4.3.3 Summary of main findings in relation to Question 3

Child protection decisions were primarily influenced by concerns of child safety, and this appeared to be equally the case in both *Practice First* and non-*Practice First* sites. In general, they were both responding to the same set of risks and problems, and both types of sites were receiving far more referrals from the Helpline than they could respond to with a face-to-face visit. Given that the same

client population is being selected for face-to-face assessment, which is dictated by the overall mission, policies and culture of the child protection service, it is not surprising that the major predictors of system-level outcomes were overwhelming any ‘treatment’ effect that may be present in *Practice First* sites. The crude but powerful proxies for risk continue to predict systems level outcomes. Young and very young children, Aboriginal children, children with a prior ROSH report history, and children with a history of OOHC are generally more likely to be seen in a face-to-face assessment, to be involved in court proceedings, have a subsequent ROSH report, and experience a placement in OOHC.

Workforce survey findings indicated around two thirds of respondents viewed *Practice First* as effective at engaging with, achieving safety for, and achieving outcomes for ROSH children. Only 40 to 50 per cent of respondents felt this to be true for Aboriginal children.

4.4 Did greater child/family/agency involvement lead to improved quality services?

Summary of main findings

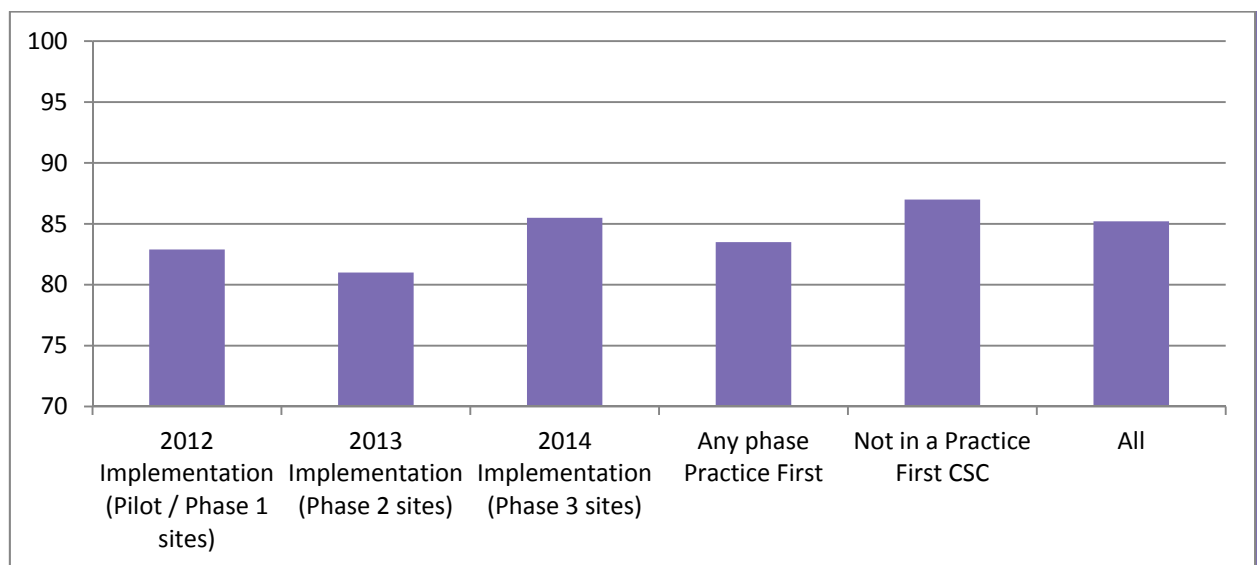
- *Practice First* appears to have improved interagency collaboration somewhat leading to more holistic service delivery, and better shared decision making.
- *Practice First* appears to have somewhat improved family involvement in decision making, with staff reporting more inclusive and collaborative practice that is less adversarial. However, these results were not always supported by families involved in the system, up to 25% of whom felt that they had not been involved as much as they wanted in decisions about their child.
- System-level barriers and the broader culture of child welfare services, including, again, the administrative burden experienced by caseworkers, do not always align with principles of *Practice First*. This tension has not been adequately addressed in the implementation of *Practice First* to date and future implementation efforts should focus on building caseworkers' skills in involving children, caregivers and others in the decision-making process.

Information from the staff workforce survey, staff interviews and focus groups and the phone survey with caregivers (assessing dynamic fidelity) was used to examine children's and families' involvement in decisions about them, the involvement of other agencies, and whether such involvement was associated with improved service quality.

4.4.1 Workforce survey

Staff confidence in involving children and families in decision making was slightly higher for workforce survey respondents who came from non-*Practice First* sites compared to those within *Practice First* sites, although the difference was small and not statistically significant (Figure 6).

Figure 6. Percentage of respondents reporting they were 'confident' or 'very confident' involving children and families in decision making (n=608)



4.4.2 Caregiver phone survey

The single item on the *Practice First Dynamic Fidelity Checklist* that related to sharing decision making indicated a lower rating relative to other items on the Checklist. Fifty-six per cent of Pilot/Phase 1 and 73 per cent of Phase 2 respondents agreed that they had been involved in decisions as much as they wanted.

Twenty-five per cent of Pilot/Phase 1 respondents and 14 per cent of Phase 2 respondents said 'no' to the item 'During the session I was involved as much as I wanted to be in decisions about my child or family'. Some of these respondents also provided additional information on their reasons for dissatisfaction:

We were planning on having our son circumcised, but we weren't allowed. I wasn't involved in that decision as much as I wanted to be.

My granddaughter is anorexic and she self-harms. FACS didn't listen to what I told them and they didn't involve me in the decision making to get her the help she needs.

I wasn't involved in decisions I was just told what would happen. I felt confused at the end. I don't know how I feel about the relationship with my caseworker.

4.4.3 Staff interviews and focus groups

Increased collaboration and shared decision making with external agencies under *Practice First* was widely regarded as a very positive change in practice for staff in all of the CSCs: "that's one of the beauties of *Practice First*", "a very significant change in our culture". Among the agencies and organisations frequently invited to group supervision sessions were: family support services; health; education; Ageing, Disability and Home Care; Housing NSW; Aboriginal organisations; NGOs; principals and school teachers. Through building relationships with families and getting to know their needs, caseworkers were able to develop a better understanding of what other agencies/organisations they could engage in order to better meet the family's needs. It was also recognised that other policy changes implemented under *Keep them Safe*, specifically around information sharing under Chapter 16A, complemented the changes implemented under *Practice First* and facilitated greater collaboration and engagement with other agencies.

More comprehensive assessments

The emphasis on collaboration under *Practice First* encouraged caseworkers to invite staff from other agencies to group supervision sessions and work together to try to address a family's needs, which contributed to more comprehensive, holistic and thorough assessments. Before *Practice First*:

We wouldn't have invited them. We would have just done our bit, let them do their bit.

For one manager who has worked in the Department for 30 years, the shift towards greater collaboration and engagement with other agencies was a massive shift in practice that led to more comprehensive and systematic assessment:

So I don't think there's ever been a time in my history with the organisation where we've really reflected deeply about the work we do... I think I could say fairly accurately that there is more of an intense service that aims to get to know what they're dealing with as a family that tries to reflect in a wider way about what's happening for them, and draws in other professionals to do that in a more systematic way.

Closer collaboration with other agencies enabled one caseworker to gain a more comprehensive understanding of a particular case:

I know there was one that sat in on one session that had they not come we wouldn't have known the piece of information

Although caseworkers engaged with external agencies pre-*Practice First*, there was a sense that the group supervision model encouraged greater input from other agencies. In one focus group, meetings prior to *Practice First* were described as, "very formal. Somebody would take minutes and everybody would leave, yippee that was another meeting." In contrast, group supervision under *Practice First* was described as "more of a discussion."

Even in one CSC (*Practice First* implemented December 2012) where staff expressed a lot of disappointment with what they perceived as the gap between the promise of *Practice First* and the reality of *Practice First*, increased collaboration with other agencies was regarded as a significant improvement over pre-*Practice First* practice.

So I think it was about you know, working together so that they could see what we see and we see what they see, so it was more of a – you know, informed decision.

Shared responsibility

Through greater collaboration with other agencies staff felt the message was being heard that the responsibility for decision making about families did not rest solely with Community Services. Increased collaboration was also regarded as important to give other agencies' insight into Community Services' workload and for encouraging other agencies to share the responsibility and work with families before reporting to Community Services:

We've got a local school that actually goes over and above in terms of what they do to intervene with children even before they come to us now because they've got a better understanding of what we're faced with every day!

Communicating the culture shift

Another important benefit of the strengthening of collaborative links with other agencies was reported to be raising other agencies' awareness about how FACS has changed under *Practice First*:

I know that sometimes people and other NGOs have had the view that you know, DoCS remove children, that's what they do. So if DoCS are involved, your children are going to be removed. I think it was about kind of shifting that view within the community that that's not actually how we work, and that we do have you know, a lot of resources that can help families at risk.

Staff valued having the opportunity to increase engagement with other agencies to educate/inform them about the change in culture under *Practice First* so that they would have a better understanding of why a child was not being removed in circumstances that pre-*Practice First* might have led to removal.

We've had comments "Oh my gosh I had no idea how much you had to think about before you did this" because some agencies and schools or police, can be one of those where they go and see what they see and the children shouldn't be in that house and you should just go and pick them up and take them, but that whole evidence base that we have to have, they are learning all of that stuff.

Occasionally, the reverse was also the case:

We were also actually able to have that discussion with the Whole Family Team at the same time, so they developed an understanding as to what we could see the risks were for the children. So that was good, because often there's some resistance from services about us bringing children into care.

Increasing capacity

Greater collaboration and shared decision making were also identified as increasing Community Services' capacity because it reduced the likelihood of services "doubling up" and overwhelming families.

This greater collaboration with other agencies extended to caseworkers doing home visits with staff from other agencies rather than another Community Services caseworker which "doubles the resources community services has."

Only one CSC (*Practice First* implemented December 2012) reported a decline in their level of engagement with external agencies since the initial months after *Practice First*-implementation, which is likely a consequence of a general disenchantment with *Practice First*.

Improving outcomes

Through collaboration and increased inter-agency work, staff felt that it was increasingly common that when they closed cases, the families were linked in with other agencies in the community and that "*we're leaving our families in a much better place.*" One casework specialist recalled a small number of cases in which children who would have entered OOHC in the absence of *Practice First*, had instead stayed with extended family members for a brief time: "*not leaving them in unsafe situations, but not actually going all the way to Court, and using family better to keep them safe*"

Involving parents in decision making

Some staff felt that families were more involved in making decisions about their lives under *Practice First* than had been the case before *Practice First* implementation. Staff hoped that their practices were more inclusive and collaborative, that they were better able to communicate with families as to why they were in their lives and what needed to happen to remove the need for further intervention from Community Services.

I've been able to say we're all on the same side. You want the best for your kids, we want the best, so let's work together.

Reflecting on their pre-*Practice First* practices, staff felt that their approach to families was very prescriptive where parents were told what they had to do in order to demonstrate to "DoCS" that they were serious about changing their ways. Pre-*Practice First* staff felt that parents who failed to meet the expectations set by DoCS, were placing their children at risk of removal. The benefits of a more inclusive, collaborative approach under *Practice First* included it being less adversarial and holding parents accountable. One staff member who had only joined FACS in recent months, spoke

of their impressions of 'old school DoCS' contrasted with his experiences in FACS under the *Practice First* framework:

I think there is scope there to put more responsibility back on the family instead of taking it away from them in out of home care... Going back to the family and going, well what do you want to see happen, what is your role in this? Can you step up to and take some control and some responsibility here, I can support you in that instead of taking that away from you.

Staff felt that under *Practice First*, they could engage families in discussions with a view to setting more realistic, achievable goals and give families the opportunity to revisit case plans and discuss why they may not have met some goals:

Whereas now it's sitting down and saying, "Look, I don't want to give you too much at once. What do you reckon something that's realistic for you in the next month?" And then, you know, if after a couple of months you haven't got anywhere, well, then you've got to probably revisit and go, "Well, look, we talked about this." But it's a bit more about collaboration I think.

4.4.4 Summary of main findings related to Question 4

Findings from the staff focus groups and interviews revealed that *Practice First* appears to have improved interagency collaboration. This has improved the way FACS works and the services it provides for families. It has also helped other agencies' work with those families by enabling a more holistic service to be provided, with fewer gaps and overlaps between agencies. Engagement with other agencies has also improved the perception of FACS by other agencies and families. There is some concern, given these positive changes have not been sustained in all sites, that the administrative burden and service environment may be impeding sustainability of the model over time.

Findings from focus groups and interviews with staff suggest that some staff felt families were more involved in decision making under *Practice First*. Staff felt *Practice First* permitted their involvement with families to be more inclusive and collaborative and less adversarial. The workforce survey supported these findings with small but not significantly higher ratings of staff confidence in involving children and families in decision making within *Practice First* sites compared to non-*Practice First* sites. Nevertheless, up to a quarter of caregivers surveyed indicated they had not been involved as much as they wanted in decisions about their child.

Given the importance of family involvement in decision making as a core principle of the *Practice First* model, future implementation efforts should focus on building caseworkers' skills in involving children, caregivers and others in the decision making process. Findings reflect that the system and broader culture of child welfare services do not always align with principles of *Practice First*. This tension has been expressed in the workforce survey and focus groups, and has not been adequately addressed in the implementation of *Practice First* to date.

4.5 Are the *Practice First* staff mix and support processes appropriate?

Summary of main findings

- Many staff reported feeling more confident in their work with families as a consequence of *Practice First*. For example, collaborative decision making through group supervision allowed staff to feel comfortable and confident in the knowledge that when a decision was made to remove a child from their parents care, they had exhausted all options.
- The *Practice First* group supervision model was described by many as having built capacity in decision making and having a focus on collaboration with other agencies and work with families. Variations in supervisor skills may be linked to the perceived effectiveness of group supervision.
- *Practice First* has not appeared to sufficiently reduce caseworker's administrative load. However, many of the factors driving administration time are beyond the scope of *Practice First*, and include staff vacancies, the structure of the KiDS database and directives from managers.
- Opportunities exist to enhance the support processes and systems in place to improve the application of the *Practice First* model.

The high proportion of time spent by caseworkers at their desks is thought to result in reduced caseworker time spent with clients. In turn, this devalues the skills that most caseworkers possess. They do not have the opportunity to practice and refine these skills because they work in a model of service delivery that does not legitimise face-to-face work with families. Under *Practice First*, the aim is for caseworkers to spend 50 per cent of their time at their desk and 50 per cent of their time face-to-face with families.

To shift the burden of administrative tasks from the caseworkers to other staff within the CSC, *Practice First* aims to establish protocols within each CSC that create role clarity around who is to perform what types of tasks, including administrative tasks. Under the *Practice First* model, it is proposed that much of the administrative load associated with child protection casework be shifted from the caseworker to other staff, specifically to administrative staff or to a designated Casework Support Position proposed to sit within each CSC. Administrative staff are expected to attend group supervision, and to manage a significant proportion of the data entry and other administrative tasks previously allocated to caseworkers.

The evaluation explored the extent to which these provisions have been implemented within *Practice First* CSCs to date, and views on their effect on staff and clients.

The evaluation also examined the implementation of a number of other strategies that have been incorporated into the design of the *Practice First* service delivery model that are aimed at building caseworker skills, knowledge and confidence, and sharing risk and decision making across the team. These strategies include:

- Availability of a small dedicated *Practice First* support team (3 positions) based within the OSP focused on maintaining high levels of contact and visibility within the CSCs,

participation in weekly teleconferences with CSC staff, running Practice Leadership Groups, attending group supervision, delivering staff training and dealing with ad-hoc requests from CSCs.

- Involvement of a Psychologist and other specialists in group supervision to improve practice expertise.
- Manager Casework running group supervision.
- Weekly teleconference meetings with all current *Practice First* CSC managers. The purposes of these meetings include problem solving, support, and discussing challenges.
- Practice Leadership Groups. These are intended as a mechanism to highlight practice successes and to raise and resolve emerging issues.²¹
- Training for managers in how to be a practice leader and run group supervision.
- A two hour 'site briefing' in the principles of practice. Delivered by the developer of *Practice First*, this briefing is sometimes referred to as the 'hearts and minds talk' and is delivered as a didactic presentation of the core principles of practice with examples, aimed at introducing staff to the *Practice First* approach, and to challenge staff to think differently.
- Care and Protection Practice Framework.
- Resources available through FACS' i-Practice website.
- Provision of the *Practice First* Operating Framework Manual²² and Practice Standards to staff.
- One day training for administrative staff.
- One day training each for specialists and caseworkers about how their role fits with *Practice First*.
- Three days training for caseworkers covering motivational interviewing, solution-focused working, and other skills development training, administrative processes (including, more recently, specific instruction on writing case notes), and how group supervision works.
- Additional training packages have been developed and delivered by the OSP, including on topics such as SARA and *Practice First*, casework recording, and a principles refresher course.
- Appointment of a site champion or executive mentor to mentor the site manager.

Using information from the staff interviews and focus groups and the online workforce survey, the following section explores the role of staff mix and support strategies, such as those outlined above, in supporting improved decision making and staff confidence in their role.

²¹ Personal communication from the OSP with the evaluators suggests that while these groups are currently run only irregularly, the OSP intends to increase the regularity of these group meetings soon.

²² Office of the Senior Practitioner. (February 2014). *Practice First: a model for child protection service delivery in NSW. Operating framework and stories from the pilot project*. NSW: FACS.

4.5.1 Online workforce Survey

Regarding the effect of staff mix and support processes on the administrative burden associated with casework, as discussed earlier (see Table 4), of the staff who completed the online workforce survey, those from *Practice First* sites were no more likely to feel the time they spent on administration was about right compared to those from non-*Practice First* sites. Although not statistically significant, participants in Phase 2 of *Practice First* implementation were more likely than those from other phases of *Practice First* implementation or non-*Practice First* CSCs to report administration time was about right: 26.3 per cent of Phase 2 sites felt it was about right compared with the average figure of 15.6 per cent.

Furthermore, there were no significant differences between *Practice First* and non-*Practice First* sites in ratings of agreement with the statement 'The interests of the children are often replaced by administrative tasks (e.g., paperwork)'.

Thus, *Practice First* does not appear to have had an effect on the administrative burden although, as noted above, many of the factors driving administration time are beyond the scope of *Practice First*, and include staff vacancies, the structure of the KiDS database and directives from managers.

The limited effect of *Practice First* on administration time was also reflected in open-ended responses to the online survey. Many felt caseworkers' administration time had not reduced, they continued to find it difficult to deal with their administrative load, and their administrative workload impacted negatively on their service delivery. When asked how *Practice First* could be improved, respondents often requested better support with administration. For example:

Get the Casework Support Worker (CSW) positions filled.... ...As part of the pilot site the admin team was keen to participate in Practice First and provide closer support for the caseworkers. The caseworkers were very excited about the prospect of not being tied to their computers, freeing them to work with the families more. There is a high level of discontent that these positions have not occurred sooner.

The online workforce survey results provide mixed evidence about the impact of *Practice First* on respondents' experiences of supervision. To illustrate, respondents from a *Practice First* site were significantly less likely than others to say there were regular opportunities to reflect on cases with a supervisor ($p < .001$). There was also limited evidence to suggest that group supervision had made a positive impact. For example, there were no differences in reported levels of confidence in supervision between sites or in staff satisfaction with supervision.

4.5.2 Staff focus groups and interviews

A frequently recurring theme in the focus group discussions was that collaborative decision making through group supervision allowed staff to feel comfortable in the knowledge that when a decision was made to remove a child from their parents care, they had exhausted all options.

Staff in one CSC (*Practice First* implemented March 2012) reported that feedback from a local solicitor was that "the caseworkers in his opinion had done everything they could for those children" by the time a matter was taken to Court. The participants in this focus group acknowledged that often caseworkers in non-*Practice First* sites do everything possible to keep children safe with their families. However in a *Practice First* CSC "you've got much more support".

The sense that staff exhaust all options before seeking child removal came up in other CSCs where participants felt confident with the decisions they had to make:

I know there was one case where I was working with a family. They were actually from my own cultural group and I could see that these - I'd done everything. We took it to group supervision and then I handed the case over to [caseworker] because it was my cultural group and I couldn't remove them.

For another manager (*Practice First* implemented December 2012), working under a *Practice First* framework gave her the confidence that when a caseworker asks her to remove a child, they have already worked through a range of options to keep the child safe at home.

When cases do end up in Court, staff in one CSC thought they were likely to be resolved in shorter timeframes, because they were able to document the prior alternative actions they had taken to prevent removal. A suggested knock-on effect of exhausting all options was there was likely to be a drop in restorations, because caseworkers had gone to such lengths prior to removing the child.

For the most part staff reported feeling more confident in their work with families as a consequence of working within *Practice First*; however this was not a unanimous view.

Through shared decision making in group supervision caseworkers reported feeling more confident in the decisions made about their clients. Having the opportunity to discuss concerning matters and role play different scenarios in group supervision were also seen as important for building confidence.

Caseworkers also reported how gaining a better understanding of why certain decisions were taken through the in-depth discussions in group supervision built their confidence in their interactions with clients:

Whereas before, when we had so many cases, we might get a direction from our manager to do a certain thing and we do it. Then when our clients would ask us, "Well, why?" You would struggle to really have a good answer. But now you have it there because you understand it on a different level.

The *Practice First* emphasis on relationship building with clients also contributed to caseworkers' sense of confidence in their work as it has helped them to get to know the families they work with far better than pre-*Practice First*. One caseworker reported feeling more confident in her work as a consequence of having a better understanding of her clients' lives and having permission to be flexible in how to address their needs:

We still have our bottom line, we're still child protection workers, but it actually allows a lot more flexibility in saying, 'This is where we want to get to, how are we going to get there?' And we can be as hands on as we need to or as absent as we need to and getting other people involved, and that level of flexibility I think works well with families

Some, however, did not feel that *Practice First* had made them feel more confident in their work with some staff expressing the view that they had always worked in accordance with the principles enshrined in *Practice First*:

I work with families who can hopefully they can provide solutions if I lead them down the right road because it is about them acknowledging what is wrong or what needs to change and that's the way I've always done it.

This was acknowledged by a manager who noted that *Practice First* boosted some caseworkers' confidence but not others:

You certainly had your very skilled confident workers previously and they've just shifted over, but then you've had other caseworkers that have not been so confident who've been really anxious who seem to have blossomed

The same point was made by another manager who felt *Practice First* would have different effects on workers' confidence depending on where they were at in terms of their career development.

4.5.3 Summary of main findings related to Question 5

Findings from the online workforce survey indicated that practitioners did not feel *Practice First* had sufficiently reduced practitioners' administrative load. However, many of the factors driving administration time are beyond the scope of *Practice First*, and include staff vacancies, the structure of the KiDS database and directives from managers.

The focus group and interview results are somewhat more positive about staff satisfaction with group supervision. Here the *Practice First* group supervision model was described by many as having built capacity in decision making and a focus on collaboration with other agencies and work with families. This had also reportedly increased caseworkers' confidence that decisions to remove are justified. Unsurprisingly, the effect of group supervision on individual staff was found to be variable, and as a group, inexperienced staff were thought to have particularly benefited.

4.6 Is there greater work satisfaction and retention of *Practice First* practitioners?

Summary of main findings

- A majority of staff reported that *Practice First* had improved organisational culture. This seemed to be reflected in higher levels of satisfaction with the quality of services delivered, with staff opportunities to make a difference and with overall job satisfaction.
- Improved job satisfaction was largely attributed to workers being given ‘permission’ to work in a way that was more akin to their view of appropriate and effective casework than undertaken in mainstream practice in FACS.
- There were minimal differences between *Practice First* and non-*Practice First* sites regarding staff intentions to leave their job, and if anything, the slight differences suggested fewer intentions to leave under *Practice First*.
- CSC managers appeared to play a significant role in maintaining the shift in organisational culture and addressing the tension between the administrative burden and facilitating more client contact. Where leaders were competent and committed, this tension appeared to be less problematic for staff.

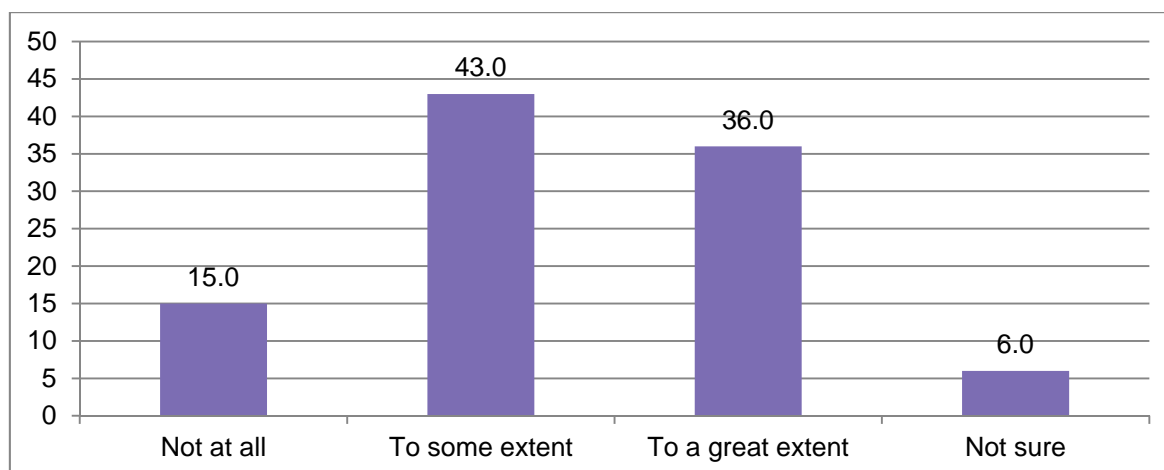
Data collected via the online workforce survey, staff interviews and focus groups were used to explore work satisfaction and factors related to staff retention in *Practice First* and non-*Practice First* sites.

4.6.1 Workforce survey

Impact on CSC culture

Survey respondents who indicated that they had worked in a *Practice First* CSC or were currently working in one were asked about the impact of *Practice First* on the culture of their CSC. A little over a third (36 per cent) felt it had improved the culture of their CSC ‘to a great extent’ (Figure 7). Relatively few (15 per cent) reported that it had not at all impacted on the culture of their CSC.

Figure 7. Extent to which *Practice First* improved the culture of your CSC (n=400) (%)



Comparison across Practice First sites

Participants were asked how strongly they agreed or disagreed with statements about the culture of their office or CSC. This allowed comparison between *Practice First* sites, according to the timing or phase of *Practice First* implementation. The data in **Table 13** suggests being in a *Practice First* site had small positive associations with participants' perceptions of CSC culture; perceptions of staff treatment of families; and perceptions that Community Services supports practice improvement. Phase 2 sites were slightly higher than others on all measures. However, neither the differences between *Practice First* and other sites, nor the differences between *Practice First* sites based on phase of implementation, were statistically significant ($p>.05$).

Table 13. Percentage of respondents who agreed to a 'great' or 'very great' extent (n=727)

	Pilot/Phase 1 sites	Phase 2 sites	Phase 3 sites	Any Practice First phase	Not in a Practice First CSC	All
Staff in your office or CSC are honest, open and transparent	60.1	63.5	58.1	60.0	54.0	56.9
Staff in your office or CSC treat families with respect	69.5	79.4	66.1	70.0	65.2	67.6
You receive useful feedback on your work	39.0	41.3	38.8	39.4	40.2	39.8
Community Services supports practice improvement	43.2	41.3	44.1	43.2	36.6	39.8

Open-ended responses

Although the quantitative data showed only small differences, practitioners' responses to the open-ended questions provide further evidence that *Practice First* has made a positive impact on organisational culture. When asked what elements of *Practice First* were working well, respondents cited improved workplace culture and support, increased respect and empathy for clients, and organisational recognition of the importance of ethical practice. For example:

Practice First has really built a great supportive professional culture in our office. This culture is encouraged by management and caseworkers feel recognised and supported.

The overall culture within the organisation has shifted to a more flexible, practical way of working enabling caseworkers to get more of what needs to be done, done. It cultivates a shared risk management framework which reduces stress for workers.

What has been working well within the Practice First model is the emphasis on the need to nurture strong working relationships with families that we work with and service providers involved in supporting families. This has led to a culture change as well as a different way of thinking about families we work with.

Practice First enables clients and caseworkers to engage better. It allows caseworkers to have more face-face time with the clients, and has a more positive approach. It appears that the office dynamics are better when there is Practice First, and group supervision is a great tool to use. The overall attitude in Practice First offices seems to be far more positive, and future focused.

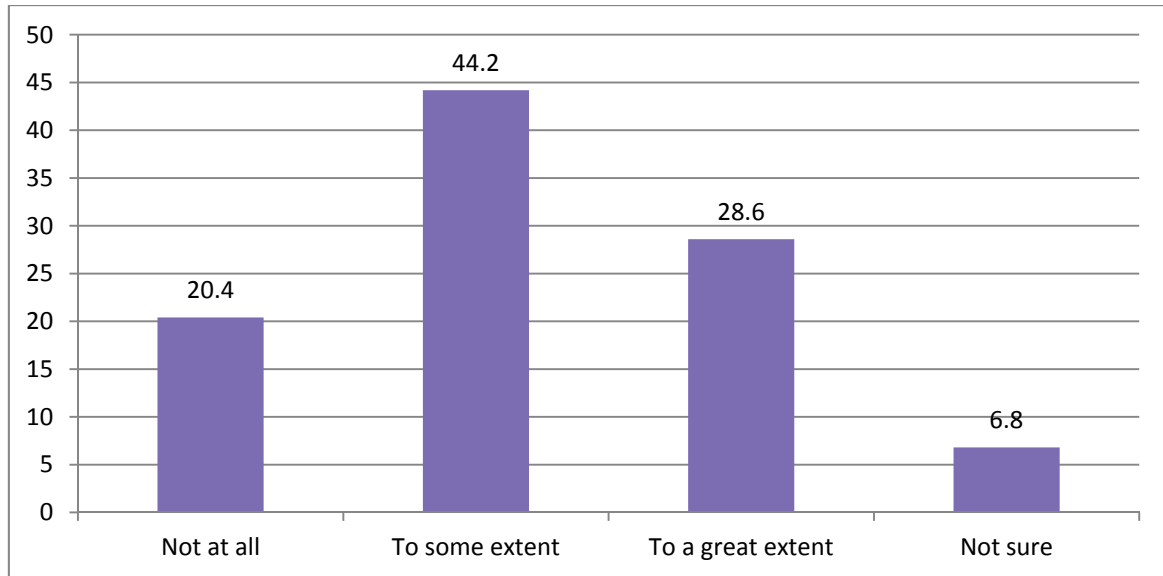
One person also noted that even though they did not work in a *Practice First* CSC, there had been spill-over of practices and principles into their site:

Even though I do not work in a Practice First site we endeavour to work in the spirit of Practice First in terms of engagement with children and families, compassion and empathy, respectful interactions and regular group case discussions.

Satisfaction with aspects of practice

Those who had worked in a *Practice First* CSC or were currently working in one were asked about the impact of the initiative on their job satisfaction. More than a quarter (28.6 per cent) said it improved their job satisfaction 'to a great extent' while a further 44 per cent said it helped 'to some extent' (**Figure 8**).

Figure 8. Extent to which respondents felt *Practice First* helped improve their job satisfaction (n=400) (%)



Moreover, compared with those outside *Practice First* sites, respondents from *Practice First* CSCs were more likely to be satisfied with the quality of service they were able to deliver ($p<.01$). High proportions of staff in Phase 2 and Phase 3 sites reported that they were satisfied with these aspects of their work ($p<.07$) (**Table 14**). Also, compared with practitioners working outside *Practice First* sites, those in *Practice First* CSCs were more likely to be satisfied with their opportunities to make a difference with others ($p<.05$). Those in Phase 2 sites were most likely to be satisfied with this aspect of their work (although this difference was not significant). Respondents from *Practice First* CSCs were also slightly more satisfied than others with the recognition received for doing a good job, although this was higher in Phase 1 and Phase 2 sites than in Phase 3 sites.

Table 14. Percentage of respondents satisfied with aspects of their work (n=727)

	Pilot/Phase 1 sites	Phase 2 sites	Phase 3 sites	Any phase <i>Practice First</i>	Not in a <i>Practice First</i> CSC	All
Quality of service you're able to deliver	77.9 [^]	84.1 [^]	80.3	79.9 ^{**}	70.8 ^{**}	75.2
Opportunities to make a difference for children and families	75.9	85.7	78.3	78.5 [*]	72.2 [*]	75.3
Opportunities for career advancement	34.2	38.7	39.8	37.0	36.1	36.5
Freedom to use your own judgment	67.5	73.0	69.0	69.0	65.2	67.1
Supervision you receive	62.0	58.1	60.5	60.7	59.6	59.6
Your working conditions	69.9	66.1	76.7	71.8	70.5	71.1
Level of pay you receive	59.5	65.1	69.8	64.2	65.9	65.1
The recognition you get for doing a good job	52.1	52.4	41.9	48.5 [*]	42.7 [*]	45.5

[^]p<.10 ^{*}p<.05 ^{**}p<.01

Intention to leave

Overall, around a third of respondents reported that they had looked for a new job in the last 4 weeks. However, much of this job searching appears to be within FACS, as most respondents reported that they intended to be either in their current role (71.5 per cent) or in a different role in FACS (20.1 per cent) in 12 months.

Staff in *Practice First* sites were, overall, slightly less likely to be looking for a new job, and slightly less likely to be intending to work in another organisation in 12 months, although differences were very small (**Table 15**). Neither the differences across *Practice First* sites, nor between *Practice First* and non-*Practice First* sites, were statistically significant.

Table 15. Percentage of respondents intending to leave (n=727)

	Pilot/phase 1 sites	Phase 2 sites	Phase 3 sites	Any phase Practice First	Not in a Practice First CSC	All
% who looked for a job in the last 4 weeks	34.1	34.9	27.9	32.0	35.2	33.7
% who intend to work in another organisation in 12 months	6.2	11.1	6.2	7.4	9.6	8.4

4.6.2 Staff focus groups and interviews

Permission

The word ‘permission’ came up frequently in the focus group discussions and interviews. There was a sense that the adoption of the *Practice First* framework was empowering for staff who felt that they were now permitted and encouraged to work in a manner that was more professionally satisfying for them. They had: permission to engage with families, to build relationships and better understand their needs; permission to conduct more home visits and spend less time in front of their computers; permission to think more creatively about how to address a family’s issues; permission to sit with risk rather than instigate removal on the first visit; permission to persist in trying to work out solutions; permission to work with rather than against clients. This was a factor that appeared to increase participants’ satisfaction with the work and help them feel more comfortable in the roles of child protection caseworkers and managers.

Increased caseworker satisfaction

There was a perception that operating under *Practice First* had increased staff satisfaction for a number of reasons. Shared decision making reduced caseworkers’ anxiety and fostered a more supportive atmosphere:

There is someone in this office that’s quite new that’s come from a non-Practice First site and was asked about how they’re finding it here and what do they think of Practice First. Their comment was that for the first time ever that they’ve been in this organisation they feel safe in their practice. I thought I needed to hear that.

Group supervision sessions have allowed caseworkers to have greater input into decision making:

As a caseworker I think you have more of an input in consultation with your manager and stuff in decision making. It’s not just about feeding information to your manager anymore.

The emphasis on home visiting over time in front of the computer allowed staff to work in a way that they found infinitely more rewarding on a personal and professional level:

So for me it actually brings me back to what I joined the department for and it really does start to focus you more on the family and the children and the skills that we have, how we can have a far greater impact on that family rather than just file reviews and unit reviews...

I think that the kind of work that Practice First encourages, that caseworkers are doing with families, is generally the kind of work that most caseworkers signed up for. They didn't really expect that when they took a job about being a caseworker working with families that they would be sitting at their desk so much.

The introduction of *Practice First* has promoted greater teamwork within the CSC:

I actually think Practice First has brought the office together more as a team and considering I was here for a number of years before that and it's brought teams together more. It's actually allowed for team building, and more than anything else it shines the light on the family and the client, it doesn't allow you to get away from that.

For staff who had only ever worked under *Practice First*, there was a sense that to work any differently was inconceivable.

When I first started people would say, 'Oh we never used to do that.' And I'd go, 'I wouldn't want to work for community services if it wasn't like this.' And I was actually quite horrified on the focus on removing

Similarly, for those who had worked in the Department both pre- and post-*Practice First*, the idea of reverting to pre-*Practice First* practices was also inconceivable.

I can't imagine working any differently now than, like, two years ago. It just seems so far ago in the past. It just - this is the way we should have always been working.

For me it's the only way to work. For me it has to happen. For me it has to go forward. I'm sorry, but I've been in the organisation 30 years. I am not, you know, and that's the big thing for me. To go back to where we were, and once you've been in this environment you can't, you just couldn't do it.

For some who had been in the Department for a relatively long period there was a sense that operating under *Practice First* principles was more aligned with their work practices when they first joined the department.

Certainly for me it was like they've gone back to the beginning because I mean, because I've been here for so long the way the guys are working now is no different to the way I was trained and worked back then.

Leadership

Focus group and interview participants felt that *Practice First* has been instrumental in facilitating a significant culture change in FACS, and this has reportedly been observed not only by FACS staff but by clients and colleagues from other agencies. While some participants felt that once staff had worked under *Practice First* it was not possible to revert to pre-*Practice First* practice, there were indications that factors outside *Practice First*, such as the challenges of the KIDS system, staff turnover and the attitudes of the Courts, could significantly undermine the progress that has been made. However, there were many CSCs where the tensions around recording and administration

had been well managed, and it is likely that this issue was not the primary cause of declining satisfaction with *Practice First* in some CSCs. Rather the commitment of managers to the *Practice First* approach appears to be an important determinant of how successful the implementation of *Practice First* is likely to be in any particular site. Where managers were committed to the *Practice First* approach, they were able to address the pressures on workers and mitigate the frustrations of changing policies and inadequate IT systems. However, where managers were resistant or unenthusiastic these pressures could eventually undermine the shifts in organisational culture and practice that were brought about by *Practice First*.

Some respondents to the online workforce survey felt that *Practice First* as a model had been difficult to implement, and needed a high level leadership to maintain the momentum for change:

I believe the motivation and effectiveness of the model has already been lost in our office, worker/facilitators not attending, groups being rescheduled and cut short. I believe it needs to be promoted from the top down and the importance kept at the forefront.

4.6.3 Summary of main findings related to Question 6

Over a third of workforce survey respondents who had ever worked in a *Practice First* CSC reported that they felt *Practice First* had improved the culture of their CSC 'to a great extent'. A small proportion (15 per cent) reported that it had not impacted on their CSC's culture at all. Evidence that *Practice First* was associated with a positive change in workplace culture was also found in respondents' open-ended reflections. Working in a *Practice First* site had small positive associations with respondents' perceptions of CSC culture; staff treatment of families; and that Community Services supports practice improvement.

Almost three quarters of *Practice First* respondents to the online workforce survey indicated *Practice First* had improved their job satisfaction 'to a great extent' or 'to some extent'. *Practice First* staff were also significantly more likely to be satisfied with the quality of services delivered and with their opportunities to make a difference.

There were minimal differences between *Practice First* and non-*Practice First* sites regarding staff intentions to leave their job, and if anything, the slight differences suggested fewer intentions to leave under *Practice First*.

Information collected through the focus groups and interviews with FACS staff revealed a strong perception that *Practice First* had improved worker satisfaction. This was largely attributed to workers being given 'permission' (or being encouraged) to work in a way that was much more akin to their view of appropriate and effective casework than is undertaken in mainstream practice in FACS.

CSC managers appeared to play a significant role in maintaining the shift in organisational culture and addressing the tension between the administrative burden and facilitating more face-to-face contact with clients. Where leaders were competent and committed, this tension appeared to be less problematic for staff.

4.7 Are there opportunities for improvement?

Practice First provides a solid platform for future improvements in the quality of service provision and practice across NSW's child protection system. There are a number of opportunities to build on and improve the model and its implementation to better achieve the objectives of *Practice First*. These are outlined below.

4.7.1 Increase adoption and implementation of evidence-informed programs and practices

Practice First has generally been implemented as intended. Group supervision is generally working well, and casework practice and organisational culture have improved. Caseworkers report spending more time with families and have increased work satisfaction. Nevertheless, it is unclear whether the changes widely attributed to *Practice First* have resulted in improved capacity and efficiency across the system. Reports from staff indicate improvements, but this is not supported by the administrative data collected from the KiDS system. These data were sometimes incomplete, unreliable or invalid and therefore unhelpful in answering questions related to the frequency, duration and content of individual client contacts.

There is an opportunity to build on the positive findings associated with *Practice First* implementation, including areas of practice to strengthen and changes to install. The consequences of de-funding *Practice First* may be more harmful than moving ahead with it as a framework in which to embed best practice child protection service delivery.

It is recommended that FACS explore opportunities to increase the adoption and implementation of evidence-informed programs and practices that specifically target the outcomes desired by FACS for children entering the system (i.e., safety, permanency and wellbeing) and that have been shown to improve practice related to these outcomes. A current example of where this is already occurring is the pilot implementation of *SafeCare*²³ in two *Practice First* sites.

4.7.2 Address the identified barriers to high fidelity implementation of *Practice First*

There has been little reduction in the administrative burden on caseworkers in *Practice First* sites and this has likely compromised the implementation of *Practice First*.

The major system-level barriers to achieving effective implementation are largely outside *Practice First*. These include the administrative burden on staff and the legal advice provided to caseworkers around recording. These barriers would need to be addressed for the model to be effectively implemented across all *Practice First* sites.

Specific recommendations aimed at improving the implementation of *Practice First* are:

- Develop and put in place a research-informed implementation plan that specifically addresses the identified barriers to effective and high quality implementation.
- Build and use implementation teams to actively drive improved implementation efforts. Implementation teams are groups of individuals who have the task of intentionally

²³ *SafeCare* is a highly structured, empirically supported parenting program developed in the United States for parents of children where safety and risks have been identified. The OSP is currently overseeing a pilot of *SafeCare* in two CSCs and one FACS funded Brighter Futures agency.

monitoring and supporting implementation. These teams are accountable for achieving the objectives of *Practice First*. Team members should have adequate knowledge and skill in a number of areas in order to support those who are doing the actual implementation of *Practice First*.

- Improve the reliability, range and quality of the data collected. Balance this against the finding that the administrative burden on caseworkers is still too high. Support managers to address the tension between administrative requirements and face-to-face work with clients.
- Build on examples of more effective and efficient recording practices across *Practice First* sites, which may be extended upon in future implementation of the model.
- Use data and feedback loops to drive decision making and promote continuous quality improvement. This means the right data is continuously collected and used to systematically assess and feedback information related to planning for new *Practice First* sites to improve implementation at the site level and achieve the intended outcomes of *Practice First*.

4.7.3 Strengthen mechanisms for involving other agencies

There is some evidence that *Practice First* has resulted in improvements in involving other agencies in decision making, but given the co-occurrence of other reforms in recent years, this may not be due to *Practice First* alone.

Nevertheless, there is an opportunity to build upon the developing examples of good practice within *Practice First* CSCs in relation to the involvement of other agencies in decisions made about families in the system. Specifically, incorporating formal mechanisms for involving other agencies is advised.

4.7.4 Improve training models associated with *Practice First* introduction and sustainment

Professional training in how to operate under a *Practice First* approach to casework practice is at present insufficient to support all levels of caseworker across the system. Training is delivered in low doses, with little post-training coaching or consultation during the course of casework. These gaps in training and post-training support do not adhere to best practice implementation in the human service sector.

Consequently, it is recommended that FACS adopts strategies to enhance the competencies of staff through the provision of best-practice training and post-training support. This may be achieved through the provision of competency-based training, structured post-training support provided in the field, and ongoing coaching to help caseworkers develop and maintain skills and take actions consistent with the *Practice First* approach.

4.7.5 Develop program logic for Practice First

The absence of a clear program logic was a limitation to the current evaluation. A clear and realistic program logic outlining the theory of change associated with the model is needed to guide implementation and any future evaluation of *Practice First*.

4.7.6 Improve supervision model associated with Practice First

Group supervision was widely endorsed by respondents in the current evaluation. However, group supervision appears to be most useful and effective when supervisors' skills are high. There is an opportunity to improve the consistency and quality of supervision and training across *Practice First* sites. This can be achieved by developing a documented implementation plan that includes enhanced strategies for workforce training and coaching. The plan, and subsequent actions should clearly explain the competencies required for delivery of supervision, training and coaching and ensure those delivering supervision, training and coaching are doing so at these standards. Where these standards are not met, additional implementation supports (e.g., additional training) can target specific skills. It is advised that FACS routinely monitors quality against staff competencies and puts implementation plans in place to overcome any issues with consistency or quality of delivery.

4.7.7 Enhance leadership skills of relevant staff

Strong leadership is clearly important. The fidelity of implementation of *Practice First* is dependent on leadership. Where managers are committed to the model and proactive in implementing it, *Practice First* is better implemented and existing challenges are better addressed.

Action can be taken to improve knowledge and understanding of the purpose and objectives of *Practice First* and to foster accountability to support effective implementation at all levels of the system, particularly at a senior leadership level (practitioner, manager and senior leadership). Attention to the leadership driver should be built into future implementation planning in order to ensure ongoing gains are maintained.

4.7.8 Improve data collection systems and quality of relevant data

Administrative data were sometimes incomplete, unreliable or invalid in relation to the frequency, duration and content of individual client contacts. Many of the evaluation questions proposed for the current evaluation could not be answered due to gaps in the available data.

It is recommended that the current data capture processes within FACS be improved to allow the routine and continuous use of more reliable and valid data to permit a continual quality improvement process to be introduced into *Practice First* implementation monitoring. Further, it is advised that work be done to enhance and improve the program logic of *Practice First* and include more reliable and valid measurement variables that are better able to monitor both implementation and progress against relevant child and family outcomes.

4.8 Conclusion

4.8.1 Conclusions from focus groups and interviews

Overall there was a general consensus that *Practice First* had been successful in changing practice, organisational culture and morale within the CSCs in which it had been implemented, and there was some evidence that the impact of *Practice First* had extended beyond these CSCs to some other CSCs.

The two components of *Practice First* that were cited as having the most important impact on casework practice were group supervision and the 'permission' for staff to spend more time in face-to-face work with families.

Group supervision encouraged sharing of risk as well as improving knowledge and skill, and resulted in closer collaboration with other team members and with agencies outside FACS. There were strong indications that the effectiveness of group supervision was greatly influenced by the skills of the group supervisor, and some participants felt that supervisors should be given more training and support. A minority of participants believed that group supervision was not a substitute for one-to-one supervision, and that both forms of supervision should be regularly provided as they serve different purposes.

Face-to-face work was reported to have improved engagement with families, facilitated more informed assessments and decisions and ultimately was perceived to lead to better outcomes for children and families. In particular, there was a strong perception that this way of working was responsible for children remaining with their birth families who may have been removed under pre-*Practice First* working practices.

Overall the implementation of *Practice First* was reported to be appropriate, although some participants would have preferred more support and mentoring during the early phases of implementation and ongoing access to training and support.

However, the changes appear to be somewhat fragile and have been undermined in some respects, particularly by the perceived continuing administrative burden. This has caused tensions for staff in *Practice First* CSCs. It appears to have undermined confidence in aspects of *Practice First* in a small number of sites, where disillusionment with the promise of *Practice First* has become apparent.

Practice First has been instrumental in facilitating a significant culture change in FACS, and this has reportedly been observed not only by FACS staff but by clients and colleagues from other agencies. While some participants felt that once staff had worked under *Practice First* it was not possible to revert to pre-*Practice First* practice, there were indications that factors external to *Practice First*, such as the challenges of the KIDS system, staff turnover and the attitudes of the courts, could significantly undermine the progress that has been made. However, there were many CSCs where the tensions around recording and administration had been well managed, and it is possible that this issue was not the primary cause of satisfaction with *Practice First* declining in some CSCs. Rather the commitment of managers to the *Practice First* approach appears to be an important determinant of how successful the implementation of *Practice First* is likely to be in any particular site. Where managers were committed to the *Practice First* approach, they were able to address the pressures on workers and mitigate the frustrations of changing policies and inadequate IT systems. However, where managers were resistant or unenthusiastic these pressures could

eventually undermine the shifts in organisational culture and practice that were brought about by *Practice First*.

Complementary practices

In discussing the degree to which *Practice First* had influenced their work practices, the structured decision-making (SDM) tools known as SARA (comprising Safety Assessment, Risk Assessment and Risk Reassessment) were frequently mentioned. On the whole, SARA and *Practice First* were considered to be mutually reinforcing. For one caseworker, completing the SARA tools was the sole purpose of visiting families pre-*Practice First*. She felt, however, that with the emphasis on building relationships under *Practice First*, SARA was being more correctly viewed as a tool “rather than just our purpose”. A casework specialist felt that using SARA under a *Practice First* framework gave clients a better understanding of why Community Services was in their lives. One caseworker also felt that the shift towards sitting with risk was attributable to SARA rather than *Practice First*. Chapter 16A was also cited as a reform that had changed practice and complemented *Practice First*.

4.8.2 Conclusions from Caregiver phone survey

Findings from phone surveys with caregivers involved with *Practice First* CSCs suggested generally high levels of fidelity to the caregiver-caseworker interaction aspects of the *Practice First* service delivery model. This was particularly true for sites that were more recent adopters of *Practice First*. Thus, fidelity to the core principles of practice in *Practice First* were generally met, including principles that families have a right to respect, caseworkers must demonstrate an appreciation of family context, relationships are of key importance, language impacts on practice, and that caseworkers use reflective practice.

4.8.3 Conclusions from administrative data

The administrative data available for the current evaluation indicate that there were few significant differences between *Practice First* and non-*Practice First* CSCs in relevant indicators of structural fidelity, and child and family outcomes. Specifically, there were no differences between *Practice First* and non-*Practice First* CSCs in:

- Number or type of cases taken to secondary assessment
- Length of the secondary assessment period
- Plan length
- Duration of intervention prior to Court
- The number of cases that went to Court
- Re-reports
- Entry to OOHC

The most likely explanation for these findings are:

- There is considerable variation within *Practice First* sites and within non-*Practice First* sites, as was found in the qualitative interviews. Thus, comparisons between *Practice First* and non-*Practice First* sites that fail to account for variation in case factors and demographic characteristics within each group (such as anecdotal or simple two-way

comparisons) would inaccurately attribute differences to *Practice First* rather than these other major drivers of high-level outcomes.

- There are a number of other reforms and initiatives that are also influencing casework in *Practice First* as well as non-*Practice First* CSCs. Thus, *Practice First* is only one reform that is likely to influence outcomes and it is difficult to disaggregate the effects of *Practice First* from these other reforms.
- Some of the main factors influencing outcomes, such as the types of cases referred to the CSC and the duration of work, are external to *Practice First*. Initiatives such as *Practice First* do not address the main drivers of the child protection system including reporting rates, the legal context, and administrative mandates regarding the duration of casework.
- The administrative data that were available for analysis for this evaluation did not provide a very good proxy for the types of processes or outcomes that *Practice First* is designed to influence. Specifically, documentation and measures relating to the way in which services were delivered, their frequency, and their quality, were unavailable, incomplete, or unreliable / invalid. Thus, any measurable *Practice First* influence on these practices or a measure of their overall effect on outcomes was not possible.

4.8.4 Summary

Overall, the evaluation has found that *Practice First* has facilitated a shift in organisational culture within FACS towards a focus on child-centred practice and increased engagement with children, carers and other agencies. *Practice First* is part of a range of reforms that are intended to transform child protection in NSW. It is working alongside other processes to improve the efficiency and effectiveness of the service and to produce better outcomes for children who enter the child protection system. *Practice First's* child-centred, family-focused approach provides a good foundation for the implementation of the types of continuing reforms needed to improve outcomes for children and families reported as at ROSH.

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Appendix A: Methodology and Evaluation Design

The evaluation adopted an approach that extended beyond the measurement of outcomes to include consideration of process and implementation. Process and implementation evaluations investigate the degree to which activities specified in an intervention’s description are implemented as planned. If interventions are not clearly specified or not delivered in a way that is consistent with the objectives and essential components of the intervention, it can result in what has been termed a “Type III error”²⁴. That is, conclusions are made that a program is not effective when, in fact, this conclusion is a result of inadequate implementation of the intervention rather than the actual effectiveness of the intervention. Several studies have documented a relationship between levels and quality of program implementation and the strength of program outcomes.²⁵ Our approach to this evaluation was therefore informed by these insights and incorporated a process and implementation evaluation with an outcomes evaluation.

The *outcomes evaluation* assessed the effects of *Practice First* by using quantitative and qualitative measures of intervention effectiveness. Specifically, we examined existing available administrative data related to child and family outcomes associated with service receipt, and we conducted a Workforce Survey, and interviews and focus groups with service providers (caseworkers, specialists and managers). We explored perceptions about the effectiveness of *Practice First* in terms of client engagement, child outcomes, child safety, service efficiency and capacity, involvement of children, families and other agencies in decision making, staff work satisfaction and retention, and staff confidence.

The *process and implementation evaluation* assessed implementation fidelity, that is, the extent to which *Practice First* had been put into practice as intended and in line with the service delivery model²⁶. Implementation fidelity typically addresses the following areas: adherence to content, quality of implementation, coverage, uptake, reach, frequency, duration and dose. Evaluation of implementation fidelity is important because fidelity not only moderates the relationship between an intervention and its outcomes, but its assessment may also:

- prevent potentially false conclusions from being drawn about an intervention’s effectiveness
- help achieve improved outcomes, that is, guide implementation of a program model as intended
- give primary researchers confidence in attributing outcomes to the intervention
- give evidence-based practitioners confidence that they are implementing the chosen intervention properly

²⁴ Dobson, L., & Cook T. (1980). Avoiding Type III error in program evaluation: results from a field experiment. *Evaluation and Program Planning*, 3, 269-276

²⁵ Lipsey, M. W., Howell, J. C., Kelly, M. R., Chapman, G., & Carver, D. (2010). *Improving the effectiveness of juvenile justice programs: A new perspective on evidence-based practice*. Centre for Juvenile Justice Reform, Georgetown University.

²⁶ Breitenstein, S. M., Fogg, L., Garvey, C., Hill, C., Resnick, B. & Gross, D., (2010). Measuring implementation fidelity in a community-based parenting intervention. *Nursing Research*, 59(3), 158-65.

- give secondary researchers more confidence when synthesising studies²⁷.

Koball and colleagues²⁸ have proposed that fidelity comprises both **structural** and **dynamic** aspects of interventions. The structural aspects demonstrate adherence to basic program elements, such as hiring staff and maintaining high-quality direct service and supervisory staff, reaching the intended target population, providing participants with the recommended service dosage and duration, and maintaining low caseloads. Dynamic aspects of the intervention relate to quality and content of the relationship between the worker and the service recipient.

Assessing dynamic aspects of fidelity such as content delivered and quality of delivery presents unique challenges. While objective measures of frequency and duration of visits are easily defined and generally available, assessing content delivery and its quality requires the development of unique fidelity criteria that relate to the components of the intervention being evaluated. A crucial step in the establishment of fidelity criteria is the identification of possible indicators or critical components of a given model. These are often based on an expert consensus process or the existence of a proven model that has been explicitly described. Sources of data need to be described for each indicator, and operational definitions need to be developed for the indicators or critical components, including specifying anchors for points on rating scales, so that they are objective and measurable²⁹.

The *Practice First* evaluation used a range of information sources to collate data related to different indicators within these domains. Specifically, structural fidelity information was collated from existing available administrative data from FACS, a workforce survey of *Practice First* staff and focus groups and interviews with *Practice First* caseworkers, specialists, administrative staff and managers. Information about dynamic fidelity was primarily collected via phone interviews with caregivers who have received *Practice First* services, but also from the focus groups and interviews and the online workforce survey.

Each of these data collection methods is described in detail in the following sections. Table A1 outlines which method was used to answer each evaluation question. This project received Human Research Ethics Committee (HREC) approval from the Parenting Research Centre HREC, University of Melbourne HREC and the University of New South Wales HREC.

²⁷ Carroll, C., Patterson M., Wood S., Booth, A. Rick, J., & Balain, S. (2007). A conceptual framework for implementation fidelity. *Implementation Science*, 2, 40

²⁸ Koball, H., Zaveri, H., Boller, K., Daro, D., Knab, J. & Paulsell, D., Hargreaves, M., Strong, D.A., Malone, L., Del Grosso, P. & Xue. Y. (2009). *Cross-Site Evaluation of the Supporting Evidence-Based Home Visiting Grantee Cluster: Evaluation Design Volume 1*. Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services. 2009 Oct. Available from Mathematica Policy Research, Princeton, NJ.

²⁹ McGrew, J. H., Bond, G. R., Dietzen, L., & Salyers, M. (1994). Measuring the fidelity of implementation of a mental health program model. *Journal of Consulting and Clinical Psychology*, 62, 670–678.

Table A1. Evaluation questions and data sources.

Key Evaluation Questions	Data Source
1. Has the <i>Practice First</i> service model been implemented as intended?	<ul style="list-style-type: none"> • Staff interviews and focus groups • Administrative data (regarding structural fidelity) • Phone interviews with caregivers (assessing dynamic fidelity)
2. Have the system, practice and culture changes led to increased capacity and efficiency?	<ul style="list-style-type: none"> • Administrative data (regarding structural fidelity) • Staff interviews and focus groups • Staff workforce survey •
3. Does the <i>Practice First</i> model work better for some groups of children (e.g., Aboriginal, age, ROSH risk categories) and families than others in terms of engagement, outcomes and safety?	<ul style="list-style-type: none"> • Administrative data (regarding outcomes; and fidelity data for client engagement); • Staff workforce survey
4. Are children, families and other agencies more involved in decision making at <i>Practice First</i> sites, and does this involvement result in improved quality services?	<ul style="list-style-type: none"> • Staff workforce survey • Staff interviews and focus groups • Phone interviews with caregivers (assessing dynamic fidelity)
5. Are the <i>Practice First</i> staff mix and support processes appropriate for providing greater support in decision making for staff and confidence to undertake their role?	<ul style="list-style-type: none"> • Staff interviews and focus groups • Staff workforce survey
6. Do practitioners in <i>Practice First</i> sites have greater work satisfaction and staff retention?	<ul style="list-style-type: none"> • Staff workforce survey • Staff interviews and focus groups
7. Are there opportunities to improve the <i>Practice First</i> service delivery model to better achieve the program objectives?	<ul style="list-style-type: none"> • Synthesis of process and implementation evaluation, outcome evaluation, and select literature.

Administrative data

The administrative data component of the *Practice First* evaluation describes activities in a child protection system, as recorded in the KiDS database, and uses a retrospective cohort design to examine whether *Practice First* has an independent influence on certain key outcomes.

The data used for this component are sourced from the Community Services annual ‘reports’ files, which contain historical information on all child protection reports and assessments made between the financial year 2003/2004 and financial year 2013/2014, and the Community Services ‘Out of Home Care (OOHC) file’ that contains placement information for every child placed by Community Services (and non-government organisations) dating back to at least the financial year 2000. Using this information, the evaluators constructed an analysis database that included the

child protective service history of children and families reported to the State's CSCs covering the period of time that *Practice First* had been delivered in NSW.

The analysis compared *Practice First* and non-*Practice First* sites on the following descriptive and outcome measures:

Descriptive

- Number and type of families receiving a face-to-face investigation
- Length of time that families receive a service (duration of secondary assessment and associated casework)
- Duration of engagement prior to Children's Court involvement

Service Outcome

- Involvement with the Children's Court during secondary assessment services
- Recurrence of reports while receiving or following secondary assessment services
- Entries to OOHC during and after secondary assessment services

The analysis was complex due to the underlying structure of the databases used, the nature of the assessment process in NSW, and the tendency that most of the events recorded in the KiDS database associated with *Practice First* occurred during the secondary (SARA/SAS2) assessment period. More specifically, *Practice First* is a family-level approach while the data are presented at the individual child level. Multiple children within the same family can have numerous and different reports on different dates, making it difficult to structure analyses that are informative about the *Practice First* service and still meet valid statistical assumptions. In the end, the approach taken by the evaluators was to control for as many demographic (e.g., age, Aboriginality) and case-level (e.g., prior child protection history, maltreatment concern) factors as possible, isolating the potential effect of *Practice First*.

The analysis accounted for these factors by first focusing on plans (single assessments or multiple assessments linked together by caseworkers in both *Practice First* and non-*Practice First* sites) rather than single ROSH reports that may or may not be linked to secondary assessments (SARA/SAS2).³⁰ Analysis involved aggregating the service period leading up to a SARA/SAS2 based on an underlying process that was similar for both *Practice First* and non-*Practice First*. Interviews with staff indicated that plans are established similarly in both *Practice First* and non-*Practice First* sites. Second, the evaluators used plans and information about when *Practice First* was implemented by CSC to control for the possibility of exposure to *Practice First*. Simply put, analysis excluded families involved in services that had an open plan at *Practice First* sites prior to the implementation of *Practice First*. Therefore, all 'plans' included in the analysis operated under *Practice First* conditions or services as usual conditions. Finally, the analysis excluded plans operated by the Joint Investigation Response Unit (JIRT) and other specialised units due to concerns that the children/families receiving such services may be very different to those receiving non-specialised services.

At the outset, it is important to note that the administrative data are limited in terms of the amount of information they contain. While this is normally the case with administrative data, this

³⁰ The OOHC analyses were conducted at the individual child level.

evaluation had particular challenges for a number of key analyses that were planned. These could not be undertaken due to substantial concerns about the reliability and/or validity of the data. For example, there were concerns that data may be entered less often into the KiDS system in *Practice First* sites than in non-*Practice First* sites due to *Practice First*'s emphasis on spending time with families. Thus, these elements could not be examined under the assumption that 'missing' items were randomly distributed between *Practice First* and non-*Practice First* sites. In other words, *Practice First* caseworkers could have been seeing clients more often but not documenting contacts, resulting in a finding that non-*Practice First* sites saw clients more often when the opposite was actually the case. Specifically, potentially important events we were unable to validly explore include:

- Frequency of contacts with clients
- Duration of individual contacts with clients
- Type of individual service received in a given contact
- Links to information only contained in the Children's Court files

Survey of Caregivers

Caregivers of children currently receiving services from 12 FACS-selected *Practice First* sites were recruited to participate in brief phone surveys with the researchers. The purpose of these surveys was to assess the dynamic fidelity associated with delivery of *Practice First*. FACS was asked by the evaluators to select 12 *Practice First* sites as randomly as possible, but also to consider including a mix of sites that went live in March 2012, December 2012 and November 2013, as well as sites of different population sizes. Selected sites were thought by FACS to provide a fair representative sample of current *Practice First* sites (see Table A2).³¹

Table A2. Sites selected to participate in the caregiver survey aspect of data collection.

Metro	Regional
Sutherland	Bathurst
Gosford*	Bateman's Bay
Penrith	Ulladulla
Liverpool	Clarence Valley
Mount Druitt	Hawkesbury
Lakemba	Nowra

*While Gosford is technically not a metropolitan site (it is about an hour drive from Sydney), it was perceived by FACS not to have the characteristics of a regional site in terms of size and infrastructure.

³¹ One of the 12 sites selected for the caregiver surveys did not respond to evaluators' attempts to contact them to arrange staff training in the recruitment of caregivers.

Caregiver participants were recruited by asking every caseworker at a selected site to invite each caregiver they were working with over a period of one to three months to participate. Caseworkers were trained³² by a member of the evaluation team to invite caregivers to sign a consent form to participate, which was then posted to the PRC who contacted consenting caregivers on at least one occasion (up to two times, separated by one month) and completed the survey over the phone.

A purpose-developed *Practice First Dynamic Fidelity Checklist* (see Appendix B) was administered during the phone call to assess the extent to which caregivers indicate they had received services that match the intent of the *Practice First* service model. The checklist is made up of items that articulate the critical components of the *Practice First* service delivery model. Respondents are asked to indicate the degree to which they agree with each item (No, A little, Yes, Not sure/No response). Examples of items are “Before the session I knew that the worker was going to come” and “During the session the worker always used words that I could easily understand”. The checklist was developed in collaboration with FACS and *Practice First* developers and is based on an approach used for the evaluation of fidelity for use of Multi-Systemic Therapy^{33 34}, and adapted and trialled for use by the PRC in the evaluation of the implementation of an Intensive Family Support Service in the Northern Territory of Australia.³⁵ The *Practice First* version of the checklist was developed based on review of documentation related to the model (i.e., the *Practice First* Operations Manual and practice standards) and on consultation with developers of the model (e.g., in face-to-face discussions and observation of training delivery). The measure operationalises the principles and essential components of *Practice First* service delivery (e.g., families have active engagement in decision making, families feel heard / listened to).

The *Practice First Dynamic Fidelity Checklist* was completed through brief (10 minute) phone conversations with caregivers. Phone calls were made by a member of the PRC’s project team. At the first phone call, the researcher explained the purpose of the call, how the caregiver’s information would be stored, and their confidentiality assured and answered any questions the caregiver had, and then administered the *Practice First Dynamic Fidelity Checklist*. At subsequent phone calls, the researcher reminded the caregiver about the purpose of the call, asked if they had any questions, and then administered the Checklist.

Fifty-eight caregivers consented to participate, and 38 caregivers could be contacted by phone by the PRC. Results for caregivers from the pilot and phase 1 sites were combined for analysis, as only one consent form was received from a pilot site.

³² Training involved an evaluation team member visiting the CSC during a group supervision or team meeting and providing instructions about recruiting caregivers. Instruction was provided verbally and in written form, describing the purpose of the phone survey, how to invite caregivers to participate, what will happen to them if they consent, and how their information will be stored and used. Caseworkers were trained to use an informed consent procedure that involved providing the caregiver with a brief statement about the project and seeking their initial interest, followed by reading aloud to the caregiver a plain language information sheet about the project if the caregiver indicated initial interest in participating, checking for understanding by asking the caregiver a few questions about what will happen if they consent, and asking them to sign the consent form.

³³ Henggeler, S. W., & Borduin, C. M. (1992). *Multisystemic Therapy Adherence Scales*. Unpublished instrument. Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina.

³⁴ Henggeler et al (2002) op cit

³⁵ Mildon et al (July, 2014) op cit

Workforce survey

All managers, caseworkers, specialists (e.g., Psychologists, Aboriginal liaison workers) and administrative staff from every CSC in NSW were invited by email to participate in an anonymous online survey addressing aspects of the structural and dynamic fidelity associated with implementation of *Practice First* across sites, as well as some of the workforce and child/family outcomes deemed important to the delivery of services in CSCs. The email invitation contained a link to the survey online, which was preceded by a plain language information statement. Consent was implied by survey completion.

The survey (see [Appendix D](#)) collected information regarding staff members' views on involvement of children, families and other agencies in decision making, quality of services provided, work satisfaction and staff retention, staff mix, support in decision making for staff, and confidence in their role. The survey included questions regarding demographic information, as well as purpose-developed questions to assess staff views on dynamic fidelity to the *Practice First* service delivery model. The survey was developed in collaboration with FACS staff and *Practice First* developers. The views of non-*Practice First* staff were gathered, to ascertain whether there had been any "spill over" of *Practice First* practices to mainstream service delivery and to provide a comparison to *Practice First* sites.

The online survey was undertaken over a two-week period in February 2015. In total, 728 valid responses were received. According to the Community Services Caseworker dashboard for the September 2014 quarter, there were 2047 FTE caseworkers in NSW. Based on this figure, we estimate the response rate was 35.6 per cent (Table A3).

Of respondents, 647 (88.9 per cent) worked in a CSC, while the remainder worked in a child and family district unit, network office or specialist unit. Respondents worked across 72 of the 82 FACS CSCs. A large group (44.5 per cent) had worked at their current office or CSC for more than 5 years. 70.7 per cent reported their job title was 'caseworker' or 'casework specialist', while 16.1 reported they were managers. The remainder included psychologists; legal officers; administration staff; policy, project or program officers; and support workers.

As shown in Table A3, roughly half of respondents were currently working in a *Practice First* CSC (48.9 per cent). The largest group were from the pilot/phase 1 sites (22.5 per cent). A list of the CSCs by phase is in [Appendix D](#). Note that as the workforce survey was conducted in February 2015, after Phase 3 sites had begun operating under the *Practice First* approach, it was necessary to distinguish data from these 14 sites from those sites that could be viewed as non-*Practice First* sites. Nevertheless, other aspects of the current evaluation are focused only on the 24 *Practice First* sites that had begun using *Practice First* prior to October 2014.

Table A3. Respondents by *Practice First* phase of implementation.

	Pilot/Phase 1 sites	Phase 2 sites	Phase 3 sites	Non-Practice First CSC	In a Practice First CSC	All
<i>n</i>	164	63	129	372	356	728
%	22.5	8.7	17.7	51.1	48.9	100.0

While the data in Table A3 is based on the respondents' selection of the current CSC they were working in, a different question asked whether staff had ever worked in a *Practice First* CSC (see Table A4). This showed that slightly over half (400 respondents, or 54.9 per cent) were working or had worked in a *Practice First* site. A further 161 (22.1 per cent) said they had not worked in a *Practice First* site but were familiar with the model. The remainder (23 per cent) said they did not know much about it with only 4 participants saying they had never heard of it.

Table A4. Respondents' familiarity with the *Practice First* model.

	Frequency	Per cent
I am working or have worked in a <i>Practice First</i> site	400	54.9
I have not worked in a <i>Practice First</i> site but am familiar with the model	161	22.1
I've heard of <i>Practice First</i> but don't know much about it	163	22.4
I've never heard of it	4	.5
Total	728	100.0

Interviews and focus groups with FACS staff

Focus groups were conducted with caseworkers, specialists (e.g., Psychologists, Aboriginal liaison workers) and administrative staff at six *Practice First* CSCs and two non-*Practice First* CSCs. Interviews were also conducted with managers at seven of the selected CSCs, six *Practice First* and one non-*Practice First* CSC. SPRC researchers contacted managers in the selected CSCs by email asking them to invite 8 to 10 staff (including caseworkers, Psychologists, Aboriginal liaison workers and administrative staff) to participate in a focus group discussion about working under a *Practice First* framework. Managers were also asked to invite a manager to participate in an individual interview. Invitations were made by email which contained a plain language information statement about the project. Consent forms were signed by participants at the time of the interview or focus group. An evaluation team member from the SPRC facilitated all interviews and focus groups.

FACS was asked by the evaluators to select six of the *Practice First* sites that had been nominated for the caregiver survey component of the evaluation plus two non-*Practice First* CSCs to be involved in the focus groups and interviews. Selected sites were thought by FACS to provide a representative sample of current *Practice First* sites (see Table A5). The six selected CSCs had been operating under the *Practice First* framework for varying lengths of time. One had been involved in the pilot phase in March 2012 (Bathurst), three in Phase 1 - December 2012 (Clarence Valley, Gosford, Liverpool) and two in Phase 2 - December 2013 (Mount Druitt, Nowra).

The two non-*Practice First* CSCs were chosen, one in Sydney and one regional (Mayfield and Parramatta), to represent 'typical' non-*Practice First* CSCs.

Table A5. Sites selected to participate in the staff interviews and focus groups.

Metro	Regional
Gosford*	Bathurst
Liverpool	Clarence Valley
Mount Druitt	Nowra

*While Gosford is technically not a metropolitan site (it is about an hour drive from Sydney), it was perceived by FACS not to have the characteristics of a regional site in terms of size and infrastructure.

The focus groups were conducted on-site at the CSCs between January and March 2015. All focus group participants were given participant information statements about the evaluation and the focus group and all provided signed consent. The focus groups ranged between 60 and 90 minutes. A total of 61 staff from the six *Practice First* CSCs participated in the focus groups. The focus groups included a range of staff working in different roles at the CSCs, including caseworkers, office support staff, psychologists, casework specialists, managers client services and managers case work. The focus groups with the non-*Practice First* CSCs included a total of 18 staff.

Interviews were also conducted with managers at the six *Practice First* CSCs and one of the non-*Practice First* CSCs. Again, managers were provided with participant information statements about the evaluation and the interview and all provided signed consent. A total of eight managers were interviewed (two managers from one CSC participated in a joint interview) and a case work specialist was also interviewed individually.

The two non-*Practice First* CSCs selected to participate in the evaluation diverged significantly in terms of how they worked and in the sense of enthusiasm and energy that came through in the discussions. Whilst neither was a *Practice First* CSC, one had adopted a number of practices aligned with *Practice First*, although caseworkers did not report having any vast knowledge of the broader *Practice First* framework. The gradual introduction of *Practice First* principles into the CSCs' work practices appeared to have been driven by management, by a casework specialist and by the sense that the Department was undergoing a cultural shift away from 'old style DoCS³⁶'. In contrast, the tone of the discussion with staff at the other non-*Practice First* CSC was far more subdued. Staff reported that many positions in their CSC were unfilled at the present time, that staff attrition rates were high (although this was considered to be across the Department as a whole rather than peculiar to their CSC). Staff in this CSC appeared to feel less confident in their work with families than staff at the *Practice First* CSCs and also compared to staff at the other non-*Practice First* CSC. Given the marked divergence in the content of the focus group discussions, the data from each are reported separately.

Measuring implementation fidelity

Here the evaluation is concerned with the extent to which the *Practice First* service model has been delivered as intended. That is, the extent to which caseworkers, managers, administrative and specialist staff follow the principles of practice of *Practice First* and deliver the practices of the

³⁶ DoCS = Department of Community Services, predecessor to FACS.

service model consistently and with high quality³⁷. This is commonly referred to as *implementation fidelity*. It is important to evaluate implementation fidelity because it can have an impact on the relationship between an intervention and its outcomes. Assessing implementation fidelity may prevent potentially false conclusions being drawn about an intervention's effectiveness. It can also provide valuable data for on-going continuous quality improvement by caseworkers, supervisors, managers, practice leaders, and organisations in the achievement of improved outcomes for children and their families³⁸.

This evaluation adopted an approach to measuring implementation fidelity proposed by Koball and colleagues³⁹ that considers both structural and dynamic aspects of fidelity. Structural fidelity helps us understand practitioner, service, and organisational characteristics at each CSC. Assessment of structural fidelity measures adherence to basic program elements such as hiring and maintaining high-quality casework and supervisory staff, reaching the intended target population, service dosage and duration, maintaining intended caseloads, frequency of supervision and other meetings, rates of completion of assessments and case plans, length of engagement with clients, completion of documentation, maintaining an appropriate staff mix, location of face-to-face client contacts, etc. Data related to structural fidelity was collated using three methods: focus groups and interviews, the online workforce survey, and available administrative data.

Dynamic aspects of fidelity relate to the quality and content of the service being delivered in the face-to-face service delivery setting, including the working relationship between the caseworker and the caregiver or client, the methods and practices used during the home visit, and the demonstration of key practices during the session. For the current evaluation, dynamic fidelity was primarily measured using data collected via the phone survey with caregivers, but also from data collected through focus groups and interviews and the online workforce survey.

Where possible, throughout this section, when reporting findings related to each method, we have highlighted the type of fidelity (structural or dynamic) that is addressed.

Purpose-developed focus group and interview schedules (see Appendices E and F) were used that addressed aspects of the structural fidelity associated with implementation of *Practice First* as well as views on outcomes of service delivery. Questions and prompts aimed to gather staff views on the value (or not) of *Practice First*. They covered whether *Practice First* was associated with greater involvement of children, families and other agencies in decision making; quality of service delivery; the organisational structure at the site; understanding and acceptability of the aims and components of *Practice First*; views on staff training, supervision and coaching; service engagement, assessment, and provision processes; staff capacity dedicated to *Practice First*; number of staff shared across other projects/activities; staff turnover since *Practice First* started; service capacity when fully enrolled; efficiency changes associated with *Practice First*; staff mix; staff support for decision making; staff skills and perceived confidence; barriers to high fidelity implementation of the *Practice First* model; and areas for improvement of the *Practice First* model or its implementation.

³⁷ Breitenstein et al., 2010, op cit

³⁸ Carroll et al., 2007, op cit

³⁹ Koball et al 2009, op cit.

Limitations associated with the evaluation

Quality of administrative data

Collection of data via existing systems (i.e., KiDS) can be inconsistent, unreliable, and therefore incomplete. The data accessed for the administrative analysis were limited in terms of the amount of information they contain. The following items were neither reliable nor valid and were not included in the analysis:

- Frequency of contacts with clients
- Duration of individual contacts with clients
- Type of individual service received in a given contact
- Links to information only contained in the Children's Court files

Thus, many items we originally wanted to include in the analysis, as they were aligned with the *Practice First* logic model, were not available in a reliable way for analysis.

Moreover, there were some challenges regarding how representative our sample and sample size were for some of the areas explored (i.e., application to Children's Court). As noted in the body of the report, we did not include specialist CSCs such as the Parramatta Adolescent Unit in our analyses, as they were not comparable to other CSCs. Therefore, findings from the administrative analyses cannot be generalised to the whole of Community Services and all families. In terms of court applications and entry into OOHC, the sample sizes were sufficiently small that any observed effect would have to have been quite large in order to be statistically significant. Thus, the fact that no differences were observed could have at least partially been a result of a type II error (false negative finding).

Another limitation was the fact that children and families could have received services from a single site, over time, which was both non-*Practice First* and *Practice First*. An attempt to solve these problems was made through the thoughtful selection of cohorts and sites for each of the research questions. Nonetheless, these selections may not have decreased bias sufficiently.

Data collected are not representative of the broader field of staff or of caregivers

We received a large number of responses ($N > 700$) for the Online Workforce Survey, however, this represents just over a third of the total full-time equivalent workforce of FACS at this time. Also, a large proportion (49 per cent) of respondents was from *Practice First* sites.

While the results of the caregiver survey do suggest generally high levels of fidelity to the caregiver-caseworker interaction aspects of the *Practice First* service delivery model, findings need to be considered within the context of how participants were recruited, and the limitations associated with that approach to recruitment. Although participating CSCs were selected "as randomly as possible" and FACS felt that selected CSCs were a reasonable representation of the mix of *Practice First* CSCs across NSW, and despite encouraging all caseworkers in these sites to invite participation of all caregivers who they met with during the recruitment period, there is likely to have been bias introduced. Bias, that is, in relation to which CSCs and which caseworkers were more enthusiastic recruiters, which families were invited by caseworkers, which caregivers agreed to be a part of the study, who actually answered the phone and potential social desirability in responding to items about a caseworker. In addition, one of the 12 sites selected for the caregiver surveys did not

respond to evaluators' attempts to contact them to arrange staff training in the recruitment of caregivers.

Individual differences in how the *Dynamic Fidelity Checklist* items were interpreted may also have affected responses. For instance, being involved in decisions about the family may be interpreted as the family member not feeling that they were included as much as they wanted to be. But it might also be that responses reflected the view that a decision was made that the caregivers didn't agree with – even though they still were part of the process.

It is therefore possible, and in the case of caregivers quite likely, that our samples of respondents are affected by a range of limitations that may indicate a selection or response bias.

Social desirability

Some items on the *Dynamic Fidelity Checklist* used for the caregiver phone survey should be examined for potential response bias. Bias may be related to social desirability, that is, caregivers may have been reluctant to disclose any type of negative interaction due to fear that their answers might be used against them. Bias could also be related to problematic phrasing. For instance, the item “*During the session the worker praised me for progress I've made with the case plan but also challenged me on areas that I still need to work on*” frequently received a ‘not sure/no response’. This may reflect difficulties posed by the item being quite long and ‘double-barrelled’.

The *Practice First Dynamic Fidelity Checklist* was developed by the evaluators during the course of the evaluation. In the absence of a pre-existing logic model, or a clearly articulated description of the core components of *Practice First*, the evaluators, in collaboration with *Practice First* developers and FACS, devised the *Dynamic Fidelity Checklist* based on information available at the time. However, it may be that over time the *Practice First* logic model is refined after further consideration of the critical elements of the service delivery approach. Consequently, further adjustments to the *Dynamic Fidelity Checklist* may need to be made, to align it more directly with the *Practice First* logic model. Once finalised in line with the critical components of *Practice First*, further testing of the checklist will be required to determine its ability to reliably measure treatment fidelity.

Appendix B: Practice First Dynamic Fidelity Checklist

	No	A little	Yes	Not sure/no response
<i>Principal 2: Families have a right to respect*</i>				
Before the session I knew that the worker was going to come				
During the session the worker showed curiosity about our family, they asked us questions and showed interest in us				
During the session the worker listened to me				
During the session the worker asked me about my views and opinions				
During the session the worker used respectful language when talking to me				
During the session the worker used positive language when talking about me and my family				
During the session the worker was clear with me about any concerns that had been reported about my child, and advised me if new concern had come up				
During the session the worker talked about the good things I am doing for my child				
<i>Principal 3: Appreciation of context</i>				
During the session I felt like the caseworker was being honest with me about his/her concerns				
During the session I felt like the caseworker understood my situation				
During the session I felt like I was given the chance to tell or show what positive things I could do for my child				
<i>Principal 4: Language impacts on practice</i>				
During the session the worker always used words that I could easily understand				
<i>Principal 6: Foster learning, hope & curiosity</i>				
During the session the worker asked me what dreams and hopes I have for my family				
<i>Principal 7: Reflective practice</i>				
During the session the worker checked that he/she had understood me correctly				
<i>Principal 8: Sharing decision making & risk</i>				
During the session I was involved as much as I wanted to be in decisions about my child or family**				
<i>Principal 9: Relationships are key</i>				
During the session the worker praised me for progress I've made with the case plan but also challenged me on areas that I still need to work on				
Right now I feel I have a strong and positive relationship with my worker				

* Some of the 10 principles of *Practice First* do not have dynamic fidelity indicators

**Item adapted from Structured Decision Making Client Questionnaire

Appendix C: Detailed Tables and Analyses^{40 41}

Duration of SARA/SAS2 Assessment

The length of time spent in the plan from the start of the SAS2/SARA until plan end was somewhat shorter for *Practice First* (median=58 days) than non-*Practice First* (median=63 days) cases when considered in isolation. Cases involving Aboriginal children, history of reports, prior OOHC, and at least one primary report type of domestic violence within plan tended to also have longer secondary assessment periods for both *Practice First* and non-*Practice First* cases when considered in isolation (Table C1). There was no clear pattern of differences between *Practice First* and non-*Practice First* with respect to how long the individual sites had been running *Practice First*. This would appear to indicate that there were no differences in terms of how long *Practice First* had been implemented in this sample, though differences may emerge over time and with a longer observation window.

⁴⁰ Please note: Our sample excludes assessments made by specialized units that handle a large proportion of these cases, particularly if the allegations are serious.

⁴¹ Children's Court data were not available in electronic format.

Table C1. Median time from SARA/SAS2 to plan end amongst *Practice First* and non-*Practice First* sites

	<i>Practice First</i>		<i>Non-Practice First</i>	
	<i>Median</i>	<i>N</i>	<i>Median</i>	<i>N</i>
Overall total	58	2094	63	6180
Demographic characteristics of children in plan				
Any child indigenous	70	505	71	1920
Any child under one	62	839	64	2809
Any child between 2 and 12	61	1413	67	4015
Any child older than 12	60	566	61	1581
Child protection history of children in plan				
No prior reports for any child in plan	49	459	49	1209
1 to 5 prior reports total for all children in plan	55	742	61	2235
5+ prior reports total for all children in plan	74	893	76	2736
Prior OOHC	92	190	77	555
Report characteristics				
Domestic violence	74	385	70	1112
Neglect	57	600	63	1922
Emotional abuse	62	289	64	790
Physical abuse	58	661	62	1981
Sexual abuse	57	372	60	1147
Other reported issue	59	997	63	2731
Months since <i>Practice First</i> implementation				
1-3	65	425	75	1021
4-6	49	388	61	1028
7-9	86	258	74	1053
10-12	71	308	66	969
13-15	57	334	62	1083
16+	49	381	43	1026

See methods section for further information about counting rules and selections for analysis

In order to further explore any potential differences in duration of plan between families that received *Practice First* and those that did not, we used Cox Proportional Hazards regression to account for the impact that demographic and case characteristics have on duration (Table C2). Over time, *Practice First* plans were slightly more likely to close sooner than non-*Practice First* (HR=1.07) plans. However, it seems that the big drivers of longer plan length were prior placements in OOHC, five or more prior reports, and the presence of at least one child who was aged one year or younger.

Taken together, these findings indicate that secondary assessments at *Practice First* sites tend to have the same duration as secondary assessments at non-*Practice First* sites. It is not known whether more visits are conducted within the same period of time (frequency), nor whether *Practice First* visits last longer (dose) or are more engaging to clients (quality) than non-*Practice First* visits.

Table C2. Cox regression examining SARA/SAS2 to plan end amongst *Practice First* and non-*Practice First* sites

	B	SE	Sig.	Exp(B)
<i>Practice First</i>	.067	.034	.046	1.069
Number of children in plan	.013	.017	.447	1.013
Any child Aboriginal	-.099	.037	.007	.906
Any child one or younger	-.269	.045	.000	.764
Any child between 2 and 12	.105	.051	.037	1.111
Any child older than 12	.281	.047	.000	1.325
1 to 5 prior reports total for all	-.243	.043	.000	.784
5+ prior reports	-.642	.046	.000	.526
Prior OOHC	-.710	.058	.000	.492
Domestic violence	-.099	.040	.014	.906
Neglect	-.100	.034	.004	.905
Emotional abuse	-.105	.043	.014	.900
Physical abuse	-.100	.033	.003	.905
Sexual abuse	.014	.040	.723	1.014
Other reported issue	-.293	.033	.000	.746
Overall (score)				
-2 Log Likelihood	Chi-square	df	Sig.	
67402.488	853.873	15	.000	

See methods section for further information about counting rules and selections for analysis

Duration of SARA/SAS2 Assessment for judgments/decisions ending in court supervision filing

We also examined the timing of a caseworker/supervisor decision to make an application to the Children’s Court (as reflected in the judgment and decision field in KiDS) in order to observe any differences in how long this decision took between *Practice First* and non-*Practice First* sites.

When considered in isolation, the median number of days from SARA/SAS2 start until the application to Children’s Court was longer in *Practice First* (median=33) than non-*Practice First* (median=28) sites (Table C3). Many of the case-level and demographic characteristics also reflected longer median time to application for *Practice First* cases. However, while the median number of days from SARA/SAS2 start to court supervision request varied across the three-month intervals since *Practice First* implementation, and across the waves of implementation, there was no clear pattern within *Practice First* or between *Practice First* and non-*Practice First* sites. This means that length of time since implementation of *Practice First* did not appear to affect the timing of Court application.

Table C3. Median time from SARA/SAS2 to Judgment and decision for cases where an application for court supervision was filed amongst *Practice First* and non-*Practice First* sites

	<i>Practice First</i>		Non- <i>Practice First</i>	
	Median	N	Median	N
Overall total	33	592	28	257
Demographic characteristics of children in plan				
Any child indigenous	36	192	27	82
Any child under one	35	353	31	157
Any child between 2 and 12	35	310	30	137
Any child older than 12	36	103	28	34
Child protection history of children in plan				
No prior reports	32	101	30	54
1 to 5 prior reports	35	149	25	68
5+ prior reports	33	342	28	135
Prior OOHC	28	111	21	43
Report characteristics				
Domestic violence	32	142	35	58
Neglect	36	269	28	114
Emotional abuse	35	131	21	59
Physical abuse	32	297	21	125
Sexual abuse	30	115	34	41
Other reported issue	34	447	24	185
Months since <i>Practice First</i> implementation				
1-3	29	108	18	57
4-6	26	93	30	39
7-9	17	114	15	40
10-12	57	97	64	31
13-15	43	103	29	46
16+	35	77	25	44

See methods section for further information about counting rules and selections for analysis

Taking into account a range of important demographic and child-level factors, there was no statistically significant difference in the timing of Court applications between households receiving services at *Practice First* and non-*Practice First* sites (Table C3). The biggest drivers of longer periods of time between SARA/SAS2 and court supervision request were related to having at least one child in the plan age less than one year, having a prior history within the household of frequent ROSH reports, and one of the children in the household having at least one prior placement in OOHC.

Table C4. Cox regression examining SARA/SAS2 to Judgment and decision for cases where an application for court supervision was filed amongst *Practice First* and non-*Practice First* sites

	B	SE	Sig.	Exp(B)
<i>Practice First</i>	.012	.076	.870	1.012
Number of children in plan	-.150	.044	.001	.861
Any child Aboriginal	-.013	.075	.867	.987
Any child one or younger	.503	.105	.000	1.654
Any child between 2 and 12	-.460	.116	.000	.631
Any child older than 12	-.879	.128	.000	.415
1 to 5 prior reports	.111	.106	.293	1.118
5+ prior reports	.493	.111	.000	1.637
Prior OOHC	.546	.100	.000	1.726
Domestic violence	-.140	.084	.096	.869
Neglect	.195	.072	.007	1.215
Emotional abuse	.202	.087	.021	1.223
Physical abuse	.301	.071	.000	1.351
Sexual abuse	.041	.096	.667	1.042
Other reported issue	.688	.081	.000	1.990

Overall (score)

-2 Log Likelihood	Chi-square	df	Sig.
14293.487	389.956	15	.000

See methods section for further information about counting rules and selections for analysis

Subsequent ROSH reports following the commencement of secondary assessment

This analysis examines the effect of *Practice First* on reports made after secondary assessment has started. The outcome of this analysis is the number of, and time to, reports being received after secondary assessment has started. The analysis first provides figures on the proportion of cases that had at least one new report by *Practice First* and non-*Practice First* site. We then constructed a statistical model to test for differences between sites while accounting for a range of demographic and case-level factors.

Table C5 displays the number and proportion of SARA/SAS2 investigations associated with a new report among *Practice First* and non-*Practice First* sites. Overall, non-*Practice First* assessments appear to have a slightly higher proportion of new reports than *Practice First* assessments (39.1%) following the commencement of SARA/SAS2. Some of these differences cut across other demographic and case factors (these were tested in the model below). The figures regarding months since *Practice First* implementation indicate that earlier stages of implementation may have been associated with lower rates of subsequent reports. However, once we controlled for the length of time that data are available for sites (i.e., Phase 2 sites had shorter periods of observation), these differences were no longer substantial (analysis not shown).

Table C5. Number and proportion of SARA/SAS2 investigations associated with a new ROSH report amongst *Practice First* and non-*Practice First* sites.

	<i>Practice First</i>		<i>Non-Practice First</i>	
	N	%	N	%
Overall total	937	39.1	2182	42.4
Demographic characteristics of children in plan				
Any child Aboriginal	270	43.4	780	48.5
Any child one or younger	411	41.9	951	42.2
Any child between 2 and 12	638	38.8	1431	43.6
Any child older than 12	312	45.5	770	50.7
Child protection history of children in plan				
No prior reports	124	24.1	244	24.9
1 to 5 prior reports	183	27.9	366	26.4
5+ prior reports	630	51.4	1572	56.6
Prior OOHC	147	45.2	409	53.6
Report characteristics				
Domestic violence	254	46.6	589	52.1
Neglect	464	50.7	1127	54.3
Emotional abuse	258	52.5	560	55.8
Physical abuse	457	47.5	1131	50.8
Sexual abuse	277	50.3	664	53.2
Other reported issue	620	46.5	1430	51.0
Months since <i>Practice First</i> implementation				
1-3	256	47.7	548	58.2
4-6	192	39.8	531	55.5
7-9	156	51.1	383	46.4
10-12	130	41.0	300	39.6
13-15	118	34.0	276	33.2
16+	85	20.9	144	17.4

Notes: See Appendix A section for further information about counting rules and selections for analysis.

One explanation for the differences observed in the rate of re-report involves the types of cases being seen. That is, if the case mix changes to reflect increased or decreased risk, we would expect to see a corresponding change in the rate of re-report that is independent of whether assessments were conducted in *Practice First* sites or not. In addition, length of follow-up differed depending on when a secondary assessment was completed, potentially biasing analyses toward cases that were followed for longer after case closure. A Cox Proportional Hazards regression was conducted to determine the influence of child characteristics, case characteristics, child protection history, and whether a site was *Practice First* or non-*Practice First* on the likelihood of a new ROSH report involving one or more children assessed following the commencement of a secondary assessment (Table C6).

When controlling for demographic and case-level factors, there was no statistically significant difference in the likelihood of a new report for children involved in secondary (SARA/SAS2) assessment among those assessed at *Practice First* sites versus those assessed at standard services sites ($p=0.515$). That is, *Practice First* as it is currently implemented does not seem to influence the likelihood of returning to the child protection system with a new ROSH report. We cannot say whether the actual functioning of parents and children involved in the assessments has changed, nor can we say whether the severity of any reported maltreatment concern following the assessment period differs.

Table C6. Cox regression examining start of SARA/SAS2 to new ROSH report amongst *Practice First* and non-*Practice First* sites

Predictor	β	ρ	SE	Exp(B)
<i>Practice First</i>	.026	.515	.039	1.026
Number of children in plan	-.020	.260	.018	.980
Any child Aboriginal	.087	.026	.039	1.091
Any child one or younger	.267	.000	.048	1.306
Any child between 2 and 12	-.130	.020	.056	.878
Any child older than 12	.113	.030	.052	1.120
1 to 5 prior reports	.058	.389	.068	1.060
5+ prior reports	.781	.000	.063	2.183
Prior OOHC	.011	.831	.050	1.011
Domestic violence	.367	.000	.042	1.443
Neglect	.611	.000	.038	1.842
Emotional abuse	.302	.000	.043	1.353
Physical abuse	.475	.000	.037	1.607
Sexual abuse	.735	.000	.042	2.085
Other reported issue	.577	.000	.039	1.780
-2LL model	50388.71			
Model chi-square	1754.96***			
Df	15			

Notes: See Appendix A section for further information about counting rules and selections for analysis.

Out of home care entry

This analysis examines the likelihood of entry into OOHC and measures whether there is any observed effect of receiving services in a *Practice First* site as a result of a ROSH report versus similar services at standard site (Tables C7 and C8). We accounted for overlap of children who may have been receiving services in both *Practice First* and non-*Practice First* conditions (i.e., they were already in a service episode when *Practice First* started at their CSC) by only including placements post ROSH reports that occurred after January 2013 for non-*Practice First* ROSH reports and only those that occurred after the commencement of *Practice First* at *Practice First* sites (please see

Appendix A for greater detail). The analysis first provides figures on the proportion of cases that entered OOHC by *Practice First* and non-*Practice First* site, stratified by case level and demographic factors of importance that were available in the administrative data (Table C7). We then constructed a statistical model to test for differences between sites while accounting for a range of demographic and case-level factors (Table C8).

Overall, there appears to be no substantial difference in entry to OOHC between *Practice First* and non-*Practice First* sites. While there is variability in the proportion of plans in which any child in the plan subsequently enters care by their case and demographic characteristics, these do not seem to vary much by whether children received services at *Practice First* or non-*Practice First* sites. The descriptive analysis shows that a greater proportion of plans with Aboriginal children, very young children, children with a prior child protection history of multiple reports, and children with a prior placement in OOHC contained at least one child who was subsequently placed in OOHC. The median number of days varied across the three-month intervals since *Practice First* implementation and across the waves of implementation, but further analysis indicated no clear pattern of difference (analysis not shown).

As with the previous analysis, another explanation for observed differences in the likelihood of entry into OOHC involves the types of cases being seen. That is, if the case mix changes to reflect increased or decreased risk, we would expect to see a corresponding change in the rate of placement into OOHC. In addition, length of follow-up differed depending on when the original ROSH report occurred, potentially biasing analyses toward cases that were followed for longer after case closure. A Cox Proportional Hazards regression was conducted to determine the influence of demographic and case characteristics, as well as whether the ROSH report was responded to by a *Practice First* site or a standard services site, on the likelihood of entry into OOHC after the ROSH report (see Appendix A). There was no statistically significant difference in the likelihood of an entry to OOHC between *Practice First* sites and non-*Practice First* sites ($p=0.886$). Plans containing very young children and children with prior child protection histories were more likely for at least one child in the plan to enter care than plans without those characteristics.

Table C7. Number and proportion of OOHC entries during or after case plans with at least one SARA/SAS2 amongst *Practice First* and non-*Practice First* sites

	<i>Practice First</i>		<i>Non-Practice First</i>	
	<i>N</i>	%	<i>N</i>	%
Overall total	658	12.8	284	11.9
Demographic characteristics of children in plan				
Any child Aboriginal	244	15.2	93	15.0
Any child one or younger	360	16.0	152	15.5
Any child between 2 and 12	360	11.0	163	9.9
Any child older than 12	169	11.1	54	7.9
Child protection history of children in plan				
No prior reports for any child in plan	91	9.3	50	9.7
1 to 5 prior reports total for all children in plan	116	8.4	68	10.4
5+ prior reports total for all children in plan	451	16.2	166	13.5
Prior OOHC	136	17.8	52	16.0
Report characteristics				
Domestic violence	171	15.1	69	12.7
Neglect	332	16.0	145	15.8
Emotional abuse	176	17.5	70	14.3
Physical abuse	340	15.3	141	14.7
Sexual abuse	155	12.4	63	11.4
Other reported issue	495	17.6	199	14.9
Months since <i>Practice First</i> implementation				
1-3	164	17.4	82	15.3
4-6	163	17.0	59	12.2
7-9	109	13.2	56	18.4
10-12	99	13.1	34	10.7
13-15	70	8.4	31	8.9
16+	53	6.4	22	5.4

Notes: See Appendix A section for further information about counting rules and selections for analysis.

Table C8. Logistic regression examining likelihood of OOHC entry at any point during or after case plan with at least one SARA/SAS2 following first report after *Practice First* commenced

Predictor	β	ρ	SE	Exp(B)
<i>Practice First</i>	-.011	.886	.079	.989
Number of children in plan	-.168	.000	.042	.845
Any child Aboriginal	.135	.083	.078	1.144
Any child one or younger	.556	.000	.105	1.743
Any child between 2 and 12	-.495	.000	.118	.610
Any child older than 12	-.507	.000	.118	.602
1 to 5 prior reports amongst all children in plan	.019	.873	.121	1.020
5+ prior reports amongst all children in plan	.813	.000	.120	2.256
Prior OOHC	.385	.000	.102	1.469
Domestic violence	.029	.739	.087	1.030
Neglect	.477	.000	.075	1.611
Emotional abuse	.349	.000	.089	1.417
Physical abuse	.393	.000	.075	1.482
Sexual abuse	.304	.001	.093	1.356
Other reported issue	.716	.000	.082	2.046
Constant	-3.025	.000	.145	.049
-2LL model	5193.294			

Notes: See Appendix A section for further information about counting rules and selections for analysis.

Appendix D: Non-Practice First Case Studies

Case study: Non-Practice First CSC No. 1

The first non-Practice First CSC involved in the Practice First evaluation was based in regional NSW. The CSC was fully staffed when the data was collected, however, there were several new staff and not all were fully trained. Echoing the view of all CSCs involved in the evaluation, the staff felt that there were not enough caseworkers to meet demand in terms of responding to the reports they received. To improve their capacity to respond to the highest needs cases, the Manager Client Services (MCS) from this CSC along with the MCS from two other CSCs in the region meet weekly to prioritise the cases across the three regions, rather than just the reports directed to their CSC. The Manager Casework (MCW) felt that it was a fair system, but she acknowledged that some caseworkers were unhappy due to the time taken to travel to other CSCs' regions. The MCW felt that the CSC had a good mix of staff and that staff retention was not an issue, with people leaving to go on secondment to other roles in the Department rather than leaving the Department. In terms of the quality of service delivery at the CSC, the MCW felt that there was always room for improvement, but that *"...a majority of people are here for the right reasons and do the best they can."*

While this CSC was not a Practice First site, it did incorporate a number of elements of the Practice First approach in the way that staff worked. The main elements discussed were meaningful engagement of families; increased collaboration with other agencies; more teamwork and discussion. There was also a perceived shift in the culture of the CSC towards working in a more Practice First way, which appeared to be influenced by the MCS and a casework specialist who had recently joined the CSC from a Practice First CSC. Another possible influence was awareness of the perceived shift in culture within the Department.

Quality of service delivery

Staff felt that the quality of service delivery at their CSC was very high and spoke of changing practices in recent times that appeared to correspond closely with the changes introduced under the Practice First framework. These included: building respectful relationships with families; working with families who have had a child removed to help them get back on track, unlike past practice where work with the family would often cease at the point of removal. This shift in practice was considered to be *"the narrative of our work now"* and staff described a training session with staff from the Office of the Senior Practitioner that they found very inspiring. The training focused on improving practice, specifically how to engage families, work with them, and speak to them in terms that are meaningful to them. Another key shift in their work practice included adopting a more *"curious"* approach to working with families and trying to understand what they feel are the issues rather than telling families what they should be doing - *"So it is a really different – it's a different paradigm for our work."*

A number of caseworkers also referred to greater engagement with families, again echoing the sentiments of the Practice First focus groups. Staff spoke of feeling encouraged and supported by management to work more closely with families than they had previously. The manner in which caseworkers described their engagement with families echoed many of the changes in practice identified by staff in the Practice First focus groups.

We're actually inviting the families to develop their own plan or their own solutions rather than us going in subscribing. It's actually now, I'm worried about this, what

do you think about it and where do you want to go with this. And it just changes the dynamics. It's not, you know, here I am with the police and I'm going to dictate the terms. It's working together because generally parents want their children to be safe. So it's actually working with them.

The manager casework interviewed also spoke of increased collaboration with other agencies, corresponding with the *Practice First* data. It was not clear what prompted this increased collaboration; however, the manager did refer to 16A and the formalisation of information sharing. The main agencies they collaborate with include Housing and Health, with the former attending the CSC's weekly allocation meetings. The view was the increased collaboration and increased information sharing was leading to improved outcomes for families and children:

We had a house that had dreadful – I mean, the family had issues to start with but there was dreadful mould and stuff in it. It had little children in it who had asthma and so Housing already knew they were on their books and were working with them. We were working with them around child protection issues as well but we worked together to get them moved out of there and in a better place. So Housing have been great.

Staff felt that the catalyst for change was recognition within the Department that the practices of the past had not worked. With leadership from senior management and the establishment of the OSP, there was a sense that the culture of the CSC was changing: *"You can feel it and people have talked about you can feel the difference."*

Although not a formal *Practice First* group supervision session, staff at the CSC also described having a weekly 'catch up' where staff give each other a quick update on how they are faring with particular families and can then discuss it further with the casework specialist if need be. The MCW also emphasised the importance of discussing cases and engaging in reflective practice, again corresponding to the discussion in *Practice First* CSCs:

We do lots of talking in my team, lots of talking about cases and what happened then and who said that and why did you – lots of information sharing and I think that just leads to reflection because then we go into, "Well, next time we go out, let's try this," and "what can we do better next time."

The MCW reported that staff felt supported in their decision making because they spend a lot of time discussing cases. She also spoke of gaining some awareness of *Practice First* through attending some training in group supervision and how the MCS had sent MCWs some readings on reflective practice and group supervision *"so I'm heading towards having a little bit of a go at it while we're waiting for Practice First or more like that."* She felt that group supervision would work well in their centre and commented that they do not want to "be left behind" as others implement *Practice First* ahead of them.

Office support staff felt that greater awareness among caseworkers of each other's cases made it easier to for them to refer pressing matters to other staff if necessary. Again, this echoes the findings of the *Practice First* focus groups, where staff felt that shared responsibility in the office resulted in clients getting a better service:

And particularly from an admin point of view that's really good that, you know, if the allocated caseworker's not there, that team in particular, no it's all about, as you said before, they know all about the case, it's not the ins and outs but they know

enough to be able to take a call, make a decision in the absence of a manager or the caseworker. Instead of it just being, no one's here to help him. So they get a service.

The MCW commented on how supportive the office support staff are, viewing them more as casework support rather than “*admin*”. To highlight the contribution the office support staff made to the running of the CSC, she gave the example of how a caseworker had to make a trip to Canberra and “*rather than take two caseworkers out, one of the admin girls went down with her*”.

Staff also felt that they worked cohesively as a team, with two caseworkers giving the example of a situation where they had to respond to someone else’s case, echoing the views expressed at *Practice First* CSCs about working collaboratively:

You can do that when you've got a culture where there's – where you're not just a siloed group of people working on my own staff and to hell with anything else, where we do actually have a sense of we deliver services to families out of this office and we take responsibility for the work of the office, you know, it's really good.

There was discussion about families’ involvement in decision making and the view was expressed that Community Services still has a way to go in terms of ensuring genuine engagement with families in decision making:

I think we're getting better at shifting paradigms I suppose. And we aren't there yet I think in terms of true shared decision making and it is really complex. We work with legislation, we can take people's children, they have to do what we say, they are scared, they don't speak our language. So true participation and collaborative decision making is a big ask and we're just moving that way I think.

In the context of the discussion about being unable to meet demand, one caseworker spoke of practice shifts similar to those implemented under *Practice First* - engaging families and developing relationships - and how this would impact on caseworkers’ time:

If you're actually really doing good relationships-based counselling then there's more home visits, more relationship, more telephone calls, more work and that actually means there's actually more casework to do. And we understand we'll get the results in that but it is actually still placing demands on case work hours.

This identified tension between investing in relationship-building while also keeping on top of the associated administrative tasks corresponds with the focus group discussions with staff at the *Practice First* sites.

Case study: Non-Practice First CSC No. 2

The second non-*Practice First* CSC involved in the evaluation was based in metropolitan NSW. While staff could highlight a number of strengths in their practice, the general tone of the discussion was subdued compared to the *Practice First* focus groups and the other non- *Practice First* focus group. Staff spoke of high staff attrition rates and the fact that many roles were not filled at the present time. Confusion was expressed about how the resource allocation model used by the Department worked and a sense that it was “*not based on the amount of reports*”.

Staff felt that they had the necessary skills and knowledge to form good relationships with the families they worked with. In terms of meeting clients’ needs, staff reported that they could access

what they needed either in-house or by outsourcing if necessary. Staff reported a lot of “cross-consultations between caseworkers” in different teams.

Until recently, one morning a week was set aside for training in topics such as how to work with difficult clients, neglect and developments in their field. In the week before the focus group discussion, however, they had started new training focussed on skills development:

Fine-tuning how we work, looking at how we can be more effective, you know, building up the skills in the CSC to get out there, to see more clients, to access more families.

Nevertheless, staff reported a lack of confidence in their dealings with families that they attributed to the conflicting advice they felt they got from managers:

We raised some of the things last week in the meeting, but consistency with management, like for Child Protection especially. We've had a lot of changes and one manager might say, you know, drastic legal action and the other would say no. And so that impacts the relationship that you have with the family because what you're telling them one week is not the same the next week and they're quite really big differences and your engagement with the family.

In trying to tease out what factors could lead to conflicting views between managers, staff suggested that managers could be influenced by their interpretation of risk and the level of risk they were prepared to sit with, as well as the complexity of the cases they are dealing with.

In contrast to the discussions at the *Practice First* CSCs, there was no sense of shared responsibility for the decision making around clients' lives. While MCWs acknowledged that they were reliant on caseworkers to provide the information and ask the right questions to enable them to make informed decisions, it was clear that they felt that the decision was theirs alone:

Ultimately that decision is the manager's, they're the person that closes the case or takes them to court and has to justify that decision.

Corresponding with some other CSCs, staff expressed a range of views when asked how they viewed the quality of service delivery at their CSC. Responses ranged from having highly skilled caseworkers who did what they could to the belief that there was always room for improvement, a response common across all the CSCs. For example one caseworker commented:

I think every individual does the best they can, that's why we have high turnover. It's a big burnout situation because if you're in that situation, got the responsibility of what's happening with those families then you're doing as much as you can and that takes a toll over a period of time. That's why there's such a high turnover.

When asked if they felt that the work they did was contributing to improved outcomes, staff were more reluctant to highlight any improvements, compared to many of the *Practice First* CSCs and the other non-*Practice First* CSC.

Perhaps the widest chasm between operating according to *Practice First* principles and not was evident in the way staff in this non-*Practice First* CSC and all of the other CSCs (including the other non-*Practice First* CSC) spoke about their engagement with the families they worked with. Staff at the *Practice First* CSCs emphasised relationship-building, investing time in getting to know families and the benefits of working in this way, even if a decision was taken to remove a child. In contrast,

staff at non-*Practice First* CSC No 2 did not appear to have the same level of confidence in their engagement with families and still appeared to be immersed in the 'us and them' culture that the *Practice First* CSCs (and the other non-*Practice First* CSC to some degree) felt they had moved away from:

We're always trying to engage the family because they are a big part of the solution making process. The challenge is always they're not in that same place to be making those decisions with us because there's already a divide but it's us and them and then there was that sense of loss and grief that they're going through that there may be an impending decision that won't work in their favour as well. So sometimes it's very difficult to address their own fears.

Appendix E: Caregiver survey responses: building relationships

Table E1. Percentage of respondents in each response category across dynamic fidelity indicators.

	Pilot (n=1) and Phase 1 (n=15)				Phase 2 (n=22)			
	Not sure/ no response	Yes	No	A little	Not sure/ no response	Yes	No	A Little
<i>Principal 2: Families have a right to respect</i>								
Before the session I knew that the worker was going to come	0	88	13	0	5	77	18	0
During the session the worker showed curiosity about our family, they asked us questions and showed interest in us	0	100	0	0	5	91	5	0
During the session the worker listened to me	0	75	6	19	9	82	9	0
During the session the worker asked me about my views and opinions	0	81	19	0	9	77	14	0
During the session the worker used respectful language when talking to me	0	100	0	0	0	95	5	0
During the session the worker used positive language when talking about me and my family	0	88	6	6	0	95	5	0
During the session the worker was clear with me about any concerns that had been reported about my child, and advised me if new concern had come up	0	75	13	13	5	95	0	0
During the session the worker talked about the good things I am doing for my child	6	75	6	6	5	86	5	5
<i>Principal 3: Appreciation of context</i>								
*During the session I felt like the caseworker was being honest with me about his/her concerns	0	63	19	19	0	95	0	0
*During the session I felt like the caseworker understood my situation	6	75	6	13	0	77	0	14

	Pilot (n=1) and Phase 1 (n=15)				Phase 2 (n=22)			
	Not sure/ no response	Yes	No	A little	Not sure/ no response	Yes	No	A Little
<i>Principal 3: Appreciation of context (continued)</i>								
*During the session I felt like I was given the chance to tell or show what positive things I could do for my child	6	88	6	0	9	82	5	0
<i>Principal 6: Foster learning, hope & curiosity</i>								
*During the session the worker asked me what dreams and hopes I have for my family	0	56	38	6	14	55	27	0
<i>Principal 9: Relationships are key</i>								
*During the session the worker praised me for progress I've made with the case plan but also challenged me on areas that I still need to work on	6	81	13	0	32	59	5	0
*Right now I feel I have a strong and positive relationship with my worker	6	81	6	6	5	91	0	0

*There was missing data for one respondent from Phase 2 on items marked with an asterisk. The survey was discontinued early at the respondent's request. There was no other missing data across participants. Note. Percentage values are rounded up to whole numbers, therefore in some cases rows do not total to 100 per cent.



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