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Evaluation of the Children's Contact Service Activity

Final report

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We acknowledge all traditional custodians, their Elders past, present and future, and we pay our respects to their continuing connection to their culture, community, land, sea and rivers.

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Glossary

Term	Definition
Case management	Discussions regarding the management of the case. This may occur on a one to one or Children's Contact Service team basis.[1]
Children's Contact Service (CCS)	Children's Contact Services work with children from separated families to establish or maintain a relationship with the parent they do not live with. Children's Contact Services provide a safe, neutral venue for the transfer of children between separated parents and supervised contact for the child of separated parents and other family members.[2]
Consent orders	Consent orders are court orders that may be made (a) without litigation following the filing of an Application for Consent Orders (and the proposed consent orders, together with a Notice of Risk in parenting matters); or (b) in matters where litigation is on foot following the filing of the proposed consent orders and an annexure or submission in court outlining how the proposed consent orders address allegations of abuse or family violence and risk to children. Proposed consent parenting orders will be endorsed where the court is satisfied that they are consistent with the best interests of the child/children in the relevant matter: Family Law Act 1975 (Cth) s 60CA.
Contravention	Parenting orders are contravened when a person bound by the order has intentionally failed to comply or made no reasonable attempt to comply with the order: *Family Law Act 1975* (Cth) s 70NAC(a). Parenting orders can also be contravened by a person not bound by the order if they have intentionally prevented a person bound by the order from complying with it or have aided or abetted the person bound by the order to contravene it: *Family Law Act 1975* (Cth) s 70NAC(b).
Family violence	Under the *Family Law Act 1975* (Cth), family violence refers to behaviour that coerces or controls a family member (including relatives, de-facto partners and spouses) or causes them to be fearful: *Family Law Act 1975* (Cth) s 4AB(1). Behaviours that may constitute family violence include assault, sexual abuse, stalking, repeated derogatory taunts, intentionally damaging property, and financial abuse: *Family Law Act 1975* (Cth) s 4AB(2). For the purposes of the *Family Law Act 1975* (Cth), a child is exposed to family violence if the child sees or hears family violence or otherwise experiences the effects of family violence: s 4AB(3). Examples of situations that may constitute a child being exposed to family violence are included in s 4AB(4).
Independent Children's Lawyer (ICL)	The court can make an order for the appointment of an Independent Children's Lawyer under s 68L of the *Family Law Act 1975* (Cth), or on the application of a child, an organisation concerned with the welfare of children, or any other person, to represent and promote the best interests of a child in family law proceedings. This usually occurs when there are allegations of violence, abuse or other complex issues.
Identity contact	Identity contact refers to limited parenting time (commonly nominated as comprising approximately 4 supervised sessions per year) to allow a child a sense of identity and connection with the relevant parent with whom they have identity contact, without the expectation that the family will move to self-managed parenting time.
Lives with parent	The parent who the child lives with or spends the majority of time living with; this definition includes those who are not the biological parent of the child but have primary care of the child.[3] Under earlier iterations of the *Family Law Act 1975* (Cth), this parent was known as the 'residence parent' or the parent with 'custody' of the relevant child.
Parental responsibility	In s 61B of the *Family Law Act 1975* (Cth) 'parental responsibility' in relation to a child, means all the duties, powers, responsibilities and authority which, by law, parents have in relation to children.
Parenting order	An order dealing with matters specified in s 64B(2) of the *Family Law Act 1975* (Cth), such as who a child is to live with, the time a child is to spend with persons, the allocation of parental responsibility for a child, and the communication a child is to have with persons: *Family Law Act 1975* (Cth) s 64B(1)–(2). Parenting orders may be made in favour of a parent of the child or another person: *Family Law Act 1975* (Cth) s 64C.
Spends time with parent	The parent who the child does not live with or who the child does not spend the majority of the time living with; this definition includes adults with parenting orders who are not biological parents but those who are significant in the child's life and spend time with the child[4] Under earlier iterations of the *Family Law Act 1975* (Cth), this parent was known as the 'contact parent' or the parent with 'access' to the relevant child.

1 Australian Children's Contact Services Association. (2008) Standards for Children's Contact Services. Retrieved from: ACCSA-Standards.pdf

2 Commonwealth Attorney-General's Department. (2018). Children's contact services: Guiding principles framework for good practice. Canberra, ACT: Department of Social Services.

3 Ibid & FLA

4 Ibid & FLA

Term	Definition
Supervised/ facilitated changeover	The supervised transition of the child(ren) from one parent to another.[5]
Supervised time/ supervised visit	The time the child(ren) spends with a parent they do not live with that is time supervised by Children's Contact Service staff as per the terms of the service delivery arrangements.[6]

5 Ibid
6 Ibid

Abbreviations

Abbreviation	Description
ACCOs	Aboriginal Community Controlled Organisation
ACCSA	Australian Children's Contact Services Association
AGD	Attorney-General's Department
AIATSIS	Australian Institute of Aboriginal and Torres Strait Islander Studies
AIFS	Australian Institute of Family Studies
ALRC	Australian Law Reform Commission
ANZACAS	Australian and New Zealand Association of Children's Access Services
AOD	Alcohol and Other Drugs
AVO	Apprehended Violence Order
CALD	Culturally and Linguistically Diverse
CCSs	Children's Contact Services
DEX	Department of Social Services Data Exchange
DFV	Domestic and Family Violence
DSS	Department of Social Services
DVO	Domestic Violence Order
DVSAT	Domestic Violence Safety Assessment Tool
FCFCoA	Federal Circuit and Family Court of Australia
FLA	Family Law Act 1975 (Cth)
FRSA	Family & Relationships Services Australia
FRSP	Family Relationships Services Program
ICL	Independent Children's Lawyer
IPV	Intimate Partner Violence
LWP	Lives with parent
RFI	Request for Information
ROVI	Rating of Visit Interactions Scale
SCORE	Standard Client/Community Outcomes Reporting
SNAICC	Secretariat of National Aboriginal and Islander Child Care
STWP	Spends time with parent

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Views expressed in this publication are those of individual authors and may not reflect those of the Australian Government or the Australian Institute of Family Studies.

Executive summary

Background

This report sets out the findings of the Evaluation of Children's Contact Centre Activity. Children's Contact Services (CCSs) facilitate the supervision of parenting time and changeover for families, most commonly where the parents are separating, or have separated, and require a safe and neutral venue to enable contact to take place. This study evaluates the work and activity of these services. There are 64 services in scope for this evaluation, operated by not-for-profit providers with funding from the Family Relationships Services Program (FRSP), administered by the AGD. The evaluation was funded by the Australian Government, AttorneyGeneral's Department (AGD).

The evaluation presented in this report is a large-scale, mixed-method evaluation comprising:

- a desktop review of literature, empirical evaluations of CCSs undertaken to date and commentary together with departmental and sector materials relevant to the introduction and operation of CCSs in Australia since 1996
- an analysis of administrative data drawn from data available from the DSS Data Exchange (DEX) and from the Request for Information (RFI) for data drawn from service provider client record management system and program policies
- an analysis of quantitative and qualitative data from a national survey of service providers, service management personnel, supervision staff and legal and non-legal professionals referring families to CCSs
- an analysis of qualitative data from semi-structured interviews with First Nations professionals working with First Nations families
- an analysis of qualitative data from the semi-structured interviews with parents/carers
- a Survey of Parents and Carers, including the collection of data in relation to their children's views and experiences of CCSs.

Evaluation design

This evaluation has been implemented in two phases:

- Phase One involved consultations with key stakeholders and the establishment of an advisory group to support the implementation of the evaluation program.
- Phase Two involved the implementation of the substantive methodology, with the data collection and analysis for each component of the evaluation culminating in the preparation of the preliminary, draft and final evaluation reports. The Evaluation Research Team liaised with key stakeholders, including via the advisory group mechanism at each stage of this phase of the evaluation.

The activities in both phases have been conducted to ensure that careful consideration is given to the extent to which data might be provided by CCSs to the AGD subsequent to the Evaluation, to support further work in this area. Specifically, the data collection protocols and instruments developed for this Evaluation were designed to facilitate workable arrangements and aim to ensure that, to the fullest extent possible, they may inform future data collection activities undertaken by the AGD.

Evaluation objectives

The objective of this project is an evaluation that considers the history of CCSs and the current context in which government-funded CCSs are operating, and to make an assessment of the extent to which:

- these services are operating in accordance with, and achieving the objectives of, the relevant guiding documents (including the Grant Opportunity Guidelines and the Guiding Principles Framework for Good Practice)
- how effectively these services are providing culturally appropriate service for culturally and linguistically diverse (CALD) and First Nations populations and are supporting families experiencing domestic and family violence (DFV)
- the current number and location of CCSs are meeting existing demand for services.

It is important to acknowledge that this evaluation does not constitute an assessment of individual CCSs and is not an accreditation audit of CCSs.

Evaluation questions

The methodology is designed to answer a series of evaluation questions. They have been developed based on the Project Objectives and the Statement of Required Services specified in the Work Order between the AGD and AIFS, together with relevant material including:

- the Children's Contact Services Guiding Principles Framework for Good Practice (AGD, 2018)
- the Family and Children Activity Administrative Approval Requirements (DSS, 2014) and the Program Information for the Families and Communities program, Families and Children Activity (DSS, undated)
- the Family Law Services Children's Contact Services Grant Opportunity Guidelines (AGD, 2019)
- the Australian Children's Contact Services Association Standards (ACCSA, 2008).

The evaluation questions are:

1. How and to what extent are CCSs providing safe, reliable and neutral places that:
    a. facilitate changeover and supervised time
    b. undertake intake, initial and ongoing risk assessment of family members separately to ensure commitment and agreement to service protocols
    c. provide child-focused information to families
    d. orient children to the service setting and surroundings
    e. make referrals and regularly review changeover and supervised time sessions with the goal that families will graduate to self-management where it is safe to do so?
2. How and to what extent are CCSs helping families to graduate to self-management (where this is safe) or to achieve sustained and workable long-term parenting and time arrangements?
3. To what extent do CCSs provide independent written reports of families' interactions with their service and the changeovers and/or contact sessions to family law courts? What are the nature and quality of these reports and how are they used to inform the decision-making process?
4. Are the service models provided child-focused/child-centred and trauma-informed? To what extent do the services comply with the National Principles for Child Safe Organisations and the Commonwealth Child Safe Framework?
5. Are CCSs operating in accordance with the Children's Contact Services – Guiding Principles Framework for Good Practice including:
    a. the role and obligations of CCSs
    b. the objectives for CCSs
        » child focus
        » safety
        » neutrality
        » client diversity and cultural sensitivity
        » collaborative service provision
    c. the priorities for service delivery
    d. the range of services provided
    e. the service safety requirements (including safety and security plan requirements, safety policy, procedures and protocols relating to critical incidents, risk assessments)
    f. record keeping, policies and procedures
    g. the good practice principles for service delivery and resources?

6. To what extent are the services provided culturally appropriate for:
    a. First Nations families
    b. CALD families?
7. To what extent are CCSs supporting families experiencing DFV? How are CCSs providing this support and how effective is the provision of this support?
8. To what extent are the current number and locations of CCSs meeting the existing demand for their services?
    a. What are the expectations of families and professionals using or seeking to use CCSs and to what extent are these expectations being met?
    b. Is the referral process operating effectively?

Findings

Services provided by CCS

The nature and extent of services provided by CCSs

The RFI data indicated that CCSs report applying rigorous processes and approaches in a range of areas, including in the areas of safety planning and child focus and inclusion. Although the data from parents/carers who use the services often confirms this, there are also more mixed and less positive experiences reported by parents and carers. These patterns indicate a need for careful attention to be paid to the consistency and quality of service provision in the context of a focus on how parents, carers and children are experiencing the services. Also noteworthy is that patterns in responses of referring professionals in the Survey of Professionals indicate limited awareness of some core aspects of CCS service provision, suggesting that a focus on improving understanding and engagement between CCS service providers and referring professionals is warranted.

In terms of client numbers; overall, the RFI data indicate that CCS client numbers were starting to increase again in 2022 (11,365 in 2022) after a decline over the period of the COVID-19 pandemic, dropping from 12,168 in 2019 to 10,324 in 2021. Of the two core kinds of services provided by CCS, supervised parenting time visits are more common than supervised changeover sessions. Markedly fewer clients used supervised changeover sessions and, again, 2022 levels (4,301) have not returned to pre-pandemic levels (2019: 4,857).

One aspect of CCS service that increased, albeit off a low base (fewer than 100 clients) during the COVID-19 pandemic was online/virtual supervision services, peaking at 709 clients in 2020 and remaining higher than pre-pandemic figures in 2022 (259). Steady declines in numbers of clients reported to be in low vigilance supported/monitored onsite contact sessions are evident. Only a minority of CCSs report providing unsupervised onsite visits or community-based offsite supervision.

Supervised changeovers were generally provided over a longer period of time than supervised visits for parenting time (approximately 48 weeks for changeovers cf. 36 weeks for supervised time).

Detailed analysis of the intake, triage and risk assessment process for families applying to use CCSs through RFI and survey data indicated comprehensive intake and risk assessment processes across the participating CCSs, with a range of risk assessment tools and processes employed. Some CCSs also described how they undertake ongoing risk assessment for the duration of the service delivery. It is notable, however, that some professionals and some parents and carers in their interview and survey data raised safety concerns for both their children and themselves. Some parents and carers indicated either concerns with or a lack of knowledge of CCS safety planning.

RFI data relating to orientation/familiarisation processes for families entering the service highlighted the child-focused and child-inclusive nature of this process for the majority of services. This involved CCSs supporting children to receive information about the CCS and the process, and to allow the child to explore the CCS setting, to support the CCS staff and child to facilitate the development of a relationship of trust and to understand the support that they will receive when at the service. It is notable, however, that very few parents and carers who were interviewed could recall orientation/familiarisation being offered to them or their children. The experiences of those parents and carers who recalled and described their family's orientation varied considerably. Some parents and carers reported that they and their children were well supported while others reported mixed feelings or that they or their child were not well supported in the orientation process.

There was limited indication of awareness among referring professionals of CCS non-supervision services, such as case management, case support, case planning and referral to education, skills and training programs. The gaps in referring professionals' knowledge of non-supervision services and referrals may reflect more limited direct and current engagement with services but it may also be due to an absence of or limited availability of up-to-date information about the range of services provided by CCSs. It was also not common for parents to report receiving non-supervision services, including referrals. These findings suggest there is a need for improved dissemination of information about CCS service provision but it may also require more effective, warm referral processes by CCSs to support families to access the non-supervision services that they need.

The provision of CCS written reports

The provision of reports for family court proceedings is an important aspect of CCS operations. Numbers of these reports being provided reached a four-year high in 2022, at 8,078. There is some variation in the way CCSs approach the provision of evidence to courts, with a minority preferring to receive a subpoena for case notes rather than developing a specific report.

Contrasting views about the quality of written reports was found in the Survey of Professionals. Statistically significant differences were recorded between the proportions of CCS professionals and referring professionals who agreed written reports provided by CCS were of high quality (81% vs 44%; cf. 26% of referring professionals indicated that they did not know the quality of these reports).

Facilitating self-management or sustained long-term parenting arrangements

CCSs apply a range of strategies to facilitate the transition to self-management. The data indicated the adoption of time-limited service provision, case management (including period reviews) and referral to support services, with these evident in both the RFI and survey data. The RFI data indicate a steady pattern of clients transitioning to self-management, with a peak in 2022 (2,299 clients) and fluctuations evident in preceding years 2019–21 between 2,160 and 2,262 clients. Self-management is not sustainable for around one-fifth (18%–22%) of families, who return to the service after transitioning out.

Nature of CCS services models including safety and children's best interest

Guidance for CCS service provision

The extent to which CCSs are operating in accordance with the relevant guiding documents including the *Guiding Principles Framework for Good Practice*, together with other relevant guidelines and standards, including the Grant Opportunity Guidelines, identified CCS policies and procedures was found to be largely consistent with the principles in the guiding documents. The policy and procedure documentation submitted by participating CCSs shows particularly strong consistency in relation to safety protocols and prioritising children's best interests. Less strongly visible in the policy and procedure documentation was collaborative practices and referrals to other services.

There was some variation in relation to principles that are quite specific to CCS service delivery; for example, the need to move to self-management and approaches to neutrality and information sharing. The aspects were articulated to clients in different ways and with different emphasis in the policy and procedure documents.

Together, the different sources of data in this evaluation indicate policies implemented by the CCSs are generally consistent with the Guiding Principles Framework and the National Principles for Child Safe Organisations (also relevant to grant agreements). Application of trauma-informed principles are also evident.

The number of staff and staff ratios show that, consistent with guiding standards, the data are indicative of a broad range of staff qualification requirements in relevant fields.

In relation to compliance with the National Principles for Child Safe Organisations and trauma-informed practice more specifically, data show that most professionals and parents/carers identified CCSs as physically and emotionally safe for the children using them, and engaging in child safe, child-focused, child-centred and child-inclusive practices.

Safety

Although most professionals (77%) agreed that CCSs were physically and emotionally safe for the children using them, some professionals, as well as some parents and carers, raised concerns that risks to children's physical and emotional safety may nevertheless remain despite the CCS arrangements, including in circumstances characterised by family violence.

Several participating professionals providing open-text responses raised concerns specifically in relation to the making of unsafe parenting orders that underpinned the referrals to CCSs, including in cases characterised by family violence or other significant risk.

Nevertheless, in the responses to the Survey of Parents and Carers, the majority of participants felt comfortable with the safety of the CCS, with 78% of participants reporting that 'the safety of the child/ren is adequately considered', with no difference by gender (80% of women; 76% of men).

Children's best interests

Most professionals agreed that CCSs could refuse to facilitate supervision arrangements and that the services provided by CCSs addressed the needs of the children using them, although there were some concerns that CCSs did not decline service provision that was not consistent with children's best interests and suggested a range of areas for improvement in relation to CCSs' capacity to address children's needs.

There were both positive and negative aspects of children's experiences using the CCSs reported by parents and carers. These participants provided reasons for why children felt positive using the CCS including that their children were not exposed to parents' conflict, were able to spend time with the supervised parent, were comfortable with the CCS staff, that the CCS facilities were fun for their children, that their children felt safe there, and attendance was a routine. Concerns expressed by parents and carers were that their children did not want to go, were attending only because they had to, and were unable to express concerns about whether the visit should proceed, and regarding children's mood or behaviour before or after visits.

Concerns were also raised by parents and carers that indicated at times staff were limited in their ability to understand what the child wanted or needed, staff had little or no time to debrief with the child prior to or after changeovers, staff having limited skills of engaging with children who have disabilities, and children having difficulties communicating with staff.

Benefits identified for their children included the opportunity to build a relationship with the visiting parent or carer and to experience safe and enjoyable time with them, and children becoming more confident with them as the relationship developed. Similar to the observations above, detriments centred on perceptions of the CCS as not intervening when the child was distressed and not being accorded a voice in the process.

Staffing

Compliance with guiding standards in relation to staffing practices is also evident and reports of staff ratios to clients suggest strong levels of compliance with guiding standards. There were challenges with recruitment and retention, including the high level of skill required of CCS staff; the nature and timing of the shift work over weekends; availability of casual staff; the locations of services, including regional locations; the level of remuneration and the level of responsibility required of the role. There was an evident focus on staff training and professional development for most CCSs across a broad range of relevant areas.

Site characteristics

RFI data relating to physical site characteristics and specifications of CCSs suggest that, overall, services meet the requirements of the guiding standards in relation to CCS required site specifications.

Self-management

The findings indicate some complexity in aiming for self-management and the achievability of this goal for some families. Although there were high levels of endorsement for the principles of self-management among both CCS professionals and referring professionals, slightly less than two-thirds agreed that CCSs successfully provided support and services that families need to transition to self-management. Strategies used to support self-management were identified.

Professionals also described a range of circumstances where long-term supervised arrangements may be required, such as illness, injury or disability, homelessness and substance abuse, or where 'identity contact' was warranted.

Parents and carers were mixed in their views about being able to move to self-management with a substantial proportion of parents indicating that they did not know whether they would be able to manage their parenting arrangements without the CCS for a range of reasons, including disability, substance use and the behaviour of the other party.

Cultural safety and disability

The findings set out in this section indicate that there is some way to go in achieving culturally safe service provision in CCSs. Less than half of professionals agreed that the services provided by the CCSs in their area were culturally safe for the children who use them, with participants raising significant concerns about the ability of CCSs to meet children's cultural safety and also their needs arising from disability.

Demand for CCS services and meeting expectations

Accessibility

Data indicated that pressure on waiting lists eased in 2022, compared to 2019, 2020 and 2021. Waiting lists were most commonly three months or less. Only 13% of CCSs reported 4–6 month waiting lists and none reported more than 7 months. These improvements in time to access were attributed to increased funding supporting case management and expedited intake processes.

On average, CCSs are open for 33 hours week, with some variations among states and territories. Again, increased funding supported more operating hours but there were also challenges associated with demand for access and providing services over a big area.

Overall, the findings suggest that there are generally sufficient services to meet existing demand, locations are appropriate and accessibility by public transport is mostly adequate. However, confidence on these issues is less evident among referring professionals. Some parents and carers interviewed also reported experiencing issues accessing their CCS. These varying views reinforce the need to understand client perspectives on key issues relating to usability.

Referral pathways

Referral pathways are mostly through family law court orders and the client caseload is particularly complex. Referral pathways vary by regional location, with CCSs located in major cities more likely to have clients referred by family law court order and inner regional locations having the highest proportion of voluntary clients. The proportion of CCS professionals who strongly agreed or agreed that referrals were effective was almost double the corresponding proportion of referring professionals. Where participants indicated that referral processes were not working well, reasons included insufficient CCS to meet demand and long waiting lists. Some participants also identified challenges with the intake process and that CCSs were receiving an increasing number of high-risk referrals.

Do CCSs meet expectations?

Some participants described CCS practices that supported families to address their underlying issues as particularly helpful. Conversely, areas that professionals were most dissatisfied with included insufficient funding for the delivery of required services. Some participants also described their concerns about the quality of services provided and the facilities and security in place, due to poor design or functionality. Some participants also referenced the need for increases in the number and location of CCSs as well as the types of services provided, reductions in waiting lists and improvements to the available activities and the length of service provision for families but this was in contrast to the overall findings that demand was being met. Some participants raised concerns about the training and quality of the CCS staff when reflecting on aspects of CCSs that they were dissatisfied with, particularly in relation to dealing with traumatised clients. A smaller proportion of responses raised concerns about inclusion and accessibility for First Nations, CALD families and families with a disability.

Parents and carers rating their and their children's satisfaction with the CCSs indicated satisfied with their use of CCS services. Positive reflections were commonly associated with the costs and hours of operation and, consistent with professionals, that the CCS addressed issues of safety for their children and/or themselves. Parents and carers who reported positively also referred to CCS staff support, child focus and neutrality. Some parents and carers raised concerns about the waiting lists to access the CCS and concerns for their safety or the safety of their children at the service. For some parents, expectations were not met regarding child safe practices such as orientation/familiarisation and debriefing.

Suggestions from parents and carers for improvements included additional funding to support an increase in locations or branches of CCSs to reduce distances to attend or decrease waiting lists, more flexibility in sessions offered, and more staff or supervisors in sessions. Many parents and carers indicated that they would like to see improvements to the infrastructure and activities for children, improvements in communication with parents and carers as well as potentially referring professionals, to training and support in relation to neutrality and report writing.

CCS service provision: meeting the diverse needs of families?

First Nations and CALD families

DEX data show that First Nations clients were over-represented among in-scope CCS clients. Proportionately fewer clients were from CALD background and 1 in 10 were reported as having a disability.

Professionals' views of the extent to which CCS services were accessible for First Nations and CALD clients varied substantially, with CCS professionals more likely agree that services were accessible and culturally safe compared to referring professionals. Pointedly, less than half (47%) of professionals participating in the Survey of Professionals agreed that the CCSs were culturally safe for the children using them.

Qualitative responses describing why the services were not culturally safe from a First Nations perspective described an absence of or inadequate culturally appropriate practices from a First Nations perspective and the absence of First Nations-led services. Participants agreeing that the CCSs were culturally safe referenced the specialist First Nations cultural awareness training and resources and First Nations staff and/or volunteers supporting First Nations inclusion.

Qualitative responses from the Survey of Professionals raising concerns about cultural safety from a CALD perspective referenced inadequate access to interpreters and a lack of CALD staff (including bilingual supervisors). Professionals expressing positive views referenced access to interpreters, the accommodation of culturally significant celebrations and the employment of CALD staff or volunteers. The RFI data reflected that practice and showed most services facilitate interpretation for intake and assessment and for supervision services and the majority of CCSs did not charge fees for interpretation services.

Participants in parent/carer interviews presented a mixed picture of cultural safety, as some parents and carers acknowledged their CCS had some culturally appropriate services. However, some parents and carers described negative experiences linked to poor cultural safety and inadequate trauma-informed practices.

Interviews with First Nations professionals revealed that CCS locations, reluctance to seek help from government-related services (in part linked to experiences of government intervention into First Nations families) and financial costs were barriers when accessing services. Culturally safe practices for First Nations families highlighted specialist First Nations staff and support people (e.g. Elders) and ensuring CCS staff are trained appropriately in trauma and cultural awareness from First Nations perspectives. First Nations professionals also described the importance of adapting the structure of service provision to the individual needs of First Nations families for cultural safety through consulting with them, especially supervised time with children outdoors and with kin.

Disability

Participants who report CCSs to be accessible for people with a disability tend to refer to the building and facilities as suitable for people with a physical disability, that staff were trained in disability and disability needs are included in families' management plans. Professionals (as well as parents and carers) who were not in agreement, cited issues with transport to travel to CCSs for people with a disability and that staff were not sufficiently trained in disability (particularly in relation to children experiencing mental health issues or neurodiversity). The RFI data also identified culturally safe and inclusive practices employed by CCSs in line with the affirmative responses but acknowledged that costs and resource constraints limited implementation.

Domestic and family violence

All data sources demonstrate that families accessing CCSs were characterised by complex needs and risk issues. Approximately 4 in 10 clients were identified as needing assistance with family functioning and more than 1 in 10 required assistance with personal and family safety (DEX data). Issues relating to emotional abuse or anger issues, mental health issues and violence or dangerous behaviour were all commonly reported in the Survey of Parents and Carers. Nearly three-quarters of parents and carers interviewed reported safety concerns and these concerns most frequently involved multiple risks. Two-thirds of professional participants in the Survey of Professionals agreed that CCSs were appropriate for families experiencing the complex risk issues associated with DFV. Most parents and carers participating in the Survey of Parents and Carers identified CCSs as having prioritised the safety of their child and that the CCS was safe and appropriate for family members experiencing DFV. However, some parents/carers and professionals raised concerns about risks to children's physical and emotional safety despite the CCS arrangements, including in circumstances characterised by DFV.

Client outcomes

In relation to meeting clients' expectations and needs, the DEX data show that most clients assessed had an overall positive outcome in relation to the Circumstances, Goals and Satisfaction DEX outcome measures in both 2019 and 2022, with satisfaction being particularly high (80% or higher). In relation to negative outcomes for DEX Goals, clients' reports were higher in 2022 than in 2019.

For child clients, clients' reports indicate a higher proportion of boys than girls had an overall positive outcome across circumstances and goals in 2019 but, in 2022, there was little difference in circumstance and goal SCORE data between boys and girls. However, a higher proportion of boys had an overall positive outcome compared to girls, although a small number of boys and girls were assessed for SCORE in 2019. The proportion of boys with an overall positive outcome in circumstances and goals declined from 2019 to 2022; however, the proportions for girls in these two areas remained stable.

When comparing state location, positive client outcomes emerged overall across states/territories and regions. Higher proportions of clients in Western Australia, Victoria and Queensland than other states had an overall positive outcome in circumstances and achieving goals, but an overall positive outcome in satisfaction was higher in Tasmania and Queensland.

For geographic location, the proportion of clients with an overall positive outcome in circumstance and goal was lower in outer regions and remote areas in 2019, compared to major cities; however, the differences were no longer apparent in 2022. Clients in outer regions and remote areas had an overall positive outcome in satisfaction compared to those in major cities and inner regions, and this pattern was evident in both years.

When comparing DEX data for client characteristics, the overall client outcomes for CALD clients, clients with disabilities and First Nations clients were similar to those of other clients, although in 2022 overall positive outcomes in circumstances and achieving goals were lower for CALD clients. Importantly, First Nations clients had higher overall positive outcomes in satisfaction than non-First Nations clients and similar positive outcomes in circumstances and achieving goals. The data also show that the proportion of clients with overall positive outcomes in circumstances and achieving goals increased for clients with a disability between 2019 and 2022.The data show, however, that in 2022 overall positive outcomes in circumstances and achieving goals were lower for CALD clients.

More nuanced insights are provided by data from the Survey of Parents and Carers and qualitative data from the interviews with parents and carers, which showed varied experiences of CCS use and how this affected participants' relationships with their children. Among survey participants, approximately one-third reported a positive change; a further one-third reported that there was no change; and 15% reported a negative change. Spends time with parents more frequently reported a positive effect on their relationship with their child than Lives with parents.

Parents and carers' qualitative insights in relation to the positive effects referenced the facilitation of a relationship in circumstances where this would not otherwise be possible, as well as the skill and experience of staff supporting the Spends time with parent to engage with their child. Negative effects identified damage to their relationship of trust with a child expressing views against time with their other parent, and behaviour changes on the part of the child.

Insights from professionals and parties regarding the strengths of the CCS's ability to adapt to meet the needs of children and families focused on the safe, affordable and child-focused and trauma-informed approach of

CCSs. Limitations centred on an absence of flexibility to adapt to families' needs, specifically CCS provision being constrained by court orders, as well as funding constraints limiting service availability and adaptions to this service provision, including the wraparound service provision or modifications to the current model to meet the needs of First Nations and CALD families.

Changes suggested by parents and carers and professionals

Changes recommended by parents and carers to better meet their needs included further resourcing for staff training to support neutral, professional and trauma-informed practice, improved communication with parents and carers, including consistency in communications provided by staff, accuracy in CCS reports and improved engagement with children and family members to provide feedback. Measures to support greater accessibility identified by parents and carers included: greater availability of CCS services, including a reduction in time period awaiting services, increased days and hours of operation and local accessibility to CCSs, a simpler/easier application process, offsite supervision, sessions with multiple children, the provision of mediation and other support services and the provision of real time reports to support the identification of issues experienced by children during supervised visits.

In relation to children's needs specifically, parents and carers recommended changes to facilitate greater understanding of children's diverse needs, behaviour changes and experience of distress, and access to support services.

Professionals similarly focused on additional funding in a number of ways for client services and supporting staff. For improving client services, these were: increased and more flexible service provision; addressing the shortcomings in facilities to better support the safety of families; the application of resources to interpretation services; and resourcing support services within or external to the CCS to address the complex needs of the families accessing them. For supporting CCS staff delivering services, views about additional funding included: improved pay and conditions, training opportunities and guidance for CCS staff, particularly in relation to child safe and child-inclusive practices, and when to terminate visits where the child's best interests directed this outcome; more flexible and creative transitional arrangements and options for more provision of limited 'identity contact' for children.

Reflections from First Nations professionals about changes to improve CCSs reflected their views about cultural safety, particularly that CCSs need to strengthen cultural safety by implementing the types of practices First Nations professionals engage in. Strategies to implement outreach services included increasing opportunities for time with children to be supervised in culturally appropriate settings, such as outdoor activities, having CCS professionals going out into communities, and developing a service model similar to Aboriginal Controlled Community Organisations. Holistic service provision was also endorsed from a First Nations perspective as potentially including family therapy and child counselling. Improving information communication and education about CCSs and explaining to families how they should implement court orders was recommended to support First Nations families better towards self-management.

Summary of findings in response to research questions

The evidence from the RFI, the Survey of Professionals, the Survey of Parents and Carers and qualitative interviews indicates that, overall, majorities of stakeholders (families as well as CCS professionals and referring professionals) report CCSs to be providing safe, reliable and neutral places for the provision of supervision services. Variations were nevertheless evident in the response patterns of CCS professionals in the RFI and Survey of Professionals, compared to responses of referring professionals in the Survey of Professionals and the parents and carers in their survey and interview data.

The evidence from the RFI, the Survey of Professionals, the Survey of Parents and Carers and qualitative interviews also shows that CCS clients are moving to self-managed arrangements and that despite their limitations, most professionals are of the view that CCSs are successful in providing the support and services that families needed to do so. Parents and carers were mixed in their views about being able to move to self-management. Although there were concerns by professionals and parents and carers about safe and successful transition, the not insignificant numbers of families returning to CCSs and endorsement by a majority of professionals suggest that CCSs are playing an important role in supporting the achievement of sustained and workable long-term parenting and time arrangements.

The RFI data, together with the quantitative and qualitative data from professionals and from parents and carers, show that CCSs commonly prepare and release reports in relation to families' receipt of supervision services for

family law court proceedings. However, quantitative and qualitative data also show that not all CCSs provide CCS reports, with some CCSs instead facilitating access to their case notes through the subpoena process. The data show that there were variations in the content of the reports but that most participating professionals indicated that the reports were of high quality. There were differences between CCS professionals and referring professionals in this regard, with CCS professionals more positive about the quality of these reports. The data suggest that consideration should be given to issues of consistency of content and quality to ensure that they better inform the decision-making process regarding the parenting and time arrangements that are in the best interests of the child.

Quantitative and qualitative data captured in the RFI process, the Survey of Professionals, the Survey of Parents and Carers as well as qualitative data from interviews with parents and carers indicate how service models and practice are child-focused/centred and trauma-informed, and in large part reflect compliance with the National Principles for Child Safe Organisations as required by the Grant Opportunity Guidelines for the CCS.

The RFI and quantitative and qualitative data from professionals and from parents and carers indicated that both CCSs' policies and their implementation of these policies in practice through their service delivery are largely consistent with the Guiding Principles Framework. Quantitative and qualitative data captured in the RFI process, Survey of Professionals and Survey of Parents and Carers, as well as qualitative data from interviews with parents and carers, illustrated how and the extent to which the implementation of policies in practice accorded with the Guiding Principles Framework.

The data show that First Nations and, to a lesser extent, CALD families are using CCSs; however, professionals varied substantially regarding whether CCSs were sufficiently accessible and culturally safe, and less than half of professionals identifying CCSs as culturally safe. Qualitative responses from professionals in the Survey of Professionals and from those participating in the interviews with First Nations stakeholders and with parents and carers provided insight into the challenges and barriers to CCSs ensuring cultural safety, as well as measures to address these from both First Nations and CALD perspectives.

The evaluation data also suggest that CCSs are providing support to families experiencing DFV and that this support is effective in the context of CCS service provision. It is noted that this finding draws on data more broadly from this evaluation because DFV is in large part the core business of the CCSs and consequently characteristic of a substantial proportion of the service users. For this reason, broader evaluation findings are of specific relevance to those experiencing DFV.

The examination of DEX and RFI data, together with data from the Survey of Professionals and from the survey and interview data from parents and carers suggest that the referral process for families to engage CCS service provision is operating effectively. Overall, the findings also suggest that there are sufficient services to meet demand, locations are appropriate and accessibility by public transport is mostly adequate. However, confidence in relation to the sufficiency of services to meet the demand is less evident among referring professionals than CCS professionals and among parents.

Recommendations

1. Consider modification of CCS program expectations relating to self-management to suit the needs of different families
   - There are some families for whom self-management is not achievable. There are 3relevant groups in this context: families where parental/carer capacity for self-management is unlikely to develop but a relationship with the child is nonetheless important; families where a no time order is the most appropriate outcome; families for whom 'identity contact' is appropriate. Guidelines and practice materials should more explicitly acknowledge these circumstances to support CCSs and CCS professionals to identify these groups and the most appropriate strategies to manage and support them.
2. Facilitate access to wrap-around supports to families where necessary
   - The evidence suggests that families need more holistic support, including therapeutic intervention for parents (to deal with risk issues) and children (to respond to trauma). The evidence indicates that this could either be provided in the CCS context or through a case managed and integrated approach through another service. On either approach, consideration of resourcing and adaptation of guidelines and practice materials is required.

3. Provide additional transition and follow up support to families
   - The proportion of families that return after an attempt at transition to self-management indicates that there is a need for greater transition support, such as referrals to therapeutic support and/or a period of monitoring in the context of the graduated approaches to self-management. A gap in the evidence concerns the extent to which families who do not return to the CCS sustain appropriate and safe self-management. Mechanisms to follow up these families, including potentially a pilot to assess the value of follow-up support, would provide evidence of the circumstances in which self-management is safe, successful, partially successful or unsuccessful.
4. Clarify expectations about the nature, quality and consistency of CCS written reports
   - Consideration of whether a consistent approach to the provision of reports or the subpoena of case notes is required, supported by a closer examination of the strengths and weaknesses of each of these approaches. Services and practitioners require greater support to fulfill this function, to ensure that this function is effective and is supporting decision making in relation to parenting time arrangements.
5. Ensure that feedback from families and the child's voice are key elements of the CCS quality improvement process
   - The findings indicate that CCSs should adopt an ongoing quality improvement process including based on obtaining and considering feedback from user families on a regular basis. Specifically, the findings indicate a need for processes and measures to be developed and used to better assess the children's experiences of the CCS service, with this being a particular area of service development. Importantly, there is a need to support efforts to identify better ways to enable children using CCSs to express what they want and need from the CCS while receiving their services ('the child's voice') and for this to inform service delivery. Although this is important for all child clients, the need was particularly evident in relation to First Nations and culturally diverse children, as well as children with a disability.
6. Greater consistency in training and professional development in relation to child safety, child-inclusive practice and DFV and trauma-informed practice and in meeting the Guiding Principles Framework would be supported by accreditation
   - There is a need for greater consistency across the sector for the application of child-focused, child-centred, child-inclusive and DFV and trauma-informed practice in delivering services to families in the CCS context.
   - This would be supported by an accreditation process that would require a consistent approach to training in relation to child safety, trauma-informed and child-inclusive practices. The findings of this study suggest that the CCS sector is ready for accreditation in its current maturity. Additionally, the data show that there are lessons that the CCS sector can share with other children's services when it comes to more formally accommodate taking into account children's voices in its processes and decision-making, and further accommodating cultural safety for First Nations families.
   - There is a need for CCSs to more consistently meet the requirements of the Guiding Principles Framework in relation to collaborative practices and referrals, neutrality and self-management. These requirements should be reinforced in ongoing staff training and professional development.
   - The concerns relating to inappropriate referrals also suggest that embedding regular and consistent DFV and trauma-informed training and professional development, including child safe and child-inclusive approaches is warranted for both CCS professionals and referring professionals. Specific measures that would enhance service provision for families and children include training and support to enhance practitioner capability to identify and respond to children with diverse needs and to children experiencing emotional distress and to make decisions as to when supervised time sessions should be terminated.
   - Refinement and greater consistency in the implementation of intake and risk assessment, safety planning and orientation/familiarisation processes that are DFV and trauma informed and child safe would also be supported by training and professional development, including with a particular focus on First Nations families, CALD families and where parents and carers and/or children have a disability. Specifically in relation to orientation/familiarisation processes, following up with families during and subsequent to these sessions will support their awareness of and effective engagement in this process.
   - An accreditation process would also support the practical implementation of these CCS service requirements.

7. Encourage the development of culturally safe services in partnership with First Nations peoples
   - To meet the needs of First Nations families, CCSs need support for greater engagement with their local First Nations communities and service providers, including Aboriginal Community Controlled Organisations (ACCOs). Relatedly, ACCOs require greater support to engage with CCSs. Additionally, there needs to be consistent, regular and ongoing training in culturally appropriate and safe service provision to embed trauma-informed approaches that are directed at individual families' needs in CCS practice. Consideration should be given as to how to support CCSs to recruit First Nations practitioners. Consideration should also be given to the development of a different models of service delivery with greater flexibility and a broader range of options for First Nations families in collaboration with First Nations peoples and involving service design and provision by First Nations peoples, based on the principle of self-determination. Learnings from First Nations peoples and their experiences of service provision can inform service provision both for First Nations and non-First Nations families.
   - Consideration needs to be given to the location of CCSs, provision of offsite and in- community settings supervision and the implementation of outreach services to support accessibility and culturally appropriate services for First Nations families. However, there also needs to be regard for strategies to provide alternative modes of service or to reduce stigma and shame associated with using these services among First Nations families.
8. Encourage the development of culturally responsive services with Culturally and Linguistically Diverse communities
   - To meet the needs of CALD families, CCSs need support to increase engagement with their local CALD communities and service providers to better inform culturally appropriate service provision for those communities. Additionally, there needs to be consistent, regular and ongoing training in culturally appropriate and safe service provision for CALD families. Consideration needs to be given to how CCSs can recruit CALD practitioners and how to resource interpreter services to support a greater uptake of CCS services among CALD families.
9. Current population and demographic data should be considered to identify potential additional locations of CCSs to service unmet demand
   - Having regard to the concerns raised by professionals and parents and carers regarding accessibility to CCSs in the context of data from CCSs, including in relation to waiting lists, further consideration of the current location of the 84 government-funded services (including the 20 new services that were out of scope for this evaluation) is warranted, with reference to current population levels to identify potential additional locations of CCSs to service unmet demand.
   - CCS opening hours and service offerings should be also responsive to the needs of local communities.

1 Introduction

The Australian Government, Attorney-General's Department (AGD) has commissioned the Australian Institute of Family Studies (AIFS) to undertake an Evaluation of the Children's Contact Service Activity. Children's Contact Services (CCSs) facilitate the supervision of parenting time and changeover for families, most commonly where the parents are separating or have separated, and they require a safe and neutral venue to enable contact to take place. This study evaluates the work and activity of these services. There are 64 services in scope for this evaluation, operated by not-for-profit service providers with funding from the Family Relationships Services Program (FRSP) administered by the AGD. A further 20 CCSs have been established under the FRSP but are not in scope for this evaluation due to the recency of their funding.[7]

The evaluation presented in this report is a large-scale, mixed-method evaluation comprising:

- a desktop review of literature, empirical evaluations of CCSs undertaken to date and commentary together with departmental and sector materials relevant to the introduction and operation of CCSs in Australia since 1996
- an analysis of administrative data drawn from data available from the DSS Data Exchange (DEX) and from the Request for Information (RFI) for data drawn from service provider client record management system and program policies
- an analysis of quantitative and qualitative data from a national survey of service providers, service management personnel, supervision staff and legal and non-legal professionals referring families to CCSs
- an analysis of qualitative data from semi-structured interviews with First Nations professionals working with First Nations families
- an analysis of qualitative data from the semi-structured interviews with parents/carers
- a survey of parents and carers, including the collection of data in relation to their children's views and experiences of CCSs.

Background

CCSs provide supervision services to families who are characterised by a range of risk issues including family violence, child abuse, substance misuse and intractable conflict, through to issues associated with parental incapacity or where support is required for the introduction or reintroduction of a child to a parent. In addition to facilitating changeover or supervising contact time (both in person and online), CCSs may also provide a written account of a family's interaction with the service and the changeovers and/or contact sessions to inform decision-making in the family law court context. They may also make referrals for families to receive services to support them to transition to self-manage their changeover and contact arrangements where this is safe to do so. Australian and international empirical research and commentary illustrates the importance of ensuring the appropriate use and operation of these services given the serious, complex and often co-occurring risk issues and support needs of the potentially vulnerable families and at-risk children accessing them (e.g. Aris, Harrison & Humphreys, 2002; Carson, 2012; Commerford & Hunter, 2015; Jenkins, Park & Peterson-Badali, 1997; Pearson & Thoennes, 2000; Saini & Birnbaum, 2015; Sheehan et al., 2005; Strategic Partners Pty Ltd, 1998a).

In 1996, the Australian Government funded an initial pilot of 10 CCSs to support the implementation of amendments to Part VII of the *Family Law Act 1975* (Cth) (FLA) that emphasised the maintenance of children's post-separation relationships with both of their parents. In 2001 the original pilot was expanded to comprise

7 Children's Contact Services – Methodology to select locations for additional services - Attorney-General's Department - Citizen Space (ag.gov.au) and Selection of locations for new Children's Contact Services – Final Methodology paper (ag.gov.au)

a total of 35 government services around Australia funded under the Family and Relationships Services Program. Currently there are 84 CCSs operating under this program, with 64 of these services in scope for this evaluation. Funding agreements require services to comply with the Children's Contact Services Guiding Principles Framework for Good Practice (Attorney-General's Department [AGD], 2018), together with the Family and Children Activity Administrative Approval Requirements (Department of Social Services [DSS], 2014). These services are also subject to site checks, service audits and a complaints process (Australian Law Reform Commission [ALRC], 2019).

Significant concerns have been raised in relation to the absence of an accreditation regime, particularly for the many CCSs that are privately operated and use a fee-for-service model, with these services not subject to the Guiding Principles Framework and Approval Requirements noted above because they are operating without funding from the FRSP. These are estimated to number more than 60 services (AGD, 2021a). The Australian Law Reform Commission (ALRC) in its Final Report on the Review of the Family Law System recommended that the FLA be amended to require organisations offering a Children's Contact Service to be accredited and for it to be an offence to provide a Children's Contact Service without such accreditation (2019, Recommendation 54). A similar recommendation was also made in the second interim report of the Joint Select Committee on Australia's Family Law System calling for the introduction of mandatory accreditation and applicable standards together with a monitoring process and complaint mechanism and requirements relating to ongoing professional development (Recommendation 9). In the context of these recommendations, the AGD is currently engaged in a consultation process to inform the potential establishment of an Accreditation Scheme for Children's Contact Services (AGD, 2021a). Furthermore, CCSs not funded through the FRSP remain an important area for future research given those services are not included in this current evaluation.

The most recent large-scale empirical research examining the operation of CCSs in Australia was based on fieldwork conducted in 2002–04 (Sheehan, Carson, Fehlberg et al., 2005). Given the considerable expansion in the program since this time, and the recent allocation of funding to enhance the operation of existing services and to enable the establishment of 20 new services (AGD, 2021), the current evaluation is both timely and significant.

Evaluation design

This evaluation has been implemented in two phases:

- Phase One involved consultations with key stakeholders and the establishment of an advisory group to support the implementation of the evaluation program.
- Phase Two involved the implementation of the substantive methodology, with the data collection and analysis for each component of the evaluation culminating in the preparation of the preliminary, draft and final evaluation reports. The Evaluation Research Team liaised with key stakeholders, including via the advisory group mechanism at each stage of this phase of the evaluation.

The activities in both phases have been conducted to ensure that careful consideration is given to the extent to which subsequent data might be provided by CCSs to the AGD subsequent to the Evaluation, to support further work in this area. Specifically, the data collection protocols and instruments developed for this Evaluation were designed to facilitate workable arrangements and aim to ensure that, to the fullest extent possible, they may inform future data collection activities undertaken by the AGD.

Evaluation objectives

The objective of this project is an evaluation which considers the history of CCSs, and the current context in which government-funded CCSs are operating, and to make an assessment of the extent to which:

- these services are operating in accordance with, and achieving the objectives of, the relevant guiding documents (including the Grant Opportunity Guidelines and the Guiding Principles Framework for Good Practice)
- how effectively these services are providing culturally appropriate service for Culturally and Linguistically Diverse (CALD) and First Nations populations and are supporting families experiencing domestic and family violence (DFV)
- the current number and location of CCSs are meeting existing demand for services.

It is important to acknowledge that this evaluation does not constitute an assessment of individual CCSs and is not an accreditation audit of CCSs.

Evaluation questions

The methodology is designed to answer a series of evaluation questions. They have been developed based on the above objectives and the Statement of Required Services specified in the Work Order between the AGD and AIFS, together with relevant material including:

- the Children's Contact Services Guiding Principles Framework for Good Practice (AGD, 2018)
- the Family and Children Activity Administrative Approval Requirements (DSS, 2014) and the Program Information for the Families and Communities program, Families and Children Activity (DSS, undated)
- the Family Law Services Children's Contact Services Grant Opportunity Guidelines, (AGD, 2019)
- the Australian Children's Contact Services Association Standards (ACCSA, 2008).

1. The evaluation questions are: How and to what extent are CCSs providing safe, reliable and neutral places that:
   - facilitate changeover and supervised time
   - undertake intake, initial and ongoing risk assessment of family members separately to ensure commitment and agreement to service protocols
   - provide child-focused information to families
   - orient children to the service setting and surroundings
   - make referrals and regularly review changeover and supervised time sessions with the goal that families will graduate to self-management where it is safe to do so?
2. How and to what extent are CCSs helping families to graduate to self-management (where this is safe) or to achieve sustained and workable long-term parenting and time arrangements?
3. To what extent do CCSs provide independent written reports of families' interactions with their service and the changeovers and/or contact sessions to family law courts? What are the nature and quality of these reports and how are they used to inform the decision-making process?
4. Are the service models provided child-focused/child-centred and trauma-informed? To what extent do the services comply with the National Principles for Child Safe Organisations and the Commonwealth Child Safe Framework?
5. Are CCSs operating in accordance with the Children's Contact Services – Guiding Principles Framework for Good Practice including:
   - the role and obligations of CCSs
   - the objectives for CCSs
     - child-focus
     - safety
     - neutrality
     - client diversity and cultural sensitivity
     - collaborative service provision
   - the priorities for service delivery
   - the range of services provided
   - the service safety requirements (including safety and security plan requirements, safety policy, procedures and protocols relating to critical incidents, risk assessments)
   - record keeping, policies and procedures
   - the good practice principles for service delivery and resources?
6. To what extent are the services provided culturally appropriate for:
   - First Nations families
   - CALD families?
7. To what extent are CCSs supporting families experiencing DFV? How are CCSs providing this support and how effective is the provision of this support?
8. To what extent are the current number and locations of CCSs meeting the existing demand for their services?
   - What are the expectations of families and professionals using or seeking to use CCSs and to what extent are these expectations being met?
   - Is the referral process operating effectively?

Evaluation methodology

As noted, this evaluation was conducted over two phases.

Phase One

Phase One involved a period of identification and collection of background information to inform the refinement of the Evaluation Framework and Project Plan. Activities in this first phase were undertaken in consultation with the commissioning agency (the AGD) to ensure that the evaluation as implemented addresses the key evaluation questions.

These Phase One activities included consultations with key stakeholders organisations or professionals (consultations: *n* = 31), AGD and DSS personnel and other key family law system stakeholders including the ACCSA, Family and Relationships Services Australia (FRSA), a range of service provider agencies and services providing CCSs, the Federal Circuit and Family Court of Australia and the Family Court of Western Australia, National Legal Aid, National Aboriginal and Torres Strait Islander Legal Services and National Family Violence Prevention Legal Services together with the Evaluation First Nations advisor regarding the refinement of the evaluation framework and project plan.

The initial consultations facilitated the following Phase One activities:

- development of an in-depth understanding of the current operation of CCSs funded under the FRSP
- establishment of the Evaluation Advisory Group to provide ongoing advice to the AIFS Research Team, with membership and terms of reference determined in consultation with the commissioning agency (AGD)
- clarifying the nature, scope and quality of administrative data maintained by the Department and by the CCSs to identify the precise data sources for the administrative data to be evaluated in Phase Two
- informing assessments made to determine the sampling of services and families to participate in the fieldwork components to be implemented in Phase Two.

Phase One activities also involved:

- an assessment of administrative data sources including a review of data available in the DSS Data Exchange (DEX) having regard to the DSS performance measurement framework and informed by the consultations with key AGD personnel to identify the scope of data available in DEX
- consultations with service providers seeking information about intake and ongoing client data collected by service providers informed by the consultations with service provider agencies and service providers providing CCSs
- a desktop review of existing research literature, empirical evaluations of CCSs undertaken to date, and commentary together with departmental and sector materials relevant to the introduction and operation of CCSs in Australia since 1996.The methodology for this review is outlined in Appendix A. This review supported the refinement of the evaluation framework and project plan in Phase One and informed the analysis of evaluation data to address the evaluation questions in Phase Two, having regard to the history and current context in which the 64 funded services operate as required by the Statement of Required Services in the Work Order between the AGD and AIFS.

The Evaluation Research Team received advice from the Evaluation Advisory Group regarding the refinement of the evaluation framework and project plan, including the sampling of services and families to participate in the fieldwork components and the nature, sources, and quality of administrative data available for review.

The Evaluation Framework and Project Plan were refined following consultation with key stakeholders and confirmation and assessment of available data and the completion of the desktop review.

Specifically, applications were submitted to:

- the AIFS Human Research Ethics Committee, which is a Human Research and Ethics Committee registered with the National Health and Medical Research Council.
- the Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS) Research Ethics Committee
- the research and ethics committees of family law system services as required, including the Federal Circuit and Family Court of Australia.

Amendments to ethical clearances due to changes in fieldwork were also cleared by the relevant committees.

The preparation of recruitment material and data collection instruments for each of the quantitative and qualitative components of the evaluation were also finalised during Phase One having regard to the insights from consultations with key stakeholders and desktop review.

Phase Two

Phase Two involved the implementation of the four core elements of the mixed-method evaluation aimed at addressing the evaluation questions. The data sources included quantitative, qualitative data from surveys and interviews, as well as administrative data that were triangulated to address the evaluation questions.

Administrative and program data

DSS Data Exchange (DEX)

The DSS Data Exchange (DEX) is the program performance reporting solution developed by the DSS. DEX collects standardised data across government grant funded services/programs with these data collected from the period 1 July 2014 to date.8 CCSs were in scope for this evaluation where:

- they were provided by not-for-profit providers with funding from the Family Relationships Services Program administered by the AGD
- that funding was granted prior to the 2021–22 federal budget (*n* = 64) (see Appendix B for the list of in-scope CCSs).

The *Program Specific Guidance for Commonwealth Agencies in the Data Exchange* (Department of Social Services (DSS), 2022) provides details of DEX data items specific to CCS service data. In relation to these DEX data, the primary client denotes members of separated families, including children, with 'grandparents and other extended family members who care for children' (p. 247). Accordingly, the DEX data presented in this report are about individual CCS clients including children involved with CCS services. The demographic characteristics of CCSs' clients in DEX are presented in Appendix C and H and in chapter 2 of this report.

The service types captured in the DEX data for CCSs are as follows, noting that the DEX data do not distinguish the supervision of changeover from the supervised parenting time in supervised contact sessions (Australian Government, 2023, p. 248):

- advocacy and support
- education and skills training, including assisting clients to learn, develop or enhance skills relevant to their circumstances, 'such as parenting and communication skills'
- information, advice and referral, including the provision of information about post-separation parenting and referrals to relevant services including Parenting Order Programs (POPs) and Supporting Children after Separation Programs (SCASPs) as well as specialist DFV services
- intake and assessment, including assessing clients at their initial intake, screening and risk assessment and safety planning, together with orientation sessions for adults and children
- supervised changeover/contact.

CCSs are also able to record data measuring the outcomes of clients' use of the services presented as the Standard Client/Community Outcomes Reporting (SCORE) and the *Program Specific Guidance* indicates that SCORE assessments are recorded at least twice in a client's engagement with the service; specifically early in the client's period of service delivery and toward the end of their receipt of the service delivery, although periodic SCORE assessments are encouraged where practical throughout the service delivery period (Australian Government, 2023, p. 247).The following domains are primarily sought in the SCORE assessments for CCSs (Australian Government, 2023, p. 248) (see further Appendix D):

- CIRCUMSTANCES:[9]
  - age-appropriate development
  - family functioning

8 According to the DEX framework, DEX data are divided into two categories: (1) a limited number of 'mandatory priority requirements' that all organisations are required to report, together with data items that 'organisations share with funding agencies in exchange for relevant and meaningful reports' and (2) data items known as the Standard Client/Community Outcome Reporting (SCORE) information that organisations are encouraged to collect and provide with respect to 'as many clients as practical' .

9 There are 11 sub-domains regarding Circumstances. Few clients were assessed in other sub-domains (e.g. housing, employment and so on) that did not have direct relevance to children's contact services.

  - mental health, wellbeing and self-care
  - personal and family safety.
- GOALS:
  - changed knowledge and access to information
  - changed skills
  - changed behaviours
  - empowerment, choice and control to make own decisions
  - engagement with relevant support services
  - changed impact of immediate crisis.
- SATISFACTION:
  - whether the service understood client issues
  - whether the client satisfied with the services received and
  - whether the client is better able to deal with issues that they sought help with.

Request for Information

The Request for Information process (RFI) collected administrative data from CCSs derived from their program record management systems. All the eligible 64 CCSs funded under the FRSP were invited to participate in the RFI process on 6 February 2023 and this data collection component closed on 16 April 2023. Most CCSs participated in the Request for Information process (54 out of the 64 in scope for the evaluation), representing an overall response rate of 84%.[10] All the eligible CCSs participated from Queensland, South Australia, Tasmania and the Australian Capital Territory. Of the other most populous states, 91% of CCSs located in Victoria participated and 79% of CCSs based in New South Wales. Noting the relatively small number of CCSs based in outer regional areas (*n* = 10), there were similar rates of participation by region, with 87% of CCSs based in major cities; 83% in inner regional locations and 80% in outer regional areas participating. Independent CCSs were more likely to participate (93%) compared to medium/larger organisations (82%) (see further Appendix E).

The purpose of the RFI data collection was to complement the data drawn from DEX, by collecting quantitative and qualitative program data from service providers to help address the evaluation questions where these data items were either not captured in DEX or where further detail was required (such as number of sessions/clients split by whether this was a supervised changeover or visit).

The data available from DEX and from the RFI process for data from service provider client record management systems not included in the DSS performance measurement framework have been used to examine the following matters on a national aggregate basis and at the level of individual state and territories for the 2021–2022 and 2022–23 financial years:

- the number and demographics of clients (including age, gender, residential location, 'Aboriginal and Torres Strait Islander' and 'Culturally and Linguistically Diverse' status, disability, impairments, or other conditions) who:
  - have applied for intake into CCSs funded by the FRSP
  - are assessed for intake into a CCS
  - are accepted into a CCS
  - are in receipt of services for supervision of changeover
  - are in receipt of services for supervised contact time
  - are engaged in family law proceedings and/or child protection proceedings
  - have transitioned to self-management
- the time frames in which matters are in receipt of supervision services:
  - the number and type of referrals to support services made by CCSs
  - the number of written reports of families' interactions with their service and the changeovers and/or contact sessions provided to family law courts
- the location of CCSs, the type of facility, number of staff and hours of operation, staff requirements and staffing ratios
- waiting lists

10 Follow-up advice to the AIFS Research Team was that the RFI data submitted for Northern Territory was intended by the service provider organisation to cover both Darwin and Alice Springs CCS locations. Further and more specific clarification has been sought by the AIFS research team.

- the types of non-supervision activities and services provided, including interpreting services.

The data obtained in this element assists in addressing research questions 1–3 and 8 and supports considered interpretation of the findings from data collected for the evaluation, comprising administrative and program data and the interview data. The data collection protocol was designed to capture data regarding each distinct service type and each mode of service provision (i.e. in person, virtual, centre-based, offsite, outreach services).

Survey of Professionals: service management personnel, supervision staff and professionals referring families to Children's Contact Services

This element of the evaluation captured the views and experiences of the broad range of professionals involved in managing, operating and providing supervision services in CCSs. Perspectives from professionals involved in referring clients to these services (including judicial officers and registrars,[11] legal practitioners and family dispute resolution practitioners) were also included. The data obtained in this element assists in addressing each of the research questions and also supported considered interpretation of the findings in the administrative and program data and interview data.

The survey link was circulated nationally through the distribution of Project Information Sheets following consultations with key stakeholders including service provider agencies and management and supervision staff at a broad range of service locations and types, and family law system services and sector organisations. This recruitment methodology was not intended to yield a representative sample, however, the broad and concerted dissemination activities led to strong uptake in each participant category. The survey instrument was designed to assess:

- professionals' perspectives and experiences of the services provided by CCSs
- the extent to which service provision is culturally appropriate and supports families experiencing DFV
- the extent to which services operate in accordance with the guiding principles
- the extent to which the service models are child-focused/child-centred and trauma-informed.

The survey also captured data relevant to whether current service availability meets the demand for supervision services. As with the RFI, the design of the survey instrument ensured that the data captured in the survey distinguished between supervision services provided in person, virtual services, centre-based services, outreach services and community-based or offsite services to provide insight into each of these modes of service provision.

The Survey of Professionals captured the views and experiences of a range of professionals and these professionals fell into two broad categories:

- CCS professionals involved in managing, operating, and providing supervision services in CCSs
- professionals involved in referring clients to these services (including judicial officers and registrars, legal practitioners, and family dispute resolution practitioners).

This component of the evaluation assists in considering each of the evaluation questions and, in particular, provides insight into:

- professionals' perspectives and experiences of the services provided by CCSs
- the extent to which service provision is culturally appropriate and supports families experiencing DFV
- the extent to which services operate in accordance with the guiding principles
- the extent to which the service models are child-focused/child-centred and trauma-informed
- whether current service availability meets the demand for supervision services.

The survey was available for completion between 10 February 2023 and 31 March 2023.[12] A total of 269 professionals participated, with 225 fully completed surveys and a further 44 partially completed surveys with sufficient useable data to be included in the final sample.

Data relating to the survey sample are provided in Table A5 in Appendix F shows that there was strong participation in the survey by both CCS professionals and professionals referring clients to CCSs. It also shows

11 The responses of judicial officers, registrars, or other Federal Circuit and Family Court of Australia personnel were provided in their personal capacity and does not represent the responses or view on behalf of the Courts.

12 The Survey of Professionals was launched for non-CCS professionals on 10 February 2023. CCS professionals were invited to participate starting 15 February 2023 as the Request for Information was launched earlier that same week for those professionals (6 February 2023).

that there were participants across each state and territory and a broad range of age groups in the survey. The data show that:

- Forty-five per cent of professionals who participated in the survey were CCS professionals including:
  - CCS coordinators: 12%
  - CCS supervisors: 12%
  - CCS program managers: 9%
  - other CCS staff members including family/contact support worker, administration officers or caseworkers: 8%
  - executives of service provider organisations operating CCSs: 3%
  - other staff members at service provider organisations: 2%.
- Referring professionals which made up the remaining 55% of the sample included:
  - lawyers (25%) including lawyers in private practice: 15%; community legal centre lawyers: 6%; Legal Aid lawyers; 3% and barristers 1%
  - judicial officers and registrars at the Federal Circuit and Family Court of Australia and Family Court of Western Australia: 9%
  - DFV practitioners: 6%
  - Family Dispute Resolution Practitioners: 5%
  - Court Child Experts: 3%.

Professionals were asked about the number of years that they had worked in their professional service sector which allows responses to be considered according to the level of experience. Across all survey participants, the mean number of years working in their sector was 13.7 years. CCS professionals reported that they had worked an average of 11.3 years in their sector, whereas referring professionals reported working slightly longer in their sector, with an average of 15.7 years.[13] Table A6 in Appendix F presents the demographic characteristics of professionals participating in the survey, noting that the data are again presented for CCS professionals and referring professionals who refer clients to CCSs. The sample is comprised of slightly more than one-quarter of participants from New South Wales (28%) and just under one-quarter from Queensland (23%) and Victoria (21%). Slightly more than 1 in 10 participating professionals were from Western Australia. South Australians, Tasmanians and professionals from the Northern Territory and Australian Capital Territory were 6%, 4%, 3% and 2% respectively.

Table A6 also illustrates that most participants were aged 35–44 years (22%), 45–54 years (28%) and 55 years or older (31%) and most participants reported that they identified as women or female for both CCS professionals and referring professionals (85% and 79% respectively).

Of note, in relation to the geographic spread of participants, a majority of participating CCS professionals reported that they were from a suburban (37%) or regional area (38%) with 13% nominating CBD locations and 8% nominating rural areas. Referring professionals were substantially more likely to report working in a CBD location (30%) compared to CCS professionals, with most of the remaining referring professionals from suburban (32%) and regional (26%) areas.

Interviews with First Nations stakeholders

Semi-structured interviews with key First Nations professional stakeholders were included in the evaluation methodology as stakeholder consultations suggested that limited numbers of First Nations families accessed CCSs and because it was important to ensure that their perspectives were included in the research. As such, interview data gathered from key First Nations stakeholders reflecting on their clients' views and experiences was incorporated into the research design. These data are relevant to addressing Objective 2 and Research Question 6 which require determination of the extent to which (and how effectively) services are culturally appropriate for First Nations peoples. Recruitment of these stakeholders was guided by the stakeholder consultations conducted at the outset of this project and the recruitment and ethical protocols and data collection and storage requirements. The sample comprised four First Nations professionals working in Aboriginal legal services or in CCSs from 4 states and territories, specifically from Victoria, New South Wales, Northern Territory and Western Australia.

13 CCS professionals 95% CI [9.7, 12.9] (n = 119); Referring professionals 95% CI [14.0, 17.4] (n = 148).

Quantitative and qualitative data from clients of CCSs

Data from CCS clients are important to understanding the views and experiences of clients (both adults and children) using CCSs and providing insight into how services operate and whether they meet client needs from the perspective of those using them. Specifically, the data collected for this part of the evaluation assists in addressing each of the research questions and supports a considered interpretation of the findings from the administrative and program data obtained through the RFI and from the survey data from professionals.

Initial research design to capture data from families

The sampling approach for the interviews and the design of the interview schedules supported the capture of data providing insight into the experiences of those using supervision services. A maximum variety sampling approach was applied to recruit participants from each state and territory and from a range of service locations (metropolitan, regional and rural) and service providers. To the extent that it was possible, participants across the range of service types accessed (i.e. supervision of time or changeover and services provided in person, virtual services, centre-based services, outreach services and community-based or offsite services) were sought to support the collection of data of sufficient breadth and depth to address the proposed evaluation questions.

Initially, the research design for this project also included observations of supervised time and changeover sessions and interviews with children and young people. The target number of interviews for this component was up to 50, comprised of up to 15–25 adults (including with both 'lives-with' parents and 'spends-time with' parents) and 15–25 children sampled from services across each state and territory. This approach reflected the priority that the Evaluation Research Team accords to listening to the views and experiences of children and young people and supporting their safe participation in research. This was also considered to be consistent with a child safe approach to evaluation research, acknowledging the imperative of involving children and young people in research about post-separation issues affecting them (e.g. Australian Human Rights Commission, 2018b; Carson et al., 2018; Kaspiew et al., 2014; Taylor & Gallop, 2013). Specifically, to supplement the interviews and facilitate data capture in relation to children not represented in the interview data (e.g. non-verbal children), the Evaluation Research Team sought to observe interactions of children, family members and service staff during supervised changeover and supervised contact sessions guided by an ethically cleared observation instrument.

The Children's Contact Service sites for the interviews with children and observations were selected based on a maximum variety sampling approach, applied to ensure data capture from a broad range of sites in terms of location, size and client base. This sampling approach was informed by the Phase One activities and finalised in consultation with the commissioning agency (AGD), and key stakeholders including service providers. It was also directed at ensuring that data captured would accommodate observation of supervision services provided in person, virtual services, centre-based services, outreach services and community based or offsite services. The implementation of the interviews with children and the observational component and the analyses of the data from these elements were to be supported by our clinical child psychology research partners and informed by targeted insights from our First Nations Research Partner with input from our AIFS Research Team members with research expertise with CALD populations.

Despite the rigorous methodology, sufficient samples for the interviews with children and young people and observations of supervised time and changeover were not able to be recruited. The reasons for this were that there were:

- very few expressions of interest in these elements of the fieldwork
- children who were in scope but not within the age range to qualify to participate in the interviews with children and young people
- families who were screened out of participation in these elements following the recruitment and ethical protocols put in place for this evaluation.

Revised research design to capture data from families

As a result of the difficulties associated with recruiting the sample of families, ethical clearance was sought and received for:

1. a minor variation to extend the parent and carer interview sample from up to 25 participants to up to 50 participants to be facilitated by the project team extending invitations to staff from each of the 64 services in scope for the evaluation to support our recruitment activities with their clients to reach this target sample
2. an additional element involving a short and simple Survey of Parents and Carers regarding their perceptions of their children's views and experiences of using the CCS. A small number of questions also sought the

participating parent/carers' views and experiences of using the service which also supplements the data from interviews with parents and carers.

Interviews with parents and carers

Ethical clearance supported an opt-in recruitment approach. Service managers were asked to provide the project information sheets to family members to inform them of the opportunity to participate in the evaluation and to ask if they have any objection to their contact details being passed to the evaluation team to discuss the potential for participating in an interview. Comprehensive ethical protocols guided all aspects of this fieldwork, including but not limited to the screening, recruitment and interview processes. Prospective interviewees were informed about the nature of the interview and about the circumstances and safeguards involved in participating in the interview (including confidentiality and the ability to cease participation at any time) and that their decision to participate or to decline participation would not affect any services that they are being provided with, or seek to be provided with, in the future. Further, participants were assured that their contact details would be kept confidential by the Evaluation Research Team and destroyed after the interview (subject to the limits of the law, and retention for a very limited time should a need for clarification of the interview arise) and their data would be de-identified and securely stored.

A $50 grocery voucher (that could not be redeemed for the purchase of alcohol or cigarettes) was offered to each interview participant to off-set any time or inconvenience involved in participating in the interview. Where clients did not consent to having their contact details passed on to the Evaluation Research Team, the service managers were able to provide the recruitment material with the Evaluation Research Team's contact details so that these clients could give further thought to whether they wanted to participate and if so, they could contact the Evaluation Research Team directly to express an interest in participating in the study.

Adult interviews were approximately one hour in duration and conducted by telephone or online. Interviews were conducted throughout the evaluation period, closing six weeks prior to the due date of the Final Report. These interviews were conducted by a member of the experienced and multidisciplinary team of qualitative researchers with a legal, psychology or social science background and who were guided by the comprehensive ethical protocols to support sensitive data collection. The interviewers also had extensive experience and training in conducting interviews on sensitive topics with potentially vulnerable populations. The ethical protocols guided interviewers to respond appropriately to participants who became distressed, revealed information that could potentially trigger reporting obligations (e.g. under state and territory child protection legislation) or revealed circumstances that indicated they may need further support. The privacy and safety of participants was safeguarded by the application of an ethically cleared data collection and storage policy and ethical protocols designed to guard against the potential for research processes being co-opted by perpetrators of family violence. The anonymised and verified interview transcripts supported a thorough analysis based on theoretical coding approaches.

The final sample comprised 50 interviews with parents and carers (92% parents cf. 8% carers). Two-thirds of the interview participants were a 'lives with' parent (66%, the parent who the child lives with or spends the majority of time living with). One-third were a 'spends time with' parent (34%, the parent who the child does not live with or who the child does not spend the majority of the time living with). Overall, the sample of interview participants had the following characteristics:

- For gender, 70% identified as woman or female and 15% as man or male, with almost all Lives with parents/carers identifying as a female (97%) and most Spends time with parents identifying as male (82%).
- Participants were most frequently between 40-49 years old (40%) or 30–39 years old (30%), with a further 18% aged over 50 years and 12% 20–29 years.
- All states and territories were represented, with 20% each from Victoria and New South Wales, 18% South Australia, 12% each for Queensland and Western Australia, 10% Australian Capital Territory, and 4% each from Northern Territory and Tasmania.
- Almost two-thirds identified as Australian born (not First Nations peoples), 24% were born overseas and 12% were Australian born with one or both parents born overseas.
- Ninety per cent spoke English as their main language at home.
- In relation the number of children, 34% had one child, 38% two children, 10% three children and 18% four or more children.
- Most parents reported having one child using the CCS (60%), 36% parents had two children using the service and 4% had three or more. Most frequently the youngest child using the CCS was 3–7 years old (58%, cf. 28% 8–12 years, 8% 0–2 years and 6% age not available).

In relation to current CCS services received, 60% of parents and carers currently received supervised parenting time (*n* = 30) and 40% (*n* = 20) were receiving supervised changeover on-site. Of those receiving supervised changeover, 14 parents and carers also previously received supervised time services before to transitioning to supervised changeover Most participants indicated that these arrangements were in place because of court orders (*n* = 39). Where further data were available, orders were usually described as interim (*n* = 19; final orders were reported in 7 cases), and usually as having been made by consent (*n* = 7; adjudicated orders were reported in one case). Other parents and carers described arrangements to use a CCS being in place as a result of a parenting plan or mediation (*n* = 5), private agreement due to risk posed by a parent (*n* = 1) or negotiated through lawyers (*n* = 1).

Parents and carers had used contact services for a range of time periods. Most frequently, parents/carers had received CCS services for less than 12 months (*n* = 19/50). Extended time using CCS services was also common, with 16 parents and carers having more than 2 years of service provision. Approximately one-quarter of parents and carers had 12 months to 2 years with their CCS (*n* = 12/50, *n* = 3 don't know). The safety concerns of the Lives with parents and Spends time with parents will be presented in chapter 5.

Survey of Parents and Carers

The Survey of Parents and Carers was launched on 15 June 2023 and remained available for completion until 16 July 2023. Participants were invited to participate through CCSs, with staff at each of the 64 participating CCSs asked to provide the Project Information Sheet (with the embedded survey link) to parents and carers who may be interested and able to participate in the survey. Participants in the survey were offered the option to be diverted from the survey to a separate webform to provide their contact details should they wish to enter a random draw for one of 10 $100 grocery vouchers (that again could not be redeemed for the purchase of alcohol or cigarettes) to off-set any time or inconvenience involved in participating in the study. Identifying information was not sought in the survey and to protect participants' privacy and confidentiality, the link between the submitted survey and participants' submitted contact detail for entry into the voucher draw were destroyed. The survey consisted of questions with specified response options and a small number of questions allowing for short open-text responses. These survey questions were designed to limit the collection of material of a sensitive or distressing nature; however, referrals to support services were also provided in the Project Information Sheet and at the start and end of the survey. A total of 112 parents and carers participated in this component of the evaluation, with 109 fully completed surveys and a further 3 partially completed surveys with enough questions answered to be included in the analyses.

Appendix G presents the demographics characteristics of participants and shows that most participants reported that they were a parent (92%), with 6% indicating that they were a carer. The final sample comprised of 38% of participants who reported they were a man or male and 61% a woman or female. Overall, *n* = 19 or 19% of the sample reported that they or at least one parent was born in a non-English-speaking country. Noting the small sample size of those who reported non-English-speaking ancestry, only limited analysis of this variable was possible with these survey data.

Most participants in the Survey of Parents and Carers were aged either 35–44 years (39%) or 45–54 years (30%). When age was analysed according to gender, 44% of women reported being aged 35–44 years, with the corresponding proportion of men reported at 30%. In terms of geographical location, participants were most likely to report living in Victoria (28%), followed by New South Wales (24%) and Western Australia (22%). Noting the small sample size of participants with a non-English-speaking ancestry, 52% of this group reported living in New South Wales, compared to 18% of those participants born in Australia or with English-speaking ancestry. There was little difference in geographical location by gender. Most participants spoke English at home (95%), for those born in a non-English speaking country or who had at least one parent born in a non-English speaking country, a lower proportion of 68% spoke English at home.

As Table A9 in Appendix H shows, almost half of the final sample reported their current relationship status as single (45%), with little difference in this response pattern by gender. A little more than one-quarter reported they were separated or divorced (28%). A further 16% reported they were married or living with a partner or in a relationship but not living together (10%). The mean length of time that participants had been separated/divorced from the other parent was 4.3 years, with men reporting a mean of 4.8 years and women 4.0 years.

Structure of this report

This report presents quantitative and qualitative findings drawn from the components of the evaluation to address the research questions in the following four chapters. Chapter 2 presents findings relating to the services provided by CCSs to address Research Question 1, Research Question 3 and Research Question 2 respectively. Chapter 3 presents findings focusing on the nature of service models characterising CCS service provision and the extent to which services are implemented consistent with the relevant guiding documents, to address Research Questions 4 and 5. Chapter 4 will examine the demand for, and expectations of, CCS services to address Research Question 8.Chapter 5 examines the extent to which service provision is culturally appropriate, presenting findings to address Research Question 6 and examining the extent to which service provision is meeting the diverse needs of families, including in the context of domestic and family violence to address Research Question 5. Chapter 6 synthesises all key evaluation findings and considers the implications of the findings in the summary and conclusion for this evaluation.

2 Services provided by CCSs

Introduction

The discussion in this chapter examines quantitative and qualitative data from RFI and survey elements of the evaluation, in addition to relevant material from the desktop review to address some key aspects of the research questions 1, 3 and 2 respectively:

- **How** and **to what extent are CCSs** providing safe, reliable, and neutral places that:
  a. facilitate changeover and supervised time
  b. undertake intake, initial and ongoing risk assessment of family members separately to ensure commitment and agreement to service protocols
  c. provide child-focused information to families
  d. orient children to the service setting and surroundings
  e. make referrals and regularly review changeover and supervised time sessions with the goal that families will graduate to self-management where it is safe to do so?
- **To what extent do CCSs provide independent written reports** of families' interactions with their service and the changeovers and/or contact sessions to family law courts? What are the **nature and quality of these reports** and how are they used to inform the decision-making process?
- **How and to what extent are CCSs helping families to graduate to self-management** (where this is safe) **or to achieve sustained and workable long-term** parenting and time **arrangements**?

For Research Question 1, the discussion in this chapter focuses on what the data show about the nature and scope of the services provided by CCSs, noting that more detailed discussion of the extent to which the data show that these services are being provided in a safe, reliable and neutral way by CCSs is presented in chapters 3 and 5.

The discussion in the first section presents material from the desktop review, exploring the introduction and expansion of CCSs in Australia and the legislative and policy context in which they have operated and are currently operating. This will support the examination of data in this and each of the following chapters having regard to a key aspect of the stated objective of this project – specifically to consider the operation of the government-funded CCSs in the context of the history of CCSs.

The next section will examine quantitative data from the RFI, the Survey of Professionals and the Survey of Parents and Carers relating to service type, to show the extent to which supervised changeover and supervised visits for parenting time are provided by CCSs in Australia. Data from the Survey of Professionals and the Survey of Parents and Carers are considered to examine professionals' knowledge about the range of supervision services and parents and carers' use of the range of supervision services respectively.

The following section examines RFI open-text responses to provide more specific insight into the nature and operation of the intake and risk assessment process and how CCSs operationalise supervised changeover and supervised visits. Data from the RFI and the Survey of Professionals are considered to show the extent to which a range of non-supervision services (also known as secondary services) are provided by CCSs in Australia, and to examine professionals' knowledge of these services. This is followed by a discussion of data from the Survey of Professionals and the Survey of Parents and Carers to identify the services that participants considered CCSs *should* provide.

The final substantive sections in this chapter present an analysis of data from the RFI and Survey of Professionals regarding (a) the number and nature of written reports provided by CCSs (b) and the approach CCSs take to providing time-limited services and transitioning and/or facilitating families to self-manage the parenting time

arrangements. Data relating to the quality of CCS reports and implementation transitions to self-management relevant to research questions 3 and 2 respectively, are presented in chapter 3.

Historical, legislative and policy context: the introduction and expansion of CCSs in Australia

As outlined in chapter 1, CCSs provide supervision of changeover (supervised changeover) and parenting time (supervised visits) for families characterised by a range of risk issues including family violence, child abuse and substance misuse and/or where support is required to introduce or reintroduce a child with a parent. Empirical evidence illustrates the importance of ensuring the appropriate operation of these services given the complex risk issues and support needs of the potentially at-risk families accessing them (Aris et al., 2002; Carson, 2012; Commerford & Hunter, 2015; Jenkins et al., 1997; Sheehan et al., 2005; Strategic Partners Pty Ltd, 1998).

On 1 July 1996, following the implementation of the *Family Law Reform Act 1995* (Cth), the Legal Aid and Family Services Division of the AGD funded an initial pilot of 10 CCSs through the then Family Services Program (Rhoades, Graycar, & Harrison, 2000; Sheehan et al., 2005; Strategic Partners Pty Ltd, 1998a, 1998b) to support the implementation of amendments to Part VII of the FLA. Australia's ratification of the United Nations Convention on the Rights of the Child (UNCROC) in December 1990 shaped these new Part VII objects and principles articulated in s 60B (the 1995 amendments). They include children's 'right to know and be cared for by both parents' and their 'right to spend time on a regular basis' with their parents and other people significant to their care (s 60B (2)(a) and (b) respectively), and for parents to 'jointly share duties and responsibilities concerning the care, welfare and development of their children' (s 60B(2)(c)).

These first 10 services comprised two different services operating in both New South Wales and Victoria, and one service in every other capital city across the country. In 1997, Strategic Partners Pty Ltd were engaged by the AGD to evaluate the program and to build an understanding of how the services worked for children and families and the effectiveness of these services. This evaluation involved a desktop review, a series of workshops and focus groups, interviews and observations and involved researchers visiting each of the 10 CCSs (Strategic Partners Pty Ltd, 1998b).

While there was a selection of community not-for-profit, voluntary organisations who provided ad hoc contact arrangements, supervision services were not widely available prior to the funding of these 10 CCSs (Strategic Partners Pty Ltd, 1998a). As a result, many Australian parents would make their own informal arrangements with the support of family members or friends to supervise changeover or parenting time, which could present a risk to their and their children's safety (Strategic Partners Pty Ltd, 1998a). For example, some parents drew on the support of family and friends to 'supervise' changeover or contact at a public place such as a park or fast-food restaurant (Family Law Council, 1998; Strategic Partners Pty Ltd,1998a). In other circumstances, changeover would occur at a local police station pursuant to court orders (Strategic Partners Pty Ltd, 1998a).

Following the initial pilot, a further 25 CCSs were funded by the Commonwealth AGD in 1999. These 35 services were administered by the then Department of Family and Community Services and operated under the Family and Relationships Services Program (Sheehan et al., 2005). The 64 CCSs currently operating under the Family Relationships Services Program that are in scope for this evaluation are those subject to Grant Opportunity Guidelines and Guiding Principles Framework for Good Practice, with increased funding announced by the Australian Government in the May 2021 budget to establish an additional 20 CCSs across Australia.[14] It is estimated that that there are currently more than 60 privately operating CCSs but these services are not subject to the Grant Opportunity Guidelines or Guiding Principles Framework (AGD, 2021a) and are **not in scope for this evaluation**.

CCSs in Australia operate in the context of the successive reforms to the family law system and to Part VII of the FLA in relation to the making of post-separation parenting arrangements. In 2006 the Australian Government introduced changes to the family law system that established a range of family law services, including the establishment of 65 Family Relationship Centres, and made amendments to the FLA. These amendments included:

- requirements for families to attend Family Dispute Resolution prior to filing an application for parenting orders in court (subject to exceptions including where there was family violence)

14 Children's Contact Services – Methodology to select locations for additional services - Attorney-General's Department - Citizen Space (ag.gov.au) and Selection of locations for new Children's Contact Services – Final Methodology paper (ag.gov.au)

- an emphasis in court orders on considering shared parenting arrangements and a children's 'rights' including in relation to meaningful engagement with both parents
- an acknowledgement of the need to protect children from exposure to family violence and child abuse
- legislative support for less adversarial court processes in children's matters.

The changes were aimed at shaping a cultural shift in managing parental separation away from litigation and towards 'co-operative parenting'. A key objective of the 2006 family law reforms was to encourage greater involvement of both separated parents in their children's lives after separation, provided that the children are protected from family violence or child abuse.

The AIFS Evaluation of the 2006 Family Law Reforms, found that approximately 1 in 5 parents reported safety concerns associated with ongoing contact with their child's other parent (Kaspiew et al., 2009). Half of the mothers and approximately one-third of fathers participating in this evaluation also reported that mental health problems, the use of drugs or alcohol, gambling or other addictions were apparent before separation (Kaspiew et al., 2009). The evaluation identified mixed impacts of the changes with some positive findings – such as an increased use of relationship services and evidence of a shift away from automatic court filing. There remained, however, challenges for families with complex issues such as violence, mental health and drug and alcohol use. The data indicated that the family dispute resolution process was being used by some families where these complex issues made it inappropriate. There was also evidence of poorer outcomes for children whose mothers still had safety concerns within the shared care arrangements that were finalised by the court, highlighting the importance of the system being able to identify family violence and safety issues (Kaspiew et al., 2009).

The introduction of the *Family Law Legislation Amendment (Family Violence and Other Measures) Act 2011* (Cth) was aimed at improving the system's response to family violence, specifically with an emphasis on supporting disclosures of family violence and professionals' responses to such disclosures to prioritise safety. It also aimed to further emphasise that when determining the parenting arrangements that accord with the best interests of the child, protection from harm was explicitly articulated as a higher priority for the arrangements than the need to have a meaningful relationship with both parents (s 60CC(2A)).

The AIFS evaluation of these family violence amendments emphasised the prevalence of family violence as a complex and dynamic issue for families in the family law system, with some 60% of 12,198 parents in the Experiences of Separated Parents Study component of the evaluation reporting a history of emotional abuse and/or physical violence before/during separation (Kaspiew et al., 2015). The evaluation also emphasised the prevalence of multiple, complex and co-occurring risk issues and harm factors for separating families, and that there was heightened prevalence of these issues for families using formal family law pathways to resolve their post-separation parenting arrangements (Kaspiew et al., 2015).

The evidence from the three components of the Evaluation of the 2012 Family Violence Amendments suggested modest, mixed or limited effects. Across the family law system, a heightened emphasis on identifying concerns about family violence and safety concerns since the reforms, particularly among lawyers and in courts, was identified. The evaluation identified very modest increases in the proportions of parents disclosing family violence and/or safety concerns to professionals since the reforms, and the findings suggested that this greater emphasis on identifying family violence and child safety concerns had supported modest, positive shifts in the making of parenting arrangements in the post-reform period. However, the evaluation identified a reduction in reports of parenting arrangements involving supervision between the pre- and post-reform periods, together with a decline in no time orders where parents held safety concerns. The reforms appeared to have had less influence on patterns in parenting arrangements around safety and the views of parent participants indicated little improvement in how their concerns were dealt with by the system (Kaspiew et al., 2015). The evaluation findings also highlighted the need for more effective education and training around family violence and child abuse, particularly in the court and related government systems (Kaspiew et al., 2015).

Proposed reforms currently before Parliament in the Family Law Amendment Bill 2023 include the removal of the presumption of equal shared parental responsibility and revisions to the objects, principles and best interests considerations that apply when making parenting orders under the FLA. These proposed changes are consistent with the findings of AIFS research, which identified the need for decisions about parenting arrangements to prioritise the safety, needs and best interests of individual children (Kaspiew et al., 2015).

Against this background, the discussion in the following sections of this chapter examine data that illustrate the extent to which CCSs are currently:

1. providing supervision services for families
2. providing written reports of families' interactions at their services

3. helping families to move to self-management or to achieve sustained and workable long-term parenting and time arrangements.

Facilitation of supervised changeover and supervised time

In this section, quantitative data from the RFI, the Survey of Professionals and the Survey of Parents and Carers relating to service type are presented to show the extent to which supervised changeover and supervised visits for parenting time are provided by CCSs in Australia.

Specifically, the discussion presents findings based on data relating to the **number** of supervised changeover and supervised visits provided in each state and territory between 2019 and 2022 as indicated in the RFI data. As may be expected, overall, the data confirm expectations that the use of CCSs reduced during the COVID-19 pandemic period of restrictions, including periods of lockdown, and this was despite the availability at some CCSs of online supervised visits for parenting time where COVID-19 restrictions limited or prevented face-to-face supervised visits.

These data are followed by RFI data regarding the **duration** of service provision for supervised changeover and supervised parenting time sessions. The data regarding the **number of applications** and **assessments for intake** are presented, followed by the number of clients **accepted** in through the intake process, together with the number of clients then **using** each type of supervision service between 2019 and 2022. It is noted that these RFI data are the focus of the analysis in this chapter as the DEX data does not distinguish between the types of supervision services offered by CCSs.

Quantitative data from the Survey of Professionals are then considered to examine professionals' knowledge about the range of supervision services, followed by consideration of data from the Survey of Parents and Carers to examine their use of the range of supervision services.

Supervised changeover

Panel 1 of Table 1 presents the number of sessions for supervised changeover reported by participating CCSs between 2019 and 2022.

The data show that overall, there was a reduction in the number of supervised changeover sessions in 2022 (*n* = 12,615) compared to 2019 (*n* = 17,703). During the period of the COVID-19 pandemic, the total supervised changeover sessions were reported to number 12,035 in 2020 and 13,083 in 2021.

More specifically, the data show that in all but one location, there were reductions in supervised changeover sessions in 2022 as compared to 2019, with this particularly evident for New South Wales and South Australia (63% reduction) and to a lesser extent Tasmania (42%), Queensland (23%) and Victoria (20%). Northern Territory reported a substantial increase of 72%, which may be accounted for by the additional site in that location and substantial increase in staffing for these sites. These data suggest that for most CCSs, the number of changeover sessions in 2022 had not returned to pre-COVID pandemic rates, particularly in New South Wales and South Australia.

Panel 2 in Table 1 presents these data as a proportion of all supervised changeover sessions in each state and territory[15] for the period 2019–22, with the data presented from the largest to the smallest proportion of sessions. The data indicate that pre- and post-COVID, sessions conducted by CCSs in Queensland (all of whom participated in the RFI process) accounted for more than one-quarter of all supervised sessions (28%–32%), with 31% of supervised changeovers reported in the most recent calendar year. CCSs in Victoria, Western Australia and Tasmania accounted for 11%–12% each and New South Wales CCSs comprised 10% of the sample.

Table 1: Request for Information: state/territory by number of supervised changeover sessions per year

State/Territory	2019	2020	2021	2022	% change 2019–22	Total *N* CCS
Number of supervised changeover sessions per State/Territory	*n*	*n*	*n*	*n*		
NT	1,380	1,298	1,539	2,376	72	1
NSW	3,237	1,644	1,134	1,212	-63	12

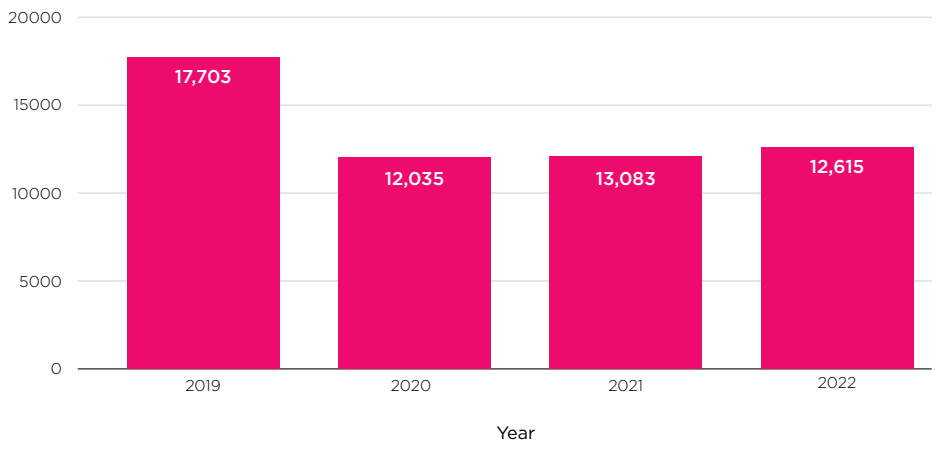
15 These data were not available for the Australian Capital Territory.

State/Territory	2019	2020	2021	2022	% change 2019–22	Total *N* CCS
Number of supervised changeover sessions per State/Territory	*n*	*n*	*n*	*n*		
SA	2,108	1,393	1,443	781	-63	5
Tas	2,451	1,214	2,001	1,421	-42	3
Qld	5,033	3,878	4,131	3,883	-23	11
Vic	1,851	1,308	1,339	1,489	-20	7
WA	1,643	1,300	1,496	1,453	-12	5
ACT	-	-	-	-	-	-
Total	**17,703**	**12,035**	**13,083**	**12,615**	**-29**	**44**
Percentage of supervised changeover sessions per State/Territory	**%**	**%**	**%**	**%**		
Qld	28.4	32.2	31.6	30.8		
NT	7.8	10.8	11.8	18.8		
Vic	10.5	10.9	10.2	11.8		
WA	9.3	10.8	11.4	11.5		
Tas	13.8	10.1	15.3	11.3		
NSW	18.3	13.7	8.7	9.6		
SA	11.9	11.6	11.0	6.2		
ACT	-	-	-	-		
Total	**100.0**	**100.0**	**100.0**	**100.0**		
Total *N* CCS	44	44	44	44		

Notes: Follow-up advice to the AIFS Research Team was that the RFI data submitted for Northern Territory was intended by the service provider organisation to cover both Darwin and Alice Springs CCS locations. Further and more specific clarification has been sought by the AIFS research team. Analysis based on CCSs that provided all 4 years of total number of supervised changeover sessions. No data for ACT. Some sites trialed providing services to more families consecutively in 2019 to minimise waiting times and then discontinued this from 2020, and this should be noted when interpreting the 2019 and following years data.

Figure 1 presents the total number of supervised changeover sessions to illustrate the pattern in the delivery of the supervised changeover overall. These data again show that in 2022, the number of changeover sessions had not returned to the pre-COVID rates delivered by CCSs. Some CCS sites indicated in their RFI responses that they had trialled the provision of services to a greater number of families consecutively in 2019 to minimise waiting times but then discontinued this from 2020 which may be reflected in the data from subsequent years for these services.

Figure 1: Request for Information: total number of supervised changeover sessions 2019–22



Supervised visits: supervision of parenting time

Panel 1 in Table 2 presents the corresponding data in relation to supervised visits for parenting time. Overall, there are variations across different states and territories, with two reporting increases in supervised sessions and the other reporting a decrease. The data indicate a significant upward shift for supervised sessions in the Australian Capital Territory from 351 sessions in 2019 to 906 sessions in 2022. The data from CCSs in Victoria reflected a slight increase (2%; 2019: *n* = 3,132; 2022: *n* = 3,207) and modest reductions in supervised contact sessions were indicated in the data from most of the remaining jurisdictions (decreases of 7%–14%), with reductions of 16%–19% in the Northern Territory and South Australia respectively.

Panel 2 indicates that CCSs in Queensland again had the largest proportion of supervised visits, although it is again noted that all eligible CCSs in Queensland participated in the RFI process (see Table 2). CCSs in Victoria and New South Wales accounted for the next largest proportion of supervised contact sessions (17%–22% respectively). Western Australian CCSs accounted for 7% of the supervised visit sessions with the remaining states and territories each accounting for between 2% and 5% of the total number of sessions.

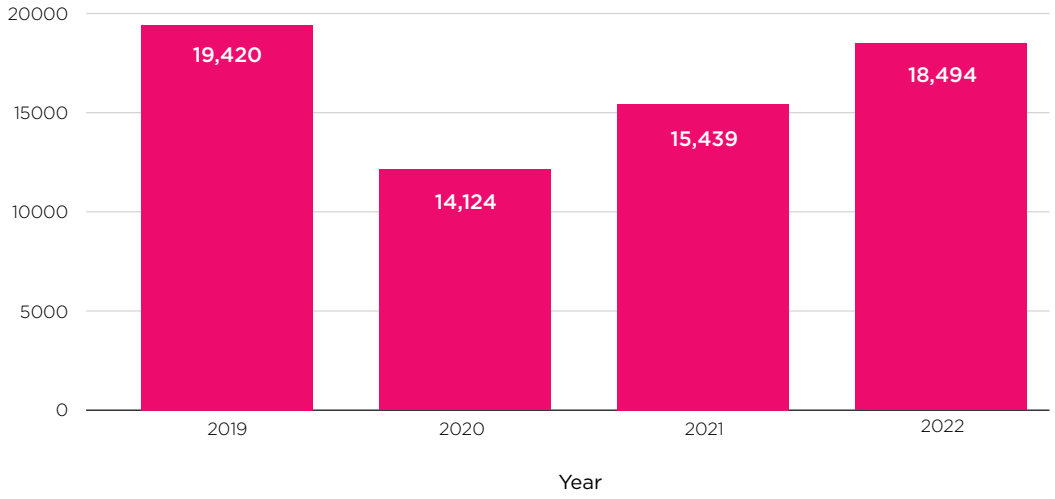
Table 2: Request for Information: state/territory by number of supervised visit sessions per year

State/Territory	2019	2020	2021	2022	% change 2019–22	Total *N* CCS
Number of supervised visit sessions per State/ Territory	*n*	*n*	*n*	*n*		
ACT	351	442	556	906	158	1
Vic	3,132	1,439	1,881	3,207	2	7
Qld	7,748	5,439	6,118	7,196	-7	11
NSW	4,434	3,576	3,135	4,007	-10	13
WA	1,470	1,046	1,203	1,270	-14	5
Tas	985	702	884	847	-14	3
NT	393	639	681	329	-16	1
SA	907	841	981	732	-19	5
Total	**19,420**	**14,124**	**15,439**	**18,494**	**-5**	**46**
Percentage of supervised visit sessions per State/Territory	**%**	**%**	**%**	**%**		
Qld	39.9	38.5	39.6	38.9		
NSW	22.8	25.3	20.3	21.7		
Vic	16.1	10.2	12.2	17.3		
WA	7.6	7.4	7.8	6.9		
Tas	5.1	5.0	5.7	4.6		
ACT	1.8	3.1	3.6	4.9		
SA	4.7	6.0	6.4	4.0		
NT	2.0	4.5	4.4	1.8		
Total	**100.0**	**100.0**	**100.0**	**100.0**		
Total *N* CCS	46	46	46	46		

Notes: Follow-up advice to the AIFS Research Team was that the RFI data submitted for Northern Territory was intended by the service provider organisation to cover both Darwin and Alice Springs CCS locations. Further and more specific clarification has been sought by the AIFS research team. Analysis based on CCSs that provided all 4 years of total number of supervised changeover sessions. No data for ACT. Some sites trialed providing services to more families consecutively in 2019 to minimise waiting times and then discontinued this from 2020, and this should be noted when interpreting the 2019 and following years data.

Figure 2 presents the total number of supervised visit sessions to illustrate the pattern in delivery of the supervised visits overall. From 19,420 in 2019, supervised visit sessions declined overall to 14,124 in 2020 but rose to 15,439 in 2021. In 2022, supervised visit sessions were substantially closer to returning to pre-COVID service delivery with 18,494 sessions facilitated nationally in 2022. Once again, it is also noted that some CCS sites indicated they had trialled the provision of services to a greater number of families consecutively in 2019 to minimise waiting times but then discontinued this from 2020 which may be reflected in the data from subsequent years for these services.

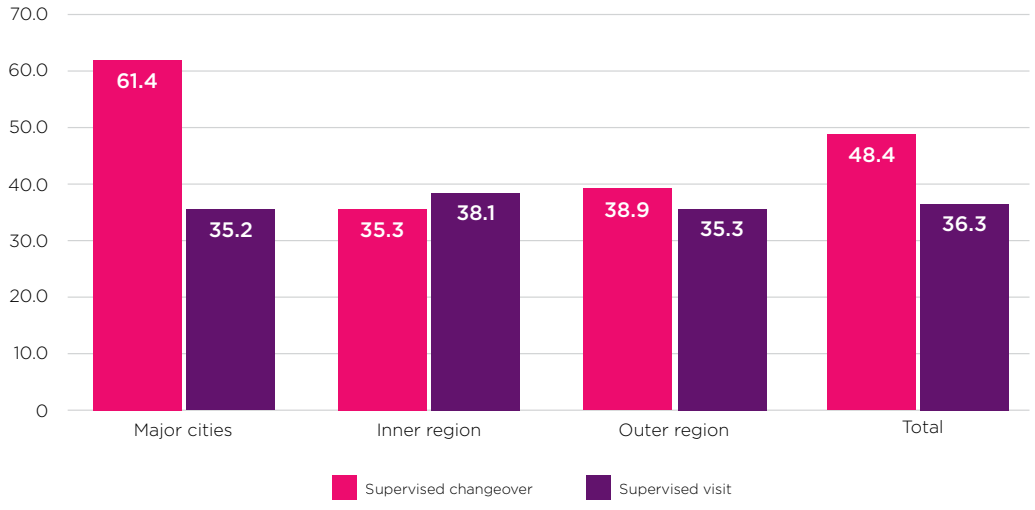
Figure 2: Request for Information: total number of supervised visit sessions 2019–22



Duration of services

Figure 3 presents data relating to the duration of services provided by the CCSs in relation to supervised changeover and supervised parenting time. The data show that, on average, clients were in receipt of changeover services for longer periods than supervised visits for parenting time by approximately 12 weeks (48 weeks supervised changeover cf. 36 weeks supervised contact sessions). The data also show that this difference between the length of time that clients accessed these services was particularly pronounced in major cities as compared to inner or outer regional areas, with clients in major cities accessing supervised changeover for 61 weeks compared to 35–40 weeks in regional areas. The average duration for clients to be accessing supervised parenting time sessions was between 35 and 38 weeks.

Figure 3: Request for Information: current clients, average number of weeks in receipt of supervision services, by region



Intake and provision of these supervision services

Table 3 presents the number of clients **applying** for and **assessed** for intake and then **accepted** in through the intake process, together with the number of clients **proceeding to engage** in supervision services.

Overall, the data from most participating services indicates a reduction of clients from 12,168 in 2019 to 9,893 and 10,324 during the COVID period, increasing again to 11,365 in 2022. More specifically, the data show a decline in the number of clients engaged in the application and assessment process at intake, with the reduction in applications particularly notable in the pre- and post-COVID periods (2019: 5,131 vs 2022: 4,420). When interpreting the client data presented below, it should be noted that the RFI collected information on the number of clients that services were provided for, across a range of activities in 2019 through to 2020. As CCSs could also be providing these services to clients who were recruited to the service prior to 2019, this explains why some categories have more clients receiving services in each year than the number of clients applied/assessed/accepted for intake.

Substantially fewer clients were accepted for services at the CCS (2019: 4,681 vs 2022: 3,763) and fewer clients were involved in supervised changeovers in 2020 (*n* = 4,187), 2021 (*n* = 3,521) and 2022 (*n* = 4,301) compared to 2019 (*n* = 4,857). Although the number of clients involved in supervised contact sessions declined substantially in the pre- and post-COVID periods (2019: *n* = 9,659; 2020: *n* = 6,806 and 2021: *n* = 6,552), there was a marked increase of clients recorded for 2022 (*n* = 7,882). Of particular note, 92 clients used online/virtual supervision of parenting time in 2019, and this increased sharply during the COVID lockdown period of 2020 (*n* = 709), albeit to a lesser degree in 2021 (*n* = 402) and were still substantially higher in 2022 (*n* = 259) as compared to the pre-COVID period.

The data in Table 3 also show a steady decline in the number of clients reported to be involved in supported/monitored onsite contact sessions where low vigilance supervision was required, with 1,213 clients engaging in these sessions in 2019, 917–922 during the COVID period and reducing further to 678 in 2022. Small numbers of CCSs reported having clients involved in unsupervised onsite visits or community-based, offsite supervision services and after a reduction of clients involved in these community-based services during the COVID period, in 2022, the number of clients engaged in these sessions increased to slightly exceed the pre-COVID rate (*n* = 83; cf. *n* = 74).

Table 3: Request for Information: number of clients per type of service sessions (including cancelled sessions) per year

Type of service provided	2019	2020	2021	2022
Applied for intake into your CCS	5,131	4,043	4,040	4,420
Total *N* CCS	38	38	38	38
Assessed for intake into your CCS[a]	5,451	4,216	4,278	5,034
Total *N* CCS	41	41	41	41
Are accepted for service into your CCS	4,681	3,511	3,339	3,763
Total *N* CCS	32	32	32	32
Supervised/facilitated changeover (on-site) sessions or services	4,857	4,187	3,521	4,301
Total *N* CCS	43	43	43	43
Supervised visit (on-site supervised parenting time)	9,659	6,806	6,552	7,882
Total *N* CCS	42	42	42	42
Online/virtual (telephone/internet based) supervision service	92	709	402	259
Total *N* CCS	24	24	24	24
Supported/monitored visits (on-site visits with one or more families who have been assessed as requiring low vigilance supervision)	1,213	917	922	678
Total *N* CCS	20	20	20	20
Unsupervised on-site visit	8	1	8	14
Total *N* CCS	2	2	2	2

Type of service provided	2019	2020	2021	2022
Community-based/off site supervision service	74	47	59	83
Total *N* CCS	9	9	9	9
Total number of clients (as reported by CCS)	12,168	9,893	10,324	11,365
Total *N* CCS	40	40	40	40

Notes: Analysis based on CCSs that provided number of clients in each category for all 4 years. For some sites, the data in each category is represented in differing formats, sometimes available as number of clients sometimes as number of families and this should be noted when interpreting this data. [a] For some sites, the CCS service counts adults as applied for intake, and then added children in the family unit as having been assessed individually which explains higher number of clients assessed for intake compared to number of clients who applied for intake. The RFI collected information on the number of clients that services were provided for, for a range of activities in 2019 through to 2020. As CCS could also be providing these services to clients who were recruited to the service prior to 2019, this explains why some categories have more clients receiving services in each year than the number of clients applied/assessed/accepted for intake.

Quantitative data from the Survey of Professionals also provides important insight in relation to professionals working with separated families and their knowledge of the range of services provided by CCSs in Australia. All participants in the Survey of Professionals were asked about their knowledge of these services funded under the FRSP, with questions directed at both supervision and non-supervision CCS services.

Key findings in relation to core supervision services (see Table A7, Appendix F) include:

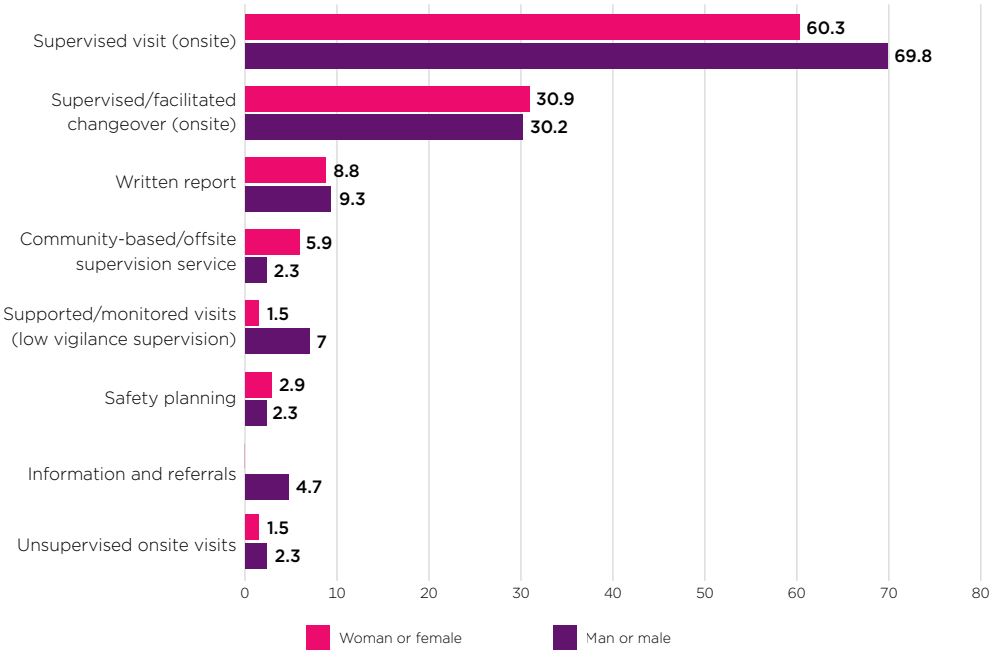
- Strong majorities of participating CCS professionals who worked at CCSs reported that CCSs provide the following services, and they were more likely to do so than referring professionals to a statistically significant extent:
  - **intake and risk assessment:** 92%; cf. referring professionals: 55%
  - **safety planning and orientation/familiarisation:** 89%; cf. referring professionals: 41%, with more than a quarter of referring professionals indicating that they did not know or could not say whether this service was provided
  - **supervised contact:** 92%; cf. referring professionals: 56%
  - **supervised changeover:** 91%; cf. referring professionals: 50%
  - **low vigilance supported/monitored visits on site:** 72%; cf. referring professionals: 17%, with 43% of referring professionals indicating that they did not know or could not say whether this service was provided.
  - **online/virtual supervision:** 68%; cf. referring professionals: 11%, with 55% of referring professionals indicating that they did not know or could not say whether this service was provided.
- In relation to community-based/offsite supervision and unsupervised onsite visits, CCS professionals were more likely to report that 'all CCSs' provided these services (42% and 26% respectively) but substantial proportions also reported that 'no CCSs' provided these services (26% and 29% respectively). Referring professionals were more likely to report that 'no CCSs' provided these services (21% and 18% respectively) or that they did not know or could not say whether these services were provided (45% and 55% respectively).

Insight in relation to the use of supervision services is also available from the participants in the Survey of Parents and Carers. These participants were asked to indicate which services the CCSs provided to their family. The data are presented in Figure 4 and show no statistically significant difference in reports of services provided by gender of participant:

- supervised visit (onsite supervised parenting time) was the most commonly received service, 63% overall (70% of men; 60% of women)
- almost one-third (31%) were provided supervised/facilitated changeover (onsite), 30% of men and 31% of women
- written reports were provided for 9% of participants (with this proportion the same for men and women)
- between 2% and 5% of participants were provided with at least one of the following: community-based offsite/supervision services; supported/monitored visits (onsite visits with one or more families for low vigilance supervision); safety planning; information and referrals; unsupervised onsite visits.

Also of note, other response categories that were available but not selected by any participants included online/virtual supervision, offsite supervision, culturally appropriate services, advocacy, education, skills or training and non-supervision services for children.

Figure 4: Online Survey of Parents and Carers: CCS services provided, by gender



Notes: Multiple responses so proportions may not sum to 100.0%. A further 3.6% of participants selected 'prefer not to say' in response to this option. Other response categories that were available but not selected by any participants included: Online/virtual supervision; Offsite supervision; Culturally appropriate services; Advocacy, education, skills or training; Non-supervision services for children.

Similarly, qualitative interviews with parents/carers, considered later in this chapter and in chapters 3 and 4, conveyed that most attended the service for supervised contact (*n* = 30/50) or supervised changeover (onsite) (*n* = 20/50). Written reports prepared for the FCFCoA were sometimes mentioned as being very important, particularly by fathers who were spending supervised time with their children. Parent and carer interviewees rarely mentioned the provision of other services, or of intake and risk assessment or safety planning and orientation/familiarisation.

Implementation of intake and risk assessment

In this section, data from the open-text responses in the RFI provide further insight into the nature and operation of the intake and risk assessment process.

Application and intake process

The RFI responses illustrate that CCSs generally received initial intake information through the completion of an intake form followed by intake sessions or intake interviews conducted by CCS staff with each parent or carer. Progressing successfully through this intake process would then culminate in parents and carers being asked to enter a service agreement with the CCS. Some RFI responses outlined a range of materials provided to parents and carers with their application form or during their intake interview and described the documents that parents/carers were required to provide to the CCS in this intake process. For example:

> *Our clients call our centre for intake information and are emailed the intake paperwork, the Data Exchange Privacy Form, and the Threatening and Intimidating Behaviour flyer. An Intake Session is booked for each individual client when both parties submit their completed paperwork. Clients are requested to email or bring copies of DVOs, Court Orders, Parenting Agreements and identification documents when booking an Intake Session. These documents are scanned and added to the family's electronic file. The staff review the Service Agreement with each client and the client is asked to sign this agreement. No services are provided to clients who refuse to sign this agreement. Clients are assessed by the Team Leaders for risk and then scheduled for supervised changeovers or supervised contact visits. (Service 55, Qld)*

The RFI responses relevant to application and intake processes also described steps put in place for CCS management to review the documents submitted by parents and carers or their legal representatives, together

with the completed service forms. Where this initial review process indicates that it is safe and appropriate from the CCS's perspective to proceed, intake appointments with the family are made. Some CCSs described a 'Child Inclusive Practice Process' at intake that involved a play-based appointment with the relevant child, as well as separate appointments with parents/carers. At these appointments further information gathering, risk assessment, family violence screening takes place, parental readiness and capacity assessments may be undertaken, and service requirements are explained to the family. Some CCSs described follow up appointments with the parents and carers, to facilitate the development of a case plan and referrals to other support services, to explain and sign the service agreement and to provide a tour of the centre and make introductions to staff. (e.g. Service 212, NSW).

The timing of risk and suitability assessments for the use of CCSs is notable in the RFI data described above, with some CCSs opting to undertake the assessment upon application and review of the submitted materials, as well as the incorporation of child inclusive practices in the intake process. This timing of the risk and suitability assessment contrasted with the approach taken by another service providing an RFI response where the risk assessment was only undertaken upon the family's progression to the top of the waiting list (e.g. Service 127, Vic).

If waiting lists are protracted, this approach may mean that families are without another option to facilitate parenting time if they had an expectation of access to supervision services that is not realised or if they are assessed as unsuitable. Alternatively, it may mean that families may lodge multiple applications at CCSs which would have an impact on CCS service administration.

Some RFI responses articulated the thorough intake process and the role played by numerous members of staff at the CCS. Some described intake staff or business support staff as gathering the initial intake information, with the process then progressing to a CCS supervisor who assesses this intake information and schedules information sessions with the parties. Risk issues could then be identified and recorded in this part of the process and parties' applications assessed and progressed to consultation with the 'Team Leader or manager prior to contact appointment scheduling to assess/review risk and ensure safety planning is undertaken covering safe access and entry points, parking and staggered arrival times' (Service 207, Vic; Service 245, state/territory redacted).

Where a dedicated member of staff has been appointed to manage the intake process, the RFI responses illustrate the significance of this role, even where other staff members played critical roles in the intake process. Intake workers provide an initial point of contact for families, undertake the initial assessment and advise family members of the process and support them to complete the intake information and service application forms. Their involvement extends to subsequent follow up appointments, including organising familiarisation/orientation sessions. They may also liaise with solicitors, mediators, or counsellors during the intake process to ensure that all information is obtained to make an appropriate decision regarding acceptance and offering of service (e.g. Service 237, Vic; Service 235, state/territory redacted).

The RFI response from some services also articulated the steps followed by the staff. One service described how the staff meet to discuss: the application and to make an initial assessment that considers a statement of the problem (completed by the parents/carers), the nature and extent of the service required, relevant history and family configuration, the goals of the parents/carers, who will be participating in the process (e.g. 'children from previous relationship, grandparents or other relatives'), any risks/safety concerns, relevant information in relation to the children (including their experiences of parenting time with the Spends time with parent), copies of relevant court orders or parenting plans and details of and likely progress of court proceedings and practical considerations for service (e.g. 'frequency, duration, diet, medication, care issues, clothing and food') (Service 235, state/territory redacted).

Some services identified in their RFI responses that they prioritised the provision of services to families with family law court orders for supervised time or changeover. One service indicated that they accepted families into the service on 'a first-come first-served basis (once both parents return a written application), and families are not prioritised for Intake Assessment Interviews ahead of others, unless the FCFCoA has specifically requested expediting the matter, for a compelling reason' (Service 54, NSW). For some CCSs, the triage process may allow consideration of the urgency of service for families on the waiting list, with one service explaining that the payment of full fee for service may enable a family's case to be expedited subject to staff availability and where they are assessed as suitable (e.g. Service 75, NSW). Other services maintained an open waiting list, and as noted earlier in this section, some services required potential clients to progress through the waiting list before proceeding with the formal intake and suitability assessment.

Although the RFI responses submitted by most CCSs described an intake process commenced by the submission of application forms, one CCS described an approach that had greater emphasis on information gathering and a

suitability assessment driven by the intake interview process without an application form (e.g Service 146, NSW). This may be an approach that supports accessibility, engagement and provision of information to diverse families while still providing the required information for a thorough intake process from the CCS.

The RFI responses generally described initial risk assessments and orientation or 'familiarisation' activities for parents/carers and children as an integral part of the intake and triage process (noting that data relating to risk assessments and child orientation/familiarisation are considered in the next section). For example:

> *Once an application form is received, either through another agency or the client(s) themselves, they are booked in for an intake appointment then an assessment appointment. Once these appointments are completed with both parties, a case management meeting will be held to assess suitability of service and safety of children and staff during supervised visits. A risk management plan is then put in place to mitigate any risks identified. The child is then invited to attend an orientation of the building and CCS process. Once completed, both parties will be informed of when supervised visits can commence. (Service 225, WA)*

Child orientation/familiarisation sessions

More detailed insight in relation to child orientation and familiarisation sessions was available from the RFI responses and interviews with parents and carers. Some CCSs in their RFI responses emphasised the child-focused and child-inclusive approach taken with their intake assessment and orientation processes, with the child orientation providing an 'opportunity for children to ask questions, express concerns, see facilities and meet their supervising staff' (e.g. Service 245, state/territory redacted). It also offers an opportunity for staff to observe the child and assess their readiness to use their service. For example:

> *Orientation is designed to provide an opportunity for engagement with all participants, for building cooperative relationships, and for ensuring that all participants have an understanding of the purpose and use of the service. For children, the process is particularly important to establish a sense of trust and security and for staff to make a thorough assessment of their support needs for the contact to occur … The purpose of the orientation process for the child is to acquaint the child with the Children's Contact Service environment and staff, and to help reduce anxiety and to assess, where possible, what the child's understanding is of what is happening. Children's Contact Service staff also seek to understand: [1] How the child feels about seeing the 'spends time with' parent and their willingness to attend the service. [2] The developmental stage of the child. [3] Any special needs the child may have. [4] What they may do to prepare and support the child for the proposed visiting arrangements.* (Service 79, Vic)

Common features of the RFI responses regarding the purpose of orientation/familiarisation sessions with children include:

- sharing of information about the CCS and the supervision process with the child
- facilitating the child's exploration of the service setting so that they are familiar with the venue and supervision process
- engaging in rapport building activities to reassure children and to support the establishment of a trust with staff
- getting to know the children, their needs and how best to support them at the service
- engaging with the child in developmentally appropriate ways to capture information and concerns held by the child.

The child orientation/familiarisation process also allows an opportunity for the consideration and identification of a signal for a child to discreetly alert the CCS staff if they are feeling unsafe or otherwise seeking to stop the session (noting that data relating to stopping sessions is presented in chapter 3). Additionally, some CCSs described how the orientation process allow the CCS staff to 'build the child's positive expectations for contact' and to assess the extent to which the Lives with parent was able to support the child to separate and to feel safe at the CCS (Service 54, NSW). The following quote provides an example of how the orientation/familiarisation session is implemented:

> *The first part of the session is play-based, [and] the 'lives with' parent is encouraged to engage the child in play alongside the worker. Consent is sought from the child to separate from their parent to a separate playroom, to speak with a worker. The parent remains in the centre and a worker shares information about how the service will support them/their child during contact sessions and addresses any arising concerns or worries. The second worker invites the child to share their thoughts and feelings about spending*

time with their other parent (using child-friendly tools such as [redacted] [illustrated] cards, drawing, playdough). The worker explains to the child the role of contact workers (to support and listen to the child first and foremost), how contact workers would keep the child safe (physically and emotionally). Any questions [and] worries are addressed, including offering the child control and choice over how they meet/interact with their parent, and providing option for the child to signal the worker for a break or to finish the session early. This appointment is also used to assess the capacity for the 'lives with' parent and child to separate from each other, and the 'lives with' parent's capacity to support the child's sense of safety at the contact centre. If there are concerns that this issue may significantly impact on the child's mental/emotional wellbeing, we may assess that it is not appropriate to proceed with contact until the parent receives therapeutic support to ensure they can adequately support the child. (Service 54, NSW)

Some RFI responses provided insight into the steps involved in implementing the child orientation/familiarisation process including:

- a preparatory phase for service staff conducting the orientation session to review the material on file and particularly in relation to the child, as well as preparing age-appropriate toys or equipment for the session
- welcoming and introducing staff to the child upon arrival
- settling the child, asking age-appropriate questions and observing the child's verbal and non-verbal cues
- a focus on providing children with information about the supervision process and answering their questions in an impartial and age-appropriate way
- providing familiarity with the service facilities and layout
- addressing any safety or other concerns that the child may have
- providing opportunities for additional orientation/familiarisation sessions where this would support the child (Service 79, Vic).

In these ways, the orientation sessions are intended to provide an important means of familiarising the child with the service and process and support staff to gather information to help plan arrangements and activities to assist the child to transition into the service.

Some CCSs described their child-inclusive approach to orientation as not only supporting children to voice any concerns but also to have autonomy at the service by planning with the staff the format and activities for their visits:

Children are given a sense of safety and control for their visits and are informed … in a child appropriate manner that they can speak to staff at any time about anything, [and that] the staff are here to protect the children and that if staff are worried about the child's safety, then the staff will take steps to assist. (Service 146, NSW)

In contrast to the detailed descriptions provided by CCSs, very few parents and carers who were interviewed recalled orientation/familiarisation being offered to them or their children. The experiences of those who described an orientation process ranged considerably, and included parents who felt that they and their children were supported, those who had mixed feelings, and those who did not feel that they or their child had been supported. For example:

Oh, that [familiarisation] was great. Like they took us through and they were explaining everything …what happens in the centre and, you know, and they were giving [child] code words. You know, if [child] was upset with his father or something[and] they were just explaining everything to us … that would happen at the centre. – That was that was really lovely. (LWP 19)

The first time we just came in 15 minutes earlier so that he [child] could see one of the rooms that they were going to put him in, but he was actually quite stressed out in that room. So by the time I'd left, he was put into a different room that was bigger and larger…But that was sort of it…I thought that the intake sort of process that they did was fine…They explained it and they asked a few questions. And that was fine. I didn't love the first day. Just going in a bit earlier and being put into a room. And I thought it felt a bit claustrophobic. (LWP 31)

We had one of those [familiarisation sessions] just recently would have been a few weeks ago. [child] went…half an hour, just in the centre with the worker … As we were leaving, I heard the worker say to [child] something like, 'And also, you know you going to come along on Saturday and you're going to give it a try and you're going to go and wave to dad and you're going to say bye to mum'. And [child] was like, 'Ohh yeah, I'll just wave and then I'll go straight back to Mum'. And she's like, 'Oh, you're going to give it a go

then'... and [child]'s nodded. And I thought, 'Ah, so I've not been in the room and she's been making some sort of arrangement with [child] to give it a go. And in different families that would be a, you know, like a benign thing ... but in our circumstance, yeah, I felt so sick that that had happened while I wasn't in the room or at all, the sort of 'Ohh, just give it a go. Oh, come on. Like you can give it a try', sort of like with the implication being, and sort of links into what teachers would say at school: 'Why you just weren't willing to give it a go?' Like, it's quite shaming if a child then says - no I'm not even willing to give it a go. (LWP 45)

Triage and risk assessment

Some RFI responses detailed how their staff triaged families as part of the application process. These responses indicated key components of the triage and risk assessment process as involving:

- the review of application and intake interview and material to screen and assess the risks and needs of each family and their suitability to access the CCS services
- identifying pathways to other support services to address family members' needs
- facilitating and following up referrals made.

Considering the needs of individual families 'can include but are not limited to disability and or physical support, Aboriginal and Torres Strait Islander peoples and CALD community, religion, and emotional and mental wellbeing' (Service 154, Qld). Some CCSs in their RFI responses described how they triage families across their waiting list with the view to balancing the needs of each family to support their timely access to supervised changeover or supervised visits for parenting time. For example, one CCS explained that they generally responded to applications on the basis of the date of application but that families may be triaged according to the service type or number of sessions they required. Families requiring shorter service provision could be prioritised, and changeovers were identified as less resource intensive and as such could be scheduled more quickly. This service also noted that in some circumstances the court may seek service provision as a priority for health reasons or to facilitate the provision of a CCS report to inform the court decision (Service 79, Vic).

Other CCS RFI responses described the triage of clients as separate to the application process, with some CCSs requiring completion of relevant education and support programs (e.g. as a post-separation parenting program) as part of a two-stage intake and triage process. For example:

Triage criteria is not linked to application form but is based on comprehensive screening and risk assessment and is based on individual client needs. (Service, 173, SA)

Specific insight into the operation of the risk assessment process was also provided in the RFI responses. For example:

Once interviews are completed and all information gathered by the intake worker, the Team Leader will undertake a risk assessment of the family to determine suitability, identify risk factors or any special needs. [The] Service has created a risk assessment template that must be completed prior to service commencement. The primary concern for Children's Contact Service's at all times is the potential risk of harm to the child and of others involved with the service. Therefore, rigorous and comprehensive assessments of risk are essential prior to commencement of service and continuously reviewed throughout the duration of client involvement. Key components of risk management include (but are not limited to):

- *All clients must be assessed for eligibility for service provision.*
- *Initial risk assessment commences from the point of receiving each parent's mandatory application form.*
- *All staff are expected to wear a personal duress alarm during any client contact, including intake interviews.*
- *Where the staff member makes an initial assessment that a client may be unsuitable for service due to safety concerns, this should be discussed with the relevant Team Leader.*
- *If risk factors have been identified and a decision by the Team Leader to proceed with intake, staff should take every precaution to ensure the level of risk is minimised by:*
  - *2 workers conducting the interview*
  - *Duress alarms worn by both workers*
  - *Scheduling the visit on a weekday*
  - *Consideration of seating arrangements to ensure workers position themselves near an exit*
  - *Where other staff are in the building, they should be alerted to any risk*
  - *Seek monitoring of the surveillance cameras for the duration of the interview where possible and practicable.* (Service 79, Vic)

CCSs indicated that they used the following tools to guide the identification and assessment of risk to client and staff safety, and to assess risk of abuse of clients and child abduction during service delivery (e.g. Service 156, WA; Service 231, state/territory redacted; Service 192, Vic; Service 235, state/territory redacted):

- well-known risk assessment tools including Multi-Agency Risk Assessment and Management (MARAM) or more commonly Detection of Overall Risk Screen (DOORS)
- a Children's Contact Services Risk Assessment Form or other bespoke risk assessment tools
- a risk assessment approach that adapted existing risk assessment tools (e.g. the Common Risk Assessment and Risk Management Framework (CRARMF), Dangerous Assessment Scale, Suicide Risk Management and Personal Safety Plan Checklist) to the context of their CCS intake processes.

For example:

> *[We use] DVSAT, suicide assessment kit (SAK), mandatory reporting as per State guidelines CCS Family Safety Assessment and CCS Community Location Assessment. (Service 216, NSW)*

More specific insight in relation to the nature of these risk assessment tools and the domains or risk issues captured were also provided in some RFI responses. For example:

> *The tool used to assess risk for CCS clients is called a 'Risk Matrix'. There are two templates used by staff, one to assess risk of staff safety, and another to assess risk of child abduction. These templates are used after the intake and assessment appointments are done with both parties. The purpose of these risk assessment tools is to firstly, identify risk, secondly, assess the risk and thirdly, control the risk. Information to identify risk is taken from assessment comments from both parties and children, court orders, lawyers, child representatives, etc. This information is then assessed by considering the likelihood of possible abuse to staff or abduction of children from highly unlikely to highly likely. Once risk is assessed, steps are put in place to control the risk such as but not limited to consideration of elimination of service, ensuring availability of phones, duress alarms, isolation rooms and correct use of policy and procedures.* (Service 225, WA)

In addition to outlining the risk assessment tools and measures, some participating CCSs described their application and noted the training that their staff received in the application of the risk assessment process, with one RFI response illustrating how these assessments overlapped with the DEX SCORE domains:

> *[Our organisation uses] screening measures to assist in identifying risk of harm, which have established reliability, validity, sensitivity and specificity. They are typically quick and easy to administer and score and can be used with many different types of people (clients, family member/caregiver, and practitioner). We screen for: psychological distress and disorder, addictions (alcohol, drugs, gambling), stressful life events, suicide, support, financial strain, DFV [and] safety concerns about children. Examples of risk screening measures used in our CCS [include]: K6 for Psychological distress/Risk for Psychological Disorder PAYKEL for Risk for Suicidality, CAGE-AID for Risk for Alcohol Use Disorder, substance use disorders HITS for Risk for DFV/IPV. These risk screening tools are weaved into the initial session(s) with clients and are offered as pen and paper measures for the client to complete on their own in the … venue and return to practitioner; or the practitioner can offer to read the items aloud to the client and the client can indicate the response that best fits their current circumstances. If a risk of harm has been identified staff further explore the risk through risk assessment. All CCS staff are trained in risk assessment and have practice resources to assist them apply a client centred, collaborative approach to assess all the following domains, including but not limited to: child neglect and abuse; domestic and family violence; mental health; addictions [and] suicide. Some of the [DEX] SCORE assessment domains overlap with the risk assessment domains allowing for a complimentary assessment of client risks, protective factors and risk factors. Following risk assessment, CCS practitioners interpret the information and form a risk analysis. Risk analysis is the process of determining how the risk may impact the client (including children), others, staff and the organisation.* (Service 244, Qld)

The application of risk assessment tools and processes also considered a range of oral and documentary evidence, with the latter including family violence/personal protection orders, child safety department involvement and other relevant court orders or details of criminal charges or proceedings. The following RFI response indicates that capture of both oral and documentary evidence and the application of the risk assessment process involves a two-stage approach that is intended to encourage full disclosure through a sensitively administered process, and one which is subject to review and amendment to ensure that it is fit for purpose:

> *The primary risk assessment is completed when a parent registers to use the Service, this generally occurs via the phone … as a general conversation to encourage a discussion with a parent about the reasons they require the Service. This conversation occurs in an informal format, as parents/care givers are often highly anxious during their initial contact with the Centre, and it has been determined to be an effective way to collect relevant information and complete a preliminary risk assessment. At this time, clients are required to provide copies of Orders/Agreements, Domestic and Family Orders, undertakings and any other documents relevant to their engagement with the service. The secondary risk assessment is completed prior to the intake interview, which generally occurs over the phone. During this time, further discussions occur, expanding on the information the parents have previously provided during their registration and a more formal discussion occurs to encourage full disclosure about the current risk factors and risk assessment. This has been an effective way to consolidate previous information provided by client's and gives staff an opportunity to finalise a client's risk assessment in a formal but sensitive and non-threatening manner … The current risk assessment has been reviewed, updated and amended to ensure the Centre is continuing to assess and address individual clients and a family's needs.* (Service 94, Qld)

This and other RFI responses were indicative of a trauma-informed approach to the risk assessment and risk management process. The following extract described how the risk assessment tools are employed to support this trauma-informed and DFV- informed approach:

> *We use a semi-structured interview guide (developed internally for specific use in our CCS), which incorporates the 'Safe & Together' model of assessing and documenting DFV. The interview (approx. 90 minutes, in-person or by video, with 2 practitioners) focuses on eliciting a sense of the child's experiences of each parent, the parent's concerns or fears about the contact arrangements, each parent's capacity and willingness to make safe and child-focused parenting choices. This includes an assessment of any risk to the child's, other clients' or staff safety, and whether the resources and case management capacity of the service would adequately mitigate this risk. We explore each parent's willingness and capacity to support the child's positive relationship with the other parent and/or to form a cooperative co-parenting alliance – with the important consideration that, for victim/survivors of DFV, their capacity to support their child's relationship with the parent who has used abuse may be impacted by their experiences of abuse. So, any fear/reluctance should be carefully considered through the lens of their responses being reasonable and protective of their child, and that the parent who has used abuse should be accountable for the consequences of their choices (i.e. rupture in relationships). Where current fears/concerns are expressed around DFV risk, we use the Domestic Violence Safety Assessment Tool.* (Service 54, NSW)

Some CCSs provided detailed descriptions of the application of these risk assessment protocols in practice, and how safety plans that are informed by this risk assessment process can be developed and implemented. The RFI responses also illustrated how the risk assessment and risk management process continues throughout the duration of the family's engagement with the service with some services identifying ongoing risk assessment as critical to safe CCS service provision (Service 55, Qld).

It is notable, however, that although CCSs in their RFI responses described rigorous processes, the data from parents and carers (explored later in this chapter) suggest that experiences of CCS risk assessment processes were mixed.

Risk assessment and safety planning were also identified in the RFI responses as being tailored to the type of supervision service offered, with some adjustments in the arrangements for online/virtual supervision sessions, (e.g. the requirement of cyber safety education for families), for onsite visits that were intermittently monitored rather than supervised and for offsite visits. Considerations included evidence from contact reports that there are no concerns over a period of time, whether the child will cope without a CCS staff member present, including that the child looks to their parent to have their needs met and is comfortable seeking assistance from the parent and the parent's ability to facilitate child-led play, engage in appropriate parent-child conversations and to monitor for safety hazards and whether these low-vigilance sessions are a 'stepping stone' to unsupervised time (e.g. Service 54, NSW).

The RFI responses identified considerations particularly relevant to virtual supervised visits for parenting time both in relation to risks to safety with the use of technology in this context and the challenges with ensuring that family members can actively participate in the virtual sessions or are not adversely impacted by this mode of service delivery, including by reason of mental or physical disability. For example:

> *CCS assesses that virtual visits would not cause harm to family functioning (e.g. if child were to become dysregulated in the home; if one parent would be triggered by hearing the other parent's voice, etc.), and*

that there is a low risk of virtual visits increasing risk (e.g. due to opportunity for stalking/discovering home location). (Service 54, NSW)

Given the need during COVID we developed a virtual model and practices. Processes were developed around additional intake requirements; for example, parents' capacity to use technology. Education was provided on how to keep children engaged, assessment of any other safety requirements and determining any additional individual support requirements. (Service 181, NSW)

The RFI also requested that CCS provide details of any changes made to the intake, screening and risk assessment processes since 2019. CCSs referenced the use of technology to support and streamline these processes and service delivery. Examples included:

- a COVID induced streamlining of intake sessions, with these shifting from in person (taking 1.5 to 2 hours) to online with forms being emailed and completed (taking 30 mins). Intake can also take place virtually (Service 55 Qld)
- key documents including practice instructions, the CCS brochure, terms and conditions booklet, intake and assessment tools being incorporated into an electronic Client Management System, with key documents including the fee schedule and the Children's Contact Service Report template reviewed annually (Service 207, Vic).

CCSs also described revisions to application and intake documentation, including in relation to the updating of language employed in forms, improving the format and flow of the forms and the information they contained (Service 70, SA) and directing focus to capturing information relevant to the 'impact on the child' (Service 75, NSW). Other developments to the risk assessment process described by the CCSs included:

- moving from an assessment of individual questions considered to provide an overall risk for the family of low, medium or high risk 'with controls for each measurement' to an ongoing risk assessment that considers changes with families and replacing ratings with risk management strategies that are dependent on the issues raised (Service 75, NSW)
- developing or updating specific risk assessment and procedures for virtual/online visits and cases involving sexual abuse (e.g. Service 79, Vic).

Improved risk assessment processes were also detailed in RFI responses, including the implementation of ongoing risk assessment processes throughout a family's engagement with the service, including:

- weekly risk assessment meetings to update changes to risk and associated action plans (Service 168, NSW)
- the application of risk assessment tools specific to children (e.g. Kids' DOORS for children aged 5–17 years) 'routinely [giving] children a voice about their own perceptions of risk' through play but with 'very serious intent' with a view to supporting child-inclusive and child safe service provision (Service 170, SA).

RFI responses described the logistics in place upon the arrival and departure of each parent and carer for both supervised changeover and supervised visits, and the way alternative entrances and exits are used as well as parking arrangements to avoid the parties coming into contact with each other, while also providing opportunities for staff to debrief with clients (e.g. Service 173, SA; Service 127, Vic). These arrangements involved:

- Lives with parent or carer arrives through one entrance 15 minutes prior to the scheduled visit and the visiting parent or carer arrives onsite 5 minutes before the visit commences through a separate entrance, with separate parking areas for each party. The primary parent or carer returns to the CCS 5 minutes before the visit is scheduled to end and leave the vicinity with the child while the visiting parent remains onsite for 15 minutes after the conclusion of the session to avoid contact with the other parent or carer (e.g. Service 146, NSW).
- These arrangements may be supplemented by locked gates and CCS staff escorts (e.g. Service 225, WA).

In contrast, while most parents and carers who were interviewed said that arrangements for families ensured that parents did not come into contact with each other, there were exceptions. For example, one parent described how she had sought permission to park in a location other than the designated area for the primary carer as the Spends time with parent had destroyed her previous car (with criminal proceedings pending) and she had observed a person seated in the Spends time with parent's car for the duration of the visit. Although the permission was sought so that her car was not identified by the Spends time with parent and for her safety, the participant indicated that CCS staff were not receptive to her request:

So I tried to explain [to the CCS] without giving too much detail, because I hate having to explain all these things, that I couldn't park in the contact centre car park for safety reasons and that I'm quite happy to just park across the road and walk over because it's in a different car park. But then a week or so after

that, they said to me 'Oh, we'd really appreciate if you could start parking in our car park'. So like OK, but I explained to you, I can't do that. And I understand it's probably part of their policy. There might be reasons why they need people to park in their car park. And I suppose that's where the problems potentially are, is that they're guided by policy and procedure, but perhaps some of those don't allow for safety issues. (LWP 1)

The issue of flexible and trauma informed service provision will be examined in detail in Chapter 3.

Non-supervision services provided by CCSs

In this section, quantitative data from the RFI and the Survey of Professionals relating to service type are presented to show the extent to which a range of non-supervision services (also known as secondary services) are provided by CCSs in Australia. These services range from case management and case support, through to information and referrals to education, skills and training programs or the provision of these services to clients directly. They also include services for children, including information or referrals to other support services in addition to the supervision services provided.

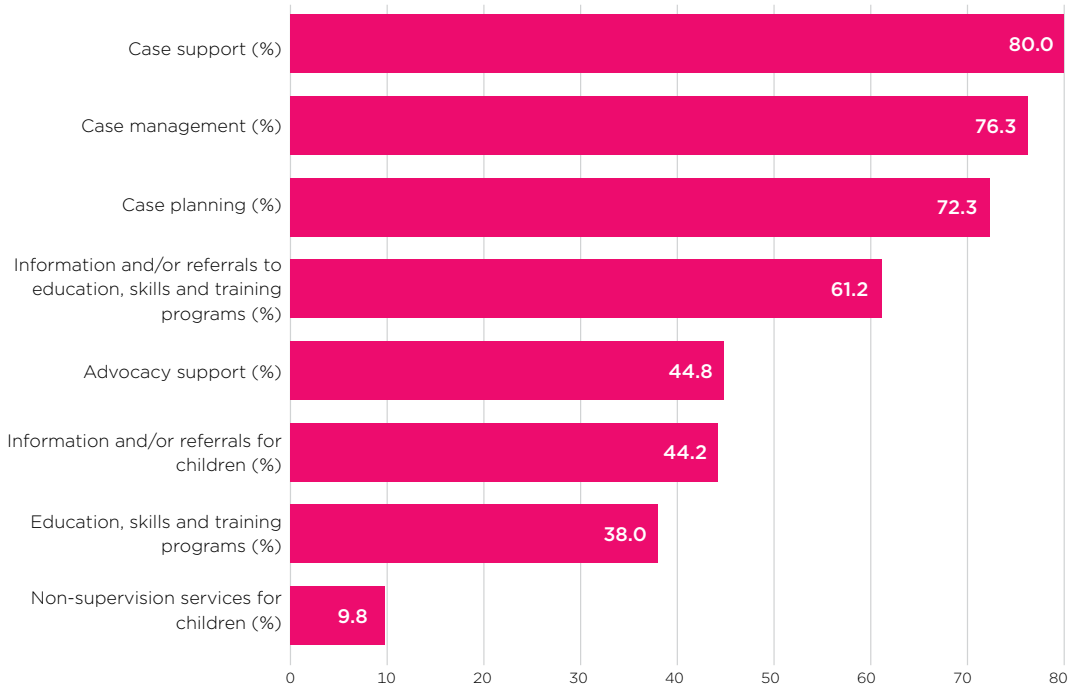
Insights from the RFI data about non-supervision services

The RFI data presented in Figure 5 presents the range of non-supervision services and the mean proportion of clients receiving these services between 2019 and 2022.

The data show that:

- more than three-quarters of the participating CCSs reported providing case support (80%) and case management (76%) services
- nearly three-quarters reported providing case planning (72%)
- nearly two-thirds (61%) of participating CCSs provided referrals to education, skills and training programs
- almost half of the participating services reported providing advocacy support (45%) and information and referrals for children (44%)
- a substantial proportion of services also reported delivering education, skills and training programs (38%)
- a small but not insignificant proportion reported providing non-supervision services (including post-separation support) for children (10%).

Figure 5: Request for Information: mean proportion of current clients receiving each type of CCS non-supervision service



In relation to the non-supervision services, data from the open-text RFI responses also provides insight into the child-focused information and education opportunities and referrals provided to families also relevant to Research Question 1. These data are indicative of the nature and provision of this information and referrals at each stage of a family's engagement with the CCS process, from the point of intake and orientation through to case review:

> *Families are provided with relevant information in the form of referrals/relevant support/linking families with agencies, brochures and reading material. ….[There is a] Review of each family's progress after 3 to 6 weeks and check-ins with parents/service users periodically. [We have an] Open door policy for clients.* (Service 154, Qld)

> *Parents are strongly encouraged (but not as a pre-condition for service) to undertake a multi-session live group course on post-separation parenting (i.e. not a self-paced online course, or a single-session seminar) Parents are encouraged to undertake this whilst they are on our waiting list. For some parents, completion of this course may become a condition of ongoing service provision, if it is identified that there are barriers to moving toward independent contact arrangements that may be addressed by engaging in such a course.* (Service 54, NSW)

Insights about non-supervision services from the Survey of Professionals

Key findings from the Survey of Professionals in relation to non-supervision services are outlined in this section (Table A8, Appendix F). Strong majorities of participating CCS professionals reported that CCSs provide the following services, and they were more likely to do so than referring professionals to a statistically significant extent:

- **case support:** 79%; cf. referring professionals: 7%, with 49% of referring professionals indicating that they did not know or could not say whether this service was provided
- **case management:** 68%; cf. referring professionals: 7%, with 49% of referring professionals indicating that they did not know or could not say whether this service was provided
- **case planning**: 69%; cf. referring professionals: 6%, with 50% of referring professionals indicating that they did not know or could not say whether this service was provided
- **written reports:** 76%; cf. referring professionals: 43%, with 16% of referring professionals indicating that they did not know or could not say whether this service was provided
- **non-supervision services for children:** 20%, with 35% indicating that no services provide this service; cf. referring professionals at 5% reporting that all services provide this service, with more than half (51%) of referring professionals indicating that they did not know or could not say whether this service was provided.

The data also show that participating CCS professionals also reported that all CCSs provide the following services, and they were more likely to do so than referring professionals to a statistically significant extent (Table A9, Appendix F):

- **information, advice or referrals to education, skills and training programs**: 76%; cf. referring professionals at 15%, with more than one-third (39%) of referring professionals indicating that they did not know or could not say whether this service was provided
- **education, skills and training programs**: 53%; cf. referring professionals at 13%, with more than one-third (37%) of referring professionals indicating that they did not know or could not say whether this service was provided
- **counselling and other therapeutic support**: 40%; cf. referring professionals at 9%, with more than one-third (40%) of referring professionals indicating that they did not know or could not say whether this service was provided
- **advocacy support**:[16] 75%; cf. referring professionals at 4%, with more than half (55%) of referring professionals indicating that they did not know or could not say whether this service was provided.

16 Advocacy support is defined in the DSS DEX. (2023) Program Specific Guidance – Attorney-General's Department as 'Advocating on a client's behalf or supporting a client in a particular circumstance' (p.16): retrieved from 2166-program-specific-guidance.pdf (dss.gov.au) 1 August 2023.

Data relating to the types of referrals CCSs made shows that participating CCS professionals were more likely to report all CCSs make the following referrals than referring professionals, and they did so to a statistically significant extent (Table A10, Appendix F):

- **referrals to DFV services**: 81%; cf. referring professionals at 19%, with 41% of referring professionals indicating that they did not know or could not say whether these services were provided
- **referrals for financial advice or assistance**: 65%; cf. referring professionals at 8%, with nearly two-thirds (63%) of referring professionals indicating that they did not know or could not say whether this service was provided
- **referrals for assistance with housing**: 62%; cf. referring professionals at 7%, with nearly two-thirds (63%) of referring professionals indicating that they did not know or could not say whether this service was provided
- **referrals for legal advice/representation in relation to family violence**: 59%; cf. referring professionals at 9%, with nearly two-thirds (61%) of referring professionals indicating that they did not know or could not say whether this service was provided
- **referrals for legal advice/representation in relation to family law matters**: 56% cf. referring professionals at 9%, with more than half (59%) of referring professionals indicating that they did not know or could not say whether this service was provided
- **referrals for legal advice/representation in relation to child protection**: 53%; cf. referring professionals at 9%, with nearly two-thirds (60%) of referring professionals indicating that they did not know or could not say whether this service was provided.

This variation in response patterns between CCS professionals and referring professionals in these data may reflect referring professionals' own direct engagement with CCSs or be based on the feedback that they receive from their clients engaging with CCSs. The equivocal responses suggest that the variations may also in part reflect limitations in their knowledge of the non-supervision services provided by CCSs. Gaps in referring professionals' knowledge may reflect more limited direct and current engagement with services, but it may also be due to limited or absent available and up-to-date information about the range of services provided by CCSs. This may suggest a need for improved dissemination of information about CCS service provision.

The qualitative open-text responses captured in the Survey of Professionals also present the views of participating professionals regarding *why* nominated CCS supervision and non-supervision services were not provided by the CCSs in their area. Of the 69 open-text responses provided, 19 reported that the reason the nominated supervision and non-supervision services were not provided by the CCS in their area related to funding or resource constraints. Some participants also reported that this was because the broader range of services were provided as part of the service provider organisation rather than the CCS specifically (*n* = 11/69). Some participating professionals reported that these broader range of services were provided by external service providers upon referral from the CCS (*n* = 7/69) or that the CCS only provides supervision services (*n* = 14/69).

Insights from parents and carers about the CCS services that they received

Parents and carers participating in the interviews were asked what services they receive at the centre or from the centre staff other than supervised parenting time or changeover. This included prompting parents and carers with a list of non-supervision services and referrals, consistent with the same types of services asked about in the Survey of Professionals and RFI.

It was uncommon for parents and carers to report having received or been aware of receiving non-supervision services and referrals. Most parents and carers stated they had not received any non-supervision services and many were unsure of what else the CCS provided other than supervised time and changeover (n = 35). The following quote exemplifies their responses when asked about non-supervision services:

> *Not that I'm aware of. We haven't received any. I know they do take case notes, but I, yeah, I'm not sure if that's only if there's an issue. I know they record if a visit's not been made or if one of us turns up late. That kind of things recorded. In terms of training you mean for the parent? No, not that. Well, not that I've been made aware of, no.* (LWP 17)

Only 15 parents and carers reported that they received any non-supervision services although 17 indicated that they received a written report (*n* = 17/50), with reports primarily being for court purposes (e.g. subpoena) (*n* = 11/17 who received a written report). The other types of non-supervision services identified were:

- parent education, skills and training programs, non-supervision services for children (*n* = 5/50)
- case management (including communication between parties, changing dates/times) (*n* = 3/50)
- adult counselling provided by the CCS staff (*n* = 3)
- community-based/offsite supervision (*n* = 2)
- supported/monitored visits (on site visit low vigilance); counselling for children provided by CCS staff (not external referral); culturally appropriate services (any); translation services for languages other than English; and safety planning (*n* = 1/50 each).

It is notable that when interview participants were asked about the range of services that they received from the CCS, only one interview participant reported receiving culturally appropriate services and translation services (STWP 22), despite 24% of interview participants being born overseas and 12% being Australian born with one or both parents born overseas.

Where counselling was provided by CCS, this was described in positive terms by parents and carers. For example:

> *The only other involvement was at the end of every session I would have like just a little counselling, little talk with one of the women that was working there about how it went which generally was pretty quick because there were no issues. They went pretty well.* (STWP 27)

Safety planning was a particular area of service provision that some parent and carers described not receiving or being aware of receiving. This finding is illustrated in the next quote from a live with parent receiving supervised time services and who has multiple safety concerns for both themselves and children in relation to the other parent:

> *No, I don't recall any safety planning or any. In that space, they normally speak to me, once a year to enquire how everything's going and for feedback, but that's about it. Yep.* (LWP 38)

In contrast, a more detailed approach to safety planning was described in this example from a Lives with Parent who also was receiving supervised time services and has multiple safety concerns for both themselves and children in relation to the other parent:

> *Normally my dad takes us because I don't drive and last week, actually he couldn't. We went on public transport and I was a bit anxious in case because I know he's [the STWP] on public transport. It was like the centre read my mind and they said look, we'll wait till you get on [the public transport] and then we'll let him go. And I thought that was really respectful. And I felt like I didn't have to say anything because I was embarrassed. But it was terrific.* (LWP 37)

Referrals from CCSs to external services was another aspect of non-supervision services that parents and carers rarely experienced, with 70% of interview participants confirming they had not received referrals to other services (*n* = 35 cf. *n* = 14 did receive referrals, *n* = 1 not sure/don't know). Where CCSs referred parents or carers to external services, these involved Psychological/counselling service/ mental health for parent/carers or children, parenting programs/education, family violence services and referral to another CCS.

Some parents and carers were not concerned about the lack of referrals but were aware that their CCS offered other services or could make a referral if they needed further support. Similarly, some parents felt they were resourceful about finding additional services themselves. For example:

> *It's primarily that [changeover and supervised time], though they have been of late offering training seminars in things like Circle of Security and things like that… So they are sort of providing additional support for parents who want it.* (STWP 41)

However, there were some parents and carers who said they would have appreciated more support from their CCS to access referrals to other services.

> *No, no. I have often thought it would be a really good place to – to offer that. But no, they haven't been suggested.* (LWP 36)

> *Interviewer: Did they refer you to another service outside the contact centre to help?*
> *Interviewee: No, no. I ended up finding my own independent one.*
> *Interviewer: OK, so you have been able to get that sort of assistance for your son?*
> *Interviewee: He's yeah. Yeah. I've got the assistance.* (LWP 8)

Concerns about safety emerged as a theme for some Lives with parents who would have preferred to access referrals made to counselling to support themselves and/or children, but indicated that doing so might activate the other parent where there was ongoing DFV or create a risk of the other parent accessing their counselling notes:

> *There was another one that was mentioned a few weeks ago. Another type of counselling. I can't remember what they called it, but when I looked into it, it's counselling for not just a child but for both parents and both parents I was told would be involved; and because we come from DV and I've still got and IVO on the father, I was very hesitant to share any information if they were going to share it back to him, it would just put us in an awkward position and the child safety. So I didn't take them up on that.* (LWP 43)

This parent/carer explained how they felt the CCS did not appreciate the safety risks of engaging in counselling when making referrals for these types of services:

> *I was encouraged to do the family therapy...with the other parent and unfortunately, I didn't feel safe enough to do so because of the - so its coercive control ... So I didn't feel safe enough to engage in it because there was an incident that happened ... And then, but even after the incident happened, and after I declined, I was again pushed to do the family therapy by the centre coordinator.* (LWP 5)

Poor communication from their CCS about the cost of services they had been referred to was raised by the following Spends time with parent who was also encouraged to undertake counselling:

> *From the same organisation, yes, I received some post separation ... counselling ... I don't know why I was offered that. I didn't request it. It may be part of the service itself. I was a little shocked when I was sent a bill, I personally, I thought it was part of getting ready to use their service.* (STWP 11)

Overall, the feedback from parents and carers interviewed showed it was uncommon to have received services other than supervised time and changeovers within the CCS. It was also uncommon for parents and carers to indicate that they had received referrals to services external to CCSs. Parents and carers described mixed experiences, with some not concerned about receiving other services or referrals, while others did want further support or were not able to access the support they needed for a range of reasons, including safety risks.

Views on the supervision and non-supervision services CCSs *should* provide

The discussion in this section considers quantitative and qualitative data from the Survey of Professionals and interviews with parents and carers showing the types of supervision and non-supervision services that professionals and parents and carers considered CCSs should provide. Overall, the responses indicate that CCSs are providing the types of services that the professionals consider they should be providing.

Following an overview of the data regarding the range of services that participants indicated CCSs should provide, specific consideration is given to the findings from both quantitative and qualitative data in relation to professionals' views about CCSs providing written reports of families' interactions with the CCS and about the changeover and/or supervised visits sessions. Data from the Interviews with parents and carers are also considered in relation to their views of both the supervision and non-supervision services that CCSs should provide.

Views of professionals: services that should be provided

Professionals participating in the survey were asked for their views on the types of services that should be provided by CCSs (Table A11, Appendix F). These data show that there is almost universal endorsement by CCS professionals and referring professionals for the provision of supervision services commonly identified as core CCS services, namely supervised changeover (98%) and supervised visits (98%).

The data also show that there was support for non-supervision services and alternative supervision services:

- written reports of families' interactions with the CCS and the changeover and/or supervised visits sessions: 89%
- supported or monitored low vigilance on site visits: 86%
- online or virtual supervision: 79%

- community-based, offsite supervision: 71%
- case support: 71%
- case management: 66%
- case planning: 66%
- unsupervised on-site visits: 44%.

Of note, the data show that CCS professionals were more likely to report that community-based offsite supervision, case management, case support and case planning should be provided compared to referring professionals, with these differences being statistically significant.

The data also show that almost all CCS professionals and referring professionals indicated that other non-supervision services that should be provided by CCSs were:

- information, advice or referrals to education, skills and training programs: 89%
- referrals to DFV services: 88%
- education, skills and training program: 81%
- referrals for financial advice or assistance: 77%
- referrals for assistance with housing: 76%
- referrals for legal advice/representation in relation to family violence: 76%
- referrals for legal advice/representation in relation to family law matters: 75%
- referrals for legal advice/representation in relation to child protection: 75%
- counselling and other therapeutic support: 65%
- advocacy support: 64%
- non-supervision services for children: 45%.

Also of note, the data show that CCS professionals were more likely to report that information, advice or referrals to education, skills and training programs, education, skills and training programs, referrals for financial advice or assistance or with housing, counselling and other therapeutic support and advocacy support should be provided by CCSs, compared to referring professionals, with these differences being statistically significant.

Views of parents and carers: services that should be provided

Qualitative interviews with parents and carers revealed a range of services that parents and carers suggested CCSs provide for them and their children. In addition to the services implementing supervised changeover and supervised visits for parenting time, parents and carers most frequently indicated that they sought information about parenting. In particular, they nominated information about how to support children who were experiencing issues such as anxiety. Parents and carers indicated that this could be provided in variety of formats, including classes that are available and brochure and pamphlets on such topics around parenting and child wellbeing:

> *So they tried to find me some sort of course of something, but as I said, there's nothing really around for that age group and they've given me some websites to have a look at to get some information, but it's all sort of for six years old...and up sort of thing. There's sort of nothing really to go to and they're sort of giving me tips you know how to like when she gets anxious...how to do things to distract her. (LWP 16)*

> *If you provide [the parent] with some kind of strategies or guidance of language we can use to support the children, that could be helpful, or it can be some handout.* (LWP 49)

Parents and carers using the CCS for supervised visits and changeovers also identified the need for counselling for themselves and for their children as a service that is important to provide. A number of these same parents reported that they were accessing counselling separately from the CCS and their children were also accessing counselling separately from the CCS. This highlights the importance of CCS staff referring parents and children to counselling services:

> *[I]f they centralised like counselling, family counselling and made it more, put supervised contact and kind of put it all under the one sort of umbrella, then it might be more helpful.* (STWP 35)

> *They have given me that support, one-on-one counselling ... and I think it would probably be a good idea for every parent that goes in there because it is every parent going through something pretty crap, right? If you're having a supervised visit.* (LWP 26)

Of importance to parents and carers using the CCS for supervised visits with their child/children was the ability to conduct supervised visits offsite. This was identified by parents and carers as particularly important for older children who were finding the service environment to be boring, and for visiting parents who wanted to be able to normalise the environment to better reflect what families would normally do together:

> *[T]raining programs that could support you to progress, support for the children, and being able to go offsite and do things that are, you know, the sort of average things that families would [do]. [M]aybe greater flexibility through [what] we can do in a session like if they were there longer and we could, I don't know, watch something on television together or play a game together … You know what we're allowed to do in that time is pretty, pretty restricted in that sense … Like a lot of the things extra I would like to do, I think would just go beyond the service itself.* (STWP 21)

Parents and carers also spoke of the CCSs as doing what the service was designed to do and there was nothing else the parent or carer needed by way of service provision:

> *I think they provide the service they are required to and they provided [it] very, you know nicely and professionally.* (LWP 12)

Non-supervision services in focus: the provision of written reports by CCSs

In this section, quantitative and qualitative open-text responses from the RFI are examined to gain specific insight into the provision of CCS written reports. Reports prepared by CCSs provide 'a written, objective account of a family's time at a service compiled from the file notes recorded by CCS staff at the time of each service session' (AGD, 2018, p 7). These reports may be requested by parents/carers or their legal representatives or Independent Children's Lawyers or other appointed court experts in family law proceedings and include information from file notes of observations taken at changeovers and supervised visits and file notes from other means of engaging with family members, including phone calls, correspondence and emails (AGD, 2018). The aim of these reports is to inform decision-making in relation to parenting arrangements or orders. Data from the Survey of Professionals regarding the quality of these reports having regard to the guidance provided by 1.1.5 of the *Guiding Principles Framework for Good Practice* (AGD, 2018) will be presented in chapter 3).

As indicated in the discussion below and in chapter 3, CCSs may also produce this information by provision of copies of the original source documents from which the information presented in the CCS reports is drawn pursuant to a subpoena. As the discussion of the data shows, some CCSs have elected to require a subpoena seeking the provision of documents, particularly with the advent of technological advancements to support the collation and copying of these materials, rather than allocating resources (including training in report writing) to prepare a report on which they may be cross-examined.

The RFI data captured the number of clients for whom a written report had been prepared in relation to their family's receipt of supervision services for family law court proceedings (data not shown). These data indicate that:

- over the reporting period, the highest number of clients with reports was in 2022 (n = 8,078)
- there was a modest reduction in the number of clients with reports prepared during the COVID period (2020: n = 6,926 and 2021: n = 7,777) compared to the pre-COVID period (n = 7,844) (data not shown).

To provide further context, as outlined in Table 3, the total number of clients as reported by CCS over those same years (2019: n = 12,168, 2020: n = 9,893, 2021: n = 10,324 and 2022: n = 11,365), indicate that the number of written reports as a proportion of total clients varied between 65%–75% between 2019 and 2022.[17]

As noted in the explanatory notes for Table 3, these numbers and corresponding proportions could also include clients who were recruited to the CCS prior to 2019 (the period from which data were collected) and received written reports within the data collection time frame (namely post 2019).

Data from the RFI also showed that more than half of the participating CCSs (n = 30/54) provided information indicating the number of written reports provided by their CCS in the period 2019–2022.[18] Data from the Survey

17 Data were not collected to indicate if multiple reports were written for one family.

18 As all RFI questions were voluntary, this does not mean than n = 24 CCS did not provide written reports, it is possible that some of these services did provide written reports but were not able to extract the number of such reports from their systems. However, this finding does give a sense of how commonly written reports are provided by CCS organisations.

of Parents and Carers (presented at Figure 4) show that 9% of participants indicated that they received a CCS report.

Qualitative data in relation to the provision of written reports provided by CCSs for family law court proceedings were also collected in the RFI process and Survey of Professionals. These data provide further insight into the information sharing and, specifically, report writing protocols in place at CCSs and their implementation. The data allow an examination of why some CCSs provide written reports, while other services facilitate access to their case notes via the subpoena process during the parties' family law proceedings as noted at the outset of this section. Examples of these two varying approaches are described below.

In relation to the provision of written reports of observations of the child with the parents/carers, relevant RFI responses indicated that these reports were based on case notes made by CCS supervisors completed in relation to the supervised changeover or supervised parenting time sessions, and that they were reviewed by management. For example: '

> *In 2022 staff engaged in training for case-noting. Court reports are compiled by trained staff (sessional support workers) and then all reports are audited by the program manager.* (Service 70, SA)

Responses from the Survey of Professionals also provided insight into the nature of CCS reports:

> *The reports are observational only, I think this is very important as we only see a snapshot of the time between the parent and child and therefore do not make assessments or recommendations.* (CCS staff, NSW, 55+ years)

> *Reports need to be factual, objective observations.* (CCS staff, NSW, undisclosed)

There was one RFI response that described the provision of recommendations as part of the report writing process:

> *Stronger focus on child's wellbeing. Report writing has taken a more professional approach, with shorter, clearer content. Professional opinion is provided and recommendations are clearly stated with a strong focus on the best interests of the child.* (Service 237, Vic)

Other RFI responses described the approach taken to facilitating subpoenas and the type of 'factual and observational case notes' provided by CCSs pursuant to the subpoena process, as well as the information sharing processes in place with other service providers and government agencies in accordance with information sharing guidelines:

> *[The CCS] do not complete reports or assessments for the purpose of any legal action. Supervisors take factual and observable case notes, including records relating to punctuality, telephone conversations, emails, text messages, correspondence, any significant or critical incidents, and interactions between children. Any contact between parties when attending [CCS] will be documented. Any criminal act witnessed by staff will be documented and reported to the appropriate authority. File notes are confidential and can only be accessed through a subpoena from the court. There is a fee payable by the party instigating the subpoena. File notes are provided to the Independent Children's Lawyer, noting they act only in the best interest of the child and generally maintain communication with CCS when making recommendations.* (Service, state/territory redacted)

> *We record detailed case notes of all conversations, emails and appointments (including intake assessment, orientations, case management sessions and contact sessions), but these are confidential and not shared with either parent or any external party unless by subpoena (or under mandatory reporting requirements). We encourage ICL/ parents to subpoena these records for their FCFCOA proceedings. However, we will share information verbally with other relevant service providers (with parents' consent, or under statutory child safety information-sharing guidelines), as part of our integrated case management model — i.e. sharing information to support the child's readiness to commence contact, to increase accountability for parents (e.g. share information about common goals with a parent's counsellor), and to support the child's wellbeing (e.g. share info with the child's therapist).* (Service 54, NSW)

This CCS response also observed the child-inclusive aspects of the provision of subpoenaed CCS file notes as they included 'mid service check-ins' that may reference concerns in relation to children during the sessions at the service:

> *Mid-service 'child check-ins' are used where indicated, e.g., due to ongoing concerns about child behaviour during visits, or to provide an appropriate explanation to children when contact is unexpectedly stopped.*

> *This may also help bring children's voices into the court process more openly, as the child check-ins are included in any subpoenas received.* (Service 54, NSW)

Open-text responses from the RFI and from the Survey of Professionals also highlighted the benefits and challenges and associated with report writing and other information sharing arrangements through the subpoena process. For example:

> *We no longer provide reports for clients. Our files are available for subpoena under the Family Law Act excluding items protected under Section 60I.The decision to remove reports related to the time involved, risk of judgement and capture of irrelevant information, [the] update to our observation note format and perceived disadvantage to one or more parties based on cost…* (Service 158, state/territory redacted)

> *Prior to enhanced funding, subpoenaed family file notes were arduous as the staff had to physically blot out the identifying information, usually with pieces of paper on a printout. Since receiving enhanced funding, we have been able to afford IT support and convert all files to electronic filing and afford software that can assist in the process of completing subpoenas.* (Service 55, Qld)

> *We do not provide reports. We provide comprehensive, neutral observation notes via subpoena. Reports are extremely time consuming, and it may be that it becomes unstainable to provide them in the future.* (CCS staff, WA, 45–54 years)

In addition to information-sharing in the context of legal proceedings and with child safety departments, data from the RFI and from interviews with parents and carers indicated that clients of CCSs could also request access to information from their file. For example:

> *Clients are also able to request access to their information as per our privacy and record keeping policies.* (Service 233, state/territory redacted)

Written reports were also mentioned as very important by parents and carers who were interviewed, although it seemed that 'written reports' was used by some to refer to notes kept by the CCS and by others to mean written reports prepared for the court. For parents and carers not subject to supervision (usually mothers), it was identified as reassuring for them to know that the CCS kept a record of what had happened during visits. For parents and carers whose time with their children was being supervised, reports could provide reassurance for the other parent and, for those engaged in parenting litigation reports could provide important evidence to relevant to the making of parenting arrangements in their case. For example:

> *[Receiving the CCS's written reports] is the most amazing thing. '"It's not that you want to know everything, but … to know that … everything is good, safe and you know, then [I am] happy … to progress to the next step because I don't believe that I should keep my child away from the parent because it's not healthy for my child to grow up without a father, but also at the same time, this service makes me feel like I can slowly progress … because they don't just write what they do inside, [but also] what I have say to after the session they've written that as well, so the other parent can see the report as well. So it's kind of like we're getting to know each other again, but without the conflict … So it's a really good service.* (LWP 6)

> *[H]is mother was apprehensive about contact, so I think it just helped give her a bit of confiden[ce] knowing there were other people around and getting that report back so she would know that everything was going fine made it a lot easier going forward.* (STWP 27)

> *[The written report for court] painted a picture that showed … that I was consistent about the way I parent … any disciplinary issues that came up, that I handled them appropriately. That I was a caring and attentive parent … It built a narrative … Whereas I think that the other party, and unfortunately in the family court, because children are often involved, the other party can just make stuff up and the court has to take it somewhat seriously.* (STWP 11)

Provision of time-limited services, process for review and transition to self-management

The discussion in this section presents quantitative and qualitive data from the RFI process and the Survey of Professionals regarding the approach CCSs take to the provision of time-limited services and transitioning and/or facilitating families to self-manage parenting time arrangements.

Discussion of this topic will be extended in chapter 3 to provide insight into professionals' views of the process and the level of success in CCSs' facilitation of families to move to self-management, together with participating professionals' views as to whether it is the role of CCSs to support families to move on to self-managed arrangements.

Provision of time-limited services

The RFI data presented in Table 4 indicates that most of the participating CCSs applied time limitations to the provision of their services. This is consistent with section 1.2 of the *Guiding Principles Framework for Good Practice* (AGD, 2018), which provides a key goal of CCSs as being to 'assist separated families to move, where possible and it is considered safe to do so, to self-management of contact arrangements' (p. 3) (See further chapter 3).

Supervised changeover and supervised visits for parenting time sessions are more likely to be reported as not being subject to time limitations by CCSs in inner regional areas (55% and 45% respectively) compared to major cities (42% and 19% respectively) and CCSs based in outer regional areas (38% for both changeover and contact). Independent CCSs are also more likely to report that supervised changeover sessions are not time-limited (57% and 36% respectively).

Nearly one-quarter of services (24%) reported access to online/virtual supervision of contact was not time-limited, with the response pattern for CCSs by region and by service provider organisation type, consistent with the pattern identified for changeover and onsite supervision of contact.

Statistically significant differences in relation to onsite supported and monitored visits were identified, with both outer regional and independent CCSs more likely to report the provision of these services without time restrictions. Small proportions of services reported that they provided community-based offsite supervision or unsupervised onsite sessions without time restrictions.

Table 4: Request for Information: proportion of CCSs indicating types of services provided without time restrictions by CCS region and organisation type

	Region		CCS rganization type		Total		
	Major cities (%)	Inner region (%)	Outer/ remote region (%)	Independent (%)	Medium / larger organisation (%)	*N*	%
Supervised/facilitated changeover (onsite)	42.3	55.0	37.5	57.1	42.5	25	46.3
Supervised visit (onsite supervised parenting time)	19.2	45.0	37.5	35.7	30.0	17	31.5
Online/virtual (telephone/internet based	19.2	30.0	25.0	35.7	20.0	13	24.1
Supported monitored visits (onsite visits with one or more families who have been assessed as requiring low vigilance supervision)	0.0	20.0	25.0 *	28.6 **	5.0	6	11.1
Community-based/ offsite supervision service	7.7	5.0	12.5	14.3	5	4	7.4
Unsupervised onsite visit	0.0	5.0	12.5	7.1	2.5	2	3.7
Total *N* CCS	26	20	8	14	40	54	

Notes: *$p < .05$; **$p < .01$; ***$p < .001$ statistically significant difference based on chi-square test.

Table 5 presents the average time limitation for services provided with time restrictions. The data show that the mean time period for the provision of time-limited supervised changeover was 13 months and 8 months for supervised contact sessions and supported and monitored onsite visits. The data indicate a 6–7 month time limit

for unsupervised onsite visits and online/virtual visits respectively and 5 months for community based/offsite supervision.

Table 5: Request for Information: average number of months for time-limited types of services

Type of time-limited service	Average number of months		
	Mean	Median	Total *N* CCS
Supervised/facilitated changeover (onsite)	12.7	12	23
Supervised visit (onsite supervised parenting time)	7.8	6	31
Online/virtual (telephone/internet based)	7.1	6	15
Supported monitored visits (onsite visits with one or more families who have been assessed as requiring low vigilance supervision)	7.8	6	17
Unsupervised onsite visit	6.0	6	1
Community-based/offsite supervision service	4.5	3	6

Transition to self-management

The data from most CCSs participating in the RFI presented in Table 6 indicate a relatively steady pattern of clients transitioning to self-management, with the highest number of clients moving to self-managed arrangements in 2022 (*n* = 2,299), and not insignificant proportions of clients returning to the service after transitioning to self-management. As a proportion of total number of clients, as reported by the CCSs, between 18% and 22% of clients transitioned to self-management between 2019 and 2022. As noted in the explanatory notes for Table 6, these numbers and corresponding proportions could also include clients who were recruited to the CCS prior to 2019 (the period from which data were collected) and transitioned to self-management within the data collection time frame (namely post 2019).

Data from a substantial proportion of the participating services showed increases in the numbers of clients for whom services were stopped for reasons of child safety or wellbeing (2019: *n* = 81 and 2022: *n* = 128) on the basis of child refusal (2019: *n* = 167; 2022: *n* = 204) or for other reasons: (2019: *n* = 145; 2022: *n* = 250). These data may reflect an increase in the complexity of risk factors for clients or improvements in the identification of these risk factors.

Table 6: Request for Information: self-management and the number of clients per type of service sessions (including cancelled sessions) per year

Type of service provided	2019	2020	2021	2022
Have transitioned to self-management	2,171	2,160	2,262	2,299
Total *N* CCS	28	28	28	28
Have returned to the service after transitioning to self-management	152	136	141	186
Total *N* CCS	22	22	22	22
Have had supervision service provision stopped for safety/wellbeing of the child	81	67	121	128
Total *N* CCS	26	26	26	26
Have had service provision stopped due to child refusal	167	150	180	204
Total *N* CCS	33	33	33	33
Have had supervision service stopped for other reasons	145	262	195	250
Total *N* CCS	24	24	24	24
Total number of clients (as reported by CCS)	12,168	9,893	10,324	11,365
Total *N* CCS	40	40	40	40

Notes: Analysis based on CCSs that provided number of clients in each category for all 4 years. For some sites, the data in each category are represented in differing formats, sometimes available as number of clients sometimes as number of families and this should be noted when interpreting these data. The RFI collected information on the number of clients that services were provided for a range of activities in 2019 through to 2022. As a CCS could also be providing these services to clients who were recruited to the service prior to 2019, this explains why some categories have more clients receiving services in each year than the number of clients applied/assessed/accepted for intake.

Review of service provision

Insight in relation to the review of service provision and families moving to self-management is available from CCS responses to the RFI. These data illustrate the range of strategies applied by CCSs to implement the review process. Regular/periodic review (commonly specified as being on a quarterly basis) was a feature of the relevant RFI responses:

> *Ideally, families are engaged with our CCS for approximately 6 to 12 months, where they are then safely moved to self-management. This 'short term' approach promotes better outcomes for children and improved throughput so that as many families as possible can safely access the service in a timely manner.* (Service 244, Qld)

> *A review of all cases will take place following the initial three months of service provision and is ongoing.* (Service 235, state/territory redacted)

RFI responses indicated a program of informal as well as formal reviews was also evident in the responses provided by some CCSs. The RFI responses indicated a range of approaches including:

- informal reviews after each session for parents and carers and children (e.g. Service 75, NSW)
- case plan reviews every 6 weeks or 6 visits unless required sooner (e.g. Service 212, NSW)
- client-informed reviews undertaken on an as needs basis, generally initiated by a change of circumstances, child-refusal, engagement with legal practitioners, updated court documents or a breach of service agreement. (e.g. Service 120, SA; Service 170, SA)
- formal reviews for parents and children (where age-appropriate) at or shortly prior to completion dates (e.g. Service 75, NSW; Service 156, Western Australia; Service 131, Vic)
- documented three monthly reviews with all clients regarding progress, supports, changes, court proceedings and referrals and check ins with children where developmentally appropriate (e.g. Service 247, NSW)
- parents and carers anonymous participation in surveys and exit interview/review upon conclusion of service provision (e.g. Service 75, NSW)
- post service review approximately 1 month after ceasing service. (e.g. Service 234, Vic).

As foreshadowed above, some CCSs described a family and child-focused nature of the review process was highlighted in the following RFI response, with a holistic approach supporting the family with engagement with relevant support services to address the family's underlying needs and which affect their potential to transition to self-management:

> *This is a family-focused and child-centred approach. CCS clients are reviewed after the first visit and then again within 3 months. This process is to support transition to unsupervised time as appropriate. Length of service and further reviews are dependent on individual situations and court outcomes. This process considers a holistic approach including other services involved in families' care, e.g., ICL, Lawyers, Health professionals, Orange Door. Case consultations with supervising practitioners. The team considers the capacity to transition, risk [as well as goals and circumstances to inform our practice. Working with other Family Law programs referrals to FDR, PSCP/POP parenting and counselling options are offered to support progression as appropriate. Length of service is on average 6–8 fortnightly visits but is dependent on the individual family's progress, court outcomes and best interest of child/ren.* (Service 207, Vic)

Some CCSs described transition planning as a feature throughout a family's engagement with the CCS when reflecting on the review process. Measures ranged from weekly case conferencing by senior CCS staff of the families they are servicing through to scheduled transition planning by family support workers and team leaders. For example:

> *Family support workers are required to complete a transition plan for each client. This plan should identify any court ordered requirements and other requirements to support the family progress (if appropriate). The Family Support worker will meet with the T[eam] L[eader] on a regular basis to review the case to ensure there is progression and if not how to best support the family. We also review a case if there has been a complaint or an incident. [There is a] team meeting on a weekly basis to discuss weekend visits and determine whether there is any action required.* (Service 79, Vic)

> *Each party is scheduled a service review to assess how the visits/service has worked. Review goals and to determine next steps, e.g. transition, continuation etc.* (Service 233, state/territory redacted)

Some CCSs described a process of reviewing a family's goals, with some CCSs describing how they engaged with clients to set short-term and long-term goals as an integral part of this review process. For example:

> *Parents are invited to participate in a 'collaborative goal setting' meeting soon after commencement of service, and agreed goals (relating to their use of the service) are reviewed in further meetings as needed. These sessions are informed by the observational contact reports (and mid-service 'child check-ins', if conducted) and used to assist parents to identify how they can address barriers to self-managed contact arrangements (i.e. address the issues which led to a court order for supervised time / changeovers in the first place). The agreed steps to achieve the goal/s may include provision of information, psychoeducation, referral to complementary services.* (Service 54, NSW)

> *Specialist Practitioners work together with parents to identify up to 3 goals which may help towards more positive and meaningful relationships with child/ren. During the Intake session, a shortlist of goals are created. At the 4th and 8th Contact visit, the Practitioner will check-in with parents and review how visits are progressing. We hope that by exploring each parent's goals they will have the opportunity to identify the skills they would like to work on. This will assist to build stronger, positive relationships with their child/ren.* (Service 152, Vic)

Professionals participating in the Survey of Professionals were also asked for their views on the review processes CCSs. The data in Table 7 show that most CCS professionals indicated that they understood that CCSs conducted periodic reviews of families in receipt of their services (70%). However, most referring professionals did not submit answers to this question, and this is likely to reflect a lack of knowledge of CCS review processes. Limited insight was also available from the data from parents and carers which suggests a similar lack of knowledge about review processes may apply to the clients of CCSs.

Table 7: Survey of Professionals: review processes in government-funded CCSs by professional type

What is the process for review for families referred to or ordered to attend government-funded CCSs 'in your organisation' or 'in your area':	CCS professionals		Referring professionals		Total	
	N	%	*N*	%	*N*	%
The government-funded Children's Contact Service conducts a periodic review of families in receipt of services* **						
Selected	83	69.7	16	10.7	99	36.9
The government-funded Children's Contact Service applies a time limit on the receipt of supervision services* **						
Selected	47	39.5	29	19.5	76	28.4
There is no time limit on the receipt of supervision services from the government-funded Children's Contact Service*						
Selected	10	8.4	4	2.7	14	5.2
There is no periodic review of families in receipt of services at the government-funded Children's Contact Service						
Selected	4	3.4	4	2.7	8	3.0
Do not know/Cannot say* **						
Selected	15	12.6	79	53.0	94	35.1

Notes: This table reports the number and proportion of CCS that selected each response option from a list of possible review processes. Not shown is the number and proportion where each response was not selected (including potentially missing responses).CSS professionals asked to rate CCS characteristics for 'my organisation' and referring professionals asked 'in my area'. *$p < .05$; ***$p < .001$ statistically significant based on chi-square test. Percentages of 'selected' responses may not total 100.0% due to multiple responses and rounding.

Summary

This chapter examined quantitative and qualitative data from the RFI process together with data from the survey elements of the study and interviews with parents and carers to examine the nature and scope of supervision services (core services) and non-supervision services (secondary services) provided by CCSs. These data were considered against the historical background and policy context for the development of CCSs in Australia drawn from the desktop review. The findings presented are relevant to Research Questions 1, 2 and 3.

Key findings relevant to Research Question 1 (the nature and extent of services provided by CCSs)

A feature of the findings reported in this chapter are that CCSs report applying rigorous processes and approaches in a range of areas, including in the areas of safety planning and child-focus/inclusion. Although the data from parents/carers who use the services often confirms this, there are also more mixed and less positive experiences reported by parents and carers. These patterns indicate a need for careful attention to be paid to the consistency and quality of service provision in the context of a focus on how parents, carers and children are experiencing the services. A further noteworthy feature of the analysis is that patterns in responses of referring professionals in the Survey of Professionals indicate limited awareness of some core aspects of CCS service provision, suggesting that a focus on improving understanding and engagement between CCS service providers and referring professionals is warranted.

In terms of client numbers, overall, the RFI data indicate that CCS client numbers are starting to increase again (*n* = 11,365 in 2022) after a decline over the period of the COVID 19 pandemic, dropping from 12,168 in 2019 to 10,324 in 2021.

Of the two core kinds of services provided by CCS, supervised parenting time visits are more common than supervised changeover sessions. In 2022, client numbers (*n* = 7,882) for supervised visits increased markedly on 2020 and 2021 numbers (*n* = 6,806 and 6,552) but still did not return to pre-pandemic levels (2019: *n* =9,659).

Markedly fewer clients used supervised changeover sessions, and again 2022 levels (4,301) have not returned to pre-pandemic levels (2019: 4,857).

One aspect of CCS service provision that did increase, albeit off a low base (*n* = 92) during the COVID 19 pandemic was online/virtual supervision services, peaking at 709 in 2020 and remaining higher than pre-pandemic figures in 2022 (*n* = 259). Steady declines in numbers of clients reported to be in low vigilance supported/monitored onsite contact sessions are evident (*n* = 678 in 2022 cf**.** *n* = 1,213 in 2019). Only a minority (*n* = 9) of CCSs report providing unsupervised onsite visits or community based offsite supervision.

Supervised changeovers were generally provided over a longer period of time than supervised visits for parenting time (approximately 48 weeks for changeovers; cf. 36 weeks for supervised visits).

Detailed analysis of the intake, triage and risk assessment process for families applying to use CCSs through RFI and survey data indicated comprehensive intake and risk assessment processes across the participating CCSs, with a range of risk assessment tools and processes employed. Some CCSs also described how they undertake ongoing risk assessment for the duration of the service delivery. It is notable however that some professionals and some parents and carers in their interview and survey data raised safety concerns for both themselves and their children, with either concerns with, or a lack of knowledge of, CCS safety planning reported by some participating parents.

RFI data relating to orientation/familiarisation processes for families entering the service highlighted the child-focused and child-inclusive nature of this process for the majority of services. This involved CCSs supporting children to receive information about the CCS and the process, and to allow the child to explore the CCS setting, to support the CCS staff and child to facilitate the development of a relationship of trust and to understand the support that they will receive when at the service. It is notable, however, that very few parents and carers who were interviewed could recall orientation/familiarisation being offered to them or their children. The experiences of those parents and carers who recalled and described their family's orientation varied considerably. Some parents reported that they and their children were well supported while others reported mixed feelings or that they or their child were not well supported in the orientation/familiarisation process.

There was particularly limited indication of awareness among referring professionals of CCS non-supervision services, such as case management, case support, case planning and referral to education, skills and training programs. The gaps in referring professionals' knowledge of non-supervision services and referrals may reflect

more limited direct and current engagement with services, but it may also be due to an absence of, or limited available and up-to-date information, about the range of services provided by CCSs. It was also not common for parents to report receiving non-supervision services, including referrals. These findings suggest that at a minimum there is a need for improved dissemination of information about CCS service provision, but it may also require more effective, warm referral processes by CCSs to support families to access the non-supervision services that they need.

Key findings relevant to Research Question 3 (the provision of CCS reports)

The discussion in this section indicates that the provision of reports for family court proceedings is an important aspect of CCS operations. Numbers of these reports being provided reached a four-year high in 2022, at 8,078. There is some variation in the way CCS approach the provision of evidence to courts, with a minority preferring to receive a subpoena for case notes rather than developing a specific report.

Key findings in relation to Research Question 2 (facilitating self-management or sustained long term parenting arrangements)

CCSs apply a range of strategies to facilitate the transition to self-management indicated that adoption of time-limited service provision, case management (including period reviews) and referral to support services, with these evident in both the RFI and survey data. The RFI data indicate a steady pattern of clients transitioning to self-management with the peak occurring in 2022 (2,299) and fluctuations evident in preceding years (2019: *n* = 2,171; 2020: *n* = 2,160; 2021: *n* = 2,262). Self-management is not sustainable for around one fifth (18%–22%) of families, who return to the service after transitioning out.

3 Nature of CCS service models

Introduction

The discussion in this chapter focuses on quantitative and qualitative data from the RFI process, the Survey of Professionals and the Survey of Parents and Carers elements of the evaluation, supplemented by qualitive data from Interviews with parents/cares, to address Research Questions 4 and 5 respectively:

- Are CCSs operating in accordance with the Children's Contact Services Guiding Principles Framework for Good Practice including:
  - the role and obligations of CCSs
  - the objectives for CCSs
    - child-focus
    - safety
    - neutrality
    - client diversity and cultural sensitivity (see chapter 5)
    - collaborative service provision
  - the priorities for service delivery
  - the range of services provided
  - the service safety requirements (including safety and security plan requirements, safety policy, procedures and protocols relating to critical incidents, risk assessments)
  - record keeping, policies and procedures
  - the good practice principles for service delivery and resources?
- **Are the service models** provided **child-focused/child-centred and trauma-informed?** To what extent do the **services comply with the National Principles for Child Safe Organisations and the Commonwealth Child Safe Framework?**

Data relevant to research question 3 (regarding the quality of CCS reports) and regarding Research Question 2 (the goal of self-management) are also presented in this chapter.

To address these research questions, the discussion in this chapter first set out the guidance currently in place for CCS service provision, specifically considering:

- the Guiding Principles Framework for Good Practice
- the Family Law Services Children's Contact Services Grant Opportunity Guidelines and other related policy documents
- the National Principles for Child Safe Organisations.

Current reform activities will also be noted.

In accordance with the objective of this evaluation, and as noted in chapter 1, the subsequent sections in this chapter examine the extent to which CCSs are also operating in accordance with these guiding documents. Specifically, this first involves an examination of the CCS policy documents submitted as part of the RFI process by participating CCSs, considered against the principles in the guiding documents outlined in the preceding section in this chapter. The next part of the chapter involves an examination of the implementation of these CCS policies and procedures in practice**,** based on relevant data captured in the RFI process, Survey of Professionals and Survey of Parents and Carers. This discussion examines relevant staffing checks and standards implemented, the number of staff and staff ratios, together with training and professional development requirements, before moving to examine the physical site characteristics and specifications of CCSs. CCSs' RFI responses to critical incidents and approaches to stopping services are considered, before a final section that draws together these

and other data from the RFI process, the Survey of Professionals and the Survey of Parents and Carers to examine compliance with the CCS objectives as set out in the *Guiding Principles Framework for Good Practice*. Specifically, these objectives include child-focus, safety, neutrality, client diversity and cultural sensitivity and collaborative service provision and service provision in the best interests of children.

Again, the data in this chapter are presented having regard to a key aspect of the stated objective of this project – specifically to consider the operation of the government-funded CCSs in the context of the history of CCSs, and the current context in which government-funded CCSs are operating. It is also noted that a more specific examination of how service provision accommodates client diversity and cultural sensitivity will be presented in chapter 5. Some data relating to Research Question 2 (self-management) and Research Question 3 (CCS Reports) are also analysed in this chapter in the context of CCS compliance with the guiding documents including Guiding Principles Framework and National Principles.

Guidance for CCS service provision

The discussion in this section sets out the guidance that is currently in place for CCS practice and service provision in the *Guiding Principles Framework for Good Practice*. It also considers the Family Law Services Children's Contact Services Grant Opportunity Guidelines and other related policy documents to provide both current and historical context to the CCS guiding documents. As the Australian Children's Contact Services Association (ACCSA) Standards for Children's Contact Services are not mandatory, they will not be presented in this section against which the CCSs services will be assessed. An outline of the National Principles for Child Safe Organisations will also be presented. The final element in this section provides a brief discussion of the current reform activities as they relate to the guiding documents and requirements that are recommended be in place for CCS practice and service provision going forward.

Guiding Principles Framework for Good Practice

A key guiding policy document outlining government expectations in the way CCSs are to operate is the *Children's Contact Services Guiding Principles Framework for Good Practice* (the Guiding Principles Framework) produced by the AGD (2018).

The ACCSA drafted the first Children's Contact Service Guiding Principles Framework for Good Practice for the AGD in 2014. In 2018, the AGD released an updated version of the Guiding Principles Framework, largely mirroring the content that is in the ACCSA Standards with explicit guidance on the government expectations around service delivery.

The Guiding Principles Framework articulate the minimum operational requirements and practice principles for safe and consistent service provision applying to all CCSs funded by the Australian Government pursuant to the FRSP. The Guiding Principles Framework outline service delivery and resource requirements, including staff training and qualification requirements. Although not required, services operating outside of this funding arrangement are nevertheless encouraged to apply the Guiding Principles Framework (AGD, 2018).

Overview

The Guiding Principles Framework identifies 5 key objectives that provide that CCSs should (AGD, 2018, pp 4–5):

a. be **child focused**, with children's needs and welfare the primary practice consideration, including their rights to a safe childhood and environment
b. provide for the **safety** of children, families and staff
c. exercise **neutrality** in service provision while maintaining a child-focused approach on children's best interests
d. ensure **client diversity and cultural sensitivity** are accounted for and the needs of diverse groups are considered in designing and delivering services and
e. operate as part of a **collaborative service system**, including in relation to the family law system, other services, and the community.

The role and obligations of CCSs outlined in the Guiding Principles Framework emphasise the importance of applying child-centred interventions to assist children and parents to have safe, sustainable and workable long-term self-management arrangements (Guiding Principles Framework, 1.2, p 3). CCSs are identified as independent and not obliged to provide a service (Guiding Principles Framework, 1.3, p 5).

To support CCSs to respond to service demands, including where families are referred by order from the FCFCoA, the Guiding Principles Framework recommend:

- having a comprehensive intake, screening and assessment process to triage families and assess suitability for services (including capacity for self-management) (Guiding Principles Framework, 1.4, p 5)
- actively managing and assessing waiting times for new clients (Guiding Principles Framework, 1.4, p 5)
- applying the organisations' own communication policies and procedures given that there are no prescribed communication protocols (Guiding Principle 1.4, p 6) and
- providing publicly available information about the CCS to Family Relationships Online (Guiding Principles Framework, 1.4, p 6).

The Guiding Principles Framework states that the range of services to be provided may include facilitated changeover from one parent to another; supervised visits onsite, offsite or via telephone/internet for time a child spends with a parent they do not live with; support/monitored visits requiring low supervision; unsupervised onsite visits, provision of reports for court; and information and referrals to assist families (Guiding Principle 1.5, p 7).

The Guiding Principles Framework indicate that the child's needs and welfare are the primary consideration of CCS practice. Specifically in relation to families experiencing DFV, this includes CCSs operating as part of an integrated family law system that ensures 'children and families at risk of harm receive a timely and well-coordinated response from those who can keep them safe' (Guiding Principles Framework,1.2, p.5). The Guiding Principles Framework reiterate that the CCSs retain the ability to decide whether to provide services to families or to cease service to families indicating that the courts do not have the power to compel CCSs to provide services.

The Guiding Principles Framework indicate the minimum safety requirements and planning that must be undertaken in relation to all aspects of service provision. This includes guidance on practical operation including physical site, work practices and OHS operations, data and IT security, staff training and supervision, client behaviour and critical incident reporting. This includes that CCSs conduct and regularly review a Safety Risk Assessment to demonstrate an understanding of safety risks related to all relevant aspects of service delivery. This does not explicitly indicate that it is a review of safety in relation to family violence. An extensive list of potential critical incidents is included in the Guiding Principles Framework and though not exhaustive, acknowledges the types of risks to personal safety that families in conflict and staff that work with them may be exposed to. The Guiding Principles Framework also indicate specific practices that must be incorporated in relation to the use of interpreters, and stresses expectations and principles around confidentiality.

Service safety requirements

Service safety requirements are established in the Guiding Principles Framework (Guiding Principles Framework 2, p 9) to support the safety of all service users and staff, and include the establishment of a safety and security plan, and the implementation of a range of safety requirements:

- staff checks for employment that include police and working with children checks and compliance with professional codes (Guiding Principles Framework, 2.2, p 9)
- safety policies and procedures for staff are also outlined to ensure all staff can comply with safety policies and procedures (Guiding Principles Framework 2.3, p 10). These require staff to receive written policies on safety as well as:
  - training to comply with these policies and procedures
  - risk assessment and safety planning
  - processes for reporting and managing critical incidents with both internal and external reporting to DSS State and Territory Offices as required (Guiding Principles Framework 2.3, p 10)
  - child protection statutory requirements (Guiding Principles Framework, 2.3, p 10) and
  - supervision and debriefing for staff. CCSs should also have processes for reporting and managing critical incidents (Guiding Principles Framework, 2.4 and 2.5). There is a non-exhaustive list of defined critical incidents and clear procedures for responding to them and safety planning debriefing following a critical incident.

Record keeping policies and procedures

The Guiding Principles Framework also provide guidance at section 3 (p 13) for record keeping policies and procedures as part of the administration of CCSs, particularly given records may be required to be produced to a court if subpoenaed. Guiding Principles Framework Section 3 details a list of records to be maintained by a CCS in respect of the families accessing the service, legibility of records so the court can use them if subpoenaed, confidentiality of records, a clear document retention policy and staff training in proper record keeping.

Good practice principles for CCS service delivery

Providing information in family law proceedings has been formally recognised as a function of the CCS sector and is broadly set out in Guiding Principles Framework at section 4 at 1.5. This indicates that preparing reports for court is a legitimate service that is (or may) be provided at a CCS. The Guiding Principles Framework do not provide detailed guidance on what these reports should entail other than 'a written account of a family's time at a service compiled from the file notes recorded by CCS staff at the time of each service session' and indicating that emails and phone call notes may be included. Reports can be requested by either parent, their legal representative or a court expert.

Guidance for the delivery of services is comprehensively addressed in the Guiding Principles Framework and covers areas of operation for all types of services provided by a CCS, specifically:

- facilitated changeovers and supervised visits including how these should be conducted onsite, by telephone and internet (Guiding Principles Framework, Section 4, Principle 1.1)
- intake and assessment (Guiding Principles Framework, Section 4, Principle 1.1 -1)
- arrivals and departures (Guiding Principles Framework, Section 4, Principle1.1.2)
- child refusal (Guiding Principles Framework, Section 4, Principle 1.1.3)
- electronic devices (Guiding Principles Framework, Section 4, Principle 1.1.4)
- fees and report writing (Guiding Principles Framework, Section 4, Principle 1.1.5)
- referrals (Guiding Principles Framework, Section 4, Principle 1.1.6)
- requests to observe by report writers (Guiding Principles Framework, Section 4, Principle 1.1.7)
- security of client information and records (Guiding Principles Framework, Section 4, Principle 1.1.8)
- suspension, termination or refusal of services (Guiding Principles Framework, Section 4, Principle 1.1.9)
- confidentiality (Guiding Principles Framework, Section 4, Principle 1.1.11)
- conflict of interest (Guiding Principles Framework, Section 4, Principle 1.1.12)
- complaints (Guiding Principles Framework, Section 4, Principle 1.1.3)

Guidance in relation to staffing, qualifications and training (Guiding Principles Framework Section 4, 2.1), building specifications and location and site guidance (Guiding Principles Framework Section 4, 2.2 and 2.3) are also provided. These include principles relating to privacy and sound proofing, security and duress alarm systems, room design and equipment and outdoor play areas and accessibility of CCS site and parking.

A key goal of CCSs, as outlined in the Guiding Principles Framework, is also to move families towards self-management of their interactions in terms of changeover and unsupervised parenting time (AGD, 2018).

Family Law Services Children's Contact Services Grant Opportunity Guidelines and related policy documents

DSS (2014) Families and Children Activity Administrative Approval Requirements[19]

The Family and Children Activity Administrative Approval Requirements (Approval Requirements) is a document that outlines a set of quality service standards that service providers may be required to comply with as part of their funding agreement. The aim is to provide a quality framework to ensure that the funding department, organisations delivering services, and families or other service users can have confidence that the services being

19 From 2022 the FRSP operated under the FRSP AGD Grant Program Framework: www.ag.gov.au/families-and-marriage/families/family-relationship-services#:-:text=The%20Family%20Relationships%20Services%20Program,Family%20Law%20Services

accessed or provided are of a high quality. Organisations can self-assess against the standards although they may also be externally assessed. The Approval Requirements cover 15 areas in their quality standards. These include:

- Values and ethics (Standard 1)
- Governance (Standard 2)
- Planning/Strategy and policy (Standard 3)
- Information and Analysis (Standard 4)
- People (Supervision of practitioners – Standard 5; Training and development – Standard 6; Standard 7; Staff appraisal – Standard 8; Safety of staff – Standard 9)
- Client Focus (Accessibility of services – Standard 10; Managing client feedback and complaints – Standard 11; Client confidentiality and privacy – Standard 12; Client safety – Standard 13)
- Processes/Products and Services – (Service design – Standard 14)
- Organisational Performance – (Assessing performance – Standard 15).

Department of Social Services. (2014) Program Information: Families and Communities, Families and Children.

The DSS program information document for Families and Communities, Families and Children (the program information) provides comprehensive information about the program's aims/objectives and responsibilities. It indicates which service organisations fall under the remit of these areas within the DSS and provides information about the aims, objectives and responsibilities for each program activity and the expectations around what these services are supposed to achieve. The program element – Families and Children Activity – includes a sub-activity called Family Law Services. This component is funded by the AGD. CCSs fall under this sub-activity.

The program information outlines what CCSs do – indicating that they 'enable children's safe contact with the parent they do not live with' (p 5). The services should also 'provide a safe neutral venue' and 'assist families to move, where possible to self-managed contact' (p 5). The program information is therefore reflective of the information in the Guidelines Framework and the ACCSA Standards highlighting safety and the best interests of the child.

The program information also indicates information of what services are allowed to do – for example, charge fees, but it stipulates that the fee policy must be on public display and the service must inform clients of their fees policy. Consistent with the Guiding Principles Framework, it is stipulated that services are also not able to refuse clients services on the basis that they are unable to pay their fees. (s 2.5, p 12).

The program information also outlines the roles of the departments within the service arrangements and that of the funding recipient.

AGD (2019) Family Law Services Children's Contact Services Grant Opportunity Guidelines – 2019

The AGD has produced Grant Opportunity Guidelines (the Grant Guidelines) to outline the requirements of the grants process within the Family Law Services Grant Program for CCSs. The grant opportunity offered to CCSs outlines the objective as providing a 'child centred model of intervention that assists children of separated parents to establish and maintain a relationship with their other parent and family members, and to help achieve sustained and workable long-term arrangements.' The Grant Guidelines also clearly stipulate that the operation of the CCS must have the best interests of the child as a central priority. The grant provides for funding to a total of $88,153,279.38 and 5 years funding is provided, starting on 1 July 2019 and finishing on 30 June 2024 (Family Law Services, 2019).

The application process for the grants was by invitation only and applicants must ensure they use staff with appropriate qualifications and have relevant checks in place. All grant recipients must also have in place child safe practices under the National Principles for Child Safe Organisations.

The Grant Guidelines clearly stipulate the activities that the funding can be used for. These include staff salaries and related expenses, administration expenses, assets used to meet deliverables and travel costs for enabling staff or clients to attend service delivery. There are also stipulations regarding what the grant funding cannot be used for.

The grant recipients have data collection and reporting obligations including performance information that must be reported through DEX. There are performance indicators to benchmark a CCS's performance. These include:

- number of participants; counted as the number of unique client records
- number of events/services instances delivered; counted as the number of service instances
- proportion of participants from priority target groups, measured as the percentage of the total unique clients who identify as being First Nations people, CALD, disabled or other as specified in program guidelines
- proportion of clients achieving improved independence, participation and wellbeing immediately after assistance
- proportion of clients achieving individual goals related to independence, participation and wellbeing.

The indicator about clients achieving individual goals related to independence participation and wellbeing is interesting as this is impacted to some extent by the make-up of the clients that the centre will be servicing. Families with more entrenched and complex issues may be in receipt of court orders that indicate this benchmark will be difficult to achieve.

The process for obtaining a grant following notification of an invitation to apply was to submit an application, which was assessed by the AGD against a set of criteria. Final decisions on recipients were made by the Attorney-General. Successful applicants received an offer and must then enter into a legally binding grant agreement. This agreement outlined their obligations under the grant and the CCS must have systems in place to enable reporting against the agreement's performance indicators as outlined above.

National Principles for Child Safe Organisations

The National Principles for Child Safe Organisations were developed in response to the Royal Commission into Institutional Responses to Child Sexual Abuse to provide a 'nationally consistent approach to embedding child safe cultures within organisations that engage with children' (Australian Human Rights Commission, 2018, p 3). The 10 principles identified as fundamental for child safe organisations, together with key indicators of these principles, are:

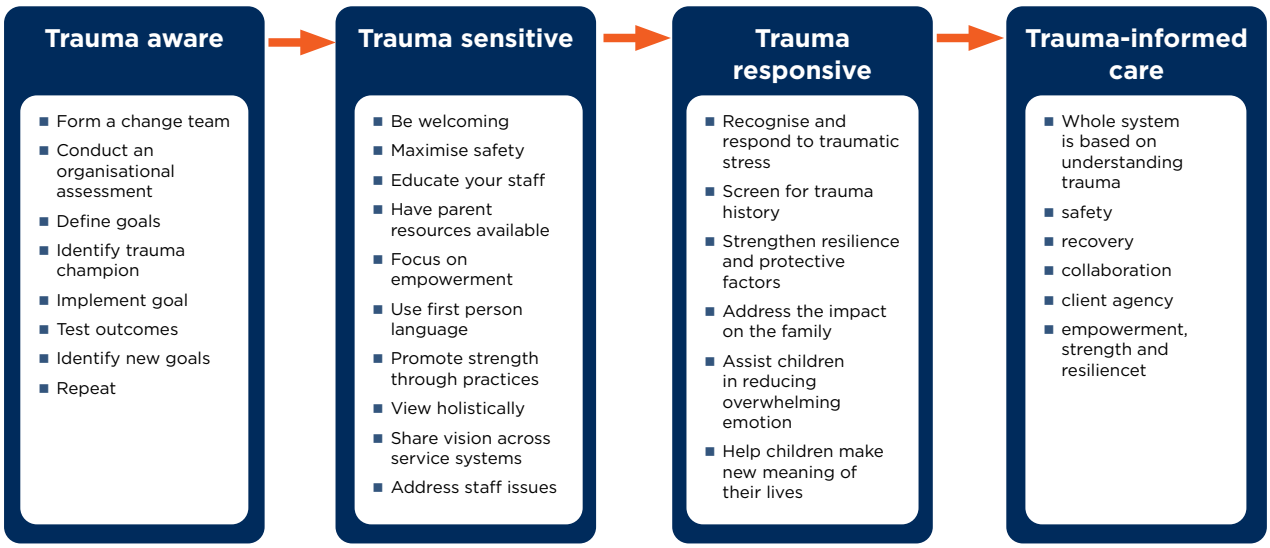
1. Child safety and wellbeing is embedded in organisational leadership, governance and culture.
   - Action areas and indicators include governance arrangements to support the implementation of child safe policies and practices; a code of conduct and risk management strategies and other relevant publicly available policies and practice guidelines; together with staff review processes and relevant staff training; professional development (Australian Human Rights Commission, 2018, p 9).
2. Children and young people are informed about their rights, participate in decisions affecting them and are taken seriously.
   - Action areas and indicators include programs and resources for children regarding their right to safety and to be listened to; age-appropriate forums to seek children's views and participation in decision-making that are documented and regularly reviewed; staff with training regarding children's developmental needs; an environment that is welcoming for children (Australian Human Rights Commission, 2018, p 10).
3. Families and communities are informed and involved in promoting child safety and wellbeing.
   - Action areas and indicators include clear and accessible information about policies, record keeping and complaints practices; responding to the needs of families including in relation to cultural safety; facilitating opportunities for feedback (Australian Human Rights Commission, 2018, p 11).
4. Equity is upheld and diverse needs respected in policy and practice.
   - Action areas and indicators include policies promoting equity and respect for diversity; child-friendly and inclusive materials to inform children of the support and complaints processes in place; staff training to support staff to respond effectively to children with diverse needs including First Nations children, children with a disability and CALD children (Australian Human Rights Commission, 2018, p 12).
5. People working with children and young people are suitable and supported to reflect child safety and wellbeing values in practice.
   - Action areas and indicators include recruitment and onboarding policies, practices and screening protocols that support the recruitment of child safe staff; organisational guiding documents and ongoing support, supervision and performance management processes for staff that focus on child safety; organisational tools to monitor and mitigate risk (Australian Human Rights Commission, 2018, p 13).

6. Processes to respond to complaints and concerns are child focused.
   - Action areas and indicators include an accessible and child focused complaints policy and complaints recording and handling processes applied by staff in a trauma informed way and which is effective, safe for children, culturally safe and understood by clients and families; effective policies and practices to report concerns with relevant authorities (Australian Human Rights Commission, 2018, p 14).
7. Staff and volunteers are equipped with knowledge, skills and awareness to keep children and young people safe through ongoing education and training.
   - Action areas and indicators include trained and supported staff who are able to respond to child safety concerns and who can identify the indicators; regular opportunities for education and training for staff in relation to child safety and wellbeing; a safe and supportive environment for staff disclosing harm or risk of harm to children and staff that respond effectively to issues of child safety cultural safety arise (Australian Human Rights Commission, 2018, p 15).
8. Physical and online environments promote safety and wellbeing while minimising the opportunity for children and young people to be harmed.
   - Action areas and indicators include effective risk identification, assessment and mitigation by staff, including online risks to child safety; risk management strategies; informing children and young people and families in culturally appropriate ways about the use of the organisation's technology and safety tools (Australian Human Rights Commission, 2018, p 16).
9. Implementation of the national child safe principles is regularly reviewed and improved.
   - Action areas and indicators include the involvement of children and young people in reviews of child safety and wellbeing policies and practices (Australian Human Rights Commission, 2018, p 17).
10. Policies and procedures document how the organisation is safe for children and young people.
    - Action areas and indicators include a child safe policy that is accessible and easily understood by staff, children and their families and feedback from children and families that demonstrate awareness of child safe policies and practices; demonstrated understanding of the policies and practices by staff (Australian Human Rights Commission, 2018, p 18).

Trauma-informed practice in service provision for children and families

Clients presenting to CCSs, like other family law system services and child and family welfare services more generally, commonly present with 'a complex range of symptoms and behaviours related to prior and/or past trauma' which may not be linked to their experience of trauma (Wall, Higgins, & Hunter, 2016). Trauma-informed service provision is critical for these clients and is based on 'knowledge and understanding of how trauma affects people's lives, their service needs and service usage' (Wall, Higgins, & Hunter, 2016). Quadara draws on Mieseler and Myers (2013) to identify service provision across a continuum ranging from trauma aware, trauma sensitive, through to trauma responsive and trauma-informed care:

Figure 6: Trauma-informed practice



Source: Wall, Higgins, & Hunter (2016) adapted by Quadara from Mieseler, & Myers (2013).

Key assumptions and principles indicative of a trauma-informed approach are (Substance Abuse and Mental Health Services Administration, 2014; Wall, Higgins, & Hunter, 2016):

- Key assumptions are that the organisation:
  - realises trauma and its impacts
  - recognises the signs of trauma
  - respond by applying principles of trauma-informed approach
  - resists re-traumatisation.
- Key principles of a trauma-informed approach are:
  - physical and psychological/emotional safety
  - trustworthy and transparent service operation
  - collaborative service provision that reduces power differentials between service staff and clients
  - taking a strengths-based approach and empowering the voice and decision-making of clients to support their recovery
  - acknowledging and being responsive to cultural, historical and gender-based issues in policies, practices and processes implementing services.

Specifically in the CCS context, consideration may be given to the articulation of an over-arching framework to support that consistent application of trauma-informed practices and models of service provision in CCSs.

Australian Law Reform Commission Review and Joint Select Committee: recommendations for reform

In this section, consideration is given to potential for adjustments to the guiding principles and standards that inform CCS practice and service delivery. It is noted that this evaluation of the CCS Activity is separate from and not connected to these recommendations for reform.

The research literature indicates that families who use CCSs frequently feature high levels of conflict and multiple and complex issues that include family violence, allegations of abuse, mental health problems and often substance abuse (Carson, 2012; Commerford & Hunter, 2015; Sheehan et al., 2005; Strategic Partners, 1999). Based on substantial empirical research, including the AIFS evaluations of the 2006 family law reforms and the 2012 family violence amendments, the ALRC's (2019) *Family Law for the Future: Inquiry into the Family Law System* (2019) inquiry, , DFV and abuse has been identified as characterising a substantial proportion of the family law court caseload. The ALRC recommended that all professionals who work in the family law court system be trained and competent in the dynamics of DFV and the impacts of trauma and the need for trauma-informed practice. The ALRC recommended (Recommendation 52) that legal professionals should be required to undertake annual continuing professional practice training related to DFV (ALRC, 2019).

The ALRC's report made some specific recommendations about CCSs. The report identified the lack of oversight of private CCSs and that there was an increasing number of these services in response to unmet service need. The ALRC report also considered the ACCSA submission to the ALRC discussion paper that contributed to the review. In this submission, ACCSA indicated that there were a number of guiding principles and standards giving clear advice to ensure CCSs are child-centred, safe environments that are able to support high-conflict families as they separate. This submission strongly advocated for accreditation and indicated that the accreditation should be at the organisational level, not just focused on individual practitioners. The submission also observed that there was no mechanism for private providers to follow standards and no accountability mechanism to ensure child safety and family safety were being prioritised. The ACCSA submission argued that the lack of compulsory standards was potentially compromising children's safety (ACCSA, 2018)

The final recommendations of the ALRC review included recommendation 54 indicating that the FLA should be amended to require that any organisation offering a Children's Contact Service be accredited; and to make it an offence to provide a Children's Contact Service without accreditation. The report explicitly acknowledged the submissions made by the ACCSA as to how an accreditation process should be structured, and the elements, principles and guidelines that should be included. These elements included a requirement for staff to hold a Working with Children Check, police check, and appropriate professional qualifications. Specifically, the ALRC suggested that the AGD may be the most appropriate body to manage accreditation. The ALRC also recommended the amendment of s 10A of the FLA to enable the development of accreditation rules.

The government in their response to the ALRC recommendations agreed in part to Recommendation 54 and established a consultation process with CCSs and relevant stakeholders to inform the development of an accreditation process (Australian Government, 2021).

The Joint Select Committee on Australia's Family Law System (the Committee) was established in 2019 to undertake a comprehensive two-year inquiry into the family law and the child support systems. The Final Report in a series of four reports were tabled in November 2021. In the course of the review the Committee received more than 1,700 submissions and heard from users of the family law system, advocacy groups, organisations, academics and legal professionals. (Australian Government, 2023). Specifically relevant to CCSs was Recommendation 9 in the Committee's second interim report – that the Australian Government establish mandatory accreditation standards and monitoring processes including complaints mechanisms and ongoing professional development, specifically identified CCSs. The Australian Government responded to each of the Committee's recommendations in January 2023 and agreed in principle to Recommendation 9 (Australian Government, 2023).

An accreditation process

In response to the review process detailed above, the AGD has been leading a series of activities designed to inform an accreditation scheme. These included comprehensive stakeholder workshops that sought feedback from the sector on a range of issues around accreditation. It is important to note that this Evaluation of the CCS Activity that is the subject of this Evaluation Final Report, is separate from the accreditation consultation process. It is noted, however, that issues raised in the accreditation consultation process are nevertheless consistent with observations made subsequently in this Evaluation Final Report.

Issues of relevance that were canvassed in the consultation process included:

- scope of an accreditation scheme
- administration
- a complaints mechanism
- staff qualifications and
- safety requirements.

The feedback from these consultations indicated strong support from the CCS sector for an accreditation scheme, with many suggestions as to the form and scope for structuring and oversight. A significant theme was that the CCS sector would expect a regulatory scheme to appropriately define the CCS role within the family law system. The workshops also raised viewpoints around managing safety, the need for high standards and consistency and the need to clarify the CCS relationship with the Family Court and other Family Law professionals and what the scope of the CCS role should be.

In a submission to the AGD consultations, National Legal Aid indicated that in 2019–2020 Legal Aid Commissions provided around 1.9 million services to people and approximately 1 in 5 of the services provided requiring a legal practitioner, were related to DFV, child protection or a family law matter (NLA, 2018). This submission also indicated that in 80% of all Commonwealth family law matters in which LACs are involved, there was DFV present (NLA, 2018). These data were identified by National Legal Aid as relevant to the operation of CCSs.

During this consultation process conducted by the AGD, the issue of CCS report writing was raised, and the consultation process found that there is inconsistency across the CCS providers and the family law sector more broadly about how reports are written, the content of the reports and a lack of clarity about the role and scope of CCS professionals and organisations providing information about families to the courts (AGD, 2021b). In submissions the family law sector was supportive of a body that could operate an accreditation and complaints handling function for family law professionals who provide information to the courts such as the CCSs. Submissions also indicated a need for government support to 'legitimise' the CCS services within the family law sector and ensure the information they provide to the court is rigorous and valued, rather than the CCS being viewed as an interim service and therefore only providing information of limited value (AGD, 2021).

This consultation also noted the importance of neutrality and independence for CCSs in providing support to families and emphasised the need to conduct and determine family needs around risk regardless of court orders. The sector highlighted concerns about the perception that CCSs work in favour of the Lives with parent and suggested that a principle of independence rather than neutrality may better reflect the primacy of focus on the child's wellbeing (AGD, 2021a). At the time of writing, an accreditation scheme remained under consideration.

Insight from the RFI: submission of CCS policies

The analysis in this section is aimed at exploring the extent to which CCS policies submitted as part of the RFI process are in accordance with guiding frameworks, primarily the *Guiding Principles Framework for Good Practice* (the Guiding Principles Framework). The CCS documentation provided to the researchers for analysis is indicative of the intention and processes in place to guide practice and may not reflect the implementation of these CCS policies and procedures in practice. However, the examination of this documentation in this section provides insight into the extent to which the Guiding Principles Framework has informed the CCS's internal procedures and policies and how organisations have interpreted the principles and guidance provided by the Guiding Principles Framework. This analysis can also be considered in conjunction with and complemented by the analysis of the qualitative information collected on client behaviour protocols and policies, and significant changes in these policies, reported later in this section. The operation of the CCSs in practice will be examined based on relevant data from the RFI process, the Survey of Professionals and the Survey of Parents and Carers in the last section of this chapter.

The methodology used for the policy component involved document analysis of CCS policies and protocols documents submitted by CCSs as part of the RFI process where services were requested to upload their CCS policies and respond to the RFI's specific questions about policies or procedures. The analysis reviewed each of these documents and related qualitative responses to assess alignment with the guidance provided in the Guiding Principles Framework (and the accompanying *Children's Contact Services Grant Opportunity Guidelines*) with a particular focus on the key underlying principles and objectives. The analysis reflected on the extent to which they had been incorporated into the development of policies about the operation of the CCS.

It is important to note the following limitations applied to this analysis. First, there were variations in the types and number of policies that were uploaded by the participating CCSs and in relation to how they were described by services providing responses about their policies in open-text RFI responses. Second, only a small number of CCSs (n = 14) uploaded their suite of policy documents and operations manuals, with most focusing on the policies and internal guidelines that related to supervised contact and changeovers specifically or formed part of their information to clients. Therefore, the scope of the analyses is subject to the policies and open-text responses provided. Despite these limitations, consideration of the uploaded policy documents and the relevant open-text RFI responses provide important insight into the extent to which CCS policies reflect the Guiding Principles Framework and key guiding documents.

Incorporating the objectives for CCSs

The Guiding Principles Framework indicates that the 'overall objective of CCSs is to provide children with the opportunity of re-establishing or maintaining a meaningful relationship with both parents, and other significant persons in their lives, when considered safe to do so' (p 3). The Guiding Principles Framework also indicates that the 'key goal of CCSs is to assist separated families to move, where possible and it is considered safe to do so, to self-management of contact arrangements, both in terms of changeover and unsupervised contact' (p 3).

In addition to these two overarching goals, the Framework provides guidance on priorities, and objectives that should underpin CCS service delivery. The Children's Contact Services Grant Opportunity Guidelines outline the parameters and conditions for funding the CCSs invited to participate in the grant funding round. These objectives have been incorporated into CCS policy documents in a range of ways and promoted in a range of practices as described in the operating procedures reviewed as part of the document analysis and RFI components of the research.

Table 8 provides a summary of the extent to which each policy document type provided by CCS organisations cover the objectives outlined in the Guiding Principles Framework. The various document types provided by CCSs have been categorised into 5 main categories:

- application forms
- service agreements
- client behaviour policies/protocols
- CCS operating procedures and
- safety and risk management policies.

It is noted that a small sample of documents was submitted with respect to client behaviour, CCS operating procedures and safety and risk management and the data presented in this chapter should be interpreted with this in mind.

Table 8 shows that the objective of safety was a key feature across all of the policy document types. In fact, for each of the document categories considered, safety was covered in every document submitted and analysed in the RFI process. Child-focused practice was the next most commonly covered objective in CCS policy documents, with between 72% and 100% of the various document types covering child-focus in their provisions.

The data also show that there was some variation in emphasis placed on the different objectives captured in the Guiding Principles Framework as reflected in each policy document type. The objectives of neutrality and collaborative service provision were most commonly covered in client behaviour policies (in each of the three documents submitted by CCSs in this category). Client diversity and cultural sensitivity were most commonly referred to in application forms (81% of this document type). CCS operating procedure and service agreement documents were most likely to contain information about moving to self-management (75% and 73% respectively). These two document types were also the policies where record-keeping and data collection systems were most likely to be included. There was very limited coverage of staff training and ratios in the policy documents and the only document type to include this objective was CCS operating procedures (50% of documents). However, this is reflective of the types of documents submitted and those related to operations including to staff, rather than client-facing documents, did include information about training and ratios.

Table 8: Request for Information, analysis of CCS policy documents and extent to which policy documents cover objectives referred to in the Guiding Principles for Good Practice and Grant Opportunity Guidelines

Objectives	Application form (%)	Service agreement (%)	Client behaviour protocol (%)	CCS operating procedures (%)	Safety and risk management policy (%)
1. Child-focused	72.7	100.0	100.0	100.0	100.0
2. Safety	100.0	100.0	100.0	100.0	100.0
3. Neutrality	9.1	45.5	100.0	25.0	50.0
4. Client diversity and cultural sensitivity	81.8	54.5	66.7	75.0	0.0
5. Collaborative service provision	54.6	36.4	100.0	50.0	0.0
6. Moving to self-management	9.1	72.7	0.0	75.0	0.0
7. Staff ratios	0.0	0.0	0.0	50.0	0.0
8. Training	0.0	0.0	0.0	50.0	0.0
9. Record keeping	54.6	72.7	0.0	75.0	0.0
10. Data collection systems	36.4	54.6	33.3	75.0	0.0
Number of documents	**11**	**11**	**3**	**4**	**2**

Notes: Multiple objectives can be covered within each document type so percentages may not sum to 100.0%

Further analysis of the documents and the responses in the RFI referring to policy documents is provided below and reflect variations in the way that CCSs have interpreted the guidance provided in the Guiding Principles Framework.

Moving to self-management

The key objective of moving to self-management is one that appears to vary the most in its interpretation by CCSs in policy documents. The intake or application forms and service agreements from many services provide that supervised contact is a time-limited service and this is frequently indicated in the CCSs' public facing information. The service limits are stipulated as either the number of sessions to be provided in total or the length of time that the service is available for. Some services do not mention timeframes at all in their policy materials (noting, however, that few CCS operating manuals were uploaded).

Based on the policy documents, the weighting given to moving to self-management as a priority appears to vary between CCSs. At least one client service agreement indicates that service may be withdrawn if progress towards self-management cannot be demonstrated while another indicates that the service will cater long-term for families for whom self-management is not possible. This reflects the issue that for some families there may not be other options for maintaining parent-child contact.

Notably, although self-management is a goal stipulated in the *Guiding Principles Framework for Good Practice* (AGD, 2018) and reflected in service policy documents, numerous CCSs indicated in their RFI responses that for some families, self-management was not feasible or safe. For example:

> *Clients are informed during the intake session that their file will be reviewed every 3 months with a view to exiting our services within 6 months. Our 'Working Towards Self-Management' policy outlines our process. We do acknowledge that self-management may not be an option for all families. Our long-term clients are generally clients who are impacted by mental health issues and acquired brain injuries.* (Service 55, Qld)

Child-focused

The Guiding Principles Framework provides that children's needs and welfare are the primary consideration of CCS practice, with professional knowledge and practice to be applied to further the best interests of children. There is evidence across the submitted policies and RFI responses relating to CCS procedures that a child-focused approach underpins the CCSs' policies guiding service delivery. The submitted policies and service delivery agreements demonstrated guidance for parents/carers and staff in the event of child refusal or distress at seeing the other parent, indicating that CCSs would (a) not force contact between the parent and child and (b) that while a CCS may encourage or support the child to have contact, ultimately the decision to participate would be made by the child. There was variation in the policy documents in relation to the emphasis that was placed on child's willingness to participate. For example, one CCS indicated that for a child to be identified as unwilling and service stopped, the child must be 'constantly, resolutely and independently unwilling to participate' (Service 235, state/territory redacted). There was also some indication from at least one CCS that the child's willingness to participate was a condition of their accepting the family into the CCS at intake.

Most participating CCSs indicated to parents/carers in their client service agreements that the child is the priority client in the family and that the processes in place were designed to facilitate that approach. Most responses specifically provide that the child's best interests would determine a decision to withdraw service in cases of child refusal or for a breach of the service agreement.

Relatedly, there were differing policies around gift giving (beyond the security concerns), with some service policies employing healthy food restrictions and others not enforcing any food restrictions without a medical certificate**.** These provisions may also be an indication of the types of issues that have potential to exacerbate conflict points for parents and carers where one party may be seen as providing more 'fun' with gifts and treats.

Most service agreements or behaviour policies indicated, for example, that the introduction of other people such as extended family was possible but was commonly implemented after the child became accustomed to the CCS environment.

Safety

The Guiding Principles Framework provides an overriding definition of safety and includes detailed guidance on what this should look like in the CSS context: 'CCSs provide for the physical and emotional safety and security of children, families and staff at all times' (AGD, p 4). Without exception, the policy documents indicate that safety is considered an essential element in all aspects of service provision, with safety of family members and safety of staff highlighted as priority considerations. The interpretations of the term safety include consideration for physical safety as well as emotional safety and service agreements mostly indicate withdrawal of service for incidents of verbal abuse as well as physical threats, often listing specific behaviours that will not be tolerated and will result in withdrawal of the service. In some instances, where service agreements are provided to clients as part of an overall service organisation rather than specifically related to a CCS service, the types of behaviours indicated appear less specific in their description. These policy documents are apparently designed to serve a broader range of clients but may lack clarity for clients regarding unacceptable behaviour. It may also be that within the CCS context and its complex family cases, compared to other service delivery contexts, there is an environment that may be more likely to elicit case-specific behaviours of serious concern.

Almost all policies indicated attention to technology-driven risks to safety and had clear policies around mobile phone use and the sharing of videos or photography. These required either that phones or cameras not be taken into the CCS, not used during the visit or that only staff take photographs and check any photographs before they are shown to the child. One CCS stipulated specifically that their photo policy would align with what was written into court orders. There were also stipulations in some policies about the rating of movies that could be brought into the CCS.

Where staff ratios are mentioned all operating documents complied with the Guiding Principles Framework and the requirement to always have a minimum of two trained staff onsite when supervised contact is taking place. For some CCSs this was satisfied by one CCS supervisor per family, supported by another CCS professional onsite during changeovers and visits. In contrast, in some circumstances, and for some CCSs, the application of the ratio may involve two CCS supervisors per family.

All the policy documents, including client-facing documents, submitted in the RFI also referred to staff in the context of physical safety, (often in outlining expected behaviours and withdrawal of services). The impact of trauma on staff and safety in the broader sense of wellbeing and emotional safety could not be more specifically examined based on the policy documents submitted; however, some internal policy documents provided by a small number of CCSs reference their Employee Assistance Program (for counselling and support or other similar support) available for staff.

Critical incidents

Definitions of what constitutes a critical incident mostly aligned with the outline provided in the Guiding Principles Framework and indicate that CCSs recognise in their policies that a critical incident should constitute a risk to life, health or safety. The Guiding Principles Framework also provides a non-exhaustive list of examples of critical incidents. The examination of policy documents and RFI responses indicated that there were differences in the interpretation of critical incidents among CCSs. For example, the critical incident policy of more than one CCS indicated that a critical incident is one in which parties 'feel' unsafe. This subjective test may be challenging to apply consistently both for parties and for staff, and while additional guidance may support the application of this guidance, it is acknowledged that an objective test would not be appropriate in this context. Other RFI responses indicated that critical incidents may include work over lengthy time frames with complex clients leading to cumulative harm, or incidents that give rise to external media scrutiny. Critical incidents were also defined as events that cause disruption to the normal functions, staff, clients and other people accessing the service, which may bring significant, real or perceived danger and risk.

Responses to critical incidents have some slight variation between services but primarily follow similar courses of action. Some indicate immediate responses such as staff activating duress alarms (in services where these are provided) or removal of self and others to safe places if possible. Contacting emergency services is generally the next priority, followed by internal reporting. Some policies and responses specifically mention the need for incident review and reflection though this is not indicated across all policies or RFI responses provided.

Neutrality

The need for CCSs to provide a neutral service is outlined in the Guiding Principles Framework though this is qualified by reiterating the primacy of the child's best interests for supporting families. Some policy documents that are client facing outline the position of the CCS in relation to neutrality from the outset to clients. This includes some organisations specifically mentioning this issue in application forms and service agreements. Those that do mention neutrality also often refer to their independence from the family law courts, seemingly to indicate to parents from the outset the priorities of the CCS being the children and that the CCS is not obligated to provide services.

Where internal policies and procedures indicate neutrality, they are primarily reflected in guidelines to staff for conducting supervised contact and changeovers. It is also noted that neutrality could be seen to be implied in many policy documents rather than explicitly indicated. Reflections on actual practice are required to provide more in-depth insights as to the extent that neutrality is being maintained in service delivery (see further later in this chapter).

Client diversity and cultural sensitivity

Although culturally appropriate service provision is a focus of chapter 5, consideration is given here to the client diversity and cultural sensitivity in the CCS policies and their compliance with the Guiding Principles Framework. Most of the submitted client-facing documents such as application forms and service agreements included reference to whether a parent or child identified as First Nations or another cultural group and which languages were spoken at home. A minority of these policy documents also provided an opportunity for clients to indicate whether an interpreter would be needed at the application stage. Multiple service agreements highlight the need for parents to speak English during the supervised contact to ensure staff can understand the conversations. The analysis of policy documents was not able to identify information for clients that would indicate how CCSs could accommodate specific cultural practices or needs that may be relevant to their family, though there was some mention of specific cultural celebrations in relation to information about gift giving provided to families. It may be that this type of information is exchanged during the orientation/familiarisation or interview stage of intake.

The internal operating policies and responses in the RFI were far more comprehensive in outlining the provision of cultural training and the expectations around incorporating culturally informed practices in providing the services, indicating that staff across most CCSs should have a good understanding about accommodating

cultural needs for clients. A majority of internal policy documents indicated that cultural competency training was mandated for staff. There is less information on how workplaces seek to incorporate diverse workforces though this may be due to the nature of policies submitted.

Consideration of disability was also a key feature of many intake forms although this was not a feature of all forms submitted in the RFI process. Where disability information was to be provided, most related to whether the child had a disability and the nature of that disability, rather than about the parents. Only a minority of intake/application forms asked specifically whether a parent or carer had a disability.

Some intake forms specifically asked about gender diversity and the LGBTIQ+ status of the adult relationships while some service agreement information indicated strongly that the service was LGBTIQ+ supportive. The internal guidance generally indicated that services should be non-discriminatory and inclusive though this was not necessarily overtly indicated in the descriptions of application procedures and client-facing documentation.

Collaborative service provision

Not surprisingly, this principle was more clearly indicated in policy documentation that was submitted in the RFI process by the CCSs that were set in a multi-service site and could offer clear referrals to other services with which they had a relationship. For some organisations, service agreements stipulated that parents and carers were required to attend specific parenting courses before they would be accepted into the CCS program. It was not always possible to ascertain from the data whether these courses were delivered by the CCS or another linked service. However, some of the operational guidance documents specifically referred to the role of the CCS in balancing neutrality by not providing advice and that referrals to other services must be provided in a manner consistent with the CCS role.

Information sharing

All policies and protocols reviewed around information sharing reflect acknowledgement of the highly sensitive nature of the information that is captured in the course of CCS service provision in accordance with the Guiding Principles Framework.

Most service agreements submitted in the RFI process indicated to clients what they could expect from the service in regard to confidentiality of information and where there were limits to this confidentiality (e.g. in relation to disclosures of child abuse or DFV, or information sharing mandated by legislation or government policies).

Data relating to internal procedures and policies indicate that information sharing must be in accordance with applicable legislative and privacy requirements and these requirements were commonly specified in the relevant policy documents. The majority of protocols and guidelines indicated that client consent must be provided in writing to share information with other services that the family may be attending or referred to for the receipt of support services.

Writing observational reports for courts is another key area in which there was variation. In relation to writing reports for courts, the majority of procedures and guidelines indicate that only information of an observational nature can be included in reports for the courts. Some CCSs indicated in their RFI responses that they no longer prepared reports and instead advised clients of the process to subpoena their case file notes. Other CCS policies indicated that significant training is provided to staff to ensure report writing is observational only, and some RFI responses noted that templates are provided to support this exercise, with multiple respondents indicating that this is a time-consuming exercise for them.

Summary of the concordance of CCS policies with the Guiding Principles Framework

Although not all CCSs submitted policy and protocol documentation, from those that were provided, safety and prioritising the child's best interests are very strongly indicated in the material. It is possible that compliance with safety protocols and prioritising best interests are principles that are more straightforward to interpret and apply consistently, and that the implications of not prioritising these elements are clear for CCSs. Other aspects of service provision outlined in the Guiding Principles Framework are less visible in the policy documentation provided, for example, opportunities for referral to other services and collaboration with other services in working with families. There is most variation in relation to principles that are quite specific to CCS service delivery; for example, the need to move to self-management. This suggests that some CCSs are considering the multiple issues that may impact a decision to move a family out of the CCS, such as risk to safety and wellbeing,

relevant court orders and other options available for families, and these CCSs are taking families' individual circumstances into account while other services are setting a single time-limited arrangement for service provision. Both approaches are likely to affect families in different ways. Neutrality and information sharing for reports also seem to reflect individual service approaches in how they are expressed in the documentation. It is evident that the Guiding Principles Framework is informing policies and protocols across the CCS sector though being expressed and articulated to clients in different ways and with different emphasis.

Implementation of policies and procedures in practice

The discussion in this section presents relevant data from the RFI, the Survey of Professionals and the Survey of Parents and Carers in relation to the implementation of key CCS policies in practice. The data relates to staff checks and training and professional development requirements, numbers of staff and staff ratios. The discussion then examines data from these elements relating to physical site characteristics and specifications, followed by critical incidents and the cessation of service. Data supporting an examination of the extent to which CCSs in practice comply with the objectives articulated in the *Guiding Principles Framework for Good Practice* and the National Principles for Child Safe Organisations, together with principles of trauma-informed practice are presented in the final part of this chapter 3, with a particular focus on CCS practice and the best interests of children.

Staff checks and staff requirements

In relation to guidelines relevant to staffing, the RFI collected information on the extent to which the following requirements were in place at their service for client-facing staff, including:

- personal disclosure statement (showing they have not been charged with or convicted of any criminal offences)
- police check
- no criminal or court record
- compliance with professional code of conduct.

In line with the requirements for CCS staff to have police and working with children checks in the Guiding Principles Framework (AGD, 2018) and the *Standards for Children's Contact Services* (ACCSA, 2008), almost all services reported in the RFI that these requirements were in place (96% for both police and working with children checks). The Grant Guidelines indicate that a child safety clause is likely to be included in grant agreements where that agreement is for services directly related to children or activities that involve contact with children. Grant recipients are also required to comply with all child safety obligations in the grant agreement or that are notified to the applicant. The grant recipient is also required to comply with state and territory relevant child safety obligations (section 10.1.1). In terms of the other staff checks, a lower proportion of CCSs indicated that they required compliance with a professional code of conduct (56%), or that staff had no criminal or court record (54%) or that a personal disclosure statement was required to be signed (41%) (see Table 9).

Responding CCSs were also provided the opportunity to specify other staff checks in place not captured in the list above. A total of 19 of the 54 (35%) participating CCSs indicated other staff checks were in place.20 The most commonly reported staff checks in this category were qualifications checks, followed by requirements for staff to sign declarations of confidentiality, COVID vaccinations and thorough processes for verifying referees on employment.

20 Although *n* = 19 CCSs selected the other specify option for this question, *n* = 13 either provided a response in the other specify section or their response was not backcoded to a response in the original question coding frame.

Table 9: Request for Information: types of staff checks/requirements in place per CCS

Type of staff check/requirement	*N*	%
Police check		
Selected	52	96.3
Working with children check		
Selected	52	96.3
Compliance with professional code of conduct (e.g. agency's code of conduct policy)		
Selected	30	55.6
No criminal or court record		
Selected	29	53.7
Personal disclosure statement (showing they have not been charged with or convicted of any criminal offences)		
Selected	22	40.7
Other		
Selected	19	35.2

Notes: Multiple responses so totals may not sum to 100.0%. This table reports the number and proportion of CCSs that selected each response option from a list of staff checks/requirements. Not shown is the number and proportion where each response was not selected (including potentially missing responses).

Number of staff and ratios

CCS organisations provided an estimate of the proportion of their current staffing by gender. The CCS sector is predominantly staffed by female employees, with the average proportion of female staff reported as 90%. A further 10% of staff were on average reported to be male, with a small proportion reported as non-binary (0.1%).

Table 10 presents the number of staff reported by 49 of the participating 54 CCSs providing 4 years of staff data. The data show that most CCSs had more than 5 but less than 10 staff members (41%–49%) or 10 or more staff members (18%–31%, with the highest number of CCSs with 10 or more staff reported in 2022 (31%). The mean total of staff rose from 7 in 2019–21 to 9 in 2022.

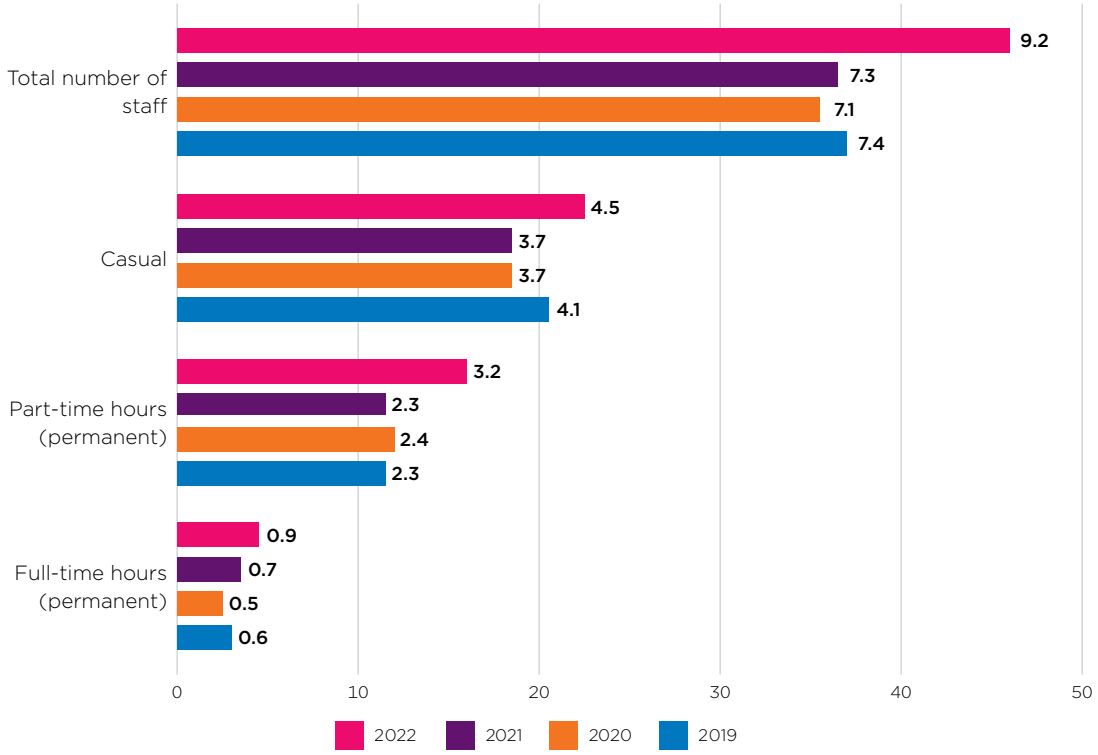
Table 10: Request for information: CCS characteristics

Total number of staff	2019		2020		2021		2022	
	N	%	*N*	%	*N*	%	*N*	%
5 or fewer	16	32.7	19	38.8	19	38.8	14	28.6
More than 5 but less than 10	24	49.0	23	46.9	21	42.9	20	40.8
10 or more	9	18.4	7	14.3	9	18.4	15	30.6
Total	49	100.0	49	100.0	49	100.0	49	100.0
Mean	7.4		7.1		7.1		9	
Median	6		6		6		8.6	
N	49		49		49		49	

Notes: Analysis based on CCSs that provided all 4 years of total number of staff data.

The data in Figure 7 show that the average number of staff has increased over time and most notably in 2022. Overall, the average number of staff per CCS organisation was 7 staff members in 2019, 2020 and 2021, with the average number of staff increasing to 9 staff members in 2022. Between 2019 and 2022, there were increases in the average number of staff employed in each employment category, with the largest average increase for those employed on a part-time hours (permanent) basis – 2.3 staff in 2019 increasing to 3.2 staff on average in 2022. These increases in staffing numbers and improved waitlists for clients may correlate with increases in funding provided to CCSs that were noted by CCS management and services providers during the Phase One initial stakeholder consultations and in open text RFI responses. The funding increase was included in the 2021–22 federal budget which provided was an additional $101.4 million over 4 years for developing the existing 64 CCSs and to establish 20 new CCSs (AGD, 2022).

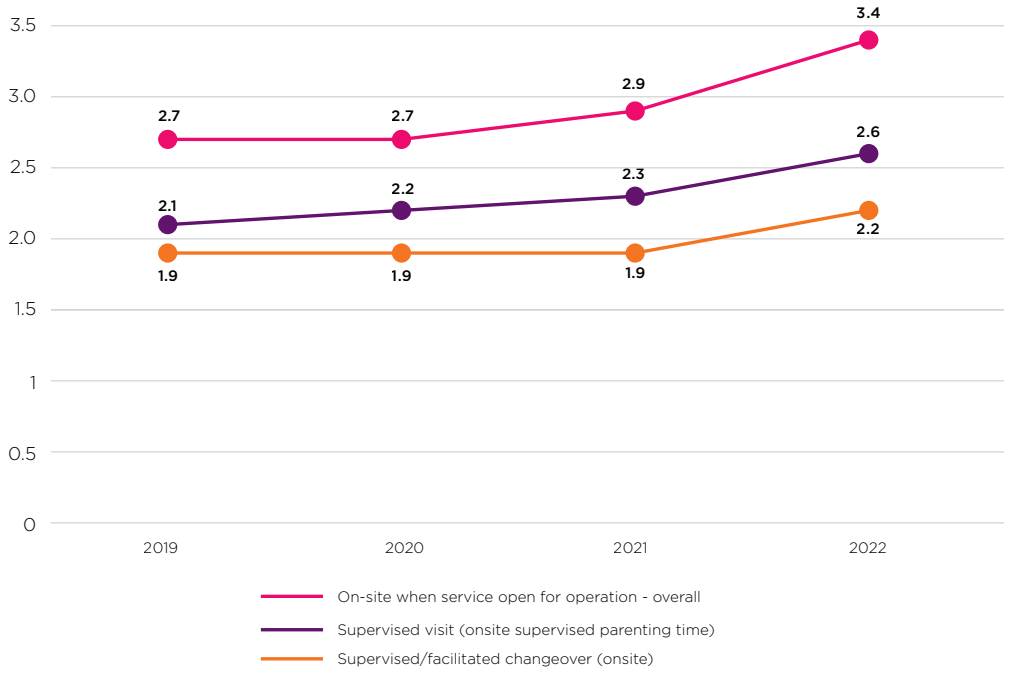
Figure 7: Request for Information: average number of staff employed by employment type, 2019–22



Notes: Information also collected on number of staff employed as 'Full-time hours (fixed term)' and 'Part-time hours (fixed term)'. These categories not reported in figure above due to low numbers of staff employed in these 2 employment types.

The RFI also collected information on the number of staff present for various activities, such as supervised visits and supervised/facilitated changeovers. Reflecting the increased number of staffing levels over time, the number of staff present at these types of activities also trended upwards over time. Figure 8 shows that, overall, the average number of staff present on-site when the service was open for operation increased from 2.7 staff in 2019 to 3.4 in 2022. For supervised visits, the corresponding increase was 2.1 staff on average to 2.6 staff. There was a smaller increase of 1.9 to 2.2 staff present on average for supervised changeovers.

Figure 8: Request for Information: average number of staff present for each service activity, 2019–22



The RFI open-text response data provide further insight into staff numbers and ratios for specific CCS activities. Most CCSs described a two-worker model, with some indicating that offsite supervision was therefore not feasible for the CCS due to staff resources. For example:

> *For all activities where clients are onsite, there must be minimum 2 contact workers onsite. For supervised visits, there is always 1 'additional' Senior Contact Worker who 'floats' and is available to provide additional support to contact workers (maximum 2 visits occurring simultaneously). The Senior Contact Worker may simultaneously conduct changeovers whilst supervised visits are occurring (maximum 34 changeover sessions per day, at interspersed intervals). Our CCS does not offer offsite supervision, as we would require 2 contact workers to be present to adequately mitigate risk, which is inefficient use of our staffing resources.* (Service 54, NSW)

> *Generally, there is one supervisor and 2 workers onsite. Workers are allocated one to each supervised family at a time with the supervisor 'floating' and available when required. For changeovers there are 2 workers for each changeover. If a family is identified as high risk/complex, there may be a requirement to have additional staff onsite including managers.* (Service 175, SA)

> *Whenever clients are accessing the building there is a minimum of 2 staff required to be able to open the doors to clients. All supervised visits and facilitated changeovers have 2 staff on, 1 in the visit doing the observations and the other staff person is supporting the 1st staff person as the 2nd practitioner and attending to clients returning for pickups and notifying the supervisor that the live with party has returned.* (Service 207, Vic)

The RFI responses also described low vigilance supported visits where parenting time is monitored onsite with a staff member intermittently checking in with the family, or offsite supervised visits where one staff member is allocated to supervise the family at the determined location (e.g. Service 156, WA; Service 55, Qld). One service explained that the offsite visit takes place 'within a defined parameter within walking distance [from the CCS] and staff have a mobile phone on them at all times' (Service 55, Qld). In addition to the 'two-worker model' for standard service provision, some CCS responses described the flexible arrangements for increased allocations of staff when multiple families are onsite concurrently and when servicing larger or more complex families (e.g. Service 233, state/territory redacted).

Where a family had multiple children or children with special needs, changes to standard staff ratios may be implemented as required, including where a child has specialised requirements having regard to their age or developmental needs (e.g. Service 120, SA; Service 154, Qld; Service 244, Qld).

Staff recruitment, qualifications and training

The RFI open-text responses and the Survey of Professionals also provided insight into the recruitment and retention of staff, as well as in relation to their training and ongoing professional development.

Relevant RFI responses illustrate the challenges associated with staff recruitment and retention of appropriately qualified staff from diverse groups to represent their community demographics (e.g. Service 70, SA; Service 192, Vic; Service 264, NSW; Service 198, state/territory redacted; Service 55, Qld; Service 54, NSW). These challenges included:

- the high level of skill required of CCS staff
- the nature and timing of the shift work over weekends (including feelings of disengagement from the organisation among staff working these hours)
- the more limited availability of casual staff who have other work and study commitments
- the locations of services, including regional locations
- the level of remuneration
- the level of responsibility required of the role.

In addition to the challenges of a casualised workforce, the RFI responses also highlighted the challenges associated with recruiting men with relevant skills and qualifications to undertake CCS work.

The opportunity to increase the wages of CCS service staff has been identified as critical to the retention of suitably qualified staff in sufficient numbers to facilitate effective service delivery, usually over a weekend period that requires pay loadings, and also for acknowledging that the qualifications for this type of work are vital (e.g. Service 54, NSW).

Some CCSs in their RFI responses referenced increased funding as supporting CCSs to address staffing needs, although the sustainability of recruitment practices was also referenced in the RFI responses (e.g. Service 127, Vic; Service 152, Vic; Service 79 Vic).

In relation to training and ongoing professional development, data from the Survey of Professionals (Table A12, Appendix F) provide insight into CCS professionals' reports. The data show that most professionals had undertaken training and professional development in *(a) the 18-month period preceding the survey or (b) in the past*:

- child safety, child abuse and/or neglect: (a) 54% and (b) 37%
- DFV: (a) 53% and (b) 37%
- cultural awareness training – 'Aboriginal and Torres Strait Islander related': (a) 52% and (b) 38%
- child safe practice: (a) 50% and (b) 40%
- trauma-informed practice: (a) 47% and (b) 42%
- cultural awareness training – CALD related: (a) 44% and (b) 40%
- child-inclusive practice: (a) 39% and (b) 44%
- service provision for adults or children with a disability: (a) 18% and (b) 37%.

Other training and professional development nominated by participating CCS professionals included leadership and management, LGBTIQA+ inclusion and awareness, de-escalation and dealing with challenging behaviours, mental health, and first aid training.

More specific insight into the training and professional development requirements of CCS staff is available from the RFI open-text responses, with CCSs indicating the breadth of training required for their service staff.

Some services described the qualifications and training and staff development requirements in general terms referencing qualifications in social science, social work, psychology, counselling and community services qualifications, together with additional training including in relation to DFV, child protection/child safety, mental health first aid and cultural awareness training, and experience working with parents and children impacted by and/or using DFV. These were evidence of the comprehensive nature of the training and expertise around trauma and child development that is required for the work in CCSs. Of note, some CCSs required degree (or in progress) qualifications from their coordinators rather than supervision staff (e.g. Service 181, NSW; Service 54, NSW).

In addition to pre-employment candidate screening, induction and ongoing professional development and training requirements were described in some RFI responses to be comprehensive and rigorous, with minimum expected standards articulated by some CCSs as well as monitoring for quality assurance, with one CCS referencing their CCS program logic and clinical competences in this regard. For example:

> *Comprehensive mandatory induction, training, onboarding processes, along with rigorous candidate screening provides workforce quality assurance across all levels of CCS. Mandatory ongoing training is critical for all staff as our service interventions operate within a framework that prioritises the safety needs of those experiencing violence and abuse. Our Clinical Governance Framework ensures minimum professional standards are met through at least 26 hours pro rata of clinical supervision and annual performance reviews. CCS staff undertake accreditation against the minimum standards for service delivery during their mandatory probationary clinical review. Ongoing clinical quality is monitored by Clinical Supervisors and Managers. Our clinical supervision team and training department provide ongoing continuous professional development in effective best practice intervention frameworks, aligned to program logic and clinical competencies. Our clinical supervisors are experienced practitioners themselves and trained in the latest evidence-based supervision competency frameworks to ensure they meet the highest supervision standards when providing guidance on client work. We have First Nations supervisors as well as those with CALD backgrounds.*

All staff are required to complete online learning modules on commencement of their employment. This includes trauma-informed practice, cultural workshop, security awareness, celebrating diversity, code of conduct, attachment, trauma foundation, information sharing scheme, DFV foundation, privacy and equal opportunity modules. New CCS staff must complete the new staff training upon commencement, this includes shadowing staff in visits (for several visits).

Training and professional development activities nominated by CCSs in their RFI responses included:

- mandatory training in first aid, mental health first aid, work health and safety training (e.g. ASIST applied suicide intervention; Suicide ideation in primary school age children)
- regular (annual) training modules in areas including family violence, trauma-informed practice, and mental health awareness, substance misuse, child attachment and child development (e.g. Circle of Security; Working with Children with Sexualised Behaviours)
- a range of DFV training (e.g. AVERT, MARAM framework CISS/FVISS Safe and Together and training to work with men who use abuse
- training in relation to autism and ADHD (e.g. Working to Support the Mental Health of Children with an Intellectual Disability and Engaging with children and parents with complex needs – a systems approach)
- regular (annual) solution focused brief therapy, cognitive behaviour therapy, de-escalation and training to assist with clients in high conflict (e.g. Intervening in entrenched parenting disputes, when, who, how, and for what purpose?; How can we ensure children and young people with disability receive a fair go?; Working to support mental health in children with intellectual disability)
- annual training in trauma-informed practice and training in relation to the impact of complex trauma, (e.g. Supporting Mental Health after Trauma; Mental Health, Terrorism and Grievance-fuelled Violence; Understanding the Nexus Construction of Complex Trauma and the implications for woman's wellbeing and safety from violence; Working with Children after Complex Trauma and Supporting Children who have disclosed trauma; Engaging mothers and children affected by family and domestic violence)
- periodic child safe training or child safe standards and child protection training including Child Safe Organisation Workshops
- regular child-inclusive practice training and child aware training (e.g. Through their Eyes and Supporting Children's wellbeing when working with separating parents.)
- cultural awareness training including in relation to Aboriginal cultural competency and CALD training and cross-cultural communication training (e.g. Boomerangs Parenting Program for Aboriginal Parents and their Young Children; Trauma-informed Aboriginal and Torres Strait Islander cultural capability training Mental Health: Do you have what it takes to engage Indigenous people? and Approaches to Support Child Mental Health in Culturally and Linguistically Diverse Communities)
- privacy training and cyber safety training (e.g. ESafety for women)
- anti-discrimination and diversity training (e.g. ACON diversity training)
- case management diploma
- regular (annual) case notes and report writing training
- client outcome measure training
- inhouse policy, procedure and case review activities at staff meetings
- periodic clinical supervision (monthly) and group supervision for all staff and group supervision by an external mental health social worker for case-management staff (e.g., Service 233, state/territory redacted; Service 212, NSW; Service 152, Vic; Service 168, NSW; Service 225, WA; Service 170, SA; Service 55, Qld; Service 75, NSW; Service 120, SA; Service 192, Vic; Service 234, Vic; Service 54, NSW; Service 70, SA; Service 154, Qld; Service 79 Vic).

In addition to CCS specific training and qualifications, as noted directly above, some RFI responses also noted the supervision of CCS staff and inhouse training that was undertaken to support their ongoing professional development. CCS-specific training, including the Certificate 4 in Children's Contact Services Work (now superseded by Certificate 4 in Community Services), and in relation to observational note taking for CCS reports and/or CCS files and regular joint reviews of CCS policies and practices to support compliance and regular staff mentoring arrangements, were also identified in the RFI open-text responses (e.g. Service 75, NSW). Some RFI responses noted that vocational training needs could be addressed upon request as identified in the performance development review process. Professional development opportunities including conferences and events conducted by ACCSA, NAPCAN and Family Law Pathways Network were also identified (e.g. Service 170, SA; Service 55, Qld).

Some RFI responses described the professional development opportunities available via the service team and peer support, as well as options now available for online training options to support accessibility of training options for staff (e.g. Service 198, state/territory redacted).

Physical site characteristics and specifications

Table 11 reports data collected in the Request for Information relating to the CCS physical site characteristics and site specifications. The most commonly reported physical site type from which services were operated were office sites (67%). A further 35% of CCSs reported delivering services in a standalone house, with one-in-five (20%) indicating outreach supervision services were provided. A similar proportion (19%) reported other physical site characteristics such as childcare and community centres.

In terms of site specifications, almost all participating CCSs indicated having age and developmentally appropriate indoor equipment (94%) and supervision rooms (94%). For those CCSs with supervision rooms, the average number of supervision rooms was 2.5 rooms. A little more than 9 in 10 CCSs reported carparks (91%) and duress alarms (91%), and where this feature was reported, the average number of duress alarms was 4.

Separate entrances and exits (89%), outdoor play areas (89%), accessibility by public transportation (87%), facilities for older children (87%) and disability access (82%) were also frequently reported. Between two-thirds and almost three-quarters of CCS reported security cameras (72%), security doors (67%) and withdrawal spaces (67%). Where withdrawal spaces were indicated, the average number of withdrawal spaces was 2.8. Much less frequently reported was sound proofing (19%). Other site specifications such as video doorbells and buzzers were reported by 4% of participating CCSs.

For selected site specification questions, further qualitative information as to the location or type was elicited. This additional information is summarised here:[21]

- Location of security cameras (*n* = 38 CCSs provided a qualitative response). The most common location of security cameras was at entrances (both front and rear), with 24 CCSs identifying this location in their response. This was followed by cameras located throughout the building (*n* = 12), carpark (*n* = 9), supervision room/s and indoor/outdoor play areas (*n* = 7) and outside the building (*n* = 4).
- Location of security doors (*n* = 36 CCSs provided a qualitative response). Almost all responding CCS reported security doors located in the entrance/main office area (*n* = 29). Smaller numbers reported security doors located in supervision areas and outdoor play areas (*n* = 5 respectively), at external doors (*n* = 3) and at the car park (*n* = 1).
- Location of duress alarms (*n* = 48 CCSs provided a qualitative response). Most frequently, duress alarms were portable devices worn by staff (*n* = 25), followed by devices located in supervision rooms (*n* = 19) and at reception (*n* = 9).

Table 11: Request for Information: CCS physical site characteristics and site specifications

CCS characteristic	*N*	%
Physical characteristics of the site [a]		
Office site	36	66.7
Stand-alone house	19	35.2
Outreach supervision service	11	20.4
Other (please specify)	10	18.5
Site specifications [b]		
Supervision rooms (specify number)	51	94.4
Age-appropriate and developmentally appropriate indoor equipment	51	94.4
Duress alarm/s (specify number and location)	49	90.7
Carpark	49	90.7
Separate entrances and exits for Lives with and Spends time with parents	48	88.9
Outdoor play area	48	88.9
Accessible by public transportation (within walking distance to your site)	47	87.0
Facilities for older children (aged 12 years or older)	47	87.0
Disability access (wheelchair access; hearing aid loops)	44	81.5
Security camera/s (specify location)	39	72.2

21 For these items, qualitative responses could be coded to more than one category, so individual categories may sum to more than number of CCS providing a response.

Security door/s (specify location)	36	66.7
Withdrawal spaces (specify number)	36	66.7
Sound proofing	10	18.5
Other (please specify)	2	3.7

Notes: Multiple responses so totals may not sum to 100.0%. a This table reports the number and proportion of CCSs that selected each response option from a list of CCS physical characteristics. Not shown is the number and proportion where each response was not selected (including potentially missing responses). Other specify options in order of frequency included: Childcare centres and community centres. b Multiple responses so totals may not sum to 100.0%. This table reports the number and proportion of CCSs that selected each response option from a list of CCS site specifications. Not shown is the number and proportion where each response was not selected (including potentially missing responses). Other specify responses include video doorbells and buzzers.

The RFI responses also provide insight into the nature of CCS sites and facilities and how they are used by families during supervised visits:

> *Each family is allocated a playroom (2 dedicated playrooms and one meeting room that is set up for contacts on Friday night and Saturday), and they have access to cook in the kitchen, toilets and an outside courtyard to play in.* (Service 127, Vic)

> *There are two separate private supervision rooms and a common area that those families can utilise.* (Service 146, NSW)

> *Four families is the maximum at a time. Each family had a room to themselves and shared kitchen and outdoor space.* (Service 156, WA)

Some RFI responses detailed the management of available space and facilities at CCSs, where there were multiple families on site at a given time. RFI responses above in relation to staffing ratios, together with extracts from the RFI responses below, indicate that the approach taken by some CCSs discourages interaction between families on site, while other RFI responses did not emphasise the prevention of interaction between families in their descriptions of the use of CCS facilities. These responses also provide insight into the logistics of facilitating sessions and how these are managed by CCSs:

> *Families pick their spaces for supervised contact initially and then rotate with other families. For example, a family might start in the back patio area and yard playing games or picnicking. Then they will move to the playground and then inside for some quieter games over the 2-hour supervised contact period. Another family may start off in the kitchen cooking or the craft/arts room, move to the foosball room and then go outside to the playground. Our staff discourage interaction between families and keep their supervised families at a distance from other families using the Centre.* (Service 55, Qld)

> *We aim to have no more than 8 children in the centre at any time. Families where there is just one child may overlap with others in service schedule to maximise session availability but for larger or complex families, we try to ensure private use of the space. Our space has outdoor facilities which are useful for spreading out families (provided staff appropriately), however weather conditions can't be predicted which needs to be managed for internal space if required.* (Service 198, state/territory redacted)

> *Sometimes families use individual rooms. Dependent on age/ number of children in a family, any visitors. If appropriate 2 families can share a space dependent of individual circumstances.* (Service 222, NSW)

Some CCS RFI responses described an arrangement whereby their CCS only accommodated one family per site, or where their CCS was located in a smaller community (e.g. Service 168, NSW; Service 120, SA and Service 212, NSW).

Some CCSs indicated in their RFI responses that their policies had a limit on the number of people who could attend with a Spends time with parent or carer for a supervised visit session and reasons included, the capacity onsite or in order to ensure compliance with the court orders (e.g. Service 152, Vic; Service 170, SA; Service 75, NSW; Service 198, state/territory redacted; Service 207, Vic; Service 79, Vic)

Some RFI responses illustrated some flexibility in this arrangement, whereby following an identified number of positive supervised visits, arrangements may be made between the CCS and family members for additional parties to attend the supervised visit between the 'Spends time with' parent or carer and the child:

> *Additional parties are only allowed [after] … five successful supervised contact sessions have been completed and when both parents/guardians agree to this in writing. Multiple parties are discouraged*

and if the request is made and accepted by the residential parent, our staff will request that the additional parties split their time ie. grandmother attends the visit for the first hour and the cousin or aunty attends the visit for the second hour. We recommend that supervised contact visits still occur without additional parties to prioritise the child–parent relationship. (Service 55, Qld)

Court ordered visiting parent and court ordered children are permitted to attend a supervised visit. After an agreed number of positive visits an extra visitor may be permitted, this extra visitor must have had a relationship with the child and/or expectation there would be a future relationship building need, and the service seeks the agreement of the Lives with parent/guardian before visitors are introduced to the supervised visits, i.e. grandparents, older sibling, step parent etc. (Service 166, WA)

The service encourages the first 2–4 visits be with only the visiting parent (unless court orders specify otherwise) or a registered support person such as a NDIS worker is required. After this then other visitors can attend upon agreement by both parties. (Service 127, Vic)

A number of services in their RFI responses described how they applied a flexible approach regarding the number of attendees at a given visit from the outset of engagement with the CCS, with this number of attendees to be determined on a case-by-case basis, with or without reference to a preference for limits to the number of attendees. For example:

This is assessed on a case-by-case basis around capacity and safety. Attachment to visiting party is also a key consideration in assessing appropriateness of having other parties attend such as siblings and extended family. Considerations are also made around frequency or duration of other parties attending, i.e. do they attend every visit or occasionally. Other parties may also attend virtually via phone or video call if assessed as safe, appropriate and consented to by the 'lives with' parent. (Service 244, Qld)

We allow extended family or siblings to attend when it has been assessed by worker and approved by manager that this will be beneficial and not detrimental to the contact between parent and child. (Service 237, Vic)

The RFI responses of some of these CCSs suggest a particular openness to facilitating larger family groups where this was logistically feasible and in the best interests of the relevant child/children as the client/s of the service. CCSs with the capacity to accommodate this flexibility may be in a position to facilitate engagement with families of diverse cultural backgrounds and family structures, and may enable the acknowledgment of events or milestones of significance to the families using the service:

There is no limit on the size of the family unit that can be supervised, but arrangements with regards to the number staff required to supervise a large family group may change and need to be increased dependent on court ordered requirements and risk factors. Requests for additional persons to attend visits with a parent may be considered if there is an agreement in place that this can occur and that the Centre can facilitate this, this is assessed on a daily basis. (Service 94, Qld)

This varies, depending on the age of the children. At some instances, family members attend for birthday parties or some form of family celebrations and could mean that up to 12 family members per family may attend depending on how many other families attending the same timeslot. Any additional person (third party) may attend if the child is ready. Additional person to sign the service agreement. Both parents or legal representatives have agreed in writing in advance to the additional third person to attend and if the child is ready for an additional person to attend. (Service 154, Qld)

Critical incidents and stopping of services

The RFI process also collected information on the number and type of critical incidents for the calendar years (2019 through to 2022). Information was also collected relating to the number of sessions that were stopped due to child wellbeing/safety concerns, child refusal or other reasons. These data are presented in Table 12.

The number of critical incidents remained stable over the 2019–22 time period (between *n* = 30 and 36 for such incidents), as did the number of these incidents that were externally reported (between *n* = 15 and 19) representing reports made of approximately one-half of the critical incidents.

There was little change in the number of supervised changeover/visits stopped for the safety/wellbeing of the child (*n* = 58 in 2019; *n* = 53 in 2022). There was a slight decrease in the number stopped due to child refusal (*n* = 252 in 2019; *n* = 231 in 2022). Conversely, the number stopped due to other unspecified reasons increased from *n*

= 70 in 2019 to *n* = 106 in 2022. When interpreting these data it should be noted that the relevant RFI items asked about the number of changeover/visits stopped for these reasons, whereas the similar items reported in Table 12 collected information about the number of clients in related categories.

Perhaps reflecting increasing complexity of caseloads, the number of statutory notifications increased by more than 50% from *n* = 117 in 2019 to *n* = 179 in 2022. Police reports made up a small number of such incidents (between *n* = 7 and 12). Overall, the total number of these incidents was similar in 2019 (*n* = 554) and 2022 (*n* = 579); however, there was a noticeable decrease in the number of these incidents in years marked by COVID-19 (*n* = 366 in 2020; and *n* = 394 in 2021).

When looking at the total number of these incidents relative to number of clients, the number of incidents as a proportion of the total number of CCS clients was highest in 2022 (5.1%), with the corresponding proportions lowest in 2020 (3.7%) and 2021 (3.8%).

CCSs also provided data regarding the number of clients involved in any of these incidents. When considering the data through this lens, a broadly similar finding holds – the number of clients involved in these incidents as a proportion of total number of clients is highest in 2022 (11.7%). However, for this measure, the lowest proportion occurred in 2019 (9.7%). Overall, the differences in this regard are small.

Table 12: Request for Information: number and type of critical incidents per year

Type of incident	2019	2020	2021	2022
Number of critical incidents	35	30	35	36
Total *N* CCS	29	29	29	29
Number of critical incidents – external reports	15	17	16	19
Total *N* CCS	23	23	23	23
Number of supervised changeover/supervised time visits stopped for safety/wellbeing of child	58	40	58	53
Total *N* CCS	23	23	23	23
Number of supervised changeovers/supervised time visits stopped due to child refusal	252	160	191	231
Total *N* CCS	23	23	23	23
Number of supervised changeovers/supervised time visits stopped for other reasons	70	74	78	106
Total *N* CCS	23	23	23	23
Number of statutory notifications	117	154	142	179
Total *N* CCS	21	21	21	21
Number of police reports	7	10	12	11
Total *N* CCS	23	23	23	23
Total of these incidents	554	366	394	579
Total *N* CCS	29	29	29	29
Total number of clients as reported by CCSs (from Table 3)	12,168	9,893	10,324	11,365
Number of **incidents** as a proportion of total number of clients	**4.6%**	**3.7%**	**3.8%**	**5.1%**
Total number of **clients** involved in any of these incidents	1,177	1,078	1,088	1,329
Number of **clients involved in these incidents** as a proportion of total number of clients	**9.7%**	**10.9%**	**10.5%**	**11.7%**

The Survey of Professionals also captured qualitative data from participating professionals relating to the reasons for stopping service provision and the regularity with which this happens. A substantial proportion of professionals providing a response to this question (*n* = 59/146) described how services are withdrawn based on the child's best interests where there is a child refusal or where they are distressed. For example, survey responses indicated that service would be declined or stopped when:

- the parent or carer is not willing to agree with the service agreement (CCS staff, NSW, 45–54 years)

- the CCS staff assess that there has been significant harm to a child or where the child has witnessed significant harm or otherwise experienced trauma (e.g. child abuse allegations or investigations (e.g. CCS staff, Qld, 45–54 years; CCS staff, NSW, 45–54 years)
- the child indicates that they do not wish to see the parent or carer or that they feel unsafe 'and all efforts have been made to support the child' (CCS staff, NSW, 45–54 years, further e.g. CCS staff, Qld, 45–54 years; CCS staff, Vic, 55+ years)
- the child is fearful of the Spends time with parent and is 'highly fearful of what further harm they may do to them, their siblings and or the LWP' (CCS, NSW, 45–54 years)
- the Lives with parent or the child's physical and/or emotional safety is at risk if the supervision arrangements proceed (e.g. CCS, NSW, 45–54 years)
- a parent or carer uses violence or threatening or other unsafe behaviour against another party, a child or the staff or other clients (e.g. CCS staff, Vic, 55+ years; CCS staff, NSW, 45–54 years; Lawyer, Qld, 35–44 years)
- the parent or carer is unable to follow direction, behaves inappropriately or significantly or persistently does not abide by the service agreement and does not engage or adhere to measures agreed to address this (CCS staff, NSW, 45–54 years (e.g. continuously discussing adult issues or involving them in conflict or undermining their relationship with the other parent/carer, despite review with CCS staff or behaving aggressively (CCS staff, Qld, 45–54 years; CCS staff, NSW, 45–54 years; Lawyer, Qld, 35–44 years)
- the parent or carer regularly cancels without explanation or attends substance affected (CCS staff, NSW, 45–54 years; Lawyer, Qld, 35–44 years)
- the Lives with parent is highly traumatised and their parenting capacity will be at risk of the supervision arrangement proceeds (e.g. CCS staff, NSW, 45–54 years)
- there are court orders for unlimited supervised time (e.g. CCS staff, Vic, 55+ years).

As foreshadowed in the above responses, some participants described the cessation of service as due to an increase in safety issues for the child or staff or otherwise arising through the risk assessment or where there is persistent breach of the service agreement (*n* = 39/146).

Most commonly, professionals described service being withdrawn where a parent is in breach of the CCS service agreement, including for reasons of substance use or breach of behaviour protocols (*n* = 67/146). The suspension of CCS service provision was identified by one participating professional as a means of encouraging parents and carers to stabilise their behaviour and to be more future focused on their engagement with the child (Service provider organisation, Qld, 55+ years). Some participants also described the cessation of services as a result of the family reaching their funding ceiling or the end of their time-limited services (*n* = 19/146). Transitioning to self-managed arrangements was also cited by smaller proportions of participants (*n* = 15/146) including where court orders are amended (*n* = 12/146).

Self-management as a goal to be facilitated by CCSs

The data presented in chapter 2 identified the extent to which CCSs provide time-limited services, case reviews and the extent to which their clients transition to self-management. In this section, the focus is on professionals' views on the goal of self-management as a part of CCS practice (Table 13). Key findings explored in this section include most professionals' agreement with the proposition that CCSs should and do support families to safely move to self-management, with a range of circumstances that nevertheless required long-term supervision, including 'identity contact'. Data from parents and carers are also presented showing mixed views about their capacity to move to managing without the CCS, with concerns about the safety of moving to self-management and CCS expertise to provide this support also considered.

The data show that most professionals (77%) strongly agreed (37%) or agreed (40%) that CCSs need to support families to safely move to self-manage their parenting arrangements. CCS professionals were more likely to consider this to be a role of CCSs than referring professionals to a statistically significant extent.

The data also show that most professionals (80%) strongly agreed (37%) or agreed (43%) that CCSs need to support families to achieve safe, sustained and workable long-term parenting and time arrangements. Again, CCS professionals were more likely to consider this to be a role of CCSs than referring professionals, to a statistically significant extent.

Table 13 also shows that more than half of professionals (61%) strongly agreed (21%) or agreed (40%) that CCSs successfully provided support and services that families need to safely move to self-management. Again,

however, CCS professionals were more likely to consider that CCSs did so than referring professionals, to a statistically significant extent. Referring professionals were more likely to indicate that they did not agree, neither agreed nor disagreed or did not know or could not say whether it was CCSs who provided this support.

The data also indicate a minority of professionals strongly agreed or agreed that CCSs should not provide supervision services in matters where there is no prospect for the family to safely move to self-management. In relation to whether long-term or permanent arrangements should be made, CCS professionals were more likely to strongly agree or agree and less likely to disagree to a statistically significant extent in both instances.

Table 13: Survey of professionals: agreement with statements about self-management of clients receiving government-funded CCSs by professional type

To what extent do you agree that government-funded CCSs 'in your organisation''in your area' are:	CCS professionals		Referring professionals		Total	
	N	%	*N*	%	*N*	%
Government-funded CCSs need to support families to safely move to self-management* **						
Strongly agree	54	51.4	28	23.9	82	36.9
Agree	39	37.1	50	42.7	89	40.1
Neither agree nor disagree	11	10.5	20	17.1	31	14.0
Disagree	0	0.0	7	6.0	7	3.2
Strongly disagree	0	0.0	6	5.1	6	2.7
Do not know/cannot say	1	1.0	6	5.1	7	3.2
Total	105	100.0	117	100.0	222	100.0
Government-funded CCSs need to support families to achieve safe, sustained and workable long-term parenting and time arrangements*						
Strongly agree	49	47.1	32	27.4	81	36.7
Agree	40	38.5	56	47.9	96	43.4
Neither agree nor disagree	13	12.5	16	13.7	29	13.1
Disagree	0	0.0	7	6.0	7	3.2
Strongly disagree	1	1.0	2	1.7	3	1.4
Do not know/cannot say	1	1.0	4	3.4	5	2.3
Total	104	100.0	117	100.0	221	100.0
Government-funded CCSs successfully provide support/services that families need to safely move to self-management* **						
Strongly agree	32	30.5	14	12.0	46	20.7
Agree	54	51.4	35	29.9	89	40.1
Neither agree nor disagree	13	12.4	31	26.5	44	19.8
Disagree	3	2.9	14	12.0	17	7.7
Strongly disagree	0	0.0	2	1.7	2	0.9
Do not know/cannot say	3	2.9	21	17.9	24	10.8
Total	105	100.0	117	100.0	222	100.0
Government-funded CCSs should not provide supervision services in matters where there is no prospect for the family to safely move to self-management						
Strongly agree	13	12.4	13	11.1	26	11.7
Agree	20	19.0	10	8.5	30	13.5
Neither agree nor disagree	15	14.3	17	14.5	32	14.4
Disagree	40	38.1	44	37.6	84	37.8
Strongly disagree	14	13.3	28	23.9	42	18.9
Do not know/cannot say	3	2.9	5	4.3	8	3.6
Total	105	100.0	117	100.0	222	100.0

To what extent do you agree that government-funded CCSs 'in your organisation''in your area' are:	CCS professionals		Referring professionals		Total	
	N	%	*N*	%	*N*	%
Long-term or permanent arrangements at a contact service should not be made*						
Strongly agree	13	12.4	7	5.9	20	9.0
Agree	24	22.9	16	13.6	40	17.9
Neither agree nor disagree	25	23.8	21	17.8	46	20.6
Disagree	28	26.7	49	41.5	77	34.5
Strongly disagree	11	10.5	20	16.9	31	13.9
Do not know/cannot say	4	3.8	5	4.2	9	4.0
Total	105	100.0	118	100.0	223	100.0
It is not appropriate for government-funded CCSs to provide the support/services that families need to move to self-management						
Strongly agree	4	3.8	5	4.3	9	4.1
Agree	6	5.7	10	8.5	16	7.2
Neither agree nor disagree	18	17.1	23	19.7	41	18.5
Disagree	37	35.2	46	39.3	83	37.4
Strongly disagree	36	34.3	25	21.4	61	27.5
Do not know/cannot say	4	3.8	8	6.8	12	5.4
Total	105	100.0	117	100.0	222	100.0

Participants captured in Table 13 were also asked to state why they agreed or disagreed with the range of statements relating to self-management as presented in the table.

Of the 120 participants providing an open-text response, more than half provided reasons for why they disagreed with these propositions (*n* = 67/120). These responses raised safety concerns about self-management, including in circumstances involving DFV, disabilities or substance misuse issues (*n* = 10), with a substantial proportion of participants indicating that some families required ongoing supervised visits or changeover (*n* = 50). Other responses raised concerns relating to the need for additional funding to support long-term supervision when families are not ready to move to self-management where service limits are reached (*n* = 7):

> *We have cases (minimal) where the only option is for supervised contact indefinitely. We would hold this family for long as we possibly can so the child can have contact with that parent in a safe environment. Usually though we like to cap our families to be in the service no longer than a year. We recently introduced and are trialling a 3-month model for voluntary clients (not Court Ordered).* (CCS staff, Qld, 45–54 years)

> *I think in some circumstances that there needs to be supervision in place for safety but that the child can still enjoy and gain knowledge and connection from their visiting parent. It depends on why there is safety issues; it depends on court orders; however if the court [order] is final and there is no movement to safe self-managed visits, then it is appropriate for continuation of service for as long as the child might need up to 18yrs.* (CCS staff, Qld, 45–54 years)

Participants described a range of circumstances where long-term supervised arrangements may be required, including circumstances characterised by illness, injury or disability including acquired brain injuries, mental ill-health, homelessness and substance abuse (e.g. Service provider organisation, Qld, 55+ years; CCS staff, SA, 45–54 years; Lawyer, Vic, 45–54 years; CCS staff, Qld, 45–54 years)

Some participants described the potential arrangements that could be put in place for long-term or indefinite supervision arrangements where the families' circumstances meant that self-managed arrangements were not safe or feasible but where it was determined that some contact, including 'identity contact' (commonly nominated as involving 4 sessions per year) was deemed to be in the best interests of the child:

> *There are some cases where it is important for children to be able to have some level of ongoing contact with the supervised parent, but it would be too much of a risk for that time to be unsupervised. It is important that there be another option available to the family law courts that is not either a final no*

contact or an order for contact that may be placing the children at risk of psychological or physical harm. (Lawyer, Vic, 35–44 years)

Some families will always require supervised visits as stated in their final orders. Our service offers a 4 Supervised Visits per year service for these families. If we did not provide this service, these children would never see their other parent. (CCS staff, Vic, 45–54 years)

There are many different circumstances where supervision is required. For most families it is not a long-term solution but there are some families where it will not be possible to move away from supervision but where the children want to maintain a connection with that parent. Typically, the availability of long-term supervision is limited, typically 4 times a year but there is a role for that. (Judicial officer, Vic, 45–54 years)

The following participant described the challenges for families and decision makers where long-term supervision options such as 'identity contact' were not an option:

At the moment, I am regularly told that contact services will not provide supervision services for more than two years. Whilst I understand the rationale behind this, there are some cases where a child may benefit from spending infrequent, supervised time with a parent (say on four to six occasions a year) for the purpose of maintaining a sense of identity or connection to that parent. Where services are time limited, it means that sometimes an order will be made for no time because supervision is unavailable. (Judicial officer, NSW, 45–54 years)

There were also a substantial proportion of open text survey responses reflecting agreement with the propositions presented in Table 13 (n = 37/120). Some of these professionals indicated that they considered that CCSs should facilitate families to transition to self-management rather than providing long term supervision so that other families could have an opportunity to access the CCS given that there was such demand for their services (n = 5).

Some professionals in their open text responses indicated that self-management had to be the goal of CCS service provision because they considered that facilitating parenting time where there was no prospect of unsupervised time was not consistent with the best interests of children:

Where there is no prospect for a child to be able to participate in unsupervised time with a parent, then I do not believe the service should be facilitating any time. If a child is spending time with a parent consider[ed] unsafe this will only further impact on their trauma. This time has no benefit to the child. This should be captured within the triage process. For instance, where there are allegations of sexual assault or high-risk family violence, or when these issues have been substantiated, I also cannot see the point of this time going for a number of years. It is not practical or natural and is often confusing for children. (Court Child Expert, NSW, 45–54 years)

[Where there is] no prospect of self-management AND long-term or permanent arrangements at a contact service, [referrals to the CCS] should not be made – If changeovers are safe long term, then it may be appropriate. If changeovers will never be safe, the benefit of long-term supervised visits is highly questionable especially in DV cases. Identity only contact may be suitable. Frequent supervised contact visits long term is very disruptive for the LWP and children and hinders their development, e.g. ability to join a weekend sport, and can significantly harm the relationship between LWP and child if the child does not want to attend. Another issue with long term orders they are not flexible and do not accommodate achild's needs and wants [which are] changing, e.g. when in school and wants to join a Saturday sport but visits are ordered for Saturday morning. When issues arise the orders are not comprehensive enough to direct parents to a solution e.g., what to do if STWP cancels visits repeatedly, what about birthdays and holidays, communication in a medical emergency concerning the child, do the orders address issues covered in AVOs and should the AVO be reflected in the orders for long term safety? (CCS staff, NSW, 45–54 years)

Supervised contact is an artificial arrangement that should only be used as a tool to keep children safe while parents are obtaining skills to be able to safely care for children unsupervised. It is not healthy for children or an appropriate use of government funds for children to have long-term or permanent supervised contact with a parent. (FDR professional, NSW, 35–44 years)

Although it benefits the children to spend time with their parent, supervision is not ideal nor practical long-term. Therefore, it would be difficult for them to comprehend spending time with a parent for a short period, then this time ceasing, without them being aware of the dynamics which are often outside the

scope of their developmental capacity to understand, and is often information they would not benefit in knowing. (Court Child Expert, Qld, 25–34 years)

Long term supervision is not in a child's best interests and should not occur. Parents have the responsibility to change not the child. These centres deal with parents at the coal face and are uniquely placed to educate parents and have them change their behaviours. This unique opportunity is not understood in the general community. (Judicial officer, NSW, 55+ years)

Some professionals focused their responses on the CCSs being in the position to provide the guidance and therapeutic support or referrals to families to facilitate them to transition to self-management, with some participants identifying this as part of their role as a service provider. As observed in the second quote below, some participants considered CCSs to be compensating for structural issues that create challenges in service provision, particularly in response to people who use violence (*n* = 10):

Children's contact services are in the best position to educate and support families to move from supervision to self-management of their change overs. Their social work training and background coupled with the relationship they ought to have built with the family puts them in the right place for this to occur, of course, if the circumstances and risk issues are not averse to moving towards self-management. (Lawyer, NSW, 45–54 years)

Ideally the CCS should provide a service that has the capability to assist families to move toward self-management. However, this requires a workforce that has the skill set to undertake the complex case work and management required. The reality is that domestic and family violence and the issues around holding perpetrators accountable in a Family Court context is limited. Hopefully improved operation of the Family Court system with the criminal justice system will address some of structural issues. (Service provider organisation, state/territory redacted, 55+ years)

I support CCS services focusing on actively engaging with families through their case management function to enable them to transition safely to managing their own contact arrangements. (Court Child Expert, Qld, 55+ years)

All CCS's should provide the support/services that families need to move to self-management where it is safe to do so. It is our responsibility to be able to ensure the families have the resources they need to exit and maintain self-management for the safety of the children. (CCS staff, Qld, 55+ years)

Some participants were supportive of CCSs facilitating the transition to self-management but identified the decision to move to self-managed arrangement as a matter for the court rather than the CCS where the family are engaged in relevant litigation (*n* = 10). For example:

I agree that the CCS services should be able to provide and assist with self-management and progressions where appropriate, however in circumstances where the family is involved in litigation that should not be driven by the CCS it should be driven in accordance with what the court has determined is in the best interests of the child. In some families, progression to unsupervised time will never be appropriate; however, long-term supervision may still be in the child's best interests. In other situations where there should be a move to semi supervision and then unsupervised it is great to be able to have that occur within the CCS where the children are familiar. (Judicial officer, NSW, 35-44 years)

I am concerned that CCS is trying to push families to self-management in future where there is overwhelming risk to the child and the primary parent and I think it is important that CCS not be a part of that. [For] Some families it is not safe to self-manage ever. Then, if CCS are not willing to do long term supervision orders, CCS should be saying that in a report to the Court and the matter should proceed to trial as a no contact matter. (Lawyer, SA, 35–44 years)

As foreshadowed in the quote above, some participants emphasised a delineation of roles among the relevant professionals in the family law service system with respect to decisions about, and facilitation of, transitions to self-management. Some professionals articulated the view that it was the prerogative of the court and not the role of CCSs to determine families' transition to self-management, or that they did not have the expertise or information, or were not in the best position due to service demands and funding (*n* = 8) to determine transitions to self-management:

The service should be providing supervision and whilst ancillary services like therapeutic counselling and parenting and like courses are beneficial, the focus should be on the availability of professionally

supervised contact centres. It is not for the centre itself to say how long supervision should occur; this is the purview of the court. (Lawyer, Vic, 25–34 years)

The funding is so scarce, it should be focused on providing safe supervised time. I worry that trying to make the services improve the functioning of families with a view to self-management is not the best use of resources. Children are most often in these services as a result of untested allegations. Not all the allegations are true. Often the allegations are true. Sometimes the experience is enough to force a parent against whom allegations are made to do the hard things they need to improve their parenting. Often it is the first time a parent is told that their parenting is deficient. The centres can't support families to move to self-management. They simply do not have the resources. Parents may need drug and alcohol rehab, psychological treatment, FV perpetrator treatment, etc. (Lawyer, NSW, 45–54 years)

If long-term supervision is an option, I think that decisions should be left to the Courts to adjudicate. If the Court considers it viable and, in the child's, best interests, it should occur. However, I accept that the CCS must set their own policies and they may choose not to offer long term supervision for whatever reason. That reason may not be philosophical, or evidence based, it may simply be a question of funding. The CCS policy would be a relevant factor in the Court's deliberation. (Lawyer, state/territory redacted, 55+ years)

I do not think it is CCS's role to support families to move to self-management. They are not a child protection service nor a family case management service. They are there to support children to have contact safely. They can do this well because they are neutral and are not responsible for identifying risks that may exist within families in the community. I see CCS's role as managing contact that is supported under their scrutiny. Making assessments outside of that scrutiny/discrete observation and widening this role will likely create challenges in the delivery of services to children and families. (Court Child Expert, South Australia, 35–44 years)

Some professionals providing open text responses indicated that the question of whether a family may be able to move to self-managed arrangements is one that should be determined on a case-by-case basis because 'no one size fits all' and the needs and best interests of children are different (e.g. Judicial officer, NSW, 55+ years; Reg 7 Family Report Writer, Qld, 55+ years; Lawyer, SA, 55+ years).

The qualitative interviews with parents and carers revealed more detail on their views about being able to move to self-management. An equal number of parents/carers using only the changeover service at CCSs indicated that they felt they would be able to move onto managing changeovers with the service (n = 4), as the number that indicated they would not be able to move to managing changeovers without the CCS (n = 4).

For those that indicated that it would not be possible to move to self-management for changeovers, the key reason was safety – either for themselves, and not wanting to experience abusive or conflictual behaviour from the other parent, or not wanting their child to see high levels of conflict.

Parents and carers who were using the CCS for supervised time rather than changeover, responded most frequently that they did not feel able to move to self-management in the future (n = 20). The main reason for this conclusion was that the parent or carer responding did not consider that it would be safe to stop using the CCS. This included reasons such as the Spends time with parent using substances (including drugs and alcohol), a lack of trust in the Spends time with parent to comply with what had been agreed, or there was ongoing fear on the part of the responding parent or carer in seeing or interacting with the Spends time with parent. The FCFCoA processes were another factor in parents and carers considering that they may not be able to move on from using the CCS describing the process as slow to make any changes to orders and final orders required ongoing supervision, meaning there was a feeling that the family was 'stuck' in the situation of using the service.

Previous experiences are a significant aspect of the caution on the part of some parents and carers about moving towards self-managed arrangements. Sixteen parents/carers previously had informal or private arrangements where they managed supervised changeovers or supervised time themselves. However, safety concerns (including examples of serious incidents) were described as the main reason for stopping those informal arrangements.

A substantial proportion of parents and carers (n = 19) indicated that they did not know if they would or would not be able to manage supervised time without the CCS. A key response in considering why they did not know was that it depended on the other party and their behaviour changing. This included requiring testing for drugs or alcohol to be undertaken by the Spends time with parent, or that the Lives with parent/carer had witnessed the Spends time with parent being angry in front of the children and did not feel that the other party was likely to change. Participating parents and carers often indicated that they had no control over whether the family

could move to self-management as this decision would depend on the other parent/carer deciding to behave appropriately in order for that to happen.

For the parents and carers who indicated that they *would* be able to manage changeovers or supervised time in the future, the age of the children seemed to be a large influencing factor. These parents or carers indicated they would be able to use their children's school as the changeover point or that the children would be able to travel without them to the other parent or carer's home in the future when they were old enough to do so, with these arrangements reflected in the court orders and in this way provided for a smooth transition from the CCS. As they get older, children were also described as being better positioned to act protectively in relation to the Spends time with parent:

> *I need that service to go on for until [child's name] is a teenager when he is probably bigger and taller and stronger. Sure. Yeah. Well, I don't know if anything happens if [child's name] can get away from him and not have any issues, but while he's still a baby no way.* (LWP 39)

A small minority indicated that they had been able to build better communication with the other parent or carer so could make plans around the children more easily in the future.

Few of the parents/carers interviewed responded affirmatively when asked if there was anything they felt CCSs could do to help families transition to self-management. Some parents felt that it was the role of the courts rather than the CCS to make decisions or to take additional action around moving to self-management. However, one parent suggested that it may be useful if the CCS could make recommendations in a formal capacity, although this would be likely to have implications for their requirement to be neutral in providing services to families (STWP 11). Other suggestions that parents and carers made included providing drug and alcohol counselling for parents/carers or offering community-based supervision on a graduated basis to help families move offsite. The responses provided in interview data did not indicate that parents or carers felt strongly that these elements would be helpful but rather that it was possibly something that could be tried where CCS supervised visits could not be indefinite. One parent indicated that co-parenting courses would be beneficial to help parents improve communication, but this could only be done in situations where it was safe to do so (STWP 13).

Process of facilitating self-management

Participants in the Survey of Professionals were asked for their views on how CCSs helped families to safely move to self-manage their parenting and time arrangements or to achieve sustained and workable long-term parenting arrangements.

Most responses reflected positively on this process (*n* = 78/124) with the responses focusing on the therapeutic support for parents, including via referrals (*n* = 35), the effectiveness of the services provided by the CCS to support families to transition out of the CCS, including with the support of case management and review and engagement with the family members (*n* = 18).

Participating professionals indicated that by providing supervision services and engaging with families, CCSs facilitate parents and carers to transition to self-managed arrangements by (e.g. Judicial officer, Qld, 55+ years; CCS staff, WA, 45–54 years; Lawyer, Vic, 45–54 years; CCS staff, Vic, 55+):

- 'creating a safe' and neutral 'space for all to learn and grow' (CCS staff, Vic, 55+ years) and:
  - develop their skills and confidence, including by 'subtlety teaching skills and increasing self-awareness of parenting techniques' (CCS staff, Vic, 55+ years)
  - establish trusting relationships between children and their parents/carers
  - be child-focused, identifying and responding to their children's needs
- providing families with the opportunity to address underlying issues; for example, through parenting courses or drug rehabilitation
- allowing risk assessment over time.

More active engagement by CCS staff was envisaged by the participants where CCS staff help families to safely move to self-management by:

- supporting families to develop strategies that work for them and their circumstances' (CCS staff, state/territory redacted, 55+ years) and strategies to support their children (CCS staff, state/territory redacted, 45–54 years)
- employing a strengths-based approach and offering or coordinating or facilitating warm referrals to education and support services such as post-separation parenting programs (CCS staff, Vic, 45–54 years)

and working with services that are providing counselling/behavioural change interventions with the family (Service Provider Organisation, NSW, 35–44 years)

- working with parents on their parenting capacity and 'parental reflective functioning practices' (Court Child Services, Qld, 45–54 years; CCS staff, Qld, 55+ years) and supporting parents to practice and implement the skills that they have learnt in parenting courses including positive communication strategies and strategies to support the child (e.g. regulating their own emotions when with the child) (Service Provider Organisation, NSW, 35–44 years)
- therapeutic support to repair or build child-parent relationships (Court Child Services, Qld, 45–54 years)
- reinforcing positive behaviours and 'coaching' or modelling child-focused and safe engagement with the child and communication with the other parent/carer (CCS staff, NSW, 45–54 years; CCS staff, Qld, 25–34 years)
- providing support to the children and facilitating engaging with children to hear their views about visits and how the CCS may support them (CCS staff, NSW, 45–54 years)
- providing a 'stepped and scaffolded model together with education on the best interest of the children' (CCS staff, WA, 55+ years) or facilitating a 'step-down' approach for example where parents meet at changeover before moving to self-management (CCS staff, NSW, 45–54 years).

While acknowledging the favourable position of CCS staff to provide families with support to transition to self-managed parenting time arrangements, some participants nevertheless had reservations about the CCSs providing the services that were identified as requiring specialist skills. For example:

> *Contact supervisors are in a good position to assist families to move toward self-management, especially if they are able to build rapport with each parent and the child/children. This appears to me, however, to extend the role, to a parenting educator or trainer rather than a supervisor. There may be a place for specialist workers to fulfil such a role, should parents want to take up the opportunity. To assist families to safely move toward self-management, they may require referral to other support services. It seems that contact services would be well placed to be able to suggest appropriate services that people might access.* (Judicial officer, NSW, 45–54 years)

Other participants also emphasised the role played by case review and case management activities, together with the provision of CCS reports in supporting a graduated transition to self-managed arrangements or to otherwise achieve sustained and workable long-term parenting arrangements (Court Child Expert, Qld, 55+ years). Some participants described how regular case support and management by CCS staff with parents and carers enabled a focus on goal planning and review (CCS staff, WA, 55+ years; CCS staff, NSW, 25–34 years; CCS Staff, Qld, 45–54 years), with time-limited services providing a motivation for change (CCS Staff, Qld, 45–54 years). CCS reports were identified as playing a role in this process by providing 'a picture of the relationship between child and parent and flag any concerns' and 'this can be used to make more informed decisions about whether things can move to safe independent management. (CCS staff, Vic, 55+ years)

Some participants referred to the implementation of transitional or graduated arrangements to support families to move to self-managed arrangements:

> *Wrap around service for families to work towards individual goals and family goals, stepped and gradual process of transitioning from centre-based visits to community visits, partially supervised. Regular case reviews.* (CCS staff, NSW, 35–44 years)

> *A step-down approach would be beneficial; the level of supervision in the centre to slowly decrease, such as a worker supervising more than one family at a time. Supervised time would then move to the community, where there is less direct oversight, though still some level of supervision. Finally, supervised visits would move to the home environment for a period before supporting the family to self-manage their time. When the latter occurs, it would be helpful for the worker to have conversations with both parents in regard to maintaining this arrangement, including information such as adhering to set times and locations for changeovers, and time with the other parent in the future.* (Court Child Expert, Qld, 25–34 years)

Success of self-management

The qualitative open-text responses in the Survey of Professionals also provided insight in relation to participants' perceptions of the success of CCSs in facilitating transitions to self-management. Responses most commonly described how CCSs were successful in helping families to safely move to self-manage their parenting and time arrangements or to achieve sustained and workable long-term parenting and time arrangements (*n* = 53/88).

These responses included reflections on the effectiveness of the CCS service (*n* = 13/88) or the CCS supporting parents and carers to focus on the best interests of children (*n* = 2/88). For example:

> *I believe our service has an important role in helping families restore some trust in parent/child relationships that may have been broken in the situation that bring families to our service. Our role at the contact centre is vital as we connect with many of systems/services which are not necessarily linked to each other in providing safety for the children as paramount in working toward sustainable parenting arrangements. Our ability to provide advocacy, support, referrals and education to parents helps parents to build increasing stability in their own lives, behaviours, and abilities to progress toward more sustainable parenting arrangements. I also believe our service is successful in this area as parents can experience support with their child at the centre, this modelling can be received in a safe, non-judgemental environment. The strong boundaries that are set out and required by staff in terms of supporting the relationship of the child with the other parent is often unique in parents experience where their support systems may be more biased and defensive. Centre staff often model the behaviours of good will and child-focus in relating with the other parent in how we support and negotiate issues that arise.* (CCS staff, Qld, 35–44 years)

As foreshadowed earlier, the provision of time-limited supervision services was identified as providing the necessary impetus for families to address the underlying issues giving rise to the need to use the CCS, which, in turn, facilitated moves to self-managed arrangements:

> *… providing a time-limited service allows parents to focus on the overall goal of self-management (when safe to do so). If there is no time limit (e.g. up to 12 months) then parents can struggle to make changes towards self-management as there is no motivation for change; furthermore, all parties can then become institutionalised without a clear exit strategy.* (CCS staff, Qld, 35–44 years)

A smaller but substantial proportion (*n* = 26/88) of professionals participating in the survey detailed reasons why CCSs were unsuccessful in helping families to move to self-management. These responses underscored the concerns examined in relation to the provision of longer-term supervision services based on the safety and feasibility of moving to self-management, and again based on views about who has the role of making decisions about if and when a family should move to self-managed arrangements. For example:

> *We are successful some of the time, but the reality is that the court orders usually determine each family's pathway. There are also many issues that affect whether a family moves to self- management, i.e. mental health issues, substance abuse issues.* (CCS staff, Qld, 45–54 years)

> *I don't think this is our primary role as the court makes this decision. Regardless of what we think the families are subject to a court order and their time spent arrangements do not change until the court order says something different. Our reports can help influence this change. Generally, court or mediation will be involved with families moving to independent management,* (CCS staff, Vic, 55+ years)

> *I think supervised contact centres – should make the supervision and record keeping their main goal, rather than making a concerted effort to transition the family out of the centre. Each matter should be assessed individually, taking into account the evidence of harm, and the goal of the parenting order or arrangement. If the arrangement is designed to be temporary while the risk is addressed, or a bond is developed, or the parent is upskilled, then this could be part of the role of the contact centre to support this to happen. And to feed the info about how the visits have been going back to the decision maker. As a secondary role, Contact Centres could offer parties support, coaching, parenting courses, encourage the parties to consider the impact of their risk taking on the child – but i do not think it is the role of the contact centre to be the driving force to transition families out of supervision in order to make room for more families.* (Lawyer, Qld, 35–44 years)

Compliance with CCS objectives

Aligned to Research Question 5, data from the Survey of Professionals is considered to assess the extent to which the service models when applied by the services meet the following objectives for CCSs as reflected in the Guiding Principles Framework for Good Practice, namely child-focus, safety, neutrality, collaborative service provision and client diversity and cultural sensitivity (see further chapter 5). These objectives will be explored throughout this section. Data relevant to safety and child-focused, child-centred and child inclusive objectives

considered are also relevant to compliance with the National Principles for Child Safe Organisations and trauma informed practice.

Specific consideration is given to the extent to which CCSs are identified as child-focused/child-centred and trauma-informed to support the analysis to address Research Question 4. Data from the Survey of Professionals provide insight into the extent to which CCS service provision embodies the objectives of CCS practice as outlined in the Guiding Principles Framework.

The following response patterns will be considered in the context of data from the Survey of Parents and Carers, and from interviews with parents and carers, presented in the final sections of this chapter.

Figure 9 presents data relating to participating professionals' assessments of the extent to which CCSs engage in collaborative, neutral, child-focused service provision that is either child-centred or child-inclusive.

Collaborative service provision

Overall, just under half of participating professionals strongly agreed (29%) or agreed (18%) that CCSs engaged in collaborative service provision. More specifically, the data show that although most CCS professionals strongly agreed (55%) or agreed (23%) that CCSs do engage in collaborative service provision, only 7% of referring professionals strongly agreed and 15% agreed with this proposition. Substantially more than one-third (40%) of referring professionals indicated that they did not know or could not say whether CCSs engaged in collaborative service provision.

Once again, these findings in relation to CCS professionals' strong agreement and referring professionals' equivocal responses reflected statistically significant differences between the 2 professional groups. It is acknowledged that while CCSs are an authoritative source of knowledge of the extent to which they are engaging in collaborative practices when providing their services, referring professionals (and parents and carers) as the parties arranging (or in receipt of) these services have insight into the operation of collaborative practices where they access CCSs that do or do not incorporate collaboration with other service providers and professionals.

Neutral service provision

Overall, most participating professionals strongly agreed (38%) or agreed (27%) that CCSs were neutral. More specifically, the data show that although most CCS professionals strongly agreed (62%) or agreed (26%) that CCSs were neutral, 17% of referring professionals strongly agreed and 28% agreed with this proposition. One-quarter (25%) of referring professionals indicated that they did not know or could not say whether CCSs were neutral.

Once again, these findings in relation to CCS professionals' strong agreement and referring professionals' equivocal responses reflected statistically significant differences between the 2 professional groups.

Reliable and helpful services

Overall, most participating professionals strongly agreed (41%) or agreed (34%) that CCSs were reliable. More specifically, the data show that although most CCS professionals strongly agreed (65%) or agreed (28%) that CCSs were reliable, 19% of referring professionals strongly agreed and 39% agreed with this proposition. Nearly one-quarter (21%) of referring professionals indicated that they did not know or could not say whether CCSs were reliable.

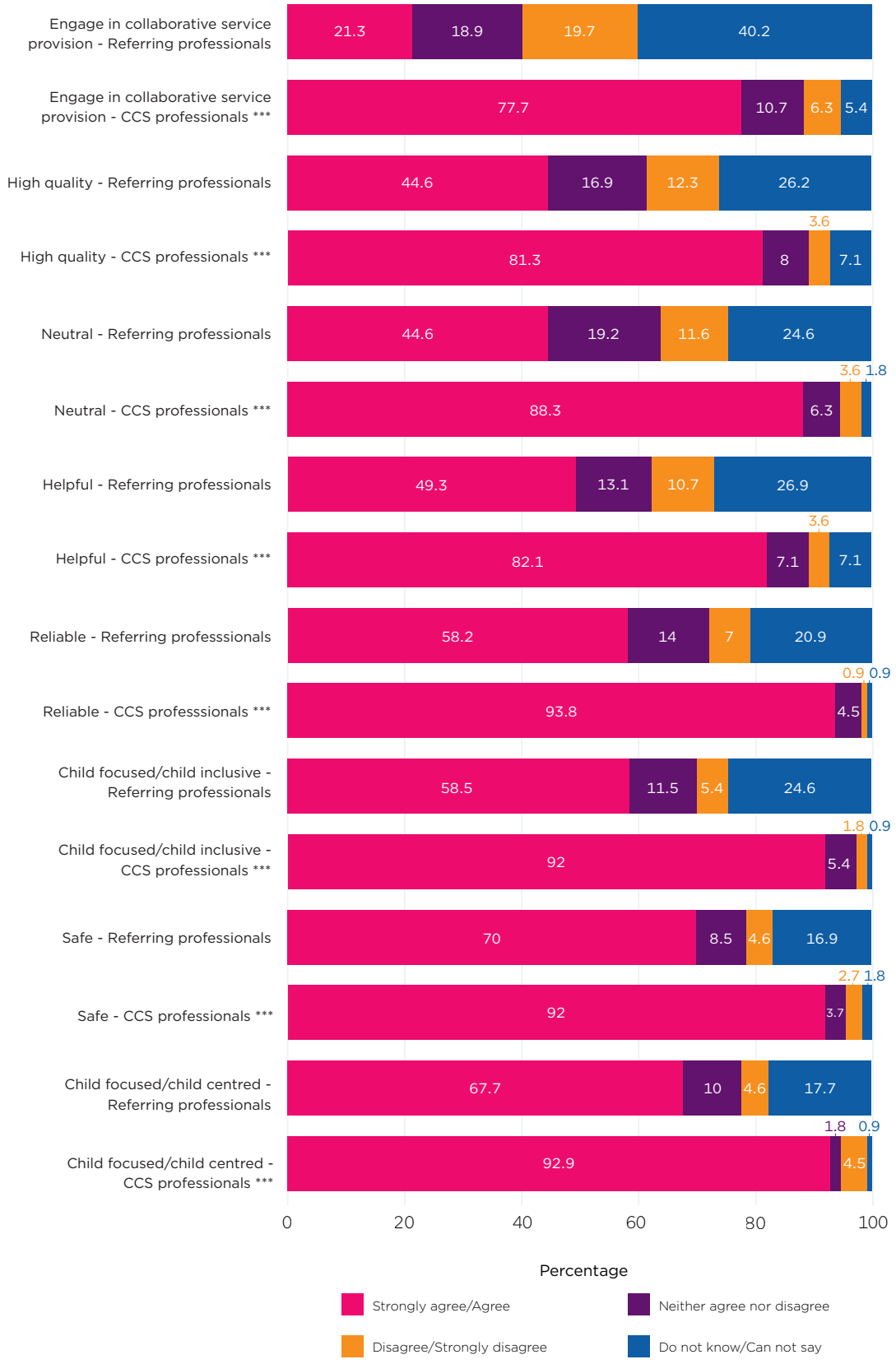
Once again, the findings in relation to CCS professionals' strong agreement and referring professionals' equivocal responses reflected statistically significant differences between the 2 professional groups.

Most participating professionals strongly agreed (39%) or agreed (25%) that CCSs were helpful. More specifically, the data show that although most CCS professionals strongly agreed (61%) or agreed (21%) that CCSs were helpful, 21% of referring professionals strongly agreed and 29% agreed with this proposition. More than one-quarter (27%) of referring professionals indicated that they did not know or could not say whether CCSs were helpful.

Again, these findings in relation to CCS professionals' strong agreement and referring professionals' equivocal responses reflected statistically significant differences between the 2 professional groups.

The extent to which CCS service provision is helpful will be considered further in the context of data relating to safety and effectiveness based on triangulated data in the latter sections of this chapter and chapter 5.

Figure 9: Survey of Professionals: agreement with effectiveness of government-funded CCSs by professional type



Notes: Question was worded as: 'To what extent do you agree that government-funded CCSs in your organisation/ in your area are ...' CSS professionals asked to rate CCS characteristics for 'my organisation' and referring professionals asked to rate those 'in my area'. ***$p < .001$ statistically significant based on chi-square test. Percentages may not total 100.0% due to rounding.

Reports provided are of high quality

Overall, participating professionals strongly agreed (34%) or agreed (28%) that the reports provided by the CCSs in the professionals' area were of high quality. More specifically, the data show that although most CCS professionals strongly agreed (55%) or agreed (26%) that the reports of the CCSs in their area were of high quality, 15% of referring professionals strongly agreed and 29% agreed with this proposition. More than one-quarter (26%) of referring professionals indicated that they did not know or could not say whether the CCS reports were of a high quality.

Once again, these findings in relation to CCS professionals' strong agreement and referring professionals' equivocal responses reflected statistically significant differences between the 2 professional groups.

These differences may reflect variations on the part of referring professionals and CCS professionals about the purpose of these reports and their assessments of the quality of the content of these reports from a legal and evidentiary perspective, and the extent to which the qualifications of the CCS professionals provide sufficient basis for the content of these reports. In either instance, this mismatch in the expectations is critical given the confines in which CCS professionals can provide these reports and that they are requested by parties or legal representatives as part of the evidence in parenting matters pursuant to Part VII of the FLA.

Open-text responses in this Survey of Professionals were also sought to elicit more detailed insight into views ofthe nature, content or quality of the reports provided by CCSs and regarding how the reports are used to inform the decision-making process. More than one-third of these participants (including both CCS professionals and referring professionals) referenced the detail in the observations included in the report or the independent and neutral nature of the report when describing reports to be of good quality (*n* = 28/67). More specifically, these reasons included:

- the comprehensive nature of reports and detail provided, including examples
- the inclusion of child reviews in the reports
- the clarity of the observational notes that present 'parent-child interactions and parental behaviour and views' (CCS staff, NSW, 55+ years)
- the importance of having access to 'independent observational data… obtained where the parents are observed long enough to allow for their 'being on my best behaviour' to slip away (Judicial officer, NSW, 55+ years).

More specifically, the insight provided by these reports was described by one participant as critical to supporting evidence-gathering activities related to children's perspectives:

> *I use contact reports to try to gain a sense of how a child feels about spending time with a parent – how readily they separate from the parent who brings them to the centre; how readily they go to and engage with the parent they are spending time with; and the way in which they separate from that parent at the end of that time. I also review reports to see whether there are any safety concerns of parenting capacity issues that are identified by the supervisors. I have been presented with 'tick a box' style reports from government-funded contact services. These reports provide only very general information and it is difficult to gain any real insight into the parent/child dynamics from these reports.* (Judicial officer, NSW, 45–54 years)

Smaller proportions of participants indicated that reports were either not provided or should be made more available (*n* = 5/67), or that improvements were required in the content of these reports (*n* = 13/69). Improvements identified by participants include:

- the provision of more detailed information, including about the child's overt and subtle presentation, interactions and responses, parental behaviour and critical incidents
- details of the risk assessment and illustration of how risks have been mitigated
- presentation of the child's perspective
- neutral and factual accounts of the sessions at the service, including how many visits were scheduled, how many sessions took place and how many did not and reasons for those not taking place.

The significance of training to support the preparation of reports of good quality and which are child and family-focused and trauma-informed was identified by these participants to ensure that reports are not perceived to be biased and to accurately document the behaviour and interactions at the supervised sessions:

> *Staff receive extensive case note training to ensure they are observational – this is particularly important when writing about risk concerns to avoid the risk of being seen as 'biased' by the court. So staff will identify the source of risk information, e.g. 'mother reported experiencing forms of coercive control such as …'* (Service provider organisation, NSW, 35–44 years)

> *It is essential that the supervisor have the skills and training to identify and accurately document behaviours and patterns displayed by both parents. To be court ordered to a contact centre indicates that there are safety concerns present that need to be assessed. If a service is simply providing positive reports to ensure ongoing business success and return clientele, then they are placing children at risk in the future if the underlying behaviours are not assessed and addressed.* (CCS staff, NSW, 45–54 years)

There were also a small number of participants who specifically suggested that increased training or support for the CCS staff to provide these reports would improve the quality of the reports, as would guidance about their content (*n* = 5/69):

> *Good reporting and record keeping is one of the purposes of supervised visits. So that the information of how the visits have been going, can be fed back to the decision makers. The report is usually written by the coordinator of the centre, and summarises the notes of the supervisor or various supervisors, along with other data the centre may have. The supervisors need to know that it is possible for them to be called as a witness in a family law matter. They can have proper training and preparation. This does not need to be alarming for them, it is just part of the job. They need to take comprehensive notes and be ready to explain what their notes meant. … Record keeping, reports, training and expertise is essential for all of this. Consistency between staff and different centres is also essential.* (Lawyer, Qld, 35–44 years)

> *The reports are a helpful tool to assess how the time/handovers are going and useful in assessing appropriate arrangements in the future. Supervisors must be properly, and consistently trained and must be culturally competent to ensure the quality of the reports.* (Lawyer, undisclosed)

These participants (and others below) also referenced the need for clarity and consistency in relation to the content of the written reports provided by CCSs. For example:

> *I think a standardised report structure across Centres would be helpful as we receive feedback from the ICLs and Court Reporters about what is and isn't helpful in our reports. Sometimes due to the number of reports and length of reports, we receive feedback that legal representatives do not have time to read the amount of material that we collect over time.* (CCS staff, NSW, 25–34 years)

> *I think proper training in a standardised format would be very helpful for our organisation.* (CCS staff, Vic, 45–54 years)

Some participants raised concerns of a legal nature relevant to the written reports, including in relation to systems abuse (*n* = 4/69) and two participants raised concerns about the reports not informing decision-making:

> *Observation reports are more often than not used by some individual parents as instruments within future family law court matters, to either discredit the other parent or the supervision service provider. Observation reports reflect the true account of parent/child interaction both positive and negative as professionally observed, conversely can be used by both parent and solicitor to suggest otherwise due to the fact that supervised contact personnel are simultaneously not legally recognised as 'qualified' to have said observation/opinion.* (Service provider, Qld, 55+ years)

> *At present, contact centres [in my area] are not providing reports to lawyers. Information is only obtained by subpoena which is extremely unhelpful for legal practitioners trying to assist clients and keep matters out of court.* (Lawyer, state/territory redacted, 25–34 years)

> *Often, they are not used to inform the decision-making process e.g. not subpoenaed by the ICL or a report writer. Our staff are all degree level trained or higher with years of prior experience in the sector. If our skills were acknowledged maybe our observational reports would be referred to more often. We also provide induction and ongoing training regarding report writing to all staff.* (CCS staff, NSW, 45–54 years)

Child-focused, child-centred and child-inclusive service provision

Overall, most participating professionals strongly agreed (50%) or agreed (29%) that CCSs were child-focused and child-centred. More specifically, the data show that the vast majority of CCS professionals strongly agreed (75%) or agreed (18%) that CCSs were child-focused and child-centred. However, only 29% of referring

professionals strongly agreed and 39% agreed with this proposition. Referring professionals were far more equivocal regarding whether CCSs were child-focused or child-centred, with nearly 2 in 10 (18%) referring professionals indicating that they did not know or could not say whether CCSs were child-focused or child-centred.

Of note, the findings in relation to CCS professionals' strong agreement and referring professionals' equivocal responses reflected statistically significant differences between the 2 professional groups.

Overall, more than half of participating professionals strongly agreed (43%) or agreed (31%) that CCSs were child-inclusive. More specifically, the data show that although a majority of CCS professionals strongly agreed (65%) or agreed (27%) that CCSs were child-inclusive, 23% of referring professionals strongly agreed and 35% agreed with this proposition. One-quarter (25%) of referring professionals indicated that they did not know or could not say whether CCSs were child-inclusive.

Once again, the findings in relation to CCS professionals' strong agreement and referring professionals' equivocal responses reflected statistically significant between the 2 professional groups. The data presented later in this chapter from parents and carers indicates that their reported views align more closely with referring professionals than the CCS professionals on child-focused, child-centred and child-inclusive service provision.

Safe service provision

Most participating professionals strongly agreed (49%) or agreed (31%) that CCSs were safe. Most CCS professionals strongly agreed (68%) or agreed (24%) that CCSs were safe, 32% of referring professionals strongly agreed and 38% agreed with this proposition. Nearly 2 in 10 (18%) of referring professionals indicated that they did not know or could not say whether CCSs were safe. Once again, data from parents and carers suggests that their views on safety are more closely aligned with that of referring professionals. The question of safe service provision is considered specifically in relation to children in the next section.

Safety and the best interests of children

In this section, data from the Survey of Professionals and from the Survey of Parents and Carers with reference to some data from the RFI are examined to extend analyses in chapters 2 and 5 to address the extent to which they comply with the National Principles for Child Safe Organisations and trauma-informed practice (Research Question 5).

Professionals participating in the Survey of Professionals were asked for their views on the extent to which CCSs were providing services that were in the best interests of children (Figure 10). Where participants responded and indicated whether they agreed or disagreed with the range of statements relating to whether CCSs were providing services that were in the best interests of children (in Figure 10), these participants were also asked to provide an open-text response about why they either agreed or disagreed with these statements.

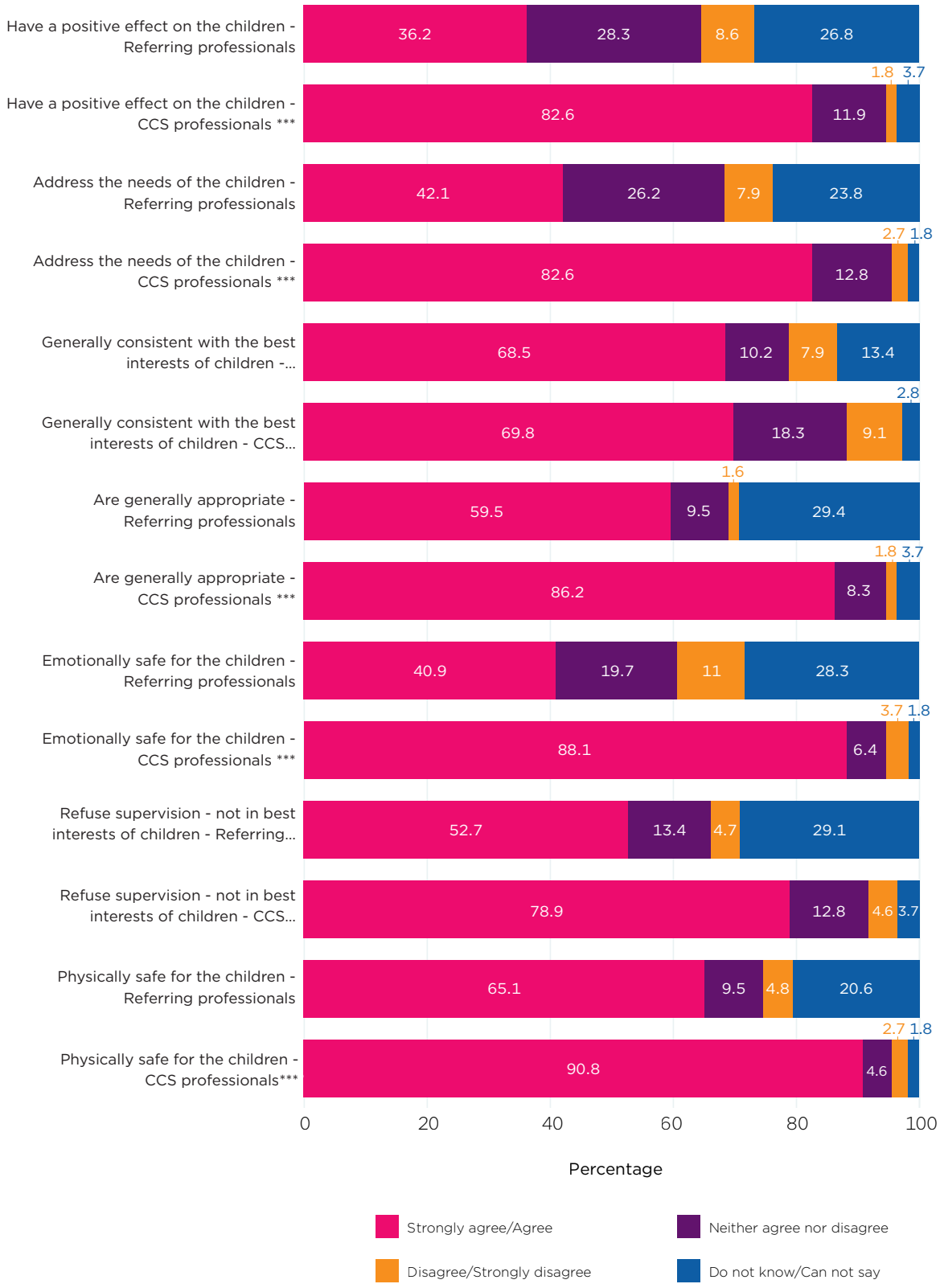
The quantitative and qualitative data drawn from the questions seeking professionals' views on the extent to which these services were in the best interests of children are presented in the discussion in this section.

The quantitative findings from Figure 10 are examined in turn, and each of the data items specified in this figure will also be examined with reference to relevant qualitative responses where available.

Overall, a substantial proportion of the participants providing an open-text response explained why they agreed the CCSs were providing services in the best interests of children (n = 42/102). Some participants described how the CCS services were consistent with children's best interests because they were child-focused, child-centred or adopted child safe and child-inclusive practices and were responsive to feedback from clients or reflected on the skill and training of staff.

A slightly larger proportion of participants in their open-text responses outlined the reasons why they disagreed with the propositions regarding service provision in the best interests of children (n = 46/102). Participants in this category raised concerns about the safety of parenting time in a range of high-risk circumstances despite the safety planning and security requirements at CCSs. These included shortcomings in child-focused and child-inclusive practices in decision-making and CCS service provision, with challenges where parenting arrangements or orders are identified as inconsistent with children's best interests and CCS practice around declining service in these circumstances. The capacity of services and staff to cater for the children of First Nations and CALD families and children with disability was also identified, together with the limitations in 'scaffolding supports' for families. These data will be considered more specifically in chapter 5.

Figure 10: Survey of Professionals: agreement with government-funded CCSs providing services in children's best interests by professional type



Notes: Question was worded as: 'To what extent do you agree that government-funded CCSs "in your organisation/ in your area" are: ...' CSS professionals asked to rate CCS characteristics for 'my organisation' and referring professionals asked to rate those 'in my area'. ***$p < .001$ statistically significant based on chi-square test. Percentages may not total 100.0% due to rounding.

Physical and emotional safety

Overall, the data in Figure 10 shows that most professionals strongly agreed (42%) or agreed (35%) that CCSs were physically safe for the children who use them. More specifically, the data show that although most CCS professionals strongly agreed (58%) or agreed (33%) that CCSs were physically safe for the children using them, 28% of referring professionals strongly agreed and 37% agreed with this proposition. Once again, these findings in relation to CCS professionals' strong agreement and referring professionals' equivocal responses reflected statistically significant differences between the 2 professional groups.

Nearly one-quarter (21%) of referring professionals indicated that they did not know or could not say whether CCSs were safe for the children using them. This absence of knowledge on the part of professionals who are referring clients to CCSs is of concern given the centrality of safety protocols in CCS service provision and the role of CCSs in facilitating safe parenting time for the families using them. Consideration should be given to measures to improve the awareness of referring professionals of the safety protocols in place at the CCSs to which they are referring clients to support them to make safe and appropriate referrals to these services.

Overall, most professionals strongly agreed (33%) or agreed (32%) that CCSs were emotionally safe for the children who use them. More specifically, the data show that although most CCS professionals strongly agreed (46%) or agreed (42%) that CCSs were emotionally safe for the children using them, 16% of referring professionals strongly agreed and 25% agreed with this proposition. More than one-quarter (28%) of referring professionals indicated that they did not know or could not say whether CCSs were emotionally safe for the children using them.

Again, these findings in relation to CCS professionals' strong agreement and referring professionals' equivocal responses reflected statistically significant differences between the 2 professional groups.

Child safety through child-focused, child-centred and child-inclusive practices

Data from the RFI provided insight into means by which concerns about children's safety and wellbeing were brought to the attention of the court in family law proceedings through the provision of written reports or subpoenaed file notes (including mid-session check-ins) and the information sharing protocols in place with child safety departments and other agencies in relation to families using their services, to facilitate the sharing of information critical to children's safety in a timely way:

> *The Information Sharing Guidelines for promoting safety and wellbeing (ISG) are overarching principles for how to share information appropriately between government and nongovernment agencies so that services are complementary, sufficient, and protective. The Organisation has agreed contractually to the ISG to ensure that staff are confident in sharing information appropriately so that services for children, young people, and vulnerable adults are provided earlier and are better coordinated.* (Service 70, SA)

Some participants in the Survey of Professionals providing an open-text response to this question who indicated agreement with the proposition that CCSs were providing services that were in the best interests of children, emphasised the safety of the CCS environment when reflecting on the physical and emotional safety of children at CCSs, including based on feedback from families:

> *The children are physically safe once they actually get to a centre.* (Lawyer, NSW, 45–54 years)

> *Our Contact Centre offers a family friendly, child safe environment which has been set up to look like a family home. Our policies, practices and activities all support safe and happy children.* (CCS staff, Vic, 55+ years)

> *Feedback from the lives with parent is usually very positive as it provides a safe environment whilst allowing the child/ren to spend time and develop a relationship with the other parent.* (Court Child Expert, NSW, 55+ years)

> *Some children have expressed that they feel better seeing the non-residential parent in these places.* (Lawyer, Vic, 45–54 years)

Other survey participants indicating agreement emphasised the child-focused and child-centred approaches employed by CCS staff as critical to service provision that was in the best interests of children. For example:

> *The staff are child-focused and tailor each situation to meet that particular child's needs.* (SA, Lawyer, 55 years +)

The children's needs come first so if you work within the framework of meeting the emotional, psychological and physical needs of children then it is best practice. (CCS Saff, Qld, 55 years +)

I think we are working to ensure that we are including the voice of the child throughout the entire CCS process from intake to exit. (CCS staff, NSW, 25–34 years)

We place importance on being a Child Safe, trauma-informed service. This is embedded into all aspects of the organisation to promote the best interest of the child. We have a high level of client participation for continuous improvement. (CCS staff, WA, 55+ years)

Some of the participants who were employees of CCSs and who provided an affirmative response, described how these child-inclusive practices operated and how they have incorporated feedback from children about their service experience to improve practice:

We have had many children able to express their concerns regarding contact and experiences in our environment. This has allowed children to feel comfortable with the parent or for the issues to be addressed in a safe and meaningful manner. (CCS staff, Qld, 25–34 years)

Staff meet with children prior to contact occurring, to explore and understand their feelings / concerns about seeing the other parent and exploring what steps can be taken to support the child to feel emotionally/physically safe. If children are extremely resistant or fearful of contact, then appropriate referrals are made before contact is attempted – e.g. referral to child counsellor, recommendations for parents to undertake counselling or men's behaviour change course. Some children have reported to witness significant domestic violence, e.g. a father's attempt to murder their mother - and present as extremely fearful of the prospect of contact, as well as experiencing ongoing impacts of trauma - and have not accessed therapy about the prospect of contact, nor may the parent alleged or found to have perpetrated violence demonstrated reform. It is critical that the family is therapeutically assessed before a referral to contact made, and if it is the wish of children to have contact, then a plan is made with both children/parents to support the reintroduction and contact time. Currently CCS are not funded or tasked with making those assessments or providing the therapy – yet are often asked to support reintroduction and time in these situations. (CCS staff, NSW, 35–44 years)

As indicated at the end of this participant's statement, some CCS professionals participating in the survey described undertaking tasks to support the safety and wellbeing of children and their families that are not necessarily considered as squarely in scope of the work that they do. This issue will be considered further in the next subsection in the context of open-text responses from participants describing why they disagreed with the statements relating to CCSs and the best interests of children.

Of the participants providing an affirmative response, some described how the service provision at the CCS was 'child-led' or how visits were stopped where children refused or for other sound reasons. Some survey participants who provided an open-text response to a separate question seeking more general reflections on the best interests of the child, also described prioritising children's participation in decision-making about whether visits will take place. For example:

We are always child focused and child-led. We never force a child to see the parent and while we do encourage and try a few times to convince the child to come into the visit room, we will cease the service if the child keeps refusing. (CCS staff, Vic, 45–54 years)

They act quickly when it is apparent that the supervised time is not going well. As an Independent Children's Lawyer, [the CCS] are always able and willing to provide me with information when requested or they contact me when there is a problem. (Lawyer, Vic, 45–54 years)

We are here to support the best interests of the children we work with. We ensure their voice is heard and we are not here to enforce visits. If a child is in distress or voicing that they do not want to see a visiting parent, we will not enforce contact regardless of court orders. It's so important that the voice of the child is heard. (CCS staff, NSW, 35–44 years)

CCSs are necessary for the maintenance of the child-parent relationship. If the child does not want this relationship to continue, we will support the child to stop the contact. We will also refer the child for support through a counselling service. (CCS staff, Qld, 55+ years)

Concerns regarding the physical and emotional safety of children using CCSs

Some participants in the Survey of Professionals providing an open-text response described why they disagreed that CCSs were providing services that were in the best interests of children, referencing the risks to the physical and emotional safety of children associated with facilitating parenting time at CCSs:

> *We do all that is possible to ensure the emotional/physical safety of children and intervene/coach to reduce any risk, however, [we] can see some children [are] impacted by parents' views, including the anxiety of the parent they live with. There is sometimes potential systems abuse by perpetrators of FDV.* (Service provider organisation, state/territory redacted, 55+ years)

> *Contact centres cannot protect a child from emotional damage when seeing the other parent or protect a damaged parent from being re-traumatised.* (Judicial Officer, NSW, 55+ years)

> *We [(the CCS)] can offer physical safety but not always emotional safety. Children can comply [with court order] to keep either parent from being distressed. Courts order [a] child to see [a] parent who has sexually abused them without prior counselling to assess the impact on the child.* (Service provider organisation, NSW, 55+ years)

As noted at the start of this section, these response patterns will be considered in the context of data from the Survey of Parents and Carers presented in the final sections of this chapter.

Cultural safety for children

Less than half of professionals strongly agreed (20%) or agreed (27%) that the services provided by the CCSs in their area were culturally safe for the children who use them. This finding is of particular significance and data relevant to the cultural safety of children and their families will be considered in further detail in chapter 5.

Specifically, the data show that although most CCS professionals strongly agreed (40%) or agreed (40%) that the CCSs addressed the needs of the children using them, only 3% of referring professionals strongly agreed and 16% agreed with this proposition. Nearly half (41%) of referring professionals indicated that they did not know or could not say whether the services were culturally safe for the children using them.

Once again, these findings in relation to CCS professionals' strong agreement and referring professionals' equivocal responses reflected statistically significant differences between the 2 professional groups.

Concerns were raised by some participants providing an open-text response regarding the inability of CCSs to meet children's specific needs, including their cultural safety needs or needs arising from their disability or neurodiversity:

> *I disagree with most of the questions [about CCS service provision being in the best interests of children] because to my knowledge children contact services in my area firstly consider physical safety of the children more than their culturally or emotional safety in the initial assessment.* (DFV professional, state/territory redacted, 25–34 years)

> *…a child's needs cannot be adequately met if the service does not take into account the children's cultural background or their disability, if there are long wait lists and if the staff are not trauma-informed and miss important interactions between the child and the parent.* (Court Child Expert, NSW, 45–54 years)

> *Agree in most instances [CCS service provision is in the best interests of children] except for children from diverse backgrounds who are neurodiverse or speak another language (or a parent does).* (WA, other demographics not disclosed)

> *Whilst some decisions by the court are in the best interests of the child, this is not always the case – especially in the instance of attachment trauma. Services are not culturally designed, led or informed … Further implementation of the child's voice is needed, especially for children who do not wish to attend contact even after intervention (i.e. strategies and support to shift them).* (CCS staff, NSW, age not disclosed)

> *They are a great idea; however, there does not seem to be any continuous improvement or recognition of changed cultural diversity of the region.* (DFV professional, Qld, 35–44 years)

> *There isn't sufficient availability [and] the services aren't culturally safe for Aboriginal people.* (Lawyer, state/territory redacted, 55+ years)

As noted above, the response patterns in each of the above data items will be examined in more detail in Chapter 5 of the Final Report based on findings from the Survey of Professionals, RFI, interviews with First Nations Professionals, and qualitative interviews with parents and carers.

Appropriate referrals to Children's Contact Services

Overall, most professionals strongly agreed (25%) or agreed (47%) that referrals to CCSs were generally appropriate. More specifically, the data show that although most CCS professionals strongly agreed (31%) or agreed (55%) that the referrals to CCSs were generally appropriate, 23% of referring professionals strongly agreed and 30% agreed with this proposition. More than one-quarter (29%) of referring professionals indicated that they did not know or could not say whether the referrals were generally appropriate.

These findings in relation to CCS professionals' strong agreement and referring professionals' equivocal responses reflected statistically significant differences between the 2 professional groups.

Concern in relation to the nature of referrals to CCSs were reflected in open-text responses from survey participants. For example:

> *… the majority of children I see for therapy after having contact with a parent at a contact service have high levels of regression in their functioning post contact, when their orders are related to the Family Court.* (Psychologist, NSW, 35–44 years)

> *[There is an] Increased number of referrals with people with co-occurring issues and in open conflict, including people who have clearly been victim of domestic and family violence and subjected to referral that places them at risk.* (Role not disclosed, state/territory redacted, 55+ years +)

A number of participants providing open text responses describing why they disagreed that CCSs were providing services that were in the best interests of children raised concerns specifically in relation to the making of unsafe parenting orders that underpin the referrals that are then implemented by the CCSs to the detriment of children, including in cases characterised by family violence or other significant risk issues:

> *I have interviewed a number of referred clients and there is often significant reported Domestic Violence – often witnessed by children … It is frustrating to see children forced by a court order to have visits with a parent with whom they have no relationship due to a parent abandoning them for years, or because of domestic violence or child abuse allegations.* (CCS staff, Qld, 45–54 years)

> *Many are suitable but a good proportion are not and put children at high risk. Often orders are made for visits before any assessment of what is in best interest of the child is completed.* (CCS staff, NSW, 45–54 years)

These data should be considered in the context of the data from the RFI process and the Survey of Professionals regarding reasons for CCSs stopping contact and indications that it is not common for CCSs to do so.

Service refusal

Overall, most professionals strongly agreed (33%) or agreed (32%) that CCSs were able to refuse to facilitate supervision as outlined in court orders where the service did not think it to be in the best interests of children. More specifically, the data show that most CCS professionals strongly agreed (44%) or agreed (35%) that CCSs could refuse to facilitate supervision in these circumstances, 23% of referring professionals strongly agreed and 30% agreed with this proposition. More than one-quarter (29%) of referring professionals indicated that they did not know or could not say whether CCSs could refuse service provision in these circumstances. As observed in the latter section of this chapter, parents and carers reflections are in close alignment with referring professionals regarding service refusal.

These findings in relation to CCS professionals' strong agreement and referring professionals' equivocal responses reflected statistically significant differences between the 2 professional groups.

Of note, some participants reflected on circumstances where CCS staff did not decline the referral for supervision and how this in turn may be cited as CCS service provision not being consistent with children's best interests:

> *I agree CCS have the ability to refuse to facilitate time spending BUT [I] say they do not opt to use this choice.* (Lawyer, SA, 35–44 years)

[We are] Not always able to refuse orders that have been made by the court, there are times when we feel a child would benefit from a parent completing other requirements prior to commencement of contact, i.e., drug and alcohol counselling first. (CCS staff, WA, 45–54 years)

The service is set up to be child focused, staff are well trained but there are times when children are traumatised by having to see the other parent or who are finding it very difficult (and they may be too frightened to express this) and I feel that orders are not always in the best interests of the child – there are times when it feels like a parent does not have a right to see the child and it is difficult for services to refuse when it has been ordered. There is a fear that if we refuse service, the family will be sent to an unregulated service or to be supervised by a family member. (CCS staff, WA, 45–54 years)

Addressing children's needs

Overall, most professionals strongly agreed (23%) or agreed (37%) that the services provided by the CCSs in their area addressed the needs of the children who use them. However, the data show that although most CCS professionals strongly agreed (37%) or agreed (46%) that the CCSs addressed the needs of the children using them, only 12% of referring professionals strongly agreed and 30% agreed with this proposition. Further, nearly one-quarter (24%) of referring professionals indicated that they did not know or could not say whether the services addressed the needs of the children using them.

Once again, these findings in relation to CCS professionals' strong agreement and referring professionals' equivocal responses reflected statistically significant differences between the two professional groups.

Areas for improvement and that affect the capacity of CCSs to address children's needs, were identified by survey participants who provided a negative open-text response regarding CCS services being consistent with children's best interests. These reasons ranged from the nature of the facilities at the CCSs and the waiting lists, through to the skills and neutrality of staff and the CCS's capacity to address the underlying therapeutic service needs of children and their parents:

More funding needs to be provided for age-appropriate toys and equipment, cultural education and toys. Our service is not able to provide appropriate services for counselling or re-unification counselling as we are not funded to do so and waitlists for external services are very high. ICLs at times will not respond to CCS staff when needing to discuss service and needs of children. (CCS staff, Qld, 55+ years)

[I disagreed that the CCS service were in the best interests of children] Based on the lack of neutrality [which] often clouds the service providers ability to be [acting] in the child's best interest. (Lawyer, WA, 55+ years)

Short-term supervision arrangements at CCSs were also identified as posing risks to the best interests of children, with this participant raising concerns that families may exit the system before it is safe to do so:

Some CCSs are short-term, which means that some families are exiting the service with safety concerns, given the high number of family violence cases, short-term contact is not in the best interest of some children. Further, the family court process takes a considerable amount of time for a case to reach final agreements, it is concerning that some CCS are short term. (CCS staff, NSW, 45–54 years)

Participants who provided a response to the more general open-text question on the best interests of children in the CCS context, highlighted the need for 'scaffolding supports' to better address children's and families' needs, and services integrated in the CCS system that could support the wellbeing of the children using CCSs:

[We need] More scaffolding supports integrated via the CCS directly, such as parent education that is 'part of' attending the CCS. Groups to normalise parents' experiences could also be a great support to parents. Each family has different needs, so a one size fits all approach is not feasible. The government funding is wonderful to make it affordable. Parents are under enough stress during breakdown without the stress of extortionate fees to see their children. More collaboration between centres, such as inter-agencies would be great and I look forward to accreditation as increasing our standards, although I believe we are at the forefront where CCS is concerned. (CCS staff, NSW, 55+ years)

Children who have supervised contact via family court orders are at a disadvantage compared to those who have supervised contact via children's court. They have less access to resources, workers who can support the visits as part of their overall needs and development. Plans are not made in a way that is child friendly or considered as part of their weekly routine. (Psychologist/counsellor, NSW, 35–44 years)

> *Generally, they do a good job in often trying circumstances. I wish we had more. I would like there to be more consideration of how to educate and support parents that lack skills and insight (e.g. dads who've not had much contact with infant children and don't know how to prepare for visits, what to bring, how to change a nappy, read a child's needs). A contact session is a great potential opportunity to educate in a hands-on situation, rather than just observe the parent flounder and then they get a negative report, due to lack of skills.* (Single expert witness, WA 55+ years)

The quotes above, among others, identify that service provision on a case-by-case basis can better support service provision in line with the best interests of individual children and their families, although this was acknowledged as challenging to implement in the CCS context. It may include, for example, the ability to 'accommodate the safety and individual needs of clients' including at changeover which was described by one CCS participant as 'rushed for both the parents and children' (CCS staff, Qld, 55+ years). It may also include better consideration of 'creative approaches for children (or indeed parents) not fitting the general model' (DFV professional, Qld, 45-45 years).

These data regarding the extent to which CCSs address children's needs should be considered in the context of data from the Survey of Parents and Carers presented in the final sections of this chapter and from the qualitative interviews with parents and carers. Findings about the extent to which CCSs are meeting the needs of children and families, outcomes for families using CCSs, and effective service provision are presented in Chapter 5.

Positive effect on the wellbeing of children

Overall, slightly more than half of participating professionals strongly agreed (22%) or agreed (36%) that the services provided by the CCSs in their area have a positive effect on the wellbeing of the children who use them. More specifically, the data show that although most CCS professionals strongly agreed (35%) or agreed (48%) that the services have a positive effect on the wellbeing of the children who use them, concerningly, only 11% of referring professionals strongly agreed and 26% agreed with this proposition. Nearly one-quarter (24%) of referring professionals indicated that they did not know or could not say whether the services have a positive effect on the wellbeing of the children who use them.

These findings in relation to CCS professionals' strong agreement and referring professionals' equivocal responses reflected statistically significant differences between the 2 professional groups.

Participants providing an open-text response that indicated they disagreed that CCSs were providing services that were in the best interests of children, suggested an absence of child-focused and child-inclusive approaches to decision-making, which in turn had detrimental effects on the wellbeing of children:

> *Sometimes the process can be quite distressing if a child feels pressured to do something that they inherently know their primary attachment figure does not want them to do. From a judicial perspective this can be troubling because we want to get some independent feedback (over a sustained period of time) about the relationship/s between the child/ren and the significant people in their lives but if a 'lives with' person is unwilling to support the process this puts both the child/ren, the 'spends time' person and the supervisors in an invidious position.* (Judicial officer, NSW, 45–54 years)

> *Children are often placed in situations that are not developmentally sensitive or based on attachment or emotionally appropriate. Children are often exposed to new staff and a parent they are unfamiliar or distressed by. Children are not included in most decisions about arrangements – the service is done to them, not with them.* (DFV professional, state/territory redacted, 45-54 years)

These participants and others emphasised the shortcomings in CCS service provision that did not involve child-inclusive practices. This included participants reflecting more generally on the best interests of children in the context of service provision:

> *Children generally do not have a voice in whether they want to attend a CCS. We try our best to make sure that their voices are heard.* (Service provider organisation, Qld, 55+ years)

> *Further implementation of the child's voice is needed, especially for children who do not wish to attend contact even after intervention (i.e. strategies and support to shift them).* (CCS staff, NSW, did not disclose)

> *More child inclusive practices could be embedded into CCSs.* (CCS staff, NSW, 45–54 years)

> *Contact services and all family law services need to listen to the needs, concerns and voices of children and factor this into care and safety planning. If children are fearful or resistant to seeing a parent, this needs to be assessed and addressed prior to attempting contact, including assessing whether the parents are willing or able to support reintroduction or time and support emotional safety.* (CCS staff, NSW, 35–44 years)

Some participants who provided a response to a more general question seeking reflections on the best interests of the child also described the challenges arising where the orders or arrangements for parenting time that underpinned the supervision arrangements at the CCS were perceived as being inconsistent with the best interests of children:

> *The best interests of children are not taken into account when they are mandated to have repeated contact with perpetrators who commit coercive control. There is no evidence that ongoing contact with fathers who perpetrate family violence and domestic abuse is beneficial for children.* (DFV professional, SA, 25–34 years)

> *It is unclear if providing contact in such an environment is in the best interest of the child. If a parent is so unsafe as to need a CCS, then it is questionable whether the child is benefiting from the relationship at all. As a short-term measure to ensure ongoing contact while safety concerns are addressed it is appropriate but if it is long-term then I would question the benefit of such a relationship.* (DFV professional, Qld, 35–44 years)

These data regarding the extent to which CCSs have a positive effect on children's wellbeing are considered in more detail in the context of interview data with parents and carers drawing on their insights into children's experiences of using CCSs. These findings are presented in the next section.

Parents' perspectives of children's experiences using the CCS

Parents and carers participating in the online survey were asked to reflect on their children's experiences using the CCS and the extent to which they agreed or disagreed in response to a series of statements about (a) how safe their child felt, (b) whether their child enjoyed attending the CCS, (c) flexibility, (d) how well the children's needs are supported and considered, and (e) the short and longer-term benefits of using the service. This information, further analysed by gender of the parent/carer, is presented in Table 14.

Overall, there was positive endorsement by parents/carers on how they think their children felt using the CCS, between 55% and 78% of parents and carers either 'strongly agreed' or 'agreed' in response to each statement. The highest level of agreement was reported for the following aspects:

- 78% of participants agreed that 'the safety of the child/ren is adequately considered', with no difference by gender, (80% reported by women; 76% reported by men)
- 74% of participants agrees that 'my child/ren is at ease/comfortable with staff at the CCS', also with no difference by gender (76% of women; 74% of men)
- with the same proportion (74%) agreeing 'my child/ren feel safe at the CCS' (76% of women; 72% of men).

There were lower levels of agreement, although a majority of participants still 'agreed' or 'strongly agreed', that 'using the Children's Contact Service benefits the child/children in the long term (in the future)' and 'my child/children's experience of the Children's Contact Service have improved with more time using the service' (56% for each statement respectively).

There was little difference in the proportion of parents and carers who disagreed or strongly disagreed with each statement, by gender (data not reported). The largest differences in response patterns were found for the following statements:

- using the CCS works for the child/children (24% of men disagreed or strongly disagreed; compared with 11% of women)
- using the CCS benefits the child/children in the long term (in the future) (24% of men disagreed or strongly disagreed; compared with 14% of women).

Table 14: Online Survey of Parents and Carers: proportion 'strongly agree' or 'agree' in response to each statement to the question, 'How do you think your child/children feel about using the Children's Contact Service'?

	Man or male (%)	Woman or female (%)	Total (%)
My child feels safe at the Children's Contact Service ***			
Strongly agree	45.2	33.3	37.6
Agree	26.2	42.4	35.8
Total strongly agree/agree	*71.4*	*75.7*	*73.4*
My child/children enjoy attending the Children's Contact Service *			
Strongly agree	33.3	31.8	32.1
Agree	28.6	31.8	30.3
Total strongly agree/agree	*61.9*	*63.6*	*62.4*
My child/children is/are at ease/comfortable with the staff at the Children's Contact Service			
Strongly agree	33.3	39.4	36.7
Agree	40.5	36.4	37.6
Total strongly agree/agree	*73.8*	*75.8*	*74.3*
The Children's Contact Service setting is flexible enough for my family			
Strongly agree	28.6	31.8	30.3
Agree	31.0	39.4	35.8
Total strongly agree/agree	*59.6*	*71.2*	*66.1*
The Children's Contact Service provides my child/ren with the support that they need			
Strongly agree	26.2	33.3	30.3
Agree	31.0	36.4	33.9
Total strongly agree/agree	*57.2*	*69.7*	*64.2*
Using the Children's Contact Service works for the child/children			
Strongly agree	31.0	36.4	33.9
Agree	31.0	31.8	31.2
Total strongly agree/agree	*62.0*	*68.2*	*65.1*
The needs of the child/children are adequately considered*			
Strongly agree	31.0	38.5	35.2
Agree	35.7	40.0	38.0
Total strongly agree/agree	*66.7*	*78.5*	*73.2*
The safety of the child/children is adequately considered			
Strongly agree	38.1	48.4	43.9
Agree	38.1	31.2	33.6
Total strongly agree/agree	*76.2*	*79.6*	*77.5*
My child/children's experience of the Children's Contact Service have improved with more time using the service			
Strongly agree	23.8	27.7	25.9
Agree	26.2	32.3	29.6
Total strongly agree/agree	*50.0*	*60.0*	*55.5*
Using the Children's Contact Service benefits the child/children in the short term (now)			
Strongly agree	38.1	36.9	37.0
Agree	23.8	38.5	33.3
Total strongly agree/agree	*61.9*	*75.4*	*70.3*
Using the Children's Contact Service benefits the child/children in the long term (in the future)			
Strongly agree	29.3	35.4	32.7
Agree	26.8	21.5	23.4
Total strongly agree/agree	*56.1*	*56.9*	*56.1*

Notes: *p < .05; **p < 0.01, ***p < .001 statistically significant difference between gender based on chi-square test. Sample size for Man or male category ranged between n = 41 and42, sample size for Woman or female category varied between n = 64 and 66, sample size for total category varied between i = 107 and 109.

These items were further analysed according to whether the participant had a CALD background. There were differences in responses between those who were born overseas or had at least one parent born in a non-English speaking country and the remaining participants. However, the small sample size of those with a non-English speaking background means that caution should be taken when interpreting the results and tests of statistical significance are not provided for that reason. The largest differences in the proportion who 'strongly agree' or 'agree' was in response to the following statements:

- My child/children's experience of the Children's Contact Service have improved with more time using the service (33% of those from a non-English speaking background cf. 60% of remaining participants)
- The needs of the child/children are adequately considered (56% of those from a non-English speaking background; cf. 77% of remaining participants).
- My child/children feel safe at the Children's Contact Service (56% of those from a non-English speaking background; cf. 77% of remaining participants).

Further quantitative and qualitative data is presented in chapter 5 from the DEX SCOREs, RFI process, the Survey of Professionals, interviews with First Nations professionals, the Survey of Parents and Carers, and interviews with parents and carers to examine the diversity of families using CCSs and meeting their needs from the perspective of cultural safety.

Qualitative interviews with parents and carers also suggested that most parents and carers, overall, were positive about their children's experiences using the CCS, and provided insight into the reasons for their views on this question.

When asked how their children felt about attending the CCS, most parents and carers who expressed a view were evenly divided between two groups: those who reported entirely positively, and those who had mixed views. Parents' and carers' main reasons for why children felt positive were that using the CCS meant that their children were not exposed to parents' conflict, were able to spend time with the parent subject to supervision (usually the father), were comfortable with the CCS staff, that the CCS facilities were fun for their children, that their children felt safe there, and that attending was now part of their children's routine:

> *I guess you don't have that conflict of the parents interacting with each other … I guess that's a good aspect … you know, that's a good safety mechanism.* (LWP 33)

> *[T]hey see the workers who have been kind to them and … they're familiar with each other. That's quite positive … for them. It's kind of routine; so every Sunday we'll … come back and say hello to the people … and then go to see their dad. It's not something that we have to be stressful about because the contact centre is a familiar environment and the people we know.* (LWP 49)

> *He likes the ladies there. He reckons they're lovely.* (LWP 19)

> *[H]e loves it because it's a big playcentre, you know, so I reckon so long as it's got pencils and paper and Lego, I think that kids are OK. Yeah, you know, it's somewhere safe where he feels safe as well.* (LWP 20)

Along with possible conflict regarding their children's wellbeing and their children wanting a relationship with the other parent, concerns expressed by parents and carers regarding how their children felt about attending the CCS were that their children did not want to go, were attending only because they had to, and were unable to express concerns about whether the visit should proceed, and regarding children's mood or behaviour before or after visits:

> *She always tells me, 'Mummy, I don't want to go. Why can't I just stay with you? … It's like he doesn't listen Mummy'. And she just looks very defeated … she's just not her happy normal self, you know … and then I think because like she's getting used to being rushed in and out, she doesn't really understand what's going on, but. Is it important to go? But like I have to do it.* (LWP 30)

> *My son – he does wet himself during the sessions so – one in two sessions – he will wet himself and he is 7 now … He doesn't have any toileting issues in day-to-day life … I do see this really steady pattern from him in particular following visitation … for example, when we get home that afternoon he is kind of very aggressive, a lot of high energy play – bashing things with sticks, hitting his head against the wall. He'll say things like 'I deserve to die' and 'You should give all my toys away, I'm a bad kid, I don't deserve anything'…. Up to 10 nights following time, he will come into my bed in the night seeking comfort … But yeah, when*

> *we have a break from contact that all settles and his levels of resilience are much stronger. And he also experiences quite extreme separation anxiety going to school the week following time as well. It's at a point at school drop off. He's trying to climb fences and screaming because he thinks his dad's gonna come and try and kidnap him from school. So yeah. I'm sorry I focused on the negatives there, but yeah, [my children], my son in particular wants to go. And there's no reluctance and he loves his dad – he wants to have a relationship with him and he wants to see him. I guess that's – that's the positive is that he does get that time with him.* (LWP 36)

Several of the same reasons were reflected in parents' and carers' views on the positive and negative aspects for their child of the CCS and the services it provided. Positives included that children were not exposed to parental conflict and violence, that CCS staff were child-focused and kind, that children enjoyed the facilities and had fun, that children felt safe at the CCS, and that the CCS made it possible for children and fathers to spend time together:

> *[I]f there would be any conflict aris[ing] between the two parents they're not going to see it, because we can't communicate or have contact in that aspect, so it makes things a lot more harmonious.* (LWP 28)

> *I'm able to see them again, that's for one. I can bond. The end goal I'm dealing with is the courts … that is the long term for me. So just hinging on that report. You know going [to the CCS] and smiling and doing everything.* (STWP 48)

> *I think being physically safe … And you know, they obviously trusted that the people watching would keep them safe. You know, they never said anything otherwise. And I think they probably would have. They're always really happy to go off with the women who greeted them. Which is great, especially you know for my son with the separation anxiety … they had fun and it was structured, it was consistent. They felt, you know, it was safe. There were other people there. I think they're all really positive experiences for them.* (LWP 32)

Negatives (which were less frequently expressed) focused on children not always being listened to or understood by CCS staff, including where parent indicated that they had attempted to advocate for the child:

> *There was a period of time where she wasn't wanting to go … So she would get upset, refuse despite everybody's efforts. And we were told to keep coming back the next day and the next day. And that was probably the worst impact … Each time we went back, she was getting more whipped up and wasn't having enough time to sort of get to a point of calm between the next that time and then and then the next day we're there again, and that was the time where she was, you know, smashing things and trying to kick the window out and spitting on herself and hitting me and yelling and all of those things. Yeah, that was the having to come back day after day. And I did ask. Could we just leave it or could we wait, could we do something else? But it was the workers driving that. They wanted us to keep coming back day after day and I tried to object. But I didn't feel like my objection was really taken on board. And I'm not sure why we did that, because the court order wouldn't require us to do it actually. But we did anyway. And I felt like I couldn't say no to it because if I said no that I could have been framed as alienating or being unsupportive in a way that would be harmful in the longer term. … So even though it was really distressing for [my child] … the safest thing in terms of long-term outcomes was to just keep taking her even though she was distressed, that was an extremely difficult time because obviously as her mum seeing her that upset and having to keep doing it again and again was devastating and made me just feel so helpless in the midst of all of it.* (LWP 45)

Concerns were also expressed that were more focused on supervision generally (rather than the CCS itself). They included that the CCS was an artificial and restrictive environment which could lack privacy and be boring for those who attended over a long period of time, and that CCSs may result in families not dealing with the realities of their relationship separation and result in stress, anxiety or trauma for children:

> *I guess the negative effects may just be that they're limited to that particular space and whatever's available there or what what's brought in the way of toys. You know, they're limited. From that point of view, I think for my eldest who's, you know, traumatised about being in the presence of a father, I think long term, I'm not sure whether, I think the fact that she's gotta visit is creating trauma. I don't think it's necessarily being at the contact centre. I think it's associated with the contact centre because he's there and that's where they meet. I guess you know, as she said, she finds it boring. She's older, and so, you know, I'm sure she'd love to be out in nature, a bit more that tends to be, where she's less anxious.* (LWP 17)

Only thing [the children] find a bit tricky at times is sometimes on a Saturday, there's more than one visit going on and they have to share the play area space inside with another family and you know they understand that … but you know, there might be four kids in total across two families or in one shared space. So that's not quite as private. For them, their dads, that's probably something that they don't like, but again, you know, it is what it is … It's not an organic natural environment obviously … there's a very, you know, regimented [setting] [CCS]. (LWP 38)

These data highlight additional concerns for children's safety where multiple families are using shared spaces at CCSs and as such may be exposed to other unsafe parties who are not their parents and carers. Data in relation to the site specifications and logistics of meeting service demand that are relevant to this issue are presented in chapter 4.

Parents' and carers' views on the benefits and detriments to their children using CCSs

Qualitative interviews with parents and carers revealed a range of benefits and detriments to the child of using CCS services and provided insight into the nature of these benefits and detriments. When asked how their child/children feel using the CCS and why the child/children felt this way, around two thirds of the parents and carers interviewed identified clear benefits to their child/children of using the service.

For parents/carers using the CCS for supervised visits these benefits included the child being able to build a relationship with the visiting parent/carer and enabling the child to experience a safe and enjoyable time with the visiting parent:

[I] think because there's an independent person supervising, actually the impression I get is that the other side is actually behaving in line with what's in the best interests of our child … [T]hat's why my child is coming back out quite calm and regulated and not upset … Like he's very calm. So the service itself serves a really good purpose. (LWP 31).

When asked to identify any changes over time that have occurred for their child/children using the CCS for supervised visits, some parents and carers reflected that using the service has led to the child becoming more confident with the visiting parent and that the relationship between the visiting parent and the child/children has developed.

Using the CCS for supervised visits was, however, seen as determinantal to the child when a child didn't want to see the visiting parent/carer but the visit took place against what the interview participant perceived to be the child's wishes:

[S]ometimes when she has said they wouldn't listen, they kept saying I had to go see my dad you know, she's been annoyed and she feels like they keep pushing her to go even when she said 'no'. She's said afterwards mum you told me it's really important to listen to people's 'No'. Why aren't they listening to my 'No'. And I'm like that's a toughie to answer. (LWP 45)

Other parents and carers commented that staff allowed the child to make their own choices about whether they wanted to see the other parent/carer or not:

But I think, yeah, they're quite good at they won't force them … They try to sort of like, 'are you sure you know this?'. They're trying to make sure it's their decision, which is understandable. So I think it's positive. It yeah gives them a voice in it too. (LWP 42)

Detriment was more generally reported by parents and carers when staff were viewed as having failed to intervene when a child was distressed, whether that intervention was to take place prior to a visit, or because of visiting parent's behaviour during the visit. Where the staff were perceived by parents and carers to not have accorded 'voice' to the child or enabled a child to 'consent' to the visit, using the CCS was considered determinantal to the child.

For parents and carers using the CCS for changeover, the benefit to the child was expressed differently to that expressed by parents using the CCS for supervised visits. Supervised changeovers were reported by parents and carers as buffering the child from the anxiety and stress of the parent/carer whom the child lives with, that happens when the parent/carer comes into contact with the other parent, as well as preventing conflict and violence.

Factors that would prevent or limit the ability of staff to understand what the child wants or needs were identified as detrimental. This included staff having little or no time to debrief with the child prior to or after changeovers, the skill of CCS engaging with children who have disabilities, and children having difficulties communicating with staff:

> *[W]hen you've got someone who can't articulate and has got those issues and that barrier you're going to have to think of different ways … [W]hether that could be just a worksheet that the child points to pictures of faces to show them how they're feeling and stuff like that. It's going to have to be different ways. And I don't think that's the workers' fault. I just think they're not [trained] to cope with that.* (LWP 43)

A further way that parents and carers identified their child/children as benefiting from using the CCS concerned the nature of the relationship between the child/children and the staff, and the CCS environment.

Parents and carers using the CCS for supervised visits spoke of their child/children liking the staff and getting along well with the staff. Staff were reported by parents and carers to be trusted by the child/children and were viewed as being kind and friendly towards their child/children. Continuity of staff and consistency in process was reported by some parents/carers as providing their child/children with certainty and helped to establish supervised visits as routine:

> *He seems quite fine with the service. I think actually having the routine of like you go in, he goes to the room, he sees his dad for an hour and at the end of the hour he says goodbye, he comes back out to me. I think he actually quite likes that. He's neurodiverse, so anything that's routine based is really helpful for him.* (LWP 31)

The absence of this continuity in staffing was seen by some parents and carers as detrimental to the child/children.

The environment and facilities at the CCS used for supervised visits were identified by some parents and carers as detrimental to the child. This included having no outdoor space for the children to play and children outgrowing the facility and activities available:

> *I think especially with a child as they grow older… I suppose there's an [8–12] year old boy[child] as opposed to having baby toys all around. The facility [no longer] meet the requirements that he needed. I can't do anything about that. I have to turn up and sit in that room.* (STWP 46)

Parents and carers who used the CCS for changeovers were less concerned about the environment and facilities but as with parents and carers who used the CCS for supervised visits, they identified continuity of staff and the environment as helping to alleviate the child/children's anxiety and normalising the visiting arrangements for the child/children such that the child/children was comfortable and relaxed attending the CCS for changeover.

For parents and carers using the CCS for changeovers and supervised visits, few parents and carers spoke of their being changes over time for the child/children using the service. Of note, there were no comments made that the use of these CCS services had led to negative changes for the child/children. Of the positive changes identified, using the service over time led to the child/children being less anxious and more comfortable with the service. For those parents and carers interviewed who used the CCS for supervised visits, favourable comparisons were made with their previous experience of private supervision arrangements or unsupervised contact visits that were distressing for children:

> *He had some very strong views about [the CCS] initially. He wasn't very comfortable with it. He was anxious. He didn't like it that they were watching them. It took him a long time to feel comfortable there … But I feel that after the time that they had some partially unsupervised time and there were a lot of issues, he formed the opinion that he would rather be at the [CCS] the whole time and have the person there and enjoy his visit with his dad.* (LWP 38)

Summary

This chapter presents analyses of quantitative and qualitative data from the RFI, the Survey of Professionals and the Survey of Parents and Carers to support an analysis of the extent to which CCSs are operating in accordance with the relevant guiding documents including the *Guiding Principles Framework for Good Practice,* together with other relevant guidelines and standards, including the Grant Opportunity Guidelines and ACCSA Standards (Research Question 4). The discussion examined the key objectives and principles in these guiding documents including in relation to child-focused and child-safe service provision, exercising neutrality, incorporating

client diversity and cultural sensitivity in CCS practice and delivering services in a collaborative environment. Data relating to whether CCSs models were child-safe and trauma-informed were also considered (Research Question 5) having regard to the National Principles for Child Safe Organisations. Some data relating to Research Question 2 (self-management) and Research Question 3 (CCS Reports) were also analysed in the context of the compliance with the guiding documents including Guiding Principles Framework and National Principles.

The data presented in this chapter apply substantively to Research Question 4 (consistency in operation with relevant guiding documents) and Research Question 5 (consistency with the National Principles for Child Safe Organisations and trauma-informed practice). Research Questions 2 (helping families graduate to self-management) and 3 (provision of written reports) are also relevant.

The examination of CCS policy documents and descriptive data submitted as part of the RFI process considered against the principles in the guiding documents, identified CCS policies and procedures as largely consistent with the principles in the guiding documents. The policy and procedure documentation submitted by participating CCS shows particularly strong consistency in relation to safety protocols and prioritising children's best interests.

Less strongly visible in the policy and procedure documentation were collaborative practices and referrals to other services. This is consistent with findings in other sections of the report that highlight limited awareness of some aspects of CCS service provision among referring professionals.

There was some variation in relation to principles that are quite specific to CCS service delivery, for example, the need to move to self-management and approaches to neutrality and information sharing. The aspects were expressed and articulated to clients in different ways and with different emphasis in the policy and procedure documents.

Together, the different sources of data in this evaluation indicate policies implemented by the CSS are consistent with the Guiding Principles Framework and the National Principles for Child Safe Organisations (also relevant to grant agreements). Application of trauma-informed principles are also evident.

For example, RFI data regarding staff checks, the number of staff and staff ratios show that, consistent with guiding principles, almost all CCS require police and working with children checks (96%) and most require compliance with a code of conduct (56%). The data are indicative of a broad range of staff qualification requirements in relevant fields such as social work, social science, psychology, counselling or community services and demonstrated skills and experience in working with parents and children impacted by and/or using DFV.

In relation to compliance with the National Principles for Child Safe Organisations and trauma-informed practice more specifically, the quantitative data show that most professionals and parents/carers identified CCSs as physically and emotionally safe for the children using them, and engaging in child safe, child-focused, child-centred and child-inclusive practices. Open-text responses regarding child-safe service provision emphasised the child-focused, child-centred and child-inclusive practices of CCS professionals including in relation to child-led facilitation of contact to support the safety and wellbeing of children, as well as incorporating feedback from children about their service experience to improve practice.

Safety

Although most professionals (77%) agreed that CCSs were physically and emotionally safe for the children using them, some professionals raised concerns that risks to children's physical and emotional safety may nevertheless remain despite the arrangements put in place by the CCS, including in circumstances characterised by DFV.

Reports in relation to critical incidents indicate that the total number of critical incidents as a proportion of the total number of CCS clients was highest in 2022 (5.1%), with the corresponding proportions lowest in 2020 (3.7%) and 2021 (3.8%).

Several participating professionals providing open text responses raised concerns specifically in relation to the making of unsafe parenting orders that underpinned the referrals to CCSs, including in cases characterised by family violence or other significant risk.

Children's best interests

Most professionals were in agreement that CCSs could refuse to facilitate supervision arrangements in court orders where they did not consider this to be in the best interests of children (65%) and that the services provided by CCSs addressed the needs of the children using them (60%). There was again a statistically significant difference between the responses of CCS professionals and referring professionals, with referring professionals being more equivocal in their responses.

Qualitative responses also highlighted concerns on the part of some professionals that CCSs did not decline service provision that was not consistent with children's best interests and suggested a range of areas for improvement in relation to CCSs' capacity to address children's needs. These areas ranged from the nature of the facilities at the CCSs and the waiting lists, through to the skills and capacity of staff and the CCS's capacity to address the underlying therapeutic service needs of children and their families.

Data from the Survey of Parents and Carers indicated that overall, there was positive endorsement by parents and carers of their children's experiences using CCSs, with 78% of parents/carers reporting that their child's safety was adequately considered; 74% reporting that their children were at ease/comfortable with the CCS staff and 74% reporting that their children felt safe at the CCS.

The Survey of Parents and Carers data also indicated that there were quite varied experiences in terms of CCS use and how this affected participants' relationships with their children. Approximately one-third (34%) of parents and carers reported no change; another third (34%), reported a positive change and a further 15% reported a negative change.

Qualitative data from interviews with parents and carers who expressed views on how their children felt about attending the CCS, were evenly divided between two groups: those who reported entirely positively and those who had mixed views.

Parents' and carers' main reasons for why children felt positive were that using the CCS children were not exposed to parents' conflict, were able to spend time with the parent subject to supervision (usually the father), were comfortable with the CCS staff, that the CCS facilities were fun for their children, that their children felt safe there, and that attending was now part of their children's routine.

Concerns expressed by parents and carers regarding how their children felt about attending the CCS were that their children did not want to go, were attending only because they had to, and were unable to express concerns about whether the visit should proceed, and regarding children's mood or behaviour before or after visits.

Concerns were also raised by parents and carers that indicated staff were not able, or were limited in their ability, to understand what the child wanted or needed, including staff having little or no time to debrief with the child prior to or after changeovers, limited skills of engaging with children who have disabilities, and children having difficulties communicating with staff.

Parents and carers identified benefits to their children of using the CCS to include the opportunity to build a relationship with the visiting parent or carer and to experience safe and enjoyable time with them, and children becoming more confident with them as the relationship developed. Similar to the observations above, detriments centred on perceptions of the CCS as not intervening when the child was distressed and not being accorded a voice in the process. An absence in continuity of staffing was identified by some parents and cares as detrimental to their children.

Staffing

Compliance with guiding standards in relation to staffing practices is also evident. For example, increases in staff numbers (average staff number of 9 compared to 7 staff in earlier years) and reports of staff ratios to clients suggest strong levels of compliance with guiding standards, and most CCSs described their application of the 'two-worker' model and with an increase over time in the average number of staff. Responses to the RFI also indicate that CCSs were often able to be flexible to increase staff ratios where families required this.

A number of challenges in the areas of recruitment and retention, specifically linked to CCS functions were identified. These include the high level of skill required of CCS staff; the nature and timing of the shift work over weekends (including feelings of disengagement from the organisation among staff working these hours); the more limited availability of casual staff; the locations of services, including regional locations; the level of remuneration and the level of responsibility required of the role.

There was an evident focus on staff training and professional development for most CCSs across a broad range of relevant areas and on an ongoing basis, including in relation to child safety; child abuse and/or neglect and child-safe practice; child development, DFV, trauma-informed practice; cultural awareness training; child-inclusive practice and to a lesser degree in relation to service provision in relation to children and adults with a disability. Additionally, supervision of CCS staff and in-house training was undertaken to support ongoing professional development.

Site characteristics

RFI data relating to physical site characteristics and specifications of CCSs suggest that, overall, most services meet the requirements of the guiding standards in relation to CCS required site specifications, with almost all participating CCSs indicating developmentally appropriate supervision rooms and equipment (94%) and between two-thirds and almost three-quarters of CCS reported security cameras (72%), security doors (67%) and withdrawal spaces (67%). Separate entrances and exits (89%), outdoor play areas (89%), accessibility by public transportation (87%), facilities for older children (87%) and disability access (82%) were also frequently reported.

Self-management

In relation to self-managed arrangements, the findings indicate some complexity in this aim, including views among professionals and parents questioning the achievability of this goal for some families. Although there were high levels of endorsement for the principles of self-management among both CCS professionals and referring professionals, slightly less than two-thirds (61%) agreed that CCSs successfully provided the support and services that families need to transition to self-management. Strategies used to support self-management included case management and transitional arrangements, together with facilitating access to therapeutic support for parents and support for children.

Professionals also described a range of circumstances where long-term supervised arrangements may be required, including circumstances characterised by illness, injury or disability including acquired brain injuries, mental ill-health, homelessness and substance abuse or to support 'identity contact'.

Parents and carers were mixed in their views about being able to move to self-management with a substantial proportion of parents indicating that they did not know whether they would be able to manage their parenting arrangements without the CCS.

Concerns relating to moving to self-management were based on considerations including the role and expertise of CCS staff or regarding safety concerns about self-management, including in circumstances involving DFV, disabilities or substance misuse issues.

Cultural safety and disability

The findings set out in this section indicate that there is some way to go in achieving culturally safe service provision in CCSs. Less than half of professionals (47%) agreed that the services provided by the CCSs in their area were culturally safe for the children who use them, with participants raising significant concerns about the ability of CCSs to meet children's cultural safety and needs arising from disability. The issue of cultural safety will be considered further in chapter 5.

4 Demand for CCS services and meeting expectations

Introduction

The discussion in this chapter explores the extent to which CCSs are able to meet the demand for their services and to meet the expectations of the families using them and professionals referring their clients to them. It draws on relevant quantitative and qualitative data from the administrative data components from DEX and the RFI process, quantitative data from the Survey of Professionals and data from the Survey of Parents and Carers. This chapter also draws on qualitative data from interviews with parents and carers.

The first part of this chapter addresses Research Question 8: the **extent to which the current number and locations of CCSs are meeting the existing demand for their services**.

The second part of this chapter addresses the sub-questions of Research Question 6. These questions are focused on the expectations of families and professionals using or seeking to use CCSs and the **extent to which these expectations are being met**, and whether the referral process is operating effectively.

The discussion in this chapter first considers data drawn from DEX regarding the number of CCS clients and the demand for CCS services, before considering RFI data relating to the hours of CCS operation. Changes to these hours of operation are explored by reference to the qualitative responses provided by CCSs in the RFI process. Data from the RFI process are then considered to examine the waiting lists for CCSs over the period 2019–22, with open-text responses from the RFI process providing further insight into the nature and duration of these CCS waiting lists and strategies employed to reduce the length of waiting lists. The chapter then presents quantitative and qualitative data from the Survey of Professionals regarding their views on whether there were enough CCSs to meet the demand, whether the location of the CCSs were able to meet the existing demand and whether these CCSs were accessible. Accessibility is considered having regard to the location and access to public transport and the length of their waiting lists. Qualitative data are also presented regarding professionals' views as to whether the facilities are fit for purpose. Data from the RFI process and both quantitative and qualitative data from the Survey of Professionals is then considered in relation to referral pathways into CCSs and the effectiveness of these referral pathways. The chapter will conclude with an examination of data from the Survey of Professionals and the Survey of Parents and Carers regarding their satisfaction with CCS services.

Again, the data in this chapter are presented having regard to a key aspect of the stated objective of this project – specifically to consider the operation of the government-funded CCSs in the context of the history of CCSs, and the current context in which government-funded CCSs are operating.

Number of clients: demand for services

Table 15 presents the number of clients that have progressed through intake in relation to the in-scope CCSs. The data available from DEX show that:

- There were 14,729 clients across in-scope CCSs in 2019. The client numbers fell by just under 2,000 in 2020 and 2021 and then increased in 2022.However, client numbers remained lower in 2022 compared to 2019 (13,198 cf. 14,729).
- Across the 4 years, New South Wales CCSs had the largest numbers of clients (26%–29%), followed by Queensland (22%–24%). These 2 states accounted for approximately one-half of clients across the 4-year period (48%–53%). Victorian clients accounted for 16%–20% of all clients, and lower proportions were from Western Australia (12%–14%).
- The number of clients declined between 2019 and 2022 for New South Wales, Queensland, Western Australia and the Australian Capital Territory; however, the data show increases in client numbers for Victoria, Tasmania and the Northern Territory.

Table 15: DEX, number of clients of in-scope CCS services, 2019–22

Clients	2019	2020	2021	2022
Number				
NSW	4,279	3,436	3,360	3,369
Vic	2,366	2,089	2,144	2,627
Qld	3,497	3,127	2,986	2,931
SA	1,287	1,163	1,225	1,232
WA	2,007	1,659	1,547	1,685
Tas	810	778	789	907
NT	281	270	342	328
ACT	202	275	189	119
All	14,729	12,797	12,582	13,198
Percentage				
NSW	29.1	26.9	26.7	25.5
Vic	16.1	16.3	17.0	19.9
Qld	23.7	24.4	23.7	22.2
SA	8.7	9.1	9.7	9.3
WA	13.6	13.0	12.3	12.8
Tas	5.5	6.1	6.3	6.9
NT	1.9	2.1	2.7	2.5
ACT	1.4	2.1	1.5	0.9
Total	100.0	100.0	100.0	100.0

Notes: Family Life Limited – Cranbourne is not included. The years nominated in this table refer to calendar years.

Table 16 shows that nearly one-half of clients resided in major cities (46%–48%), and similar but lower proportions were from inner regional areas (41%–44%).

Table 16: DEX, number of clients of in-scope CCS services, 2019–22

Clients	2019	2020	2021	2022
Number				
Major cities	7,134	6,173	5,782	6,284
Inner region	6,076	5,361	5,553	5,712
Outer region	1,478	1,220	1,218	1,183
Remote	41	43	29	19
All	14,729	12,797	12,582	13,198
Percentage				
Major cities	48.4	48.2	46.0	47.6
Inner region	41.3	41.9	44.1	43.3
Outer region	10.0	9.5	9.7	9.0
Remote	0.3	0.3	0.2	0.1
All	100.0	100.0	100.0	100.0

Notes: Family Life Limited – Cranbourne is not included. Calendar years and outlet areas.

The next table (Table 17) presents data from the RFI process on the average number of hours CCSs operate, further analysed by state/territory, region and CCS organisation type. Overall, CCSs are open for 33 hours per week on average. There was some variation in average hours by state/territory, with CCSs located in South Australia and Western Australia open fewer hours on average compared to other locations (this difference is statistically significant). While noting this difference in hours of operation, qualitative data from one site in South Australia indicated that opening hours were extended if there was sufficient client demand and that operating hours were extended in summer and over school breaks (with no further detail on the number of hours this entailed). CCSs located in inner regional areas were open for 39 hours per week on average, significantly higher than the corresponding average for CCS in major cities (30 hours) and outer regional areas (28 hours). Similarly,

independent organisations were open for more hours (40 hours) compared with medium or larger organisations (30 hours).

Table 17: Request for Information: average hours of operation per week by CCS characteristics

CCS characteristic	Hours of CCS operation		
	Mean	Median	Total *N* CCS
State/Territory[a]			
ACT	56.0	56.0	1
NT	53.5	53.5	1
NSW	39.4	43.0	14
Vic	37.1	30.5	10
Tas	35.0	32.0	3
Qld	33.8	33.0	12
SA***	18.0	21.0	7
WA***	17.7	16.0	5
Total	33.2	32.0	53
Region[b]			
Major cities	30.0	30.0	25
Inner region*	39.2	41.0	20
Outer/remote region	27.8	20.5	8
Total	33.2	32.0	53
Organisation type[c]			
Independent organisation	39.8	35.0	14
Medium/larger organisation *	30.8	32.0	39
Total	33.2	32.0	53

Notes: Follow-up advice to the AIFS Research Team was that the RFI data submitted for Northern Territory were intended by the service provider organisation to cover both Darwin and Alice Springs CCS locations. The asterisks indicate that the difference in the mean scores between categories was statistically significant based on bivariate regression analysis, ***$p < .001$, **$p < .01$, *$p < .05$. [a] NSW is the base category in the regression model. [b] Major cities is the base category in the regression model. [c] Independent organisation is the base category in the regression model.

As Table 18 shows, service provision during the weekend is a key feature in this sector, with almost all CCSs providing services during weekend hours (96%).

Table 18: Request for Information: CCS open weekends

CCS open weekends	*N*	%
Yes	52	96.3
No	0	0.0
Not clear	2	3.7
Total	**54**	**100.0**

The RFI also captured qualitative responses from CCSs in relation to any changes that CCSs had made to their hours of operation since 2019. In addition to the challenges to hours of operation arising from COVID-19 pandemic lockdowns and the effects of recent natural disasters, several CCSs described the nature of, and factors that were associated with, an increase in hours of operation, including in response to an increase in the demand for their services. For example:

> *Due to COVID we shut down off site locations (community visits and home visits ceased). We extended the operational hours 8.30am to 7pm to compensate. This action has resulted in the CCS not having a wait list … To meet client need, operational hours are extended during the summer months and over school breaks … The CCS has adjusted opening hours when clients have been required to travel longer distances*

across the [redacted] … The CCS offers greater flexibility for start/finish times for the clients who are travelling longer distances on the country roads during the winter months. (Service 70, SA)

Most CCSs in their RFI responses reflected on increased funding as supporting the increased hours of operation. For example:

Due to increased funding in 2021, we changed from 6 days a week (closed on Mondays) to 7 days a week and extended our openings hours until 7pm. (Service 94, Qld)

There were, nevertheless, challenges associated with managing the increased funding and staffing availability while at the same time managing the demand for access to services. These included the challenges of managing the CCS budget and staffing arrangements, the allocation of staff hours at times that are most suitable to clients and the challenges of service delivery over a large geographic location. For example:

Until 2021, operating hours were flexible during the week, to accommodate parents' work schedules. To support Contact Centre staff to provide services within usual business hours, this was changed in 2021 to a more fixed operating schedule. (Service 235, state/territory redacted)

The responses of some CCSs participating in the RFI conveyed that changes in hours of operation and staffing models reflected not only the need for flexibility from families using the service but also enabled CCSs to adapt to the new service environment and staff availability. For example:

Before August/September 2020 the CCS was open Saturday and Sunday only, 9:30–5:30 both days. In August/September 2020 the service manager restructured the service for opening hours to be Tuesday–Saturday one week and Tuesday–Friday one week – 9:30–5:30 all days. The reasons for this were due to an increased number of cancellations of weekend visits, no senior staff to oversee staff if they only worked weekends, [the need] to increase service delivery by having more options for families, [and] issues with finding staff to work weekends or to cover shifts if staff were unwell/needed leave. The current CCS opening hours are Tuesday, Thursday and Friday 9 am–5 pm, Wednesday 12 pm–8 pm and every second Saturday 9 am–5 pm. Wednesday hours were changed to provide a dinner service and a late-night alternative to parents if children have sports, etc., on weekends. (Service 212, NSW)

The centre no longer operates on a Sunday at all. Saturdays only. The Family Relationship Program, which includes the CCS, has been subject to a change plan which has resulted in a more effective staffing model which supports relationship building and consistency between [redacted staff] Family relationship practitioners and the clients. The casual weekend staff were a casualty… We now have 3 x 0.8 on a rotating roster during the week and every second Sat and 2 x 0.5 staff who work every Saturday. (Service 234, Vic)

[O]ur CCS also run visits on Thursday nights (4:30–6:30 pm) to create more spaces for school-aged children. (Service 160, NSW)

Waiting lists

The data in Table 19 presents the waiting lists over the period 2019–22 for new clients at intake for most participating services and shows a reduction in the length of waiting lists over time, with the duration shortest in 2022.

Based on data from 45 CCSs, the pre-COVID waiting lists show that for more than one-quarter of these services (28%) the waiting list was nil (13%) or up to 2 months in duration (4%–11%). During 2019, substantial proportions of services reported 3 month waiting periods (16%); 4–6 month waiting periods (27%) and 7–12 month waiting periods (18%). For a small proportion of services (11%), the waiting period in 2019 was more than one year. A reduction in the waiting periods is identified in the data from the COVID period with only 4% and 6% of services reporting waiting periods of more than one year in duration. Substantial reductions in waiting periods are observable in 2022, although it is noted that these data were provided by 53 of the participating services. These data show that nearly one-quarter of services (23%) reported that they did not have a waiting list, with 15% and 21% reporting a one-month and 2-month waiting period respectively. Slightly more than one-quarter (28%) reported a 3-month waiting period and 13% reported waiting periods of 4–6 months. No services reported waiting periods more than 7 months in the 2022 calendar year.

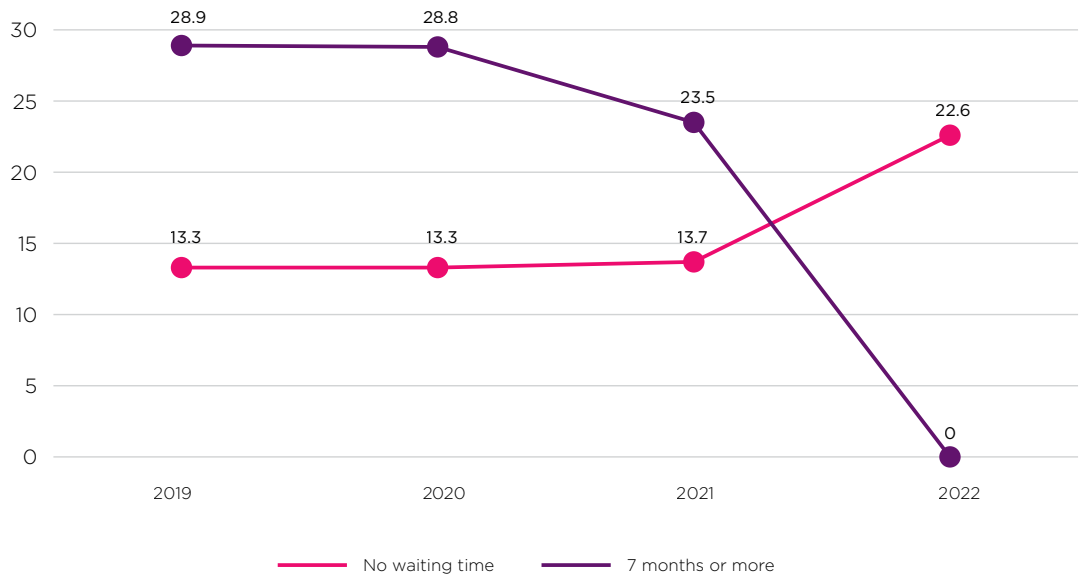
These reductions in waiting time are also illustrated in Figure 11 below. They should be considered in the context of the data indicating a fluctuation in client numbers between the period prior to the COVID-19 pandemic during the pandemic restrictions and after these restrictions, together with increasing staff numbers across this time

frame. These factors, which are likely to affect the length of, and time spent on, waiting lists and are considered together with insights from the qualitative components below.

Table 19: Request for Information, CCS average waiting time (months) for new clients by year

Waiting list time	2019		2020		2021		2022	
	N	%	*N*	%	*N*	%	*N*	%
No waiting time	6	13.3	6	13.3	7	13.7	12	22.6
1 month	5	11.1	3	6.7	6	11.8	8	15.1
2 months	2	4.4	5	11.1	3	5.9	11	20.8
3 months	7	15.6	7	15.6	10	19.6	15	28.3
4–6 months	12	26.7	11	24.4	13	25.5	7	13.2
7–12 months	8	17.8	11	24.4	9	17.6	0	0.0
More than 1 year	5	11.1	2	4.4	3	5.9	0	0.0
Total	**45**	**100.0**	**45**	**100.0**	**51**	**100.0**	**53**	**100**

Figure 11: Request for Information: average waiting time (months), 2019–22



Open-text responses from the RFI provide further insight into wait times, the length of waiting lists, the factors affecting waiting times and the effects of recent funding increases on waiting lists. For example:

> *The additional money we received in 2021 basically eliminated the waiting list.* (Service 262, SA)

> *We were given additional funding in 21/22 to help alleviate the wait list. These funds enabled us to increase service delivery of a weekend and in turn reduce the wait list.* (Service 79, Vic)

Some RFI responses described how the funding increases had supported CCSs to allocate staff resources to case management activities to expedite intake processes or to provide increased services across extended operating hours which had in turn reduced the CCS waiting lists. The responses also illustrate reduced demand for services from court-ordered clients which affected CCS waiting lists. For example:

> *Following the additional funding [redacted] which has allowed the expansion of supervised services during the week and operational on Sunday, and the new additional contact centres [redacted], the current waitlist has reduced to no wait list during the week or Friday night and 3–6 months on a Saturday or Sunday, though we currently have a vacancy on both Saturday and Sunday due to families moving on. [redacted CCS] has also experienced a decline in waitlist as a lot of the referrals we have received from the court are assessment only and time is yet to be ordered by the court. The bulk of our practice is [referred*

from] the Lighthouse Project. There is no wait list for changeover on weekends. Zoom sessions are offered during the week and there is currently one vacancy. (Service 146, NSW)

Only one CCS indicated in their RFI response that their more limited service offering likely had an impact on the lower demand for their services and short waiting list. Other RFI responses nominated factors such as parent/carer engagement with the intake process, directions in court orders regarding whether families require further supervision of their parenting arrangements or whether families can transition to self-managed arrangements (e.g. Service 207, Vic; Service 235, state/territory redacted)

Some RFI responses described improvements in waiting lists arising from changes in procedures that affected the intake activities required prior to the placement of families on the waiting list or in the conceptualisation of the waiting list. For example:

Our processes have changed – we now complete an intake with a family then place them on a waitlist for contact to commence. The previous process was a family wouldn't commence intake until a contact place was available. The process changed to ensure that if a family was not suitable to use the service, we could provide referrals for the family much sooner. Our current waitlist for an intake appointment is 3–4 weeks – and for contact to commence depends on what days and times – for a Saturday around 6 months for a weekday contact could be around 4–6 weeks, the late Wednesday nighttime is around 3–6 months. (Service 212, NSW)

We have recently introduced a more accurate measure for wait time. Noting that until both parties have completed intake the wait time is impacted by the engagement of the other party who may or may not be in support of visitation or changeover. We are now tracking request for service enquiry through to 2nd party intake and wait time commences then. (Service 198, state/territory redacted)

This service focuses on being child centred as it offers 'something until a scheduled place opens up' e.g. ad hoc 1 hour contact sessions which are designed to support the connection between the child/parent. This flexibility in the scheduling of clients has opened up opportunities for additional clients to be rostered onto the service while preventing a growing waitlist. (Service 70, SA)

Several services reflected in their RFI on the strategies employed to address the impact of waiting lists on families and to support a greater number of people to access their supervised visits. These strategies involved providing services at days and times that are likely to be more suitable to school-aged children and facilitating an increased number of supervised visits of shorter duration. This approach also included integrating CCS and post-order programs to support families to receive timely therapeutic support that may assist them to move to self-managed parenting arrangements. One participant indicated that the intake process 'enables CCS practitioners to identify the specific needs of each child and their family to assess suitability for services' and that in appropriate cases, shorter term, more intensive service provision could be employed by CCSs where safe to do so to support families to transition to self-managed parenting arrangements. This approach was identified as recognising 'the high demand for [the] CCS and the need to manage wait lists, while still maintaining the best interests and safety of children' (Service 244, Qld).

The COVID-19 pandemic was also identified as leading to innovation that shaped ongoing service provision, with some responses to the COVID restrictions leading to longer-term developments. For example:

Prior to COVID our waiting lists were very lengthy (7–12 months). This was due to the CCS providing ongoing supervised time/changeovers to families as they navigated the very lengthy Family Court process…. we provided therapeutic support alongside the CCS, (i.e.: POP) – and often whilst they received counselling, [the] CCS paused. As a result, many families utilised the CCS for 1–2 years. During the COVID lockdowns our CCS ceased providing visits, however, we conducted regular safety check ins and planning with every family. In addition, as the lockdowns progressed and the family law system adapted, some families were able to negotiate alternate arrangements. This enabled us to support those families most in need of our CCS. In 2021 we began to implement a new integrated CCS/POP model which provides 8 supervised visits/changeovers and offers therapeutic support to families. This new model enables us to have a minimum wait list and encourages families to work towards a positive co-parenting relationship and self-management of their arrangements. (Service 152, Vic)

Professional and parent/carer views on CCS characteristics relevant to meeting demand for service

Figure 12 presents the views of professionals participating in the Survey of Professionals on a range of CCS service characteristics relevant to meeting service demand. The data show statistically significant differences between the views of CCS professionals and referring professionals in relation to a range of characteristics:

- Professionals' views on whether there were **sufficient number of services to meet demand** varied significantly, with CCS professionals strongly agreeing (6%) or agreeing (28%) with this proposition compared to small proportions of referring professionals strongly agreeing (1%) or agreeing (7%) with this proposition.
- Views on the extent to which the **location of CCSs were able to meet the existing demand** also varied significantly, with 7% of CCS professionals and no referring professionals strongly agreeing and 38% of CCS professionals compared to 8% of referring professionals agreeing that the location of CCSs were meeting the existing demand.
- CCS professionals again reflected more positively on the **accessibility of CCSs by public transport** with 20% strongly agreeing and 50% agreeing compared with 4% of referring professionals strongly agreeing and 30% agreeing with this proposition.
- CCS professionals and referring professionals held vastly different views of the **length of waiting lists** with 14% and 38% of CCS professionals strongly agreeing or agreeing that the length of waiting lists were minimal, compared to no referring professionals strongly agreeing and only 4% agreeing that waiting lists were minimal.

These data illustrate significantly different perceptions of CCS service provision between CCS professionals and referring professionals, in some instances suggesting challenges in communication between these professional groups. In other instances this may suggest differing views on what constitutes modest waiting lists, having regard to their clients' particular needs. For example, consistent with CCS professionals' views, the data relating to waiting lists provided in the RFI component and detailed earlier in this chapter, are indicative of modest waiting lists for a substantial proportion of CCSs. This is particularly so having regard to the substantial reductions in waiting periods observable in 2022 (see Table 19 and Figure 11).

Location of CCSs

Some professionals captured in the data presented in Figure 12 provided a follow-up open-text response describing why they agreed that the location of CCSs was able to meet the existing demand for access to their services in their area. In these 42 responses, participants were most likely to indicate that this was because the CCS was well-positioned or centrally located having regard to the population size of the service area (*n* = 12/42), or because the CCS's positioning with respect to manageable travel arrangements and means of travel meant that it was well located (*n* = 13/42). For example:

> *Most people are not travelling more than 30 minutes.* (CCS staff, Vic, 55+ years)

> *The facility is centrally located and easy to access.* (Lawyer, state/territory redacted, 25–34 years).

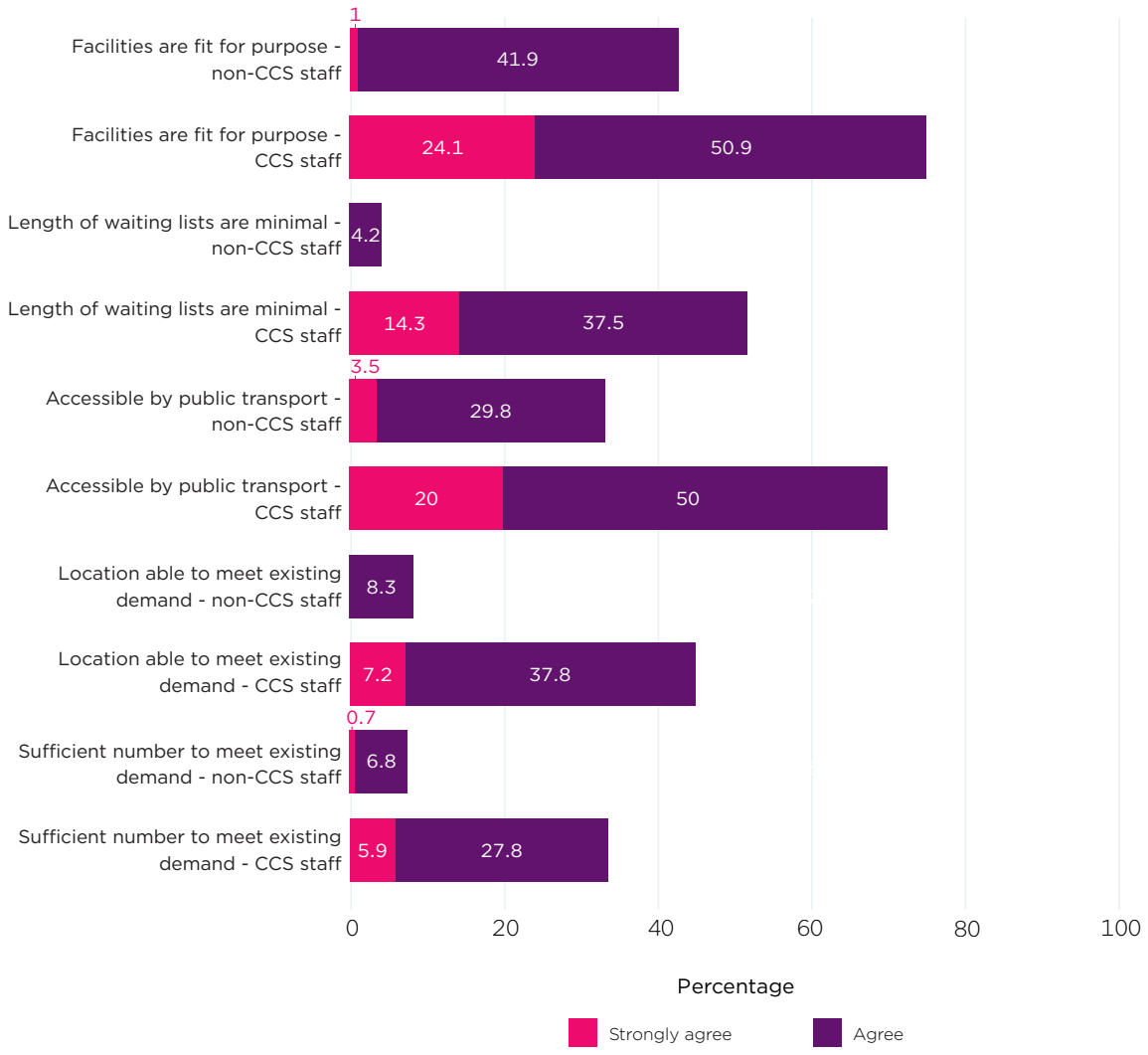
A greater proportion of participants provided an open-text response describing why they disagreed that the location of CCSs was able to meet the existing demand in their area. Most of these participants described the availability of CCSs in their local area as insufficient to meet the demand to be evidenced by the waiting lists (*n* = 76/132). A substantial proportion of participants reported that the travel required to reach CCSs meant the location of CCSs were insufficient to meet the demand (*n* = 34/132), that there was a lack of CCSs located in regional or rural areas (*n* = 21/132) or having regard to the growth in population in their local area (*n* = 21/132).[22] For example:

> *Parties are required to travel long distances to attend Service location, particularly in rural, regional and remote areas.* (Lawyer, undisclosed)

> *It is not in a particularly central area, and [redacted] public transport in general is not very good. These two things combined make it difficult for clients to access this service.* (CCS staff, state/territory redacted, 25–34 years)

22 It is acknowledged that the impact of availability of private supervision services in these locations on waiting lists could not be reliably examined in this evaluation.

Figure 12: Online Survey of Professionals, CCS characteristics by professional type



Notes: Questions was worded as: 'To what extent do you agree or disagree with the following statements:' Don't know/ Cannot say responses excluded from analysis. *** All differences between CCS and non-referring staff were significantly different at $p < 0.001$ level using Pearson Chi square test.

Number of CCSs

Participants in the Survey of Professionals who provided an open-text response on why they agreed that there was a sufficient number of CCSs to meet the existing demand for CCS services in their area, most commonly referred to low wait times to access these services (n = 22/37). A smaller number of participants referenced the number of CCSs to illustrate that there were enough services to meet the demand in their area (n = 13/37) or that the location of the CCSs in their area was such that there was enough to meet the demand in their area (n = 2/37).

On the other hand, participants who disagreed that there was a sufficient number of CCSs in their area to meet the existing demand for access to services were asked to indicate why they disagreed. Most of these professionals (n = 93/158) suggested this was evidenced by the waiting lists being too long in their area. A substantial proportion of participants reported that there was an insufficient number of services because the available services were not accessible by reason of the distance or cost required to travel to them, including in suburban areas as well as regional or rural areas (n = 44/158). For example:

> *Waitlist and number of accessible locations impact one another. [The] current sites are not able to meet demand for court-ordered contact and more often than not see families being placed on months long waitlists – this is more often than not seen in regional areas, where towns are not as closely located as urban areas and centre locations may be.* (CCS staff, Vic, under 25 years)

> *Wait times are often weeks to months before parents can be booked for assessment. If there were more CCSs in the area, this would reduce the wait times. (Lawyer, Vic, 25-34 years)We are the only CCS in the entire [location redacted]. Families often have to travel 100s of kms to access our service and…often public transport is limited. The expense of travel and accommodation is often a barrier to accessing services for the families we support. We often have a waiting list for families to be able to use our service as the demand is high.* (CCS staff, NSW, 35–44 years)

> *Because my clients need to drive long distances to other parts of [city] for contact visits, and this means children are under extra demands to regulate their emotions and behaviour during a long drive, and therefore the regression that occurs after contact visits is increased and impacts their functioning in their daily routines e.g. school, early intervention appointments* (Psychologist, NSW, 35–44 years)

The quotes directly above illustrate the impact of the number and location of services on the wellbeing of children and families travelling to and from these services.

Smaller proportions of participants considered that there were an insufficient number of CCSs in their area to meet the demand because the service area was too large (*n* = 28/158), that there were no CCSs in their area (*n* = 11/158) or the CCS services were not sufficiently flexible (*n* = 15/158):

> *Demand far exceeds supply. Private supervision operators are making a fortune because they are filling the service gap.* (Lawyer, Vic, 45–54 years)

> *There is only one CCS in my area, and it is definitely not sufficient for our communities' need. Our community's population growth over recent years has significantly increased and continues to increase. Our community also has some of the highest VIC statistics in relation to family violence, child protection involvement and child wellbeing issues which all impacts on families and their need for suitable child contacts services. Especially to benefit children's safety and wellbeing during supervised handover and contact … Our community needs at least two CCS and outreach services to outlying towns.* (DFV professional, Vic, 35–44 years)

> *There are NO Children's Contact Services in my area. None at all.* (FRC professional, WA, 55* years)

> *There is one CCS in this region, that is limited to mostly after-hours service provision. A centre that is available for more hours would better meet the needs of the community.* (CCS Staff, Vic, 45–54 years)

Accessibility to CCSs by public transport

Professional survey participants were invited to provide an open-text response in relation to why they agreed or disagreed that the CCSs in their area were accessible by public transport. Most of the participants who agreed with this proposition indicated that the CCS was accessible by public transport as it was a reasonable distance to a bus, tram or train route (*n* = 84/90) with a smaller number noting that taxi or rideshare services were available (*n* = 5/90).

Of the participants who disagreed that the CCS in their area was accessible by public transport, most indicated that there was no public transport or inadequate public transport by reason of being located in a regional or rural area (*n* = 30/64) or despite being in a suburban or urban location (*n* = 16/64) or that although the CCS was located near to public transport, it was not well-serviced having regard to the transport timetabling, long distances or unreliability (*n* = 10/64). Other participants indicated that the CCS was located too far away to be accessible by public transport (*n* = 9/64) or that it was inaccessible because it was very difficult to manage public transport with children, particularly with a disability (*n* = 7/64). For example:

> *It can be very difficult for some parents to transit to the allocated children's contact service. I have a client who has to catch 4 different transports to get to the allocated children's contact service with the child. this is not ideal. this is not easy.* (Lawyer, SA, 35–44 years)

> *Often the families live in locations where there is not reliable and regular public transport. Also, many parents cannot afford public transport or cannot manage other children on public transport.* (Court Child Expert, NSW, 45–54 years)

Parents and carers were asked in their qualitative interviews about their usual transport arrangements to access their CCS and how manageable transport was for them and their children. Of the 45 parents/carers who provided a response to this question, almost two-thirds said they mainly travel by car to the CCS and that this was a manageable distance and time (*n* = 28/45). However, some parents experienced issues accessing their CCS

by car and/or public transport. Those parents/carers described having difficult or costly car journeys and lengthy, complex public transport arrangements. The following example illustrates issues using public transport where the CCS location was not reasonably assessable:

> *It's a fair trip, given that I spend like an hour and a half actually seeing [child], I probably spend more time for actually travelling just to get there and then more time than what I see [child] for getting home. So... it probably takes me over an hour and a half all up to actually get there...because, you know, train, bus and tram,... Getting to and from is double the time that I'm actually spending with my [child], so. Yeah, that's a bit of a challenge.* (STWP 35).

Length of waiting lists

Participants in the survey provided an open-text response in relation to why they agreed or disagreed that the waiting list for the CCS in their area was minimal. Of the 50 participants providing an open-text response indicating their agreement, (consistent with a majority of RFI responses), most referenced the reasonable waiting times on the CCS waiting lists in their area (*n* = 31/50) or described how the increased funding had supported a reduction in waiting lists and an increase in services available (*n* = 11/50). Some participants also described how the intake process supported a reduction in waiting times where this was effectively implemented (*n* = 6/50). For example:

> *Due to increased funding and changes in the Court, we have no current waiting list and believe that this is the case for majority of our Centres.* (CCS staff, NSW, 25–34)

Of the participants providing an open-text response indicating that they disagreed that the length of waiting lists at the CCS in their area were minimal, most categorised the waiting lists as unreasonable and too lengthy (*n* = 108/146). Some participants reported the high demand for services resulted in lengthy waiting lists (*n* = 7/146). Others nominated inadequate funding as affecting staffing numbers, hours of operation and the number and type of services that can be provided, which in turn affected the waiting lists (*n* = 17/146). For example:

> *There is always a waitlist and while increased funding has reduced this, we are still finding at times families are waiting up to three months to commence. This is an entire court circuit where nothing occurs for a family.* (CCS staff, Vic, 35–4 years)

> *The funding is insufficient for the need/demand that results in turn always, people not even trying because they have heard how bad it is with the waiting time, plus long waiting lists. Supervision is being rationed - and that isn't acceptable either.* (Lawyer, state/territory redacted, 55+ years)

Facilities fit for purpose

Most professional survey participants providing an open-text response regarding whether they agreed or disagreed that the service in their area was fit for purpose, agreed with this proposition. Around half of these participants described the facilities as fit for purpose based on them being child friendly, family friendly spaces that were suitable for the families attending and for the services provided (*n* = 47/99). For example:

> *The centre is set up to have warm inviting spaces. Indoors rooms and resources create an environment for warmth, connection, and attachment. Rooms are all set up with couches, floor rugs, toys and access to games, and food storage and heating facilities. Our outdoor areas have shared spaces that families can choose different areas to play, eat together, and engage in sporting activities (e.g. basketball hoop, balls, mini soccer goal, etc.).* (CCS staff, Qld, 35–44 years)

Some participating professionals characterised the building as fit for purposes because it was purpose built for CCS service provision or renovated to provide these services (*n* = 16/99) or because of the safety features, including duress alarms, secure and separate entry and exit features (*n* = 23/99), or because the facility was in an accessible location and had accessible features such as parking (*n* = 7/99). For example:

> *The Centre is located near the CBD and close to public transport. This building is located with two street access, separate carparking and waiting areas that ensures that parents do not come into contact with each other. The playground is large and contains various play activities and experiences and has several play areas. The inside has 5 separate supervision areas and a large range of toys and activities are provided. The building is fitted with an alarm system, outside cameras and staff can easily monitor the surrounds due to the open plan environment. The building is fully fenced with child proof gates. The building has security*

doors that separate the waiting area from the rest of the building as well as security doors on entrance and exits. (CCS Staff, Qld, 55+ years)

A very small number reported that the facilities were fit for purpose because they met the Guiding Principles Framework for Good Practice and child safe principles (*n* = 3/99). A small number of professional participants reflected on why they disagreed that the CCS facilities in their area were fit for purpose. Most of these participants described the quality of service provision (*n* = 15/34) or that the building was not purpose built or refitted to ensure the facilities were fit for purpose (*n* = 13/34). Some also described facilities such as the play areas or the outdoor areas as inadequate from a child friendly perspective. Other participants described them to be inadequate because they were using inappropriate or makeshift facilities such as childcare centres (*n* = 3/34). For example:

The building and facilities are old, outdated, not enough room and maintenance is difficult. Parking availability is very limited and often parents will still see each other which can cause conflict and safety issues. (DFV professional, Vic, 35–44 years)Many clients that have attended them say that it is difficult to have quality contact with their children, as there is nothing for the kids to do with them and become bored despite the parent desperately wanting quality time. (Family Relationships Service Provider, NSW, 55+ years).

Data from the RFI process also provide insight into the location, accessibility and suitability of the CCS facilities and amenities.

The responses from some CCSs described how the location of the service, its facilities or amenities, its hours of operation or its accessibility supported the CCS to meet the demand for service:

Locations are within walking distance of public transport. They are wheelchair accessible and have hearing aid loops. (Service 261, Qld)

The h[ou]rs of operation are consistently being monitored due to the continual increase in demand for supervised sessions. (Service 115, WA)

This Centre is located within walking distance to the [city] and bus station, there is a bus stop within a few metres from the front of the building. The site has two street entrances and is located on a large block with a playground outside including two large sandpits, table tennis, basketball hoop, soccer nets, cubby houses, outdoor sporting equipment and water play activities, bikes, trikes and scooters. (Service 94, Qld)

Some RFI responses described changes that had been made to their location and facilities to both improve the appearance of the sites and to better meet the demand for services and support safe service delivery. For example:

Our [CCS redacted] was located in a rental property [that] was unsafe for clients and staff..., Since we received enhanced funding, we were able to move premises ...Our [redacted CCS] is now larger than the previous accommodation and more conducive for positive interactions for families with more space and a large playground and backyard. There has been a gradual increase in demand for this service as rental prices and home affordability in the [redacted location] region has forced many families to relocate to the [redacted] region. (Service 55, Qld)

Our office moved in 2019 from a house into a purpose-built office adjoining the main [redacted] office. This move allowed us to better cater for people with special needs, e.g. ramps, disability toilet. We also designed the building to suit the service and equipped each contact room with a kitchenette and necessities to be self-sufficient. . (Service 79, Vic)

Extra security cameras [were] installed – digital and several with zoom and rotate features. (Service 127, Vic)

Nevertheless, some CCSs in their RFI responses described shortcomings in the facility locations, amenities and accessibility of their service that prevented them from meeting the demand for their services. For example:

The sites are not purpose built and not independent from other services. The main CCS site is not close to public transport. (Service 70, SA)

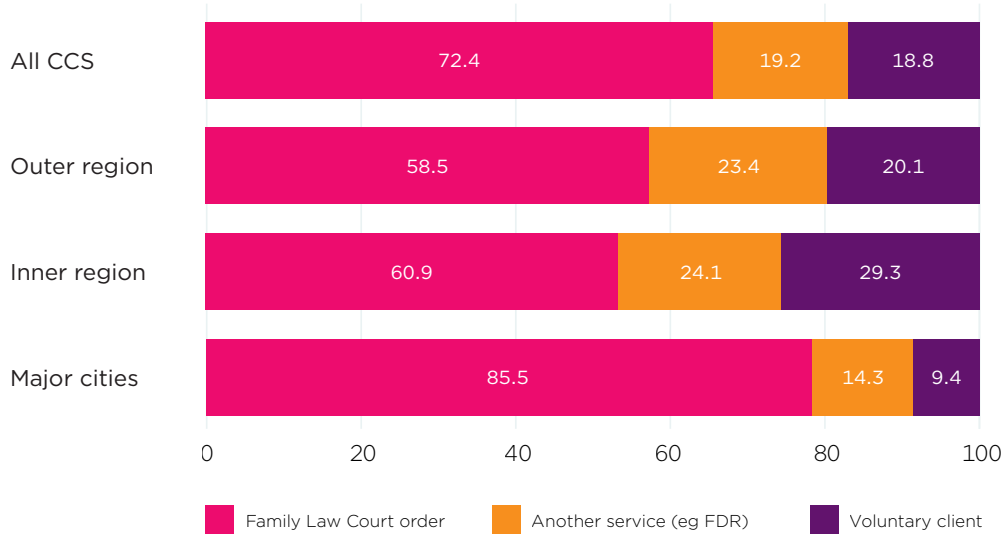
All sites are used for business/office purposes on weekdays; hence sessions can only be delivered on weekends to ensure the space is quiet and confidential for CCS. Each site can also accommodate one family at a time for anonymity. (Service 120, SA)

Referral pathways into CCS

The RFI data also provide an opportunity to explore the various pathways that clients are referred into CCS organisations. Reflecting the earlier findings that the majority of clients are currently engaged in family law proceedings, the most common referral pathway was through a family law court order; on average 72% of clients were referred in this manner.[23] Approximately 1 in 5 clients (18%) were voluntary clients, followed by referral from another service such as FDR (14%).[24]

These data also highlight that the pattern of referrals varies by regional location. As shown in Figure 13, CCSs located in major cities were more likely to be referred by a family law court order (86% on average) compared with 61% and 59% in inner and outer regional areas respectively. Conversely, CCSs located in inner regional areas had the highest proportion of voluntary clients (29% on average) compared with 9% of clients for CCSs located in major cities.

Figure 13: Request for Information: average proportion of current clients using the service through each referral type, by region



Notes: Multiple referrals possible so average proportion in each category may not sum to 100.0%

Parents and carers were asked in their interviews how they started using the CCS, particularly their referral source in relation to how they found the centre. More than half had received a referral from family law court proceedings with the CCS specified in an interim order (*n* = 26/50). Lawyers were the next most frequent referral source, followed by the service being nominated in a final court order, referral from family dispute resolution or mediation, and finding the CCS themselves. This confirms most parents and carers are referred to CCSs via court orders; however, a small number of parents and carers have found the CCS of their own accord or through other family law related services.

Effectiveness of referral process

Table 20 shows the extent to which professionals agreed or disagreed that referrals to government-funded CCSs in their organisation (CCS professionals) or their area (referring professionals) operate effectively (i.e. meeting their objectives as outlined in the relevant guiding documents, for example, the Grant Opportunity Guidelines and the Guiding Principles Framework for Good Practice). CCS professionals were significantly more likely to strongly agree that referrals were effective. It was also notable that 40% of referring professionals indicated they do not know/cannot say if these referrals are effective (cf. 16% CCS staff). It is possible the level of uncertainty reported by referring professionals for this question, may in part be explained by their unfamiliarity with the Guiding Principles Framework.

23 Noting this is strictly not a referral as clients were ordered by the court to attend.

24 As multiple referrals are possible, these percentages may not sum to 100.0%.

When the same data is analysed with the 'Do not know/Cannot say responses' excluded (Table 20, Panel 2), we can see that the proportion of CCS professionals who strongly agreed or agreed that referrals were effective was almost double the corresponding proportion of referring professionals (83% cf. 43%). The implications of this finding will be considered in more detail in the context of data from the qualitative interviews with parents and carers later in this chapter.

Table 20: Survey of Professionals: effectiveness of referrals by professional type

To what extent do you agree or disagree that referrals to government-funded CCS/s in your organisation/your area operate effectively?***	CCS professionals		Referring professionals		Total	
	N	%	*N*	%	*N*	%
Panel 1 - All responses						
Strongly agree	37	32.5	2	1.4	39	15.1
Agree	43	37.7	35	24.3	78	30.2
Neither agree nor disagree	8	7.0	26	18.1	34	13.2
Disagree	4	3.5	15	10.4	19	7.4
Strongly disagree	4	3.5	9	6.3	13	5.0
Do not know/Cannot say	18	15.8	57	39.6	75	29.1
Total	**114**	**100.0**	**144**	**100.0**	**258**	**100.0**
Panel 2 – Do not know/Cannot say responses excluded						
Strongly agree	37	38.5	2	2.3	39	21.3
Agree	43	44.8	35	40.2	78	42.6
Neither agree nor disagree	8	8.3	26	29.9	34	18.6
Disagree	4	4.2	15	17.2	19	10.4
Strongly disagree	4	4.2	9	10.3	13	7.1
Total	**96**	**100.0**	**87**	**100.0**	**183**	**100.0**

Notes: ***$p < .001$ difference between CCS professionals and referring professionals statistically significant based on chi-square test. Percentages may not total 100.0% due to rounding.

The Survey of Professionals also captured open-text responses regarding the reasons participants specified in relation to whether they agreed or disagreed that referrals to the CCSs in their area operate effectively. A greater proportion of participants described how the referral processes worked well. Most of these participants indicated that either the referrals process operated in accordance with the applicable guidelines and standards (n = 20/52) or that there was a well-managed intake process (n = 20/52), and some participants also referenced the positive feedback that they had received from clients and referring services in this regard (n = 7/52):

> *We are lucky enough to have an FRC within the same building who we work collaboratively with. The process of mediators referring through to our CCS is efficient and effective. We also refer out to external Children's Contact Centres particularly if they in another town, however the wait list for this external service can be up to 9 months.* (CCS staff, NSW, 35–44 years)

> *Clients provide feedback on referrals to the contact centre and feedback is generally positive.* (CCS staff, Qld, 55+ years)

Some participants also described the CCS in their area as being well-integrated with the broader service system (n = 27/52), including because of CCS staff's knowledge of the available services and their capacity to meet families' needs. Some participants specifically described the established and positive lines of communication between the referring services, support services, family law courts and the CCSs (n = 19/27). Other participants referenced the service's co-location of the CCS with relevant services (n = 2/27). For example:

> *This Centre works closely with the Court and key stakeholder to ensure they are fully informed about the Centre and its capacity and referral requirements. We receive phone calls from many key stakeholders while they are preparing referrals and we able to assist with this process.* (CCS staff, Qld, 55+ years)

> *We have a very good relationship with all the lawyers in our region and they are always happy to refer to our Service. We have also created and maintain a relationship with Judges.* (CCS staff, NSW, 45–54 years)

On the other hand, participants' reasons for indicating the referral processes were not working well included that there were insufficient CCSs in the locations to meet the demand which impacted on the referral process (*n* = 12/44) or that the waiting lists were too long and services were unable to meet the referral demand (*n* = 23/44). For example:

> *It is not the referral that is the problem. They can be referred but then the family isn't able to use the service. [There are] not enough centres around Brisbane or regionally in Queensland. Long waiting lists. Limited availability for the hours.* (Lawyer, Qld, 35–44 years)

> *There are obscenely long wait times, the service that they can provide is very limited and leaves many families unable to have safe contact between children and parents. They are under-resourced and having to 'make-do' in a way that is not good for families or the workers.* (DFV professional, Qld, 35–44 years)

Some participants identified challenges with the intake process generally. One participant considered the screening process at referral to be too strict, although four participants described how CCSs were receiving an increasing number of high-risk referrals (especially court-based referrals). For example:

> *More intake officers [are] needed. [There is a] slow screening process-review of the compulsory paperwork (atm clients are not able to fill out their forms as a PDF)* (CCS staff, state/territory redacted, 25–34 years)

> *Staff are too easily screening out parents and families who need help most.* (Lawyer, Vic, 45–54 years)

> *Referrals, particularly from the Family Court increasingly involve people with complex co-occurring issues and conflict. This has required much more of a focus in risk assessment, safety planning, service coordination and documentation management.* (Service provider organisation, state/territory redacted, 55+ years)

As observed in chapter 3, other participants focused their responses on the nature of referrals to CCSs in circumstances where referring professionals had referred families to the CCS where supervised arrangements were deemed unsafe:

> *Most are effective however there is ongoing concern about referral of extremely unsafe/unsuitable matters for the CCS to assess, and often decline service, impacting families by re-traumatising victim survivors and children, and taking considerable case management resources for matters that cannot proceed.* (Service provider organisation, NSW, 55+ years)

> *Our service does operate effectively as possible with the resources provided, BUT we can only do that to the extent that we receive appropriate referrals … When we do not operate effectively, it is often due to the safety risks of the case being too high even for centre-based supervised contact and this referral placing considerable additional casework load on the program. This results in our program undertaking duties such as lengthy assessments, safety planning, managing hostile STWPs, making referrals to external services for safety support and/or men's behaviour change or like programs. While this process will help keep the LWP and child safe (for a time) these referrals ultimately should never have been made to any CCS. At times we have been informed that our CCS has been referred cases with the belief that we will refuse due to safety risks. From time-to-time we also receive referrals from court for cases which have already been refused by another gov-funded CCS and we are required to conduct a second assessment of the case, [which is] both re-traumatising the LWP and child and using CCS resources with no hope for contact visits.* (CCS staff, NSW, 45–54 years)

Participants also reported concerns about the quality of CCSs in their responses regarding referrals to CCSs including concerns regarding operating without sufficient funding, service provision below the relevant principles and standards or did not address safety concerns, including in relation to cultural safety (*n* = 9/44). Two participants also described the challenges where the CCS was not well-integrated with the service system, including where the CCS staff had limited knowledge of other services and their capacity to meet clients' needs or where there was inadequate exchange of information between the CCSs and the courts.

It is also notable that when participants were asked whether they had any further comments regarding referrals and whether the number and location of CCSs were sufficient to meet demand, most participants described the challenges of waiting lists and how there was a greater need for government-funded CCSs to meet demand or that more of these services were required in regional and rural locations (*n* = 44/83). A substantial proportion of participants also referenced the need for more CCS resourcing for staffing, hours of operation and types of services available and to support premises that are fit for purpose (*n* = 16/83) and for the provision of other

support services, and therapeutic and post-separation services (*n* = 7/83). A small number of these responses referenced concerns about the operation of CCSs in accordance with standards and practices (*n* = 5/83).

Satisfaction with services

The Survey of Professionals sought participants' views on what they were most satisfied with and least satisfied with in relation to their CCS or the CCSs in their area.

Aspects of CCS service that professionals are satisfied with

Of the 163 positive responses to this open-text question, the quality (including neutrality and child-focused nature) of services provided was most referenced (*n* = 72/163) with specific commentary around the professionalism, quality and neutrality of the services being mentioned. For example:

> *The professionalism of the service and its child focused responses.* (Lawyer, state/territory redacted, 55+ years)

> *The importance placed on a child focused service that is safe and positive for all family members to attend and build positive childhood experiences of connection with both sides of their family.* (CCS Staff, Qld, 55+ years)

> *They are impartial and provide a safe and secure environment that the primary carer can trust.* (Lawyer, Vic, 35–44 years)

A substantial proportion of participants in the Survey of Professionals described aspects of the service provision that were of benefit to the children and/or their families (*n* = 46). Positive reference to the accessibility to services, including financially, was made by some participants (*n* = 11). For example:

> *They are available to clients who are on low incomes and unable to otherwise afford the costs of spending supervised time with their children.* (Lawyer, Vic, 45–54 years)

When describing their satisfaction with services, participants also emphasised the safety of services and the priority accorded to children's needs and safety in particular (*n* = 7). This category of participants also included those referencing the guiding principles and standards applicable in relation to CCS service provision, and the provision of services that met these standards. For example:

> *We are child focused and child inclusive and advocate for the safety and wellbeing of children at risk. We [work] directly with children to support them as they navigate contact visits including at times being a voice for the child when their needs, within the context of visits, are not being met. When it is safe (enough, as far we are made aware) we work hard to support parents to focus on the needs of the children and support them making better parenting choices and work towards safe independent management of contact. Empower parents with suitable resources to work towards this goal.* (CCS staff, NSW, 45–54 years)

> *As an ICL, I find that the Centre is very much focused on the children's needs and alert to any undue parental influence. We are able to work together to ensure that the children's needs are best met within the Centre.* (Lawyer, SA, 55+ years)

> *Child focused, operate within best practice guidelines, positive outcomes for family, holistic view of the family, ability to recommend other agency support or internal referrals.* (Service provider organisation, state/territory redacted, 45–54 years)

Some participants described CCS practices that supported families to address their underlying issues, including by engaging in collaborative practice by warm referrals, including to internal and external services providers who could support the families to address the issues giving rise to their need to use the CCS. For example:

> *We are able to collaboratively support families with a wrap-around service that is focused on the children. We have many internal referral options and have creative ways to make use of both indoor and outdoor spaces to ensure that contact is child-focused and child-inclusive.* (CCS staff, NSW, 25–34 years)

The nature of CCSs providing services to a diverse range of children and using an inclusive approach with their families, was a factor highlighted by those participants in the Survey of Professionals who indicated that they

were satisfied with the CCS services. These data illustrate the significance of independent, neutral, child-focused and child safe service provision. For example:

> *That we have a high proportion of service users who are Aboriginal. That we are co-located and have a focus on service integration.* (Service provider organisation, state/territory redacted, 55+ years)

> *[We are] Child and family inclusive, strong restorative practice.* (CCS staff, SA, 45–54 years)

Some participants referenced the quality of the staff of CCSs, including in the context of providing child-focused services. This was referred to by non-CCS professionals as well as those working within the CCS environment (*n* = 26):

> *Staff are well-trained and operate at all times with a child-focused approach. Staff are trained to mitigate risk for all participants, ensuring children feel safe and empowered to provide staff with indication that they are not feeling comfortable during the visits. They allow children to have a voice and encourage resident and non-resident parents to place the interests of their child as the ultimate goal to work towards.* (Service provider organisation, WA, 55+ years)

> *Our organisation has Child Safety as one of its guiding principles and we are lucky to have a Child Safeguarding team to refer to for advice and information. We follow practices that always support the safety of children first. Our professional development for staff is extensive and diverse, from cultural awareness, disability, child safeguarding, risk management, MARAM, safety planning, case notes, etc.* (CCS staff, Vic, 55+ years)

> *The skill and capacity of the staff and assistance they provide to parents to become better parents overlaid with the safety of children as being paramount.* (Judicial officer, NSW, 55+ years)

Participants also described the quality of CCS written reports (*n* = 15) when reflecting on what they are most satisfied with in relation to CCSs. Particularly important are the responses from referring professionals who are most frequently the end-users of such reports to inform decision making: For example:

> *[The CCS provides] Safe reliable supervision for children. Excellent reports on observations.* (Judicial officer, NSW, 55+ years)

> *I read their reports and find the reports are usually very helpful around defining the quality of children's relationship with attending parent and also the level of parenting capacity.* (Single expert witness, WA, 55+ years)

Aspects of CCS service that professionals are dissatisfied with

A similar proportion of open text responses from participants in the Survey of Professionals described what they were least satisfied with in relation to the CCSs in their area (*n* = 161). A substantial proportion of participants referenced insufficient funding for the delivery of required CCS services, including the increases in the types of services, reduction in waiting lists, improvement in activities and the length of service provision for families (*n* = 44). For example:

> *With more funding, the service could provide a better, more engaging experience for children by providing a space and activities that are tailored to the children's interests.* (CCS staff, Vic, 35–44 years)

Consistent with several participant responses throughout this section, 43 of the open-text responses referenced the length of waiting lists when describing their dissatisfaction with the CCS services (*n* = 43/161). For example:

> *The wait times, the lack of flexibility of times available which can restrict families (i.e. they don't stay open late to facilitate after school time), the lack of authority in enacting court ordered time, the lack of guidance for families about progressing to unsupervised time e.g. recommendations based on their assessments of interactions.* (Court Child Expert, state/territory redacted, 35–44 years)

Other survey responses relating to the reasons professionals were dissatisfied described insufficient CCSs to meet the demand for the services they deliver (*n* =26), including a need for more rural and regional locations (*n* = 7). For example:

> *[I] Wish we could open more CCSs in other locations, including inner city suburbs where there is a shortfall of services.* (CCS staff, Vic, 45–54 years)

> *The lack of availability of services outside of the major regional town (though this is not a fault of the Centre but rather funding issues and appropriate venue availability). (Lawyer, SA, 55+ years)That there is in fact only one children's contact centre in the area and it is two hours away, with minimal to no public transport for clients to get there.* (Lawyer, Vic, 45–54 years)

CCS staff participating in the survey also described the challenges in the way that they were able to undertake their day-to-day work, such as making time for labour intensive administrative tasks, collaborative practice with other service providers or service delivery limitations, that, in turn, impacted satisfactory service provision. Specifically, concern was raised about the:

> *Labor intensive reporting requirements which actually only partially report casework undertaken, e.g. [it] does not reflect the variety of types of service we provide [and a] Reporting management system that does not track detail of the client journey, e.g. track stats on cases refused service after intake assessment completed, cases that progressed to changeovers from visits, and cancellations, to demonstrate the effort required to engage traumatised LWP's, etc.* (CCS staff, NSW, 45–54 years)

> *[We have] Difficulty in collaborating with other organisations due to inability for them to assist in supporting the family due to their organisation restrictions. [There] Needs to be allowances made for family support services to be able to share information in order to support the clients to move to self-management where possible.* (CCS staff, Qld, 25–34 years)

Some participants also described their concerns about the quality of services provided and the facilities and security in place, due to poor design or functionality. This was identified as raising concerns for some parents and carers, including reduced feelings of safety (*n* = 27). Concerns about the quality of services provided also related not only to the accessibility of services and responding to the needs of different families, but also having regard the implementation of timely, trauma-informed and culturally sensitive and inclusive practice:

> *The building design and functionality is very poor. This does cause stress for the parents using the centre. Supervised rooms are open to other rooms, access to the building very poor.* (CCS staff, Qld, 55+ years)

> *The extensive waiting times, the services are often unavailable, and people need to travel, and their services are not culturally appropriately or competent. I also think staff need trauma-informed training to allow them to better observe the interactions and report on these.* (Court Child Expert, NSW, 45–54 years)

> *[There are] Not enough resources to provide onsite interpreters for Linguistically Diverse clients. Lack of knowledge around disability and working with neurodiverse children - such children often don't 'fit' into our services and behaviour observed, not done through a neurodiverse lens. Might need resources to include NDIS support workers., etc. in their visits.* (Undisclosed, WA, 45–54 years)

CCS professionals and referring professionals also identified concerns about the high-risk profile of cases being referred to CCSs that led to dissatisfaction with the CCS service provided and an impact on CCS staff:

> *Referrals that come from the family court where safety is still an ongoing concern, i.e. serious family violence, ongoing child protection concerns.* (CCS staff, NSW, 45–54 years)

> *The increased level of risk, particularly of people with co-occurring issues, this requires increased level of assessment, risk management and workforce development.* (CCS staff, state/territory redacted, 55+ years)

Some participants also raised concerns about the training and quality of the CCS staff when reflecting on aspects of CCSs that they were dissatisfied with (*n* = 18), staff neutrality (e.g. Lawyer, WA, 55+ years) and concerns particularly in relation to dealing with traumatised clients and a lack of DFV-informed and trauma-informed practice (e.g. Lawyer, WA, 45-54 years; Lawyer, Vic, 45-54 years). Some participants specifically raised concerns about staff capacity to identify DFV and coercive control used at visits with children, and to acknowledge and respond to the 'impact of previous abuse and neglect on children's attachment, regulation of emotions and behaviour and the choices on offer around venue, access to a consistent supervisor, quality of reports post visit. I do not see this considered or evident in decisions made around how contact visits are managed and set up' (Psychologist, NSW, 35–44 years).

Although explored in detail in Chapter 5, it is notable in this context also that a smaller proportion of responses raised concerns about inclusion and accessibility for First Nations, CALD families and families with a disability, and as such, meeting the demand for all those needing to access their services (*n* = 9). For example:

> *Indigenous families and those from a culturally diverse background are reluctant to utilise the service – possibly having a Cultural Officer to assist with engaging these families may be of assistance.* (Court Child Expert, Queensland, 25–34 years)

Relevant to data on the preparation and quality of CCS reports and facilitating transitions to self-management presented in chapters 2 and 3, when reflecting on aspects of CCS service provision that they were dissatisfied with, some professional participants identified the need for time and training to support CCS staff: (a) in the preparation of observational reports, and (b) in the provision of services to family members to address the underlying issues necessitating their use of the service:

> *I think there should be training centred around court reports as I don't think all the workers have the same skill level when creating reports. I think court reports in general should have a standard format.* (CCS staff, Vic, 45–54 years)

> *For legal professionals, the objective is to try to assess safety of children with a non-primary carer – often the reports don't report on behaviour in a trauma informed way – e.g. fawning behaviour seen as affectionate and comfortable when it may be placatory to an abusive parent.* (Lawyer, WA, 35–44 years)

> *More case management and tailored support could be a game changer for many families. There is no other service in the post-separation world where the whole family, by nature of service, is involved in this way.* (FDR professional, SA, 45–54 years)

Participants in the Survey of Professionals were also asked for their views on what was preventing or inhibiting the CCSs from providing the services or aspects of CCSs that they were least satisfied with. The vast majority of open-text responses provided (n = 90/142) refenced funding and resources and facilities as the barriers but other barriers nominated included related barriers including access to the required number of staff and staff who were qualified to deliver the services (n = 25) and that there were insufficient numbers of CCSs to meet the demand and to reduce waiting lists (n = 12). Geographical remoteness was referenced in some responses regarding these inhibiting factors (n = 7) as were family law system processes (n = 17) as were barriers in relation to accessibility (n = 3). It is notable that some interview data from parents/carers and from the First Nations stakeholders are consistent with these survey data, indicating that families were unable to access the services in a timely manner (see Chapter 5; however, the RFI data suggest that the recent increase in funding to CCSs has substantially reduced current waiting lists (see Table 19).

Parent and carer satisfaction with CCS services

Participants in the Survey of Parents and Carers were also asked to rate their level of satisfaction with CCS services, on a scale of 0 to 10, where 0 is not at all and 10 is extremely. The survey also collected their perspectives of how satisfied their child/children is with the CCS. Parents and carers were asked to reflect on how satisfied each child was with the CCS, using the same 10-point scale. It is important to note, that information was not collected directly from children, but from the parents and carers of children. There was a high level of correlation between parent/carer ratings and parent/carer ratings of their children's experience (correlation coefficient of 0.77, n = 82 between parent/carer rating and parent rating for their first child; and correlation coefficient of 0.66, n = 49 between parent/carer rating and parent/carer ratings for their second child).

The data in Table 21 presents the average satisfaction rating for parents/carers and children further analysed by various characteristics such as parent/carers' gender, age, parenting arrangements and cultural background. Parent and carer ratings of their children's satisfaction were further analysed according to child gender and age.

Overall, parents and carers were quite satisfied with their use of CCS services, reporting an average rating of 7.6 on the 10-point scale used. There were no statistically significant differences in rating levels for each of the characteristics considered. The largest difference in satisfaction ratings was found for cultural background and parenting arrangements.

Participating parents and carers who were born overseas in a non-English speaking country or who had at least one parent born in a non-English speaking country reported an average satisfaction rating of 6.5 compared to all other participants who reported a 7.8 rating.

Participating parents and carers who indicated their parenting arrangement was 'All or most of the time with the other parent/carer and supervised time with me' reported an average satisfaction level of 6.8 compared with parents and carers who had parenting arrangements that involved 'All or most time with me and supervised parenting time with the other parent/carer', who reported an average rating of 7.8.

Table 21: Online Survey of Parents and Carers: average level of satisfaction with CCS services, parents and parent's rating of child satisfaction

	Parent's rating of child satisfaction (Mean)	*N*
Parents		
All parents	7.6	104
Gender		
Man or male	7.3	40
Woman or female	7.9	63
Age		
25–34 years	7.3	20
35–44 years	7.5	41
45–54 years	7.8	33
55 years or older	7.8	9
Parenting arrangements		
All or most of the time with me and supervised time with the other parent	7.8	38
All or most of the time with the other parent and supervised time with me	6.8	26
Cultural background		
Participant or at least one parent born overseas in a non-English speaking country	6.5	17
All other participants	7.8	87
Children		
All children	7.3	153
Gender		
Male	7.5	76
Female	7.4	71
Age		
0–4 years	7.1	38
5–9 years	8.3	55
10–14 years	7.2	46

Notes: *n* = 1 parent aged 18–24 years not reported due to small sample size. Other parenting arrangement categories collected in the survey not reported due to small sample sizes, including 'Most of the time with me and supervised changeover for time with the other parent', 'Most of the time with the other parent and supervised changeover for the time with me', 'Roughly a 50/50 split and supervised changeover used'. *N* = 10 children aged 15 years or older not reported due to small sample size.

Qualitative data from the interviews with parents and carers also suggested that overall, most were satisfied with CCS services, and provided insight into their reasons.

Comments from the interviews with parents and carers were mostly positive about their CCS for their experiences with opening hours (*n* = 22/27 responses) and cost for services provided (*n* = 23/31 responses). Some parents/carers who were concerned about the cost of their CCS services acknowledged that the fees were relatively low (particularly compared to private contact services); however, this was still challenging to manage amongst budget constraints with low incomes:

> *It's hard … when I get paid, I'm usually out of cash right now cause like I said, my oldest two, they've moved out of home now and the cost of living at the moment is pretty rich and the cost of rent is ridiculous. So, and I know it's only 10 bucks. But yeah, it's all makes a difference, absolutely.* (LWP 25)

Feedback about waiting lists was equivocal for the few participants who spoke about this issue. Some parents and carers were aware of long waiting lists to access services. The delay to see their children and additional costs attributed to waiting lists was a concern particularly for a small number of Spends time with parents. For example, this Spends time with parent explained their concerns in the following quote:

> *...while waiting for the service I use now, there was like an 8-month waiting period. So while I was waiting I was using the private service just so my [children] could see each other.* (STWP 14)

When asked what the most important things were that the CCS and its staff did for their family, parents and carers most often mentioned that the CCS addressed issues of safety for their children and/or themselves. Other things often mentioned were the CCS's and its staff's care and support of parents/carers, child-focus and neutrality. These positives were also mentioned by professionals as aspects of CCS services that that they were satisfied with (see earlier in this chapter). Friendly and welcoming CCS staff, and the role of the CCS in making possible continuing contact between a child and a parent subject to supervision, and the reporting role of the CCS were also mentioned as important. For example:

> Just ensuring that she is safe physically, emotionally. I guess stepping in if anything was inappropriate ... I guess I know...that they are employed and that they've gone through checks and that, you know it's an adult there that's not under the influence ... So it's eliminating those risk factors. (LWP 26)

> Peace of mind. I don't have to panic anymore, which is fantastic ... because [my child] is not frightened anymore and he's relaxed and calm ... Yeah, he was very, very anxious. Very, very clingy, very, very. And now that's not an issue at the moment. Is very, yeah, calm. (LWP 40)

> [M]y daughter was [0–2 years old], when supervised time began and my son was [3–7 years old] so very young children and they have had very consistent staff with their sessions. When there has been a change of staff, it's then been that same person for an extended period of time, so they don't have a high turnover. And I think that really helps the kids feel really secure and safe. And the environment is really fantastic ... Landing at [CCS location] was a huge relief and it just feels like a really child friendly environment. It feels like home and there's lots of really brilliant, age-appropriate toys and a nice outside play area so it doesn't feel like a sterile environment, which I think helps a lot ... they are genuinely very nice people ... I think that goes a long way to making it a positive experience for us all. (LWP 36)

> The most important thing is they ... allow me to see my kids. ... With without it, I, I wouldn't see my kids ... I would still be corresponding by snail mail, which is what we did ...in the two gaps actually, where I didn't see them... It's better than nothing, but. At least it means I can see them. At least it means they can see me. (STWP 21)

> The report is, frankly, the thing that they provided that was the most useful to me because it demonstrated over a more than 12-month period that the allegations and doubts of my parenting capability put forward by the other person were completely unfounded. (STWP 11)

Positive observations, however, were not always expressed. For example:

> They gave me somewhere to go where I didn't have to have direct contact, but yes, you know, there were so many things they don't do ... when I initially went there, I said, because ... I got a different car and I didn't want him to see my car, I said, 'Why can't he always go in the back entrance and I go in the front entrance so that I know he's at the back and I can leave and go and I can feel safer? Whereas if I go out the back, I've got to go past the front to get out. And then, like he could be looking out the front door and he could see me driving out and see what car I'm in.' I said, 'I'm trying to keep myself safe, discreet. I didn't want him knowing what car I drove' and I said, 'I don't feel safe, I said I want to do it this way' and they said 'No, you have to do it this way.' ... I had so many triggers, I mean it, it did give me somewhere to go where I didn't have to have direct contact but then there was so many loopholes and I feel breaches of confidentiality. I felt unsafe and I felt interrogated at times ... I'm sure, [child] hated going there as well. And it was just like, I just felt, you know, sometimes you'd have a lovely person there and sometimes you didn't. (LWP 33)

In contrast to the detailed descriptions of CCS professionals, parents and carers rarely described orientation/familiarisation processes for children or parents (chapter 2), arrangements for different children, culturally specific services or debriefing arrangements for parents or children. Those who did describe orientation/familiarisation or debriefing processes were mixed in their descriptions of the former (chapter 2) and did not describe established or careful debriefing processes. For example:

> Interviewer: What are the arrangements for debriefing you as the as the carer, what are their arrangements after the sessions for debriefing you do they sort of provide you with information?
> Interviewee: No, they just let me know that everything went OK and. That's about it. Like if there would have been a problem, they'd tell me and that sort of thing. (LWP 19)

The following reflections from Lives with parents and carers also raised concerns about the debriefing arrangements for adults and children after the visits.

> Uh, sometimes I wish there was a lot more of that because uh, because she's so *young as well. So quite often I'm not … I just want to know what she's had to eat and what she's done. And they seem quite reluctant to talk about it … [It's] more from just a sense of 'I'm taking her home now, you know. Has she eaten? Has she been to the toilet?' That kind of thing. But usually they're pretty much like, 'Oh, yeah, everything was good. See you next [time]'.* (LWP 26)

> *I've found that I've always been the one that has to initiate the questions, and I would say to [child's name], 'Start from the beginning. How did you feel in the beginning of the visit? Tell us what happened during the visit' and I've had to get him to really open up and expand and one of the workers, one of the younger ones, might ask a question or two. And then … he starts to really open up and then the supervisor would say, 'What do you want me to do with this information?' and that will shut him down again.* (LWP 43)

Further insight is provided into parents and carers' satisfaction with CCS services in response to the interview question that asked how they would like to see contact services change in the future. Some responding parents and carers indicated that they would not make changes to the CCS (n = 6). However, a total of 36 parents and carers made one or more suggestions to improve CCSs for the future. Their responses indicated that more funding for the CCS would be a positive change that they would like to see (n = 7). This additional funding was considered to be best directed to increasing locations or branches of CCS sites to reduce distances to attend or decrease waiting lists, more flexibility in sessions to offer and more staff or supervisors in sessions. One suggestion was that CCSs could be funded to offer broader services such as parent counselling to improve their communication and support their moving towards self-management (STWP 15).

Extending the analysis of data presented in chapter 2 regarding the services professionals and parents thought CCSs should provide, many parents and carers (n = 9) indicated that they would like to see improvements to the infrastructure and activities for children. These included prioritising funding for expanded spaces with a particular focus on improving outdoor play spaces and sports as these were seen as integral for engaging older children. Speaking from the perspective of their children's experiences, the following parents and carers describe how improvements to infrastructure and facilities for children would better support them during the process of changeover or supervised time:

> *Like when I first started, I thought it was going to be like one parent dropped kids off to like a playground sort of room sort of thing where it just distracts them from what's happening. And then the other part, getting them from there. If that makes sense. But right now It's just a walking hand over, but if there was like a little playground or like a drawing room or something that the kids can just go in there and draw. Playing stuff and then the other parent, once the other parent's left, and the other parent comes in and hands over, I think that would be a better option.* (LWP 10)

> *I think like there's possibly changes that could be made to make it more appropriate for older kids, but then, you know, it does seem to be a centre that's utilised more for younger children, but I guess they sort of have to you know, focus resources on the majority of users of the place, so … But like I. Sorry. Yeah, like I feel like, you know, when the weather's nice, like we spent most of the time outside, but I feel like when the weather's not as good, like you know, kids that are older and especially teens can feel a little bit boxed in and a little bit bored like with some of the, you know, things that are on offer there. So it's tricky.* (STWP 13)

Other comments about improvements to CCS infrastructure indicated that adding sheltered areas and improving waiting areas were important as much time was spent waiting at the centre often with older children in tow. Although 4 parents mentioned improving safety would be the change they would most like to see, their concerns mostly related to infrastructure issues such as a lack of parking or lack of waiting areas. This meant there was a risk they would run into the other party while searching for a park or having to wait outside when sessions were running late, as the following quote illustrates:

> *Waiting out outside [is an issue]. Because you're right where the drop off thing is, right where the opposite car park entrance is. So if you're still waiting outside when the other party comes in. You know it's not, you know, depending on what the situation is, it's not always the place you want to be.* (LWP 3)

Improvements to staffing were priority future changes for 9 parents and carers. This extended to comments that training of staff in the impacts of trauma and the family law system would enable better support for the parents. A participant that had used contact services at 2 locations noted that staff at one site appeared to be better trained in this aspect than at the other one (LWP 5). One parent/carer mentioned that staff needed more training

in DFV informed practice, and in particular in relation to coercive control and how that operates and impacts victim/survivors (LWP 9). Similarly, another participant commented that although it was clearly appropriate that the CCS be child-focused, additional training in DFV, mental health and trauma impacts would potentially remove pressure from the Lives with parent/carer and support them in relation to their parenting capacity:

> *That I love that the contact centre is so child-focused, but when you only are child-focused then you're not thinking about the mental health of the victim survivor or the parent and that, that mental clarity and stability so important for further caregiving.* (LWP 31)

A Spends time with parent indicated that staff having training in trauma and having more time available to listen to parents would be helpful in supporting them rather than the CCS just being a place for dropping off children:

> *Also training, I think they do need some more training. Look, it's not for me to judge them they do a great job. But you know, some small things obviously like taking a bit more time to listen to, you know.* (STWP 15)

For one parent/carer it was important to make it clearer whether staff were volunteers or paid workers because of some of the comments they had made and that training would help support a warmer, friendlier environment (LWP 25). Other comments around training indicated that this could improve report writing (LWP 9) and potentially staff ability to operate neutrally (STWP 14).

One of the common suggestions was improving communication from the CCS (*n* = 9). This included advertising their services more broadly so that they were easier to find – some people had not known about CCS services until they were court ordered to attend and feel it would have been a useful option to know about. Many of these parents and carers indicated they would simply like more communication opportunities to debrief with staff about how the visits were generally going for their children and be able to have more regular check-ins to understand any issues or positives that staff were seeing. This was more in relation to pragmatic information that would help the Lives with parent or carer support their child following the sessions and informing them for future preparation for sessions.

More specific consideration of data from the DEX SCORE data and from the Survey of Parents and Carers relating to outcomes for the diversity of families accessing CCSs are examined in detail in the next chapter, chapter 5, which includes analyses of relevant data from the qualitative interviews with parents and carers and with First Nations Stakeholders.

Summary

This chapter presented insights drawn from the DEX administrative data, together with RFI data, views of professionals from the Survey of Professionals and from the survey and interview data from parents and carers relevant to Research Question 8 (meeting demand for service) and Research Question 6 (meeting expectations of families and professionals and whether the referral process is operating effectively).

Below are the key findings relevant to Research Question 8.

Accessibility

The RFI data indicate that pressure on waiting list eased in 2022, when 23% of CCSs reported no waiting list compared to 13%-14% in 2019, 2020 and 2021. Waiting lists were most commonly three months (28%) or less (one month: 15%; 2 months: 21%). Only 13% of CCSs reported 4–6 months waiting lists and none reported more than 7 months. These improvements in time to access were attributed to increased funding supporting case management and expedited intake processes.

On average, CCSs are open for 33 hours week, with some variations among states and territories. Again, increased funding supported more operating hours but there were also challenges associated with demand for access and providing services over a big area. Nine-tenths of clients were from major cities or inner regional areas.

Overall, the findings suggest that there are sufficient services to meet demand, locations are appropriate and accessibility by public transport is mostly adequate. However, confidence in these questions is less evident among referring professionals than CCS professionals. These varying response patterns may in some instances suggest challenges in communication and information sharing between these professional groups. Additionally, some parents and carers interviewed reported experiencing issues accessing their CCS and described difficult or

costly car journeys and lengthy, complex public transport arrangements. These varying views reinforce the need to understand client perspectives on key issues relating to usability.

Below are the key findings in relation to Research Question 6.

Referral pathways

Referral pathways are mostly through family courts orders (on average 72% of clients), and the client caseload is particularly complex. Referral pathways vary by regional location, with CCSs located in major cities more likely to have clients referred by family law court order and inner regional locations having the highest proportion of voluntary clients. CCS professionals were significantly more likely than referring professionals to strongly agree that referrals were effective and when uncertain responses were excluded, the proportion of CCS professionals who strongly agreed or agreed that referrals were effective was almost double the corresponding proportion of referring professionals. Where participants indicated that referral processes were not working well, reasons included insufficient CCS to meet demand and long waiting lists. Some participants also identified challenges with the intake process and that CCS were receiving an increasing number of high-risk referrals, commonly linked with court orders.

Do CCSs meet expectations?

In relation to services meeting the expectations of the parties using them, qualitative data collected in the Survey of Professionals referenced the quality of CCS services (including neutrality and child-focused and child-inclusive nature of services and the CCS reports provided). Some participants described CCS practices that supported families to address their underlying issues as particularly helpful.

Conversely, areas that professionals were most dissatisfied with included insufficient funding for the delivery of required services. Some participants also described their concerns about the quality of services provided and the facilities and security in place, due to poor design or functionality. The concerns described in some instances suggest that facilities may not be sufficiently consistent with the requirements of the Guiding Principles Framework. However, it was difficult for the Evaluation Research Team to be definitive on the question of consistency with the framework on the basis of the limited detail provided in the survey responses, because the information may be insufficient to establish an inconsistency, CCSs may have put mitigating arrangements in place or because the concerns may relate to specific details relating to facilities that are not captured in the Guiding Principles Framework.

Participants also referenced the need for increases in the number and location of CCSs as well as the types of services provided, reductions in waiting lists and improvements to the available activities and the length of service provision for families. As noted in this chapter (see Table 19), the RFI responses suggest that the most current waiting list data illustrate a significant improvement in the post-COVID pandemic period, with the increase in funding assisting in the amelioration of wait times; however, issues associated with the location of services are acknowledged by CCS professionals as well as non-CCS professionals and parents/carers.

Some participants raised concerns about the training and quality of the CCS staff when reflecting on aspects of CCSs that they were dissatisfied with, particularly in relation to dealing with traumatised clients. A smaller proportion of responses raised concerns about inclusion and accessibility for First Nations, CALD families and families with a disability.

Survey data from the parent and carers' perspective showed that parents and carers rating theirs and their children's satisfaction with the CCSs were quite satisfied with their use of CCS services. Parents reported an average satisfaction level of 7.6 on a 10-point scale and an average satisfaction level of 7.3 for children as rated by their parents.

The data from the qualitative interviews with parents and carers indicate that, overall, most were satisfied with CCS services. Positive reflections were commonly associated with the costs and hours of operation, and consistent with professionals, that the CCS addressed issues of safety for their children and/or themselves. Parents and carers who reported positively also referred to CCS staff support, child-focus and neutrality. Some parents and carers raised concerns about the waiting lists to access the CCS and concerns for their safety or the safety of their children at the service. For some parents, expectations were not met regarding child safe practices such as orientation/familiarisation and debriefing.

Suggestions from parents and carers for improvements included additional funding to support an increase in locations or branches of CCSs to reduce distances to attend or decrease waiting lists, more flexibility in sessions offered, and more staff or supervisors in sessions. Many parents and carers indicated that they would like to see

improvements to the infrastructure and activities for children, as well as improvements in communication with parents and carers as well as potential referring professionals and training and support in relation to neutrality and report writing.

5 CCS service provision: meeting the diverse needs of families?

Introduction

The discussion in this chapter will focus on quantitative and qualitative data from the DEX SCOREs, together with data from the RFI process, the Survey of Professionals, interviews with First Nations professionals, the Survey of Parents and Carers, and interviews with parents and carers to address Research Questions 6 and 7. These research questions examine the **extent to which the services provided are culturally appropriate** for First Nations families and CaLD families and examining the **extent to which CCSs support families experiencing DFV**, **how they are providing this support** and **how effective** the provision of this support is. This chapter expands upon the initial findings about cultural safety for children presented in chapter 3 to assess culturally appropriate and inclusive CCS practices.

To examine the extent to which CCS service provision is culturally appropriate and supports families, including those families experiencing DFV, the chapter begins by exploring the diversity of families using CCSs and their identified needs and risk profiles. This discussion is based on data from DEX and the Survey of Professionals, followed by an examination of the issues for families using CCSs from the perspective of parents and carers through the Survey of Parents and Carers and interviews. The next sections of the chapter examine the accessibility and cultural safety of CCSs for First Nations and CALD families based on data from the Survey of Professionals, from the RFI process, the Survey of Parents and Carers and interviews with First Nations stakeholders and interviews with parents and carers. Accessibility in relation to interpretation support with language and signing services is also discussed.

In the final part of this chapter, data from the Survey of Parents and Carers is presented together with DEX SCORE data the interviews with parents and carers about the outcomes for the diverse range of families accessing CCSs. These data provide insight into parent and carer views about the CCSs that they have accessed and whether, from their perspectives, they are meeting their needs. Quantitative data from the Survey of Professionals is presented regarding professionals' views of the extent to which CCSs are meeting the needs of families experiencing DFV. Qualitative data from professionals are also presented, providing insight into the strengths and limitations of CCSs to adapt to meet the diverse needs of children and families, as well as recommendations for change to CCSs to better meet the diverse needs of children and families . The qualitative data from the Survey of Parents and Carers informs this examination of how CCSs could adapt to better meet the diverse needs of children and their families, with the data in this chapter considered in the context of the history of CCSs, and the current context in which government-funded CCSs are operating. First Nations professionals provide detailed insight into improving culturally safe service provision and increasing the prospect of future self-management for First Nations families.

Diversity of families using CCSs and their needs

Insight from the DEX, the Survey of Professionals and the Survey of Parents and Carers are examined respectively in this chapter to consider the diversity of families accessing CCSs and their identified needs.

Detailed insight into characteristics of CCS clients

DEX data provide insight into relevant demographic characteristics for in-scope CCS clients, including in relation to First Nations and CALD backgrounds, disability status, carer status, housing stability, family composition and income source (Table A17 and A18, Appendix H). *The Program Specific Guidance for Commonwealth Agencies in the Data Exchange* (Australian Government, 2023) identifies that in relation to the DEX data, the primary

client denotes members of separated families including children, with 'grandparents and other extended family members who care for children' (p 247).

The data show that client characteristics were similar between 2019 and 2022, as shown in Table A18 and notable findings include:

- Over one-third of clients were aged 0–17 years (or child clients) (36% in 2019 and 38% in 2022), with age group of 5–9 years being most common (16%–17%), followed by age group of 0–4 years (11%).[25] One-third of clients were aged in their thirties or forties (33% in 2019 and 34% in 2022).
- There were slightly more female clients than male (52% cf. 48% in both 2019 and 2022).
- First Nations clients represented 8%–9% of in-scope CCS clients which represents a higher proportion of First Nations people than in the general population (3% according the 2021 Census). Fewer clients were from CALD background (3%–4%), which represents a lower proportion of people from CALD backgrounds in the general population (21% according to the 2021 Census).[26] These figures may be underestimates given that the data relies on clients reporting their status to the CCS staff.
- Approximately 1 in 10 clients were reported as having a disability.[27]
- There were limited data relating to clients' housing stability, carer status, household composition and income source, with data missing on these characteristics for around half of clients. Missing data was generally higher in 2021 and 2022 compared to 2019 and 2020.
- The data in relation to household composition illustrate that approximately one-quarter (23%–26%) of clients were reported to be living as single parents with dependent children, and between 8% and 10% were either living in a couple relationship with dependent children, living with a group with related or unrelated people or that they lived alone.

The DEX also provides the most recent demographic data according to state and territory (Table A19, Appendix H). Notable findings include:

- Substantial proportions of clients identify as First Nations, with nearly one-quarter (23%) of clients in the Northern Territory reported as 'Aboriginal and/or Torres Strait Islander', with 11% and 10% of clients in New South Wales and Queensland reporting First Nations status respectively. A proportionally higher share of Tasmanian (7%) and South Australian clients (8%) were reported as being First Nations. These data are particularly notable given feedback in Phase One initial stakeholder consultations that services were not commonly accessed by First Nations people. The DEX data indicate a higher proportion of First Nations people using CCSs than would be expected having regard to their proportion of the Australian population (ABS, 2022).[28]
- Very small proportions of clients were identified as being from CALD backgrounds, with the highest proportion of these clients in Victoria and New South Wales. In both states, 5% of clients were reported as being from a CALD background and this is substantially lower than the proportion of CALD representation among separated parents identified in census data in these locations.[29]
- The data from Western Australia and Northern Territory in relation to housing stability is based on far lower proportions of 'unknown' responses compared to other states/territories, and indicates that most clients in these locations were not identified as being at risk of homelessness (Northern Territory: 98%; Western Australia: 63%).
- In relation to disability status, the highest proportions of clients with a disability were reported in Victoria (15%) and South Australia (15%) followed by the Northern Territory (12%) and Queensland (11%), with the

25 The administrative data did not differentiate child clients and parents or other clients. This age range is consistent with current child support scheme, that is, child support often stops when child turns 18.

26 Note that for DEX data, a client is considered to be Culturally and Linguistically Diverse where their Country of Birth is NOT 'Australia' and their Main Spoken Language is NOT 'English' or 'Not Stated'. To extract this CALD data from the 2021 Census, CALD is defined as people who were born overseas or whose country of birth were not stated AND who spoke a language other than English at home. Note however that the census question on language spoken at home differs from the DEX question. The 2021 Census asked: 'Does the person use a language other than English at home?' The DEX refers to the 'Main language spoken at home'.

27 Clients are asked to self-identify whether they have a disability, impairment or condition because it is important for organisations and funding agencies to know whether clients with disability are accessing services.

28 Data released by the ABS on 21 September 2022 indicate that as at 30 June 2021, First Nations peoples represented 3.8% of the total Australian population: Estimates of Aboriginal and Torres Strait Islander Australians, June 2021 | Australian Bureau of Statistics (abs.gov.au)

29 Based on data from the 2021 Census, 13 of the 19 CCS locations in NSW had a proportion of persons aged 18 years or older who spoke a non-English language at home of 5% or more. The corresponding proportion for CCS locations in Victoria was 10 out of the 11 locations.

highest proportion of 'unknown' responses provided with respect to Victoria, Queensland and the Australian Capital Territory.

- With more limited 'unknown' data in South Australia and Northern Territory in relation to household composition compared to other states/territories, the data in these jurisdictions illustrates that the most common family type in South Australia (30%) and the Northern Territory (50%) was a single parent with dependent children.

The DEX also collates most recent demographic data according to whether the CCS is located in a major city, an inner regional area or an outer regional area or remote location (Table A20, Appendix H). Notable findings include:

- Nearly one-half of clients are in major cities (48%) and 43% are inner regional areas. Clients in other areas (i.e. outer regional or remote areas) account for 9%.
- The majority of individual clients are from not-for-profit service provider CCSs (69%).
- First Nations clients are most likely to be reported as accessing CCSs in inner regional (11%) or outer regional and remote areas (14%).
- Clients who were from CALD backgrounds (5%) and non-First Nations clients (91%) were most likely to access CCSs in major cities.
- Relatively even proportions of First Nations and CALD clients accessed stand-alone services and not for profit service provider CCSs.
- Relatively even proportions of clients with an identified disability accessed CCSs in major cities (10%), in an inner region (10%) and in an outer regional or remote area (9%) and both stand-alone (12%) and not-for profit service provider CCSs (9%). Pre-COVID data are presented in Appendix B.

Table 22 provides demographics by two broad age groups, clients aged 0–17 years and clients aged 18+ years, in 2019 and 2022. In summary:

- Of clients aged 0–17 years, the most common age group was 5–9 years (45% for both 2019 and 2022), followed by the youngest age group 0–4 years (32% in 2019 and 29% in 2022). Approximately one-quarter were in the age group of 10–17 years (24% in 2019 and 26% in 2022). The age distribution was similar, with a slight shift toward older age, between 2019 and 2022.
- Of clients aged 18+ years, the age group 30–39 was the most common (41% in 2019 and 42% 2022), followed by the age group of 40–49 years and under 30 years. Only one-tenth were in the top age group of 50+ years.
- Clients aged 0–17 years had similar gender split. Of clients aged 18+ years, the number of female clients was slightly higher than the number of male clients. As noted, the child/children, together with the Lives with and Spends time with parents/carers are identified as clients of the CCSs in the DEX data.
- Approximately 1 in 10 clients aged 0–17 years in both years were First Nations, while 8% of clients aged 18+ years were First Nations. The proportions were higher compared to the proportion of the population that was First Nations (5.7% and 2.5% for the population aged 0–17 years and 18+ years respectively in the 2021 Census).
- Clients from CALD backgrounds (i.e. born overseas with a main language other than English) accounted for approximately 5% of clients aged 18+ years and less than 2% of clients aged 0–17 years.
- Approximately one-tenth of clients for both the broad age groups in both years were with a disability.
- For clients in both broad age groups (0–17 years and 18+ years), more clients were in single-parent families than couple families with dependent children (0–17 years: 17%–20% cf. 4%–6%; 18+ years: 24%–26% cf. 10%). It is worth noting that for the majority of clients aged 0–17 years and one-third of clients aged 18+ years, household composition in which they were living was unknown.

Table 22: DEX: Demographic characteristics of clients of in-scope CCS services (proportion), clients aged 0–17 years and aged 18+ years, 2019 and 2022

Demographic characteristics	Clients aged 0–17 years (%)		Clients aged 18+ years (%)	
	2019	2022	2019	2022
Age				
0–4	31.5	28.9		
5–9	45.0	45.1		
10–17	23.5	26.0		

Demographic characteristics	Clients aged 0–17 years (%)		Clients aged 18+ years (%)	
	2019	2022	2019	2022
18–29			21.6	18.5
30–39			40.7	42.1
40–49			26.3	28.4
50+			11.4	11.0
Total	100.0	100.0	100.0	100.0
Gender				
Male	50.4	50.7	45.9	46.7
Female	49.4	49.0	54.0	53.1
Other/unknown	0.2	0.2	0.1	0.2
Total	100.0	100.0	100.0	100.0
Indigenous status				
Indigenous	9.4	10.3	7.8	8.4
Non-Indigenous	85.8	87.6	89.1	90.0
Unknown	4.8	2.1	3.0	1.6
Total	100.0	100.0	100.0	100.0
CALD				
CALD background	1.6	0.5	4.8	4.7
Else	98.4	99.5	95.2	95.3
Total	100.0	100.0	100.0	100.0
Homeless status				
Yes	0.2	0.0	0.6	0.7
At risk of homeless	0.1	0.2	0.4	0.7
No	44.1	31.5	58.5	50.8
Unknown	55.7	68.2	40.5	47.8
Total	100.0	100.0	100.0	100.0
Disability status				
Yes	8.5	11.0	9.7	9.7
No	87.6	86.1	85.6	87.0
Unknown	4.0	2.9	4.7	3.3
Total	100.0	100.0	100.0	100.0
Carer status				
Yes			1.0	1.6
No			29.8	22.4
Unknown			69.2	76.1
Total				
Household composition				
Couple only			3.7	3.6
Couple with dependent children	5.6	3.8	9.7	10.2
Single parent with dependent children	19.9	17.0	24.3	26.0
Group (related or unrelated)	3.0	2.8	9.9	11.7
Living alone			13.4	14.4
Homeless or no household			0.3	0.4

Demographic characteristics	Clients aged 0–17 years (%)		Clients aged 18+ years (%)	
	2019	2022	2019	2022
Unknown [a]	71.6	76.4	38.6	33.7
Total	100.0	100.0	100.0	100.0
Number of clients	5,128	4,849	9,303	8,083

Notes: (a) For clients aged 0–17 years, 'unknown' includes other composition. The number of clients aged 0–17 years and 18+ years may not sum to the numbers in Table 1 (e.g. client's age was unknown).

Gendered patterns in employment, income source and household composition among clients aged 18+ years were evident in the DEX data (Table A21, Appendix H): Notable findings include:

- Although the majority of clients aged 18+ years did not have information on their employment, in both years, a higher proportion of male clients than female clients aged 18+ years were in full-time employment (e.g. 19% cf. 6%). On the other hand, a higher proportion of the female clients than the male clients were in the category of carer, parenting or other unpaid work (e.g. 11% cf. 3%).
- Consistent with the patterns of employment, for a higher proportion of the male clients, their income source was from employment, while a higher proportion of female clients had government benefits/pensions as their income source.
- Types of households in which clients were living also differed between female and male clients. Single-parent families with dependent children were more common among female than male clients aged 18+ years (e.g. 39% cf. 11% in 2022), whereas living alone was more common for male than female clients (e.g. 24% cf. 6% in 2022). Living in group households was also more common for the male than female clients (e.g. 16% cf. 8% in 2022). For significant proportions in both genders, household composition was unknown.
- Although lack of information was common across the 3 variables, the proportions of clients with unknown employment and unknown household composition were lower in 2022 than in 2019 for both genders.

Identified needs of CCS clients

The DEX data presented in Table 23 provide insight into the issues that families accessing the service were identified as experiencing over the period 2019–22. The data show that approximately 4 in 10 clients (41%–46%) were identified as needing assistance with family functioning, followed by more than one in ten families identified as requiring assistance with personal and family safety (12%–15%).

Of note, however, the needs of approximately one-third of clients were reported to be unknown (31%–36%). It is also important to note that these data relate to clients identified as being in need of assistance, some may experience issues which are not identified here and for which they may already be in receipt of relevant services.

Table 23 also shows that for a substantial proportion of clients, the details of referrals to services are unknown (41%–43%) and approximately one-third were referred to a legal agency (32%–33%).

Table 23: DEX: assistance needs and referral of in-scope CCS clients (proportion), 2019–22

	2019 (%)	2020 (%)	2021 (%)	2022 (%)
Assistance needed [a]				
Age-appropriate development	3.1	3.4	3.2	2.9
Family functioning	41.1	44.1	45.5	46.1
Mental health, wellbeing and self-care	3.5	4.2	3.6	3.9
Personal and family safety	14.7	15.2	13.8	12.4
Other	1.8	1.8	2.1	2.5
Unknown	35.8	31.3	31.9	32.2
Total	100.0	100.0	100.0	100.0
Number of client needs	17,984	16,099	15,657	16,807
Referral from:				
Centrelink/DHS	0.3	0.3	0.3	0.3
Legal agency	33.0	31.7	31.7	31.7

	2019 (%)	2020 (%)	2021 (%)	2022 (%)
Family/friend	6.7	6.1	5.6	6.6
Self	7.4	9.6	9.4	10.0
Other [b]	10.0	10.0	9.7	10.1
Unknown	42.5	42.3	43.2	41.4
Total	100.0	100.0	100.0	100.0
Number of clients	14,899	12,927	12,689	13,604

Notes: [a] Clients may have multiple assistance needs and each specific need was counted separately (i.e. multiple needs were counted multiple times). [b] Other includes general medical practitioner, health agency, child protection and other unspecified sources, with unspecified sources being the most common in this group.

Data from the Survey of Professionals also provide insight into the needs of families accessing CCS from the perspective of CCS professionals and referring professionals with reference to their client base.

Table 24 presents the characteristics of clients reflected in 'about three-quarters or more' of the work of participating professionals. The data show statistically significant differences between CCS professionals and referring professionals, with greater proportions of CCS professionals reporting that three-quarters or more of their work involved children and young people and families where there are issues relating to child safety, child abuse and/or neglect, as might be expected. They were also slightly more likely to report that their work involved First Nations families (8% cf. 7%), and CALD families (14% cf. 10%) and people with a disability (10% cf. 6%) but these differences were not statistically significant. On the other hand, referring professionals were more likely to report that about three-quarters or more of their work involved the provision of services to families experiencing or using DFV. Again, this difference was not statistically significant.

Table 24: Survey of Professionals: client characteristics by professional type

About three-quarters or more of your work involves the provision of services to:	CCS professionals		Referring professionals		Total	
	N	%	*N*	%	*N*	%
People with post-separation/family law issues	90	76.9	133	89.8	223	84.1
People experiencing or using domestic and family violence	81	69.8	113	75.8	194	73.2
Children and young people***	95	81.9	81	55.1	176	66.9
Families where there are issues relating to child safety/child abuse/and/or neglect*	53	45.2	70	47.3	123	46.4
Culturally and linguistically diverse families	16	13.9	15	10.0	31	11.8
People with a disability	11	9.6	9	6.0	20	7.6
Aboriginal and Torres Strait Islander people	9	7.8	10	6.7	19	7.2

Notes: *$p < .05$; ***$p < .001$ statistically significant based on chi-square test. Percentages do not total 100.0% because multiple responses could be selected.

The Survey of Parents and Carers also captured data regarding whether families were using CCS services because of any of the following issues:

- alcohol or substance abuse
- mental health issues
- gambling problems
- violent or dangerous behaviour
- emotional abuse or anger issues (e.g. getting angry easily).

Participant responses are shown in Table 25 and show the range of complex issues faced by substantial proportions of families accessing CCS services as reported by the parents and carers themselves. The data show that issues associated with emotional abuse or anger issues were most commonly reported (46%), followed by mental health issues (40%) and violence or dangerous behaviour (39%). Nearly one-third of participants reported issues associated with alcohol or substance abuse (30%) and nearly half (48%) of parents and carers participating in the survey reported that two or more of these issues characterised their family's circumstances.

It is also notable that statistically significant differences emerged between the responses of male and female parents and carers participating in the survey, with women more likely to report emotional abuse or anger issues (63% vs 19%), violent or dangerous behaviour (53% vs 19%), mental health issues (49% vs 26%) and alcohol and substance abuse issues (38% vs 16%).

The data in Table 25 also indicate that the most commonly co-occurring risk factors were alcohol or substance abuse, mental health issues, violent or dangerous behaviour and emotional abuse or anger issues.

Table 25: Survey of Parents and Carers: number and type of issues the family is using the CCS for, by gender

Is your family using the Children's Contact Service because of any of the following issues?:	Man or male (%)	Woman or female (%)	Total (%)
Alcohol or substance abuse *	16.3	38.2	29.5
Mental health issues *	25.6	48.5	40.2
Gambling problems	7.0	4.4	6.0
Violent or dangerous behaviour **	18.6	52.9	39.3
Emotional abuse or anger issues (e.g. getting angry easily) ***	18.6	63.2	45.5
N	43	68	112
Number of issues selected * **			
0	67.4	14.7	34.8
1	9.3	20.6	17.0
2 or more	23.3	64.7	48.2
Total	100.0	100.0	100.0
N	43	68	112
Most frequently co-occurring issues			
Alcohol or substance abuse, Mental health issues, Violent or dangerous behaviour and Emotional abuse or anger issues (e.g. getting angry easily)	-	19.0	19.2
Violent or dangerous behaviour and Emotional abuse or anger issues (e.g. getting angry easily)		15.5	12.3
Mental health issues, Violent or dangerous behaviour and Emotional abuse or anger issues (e.g. getting angry easily)		10.3	9.6
Mental health issues, and Emotional abuse or anger issues (e.g. getting angry easily)		10.3	9.6
N	14	58	73

Notes: The top panel of this table reports multiple responses so proportions may not sum to 100.0%. *n* = 1 response for gender prefer not to say, not included in reported table. The top panel of this table reports the number and proportion of parents and carers who selected each response option from a list describing their family issues. Not shown is the number and proportion where each response was not selected (including potentially missing responses). The third panel of this table, responses by gender not reported due to small sample size of male category. *$p < .05$; **$p < 0.01$, ***$p < .001$ statistically significant based on chi-square test.

The interviews with parents and carers also explored whether participants had any concern about their (child/ren)'s safety or their own safety because of ongoing contact with the other parent. Nearly three quarters (74%) reported having safety concerns (cf. 24% no, 2% don't know/not available). For Lives with parents and carers, 91% reported holding safety concerns (52% both self and child/children, 33% children only, 6% self only). These concerns most frequently involved multiple risk factors (61%) rather than a single or primary safety concern. Where one main safety concern was identified this was most likely to involve alcohol/substance abuse, emotional abuse/anger, child abuse, or domestic violence/family violence. More than half of spend time with parents did not report any safety concerns about the other parent (53%), while 24% held concerns for children and 12% for themselves. Spend time with parents' safety concerns involved the other parent's mental health, emotional abuse or multiple concerns, although to a much lesser extent than Lives with parents and carers.

Accessibility and safety of CCSs for First Nations and CALD families

In this section, data from the Survey of Professionals, the RFI process and the Survey of Parents and Carers will be presented to allow examination of the extent to which CCSs are identified as accessible and culturally safe for First Nations and CALD families. It is noted that data from the qualitative interviews with parents and carers and First Nations stakeholders will also be considered in relation to CALD families in this section.

Access to CCSs for First Nations and CALD families

Data from the Survey of Professionals are presented in Figure 14 regarding professionals' views on the accessibility of CCSs for First Nations and CALD clients. The data show that:

- CCS professionals and referring professionals varied substantially in the extent to which they considered the CCSs **accessible for First Nations clients and CALD clients**:
  - In relation to First Nations clients, most CCS professionals either strongly agreed (19%) or agreed (56%) that they were accessible, compared to only 1% and 29% of referring professionals strongly agreeing or agreeing respectively.
  - In relation to CALD clients, most CCS professionals either strongly agreed (18%) or agreed (57%) that they were accessible, compared to only 1% and 27% of referring professionals strongly agreeing or agreeing respectively.
- CCS professionals and referring professionals also varied substantially in the extent to which they considered the CCSs to be **culturally safe for First Nations clients and CALD clients**:
  - In relation to First Nations clients, most CCS professionals either strongly agreed (18%) or agreed (48%) that they were culturally safe, compared to 20% of referring professionals agreeing and none strongly agreeing with this proposition.
  - In relation to CALD clients, most CCS professionals either strongly agreed (19%) or agreed (51%) that they were culturally safe, compared to 24% of referring professionals agreeing and none strongly agreeing with this proposition.
- In relation to **accessibility for people with a disability**, most CCS professionals either strongly agreed (17%) or agreed (56%) that CCSs were accessible to these clients, compared to 37% of referring professionals agreeing and none strongly agreeing with this proposition.
- In relation to whether CCSs were fit for purpose, again, most CCS professionals either strongly agreed (24%) or agreed (51%) that CCSs were fit for purpose, compared to 42% of referring professionals agreeing and only 1% strongly agreeing with this proposition.

Data from the open-text responses of participants in the Survey of Professionals provided qualitative insights into the cultural accessibility of CCSs.

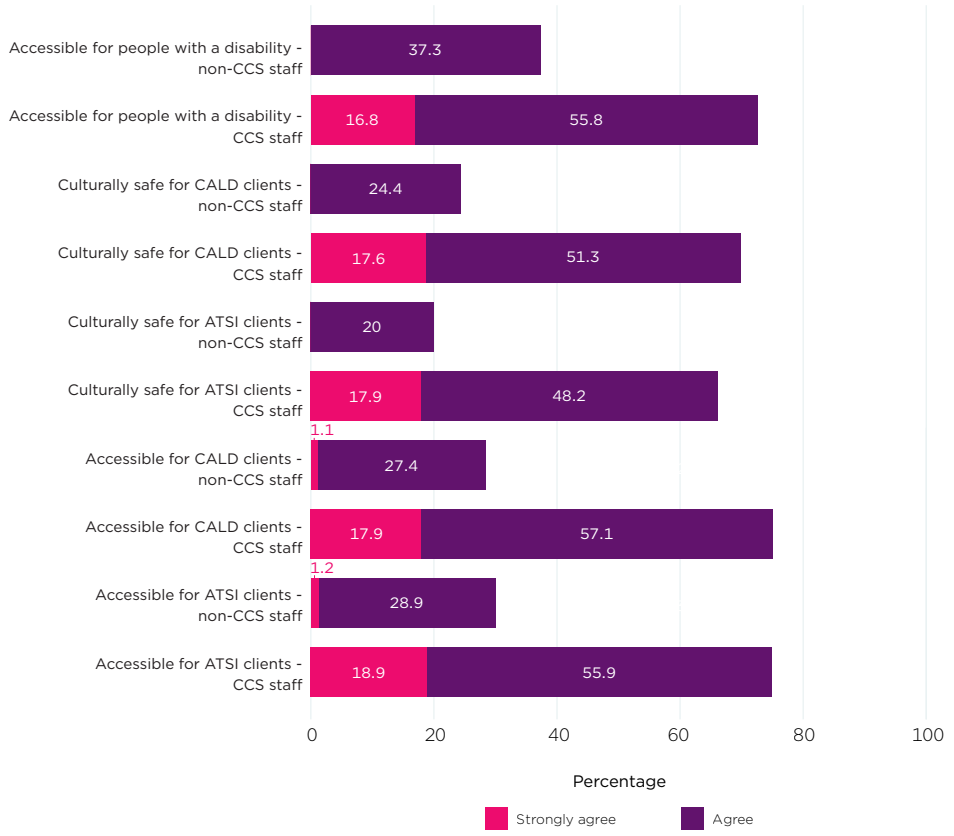
In relation to First Nations families, 83 participants provided an open-text response indicating why they agreed that CCSs in their area were accessible for these families and 37 professionals provided an open-text responses describing why they disagreed that CCSs in their area were accessible for these families.

Where participants were able to provide specific reasons for why they considered the services to be accessible for First Nations people, most indicated that the CCS employees had received specialist First Nations or cultural inclusion training and resources (*n* = 23/83). For example:

> *Our service provides mandatory cultural awareness training for all staff. This is part of onboarding/ orientation, and further through online and face-to-face facilitation. The team is supported by First Nations Cultural Consultant and Program Advisor.* (CCS staff, NSW, 35–44 years)

> *Our services are accessible for indigenous clients, and we consult with our Practice Specialist for Aboriginal and Torres Strait Island People to ensure that we are culturally fit. All staff complete training in cultural fitness to ensure we are inclusive, respectful, and responsive to the needs of aboriginal families. We consult with families about their specific needs and encourage parents to bring culturally appropriate resources such as toys and food. We strive to review our practices with input from Aboriginal families to ensure their cultural safety.* (Service provider organisation, NSW, 55+ years)

Figure 14: Online Survey of Professionals, CCS characteristics by professional type



Notes: The question was worded as:' To what extent do you agree or disagree with the following statements:' Don't know/Cannot say responses excluded from analysis. *** All differences between CCS and non-referring staff were significantly different at $p < 0.001$ level using the Pearson chi square test.

> *CCSs in our area actively recruit First Nation's staff member. All staff are trained in First Nation's cultural awareness. Our [propo]rtion of First Nation's clients exceeds the percentage of First Nation's people in our regions.* (Service provider organisation, Qld, 55+ years)

In addition to specialist training and resources, other participants described established partnerships or links between the CCS and First Nations service providers (n = 13/83). For example:

> *This Centre liaises with local organisations to ensure that parents who need our service are aware of our service.* (CCS Staff, Qld, 55+ years)

A similar proportion of participants also referenced their CCS employing First Nations staff and volunteers as another important means of facilitating access to their services by First Nations families and tailored engagement to suit the family's particular circumstances and needs (n = 12/83). For example:

> *At our CCS, we are ensuring to be as inclusive as possible in the recruitment stages and are looking to hire staff who come from either Aboriginal or Torres Strait Islander backgrounds. Hiring such staff will hopefully encourage diversity and inclusion which will reflect through to our clients and make them feel as if they belong and are welcome in our centre.* (CCS staff, NSW, under 25 years)

> *We tailor our service and meet families where they are. Sometimes we will also offer intakes in locations close to where families live or in locations of their choice on their Country. We also have an available [Aboriginal Liaison Officer] ALO who we seek consultation with and have connected with a local Aboriginal Organisation to talk about the shared use of spaces.* (CCS staff, NSW, 25–34 years)

> *This Centre liaises with local organisations to ensure that parents who need our service are aware of our service. We have a volunteer indigenous liaison representative that supports the [CCS] to provide culturally appropriate services.* (CCS staff, Qld, 55+ years)

> *[Our] organisation has a First Nations Community Development worker which supports First Nations families to access the CCS; service has strong links to other First Nations services.* (Service provider organisation, state/territory redacted, 45–54 years)

Other responses describing the reasons for agreement with the proposition that CCSs were accessible for First Nations families were more general in their reflections on why they considered the services to be accessible (*n* = 44/83). Reasons specified ranged from the location of the service, waiver of fees, and the inclusive and non-discriminatory values of staff and welcoming environment and culturally inclusive facilities. Some examples include:

> *The CCS location is central and accessible for clients and referral pathways are noted from Aboriginal legal services locally.* (Service provider organisation, WA, 55+ years)

> *We offer a ATSI fee waiver, and our centre and staff reflect culturally appropriate practices. Organisationally led training and learning throughout.* (CCS staff, NSW, 35–44 years)

> *We have increased our training with all staff attending culturally appropriate training. We have updated our resources and completed artwork around the building to foster and promote an environment that is welcoming and inclusive.* (CCS staff, Qld, 55+ years)

> *We have the acknowledgment of Country and acknowledgement of Traditional Owners of [redacted] Nation displayed on our front door in [redacted] language. We also acknowledge … our … Reconciliation Action Plan. Our office follows Cultural protocols through acknowledging all the Nations of Traditional Lands of the Aboriginal People. We waive all service fees for Aboriginal and Torres Strait Islander families. In many of our centres we have Aboriginal clinical staff. We provide culturally inclusive toys and activities for a culturally safe environment for families accessing our service.* (CCS Staff, NSW, 55+ years)

Open-text survey responses disagreeing that the CCSs in their area were accessible for First Nations families most commonly indicated that CCSs lacked sufficient specialist Indigenous support workers, liaison or partnerships with external specialist First Nations services, and cultural competency to support First Nations families (*n* = 20/37). For example:

> *Processes for intake, orientation and service delivery are extremely western, systemic and not culturally informed, designed or adjusted. The workforce and leadership do not match the representation of the First Nation's communities we support– recruitment and leadership mainly Caucasian. First Nation's fathers are often screened at higher risk, highlighting the systemic bias in the process.* (CCS staff, NSW, undisclosed)

> *Often the service is culturally unsafe, meaning the service does not have Aboriginal workers, identified positions, the service is not culturally competent, and the office space is not culturally welcoming.* (Court Child Expert, NSW, 45–54 years)

A substantial proportion of participants referenced the lack of, or absence of, CCSs in the areas local to First Nations families, and issues with transportation to the CCSs as impacting accessibility (*n* = 12/37). For example:

> *There are no services within a one-hour drive of my practice. This means that, for many people, there are no services available to them, as they cannot travel to the services more than one hour away.* (Lawyer, Vic, 35–44 years)

> *Service is not located in an area with larger Aboriginal and Torres Strait Islander population.* (CCS Staff, WA, 55+ years)

A small number of open text responses identified the reluctance of First Nations families to engage with CCSs due to the history of government intervention and the harm and trauma arising from this intervention (*n* = 3/37). For example:

> *The structure, design and set up is unlikely to feel natural and respectful of culture and I suspect further entrenches belief of unnecessary government intervention and control in their lives.* (Court Children's Services, Qld, 45–54 years)

As will be discussed in chapters 3 and 4, features of the structure, design and set up of CCSs include the predominant location for the supervised sessions and capacity to accommodate larger numbers of kin to participate, as well as the experience of monitoring at the CCSs for First Nations clients in the context of a history of intervention in the lives of First Nations people, the removal of their children and the intergenerational trauma arising from colonisation.

In relation to CALD families, 84 professionals provided an open-text response describing why they agreed that CCSs in their area were accessible for these families and 40 professionals provided an open-text responses describing why they disagreed that CCSs in their area were accessible for these families. Of the 84 participant responses, a substantial proportion (*n* = 21/84) described how the CCS facilitated access to interpreters or used culturally appropriate processes, information and resources (*n* = 14/84) or that the CCS had specialist CALD staff and/or volunteers (*n* = 10/84). For example:

> *We tailor our service and meet families where they are. We offer the use of translators for appointments and invite families to continue with their cultural practices during sessions. We do not create limits for gifts to set dates and respect that families have their own traditions and different days that are important to their religions and cultures. We seek to understand what would be helpful for the family and seek to understand the differences that may exist between their culture and our own.* (CCS staff, NSW, 25–34 years)

> *We provide Culturally and Linguistically Diverse Clients with information on our service in several languages. We regularly use Interpreters if required. Our staff are regularly trained in Cultural Awareness practices. We check in with clients regarding their culture, e.g. children calling staff Aunty or Uncle as an acknowledgement of respect.* (CCS staff, NSW, 55+ years)

> *This Centre networks with a number of local organisations to ensure that parents who need our service are aware of our service. We have completed training to provide culturally appropriate services and employed staff with diverse backgrounds who are able to speak a number of different languages. We access translation services. We have updated our resources to foster and promote an environment that is welcoming and inclusive.* (CCS staff, Qld, 55+ years)

As observed in the quote above, some participants also described the external links that the CCS has to CALD services and organisations (*n* = 8/84) and their flexibility with the English-only policy where it is safe and appropriate to do so (*n* = 1): For example:

> *CCSs in our area actively engage with services that are contact points for CaLD clients.* (Service provider organisation, Qld, 55+ years)

> *While supervision requires that our families speak in English for the purpose of supervising all verbal exchanges (e.g. to maintain protection for all parties if there DVOs in place so no information that should not be exchanged occurs, or no conversations occur that are uncomfortable for the child), our services are made accessible to CALD families in multiple ways. Our facilities accommodate things like eating together and connecting together through multiple play-based options.* (CCS staff, Qld, 35-44 years)

Other responses described CCSs as accessible for CALD families but did not provide a specific reason for this assessment of services to be accessible (*n* = 40/84).

First Nations professionals' views about accessibility

Interviews with First Nations professionals provide further evidence about the barriers and challenges First Nations families experience to access CCSs. Key concerns involved the CCS being seen as part of government, reluctance to seek help from services, financial barriers, and the location of CCS services.

In relation to perceptions about CCSs as being part of government services, participants indicated that First Nations communities have a historical lack of trust in government services connected with the trauma of past and current child removal in Australia. The risk of having further intervention in the family as a result of using the CCS was also linked to women not wanting partners or ex-partners to experience legal intervention, such as being taken into police custody. This could result in some clients not identifying themselves as First Nations or avoiding services to maintain their independence. Fear about being watched or monitored by government was also reported with reference to having documentation recorded about First Nations families during the referral process and when receiving services from the CCS:

> *Aboriginal people are sometimes nervous to take referrals from us because it's getting documented and it'll go back before the court and they're seen as having to need all of these, so they're wanting to be seen as more independent than having to need all these services that are available* (First Nations professional 1)

> *Sitting in a room and being watched and monitored and supervised and then documented on, case notes of everything they do and say, it is quite confronting for many.* (First Nations Professional 2)

Financial barriers were acknowledged as occurring for First Nations families accessing CCSs, both in terms of the cost of services through co-payments and the cost of travel to the CCS location. One First Nations professional described how their service was aware of this barrier and had implemented flexible payment options to ensure access for all Aboriginal families. A First Nations professional indicated that there was frequently no charge for this service where it would present as a barrier for Aboriginal families with no other option for seeing their children (First Nations professional 1), although it is noted that the Guiding Principles Framework provides for this measure to be available to all clients accessing services.

The location of services and travel distances required to access services was a barrier, similar to other families identified in the professionals' survey and parent and carer data. However, this was particularly acute for First Nations families in regional and remote locations. The distance between CCS locations also meant First Nations families might not know about services so far away from where they live and be another barrier for referrals (First Nations Professional 3).

Accessibility: interpretation (language and signing services)

Data relating to interpretation (language and signing) services from the RFI process also provided insight into the cultural accessibility of CCSs.

Table 26 presents the data relevant to the provision of interpreting services for each service type provided by the participating CCSs. The data show that most services facilitate interpretation for intake and assessment (91%) and for supervised contact sessions (59%). This reflects the critical need for interpreting services to safely implement these services.

More specifically, the data show that inner regional services and CCSs delivered by medium to larger service provider organisations were most likely to report the provision of these interpretation services for intake and assessment and supervised contact sessions. Medium to larger service provider organisations were also more likely to report providing interpreting services for online/virtual supervision to a statistically significant extent and inner regional services were more likely to report facilitating interpretation for supervised changeover with this also to a statistically significant extent. One-third of services provided interpreting services for supported and monitored onsite visits and less than one-quarter reported the provision of interpreting services for community-based supervised sessions; regional and medium to larger service provider organisations were substantially more likely to report providing these services.

Table 26: Request for Information: proportion of CCSs indicating provision of interpretation (language and signing) services per type of service by CCS region and organisation type

	Region		CCS organisation type		Total		
	Major cities (%)	Inner region (%)	Outer/ remote region (%)	Independent (%)	Medium / larger organisation (%)	*N*	%
For intake and assessment	88.5	95.0	87.5	85.7	92.5	49	90.7
Supervised visit (onsite supervised parenting time)	50.0	75.0	50.0	50.0	62.5	32	59.3
Supervised/facilitated changeover (onsite)	30.8	70.0 *	50.0	28.6	55.0	26	48.1
Online/virtual (telephone/ internet based) supervision service	26.9	55.0	25.0	14.3	45.0 *	20	37.0
Supported/monitored visits (onsite visits with one or more families who have been assessed as requiring low vigilance supervision)	23.1	45.0	37.5	21.4	37.5	18	33.3
Community based/offsite supervision service	11.5	30.0	25.0	7.1	25.0	11	20.4
Unsupervised on-site visit	3.8	15.0	12.5	7.1	10.0	5	9.3
Total *N* CCS	26	20	8	14	40	54	

Notes: *$p < 0.05$; **$p < 0.01$; ***$p < 0.001$ statistically significant difference based on chi-square test.

The data presented in Table 27 show that the vast majority of services (88%) covered the costs of these interpreting services supporting greater accessibility to the services for clients:

Table 27: Request for Information: proportion of CCSs indicating fees are charged or received for provision of interpretation (language and signing) services by CCS region and organisation type

	Region			CCS organisation type		Total	
	Major cities (%)	Inner region (%)	Outer/ remote region (%)	Independent (%)	Medium / larger organisation (%)	*N*	%
Yes	13.0	15.8	0.0	9.1	13.2	6	12.2
No	87.0	84.2	100.0	90.9	86.8	43	87.8
Total	100.0	100.0	100.0	100.0	100.0	49	100.0
Total *N* CCS	23	19	7	11	38		

Table 28 also shows that the vast majority of the participating CCSs reported that the interpreting services were provided by external organisations (86%) with medium to larger service provider organisations more likely to report the provision of these services by external interpreting services to a statistically significant extent (92%).

Table 28: Request for Information: proportion of CCSs indicating who provides interpretation (language and signing) services by CCS region and organisation type

	Region			CCS organisation type		Total	
	Major cities (%)	Inner region (%)	Outer/ remote region (%)	Independent (%)	Medium /larger organisation (%)	N	%
In-house staff	0.0	0.0	0.0	0.0	0.0	0	0.0
External interpreting services	87.0	85.0	83.0	66.7	91.9 *	42	85.7
Combination of in-house staff and external interpreting services	13.0	15.0	17.0	33.3	8.1	7	14.3
Total	100.0	100.0	100.0	100.0	100.0	49	
Total *N* CCS	23	20	6	12	37		

Note: *$p < 0.05$; **$p < 0.01$; ***$p < 0.001$ statistically significant difference based on chi-square test.

Accessibility for people with a disability

Most professional survey participants providing an open-text response regarding whether they agreed or disagreed that the service in their area was accessible for people with a disability, indicated their agreement with this proposition. Of these participants, most described the CCS building and facilities as suitable for people with a physical disability (*n* = 56/88) or that the staff were trained in disability (including mental health issues) and that they included the disability needs in families' management plans (*n* = 21/88). For example, participants referenced disability parking, ramp access, hearing aid loops, calm environments and rooms where lighting could be adjusted and staff support for neurodiverse clients (CCS Staff, Qld, 35-44 years) as well as other features to support accessibility:

> *This Centre has an access ramp and the environment is supportive of people with a variety of needs. The building is open plan and easily accessible. We have disability parking in close proximity and we have additional staff available to assist clients with several staff with disability support services. An intake process is completed online and the service provides online access for those families who cannot attend the Centre in person.* (CCS staff, Qld, 55+ years)

> *The contact service has a physical environment that supports clients with physical disability. Workers adapt play activities to support engagement between children or parents who may have a disability. Disability*

> *support workers have been included in contact visits to support families to move to self-management (where disability support workers would usually be with the family outside of the centre). Adjustments to play activities and support workers have also been used for families with cognitive disabilities or with significant mental health difficulties; where there may be additional needs around regulation, attention, etc. This focuses on working on parent-child engagement plans that would work outside of the centre, to support families to move to self-management where there would be no contact worker support.* (Service provider professional, NSW, 35–44 years)

Of those participants who disagreed that the CCSs in their area were accessible for people with a disability, most either described how the CCS building and facilities were not sufficiently disability accessible (*n* = 16/35) or that the CCS staff were not well-trained in disability, including in relation to intellectual disability and mental health issues (*n* = 8/35) or that the location of the CCS was not sufficiently disability accessible. Examples included insufficient public transport to the CCS, a lack of Auslan interpreters, limitations in staff training to provide services to people with a disability, including clients with mental health issues, entrance points and areas that are not accessible to wheelchair users and limited play equipment that can be used by children independently if they are in a wheelchair (POP professional, Vic, undisclosed; CCS Staff, NSW, 45-54 years; Lawyer, Qld, 35-44 years) (*n* = 9/35).

A small number of parents and carers provided feedback in their interviews about their experiences with disability access and inclusion for themselves and/or children at their CCS (*n* = 8). Most of these parents and carers discussed this issue from the perspectives of their children experiencing mental health issues and neurodiversity. Some parents and carers were positive overall about the ways in which CCSs ensure services were provided in appropriate ways for their children but some were not. For example, this Lives with parent/carer described how the CCS had improved their professional practice to be more inclusive of her child's disability after initially not responding to her child's communication needs. She also felt the most important thing the CCS had done was to accommodate her child's needs:

> *We had a situation with [child]'s iPad. And now originally, I was told he couldn't take an iPad and I had informed them that his iPad is his communication device. So really by right he was meant to have that with him. So if you wanted to communicate with his dad. They could play around with it and stuff like that. It was very confusing because I've been told no and no and no, and then, all of a sudden, I'm told yes, that's fine … Those little things were frustrating, but it's all been sorted out now. So yeah, just, you know. Are we allowed to do it? Aren't we allowed to do it … Yeah, because I think they were sort of a bit stuck because part of their policies is no, you know, no technology. But unfortunately [child] needed that technology, like that technology that he uses for communication, and they can't legally take that away so.* (LWP 25)

Similarly, other parents/carers raised concerns about the extent to which CCS staff were able to respond appropriately to children with disabilities. For example, LWP 43 described her negative experiences with disability inclusion for her child:

> *I find I've questioned their work ethics towards children …because my [child] has autism and can't articulate unless you prompt . You have got to be careful not to give him information, but to prompt. How do you feel and how do you feel when that happens? I just think that their training is not in keeping with a child's mental health issues and they don't know how to because talking to [child] normally you wouldn't know he had any issues* (LWP 43).

She gave the following example where staff communication had been poorly managed in response to her child's autism and placed her child in a position of being scared with their father at the CCS:

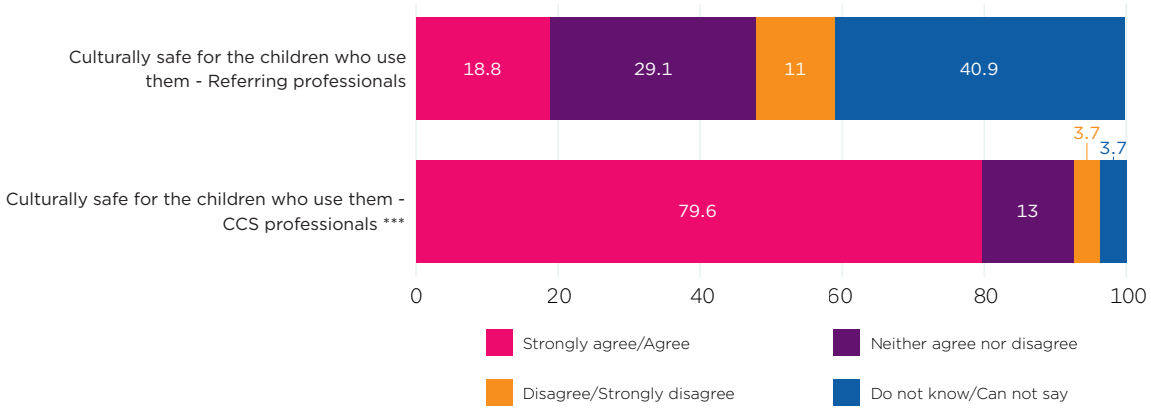
> *[The child] had some issues with [their] father and the worker spoke to [child] and said, let's go tell your father. So she dragged [child] down to the other end and got [child] to say it in front of [child's] father, that [child] is scared of. And then they went off to a visit. And when [child] came back, I said, what position did that put you in? Because she made you say a lot of stuff to your father that you didn't want. And you know, were you alright? And [child] said no, [child] said I was really scared. But [child] said I changed everything that I was going to tell him. So I wouldn't be, he wouldn't get upset. So [child] didn't really say what [they] wanted to say to [their] father. [Child] had to change it all to protect [themselves], and that's what the worker put [child] in that awkward position.* (LWP 43)

In summary, a small number of parents and carers discussed CCS accessibility for people with a disability. Where some concerns were raised, these were in relation to inclusion of children and how staff respond to children's needs.

Culturally safe service provision

Less than half of professionals participating in the Survey of Professionals strongly agreed (20%) or agreed (27%) that the services provided by the CCSs in their area were culturally safe for the children who use them (Figure 15). More specifically, the data show that although most CCS professionals strongly agreed (40%) or agreed (40%) that the CCSs were culturally safe for the children using them, only 3% of referring professionals strongly agreed and 16% agreed with this proposition. Nearly half (41%) of referring professionals indicated that they did not know or could not say whether the services were culturally safe for the children using them.

Figure 15: Survey of Professionals: agreement with government-funded CCSs providing services in children's best interests by professional type



Notes: Question was worded as: 'To what extent do you agree that government-funded CCSs "in your organisation/ in your area" are:' CSS professionals asked to rate CCS characteristics for 'my organisation' and referring professionals asked 'in my area'. ***$p < .001$ statistically significant based on chi-square test. Percentages may not total 100.0% due to rounding.

Data from the open-text responses of participants in the Survey of Professionals also provided qualitative insights into the cultural safety of CCSs.

In relation to First Nations families, 69 professionals provided an open-text response describing why they agreed that CCSs in their area were culturally safe for these families and 25 open-text responses described why professionals disagreed that CCSs in their area were culturally safe for these families.

Almost half of these 69 open-text responses referenced the CCS's specialist First Nations cultural awareness training and resources (*n* = 30/69). Some participants indicated that their agreement was based on the CCS employing First Nations staff and/or volunteers (*n* = 11/69) or that the CCS was connected to an external First Nations specialist service or organisation (*n* = 5/69). There were two participants describing the CCSs as having specialist First Nations facilities (*n* = 2) with the remainder of the responses agreeing that the CCS in their area was a culturally safe, diverse and inclusive service without giving further specifics (*n* = 24/69). Services that indicated their CCS was culturally safe frequently mentioned training and in CCS site facilities. Some services specifically mentioned cultural advisors or workers supporting First Nations inclusion, as well as relevant toys and resources. For example:

> *[The] Organisation has a First Nations Community Development worker which supports First Nations families to access the CCS; consultation and implementation of this consultation in providing First Nations toys and resources to families in the CCS* (CCS staff, NSW, 45–54 years)

Open-text responses disagreeing that the CCSs in their area were culturally safe from a First Nations perspective (*n* = 28) most commonly described as an absence of, or inadequate, culturally appropriate practices from a First Nations perspective (*n* = 15/28). For example:

> *Few services in this area operate in a culturally sensitive way and are aware of challenges and matters that are important to this community.* (DFV professional, Qld, 35–44 years)

Some open-text responses described a lack of specialist or First-Nations-led services (*n* = 5/28) and a need for more CCSs to employ First Nations staff and volunteers (*n* = 4/28). For example:

> *Without community designed and led processes, we are asking First Nations clients to have to conform to western practice that goes against their cultural practices. Staffing are not representative of the communities and therefore working cross culturally does not allow for the same service provision.* (CCS staff, NSW, undisclosed)

> *If a service is not culturally accessible it is culturally unsafe. Aboriginal people need Aboriginal people employed within every service. They also need an assurance that their confidentially is upheld, and the local community is not advised about confidential details of family matters. Aboriginal Elders should be consulted about how an agency could be culturally competent and sensitive and ongoing community consultation should be accruing.* (Court Child Expert, NSW, 45–54 years)

In relation to CALD families, 71 professionals provided an open-text response describing why they agreed that CCSs in their area were culturally safe for these families and 24 open-text responses described why professionals disagreed that CCSs in their area were culturally safe for these families.

Some professionals' open-text responses described the CCS in their area as culturally safe for CALD families because the CCS had specialist CALD training for staff and resources to support cultural safety (*n* = 13/71):

> *Mandatory and ongoing training for all staff to ensure awareness of Culturally and Linguistically Diverse clients and updated effective client engagement and casework practices. This includes training in awareness of impacts of DV on our protective clients with consideration of this throughout the assessment and ongoing of service and when necessary safety planning, e.g. understanding cultural intersections and intersectionalities of our clients. Offering free telephone interpreters to all clients for online and telephone sessions. Our staff attend Professional Supervision with a highly qualified and experienced Social Worker who often informs staff of Culturally and Linguistically Diverse clients' cultural needs and practices that inform and support our casework practice. Several of our staff are immigrants and speak languages other than English.* (CCS staff, NSW, 45–54 years)

Other participant responses linked the CCS's cultural safety to the CCS's employment of CALD staff and/or volunteers (*n* = 8/71), access to interpreters (*n* = 6/71) or accommodating the CALD-specific needs of the families who use their services, including culturally significant celebrations (*n* = 5/71):

> Our workforce is 90% CALD. (CCS staff, NSW, 25–34 years)

Nearly half of the responses described CCSs as culturally safe for CALD families but did not provide a specific reason for this (*n* = 33/71).

A small number of participants provided open text responses that described why they disagreed that the CCS in their area was culturally safe for CALD people (*n* = 24). A lack of CALD staff (including bilingual supervisors) was most commonly identified by these participants as the reason that the CCS was not culturally safe (*n* = 7/24). For example:

> *There is not always supervision at these centres by people who speak the same language as the clients. Clients have sometimes reported that their ex-partner is saying inappropriate things to the children while at the centre.* (Court Child Expert, Qld, 25–34 years)

Other participants described inadequate access to interpreters (*n* = 5/24) or that there was a lack of CALD appropriate practices employed in the CCS, with specific references to staff training and resources and information not being available in languages other than English (*n* = 4/24), or a lack of flexibility employed in the application of the English only policy (*n* = 3/24). For example:

> *It is rare that the supervisor speaks the same language as the family. It is rare that the supervisor wears the same traditional dress or has the same cultural / religions background as the family. I have heard of cases where a father was not permitted to speak Hindi to his 3-year- son. The son could speak English but the father could not, as the supervisor could only supervise what was spoken if it was in English.* (Lawyer, Qld, 35–44 years)

The RFI responses from participating CCSs also provide insight into culturally safe and inclusive practices in the CCS context. A total of 41 CCSs provided additional comments about current cultural safety and inclusion practices and whether there had been any significant changes to their service since 2019. Of these 41, just 3 CCSs noted that there had not been significant changes since 2019 but that ongoing refinement of practice and supervision provision occurs. Ten of the 38 CCSs who provided additional information reported that their service has reviewed relevant policies, service strategies and practice frameworks since 2019, including having specialist staff committees to advise the service. For example, in relation to culturally safe practices and inclusive practices,

one service described the reference groups that they had in place at their CCS to examine service provision for First Nations, CALD, LGBTIQ+ clients and staff (Service 181, NSW). Another service indicated that:

- *they had reviewed the Vulnerable and Disadvantaged Client Access Strategy*
- *all new staff to complete 4 units of cultural awareness training within the first 4 weeks of employment*
- *all staff were to complete ongoing cultural awareness training on a yearly basis*
- *they had decorated the Centre with Indigenous artwork; added Indigenous puzzles and culturally diverse dolls to the play area; displayed acknowledgement of Country in both waiting rooms and on their website*
- *provided interpreters for intake interviews*
- *encouraged all CALD and Indigenous clients to attend intakes in person with a support person.* (Service 94, Qld)

As the above description illustrates, improving service provision occurs within the context of multiple strategies for cultural safety and inclusion. Cultural awareness training and monitoring practice (e.g. clinical supervision) were raised by the majority of the CCSs as an area of ongoing improvement. For example:

> *[There is] Ongoing mandatory training for all staff around cultural safety and inclusive practices to support service users and staff. Staff have a point of contact within the organisation to ask questions or raise concerns.* (Service 247, NSW)

> *Our staff undergo training to ensure cultural awareness in our work. Staff are scheduled for regular clinical supervision and can also discuss cultural safety and inclusive practice concerns in this forum. Our centres cater for the needs of a diverse client group.* (Service 233, state/territory redacted)

Many CCSs emphasised the importance of recruiting and employing First Nations, CALD, and/or LGBTIQ+ staff to implement cultural safety and inclusion. For example:

> *Our CCS service includes Aboriginal staff who can consult and provide culturally specific service. Our organisation also employs an Aboriginal and Torres Strait Islander Practice Specialist who can consult on cases, overall service delivery, as well as training and skills development for staff.* (Service 264, NSW)

The provision of interpreter services was another aspect of cultural safety and inclusion acknowledged by most CCSs who provided a RFI comment about this aspect of service provision. As well as referring to the provision of interpreter services more generally, some CCSs specified the importance of interpreters being available at the time of intake and having information available in a range of languages other than English, even if budget restrictions meant that interpreters could not always be available during supervised time with children. For example:

> *The organisation engages interpreting services free of charge to clients as needed.* (Service 245 state/territory redacted).

> *All families are welcome at CCS. CCS staff will use interpreters (either on the phone or face to face) for intake assessments. CCS staff will try and make visits requiring interpreters assessable if resources allow it.* (Service 160, NSW)

As part of the RFI, CCSs were also offered the opportunity to comment generally on any other aspect of cultural safety, inclusion and accessibility they would like to raise. Twenty-one services provided further feedback in response. Many acknowledged this is an area of continuous improvement for their CCS. For example:

> *There is still a long way to go to better support our diverse families and will continue to work towards a more inclusive and accessible environment for all. Cost can be a factor particularly for interpreters, this is a significant expense on the service and not sustainable long term. It would also be great if we could obtain additional resources specific to the CCS and separation for our families in other languages.* (Service 79, Vic)

As in the comment above, costs and resource constraints were acknowledged by some CCSs as negatively impacting the extent to which cultural safety and inclusion could be implemented. The cost of interpreter services and difficulties accessing appropriately safe, and confidential, interpreter services were raised as concerns by some CCSs. This issue particularly affected some services located outside of metropolitan areas. For example, one service explained that they were unable to offer translation at supervised visits as they were unable to absorb the costs for the provision of language or Auslan interpreters and in small communities, the available interpreters may be known to the family (Service 156, WA).

As this comment illustrates, barriers to cultural safety and inclusion specifically in relation to interpreter services can arise from issues outside to the CCS.

Previously, in chapter 3, data from the Survey of Parents and Carers about cultural safety for children showed some differences in views between those who were born overseas or had at least one parent born in a non-English speaking country and the remaining participants. Although the sample size for parents and carers with a non-English speaking background was small, the pattern of differences in agreement between groups suggested these families were less positive about their children's experiences using CCSs than Australian-born parents with only an English-speaking background. Parents and carers with a non-English speaking background less frequently agreed their child/children's experience of the CCS had improved over time, that children's needs are adequately considered, and children feel safe at the CCS than remaining parents. However, the small sample size is a limitation.

Further data from the interviews with parents and carers provides insight into the range of experiences of cultural safety for families. A small number of parent and carer interview participants provided feedback about their experiences of cultural inclusion with contact services. Their perspectives give a mixed picture of cultural safety. From a positive perspective, these parents and carers acknowledged their CCS had some culturally appropriate services available if these were needed, particularly translation services. However, the following example illustrates how interactions with CCS staff were not always culturally safe:

> *Here's a tough truth. ...most of the staff ...I think are quite well trained as a professional, but some of the staff ...probably lack training [for] trauma responses... and sometimes they're not very aware of how hard [it has been and what] these children have been through. And sometimes I even feel because I have a CALD background, that I can't speak English, I still can feel some of them are quite racist. Racist. Sometimes they don't even need to say anything, but just like you, you just can tell. It's very easy ... The attitudes are very arrogant. And sometimes they [are] just being very biased, because in our case the dad is whiter than us.* (LWP 49)

When the interviewer asked if the CCS provided any culturally specific services for her or generally, the participant replied, 'Not that I'm aware.' (LWP 49) This participant also shared an example of how she felt she was judged in a negative way by some CCS workers and was aware of others who had similar issues linked to cultural safety.

First Nations professionals' views about cultural safety: barriers and improving CCS practice

First Nations professionals identified strengths and limitations with current cultural safety practices that aim to support First Nations families using CCSs. These themes focused on having First Nations staff and involving other Aboriginal people (e.g. Elders); adapting the structure of service provision; and having responses to trauma and cultural awareness from First Nations perspectives.

Consistent with the RFI and professionals survey data, First Nations professionals reported on the value of having Aboriginal staff to liaise with Aboriginal families for cultural safety. This was described as making First Nations clients more comfortable and overcome some of the issues around feeling like the CCS was a government environment. The following quote provides an example of implementing this practice where the First Nations professional provided additional support to a First Nations client to access the legal support that they needed and that they were comfortable with:

> *I support clients with seeing our lawyers, if they don't feel comfortable seeing our lawyers, because our lawyer is a male lawyer here in [location] and he's also not Aboriginal.* (First Nations Professional 3)

Participants also indicated that it was important to ensure that clients should be well supported by Aboriginal organisations where that was possible locally, and by local support people also, rather than an external service. First Nations Professional 1 explained this aspect of culturally safe practice:

> *... sometimes it's about bringing their support people with them and there was one family in specific, where one of the clients was very scared to access the service. So I engaged with that client over the phone and ensured that they hooked in with one of the Elders and we had an Elder attend the intake assessment with that client to support.* (First Nations Professional 1)

However, having local First Nations services and support people might not always be culturally safe for everyone. Some First Nations participants reported that there are some First Nations families who prefer to work outside

of the Aboriginal service system because of concern about other people in the community knowing about their family. The participants described the shame and stigma that Aboriginal clients can feel in using the CCS service. This was potentially a barrier to seeking help initially or to access CCS services. First Nations Professional 3 commented that it was better, however, if the Aboriginal staff were from other areas as this reduced stigma and allowed parents and carers to maintain some privacy. This indicates some choice or adaptation to individual needs would be appropriate:

> *I tend to always give clients an option because a lot of Aboriginal clients want to be put in with culturally appropriate services where[as] others will simply say 'I don't want to use an Aboriginal service because I don't want the community knowing my business.'* (First Nations Professional 1)

This aspect of cultural safety also required sensitivity when engaging First Nations men in CCSs:

> *Yeah, particularly for, I see it more with the men, I think. Um, for whatever reason that it is a lot less, they're … They're a lot more uncomfortable I think perhaps because it is a heavily dominated by females, which … everyone is great and I don't think anyone's unprofessional and makes anyone feel bad, but particularly. But you know, First Nations men do have, you know, knowing that you know men's business, women's business and they sort of and we do allocate and I often do take a lot of those clients to aid with that.* (First Nations Professional 2)

The importance of adapting service provision to the individual needs of the local First Nations peoples and each individual First Nations family featured in concerns about the structure of CCS service provision around cultural safety. Participants generally indicated that their services did not do anything specifically different in their processes for First Nations families, but that they took an individual approach to these clients or way of making them feel comfortable using the service. These practices included choices about engaging with First Nations staff, through to ensuring the facilities were welcoming:

> *… giving that opportunity to speak to someone like our Aboriginal practice lead, them knowing that, seeing open around our office, we have a lot of local art from local Aboriginal artists. We have wording for both [dialect] language and English. And so to make that like a homely and supporting environment.* (First Nations Professional 2)

The First Nations professional participants indicated strongly that it was important to consult closely with their Aboriginal families and work with them to get their plans in place. They indicated that rather than imposing and enforcing orders, solutions and time frames, planning should be developed in consultation and conjunction with their clients to increase the likelihood of them succeeding. This approach was identified as supporting the goal for improving First Nations cultural safety in CCSs but the flexible and individualised approaches would also benefit non-First Nations families:

> *You know, it's really about giving choices because for so long, Aboriginal people haven't had [choices]. You know, in many ways these people… they feel like they haven't had or been able to make those choices. So if they're working within a system that's already restricting them, and you're able to say, well, you know, 'this is what we're given. But how is this going to work for you?' and letting them have that choice and letting them guide their own. That can be very, very empowering for them, and they at least feel like they're heard and they're being consulted and they're part of that process. Rather than being told 'you've got two hours of fortnight' and that's it.* (First Nations Professional 1)

> *I am very big on hearing the family and hearing what they or how they're going to, you know, act out the plan or what they want to see. But you know, it depends on the workers that they get, the team leader or the case worker and then the situation as well.* (First Nations Professional 3)

In addition to consulting First Nations parents and carers, participants indicated that it was important to be flexible with responses that could be worked out together. This required taking an 'outside the box' approach to clients to understand and implement what would work with them, including supporting involvement of extended families' members where appropriate. This was not always possible within the constraints of the CCS standard model and the court orders that families were given.

> *I also work with them specifically because we're inside the service and sometimes it's about more frequent, shorter visits than … so your standard visit is 2 hours a fortnight.* (First Nations Professional 1)

First Nations Professional 1 further explained the barriers of implementing cultural safety for parents, carers and children along with court orders and the structure of CCS service provision:

> *[W]ith Aboriginal people, it's very, very important that you think outside of that and you, you've really got to think outside the box. So it's about engaging and allowing, you know, family to come in as well because … Because it doesn't happen, but it's also about being children having voices and making sure the children are heard. And what does [the child want] - does the child want Aunty to come in? Does the child want grandma to come in? And if that's the case, then we need to be listening to them rather than saying, well, the court orders say no.* (First Nations Professional 1)

Adapting the mainstream structure of CCSs from being centred around supervised time indoors with the Spends time with parent to instead having choices for outside activities was a common strategy within the current structure of CCSs when supporting cultural safety. First Nations staff often met with clients outside the CCS and in outdoor places. The opportunity to provide First Nations clients with offsite and outdoor visiting options was indicated to be important when trying to engage these families. It was also explained that outdoor activities with children could sometimes be more culturally appropriate and bring cultural benefits for children and Spends time with parents together.

> *Whether it be Dreamtime stories or whatever, or going fishing and often… going fishing is where they'll sit and talk where they don't have that at a contact centre. … The family is overall aware of that and the children are very conscious of that, where if they're in nature, it's just in our genetic makeup basically that we're more relaxed, we're more at home, you're going to learn more and everything like that. Rather than being cooped up indoors. So if you're able to, you know, if you're sitting by fishing or you're, you know you're in a park or, or whatever. You'll have those conversations while you're walking, because eye contact is huge.* (First Nations Professional 1)

The ability to hold visits offsite accords with the idea that CCS supervised visits options are likely to be more successful for First Nations clients when flexible options are provided. For example:

> *I took, who's an Aboriginal client with [me], we went to the botanical gardens for the visit. Of course, all parties had agreed to it. So did the manager because of the being offsite and what not. And I've seen them for almost a year now and we went and did the visit down at the botanical gardens, which is like a 4-minute walk. We all walk down there and it was an amazing visit and there had been some issues with that client.* (First Nations Professional 2)

Participants explained the importance of having responses to trauma and cultural awareness from First Nations perspectives for implementing cultural safety in staff training. This meant improving all staff training and their understanding about trauma, including intergenerational trauma from the perspectives of First Nations peoples:

> *I think the workers need to have a bit more of a trauma-informed lens. Yeah. And realise you know there's intergenerational trauma, there's emotional trauma*. (First Nations Professional 3)

Cultural awareness training was also observed to be outdated in some circumstances:

> *But I find there's still very old school [CCS staff] in, and I don't think they're racist, I don't think that they're unsupportive, but I feel like it's not the right approach sometimes when like using things like, 'are you ATSI like?* (First Nations Professional 3)

Participants noted that CCS staff training and practice to improve cultural safety and cultural awareness should not be general but include specific information about the local culture and practices (where this was applicable), acknowledging that First Nations are multiple groups and nationalities and that all have their own specific cultural traditions and practices.

Meeting the needs of children and their families?

The discussion in this section presents data from the DEX, Survey of Parents and Carers and the Survey of Professionals regarding the extent to which CCS services are appropriate for families, including those experiencing domestic and family violence. Qualitative open-text responses from the Survey of Professionals will also then be considered to examine professionals' insights into the strengths and limitations in the ability of CCSs to adapt to meet the needs of children and families and suggested changes to support CCSs to adapt to meet these needs. Relevant to these data are insights from the data from the Survey of Parents and Carers and interviews with parents and carers presented in chapters 2, 3 and 4.

Outcomes for families using CCSs

In this section, data from the Survey of Parents and Carers and from the DEX data relating to reported outcomes for families using CCSs are examined. In addition to providing insight regarding all families, these data support an exploration of the extent to which CCS service provision is culturally appropriate and supports families, including those families experiencing DFV.

Parent and carer views about the CCS and whether they are meeting their needs

Previously, in chapter 3, data from the Survey of Professionals showed a mixture of positive agreement from CCS professionals that CCSs in their area address the needs of children who use them while referring professionals were less frequently in agreement.

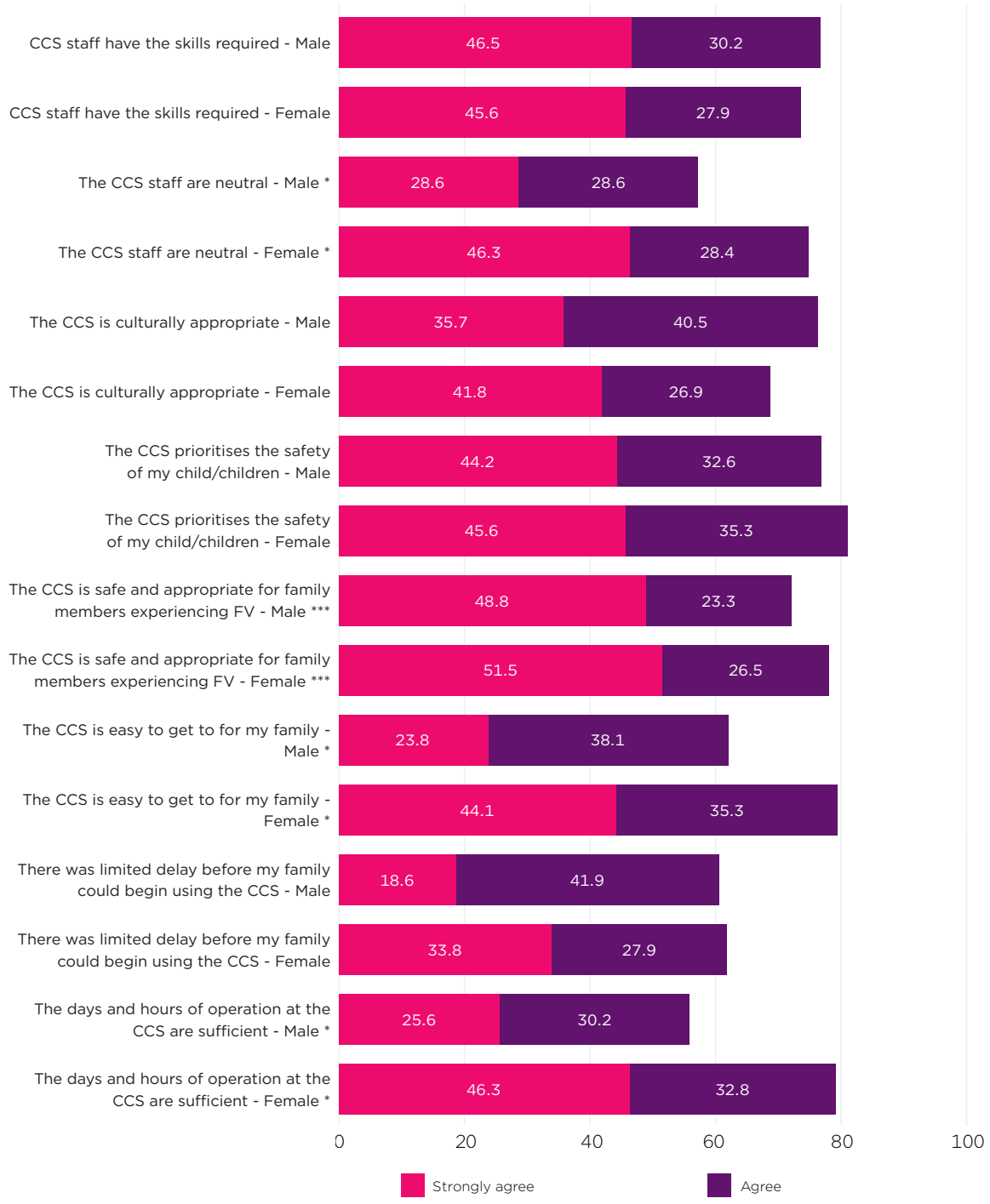
For parents and carers perspectives, the data in Figure 16 show the proportion of participants in the Survey of Parents and Carers responding 'strongly agree' or 'agree' to a series of statements about what it is like using the CCS. These statements canvased the views of parents and carers regarding the skills of CCS staff, safety issues, cultural appropriateness and logistical issues such as ease of accessibility, hours of operation and waiting lists before services could commence.

For most of these items there was little difference in the pattern of results by gender. Overall, 79% of participants strongly agreed or agreed that the CCS prioritised the safety of their child, and 75% agreed that the CCS was safe and appropriate for family members experiencing family violence. A higher proportion of women either strongly agreed or agreed that:

- the staff at the CCS are neutral, 75% of women cf. 57% of men (67% overall)
- the CCS is safe and appropriate for family members experiencing family violence, 78% of women, 72% of men, 75% overall
- the CCS is easy to get to for my family, 79% of women, 62% of men, 72% overall
- the days and hours of operation at the CCS are sufficient for my family, 79% of women, 56% of men, and 69% overall.

While noting the small sample size of those born overseas or with at least one parent born in a non-English speaking country, no statistically significant difference was found in the proportion of respondents who 'strongly agreed' or 'agreed' in response to the statement that 'The Children's Contact Service is culturally appropriate', by ancestry. A little more than 6 in 10 (63%) participants who were either born overseas or had one parent born in a non-English country agreed with this statement, compared to 73% of the remaining sample. Those participants with a non-English speaking background were more likely to report challenges in getting to the service. Slightly more than one-half (56%) of participants from a non-English speaking country 'strongly agreed' or 'agree' that the CCS was easy to get to for my family, lower than the 75% of remaining participants.

Figure 16: Online Survey of Parents and Carers: proportion responding 'strongly agree' or 'agree' to each statement about 'What it is like using the CCS?'



Note: *$p < .05$; **$p < .01$, ***$p < .001$ statistically significant based on chi-square test.

Insights from the DEX SCORE outcome data

Table 29 presents overall client outcomes in three domains of CCS individual clients assessed in 2019 and 2022. For each domain, the table shows the proportions of assessed clients who had an overall positive, neutral, or negative outcome (see Appendix D and Box 1 for how these outcomes were derived). (Client outcomes for clients aged 0-17 years and clients aged 18+ years are presented Tables 30 and 31.) The data in Table 29 show:

- The majority of clients assessed had an overall positive outcome in three broad areas in both 2019 and 2022. For example, in 2022, 64% achieved an overall positive outcome in circumstances and 66% in achieving goals, and 80% in satisfaction about the services received. The remainder were more likely to have an overall neutral outcome than an overall negative outcome across the three broad areas in both years.
- The proportions of clients with an overall positive outcome in the areas of circumstances SCORE and goal SCORE appeared to be trending up slightly.
- However, the proportion of clients with an overall positive outcome in the SCORE area of satisfaction declined from 91% in 2019 to 80% in 2022. It is worth noting that only 6% of individual clients in 2019 were assessed regarding satisfaction, whereas in 2022 one-quarter of individual clients were assessed for this area. It is also noteworthy that the proportion of clients who were assessed for SCORE also increased between 2019 and 2022 for the other 2 areas (circumstances, from 14% to 40%; achieving goals, from 12% to 40%).
- The table also shows that the proportion of clients who had an overall positive outcome was similar for both female and male clients across the three SCORE areas in both 2019 and 2022.

Box 1. DEX SCORE outcome terms

Clients with an overall positive outcome:

For Circumstances and Goals, a client is positive when over 50% of their domains that have changed have an increase in SCORE between earliest and latest (e.g. if a client has four paired domains where the first and second increased from 3 to 4, stayed at 2 for the third domain, and decreased from 4 to 1 for the fourth domain, then this client is deemed to have a positive outcome). For Satisfaction, a client is positive when of their domains not equal to 3, more than 50% have a SCORE of 4 or 5 (tend to agree or agree).

Clients with an overall neutral outcome:

For Circumstances and Goals, a client is neutral when the number of domains that increases in SCOREs between earliest and latest assessment equal the number of decreases in SCOREs between earliest and latest assessment. For Satisfaction, a client is neutral when the number of domains with a SCORE of 4 or 5 (tend to agree or agree) equals the number of domains with a SCORE of 1 or 2 (disagree or tend to disagree).

Clients with an overall negative outcome:

For Circumstances and Goals, a client is negative when more than 50% of their domains that have changed have a decrease in SCORE between earliest and latest. For Satisfaction, a client is negative when of their domains not equal to 3, more than 50% have a SCORE of 1 or 2 (disagree or tend to disagree).

Source: DEX term glossary.

Table 29: DEX: SCORE of in-scope all CCS clients assessed, 2019 and 2022

	2019			2022		
	Females	Males	All	Females	Males	All
Circumstances						
Number of clients assessed	1,065	986	2,053	2,630	2,501	5,141
As a % of all clients	14.1	14.4	14.2	39.5	40.1	39.8
Clients with an overall positive outcome (%)	61.0	62.8	61.9	63.7	64.1	63.9
Clients with an overall neutral outcome (%)	28.6	25.4	27.0	22.1	22.7	22.3
Clients with an overall negative outcome (%)	10.3	11.9	11.1	14.3	13.2	13.8
Average change (from earliest to latest)	0.9	0.91	0.91	0.71	0.74	0.72

	2019			2022		
	Females	Males	All	Females	Males	All
Goals						
Number of clients assessed	850	818	1,669	2,691	2,524	5,226
As a % of all clients	11.3	11.9	11.6	40.4	40.5	40.4
Clients with an overall positive outcome (%)	63.1	64.4	63.8	65.8	66.8	66.3
Clients with an overall neutral outcome (%)	27.2	27.0	27.1	20.5	19.7	20.1
Clients with an overall negative outcome (%)	9.8	8.6	9.2	13.7	13.5	13.6
Average change from (earliest to latest)	0.76	0.77	0.77	0.72	0.77	0.74
Satisfaction						
Number of clients assessed	436	386	822	1,719	1,609	3,332
As a % of all clients	5.8	5.6	5.7	25.8	25.8	25.5
Clients with an overall positive outcome (%)	92.2	90.2	91.2	80.3	80.5	80.4
Clients with an overall neutral outcome (%)	6.2	5.4	5.8	14.6	14.5	14.6
Clients with an overall negative outcome (%)	1.6	4.4	2.9	5.1	5.0	5.0
Average satisfaction score	4.51	4.46	4.49	4.16	4.14	4.15

Tables 30 and 31 present SCORE for individual clients assessed, separated by two broad age groups of 0–17 years and 18+ years. A number of key findings were identified.

- Regardless of age groups, most clients had an overall positive outcome across the three SCORE areas in both years.
- A higher proportion of boys than girls had an overall positive outcome across all the two areas in 2019 (circumstances: 72% cf. 62%; goals: 70% cf. 63%). (Numbers of boys and girls assessed for satisfaction SCORE in 2019 were too small and data were not shown.) In 2022, there were little differences in circumstance and goal SCORE between boys and girls, however, boys had a higher proportion of having an overall positive outcome compared to girls. It is important to point out that numbers of boys and girls assessed for SCORE were small in 2019.
- The proportion of boys with an overall positive outcome in circumstances and goals declined from 2019 to 2022, however, the proportions for girls in these two areas remained stable.
- The patterns in SCORE for individual clients aged 18+ years were largely similar to those described above for all clients assessed.

Table 30: DEX: SCORE of in-scope CCS clients aged 0–17 years, 2019 and 2022

	2019			2022		
	Girls	Boys	All	Girls	Boys	All
Circumstances						
Number of clients assessed	195	209	404	734	792	1,531
As a % of all clients	7.7	8.1	7.9	30.9	32.2	31.6
Clients with an overall positive outcome (%)	61.5	71.8	66.8	63.4	63.0	63.2
Clients with an overall neutral outcome (%)	28.7	20.6	24.5	24.0	24.7	24.3
Clients with an overall negative outcome (%)	9.7	7.7	8.7	12.7	12.2	12.5
Average change (from earliest to latest)	0.97	1.34	1.17	0.72	0.74	0.73
Goals						
Number of clients assessed	114	140	254	657	695	1,357
As a % of all clients	4.5	5.4	5.0	27.6	28.3	28.0
Clients with an overall positive outcome (%)	63.2	70.0	66.9	65.8	65.2	65.5

	2019			2022		
	Girls	Boys	All	Girls	Boys	All
Clients with an overall neutral outcome (%)	28.1	25.7	26.8	22.2	21.4	21.7
Clients with an overall negative outcome (%)	8.8	4.3	6.3	12.0	13.4	12.7
Average change from (earliest to latest)	0.73	0.91	0.82	0.7	0.72	0.71
Satisfaction						
Number of clients assessed	-	-	86	326	348	675
As a % of all clients	-	-	1.7	13.7	14.2	13.9
Clients with an overall positive outcome (%)	-	-	84.9	67.2	71.6	69.5
Clients with an overall neutral outcome (%)	-	-	11.6	24.2	18.7	21.3
Clients with an overall negative outcome (%)	-	-	3.5	8.6	9.8	9.2
Average satisfaction score	-	-	4.29	3.86	3.86	3.86

Table 31: DEX: SCORE of in-scope CCS clients aged 18+ years, 2019 and 2022

	2019			2022		
	Females	Males	All	Females	Males	All
Circumstances						
Number of clients assessed	870	777	1,649	1,896	1,709	3,610
As a % of all clients	17.3	18.2	17.7	44.2	45.2	44.7
Clients with an overall positive outcome (%)	60.9	60.4	60.7	63.8	64.7	64.2
Clients with an overall neutral outcome (%)	28.6	26.6	27.7	21.3	21.8	21.5
Clients with an overall negative outcome (%)	10.5	13	11.6	14.9	13.6	14.3
Average change (from earliest to latest)	0.89	0.82	0.86	0.7	0.74	0.72
Goals						
Number of clients assessed	736	678	1,415	2,034	1,829	3,869
As a % of all clients	14.7	15.9	15.2	47.4	48.4	47.9
Clients with an overall positive outcome (%)	63	63.3	63.2	65.8	67.4	66.6
Clients with an overall neutral outcome (%)	27	27.3	27.1	20	19.1	19.6
Clients with an overall negative outcome (%)	9.9	9.4	9.7	14.2	13.5	13.9
Average change from (earliest to latest)	0.77	0.7	0.76	0.72	0.79	0.76
Satisfaction						
Number of clients assessed	388	348	736	1,393	1,261	2,657
As a % of all clients	7.7	8.2	7.9	32.5	33.4	32.9
Clients with an overall positive outcome (%)	93.3	90.5	92.0	83.3	83.0	83.2
Clients with an overall neutral outcome (%)	5.2	5.2	5.2	12.3	13.3	12.8
Clients with an overall negative outcome (%)	1.5	4.3	2.9	4.3	3.6	4.0
Average satisfaction score	4.53	4.48	4.50	4.24	4.23	4.24

Table 32 shows the proportion of clients assessed with an overall positive outcome across three areas, by state, in 2022. The data for 2019 by state and territory are not shown because of small numbers of clients assessed (for example, only three states had the number of clients assessed for satisfaction SCORE exceeding 100). SCORE data for Northern Territory and Australian Capital Territory in 2022 were not shown, given that only two or fewer outlets provide SCORE.

- Most clients assessed in all states had an overall positive outcome across three SCORE areas in 2022: 50%–80% for circumstance; 52%–82% for achieving goals; and 69%–96% for satisfaction.
- Regarding circumstances, the proportion of clients with an overall positive outcome was the highest in Western Australia (80%), followed by Victoria (68%) and Queensland (69%).
- In relation to achieving goals, again, Western Australia had the highest proportion of clients with an overall positive outcome (82%), followed by Victoria (74%) and Queensland (71%).
- The proportion of clients with an overall positive outcome in satisfaction SCORE was high across all the states, especially for Tasmania (96%) and Queensland (93%).
- It should be pointed out that clients assessed as a proportion of all clients varied markedly across the states and SCORE areas. For example, 57% of clients in South Australia were assessed for circumstance SCORE while only 30% of clients in New South Wales were assessed for this domain in 2022. Therefore, caution should be exercised when considering SCORE data comparisons across states and territories.

Table 32: DEX: SCORE of in-scope CCS clients, by state/territory, 2022

	NSW	Vic	Qld	SA	WA	Tas
Circumstances						
Number of clients assessed	1,007	1,048	981	690	924	359
As % of all clients	30.2%	39.9%	33.8%	57.3%	55.4%	40.7%
Clients with an overall positive outcome (%)	50.0%	67.9%	68.6%	59.1%	79.5%	56.3%
Goal						
Number of clients assessed	1,000	972	1263	639	866	358
As % of all clients	30.0%	37.0%	43.5%	53.0%	51.9%	40.6%
Clients with an overall positive outcome (%)	52.0%	73.5%	70.9%	58.5%	81.6%	56.1%
Satisfaction						
Number of clients assessed	601	961	715	183	645	138
As % of all clients	18.0%	36.6%	24.6%	15.2%	38.7%	15.6%
Clients with an overall positive outcome (%)	74.5%	81.6%	92.6%	71.0%	69.3%	96.4%

Notes: The numbers of clients assessed for NT and ACT in both years and QLD in 2019 were small (less than 100) and data were not shown.

Table 33 presents SCORE data by type of (e.g. major cities, etc) region in 2019 and 2022. Key findings are described below.

- Regardless of regions, overall positive outcome was pervasive across the three SCORE areas in both years.
- Regarding the circumstance SCORE, in 2019 the proportion of clients with an overall positive outcome among CCSs of outer region and remote areas (53%), the proportion was highest among clients assessed for CCSs of major cities (68%). However, the proportions across three regions were similar in 2022 (62%–66%).
- Similar patterns applied to goal SCORE. In 2019, the proportion of clients of CCSs in outer region and remote areas assessed with an overall positive outcome on achieving goals was the lowest among CCSs in outer region and remote areas outer region/remote areas (52%) and highest for CCSs of major cities (70%). In 2022, the proportions were similar for CCSs in outer regions and remote areas and major cities (63%–64%), while the proportion for CCSs of inner regions was slightly higher (69%).
- Different patterns emerged regarding satisfaction SCORE. In 2019, the proportion of clients assessed with an overall positive outcome was the highest for CCSs of outer regional and remote areas (98%), followed by CCSs of inner regional areas (94%), it was the lowest for CCSs of major cities (86%). Similar patterns applied to 2022, with the proportion of clients assessed with an overall positive outcome being higher for CCSs of outer region and remote areas (87%) compared to major cities and inner region (79% and 80% for respectively.

Table 33: DEX: SCORE of in-scope CCS clients, by region, 2019 and 2022

	2019			2022		
	Major cities	Inner region	Outer/remote region	Major cities	Inner region	Outer/remote region
Circumstances						
Number of clients assessed	1,033	775	246	2,523	2,224	423
As % of all clients	14.5%	12.8%	16.2%	40.1%	38.9%	35.2%
Clients with an overall positive outcome (%)	67.6%	57.2%	53.3%	62.0%	65.6%	63.4%
Goal						
Number of clients	824	668	177	2,577	2,282	401
As % of all clients	11.6%	11.0%	11.7%	41.0%	40.0%	33.4%
Clients with an overall positive outcome (%)	69.7%	59.6%	52.0%	63.3%	69.4%	63.8%
Satisfaction						
Number of clients	312	414	96	1,472	1,538	326
As % of all clients	4.4%	6.8%	6.3%	23.4%	26.9%	27.1%
Clients with an overall positive outcome (%)	86.2%	93.5%	97.9%	78.9%	80.4%	86.8%

Note: Calendar years and outlet areas.

Table 34 presents the DEX SCORE data according to 3 demographic groups, namely CALD, disability and 'Indigenous status'.

- Key points for DEX SCOREs by CALD status:
  - In 2019, the proportion of clients with an overall positive outcome in circumstances were similar but slightly higher for CALD clients than non-CALD clients. By 2022, the proportion of having an overall positive outcome in circumstances was slightly higher for non-CALD clients than CALD clients (64% cf. 59%), but the difference is not statistically significant.
  - Similar patterns also emerged for achieving goals. Differences in overall positive outcomes between CALD and non-CALD clients in both years were small.
  - The proportions of clients with an overall positive outcome in circumstances and achieving goals declined slightly between 2019 and 2022 for CALD clients, but not for non-CALD clients.
  - Overall positive outcomes in satisfaction between CALD and non-CALD clients were similar.
- Key points for DEX SCOREs by disability status:
  - The proportion of clients with an overall positive rating in circumstances in 2019 was lower for clients with a disability than clients without a disability (53% cf. 63%). Overall positive outcomes in achieving goals were similar between clients with disability and those without disability (61% and 65% respectively).
  - By 2022, overall positive outcomes in circumstances were similar between the 2 groups, and overall positive outcomes in achieving goals were slightly higher for clients with a disability than clients without a disability (70% cf. 66%).
  - The proportion of clients with an overall positive outcome in circumstances and achieving goals increased for clients with a disability between 2019 and 2022.
  - Overall positive outcomes in satisfaction were high for both groups in both years.
- Key points for DEX SCOREs in 3 domains between First Nations clients and non-First Nations clients were largely similar.

- In 2019, the proportion of clients with an overall positive outcome was similar between 'Indigenous' clients and non-Indigenous in circumstances (62% for both groups) and achieving goals (64% for both groups). The proportion of having an overall positive outcome in satisfaction was higher for Indigenous clients (98%, cf. 91%).
- The proportion of 'Indigenous' clients with an overall positive outcome in circumstances increased slightly between 2019 and 2022 The proportion of Indigenous clients with overall positive outcomes in achieving goals was similar between the 2 years.
- In 2022, 'Indigenous' clients and non-Indigenous clients were similar in overall positive outcomes in circumstances (67% and 64% respectively), achieving goals (63% and 67% respectively) and satisfaction (83% cf. 80%).

Table 34: DEX: SCORE of in-scope CCS clients, by selected demographics, 2019 and 2022

	CALD status		Disability		Indigenous status	
	No	Yes	No	Yes	No	Yes
2019						
Circumstances						
Number of clients	1,934	119	1,722	246	1,781	178
As % of all clients	13.9%	22.6%	13.8%	18.5%	14.0%	14.7%
Clients with an overall positive circumstance (%)	61.8%	63.0%	63.4%	53.3%*	61.8%	62.4%
Goal						
Number of clients	1,562	107	1,410	198	1,464	143
As % of all clients	11.2%	20.3%	11.3%	14.9%	11.5%	11.8%
Clients with an overall positive (%)	63.4%	68.2%	64.8%	60.6%	64.1%	63.6%
Satisfaction						
Number of clients	..	..	644	146	715	80
Number of clients assessed	..	..	5.2%	11.0%	5.6%	6.6%
Clients with an overall positive (%)	..	..	90.7%	91.8%	90.5%	97.5%*
2022						
Circumstances						
Number of clients	4,961	180	4,441	499	4,639	424
As of all clients	39.6%	45.0%	39.7%	37.9%	40.3%	36.1%
Clients with an overall positive circumstance (%)	64.1%	59.4%	63.9%	64.1%	63.6%	66.5%
Goal						
Number of clients	5,036	190	4,530	523	4,707	444
As % of all clients	40.2%	47.5%	40.4%	39.7%	40.9%	37.8%
Clients with an overall positive outcome (%)	66.4%	63.2%	66.0%	70.4%*	66.6%	63.3%
Satisfaction						
Number of clients	3,196	1,36	2,941	273	3,031	272
As % of all clients	25.5%	34.0%	26.3%	20.7%	26.3%	23.1%
Clients with an overall positive outcome (%)	80.4%	79.4%	79.9%	83.2%	80.3%	83.1%

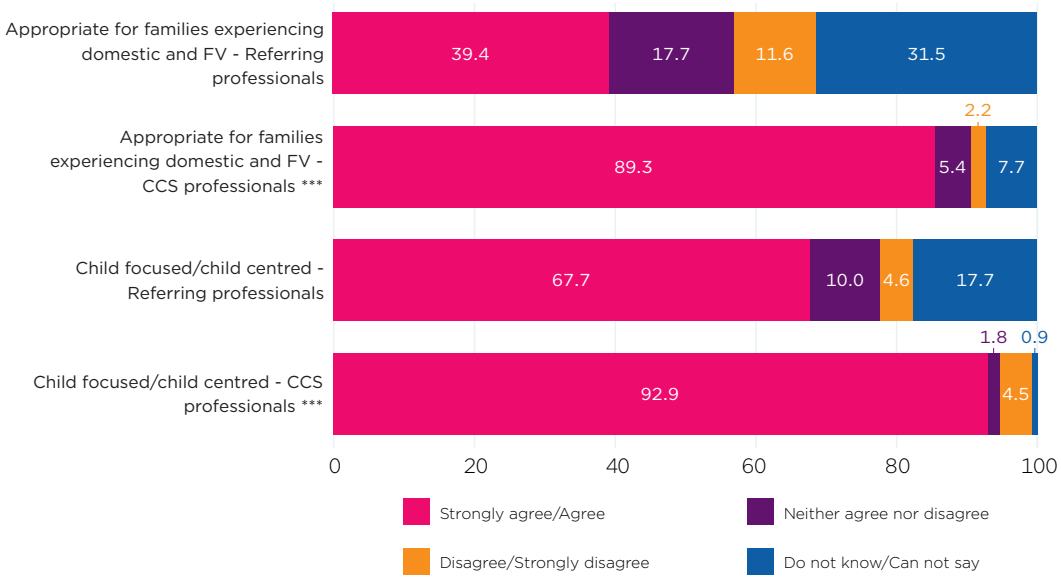
Notes: '..' indicates that the results were not shown because the number of CALD clients for CALD was fewer than 50. * indicates that the difference in the percentage with an overall positive outcomes between the two groups for each of the variable (i.e. CALD, disability, Indigenous) is statistically significant ($p < .05$).

Professionals' views on whether CCSs were appropriate for families experiencing DFV

Figure 17 shows that most participating professionals strongly agreed (36%) or agreed (26%) that CCSs were appropriate for families experiencing DFV. More specifically, the data show that although most CCS professionals strongly agreed (61%) or agreed (29%) that CCSs were appropriate for these families, 15% of referring professionals strongly agreed and 25% agreed with this proposition. Of particular concern, nearly one-third (32%) of referring professionals indicated that they did not know or could not say whether CCSs were appropriate for families experiencing DFV. This finding may be indicative of a lack of knowledge of CCS service provision or an absence of confidence in the safety arrangements relating to CCS service provision for families experiencing DFV.

Once again, these findings in relation to CCS professionals' strong agreement and referring professionals' equivocal responses reflected statistically significant differences between the 2 professional groups.

Figure 17: Survey of Professionals, agreement with effectiveness of government-funded CCSs by professional type



Notes: Question was worded as: 'To what extent do you agree that government-funded CCSs "in your organisation/ in your area" are:' CSS professionals asked to rate CCS characteristics for 'my organisation' and referring professionals asked 'in my area'. ***$p < .001$ statistically significant based on chi-square test. Percentages may not total 100.0% due to rounding.

Effective service provision to support families?

Accessing CCS services and the impact on parents' and carers' relationships with children

In this section, data from the Survey of Parents and Carers and from the qualitative interviews with parents and carers are presented to explore the parents' views of the effects of using their CCS on their relationship with the children.

Participants in the Survey of Parents and Carers were asked about the extent to which accessing the CCS had affected their relationship with their children. Participants could choose 'yes' options that canvassed both changes in a positive or negative way, or no change. These data are presented in Table 35.

- Overall, there were quite varied experiences in terms of CCS use and how this affected participants' relationships with their children. Around one-third (34%) of parents and carers reported no change, another third (34%), reported 'yes, in a positive way' and a further 15% reported 'yes, in a negative way'. Almost

one-in-five (18%) of participating parents and carers reported they did not know or preferred not to say in response to this option.

- When this survey question was further analysed according to participants' gender, parenting arrangements and cultural background, statistically significant differences were only found for parenting arrangements. For parents and carers who reported parenting arrangements where all or most of the time was with the other parent/carer and supervised time with them, 58% reported that accessing the CCS had affected their relationship with their child in a positive way. The corresponding proportion for parents/carers who had all or most of the time with the child and supervised time with the other parent was lower at 15%.

Table 35: Online Survey of Parents and Carers, has accessing the CCS affected your relationship with your child/ren, by various characteristics

	Yes, in a positive way (%)	Yes, but in a negative way (%)	No (%)	Do not know/ Prefer not to say (%)	Total (%)
All parents (*n* = 107)	33.6	15.0	33.6	17.7	100.0
Gender					
Man or male (*n* = 41)	41.5	17.1	17.1	24.4	100.0
Woman or female (*n* = 65)	29.2	12.3	44.6	13.8	100.0
Parenting arrangements**					
All or most of the time with me and supervised time with the other parent (*n* = 39)	15.4	15.4	53.8	15.4	100.0
All or most of the time with the other parent and supervised time with me (*n* = 26)	57.7	19.2	3.7	19.2	100.0
Cultural background					
Participant or at least one parent born overseas in a non-English speaking country (*n* = 18)	27.8	27.8	16.7	27.8	100.0
All other participants (*n* = 89)	34.8	12.4	37.1	15.7	100.0

Notes: *$p < .05$; **$p < 0.01$, ***$p < .001$ statistically significant difference between gender based on chi-square test. *n* = 1 parent who answered 'prefer not to say' to gender question, not reported due to small sample size. Other parenting arrangement categories collected in the survey not reported due to small sample sizes, including 'Most of the time with me and supervised changeover for time with the other parent', 'Most of the time with the other parent and supervised changeover for the time with me', 'Roughly a 50/50 split and supervised changeover used.'

The qualitative interviews provided further insights into parents' and carers' perceptions of the effect of using the CCS on their relationships with their children.

Most parents and carers providing responses to interview questions relevant to this issue described how attending the CCS had either had a positive effect on their relationship with their child or children or had no effect, with slightly more indicating they thought it was positive. Spends time with parents most frequently reported that the visits had a positive effect on their relationship with children as it provided an opportunity to strengthen the bond with the child or reintroduce a connection with their child where they had not seen each other for some time. For example, one Spends time with parent indicated that the staff members' skill and experience with children had helped them in spending time with the children. Other Spends time with parents indicated that the activities the CCS had were fun for spending time together. Some parents and carers using changeover indicated that the use of the CCS made the transition less stressful and that this had reduced the anxiety in their child. One Lives with parent/carer described how it was beneficial for the parent and child relationship to spend some time apart as it seemed to reduce the dependency (LWP 26). Another Lives with parent/carer indicated that it reduced stress knowing that the child was visiting at the centre and the child seemed to have improved regulation after the visit than previous visits to the home of the Spends time with parent (LWP 1).

For the parents and carers that considered attending the CCS had had a negative effect on their relationship with their child or children, most of these were Lives with parents/carers. A range of reasons were identified by

these parents/carers for their child feeling this effect. These included feeling that their child's trust in them was damaged by having to make them see the other parent, particularly in one case where the child had a disability and behaviour would change negatively prior to the visit (LWP 43). Another Lives with parent/carer described how they felt that the child thought they were handing over responsibility as a parent to someone else (LWP 23). One parent/carer indicated that using the CCS made her feel resentful as the child frequently talked about the money the other parent had and the gifts they had provided while she had to undertake chores for the child, which made her feel like the other parent was seen as being more fun (LWP 12).

Some participants indicated that the visits created stress for the Lives with parent/carer and child/ren as they would have to rush, or to try and find parking. It also meant children and or the Lives with parent/carer experienced tiredness from having to travel long distances and reflected on the challenges for the family and particularly children of having to commit a whole day every fortnight to engage in the services at the CCS. For example:

> *Probably the biggest impact is just … we leave at nine and we get back. It's like half three. So it's just huge day, huge drive.* (LWP 36)

Other participants described how their children's behaviour was different after the visit and could be difficult to settle again which created negative or more difficult interactions.

Very few parents or carers reported that using the CCS had had any effect on their relationships with other people. A small number of Lives with parents/carers described a positive effect in that using the service had improved their relationships with other family members as they sometimes accompanied the Lives with parent/carers to the CCS. These participants indicated that they felt more supported by these family members and also able to spend time with them while the child was at the CCS. Some parents and carers also reported that their relationship with their ex-partner had improved as they no longer had to see each other in person or to have any direct contact which removed the opportunity for conflict or violent or abusive behaviour.

Of the parents and carers describing a negative effect on other family members (n = 4), 2 identified that it was in relation to older siblings who had to wait around at the centre with the Lives with parent/carer or who had activities interrupted or affected by the need to collect the child at the CCS, or older children who worried that they may accidentally see a parent they no longer wished to spend time with.

Where parents and carers reported that they didn't feel like the visits to the CCS impacted their relationship with the children, the reasons for this were often due to the informal setting or the atmosphere of support in the CCS and the fact that they thought the child/ren felt secure and comfortable attending. For example:

> *I think she feels safe and secure there and the support I've been given enable [us] to handle what's happened in the past.* (LWP 37)

Strengths and limitations affecting ability of CCSs to adapt to meet the needs of children and families: qualitative insights

Previously in chapter 3, findings showed how a large majority (83%) of CCS professionals strongly agreed or agreed that CCSs have a positive effect on the wellbeing of children, while referring professionals less frequently agreed with that outcome (37% strongly agree or agree). Professionals participating in this survey were asked to provide an open-text response regarding the strength and limitations in CCSs adapting to meet the needs of children and their families. Participants provided strong insight into CCS capacity with 12 of 99 responses reflecting on the strengths and 51 responses reflecting on limitations. Of the 99 participants providing a response, a further 35 reported both strengths and limitations in their responses in relation to the CCSs adapting to meet the needs of children and families.[30]

In relation to strengths, some participants emphasised the child-focused approach and child-centred practices employed by CCSs that prioritised the safety of children. Some participants referenced CCSs' engagement of orientation or familiarisation sessions for children prior to service commencing to support the identification of the child's specific needs, their referral of children and their parents to relevant support services as well as their uptake of training opportunities to support staff to respond to the needs of children using their services. The colocation of CCSs with community service providers were nominated in this context, as was trauma-informed practice (e.g. Service provider organisation, state/territory redacted, 55+ years). Other participants' responses

30 One open-text response submitted to this question indicated that they were unable to answer this question as stated.

focused on the physical and emotional safety of children when using the CCS (CCS staff, NSW, 45-54 years; CCS staff, Vic, 35-44 years).

In addition to the child-focused approach, the strengths of a neutral or independent approach to service provision were also sometimes noted by survey participants. Some participating professionals also reflected on the need for CCSs to be affordable to support access. Other participants reflected on the flexibility and adaptability of the CCS model of practice, including CCSs' ability to adapt processes to meet the individual needs of families (e.g. CCS staff, NSW, 25-34 years) and the 'issues in the community and the changing social challenges with families [and] we can adept to meet those demands' (CCS staff, WA, 45-54 years). , with some also identifying their ability to support families to address the underlying issues that were giving rise to their need to use the CCS. Participants described the strength in CCSs delivering their core services of facilitating safe and consistent parenting time, as well as the CCSs' ability to adapt to meet the needs of children and families where they have a range of needs, including those arising from disability or where they have experienced DFV:

> *Staff are ...able to support all types of needs for children, i.e. disability, medication awareness, mental health and trauma, resilience and general anxiety etc.* (CCS staff, WA, 45–54 years)

> *We meet with children, provide information, implement safety plans, listen to their needs. Each family is assessed to understand their needs, consult with them and review their goals. We can provide casework support and refer to appropriate services as needed.* (Service provider organisation, NSW, 55+ years)

In addition to safe, flexible and adaptable service provision, the following participant reflects on the strengths associated with consistency in the service provision by staff who have the requisite skills and training that is ongoing and informed by relevant research:

> *[A strength is the] Consistency of service provision, skills and training of staff, capacity to offer parenting program skills training on site and the importance of learning through funded research and ongoing personal development of staff within these services. Also important is purpose-built facilities to support positive family contact that offers a range of contact times to accommodate children's extra –curricular activities and FIFO and shift workers.* (CCS staff, Qld, 55+ years)

Other participants also reflected on the strengths associated with the CCS staff and their engagement with families:

> *Strengths [are] tertiary educated staff, ongoing training and regular supervision.* (CCS staff, Qld, 45–54 years)

> *[CCSs are] professional, well-trained staff working with the children's best interests in mind is one of the strengths of service. Staff are able to liaise with key stakeholders and support families experiencing a range of issues.* (CCS staff, Qld, 55+ years)

> *Strengths [include] wonderful staff, wonderful management. Clear guidelines and boundaries – these are the backbone to safety for the children (e.g. having a guideline that requires parents not to engage in conversations with the children [where they] appear uncomfortable participating...[There is a] willingness to have difficult conversations with parents to support them to remain child-focused.* (CCS staff, Qld, 35–44 years)

> *When reflecting on the strengths associated with professional and well-trained staff, some professionals referenced the importance of guiding policies and procedures and an established support network across the sector* (e.g. Service provider organisation, state/territory redacted, 45-54 years*). F*

More specifically, some participants also described the practices of CCSs when engaging in case management, case reviews and in applying risk assessment approaches in their open-text responses about the strengths of CCSs to adapt to meet the needs of children and their families:

> *Strengths are that the cases are reviewed and discussed by a panel of experienced staff and professionals, not just reliant on individual feedback to make the assessment of moving forward for staying in relation to contact progression.* (CCS staff, Qld, 45–54 years)

> *[A strength is that] We can review both the parent and child experience and adapt to ensure that we have delivered in a way that meets the Family Court and clients need.* (CCS staff, WA, 55+ years)

However, as foreshadowed in the introduction to this section, a greater number of professional participants reflected on the limitations in the ability of CCSs to adapt to meet the needs of children and families (*n* = 51/99).

Some participants reflected on the issues associated with working within the 'parameters set by the court' in their orders and the decisions about whether there should be supervised changeover or parenting time and regarding the transition to self-managed arrangements (CCS staff, NSW, 45-54 years; Judicial officer, Qld, 35-44 years).

The following participant described how facilitating court-ordered parenting time had the potential to place staff and families at risk of harm, and that orders acted as limitations on the extent to which their service provision could adapt to children and families' needs:

> *CCSs receive court orders for contact for extremely high-risk families and make decisions with limited information, that is information provided in the court order, during assessment of both parties, orientations and 16As. CCSs are required to make determinations of suitability prior to commencing and at times this causes parents to escalate and have the CCS staff and individuals put at risk.* (CCS staff, NSW, 35–44 years)

Factors also identified as limiting the CCSs' capacity to adapt to meet the needs of children and families included circumstances where support was not available from an ICL or the family members' lawyers (e.g. CCS staff, Qld, 55+ years):

> *Funding constraints on service provision was the factor most commonly identified by participants as impeding CCSs' ability to adapt to meet the needs of children and families e.g. Judicial officer, Vic, 55+ years; CCS staff, Vic, 35-44 years; Lawyer, state/territory redacted, 55+ years).*

It is notable that these observations were largely made by referring professionals rather than CCS staff, although some CCS professionals did make this observation, and some CCS professionals observed more specifically the challenges associated with funding limitations with respect to the premises that can be secured for service provision. For example:

> *Limitations are [a] lack of government funding to set up a purpose-built facility. We are applying for grants though and hope to be successful doing this this year.* (CCS staff, Qld, 45–54 years)

> *Limits [include] –funding – no clout - having to lease sites to operate – is a liability for service.* (CCS staff, NSW, 45–54 years)

Greater availability of service locations was also a limitation nominated by professionals providing an open-text response on the limitations of CCSs. For example:

> *Stretched services are the major problem. It affects families in different ways – for example, they may be too quick to reject a family. Generally if there were more services that would be better.* (Judicial officer NSW, 55+ years)

> *[A limitation is the] Need to adapt by providing more services to those in need in rural communities.* (Lawyer, Vic, 45–54 years)

Other participating professionals nominated CCS staff skills and training and the risk of burn out as a potential limitation (FDR practitioner, Qld, 35-44 years; Court Child Expert, NSW, 45-54 years), Some participants specifically referenced language barriers and limitations in relation to there not being enough diverse staff with language and translation skills to support engagement with families:

> *It is imperative that the supervisor speaks the same language as the parties to monitor their communication. Contact centres need to employ a range of staff from a range of different language groups or have translators available to attend at the same time. This can be very costly and a bit uncomfortable for the parties. Another limitation is how hard it is to closely supervise every interaction between the parent and the child. This participant stated that 'even a squeeze, pinch or a whispered comment can be frightening, and traumatising for a child who has been abused'* (Lawyer, no disclosure of state or age).

Limitations in trauma-informed practice and child-focused approaches were factors also identified:

> *There could be more availability, more trauma-informed and decisions made from a child-focused/child development lens.* (Psychologist/counsellor, NSW, 35–44 years)

Some participants referred to the difficult nature of the work and that it was important to be mindful of the role of CCSs and that they were not funded to provide the support services that families may require to transition to self-managed or other long-term parenting arrangements. For example:

> *Limitations [include] clarity around expectations that go with the funding at times. Burnout – the work is hard; clients can be very difficult and the work is emotionally tolling at times.* (CCS staff, NSW, 55+ years)

> *I think we need to be clear on what the role of a CCS is – they are not funded adequately to provide a suite of services. Wraparound services are great but not all organisations have all of the services so CCS staff can assist by helping with referrals or suggestions but cannot provide everything.* (CCS staff, Vic, 55+ years)

The participant directly above, along with others, identified the inability of CCSs to provide 'wraparound services', including therapeutic and other services to families, as a limitation in the ability of CCSs to meet the needs of children and families:

> *It is always difficult to balance trying to facilitate the contact while respecting the child's voice if they are reluctant. It is always difficult working with parents who are not encouraging of contact and who try to sabotage the conflict. A wraparound service model that can provide other post-separation support services would be ideal.* (CCS staff, Vic, 55+ years)

> *The limitations are often posed by the complexity of the cases/people that are involved in the process.* (FDR practitioner, NSW, 25–34 years)

> *Offending parents and non-offending parents are equally not provided with the right type of parenting support.* (DFV professional, SA, 25–34 years)

> *Funding for therapeutic case management is a limitation. Families at CCSs often have complex needs and require a higher dose of case management.* (Service provider organisation, NSW, 35–44 years)

Consistent with concerns raised in chapter 4 in the context of CCSs' ability to meet the demand for their services, several participants also identified limitations arising from a broad range of logistical constraints. These related to the availability of sessions at services, the days and hours of operation (outside of standard work hours to cater for shift workers and school aged children and on public holidays), the delays or costs to families of accessing services, limitations in the types of services that can be provided to families and time limitations on service provision. The utility of case management for families and the need for variations in the mode of service provision were also identified. One participant suggested an alternative approach would be to provide different levels of supervision services at different locations to better cater for families' needs and for different types of services (e.g Lawyer, state/territory redacted, 25-34 years; Lawyer, WA, 25-34 years; Judicial officer, Vic, 35-44 years; CCS staff, WA, 45-54 years; Lawyer, Vic, 35-44 years; CCS staff, WA, 35-44 years).

Having the flexibility to tailor service provision to families' specific needs was also identified as critical to being able to meet the needs of diverse families using the services. For example, the ability to accommodate extended family for supervised visits or more regular contact may be of particular support to First Nations and CALD families who need to use CCSs:

> *CCS services can provide a service that will meet some parents' needs. Having the opportunity to have extended family at the centre, having the opportunity to have weekly visits given demand of service usually limits the opportunity to provide fortnightly contact.* (CCS staff, Vic, 55+ years)

Potential variations to support CCSs to better meet the needs of the children and families that use them were suggested by professionals participating in the Survey of Professionals are considered in more detail below.

Suggestions for changes to CCSs to better meet the needs of the children and families that use them

Open-text responses from the Survey of Professionals and the Survey of Parents and Carers as well as the parent and carer interviews provide insight into changes that CCSs may make to better meet the needs of the children and families using them.

Approximately one-third of participants in the Survey of Parents and Carers (*n* = 38/112) provided an open-text response to questions seeking suggestions about what the CCS could do to help them, their child or both.

Of the participants providing 38 open-text responses, approximately one-quarter (*n* = 11) described improvements in staff knowledge and training to better support their family. The types of changes sought included:

- neutral and professional service provision by staff

- staff knowledge of the nature and presentation of coercive control
- application of trauma-informed practice
- communication with parents and carers, including consistency in communications provided by staff
- engaging with and encouraging families to provide feedback on the service provision
- accuracy in observation reports.

For example, in relation to the first dot point:

> *The CCS [should] provide a welcoming and safe environment for my family. Some staff have made the experience extremely uncomfortable for me and my children.* (STWP)

> *Some of the staff there treat me with suspicion or like I am a second-rate citizen. I don't feel emotionally safe there to talk to staff and I know my children don't either. They need to have staff who are better trained and better informed. It feels somewhat unprofessional/lax and doesn't instil me [with] confidence that they would know what to do if something bad happened. They need to know more about my children and their needs – not doing that and writing records for court is risky as their behaviours can be misunderstood/misinterpreted. Having said all that, I'd be lost without the service.* (LWP)

> *It is too late now but I felt it was intrusive that staff at CCS felt that they have the right to make physical contact with my children without the permission of both parents … They are generally good but to allow more space between themselves and the parents and kids may be better.* (STWP)

The last quote above references measures to support accessibility to services, which was another factor identified by 13 parents and carers participating in the survey. More specifically, parents and carers sought:

- greater availability of CCS services, including a reduction in time awaiting services, increased days and hours of operation and local accessibility to CCSs
- a simpler/easier application process
- offsite supervision
- sessions with multiple children
- the provision of mediation and other support services
- the provision of real time reports to support the identification of issues experienced by children during supervised visits.

Reiterating the concerns raised in chapter 3 specifically relating to meeting children's needs, the small number of parents providing a response (n = 9) referenced age-appropriate activities for older children and allowing longer sessions for identity contact visits, as well as opening hours that suit younger children and their nap times.

Some parents and carers suggested:

- better understanding on the part of staff of their children's needs, including children with special needs or children whose behaviour changes or are distressed at the CCS
- access to support services for children.

Others suggested a need for greater encouragement of children to attend the CCS. For example:

> *They need to know my children more and their special needs and make adaptions to accommodate them. My kids often don't want to go but find the questions very stressful so often agree and then staff will make comments like 'you ran down the hallway, which tells me you are so very excited to see your father', which isn't true. They run everywhere and this makes them feel misunderstood and confused.* (LWP)

> *Not persist with the visit when my one-year-old is distressed. I have heard her screaming for me through the doors for over 10 minutes, and they never contact me to come and get her. I find that totally unacceptable. She is a baby.* (LWP)

> *They need to look after children's mental health more when children disclose distressing content … Support children more and navigate parents that need parenting programs and counselling and make referral suggestions and reports for parents and children.* (STWP)

One parent raised concerns their child being 'pressured' to attend meetings with a parent who sexually assaulted the child. Another parent described their concern with their child changing demeanour when attending the service and seeking staff awareness of 'how they are dropped off, and noticing the huge changes from happy

children to unhappy children upon pick up' (LWP (shared time arrangement)). This parent indicated that they wanted the CCS to:

> *… be more concerned with the children's mannerisms and mental state when they are dropped off by the other parent. For example from being happy, playful, excited to see me to not making eye contact not running to give me hugs and being very upset that they are there.* (LWP)

Open-text responses were also provided by 73 participants in the Survey of Professionals to a question seeking suggestions for any changes that CCSs needed to make to better meet the needs of the children and families using them. A substantial proportion of these participants (*n* = 25/73) made comments that centred on a need for greater funding, with some specifying this need to support additional or more flexible hours of operation, and more resources to allow for more CCS locations, longer supervised sessions and evening sessions to reduce waiting lists (e.g. CCS staff, Qld, 35-44 years; Lawyer, NSW, 45-54 years; Lawyer, Qld, 35-44 years).

Some professional participants reflected that the additional funding was required to address shortcomings in the facilities (upgrading the safety of separate entries and parking areas) and toys and equipment to ensure services are 'fit for purpose' (e.g. CCS staff, NSW, 45-54 years) as well as the application of resources to interpretation services (e.g. DFV professional, Qld 35-44 years; Service provider organisation, Qld, 55+ years; CCS staff, NSW, 45-54 years):

Other participants also suggested that additional funding should be directed at the provision of services additional to supervision. In addition to improvements to the facilities, and increasing the reach of those facilities, the following participant suggested that funding was required to enable CCSs to provide support services to the children using them. For example:

> *[Changes needed include] Funding for stand-alone CCSs to provide counselling services for children. Lifting the profile of CCSs so that we are seen as a vital part of the family law system, domestic and family violence service system etc. Better facilities for CCSs so that spaces are safer and more conducive to positive family time. CCSs are located in areas where offsite supervised contact can occur within walking distance. CCSs located in regional or remote areas so children and their families do not have to travel so far. This does not require fully-funded CCSs but rather outreach services provided by experienced CCS operatives.* (Service provider organisation, Qld, 55+ years)

Some professionals suggested resourcing support services within or external to the CCS to address the complex needs of the families accessing them. For example, one participant called for

> *funding for CCS to have their own counsellor and mediator to work on case from the beginning.* (CCS staff, NSW, 45–54 years)

Separate to the specific suggestions for more funding, a further 48 of the 73 professional participants provided an open-text response regarding changes that may be needed that would likely require an increase in resources for CCSs. These participants called for extensions to the availability of services – be that in relation to the frequency and duration of service provision, the reduction of waiting lists to support timely access, together with an expansion in the location of CCSs. For example:

> *There needs to be more visits available for longer.* (Judicial officer, SA, 35–44 years)
>
> *[There is a] Need to offer supervised visits for more hours in the day (e.g. up to 8 pm) and to find a way to decrease wait time.* (Lawyer, ACT, 25–34 years)
>
> *The only issue is the waiting list which varies considerably and at times has meant that families are waiting too long (months instead of up to 4 weeks) to access supervised visits. We are trying to address this issue by employing more staff and conducting a greater number of visits on weekends.* (CCS staff, Qld, 45–54 years)
>
> *Space and staffing challenges makes this difficult. We don't offer off site visits – this may help.* (CCS staff, WA, 45–54 years)
>
> *More services and more flexible times for the use of services and 'pop up' services in regional and remote areas for users who cannot travel to the current locations.* (Lawyer, no details disclosed)

Other participants referred to improved pay and conditions as well as training opportunities and guidance for CCS staff, particularly in relation to child-safe and child-inclusive practices, including to empower staff to act proactively to terminate visits where the child's best interests directed this outcome:

> *[Changes needed include] Good training so that the staff are confident when stepping in to intervene if needed. Support for staff if they need to terminate a visit or terminate all future visits … I think it would be good practice for the supervisor to 'check in' with the child about how they felt it went at the end of each visit, or have a 'safe' signal – that they can use if they feel uncomfortable during the visits, if the child needs a break or needs to speak to the supervisor or they want to end the visit. Supervisors need to have a psychology or social work background – and have experience working with the Department of Child Safety – rather than have a child care/child education background. Supervisors need to be paid well and have good support systems in place as it can be demanding and stressful.* (Lawyer, Qld, 35–44 years)

> *[Changes needed include] Best practice guidelines for assessing and hearing children's needs and voices for contact – to ensure children are centred in practice and feeling included in case management plans that address their needs. Guidelines for working with parents in a child-centred way. Skills to assess and respond to risk, e.g. safe and together training. Contact Centres/Staff sometimes have confusion around what being 'neutral/unbiased' means but also needing to assess and respond to risk for children's and families' safety. Frameworks such as safe and together, would support services to provide child centred and safe practice.* (Service provider organisation, NSW, 35–44 years)

Changes to service provision to better meet the needs of children and families included suggestions relating to more flexible and creative transitional arrangements. These included progressing to offsite supervision or group sessions to improve the engagement of families with older children and to support safe transitions to unsupervised time:

> *[Changes needed are to ensure services] Be available for longer periods of time and have even a limited option for some supervised time in the supervised parent's home before transitioning to unsupervised time.* (Lawyer, Vic, 35–44 years)

> *There needs to be a stepped approach to children's contact to gain both an authentic insight into the parent/child dynamic, and in promoting healthy and positive relationships … Offering contact services where progression is very visible to those participating and deemed suitable, by the movement through the various environments, would encourage confidence in the motivation of service providers and subsequently may result in greater receptiveness to wider resources and support.* (CCS staff, WA, 45–54 years)

Some participants also identified a need for longer-term supervision arrangements where families were unable to transition safely to self-managed arrangements, with improved options to engage older children and to provide a limited number of supervised visits per year to support 'identity contact' for children:

> *[Changes needed are] Making available for certain families' longer-term access to the service for visits.* (Lawyer, Vic, 45–54 years)

Other participants in the Survey of Professionals suggested greater diversity in the service provider organisations and models to suit First Nations and CALD families (e.g. Lawyer, state/territory redacted, 55+ years) and referred to the potential for service provision within a broader service hub (e.g. FDR practitioner, SA, 45-54 years) or by other means, including case management models, to support access to the therapeutic services that children and their families need. Participants also recommended 'increasing investment in trauma-informed and child centred practices and service integration': (e.g. Service provider organisation, state/territory redacted, 55+ years) and 'greater focus on the child's voice and implementing their voice, not just gathering it' (CCS staff, NSW, no details disclosed).

As noted in chapter 2 in relation to views of the services that CCSs *should* provide, qualitative interviews with parents and carers also revealed a range of additional services that parents and carers suggested CCSs provide that would better meet their needs and the needs of their children. Parents and carers using the CCS for supervised visits and changeovers most frequently nominated extending the opening hours of the CCS for changeovers to accommodate public holidays. Parents and carers reported wanting the CCS to be open for changeovers for extended hours outside of standard work hours, such as for evening activities with children and after 5:00 pm for parents who are working. Generally, parents and carers were looking for greater flexibility in using the service. For example:

> *For those parents and carers using the CCS for supervised visits, the need for flexibility of time was expressed in terms of being able to change the length of time for the visit to accommodate a developing relationship with the child. The two hours is probably not long enough for an older child. Because we've got other children coming, but they're trying to service as many children as they can so that they parents*

can maintain their relationships. But just thinking that for [child], a longer supervised visit would probably benefit him in really getting to know his dad and would benefit his father because then the father in the space of, in the space of two hours, that father and [child] are doing activities that were very like, let's go here let's do this. Let's squeeze everything in two hours and he's not really parenting [the child], he's just playing with him. (LWP 47)

Some parents and carers identified the cost of supervised visits was onerous for the Spends time with parent. Only one parent suggested that the cost of changeovers could be reduced for long-term users of the service (LWP 49).

Improving service provision and future self-management for First Nations families

First Nations professionals shared their perspectives about changes to CCSs to better meet the needs of First Nations families, including strategies to facilitate their transition to self-management where feasible. Some of these themes reflected the suggested changes to service provision in the Survey of Professionals, Survey of Parents and Carers and parent and carer interviews reported earlier in this section but with additional considerations for First Nations families. From a practical perspective, access to CCSs for First Nations families could be improved if there were better transport options available, particularly where distance and/or cost of transport was an added barrier. Supported transport services must accommodate specific timing required for CCS arrangements however:

I think more families would and want to if there was more support in transport and things … like I've had CCS clients before, other community members who have got transport from the [Aboriginal Organisation 1] could get transport from them, which is great and lovely, but it's also a bit of a strain when they probably are doing 13 different other appointments so that that individual [would be] dropped off slightly later or early and then be waiting around, which is in my mind uncomfortable [because] that's… outside somewhere that they wouldn't likely [want to] be associated with. (First Nations Professional 2)

Other strategies to improve CCS service provision emphasised the importance of providing services in a more holistic model from First Nations perspectives, including family therapy, programs for men and specialised counselling for children:

I'd like to see us be able to, particularly here, offer more holistic approach to the family law support through what courts require, and by that I mean be able to offer things such as, family therapy for one. I know, I believe there's family therapy in another and I believe one of them is mainly offered through the court. So I understand there's a limitation there, but I mean also more like I'd love to see and hope to see something like men's, men's behaviour change programmes be offered through like an FRC or CCS because I find that training, your rapport for some of these individuals, even guys, is, is really imperative for just being able to open up about information … Children's counsellors as well in the CCS to hear their voice and how it is, how it's going and where they're at. (First Nations Professional 2)

This First Nations Professional describes a 'holistic approach to service provision' to assist the family to address their underlying issues.

First Nations Professional 3 suggested a possible way of improving engagement with CCSs would be to offer events that were fun and community strengthening rather than just a service offering:

Yeah, like. It would be great if we could get some more Aboriginal workers, but even as I said, if we can get more community engagement from or, you know, like an open day, even just a barbecue at the office or BBQ at [CCS Organisation], , …not because they have to be [there, but] because they want to come. (First Nations Professional 3)

Building on the recommendations to improve First Nations cultural safety reported previously in this chapter, First Nations professionals strongly emphasised the importance of expanding outreach services across CCSs. Increasing the possibility of some First Nations families moving to self-management would be a benefit of outreach service models because time with children could be linked with kin and community in ways that strengthen cultural safety for when CCSs are no longer involved. Outreach was proposed in three ways. The first approach was increasing the choices for outdoor supervised time based around current CCS locations, which

was part of the positive cultural safety practice discussed earlier in this chapter. The second approach was to have CCSs going out into communities (similar to a mobile service):

> *I would like to see contact centres have an outreach programme where or even if you had a specific Aboriginal worker … I don't know whether you [would] get the numbers for a full time [worker], but I think Aboriginal worker that … can go and do … outreach, supervision. So in a park or, you know, going out to [suburb 9] and fishing by the river or going to [Local Park] where they've got activities and you know it might be like they would, they do boomerang making and all of that sort of stuff. So it's about sometimes it's about Dad spending time. Or Mum spending time with the kids, engaging in social activities rather than just one on one because one on one can be very difficult for Aboriginal people because we're not nuclear.* (First Nations Professional 1)

First Nations Professional 1 provided a further example of how CCS standards could be maintained when implementing outreach services:

> *… And my suggestion would be is that we need to start looking at or working with some of those services on how can we do that as from an outreach perspective? So you'll still get the same staff that are going in and providing it with the same background and everything else, but you're doing it at a premises that's more likely to be approachable for them.* (First Nations Professional 1)

The third approach to outreach proposed a model of specialised First Nations support where, for example, the clients do not have to go through a mainstream service first but could go through an Aboriginal service, including Aboriginal-led or Aboriginal Controlled Community Organisations that could then link them in with CCSs with an Aboriginal worker

> *You couldn't have an Aboriginal contact service because it would be stuck in one area, right? But I think it would be good if we had like…..a service where you can have specific Aboriginal contact services without having to come to a mainstream contact service to begin with … because at the moment, they've got to contact us to get to an Aboriginal worker or whatever, whereas if they, you know, with the Aboriginal Legal Service, they have their own things and they have their field, you know, their field offices and things like that. So there's a lot there. It's all, it's all there, but it's just not there for contact services for these families.* (First Nations Professional 1)

Increasing outreach services, including developing specialised First Nations approaches to delivering CCSs, and cultural safety would need to be connected to local culture and practices:

> *we spoke about the cultural sensitivity and cultural training and safety and being specific to that [local] area as well, not just a generalised piece. But I don't think it should be held in [Aboriginal Organisation] or anything, because - [for example] like myself, - I'm from the [Aboriginal Community] up in [location] and I'd feel pretty left out if I had to see someone [for] support , I'd have to go somewhere where I'm not connected and [to see someone] who would potentially universally prioritise someone else from their own community.* (First Nations Professional 2)

Developing strategies for access to information and understanding legal information, including practical advice about how to manage court orders was another area for improving service provision for First Nations families recommended by interview participants. It was suggested that these improvements may be instrumental in helping First Nations families to move on to manage without the CCS, as might other families in similar situations:

> *I think having someone that would be able to have information, maybe even like more information in the communities information sessions on the processes of how things work. Particularly with, you know, what they can and can't do. Like interpreting that? We're not lawyers, but interpreting what the parameters are with their intervention order cause a lot of them don't even understand that. And that's not just First Nations but particularly First Nations what they can and cannot do with that order.* (First Nations Professional 2)

This included linking in with Aboriginal legal services and other Aboriginal Community Controlled Organisations throughout the CCS process and improving understanding of the extent of the processes in the family law system and the orders they had received.

> *Because a lot don't even know about mediation and, and [the] difference between parenting plans, parenting orders and consent orders. That would be a big one as well for progression [to self-management].* (First Nations Professional 2)

First Nations Professional 2 suggested that this approach could be a particular stream within the CCS offerings that would provide closer support for these clients.

Summary

This chapter examined quantitative data from the DEX, RFI, and survey elements of the study as well as qualitative information from the Survey of Professionals and the qualitative interviews to address Research Question 6 regarding the extent to which services provided are culturally appropriate for First Nations families and CaLD families and Research Question 7 regarding how and the extent to which CCSs are supporting families experiencing DFV and how effective they are at doing so. To support the consideration of these research questions, the analysis extended to an examination of data assessing the extent to which CCSs were meeting the needs of the children and families using them.

Key findings in relation to Research Question 6 (culturally appropriate services) are summarised in each of the following themes.

First Nations and CALD Families

First Nations clients were overrepresented among in scope CCS clients (8%–9%, compared to 3% of the population). Proportionately fewer clients were from CALD background (3%–4%; compared to 21% in the population) and 1 in 10 were reported as having a disability. Single-parent families were the most common in term of household composition.

Professionals' views of the extent to which CCS services were accessible for First Nations and CALD clients varied substantially, with CCS professionals more likely agree that services were accessible compared to referring professionals. There was a similar difference in response patterns on the issue of culturally safe service provision.

Most CCS or service provider professionals answering in the affirmative in relation to accessibility for First Nations peoples indicated that CCS staff were in receipt of specialist First Nations or cultural inclusion training and resources, or the CCS had established links with First Nation service providers, or the CCS's recruitment of First Nations staff members. Participants also referenced the location of the service, waiver of fees and the inclusive and non-discriminatory values of staff and welcoming environment and culturally inclusive facilities.

Professionals disagreeing that the CCSs in their area were accessible for First Nations families most commonly indicated that CCSs lacked sufficient specialist services and cultural competency to support First Nations families. A substantial proportion of participants referenced the lack of, or absence of, CCSs in the areas local to First Nations families, and issues with transportation to the CCSs as impacting accessibility. Some professionals also described how the 'structure, design and set up' was 'unlikely to feel natural and respectful of culture' and may 'further entrenches belief of unnecessary government intervention and control in their lives'.

Significantly, less than half (47%) of professionals participating in the Survey of Professionals agreed that the CCSs were culturally safe for the children using them.

Qualitative responses describing why the services were not culturally safe from a First Nations perspective most commonly described an absence of or inadequate culturally appropriate practices from a First Nations perspective and the absence of First Nations-led services. Participants agreeing that the CCSs were culturally safe referenced the specialist First Nations cultural awareness training and resources and First Nations staff. Services that indicated their CCS was culturally safe frequently mentioned the presentation of their CCS and some specifically mentioned cultural advisors or workers supporting First Nations inclusion.

More specifically, qualitative responses from the Survey of Professionals describing why the services were not culturally safe from a CALD perspective, referenced inadequate access to interpreters and a lack of CALD staff (including bilingual supervisors) whereas those answering in the affirmative referenced access to interpreters, the accommodation of culturally significant celebrations and the employment of CALD staff or volunteers.

On another measure of cultural accessibility, the provision of interpreting services, the RFI data showed that most services facilitate interpretation for intake and assessment (9 in 10) and for supervision services (almost 6 in 10). The vast majority of CCS (88%) did not charge fees for interpretation services.

Participants in parent/carer interviews presented a mixed picture of cultural safety. From a positive perspective, these parents and carers acknowledged their CCS had some culturally appropriate services available, particularly translation services. However, some parents and carers described experiences of feeling judged in a negative

way by some CCS staff and these experiences were linked to an absence of cultural safe and trauma-informed practices, with the failure to acknowledge the traumatic experiences of the children using the service.

Interviews with First Nations professionals provided insight into the challenges First Nations families can experience accessing CCSs and strengths and limitations when implementing cultural safety. When accessing services, the location of CCSs was an added barrier particularly for First Nations families in rural and reginal areas. This was consistent with the location issues raised in the Survey of Professionals. Reluctance to seek help from government-related services, in part linked to experiences of government intervention in First Nations families, and financial costs were additional barriers to accessing CCSs. Practices that implement cultural safety for First Nations families highlighted the importance of CCSs having specialist First Nations staff and support people (e.g. Elders) and ensuring CCS staff are trained appropriately in trauma and cultural awareness from First Nations perspectives. First Nations professionals also described the importance of adapting the structure of service provision to the individual needs of families, including First Nations families for cultural safety by consulting with them, especially supervised time with children outdoors and with kin.

Disability

Parties were more likely to report CCSs to be accessible for people with a disability as compared to First Nations and CALD families, referencing the building and facilities as suitable for people with a physical disability or that the staff were trained in disability (including mental health issues) and that they included the disability needs in families' management plans. Professionals (as well as parents and carers) who were not in agreement, cited issues with transport to travel to CCSs for people with a disability and that staff were not sufficiently trained in the disability (particularly in relation to children experiencing mental health issues or neurodiversity).

The RFI data also identified culturally safe and inclusive practices employed by CCSs in line with the affirmative responses but acknowledged the costs and resource constraints that limited implementation.

Domestic and family violence

ey findings in relation to Research Question 7 (support for families experiencing DFV) included that families accessing CCSs were characterised by complex needs and risk issues. Although not exclusive to families characterised by DFV, the DEX data identified that approximately 4 in 10 clients were identified as needing assistance with family functioning and more than 1 in 10 required assistance with personal and family safety. The Survey of Parents and Carers also highlighted the range of complex issues faced by families accessing CCS services. Issues relating to emotional abuse or anger issues, mental health issues and violence or dangerous behaviour were all commonly reported. Nearly three-quarters of parents and carers interviewed reported safety concerns and for the Lives with parent, these concerns most frequently involved multiple risks.

Two thirds of professional participants in the Survey of Professionals agreed that CCSs were appropriate for families experiencing the complex risk issues associated with DFV (62%). Qualitative insights from professionals into the ability of CCS to adapt to meet the needs of children and families indicate that strengths include a child-focused approach employed by CCSs, and their neutral and independent approach to service provision. The limitations for CCSs in this respect centred around their having to work within the constraints of the court-ordered arrangements and how facilitating court ordered parenting time had the potential to place staff and families at risk of harm.

Most parents and carers participating in the Survey of Parents and Carers identified CCSs prioritised the safety of their child (79%), and 75% agreed that the CCS was safe and appropriate for family members experiencing family violence.

Client expectations and needs

In relation to meeting clients' expectations and needs, the DEX data show that most clients assessed had an overall positive outcome in relation to Circumstances, Goals and Satisfaction DEX outcome measures in both 2019 and 2022, with satisfaction being particularly high (80% or higher). This pattern is evident regardless of age groups and gender. In relation to negative outcomes for goals, clients' reports were higher in 2022 than in 2019.

In relation to child clients, a higher proportion of boys than girls reported an overall positive outcome across circumstances and goals in 2019 but in 2022, there was little difference in circumstance and goal SCORE data between boys and girls. Although boys had a higher proportion having an overall positive outcome compared to girls, it is important to point out that numbers of boys and girls assessed for SCORE were small in 2019. The

proportion of boys with an overall positive outcome in circumstances and goals declined from 2019 to 2022; however, the proportions for girls in these two areas remained stable.

Positive client outcomes emerged overall across states/territories and regions, and higher proportions of clients in Western Australia, Victoria and Queensland than other states had an overall positive outcome in circumstances and achieving goals, but an overall positive outcome in satisfaction was higher in Tasmania and Queensland.

While in 2019 the proportion of clients with an overall positive outcome in circumstance and goal was lower in outer regions and remote areas, compared to major cities, the differences were no longer apparent in 2022. Clients in outer regions and remote areas had an overall positive outcome in satisfaction compared those in major cities and inner regions and this pattern was evident in both years.

Overall, client outcomes for CALD clients, clients with disabilities and First Nations clients were similar to those of other clients although, in 2022, overall positive outcomes in circumstances and achieving goals were lower for CALD clients. Importantly, First Nations clients had higher overall positive outcomes in satisfaction than non-First Nations clients and similar positive outcomes in circumstances and achieving goals. The data also show that the proportion of clients with an overall positive outcome in circumstances and achieving goals increased for clients with a disability between 2019 and 2022.The data show, however, that in 2022, overall positive outcomes in circumstances and achieving goals were lower for CALD clients.

More nuanced insights are provided by data from the Survey of Parents and Carers and qualitative data from the interviews with parents and carers showed that there were varied experiences of CCS use and how this affected participants relationships with their children. Among survey participants, approximately one-third reported that that there was a positive change; a further one-third reported that there was no change and 15% reported a negative change. There was a statistically significant difference between the reports of Spends time with parents and Lives with parents, with the more than more than half of Spends time with parents reporting a positive effect on their relationship with their child (cf. 15% for the Lives with parent).

Parents and carers' qualitative insights in relation to the positive effects referenced the facilitation of a relationship in circumstances where this would not otherwise be possible, as well as the skill and experience of staff supporting the Spends time with parent to engage with their child.

Parents and carers described negative effects identified damage to their relationship of trust with a child expressing views against time with their other parent/carer, and behaviour changes on the part of the child before and after visits, as well as arising from effects of travelling long distances.

Insights from professionals and parties regarding the strengths of CCSs ability to adapt to meet the needs of children and families focused on the safe, affordable and child-focused and trauma-informed approach of CCSs. Limitations centred on an absence of flexibility to adapt to families' needs, specifically CCS provision being constrained by court orders, as well as funding constraints limiting service availability and adaptions to this service provision, including the wraparound service provision or modifications to the current model to meet the needs of First Nations and CALD families.

Changes suggested by parents and carers and professionals

Changes recommended by parents and carers to better meet their needs included further resourcing for staff training to support neutral, professional and trauma-informed practice, improved communication with parents and carers, including consistency in communications provided by staff, accuracy in CCS reports and improved engagement with children and family members to provide feedback on the service provision. Measures to support greater accessibility identified by parents and carers included: greater availability of CCS services, including a reduction in time awaiting services; increased days and hours of operation and local accessibility to CCSs; a simpler/easier application process, offsite supervision, sessions with multiple children; the provision of mediation and other support services and the provision of real time reports to support the identification of issues experienced by children during supervised visits.

In relation to children's needs specifically, parents and carers recommended changes to facilitate greater understanding of children's diverse needs, behaviour changes and experience of distress, and access to support services.

Professionals similarly focused on additional funding to support increased and more flexible service provision and to address the shortcomings in facilities to better support the safety of families using the service; the application of resources to interpretation services; resourcing support services within or external to the CCS to address the complex needs of the families accessing them; improved pay and conditions, training opportunities and guidance for CCS staff, particularly in relation to child-safe and child-inclusive practices, including to terminate visits where

the child's best interests directed this outcome; more flexible and creative transitional arrangements and options for more limited 'identity contact' for children.

Reflections from First Nations professionals about changes to improve CCSs reflected their views about cultural safety, particularly that CCSs need to strengthen cultural safety by implementing the types of practices First Nations professionals engage in. Strategies to implement outreach services included increasing opportunities for time with children to be supervised in culturally appropriate settings, such as outdoor activities, having CCS professionals going out into communities and developing a service model similar to Aboriginal Controlled Community Organisations. Holistic service provision was also endorsed from a First Nations perspective, including family therapy and specialised counselling for children. Improving information communication and education about CCSs and implementing court orders was recommended to support First Nations families better towards self-management.

6 Summary and conclusion

This report presents findings from the mixed-method Evaluation of the Children's Contact Service Activity based on:

- a desktop review of literature, empirical evaluations of CCSs undertaken to date and commentary together with departmental and sector materials relevant to the introduction and operation of CCSs in Australia since 1996
- an analysis of administrative data drawn from the DSS Data Exchange (DEX) and from the Request for Information (RFI) for data drawn from service provider client record management system and program policies
- an analysis of quantitative and qualitative data from a national survey of service providers, service management personnel, supervision staff and legal and non-legal professionals referring families to CCSs (Survey of Professionals)
- an analysis of qualitative data from semi-structured interviews with First Nations professionals working with First Nations families
- an analysis of qualitative data from the semi-structured interviews with parents/carers
- a Survey of Parents and Carers, including the collection of data in relation to their children's views and experiences of CCSs.

This chapter synthesises the findings set out in the preceding chapters to address the research questions that have guided this evaluation. Recommendations are set out at the end of this summary of findings.

Responses to research questions

Research Question 1

How and to what extent are CCSs providing safe, reliable and neutral places that:

- facilitate changeover and supervised time
- undertake intake, initial and ongoing risk assessment of family members
- provide child-focused information to families
- orient children to the service setting and surroundings
- make referrals and regularly review changeover and supervised time with the goal that families will graduate to self-management where it is safe to do so?

The evidence from the RFI, the Survey of Professionals, the Survey of Parents and Carers and qualitative interviews indicates that, overall, majorities of stakeholders (families as well as CCS professionals and referring professionals) report CCSs to be providing safe, reliable and neutral places for the provision of supervision services. Variations were nevertheless evident in the response patterns of CCS professionals in the RFI and Survey of Professionals, compared to responses of referring professionals in the Survey of Professionals and the parents and carers in their survey and interview data.

Facilitating changeover and supervised time

The RFI data and DEX data, supported by the survey data, show that CCSs are delivering their core services, supervision of changeover and supervised visits for parenting time to an increasing number of clients after a decline during the COVID-19 pandemic, although not as yet at pre-pandemic levels. More clients engage CCSs for supervised visits (n = 7,882) than for supervised changeover (n = 4,301) although supervised changeovers were generally provided over a longer period of time than supervised visits for parenting time (approximately 48 weeks for changeovers; cf. 36 weeks for supervised time).

The data show a steady decline in the number of clients reported to be involved in low vigilance supported/monitored onsite contact sessions, and small numbers of CCSs reported having clients involved in unsupervised onsite visits or community-based, offsite supervision services and virtual/online visits. Some First Nations professionals and some parents and carers indicated that this type of service was more natural and less contrived for families and children, suggesting that this type of transition service may be an area for CCS development.

Intake and initial and ongoing risk assessment

Detailed analysis of the intake, triage and risk assessment process for families applying to use CCSs through RFI and survey data indicated comprehensive intake and risk assessment processes across the participating CCSs, with a range of risk assessment tools and processes employed. The data also show that CCSs described how they undertake ongoing risk assessment for the duration of the service delivery. It is notable, however, that despite the intake and risk assessment processes in place, some parents and carers in the interview and survey data raised safety concerns for both them and their children, with either concerns with or a lack of knowledge of CCS safety planning reported by some participating parents/carers,.

Orientation/familiarisation for children and child-focused information

The RFI data relating to orientation/familiarisation processes for families entering the CCSs highlighted the child-focused and child-inclusive nature of this process for the majority of services. This involved CCS reports of supporting children to receive information about the CCS and the process, allowing the child to explore the CCS setting, and supporting the CCS staff and child to develop a relationship of trust and for the child to understand the support that they will receive when at the service.

It is again notable, however, that very few parents and carers who were interviewed could recall orientation/familiarisation being offered to their children or themselves. This mismatch in the data from CCS professionals and from parents and carers in relation to orientation/familiarisation suggests that the sessions were not sufficiently signposted for families, that they were not sufficiently comprehensive in nature or that families needed greater support, including from DFV and trauma-informed approaches, to receive the benefit of these sessions. The experiences of those parents and carers who recalled and described their family's orientation/familiarisation session varied considerably. Some parents reported that they and their children were well supported while others reported mixed feelings or that they or their child were not well supported in the orientation/familiarisation process.

Child-focused information, referrals and regular review

Quantitative and qualitative insights in relation to the number and nature of non-supervision services provided by the CCSs identified services ranging from the provision of information and case support services and referrals to relevant support services, case management and periodic review of families' trajectories in the service.

The RFI data show that almost half of the participating services reported providing advocacy support (45%) and information and referrals for children (44%). The open-text RFI responses also provide insight into the child-focused information and education opportunities and referrals provided to families. These data are indicative of the nature and provision of this information and referrals at each stage of a family's engagement with the CCS process, from the point of intake and orientation/familiarisation through to case review.

There were, however, gaps in referring professionals' knowledge of non-supervision services and referrals, and it was uncommon for parents and carers to report having received non-supervision services, including referrals. Parents and carers indicated that they would welcome greater provision of these non-supervision services including to support their receipt of relevant support services, given their direct engagement with CCSs. The contrast of their reported experience with the reported position of CCSs requires attention. Professionals'

responses may reflect more limited direct and current engagement with services on the part of referral agents but it may also be due to an absence of, or limited available and up-to-date information, about the range of services provided by CCSs. Parents' and carers' responses may reflect that further consideration needs to be given to effective communication by CCSs to them about the availability of additional services and referrals.

Together, these data suggest that at a minimum there is a need for improved dissemination of information about CCS service provision, and may also suggest a requirement for more effective, warm referral processes by CCSs to support families to access the non-supervision services that they need.

In relation to the review processes of changeover and supervised time arrangements with the goal of self-management for families, the RFI data indicated a program of informal as well as formal reviews was also evident in the responses provided by some CCSs. This occurs through a range of approaches including informal reviews after each session, periodic case plan reviews (including every 6 weeks and more formally on a 3 monthly basis, client-informed reviews and post-service reviews). Some CCSs described a process of reviewing a family's goals, with some CCSs describing how they engaged with clients to set short-term and long-term goals as an integral part of this review process. Some CCSs described a family and child-focused holistic approach that directed attention to facilitating families to engage with relevant support services to address the family's underlying needs and which affect their potential to transition to self-management. Interviews with parents and carers did not ask participants directly about review processes.

Research Question 2

How and to what extent are CCSs helping families to graduate to self-management (where this is safe) or to achieve sustained and workable long-term parenting and time arrangements?

The evidence from the RFI, the Survey of Professionals, the Survey of Parents and Carers and qualitative interviews show that CCS clients are moving to self-managed arrangements and that, despite their limitations, most professionals are of the view that CCSs are successful in providing the support and services that families needed to safely move to self-management. Parents and carers were mixed in their views about being able to move to self-management. Although there were concerns by professionals and parents and carers about the safe and successful transition, the not insignificant numbers of families returning to CCSs and endorsement by a majority of professionals suggests that CCSs are playing an important role in supporting the achievement of sustained and workable long-term parenting and time arrangements.

Number of families transitioning to self-management with support of CCS

The data from most CCSs participating in the RFI indicated a relatively steady pattern of clients transitioning to self-management, with the highest number of clients moving to self-managed arrangements in 2022 (n = 2,299), and not insignificant proportions (between 18%–22%) returning to the service after transitioning to self-management.

More than half of professionals participating in the survey (61%) agreed that CCSs were successful in providing the support and services that families needed to safely move to self-management. Time-limiting services, case management and transitional arrangements, together with facilitating access to therapeutic support for parents and support for children, were strategies identified by professionals as provided by CCSs to help families to move to self-managed arrangements.

Of particular significance, parents and carers who participated in this evaluation were mixed in their views about being able to move to self-management, with a substantial proportion of parents indicating that they did not know whether they would be able to manage their parenting arrangements without the CCS. Parents and carers who were using the CCS for supervised visits, rather than changeover, responded most frequently that they did not feel able to move to self-management in the future. The main reason for this conclusion were reports of not feeling that it would be safe to stop using the CCS, including because the Spends time with parent is using substances (including drugs and alcohol), a lack of trust in the Spends time with parent to comply with what had been agreed, or ongoing fear on the part of the responding parent or carer in seeing or interacting with the Spends time with parent. Court processes were another factor in parents and carers considering that they may not be able to move on from using the CCS, describing the process as slow to make any changes to orders and

final orders requiring ongoing supervision, meaning that there was a feeling that the family was 'stuck' in the situation of using the service.

For the parents and carers who were more confident of their family's ability to manage changeovers or supervised time in the future without the CCS, the age of the children seemed to be a significant influencing factor, with the child thought to be better positioned to act protectively as they age and with changeovers able to take place at school or the child having the ability to travel to the other parent or carer's home without them. Only a small minority of participating parents and carers indicated that they had been able to build better communication with the other parent or carer during their use of the CCS and so could make plans around the children more easily in the future.

CCS strategies to support families to transition to self-management

The RFI and survey data presented a range of strategies that CCSs applied to facilitate the transition to self-management including case management (involving period reviews) and referral to support services, with these evident in both the RFI and survey data. In addition to the review process (noted in more detail in relation to Research Question 1), CCSs reflected in their RFIs how they operationalised the Guiding Principles Framework objective of transitioning to self-management in their policies and practices.

The RFI data indicated that most CCSs reported the provision of time-limited services or review of cases with a view to supporting families to transition to manage their arrangements for parenting time without their service. Reports of time-limited service provision were more likely from CCSs in inner regional areas compared to major cities (42% and 19% respectively) and CCSs based in outer regional areas (38% for both changeover and contact). Independent CCSs were also more likely to report that supervised changeover sessions are not time limited (57% and 36% respectively).

The data from professionals participating in the survey indicated that by providing supervision services, CCSs were seen as facilitating parents and carers to transition to self-managed arrangements by 'creating a safe' and neutral 'space for all to learn and grow' and to develop their skills and confidence, including by CCS staff modelling child-focused and safe engagement with the child and communication with the other parent/carer and an opportunity to re-establish a positive relationship of trust with their children.

Active engagement by CCS staff was also identified by some participating professionals, involving CCS staff helping families to safely move to self-management by:

- supporting families to develop strategies to support their children, employing a strengths-based approach and offering or coordinating or facilitating warm referrals to education, therapeutic and support services
- providing support to the children and facilitating engagement with children to hear their views about visits and how the CCS may support them
- case review, including with clients to focus on planning and reviewing goals, with time-limited services providing a motivation for change
- preparation of CCS reports that provide evidence of the interactions between the child and parent at the CCS and that can inform decisions about whether it is safe for a family to move to self-management
- case management process as part of a case review process that provides scaffolding through a 'step-down' or graduated approach to progress to self-management; for example, where parents meet at changeover before moving to self-management.

CCS role and resourcing to facilitate transitions to self-management?

The examination of submitted policy documents (including application forms, service agreements) as a part of the RFI process indicated variability in the interpretation of the goal of moving to self-management (see further answer to Research Question 5). However, and critical to answering this Research Question 2, most professionals agreed that CCSs needed to support families to safely move to self-manage their parenting arrangements (77%) and to support families to achieve safe, sustained and workable long-term parenting and time arrangements (80%).

Notably, CCS professionals were more likely to consider facilitating moves to self-management to be the role of CCSs than referring professionals to a statistically significant extent. Referring professionals raised a range of concerns relating to moving to self-management including the role and expertise of CCS staff in facilitating this and regarding safety concerns about self-management, including in circumstances involving DFV, disability

or substance misuse issues. Some professionals were supportive of CCSs facilitating the transition to self-management but identified the decision to move to self-managed arrangements as the prerogative of the court rather than the CCS when the family is engaged in relevant litigation. These participants emphasised a delineation of roles among the relevant professionals in the family law service system with respect to decisions about, and facilitation of, transitions to self-management. There were also some professionals who indicated that CCSs were well placed to facilitate the holistic response by way of access to the support services that families needed to address their underlying risk issues. Other professionals indicated that it was the role of CCSs to manage families' transition to self-management, or that CCSs did not have the expertise or information, or were not in the best position due to service demands and funding to determine transition to self-management.

Professionals also described a range of circumstances where long-term or indefinite supervision arrangements may be required because self-managed arrangements were not safe or feasible but it was nevertheless determined that some contact was deemed to be in the best interests of the child. These circumstances included illness, injury or disability including acquired brain injuries, mental ill-health, homelessness and substance abuse or to support limited 'identity contact' (commonly nominated as involving 4 sessions per year).

The responses from both professionals and parents and carers indicate concerns that CCSs are compensating for structural issues that create challenges in service provision, particularly in response to people who use violence, including through inappropriate or unsafe referrals to CCSs.

Research Question 3

To what extent do CCSs provide independent written reports of families' interactions with their service and the changeovers and/or contact sessions to family law courts?

What are the nature and quality of these reports and how are they used to inform the decision-making process?

The RFI data, together with the quantitative and qualitative data from professionals and from parents and carers, show that CCSs commonly prepare and release reports in relation to families' receipt of supervision services for family law court proceedings. However, quantitative and qualitative data also show that not all CCSs provide CCS reports, with some CCSs instead facilitating access to their case notes through the subpoena process. The data show that there were variations in the content of the reports but that most participating professionals indicated that the reports were of high quality. There were differences between CCS professionals and referring professionals in this regard, with CCS professionals more positive about the quality of these reports. The data suggest that consideration should be given to issues of consistency of content and quality to ensure that they better inform the decision-making process regarding the parenting and time arrangements that are in the best interests of the child.

Number of CCS reports

The RFI data show the number of clients for whom a written report had been prepared in relation to their family's receipt of supervision services for family law court proceedings, with a 4-year high in the number of reports prepared in 2022 (n = 8,078). There was a modest reduction in the number of clients with reports prepared during the COVID period (2020: *n* = 6,926 and 2021: *n* = 7,777) compared to the pre-COVID period (n = 7,844).

The total number of clients as reported by CCSs over those same years (2019: *n* = 12,168, 2020: *n* = 9,893, 2021: *n* = 10,324 and 2022: *n* = 11,365) indicate that the number of written reports as a proportion of total clients varied between 65% and 75% between 2019 and 2022.

Data from the RFI also showed that more than half of the participating CCSs (n = 30/54) provided information indicating the number of written reports provided by their CCS in the period 2019–2022.31

In an alternative approach to providing a report, some CCSs provide the original source documents, pursuant to a subpoena. It is notable that some CCSs have elected to require a subpoena seeking the provision of documents, particularly with the advent of technological advancements to support the collation and copying of these

31 As all RFI questions were voluntary, this does not mean that *n* = 24 CCS did not provide written reports, it is possible that some of these services did provide written reports but were not able to extract the number of such reports from their systems. However, this finding does give a sense of how commonly written reports are provided by CCS organisations.

materials, rather than allocating resources (including training in report writing) to prepare a report on which they may be cross-examined.

Nature of CCS reports

CCS reports are intended to provide 'a written, objective account of a family's time at a service compiled from the file notes recorded by CCS staff at the time of each service session' (AGD, 2018, p 7). Data from the RFI indicate that written reports of observations of the child with the parents/carers were based on case notes made by CCS supervisors completed in relation to supervised changeover or supervised parenting time sessions. Some RFI responses indicated that they were compiled by staff trained in case noting, and 'audited by the program manager'.

Although the RFI open-text responses indicate that the reports are 'observational only' and included 'factual, objective observations' rather than assessments or recommendations, one participant indicated that they included recommendations 'with a strong focus on the best interests of the child'.

CCS reports were identified as playing a significant role from an evidentiary perspective in informing decisions about service provision and potential progression to self-management of parenting arrangements. They did so by providing 'a picture of the relationship between child and parent and flag[ging] any concerns' and 'this can be used to make more informed decisions about whether things can move to safe independent management'. A small number of professional participants did, however, raise concerns about the potential for written reports to be a tool for systems abuse given their use in the legal context and the potential implications for families.

Written reports were mentioned as very important by parents and carers who were interviewed, although it seemed that the term 'written reports' was used by some to refer to notes kept by the CCS and by others to mean written reports for the court. For parents and carers not subject to supervision (usually mothers), it was reassuring to know that the CCS kept a record of what had happened during visits. For parents and carers whose time with their children was being supervised, reports could reassure the other parent and, for those engaged in parenting litigation, provide important evidence to support their case.

Quality of CCS reports

Most professionals (62%) indicated that they agreed that the written reports provided by CCSs were of high quality but statistically significant differences were recorded between CCS professionals and referring professionals on this question (81% vs 44%; cf. 26% of referring professionals indicated that they did not know the quality of these reports).

These differences may reflect variations in views on the part of referring professionals and CCS professionals about the purpose of these reports, and in their assessments of the quality of the content of these reports from a legal and evidentiary perspective including the extent to which the qualifications of the CCS professionals provide sufficient basis for reliance on the content of these reports. In either instance, this mismatch in expectations is critical given the confines within which CCS professionals can provide these reports (noting that they intended to be observational in nature and that CCS professionals may not have a detailed appreciation of the rules of evidence) and that they are requested by parties or legal representatives as part of the evidence in parenting matters pursuant to Part VII of the FLA.

Positive responses cited reasons including the comprehensive nature of the reports and the detail provided, the inclusion of child reviews, and the clarity and neutrality of the observational notes. Areas for improvement included the need for greater presentation of the child's perspective, information about risk assessments and more detailed and neutral accounts of the sessions. Increased training and support regarding report writing were suggested by some participating professionals to assist the preparation of reports of good quality, which are child and family-focused and trauma-informed, to ensure that reports are not perceived to be biased, and to accurately document the behaviour and interactions at the supervised sessions.

Research Question 4

Are the service models provided child-focused/child-centred and trauma-informed? To what extent do the services comply with the National Principles for Child Safe Organisations?

Quantitative and qualitative data captured in the RFI process, the Survey of Professionals, the Survey of Parents and Carers as well as qualitative data from interviews with parents and carers indicate how service models and

practice are child-focused/centred and trauma-informed, and in large part reflect compliance with the National Principles for Child Safe Organisations as required by the Grant Opportunity Guidelines for the CCS.

Embedding child safety and wellbeing in policies and procedures

Overall, the data indicate that child safety and wellbeing are embedded in CCS organisations to varying degrees through their policies and protocols, with the safety protocols and prioritisation of the child's best interests strongly indicated in the policy and procedure material submitted by the participating CCSs. A small number of CCSs specifically identified training in relation to the National Principles for Child Safe Organisations, suggesting that for these services, and for services indicating child safe training and professional development more generally, the embedding of child safe principles was supported by these training and professional development practices (Principle 1).

The DEX data relating to child clients, together with the articulated review processes of some CCSs that seek feedback from children regarding child safe practices and approaches, also suggest compliance (Principle 9). However, it was unclear from the data as to the knowledge that children and families have of child safe policies and how accessible these materials are to them (Principles 9 and 10). Some RFI responses provided specific detail about their child safe policies and a substantial proportion provided responses detailing their training for staff specific to child safety (see further below).

Details of complaints policies were more limited but information provided in the RFI suggests that some CCSs have practices in place to case manage and review families engagement with the service and to manage complaints in a trauma-informed and parent and child-focused manner. Some also indicated a child-inclusive approach to their service feedback mechanism, and the data relating to critical incident reporting supports this observation (Principle 6).

Staff capacity in relation to child safety and wellbeing, appropriate training and equity and diversity

Data from the RFI suggest that the recruitment and onboarding of staff and the staff checks facilitate the recruitment of child safe staff and the training and staff development activities outlined in both the RFI and Survey of Professionals indicate compliance (Principles 5 and 7). Specifically, the RFI data indicate that almost all require police and working with children checks (96%) and that CCSs seek to employ staff with qualifications across a range of relevant fields and with skills and experience in working with parents and children impacted by and/or using DFV.

The RFI suggest that CCSs and their service provider organisations provide regular and ongoing opportunities for education and training of staff in relation to child safety and wellbeing and trauma-informed practice and child-inclusive practice to skill staff to respond effectively to issues that emerge in relation to child safety, but to a lesser degree in relation to children's cultural safety. CCS professionals' reports in the Survey of Professionals regarding training undertaken anytime in the past or in the 18-month period preceding the survey suggest improvements may be required more generally, with approximately half of CCS professionals indicating that they had undertaken training in child safety, child abuse and/or neglect, cultural awareness training for First Nations families, child safe practice and trauma-informed practice in the past 18 months (47%–54%). Less than half of CCS professionals reported cultural awareness training for CALD families (44%), child-inclusive practice (39%) and service provision for adults or children with a disability (18%) in the 18-month period preceding the survey. Notably, some participants in the Survey of Professionals also raised concerns about the training and quality of the CCS staff when reflecting on aspects of CCSs that they were dissatisfied with, particularly in relation to dealing with traumatised clients and a lack of trauma-informed practice.

Safety of physical and online environments

The data relating to risk assessments in the RFI show the identification and assessment of, and response to, risk to child safety is prioritised although there were mixed reports from referring professionals and parents and carers in this regard. The security arrangements described by most CCS sites, including the separate entrances, security cameras, staggered arrival and departure arrangements, the two-worker model for onsite service provision and arrangements in relation to risk identification and mitigation for online/virtual visits also suggest compliance with the National Principles for Child Safe Organisations (Principle 8).

The quantitative data show that most professionals and parents/carers identified CCSs as physically and emotionally safe for the children using them, and engaging in child safe, child-focused, child-centred and child-inclusive practices.

Specifically, data from the Survey of Parents and Carers indicated that, overall, there was positive endorsement by parents and carers of their children's experiences using CCSs, with 78% of parents/carers reporting that their child's safety was adequately considered; 74% reporting that their children were at ease/comfortable with the CCS staff and 74% reporting that their children felt safe at the CCS. There were differences in parents and carers reports where they had a CALD background in relation to whether the child's needs were adequately considered, whether they felt safe at the service and whether their experience of the CCS had improved over time (although caution is required when interpreting these data given the small size of the CALD sample).

The Survey of Parents and Carers data also indicated that there were quite varied experiences in terms of CCS use and how this affected participants' relationships with their children. Approximately one-third (34%) of parents and carers reported no change; another third (34%), reported a positive change and a further 15% reported a negative change.

Qualitative data from interviews with parents and carers who expressed a view about how their children felt about attending the CCS, were evenly divided between 2 groups: those who reported entirely positively, and those who had mixed views. Parents' and carers' main reasons for why children felt positive were that using the CCS meant that their children were not exposed to parents' conflict, were able to spend time with the parent subject to supervision (usually the father), were comfortable with the CCS staff, that the CCS facilities were fun for their children, that their children felt safe there, and that attending was now part of their children's routine. Among these responses was an emphasis on CCSs as child-friendly, caring and welcoming places. Concerns expressed by parents and carers regarding how their children felt about attending the CCS were that their children did not want to go, were attending only because they had to, and were unable to express concerns about whether the visit should proceed, and regarding children's mood or behaviour before or after visits.

While some parents and carers described approaches to risk assessment and safety planning that were consistent with the thorough processes identified in the RFI data, some qualitative data from parents and carers highlighted concerns. Some parents and carers indicated that they did not receive or were unaware of the safety planning activities at the CCS or that their safety concerns persisted. On the other hand, parents and carers identified benefits to their children of using the CCS to include the opportunity to build a relationship with the visiting parent or carer and to experience safe and enjoyable time with them, and children becoming more confident with them as the relationship developed.

Although 77% of professionals participating in the Survey of Professionals identified CCSs as physically and emotionally safe, only slightly more than half of participating professionals (58%) agreed that CCSs had a positive effect on the wellbeing of children. Some professionals raised concerns that risks to children's physical and emotional safety may nevertheless remain despite the arrangements put in place by the CCS, including in circumstances characterised by family violence. Notably, less than half of professionals (47%) agreed that the services provided by the CCSs in their area were culturally safe for the children who use them, with participants raising significant concerns about the ability of CCSs to meet children's cultural safety and needs arising from disability.

CCS participants in the RFI and Survey of Professionals also provided insight into the initial and ongoing application of the risk assessment and risk management processes, and the decline or withdrawal of services by CCSs, which was primarily due to increased risk to safety including safety risks to the child and other parent and on the basis of child refusal or distress or otherwise on the basis that the commencing or continuing the service is not in the best interests of the child. Some RFI responses illustrated how CCS staff were able to identify trauma in the presentation of CCS clients and had an understanding of how trauma affects children and their families and how the CCS needs to respond and tailor their service provision. CCS policies and practices relating to the decline or cessation of visits reflect a trauma-informed approach and an intent to avoid re-traumatisation. Ongoing risk assessment and review practices outlined in data from the RFI illustrated how concerns about child safety and wellbeing were identified (e.g. through mid-session check-ins and child-inclusive practice approaches) and information sharing arrangements through CCS reports, provision of subpoenaed material and notifications to child safety departments. Professionals participating in the survey also emphasised the child-focused and child-centred approaches employed by CCSs and their staff as critical to service provision that was in the best interests of children.

However, data from some professionals and parents and carers suggest variations in the decline or cessation of service delivery in a trauma-informed way. As discussed further in relation to Research Question 8, most professionals were in agreement that CCSs could refuse to facilitate supervision arrangements in court orders where they did not consider this to be in the best interests of children (65%) and that the services provided by CCSs addressed the needs of the children using them (60%).There were again a statistically significant difference

between the responses of CCS professionals and referring professionals, with referring professionals being more equivocal in their responses. Significantly, qualitative responses also highlighted concerns on the part of some professionals that CCSs did not decline service provision that was not consistent with children's best interests, with several participating professionals providing open-text responses raising concerns specifically in relation to the making of unsafe parenting orders that underpinned the referrals to CCSs, including in cases characterised by family violence or other significant risk.

Additionally, the data relating to collaborative service provision, particularly for CCSs in supporting children and their families to access the therapeutic and other support services that they may need reflects a mixed picture. Data relating to the types of referrals CCSs made show that participating CCS professionals were more likely to report all CCSs make the referrals than were referring professionals, and they did so to a statistically significant extent. Parent and carer response patterns on this question were more consistent with referring professionals. Although these response patterns may reflect more limited direct and current engagement with services, given that most parents and carers interviewed stated that they had not received referrals from CCSs to external services (70%), the data may suggest not only a need for improved dissemination of information about these CCS services but also the implementation of targeted warm referrals.

Child participation and the provision of information promoting child safety and wellbeing

Consistent with the National Principles for Child Safe Organisations, and as noted in more detail in relation to Research Question 5, quantitative data from the Survey of Professionals in relation to a question about CCS compliance with the objectives in the Guiding Principles Framework indicate that, overall, most participants agreed that CCS service provision is safe (80%) and involved child-focused, child-centred service provision (79%) and child-inclusive service provision (74%). However, the data also identify statistically significant variations in the CCS professionals' and referring professionals' assessments in relation to the child-focused, child-centred and child-inclusive service provision.

Open-text responses regarding child-safe service provision emphasised the child-focused, child-centred and child-inclusive practices of CCS professionals including in relation to child orientation and familiarisation with CCSs prior to the commencement of sessions and initial and ongoing risk assessments (including through the use of child-specific risk assessment tools), child-led facilitation of contact to support the safety and wellbeing of children, as well as incorporating feedback from children about their service experience to improve practice.

Acknowledging the variations in perspectives regarding child orientation/familiarisation, together with policies and practice regarding cessation of sessions, RFI responses and the responses of some professionals and parents and carers indicate compliance with principles directed at supporting children to be kept informed about their rights and to participate in decisions regarding their involvement in the sessions in age-appropriate ways with staff with appropriate training in relevant areas. The provision of information during intake, including via application materials and service agreements, indicate compliance with National Principle 3 relating to the provision of clear and accessible information about CCS policies and practices to keep families informed in the promotion of child safety and wellbeing at the CCS. However, improvements in some CCSs' culturally safe practices would better support compliance with this principle. Measures for regular review of decision making relating to participation in sessions at the CCS and, to the extent that is possible, regarding their nature and progression also support compliance with National Principle 2 and related principles, as do the environments at the CCS sites that are welcoming and engaging for children. To varying degrees, the open-text responses captured in the RFI and the survey data indicate that children's participatory rights and role in decision making are prioritised both in the adoption of child-inclusive practices and mechanisms to support CCS staff to stop contact where the child's views or their behaviour, or best interests otherwise indicate.

As foreshadowed above, however, in contrast to the detailed descriptions of CCSs, very few parents and carers who were interviewed recalled orientation/familiarisation being offered to their children or themselves. Further the experiences of those who described an orientation process ranged considerably, and included parents who felt that they and their children were supported, those who had mixed feelings, and those who did not feel they or their child had been supported. Parents and carers also raised concerns in their interviews that indicated staff were not able or were limited in their ability to understand what the child wanted or needed, including staff having little or no time to debrief with the child prior to or after changeovers, limited skills of engaging with children who have disabilities, and children having difficulties communicating with staff. Several of the same reasons were reflected in parents' and carers' views on the positive and negative aspects for their child of the CCS and the services it provided. Negatives (which were less frequently expressed) focused on children not always being listened to or understood by CCS staff. Concerns were also expressed that were more focused

on supervision generally (rather than the CCS itself). Several also reflected on the artificial and restrictive environment, that CCSs may result in families not dealing with the realities of their relationship separation, and that attendance at the CCS resulted in stress, anxiety or trauma for children.

The concerns raised by parents and carers in their interviews also centred on perceptions of the CCS as not intervening when the child was distressed and not being accorded a voice in the process. An absence in continuity of staffing was identified by some parents and carers as detrimental to their children.

Research Question 5

Are CCSs operating in accordance with the Children's Contact Services – Guiding Principles Framework for Good Practice including:

- the role and obligations of CCSs
- the objectives for CCSs (child focus; safety; neutrality; client diversity and cultural sensitivity and collaborative service provision)
- the priorities for service delivery
- the range of services provided
- the service safety requirements
- record keeping, policies and procedures
- the good practice principles for service delivery and resources?

The RFI and quantitative and qualitative data from professionals and from parents and carers indicated that both CCSs' policies and their implementation of these policies in practice through their service delivery are largely consistent with the Guiding Principles Framework. Quantitative and qualitative data captured in the RFI process, Survey of Professionals and Survey of Parents and Carers, as well as qualitative data from interviews with parents and carers, illustrated how and the extent to which the implementation of policies in practice accorded with the Guiding Principles Framework.

CCS policy compliance with guiding documents including Guiding Principles Framework

The examination of CCS policy documents and descriptive data submitted as part of the RFI process, considered against the principles in the guiding documents, identified CCS policies and procedures as largely consistent with the principles in the guiding documents.

Specifically, safety protocols and prioritising the child's best interests are very strongly indicated in the policy and procedure material submitted by participating CCSs. The objective of safety was a key feature across all the policy document types, with safety covered in each of the document categories considered. The interpretations of the term 'safety' included consideration of physical safety as well as emotional safety, and service agreements mostly indicated the withdrawal of service for incidents in both these categories. Almost all policies indicated attention to technology-driven risks to safety and had clear policies around mobile phone use and the sharing of videos or photography. Child-focused practice was the next most commonly covered objective in CCS policy documents, with between 72% and 100% of the various document types covering child focus in their provisions.

RFI data regarding staff checks show that almost all CCSs required police and working with children checks (96%). Compliance with a code of conduct was less strongly evident at 56%. The RFI qualitative data indicated that CCSs nominated a broad range of staff qualification requirements in relevant fields such as social work, social science, psychology, counselling or community services and skills and experience in working with parents and children impacted by and/or using DFV. (See Survey of Professionals, Table A12, Appendix F indicating that a majority of CCS professionals report having this qualification (90%; 53% in last 18 months; 37% in the past).

Also relevant to compliance with the Guiding Principles Framework, reports of staff ratios to clients suggest strong levels of compliance with guiding standards. Most CCSs described their application of the 'two worker' model, supported by an increase over time in the average number of staff retained (average staff number of 9 compared to 7 staff in earlier years). The responses to the RFI also indicate that CCSs were often able to be flexible to increase staff ratios where families required this. Despite these improvements, CCSs also identified significant challenges to recruiting and retaining staff with the high level of skill required, due to the nature and timing of the work over weekends, the casualised workforce for some CCSs, the level of remuneration,

particularly having regard to the responsibilities in CCS professional roles, and the geographical locations of the services.

Definitions of what constitutes a critical incident mostly aligned with the outline provided in the Guiding Principles Framework and indicate that CCSs recognise in their policies that a critical incident should constitute a risk to life, health or safety. As discussed below, reports in relation to critical incidents indicate that the total number of critical incidents (n = 579 incidents) as a proportion of the total number of CCS clients was highest in 2022 (5.1%), with responses to these critical incidents including the cessation of the session and withdrawal of service.

In relation to client diversity and cultural sensitivity, most of the submitted client-facing documents, such as application forms and service agreements, included reference to whether a parent or child identified as First Nations or another cultural group and which languages were spoken at home. A majority of internal policy documents indicated that cultural competency training was mandated for staff and this was underscored by RFI responses on cultural training and culturally informed practices (see further chapter 5 and answer to Research Question 6).

Collaborative practices and referrals to other services were less visible in the policy material submitted but there appeared to be most variation in relation to principles specific to CCS service delivery. For example, approaches to neutrality and information sharing for reports were expressed and articulated to clients in different ways and with different emphasis. Where internal policy documents and procedural data indicated neutrality, this was primarily reflected in guidelines to staff for conducting supervised contact and changeovers. However, neutrality could be seen to be implied in many policy documents rather than explicitly indicated.

Of particular note in this context (and as noted in relation to Research Question 2) the examination of submitted policy documents (including application forms and service agreements) as a part of the RFI process also indicated variability in the interpretation of the goal of moving to self-management. Variations were exemplified by one CCS's service agreement indicating that service may be withdrawn if progress towards self-management could not be demonstrated, while another indicated that their service would cater for families on a long-term basis where self-management is not safe or feasible. These varying policy approaches may reflect differing approaches by CCSs to the application of their resources among families using their services and suggest a role for CCSs to support families where there may be no other options for maintaining parent contact. Notably, although self-management is a goal stipulated in the *Guiding Principles Framework for Good Practice* (AGD, 2018) and reflected in service policy documents, numerous CCSs indicated in their RFI responses that for some families, self-management was not feasible or safe. Furthermore, the RFI data indicated that self-management was not sustainable for around one-fifth (18%–22%) of families who return to the service after transitioning out, and that it is not known what happens when families have transitioned out of CCSs. These are additional considerations when assessing the goal of self-management.

Compliance of CCS service delivery with guiding documents including Guiding Principles Framework

Quantitative and qualitative data captured in the RFI process, Survey of Professionals and Survey of Parents and Carers, as well as qualitative data from interviews with parents and carers, illustrated how the implementation of policies in practice accorded with the Guiding Principles Framework.

Data from the Survey of Professionals relating to CCS compliance with the objectives in the Guiding Principles Framework in practice when implementing their service delivery indicate that, overall, most participants agreed that CCS service provision is safe (80%), reliable (75%), helpful (64%), neutral (65%), child-focused/child-centred (79%) and child-inclusive (74%). However, the data also identify statistically significant variations in CCS professionals' and referring professionals' assessments in this regard, except in relation to safe service provision.

Just under half of professionals were in agreement in relation to the achievement of collaborative service provision in practice, with statistically significant differences between CCS professionals and referring professionals. CCSs are an authoritative source of knowledge of the extent to which they are engaging in collaborative practices when providing their services. However, referring professionals (and parents and carers who were also in disagreement with CCS professionals), as the parties arranging (or in receipt of) these services, also have insight into the operation of collaborative practices where they access CCSs that do or do not incorporate collaboration with other service providers and professionals.

Consistent with the guiding standards, the RFI data indicate that staff training and professional development were also identified as priorities for most CCSs across a broad range of relevant areas and on an ongoing

basis. These areas included child safety, child abuse and/or neglect and child-safe practice, child development, DFV, trauma-informed practice, cultural awareness training, child-inclusive practice and to a lesser degree in relation to service provision in relation to children and adults with a disability. Additionally, some CCSs also detailed the supervision of CCS staff and in-house training that was undertaken to support ongoing professional development.

RFI data relating to physical site characteristics and specifications of CCSs also suggest that, overall, moat services meet the requirements of the guiding standards in relation to CCS required site specifications, with almost all participating CCSs indicating that they had developmentally appropriate supervision rooms and equipment (94%). Between two-thirds and almost three-quarters of CCS reported security cameras (72%), security doors (67%) and withdrawal spaces (67%). Separate entrances and exits (89%), outdoor play areas (89%), accessibility by public transportation (87%), facilities for older children (87%) and disability access (82%) were also frequently reported.

In relation to the range of services provided, the data examined in chapter 2 and presented in the answer to Research Question 1 above indicate that in addition to providing the core supervision services on site, some CCSs were also able to exercise flexibility in relation to facilitation of a range of supervision services (e.g. low vigilance onsite supervision, offsite or virtual supervision) or were able to take a flexible approach to the number of family members participating in supervised visits. These data also indicate strong uptake in relation to non-supervision services, including the provision of orientations and familiarisations, case management and review, CCS reports and referral to support services, although the variation in response patterns set out in response to Research Question 1 should be noted.

Of particular significance in relation to safe service provision was that although most professionals (77%) agreed that CCSs were physically and emotionally safe for the children using them, some professionals, and some parents/carers, raised concerns that risks to children's physical and emotional safety may nevertheless remain despite the arrangements put in place by the CCS, including in circumstances characterised by DFV. This concern is reflected in the data relating to inappropriate referrals to CCSs (see further Research Question 8) and also raises some fundamental questions about the extent to which orders or arrangements for supervised time (including in place of no time orders or arrangements) that are outside the scope of this Evaluation.

Reports in relation to critical incidents indicate that the total number of critical incidents as a proportion of the total number of CCS clients was highest in 2022 (5.1%), with the corresponding proportions lowest in 2020 (3.7%) and 2021 (3.8%).

CCS participants in the RFI and Survey of Professionals also provided insight into the withdrawal of services by CCSs. This occurred primarily due to assessment of increased risk to safety, if a client breached the service agreement, or where there was a child refusal to proceed with the visit or they were distressed.

Notably, fewer than half of professionals (47%) agreed that the services provided by the CCSs in their area were culturally safe for the children who use them, with participants also raising significant concerns about the ability of CCSs to meet children's cultural safety and needs arising from disability.

Research Question 6

To what extent are the services provided culturally appropriate for:

a. First Nations families

b. CALD families?

The data show that First Nations families and, to a lesser extent, CALD families are using CCSs; however, professionals varied substantially regarding whether CCSs were sufficiently accessible and culturally safe, with less than half of professionals identifying CCSs as culturally safe. Qualitative responses from professionals in the Survey of Professionals and from those participating in the interviews with First Nations stakeholders and with parents and carers provided insight into the challenges and barriers to CCSs ensuring cultural safety, and measures to address these from both First Nations and CALD perspectives.

Use of and accessibility of CCSs for First Nations families and CALD families as well as families with disability

The DEX data show that clients identifying as First Nations were overrepresented among in-scope CCS clients accessing CCSs (8%–9%, compared to 3% of the population). Nearly one-quarter (23%) of clients in the Northern Territory reported as 'Aboriginal and/or Torres Strait Islander', with 11% and 10% of clients in New South Wales and Queensland reporting First Nations status respectively. A proportionally higher share of Tasmanian (7%) and South Australian clients (8%) were reported as being First Nations. First Nations clients are most likely to be reported as accessing CCSs in inner regional (11%) or outer regional and remote areas (14%). These data are particularly notable given feedback in Phase One initial stakeholder consultations that services were not commonly accessed by First Nations people. Unfortunately, the DEX data only reports the First Nations status for each individual client without reference to which of their family members are First Nations. This level of data would support more detailed insight of the First Nations clients using CCSs and their outcomes as indicated in the DEX.

Proportionately fewer clients were from CALD background (3%–4%; compared to 21% in the population). Clients who were from CALD backgrounds (5%) and non-First Nations clients (91%) were most likely to access CCSs in major cities. Relatively even proportions of First Nations and CALD clients accessed stand-alone services and not-for-profit service provider CCSs.

The data also show that 1 in 10 clients were reported as having a disability. Relatively even proportions of clients with an identified disability accessed CCSs in major cities (10%), in an inner region (10%) and in an outer regional or remote area (9%), and through both stand-alone (12%) and not-for-profit service provider CCSs (9%).

Professionals' views of the extent to which CCS services were accessible for First Nations and CALD clients varied substantially, with most CCS professionals agreeing that CCSs were accessible to First Nations and CALD families (75% each), compared to referring professionals where only 30% and 28% agreed respectively. There was a similar difference in response patterns on the issue of culturally safe service provision (see below).

More specifically, most CCS or service provider professionals answering in the affirmative in relation to accessibility for First Nations peoples referenced that CCS staff were in receipt of specialist First Nations or cultural inclusion training and resources. Other professionals referenced CCSs' established links with First Nations service providers, or the CCSs' retention of First Nations staff members. Participants also referenced the location of the service, waiver of fees for clients who cannot afford them, and the inclusive and non-discriminatory values of staff and welcoming environment and culturally inclusive facilities.

Professionals disagreeing that the CCSs in their area were accessible for First Nations families most commonly indicated that CCSs lacked sufficient specialist services and cultural competency to support First Nations families. A substantial proportion of participants referenced the lack of, or absence of, CCSs in the areas local to First Nations families, and issues with transportation to the CCSs as impacting accessibility. Some professionals also described how the 'structure, design and set up' was 'unlikely to feel natural and respectful of culture' and 'further entrenches belief of unnecessary government intervention and control in their lives'.

Particular insights into this barrier, and issues for First Nations families, more generally, were captured in the interviews with First Nations professionals. These participants referenced perceptions of CCSs as being part of government services, indicating that First Nations communities have a historical lack of trust in government services connected with the trauma of past and current child removal in Australia. The risk of having further intervention in the family as a result of using the CCS was also linked to women not wanting partners or ex-partners to experience legal intervention, such as being taken into police custody. This could result in some clients not identifying themselves as First Nations or avoiding services to maintain their independence. Fear about being watched by government was also reported to occur because of having documentation recorded about First Nations families during the referral process and when receiving services from the CCS according to the First Nations professionals interviewed.

First Nations professionals also referenced financial barriers as affecting First Nations families accessing CCSs, both in terms of the cost of services through co-payments and the cost of travel to the CCS location. Some CCSs were aware of this barrier and had implemented flexible payment options or payment waivers to ensure access for all Aboriginal families. The location of services and travel distances required to access services was a barrier, similar to other families identified in the professionals' survey and parent and carer data. However, this was particularly acute for First Nations families in regional and remote locations. The distance between CCS locations also meant First Nations families might not know about services so far away from where they live and be another barrier for referrals.

In relation to the needs of both First Nations families and CALD families, measures described by CCSs included tailoring service provision to suit families' particular circumstances or needs. Services with the capacity to accommodate this flexibility may be able to facilitate engagement with families of diverse cultural backgrounds and family structures (e.g. taking a flexible approach to the number of attendees participating in supervised visits to accommodate extended family members).

In relation to CALD families, some participants also described the external links that the CCS had to CALD services and organisations and their flexibility with the English-only policy where it was safe and appropriate to do so. On another measure of cultural accessibility, the provision of interpreting services, the RFI data showed that most services facilitate interpretation for intake and assessment (9 in 10) and for supervision services (almost 6 in 10). The vast majority of CCSs (88%) did not charge fees for interpretation services.

Professionals were more likely to report CCSs to be accessible for people with a disability (CCS professionals: 73%; referring professionals: 37%). Participants who took this view referenced the building and facilities as suitable for people with a physical disability or that the staff were trained in disability (including mental health issues) and that they included the disability needs in families' management plans. Professionals (as well as parents and carers) who disagreed that services were accessible for people with a disability cited issues with transport to travel to CCSs for people with a disability and that staff were not sufficiently trained in the disability (particularly in relation to children experiencing mental health issues or neurodiversity).

Culturally safe service provision

Significantly, less than half (47%) of professionals participating in the Survey of Professionals agreed that the CCSs were culturally safe for the children using them, although most CCS professionals (73%) reported that they were culturally safe (cf. 37% referring professionals). The RFI data also identified culturally safe and inclusive practices employed by CCSs in line with these affirmative responses but acknowledged the costs and resource constraints that limited implementation.

Relevant to the findings discussed in relation to the National Principles for Child Safe Organisations above (and Principle 4 in particular) in relation to First Nations clients, most CCS professionals (66%) reported that they were culturally safe compared to 20% of referring professionals.

In relation to CALD clients, most CCS professionals (70%) agreed that the CCSs were culturally safe compared to 24% of referring professionals.

Qualitative responses describing why the services were not culturally safe from a First Nations perspective most commonly referred to an absence of or inadequate culturally appropriate practices from a First Nations perspective and the absence of First Nations-led services. Participants agreeing that the CCSs were culturally safe referenced the specialist First Nations cultural awareness training and resources and First Nations staff and/or volunteers. Services that indicated their CCS was culturally safe frequently mentioned the presentation of their CCS and some specifically mentioned cultural advisors or workers supporting First Nations inclusion.

The involvement of First Nations staff in service provision was a key feature of the interviews with First Nations professionals, together with the adaption of the structure of service provision and having responses to trauma and cultural awareness from First Nations perspectives. Consistent with the RFI and professionals survey data, First Nations professionals reported on the value of having Aboriginal staff to liaise with Aboriginal families for cultural safety. This was described as making First Nations clients more comfortable and could overcome some of the issues around feeling like the CCS was a government environment. The retention of First Nations CCS personnel supports the determination of cultural safety by First Nations peoples, where these First Nation staff members have a role in decisions about service delivery. Feedback from First Nations clients regarding their experiences of these services can also inform a CCS's assessments of the extent to which their service is culturally safe.

However, having local First Nations services and support people might not always be culturally safe for everyone. Participants reported that some First Nations families preferred to work outside of the Aboriginal service system because of concern about other people in the community knowing about their family. The participants talked about the shame and stigma that First Nations clients can feel in using the CCS service. This was potentially a barrier to seeking help initially or due to the shame of being seen to be needing the services. First Nations professionals also noted that particular cultural sensitivity was required when engaging First Nations men in CCSs.

The importance of service provision meeting the individual needs of the local First Nations peoples and each individual First Nations family, featured in concerns about the structure of service provision around cultural

safety. Most participants indicated that their services did not do anything specifically different in their processes for Aboriginal families but had an individual approach to these clients or tried to help them feel comfortable using the service. These practices included choices about engaging with First Nations staff, through to ensuring the facilities were welcoming.

The First Nations professional participants indicated strongly that it was important to consult closely with Aboriginal families and work with them to get their plans in place. They indicated that rather than imposing and enforcing orders, solutions and time frames, plans should be developed in consultation and conjunction with their clients to increase the likelihood of them succeeding. This was a goal for improving First Nations cultural safety in CCSs. In addition to consulting First Nations parents and carers, it was important to be flexible with responses that could be devised together rather than a standardised or one-size-fits all approach. This required taking an 'outside the box' approach to clients to understand and implement what would work with them, including supporting involvement of extended family members where appropriate. This was not always possible within the constraints of the CCS standard model and the court orders made for families. Rather than adapting the standard model of service delivery, this culturally safe approach involved engaging with local First Nations communities and CCS clients to identify the model of service delivery that is best for them Embedding cultural humility among CCS staff whereby they engage in reflective practice, acknowledge any biases and are open to learning from First Nations families about what works for them, in turn supports a workforce that is better able to respond to the diversity of all Australian families, who have a broad range of abilities and family structures.

Cultural awareness training was also observed to be outdated in some circumstances so improving all staff training and their understanding about trauma, including intergenerational trauma from the perspectives of First Nations peoples is required. Participants noted that CCS staff training and practice to improve cultural safety and cultural awareness should not be general. Rather, it should include specific information about the local culture and practices, acknowledging that First Nations are multiple groups and nationalities and that all have their own specific cultural traditions and practices. Taking an intergenerational trauma lens that, for example, acknowledges the degree of surveillance that First Nations people experience and the impact of this, or of clients' parenting being learned from parents who were affected by intergenerational trauma, can support CCS staff to navigate culturally safe service delivery. Providing intergenerational trauma responses was also identified as critical to cultural safety. Other strategies to improve CCS service provision emphasised the importance of providing services in a more holistic model from First Nations perspectives, including family therapy and specialised counselling for children.

More specifically in relation to CCS sites and facilities, adjusting the mainstream structure of CCSs from being centred around supervised time indoors with the Spends time with parent, to instead facilitate choices for outside activities was a common strategy currently employed by staff to adapt the structure of CCSs when supporting cultural safety. First Nations staff were able to meet with clients outside the CCS and in outdoor places. The opportunity to provide First Nations clients with offsite and outdoor visiting options was indicated to be important when trying to engage First Nations families. It was also explained that outdoor activities with children could sometimes be more culturally appropriate and bring cultural benefits for children and the Spends time with parents. The ability to hold visits offsite accords with the idea that CCS supervised visit options are likely to be more successful for First Nations clients when flexible options are provided.

This offsite service provision and outreach service models were emphasised for First Nations families because time with children could be linked with kin and community in ways that strengthen cultural safety for when CCSs are no longer involved. The analyses of the interview data from First Nations professionals proposed outreach in 3 ways. The first approach was increasing the choices for outdoor supervised time based around current CCS locations, which was part of cultural safety discussed earlier in this chapter. The second approach was to have CCSs going out into communities (similar to a mobile service). The third approach to outreach proposed a model of specialised First Nations services provided by First Nations people similar to other Aboriginal-led or Aboriginal Community Controlled Organisations providing services to First Nations families.

Qualitative responses in interviews with parents and carers describing why the services were not culturally safe from a CALD perspective referenced inadequate access to interpreters and a lack of CALD staff (including bilingual supervisors), whereas those answering in the affirmative referenced access to interpreters, the accommodation of culturally significant celebrations and the employment of CALD staff or volunteers.

It is notable that participants in the interviews with parents and carers presented a mixed picture of cultural safety. From a positive perspective, parents and carers acknowledged their CCS had some culturally appropriate services available, particularly translation services. However, some parents and carers described experiences of feeling judged in a negative way by some CCS staff and these experiences were linked to an absence of culturally

safe and trauma-informed practices, and failure to acknowledge the traumatic experiences of the children using the service.

Outcomes for First Nations clients and CALD clients

Overall, client outcomes for CALD clients, clients with disabilities, and First Nations clients were similar to those of other clients.

Importantly, despite the concerns regarding accessibility and cultural safety, First Nations clients had higher overall positive outcomes in satisfaction than non-First Nations clients and similar positive outcomes in circumstances and achieving goals.

The data show, however, that in 2022, overall positive outcomes in circumstances and achieving goals were lower for CALD clients. The data also show that the proportion of clients with overall positive outcomes in circumstances and achieving goals increased for clients with a disability between 2019 and 2022.

Research Question 7

To what extent are CCSs supporting families experiencing DFV?

How are CCSs providing this support and how effective is the provision of this support?

The response to this question draws on all evaluation data sources and together these data suggest that CCSs are providing support to families experiencing DFV and that this support is generally regarded as effective in the context of CCS service provision. It is noted that the reason this discussion draws on data more broadly from this evaluation is because DFV is in large part the core business of the CCSs and consequently characteristic of a substantial proportion of the service users. For this reason, broader evaluation findings are of specific relevance to those experiencing DFV.

Service provision to families characterised by DFV

The DEX and survey data indicate that families accessing CCSs were characterised by complex needs and risk issues. The DEX data identified that approximately 4 in 10 clients were identified as needing assistance with family functioning and more than 1 in 10 required assistance with personal and family safety. The Survey of Parents and Carers also highlighted the range of complex issues faced by families accessing CCS services. Issues relating to emotional abuse or anger issues, mental health issues and violence or dangerous behaviour. Nearly three-quarters of parents and carers interviewed reported safety concerns, and for the Lives with parent, these concerns most frequently involved multiple risks. Consistent with these reports, CCS professionals and referring professionals in the Survey of Professionals were most likely to report that three-quarters of their client base were characterised by child safety issues or DFV.

Effectiveness of support provided by CCSs

Most professional participants in the Survey of Professionals agreed that CCSs were appropriate for families experiencing the complex risk issues associated with DFV (62%). The qualitative data from professionals regarding the ability of CCS to adapt to meet the needs of children and families indicate that strengths include a child-focused approach employed by CCS, and their neutral and independent approach to service provision. The limitations centred around working within the constraints of the court-ordered arrangements and how facilitating court-ordered parenting time had the potential to place staff and families at risk of harm.

As noted in relation to addressing Research Question 4 and 5, most parents and carers participating in the Survey of Parents and Carers identified CCSs as prioritising the safety of their child (79%), and 75% agreed that the CCS was safe and appropriate for family members experiencing DFV; most professionals (77%) agreed that CCSs were physically and emotionally safe for the children using them. However, as noted in this context, some parents/carers and professionals raised concerns about risks to children's physical and emotional safety despite the CCS arrangements, including in circumstances characterised by DFV.

Broader evaluation data are also relevant to the question of effectiveness, with the DEX data showing that most clients assessed had an overall positive outcome in relation to their Circumstances, Goals and Satisfaction DEX outcome measures in both 2019 and 2022, with satisfaction being particularly high (80% or higher). This pattern

is evident regardless of age groups and gender. In relation to negative outcomes for goals, clients' reports were higher in 2022 than in 2019.

As also noted in relation to addressing Research Question 4, more specifically in relation to child clients, a higher proportion of boys than girls had an overall positive outcome across circumstances and goals in 2019 but, in 2022, there was little difference in circumstance and goal SCORE data between boys and girls.

However, boys had a higher proportion having an overall positive outcome compared to girls, although it is important to point out that numbers of boys and girls assessed for SCORE were small in 2019. The proportion of boys with an overall positive outcome in circumstances and goals declined from 2019 to 2022; however, the proportions for girls in these two areas remained stable.

Positive client outcomes emerged overall across states/territories and regions, and higher proportions of clients in Western Australia, Victoria and Queensland than other states had an overall positive outcome in circumstances and achieving goals, but an overall positive outcome in satisfaction was higher in Tasmania and Queensland.

While in 2019 the proportion of clients with an overall positive outcome in circumstances and goals was lower in outer regions and remote areas, compared to major cities, the differences were no longer apparent in 2022. Clients in outer regions and remote areas had an overall positive outcome in satisfaction compared to those in major cities and inner regions, and this pattern was evident in both years.

More specific data from the Survey of Parents and Carers and qualitative data from the interviews with parents and carers showed that there were varied experiences of CCS use and how this affected participants' relationships with their children, noting that most participants were characterised by DFV or other complex risk issues. Approximately one-third reported that that there was a positive change; a further one-third reported that there was no change and 15% reported a negative change. There was a statistically significant difference between the reports of Spends time with parents and Lives with parents, with more than half of Spends time with parents reporting a positive effect on their relationship with their child (cf. 15% for the Lives with parent).

Qualitative insights from the Survey of Parents and Carers in relation to the positive effects referenced the facilitation of a relationship in circumstances where this would not otherwise be possible, as well as the skill and experience of staff supporting the Spends time with parent to engage with their child. On the other hand, parents and carers described negative effects, identifying damage to their relationship of trust with a child expressing views against time with their other parent/carer and behaviour changes on the part of the child before and after visits, as well as arising from effects of travelling long distances.

Insights from professionals and parties regarding the strengths of CCSs' ability to adapt to meet the needs of children and families focused on the safe, affordable and child-focused and trauma-informed approach of CCSs. Limitations centred on an absence of flexibility to adapt to families' needs, specifically CCS provision being constrained by court orders, as well as funding constraints limiting service availability and adaptions to this service provision, including the wraparound service provision or modifications to the current model to meet the needs of First Nations and CALD families.

Meeting families' expectations and needs

As noted in relation to addressing Research Question 4, survey data from the parent and carers' perspective showed that parents and carers rating their and their children's satisfaction with the CCSs were quite satisfied with their use of CCS services. Parents reported an average satisfaction level of 7.6 on a 10-point scale and an average satisfaction level of 7.3 for children as rated by their parents. More specifically, parents and carers of children aged 5–9 years were most satisfied with a rating of 8.3, followed by ratings of 7.1 and 7.2 for children aged 0–4 years and 10–14 years respectively. Spends time with parents reported an average satisfaction level of 6.8, compared with Lives with parents who reported an average rating of 7.8.

The data from the qualitative interviews with parents and carers indicate that, overall, most were satisfied with CCS services. Positive reflections were commonly associated with the costs and hours of operation, and consistent with professionals, that the CCS addressed issues of safety for their children and/or themselves. Parents and carers who reported positively also referred to CCS staff support, child focus and neutrality.

Some parents and carers raised concerns about the waiting lists to access the CCS and concerns for their safety or the safety of their children at the service. For some parents, expectations were not met regarding child safe practices such as orientation/familiarisation and debriefing. Suggestions from parents and carers for improvements included additional funding to support an increase in locations or branches of CCSs to reduce distances to attend or decrease waiting lists, more flexibility in sessions offered, and more staff or supervisors in

sessions. Many parents and carers indicated that they would like to see improvements to the infrastructure and activities for children, as well as improvements in communication with parents and carers as well as potential referring professionals and training and support in relation to neutrality and report writing.

Qualitative data collected in the Survey of Professionals referenced the quality of CCS services (including neutrality and child-focused and child-inclusive nature of services and the CCS reports provided). Some participants described CCS practices that supported families to address their underlying issues as particularly helpful.

Conversely, areas that professionals were most dissatisfied with included insufficient funding for the delivery of required services. Some participants also described their concerns about the quality of services provided and the facilities and security in place, due to poor design or functionality. Although the RFI data show modest and improved waiting lists, participants in the Survey of Professionals also referenced the need for increases in the number and location of CCSs as well as the types of services provided, reductions in waiting lists and improvements to the available activities and the length of service provision for families. This may suggest that there are families who may need the services of a CCS but may not be able to be referred to one. As noted above, some participants raised concerns about the training and quality of the CCS staff when reflecting on aspects of CCSs that they were dissatisfied with, particularly in relation to dealing with traumatised clients. A smaller proportion of responses raised concerns about inclusion and accessibility for First Nations, CALD families and families with a disability, with the data overall consistent with these concerns.

Suggested changes to better meet families' needs

Changes recommended by parents and carers to better meet their needs included further resourcing for staff training to support neutral, professional and trauma-informed practice, improved communication with parents and carers, including consistency in communications provided by staff, accuracy in CCS reports and improved engagement with children and family members to provide feedback on service provision. Measures to support greater accessibility identified by parents and carers included: greater availability of CCS services, including a reduction in time period awaiting services, increased days and hours of operation and local accessibility to CCSs, a simpler/easier application process, offsite supervision, sessions with multiple children, the provision of mediation and other support services and the provision of real-time reports to support the identification of issues experienced by children during supervised visits.

In relation to children's needs, specifically, parents and carers recommended changes to facilitate greater understanding of children's diverse needs, behaviour changes and experience of distress, and access to support services.

Professionals similarly focused on additional funding to support increased and more flexible service provision and to address the shortcomings in facilities to better support the safety of families using the service; the application of resources to interpretation services; resourcing support services within or external to the CCS to address the complex needs of the families accessing them; improved pay and conditions, training opportunities and guidance for CCS staff, particularly in relation to child-safe and child-inclusive practices, including to terminate visits where the child's best interests directed this outcome; more flexible and creative transitional arrangements and options for more limited 'identity contact' for children.

Research Question 8

To what extent are the current number and locations of CCSs meeting the existing demand for their services?

What are the expectations of families and professionals using or seeking to use CCSs and to what extent are these expectations being met?

Is the referral profess operating effectively?

The examination DEX and RFI data, together with data from the Survey of Professionals and from the survey and interview data from parents and carers suggest that the referral process for families to engage CCS service provision is operating effectively. Overall, the findings also suggest that there are generally sufficient services to meet existing demand, locations are appropriate and accessibility by public transport is mostly adequate. However, confidence in relation to the sufficiency of services to meet the demand is less evident among referring professionals than CCS professionals and among parents and carers.

CCSs meeting the demand for service

The DEX data show that client numbers fell by about 2,000 in 2020 and 2021 during the COVID-19 pandemic and then increased in 2022. Client numbers nevertheless remained lower in 2022 compared to 2019 (13,198 cf. 14,729) and 90% of clients were identified as being from major cities or inner regional areas.

The RFI data indicate that pressure on waiting lists eased in 2022, when just under one-quarter (23%) of CCSs reported that they had no waiting list compared to 13% in each of 2019, 2020 and 2021. Where there were waiting lists, they were most commonly 3 months (28%) or less (one month: 15%; 2 months: 21%). Only 13% of CCSs reported 4–6 months' waiting lists and none reported more than 7 months. Of note, these improvements in waiting times to access services were attributed to increased funding supporting expedited intake processes and additional case-management support.

In terms of accessibility of hours of operation, on average, CCSs were reported to be open for 33 hours per week, with some variations among states and territories. Again, increased funding supported more operating hours but there were also challenges associated with managing budget and staffing arrangements and implementing increased hours of operation to respond to the demand for access, as well as challenges associated with providing services over a large catchment area. The responses of some CCSs participating in the RFI conveyed that changes in hours of operation and staffing models reflected not only the need for flexibility from families using the service but also enabled CCSs to adapt to the new service environment and staff availability.

The RFI data also indicated strategies employed to address the impact of waiting lists on families and to support a greater number of people to access their supervised visits. These strategies involved providing services at days and times that are likely to be more suitable to school-aged children, facilitating an increased number of supervised visits of shorter duration and integrating CCS and post-order programs to support families to receive timely therapeutic support that may assist them to move to self-managed parenting arrangements. Measures of this nature were identified as responding to the high demand for CCSs and the need to manage waiting lists while at the same time ensuring the best interests and safety of children.

Professionals' views on CCS characteristics relevant to meeting demand for service in the survey showed that most participants agreed that:

- there were a sufficient number of services to meet demand
- that the location of CCSs met demand
- the length of waiting lists were minimal
- they were accessible from a logistical perspective (accessible by public transport).

However, CCS professionals were more likely than referring professionals to agree with these propositions to a statistically significant extent, reflecting varied experiences of professionals and their clients when accessing the services when they needed them. These varying response patterns may in some instances suggest challenges in communication and information sharing between these professional groups or that some areas are still under serviced.

Qualitative insights from the Survey of Professionals also provided insight into the factors that supported or prevented CCSs from meeting the demand for their services.

In relation to the number of CCSs, participants referenced their experience of waiting list times as evidence of either a sufficient or insufficient number of CCSs to meet the demand, as well as the distance and costs required to travel to a CCS, in both suburban and regional and rural areas.

Participants were most likely to indicate that the location of CCSs met the demand because the CCS was well-positioned or centrally located having regard to the population size of the service area or because the CCS's positioning with respect to manageable travel arrangements. Inhibiting factors included insufficient availability of CCSs in the local area and that the geographical area covered by the CCS was too large.

When referencing accessibility from a logistical perspective, most professionals who agreed indicated that the CCSs were accessible by public transport and those who disagreed indicated that the CCSs were inaccessible by public transport or that this transport was difficult to manage with children, especially with a disability. Some parents and carers interviewed reported experiencing issues accessing their CCS and described difficult or costly car journeys and lengthy, complex public transport arrangements.

Facilities that were fit for purpose in terms of being child and family friendly spaces and with adequate safety and accessibility features such as location and parking were also cited by professionals and parents and carers. Some CCSs completing the RFI described changes that had been made to their location and facilities to both

improve the appearance of the sites and to better meet the demand for services and support safe service delivery. Other CCSs described shortcomings in the facility locations, amenities and accessibility of their service that prevented them from meeting the demand for their services.

Operation of the referral process

In relation to the referral process, overall the survey data show that most professionals (72%) described referrals to CCS services were generally appropriate but there was again a statistically significant difference between CCS professionals who were more likely to agree than other professionals that referrals were appropriate.

However, several participating professionals providing open-text responses raised concerns specifically in relation to the making of unsafe parenting orders that underpinned the referrals to CCSs, including in cases characterised by family violence or other significant risk.

Most professionals were in agreement that CCSs could refuse to facilitate supervision arrangements in court orders where they did not consider this to be in the best interests of children (65%) and that the services provided by CCSs addressed the needs of the children using them (60%). There was again a statistically significant difference between the responses of CCS professionals and referring professionals, with referring professionals being more equivocal in their responses.

Qualitative responses also highlighted concerns on the part of some professionals that CCSs did not decline service provision that was not consistent with children's best interests and suggested a range of areas for improvement in relation to CCSs' capacity to address children's needs. These areas ranged from the nature of the facilities at the CCSs and the waiting lists, through to the skills and capacity of staff and the CCS's capacity to address the underlying therapeutic service needs of children and their parents.

Recommendations

1. **Consider modification of CCS program expectations relating to self-management to suit the needs of different families**

   There are some families for whom self-management is not achievable. There are 3 relevant groups in this context: families where parental/carer capacity for self-management is unlikely to develop but a relationship with the child is nonetheless important; families where a no time order is the most appropriate outcome; families for whom 'identity contact' is appropriate. Guidelines and practice materials should more explicitly acknowledge these circumstances to support CCSs and CCS professionals to identify these groups and the most appropriate strategies to manage and support them.

2. **Facilitate access to wrap-around supports to families where necessary**

   The evidence suggests that families need more holistic support, including therapeutic intervention for parents (to deal with risk issues) and children (to respond to trauma). The evidence indicates that this could either be provided in the CCS context or through a case managed and integrated approach through another service. On either approach, consideration of resourcing and adaptation of guidelines and practice materials is required.

3. **Provide additional transition and follow up support to families**

   The proportion of families that return after an attempt at transition to self-management indicates that there is a need for greater transition support, such as referrals to therapeutic support and/or a period of monitoring in the context of the graduated approaches to self-management. A gap in the evidence concerns the extent to which families who do not return to the CCS sustain appropriate and safe self-management. Mechanisms to follow up these families, including potentially a pilot to assess the value of follow-up support, would provide evidence of the circumstances in which self-management is safe, successful, partially successful or unsuccessful.

4. **Clarify expectations about the nature, quality and consistency of CCS written reports**

   Consideration of whether a consistent approach to the provision of reports or the subpoena of case notes is required, supported by a closer examination of the strengths and weaknesses of each of these approaches. Services and practitioners require greater support to fulfill this function, to ensure that this function is effective and is supporting decision making in relation to time arrangements.

5. **Ensure that feedback from families and the child's voice are key elements of the CCS quality improvement process**

   The findings indicate that CCSs should adopt an ongoing quality improvement process based on obtaining and considering feedback from user families on a regular basis. Specifically, the findings indicate a need for processes and measures to be developed and used to better assess the children's experiences of the CCS service, with this being a particular area of service development. Importantly, there is a need to support efforts to identify better ways to enable children using CCSs to express what they want and need from the CCS while receiving their services ('the child's voice') and for this to inform service delivery. Although this is important for all child clients, the need was particularly evident in relation to First Nations and culturally diverse children, as well as children with a disability.

6. **Greater consistency in training and professional development in relation to child safety, child-inclusive practice and DFV and trauma-informed practice and in meeting the Guiding Principles Framework would be supported by accreditation**

   There is a need for greater consistency across the sector for the application of child-focused, child-centred, child-inclusive and trauma-informed practice.

   This would be supported by an accreditation process that would require a consistent approach to training in relation to child safety, trauma-informed and child-inclusive practices. The findings of this study suggest that the CCS sector is ready for accreditation in its current maturity. Additionally, the data show that there are lessons that the CCS sector can share with other children's services when it comes to more formally accommodate taking into account children's voices in its processes and decision making, and further accommodating cultural safety for First Nations families.

   There is a need for CCSs to more consistently meet the requirements of the Guiding Principles Framework in relation to collaborative practices and referrals, neutrality and self-management. These requirements should be reinforced in ongoing staff training and professional development.

   The concerns relating to inappropriate referrals also suggest that embedding regular and consistent DFV and trauma-informed training and professional development, including child safe and child-inclusive approaches is warranted for both CCS professionals and referring professionals. Specific measures that would enhance service provision for families and children include training and support to enhance practitioner capability to identify and respond to children with diverse needs and to children experiencing emotional distress and to make decisions as to when supervised time sessions should be terminated.

   Refinement and greater consistency in the implementation of intake and risk assessment, safety planning and orientation/familiarisation processes that are DFV and trauma informed and child safe would also be supported by training and professional development, including with a particular focus on First Nations families, CALD families and where parents and carers and/or children have a disability. Specifically, in relation to orientation/familiarisation processes, following up with families during and subsequent to these sessions will support their awareness of and effective engagement in this process.

   An accreditation process would also support the practical implementation of these CCS service requirements.

7. **Encourage the development of culturally safe services in partnership with First Nations peoples**

   To meet the needs of First Nations families, CCSs need support for greater engagement with their local First Nations communities and service providers, including Aboriginal Community Controlled Organisations (ACCOs). Relatedly, ACCOs require greater support to engage with CCSs. Additionally, there needs to be consistent, regular and ongoing training in culturally appropriate and safe service provision to embed trauma-informed approaches that are directed at individual families' needs in CCS practice. Consideration should be given as to how to support CCSs to recruit First Nations practitioners. Consideration should also be given to the development of a different models of service delivery with greater flexibility and a broader range of options for First Nations families in collaboration with First Nations peoples and involving service design and provision by First Nations peoples, based on the principle of self-determination. Learnings from First Nations peoples and their experiences of service provision can inform service provision both for First Nations and non-First Nations families.

   Consideration needs to be given to the location of CCSs, provision of offsite and in- community settings supervision and the implementation of outreach services to support accessibility and culturally appropriate services for First Nations families. However, there also needs to be regard for strategies to provide alternative

modes of service or to reduce stigma and shame associated with using these services among First Nations families.

8. **Encourage the development of culturally responsive services with Culturally and Linguistically Diverse communities**

   To meet the needs of CALD families, CCSs need support to increase engagement with their local CALD communities and service providers to better inform culturally appropriate service provision for those communities. Additionally, there needs to be consistent, regular and ongoing training in culturally appropriate and safe service provision for CALD families. Consideration needs to be given to how CCSs can recruit CALD practitioners and how to resource interpreter services to support a greater uptake of CCS services among CALD families.

9. **Current population and demographic data should be considered to identify potential additional locations of CCSs to service unmet demand**

   Having regard to the concerns raised by professionals and parents and carers regarding accessibility to CCSs in the context of data from CCSs, including in relation to waiting lists, further consideration of the current location of the 84 government-funded services (including the 20 new services that were out of scope for this evaluation) is warranted, with reference to current population levels to identify potential additional locations of CCSs to service unmet demand.

   CCS opening hours and service offerings should also be responsive to the needs of local communities.

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Legislation

Family Law Act 1975 (Cth)

Case law

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Bant & Clayton (2019) FLC 93-924

Appendix A: Desktop review methodology

The AIFS Library database Catalogue Plus[32] and Google Scholar were searched for peer-reviewed literature, grey literature and broader commentary on CCSs and their operation in the Australian context. However, we did not limit searches to Australia, allowing us to capture any important international developments to complement the Australian literature but focusing only on recent key works (rather than commentary and grey literature). Of particular interest were the international jurisdictions of Scotland and Florida in the United States, given recent activities in relation to CCSs occurring in these locations. Due to relevant activity in the Children's Contact Service sector in Florida in the United States, the Clearinghouse on Supervised Visitation at the University of Florida was also searched. The key search terms used were as follows:

1. "child contact service*" or "childrens contact service*" or "supervised changeover*" or "supervised contact" or "supervised visit*" or "supervised access" or "supervised handover*" or "supervised access" or "supervised parental" or "monitored changeover*" or "monitored contact" or "monitored visit*" or "monitored access" or monitored handover*" or "facilitated changeover*" or "facilitated contact" or "facilitated visit*" or "facilitated access" or "facilitated handover*" or "supported visit*" or "supported access"

   AND

   Australia* or "new south wales" or queensland or Tasmania

   AND

   "new zealand" or France or "united states" or scotland or "united kingdom" or canada* or england or sweden or scandinavia* [for years 2010-2022]

   AND

   NOT Australia* or "new south wales" or queensland or Tasmania

2. "child contact service*" or "childrens contact service*" or "supervised changeover*" or "supervised contact" or "supervised visit*" or "supervised access" or "supervised handover*" or "supervised access" or "supervised parental" or "monitored changeover*" or "monitored contact" or "monitored visit*" or "monitored access" or monitored handover*" or "facilitated changeover*" or "facilitated contact" or "facilitated visit*" or "facilitated access" or "facilitated handover*" or "supported visit*" or "supported access"

   AND

   "Systematic review" or "meta-analysis" or "literature review" or "scoping review" or "scoping study" or "narrative review" or evaluation or CALD or Indigenous or culturally or ethnic or "First nations" or refusal or refuse or safety or "self manag*" or transition* or regulat* or accreditat* or funding or "advances" or "developments" or reform

A total of 136 records of interest were yielded from these initial literature searches and additional literature searches were conducted as the Evaluation progressed to ensure the desktop review was both comprehensive and up to date.

32 The databases included in Catalogue Plus are: Attorney-General's Information Service. Australia/New Zealand Reference Centre, Australian Criminology Database, Australian Education Index, Australian Family & Society Abstracts, Australian Federal Police Digest, Australian Public Affairs Information Service, Business Source Complete, EconLit, Medline, Multicultural Australia and Immigration Studies, PsychInfo, Psychology and Behavioural Sciences Collection, and SocINDEX.

Appendix B: List of Children's Contact Services in scope

Table A1: List of in-scope CCSs

Outlet name	State
18 Clare	TAS
Anglican Community Care Inc	SA
Anglicare WA - Albany	WA
Anglicare WA - Bunbury	WA
Anglicare WA - East Perth	WA
Anglicare WA - Joondalup	WA
Berri	SA
Bethany Community Support Inc	VIC
Blacktown Centre	NSW
Caboolture	QLD
Campbelltown	NSW
Caringbah	NSW
CatholicCare - Redfern - SDN Children's Services	NSW
CatholicCare NT - Alice Springs	NT
CatholicCare NT - Darwin	NT
CatholicCare Wollongong (Campbelltown)	NSW
CatholicCare Wollongong Children's Cottage Gville	NSW
CCS Gold Coast	QLD
CCS Ipswich	QLD
Central Coast Centre	NSW
Central West Contact Service	NSW
Centrecare - Kalgoorlie	WA
Child & Family Services Ballarat	VIC
Childrens Contact Service	NSW
Children's Contact Service - Gippsland (Morwell)	VIC
Coffs Harbour	NSW
CommUnity Plus Inner	VIC
Community West Inc	VIC
Cranbourne - Family Life Limited	VIC
Dubbo	NSW
Eight Mile Plains	QLD
Elizabeth	SA
Far North Queensland	QLD

Outlet name	State
Frankston Service Centre	VIC
Fremantle	WA
Gosnells	WA
Greater Townsville Region	QLD
Hervey Bay	QLD
Hindmarsh	SA
Hunter Centre	NSW
Lismore	NSW
Logan-Beaudesert	QLD
Mackay Children's Contact Service	QLD
Mallee Family Care - Child Contact Service	VIC
Mandurah George Street	WA
Moruya Office	NSW
Narrabundah	ACT
Noarlunga Community Children's Centre	SA
North Fenton	TAS
Orange	NSW
Paterson	TAS
Penrith Centre	NSW
Port Macquarie	NSW
Rockhampton	QLD
Shepparton CCS	VIC
Sunshine Coast Family Contact Centre Association	QLD
Taree	NSW
The Roman Catholic Bishop of Geraldton Centacare Family Services	WA
The Salvation Army - Bendigo ChContS	VIC
Toowoomba	QLD
UCSA Whyalla	SA
Upper Murray Family Care Incorporated - Albury	NSW
Wagga Wagga Office	NSW
Warrnambool	VIC

Appendix C: DEX, Demographic characteristics of Children's Contact Services clients, pre-Covid period, 2019

Table A2: DEX: Demographic characteristics of individual clients of in-scope CCS services, by state/territory, 2019

	NSW (%)	VIC (%)	QLD (%)	SA (%)	WA (%)	TAS (%)	NT (%)	ACT(%)
Indigenous status								
Indigenous	12.0	6.7	8.1	5.6	4.6	4.2	29.5	1.0
Non-Indigenous	82.9	89.1	89.0	84.7	94.6	95.7	70.5	98.5
NS	5.0	4.2	2.9	9.7	0.8	0.1	0.0	0.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
CALD								
CALD background	4.9	9.2	1.2	2.5	1.1	0.2	3.6	2.0
Else	95.1	90.8	98.8	97.5	98.9	99.8	96.4	98.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Years since arrived in Australia								
0–5 years	1.0	0.1	0.7	1.3	0.1	0.0	0.4	0.0
Over 5 years	4.9	0.6	3.1	5.7	1.8	0.7	0.0	1.5
Unknown	94.1	99.3	96.2	92.9	98.1	99.3	99.6	98.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Visa type								
Family	2.0	0.8	0.7	1.6	0.5	0.2	0.0	0.0
Humanitarian	0.3	0.3	0.2	1.0	0.0	0.0	0.0	0.0
Skilled	0.9	0.5	0.4	1.6	0.1	0.1	0.7	0.0
Other	1.5	1.4	0.9	1.5	0.2	0.0	1.4	1.5
Unknown	95.2	97.0	97.9	94.3	99.2	99.6	97.9	98.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Homeless status								
Yes	0.6	0.3	0.3	0.3	0.2	1.2	0.4	0.0
At risk of homeless	0.2	0.3	0.6	0.1	0.2	0.1	0.0	0.0
No	49.0	24.3	50.1	74.5	80.3	73.0	65.8	64.4
Unknown	50.2	75.1	49.0	25.1	19.3	25.7	33.8	35.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Disability status								
Yes	8.9	13.7	8.2	11.6	5.5	6.3	14.9	3.0
No	88.1	79.2	87.6	85.0	89.3	91.6	84.7	70.8
Unknown	3.0	7.2	4.1	3.4	5.2	2.1	0.4	26.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

	NSW (%)	VIC (%)	QLD (%)	SA (%)	WA (%)	TAS (%)	NT (%)	ACT(%)
Carer status								
Yes	1.2	0.3	0.7	0.4	0.2	0.1	1.8	0.0
No	29.9	4.8	12.4	54.1	43.4	37.2	47.3	40.6
Unknown	68.9	94.9	86.9	45.5	56.4	62.7	50.9	59.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Household composition								
Couple only	3.5	1.4	1.8	3.4	2.5	1.2	3.6	1.0
Couple with dependent children	7.5	5.6	7.4	12.4	11.2	12.1	7.8	2.5
Single parent with dependent children	19.1	16.7	21.0	32.3	27.7	30.7	46.6	31.7
Group (related or unrelated)	6.8	5.7	7.7	7.5	8.8	14.3	5.3	6.4
Living alone	9.5	5.8	6.9	13.0	11.2	11.7	10.7	5.9
Homeless or no household	0.0	0.3	0.1	0.0	0.3	0.7	0.0	0.0
Unknown	53.5	64.4	55.2	31.4	38.3	29.1	26.0	52.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Income source								
Employment wage/salary	20.0	11.8	15.4	21.3	17.4	19.4	20.6	7.4
Government pension/ benefits	23.6	15.0	17.4	27.7	20.3	32.3	14.2	3.5
Self-employed	2.5	1.3	2.0	2.7	1.7	2.3	1.1	0.5
Other sources (incl. Super)	0.4	0.3	0.3	0.4	0.0	0.0	0.4	0.0
Nil income	11.4	1.5	7.9	8.2	12.5	11.6	17.8	0.5
Unknown	42.2	70.1	57.1	39.6	48.0	34.3	45.9	88.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of clients	4,279	2,366	3,497	1,287	2,007	810	281	202

Appendix D: DEX SCORE Domains

For both the Client Circumstance SCORE and Client Goal SCORE,[33] each domain is assessed on a five-point rating scale about a client's progress in achieving outcome or goals, with 1 indicating no progress, 2 limited progress, 3 some progress, 4 moderate progress and 5 outcome (or goal) fully achieved.

A five-point rating scale applies to each domain of Client satisfaction SCORE, with 1 indicating disagree, 2 tend to disagree, 3 neither agree or disagree, 4 tend to agree, and 5 indicating agree.

SCORE data may be collected and reported either by a client self-assessment, a practitioner assessment, support person assessment or a joint assessment, though assessment methods were not available for some clients.[34] In this report, the SCORE data include all assessments regardless of how they were made, considering that the number of clients assessed across the broad domains by assessment methods would be too small, especially for 2019 data. Appendix 3 contains the relevant response descriptions for each SCORE rating from 1 through to 5 on each domain contained in the *Task Card – How to use SCORE with clients* (Australian Government, 2023) that illustrates how each score is measured (See Appendix C).

Table A3: DEX SCORE domains

	SCORE				
Circumstance domain	**1: Negative impact**	**2: Moderate negative impact**	**3: Middle ground**	**4: Adequate over the short term**	**5: Adequate and stable over the medium term**
Physical health	Significant negative impact of poor physical health on independence, participation and wellbeing	Moderate negative impact of poor physical health on independence, participation and wellbeing	Progress towards improving physical health to support independence, participation and wellbeing	Sustained initial improvements in physical health to support independence, participation and wellbeing	Adequate ongoing physical health to support independence, participation and wellbeing
Mental health, wellbeing and self-care	Significant negative impact of poor mental health, wellbeing and self-care on independence, participation and wellbeing	Moderate negative impact of poor mental health, wellbeing and self-care on independence, participation and wellbeing	Progress towards improving mental health, wellbeing and self-care to support independence, participation and wellbeing	Adequate short term mental health, wellbeing and self-care to support independence, participation and wellbeing	Adequate ongoing mental health, wellbeing and self-care to support independence, participation and wellbeing
Personal and family safety	Significant negative impact of poor personal and family safety on independence, participation and wellbeing	Moderate negative impact of poor personal and family safety on independence, participation and wellbeing	Progress towards improving personal and family safety to support independence, participation and wellbeing	Adequate short term personal and family safety to support independence, participation and wellbeing	Adequate ongoing personal and family safety to support independence, participation and wellbeing

33 SCOREs are not mandatory for service providers, instead service providers and organisations are encouraged to collect SCORE information for as many clients as practical for them (see dex.dss.gov.au/sites/default/files/documents/2022-07/1141-measuring-outcomes.pdf)

34 See Australian Government (2023) *Task Card – How to use SCORE with clients.* Retried from 1976-how-use-score-clients.pdf (dss.gov.au)

	SCORE				
Circumstance domain	**1: Negative impact**	**2: Moderate negative impact**	**3: Middle ground**	**4: Adequate over the short term**	**5: Adequate and stable over the medium term**
Age-appropriate development	Significant negative impact of poor age-appropriate development on independence, participation and wellbeing	Moderate negative impact of poor age-appropriate development on independence, participation and wellbeing	Progress towards improving age-appropriate development to support independence, participation and wellbeing	Adequate short term age-appropriate development to support independence, participation and wellbeing	Adequate ongoing age-appropriate development to support independence, participation and wellbeing
Community participation and networks	Significant negative impact of poor community participation and networks on independence, participation and wellbeing	Moderate negative impact of poor community participation and networks on independence, participation and wellbeing	Progress towards improving community participation and networks to support independence, participation and wellbeing	Adequate short term community participation and networks to support independence, participation and wellbeing	Adequate ongoing community participation and networks to support independence, participation and wellbeing
Family functioning	Significant negative impact of poor family functioning on independence, participation and wellbeing	Moderate negative impact of poor family functioning on independence, participation and wellbeing	Progress towards improving family functioning to support independence, participation and wellbeing	Adequate short term family functioning to support independence, participation and wellbeing	Adequate ongoing family functioning to support independence, participation and wellbeing
Financial Resilience	Significant negative impact of poor financial resilience on independence, participation and wellbeing	Moderate negative impact of poor financial resilience on independence, participation and wellbeing	Progress towards improving financial resilience to support independence, participation and wellbeing	Adequate short term financial resilience to support independence, participation and wellbeing	Adequate ongoing financial resilience to support independence, participation and wellbeing
Employment	Significant negative impact of lack of employment on independence, participation and wellbeing	Moderate negative impact of lack of employment on independence, participation and wellbeing	Progress towards improving employment to support independence, participation and wellbeing	Adequate short term employment to support independence, participation and wellbeing	Adequate ongoing employment to support independence, participation and wellbeing
Education and skills training	Significant negative impact of lack of engagement with education and training on independence, participation and wellbeing	Moderate negative impact of lack of engagement with education and training on independence, participation and wellbeing	Progress towards improving engagement with education and training to support independence, participation and wellbeing	Adequate short term engagement with education and training to support independence, participation and wellbeing	Adequate ongoing engagement with education and training to support independence, participation and wellbeing
Material well-being and basic necessities	Significant negative impact of lack of basic material resources on independence, participation and wellbeing	Moderate negative impact of lack of basic material resources on independence, participation and wellbeing	Progress towards stability in meeting basic material needs to support independence, participation and wellbeing	Adequate short term basic material resources to support independence, participation and wellbeing	Adequate ongoing basic material resources to support independence, participation and wellbeing
Housing	Significant negative impact of poor housing on independence, participation and wellbeing e.g. 'rough sleeping'	Moderate negative impact of poor housing on independence, participation and wellbeing e.g. living in severe overcrowding; or at significant risk of tenancy failure	Progress towards housing stability to support independence, participation and wellbeing e.g. supported transitional housing	Adequate short term housing stability to support independence, participation and wellbeing e.g. supported transitional housing	Adequate ongoing housing stability to support independence, participation and wellbeing e.g. stable private rental or social housing

Source: 'Table 5: Circumstances SCORE domains' from Australian Government, 2019, The data exchange framework, dex.dss.gov.au/document/86

Appendix E: Request for Information – sample description

Table A4. Request for Information: CCS characteristics

CCS characteristic	Number CCS participating (*n*)	%	Number CCS in evaluation scope (*n*)	Response rate % [a]
Number of CCSs participating in each State/Territory				
NSW	15	27.8	19	78.9
VIC	10	18.5	11	90.9
QLD	12	22.2	12	100.0
SA	7	13.0	7	100.0
WA	5	9.3	9	55.6
TAS	3	5.6	3	100.0
NT	1	1.9	2	50.0
ACT	1	1.9	1	100.0
Total	54	100.0	64	84.4
Region				
Major cities	26	48.1	30	86.7
Inner region	20	37.0	24	83.3
Outer/remote region	8	14.8	10	80.0
Total	54	100.0	64	84.4
Organisation type				
Independent organisation	14	25.9	15	93.3
Medium/larger organisation	40	74.1	49	81.6
Total	54	100.0	64	84.4

Note: [a]Response rate calculated as proportion of CCS participating/number CCS in evaluation scope x 100.

Appendix F: Survey of professionals: sample description

Table A5: Survey of Professionals: Professional role by profession type

Type of professional role	CCS professionals		Referring professionals		Total	
	N	%	*N*	%	*N*	%
Program manager of a Children's Contact Service	23	19.3	0	0.0	23	8.6
Coordinator of a Children's Contact Service	31	26.1	0	0.0	31	11.6
Supervisor at a Children's Contact Service	32	26.9	0	0.0	32	11.9
Other staff member at a Children's Contact Service such as Family/contact support worker, admin support or caseworkers	20	16.8	0	0.0	20	7.5
Executive at a service provider organisation that operates a Children's Contact Service	9	7.6	0	0.0	9	3.4
Other staff member at a service provider organisation	4	3.4	0	0.0	4	1.5
Subtotal: CCS professionals	*119*	*100.0*	*0*	*0.0*	*119*	*44.5*
Judicial officer or registrar at the Federal Circuit and Family Court of Australia or Family Court of Western Australia	0	0.0	25	16.8	25	9.3
Judicial officer or registrar at a state or territory Children's Court	0	0.0	1	0.7	1	0.4
Lawyer – barrister	0	0.0	2	1.3	2	0.7
Lawyer – legal aid solicitor	0	0.0	9	6.0	9	3.4
Lawyer – community legal centre	0	0.0	16	10.7	16	6.0
Lawyer – private practice	0	0.0	41	27.5	41	15.3
Family Dispute Resolution Practitioner	0	0.0	12	8.1	12	4.5
Family Relationship Centre employee including Family Counsellor	0	0.0	6	4.0	6	2.2
Domestic and family violence practitioner	0	0.0	15	10.1	15	5.6
Court Child Expert	0	0.0	9	6.0	9	3.4
Therapist/Psychologist	0	0.0	5	3.4	5	1.9
Other non-CCS Staff not elsewhere categorised	0	0.0	8	5.4	8	3.0
Subtotal: Referring professionals	*0*	*0.0*	*149*	*100.0*	*149*	*55.7*
Total	**119**	**100.0**	**149**	**100.0**	**268**	**100.0**

Notes: *n* = 1 Other role specifier was missing and could not be categorised as either CCS/non-CCS professional. Therefore, when data analysed by CCS/referring professional role, total *n* = 268.

Table A6: Survey of Professionals: Demographic characteristics by professional type

Demographic characteristics	CCS professionals		Referring professionals		Total	
	N	%	*N*	%	*N*	%
State/Territory of work						
New South Wales	39	32.8	35	23.5	74	27.6
Queensland	29	24.4	32	21.5	61	22.8
Victoria	21	17.6	36	24.2	57	21.3
Western Australia	16	13.4	14	9.4	30	11.2
South Australia	6	5.0	11	7.4	17	6.3
Tasmania	3	2.5	7	4.7	10	3.7
Northern Territory	2	1.7	6	4.0	8	3.0
Australian Capital Territory	2	1.7	3	2.0	5	1.9
Multiple states/territories	0	0.0	3	2.0	3	1.1
Other	0	0.0	2	1.3	2	0.7
Missing	1	0.8	0	0.0	1	0.4
Total	119	100.0	149	100.0	268	100.0
Age (years)						
Under 25 years	2	1.7	0	0.0	2	0.7
25–34 years	14	11.8	24	16.1	38	14.2
35–44 years	29	24.4	30	20.1	59	22.0
45–54 years	35	29.4	39	26.2	74	27.6
55 years or older	36	30.3	46	30.9	82	30.6
Prefer not to say	3	2.5	8	5.4	11	4.1
Missing	0	0.0	2	1.3	2	0.7
Total	119	100.0	149	100.0	268	100.0
Are you:						
Woman or female	101	84.9	118	79.2	219	81.7
Man or male	17	14.3	17	11.4	34	12.7
I use a different term	0	0.0	4	2.7	4	1.5
Non-binary	0	0.0	1	0.7	1	0.4
Prefer not to say	1	0.8	7	4.7	8	3.0
Missing	0	0.0	2	1.3	2	0.7
Total	119	100.0	149	100.0	268	100.0
Do you identify as Aboriginal and/or Torres Strait Islander?						
Yes Aboriginal	3	2.5	2	1.3	5	1.9
Yes, both Aboriginal and Torres Strait Islander	1	0.8	1	0.7	2	0.7
No	113	95.0	135	90.6	248	92.5
Prefer not to say	1	0.8	9	6.0	10	3.7
Missing	1	0.8	2	1.3	3	1.1
Total	119	100.0	149	100.0	268	100.0
Do you speak any languages other than English?						
Yes	13	10.9	16	10.7	29	10.8
No	103	86.6	122	81.9	225	84.0
Prefer not to say	1	0.8	7	4.7	8	3.0
Missing	2	1.7	4	2.7	6	2.2
Total	119	100.0	149	100.0	268	100.0

Demographic characteristics	CCS professionals		Referring professionals		Total	
	N	%	*N*	%	*N*	%
Geographic area of work*						
Suburban area	44	37	48	32.2	92	34.3
Regional area	45	37.8	39	26.2	84	31.3
Central Business District (CBD)	16	13.4	45	30.2	61	22.8
Rural area	9	7.6	10	6.7	19	7.1
Multiple geographical locations	5	4.2	4	2.7	9	3.4
Other: (Please specify)	0	0	1	0.7	1	0.4
Missing	0	0	2	1.3	2	0.7
Total	119	100.0	149	100.0	268	100.0

Notes: *n* = 1 Other role specifier was missing and could not be categorised as either CCS/referring professional. Therefore, when data analysed by CCS/referring professional role, total *n* = 268. *p < .05 statistically significant based on chi-square test. Percentages may not total 100.0% due to rounding.

Table A7: Survey of Professionals: primary services government-funded CCSs provide by professional type

Do the government-funded CCSs in your organisation/in your area provide the following services?	CCS professionals		Referring professionals		All	
	N	%	*N*	%	*N*	%
Supervised/facilitated parenting time (onsite)* **						
All CCSs provide this service	110	92.4	80	55.9	190	72.5
Most CCSs provide this service	5	4.2	29	20.3	34	13.0
Some CCSs provide this service	1	0.8	6	4.2	7	2.7
Few CCSs provide this service	0	0.0	1	0.7	1	0.4
No CCSs provide this service	0	0.0	0	0.0	0	0.0
Do not know/Cannot say	1	0.8	17	11.9	18	6.9
Not applicable	2	1.7	10	7.0	12	4.6
Total	119	100.0	143	100.0	262	100.0
Intake and risk assessment* **						
All CCSs provide this service	109	91.6	79	55.2	188	71.8
Most CCSs provide this service	4	3.4	22	15.4	26	9.9
Some CCSs provide this service	2	1.7	4	2.8	6	2.3
Few CCSs provide this service	1	0.8	2	1.4	3	1.1
No CCSs provide this service	0	0.0	0	0.0	0	0.0
Do not know/Cannot say	2	1.7	26	18.2	28	10.7
Not applicable	1	0.8	10	7.0	11	4.2
Total	119	100.0	143	100.0	262	100.0
Supervised/facilitated changeover (onsite)* **						
All CCSs provide this service	108	90.8	71	49.7	179	68.3
Most CCSs provide this service	7	5.9	30	21.0	37	14.1
Some CCSs provide this service	1	0.8	10	7.0	11	4.2
Few CCSs provide this service	0	0.0	1	0.7	1	0.4
No CCSs provide this service	0	0.0	0	0.0	0	0.0
Do not know/Cannot say	1	0.8	19	13.3	20	7.6
Not applicable	2	1.7	12	8.4	14	5.3
Total	119	100.0	143	100.0	262	100.0

Do the government-funded CCSs in your organisation/in your area provide the following services?	CCS professionals		Referring professionals		All	
	N	%	*N*	%	*N*	%
Safety planning and orientation/familiarisation* **						
All CCSs provide this service	106	89.1	58	40.8	164	62.8
Most CCSs provide this service	6	5.0	24	16.9	30	11.5
Some CCSs provide this service	2	1.7	7	4.9	9	3.4
Few CCSs provide this service	2	1.7	3	2.1	5	1.9
No CCSs provide this service	0	0.0	1	0.7	1	0.4
Do not know/Cannot say	2	1.7	38	26.8	40	15.3
Not applicable	1	0.8	11	7.7	12	4.6
Total	119	100.0	142	100.0	261	100.0
Supported/monitored visits (onsite visits with one or more families who have been assessed as requiring low vigilance supervision)* **						
All CCSs provide this service	86	72.3	24	17.0	110	42.3
Most CCSs provide this service	4	3.4	13	9.2	17	6.5
Some CCSs provide this service	4	3.4	19	13.5	23	8.8
Few CCSs provide this service	3	2.5	3	2.1	6	2.3
No CCSs provide this service	7	5.9	9	6.4	16	6.2
Do not know/Cannot say	6	5.0	60	42.6	66	25.4
Not applicable	9	7.6	13	9.2	22	8.5
Total	119	100.0	141	100.0	260	100.0
Online/virtual (telephone or internet based) supervision service* **						
All CCSs provide this service	79	67.5	16	11.2	95	36.5
Most CCSs provide this service	7	6.0	7	4.9	14	5.4
Some CCSs provide this service	3	2.6	11	7.7	14	5.4
Few CCSs provide this service	5	4.3	4	2.8	9	3.5
No CCSs provide this service	8	6.8	11	7.7	19	7.3
Do not know/Cannot say	6	5.1	79	55.2	85	32.7
Not applicable	9	7.7	15	10.5	24	9.2
Total	117	100.0	143	100.0	260	100.0
Community-based/offsite supervision service* **						
All CCSs provide this service	48	42.1	6	4.3	54	21.2
Most CCSs provide this service	4	3.5	2	1.4	6	2.4
Some CCSs provide this service	5	4.4	15	10.6	20	7.8
Few CCSs provide this service	5	4.4	13	9.2	18	7.1
No CC/s provide this service	30	26.3	29	20.6	59	23.1
Do not know/Cannot say	12	10.5	63	44.7	75	29.4
Not applicable	10	8.8	13	9.2	23	9.0
Total	114	100.0	141	100.0	255	100.0
Unsupervised on-site visit* **						
All CCSs provide this service	30	25.9	3	2.1	33	12.8
Most CCSs provide this service	4	3.4	4	2.8	8	3.1
Some CCSs provide this service	8	6.9	10	7.1	18	7.0
Few CCSs provide this service	3	2.6	6	4.3	9	3.5
No CCSs provide this service	34	29.3	25	17.7	59	23.0

Do the government-funded CCSs in your organisation/in your area provide the following services?	CCS professionals		Referring professionals		All	
	N	%	*N*	%	*N*	%
Do not know/Cannot say	17	14.7	78	55.3	95	37.0
Not applicable	20	17.2	15	10.6	35	13.6
Total	116	100.0	141	100.0	257	100.0

Notes: CSS professionals asked to rate CCS characteristics for 'my organisation' and referring professionals asked 'in my area'. *$p < .05$; **$p < .01$; ***$p < .001$ statistically significant based on chi-square test. Percentages may not total 100.0% due to rounding.

Table A8: Survey of Professionals: secondary services government-funded CCSs provide by professional type

Do the government-funded CCSs in your organisation/in your area provide the following services?	CCS professionals		Referring professionals		Total	
	N	%	*N*	%	*N*	%
Case support* **						
All CCSs provide this service	94	79.0	10	7.1	104	40.0
Most CCSs provide this service	3	2.5	7	5.0	10	3.8
No, Few or Some CCSs provide this service	12	10.2	42	29.8	54	20.8
Do not know/Cannot say	6	5.0	69	48.9	75	28.8
Not applicable	4	3.4	13	9.2	17	6.5
Total	119	100.0	141	100.0	260	100.0
Case management* **						
All CCSs provide this service	80	68.4	10	7.1	90	34.9
Most CCSs provide this service	4	3.4	11	7.8	15	5.8
No, Few or Some CCSs provide this service	24	20.5	38	26.9	62	24.1
Do not know/Cannot say	4	3.4	69	48.9	73	28.3
Not applicable	5	4.3	13	9.2	18	7.0
Total	117	100.0	141	100.0	258	100.0
Case planning* **						
All CCSs provide this service	79	68.7	9	6.4	88	34.5
Most CCSs provide this service	3	2.6	10	7.1	13	5.1
No, Few or Some CCSs provide this service	19	16.5	39	27.8	58	22.7
Do not know/Cannot say	8	7.0	70	50.0	78	30.6
Not applicable	6	5.2	12	8.6	18	7.1
Total	115	100.0	140	100.0	255	100.0
Written reports of families' interactions with the Children's Contact Service and the changeover and/or visit at the service* **						
All CCSs provide this service	90	76.3	60	42.9	150	58.1
Most CCSs provide this service	5	4.2	30	21.4	35	13.6
No, Few or Some CCSs provide this service	13	11.0	18	12.8	31	12.1
Do not know/Cannot say	4	3.4	23	16.4	27	10.5
Not applicable	6	5.1	9	6.4	15	5.8
Total	118	100.0	140	100	258	100
Non-supervision services for children* **						
All CCSs provide this service	22	19.5	7	5.0	29	11.5
Most CCSs provide this service	6	5.3	5	3.6	11	4.3
No, Few or Some CCSs provide this service	45	39.8	41	29.3	86	34.0
Do not know/Cannot say	20	17.7	72	51.4	92	36.4

Do the government-funded CCSs in your organisation/in your area provide the following services?	CCS professionals		Referring professionals		Total	
	N	%	*N*	%	*N*	%
Not applicable	20	17.7	15	10.7	35	13.8
Total	113	100.0	140	100.0	253	100.0

Notes: CSS professionals asked to rate CCS characteristics for 'my organisation' and referring professionals asked 'in my area'. *$p < .05$; **$p < .01$; ***$p < .001$ statistically significant based on chi-square test. Percentages may not total 100.0% due to rounding.

Table A9: Survey of Professionals: non-supervision/secondary services government-funded CCSs provide by professional type

Do the government-funded CCSs in your organisation/in your area provide the following services?	CCS professionals		Referring professionals		Total	
	N	%	*N*	%	*N*	%
Information, advice and/or referrals to education, skills and training programs (including post-separation parenting programs and parenting orders programs) for adults and services for children* **						
All CCSs provide this service	89	76.1	21	15.0	110	42.8
Most CCSs provide this service	3	2.6	17	12.1	20	7.8
No, Few or Some CCSs provide this service	17	14.5	35	25.0	52	20.2
Do not know/Cannot say	6	5.1	54	38.6	60	23.3
Not applicable	2	1.7	13	9.3	15	5.8
Total	117	100.0	140	100.0	257	100.0
Education, skills and training programs (including post-separation parenting programs and parenting order programs for adult clients)* **						
All CCSs provide this service	61	52.6	18	12.9	79	30.9
Most CCSs provide this service	6	5.2	11	7.9	17	6.6
No, Few or Some CCSs provide this service	27	23.3	46	32.9	73	28.5
Do not know/Cannot say	11	9.5	52	37.1	63	24.6
Not applicable	11	9.5	13	9.3	24	9.4
Total	116	100.0	140	100.0	256	100.0
Counselling or other therapeutic support* **						
All CCSs provide this service	46	40.4	13	9.3	59	23.2
Most CCSs provide this service	6	5.3	10	7.1	16	6.3
No, Few or Some CCSs provide this service	38	33.4	49	35.1	87	34.3
Do not know/Cannot say	12	10.5	56	40.0	68	26.8
Not applicable	12	10.5	12	8.6	24	9.4
Total	114	100.0	140	100.0	254	100.0
Advocacy support* **						
All CCSs provide this service	87	75.0	5	3.6	92	36.1
Most CCSs provide this service	2	1.7	2	1.4	4	1.6
No, Few or Some CCSs provide this service	14	12.1	40	28.8	54	21.1
Do not know/Cannot say	8	6.9	77	55.4	85	33.3
Not applicable	5	4.3	15	10.8	20	7.8
Total	116	100.0	139	100.0	255	100.0

Notes: CSS professionals asked to rate CCS characteristics for 'my organisation' and referring professionals asked 'in my area'. *$p < .05$; **$p < .01$; ***$p < .001$ statistically significant based on chi-square test. Percentages may not total 100.0% due to rounding.

Table A10: Survey of Professionals: non-supervision/secondary services government-funded CCSs provide by professional type

Do the government-funded CCSs in your organisation/ in your area provide the following services?	CCS professionals		Referring professionals		Total	
	N	%	*N*	%	*N*	%
Referrals to family and domestic violence services* **						
All CCSs provide this service	95	80.5	27	19.3	122	47.3
Most CCSs provide this service	6	5.1	17	12.1	23	8.9
No, Few or Some CCSs provide this service	9	7.6	28	20.0	37	14.4
Do not know/Cannot say	6	5.1	58	41.4	64	24.8
Not applicable	2	1.7	10	7.1	12	4.7
Total	118	100.0	140	100.0	258	100.0
Referrals for financial advice or assistance* **						
All CCSs provide this service	77	65.3	11	7.9	88	34.2
Most CCSs provide this service	6	5.1	3	2.2	9	3.5
No, Few or Some CCSs provide this service	17	14.4	24	17.2	41	15.9
Do not know/Cannot say	12	10.2	87	62.6	99	38.5
Not applicable	6	5.1	14	10.1	20	7.8
Total	118	100.0	139	100.0	257	100.0
Referrals for assistance with housing* **						
All CCSs provide this service	73	62.4	10	7.1	83	32.3
Most CCSs provide this service	8	6.8	3	2.1	11	4.3
No, Few or Some CCSs provide this service	19	16.3	25	17.8	44	17.1
Do not know/Cannot say	10	8.5	88	62.9	98	38.1
Not applicable	7	6.0	14	10.0	21	8.2
Total	117	100.0	140	100.0	257	100.0
Referrals for legal advice/representation in relation to family violence (e.g. Intervention orders)* **						
All CCSs provide this service	69	59.0	13	9.4	82	32
Most CCS/s provide this service	9	7.7	9	6.5	18	7
No, Few or Some CCSs provide this service	17	14.5	21	15.2	38	14.8
Do not know/Cannot say	13	11.1	85	61.2	98	38.3
Not applicable	9	7.7	11	7.9	20	7.8
Total	117	100.0	139	100.0	256	100.0
Referrals for legal advice/representation in relation to family law matters (including children and/or property/ financial matters)* **						
All CCSs provide this service	65	56.0	13	9.3	78	30.5
Most CCSs provide this service	9	7.8	7	5.0	16	6.3
No, Few or Some CCSs provide this service	19	16.3	26	18.6	45	17.5
Do not know/Cannot say	14	12.1	82	58.6	96	37.5
Not applicable	9	7.8	12	8.6	21	8.2
Total	116	100.0	140	100.0	256	100.0
Referrals for legal advice/representation in relation to child protection* **						
All CCSs provide this service	62	53.4	13	9.3	75	29.3
Most CCSs provide this service	8	6.9	8	5.7	16	6.3
No, Few or Some CCSs provide this service	20	17.2	23	16.4	43	16.8
Do not know/Cannot say	14	12.1	84	60.0	98	38.3
Not applicable	12	10.3	12	8.6	24	9.4
Total	116	100.0	140	100.0	256	100.0

Do the government-funded CCSs in your organisation/ in your area provide the following services?	CCS professionals		Referring professionals		Total	
	N	%	*N*	%	*N*	%
Other* **						
All CCSs provide this service	9	26.5	1	1.4	10	9.3
Most CCSs provide this service	1	2.9	0	0.0	1	0.9
No, Few or Some CCSs provide this service	2	5.9	3	4.1	5	4.7
Do not know/Cannot say	3	8.8	41	55.4	44	40.7
Not applicable	19	55.9	29	39.2	48	44.4
Total	34	100.0	74	100.0	108	100.0

Notes: CSS professionals asked to rate CCS characteristics for 'my organisation' and referring professionals asked 'in my area'. *$p < .05$; **$p < .01$; ***$p < .001$ statistically significant based on chi-square test. Percentages may not total 100.0% due to rounding. Other specify responses include: referrals to other programs within CCS service; consultation with ICLs; support to move to unsupervised changeovers; re-introductory contact skills sessions; and toys and Christmas hampers.

Table A11: Survey of Professionals: agreement with primary services government-funded CCSs should provide by professional type

Strongly agree/agree that government-funded CCSs 'in your organisation/ in your area' should provide:	CCS professionals		Referring professionals		Total	
	N	%	*N*	%	*N*	%
Intake and risk assessment	113	99.1	137	98.6	250	98.8
Safety planning and familiarisation/orientation	113	99.1	135	97.8	248	98.4
Supervised/facilitated parenting time (onsite)	112	98.3	136	97.8	248	98.0
Supervised/facilitated changeover (onsite)	112	98.3	136	97.9	248	98.0
Written reports of families' interactions with the Children's Contact Service and the changeover and/or visit at the service	97	85.1	127	92.7	224	89.3
Supported/monitored visits (onsite visits with one or more families who have been assessed as requiring low vigilance supervision)	97	85.8	118	86.1	215	86.0
Online/virtual (telephone or internet based) supervision service	94	82.5	104	75.9	198	78.9
Case support***	95	84.8	81	59.5	176	71.0
Community-based/offsite supervision service*	72	63.7	105	76.6	177	70.8
Case management**	87	77.0	77	56.7	164	65.9
Case planning***	88	79.3	76	55.9	164	66.4
Unsupervised onsite visit	50	45.0	58	42.9	108	43.9
Information, advice and/or referrals to education, skills and training programs (including post-separation parenting programs and parenting orders programs) for adults and services for children*	102	89.5	121	88.4	223	88.8
Referrals to family and domestic violence services	104	92.0	116	84.0	220	87.6
Education, skills and training programs (including post-separation parenting programs and parenting order programs for adult clients)*	94	82.5	108	78.9	202	80.5
Referrals for financial advice or assistance*	94	83.2	98	71.5	192	76.8
Referrals for assistance with housing*	95	84.0	96	70.1	191	76.4
Referrals for legal advice/representation in relation to family violence (e.g. Intervention orders)	90	78.9	100	73.0	190	75.7

Strongly agree/agree that government-funded CCSs 'in your organisation/ in your area' should provide:	CCS professionals		Referring professionals		Total	
	N	%	*N*	%	*N*	%
Referrals for legal advice/representation in relation to child protection	89	78.0	99	72.3	188	74.9
Referrals for legal advice/representation in relation to family law matters (including children and/or property/financial matters)	88	77.2	97	72.4	185	74.6
Counselling or other therapeutic support**	86	76.1	76	55.5	162	64.8
Advocacy support***	101	88.6	59	43.4	160	64.0
Non-supervision services for children	58	52.2	54	39.7	112	45.3
Other	11	30.6	5	9.1	16	17.6

Notes: CSS professionals asked to rate CCS characteristics for 'my organisation' and referring professionals asked 'in my area'. *$p < .05$; **$p < .01$; ***$p < .001$ statistically significant based on chi-square test. Percentages may not total 100.0% due to rounding.

Table A12: Survey of Professionals: CCS professionals' training and ongoing professional development

Type of training and professional development	*N*	%
Child safety/child abuse and/or neglect		
Yes, in the last 18 months	57	54.3
Yes, in the past	39	37.1
No	6	5.7
Missing	3	2.9
Total	105	100.0
Domestic and family violence		
Yes, in the last 18 months	56	53.3
Yes, in the past	39	37.1
No	9	8.6
Missing	1	1.0
Total	105	100.0
Cultural awareness training – Aboriginal and Torres Strait Islander related		
Yes, in the last 18 months	55	52.4
Yes, in the past	40	38.1
No	7	6.7
Missing	3	2.9
Total	105	100.0
Child safe practice		
Yes, in the last 18 months	52	49.5
Yes, in the past	42	40.0
No	6	5.7
Missing	5	4.8
Total	105	100.0
Trauma-informed practice		
Yes, in the last 18 months	49	46.7
Yes, in the past	44	41.9
No	8	7.6

Type of training and professional development	*N*	%
Missing	4	3.8
Total	105	100.0
Cultural awareness training – culturally and linguistically diverse backgrounds		
Yes, in the last 18 months	46	43.8
Yes, in the past	42	40.0
No	13	12.4
Missing	4	3.8
Total	105	100.0
Child-inclusive practice		
Yes, in the last 18 months	41	39.0
Yes, in the past	46	43.8
No	12	11.4
Missing	6	5.7
Total	105	100.0
Service provision for adults and/or children with a disability		
Yes, in the last 18 months	19	18.1
Yes, in the past	39	37.1
No	37	35.2
Missing	10	9.5
Total	105	100.0
Other		
Yes, in the last 18 months	14	13.3
Yes, in the past	8	7.6
No	6	5.7
Missing/Not selected	77	73.3
Total	105	100.0

Notes: This question was asked only of CCS professionals who were program managers, coordinators, supervisors or other staff member at a CCS. Percentages may not total 100.0% due to rounding. Examples of other training include: leadership and management, LGBTIQA+ inclusion and awareness, de-escalation and dealing with challenging behaviours, mental health, and first aid training.

Appendix G: Survey of Parents and Carers

Table A13: Online Survey of Parents and Carers: relationship characteristics, by gender and ancestry

How would you describe your current relationship status?	Gender		Participant or at least one parent born overseas in a non-English speaking country?		Total	
	Man or male (%)	Woman or female (%)	No (%)	Yes (%)	*n*	%
Single	46.5	44.1	47.3	31.6	50	44.6
Separated/divorced	27.9	26.5	20.4	63.2***	31	27.7
Married or living with a partner	16.3	14.7	17.2	10.5	18	16.1
In a relationship (not living together)	9.3	10.3	10.8	5.3	11	9.8
Prefer not to say	4.7	7.4	7.5	0	7	6.2
N =	43	68	93	19	112	

Notes: Multiple responses so totals may not sum to 100.0%. This table reports the number and proportion of parents and carers that selected each response option from a list describing their current relations status. Not shown is the number and proportion where each response was not selected (including potentially missing responses). *$p < .05$, ** $p < 0.01$, ***$p < .001$ statistically significant based on chi-square test.

Table A14: Online Survey of Parents and Carers: number, age and gender of children

	Number	%
Parents		
How many children do you have?		
1	44	39.3
2	35	31.3
3	21	18.8
4	10	8.9
5	1	0.9
Prefer not to say	1	0.9
Total	112	100.0
Children		
Child gender		
Male	107	49.5
Female	104	48.1
Non-binary	1	0.5
Prefer not to say	4	1.9
Total	216	100.0
Child age		
0-4 years	58	27.4
5-9 years	67	31.6
10-14 years	61	28.8
15 years or older	26	12.3
Total	212	100.0

Notes: *n* = 6 responses missing child gender, *n* = 10 responses missing child age.

Appendix H: DEX demographic and SCORE data, 2019–22

Table A15: DEX: demographics of clients aged 18 years and over by state/territory, 2019

	NSW	Vic	Qld	SA	WA	Tas	NT	ACT
Age								
18–29	21.0	20.6	19.8	23.3	20.4	26.9		
30–39	37.5	43.1	41.4	41.5	42.9	43.6		
40–49	27.5	27.5	27.9	25.2	22.8	22.8		
50+	14.0	8.8	10.9	9.9	13.9	6.6		
Total	100.0	100.0	100.0	100.0	100.0	100.0	..	..
Gender [a]								
Male	45.5	46.1	45.5	46.8	45.9	48.2	46.5	47.5
Female	54.5	53.9	54.5	53.2	54.1	51.8	53.5	52.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Indigenous status								
Indigenous	11.4	5.4	8.0	4.2	4.9	5.0	26.4	..
Non-Indigenous	85.5	89.7	89.8	88.5	94.1	95.0	73.6	..
NS	3.1	4.9	2.3	7.3	1.0	..	..	..
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	..
CALD								
CALD background	6.9	10.6	1.7	3.8	1.7	..	5.0	
Else	93.1	89.4	98.3	96.2	98.3	..	95.0	
Total	100.0	100.0	100.0	100.0	100.0	..	100.0	..
Disability status								
Yes	9.8	15.1	7.7	11.2	6.2	8.2	15.2	..
No	87.3	77.7	88.2	85.8	87.5	88.4	84.8	69.7
Unknown	2.9	7.3	4.1	3.0	6.3	3.4	..	30.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Household composition								
Couple only	5.3	2.1	2.8	4.7	3.8	2.0	6.3	..
Couple with dependent children	7.8	7.6	8.6	14.1	14.2	13.1	11.3	..
Single parent with dependent children	17.6	22.9	23.3	33.7	30.9	32.5	34.0	27.6
Group (related or unrelated)	7.9	8.7	10.7	10.0	10.5	19.7	8.2	9.5
Living alone	13.4	8.9	10.4	20.3	16.9	18.5	18.9	10.3
Homeless or no household	..	0.5	..	..	0.5	1.2	..	..
Unknown	47.9	49.3	44.1	17.2	23.2	13.1	21.4	52.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Male clients: employment status								
Full-time	13.3	3.4	13.9	5.7	13.3	8.5	28.4	..
Part-time	3.8	1.5	3.3	1.5	2.5	..	9.5	..

	NSW	Vic	Qld	SA	WA	Tas	NT	ACT
Not employed	10.0	5.0	7.6	4.0	6.9	6.8	13.5	..
Unknown	72.9	90.2	75.1	88.8	77.3	84.7	48.6	..
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	..
Female clients: employment status								
Full-time	4.7	1.4	5.0	1.5	4.0	3.1	15.3	
Part-time	6.8	2.6	5.0	1.3	3.4	5.0	8.2	
Not employed	14.4	8.5	14.5	7.2	12.0	10.9	27.1	
Unknown	74.1	87.5	75.6	89.9	80.6	81.0	49.4	
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	..
Number of clients aged 18+ years	2,634	1,486	2,246	858	1,299	498	158[b]	119[b]

Notes: '..' refers to data not available through the process of data confidentialisation due to small numbers and the percentages for the variable were based on available categories. [a] Categories 'other' and 'unknown' were not available through the process of data confidentialisation due to small numbers. [b] The number is derived from summing subcategories of a variable with more complete data and may vary slightly with actual total number of clients.

Table A16: DEX: demographics of clients aged 18 years and over by state/territory, 2022

	NSW	Vic	Qld	SA	WA	Tas	NT	ACT
Age								
18–29	19.0	16.9	17.6	21.7	14.6	22.3		
30–39	39.3	43.1	43.4	43.3	43.5	43.7		
40–49	28.3	30.8	29.1	25.3	28.3	26.0		
50+	13.4	9.2	9.9	9.7	13.6	8.0		
Total	100.0	100.0	100.0	100.0	100.0	100.0	..	..
Gender [a]								
Male	45.9	49.6	46.8	46.5	45.1	47.3	46.8	..
Female	54.1	50.4	53.2	53.5	54.9	52.7	53.2	..
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	..
Indigenous status								
Indigenous	11.6	5.4	9.0	7.7	5.0	7.3	16.7	..
Non-Indigenous	86.2	92.0	89.9	89.7	91.5	91.9	73.0	..
NS	1.6	2.2	0.6	1.9	2.8	..	..	..
Total	99.5	99.6	99.6	99.3	99.3	99.2	89.6	..
CALD								
CALD background	6.7	8.1	2.2	4.7	2.0	..	5.4	
Else	93.3	91.9	97.8	95.3	98.0	..	94.6	
Total	100.0	100.0	100.0	100.0	100.0	..	100.0	..
Disability status								
Yes	8.8	13.3	9.2	14.5	3.6	8.6	10.8	..
No	90.2	80.1	85.4	83.4	94.5	90.2	89.2	..
Unknown	1.0	6.6	5.4	2.1	1.9	1.2	..	..
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	..
Household composition								
Couple only	4.2	1.5	3.7	5.0	4.5	3.4	5.9	..
Couple with dependent children	8.7	7.6	11.6	16.2	11.0	10.0	8.6	..
Single parent with dependent children	21.1	20.4	30.5	32.7	28.0	29.1	38.2	..

	NSW	Vic	Qld	SA	WA	Tas	NT	ACT
Group (related or unrelated)	10.8	9.3	14.7	12.2	8.5	18.5	10.8	..
Living alone	12.6	10.5	16.2	19.9	15.2	16.6	18.8	..
Homeless or no household	..	0.3	0.3	..	0.8	1.4	..	..
Unknown	42.6	50.4	23.1	14.1	32.1	21.0	17.7	..
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	..
Number of clients								
Male clients: employment status								
Full-time	15.3	7.3	35.0	10.7	19.0	18.1	36.8	
Part-time	3.2	1.8	10.6	2.1	4.1	4.5	10.3	
Not employed	8.8	8.7	18.4	7.2	10.2	13.6	13.8	
Unknown	72.7	82.3	36.0	79.9	66.7	63.8	39.1	
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	..
Female clients: employment status								
Full-time	4.3	2.9	13.3	2.3	3.9	5.1	19.2	
Part-time	7.5	6.8	15.8	5.1	9.5	7.5	10.1	
Not employed	15.3	12.4	34.1	11.4	21.2	17.6	33.3	
Unknown	72.8	77.9	36.7	81.2	65.4	69.8	37.4	
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	..
Number of clients aged 18+ years	2,090	1,585	1,791	806	1,041	561	185[b]	..

Notes: '..' refers to data not available through the process of data confidentialisation due to small numbers and the percentages for the variable were based on available categories. [a] Categories 'other' and 'unknown' were not available through the process of data confidentialisation due to small numbers. [b] The number is derived from summing subcategories of a variable with more complete data and may vary slightly with actual total number of clients.

Table A17: DEX: Demographic characteristics of clients (proportion), 2019–22

Demographic characteristics	2019	2020	2021	2022
Age				
0–17 years	35.5	34.8	36.1	37.5
0–4 years	11.2	10.5	10.9	10.8
5–9 years	16.0	15.7	16.1	16.9
10–17 years	7.6	7.9	8.3	8.7
18–29 year	13.9	12.9	12.4	11.5
30–39 years	26.2	27.2	26.8	26.3
40–49 years	16.9	17.9	17.7	17.8
50 years and over	7.4	7.2	7.0	6.9
Total	100.0	100.0	100.0	100.0
Gender				
Male	47.5	48.0	48.4	48.2
Female	52.4	51.8	51.5	51.6
Other	0.1	0.1	0.1	0.2
Total	100.0	100.0	100.0	100.0
Indigenous status				
Indigenous	8.4	8.0	8.9	9.0
Non-Indigenous	87.8	89.2	89.3	89.1
NS	3.8	2.8	1.8	1.9

Demographic characteristics	2019	2020	2021	2022
Total	100.0	100.0	100.0	100.0
CALD				
CALD background	3.7	4.0	3.1	3.2
Else	96.3	96.0	96.9	96.8
Total	100.0	100.0	100.0	100.0
Homeless status				
Yes	0.4	0.5	0.5	0.5
At risk of homeless	0.3	0.5	0.6	0.5
No	53.6	50.9	48.5	43.5
Unknown	45.7	48.0	50.5	55.5
Total	100.0	100.0	100.0	100.0
Disability status				
Yes	9.2	10.1	9.9	10.1
No	86.3	86.1	86.5	86.7
Unknown	4.5	3.8	3.6	3.2
Total	100.0	100.0	100.0	100.0
Carer status				
Yes	0.7	0.8	1.0	0.9
No	26.5	22.6	20.8	18.6
Unknown	72.8	76.6	78.2	80.4
Total	100.0	100.0	100.0	100.0
Household composition				
Couple only	2.5	2.5	2.6	2.3
Couple with dependent children	8.3	8.5	8.6	7.9
Single parent with dependent children	22.8	25.5	24.8	22.7
Group (related or unrelated)	7.5	7.9	8.3	8.5
Living alone	8.9	10.0	9.7	9.2
Homeless or no household	0.2	0.2	0.3	0.3
Unknown	49.8	45.4	45.7	49.2
Total	100.0	100.0	100.0	100.0
Income source				
Employment wage/salary	17.1	18.1	17.8	17.5
Government pension/ benefits	20.7	22.5	21.9	18.7
Self-employed	2.1	2.4	2.4	2.3
Other sources (incl. Super)	0.3	0.3	0.3	0.2
Nil income	8.8	7.7	7.2	5.9
Unknown	51.1	48.9	50.4	55.3
Total	100.0	100.0	100.0	100.0
Number of clients	14,729	12,797	12,582	13,198

Notes: 1. Family Life Limited – Cranbourne is not included. 2. The years nominated in this table refer to calendar years.

Table A18: DEX: Demographic characteristics of clients (proportion), 2019–22

Demographic characteristics	2019	2020	2021	2022
Age				
0–17 years	35.5	34.8	36.1	37.5
0–4 years	11.2	10.5	10.9	10.8
5–9 years	16.0	15.7	16.1	16.9
10–17 years	7.6	7.9	8.3	8.7
18–29 year	13.9	12.9	12.4	11.5
30–39 years	26.2	27.2	26.8	26.3
40–49 years	16.9	17.9	17.7	17.8
50 years and over	7.4	7.2	7.0	6.9
Total	100.0	100.0	100.0	100.0
Gender				
Male	47.5	48.0	48.4	48.2
Female	52.4	51.8	51.5	51.6
Other	0.1	0.1	0.1	0.2
Total	100.0	100.0	100.0	100.0
Indigenous status				
Indigenous	8.4	8.0	8.9	9.0
Non-Indigenous	87.8	89.2	89.3	89.1
Not stated	3.8	2.8	1.8	1.9
Total	100.0	100.0	100.0	100.0
CALD				
CALD background	3.7	4.0	3.1	3.2
Else	96.3	96.0	96.9	96.8
Total	100.0	100.0	100.0	100.0
Homeless status				
Yes	0.4	0.5	0.5	0.5
At risk of homeless	0.3	0.5	0.6	0.5
No	53.6	50.9	48.5	43.5
Unknown	45.7	48.0	50.5	55.5
Total	100.0	100.0	100.0	100.0
Disability status				
Yes	9.2	10.1	9.9	10.1
No	86.3	86.1	86.5	86.7
Unknown	4.5	3.8	3.6	3.2
Total	100.0	100.0	100.0	100.0
Carer status				
Yes	0.7	0.8	1.0	0.9
No	26.5	22.6	20.8	18.6
Unknown	72.8	76.6	78.2	80.4
Total	100.0	100.0	100.0	100.0
Household composition				
Couple only	2.5	2.5	2.6	2.3
Couple with dependent children	8.3	8.5	8.6	7.9
Single parent with dependent children	22.8	25.5	24.8	22.7
Group (related or unrelated)	7.5	7.9	8.3	8.5

Demographic characteristics	2019	2020	2021	2022
Living alone	8.9	10.0	9.7	9.2
Homeless or no household	0.2	0.2	0.3	0.3
Unknown	49.8	45.4	45.7	49.2
Total	100.0	100.0	100.0	100.0
Income source				
Employment wage/salary	17.1	18.1	17.8	17.5
Government pension/benefits	20.7	22.5	21.9	18.7
Self-employed	2.1	2.4	2.4	2.3
Other sources (incl. Super)	0.3	0.3	0.3	0.2
Nil income	8.8	7.7	7.2	5.9
Unknown	51.1	48.9	50.4	55.3
Total	100.0	100.0	100.0	100.0
Number of clients	14,729	12,797	12,582	13,198

Notes: 1. Family Life Limited – Cranbourne is not included. 2. The years nominated in this table refer to calendar years.

Table A19: DEX: Demographic characteristics of clients of in-scope CCS services (proportion), by state/territory, 2022

Demographic characteristics	NSW	Vic	Qld	SA	WA	Tas	NT	ACT
Indigenous status								
Indigenous	11.2	6.6	10.4	8.4	4.8	7.2	22.6	4.2
Non-Indigenous	85.9	91.0	88.5	89.4	93.1	92.8	77.1	95.0
Not stated	2.8	2.4	1.1	2.2	2.1	0.0	0.3	0.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of clients	3,369	2,627	2,931	1,232	1,685	907	328	119
CALD								
CALD background	4.6	5.3	1.6	3.2	1.3	0.1	4.0	0.8
Else	95.4	94.7	98.4	96.8	98.7	99.9	96.0	99.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of clients	3,369	2,627	2,931	1,232	1,685	907	328	119
Homeless status								
Yes	0.3	0.6	0.6	0.5	0.2	0.9	0.0	0.0
At risk of homeless	0.2	0.7	0.9	0.2	0.2	1.3	0.0	0.0
No	33.0	34.9	46.7	39.0	62.7	51.2	98.2	18.5
Unknown	66.4	63.8	51.8	60.3	36.9	46.6	1.8	81.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of clients	3,369	2,627	2,931	1,232	1,685	907	328	119
Disability status								
Yes	8.4	15.0	10.5	14.5	3.7	6.3	11.9	4.2
No	90.3	79.8	83.2	83.8	94.9	92.6	87.8	88.2
Unknown	1.3	5.1	6.3	1.7	1.4	1.1	0.3	7.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of clients	3,369	2,627	2,931	1,232	1,685	907	328	119
Carer status								
Yes	1.3	1.1	1.1	1.2	0.2	0.1	0.6	0.0
No	25.6	10.8	18.1	25.2	14.6	22.6	0.0	15.1

Demographic characteristics	NSW	Vic	Qld	SA	WA	Tas	NT	ACT
Unknown	73.1	88.0	80.8	73.5	85.2	77.3	99.4	84.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of clients	3,369	2,627	2,931	1,232	1,685	907	328	119
Household composition								
Couple only	2.8	0.9	2.3	3.5	2.8	2.2	3.4	0.0
Couple with dependent children	7.6	5.5	7.8	13.6	9.2	6.4	7.3	1.7
Single parent with dependent children	20.7	15.9	22.2	29.9	27.8	22.3	50.0	23.5
Group (related or unrelated)	8.9	6.8	9.5	9.6	6.5	12.2	6.7	1.7
Living alone	8.7	6.7	10.2	12.4	9.3	11.0	10.7	0.0
Homeless or no household	0.1	0.2	0.2	0.2	0.5	0.9	0.0	0.0
Unknown	51.1	64.1	47.9	30.8	43.7	45.0	22.0	73.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of clients	3,369	2,627	2,931	1,232	1,685	907	328	119
Income source								
Employment wage/salary	18.3	11.8	20.6	23.9	14.6	19.8	18.6	0.8
Government pension/benefits	18.0	13.9	20.8	27.4	15.4	26.4	14.6	0.0
Self-employed	2.3	1.8	3.4	3.7	1.5	1.4	0.9	0.0
Other sources (incl. Super)	0.4	0.2	0.2	0.2	0.1	0.1	0.3	0.0
Nil income	5.7	0.7	4.3	9.3	14.3	7.6	6.1	0.0
Unknown	55.3	71.6	50.6	35.6	54.1	44.7	59.5	99.2
Total	100	100	100	100	100	100	100	100
Number of clients	3,369	2,627	2,931	1,232	1,685	907	328	119

Table A20: DEX: Demographic characteristics of clients of in-scope CCS services (proportion), by region, by whether standalone CCS, 2022

Demographic characteristics	By region			By service provider	
	Major cities	Inner region	Outer region/ remote	Standalone service	Not-for-profit service provider
Indigenous status					
Indigenous	6.4	10.9	13.5	9.5	8.6
Non-Indigenous	90.6	88.2	85.5	88.5	89.3
Not stated	3.1	0.9	1.0	2.1	2.0
Total	100.0	100.0	100.0	100.0	100.0
Number of clients	6,284	5,712	1,202	4,430	9,660
CALD					
CALD background	5.1	1.3	1.8	4.7	2.4
Else	94.9	98.7	98.2	95.3	97.6
Total	100.0	100.0	100.0	100.0	100.0
Number of clients	6,284	5,712	1,202	4,430	8,768
Homeless status					
Yes	0.5	0.5	0.4	0.6	0.4
At risk of homeless	0.4	0.7	0.8	0.7	0.5
No	47.1	36.6	57.7	42.5	44.0
Unknown	52.1	62.2	41.1	56.3	55.1
Total	100.0	100.0	100.0	100.0	100.0

Demographic characteristics	By region			By service provider	
	Major cities	Inner region	Outer region/ remote	Standalone service	Not-for-profit service provider
Number of clients	6,284	5,712	1,202	4,430	8,768
Disability status					
Yes	10.4	9.9	9.2	12.4	8.9
No	84.5	88.6	89.3	83.6	88.3
Unknown	5.1	1.5	1.5	4.0	2.8
Total	100.0	100.0	100.0	100.0	100.0
Number of clients	6,284	5,712	1,202	4,430	8,768
Carer status					
Yes	1.2	0.7	0.6	0.4	1.2
No	26.3	9.5	22.2	1.9	27.1
Unknown	72.5	89.8	77.2	97.7	71.7
Total	100.0	100.0	100.0	100.0	100.0
Number of clients	6,284	5,712	1,202	4,430	8,768
Household composition					
Couple only	2.4	2.2	2.5	1.8	2.6
Couple with dependent children	8.2	7.4	8.7	7.0	8.3
Single parent with dependent children	23.1	20.3	32.0	18.3	24.9
Group (related or unrelated)	8.6	8.5	7.7	8.8	8.3
Living alone	9.4	8.9	9.7	9.1	9.2
Homeless or no household	0.2	0.3	0.3	0.2	0.3
Unknown	48.1	52.5	39.1	54.9	46.3
Total	100.0	100.0	100.0	100.0	100.0
Number of clients	6,284	5,712	1,202	4,430	8,768
Income source					
Employment wage/ salary	17.7	17.5	16.7	18.2	17.2
Government pension/ benefits	18.6	18.9	17.8	18.1	19.0
Self-employed	2.5	2.1	2.7	2.8	2.1
Other sources (incl. Super)	0.2	0.2	0.2	0.2	0.2
Nil income	6.2	6.1	3.5	3.2	7.3
Unknown	54.7	55.1	59.1	57.5	54.2
Total	100.0	100.0	100.0	100.0	100.0
Number of clients	6,284	5,712	1,202	4,430	8,768

Notes: Calendar years and outlet areas.

Table A21: DEX: Employment, income and household composition of clients aged 18+ years (proportion), by gender, 2019 and 2022

Demographic characteristics	Females		Males	
	2019	2022	2019	2022
Employment				
Full-time employed	3.9	6.2	10.9	18.7
Part-time employed	4.6	9.2	2.8	4.8
Studying (full-time/part-time)	1.3	2.1	0.5	0.6
Carer, parenting, other unpaid work	5.8	10.7	1.4	2.8
Not employed (unemployed, not in labour force)	5.2	7.1	5.5	8.0
Unknown	79.2	64.7	78.8	65.1
Total	100.0	100.0	100.0	100.0
Income source				
Employment wage/salary	20.5	21.5	32.3	33.9
Government pension/benefits	39.0	37.3	22.4	20.3
Self-employed	1.4	2.0	5.1	5.6
Other sources (incl. Super)	0.4	0.3	0.4	0.4
Nil income	1.4	1.1	1.7	1.5
Unknown	37.3	37.9	38.1	38.4
Total	100.0	100.0	100.0	100.0
Household composition				
Couple only	2.9	2.7	4.6	4.6
Couple with dependent children	10.0	10.3	9.4	10.1
Single parent with dependent children	35.7	39.0	11.0	11.1
Group (related or unrelated)	6.6	8.4	13.8	15.5
Living alone	6.0	6.1	22.1	23.8
Homeless or no household	0.2	0.3	0.3	0.4
Unknown	38.6	33.0	38.7	34.4
Total	100.0	100.0	100.0	100.0
Number of clients	5,022	4,269	4,292	3,778

Table A22: DEX: clients with a positive outcome in specific domains across circumstance SCORE, goal SCORE and satisfaction SCORE, in 2019 and 2022

Items	2019		2022	
	Clients with a positive outcome (%)	Number of clients assessed	Clients with a positive outcome (%)	Number of clients assessed
Circumstance SCORE				
Family functioning	58.9	1989	58.2	5064
Personal and family safety	59.7	886	55.8	3347
Mental health, wellbeing and self-care	51.1	854	48.4	3022
Age-appropriate development			44.7	1529
Goal				
Changed behaviours	56.1	873	53.7	3313
Changed impact of immediate crisis	57.6	582	57.8	2863
Changed knowledge and access to information	52.1	745	59.1	3438
Changed skills	53.3	674	53.7	2952

Items	2019		2022	
	Clients with a positive outcome (%)	Number of clients assessed	Clients with a positive outcome (%)	Number of clients assessed
Empowerment, choice and control to make own decisions	50.9	424	55.8	2224
Engagement with relevant support services	50.8	480	51.7	2197
Satisfaction				
I am better able to deal with issues that I sought help with	80.0	721	66.8	3222
I am satisfied with the services I have received	90.0	688	77.8	2949
The service listened to me and understood my issues	88.3	702	77.9	3303