Exploring collaborative practice and shared goals for families known to child protection

by

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Bachelor Applied Science (Occupational Therapy)

Bachelor Health Science (Honours)

A thesis submitted for the degree of

Doctor of Philosophy

University of South Australia: Justice and Society



University of South Australia

January 2024

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Glossary

The following definitions clarify the meaning of the below terms as used in this thesis.

Case management pertains to assigned oversight of assessment, planning, and facilitation of services to meet a family's needs through communication, collaboration and available resources.

Differential response systems are a flexible approach to responding to child protection notifications where families may be assigned to either a family support or investigative pathway. They vary across jurisdictions and are designed to move families out of or away from the statutory child protection system, with a statutory response only being provided to families with the highest risk of harm.

Investigation the process whereby the relevant department obtains more detailed information about a child who is subject to a notification and staff make an assessment about the harm and the child's protective needs.

Known to child protection children and their families who have been subject of a notification to the statutory child protection authority but have not yet reached the threshold for removal of children into out of home care. The child/ren are in the care of their parents/caregivers.

Notification any allegation of child abuse or neglect, or harm to a child, made to an authorised department.

A public health approach aims to prevent, or address child protection related problems early to minimise escalation of issues and minimise long-term impacts. It requires a holistic approach and efforts from primary, secondary and tertiary services. Primary services include universal services that are available to the whole community and are intended to provide

support before problems occur. Secondary services target families where risk factors for child maltreatment are present such as parental mental illness, poverty, family violence and parental drug/alcohol misuse. Tertiary services are delivered to families where child maltreatment has either occurred or believed to have occurred. These typically include statutory services and aim to reduce recidivism and long-term impact of child maltreatment for children.

Substantiation of a notification occurs when an investigation by the statutory authority has concluded and there is reasonable cause to believe that the child had been, was being, or was likely to be, abused, neglected, or otherwise harmed.

Summary

Background

To improve outcomes for children and their families who become known to child protection, there is a pressing need to strengthen collaboration both with and for families. While research suggests shared service goals can enhance interprofessional collaboration in this field, little is known about what these goals are or should be and their specific role as an enabler for collaboration. Further, parents are key stakeholders who must be better supported to participate in these collaborations. To strengthen collaboration both with and for families known to child protection, new knowledge is required to yield specific guidance for practitioners and policy makers.

Methods

The overall aim of this thesis is to investigate (i) shared goals as an enabler of collaboration to support families known to child protection and (ii) collaborative practices between professionals, and between professionals and parents that influence attainment of these goals. Four studies were undertaken to address this aim: a systematic scoping review of international literature (study 1); interviews with 14 Australian professionals with expertise in supporting families known to child protection (study 2a & 2b); and interviews with South 10 Australian parents receiving family support as part of a differential response (study 3). Findings from these studies were triangulated and presented in a narrative synthesis addressing the objectives of the thesis.

Key contributions

Findings from this thesis offer several key insights to inform future efforts to enhance interprofessional collaboration and parental participation. These include: the role and value of shared goals as a driver of interprofessional collaboration at both the organisational and individual client level; insights into what shared goals exist across services; and influences on

identifying and working towards these goals. Recommendations for research and practice are made regarding the focus of these goals and involvement of parents in goal setting processes.

Interprofessional practices thought to underpin attainment of shared goals were also identified from the literature, perspectives of professionals and parents. Key practices identified include effective lead case management; collaborative approaches to risk management; and flexible funding and service models that enable practitioners to position client needs as the strongest driver of their practice. Findings from this thesis also offer new insights to strengthen parent participation in these collaborations. These include the need for a more community-oriented approach to practitioner-family relationships, where practitioners have a collective responsibility to welcome families into an integrated network of community services; the importance of transparent communication; and tailoring service responses to each family.

Conclusion

This thesis offers new insights into shared goals as an enabler of interprofessional collaboration among services that support families known to child protection. Attention is drawn to the need for participatory goals setting processes and the identification of goals that reflect a focus on child wellbeing alongside safety. To better empower parental participation in service responses, findings point to the need for strengthened family-centred approaches to practice. Knowledge gained from this research offers guidance for practice, policy and research regarding interprofessional practices that may influence attainment of goals and strengthening parental participation in collaborative service responses.

Declaration

I declare that:

this thesis presents work carried out by myself and does not incorporate without acknowledgment any material previously submitted for a degree or diploma in any university; to the best of my knowledge, it does not contain any materials previously published or written by another person except where due reference is made in the text; and all substantive contributions by others to the work presented, including jointly authored publications, is clearly acknowledged.

Signed:



Date 21 January 2024

Acknowledgements

First, I would like to thank my husband Clint and my three children Ella, Gus and Seb for their patience and support as I completed this 'marathon'. Your love is my most cherished possession and gave me strength to push on.

I would like to acknowledge that this thesis was written on the land of the Kaurna people and pay my respects to Elders past, present and emerging. As an ally, I am deeply committed to reconciliation and 'Closing the Gap' for Aboriginal Australians.

Thank you to my supervisors, without whom this thesis would not have been possible. I am grateful that each of you generously contributed a different lens to my research affording me a breadth of wisdom and expertise. Lesley, thank you for taking over as principal supervisor. Your unwavering child focus, constant affirmation in my ability to undertake this work and ongoing support were invaluable. Margarita, your unwavering commitment, insights into process, and focus on what needs to be done, provided reassuring clarity throughout the process. James, your reflections on my inferences and conclusions helped me think through my logic to a point of greater clarity- thankyou.

Thank you to Fiona Arney- for helping conceptualise this research program and for your continued support. I admire your grounded greatness and talking with you always opens my mind further. Thank you to Alwin Chong and Michael Watkins for cultural guidance during planning of this research and thank you to the participants from my qualitative studies. It was truly a privilege to hear the perspectives of each of you.

I would like to acknowledge the financial support I received through the Australian Government Research Training Program Scholarship and Enhancing Practice – South Australia Department for Child Protection PhD Research Program. This financial support ultimately made this research possible.

Publications arising from candidature

Seekamp, S., Ey, L. A., Wright, S., Herbert, J., & Tsiros, M. D. (2022). Service delivery goals and underlying interprofessional practices: a scoping review to support interprofessional collaboration in the field of child protection. *Children and Youth Services Review*. https://doi.org/10.1016/j.childyouth.2022.106680
(Q2- Developmental and Educational Psychology; Impact factor 3.71; Journal ranking 4392)
(Included as chapter 3)

Seekamp, S., Ey, L. A., & Tsiros, M. D. (2023). Partnering with families known to child protection in an interprofessional context. *Child Abuse and Neglect*. https://doi.org/10.1016/j.chiabu.2023.106426
(Q1- Developmental and Educational Psychology; Impact factor 2022-23 5.09; Journal ranking 1682)
(Included as chapter 5)

Publications currently under review arising from candidature

Seekamp, S., Ey, L. A., Herbert, J., & Tsiros, M. D. (Submitted 2023; currently under review), Exploring service goals and underlying interprofessional practices for children and families known to child protection, *Children and Youth Services Review.*
(Q2- Developmental and Educational Psychology; Impact factor 3.71; Journal ranking 4392)
(Included as chapter 4)

Seekamp, S., Ey, L. A., Wright, S., Herbert, J., & Tsiros, M. D. (Submitted 2023: currently under review), Participation of parents known to child protection in service responses: Experiences of parents in an interprofessional context, *Children and Youth Services Review.*
(Q2- Developmental and Educational Psychology; Impact factor 3.71; Journal ranking 4392)
(Included as chapter 6)

Introductory contextual statement

This thesis is submitted as a Thesis Containing Published Research in accordance with UniSA Academic Regulations for Higher Degrees by Research Procedure AB-58 AD7. The aims and objectives of the thesis and each of the studies are outlined in chapter two (page 35-36). This thesis includes two published studies (chapter 3 and chapter 5) and two studies under review (chapters 4 and 6). The significance of each study in addressing these objectives is discussed in chapter seven. The contributions of each author to each study are outlined in the statements of authorship provided in the appendices (Appendix A, E, F & L).

Contribution of published studies

Study one (Chapter 3 - published), systematically reviewed, mapped and described the literature pertaining to service delivery goals and underlying interprofessional practices of statutory child protection services and services that support children and their families known to child protection. This study addressed a knowledge gap in the literature and provided context for the subsequent studies. Study 2b (Chapter 5 – published), explored professionals' experiences and perceptions of working in partnership with families known to child protection in an interprofessional context. This study contributed to addressing the knowledge gap in the literature pertaining to collaborative practices with parents known to child protection in an interprofessional context.

Chapter 1: Introduction

My personal background

Here follows a brief introduction to myself and my background as the researcher showing how I came to this research and how I fit within it.

I was blessed to be born into a family that was able to provide all the love and care that a child needs to grow up safe and well. I do not know what it may be like to be without the constant support- both emotional and concrete from my family. As a wife and mother of three wonderful children, I strive to offer my children the same blessing that I had and continue to have. Being a mother provides me with insight into how challenging and constantly whole consuming this role can be. However, I am blessed as a mother too, and have not had to experience what it might be like to not be able to meet my children's needs.

I have always enjoyed working with people and this led me to a career as an occupational therapist. I completed my occupational therapy degree in 1999, and as a graduate was always keen to work with children and families. Since graduating I have worked in a range of settings with a wide range of client groups in both rural and metropolitan locations. I regularly worked alongside other disciplines and sectors to engage and support children and families, many living with multiple complexities in their lives. Reflecting on my time working rurally, I did not realise at the time how fortunate my colleagues and I were to have strong cross discipline, service and sector relationships. These relationships contributed to my learning as a practitioner and to the provision of holistic care for the communities we served.

More recently I spent three years working in Children's Centres in Adelaide. These centres are located in areas of relatively high disadvantage and are designed to provide integrated early intervention support to children and their families. While working in these

centres, I noticed the need to strengthen collaboration across disciplines within these centres and with other services and sectors to support families. In particular, I recognised a need to better understand how interprofessional collaboration across sectors could be enhanced to meet the specific needs of children who were at risk of/or had experienced maltreatment. My work as an academic in the occupational therapy program at the University of South Australia highlighted opportunities to influence practice via research and through shaping the education of our future practitioners. Together these experiences led me to undertake this PhD – with an ambition to contribute to strengthening collaboration both with and for children and their families who become known to child protection. I was fortunate to be awarded one of ten South Australian Department for Child Protection-Enhancing Practice scholarships to undertake this research.

Background

Child maltreatment is a growing problem globally (Lines et al., 2023). Child protection systems are under pressure to respond to increasingly high numbers of notifications pertaining to families presenting with complex and chronic needs (Higgins, 2015; Wise, 2017). Illustrative of this increasing pressure, in Australia between 2016 and 2021, notifications of child maltreatment increased by 40% and substantiations increased by 7.2% (Australian Institute of Health and Welfare, 2022a).

It is difficult to identify the true prevalence of child maltreatment due to data limitations and variations in how child maltreated is defined, recorded, and reported across jurisdictions (Geiger & Schelbe, 2021). There is no agreement about which experiences constitute child maltreatment, so not all prevalence studies assess the same types of maltreatment (Mathews et al., 2020). Around the world, emotional abuse, neglect, physical abuse, and sexual abuse are broadly recognised as child maltreatment in practice, policy, and law (Mathews et al., 2020). Acknowledgement of the adverse effects of exposure to domestic violence has led to it being increasingly recognised as child maltreatment (Radford et al., 2013). Current Australian government data indicates that around 3.2% of all children aged less than 18 years become involved with Australia's child protection systems each year (Australian Institute of Health and Welfare, 2022a). However, recent findings from Higgins et al. (2023) highlight the potential magnitude of the gap between children experiencing maltreatment and those coming to the attention of child protection services. Findings from their retrospective cross-sectional survey that collected data pertaining to five forms of child maltreatment (physical abuse, sexual abuse, emotional abuse, neglect, and exposure to domestic violence) revealed that 62% of Australians have experienced maltreatment in childhood.

The adverse impacts of child maltreatment are well recognised leading to changes in biological regulation and brain development (Tabachnick, 2022). All five forms of child maltreatment, (physical abuse, sexual abuse, emotional abuse, neglect and witnessing or experiencing domestic abuse), have been linked with subsequent traumatic mental and physical health effects across the life span (Asmussen et al., 2020). These effects impact children, throughout their childhood, across their lives (Winter et al., 2022), and into future generations (Russotti et al., 2021). This contributes to adverse life outcomes including increased rates of academic failure, poverty, juvenile delinquency, adult crime and substance misuse (Ballard et al., 2015; Mortensen & Barnett, 2016; Osofsky & Lieberman, 2011; Walsh et al., 2017). Critically, these adversities perpetuate the cycle of intergenerational family adversity and present risks for further involvement with the child protection system for affected children – when they become parents (Russotti et al., 2021).

Parents who come into contact with the child protection system, typically experience multiple adversities, potentially as an outcome of their own history of maltreatment as a child (Armfield et al., 2021). This picture is consistent internationally with adversities often including low income, limited social supports, domestic and family violence, parental substance abuse and mental health concerns (Abbasi et al., 2015; Early Intervention Research Directorate, 2019; World Health Organisation, 2022). Illustrative of the complexity facing practitioners working with families known to children protection, data collected at the end of 2016 in South Australia reflected very high levels of multiple and complex needs within families (Octoman et al., 2022). Children's lives were found to be characterised by ongoing and extreme forms of family violence that were often intergenerational, and other chronic problems including untreated mental health concerns and alcohol and illicit drug addiction. The devastating outcomes for these children were found to include suicidal ideation and self-harm from a young age (Octoman et al., 2022).

Like many countries with Indigenous populations, Aboriginal and Torres Strait Islander children are overrepresented in the child protection system- being approximately eight times as likely as non-Indigenous children to receive child protection services (Australian Institute of Health and Welfare, 2021). Australia's history of colonisation and disempowering protectionist policies enacted upon Aboriginal and Torres Strait Islander peoples have caused considerable trauma for Aboriginal and Torres Strait Islander peoples (Duthie et al., 2019). This trauma continues to have an impact today through intergenerational transmission of this trauma, marginalisation and discrimination resulting in ongoing disadvantage positively correlated with increased child abuse and neglect (Lonne, Flemington, et al., 2021). During 2020–21, 58,000 Aboriginal and Torres Strait Islander children received child protection services, a rate of 172 per 1,000 Indigenous children. In the same period, 112,400 non-Indigenous children received child protection services, a rate of 21 per 1,000 children (Australian Institute of Health and Welfare, 2022a).

Aboriginal Australians experience high rates of poverty, social exclusion, and a lack of resources alongside a reluctance of main-stream services to accept differences in family structure and child rearing practices between Aboriginal and non-Aboriginal societies (Duthie et al., 2019; Oates, 2020). Their history of disempowerment and this context inform interpretation of the over-representation of Aboriginal families in the child protection system. To address the persistent inequities in wellbeing outcomes for Aboriginal Australians, there is an urgent need for new Aboriginal led innovations supported by funding that reflects the over-representation of Aboriginal families known to child protection (Moore et al., 2023).

The complexity of needs present within families known to child protection requires service responses that recognise the structural inequality and full diversity of problems that impact on each family (Dolan & Frost, 2017). A public health approach to child protection is being increasingly called for to afford this type of support at the individual, family, and

community level (Lonne et al., 2019; Mathews et al., 2023). It has been suggested that the public health model may enhance outcomes for children and their families by reducing risks in their environments, and strengthening protective factors at the individual, family, and community levels (Herrenkohl et al., 2015). Public health approaches move away from overemphasising individual agency to better recognise and address contextual and ecological influences on family and individual functioning (Lines et al., 2023). These approaches are grounded in early intervention and prevention and reflect a conceptual shift towards recognising that child protection must happen in the context of excellent prevention and family support (Devaney et al., 2017; Lonne et al., 2019).Via this frame of reference, care and protection of children is seen as everyone's business and it is only when community service systems are unable to ensure safety for children that the statutory child protection system becomes involved (Harries & O'Donnell, 2019).

Successful implementation of a public health approach is dependent upon a commitment from all sectors who provide services to children and families (Council of Australian Governments, 2009). A public health approach prioritises strengthening interprofessional collaboration across organisations with diverse expertise, mandates and resources to meet the multiple needs of children and their families (Colvin & Miller, 2018; Herrenkohl, 2019). To achieve this, there is a need for strengthened collaboration among community services (for example, mental health, housing, family violence, education and drug and alcohol services), family support services, child protection and families (Kothari et al., 2022).

Interprofessional collaboration

In the field of child protection, it is increasingly recognised that when interprofessional collaboration occurs well, delivery of services and outcomes for families improve (Albuquerque et al., 2020). Subsequently, interprofessional collaboration has

become an important and expected practice of services that support families known to child protection internationally (Colvin & Miller, 2018; Herlihy, 2016; HM Government, 2018; Price-Robertson et al., 2020). A recent international review highlights that most jurisdictions have enacted strategies that aim to help families in a more holistic way, through collaborative service delivery providing a wide range of child and family services (Devaney et al., 2021). For example, in Australia, *Safe and Supported the National Framework for Protecting Australia's Children 2021–2031* (Commonwealth of Australia, 2021) demands a collaborative approach across sectors to protecting Australia's children. Equally, the preceding framework emphasised that 'child protection is everyone's business' – calling for collaboration among all sectors (Council of Australian Governments, 2009). In England and Wales, the Children and Social Work Act 2017 places a duty on local authorities to implement strategies to support collaboration between services to safeguard children (Local Government Association, 2017). In Ireland, Tusla –a statutory agency tasked with promoting the welfare of children and families, is required under the Child and Family Agency Act 2013 to facilitate interagency collaboration to meet the needs of children and their families (Devaney et al., 2021). In the United States (US), The Family First Prevention Services Act (2017) emphasises early intervention and prevention for families at risk of child protection involvement facilitating greater access to interprofessional responses (including mental health services, substance use treatment, and/or parenting skills courses) (Tung et al., 2019).

As part of efforts to advance interprofessional collaboration various typologies have been proposed to aide understanding of different collaborative approaches. For example, Henneman et al. (1995) describes varying levels of intensity of interprofessional collaboration: *networking*, which pertains to exchanges of information; *coordination,* which involves information exchange and some shared planning of services; *cooperation,* which adds sharing resources to the previous two levels; and *collaboration* that represents the most

advanced level, combining all levels in a way that is mutually beneficial for both agencies. Alternatively, Warmington et al. (2004) describes three different types of interagency work. These include *interagency working* where more than one agency works together in a planned and formalised way; *multiagency working* where more than one agency works with a client, but not necessarily together, but concurrently or sequentially; and *joined-up working, policy or thinking*: where active planning is undertaken to inform collaborative approaches that considers relevant policies and different agency practices. In practice an endless variation of collaborative approaches exists, reflecting local legislative and policy contexts and service models as well as intent of the collaborators (Devaney et al., 2021). In this thesis the term interprofessional collaboration as described by Juhila (2021), will encompass professionals working together across professional and organisational boundaries, at varying levels of formality and intensity.

Benefits, barriers and enablers of interprofessional collaboration

Benefits of interprofessional collaboration in the field of child protection are well established. These include concurrently addressing a range of complex, related issues, reducing service costs, improving service quality, and enabling increased access to resources (Herlihy, 2016; Horwath & Morrison, 2011; Kothari et al., 2022; Lalayants, 2013). Further, effective interprofessional collaboration has also been reported to benefit staff working in the field of child protection, offering them increased feelings of support, improved assessment skills and enhanced access to relevant client services (Kothari et al., 2022; Wade et al., 2016). Conversely, poor collaboration and coordination of responses have consistently been blamed for adverse outcomes for children, especially those experiencing multiple vulnerabilities (Caffrey, 2020). Ineffective interprofessional collaboration has been reported to have resulted in failures to communicate critical information between workers; inappropriate and potentially avoidable risks to children and families; families moving from assessment to

assessment without a service response and/or being missed all together (Herlihy, 2016; Knight et al., 2007).

While the mandated duty to collaborate evident in policy frameworks in Australia and internationally is helpful in advancing interprofessional collaboration, it is not a standalone solution (Devaney et al., 2021; Lines et al., 2023). Effective interprofessional collaboration is recognised as challenging and in need of improvement (Devaney et al., 2021; Flaherty, 2018; Harries & O'Donnell, 2019; Wood, 2016). Numerous obstacles to effective collaboration have been identified including, insufficient resources - such as time, funding, training, and staffing, as well as a lack of support from leadership (Devaney et al., 2021; Kothari et al., 2022). Further, competition among services for funding, poor communication, unclear roles (Coates, 2017; Pharo et al., 2014) and divergent perspectives on children, families, and maltreatment among professionals from different disciplines (Grant et al., 2018) have also been identified as barriers.

Compounding the complexity of collaborative approaches in the field of child protection, collaboration is required across a spectrum of services including child protection, family support and community services (including mental health, housing, family violence, education, and drug and alcohol services). The willingness and capacity of community service providers to play their part in supporting families presenting with risks for child maltreatment is unclear. As highlighted by Harries and O'Donnell (2019) adult services are not usually funded to reduce the risk of child maltreatment and hence may be reluctant to take on this work without additional funding. To advance a public health approach to child protection, the willingness and capacity of universal community services to play their part needs to be ensured.

Enablers of interprofessional collaboration have been well researched and include consistent processes and expectations, shared management of risk (Coates, 2017), senior management support, adequate resourcing (Devaney et al., 2021), trust, communication, and clarity of the intended practice outcomes (Kothari et al., 2022; Lalayants, 2013; Price-Robertson et al., 2020). The importance of clarity regarding intended practice outcomes is well documented (Price-Robertson et al., 2020; Tung et al., 2019). Authors have reported that a common mission or purpose among collaborating partners is a key element of collaborative partnerships (Corbin et al., 2018; White & Winkworth, 2018; Woulfe et al., 2010). The process of identifying shared practice, or services goals has been reported to help collaborators pinpoint areas where their values align, ultimately supporting collaboration (Lippman et al., 2011; Macvean et al., 2018; Zannettino & McLaren, 2014). Theoretical models of interprofessional collaboration also recognise the centrality of shared goals as a driver of collaboration (D'Amour et al., 2008; Winkworth & White, 2010). It has also been highlighted that collaboration is ultimately enacted between individual practitioners (Juhila, 2021) and that practitioners who value collaboration and are willing to build relationships across professions are seen to enhance collaboration (Lalayants, 2013).

Despite shared goals being reported as an important enabler of interprofessional collaboration in the field of child protection, what these shared goals are or should be and their role in enabling collaboration needs to be better understood. Current child protection and family support outcome measures tend to focus on service outputs and objectives, such as referrals to support services, shared case review meetings, family preservation and placement prevention (Herlihy, 2016; Malvaso et al., 2020), missing a focus on outcomes for children and their families. Further, existing research on cross-sector collaborations within child protection has largely focused on specific practice areas such as mental health, substance abuse, domestic violence, and juvenile justice (Boatswain-Kyte et al., 2022). While this

research offers valuable insights into these unique collaborations, it does not capture the breadth of collaboration required to meet the diverse needs of families known to child protection. Potential shared goals across the range of services required to support families known to child protection (including family support and community services) are unknown.

Additionally, much of the research on barriers and enablers of collaboration has focused on system and leadership influences. Subsequently, there is a relative lack of literature that provides guidance for professionals implementing interprofessional collaboration at the coal face (Price-Robertson et al., 2020). Lines et al. (2023), following their recent review on Australian child protection policy, highlighted this gap citing the need for further guidance for professionals required to implement cross-sector collaboration.

To strengthen interprofessional collaboration in the field of child protection, there is a need for a more nuanced understanding of specific enablers (Kothari et al., 2022; Oscar et al., 2016). The first two objectives of this thesis contribute to addressing this need by exploring shared goals and underpinning interprofessional practices.

The first objective of this thesis is to enhance understanding of shared goals as a driver for interprofessional collaboration across services that support families known to child protection. This will include exploring what these goals are or could be, as well as their function as an enabler for interprofessional collaboration. Goals from services/practitioners who provide support to families known to child protection (i.e., child protection, family support and community services that aim to improve outcomes for children known to child protection) are explored. *Families known to child protection* in this thesis refers to families who have been subject of a notification to the statutory child protection authority but have not reached the threshold for out-of-home care and as such are still caring for their child/ren at

home. These families may be receiving support from child protection, or family support services.

The second objective of this thesis reflects the need for guidance for practitioners who must implement interprofessional collaboration. Therefore, this thesis will explore the interprofessional practices that underpin work towards shared goals for families known to child protection. Reflecting the breadth of collaboration required to support families known to child protection, this objective will explore interprofessional practices between child protection and family support services as well as between these two service types and other sectors such as health, housing, education, and drug and alcohol support.

Parental participation

Alongside the drive to strengthen interprofessional collaboration, a concurrent drive to strengthen parental participation in service delivery has been occurring (Gibbons & Connolly, 2021; Lehtme & Toros, 2020). The underlying philosophy of consumer participation in service delivery is that service users should have the authority and opportunity to influence and make decisions on matters that are important to them (Juhila, 2021, p. 19). It is considered important that family members are provided with information and actively participate in setting goals, defining support measures, and making choices regarding the support they receive (Gibbons & Connolly, 2021; Muench et al., 2017; Toros et al., 2018). Growing evidence highlights the link between the strength of collaboration between the practitioner and the family, and better outcomes, including a reduction in child maltreatment (McGregor & Devaney, 2020; Visscher et al., 2022). Combining the experience of practitioners from relevant professional background/services and that of service users themselves provides a richer understanding of the challenges present in each family, therefore enabling these challenges to be addressed more efficiently and effectively (Goodwin, 2015; Visscher et al., 2022).

Typically, parental participation in service responses and interprofessional collaboration are addressed in two separate bodies of literature. However, broader understandings of interprofessional collaboration exist such as that offered by Kvarnström et al. (2012) that recognise families as important partners/stakeholders of collaborative service responses. Similarly, Hodges et al. (1999, p. 8) describe interprofessional collaboration as "the process of agencies *and* families joining together for the purpose of interdependent problem solving that focuses on improving services for children and families". These ideas broaden thinking around interprofessional collaboration and reflect an area for extension in the literature and a focus of this thesis.

Facilitating parental participation has been emphasised as challenging (Arbeiter & Toros, 2017; Lehtme & Toros, 2020) with two recent reviews highlighting that considerable work is required to better empower parents and children to participate in their service responses (Bekaert et al., 2021; Toros et al., 2018). Existing literature that explores parental participation has focused on statutory child protection responses (Charest-Belzile et al., 2020; Lehtme & Toros, 2020; Toros et al., 2018). This research has revealed several barriers to facilitating parental participation in service responses. Barriers identified by parents include fear of child protection involvement leading parents to be guarded in their interactions (Slettebo, 2013) and authoritarian approaches by workers leading to feelings of disempowerment (Harris, 2012; Mirick, 2014). Further, parents report that despite wanting to participate in service responses and contribute to decision making, their voices are not sought, or, not acted upon (Arbeiter & Toros, 2017; Khan et al., 2018).

In contrast, professionals have identified a lack of parental willingness to collaborate and make changes, as well as limited insight into their children's needs as barriers to partnering with parents (Darlington et al., 2010). Limited time to establish a partnered approach and inherent power differentials for statutory workers have also been identified by

professionals as barriers to partnering with parents (Darlington et al., 2010; Gentles-Gibbs, 2016). For child protection practitioners these power differentials represent a tension between empowerment and protection. Acknowledging legal mandates and risk-oriented child protection systems, finding an appropriate balance between reducing risks to child safety and strengthening and recognising family capacities is described as difficult (Gentles-Gibbs, 2016; Kemp et al., 2014; Toros et al., 2018).

Several helpful practices for partnering with parents in the field of child protection have been identified. The interpersonal style of the practitioner has been emphasised as important for facilitating partnered work (Muench et al., 2017; Navarro, 2014). Practices that are empowering and respectful have been reported to create an alliance with parents, strengthening their engagement and contributing to better outcomes (Lange et al., 2017; Munford & Sanders, 2016). Factors said to enable this empowerment include establishing trusting parent-practitioner relationships that enable free communication and facilitate an openness to change (Charest-Belzile et al., 2020; Gallagher et al., 2011). Non-judgmental approaches and conveying a genuine interest in the family's perspective have also been identified to facilitate parent's openness to collaboration (Visscher et al., 2022). At a system level, support from leadership to allow flexible service delivery and training in family-centred practice approaches have been identified as supportive of parental participation (Gentles-Gibbs, 2016).

Enablers of partnered work with families align with family-centred practice approaches that have been widely implemented across child protection and community service systems (Ahn et al., 2016; Xu et al., 2020). These approaches are strengths-based, grounded in trusting parent-practitioner relationships, and recognise families as capable of contributing to decisions that affect their lives (Allen & Petr, 1998; Lietz & Geiger, 2017). Allen and Petr (1998) outline key principles of family-centred practice including (1) the

family being assessed and supported as a whole unit, (2) creating family-practitioner partnerships; (3) honouring family choice; (4) using and building on family strengths, including those within the immediate family and their community; and (5) individualising services to reflect the unique needs of each family.

Family-centred practice approaches offer guidance for how practitioners can collaborate across services and with parents (Xu et al., 2020). As part of a family-centred approach, strengths-based practice has been reported to predict parent's active participation in services (Kemp et al., 2014) and is increasingly being positioned as critical to achieving positive outcomes with families known to child protection (Geiger & Schelbe, 2021; Khan et al., 2018; Toros & Falch-Eriksen, 2021). These findings position family-centred practice as a critical lever for enhancing parental participation in service delivery. Despite the recognised value of family-centred practice approaches, research suggests that family-centred practice needs to be better embedded in practice (Geiger & Schelbe, 2021; Lietz & Geiger, 2017; Toros et al., 2018).

Practitioners have a critical role to play in enabling parents to participate in their service responses (Juhila, 2021). New knowledge is needed to provide specific guidance for practitioners to enhance their confidence and competence in enabling participation of parents known to child protection (Toros et al., 2018). In particular, there is a need to understand parental participation in an interprofessional context - reflecting the need for parents to interact with the spectrum of service providers (including child protection, family support and community services). As stated by Hopwood and Edwards (2017), participation of service users in their service responses is a complex emergent phenomenon influenced by the contexts and practice settings in which it takes place that warrants further exploration. There is a lack of studies that investigate parent's participation in service responses in an interprofessional context. Acknowledging parents as important stakeholders in collaborations

intended to meet their needs, their participation within an interprofessional context needs to be better understood. The third and final objective of this thesis will contribute to addressing this gap in the literature by exploring collaborative practices between parents and practitioners (working in an interprofessional context) from the perspective of professionals and parents.

Context

This section provides an overview of the Australian child protection system in which this thesis is situated.

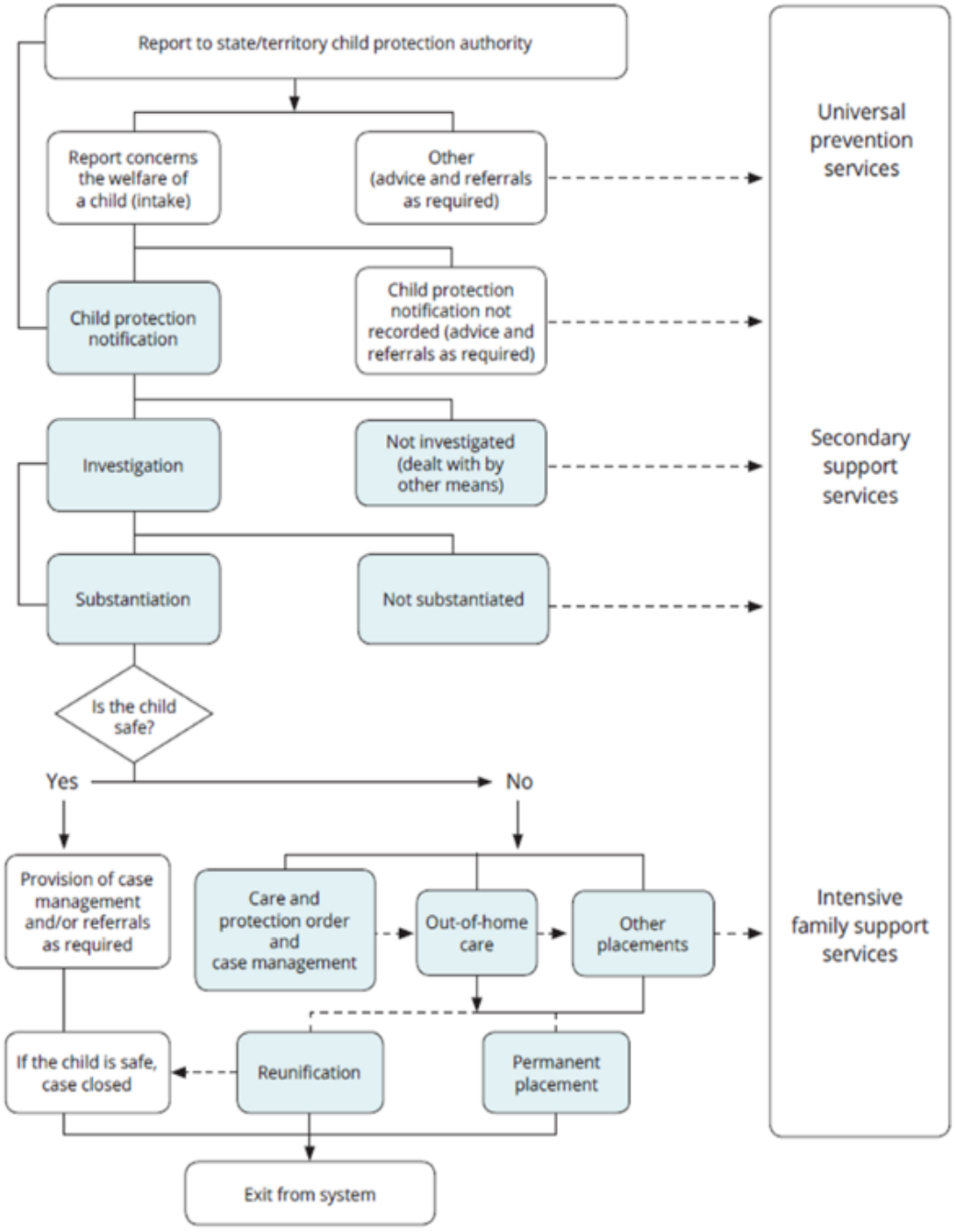
In Australia, government structure is comprised of the Federal Government and eight state of territory governments (Lines et al., 2023). Each state and territory have its own Act of Parliament that governs how child protection interventions work however, *Safe and Supported: The National Framework 2021-2031*, sets out key priorities for managing child protection issues in Australia across jurisdictions (Commonwealth of Australia, 2021). The National Framework was developed by the federal, state and territory governments, in partnership with Aboriginal and Torres Strait Islander representatives and consultation with the non-government sector. It aims to encourage consistent legislation and practice and sets benchmarks for assessing progress (Commonwealth of Australia, 2021). The framework states that protecting children is everyone's business and calls for collaboration across government, non-government organisations, service providers, researchers and families and communities to achieve its objectives (Commonwealth of Australia, 2021).

State and territory governments are responsible for child protection and areas of law, policies and services relating to child safety (Commonwealth of Australia, 2021). Across jurisdictions there is a focus on strengthening integrated and holistic approaches to supporting vulnerable families (Wise, 2017). Accordingly, most Australian states and territories have enacted strategies that help families in a more holistic way, by coordinating family support

service delivery and providing better access to different types of child and family services (Devaney et al., 2021).

Child protection authorities in each state and territory have the primary role of keeping children safe from harm, or potential harm (Australian Institute of Health and Welfare, 2023). In Australia, commonwealth and jurisdiction-specific legislation governs the reporting of suspected child abuse and neglect. There is variation across jurisdictions regarding who is legally obliged to report child protection concerns, however anyone can report their concern to a child protection department for further action (Australian Institute of Health and Welfare, 2023). In Australia, the three most common sources of notification to child protection are police, school personnel and health workers (Mathews et al., 2016; Pilkington et al., 2017). Reports of concern are screened by the relevant child protection authority to determine whether the situation meets a threshold for further action. The defined threshold for further action varies across jurisdictions, and this can lead to jurisdictional differences in the responses to initial reports (Australian Institute of Health and Welfare, 2023). A summary of approaches to child protection intervention and investigation from the Australian Institute of Health and Welfare (2022b) is provided in Figure 1 below.

Figure 1. Summary of child protection processes in Australia (Australian Institute of Health and Welfare, 2022b)



Notes:

1. Shaded boxes are items for which data are collected nationally.
2. Dashed lines indicate that clients might or might not receive these services, depending on need, service availability, and client willingness to participate in what are voluntary services.
3. Support services referred to in the box on the right include family preservation and reunification services provided by government departments responsible for child protection, and other agencies. Children and families move in and out of these services and the statutory child protection system, and might also be in the statutory child protection system while receiving support services.

Following a notification, the statutory child protection authority's involvement may include services to keep children with their families, investigations of reports of maltreatment, protection orders, and/or placement in out-of-home care (Australian Institute of Health and Welfare, 2022a). However, many families notified to child protection do not meet the threshold for a response (Lonne, Russ, et al., 2021). Further, incident-based screening has been reported to underestimate risk by failing to recognise the chronicity and complexity of risks within families, leading to children being screened out who are at high levels of risk (Sheehan, 2019). Reports deemed serious enough to require further action are typically classified as a 'family support issue' and referred to support services, or as a 'child protection notification' requiring further intervention. If investigated, the department is then responsible for determining whether the notification is substantiated or not substantiated (Australian Institute of Health and Welfare, 2023).

For families who do not meet the threshold for statutory intervention, differential responses are common across Australia. Differential responses vary in their constitution across jurisdictions, however, typically involve a referral from child protection to intensive family support services (Lonne et al., 2014; Piper, 2017). Representing one of the fastest growing populations in child protection, in 2021-2022 36,200 children were referred to intensive family support services (Australian Institute of Health and Welfare, 2022a). The main purpose of family support services in Australia is to provide intensive support and case management to help prevent children entering or returning to the child protection system and avoid the need for more intrusive interventions (Australian Institute of Health and Welfare, 2021; Lines et al., 2023). Family support services frequently interact with a range of community services to link families with support to reduce risks and respond to the unique needs within each family (Wise, 2017).

Problem statement and aims of thesis

Children and families known to child protection who are receiving family support services are a rapidly growing population in child protection settings. They present with multiple and complex needs, and the multiple sectors that these families may be referred to and/or engaged with operate in contexts of high risk. Interprofessional collaboration needs strengthening to meet the diverse needs of these families and interrupt the seemingly inevitable trajectories of children within these families. There is potential for shared goals to enhance interprofessional collaboration. However, to date what these shared goals are or could be is unclear and richer insight into their function as a driver of collaboration is required to guide practice and policy. Further, to advance participation of parents in these service responses, a better understanding of collaborative practices both between professionals and professionals and parents is needed. It is imperative that service design and practice improvement is informed by the multiple perspectives held by the multiple actors involved in improving safety and wellbeing for children and young people. This thesis extends the existing literature by exploring these multiple perspectives regarding collaborative practices across the spectrum of services both with and for children and their families known to child protection.

The overarching aim of this thesis is to investigate (i) shared goals as an enabler of collaboration to support families known to child protection and (ii) collaborative practices between professionals, and between professionals and parents that influence attainment of these goals. Three objectives were developed to guide a program of research.

To explore:

1. goals for families known to child protection held by services, practitioners and families, including how these goals are similar or different, with a view to better understanding shared goals as an enabler of interprofessional collaboration.

2. interprofessional practices thought to influence attainment of goals as identified from the literature, the perspectives of professionals and parents.
3. collaborative practice between parents and practitioners within these collaborations thought to influence attainment of goals from the perspectives of professionals and parents.

Thesis structure

This thesis includes seven chapters. This chapter **(chapter 1)** provides the background to the thesis including the context, and impetus for this research. **Chapter 2** presents the objectives of the thesis, research paradigm, methodology and methods. **Chapter 3** (Study 1) presents the findings of the scoping review of goals for families held by services for families known to child protection and underlying interprofessional practices. This study is presented as published by *Children and Youth Services Review* (Seekamp et al., 2022). **Chapter 4** (Study 2a) reports the findings of semi-structured interviews with professionals exploring their perceptions and experiences of service goals and underlying interprofessional practices for families known to child protection. This study is currently under review with *Children and Youth Services Review*. **Chapter 5** (study 2b) reports on the findings of these semi-structured interviews with professionals regarding partnering with parents known to child protection in an interprofessional context. This study is presented in this chapter as published in the journal *Child Abuse & Neglect* (Seekamp et al., 2023). **Chapter 6** (Study 3) presents findings from interviews with parents known to child protection regarding (i) goals for their children and themselves from family support, (ii) their perceptions of collaborative practices between practitioners and themselves and (iii) collaborative practices between service providers involved with their family. This study is currently under review with *Children and Youth Services Review*. **Chapter 7** presents the triangulation of studies 1, 2a, 2b, and 3 responding to the overarching objectives of this thesis including a discussion of the key findings, limitations, and recommendations for future research, policy, and practice.

Chapter 2: Research Design

This chapter provides an overview of the program of research undertaken and rationale for decisions underpinning this approach. Chapters three to six present each study in manuscript format and as such are written within the word limit of the journal to which they were each submitted for publication. Subsequently, descriptions of methodology, methods, and strategies used to ensure rigour in those chapters are necessarily brief. This chapter supplements those descriptions and begins by introducing the overarching objectives of the thesis, philosophies of the researcher and the theoretical framework that underpins the thesis. The methodologies and methods are then introduced with links between these, and the epistemologies made explicit. This chapter concludes with an explanation of strategies used to ensure rigour and ethical practice throughout the research.

Research aims

The overall aim of this thesis is to investigate (i) shared goals as an enabler of collaboration to support families known to child protection and (ii) collaborative practices between professionals, and between professionals and parents that may influence attainment of these goals. Three overarching objectives were developed to guide a program of research to yield new knowledge useful for researchers, policy makers and practitioners in advancing collaboration with and for families known to child protection. This program of research was designed to gather knowledge from a range of sources including existing literature, professionals and consumers. This range of sources were selected to provide rich contextualised insights into the phenomena under study. The objectives of this thesis along with an overview of the methodology and methods for the program of research are presented in Table 1.

Table 1. Summary of thesis objectives and corresponding studies

<table>
<tr><td colspan="4">Thesis objectives
To explore:
1. goals for families known to child protection held by services, practitioners and families including how these goals are similar or different with a view to better understanding shared goals as an enabler of interprofessional collaboration.
2. interprofessional collaborative practices thought to influence attainment of goals as identified from the literature, the perspectives of professionals and parents.
3. collaborative practice between parents and practitioners thought to influence attainment of goals from the perspectives of professionals and parents.</td></tr>
<tr><td colspan="4">Theoretical framework
White and Winkworth's model of collaboration (2018)</td></tr>
<tr><td colspan="4">Epistemology
Pragmatism & Constructionism</td></tr>
<tr><td>Secondary Research</td><td colspan="3">Primary Research</td></tr>
<tr><td>Scoping Review</td><td colspan="3">Interpretive qualitative design</td></tr>
<tr><td>peer reviewed and grey literature research</td><td colspan="2">Semi-structured interviews with professionals</td><td>Semi-structured interview with parents</td></tr>
<tr><td>Study 1</td><td>Study 2a</td><td>Study 2b</td><td>Study 3</td></tr>
<tr><td>Objective 1
Objective 2</td><td>Objective 1
Objective 2</td><td>Objective 3</td><td>Objective 1
Objective 2
Objective 3</td></tr>
<tr><td colspan="4">Narrative synthesis- triangulation of studies 1, 2a, 2b & 3</td></tr>
</table>

To comprehensively address the objectives of the thesis, four studies were designed to contribute insights from literature, professionals, and parents. The research questions/objectives of each of these studies are outlined below.

Study 1- Scoping review to identify and map the literature regarding:

- What is known about service goals of statutory child protection services and services that support children and their families known to child protection?
- In what ways are the goals of services that support children and their families known to child protection similar and/or different?
- What is known about interprofessional practices to achieve the identified goals by services that support children and their families known to child protection?

Study 2a- Interviews with professionals to explore:

- What goals for children and for their parents/caregivers are held by services and professionals for families known to child protection?
- What interprofessional practices are perceived to influence attainment of these goals?

Study 2b- Interviews with professionals to explore:

- What are professional's experiences and perceptions of working in partnership with children and families known to child protection in an interprofessional context?

One round of interviews was undertaken with professionals to collect data for studies 2a and 2b. Data from these interviews were then analysed in relation to the specific objectives of these two studies.

Study 3- Interviews with parents receiving family support to explore:

- What goals are held by parents/caregivers for their children and for themselves from family support?
- What are parent's experiences and perceptions of collaborative practices between service providers involved with their family that influence achievement of their goals?
- What are parent's experiences and perceptions of collaborative practices between practitioners and themselves?

Epistemology

Acknowledging the impact of myself as the researcher on this body of work I have provided some insight into my background in chapter one. As stated, I came to this research with experience working with children and families as a clinician and team leader in the field of community health. This work as an occupational therapist and team leader was underpinned by a commitment to critically considering how service delivery could be enhanced to improve outcomes for clients. This commitment has now contributed to the development of a research program designed to produce useful knowledge to contribute to enhancing practice for families known to child protection.

Aligning with the positioning of the researcher, the methodology of this thesis is based on the epistemology of pragmatism also drawing upon elements of constructionism. Pragmatism is a fitting epistemological framework for this thesis due to its real-world emphasis and focus on what works (Creswell, 2022). Fitting with the intent of the thesis, pragmatism offers a framework for guiding research that provides useful and actionable knowledge anchored in respondent experience (Kelly & Cordeiro, 2020, p. 3). As a framework, pragmatism does not align itself with any specific methodologies or methods, instead it calls for the identification and use of those found to be most suitable and practical for answering complex questions (Creswell, 2022). Pragmatism allows for recognition of multiple truths and recognises the interconnectedness between experience, acting and knowing (Kelly & Cordeiro, 2020).

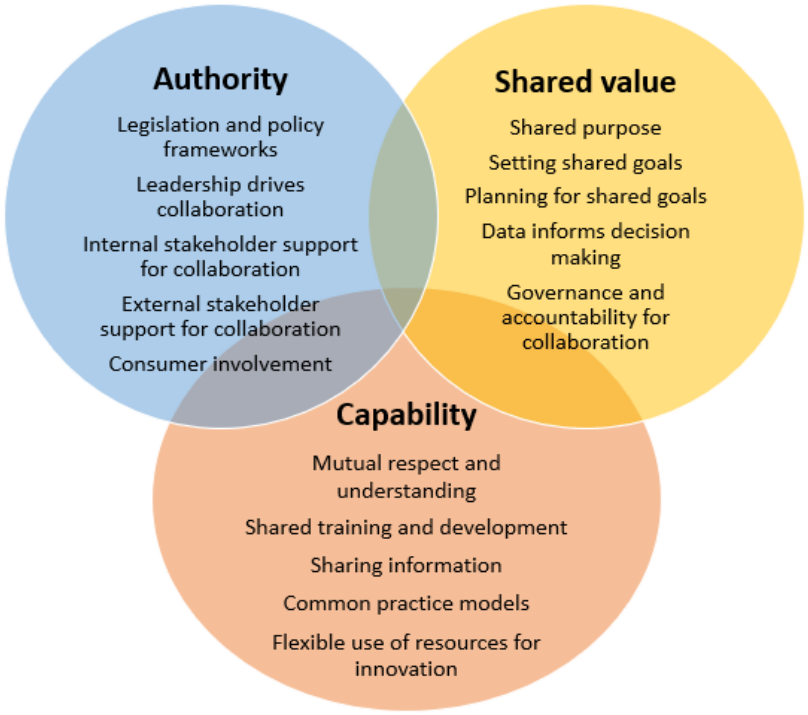
Social constructionism was also identified as a useful epistemological framework for this thesis. It was deemed suitable due to its acknowledgement of the influence of context on the phenomenon under study and focus on interactions between people as they co-create realities (Sommers-Flanagan & Sommers-Flanagan, 2012). Constructionism argues that understandings of the world do not come from objective reality but from other people, both past and present, thus acknowledging the influence of context (Patton, 2015). This acknowledgment of context and co-construction is important given the focus of this thesis on collaboration between professionals, and professionals and parents in real world settings. The influence of participants' experiences and the diverse contexts in which collaboration occurs represent an important element of understanding collaboration with and for families known to child protection. Through gathering insights from professionals, parents, and existing literature, this thesis draws upon pragmatism and constructionism together to explore diverse experiences and understandings of the phenomena under study (Patton, 2015; Feilzer, 2010). The impact of context on findings

from this research are acknowledged as important, complex, and dynamic influences on collaboration. Acknowledgement of this influence in the presentation of findings supports appropriate interpretation and application of this knowledge to advance collaboration with and for families known to child protection.

The theoretical framework

The methodology used in this program of research is informed by the theoretical framework of White and Winkworth (2018). White and Winkworth (2018) provide a model for analysing and informing work to enhance collaboration. Their model was initially developed from work evaluating collaboration between state (Victorian) and commonwealth agencies for vulnerable children (Winkworth & White, 2010). The model was developed from Moore's Public Value Model (Moore, 2000), existing literature, and insights from stakeholders gathered during the evaluation. Moore's Model (2000) identifies three key drivers that each must be in place for a strategy to be effective and sustainable. These three drivers suggest that for a collaboration to be successful it has to be valuable (shared value), authorised (authority) and doable (capability). White and Winkworth built on this model, adding five action areas to each of these three driver domains. (Fig. 1; White & Winkworth, 2018).

Figure 1. Key drivers of collaboration. (White & Winkworth, 2018)



The domain *Authority* pertains to 'what may be done' and emphasises the need for high level support and endorsement of the collaboration. The domain *Shared value* pertains to what a collaboration 'should do', highlighting the need for agreement on the purpose and intended outcomes of the collaboration. Establishing this shared vision for what the collaboration will achieve is identified as a critical starting point for establishing collaborations. The domain *Capability* pertains to 'what can be done' and reflects that for a collaboration to be successful it must be appropriately resourced. This includes an appropriately skilled workforce as well as system supports such as mechanisms for information sharing.

This thesis draws on this model to provide a framework for exploring shared goals as an enabler of interprofessional collaboration (*Shared value* domain) and collaborative practices and conditions that influence attainment of these goals (all three domains). This model was identified as suitable for informing work in this thesis for several reasons. It was developed to strengthen collaboration between Australian agencies to support vulnerable

children (Winkworth & White, 2010) - suggesting its applicability to collaborations for families known to child protection. It recognises the importance of shared goals as a driver of interprofessional collaboration- the primary focus of objective one of this thesis. It offers a comprehensive framework for exploring professional practices and conditions determined to be essential for successful collaboration - reflecting the focus of objective two of this thesis. (Exploring interprofessional collaborative practices thought to influence attainment of goals). Finally, as evident in the *Authority* domain, the model acknowledges the importance of consumers having a voice in reviewing and informing collaborations designed to support them. This fits with the third objective of this thesis that seeks to understand collaboration between parents and practitioners from the perspective of professionals and parents.

This PhD extends the use of this model by applying it to broader contexts. This includes exploring interprofessional collaboration between child protection, family support and community services, as well as collaborations of varying intensity and formality. Findings from this program of research are examined in relation to White and Winkworth's model (2018) to highlight strengths and areas for focus to enhance collaboration with and for families known to child protection. Further findings are critiqued against this model to offer new insights into the applicability of this model in these broader contexts.

Methodology and methods

The program of research in this thesis is informed by multi-dimensional evidence-based practice as described by Petr and Feit (2008). This is an approach to enquiry designed to inform enhanced practice in human services fields with a focus on broad client populations and the programs designed to address their needs (Petr & Feit, 2008). Petr and Feit (2008) suggest that enquiry to improve practice is strengthened when it draws upon existing literature, includes experiences and preferences of consumers, and insights form professionals. Triangulation of these three sources enables findings to be generated that integrate research, and the knowledge and values of those working and receiving services in

the designated field. For this thesis, a scoping review was designed to review the literature (study 1), and semi-structured interviews to gather the perspectives of professionals (study 2a & 2b) and parents (study 3).

A scoping review was chosen for study one to address objectives one and two by identifying and mapping the breadth and depth of what was known about:

- *service goals of statutory child protection services and services that support children and their families known to child protection, including how these goals are similar or different.*
- *interprofessional practices by services that support children and their families known to child protection thought to influence attainment of goals.*

A scoping review was chosen given their suitability for mapping and describing the literature in a particular area (Arksey & O'Malley, 2005; Tricco et al., 2018). The scoping review was selected given the exploratory nature of the thesis objectives and lack of literature identified in preliminary searches describing goals for families known to child protection. The approach to undertaking this review was informed by the five-stage scoping review framework developed by Arksey and O'Malley (2005) and built upon by Levac et al. (2010) and reported according to PRISMA-scoping reviews (Tricco et al., 2018). The protocol for this review was registered a-priori - Open Science- http://osf.io/9mnpa/. The methods used to complete this scoping review are further explained in chapter three.

Qualitative research was chosen for studies *2a*, *2b*, and *3* to enable a rich and contextualised exploration of shared goals and collaboration with and for families known to child protection. A qualitative approach was selected for its capacity to delve deeply into complex issues with careful attention to detail, context, and nuance recognising multiple realties and the value of exploring these (Patton, 2015, p. 257). Semi-structured interviews were selected to explore the perspectives of professionals (studies 2a & b) and parents (study 3). Semi-structured interviews were chosen for their ability to provide a flexible and open

exploration of the research questions (DePoy & Gitlin, 2015), allowing the researcher to see and hear what is meaningful to each participant as they respond to the questions and prompts (Liamputtong, 2013). The use of semi-structured interviews fits well with the epistemology and ambitions of the researcher, offering a feasible approach to data collection that yields rich understandings of the phenomenon under study anchored in respondent experience (Kelly & Cordeiro, 2020). Alternate approaches to gathering data were considered by the candidate and deemed less suitable. Surveys were recognised as offering an efficient way to gather information from many participants, however, would not afford the rich contextual information sought to answer the research questions (DePoy & Gitlin, 2015). Focus groups were precluded as it was determined that some of the information to be discussed may be sensitive and hence interviews were more likely to offer an environment that would elicit fuller responses from participants (Liamputtong, 2013).

A purposive approach to sampling was chosen, to identify information rich respondents most likely to provide knowledge useful to practice, while ensuring a range of perspectives (DePoy & Gitlin, 2015; Liamputtong, 2013). Reflecting a pragmatic approach to sampling, sample sizes for each study were informed by reflexive thematic analysis as described by Braun and Clarke (2019). Braun and Clarke propose that rather than data collection, coding and analysis each reaching a fixed point, the researcher makes a situated interpretative judgement about when to cease data collection and coding and move to theme generation (Braun & Clarke, 2021, p. 10). As such, data collection was ceased when the PhD candidate in consultation with their supervisory team felt satisfied with the depth to which the interview questions had been addressed. This was determined to be when sufficient data had been gathered relevant to the research questions so that several patterns in these data were evident, with limited new insights being gained from additional interviews. Termination of data collection also considered the scope viable within the PhD, and likely acceptability of

the sample size to the relevant research assessors/reviewers (in this case journal reviewers and PhD examiners).

For study 2a and 2b, 14 professionals who possessed high level knowledge and/or experience pertaining to interprofessional practices that support children and their families known to child protection were recruited and interviewed. These practitioners were drawn from Adelaide (n=9) and rural South Australia (n=3), New South Wales (n=1), and The Northern Territory (n=1). For study three, ten parents, including two couples were recruited from a South Australian family support provider. These parents were receiving family support following assessment by child protection that identified them as having moderate to high risk – just below the threshold for a child protection response. Participants and sampling for professionals are further described in chapters four (study 2a) and five (study 2b) and parents in chapter six (study 3).

Reflexive thematic analysis as described by Braun and Clarke (2021) was chosen for data analysis. This approach fits with the epistemologies of the researcher (pragmatism and constructionism). Pragmatically, thematic analysis is considered a fundamental method for qualitative analysis used to generate, analyse, and report patterns within the data (Braun & Clarke, 2006; Liamputtong, 2013). Fitting with constructionism, reflexive thematic analysis also acknowledges the influence of the researcher and their perspectives on the research process as opposed to objectively depicting reality (Braun & Clarke, 2021; Patton, 2015). Content and narrative analysis were identified as potential alternative methods of data analysis. However, due to the focus of content analysis on organising and categorising data (Patton, 2015), it was deemed less suitable than thematic analysis for providing rich contextualised descriptions of the findings sought to answer the research questions. Narrative analysis offered an alternative approach to thematic analysis to capture and tell the story of the parents' experiences in study three. However, the emphasis of narrative analysis on

telling a chronological story (DePoy & Gitlin, 2015) rather than re-presenting the data in themes generated to answer the identified research questions made it less suitable than thematic analysis.

The analytic process in reflexive thematic analysis is iterative, highly reflexive and involves immersion in the data, reading, reflecting, questioning, imagining, wondering, writing, retreating, and returning (Braun & Clarke, 2021, p. 332). Braun and Clarke's (2021) six-phase process was used to guide data analysis: 1) data familiarisation and writing familiarisation notes; 2) systematic data coding; 3) generating initial themes from coded and collated data 4) developing and reviewing themes; 5) refining, defining, and naming themes; and 6) writing the report.

This thesis concludes with a grand discussion that triangulates and synthesises the findings from the scoping review, interviews with professionals, and interviews with parents in response to the three overarching objectives of this thesis (chapter 7). This triangulation adds credibility to findings (Patton, 2015) and reflects the intent of a pragmatist – to offer useful knowledge anchored in the experience of participants (Kelly & Cordeiro, 2020; Patton, 2015, p. 157), and constructionism, acknowledging the contextualised nature of findings (Patton, 2015). The approach to undertaking this triangulation was guided by Petr and Feit's (2008) multi-dimensional evidence-based practice approach. Steps from this approach undertaken include reflecting and reporting on: (i) the key findings from each source; (ii) the level of agreement across sources; (iii) the gaps that may exist in the findings and (iv) making recommendations based on these (Petr & Feit, 2008).

Rigour in qualitative studies (2a, 2b & 3)

Several strategies were employed to ensure the rigour of the qualitative research undertaken. Four criteria for rigour in qualitative research were developed by Guba & Lincoln (1989) - credibility, transferability, dependability, and confirmability and are widely

accepted as the key criteria for rigour in qualitative research (Liamputtong, 2013). Credibility reflects the truth value of findings and considers the fit between what the participants say and the representation of these findings by the researcher (Liamputtong, 2013). Transferability concerns the applicability of findings to other similar contexts, individuals, groups, or situations (Sandelowski, 2004). Dependability reflects the consistency and transparency of research methods and evidencing how the findings have been generated from the data (Guba & Lincoln, 1989). Confirmability reflects the degree to which findings and interpretations of findings are evident as coming from the data and not by any biases, or interests of the researcher (Guba & Lincoln, 1989). Several strategies, or techniques have been identified to contribute to each of these rigour criteria. A summary of those used in this thesis are listed in Table 2. and described below.

Table 2. Summary of approaches to rigour

Rigour Criteria	Techniques used to ensure rigour
Credibility	Member checking, Triangulation, Audit trail
Transferability	Thick description of context and participants
Dependability	Triangulation, Member checking, Peer review/reflexivity, Audit trail
Confirmability	Audit trail, Reflexivity, Thick description (use of participant voice in presentation of results)

Member checking contributes to establishing credibility of the research (Guba & Lincoln, 1989). In this thesis, member checking was used to validate summaries of participants transcripts written by the researcher. Participants were sent a written summary of key points from the transcripts as they relate to the interview questions and invited to clarify or expand upon their responses. It is acknowledged that member checking can also be used following analysis to check findings with participants. However, as described by

Liamputtong (2013), this process of looking for participant validation following analysis suggests that a fixed truth exists and raises the dilemma of participants potentially changing their perspectives. The idea of a fixed truth contrasts with the constructionist perspective taken in this thesis that recognises people's interaction with the context around them influences their understanding of the world (Patton, 2015). This world view anticipates that people's perspectives shift over time as they continue to interact with their social context evolving their understandings. Member checking was used following the interviews with professionals with each participant, however when invited, no participants in study three (parents) wished to participate in a member checking process.

Triangulation strategies expose different perspectives of reality therefore adding to the credibility of the research (Patton, 2015). Triangulation adds credibility to this thesis via source triangulation. Findings from the scoping review, interviews with professionals and interviews with parents are compared in chapter seven illuminating where commonalities and divergence across these sources exist. As suggested by Patton (2015), when consistencies are identified across more than one source, the validity, or credibility of findings are enhanced.

Audit trail: As stated by DePoy and Gitlin (2015), an audit trail that provides detailed clarification of the theoretical, methodological, and analytic choices allows readers to see how decisions were made and the reason for making them thus enhancing reliability of findings. The overarching theoretical, methodological, and analytic choices and rationale for these are presented in this chapter. Further, chapters four to six present the methods undertaken in each study and the rationale for these. Throughout the duration of the PhD records were kept of key decisions made and underpinning discussions with supervisors, or links to literature reviewed that may have informed these decisions.

Thick description as described by Liamputtong (2013) allows informed decisions to be made about the potential transferability of research findings. Acknowledging the context embedded nature of findings from the qualitative studies, thick description was provided of the research context, participants and methods when reporting findings of the research (see chapters four to six). Further, use of participant voice in the form of quotes was used in presenting results to contribute to this rich description adding confirmability to the findings- where readers can see the link between results and the participants' own words (see chapters four to six).

Reflexivity helps to make explicit the researcher's contribution to the interpretive process and requires the researcher to critically reflect on themself as a researcher/research instrument (Braun & Clarke, 2019; Liamputtong, 2013). Reflexivity was implemented via the researcher undertaking their own continuous personal reflection on the research process and journey, including making notes to clarify these reflections. This process was extended through regular supervision meetings that included discussion regarding reflections of the researcher in relation to the research process.

Peer review can help identify the influence of the researcher on the data analysis process (DePoy & Gitlin, 2015). As described in chapters four to six, peer review was used throughout coding and development of themes during thematic analysis. Fitting with reflexive thematic analysis, as described by Braun and Clarke (2019, p. 594), this collaborative approach was used to support the reflexivity of the researcher 'to develop a richer more nuanced reading of the data, rather than seeking a consensus on meaning'.

Ethical considerations

Ethics approval was gained from the University of South Australia's Human Research Ethics Committee prior to undertaking the qualitative studies ensuring all ethical obligations were addressed (see appendices G and M). Ethics approval numbers are provided for study

2a, 2b and 3 in chapters four, five and six respectively. Given the greater ethical complexity of interviewing parents known to child protection, additional protocols to safeguard participants and the researcher were developed in partnership with the manager of the family support program where participants were recruited from. These protocols formed part of the approved ethics applications and are available as Appendices N (recruitment protocol), O (initial invitation) and P (participant distress/wellbeing protocol). The recruitment protocol was developed to guide the family practitioners when identifying eligible participants, inviting them to participate and ensuring potential participants who declined to participate were not pressured to re-consider. The initial invitation was developed for family practitioners to share with potential participants to offer a brief first overview of the study when they invited them to participate. The participant wellbeing/distress protocol was developed to minimise the likelihood of any participant experiencing distress from participating in the interview and ensure that timely and appropriate support was provided to any participant in the unlikely event that they become emotionally distressed during the interview. Parents who were interested in participating were provided the participant information sheet (Appendix Q) and signed a consent form prior to the interview commencing (Appendix R).

Note regarding study three:

The PhD candidate intended to gather perspectives of children and young people (aged seven or more years) in addition to those of their parents in study three. With support from their supervisory team, the PhD candidate discussed the proposed study with the chair of The University of South Australia Human Research Ethics Committee. This preliminary discussion was intended to support an ethics application via identification of and subsequent planning for potential ethical concerns regarding participation of children and young people in study three. From this meeting it was determined that ethics approval to include children

and young people in this study would not be obtainable from the University of South Australia's Human Research Ethics Committee. Concerns regarding potential negative reactions by parents towards their children following their participation were primarily cited by the chair of the committee as the prohibitive risk. As such, the omission of children as participants is reported as a limitation in study three alongside recommendations to include children and young peoples' voices as part of future research in this area.

The issue of 'gatekeeping' where adults make decisions about the capacity of children and young people to have a say on matters of importance to them is not new (Powell et al., 2020). A range of stakeholders have been identified who may enact the role of 'gatekeeper'. These include parents, professionals, organisations and ethics committees (Powell et al., 2020). In a study exploring social experiences of children with mothers with intellectual disability, Collings et al. (2016) describes a range of instances of gatekeeping by both mothers and professionals. Reasons for gatekeeping by professionals included high workloads, concerns for added burden on their client (the mothers), and perspectives that supporting research is not their role. Suggested reasons for gatekeeping by mothers included mother's not prioritising the study, and discouragement from other family members due to concerns regarding additional scrutiny on the mother's parenting capacity (Collings et al., 2016). University ethics committees have also been recognised as potential gatekeepers in research with children, with suggestion these committees may be becoming overly risk averse regarding participation of populations perceived as vulnerable in research (Hildebrand et al., 2015).

Despite these barriers to enabling children to participate in research on matters that are of importance to them, their involvement in research is increasingly recognised as important (Moore et al., 2021). Powell et al. (2020) offer important insights into effectively engaging stakeholders to enhance participation of children and young people in research in

the future. In particular, they highlight the importance of mutually respectful relationships between researchers and all relevant stakeholders as the basis for designing and implementing ethical research (Powell et al., 2020). To enable children and young people to have a voice on matters that affect them, opportunities for relationships to be fostered and maintained between stakeholders and researchers who seek to undertake research with children and young people on sensitive topics, warrant attention.

Reflection:

Upon completion of study three, it is my view that children could have been safely involved in this study. Several factors contribute to this view. The planned approach to involving children was conceptualised with support and guidance from Associate Professor Tim Moore, who is an expert in undertaking research with children and young people known to child protection. The proposed approach to gaining informed consent and interviewing children was child-centered and would have been tailored to each child/young person as they were identified. This approach included use of activities to build rapport, the use of a 'stop button' to cease the interview at any time, a range of creative play-focused data gathering options, potential for advocates to be present, and multiple rapport building visits if desired by the young person. Additionally, the manager of the family support program from where families were recruited was supportive of gathering children's voices therefore ensuring support from the organisation. The staff who recruited participants evidenced strong commitment to the needs of their clients (parents and children) and as such the PhD candidate had confidence in their capacity to appropriately and safely screen potential child/youth participants. Finally, as an Occupational Therapist the PhD candidate has over fifteen years of experience working directly with children and their families and is confident in engaging and communicating safely with children living with a range of complexities.

Chapter 3: Service delivery goals and underlying interprofessional practices: A scoping review to support interprofessional collaboration in the field of child protection (Study 1)

Chapter Overview

This chapter presents findings from study 1 of this thesis, a scoping review of goals for children and their parents/caregivers held by services for families known to child protection (ii) and underlying interprofessional practices that influence attainment of these goals. The position of this study in the program of research is presented below. This study was designed to determine what was known in the literature regarding these objectives to provide context for the following studies.

Position of Study 1 within the program of research

Objectives *To explore:*	**Study 1** Scoping review[1] *Chapter 3*	**Study 2a** Professional interviews *Chapter 4*	**Study 2b** Professional interviews[2] *Chapter 5*	**Study 3** Parent interviews *Chapter 6*
Goals for families known to child protection including how these goals are similar or different				
Interprofessional collaborative practices thought to influence attainment of goals				
Collaborative practice between parents and practitioners thought to influence attainment of goals				

[1](Seekamp et al., 2022) [2](Seekamp et al., 2023)

Publication

This study is presented in this chapter as published in Children and Youth Services Review in 2022. Supplementary data for this chapter is presented in Appendix B – search terms used in Medline, Appendix C – data table, and Appendix D - summary of studies excluded at full text.

Citation details

Seekamp, S., Ey, L.-A., Wright, S., Herbert, J., & Tsiros, M. D. (2022). Service delivery goals and underlying interprofessional practices: A scoping review to support interprofessional collaboration in the field of child protection. *Children and Youth Services Review*, *143*, 106680-. https://doi.org/10.1016/j.childyouth.2022.106680

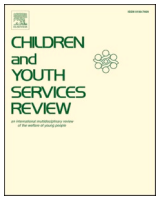
Children and Youth Services Review 143 (2022) 106680



Contents lists available at ScienceDirect

Children and Youth Services Review

journal homepage: www.elsevier.com/locate/childyouth





Service delivery goals and underlying interprofessional practices: A scoping review to support interprofessional collaboration in the field of child protection

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ARTICLE INFO

Keywords:
Child welfare
Child protection
Child maltreatment
Family services
Service goals
Interprofessional collaboration

ABSTRACT

To improve outcomes for vulnerable children, there is a pressing need to strengthen collaboration between services that support children and families known to child protection. There is potential for shared service goals to enhance interprofessional collaboration in this field. To better understand shared service goals as an enabler of interprofessional collaboration, a scoping review was undertaken to critically explore (i) goals for children and for their parents/caregivers held by services for children and families known to child protection (ii) interprofessional practices underpinning these goals. Ninety-one studies met the inclusion criteria. Safety, family preservation and increasing parenting capacity were identified as the most universally common goals across the range of services included in the review. Findings to enhance interprofessional collaboration are presented including: the role and value of shared goals at both the organizational and individual client level, as well as interprofessional practices that underpin the attainment of these shared goals. Recommendations for future research are made including the need to explore involvement of consumers in design and evaluation of collaborative approaches and how work to support children's wellbeing is balanced with work to improve the context in which they live.

1. Background

Interprofessional collaboration is an essential and expected practice of services that support children and families known to child protection to enhance their safety and wellbeing (Government of South Australia, 2016; Herlihy, 2016; Horwath & Morrison, 2011; Price-Robertson et al., 2020). In this review, the definition of interprofessional collaboration has an intersectoral focus as described by Price-Robertson et al. (2020) and refers to collaboration and coordination of service responses between professionals from different service organizations supporting children and families known to child protection.

The benefits of interprofessional collaboration in the field of child protection are well established and include concurrently addressing complex related issues experienced by families, reducing service costs, improving service quality, and enabling increased access to resources (Government of South Australia, 2016; Herlihy, 2016; Horwath & Morrison, 2011; Lalayants, 2013). Effective interprofessional collaboration has also been reported to benefit staff working in the field of child protection, offering them increased feelings of support, improved assessment skills and enhanced access to relevant client services (Darlington et al., 2005; Wade et al., 2016). In contrast, ineffective interprofessional collaboration can increase the vulnerability of already at-risk children. For example, ineffective interprofessional collaboration has resulted in failure to communicate critical information between

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https://doi.org/10.1016/j.childyouth.2022.106680
Received 1 April 2022; Received in revised form 17 August 2022; Accepted 1 October 2022
Available online 7 October 2022
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workers, inappropriate and potentially avoidable risks to children and families, and families moving from assessment to assessment without a service response and/or being missed all together (Herlihy, 2016; Knight et al., 2007).

1.1. Context for collaboration

The known benefits of interprofessional collaboration have led to organizational, legislative and policy pushes to enhance collaboration between services in the field of child protection in countries such as Australia, England, and United States of America (USA) (Colvin & Miller, 2018; Flaherty, 2019; HM Government, 2018). Interprofessional collaboration is a key element of family support service systems which have become a focus on over the past two decades (HM Government, 2018; Hughes et al. 2013). These service systems are typically designed to divert vulnerable families and children away from statutory services to voluntary early intervention and prevention services, while families with severe and complex needs and high risk of harm receive a response from the statutory service (Hughes et al. 2013). Examples include the Safeguarding Children Framework in the United Kingdom and differential response type systems in Australia, Canada, and the USA (HM Government, 2018; Hughes et al. 2013; Lonne et al. 2015; Marshall et al. 2010).

Despite the push for collaboration, implementation of collaborative practices in the field of child protection and family support remains a challenge internationally (Chuang & Lucio, 2011; Commission for Children and Young People, 2018; Government of South Australia, 2016; Horwath & Morrison, 2011). Issues related to conflicting mandates, competition for funding, and communication and decision-making between agencies remain as barriers to sustainably implementing collaborative practices (Coates, 2017; Darlington et al., 2005; Pharo et al., 2014). Systemic barriers to interprofessional collaboration are further compounded by the complexity of families these services support, the high level of risk within families, and the chronicity of these risks. Typically, families referred by child protection to family support services present with multiple and complex risk factors including low income, limited social supports, domestic and family violence, parental substance abuse and mental health concerns (Early Intervention Research Directorate, 2019; Wood, 2008). The range and complexity of needs presented by these families demands collaboration across a range of services to meet their varied needs.

Enablers of interprofessional collaboration in child protection are well known and include shared management of risk, consistent processes and expectations (Coates, 2017) as well as strong leadership, trust, communication, and clarity of the intended practice outcomes or goals (Lalayants, 2013; Price-Robertson et al., 2020; Winkworth & White, 2010). Shared practice goals are a well-documented enabler of interprofessional collaboration. The process of identifying shared practice goals helps collaborators identify where their values align and can provide clarity regarding their respective roles in contributing to achieving these goals (Coates, 2017; Lippman et al., 2011; Zannettino & McLaren, 2014). Theoretical models of interprofessional collaboration further affirm the importance of shared practice goals as a driver of collaboration (D'Amour et al., 2008; Winkworth & White, 2010). There is potential for shared service goals to enhance interprofessional collaboration in the field of child protection. However, to enable this, shared service goals, and their role as an enabler of interprofessional collaboration need to be better understood.

1.2. Theoretical models

Winkworth and White (2010) developed a model based on Moore's Public Value Model (2000), that reflects the importance of shared practice outcomes/goals as a key component of successful collaboration. Their model depicts three interrelated essential drivers of interprofessional collaboration with each of these three drivers underpinned by five action areas (Fig. 1) (Winkworth & White, 2010). The three drivers are: 1) Capability- an organization's capacity to collaborate, including financial, physical, and human resources; 2) Authority- the support and leadership of influential stakeholders that enable partners to collaborate; and 3) Shared value- the shared understanding of the purpose of the collaboration and how outcomes for clients will be improved (White & Winkworth, 2018). This shared value domain identifies having shared purpose and identifying and planning for shared goals as important action areas for enhancing interprofessional collaboration (White & Winkworth, 2018). This model provides a framework for analyzing and informing work to enhance collaboration (Winkworth & White, 2010) and provides a theoretical underpinning for this study and is used to support the discussion of findings from this review related to interprofessional collaboration.

A family-centered and child-focused approach is recommended in child protection. This approach acknowledges the interrelatedness of a family and their needs, without losing sight of the child and their needs (Scott et al., 2010). With the focus on the needs of all family members, this approach also provides a useful framework for furthering interprofessional collaboration, where different services may focus on the needs of different family members, while acknowledging the interrelated nature of their challenges (Scott et al., 2010). A family-centered and child-focused lens will be taken in this review, with the researchers considering how the needs of children and their parent/caregivers are reflected in service goals.

This review aimed to better understand shared service goals as an enabler of interprofessional collaboration by statutory child protection and family support services for families who are known to child protection but have not yet reached the threshold for out of home care (OOHC). To achieve this the review critically explored (i) goals for children and for their parents/caregivers held by services for children and families known to child protection (ii) interprofessional practices applied by these services to achieve the identified goals. To capture data from studies conducted in more comparable socio-economic contexts, this review included literature from Organization for Economic Co-operation and Development (OECD) countries. No prior reviews have explored shared practice goals as an enabler of interprofessional collaboration, including the relationship of goals across services that support children and families known to child protection and how the needs of children and their parent/caregivers are reflected in these goals. Findings from this review will provide new insights into shared service goals as an enabler of interprofessional collaboration including

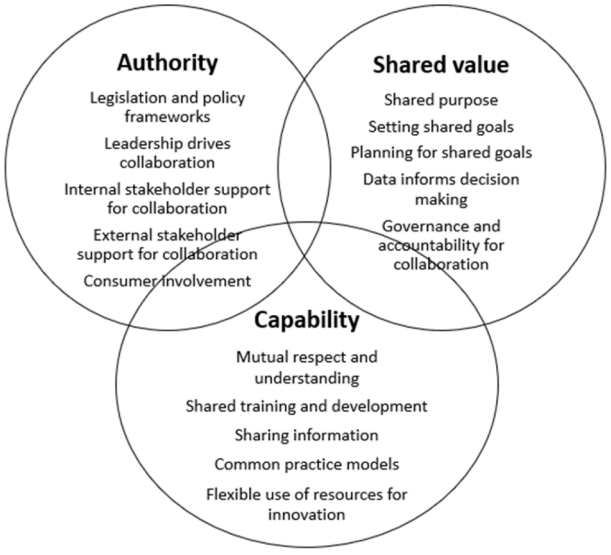


Fig. 1. Key Drivers of Collaboration Figure reproduced with permission (White & Winkworth, 2018).

what these shared goals may be and their role in supporting interprofessional collaboration. This knowledge will enable funders, practitioners, and policy makers to make more informed choices as to how they may draw upon shared service goals to support interprofessional collaboration in the field of child protection.

2. Method

A scoping review was undertaken to address the following review questions that were identified from a preliminary review identifying gaps in current literature:

What is *known about service goals of statutory child protection services and services that support children and their families known to child protection?*

In *what ways are the goals of services that support children and their families known to child protection similar and/or different?*

What is known about interprofessional practices by services that support children and their families known *to child protection to achieve the identified goals?*

A scoping review was undertaken given their efficiency in broadly mapping and describing the literature in a specific area, including key characteristics and factors related to a particular concept (Arksey & O'Malley, 2005; Tricco et al., 2018). The approach to undertaking the review was informed by the five-stage scoping review framework developed by Arksey and O'Malley (2005). The five stages of the review included: (1) identifying the research quesiton; (2) identifying relevant studies; (3) selection of studies; (4) charting the data; and (5) collating, summarising and reporting the results. This review protocol was registered apriori on 3rd August 2021-Open Science- https://osf.io/9mnpa/.

2.1. Identifying relevant studies

Relevant studies were identified by searching the following databases: Ovid Embase, PsycINFO, ProQuest, MEDLINE, and Ovid Emcare. Appropriate MeSH terms, truncations, and Boolean operators were used in each database. A search of the grey literature involved searching the Australian Institute of Family Studies database, as well as Trove and ProQuest Dissertations for potentially eligible theses. A Google search was undertaken where the first 100 results were screened for inclusion (Archambault et al., 2013). The search strategy was developed in conjunction with an academic research librarian. The search terms used in Medline are included in Appendix 1. Search terms were adapted for grey literature searches. Studies from the year 2000 onwards were included, to capture literature describing contemporary approaches to supporting children and families known to child protection, reflecting the strengthened push for collaborative, cross sector approaches since this time (Council of Australian Governments, 2009; Horwath & Morrison, 2007). Searches using Ovid Embase, PsycINFO, ProQuest, MEDLINE and Ovid Emcare were conducted on the 27th and 28th May 2021. Grey literature searches were conducted on 7th and 8th June 2021. References identified from each database were imported into Endnote 20 (Clarivate Analytics, Philadelphia, USA).

2.2. Study selection

Eligibility criteria were developed to reflect the scope of this review – services with a focus on supporting families who are known to child protection but have not yet reached the threshold for out of home care (OOHC). Each study was screened against the following inclusion/exclusion criteria:

2.2.1. Inclusion criteria

Studies that described service or program goals for children and families known to child protection (have been subject of a notification to the statutory child protection authority) by the following service types:

- Statutory child protection authorities and family support services, including intensive family support services, family preservation and placement prevention services.
- Services that address adult problems with the aim of improving outcomes for children and families known to child protection.

2.2.2. Exclusion criteria

Studies reporting on:

- Service responses with a focus on forensic or prosecution processes and treatment of trauma.
- Out of Home Care Services, or services with a sole focus on supporting families where children have been removed.
- Universal services.
- Services that focus only on adult needs with no focus on children's needs and outcomes.
- Studies from countries not registered with The Organisation for Economic Co-operation and Development (OECD)
- Studies not in English
- Conference abstracts and books / book chapters.

The lead researcher (SS) and one other member of the research team (SW) independently screened titles and abstracts against the inclusion / exclusion criteria for eligibility. The full texts of potentially eligible studies were retrieved and assessed for eligibility independently by the same two reviewers. A number of studies discussed more than one service/program. Studies that included at least one service/program that met the inclusion criteria were included. Several studies reported on services/programs that provided services to both families with their children at home and families whose children were in OOHC. In this instance where the screeners determined a primary focus of the service/program was supporting families who still had their children in their care, these studies were included. Any disagreements on study inclusion were resolved by discussion between the two reviewers or a third reviewer when consensus could not be reached. Covidence (Covidence, Victoria, Australia) was used to remove duplicate studies and support screening studies.

2.3. Charting the data

A data extraction form in Microsoft Excel (Microsoft Corp, Redmond, USA) was developed and key information such as: authors, date, study design, country of origin, study aim, program/service type and goals for children and their parents/caregivers, and any descriptions of interprofessional practices contributing to achieving goals was extracted. For included studies that discussed more than one service/program, the reviewers screened each of these services/programs against the inclusion /exclusion criteria and extracted data for each program/service that met the criteria. Three members of the research team (SS, LE and MT) piloted the spreadsheet, independently extracting data from a sample of 10 % of the eligible studies to determine whether the approach to data extraction was consistent with the research question and purpose. No changes were made to the data extraction form or process following this pilot. Following this, the lead researcher (SS) completed the remaining data extraction.

2.4. Collating, summarizing, and reporting the results

The approach to data analysis was determined in consultation with the research team. Services/programs were grouped into categories reflecting their focus. Two separate tables were created, one recording goals described for the child/ren and the other recording goals with a parent/caregiver focus – addressing parental needs and risk factors. The lead researcher (SS) formed the program/service goals into categories reflecting their focus. This enabled the frequency of service/program goals for both parents/caregivers and children to be mapped by

program/service type. Data extracted describing interprofessional practices were analyzed and mapped separately to the program/service goals. The lead researcher (SS) reviewed and coded these data allowing categories to form from the data itself. The resultant categories were then reviewed in relation to White and Winkworth's Interprofessional Model (2018). During and upon completion of the data analysis, the lead researcher consulted with the second screener (SW) to review and validate the findings.

3. Results

Of a total of 10,580 studies identified, 91 studies met the inclusion criteria. From these 91 studies, 104 eligible programs/services were identified. As anticipated, a number of studies that met the inclusion criteria did not address interprofessional collaboration as they were evaluations of specific programs/services. Data pertaining to interprofessional practices was able to be extracted from 33 studies. The flow of studies through the screening process of this review is described in Fig. 2. A data table for the 91 eligible studies and their full citations is provided in Appendix 2. A summary, including references of studies excluded at full text review is provided in Appendix 3. Eligible studies were predominantly from the United States of America (USA) (64). The remaining studies were from Canada (9), Australia (8), Spain (5), Singapore (2), England (1), Italy (1) and Portugal (1). Eligible studies included a range of methodologies including quasi-experimental design (n = 24), non-controlled evaluation (N = 17), mixed methods (n = 14), randomized controlled trial (n = 13), narrative description (n = 11), qualitative (n = 10), a scoping review (n = 1) and a protocol (n = 1).

3.1. Service/program goals of services that support children and their families known to child protection.

Overall, 429 parent/caregiver focused goals and 270 child-focused goals were extracted from descriptions of 104 eligible program/services. (See Table. 1 and 2). The lead researcher collated the program/service goals into categories reflecting their focus. This created ten parent/caregiver focused goal categories and five child focused goal categories. Of the total 15 goal categories, 13 reflected a focus on addressing the child's context – that is addressing parental needs and the child's social and physical environment. Two of the 15 goal categories (child wellbeing and reducing challenging behavior) reflected addressing intrinsic needs of the child. The 104 programs/services were grouped into ten categories reflecting the focus of the services/programs. These included five service types provided by individual providers: parenting programs (n = 38), family support services (n = 29), child protection (n = 7), substance use disorder (SUD) services (n = 7), and domestic violence services (n = 1). The remaining five service categories included the following collaborations: child protection and substance use disorder (SUD) services (n = 10); mental health, SUD and child protection services (n = 2); family support and child protection services (n = 2); child protection and housing services (n = 2), and 'other' (n = 6). The 'other' category included mixes of service collaborations that did not fit with existing categories.

As presented in Table 1 and 2, the prevalence of each goal category across all programs was calculated. The most prevalent goal overall was child safety which was cited as a goal in 75 % of programs. This was followed by increasing parenting capacity which was a goal in 74 % of

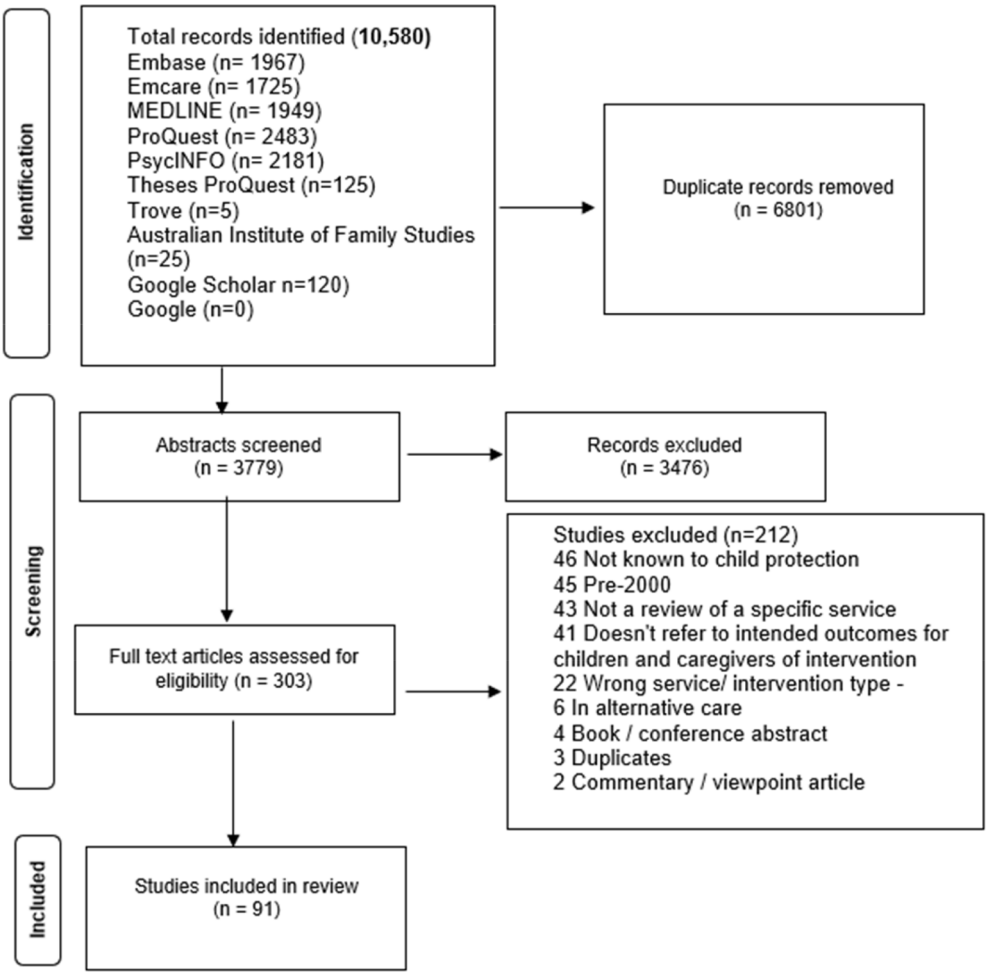


Fig. 2. Article selection process.

Table 1
Child focused program/service goals.

Service/Program types & collaborations	Safety n (%)	Family preservation n (%)	Strengthen parent - child relationship n (%)	Wellbeing n (%)	Reduce challenging behaviour n (%)
Parenting Program n = 38	22 (58)	10 (26)	32 (84)	9 (24)	13 (34)
Family Support n = 29	28 (97)	26 (90)	11 (38)	21 (72)	5 (17)
CP[1] & SUDs[2] n = 10	8 (80)	9 (90)	5 (50)	5 (50)	–
CP n = 7	7 (100)	7 (100)	–	2 (29)	1 (14)
SUDs n = 7	2 (29)	2 (29)	7 (100)	4 (57)	4 (57)
Other Collaboration[3] n = 6	6 (100)	5 (83)	2 (33)	3 (50)	–
Family Support & CP n = 2	2 (100)	2 (100)	–	1 (50)	–
CP & Housing n = 2	–	2 (100)	–	–	–
Mental Health, SUDs & CP n = 2	2 (100)	2 (100)	–	2 (100)	–
Domestic Violence Service n = 1	1 (100)	–	–	–	–
Total goals from 104 programs	**78**	**65**	**57**	**47**	**23**
% Prevalence across all programs*	**75 %**	**63 %**	**55 %**	**45 %**	**22 %**

n = no. of services/ programs; **(n)** = percentage of that program/service type with that goal; * Percentage prevalence of each goal type across all programs = the sum of n for each goal type and divided by 104 (the number of programs) X 100; [1]child protection authority, [2]Substance abuse disorder support service, [3]Service collaborations not already included. **Safety** (Preventing abuse and neglect); **Family preservation** (maintaining family unity when safe to do so or arranging permanency in a timely manner); **Wellbeing** (Mental health, development, health, resilience, school engagement/readiness and attachment); **Strengthen parent /child relationship** (Enhancing parental sensitivity & responsiveness); **Reduce challenging behaviour** (Inc. enhancing emotional regulation).

Table 2
Parent/Caregiver focused goals.

Service/ Program types & collaborations	Improved parenting capacity n (%)	Family preservation n (%)	Risk reduction n (%)	Strengthen parent–child relationship n (%)	Links to community services n (%)	Mental health n (%)	SUDs support/ sobriety n (%)	Improve Family functioning n (%)	Housing & concrete services n (%)	DV Support n (%)
Parenting Program n = 38	35 (92)	10 (26)	11 (29)	32 (84)	11 (29)	6 (16)	1 (3)	6 (16)	–	3 (8)
Family Support n = 29	21 (72)	26 (90)	24 (83)	11 (38)	22 (76)	15 (52)	5 (17)	9 (31)	9 (31)	2 (7)
CP[1] & SUDs[2] n = 10	7 (70)	9 (90)	6 (60)	5(50)	4 (40)	5 (50)	10 (100)	2 (20)	3 (30)	2 (20)
SUDs n = 7	7 (100)	2 (29)	1 (14)	7 (100)	1 (14)	6 (86)	7 (100)	–	1 (14)	–
CP n = 7	2 (29)	7 (100)	7 (100)	–	7 (100)	1 (14)	–	3 (43)	–	1(14)
Other Collab[3] n = 6	2 (33)	5 (83)	4 (67)	2 (33)	5 (83)	1 (17)	4 (67)	1 (17)	1 (17)	2 (33)
Family Support & CP n = 2	1 (50)	2 (100)	2 (100)	–	1 (50)	1 (50)	–	2 (100)	1 (50)	–
CP & Housing n = 2	–	2 (100)	–	–	–	–	–	1 (50)	2 (100)	–
MH[4], SUDs & CP. n = 2	2 (100)	2 (100)	1 (50)	–	–	2 (100)	2 (100)	–	–	–
DV[5] n = 1	–	–	–	–	–	–	–	–	–	1 (100)
Total goals	**77**	**65**	**61**	**57**	**51**	**37**	**29**	**24**	**17**	**11**
% Across all programs*	**74 %**	**63 %**	**59 %**	**55 %**	**49 %**	**36 %**	**28 %**	**23 %**	**16 %**	**11 %**

n = no. of services/ programs; **(n)** = percentage of that program/service type with that goal; * Calculated the sum of n for each goal type and divided by 104 (the number of programs) X 100; [1]Statutory child protection authority, [2]Substance abuse disorder support service, [3]Service collaborations not already included, [4]Mental health service, [5]Domestic violence service. **Family preservation** (maintaining family unity when safe, or permanency in a timely manner); **Improved parenting capacity** (knowledge & skills); **Risk reduction** (Tailored work to reduce risks for child abuse & neglect); **SUDs support/ sobriety** (Reduction in SUDs as a risk factor for abuse & neglect); **Links to community services** (services Inc. social support); **Mental health** (treatment for mental illness &/or wellbeing support, e.g., stress reduction; **Housing and concrete supports** (includes housing and concrete supports including food, transport, childcare, immediate financial support); **Parent/child relationship** (enhancing parental sensitivity and responsiveness); **Improve Family functioning** (goals stated as 'to improve family functioning')

programs and family preservation which was cited as a goal in 63 % of programs. The most common child focused goal after safety and family preservation was strengthening parent–child relationship (55 %), followed by wellbeing (45 %). The wellbeing category included goals that stated child wellbeing as a goal specifically, as well as goals related to child physical and mental health, development, school engagement/readiness, and attachment, as there were insufficient numbers of these subcategories to form a category of their own. The most common parent/caregiver focused goal across all programs after improved parenting capacity and family preservation was risk reduction (59 %), followed by strengthening parent–child relationship (55 %) and links to community services (49 %).

Patterns of goals by service type for children and parents/caregivers can be seen in Table 1 and 2. All seven child protection services included safety, family preservation, risk reduction and links to community services as goals. Family support services had similar goals with 97 % of services including safety, 90 % family preservation, 83 % risk reduction and 76 % links to community services. However, 72 % of family support services also included child wellbeing and improving parenting capacity as goals, compared to 29 % of child protection services. The most common goals of parenting programs were improving parenting capacity (92 %) and strengthening parent–child relationship (84 %). All seven SUD services also included strengthening parent/child relationship and improving parenting capacity as goals along with SUD support. Mental health was also a goal of 86 % of these seven SUD services. Service collaborations including a SUD service reflected similar goal profiles to the seven SUD only services. Strengthening parent–child relationship was one of the more prevalent goals overall in both Table 1 and 2, however, it was cited across a narrower range of program types than other less frequently cited goals such as child wellbeing and parental mental health.

3.2. Interprofessional practices

Of the 91 studies, 33 reported information on interprofessional practices. Six key categories of interprofessional practices were identified, including: a shared vision; collaborative assessment, planning and service delivery; communication and relationships; systems and processes; cross agency training and leadership support.

3.2.1. Shared vision

Ten studies recognized the importance of identifying a shared vision at the organizational level for driving cross agency collaborations. This vision was described as being underpinned by a commitment across agencies to improved outcomes for their clients (Chahine et al., 2005; Humphreys et al., 2018; Marts et al., 2008). D'Andrade et al. (2017) described how a shared vision can help staff from each program see the other's role in strengthening families, and meeting program goals on both sides, providing a driver for collaboration. The development of a shared vision was described as requiring the needs of different family members to be balanced and the interrelatedness of these needs to be acknowledged. In collaborations between domestic violence and child protection services, this balancing reflected a need to have a shared focus on supporting the mother and keeping her, and her children safe (Humphreys et al., 2018; Pennell & Burford, 2000). For collaborations between SUD and child protection services, this balancing reflected work to try and safely enable children to remain with their parents, while parents receive appropriate clinical support for their SUD (Bosk et al., 2019; Hanson et al., 2015).

3.2.2. Collaborative assessment, planning, and service delivery

The value of collaborative approaches to assessment, developing service plans and supporting families was described in 15 of the 33 studies that discussed interprofessional practices. Collaborative approaches described included- sharing assessment information (Cunningham & Pergamit, 2015; Faller et al., 2008) creating joint case plans and goals (Cunningham & Pergamit, 2015; Lawrence et al., 2011; Traube et al., 2015), and sharing information relating to ongoing review and monitoring of clients (Huebner et al., 2015; Olsen et al., 2015; Schaeffer et al., 2013). In some studies, this collaborative approach included sharing accountability for client outcomes, with acknowledgement that child protection concerns were an issue not only for child protection workers, but other treatment providers working with these families (Hanson et al., 2015; Swenson & Schaeffer, 2018).

Through collaborative assessment, planning, and service delivery, professionals were more able to fully understand the client's strengths and needs and the implications for supporting the child and their family (Coates, 2017; Cunningham & Pergamit, 2015). Collaboration enabled development of goals that complemented one another and reflected a deeper understanding of the family, which supported families to complete treatment (Karatekin et al., 2014; Lawrence et al., 2011; Swenson & Schaeffer, 2018). Hammond and McGlone (2013) reported that collaborative service plans, supervision and client visits by SUD and child protective services improved caregiver compliance with service plans and ensured better child safety outcomes. Similarly, Crane et al. (2019) described how a collaboration between health, welfare and a SUD service addressed some of the barriers to women engaging in treatment. Clarification of service goals addressed some fears held by mothers that child welfare involvement will likely lead to a loss of custody (Crane et al., 2019).

3.2.3. Communication and relationships

The importance of regular transparent and respectful communication in establishing and maintaining interprofessional collaboration was presented in 21 of the 33 studies. The focus of this communication was twofold, firstly, to establish and maintain the collaboration and secondly to provide collaborative services to the clients. Regarding maintaining collaborations, regular interagency communication was described as important to ensure timely resolution of any issues related to implementing and maintaining commitment to the collaboration (Freisthler et al., 2021; Humphreys et al., 2018; Lange et al., 2011).

To facilitate collaborative services to the clients, regular intensive communication helped to support partnerships around common goals (Lawrence et al., 2011). Examples of communication included regular meetings (Cunningham & Pergamit, 2015; Huebner et al., 2017; Peckover & Everson, 2014), case managers sharing progress and outcome reports with child protection services (de Paul & Arruabarrena, 2003) and the use of liaison workers to communicate between an intensive family support service and child protection authority when a family's risk was increasing (Lonne et al., 2015). The benefit of having a child protection contact to ask about mandatory reporting protocols and facilitate communication for child welfare involved families was also reported by nurses delivering a home visiting program (Tung et al., 2019).

Relationships at both leadership and practitioner levels fostered through regular communication were described as an important element of successful interprofessional collaboration (Hanson et al., 2015; Humphreys et al., 2018; O'Connor et al., 2005). Strong interagency relationships were credited with improving program effectiveness (Hanson et al., 2015). Positive interprofessional relationships were described as critical to positive client outcomes, through enabling the development of shared goals, making completing treatment plans more manageable for clients (Swenson & Schaeffer, 2018). Relationships were also valued for building capacity at the family, agency, community, and system levels through ongoing sharing of knowledge and information (O'Connor et al., 2005).

3.2.4. Systems and processes

Of the 33 studies, 19 identified supportive systems and processes as essential to collaborative responses. These systems and processes were described as necessary to support the collaborative practices required to achieve their shared vision of improved outcomes for clients (D'Andrade et al., 2017). Practices and strategies described included: agreed practice guidelines and memorandums of understanding (MOUs) (Cunningham & Pergamit, 2015; Fowler & Chavira, 2014; Freisthler et al., 2021); ensuring role clarity across agencies (Coates, 2017; Lonne et al., 2015); clear referral processes (Fowler & Chavira, 2014); and protocols for information sharing (Lawrence et al., 2011). Data collection and sharing was thought to be useful in identifying common clients and monitoring service delivery (D'Andrade et al., 2017; Freisthler et al., 2021; Huebner et al., 2017). Resource sharing (Chahine et al., 2005) and co-location of staff (locating staff in partnering agencies) (Arney et al., 2010; Olsen et al., 2015; Traube et al., 2015) were identified as further practices that supported interprofessional collaboration.

3.2.5. Cross agency training

Cross agency training was identified as important in enhancing interprofessional collaborations in nine of the 33 studies. Cross agency training was recognized as important for initiation of collaborations and to maintain collaborations (Crane et al., 2019; Huebner et al., 2012; Swenson & Schaeffer, 2018; Traube et al., 2015). This training was described as enabling staff to learn about each other's services, approaches and various worker roles (Freisthler et al., 2021; Tung et al., 2019) and how the collaboration would enhance outcomes for clients (D'Andrade et al., 2017). Cross agency training that developed knowledge of overlapping approaches and concepts such as trauma informed care and the interconnectedness of substance abuse, child maltreatment, and family violence were also described as supportive of successful collaborations and improved practices with clients (Freisthler et al., 2021; O'Connor et al., 2005).

3.2.6. Leadership support

Leadership was identified as an important enabler of interprofessional collaboration in eight of the 33 studies. The role of leadership was recognized as critical in both establishing and maintaining interprofessional collaborations (D'Andrade et al., 2017; Huebner et al., 2017; Lange et al., 2011; Lonne et al., 2015). Leadership communicating and endorsing a clear vision for the collaboration and its intended benefits for all parties was described as essential to generate staff support for establishing a collaboration (D'Andrade et al., 2017). To sustain collaborations, leadership support was identified as vital in providing resources, including staff time, and funding and enabling flexible use of resources to support innovations (Humphreys et al., 2018; Lonne et al., 2015; Traube et al., 2015). The role of leadership in providing encouragement and support to staff in making decisions, exercising judgment, and working in multidisciplinary teams was identified (O'Connor et al., 2005).

4. Discussion

There is a critical need to enhance interprofessional collaboration by statutory child protection authorities and family support services to better meet the needs of children and families (Coates, 2017; Government of South Australia, 2016; Herlihy, 2016; Price-Robertson et al., 2020). To better understand shared service goals as an enabler of interprofessional collaboration in this field, this review explored (i) goals for children and for their parents/caregivers held by services for children and families known to child protection and (ii) interprofessional practices underpinning these goals. Results provide insights to further inform planning, implementation, and evaluation of interprofessional collaborations in the field of child protection and recommendations for further research. Fig. 3. illustrates the key findings from the review and proposes how they are interrelated.

To establish collaborations, results highlighted the importance of identifying an overarching shared vision for the goals of a collaboration and clarifying the role of each collaborator in achieving these goals. Recognizing the needs and wishes of all family members and how these needs are interrelated can support the identification of a shared vision. To garner internal support for the collaboration, leadership plays a key role in clearly articulating this vision and its benefits to staff. These findings reflect White and Winkworth's (2018) model, where a shared vision endorsed and communicated by leadership reflect key action areas of both driver domains 'authority' and 'shared value' (Fig. 1).

The breadth of program/service goals identified in this review, particularly for parent/caregivers, reflect the complex needs of families known to child protection authorities (Early Intervention Research Directorate, 2019; Wood, 2008). Despite this, safety, improving parenting capacity and family preservation were identified as common goals across the range of included services/programs. These goals may offer common ground to form a shared vision across agencies. Safety and family preservation have previously served as shared goals for services with historically divergent philosophies and foci. Child welfare and domestic violence services found common ground with interventions needing to be accountable to children's safety needs, as well as attentive to women's relationships with their children (Pennell & Burford, 2000; Zannettino & McLaren, 2014). The shared goal of family preservation has also been described as a motivator for parents with substance abuse disorders. Parental desire to reunite with children and resolve their child welfare case, can provide motivation to engage in substance abuse

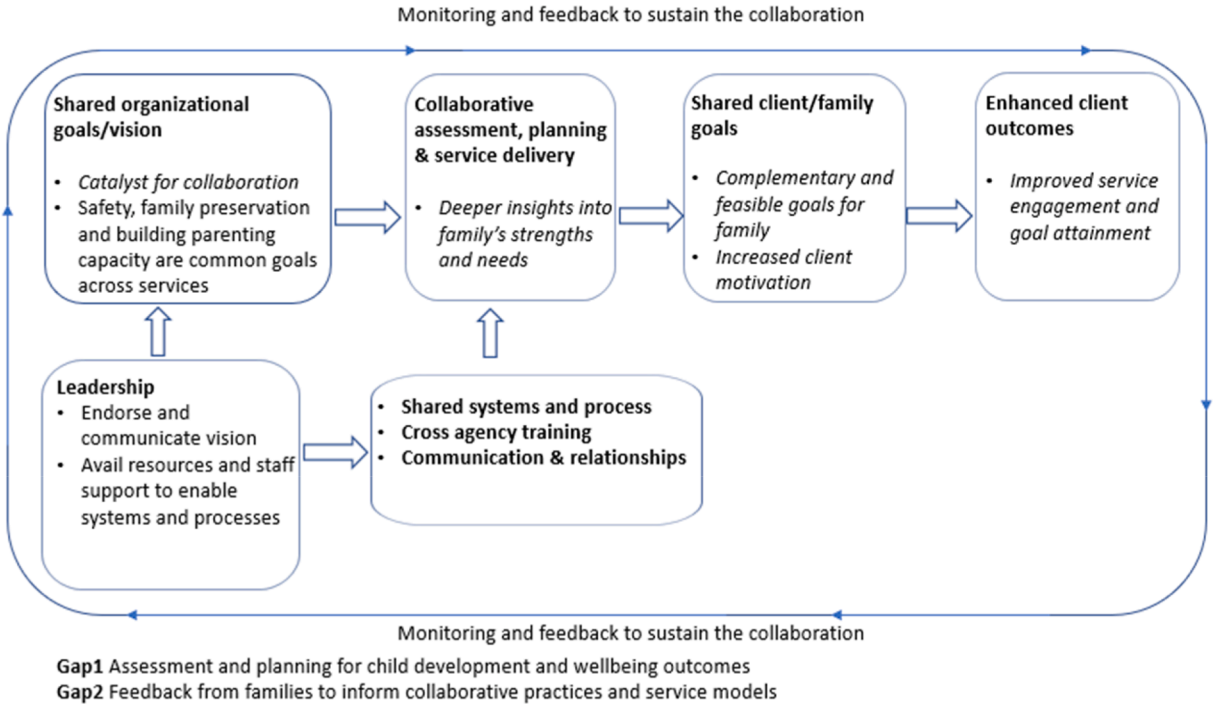


Fig. 3. Proposed role of shared goals and interprofessional practices.

treatment (Hanson et al., 2015; Traube et al., 2015). Similarly, Thompson et al. (2013) report that parents are more strongly motivated to enroll in SUDs programs to work towards keeping their children than to get sober.

The goals identified in this review overall reflected a strong focus on achieving safety and permanency for children through addressing contextual risk factors. Such goals included building parenting capacity, addressing domestic violence, mental illness, substance use disorders and homelessness and connecting caregivers with community supports. These results reflect previous findings that practitioner responses from child protection and non-government agencies typically focus on addressing the needs and concerns of parents, with the intent to positively influence parental behaviors and living circumstances to help them better care for their children (Cahill et al., 2020). The risk however, with a predominant focus on addressing parental needs to improve outcomes for children, is that children's needs may be overlooked. Gap 1, in Fig. 3. represents a lack of goals identified in this review reflecting explicit assessment and planning for child development and wellbeing. Samples et al. (2013) state that child protection services need to ensure a proportionate focus on child wellbeing as well as safety and permanency. Lippman et al. (2011) in their research regarding indicators for child wellbeing contend that it is extremely important not to confuse measures of a child's context with measures of child wellbeing itself.

The need to more effectively support children known to child protection to receive services to address trauma, or other developmental or wellbeing needs has been widely acknowledged (Cahill et al., 2020; Corr & Santos, 2017). In a study conducted by Karatekin et al. (2014), results indicated that ensuring children's safety did not translate into good developmental and educational outcomes and that targeted support is required to impact child development and educational outcomes. Given the high rates of intergenerational transmission of child maltreatment (Armfield et al., 2021), taking steps to ensure children in such families, are not just safe and with their families, but meeting their full potential seems imperative. Findings from this review highlight the need to increase attention to goals reflecting children's intrinsic needs and wellbeing, ensuring a family-centered *and* child-focused approach.

As illustrated in Fig. 3, the identification of shared client goals, or at least a shared oversight of goals at the individual client level is an important element of interprofessional collaboration and contributes to improving client outcomes. This reflects White and Winkworth's (2018) model that includes setting and planning for shared goals as key action areas of interprofessional collaboration within the driver domain "shared value" (White & Winkworth, 2018). Results from this review suggest that practitioners who collaboratively oversee goals will have a deeper understanding of families' needs and strengths (Lawrence et al., 2011; Swenson & Schaeffer, 2018), increase client engagement in services (Crane et al., 2019; Hammond & McGlone, 2013), and establish goals that are feasible and not conflicting for families (Karatekin et al., 2014). Sharing the achievement of common goals among collaborators can also contribute to energizing commitment to collaborative work being undertaken (D'Andrade et al., 2017).

Child protection system inquiries in Australia and internationally have reported system-level barriers to collaboration between child protection and child and family welfare services (Price-Robertson et al., 2020, p. 2). Results of this review speak to these barriers and identify several systems and processes that enable interprofessional collaboration. These results align with previous studies and White and Winkworth's (2018) model, citing the need for clear systems and processes as well as effective relationships and communication to enable interprofessional collaboration (Lalayants, 2013; Price-Robertson et al., 2020). Under the driver 'capability', shared training and development, information sharing, flexibility and common practice approaches are all identified as action areas that support interprofessional collaboration (White & Winkworth, 2018). While results from this review further affirm the importance of systems and processes as enablers of interprofessional collaboration. Findings add that it may be challenging for front line practitioners to establish and maintain interprofessional collaborations without leadership support to avail these systems and processes.

White and Winkworth's model (2018) (Fig. 1) was used to evaluate the results pertaining to interprofessional practices in this review. Results supported White and Winkworth's model (2018), identifying practices relating to almost all the action areas from the three driver domains. The only action area that practices were not identified from in this review was consumer involvement, from the driver domain, 'authority'. The absence of this consumer input into service design identified in this review is depicted in Fig. 3. as Gap 2. This action area refers to involvement of consumers in design and evaluation of collaborative approaches and asks the question, "Has the collaboration truly been authorized by all the stakeholders affected?" (White & Winkworth, 2018). Studies in this review discussed the involvement of consumers in the identification of their own family needs and strengths and goal setting. However, consumer input into the design and evaluation of collaborative service delivery practices/models was not discussed. Research to explore how families do and/or can have input into interprofessional service delivery approaches is recommended. Further, practitioners and policy makers are encouraged to consider how they may support the involvement of consumers in design and evaluation of collaborative approaches.

5. Limitations/Future research

Results from this review point to several benefits of collaborative development and oversight of goals for clients across agencies. However, the relative contribution of specific collaborative practices to improved client outcomes remain unknown. Future research that provides deeper insight into which specific mechanisms of interprofessional client goal setting/oversight contribute to improved outcomes for clients would provide further direction for practitioners and policy makers in this space.

The primary focus of many of the studies included in this review was not describing the program /service goals. It is therefore possible that the descriptions of the program/service goals were not comprehensive. Nevertheless, the results can still be considered useful for identifying common goals of services supporting families and children known to child protection. The review was also limited to studies written in English, which may limit understanding of practices in other countries.

6. Conclusion

This review sought to better understand shared service goals as an enabler of interprofessional collaboration, with the intent to inform efforts to enhance interprofessional collaboration in the field of child protection. Results from this review provide three key messages to inform interprofessional collaboration in the future. First, identifying a shared vision and goals at the organizational level provides a catalyst for establishing interprofessional collaborations. Safety, improving parenting capacity and family preservation may provide common ground for agencies to identify this shared vision. To garner buy-in and support for the collaboration, leadership need to endorse and communicate the shared vision to staff. Second, the collaborative development and oversight of goals for clients across agencies facilitates a deeper understanding of client's needs and strengths, supports client service engagement and motivation for treatment, and ensures goals are feasible for families -all of which contribute to improved outcomes for clients. Third, the collaborative work required to develop and work towards shared goals depends upon a range of systems and processes, as well as continuous monitoring and evaluation of the collaboration itself. Leadership support to avail these systems and processes is an essential element of achieving and sustaining successful interprofessional collaboration.

Finally, three key areas for further research and attention in practice

were identified. Firstly, as part of a family-centered and child-focused approach, further research is required to better understand how children's developmental and wellbeing needs are assessed and supported alongside those of their parents/caregivers. Secondly, research is required to explore how consumers are/can be supported to have a voice in design and evaluation of collaborative service models. Finally, research that provides insight into which specific mechanisms of interprofessional client goal setting/oversight contribute to improved outcomes for clients would provide further direction for practitioners and policy makers in this space. Policy makers and practitioners are encouraged to consider how they can ensure children's needs are addressed alongside those of their parents/caregivers, and how family members may be given a genuine voice in design and evaluation of collaborative service models in the field of child protection.

Declaration of Competing Interest.

The authors declare that they have no known competing financial interests or personal relationships that could be seen to influence work on this review.

CRediT authorship contribution statement

Sarah Seekamp: Methodology, Investigation, Writing – original draft. **Lesley-Anne Ey:** Methodology. **Shelley Wright:** Methodology. **James Herbert:** Methodology. **Margarita D Tsiros:** Methodology, Validation.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Data availability

Data is shown in appendix 2

Acknowledgements

Professor Fiona Arney contributed to the conception and design of this review. SS received financial support in the form of an Australian Centre for Child Protection, University of South Australia, and South Australian Department for Child Protection PhD Research Scholarship.

Appendix A. Supplementary material

Supplementary data to this article can be found online at https://doi.org/10.1016/j.childyouth.2022.106680.

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Chapter 4: Exploring service goals and underlying interprofessional practices for children and families known to child protection (Study 2a)

Chapter Overview

This chapter presents findings from study 2a of this thesis, a qualitative study exploring perspectives of professionals with experience collaborating across the range of services required to support families known to child protection regarding: (i) goals for children and for their parents/caregivers held by services for children and families known to child protection in Australia and (ii) interprofessional practices influencing attainment of these goals. This study was designed to gather rich insights from professionals reflecting the current working context in Australia. Findings add a qualitative and contextualised perspective to findings from the scoping review.

This study is presented in this chapter as submitted to Children and Youth Services Review and is currently under review.

Publication currently under review

Seekamp, S., Ey, L.-A., Wright, S., Herbert, J., & Tsiros, M. D. (Submitted 2023) Exploring service goals and underlying interprofessional practices for children and families known to child protection. *Children and Youth Services Review*.

Position of Study 2a within the program of research

Objectives *To explore:*	**Study 1** Scoping review[1]	**Study 2a** Professional interviews	**Study 2b** Professional interviews[2]	**Study 3** Parent interviews
	Chapter 3	*Chapter 4*	*Chapter 5*	*Chapter 6*
Goals for families known to child protection including how these goals are similar or different				
Interprofessional collaborative practices thought to influence attainment of goals				
Collaborative practice between parents and practitioners thought to influence attainment of goals				

[1](Seekamp et al., 2022) [2] (Seekamp et al., 2023)

Introduction

Statutory child protection services in Australia, and comparable countries such as the United Kingdom, the United States of America, Canada and New Zealand are struggling under the weight of unsustainably high levels of notifications of child protection concerns (Higgins, 2015). This pressure on child protection services has driven a shift towards early intervention for families with, or at risk of child protection involvement (Devaney et al., 2021). A key objective of this shift internationally and in Australia, is to divert families away from statutory child protection, and assist families in a more holistic way (Commonwealth of Australia, 2021; Devaney et al., 2021). To enable more holistic support for families, internationally there has been adoption of policy and practice frameworks that emphasise collaboration across the range of sectors and services required to support families known to child protection (Colvin & Miller, 2018; Flaherty, 2018; HM Government, 2018). This collaboration is critical to meet the diverse needs and risk factors experienced by parents/caregivers including low income, limited social supports, domestic and family violence, parental substance abuse and mental health concerns (Early Intervention Research Directorate, 2019; White et al., 2015). Furthermore, children of families living with these vulnerabilities typically require specialist services to address their own developmental and wellbeing needs (Ballard et al., 2015; Walsh et al., 2017).

Reflecting this motion for collaborative approaches to support families known to child protection, a developing body of research exists that describes barriers and enablers of collaboration. As highlighted by Colvin and Miller (2018), much of this research explores collaboration between only two, or a few services, rather than a full network of contributing organisations. For example, studies have explored collaboration between child protection and domestic and family violence services (Langenderfer-Magruder et al., 2019; Wendt et al., 2021), drug and alcohol services and child protection (He, 2015), and mental health services

and child protection (He et al., 2015; Mason et al., 2018). While these discrete collaborations are important, there is a lack of studies that explore work between the broader range of services typically required to support families known to child protection (Colvin & Miller, 2018, p. 667).

To strengthen collaborations for families involved with child protection, it has been suggested that a more nuanced understanding of specific enablers of interprofessional collaboration might help (Kothari et al., 2022; Oscar et al., 2016). For example, Price-Robertson et al. (2020) recently undertook a focused exploration of practitioner practices as an enabler of collaboration between child protection and child and family welfare practitioners in Australia. Findings from this study provide specific recommendations to support practitioner collaborative competence including developing an understanding of the differences between collaborating sectors; clarifying the nature and purpose of collaboration; and communicating effectively with other practitioners and family members (Price-Robertson et al., 2020). Few studies provide this 'deep dive' into particular enablers of collaboration, thus sufficient understanding of the mechanisms of individual enablers in specific contexts is lacking. A nuanced understanding of how specific enablers work, for who, and under what circumstances, may provide clearer guidance for practitioners, policy development, as well as future experimental research to test the impact of collaborative approaches.

Shared goals across services are widely described as an important enabler for interprofessional collaboration in work supporting children and families known to child protection (Lippman et al., 2011; Price-Robertson et al., 2020; Zannettino & McLaren, 2014). Theoretical models of interprofessional collaboration affirm the importance of shared practice goals as a driver of collaboration (D'Amour et al., 2008; Winkworth & White, 2010). However, knowledge to provide specific guidance for practitioners and policy makers to draw upon shared goals as a driver of interprofessional collaboration is lacking. Knowledge

of what shared practice goals are or could be for services supporting families known to child protection, and *how* these goals can align service delivery, supporting collaboration in various contexts is needed.

The research team recently conducted a systematic literature review that explored and described service delivery goals and underlying interprofessional practices of services/programs that support families known to child protection (Seekamp et al., 2022). Findings from the 91 studies included in this review identified that: (i) shared goals endorsed by leadership provide a catalyst for collaboration across services; (ii) safety, improving parenting capacity and family preservation may provide common goals across services; (iii) identification of shared goals across services is thought to contribute to positive outcomes for clients; and (iv) sustaining collaboration is considered dependent upon a range of systems and processes (Seekamp et al., 2022). The current qualitative study aims to add to the findings of this review by providing a rich, contextualised exploration of (i) goals for children and for their parents/caregivers held by services for children and families known to child protection in Australia and (ii) interprofessional practices influencing attainment of these goals. To achieve this, perspectives of professionals with experience collaborating across the range of services required to support families known to child protection are needed. This reflects the importance of understanding the contextual influences on front-line workers relevant to the innovation, or phenomenon being investigated (Høiland & Willumsen, 2016).

Methods

This study used an interpretive qualitative design. This approach was chosen as it enables an open exploration of the research topic, yielding rich information to inform professional practice and policy (Patton, 2015). Semi-structured interviews were used to explore:

1. Goals for children and for their parents/caregivers held by services for families known to child protection.
2. Interprofessional practices that are perceived to influence attainment of these goals.

A social constructionist perspective informs this study, recognising that the various personal and professional backgrounds and contexts of the participants will shape their experiences and hence responses to the interview questions (Patton, 2015). The influence of context is particularly relevant in a study such as this, where collaboration across services and professionals from differing backgrounds, or contexts is the phenomenon of interest.

This study pertains to work undertaken in Australia by child protection and family support services with families who are known to child protection but have not yet reached the threshold for removal of children into out of home care. In Australia, family support services play a key role in diverting families from child protection and minimising the need for statutory interventions. Typically, family support services provide intensive case management and coordination of services to assist families with high level safety concerns to move out of (or away from) the child protection system (Commonwealth of Australia, 2021). Practitioners from family support services work with families, usually referred by child protection. Practitioners from family support services and child protection are required to collaborate with a range of services and sectors to address safety concerns and enable improved family functioning.

Sampling

A purposive sampling strategy was used to identify participants who were perceived to be able to offer rich information related to the research questions (DePoy & Gitlin, 2015). Participants sought were professionals from Australia, identified as having high level knowledge and/or experience regarding interprofessional practices that support families and children known to child protection. High-level knowledge/experience was evidenced by

publications in the field, presentations at key conferences, or practice achievements in leadership roles. Twelve participants were identified by the researcher's supervisory team and discussion with their networks. Snowball sampling was also used, acknowledging the likelihood that participants could identify further participants who would be able to offer rich information related to the research questions (DePoy & Gitlin, 2015). Two further participants were identified this way.

Interviews were conducted with 14 participants, two male and 12 female. All participants were in senior/leadership positions, one had seven years' relevant experience, all other participants had more than 20 years' relevant experience each. Six participants were working in family support services, including one in an Aboriginal Community Controlled Health Organisation, five in child protection, two in policy development and research, and one in health. Most of the participants had also worked in a range of settings across their careers supporting children and families known to child protection.

Procedure

Potential participants were invited to partake in this research via email (Appendix H) with an attached information sheet describing the study (Appendix I). Participants who agreed to partake signed a consent form (Appendix J) prior to the interview and determined a time and place for the interview with the first author (SS). Semi-structured interviews were used, allowing a flexible discussion so that participants could raise issues that they saw as important (Patton, 2015). The interview questions guided exploration of goals held for children and their parents/ caregivers by these practitioners and their services, and interprofessional practices that influence attainment of these goals. The interview guide was piloted with a practitioner who had relevant experience in child protection and family support. No adjustments were made following this pilot (Appendix K). This project was

approved by the University of South Australia's Human Research Ethics Committee – Protocol number 203984.

Interviews were conducted between November 2021 and June 2022, with interviews ranging from approximately 45 minutes to 90 minutes. In response to the geographical spread of participants and managing COVID related restrictions, seven interviews were conducted via zoom, and seven were face to face. Interviews were digitally recorded with participant consent and transcribed verbatim by a professional transcription service with a confidentiality agreement in place. Following transcription, participant's names were replaced with a pseudonym.

Data analysis

Prior to commencing analysis, participants were sent a summary of their interview for member checking and invited to add, clarify, or remove any elements. Two participants provided minor additional clarifying comments to their summaries and two participants sought clarity regarding the de-identification of services discussed in their interview. Transcripts were imported into NVivo 12 Pro ™ (QSR International, 2018) to support data management and analysis. Reflexive thematic analysis was used to guide data analysis. The six-stage approach included familiarisation with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report (Braun & Clarke, 2006, 2021).

Initial coding was undertaken by SS to gain an overall sense of the data and identify patterns within the data. A sample of three transcripts were also coded by members of the research team (LE, JH & MT). The research team discussed the results of this peer review to facilitate deeper engagement with the data. During the next phase of coding, SS iteratively compared codes and organised data to create preliminary themes and subthemes from the data itself. Themes were created from codes depicting concepts directly communicated by

participants, although thought was given to possible deeper, less apparent concepts. The research team (LE, JH, and MT) reviewed the data that comprised each of these preliminary themes and subthemes and together with SS discussed how the themes reflected the data and whether more latent concepts were present. In the final phase of coding, SS reviewed codes within each theme to ensure they were consistent with the theme. Finally, quotes from the interviews were selected to illustrate the themes and the theme's names were refined.

Strategies to enhance rigour

Approaches to enhancing rigour included member checking to ensure that key messages taken from the data reflect the participants experience (DePoy & Gitlin, 2015). Dependability was addressed through use of thick quotes directly from the participants in communicating results (DePoy & Gitlin, 2015). Reflexivity was supported via regular meetings with the research team during data analysis, including discussion as to how the researchers' own backgrounds, perceptions and interests may influence the research (Malterud, 2001). The research team consisted of an occupational therapist, a teacher, a physiotherapist, and a social researcher, all with research experience in the field of child protection. An audit trail to document decisions made throughout the research process was maintained by SS.

Results

Following analysis, three key themes, each with subthemes were generated (See Table 1.).

Table 1. Themes and subthemes

Theme 1 **Family and child focused goals**	Theme 2 **Collaborating to meet family needs**	Theme 3 **Influences on interprofessional practices**
• Keeping families together and building capacity. • Acting in the child's best interest. • Barriers to identifying shared goals.	• Lead cross-agency case management. • Working together to manage risk. • Needing other agencies to meet client needs. • Cross-agency communication.	• Relationships & blame. • System influences on collaboration. • Workforce.

Theme 1- Family and child focused goals

When asked about the goals of their work with children and their families known to child protection, participants described the diversity of needs and hence goals for children and families and how goals are different for everyone. Following analysis, three sub-themes were created relating to goals for children and families; keeping families together and building capacity; acting in the child's best interest; and barriers to identifying shared goals.

Keeping families together and building capacity: Keeping children with their family in their home when this could be done safely was recognised as an overarching goal shared by family support services and child protection services. Participants highlighted the importance of services being delivered in ways that avoided fracturing the family unit, even for a short period of time. A deep understanding of the impact on children and their relationship with their parents when removed from their family, even if removal was temporary, was conveyed by participants. The following quote is indicative of the types of comments made about the centrality of keeping children with their families.

I think it's just really important that people understand we're all trying to work collectively to, I guess, have children kind of be safe and do well. Our ultimate goal if we can,

*is to keep children in their families. I think that is the most important kind of goal***.** (Louise, child protection (CP))

The need to build parent's capacity was described as a key goal of participant's work that underpinned the overarching goal of family preservation. This pertained to supporting parents to 'take control of their lives', enable good family functioning and parent positively.

The need to build a parent's capacity to manage life beyond the timeframe of the intervention/service was explained, acknowledging that families were likely to face challenges throughout their life, beyond the time that they would be supported by their current service. As part of this preparation for managing in the future, participants described endeavours to connect families with their community and services that can support them in the future.

We may be able to work really hard with their family to get them to a certain point, but we know that life has ups and downs, so really, it's (..) providing those skills for people to navigate those ups and downs when they come again in the future; know where to go, know what to do, know who to contact. (Rose, family support (FS))

The importance of addressing parental risk factors and needs to enable their capacity to improve family functioning was highlighted. This reflected addressing a breadth of risk factors such as poverty, mental illness, drug and alcohol abuse and housing instability/homelessness. There was recognition that adequately addressing these risk factors was imperative to enabling good outcomes for parents and their children.

Building empowerment for families and supporting families well enough so that they can take control of their lives and their circumstances. And that's about therapeutic support, but it's also about practical support as we talked about. It's also about the means and bridges

out of poverty. All of those things need to be elements that have to be addressed for there to be... for all of the areas of wellbeing, for a child and family to be improved. (Ruth, FS)

The need to build the child's capacity to grow and develop well, despite the adversities in which they lived, was also identified as a practice priority. Participants described strategies to build children's resilience through connection with positive role models and participation in activities, such as sport, that provide purpose and belonging. The importance of support to access and engage with education to build young people's capacity for a positive future was highlighted. In addition, for older children, building their capacity for independence in life skills was also explained.

Acting in the child's best interest

*"It's not on my turf, or your turf. What is best for the kids? "(*Annie, CP)

The child's best interest was identified as a guiding principle of practice across child protection and family support. Further, it was described that different services and/or practitioners from a range of sectors worked better together when they were able to keep their focus on what is best for the child/ren. The child and their needs provided a shared focus for decision making and a driver for interprofessional collaboration to achieve a good outcome for the child. Achieving a shared understanding of what the child's best interests were, and everyone's role in contributing to this, was conveyed as an important step in working towards a positive outcome for the child/ren.

It's really getting back to that shared understanding of, "What does child wellbeing look like, regardless of what agency you're employed by? And then how can your agency meet that or achieve child wellbeing within your agency's mandate?" (Lara, health (H))

Despite this commitment to the child's best interests, it was also emphasised that the child's needs can get lost in the busyness and chaos of daily practice in an overwhelmed

service system. Participants described how particularly when working collaboratively across a range of services, it can be necessary to assertively bring discussions back to the needs of the child to refocus people's perspectives.

I just dumb it down to a simple level and go, well look, who are we here for? We're here for the kids. Just try and keep it simple and keep the white noise that often bubbles around politics or different people's agendas and go, ah, whatever let's just focus on what's important and why we're here and what we're trying to achieve and not buy into that other stuff. (Natalie, CP)

The complexity of this goal – acting in the child's best interests was illustrated by participants. The challenge of practitioners working together from a range of sectors knowing and agreeing what was in the child's best interest was highlighted. Participants described the child's best interests to be multi-faceted and sometimes these facets were conflicting. As portrayed by one participant.

You see often these pulls from side to side between notions of children's best interests, and children's safety as if they are diametrically opposed, which in my world they're not. Children's safety is a component of their best interests. But I guess the prioritisation of children's safety out of those best interests may be up, interests are seen as less prioritised. (Julia, policy/research (P/R))

Barriers to identifying shared goals: A range of barriers to services identifying shared goals were described. The complexity of the work was evident as a barrier, including the range of needs of both the children and their parents/caregivers. The tension between prioritising what is in the best interests of the parent versus the child/ren was reported to be a potential point of conflict when identifying shared goals. Discipline and sector specific perspectives also presented challenges to identifying shared goals. Participants explained how

various allied health professionals working with children can each perceive the goals of their discipline to be of the greatest importance. One participant described trying to identify shared goals across services as ‘trying to align the planets’ (Lara, H).

It's a very basic example of, you could have the one child protection type case and a domestic violence service would look at that differently to a child protection service, would look at differently to a family court, or family law service. So, it looks like the agencies are all on different planets, looking at the same issue. (Lara, H)

Beyond philosophical differences that may emanate from various professional or service backgrounds, it was described how funding agreements pre-determine what practitioners *can* prioritise. The mandate of the service was found to constrain the way practitioners can respond to needs and which needs, they can prioritise. These service constraints lead to practitioners who by necessity become focused on the priorities of their service/funding agreement, rather than on the specific, individualised needs of the family or child/ren, regardless of their own professional perspectives. For example -

I think in so much of this, you have the tail wagging the dog, where agencies that are based on funding to survive can only do what they're funded to do or else they have to do it voluntarily. (Julia, P/R)

Staff capacity in terms of skill and time were also raised as barriers to identifying shared goals. One participant described how in their consultancy work with family support services, they observed that some staff struggled to articulate what the goals of their work with families were. These practitioners described their practice goals as providing family support, reflecting the overarching focus of their work, rather than the specific needs of clients. Participants also described the challenge for practitioners in their teams to take the

time needed to identify shared goals across services for each family, particularly given the range of goals required.

There are so many goals and I think that is one of the challenges. Just to invest the time to identify those shared goals seems to be such a challenge. (Kate, P/R)

Theme 2- Collaborating to meet family needs

The need for families to connect with a range of services to receive support for their diverse needs formed the basis of the second theme. This theme depicted the centrality of interprofessional collaboration to meet the needs of children and their families known to child protection. Four sub-themes of this second theme- collaborating to meet family needs, were generated: lead cross-agency case management; working together to manage risk; needing other agencies to meet client needs; and cross-agency communication. These sub-themes reflected what were described as the critical interprofessional practices to meet family needs.

Lead cross agency case management: Participants described how for effective cross agency collaboration to occur; someone needed to take responsibility for driving it. This role was described as lead case management. This lead case management facilitated the collaborative approaches required to fully understand and meet the diverse and complex needs of families. The role was depicted as requiring an assertive approach to working with other service providers who were involved with a family. Key activities of the role included driving collaborative thinking and planning, documenting and communicating plans, and then holding people accountable to implementing the developed plan.

I mean, you need good leadership. You need good commitment to keeping teams on track and holding everybody accountable to the intervention that's been planned with a family. (Ruth, FS)

Having a dedicated lead case manager across services was also described as contributing to services being delivered in more family friendly ways. This included reducing the risk of families becoming confused and overwhelmed by multiple case managers and services independently working with families in uncoordinated ways.

Making sure that everyone is seeing things the same way and not confusing the family or taking the family on different journeys…. I think there's a family having four different plans from different agencies. And they're [the family] just, "What am I supposed to do? How many hoops do I have to jump through?" (Rose, FS)

A dynamic was depicted between child protection and family support services regarding case management of families referred to family support by child protection. This was well illustrated by one family support service practitioner who described their experience of needing to provide assertive lead case management for families referred by child protection. This included communicating their planned response to child protection, to reassure them that the family was being appropriately supported to avoid further statutory involvement with the family.

When you're the lead case management service, we have the space to be the lead case management service, and I think what I'm starting to see, is that if you don't take that strong, assertive approach, then child protection will be wondering... And they will step in and try and fill those gaps, if they're not seeing the things that they think should be happening. (Carolyn, FS)

Correspondingly, participants from child protection described a desire for family support services to provide effective lead case management of families that child protection refer to them. It was explained that child protection wants to feel confident that the family support service has enabled the necessary supports and is managing the family. It was

described how when this occurs, child protection is able to leave the family to be supported outside of their system and that they can withdraw their services and close their file.

*Ultimately, we [child protection] were able to step back and leave that group of services that had come around the family to it, and we closed it. And we still get notifications, but we're confident enough of what's happening that we don't need to respond to them in a way that we normally would***.** (Clinton, CP)

Despite the benefits described for families and service providers of a lead case manager across services for each family, participants shared that it is not consistently implemented. Processes related to the provision of lead case management, and how the role is undertaken are localised and described as dependent on individual organisational policy, and practitioner expertise. The capacity of the workforce to provide effective lead case management across the family support sector was questioned by one participant.

In a lot of the situations, there's not a lead case management service, and I'm not quite sure we even as a sector, have got enough resources or even experience to do that work in a real confident way. (Carolyn, FS)

Working together to manage risk: Managing risk was reflected as an ongoing and fundamental part of working with children and families known to child protection. A scale of risk tolerance was evident, with child protection having the highest tolerance, followed by family support services and then other services and sectors that play a role in supporting children and families, such as health, education, and housing. It was also conveyed that approaches to responding to risk escalations for families varied across different family support services.

Participants from child protection described that they were at times called upon for guidance by family support services. This typically involved family support case managers

reaching out to child protection practitioners for guidance if a family's risk escalated to intolerable levels. Child protection practitioners, despite not having an open file for the family, provided guidance in a range of forms. This included via phone conversations, joint home visits by child protection and the family support provider, and child protection suggesting strategies to address risks and talking to families about the potential implication of them not addressing their risks. It was conveyed that this collaborative approach was useful in building confidence of family support services to hold higher levels of risk. This in turn meant family support were more likely to continue to service these families, in contrast to re-referring them back to child protection. As described by one participant:

With one of the Aboriginal Community Controlled Organisation that we've been working with, they are quite happy to stay involved. They want to try and make a difference with the family, but it just scares the living daylights out of them when they see what's actually going on there and they don't want to do it on their own. And so that for me is really a very important component of recognising within a partnership, there's got to be that flex that says, "Well, yeah, you can probably only take a small percentage of the lead in this until it gets a bit more stable." (Clinton, CP)

The approach of one family support service with a very high-risk tolerance was described. This service is referred families from child protection who are on the cusp of having their children removed, and hence the families typically present with very high levels of risk. In response to an escalation in risk, or a notifiable incident, this service makes the necessary mandatory notification to child protection, and at the time of making the notification, report their planned response to manage the risks reported, without seeking any involvement from child protection. Family support services being able to hold families with a high level of risk like this was seen as conducive to achieving the goal of family preservation. It was acknowledged that while family support services are obligated to make mandatory

notifications, if they are able to continue to safely support a family during periods of risk escalation, they may enable the family more time to address their risk without statutory intervention – and possible removal of children.

It was expressed how family support services played a supportive role to services outside of child protection to work with families who have high levels of risk. For example, when family support services needed other sectors, such as housing and education, to partner with them to meet the family's needs, it was helpful to reassure these services that adequate supports were in place to support the family. Partner services were more willing to play a role in supporting a family when family support practitioners clearly communicated the plan to ensure risks were being managed, and how the partner could support a positive outcome for the family.

One participant illustrated how this support can overcome the tendency of some services to notify concerns without taking on a role in supporting the family.

Often the schools, just do lots of notifications because they're really concerned. But actually, if you communicate with them what's happening and involve them, then they're really okay to sit with you around that table. (Rose, FS)

Needing other agencies to meet client needs: Participants described how positive outcomes for families were dependent on collaboration from a range of service providers. Commonly required services included health, mental health, education, housing, police, drug and alcohol services and Aboriginal services. Family support practitioners in particular described how when they were unable to access support needed for a family from other services, outcomes for families were compromised. Family support participants recounted a range of examples where they were unable to gain the support required from other sectors and hence the family experienced an adverse outcome.

One participant described the need for a father to get mental health support urgently to stabilise the situation at home.

There's significant mental health issues with his dad, there's a high level of anxiety, he needs help, we need to do something." And it was only last week, the family practitioner said to me, "Oh, apparently he went to the doctor, and the doctor wouldn't write out a mental health care plan[1]*."* (Carolyn, FS)

Similarly, participants explained how when parents are unable to get support to address their own needs, children are left vulnerable and child protection risks are unable to be effectively managed. One participant described the lack of connection between adult drug and alcohol services and child protection.

[Parents] don't necessarily get a drug and alcohol service, but that is a crucial issue for children in child protection, because we know that when parents are using ice, the safety of their children is compromised. (Kate, R/P)

Housing was identified as a key challenge in meeting the family's needs to ensure a positive outcome. While getting housing for clients was described as a challenge, participants particularly shared the challenge of getting appropriate housing, that meets the family's particular needs.

We need that to be supportive accommodation, because just by giving them a house, it's not going to work. We need that to be supported totally. It needs to be safe and secure. It probably will need a fence, so we need more supported accommodation that has security. (Helen, FS)

[1] In Australia, a mental health care plan from a doctor is required to enable access to government funded mental health care.

These descriptions point to the need for effective, designated lead case management to procure and coordinate services to meet the diverse and specific needs of families. While the benefits of interprofessional collaboration for families and service providers were clear, unfortunately, the negative impact of a fragmented service system for practitioners, families, and in particular children, was also made clear.

Cross agency communication: Cross agency communication, driven by a commitment to supporting families was described as critical to interprofessional collaboration and enabling dynamic and responsive service delivery. It was said that this communication needed to be regular, provide clarity regarding the goals of intervention, and hold people accountable to implementing their part of the plan.

A good partnership where we [child protection] are doing what we need to be doing and the NGO [non-government organisation] is doing what they need to be doing is really very dynamic. And it changes a lot, and it just relies on really good communication and a real genuine commitment to getting an outcome for the family. (Clinton, CP)

Participants talked about a range of forums that support cross agency communication. Forums where practitioners from a range of services can come together and talk about clients with complex needs were described as providing an opportunity for collaborative problem solving and clarification of the roles of each of the services involved with a family.

Our investigation and assessment teams meet with all of those [services] on a regular basis in all of the areas in the country, so that we're actually putting on the table, "These are the ones [families] we are really worried about. What can you do? I can do this bit." Or "I'll try this bit first." And then if it's not working, they bring it back to the table. It's a bit more at that really collaborative approach I think is what makes a difference. (Joanne, CP)

While the value of networking meetings for enabling cross agency communication was presented, participants described that it is easier to collaborate with some sectors than others. For example, health and mental health were said to be more difficult to establish effective communication and collaboration with regarding common clients. Participants from family support services in particular also shared how they needed to assertively seek to be included in some cross agency forums that were designed to coordinate responses for families known to child protection. As illustrated below.

There are a lot of networks, but we are not. And a lot of NGOs aren't necessarily incorporated. So, I know previously about child protection and housing and police, they have their framework meetings. So, they discuss certain families, but from an NGO perspective, you wouldn't necessarily get a seat at that table. But we have invited ourselves along too, ……. We want to know what's happening. Want to work with you. You have to be quite proactive. (Megan, FS)

Theme 3- Influences on interprofessional collaboration

Discussion of interprofessional collaboration yielded insights into factors that influence how collaboration takes place. Three subthemes that captured key influences on interprofessional collaboration were generated: relationships & blame; system influences on collaboration; and workforce.

Relationships: Interprofessional relationships across agencies were described as imperative to the work undertaken by agencies supporting families known to child protection. Where relationships across agencies exist, practitioners described being more able and likely to collaborate with each other effectively. When solid relationships existed across agencies, the respectful and robust conversations that were required to undertake the complex work needed across agencies were enabled.

The fact that we've got maybe an existing partnership, or a relationship means that you can pick up the phone, or you can say, "can I come catch up with you? We want to have a bit of a chat about how the case is going," because that allows for some, I guess collective problem solving. (Louise, CP)

Participants shared factors that influence how easily relationships across agencies are formed. These included individual factors, such as whether practitioners valued relationships as part of their way of working, as well as cross agency training opportunities. Shared training was credited with enabling practitioners from a range of services to come together and hear information at the same time, effectively putting them on the same page. Despite these benefits, it was said by some participants that these shared training opportunities seem to be happening less often in recent times.

I mentioned joint training to enhance relationships, but also to hear the information at the same time. By having interagency training, everyone turning up to that four-day training, like NGO, health, statutory child protection, whoever else is involved, all having that training at the same time, it's really powerful. (Lara, H)

In contrast to the benefits described of healthy interprofessional relationships, issues of blaming were highlighted. The discussions of blame painted a picture of an 'us and them' culture between child protection and family support that was seen to be unhelpful by both services. Most commonly blaming remarks were observed by participants within teams from family support towards child protection services/practitioners. Endeavours to address blame were described by participants from family support who were managers of these staff. They shared how they would remind their staff that child protection ultimately has the same goal as family support and that child protection practitioners are doing the best that they can with the resources they have.

We have to find ways to walk as an ally with child protection, ultimately, we've got the same goal. (Carolyn, FS)

Positive relationships, regular face to face meetings and transparent conversations were described as activities that reduce blame.

It does turn into a bit of a blame game like you didn't do this, or you didn't do that. In actual fact, when you have everyone sitting around the table, you find that you have a lot less of that [blame]. (Joanne, CP)

System influences on collaboration: The complexity of the service systems was identified as a barrier to working collaboratively. It was described how it was difficult for practitioners to 'know the service system'. The range of services needed by families, coupled with the range of providers, and various eligibility criteria of services were described as contributing to difficulty collaborating across services.

We don't know the service system. We might know our little patch, but then being able to walk alongside someone to navigate the NDIS (National Disability Insurance Scheme), plus Centrelink (social security system), plus maybe getting drug and alcohol counselling, plus getting a mental health service. I mean, that's an extremely complex system that those families are operating in; that also changes. (Kate, R/P)

The rigidity of the service system and funding agreements was cited as a constraint on services innovating together to meet client needs. Participants described how funding models contributed to the siloing of services, creating single problem interventions that failed to reflect a local context, limiting place-based approaches to supporting vulnerable families.

Most structures of role or requirement are so forcefully bound that you don't get the opportunity to go beyond them and I think it's funding and leadership. (Julia, P/R)

Workforce: Working with families known to child protection was depicted as highly complex and becoming more so, requiring a high degree of skill. The impact of highly skilled practitioners was acknowledged, including that sometimes, good outcomes for clients are more a product of practitioner skill than an effective service delivery model.

Sometimes you see amazing stuff where case workers just do incredible work and get great outcomes. And there's not in my mind a formula that contributes to that success. I think it's actually just really skilled operators that are able to take that broad view that says, "These are the bits or the process I have to do." (Clinton, CP)

Despite the complexity of the work and the impact of skilled practitioners, it was explained that practitioners often don't receive the support and training that they deserve and need.

Sometimes the way you were treated was you are overworked, you are under resourced, you did everything you could to try and support these families, put in huge hours... It was not acknowledged, and it just didn't fit. (Helen, FS)

Discussion

This study provides a contextualised, deep exploration of (i) goals for children and for their parents/caregivers held by services for children and families known to child protection in Australia and (ii) interprofessional practices that influence attainment of these goals. Findings from this study provide new insights into what shared goals exist and their role as an enabler of collaboration across a range of services supporting families known to child protection. Specific collaborative practices that are seen to influence attainment of shared goals were identified and provide guidance for strengthening collaborative practice. Results provide important considerations to inform funding/service agreements, workforce development, policy, and future research.

Shared goals and collaboration

Results identified family preservation as an overarching shared goal for family support and child protection work. Similarly, in our recent systematic literature review, family preservation was identified as a common goal across a range of programs supporting families known to child protection (Seekamp et al., 2022). Given shared goals across services are a recognised enabler for interprofessional collaboration (Price-Robertson et al., 2020; Winkworth & White, 2010), the goal of family preservation may be useful for strengthening collaboration, where agencies can each consider their contribution to preserving the family.

Sitting beneath the goal of family preservation were more specific goals related to building parenting capacity through addressing parental risk factors and needs, as well as meeting the child's needs. Given the breadth of needs of parents and their children, identification of shared client goals necessarily involves a broad range of service providers. This presents a complicated context in which shared goals need to be determined. Previous research has described how service mandates and philosophies, and professional backgrounds and personal value systems can influence the focus of service responses (Blakey, 2014; Coates, 2017; Grant et al., 2018). Similarly, the current study highlighted that rigid service agreements can constrain practitioner's service responses, limiting capacity to respond in ways that the client may specifically need. Practitioners may find that these personal, professional, and systemic influences limit or impede the ability for shared goals to be identified, or indeed goals that are unique to an individual client beyond the broader remit/goals of a service. A more client-centred system may contribute to overcoming this challenge. As Marthinsen et al. (2020) stated, practitioners need to be enabled to position client needs as the strongest driver of their practice orientation, with professional and organisational policy frameworks that support this client-centred orientation.

Despite the varying influences on practice, acting in 'the best interests of the child' was identified as a shared goal across a range of services, including health, education, family support, and child protection. This shared goal could be leveraged to unify diverse perspectives and focus cross-agency discussions to support children and their families. The benefits of a united focus on the needs of the child have been described by Lacharite (2014) in their article discussing responses to child neglect in Canada. Professionals and parents were encouraged to be attentive and responsive to the needs of the child, thus supporting agreement and collaboration in meeting these needs.

Importantly, the current study found that the best interests of the child can come out of focus amidst the diversity of needs at play, and that not all services see the needs of the child. Some adult focused services such as housing, and drug and alcohol were said to at times fail to see how 'adult' issues impact children. The need to ensure focus on the needs of the child/ren alongside those of the parents has been previously highlighted (Cahill et al., 2020; Corr & Santos, 2017). To ensure the needs of all family members and their interrelatedness is acknowledged, systems that are family-centred and child-focused as promoted by Scott et al. (2010) are required. As part of this approach, practitioners need to be prepared to bring the best interests of the child to the forefront and have robust discussions to determine what this may actually be. At a system level, better clarity regarding priorities for children known to child protection beyond safety and family preservation is warranted. A system that enables the identification of children's specific needs, alongside their parent's, and offers evidence-based support tailored to respond to these needs within the family context is required.

The context in which practitioners need to identify goals and communicate across agencies regarding these goals needs consideration. From this study, the capacity of the workforce across the range of services supporting children and their families to identify

shared goals, in terms of both skills and resources such as time and system supports is not clear. Further research is needed to determine what is required to enable practitioners to undertake this complex work of identifying shared goals for specific family members with relevant partners. It is noteworthy that a brief search of the literature regarding goal setting in family support and child protection did not identify any studies that explicitly address the practice of goal setting at a single service or multiple service level. Given the complexity and importance of goal setting in an interprofessional child protection context, this is a concerning gap, necessitating further research to better understand how goals are identified, documented, communicated, and reviewed.

Interprofessional practices

Results highlight a number of interprofessional practices that influence attainment of goals for children and families known to child protection. Lead case management was perhaps the most critical interprofessional practice described to influence outcomes for families. The value of this practitioner leadership in driving cross agency collaboration is well recognised (Alfandari & Taylor, 2022; Drabble & Poole, 2011). This study provides further clarity regarding the key elements of this role. It was defined as driving collaboration with relevant partner services, facilitating clarity regarding goals and responsibilities, and ensuring accountability to plans and actions. Furthermore, for the role to be successfully undertaken, results suggest a confident and assertive practitioner, with capacity to build respectful relationships with both service providers and families is required. These results may be helpful in informing workforce development and recruitment.

A collaborative approach to risk management underpinned by an authorising environment of service flexibility was highlighted as supporting positive outcomes for families. Results conveyed the perceived benefits of child protection practitioners (despite not having an open file for the family) providing professional guidance to family support

practitioners for work with families with particularly high levels of risk. This support was seen to build capacity of family support practitioners to manage higher levels of risk more confidently within families. This was perceived to reduce the flow of families into statutory child protection by enabling family support services to maintain case management of the family. Similarly, the benefits of family support services reassuring other sectors needed to support families by clearly communicating their support plan were explained. With such reassurance, other sectors were more willing to play their part in supporting families with high risk, in contrast to solely making mandatory notifications. These findings suggest that a flexible and collaborative approach to managing risk across agencies may help sustain families among community supports, diverting them away from child protection.

Influences on interprofessional collaboration were identified and found to be of an intrinsic and extrinsic nature. Intrinsic factors related to the perspective and values of the practitioner. As indicated by Price-Robertson et al. (2020) and Blakey (2014), practitioners who are committed to establishing relationships across services are essential to enable a collaborative approach to understanding and responding to family's needs. A key extrinsic influence on collaborative work was the rigid and top-down nature of funding models and service agreements. This rigidity as Marthinsen et al. (2020) suggest, reflects a preference for prescribed service delivery at the expense of innovation that may better meet the needs of individual families. Funding and service agreements are recommended that allow localised decision making, based on the needs of families within their particular community context.

Finally, the impact of time pressures on practitioners' capacity to work in family-centred and collaborative ways cannot be overlooked. A context of overwhelming workloads and the need to respond swiftly to address risks within families is acknowledged. Space needs to be created to allow practitioners to make decisions based on best practice to address their

client's specific needs, in contrast to decisions based on expediency and routine service delivery.

Strengths and limitations

Some limitations of the current study should be considered. The participants perspectives gathered during the interviews may not reflect the perspectives of others from their respective organisations. However, given the participants' extensive experience and leadership positions, they bring a knowledgeable overview of their service and were highly familiar with the day-to-day functions of their teams. Due to the small sample and contextualised nature of findings from qualitative research, transferability of the findings should be carefully considered. However, the findings have provided new and rich insights from very experienced practitioners who work with children and families known to child protection. As such, results can be considered to inform, policy and practice in the Australian context, and may be helpful to practitioners in similar socio-economic contexts.

While useful insights were gathered into shared goals as an enabler of interprofessional collaboration, overall, more research is needed into how goals are determined, documented, and communicated both within and across organisations. Furthermore, experimental research is needed to test findings from this study, such as the impact on client outcomes of a specified lead case management role.

Conclusion and implications for research and practice

This study sought to better understand shared goals as an enabler of interprofessional collaboration, with the intent to inform efforts to enhance interprofessional collaboration in the field of child protection. Results provide several points of guidance for future practice, policy, and research. First, the shared goals of family preservation and acting in the child's best interest may support collaboration across a range of services supporting families known to child protection. These goals may provide traction for collaboration against the challenges

of differing professional and philosophical backgrounds. Second, lead case management is seen to be a critical interprofessional practice that influences outcomes for families. Further work to clarify and evaluate this role, including how it may contribute to identifying and achieving shared goals is recommended. Third, a collaborative approach to risk management underpinned by an authorising environment of service flexibility was highlighted as supporting positive outcomes for families, potentially deferring them away from child protection. Fourth, to support effective interprofessional collaboration, a highly skilled, well resourced, and supported workforce is required. These are practitioners who can confidently and assertively engage partners through building relationships and establishing respectful and robust communication. Finally, practitioners need professional and organisational practice and policy frameworks that enable them to position client needs as the strongest driver of their practice, with a focus on the best interests of the child. Funding and service models should be reviewed and developed with consideration as to how flexibility at the practice level can be enhanced to enable this responsive, innovative service delivery within a local context.

Chapter 5: Partnering with families known to child protection in an interprofessional context (Study 2b)

Chapter Overview

This chapter presents findings from study 2b of this thesis, a qualitative exploration of professional's experiences and perceptions of working in partnership with children and families known to child protection in an interprofessional context. This study was designed to gather the perspective of professionals on partnering with parents as part of collaborative practice in practice within the Australian context.

Position of Study 1 within the program of research

Objectives *To explore:*	**Study 1** Scoping review[1]	**Study 2a** Professional interviews	**Study 2b** Professional interviews[2]	**Study 3** Parent interviews
	Chapter 3	*Chapter 4*	*Chapter 5*	*Chapter 6*
Goals for families known to child protection including how these goals are similar or different				
Interprofessional collaborative practices thought to influence attainment of goals				
Collaborative practice between parents and practitioners thought to influence attainment of goals				

[1](Seekamp et al., 2022) [2] (Seekamp et al., 2023)

Publication

This study is presented in this chapter as published in the journal of Child Abuse and Neglect. Supplementary data for this study is presented in the appendices of this thesis. Appendix G – ethic approval, Appendix H - recruitment email, Appendix I – participant information sheet, Appendix J – consent form and Appendix K – interview guide.

Citation details

Seekamp, S., Ey, L. A., & Tsiros, M. D. (2023). Partnering with families known to child protection in an interprofessional context. *Child Abuse and Neglect*. https://doi.org/10.1016/j.chiabu.2023.106426

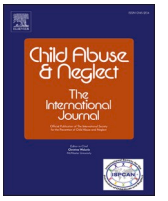
Child Abuse & Neglect 145 (2023) 106426



Contents lists available at ScienceDirect

Child Abuse & Neglect

journal homepage: www.elsevier.com/locate/chiabuneg





Partnering with families known to child protection in an interprofessional context

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ARTICLE INFO

Keywords:
Child protection
Family participation
Family support services
Family-centered practice

ABSTRACT

Background: To meet the diverse needs of children and their families known to child protection, interprofessional collaboration across a range of services is critical. Children and their parents/caregivers are key stakeholders in these collaborations and current research highlights the need to strengthen their participation in these service responses. Practitioners have a critical role in strengthening family member participation in child welfare and protection responses.
Objective: To explore professional's experiences and perceptions of working in partnership with children and families known to child protection in an interprofessional context.
Participants and setting: 14 professionals with extensive experience in the fields of family support and child protection.
Methods: Semi-structured interviews were completed, recorded, transcribed, and then coded using NVivo 12 Pro. Reflexive thematic analysis was used to guide data analysis.
Results: Trusting practitioner-family relationships were affirmed to be critical to engaging and partnering with families. Results pertaining to the interprofessional context encourage a more community-oriented perspective of practitioner-family relationships, where practitioners have a collective responsibility to welcome families into an integrated network of community services. Further, the conflict for child protection practitioners between their legislated role and their need to build trusting relationships with families to support partnered work is discussed.
Conclusions: The centrality of practitioner-family relationships needs to be better recognized and supported in policy and practice across all sectors supporting children and families known to child protection. An interprofessional approach to building practitioner-family relationships across this range of services may enhance family engagement and partnerships in their service responses.

1. Introduction

To meet the diverse needs of children and their families known to child protection, collaboration across a range of services is critical

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https://doi.org/10.1016/j.chiabu.2023.106426
Received 6 March 2023; Received in revised form 3 August 2023; Accepted 18 August 2023
Available online 26 August 2023
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(Devaney et al., 2021; Early Intervention Research Directorate, 2019; Kothari et al., 2022). The complexity of working across disciplines, and services is well recognized, and globally there are efforts in policy, practice, and research to strengthen this collaboration (Colvin & Miller, 2018; Flaherty, 2018; HM Government, 2018). Families are a critical stakeholder in these collaborations and should be able to influence their own service responses (Devaney et al., 2021; Toros et al., 2018). Consistent with this, research and government reviews highlight the need to strengthen participation of children and their parents/caregivers in these service responses, including identifying their own needs, strengths, and strategies (Gibbons & Connolly, 2021; Muench et al., 2017; Nyland, 2016; Toros et al., 2018).

Current research emphasizes the need to improve partnered work with families. Two recent reviews that explored family member's experiences of their child protection and welfare interactions highlighted the need for a paradigm shift from power *over* families to power *with* families (Bekaert et al., 2021; Toros et al., 2018). Similarly, parent experiences of child protection practice decisions have been described as frequently based on the worker's views without including the parent's perspectives and needs (Arbeiter & Toros, 2017). Further, parents describe child protection processes to be intrusive with a focus on deficits, reducing parent's confidence to engage in the service response (Harris, 2012; Toros et al., 2015). Alongside parental participation, the importance and value of children having input into decisions that affect them has been stressed (Kelly & Smith, 2017; Nyland, 2016), reflecting their rights under article 12 in the United Nations Convention on the rights of the child (UNCRC, 1989). Despite this, research indicates that most children involved with child protection and welfare services experience limited to no opportunity to take part in decisions that affect them, and that typically they are informed by workers of decisions already made for them (Cossar et al., 2016; Husby et al., 2018; Toros, 2021).

Facilitating engagement and participation of families in their child protection and welfare service responses is recognized as challenging (Arbeiter & Toros, 2017; Lehtme & Toros, 2020). This challenge is compounded by the complexity of families' needs, necessitating their involvement with a range of services beyond child protection and welfare- for example, housing, mental health, drug and alcohol and domestic violence services (Early Intervention Research Directorate, 2019). Family-centered practice frameworks have been implemented across the child welfare service continuum and provide guidance for how services can collaborate with each other *and* families to better meet family needs (Ahn et al., 2016; Xu et al., 2020). Family-centered practice approaches emphasize the importance of the practitioner-family relationships; working in ways that reflect a family's cultural preferences; and empowering families to identify and work towards their own goals (Lietz & Geiger, 2017). Allen and Petr (1998) present three key elements of family-centered-practice: respecting family choice, treating the family as a service unit, and having a strengths-based perspective.

Research highlights benefits of family-centered practices for families known to child protection including increased satisfaction with their services (Ahn et al., 2018), and attainment of family goals (Toros et al., 2018; Xu et al., 2020). However, research drawing on feedback from families involved in child welfare and protection suggests that family-centered practice is not being consistently implemented across these services (Lietz & Geiger, 2017). If we are to improve outcomes for children and their families known to child protection, a service system is needed whereby child protection services work in partnership with other community services *and* the family to enable a collaborative approach to meeting the family's needs.

The most critical factor supporting both child and parent participation in child protection/welfare service responses, is reported to be the interpersonal style of the practitioner and their capacity to establish a trusting and supportive relationship with the family (Lehtme & Toros, 2020; Muench et al., 2017; Navarro, 2014). Practitioners therefore present as a critical influence on the participation of children and parents/caregivers in their service responses (Doyle, 2022). New knowledge is required to yield specific guidance for practitioners and policy makers to strengthen practices that enable family participation in service responses. To enhance family participation across services, processes are needed to help practitioners increase their competence and confidence in partnering with families known to child protection (Toros et al., 2018). Further, insights are needed into partnering with families in an interprofessional context, where families require support from a range of services to meet their complex and varied needs. While these insights must be informed by the perspectives of both practitioners and family members, the aim of this study is to explore professional's experiences and perceptions of working in partnership with children and families known to child protection in an interprofessional context. A further study exploring the perspectives of family members is currently being undertaken by the researchers.

1.1. Context

Consistent with international trends, in Australia there is an overarching aim to support families known to child protection in more holistic ways, with an increased focus on early intervention, and coordinated service delivery to connect families with the range of services required to meet their needs (Devaney 2021). In Australia, child protection has the primary role of keeping children safe from harm or potential harm. This may involve removing children from their family environment if they are considered at risk of harm, supporting families, or diverting families from the child protection system to a family support provider. The main purpose of family support services in Australia is to provide families referred from child protection with intensive support and case management, to divert them away from the child protection system, with a statutory response only being provided to families with the highest risk of harm (Commonwealth of Australia, 2021; Piper, 2017). These service systems typically reflect a differential/alternate response system like those that have been implemented internationally over the past 3 decades (Merkel-Holguin et al., 2015; Piper, 2017). As differential response systems tend to be locally developed and respond to a diversity of needs and risks, both in Australia and internationally there are variations in the configuration and delivery of these systems (Lonne et al., 2014; Piper, 2017). This study relates to work in Australia with families known to child protection, whose children are at home, in their care and who may be receiving a service from family support services, or the statutory child protection authority. The interprofessional context of this study captures the interface between child protection and family support services and their work with other sectors (such as housing, children's services,

and mental health) to meet the needs of each family.

2. Methods

An interpretive qualitative design was chosen for this study as it enables an open exploration of the research topic, providing rich information to inform professional practice and policy (Patton, 2015).

2.1. Sampling

Using a purposive sampling strategy (DePoy & Gitlin, 2015), Australian professionals with high level knowledge and/or experience of working with families known to child protection in an interprofessional context were sought. The research team, via discussion with their networks, purposively identified 12 participants. Participants were invited to recommend additional participants with relevant expertise. A further two participants were identified via this method. A summary of the 14 participants is provided in Table 1.

2.2. Procedure

An email with an attached information sheet describing the study was forwarded to potential participants inviting them to join in the study. Those who agreed to participate determined a time and place for an interview with the first author (SS) and signed a consent form prior to taking part. Semi-structured interviews were used to facilitate open and flexible discussion enabling participants to express ideas that they perceived as important (Patton, 2015). The semi-structured interview guide facilitated exploration of ways of working in partnership with families in collaboration with other relevant service providers that influenced attainment of positive outcomes for families. The interview guide (Appendix 1) was piloted with a practitioner who had relevant experience in child protection. No amendments were made following this pilot.

Interviews were completed from November 2021 to June 2022. Seven interviews were conducted via zoom, and seven were face to face, accommodating the geographical spread of participants and COVID restrictions. With participant consent, interviews were digitally recorded and transcribed verbatim prior to analysis.

2.3. Data analysis

Member checking was undertaken prior to data analysis (DePoy & Gitlin, 2015). Participants were sent a summary of their interview and invited to clarify, add, or remove information. Minor clarifying amendments were made by two participants. Participant's names were replaced with a pseudonym and transcripts were imported into NVivo 12 Pro™ (QSR International, 2018) to facilitate data analysis and management. Data analysis was guided by Braun and Clarke (2021) reflexive thematic analysis. The six-stage approach included familiarization with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report (Braun & Clarke, 2006, 2021).

SS reviewed all transcripts to gain an overall sense of the data and completed initial coding of all transcripts identifying patterns within the data. Members of the research team (LE & MT) also reviewed and coded three transcripts to enable reflective team discussions and engagement with the data. SS then reviewed the codes, iteratively comparing them and sorting the data into preliminary themes and subthemes from the data itself. The research team then reviewed these initial themes and subthemes and the codes that comprised them considering how the themes reflected the data. SS then reviewed the consistency between the codes allocated to each of the developed themes and subthemes. Finally, the names of the themes were refined, and illustrative quotes selected.

2.4. Strategies to enhance rigor

Member checking was undertaken to enhance reliability of the data, checking that key messages from the interviews reflected

Table 1
Participant characteristics.

Characteristic	Number of participants			
Current field of practice	Child Protection: Team leader	Family Support: Team leader	Research, Service Design/ Eval[a]	Health: Manager CP response team
	5	6	2	1
(n) with direct care responsibilities	4	4	0	0
Years relevant experience[b]	5–10 yrs	20–25 yrs	25–30 yrs	35–40 yrs
	1	6	6	1
Gender	Female		Male	
	12		2	

[a] In the field of child protection and family support. CP (Child Protection).
[b] Relevant experience included work in child protection & family support (including research), youth justice, domestic violence, family counselling and mental health.

participant perspectives (DePoy & Gitlin, 2015). Thick verbatim quotes were used to present results to enhance dependability (DePoy & Gitlin, 2015). The research team met regularly during data analysis and considered and discussed how their respective backgrounds may influence the research and their interpretations of the data (Malterud, 2001). The research team comprised an occupational therapist, a teacher, and a physiotherapist, all with research experience in the field of child protection. SS maintained an audit trail to record decisions made during the research project.

3. Results

Two themes, each with three subthemes were generated by the researchers that describe partnering with families known to child protection in an interprofessional context. An overview of these themes can be seen in Table 2.

Fig. 1. presents the interrelated nature of the themes and subthemes. *Practitioner-family relationships* are shown to underpin an authentic approach to engaging with families. This authentic engagement empowers families to more readily share their perspectives (*voice and empowerment*) supporting *partnering with families*. Two interprofessional approaches to engaging families are illustrated in Fig. 1. First, when an existing service *partnering with a family* makes a referral to bring a new service into the family's service plan, they are encouraged to support this new service to build a relationship with the family. This is illustrated by the subtheme *working through others*. Second, a coercive approach to engagement is depicted outside the optimal approach to partnering with families as this approach does not reflect a relationship-based approach to engagement. The themes and subthemes are presented in detail below.

3.1. Theme 1- engaging families in service provision

Engaging families in service provision was described by participants as a shared goal across child protection and family support services, and a critical first step towards partnering with families. Three sub themes were generated within this first theme: approaches to and influences on engaging families; practitioner-family relationships; and working through others.

3.1.1. Approaches to and influences on engaging families

Engaging families in service provision was described as critical to working in partnership with families known to child protection. Two main approaches to engagement were described that could be seen as coercive and authentic. Engagement reflective of a coercive approach was described as facilitated by the threat of child protection using their statutory authority to remove children from their family. These approaches to engagement that were explained to be used in both family support and child protection settings are illustrated by the following quote:

> *Sometimes they [family support service] need the statutory service to be the bad guy. And it's very crafty sounding but 'they're going to take your children away if we don't do this work together'.*
>
> (Natalie, policy/research (P/R))

Participants described how these coercive approaches were most often used to assist family support services to engage families who were more challenging to engage. While participants with a child protection background indicated they were willing to assist with engaging families through this coercive approach, the preference for a more authentic approach to engagement was conveyed. This more authentic approach to engagement involved practitioners building a relationship with the family and the family engaging via their own volition. It was acknowledged that building a genuine authentic partnership is much more difficult than using the 'big stick' and that practitioners need to be highly skilled to find ways to engage families authentically:

> *It really comes back to their [practitioner's] skills in engaging with families because it's sometimes easier to say that you've got the big stick. "If you don't do this, then we will remove your children". It's much harder to form relationships and partner with families and work together with them to create change.*
>
> (Megan, family support (FS))

Participants described strategies that support this more authentic style of engagement. These included: taking a strengths base approach; not bombarding the family with what is wrong; choosing one thing to work on at a time; and demonstrating a genuine commitment to supporting the family. One participant recommended the following for services trying to engage families in supporting their children:

Table 2
Summary of themes and subthemes.

Theme 1- engaging families in service provision	Theme 2- partnering with families
Subthemes:	Subthemes:
• Approaches to and influences on engagement • Practitioner-family relationships • Working through others	• Family voice and empowerment • Walking alongside families • Recognizing the needs of all family members

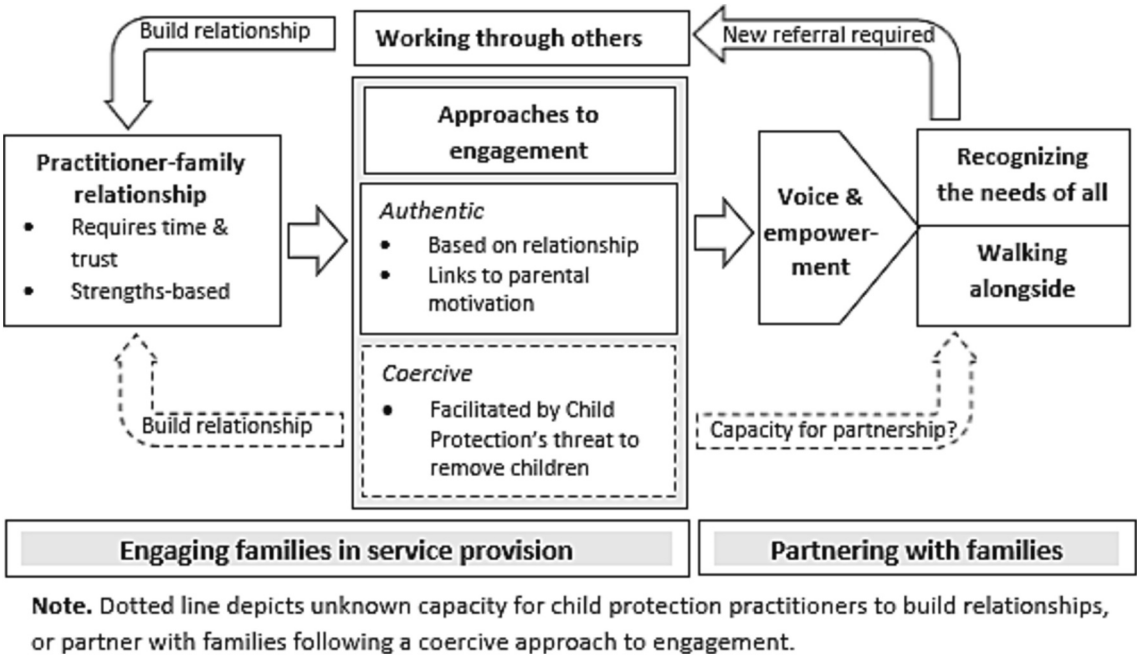


Fig. 1. Relationships between Theme 1 (*Engaging families in service provision*) and Theme 2 (*Partnering with families*) and interplay between sub-themes.

> *Start with, which is good practice, what's really going well for this little boy, and you will see that mother engage with you. They will listen. They won't prop their head. They won't tune out… And maybe just focus on one little thing that's not working quite right and that we'll work together to try and sort that out.*
>
> (Helen, FS)

To achieve authentic engagement, the importance of understanding parental motivation and building motivation for change was highlighted. However, determining a parent's motivation for engagement was seen to be challenging. Participants described how sometimes the child's needs can be a driver:

> *Sometimes parents are really motivated by their children's outcomes and feelings and thoughts. If they are motivated by their children, then that can be really helpful in moving forward.*
>
> (Breanna, FS)

However, participants also shared that some parents are more driven by their own needs, particularly where the parent-child relationship is not strong. This presented a flaw in the coercive approach to engagement, where the threat of having their children removed may not motivate action by the parent. As one participant reflected:

> *How do I hook into your [parent's] motivation? Because I think it's not necessarily, I'm going to take your children. It's not necessarily enough motivation for people to make change, especially if there's not a strong connection. If there's not been really strong attachment.*
>
> (Angela, Child Protection (CP))

Services and systems that enable culturally safe and appropriate service responses were described as critical to engaging with Aboriginal families. The value of Aboriginal lead organizations and practitioners providing culturally safe services was highlighted. Participants communicated the need to support and grow these services:

> *I mean, you only have to ask Aboriginal families, "If you were in a spot of trouble where would you go?" They're not going to say child protection. They're going to say X [de-identified Aboriginal organization]. It's really clear where they would seek support and help from, and I guess that means we should be privileging those organizations and supporting those organizations.*
>
> (Lindy, FS)

Barriers to engaging families were conveyed. Families feeling judged were described as a key barrier to engagement. One participant described how feeling judged triggers feelings of shame which leads families to avoid the very services that may be helpful. Participants added that this challenge is compounded by the fact that many families have had a string of negative experiences with services in the past. One participant who works with Aboriginal families described the following:

> *We have families who don't take their kids to specialist appointments, or rarely do, because they might get growled at, at the hospital or, they feel judged walking in. Or kids may not go to school because they don't have clean clothes, or they've got there late or something,*

because of that sense of judgment. There's a real fear of judgment, their self-esteem and self-worth is quite low. So, there's got to be a lot of support and nurturing to get people to feel comfortable to see it [support] as a resource, not as making them feel bad.

(Helen, FS)

Participants described how organizational policy can present a barrier to engaging families. They shared frustration regarding how some organizational policies contribute to pushing families who are difficult to engage, away, rather than working to bring them in- as highlighted below:

A goal is obviously attendance and engagement, which is not new, as you know. But where some services might have a failure to attend policy, say, three times the family doesn't come and then they're either back on the waiting list, which is 12 months, or just exited from being able to receive a service until they're re-referred, which I think really continues to be quite tragic.

(Kirsten, Health (H))

3.1.2. Practitioner - family relationships

Building relationships between practitioners and the family was seen to be critical to engaging them in service delivery and hence achieving a positive outcome for the family. Trust was emphasized as vital to achieving genuine and effective practitioner-family relationships. Establishing this trust was said to require a nuanced approach that reflects the unique values of each family. It was explained that once trust is established, more effective work can be undertaken, leading to positive outcomes for families:

I think for families, we've just got to find the hook or the trust in the relationship that you can establish to work it out what it is that's getting in the way of the strength of that family, and how to support parents and engage parents in… or whoever's caring for kids.

(Helen, FS)

The value of Aboriginal services and practitioners when building trusting relationships with Aboriginal families was highlighted. As explained by one participant:

Families need to feel safe. Families need to know that there's people that they're working with that they can trust. We know that the evidence tells us that Aboriginal delivered and owned and managed programs work best for Aboriginal families.

(Lindy, FS)

Time was identified as essential to building trusting relationships and some families need more time. For example, the importance of allowing more time for Aboriginal families and migrant families who may find it harder to trust their practitioner was discussed. Illustrating the importance of allowing this time, participants acknowledged that it was very difficult to make progress with a family until this relationship was established:

It takes at least three to six months just to build some trust, yeah, that you can actually start to have these conversations and actually work with the family.

(Julie, CP)

Across participants it was acknowledged that it is more challenging for practitioners from child protection to build a trusting relationship with families, than for practitioners from other organizations due to the nature of their work. It was described how families perceive child protection negatively, whereas they are more inclined to perceive family support and other service sectors as wanting to help. Participants reported that it takes a highly skilled child protection practitioner to be able to build a trusting relationship with a family. As explained by one participant:

I mean in the [child protection worker] role, it's pretty hard to be… It's a really unique practitioner who can do that work in a way that families feel safe and connected, not judged, and have a trusting and genuine, authentic relationship with. Because the nature of that hard end child protection work makes that very difficult to achieve

(Lindy, FS)

3.1.3. Working through others

This subtheme evidences the centrality of practitioner-family relationships and how when these relationships exist, they can be leveraged to support family engagement with the range of services required to meet a family's needs. Participants emphasized their view that flexible interprofessional work that privileges family-practitioner relationships increases the likelihood of a successful outcome with families. This is particularly relevant when an existing service who has a relationship with the family is linking the family with a new service- such as mental health, children's services, or drug and alcohol support. Referring practitioners who have a relationship with the family need to be prepared to work alongside the new service/practitioner for a period, while they establish their own relationship to engage the family. As described by one participant:

So not everybody's a doer. You might be working through somebody else to achieve the outcome of your program, because they have the best chance of success with the family.

(Lindy, FS)

This skilled and flexible cross sector collaboration is well illustrated by the following quote:

It was interesting that the person that she [Mother] lent on all the way through this journey was the caseworker in our team. Even though we tried to refer and work alongside mental health, she disengaged from mental health and would come back. So, then my staff member and myself needed support, as in advice, of what to do to support her [from mental health] until she was ready for a referral.

(Helen, FS)

Another participant described how to optimize family engagement child protection tailored their approach to facilitating a family conference to better reflects the family's connections:

An Aboriginal service ran the family conference, and we didn't use the usual arrangements that we've got funded. We went to someone that was more connected to that family's community that would be able to navigate that.

(Matthew, CP)

Building on this collaborative relationship-focussed approach to practice, it was discussed how 'working through others' could be used to provide services more efficiently to families, thus supporting their engagement with needed services. Working through practitioners/services with an existing relationship with the family was seen to present an opportunity to streamline and simplify case management for families, reducing duplication, with one lead case manager communicating with all service providers:

….. not saturating families. I think that that's one of our biggest problems. We haven't worked out how to successfully work in streamlined ways so that families have key relationships with service providers, and that the others can work through those key relationships for better outcomes.

(Kirsten, H)

Overall, participants clearly communicated that trusting practitioner-family relationships are critical to engaging families in service provision. Results regarding the interprofessional context highlight (a) challenges for child protection practitioners in building trusting relationships with families and (b) that practitioners need to be prepared to work in flexible and collaborative ways that honour and draw on existing practitioner-family relationships, while allowing time for new relationships to be developed.

3.2. Theme 2- partnering with families

The second theme *partnering with families* follows on from engaging families and captures ways of working *with* families known to child protection that were seen to influence positive outcomes for these families. Three subthemes were created including: family voice and empowerment; walking alongside families; and recognizing the needs of all family members. As depicted in Fig. 1, practices presented in this theme are supported by a trusting practitioner-family relationship and authentic engagement in the service response. A trusting practitioner-family relationship and authentic engagement were described to contribute to an environment that enables families to share their voices more readily. When families can share their perspectives more openly, practitioners are better positioned to *walk alongside families*, understanding and meeting *all of their needs*.

3.2.1. Family voice and empowerment

Participants explained how they endeavored to position families as drivers in their own lives, empowering them to have a say in developing a shared plan for the work to be undertaken. It was also highlighted how partnering with extended families to develop a family's support plan contributes to positive practice outcomes. However, participants explained that many families have shared a history of not having a voice in their service receipt, particularly from child protection:

A lot of families will say to us that when they've had child protection involved, it's like this real disempowerment. "Everything's taken from me, there's a plan and the case plan's been developed for me, and there is goal setting, this safety plan I have to adhere to".

(Breanna, FS)

Further, it was highlighted across participants that despite practitioner's being aware that families should play a key role in developing their service plan, this is not common practice. This sentiment is illustrated by the following quote:

it's [developing the case plan] actually not done with families. It's about gathering all the information and then you should go to the family about these are the worries, or what are your worries, and these are our worries. But then, and we've talked about it a lot, because what happens is workers will write a case plan, but the case plan should actually come from the families.

(Helen, FS)

Participants reflected that it is not easy to enable families to genuinely have a voice in their service responses. It was shared that practitioners need to proactively find ways to enable families to have a voice. This included finding ways to make the immediate and extended family comfortable to share their perspective. Further, participants described how the voice of the family, when it was heard needed to be genuinely valued, and practitioners need to take on board what the family were saying:

Really genuinely having everyone around the table and listening to them and taking on what they say, even if it's different from what we think.

(Matthew, CP)

For Aboriginal families, the use of culturally appropriate practice tools and non-Aboriginal practitioners valuing and collaborating with Aboriginal practitioners to create a safe space for Aboriginal families to engage in and share their voice was emphasized. For

example:

> *I've seen processes of engagement with families that have worked really well. That includes the use of yarning and family storytelling and things like that.*
>
> (Natalie, R/P)

and

> *Bi-cultural practice and the recognition of cultural skill and the ability to navigate cultural settings as valuable as the academic skill base that people have. I've seen that work incredibly well.*
>
> (Helen, FS)

Participants also described the importance of gathering children's voices as part of working with families and identifying needs. The child's perspective was described as being critical to identifying priorities for a family. Participants explained the need for practitioners to be flexible as to how they gathered the perspectives of children. Strategies shared included gathering information over time, reading children and young people's informal cues, and spending time with them to learn about what matters to them, in contrast to using formal assessment approaches. Participants expressed a need for children's voices to be heard more consistently, as illustrated below:

> *I don't think we hear children's voices enough. It's something that we're trying to do a whole lot more here. A lot of our practitioners are really great at that, engaging with the children on different levels like art therapy or walking the kids to school or just-… informal ways. But I think a lot of it probably is building relationships in informal ways and gathering voices along the way.*
>
> (Megan, FS)

In addition to families having a voice in relation to their own service plans, participants talked about the value of gathering lived experience expertise as part of service evaluation and design. All participants expressed that there are few mechanisms in place to do this at present. Participants emphasized how the voices of families who have received services need to be sought as part of service evaluation and utilized to inform provision of services that better reflect the preferences of families. The following quote appropriately captures the responses of participants:

> *If we were truly focused on developing a system that meets the needs of the clients it's here to serve, then we need to get that feedback and be adjusting the way we do business to respond to that consumer feedback.*
>
> (Donna, CP)

3.2.2. Walking alongside families

Walking alongside families reflected a balancing act, with participants describing how there is a need to find the right balance between providing enough support for families to achieve their goals, but not doing the work for them. This approach was seen to contribute to empowering families to grow and is well illustrated by the following quote:

> *I guess give them the confidence. Like, be walking alongside them for a certain amount of time. You don't want families to become dependent on you, but you want to kind of walk with them along that journey.*
>
> (Julie, CP)

However, family support participants conveyed frustration that they at times feel families are set up to fail. They described how child protection does not always provide families the level, or type of support they require to be able to meet the requirements placed on them by child protection:

> *If the department [child protection] is going to say that it's unsafe, then does the parent know how to make it safe? And if they do know how to make it safe, do they have the resources to be able to fulfill on those things and quite often it's no.*
>
> (Louise, FS)

Time was identified as a critical influence on providing families with the right level support. Participants shared further frustration that the timeframes of many service models don't reflect the entrenched, intergenerational nature of many family's needs. Practitioners clearly articulated that for families to achieve positive outcomes they need support for a long time, and that some families may always need some level of support:

> *Yeah, especially if they've got all these other underlying issues, alcohol, violence, it's a slow… It's a five-year journey, not six months, because I often say family support for six months, you're lucky if you engage with them over six months. And some families will need support all their life.*
>
> (Helen, FS)

3.2.3. Recognizing the needs of all family members

This subtheme demonstrates the need for services to work together to meet the needs of families and highlights elements of the interprofessional context in which families are supported. Participants expressed that to achieve positive outcomes for families, the needs of all family members and the interrelated nature of these needs must be recognized. Participants communicated the complexity and the breadth of needs within families. As illustrated by one participant:

My experience is that child abuse and neglect is never the only thing going on in someone's family. And to adequately address the needs of a family, it has to be recognized how many of those other things are going on.

(Brenton, FS)

Participant responses reflected that at present not all members of the family have their needs routinely recognized and supported. For children, their specific needs beyond safety and family preservation are not always well recognized or addressed. The priority of child protection and family support services was described by one participant as ensuring child safety and family preservation and that services may not extend to assessing and identifying the child's personal developmental and wellbeing needs:

It doesn't mean that the children's developmental needs are going to be met on-going… And go in a positive direction exponentially, it doesn't mean that… Just because child protection has closed doesn't mean that children are thriving.

(Louise, FS)

Participants explained how the impact on children of 'adult problems' is not always recognized the way it needs to be to address the intergenerational nature of child maltreatment. These observations particularly related to other sectors such as housing, drug and alcohol, and domestic violence services. This reliance on other sectors seeing their clients in the context of their family was highlighted. One participant described children as invisible consumers, whose futures are dependent on these adult focused services addressing the needs of their care givers:

Children are consumers of adult services, even though they're often invisible in those adult services. …. a child's outcome in terms of having a positive and happy and healthy life, is actually dependent on those adult services that often don't view children. For example, drug and alcohol is a classic example where someone's capacity as a parent is not necessarily considered in their treatment plan, or even their prioritization for service. But if you want to interrupt intergenerational child abuse and neglect, that's absolutely critical.

(Karen, P/R)

Participants explained how failure of practitioners to recognize and support the needs of parents can lead to misjudgments about their intentions and capacities in relation to parenting.

As one participant explained:

I don't think people understand the level of depression and the mental health that impacts [for parents], and they think that parents may not care about their kids, but they're coping with their own stuff.

(Helen, FS)

This subtheme emphasizes the complexity of needs within families and that these can only be adequately supported via collaboration across a range of service sectors. The need for practitioners from services across this range of sectors to consider the needs of individuals more effectively within the context of their family was also emphasized.

4. Discussion

Findings from this study provide important insights into working in partnership with children and families known to child protection within an interprofessional context. The findings emphasize how the roles of family support and child protection services influence partnership work with families, and how essential sectors such as health, alcohol and drug support, housing, and children's services may be brought into these partnerships with families to better meet their needs. While themes were generated inductively from the data itself, family centered practice principles were evident throughout the results, further affirming the key role of these principles in facilitating family participation in service responses. The importance of practitioner-family relationships (Lietz & Geiger, 2017), treating the family as a service unit, eliciting and respecting family choice, and having a strengths-based perspective (Allen & Petr, 1998) were particularly pertinent in the findings.

4.1. Practitioner-family relationships

Family-centered practice approaches that prioritize practitioner-client relationships (Allen & Petr, 1998; Lietz & Geiger, 2017) were found to underpin all elements of partnering with families, from engagement through to forming and implementing service plans. This affirms existing literature that cites a trusting relationship between the parent/child and the practitioner as the most critical factor in meaningful engagement and partnerships in child welfare and protection (Lehtme & Toros, 2020; Navarro, 2014). Similarly, results support previous findings that these critical relationships are encouraged when practitioners are strengths based, non-judgemental, considerate, and present a supportive attitude (Kemp et al., 2014; Lehtme & Toros, 2020). The current study adds that avoiding overwhelming the family with too many demands and using culturally appropriate tools and services, particularly for Aboriginal families help build practitioner-family relationships.

4.2. Interprofessional context and practitioner-family relationships

Exploration of the interprofessional context in this study presented several collaborative practices that may enhance family partnerships by privileging and supporting trusting practitioner-family relationships. These approaches were evident in family support and child protection practice and included: (a) using services that reflect the cultural needs of families, such as using Aboriginal

services and practitioners for Aboriginal families; (b) leveraging established relationships, such as practitioners with existing relationships with families supporting the establishment of family-practitioner relationships with newly identified services; and (c) being prepared to work through services/practitioners with existing family relationships when receiving referrals until new relationships are fostered. These results encourage the broadening of our view of the practitioner-family relationship, beyond discrete relationships with individual practitioners. This broader view requires a more community-oriented perspective of family-practitioner relationships where practitioners have a collective responsibility to invite and orient families into an integrated network of community services. Reflecting an ecosystemic framework (Bronfenbrenner, 1979), and as proposed by Lacharite (2014), this would contribute to transforming the support and organizational structure surrounding parents and their children. This transformation would then ideally increase the likelihood children are surrounded by a network of professionals (including their parents) who can collaborate to be responsive to their needs.

Consideration of the interprofessional context also presents important insights into barriers to relationship-focused practices that underpin partnered work with families. The coercive approaches to engaging families in service delivery facilitated by child protection were recognized across participants as playing an effective role in engaging families who are reluctant to engage. Given many families fail to engage with voluntary family support services as part of an alternate, or differential response (Piper, 2017), value can be seen in child protection compelling family engagement with these alternate services. However, coercive practices contrast with, and have previously been found to work against the development of positive practitioner relationships (Mirick, 2014; Ney et al., 2013). These results highlight a tension for child protection practitioners whose legislated responsibility to protect children from harm requires that they ensure an appropriate response for families who become known to child protection (Commonwealth of Australia, 2021). These practitioners are faced with a conflict between using their statutory authority to *encourage* family engagement with services and their need to build relationships with families to enable a partnership approach to practice. Family support services on the other hand can benefit from the statutory authority of child protection practitioners to engage families with their *voluntary* service without damaging their capacity to build a relationship with families. Together, these results highlight important considerations for practice and future research regarding (a) child protection practitioners facilitating family engagement with voluntary services as part of a differential response; and (b) the capacity of child protection practitioners to build effective relationships with families who require child protection involvement to enable a partnered approach to practice.

4.3. Hearing and supporting all family members

The family-centered practice principle of *recognizing and treating the family as a service unit* (Allen & Petr, 1998) was evident in the theme *recognizing the needs of all family members*. This theme provides further insight into the complexity of the interprofessional context practitioners must navigate as they seek to link families with the range of services required to meet *all* of their needs. Results highlight that work needs to be done with key service sectors, including children's services, mental health, and drug and alcohol support to better enable a partnered approach to practice with families, child protection and family support services. This approach must prioritize establishing positive practitioner-family relationships with all required services and allow clients to be supported more effectively within the context of their families. Findings suggest that this improved partnering both with families and between services may be enabled through the community-oriented perspective of family-practitioner relationships discussed above and evident in the theme *working through others*.

4.4. Empowering families

Participants consistently highlighted the importance of empowering families to partner in their service response, through having a voice in the development of their service plans. Despite this, participants from family support services relayed accounts of families' experiences of disempowerment by child protection. For example, families not having a say in their service plans or being provided with needed support to meet the objectives outlined by child protection. However, family support service participants also shared their own challenge of empowering families to have a genuine voice in constructing their service plan. These results affirm existing literature that the family-centered practice of gathering family voice in the development of tailored service responses needs strengthening (Allen & Petr, 1998; Gibbons & Connolly, 2021; Muench et al., 2017; Nyland, 2016; Toros et al., 2018). Results indicate that to better include the voices of family members, practitioners can make use of culturally appropriate service providers and tools, invite and genuinely value family member contributions, use informal approaches, over time, to gather the voices of children, and most critically establish effective practitioner-family relationships.

The primary barrier cited across participants to hearing families' voices and empowering them in their service responses was a lack of time. Time has previously been identified by child welfare practitioners as a barrier to implementing relationship focused, family-centered approaches (Kemp et al., 2014; Michalopoulos et al., 2012). The overwhelming demand on services, and service models and objectives that are time limited fail to afford the time required to undertake the processes necessary to genuinely partner with families. Further, it was highlighted that to impact the entrenched and intergenerational needs of many families, support is required beyond the timelines of existing service models and that some families will need support all of their lives.

5. Strengths and limitations

There are several limitations to this study that should be considered. In particular, the small sample size and context specific nature of qualitative research limit generalizability of the results. Although the study included some essential participant characteristics, it

would have been beneficial to gather additional socio-demographic details, such as parental status and age. These factors could have offered further context and deepened our understanding of the participants' perspectives. However, useful new insights have been drawn from very experienced practitioners and as such results can be considered in practice, service design and policy in the Australian context, and potentially in countries with similar socio-cultural profiles. In addition, this study provides unique insights into partnering with families alongside other practitioners, reflecting the interprofessional context of work with families known to child protection.

While this research has provided useful insights into working with families in an interprofessional context, findings need to be considered alongside the perspectives of families partnering with practitioners in an interprofessional context.

6. Conclusion and implications for research and practice

This study sought to better understand professional's experiences and perceptions of partnering with children and families known to child protection in an interprofessional context. Results upheld practitioner-family relationships as central to supporting family participation in their service responses. However, new insights call for a community-oriented, interprofessional approach to practitioner-family relationships and suggest this may support voluntary engagement and participation of families with needed services.

Coercive approaches to engaging families facilitated by child protection were recognized as having value for both child protection and family support services. However, results highlight a conflict for child protection practitioners between using their statutory authority to *encourage* family engagement and their need to build relationships with families to enable a partnership approach to practice. Further research is needed to better understand (a) the role and potential benefits of child protection practitioners facilitating family engagement, particularly with voluntary services as part of a differential response; and (b) the capacity of child protection practitioners to build effective relationships with families who require child protection involvement to enable a partnered approach to practice.

Results also offer recommendations to create service systems that better support partnered work with families known to child protection: First, service models that allow practitioners time to build relationships both with families and other needed services are required. Second, models of support are needed that provide families with the time that they require to make necessary changes. Third, Aboriginal services and workforce should be expanded to better enable partnered work with Aboriginal families. Finally, any development of family support/child protection services and systems should include the voice of families.

CRediT authorship contribution statement

Sarah Seekamp: Conceptualization, Methodology, Investigation, Formal analysis, Writing – original draft, Writing – review & editing. **Lesley-Anne Ey:** Conceptualization, Methodology, Validation, Writing – review & editing. **Margarita D. Tsiros:** Conceptualization, Methodology, Validation, Writing – review & editing.

Declaration of competing interest

None.

Data availability

The authors do not have permission to share data.

Acknowledgements

Sarah Seekamp received financial support in the form of an Australian Centre for Child Protection, University of South Australia, and South Australian Department for Child Protection PhD Research Scholarship.

Appendix. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.chiabu.2023.106426.

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Chapter 6: Participation of parents known to child protection in service responses: Experiences of parents in an interprofessional context (Study 3)

Chapter Overview

This chapter presents findings from study 3 of this thesis, a qualitative study exploring the perspectives of parents receiving family support regarding (i) collaborative practices between practitioners and themselves, and (ii) collaborative practices between service providers involved with their family that influence achievement of their goals.

This study is presented in this chapter as submitted to Children and Youth Services Review and is currently under review.

Publication under review

Seekamp, S., Ey, L.-A., Wright, S., Herbert, J., & Tsiros, M. D. (Submitted 2023; currently under review), Participation of parents known to child protection in service responses: Experiences of parents in an interprofessional context. *Children and Youth Services Review.*

Position of Study 1 within the program of research

Objectives *To explore:*	**Study 1** Scoping review[1]	**Study 2a** Professional interviews	**Study 2b** Professional interviews[2]	**Study 3** Parent interviews
	Chapter 3	*Chapter 4*	*Chapter 5*	*Chapter 6*
Goals for families known to child protection including how these goals are similar or different				
Interprofessional collaborative practices thought to influence attainment of goals				
Collaborative practice between parents and practitioners thought to influence attainment of goals				

[1](Seekamp et al., 2022) [2] (Seekamp et al., 2023)

Introduction

The importance of increased parent participation in child protection and family support service responses is recognised internationally (Child Protection Systems Royal Commission, 2016; Devaney et al., 2021; Gibbons & Connolly, 2021). Parental engagement and participation are increasingly recognised as practice elements that contribute to positive outcomes for families known to child protection (Charest-Belzile et al., 2020). Parental participation can take various forms, such as acceptance of help, cooperation, and compliance with service requirements. However, power imbalances are often reported in interactions with child protection, where parents' participation may be tokenistic, without genuine influence (Gibbons & Connolly, 2021). Genuine participation requires power sharing, where the parent is an active partner with genuine influence in identifying their goals and service responses. As described by Slettebo (2013), power sharing requires a change in practitioner perspective from seeing parents as passive recipients of a service to recognising their capacity to contribute to decisions that affect their lives.

Family-centred practice is recommended in child protection work and emphasises the importance of empowering families to participate in decisions about their service responses (Lietz & Geiger, 2017; Xu et al., 2020). A family-centred approach seeks to empower families through prioritising practitioner-family relationships, leveraging existing family strengths and community resources, and tailoring services to meet unique family needs and goals (Allen & Petr, 1998). Despite the known benefits of enabling parental participation as part of family-centred practice, considerable work is still needed to implement this practice element for families known to child protection (Lietz & Geiger, 2017; Toros et al., 2018). For example, family members have reported that despite their willingness to participate in their child protection responses, their perspectives are often not sought or considered in decision making (Arbeiter & Toros, 2017; Khan et al., 2018).

Existing literature exploring parental participation has focused on statutory child protection responses (Charest-Belzile et al., 2020; Lehtme & Toros, 2020; Toros et al., 2018) and identifies key influences on parental engagement and participation. Positive influences include practitioner-parent relationships and worker's interpersonal style (Lehtme & Toros, 2020; Toros et al., 2018; Visscher et al., 2022). Strengths-based practice as part of a family-centred approach that identifies and builds on resources within and around the family has also been reported to support parental engagement and participation (Toros & Falch-Eriksen, 2021). Barriers identified include authoritarian practice approaches (Cossar et al., 2016; Lehtme & Toros, 2020; Toros et al., 2018) and the inherent power differential between families and statutory child protection services (Merkel-Holguin et al., 2015; Slettebo, 2013). Time pressures have also been cited as barriers to enabling parents to participate in their service responses. Child protection practitioners report limited intervention periods and lacking time to build necessary practitioner-family relationships to support a collaborative approach with families as impeding efforts to empower parents to participate (Gentles-Gibbs, 2016).

From the early 1990's differential response systems have been implemented in various forms in child protection. These systems were established to offer an *alternate* response for families presenting with risk levels just below those requiring a statutory response (Hughes et al., 2013; Lonne et al., 2014). These *alternate* responses can offer a less authoritarian approach, potentially better enabling collaboration between practitioners and family members (Merkel-Holguin et al., 2015; Piper, 2017). Evaluations have indicated that families typically experience an *alternate response* more favourably than a traditional investigative response (Merkel-Holguin et al., 2015). Compared to statutory child protection responses, relatively little is known about parental participation in family support services as part of a differential response system. This is a significant gap in the literature as it pertains to

service responses that may interrupt escalation of family complications, avoiding a subsequent child protection response.

Parental participation and collaborative responses

Families known to child protection and referred to family support as part of differential response systems typically have multiple problems such as low income, limited social supports, domestic and family violence, parental substance abuse and mental health concerns (Early Intervention Research Directorate, 2019; White et al., 2015). Families therefore often require an interprofessional response with support from a range of services to meet their specific needs. A recent study that explored the perspectives of families with multiple problems found that they want support to create a network around them that includes the range of professionals and services required to meet their needs (Visscher et al., 2022). Further, existing research and practice recommendations state that this 'network' of service providers should collaborate to provide integrated services to better enable families to access the specific supports they need (Child Protection Systems Royal Commission, 2016; Herlihy, 2016; Horwath & Morrison, 2011; Lalayants, 2013). However, recent literature emphasises that more work is needed by community organisations serving families involved with child protection and welfare systems to achieve this integrated approach to collaboration (Kothari et al., 2022; Price-Robertson et al., 2020).

Parents are a key stakeholder in collaborations across child protection, family support and other community services and they must be supported to take their place in these collaborations; contributing to decisions that affect their lives. Parents perspectives are important in guiding efforts to strengthen these collaborations to better support families. While literature exists that describes barriers and enablers of cross sector collaboration (for examples see Coates, 2017; Lalayants, 2013; Pharo et al., 2014; Price-Robertson et al., 2020; Seekamp et al., 2022; Zannettino & McLaren, 2014), little is known about parent's

experiences of how these services work with each other *and* parents to meet the needs of families (Ellis & Dietz, 2017). This is important as parents' experiences of how services work with each other and parents themselves can have a significant impact on whether families access the support that they need. This study uniquely brings together these two practice imperatives for working with parents known to child protection; parental participation in service responses and collaboration between service providers to support families. Insights from parents themselves may provide new direction to enhance family participation in service responses, as well as ways services can better collaborate to support families receiving family support services.

Study context

In Australia, state and territory governments are responsible for statutory child protection. Their primary role is to support children who have been, or are at risk of being abused, neglected, or otherwise harmed, or whose parents are unable to provide adequate care or protection (Australian Institute of Health Welfare, 2020). Family support services in Australia can function as a differential response system in arrangements with child protection agencies. Families are referred by child protection to selected family support providers for intensive support and case management, with a statutory response only being provided to families with the highest risk of harm (Commonwealth of Australia, 2021). Similar to differential responses internationally, in Australia there are variations in these systems as they are locally developed and respond to a diversity of needs (Lonne et al., 2014; Piper, 2017). This study explores the perspective of parents living in South Australia who are receiving family support services as part of a differential response and have their children in their care. Families were assessed by the statutory child protection authority to have reached a moderate to high risk of harm but were considered safe with a plan for in-home support (provided by the family support service). All families in this study were referred to the same family support

provider that offers intensive in-home support to families presenting high levels of risk. The service has a focus on increasing safety through addressing risk factors; strengthening family relationships; and improving parental self-efficacy to prevent children entering out-of-home care. The service works to link families with additional community service providers to meet the unique needs of each family. Families have access to a 24/7 on-call service and receive tapered support for up to 12 months.

Method

Study design

This study employed an interpretive qualitative design to facilitate an open exploration of the research questions, providing valuable insights for professional practice and policy development (Patton, 2015). Semi-structured interviews were conducted to explore the following questions:

- What goals are held by parents/caregivers for their children and for themselves from family support?
- What are the perspectives of parents receiving family support regarding collaborative practices between practitioners and themselves?
- What are the perspectives of parents receiving family support regarding collaborative practices between service providers involved with their family that influence achievement of their goals?

Recruitment and study sample

To gather rich information relevant to the research question, purposive sampling was used (DePoy & Gitlin, 2015). Participants were recruited from a family support provider (described above) and practitioners/case managers from this program facilitated recruitment. The lead researcher (SS) provided case managers with information about the study, including its purpose, methods, and inclusion/exclusion criteria. To guide recruitment case managers

were provided with an information sheet to guide their initial conversation with parents, covering the study's aim, interview process, confidentiality, record keeping, and the researcher's mandatory reporting obligations. Parents who were receiving a service from the program who were assessed by their case manager as having the capacity to participate in an interview without adding further stress to their situation were invited to participate in the study. Families undergoing acute crises or court proceedings were excluded.

The lead researcher worked out of the family support service's office one day each week during recruitment and data collection to be available to answer questions case managers may have about potential participants and the study. Being present in the office with case managers afforded several benefits to the research process. The researcher was able to build relationships with case managers and this was perceived to contribute to 'buy in' into the study by the case managers therefore supporting recruitment efforts. The researcher was also able to talk directly with case managers about their experiences to contribute to a more contextualised understanding of their family support work.

Case managers provided the contact details of interested parents to the lead researcher who contacted each potential participant to provide them the opportunity to ask questions and determine their interest in participating in an interview. A time and location for each interview was chosen by each participant who agreed to participate. A total of ten participants, including two couples were recruited from eight families. Six interviews were undertaken in participant's homes, and four in an interview room at the family support service's office.

All participants had undergone a child protection assessment prior to their referral to the family support program and families were considered to have moderate to high risk, just below the threshold for a child protection response. Participants were either nearing or just

completing the maximum 12-month duration of family support. To avoid intrusive questioning, families were not asked to provide details of their reason for referral from child protection. Typically, families referred to this family support service experience one or more of the following issues- substance misuse, domestic violence, poor mental health and/or neglect. The age of participants ranged from 23 to 42 years with a median age of 30 years. Three participants were single parents, while the remaining seven were parenting as part of a couple. Participants had between one and four children living in their care. Six participants were female and four were male.

Interview design and data collection

Semi-structured interviews were conducted to encourage a flexible discussion to allow participants to raise issues they perceived to be important (Patton, 2015). Before starting the interview, the researcher explained the consent process to each participant, emphasising that participation was voluntary and their option to withdraw at any time without consequence (Appendix O). It was explained that their participation would not affect their involvement with their family support provider, or any other service. All interviews were conducted by SS and lasted an average 50 minutes, ranging from 30 to 120 minutes. Participants were provided with a $40 AUD voucher as compensation for their time. Interviews were audio recorded with participants' permission and transcribed verbatim by a professional transcription service, adhering to confidentiality agreements. The interview guide (Appendix P) was designed to foster an open conversation exploring topics such as participant goals for themselves and their family, their experiences working with a range of services to meet their needs, and helpful and unhelpful approaches of workers/practitioners. Interviews were conducted from December 2022 to March 2023. The University of South Australia's Human Research Ethics Committee approved this project under protocol number 204226.

Data analysis

Transcripts were imported into NVivo 12 Pro TM (QSR International, 2018) to facilitate data management and analysis. To protect participant anonymity, their names were replaced with a pseudonym. Reflexive thematic analysis was employed as the guiding approach for data analysis, following a six-stage process that included: becoming familiar with the data; generating initial codes; searching for themes; reviewing themes; defining and naming themes; and producing the final report (Braun & Clarke, 2006, 2021). SS conducted the initial coding to gain an overall understanding of the data and identify patterns. To ensure a comprehensive analysis, a subset of three transcripts was also coded by other members of the research team (LE, JH, & MT). The results of this peer review were discussed within the research team to clarify discrepancies and foster deeper engagement with the data. In the subsequent coding phase, SS iteratively compared codes and organised the data to develop preliminary themes and subthemes directly from the data. These themes were derived from the explicit concepts communicated by the participants, while considering the possibility of uncovering underlying, less apparent concepts. The research team (LE, JH, and MT) then reviewed the data pertaining to each preliminary theme and subtheme. Together with SS, they examined how well the themes reflected the data and whether any latent concepts were present. This process resulted in some minor changes to the coding of data. In the final coding phase, SS reviewed the codes within each theme to ensure their consistency.

To enhance the rigour of the study, thick quotes, directly extracted from the participants' responses were incorporated to convey the results (DePoy & Gitlin, 2015). Reflexivity was fostered through regular meetings with the research team during data analysis, allowing for discussions on how the researchers' own backgrounds, perceptions, and interests might influence the research process (Malterud, 2001). The research team consisted of professionals with research experience in the field of child protection, including an

occupational therapist, a teacher, a physiotherapist, and a social researcher. To maintain transparency and traceability, an audit trail was maintained by SS to document the decisions made throughout the research process.

Results

Three themes with corresponding subthemes were generated from the data analysis. These are presented in Table 1 and discussed below.

Table 1

Themes and subthemes

Theme 1. Interaction between services	**Theme 2.** Partnering with families- One size doesn't fit all	**Theme 3.** Getting help to meet needs
• Communication & collaboration • Advocacy	• Relationship first • Work with me to tailor your approach • Honesty and kindness	• Influences on help seeking • Getting help

Theme 1. Interaction between services

This first theme highlights that participants' value collaboration between services and that family support practitioners play a critical role in facilitating this collaboration. The subtheme *communication and collaboration* conveys participants' experience of services interacting with each other, including the benefits of when this happens well and focal points for improvement. The subtheme *advocacy* highlights the crucial role of family support practitioners in fostering collaboration among various community services, including housing, schools, and health, to provide enhanced support for families.

Communication & collaboration. Participants valued communication between services with whom they were concurrently involved. Predominantly, this communication was described as being initiated by their family support practitioner with community services related to health,

education, and housing. Participants reported that this communication led to practitioners from these agencies having a better understanding of their family's situation, and more appropriate support. Participants also described communication between their family support practitioner and child protection. Despite child protection closing their file once they referred the family to the family support provider, participants were aware that child protection and their family support practitioner communicated if any further child protection notifications were made against their family. Participants conveyed comfort with this arrangement; feeling that their family support practitioner could accurately respond to any concerns due to their close working relationship with the family.

> *I know that [family support practitioner] report back to child protection and things like that. But they have been good for us in the sense that I think there was a report, a false allegation, made against us earlier this year. And the good thing about that was we were already connected with [family support practitioner]. So, they called child protection, and they said, 'we are working with them, we know there's nothing going on'. So that's been a good safety frame for us.* (Kate)

Another form of service interaction discussed involved family support practitioners linking families to additional, or new services. One participant described how she was grateful when her family support practitioner attended a new service with her, to enable her to connect with a mother's group despite her anxiety:

> *She [family support practitioner] was actually the first person that introduced me to the mother's group that I now go to on a regular basis now. And I'm eternally grateful for that too. In the beginning, I was very sceptical of it. Again, my anxiety started at that time. But over time and with the help of [family support practitioner]*

being there for the first two, three days with me going there really did help to nudge me in a spot where I'm like, "Okay, it's not bad." (Christie)

Despite participants valuing collaboration between services such as housing, education, midwifery, mental health and drug and alcohol support, the dominant message was that without the support of their family support practitioner, this didn't occur frequently enough. It was described how this led to participants having to repeat information for multiple services, services having an inadequate understanding of their situation, and therefore feeling unfairly assessed or inappropriately supported. Participants further explained that having several services involved can be overwhelming.

Maybe they [services] should communicate with each other more and go, "All right, well I've taken care of this aspect of it. Can you help them with this?"... So that they can sort of span their resources out for the family better. (Kate)

Participants also described their experience of practitioners from community services (outside child protection and family support) focusing on their role to notify any concerns to child protection, without concurrently offering support to the parent(s).

And she [drug and alcohol worker] said, 'I'm telling the midwife you smoke dope'. And I'm like, but I just told the midwife that, why do you think I'm here? And she's like, 'well, I'm going to be reporting this DCP then. (Harrison)

Advocacy. The role of family support practitioners acting as advocates for families with other service providers was emphasised by participants as an essential interprofessional activity. Family support practitioners were identified as driving collaboration across services, supporting families to access services such as housing, mental health support, education support, and funding therapy services. It was apparent participants felt that without this intervention from family support practitioners, they would not have received needed services

and little, if any, cross-service collaboration with agencies other than child protection would occur.

> *It would be better if the schools, the education department and also housing would be more involved with the [family support] services. They're involved with you because the [family support] workers tend to be chasing them all the time…… They're very hard to get on board.* (Chelsea)

Participants also highlighted the importance of their family support practitioners acting as advocates to ensure they received a respectful response from community services beyond child protection and family support.

> *Having someone there as an advocate, that's listening in on the conversation, who can help us have a voice. And so, rather than being shut down by the school and them saying you know, no, this can't happen or, this is not possible.* (Aaron)

Participants conveyed a very consistent picture that without this advocacy, they were often treated without respect, not given a voice, and were at risk of being misunderstood with potentially significant implications from a child protection perspective.

Theme 2. Partnering with families- One size doesn't fit all.

This theme has three key elements, first that practitioner – family relationships are the foundation to partnering with families. Second, practitioners must collaborate with families to identify and tailor their response to the unique needs of the family. Third, for participants to participate in services, they need honesty and to be treated with kindness.

Relationship first. This subtheme was dominant in participant accounts of their positive working relationships with their family support practitioners. Participants explained that the progress their family had made towards positive outcomes was built upon the supportive and trusting relationship with their family support practitioner. Further, without these relationships' participants felt reluctance to open-up and partner with practitioners, stifling any attempts to achieve positive change with their family.

> *I trust [family support practitioner], I'll work with them any day. I don't mind collaborating with or working with them because they have morals and integrity.* (Aaron)

It was highlighted that these relationships take time to develop and that participants valued their family support practitioner focusing on establishing their relationship as an initial priority for their work together. Participants described how these practitioners did not rush, or push them, instead focused on getting to know them.

> *I think it started with her getting to know me. Just to get to know me, as a person… So just slowly, and then, she would then tell me a little bit about what she could provide, or what the organisation did, but then, it was more her learning about me and the kids. Which really helped me to feel like, "All right, she's not just here to gawk."* (Nicole)

Participants described several other practices that supported the development of positive relationships with their family support practitioner. These included highlighting family member strengths and achievements, involving participants in decision making and offering choice, conveying a genuine commitment to supporting the family, seeking to understand the family's experience, and listening without judgement. Participants consistently highlighted the therapeutic benefit of these genuine relationships, including

helping them feel calmer, supported, and less overwhelmed, and therefore sustaining them in their parenting role.

> *She [family support practitioner] helped regulate my emotions. So, a bit of a supportive ear, kind of, and a person to help you feel much calmer. She was a good listener.* (Christie)

Work with me to tailor your approach. This subtheme extends from *relationship first.* It was consistently emphasised that participants want practitioners to respond to their family in personalised ways that reflect knowledge of their unique strengths and needs. When family support practitioners tailored their approach to supporting participants and their family, participants felt the practitioner understood their family's unique situation. Feeling understood by their practitioner contributed to a willingness to engage with the service and enabled participants to form a partnership with their family support practitioner.

> *I think [family support organisation] learnt about how we function, how we work and they over time- when they started to get to know us and understand us as a family, then they sort of synchronised themselves to work better with us. (Aaron)*

Participants described this collaborative and tailored approach by their family support practitioners to include being flexible, in contrast to following a 'textbook' predetermined approach, and actively seeking parent's perspectives on decisions. Participants explained how they were empowered to contribute to service planning and provide feedback on different strategies that were recommended, rather than just being told to do it this way, with no option for an alternative.

> *They [family support practitioner]* actually work with you, not against you…… *They're the perfect combination of, "We want to get to this step, this is the*

steps we need to take. How do you feel about this? And if not, let's change this to get to here." (Jacob)

In contrast to these tailored approaches built upon a relationship and partnership with the family, participants highlighted that fixed and authoritarian approaches were counterproductive and led them to shut down and withdraw.

The minute you come in with authority, people are going to shut down. The minute you try to tell them how to do something, parents are going to shut down. (Chelsea)

Participants explained how they were frustrated by disempowering approaches that offered them little to no voice in their service responses. These were reported to be most commonly experienced with services external to family support such as education, health, and housing. Participants also shared how their interactions with child protection tended to reflect this authoritarian style – telling families what they must do by when.

Instead of asking us what we want or what would help us, they've [child protection] been telling us... what we need and what we need to do. Whereas they [family support provider] have asked us what we want and what we need. (Leah)

Honesty and kindness. Participants stressed their desire for honest and transparent communication from workers across all services. Participants explained that they preferred to know where they stood with services, including what support was/wasn't available and what processes may unfold. Participants shared frustration with what one participant described as "*false promises"*. For example, practitioners saying they would call back, undertake maintenance tasks on the home, or fund a service, and then not undertaking these promised actions. These experiences were had across a range of services, mostly outside family support and child protection.

My social worker [from men's support service] said, "Oh, when you move, we'll get you a new this and that." Then I ring him, he's like, "Oh, I can't do it." (Darren)

Extending their desire for honest and open communication, participants also highlighted that when practitioners make mandatory notifications, they want to hear these concerns and have the opportunity to discuss them. They shared how this provided them with an opportunity to hear what they may be doing wrong, respond to the concern, and to understand that child protection may become involved. One participant described how notifications by midwives made during her pregnancy (without her knowledge) resulted in child protection involvement that caught her completely off guard leaving her feeling lied to:

Every time I went in [for an antenatal check-up] it was sort of like they [midwives] would jot some notes down, but they were being very quiet about it. And then they said, "You're a higher-risk pregnancy." And I was like risk of what? They don't even warn you…. I felt like I'd got lied to a lot through the pregnancy. (Kate)

Participants shared a wide range of experiences of being treated unkindly. These experiences were most commonly with sectors beyond child protection and family support such as education, housing, and health. However, negative experiences with child protection were also described. Participants described interactions that were attacking, rude, condescending, and lacking empathy.

I felt like some of the nurses (midwives) were rock solid…., like no empathy whatsoever. And it didn't help my situation. The hospital was a nightmare. (Christie)

*I'd go to meetings. They'd [the school] talk down and it's about everything I'm doing wrong and they're not taking [our situation] into consideration (*Chelsea)

Participants further explained that when they had these negative experiences with service providers, they felt less inclined to try to work with that service, potentially leaving the needs of their family unmet.

Theme 3. Getting help to meet needs.

During the interview, participants were asked about their goals for themselves and their families from working with their family support service. In response, one participant described a clear goal to strengthen his relationship with his partner and how his family support practitioner helped them achieve this. Another participant explained how the goal setting discussion with his family support practitioner felt insulting, as he believed he was already doing what the practitioner suggested as a goal. Overwhelmingly however, participants responded to questions about their goals by talking about what help they needed, rather than stating specific goals. These needs commonly related to housing, mental health, drug and alcohol use, as well as educational and therapeutic support for children. Participants went on to talk about their experiences of seeking help to meet these needs both prior to receiving family support and during their time with this service. These conversations led to two subthemes being generated: *Influences on help seeking* and *Getting help.*

Influences on help seeking: Building on the challenges described by participants when interacting with service providers in Theme one and two, it was evident that seeking and accessing support was influenced by a range of factors. Past experiences with services influenced participant willingness to engage with or seek-out support. Where participants had positive past experiences, or knew of others who had had positive experiences, they were more willing to engage with these services.

> *The only reason why I've gone through with seeing [Drug and Alcohol Service] was because [my partner's] Mum and Dad were with them. And they were pretty useful for her parents.* (Harrison)

Participants' experiences of low responsiveness and rudeness when trying to access support with housing, drug and alcohol support, health, and education resulted in scepticism towards services. Such scepticism presented an obstacle to families seeking and getting the help they need to achieve a positive outcome. Further, many participants explained that their interactions with child protection were scary and disempowering and that this negative experience meant that when child protection referred them to family support, they were reluctant to engage at first. It was explained that this reluctance was exacerbated by a lack of understanding that family support and child protection were separate entities with different roles. Participants indicated that once they were aware the two organisations were separate that they were more willing to engage with family support.

> *I had a great distrust for the [child protection] system because of the way it worked against us. It just took me time to adjust between the two services [child protection and family support] and to see that this new service was here to help.* (Aaron)

Participants stressed that following previous negative experiences, they especially needed practitioners to prioritise establishing a trusting and supportive relationship to encourage them to engage with a service.

Getting help: Participants described how when they did seek help, it was sometimes hard to get, and continuing to seek help was exhausting. This difficulty accessing help often reflected a lack of responsiveness from services. This was particularly the case for services beyond child protection and family support.

> *We had been trying to get hold of the housing officer and I rang several times. No one was ever ringing me back… nothing ever happened.* (Chelsea)

Further, one participant conveyed his frustration that his ex-partner was not receiving adequate mental health support, despite the impact on their daughter.

> *It's her [mother's] mental health. Not getting the right help, just slipping through the system. She's not even, still to this point, with everything going on, seeing a psychiatrist.* (Jack)

And one participant described how he was referred for drug and alcohol support and was declined this service due to a co-existing mental health concern:

> *I walked in with the referral thing. She [drug and alcohol worker] was…. 'To be honest I think with your mental health, you know there's nothing I can do about it [the weed smoking], and you just need to get that [mental health] in control, and I don't want to see you again'.* (Harrison)

Participants also discussed needing and wanting family support for longer than the service model allowed. As one family recently discharged from family support after the 12-months service time explained:

> *I wish we were still with them [family support]. ... unfortunately, they [family support] only get a certain amount of time, and then you're booted. I mean realistically, to work with parents to slowly get themself capable…. At the moment, and I know this is going to incriminate us and all that, we still need frigging help***.** (Jacob)

When participants were able to secure help, they expressed gratitude. This help was predominantly either from or procured by their family support service and related to the individualised needs of their family. Help included tangible things to support the daily lives of families, emotional support and guidance, and support to develop needed skills such as managing relationships, or household routines.

I've pretty much got everything I needed from [family support practitioner], she's been very accommodating to everything, what my needs are and stuff like that. She helped me get things I needed. (Christie)

Overall, it was apparent that participants wanted help and had actively sought it from a range of services. Help required beyond the remit of the family support service was most often only obtained from external services (housing, education or therapeutic support for children, and mental health care) following strong advocacy by family support practitioners.

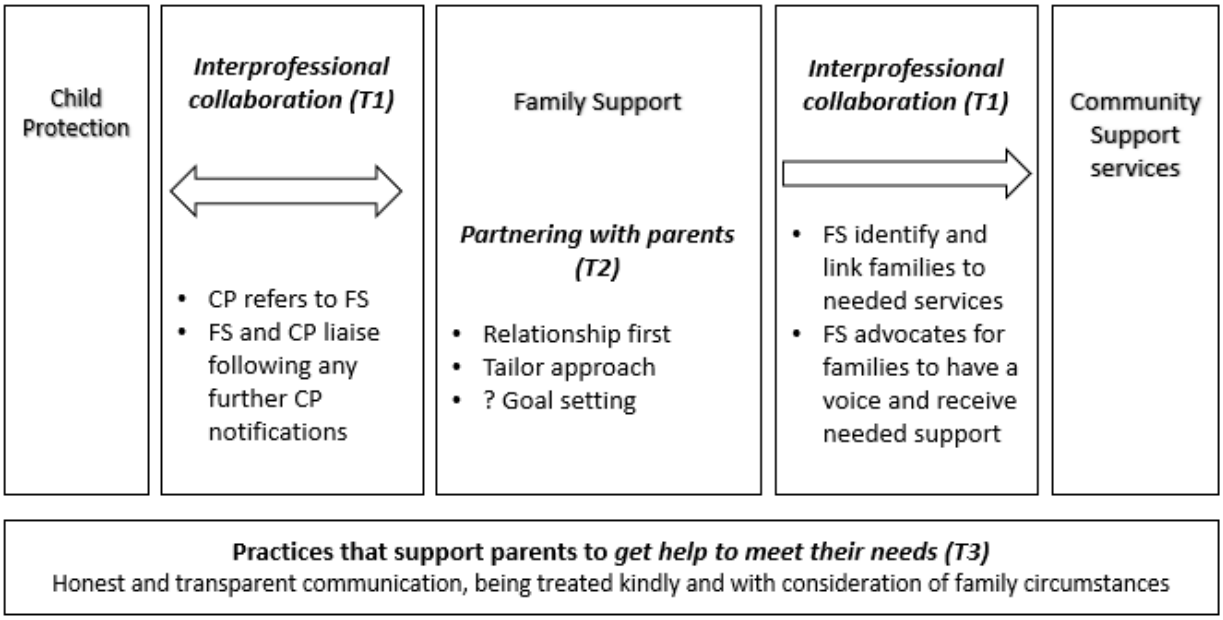
Discussion

This study uniquely examined perspectives of parents' receiving family support regarding collaboration between themselves and practitioners, as well as between practitioners from the range of services involved with each participant's family. Results highlight the critical role family support practitioners can play in driving collaboration between services and enabling family members to participate in these collaborations. Insights gained can inform efforts to enhance partnership work with families and between service providers for more effective support.

Figure 1. provides a preliminary conceptual presentation of the results including relationships between the three themes. Family support practitioners are positioned as central to a partnered approach to practice with families and interprofessional collaboration between service providers. The key elements of this figure and findings related to interprofessional collaboration, partnering with parents, and parent goals and getting help are discussed below.

Figure 1

Parental participation and interprofessional collaboration



T1- Theme 1; T2- Theme 2; T3- Theme 3; CP-Child protection; FS- Family Support; ? Goal setting as part of family support requires further research.

Interprofessional collaboration

Participants emphasised that they valued collaboration between service providers when it occurred and cited several benefits of this. Participants explained that when professionals with specific areas of expertise (e.g., health or education) communicated with family support or child protection, all professional gained a greater understanding of the family's situation. Further, when collaboration occurred across services, participants shared that they did not need to continuously repeat information, and services could be delivered more efficiently by avoiding duplication. These results add a parent perspective to previously identified benefits of interprofessional collaboration- concurrently addressing complex related issues experienced by families, reducing service costs, improving service quality, and enabling increased access to resources (Herlihy, 2016; Horwath & Morrison, 2011; Lalayants, 2013; Visscher et al., 2022). These findings strengthen calls to enhance collaboration between services supporting families known to child protection in Australia (Child Protection Systems Royal Commission, 2016; Coates, 2017).

Results highlight that collaboration, particularly between community services (including housing, health, education, and drug and alcohol support) did not happen as frequently as participants would like. When collaboration did occur it was almost always driven by family support practitioners and it was apparent that without their drive, interprofessional collaboration across these services would be significantly limited. The importance of practitioner leadership in driving cross agency collaboration has been previously reported (Alfandari & Taylor, 2022; Drabble & Poole, 2011). The current study offers further insight into this leadership role for families receiving family support. As shown in Figure 1., key elements of this role described in this study included family support practitioners linking families with necessary services, advocating for the specific service responses needed, and holding service providers accountable for respectful interactions with families. These results have implications for recruitment, training, and support of family support practitioners to ensure they have the capacity to undertake these tasks that require confident and assertive cross agency communication.

Collaboration between child protection and family support displayed a unique profile (see Figure 1.), setting it apart from the collaboration between family support services and other community organisations. This collaboration included all participants being referred to the family support service from child protection and family support practitioners becoming a liaison between child protection and the participants and their families. For example, in the event of new child protection notifications, to determine what, if any, response may be required, child protection would contact the family support practitioner rather than the family directly. This collaborative practice appeared to offer benefits for child protection and parents. Participants appreciated this process as they felt their family support practitioners knew them and their family well and were able to advocate for them with child protection. This was also seen as a safety net for parents as family support practitioners could also

advocate to obtain further support if required. This process also likely created efficiencies for child protection, alleviating the need to investigate every new notification.

Partnering with parents

This study highlights a number of key practices identified by parents for partnering with families. These practices align with family-centred practice principles and include prioritising positive practitioner-family relationships, transparent communication, and tailoring service responses to the unique needs of each family (Allen & Petr, 1998). As proposed in Figure 1., relationship-focused approaches by family support practitioners were described as a catalyst and pre-requisite for partnership work with parents. Participants explained how this focus on relationships made them feel respected and supported. Similar to previous research, listening without judgement, showing genuine care for the family, and not rushing processes (Lehtme & Toros, 2020) were also reported to support establishing effective practitioner-family relationships. Given time constraints have previously been identified as a barrier to establishing effective relationships with parents known to child protection (Gentles-Gibbs, 2016), the family support service model in the current study may have played a role in enabling the family support practitioners to prioritise relationship building. This service model provides up to 12 months' support, which is lengthy compared to many other family support models, potentially affording practitioners more time for relationship building practices.

A second key element of partnering with parents valued by participants was the family-centred practice of contributing to decisions as part of their service responses (Allen & Petr, 1998). This reflects previous findings that parents receiving a child protection response value the opportunity to contribute to decisions that affect their family's lives (Lehtme & Toros, 2020). Notably, results indicated that when parents contributed to decision making with their family support practitioner, they were more likely to engage in the work

needed to support child safety. These findings strengthen existing literature that cites participation of parents known to child protection in service responses as important for enhancing outcomes for children and their families (Charest-Belzile et al., 2020; Dawson & Berry, 2002). As shown in Figure 1., family support practitioners collaborated with parents to tailor their service response within the scope of the family support program, as well as identifying and linking families to support needed from external services. In contrast however, participants were less often afforded the opportunity to participate in decision making with services such as housing, health, education, and child protection. While it has been identified that child protection practitioners do not routinely enough invite parents to genuinely contribute to decisions that affect their lives (Khan et al., 2018; Toros et al., 2018), new findings from this study also highlight that this is an issue across multiple sectors and agencies. Further research to understand how practitioners across all sectors supporting families known to child protection can be supported to empower parents to participate in decisions that affect their families is needed.

While the current study cites a number of practices that may empower parents receiving family support to partner in their service responses, barriers to this kind of practice have been reported. The tension between child protection practitioner's legislated responsibility to ensure child safety and empowering parents through shared decision making has been highlighted (Gentles-Gibbs, 2016). Child protection practitioners have cited mandates related to timelines for assessment and parents to address risks as barriers to empowering parents in child protection responses (Gentles-Gibbs, 2016). Further, to manage risk and implement evidence-based practices in child protection, there has been a move towards prescriptive programs that limit practitioner autonomy to enable shared decision-making and tailoring of services with families (Marthinsen et al., 2020). It is important to note that results from this study and research exploring parents' preferences regarding

elements of support models (Visscher et al., 2022) highlight parents' dislike for prescriptive programs - feeling these fail to acknowledge their family's unique profile.

Despite these reported barriers to empowering parents to participate in service responses, the work of the family support practitioners described in this study suggest that it is possible to address child safety concerns *and* empower parents to participate in their service response. Similarly, Gentles-Gibbs (2016) report child welfare practitioners and supervisors from the United States suggest that under certain circumstances it is possible to achieve a shared focus on family empowerment and child protection. Participants from the Gentles-Gibbs (2016) study cite large and well-resourced services offering a range of programs including differential/alternate response, an overall focus on the entire family system, and not just the child, and strong leadership support as necessary for a dual focus on family empowerment and child protection. Further research is recommended to better understand specific practices and service models that concurrently address child safety and empower parents to participate in service responses. For example, optimal family support service periods, how relationships are effectively prioritised, and best practices for partnering with parents to develop a tailored service response.

Getting help to meet needs

Findings from this study suggest that participants attempted to seek help for their families, however seeking this help was challenging. Without advocacy from family support practitioners, seeking help, particularly from community services such as housing, education, mental health, antenatal care, and drug and alcohol support, frequently led to negative experiences. These negative experiences included unkind treatment, a focus on reporting child protection concerns without concurrently offering support, unfulfilled promises, and low responsiveness. Of concern, these findings resonate with results from another Australian study that explored experiences of parents with child protection involvement. Results from

this study indicated that parents' early help seeking attempts (prior to child protection involvement) were ignored and undermined, leaving them disappointed and frustrated (Khan et al., 2018, p. 211). This history of negative interactions is concerning as results from this study found that parent's experiences in seeking support from community services influence whether they engage effectively with them; affirming previous findings (Piper, 2017; Toros et al., 2018). Some participants in this study discussed that their decisions to seek help were influenced by past experiences. Participants explained that they were less likely to seek support from services that they have previously had negative experiences with and more likely to seek help from services understood to be helpful. Together these results highlight an urgent need to ensure vulnerable families are treated in ways that reinforce help seeking and engagement when they reach out to community services. Parents in this study identified honest and transparent communication and being treated kindly and with empathy as enablers for them to seek help.

Finally, one objective of this study was to learn about participant goals for themselves and their families from family support services. Despite efforts to seek this information using a range of probing questions, participants had difficulty identifying these goals. This may be due to a number of factors including: the time passed since goal setting was undertaken, given most participants were at the end of their service time; some family support practitioners did not explicitly talk about goal setting with families; or families lacking familiarity with setting goals. Participants tended to respond to interview questions about goals by talking about what they needed. Ideally drawing on strengths-based practice as a component of family-centred practice, families articulating their needs would be supported to co-construct goals that relate to meeting these needs (Toros & Falch-Eriksen, 2021, p. 1593). Various tools exist to support goal setting, such as the Canadian Occupational Performance Measure (COPM) that emphasises practitioner-client partnerships in goal setting (Kirsh &

Cockburn, 2009). Goal setting tools may be useful in promoting participation of parents known to child protection in goal setting as well as measuring outcomes. The apparent lack of understanding about goal setting by parents highlights an important area for future research, including how goal setting is being used with families receiving family support as part of a differential responses and what tools may support parental participation in this process. Further, the capacity of practitioners' supporting families known to child protection to undertake goal setting with family's needs to be better understood.

Strengths and limitations

When interpreting the findings of this study, there are several limitations that should be considered. The small number of participants and the context specific nature of results from qualitative studies means that the findings are not generalisable. As participants were recruited by family support practitioners and all participants were nearing the end of their family support service, this may have yielded participants with more positive experiences and outcomes with family support. Further, all participants were recruited from the same family support provider, hence results do not reflect experiences of parents engaged with other family support providers. Nevertheless, this study has given some insight into influences on parental participation in service responses within an interprofessional context. It has also highlighted the impact of negative experiences on participation. While this study only had a small number of participants, findings can inform future practice and service design in Australia, and potentially in similar socio-economic settings. Additionally, findings can inform other sector responses.

Important new insights were obtained from the often-missing voice of parents regarding partnering with families alongside other practitioners. It is noteworthy that the participants appeared to welcome the opportunity to share their stories from their own perspective. Further research is required to gather voices of children from families receiving

family support to understand their perspective on partnering with practitioners in an interprofessional context.

Conclusion

The perspectives of parents receiving family support provide much needed and important insights to guide efforts to strengthen partnering with parents and collaboration among service providers to better support families. First, parental participation may be enhanced by family support models that allow practitioners time to prioritise practitioner-family relationships and flexibility to formulate tailored service responses. Second, family support practitioners can play a critical role in driving collaboration between community services relevant to each family's needs and advocating for respectful and appropriate responses from these services. Third, as part of supporting parental participation in service responses, goal setting with families receiving family support services needs to be further explored and understood. Finally, considerable work is still required to re-orient essential services such as health, education, housing, and drug and alcohol support to consistently provide family-centred responses that encourage help seeking from vulnerable families.

Chapter 7: Grand Discussion

Chapter Overview

This chapter presents a narrative synthesis of the findings from study 1, 2a, 2b and 3 of this thesis. Bringing together insights from the literature, professionals and parents, the findings from each study were triangulated and synthesised in response to the three overarching objectives of this thesis. Insights presented in this chapter may inform efforts in practice and policy to enhance collaboration both with and for families who are known to child protection but have not yet reached the threshold for removal of children into out of home care.

Table 1. Contribution of each study to addressing the thesis objectives

Objectives *To explore:*	**Study 1** Scoping review[1]	**Study 2a** Professional interviews	**Study 2b** Professional interviews[2]	**Study 3** Parent interviews
	Chapter 3	*Chapter 4*	*Chapter 5*	*Chapter 6*
Goals for families known to child protection including how these goals are similar or different	■	■		■
Interprofessional collaborative practices thought to influence attainment of goals	■	■	■	■
Collaborative practice between parents and practitioners thought to influence attainment of goals			■	■

[1](Seekamp et al., 2022) [2] (Seekamp et al., 2023)

This thesis is underpinned by the knowledge that: (i) interprofessional collaboration is critical to supporting families known to child protection and must be strengthened (Child Protection Systems Royal Commission, 2016; Herlihy, 2016; Horwath & Morrison, 2011; Price-Robertson et al., 2020); (ii) shared goals can support interprofessional collaboration (Coates, 2017; Winkworth & White, 2010; Zannettino & McLaren, 2014); and (iii) families as stakeholders must be better enabled to participate in these collaborations (Devaney et al., 2021; Toros et al., 2018). This thesis has three overarching objectives designed to deepen our understanding of these three knowledge points to generate guidance for practitioners and policy makers to enhance practice in these areas.

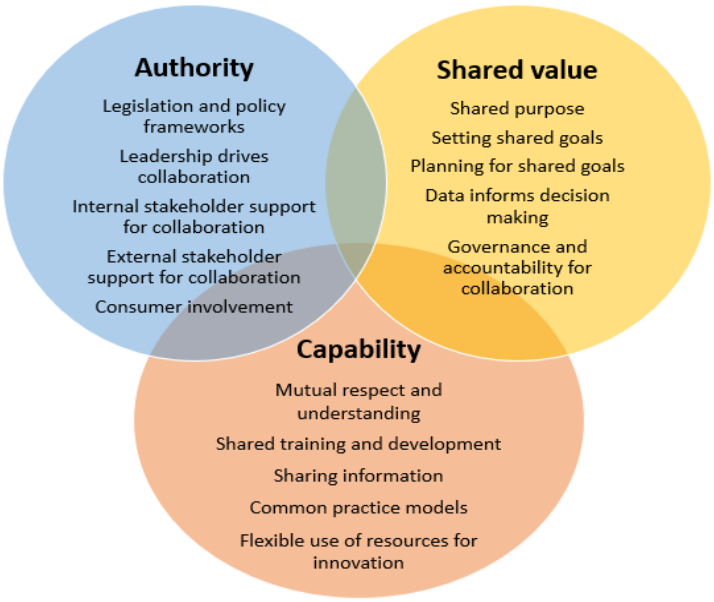
Drawing upon multi-dimensional evidence-based practice as described in chapter two, four studies were completed to address these three objectives via three knowledge sources- literature, perspectives of professionals, and perspectives of parents receiving family support. As described in chapter two, triangulation of these sources was guided by Petr and Feit's (2008) description of multi-dimensional evidence-based practice. Key findings from each of the studies (reflecting the three sources – literature, professionals and parents) were mapped against the three objectives of this thesis. This revealed the level of agreement across sources as well as gaps that may exist in the findings, enabling recommendations for practice to be made based on these (Petr & Feit, 2008).

In this chapter, findings from this triangulation are presented in sections one, two and three, addressing each objective sequentially. Key findings from this triangulation are discussed in relation to existing literature including White and Winkworth's model (2018) (see Figure 1. below) and new knowledge is identified to inform future practice, policy, and research. In section four of this chapter, strengths and limitations of the thesis are presented followed by recommendations for future directions for research. To finish, the overall

conclusion and recommendations for how findings may be translated into policy and practice are presented.

Figure 1

Key drivers of collaboration (White & Winkworth, 2018)



Section 1. Shared goals as an enabler of interprofessional collaboration.

Section one of this chapter addresses objective one of the thesis: *exploring shared goals for families known to child protection as an enabler of interprofessional collaboration.* As discussed in chapters two and three, three action areas of the shared value domain of White and Winkworth's (2018) model - *identifying a shared purpose, setting shared goals, and planning for shared goals* underpin this objective. As shown in Table 1., this objective was addressed by study one (Seekamp et al., 2022), 2a and three to provide insights from existing literature (scoping review), professionals, and parents respectively. Findings from the scoping review (Seekamp et al., 2022) and interviews with Australian professionals (study 2a) are drawn upon to offer new insights into what shared goals exist across services supporting families known to child protection and how they may contribute to enhancing interprofessional collaboration. Findings from parents (study 3) did not identify any clear

goal foci for parents, or for their families, suggesting that their involvement in and awareness of goal setting is unclear. It was not clear whether goals are not explicitly being set with parents, if goals are being documented by practitioners without direct involvement from parents, or whether other factors led to this finding. Given the need for parents to be empowered to have a voice in their service responses, and the importance of goal setting in this participation, this is an important area for further exploration. Recommendations for this research are made in section four of this chapter.

This chapter section includes two subsections:

- the role of shared goals as an enabler of interprofessional collaboration and
- shared goals that may offer a shared focus for driving collaboration.

The role of shared goals as an enabler of interprofessional collaboration

Findings from the scoping review and professionals suggest that shared goals can enhance collaboration across services at two levels (i) the overarching service level and (ii) the practitioner level in work with individual families. Results from the scoping review provide new insights into the role of shared goals at the first level- the overarching service level when establishing formalised and on-going collaborations between services. Findings from professionals did not yield insights into the role of goals as an enabler of collaboration at the overarching service level. This difference in findings may reflect differences in models of collaboration internationally and in Australia. The scoping review predominantly identified literature from the US (64 of 91 included studies) describing formalised and on-going collaborations supporting families known to child protection. In contrast, findings from professionals in study 2a reflecting the Australian context indicated that most collaborative interactions were informal and ad hoc. It could be inferred that where collaborations are more ad hoc, shared goals at the overarching service levels would not be established. These

findings highlight the suitability of shared overarching service goals as an enabler of formalised on-going collaborations.

Insights regarding shared goals as a driver of collaboration at the overarching service level reflect White and Winkworth's model (2018) (Figure. 1), where a shared vision for the purpose of a collaboration endorsed and communicated by leadership reflect key action areas of both driver domains 'authority' and 'shared value'. These findings highlight that leaders' efforts to establish formalised collaborations may be enhanced by identifying who their strategic partners are, developing a shared vision and purpose for the collaboration with these partner services, and communicating this vision to their respective teams.

New insights into the role of shared goals as an enabler of collaboration at the second level - practitioner work supporting individual families, were gained from the scoping review and professionals (study 2a). For these practitioner driven collaborations, the value of shared goals as an enabler of interprofessional collaboration was found in goals for individual families, rather than services, reflecting White and Winkworth's (2018) action area *planning for and setting shared client goals* from the driver domain "shared value". Results from these two studies combine to highlight that shared goals for individual families across services may support interprofessional collaboration. Further benefits of this shared oversight of goals were reported in the scoping review (chapter 3) including deeper understanding of families' needs and strengths (Lawrence et al., 2011; Swenson & Schaeffer, 2018), increased client engagement in services (Crane et al., 2019; Hammond & McGlone, 2013), and establishment of goals that are feasible and not conflicting for families (Karatekin et al., 2014). However, as indicated at the beginning of this section, family involvement in identifying these goals while critical, is unclear and requires further exploration.

Shared goals identified at the practitioner level may suit the current Australian context where interprofessional collaboration appears to predominantly be informal and in response to the unique needs of each family. However, as discussed below in section two, findings from this thesis suggest that coordination of shared goals for individual families appears to depend on effective lead case management from family support practitioners. For families who have not reached the threshold for family support services, the availability of this practitioner-led shared oversight of goals to support collaboration is not known.

Initiatives such as Safe Start (Government of South Australia, 2022) may help provide this practitioner-led shared oversight of goals for families prior to child protection involvement. This model provides support to infants in their first 1,000 days and their families identified as having complex issues and child protection risk factors. Safe Start assertively engages with families to provide support to improve health, development, safety and wellbeing through capacity building and collaborating with relevant services (Government of South Australia, 2022). As part of enhancing collaboration with service delivery partners, Safe Start practitioners likely have the opportunity to drive shared oversight of goals across services for individual families. To strengthen collaboration, practitioners working in case management roles in programs such as Safe Start are encouraged to foster shared oversight of goals in partnership with families across services.

Shared goals

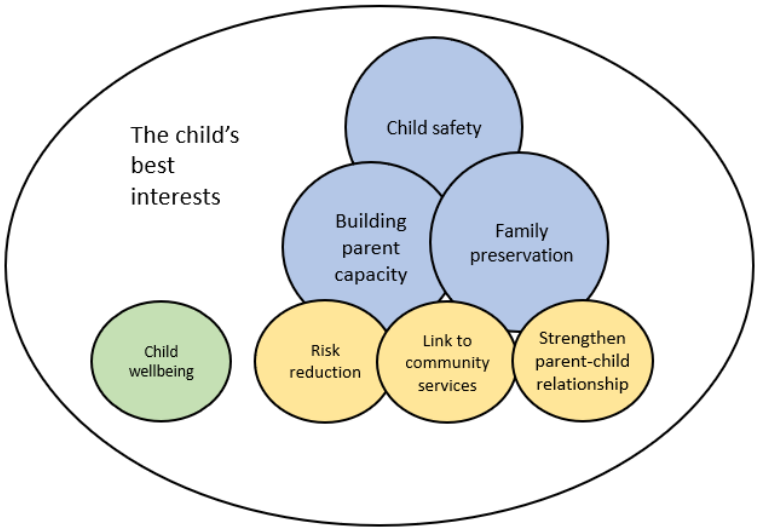
Results from the scoping review (study 1, Seekamp et al., 2022) and professional interviews (study 2a) offer new insights into goals that are shared across services and practitioners whose primary role it is to support families known to child protection**.** Findings from both the scoping review and professionals aligned tightly to reveal several goals as shared by these services. These goals are discussed below, including their links to policy

frameworks, their interrelatedness and potential role as a driver of interprofessional collaboration.

Goals pertaining to *child safety, family preservation* and *building parental capacity* stood out as the most common goals across services supporting families known to child protection (shown in Figure 2. in blue). *Strengthening parent-child relationship, reducing parental risk factors, and linking families with community services* were found to be the next most common goals across these services (shown in Figure 2. in yellow). These goals shown in blue and yellow reflect a focus on the child's care environment and were found to be interrelated as depicted in Figure 2 and discussed below. *Child wellbeing* was also identified as a common goal from the scoping review and professional interviews (shown in green in Figure 2.). *Child wellbeing* is positioned alone in Figure 2., as it reflects a focus on the intrinsic needs of the child in contrast to their care environment. All identified goals can be viewed as in *the child's best interests* (see Figure 2.), which was identified as an overarching goal by professionals in study 2a.

Figure 2

Shared goals of services whose role it is to support families known to child protection



The best interest of the child is the underpinning principle of The National Framework- Safe and Supported 2021-2023 (Commonwealth of Australia, 2021) and this being identified as an overarching goal by professionals suggests that the intent of The National Framework is being understood by professionals. However, as discussed below, the best interest of the child is multi-faceted, and identifying these facets and addressing all of them is challenging.

It is unsurprising that the goal of *child safety* was identified as one of the most common goals as it reflects the primary mandate of work with families who become known to child protection both in Australia and internationally (Commonwealth of Australia, 2021; Geiger & Schelbe, 2021; HM Government, 2018). Similarly, the goal of *family preservation* aligns with mandates for statutory agencies to achieve to permanency for children (Commonwealth of Australia, 2021; Geiger & Schelbe, 2021; HM Government, 2018) and the objective of family support services - to keep children with their families when it is safe to do so. The third goal of those found to be most common - *building parent capacity* can be seen as a means to achieving these two goals of child safety and family preservation and signals an opportunity for a family support orientation to practice in contrast to a child protection orientation. This aligns with reforms in Australia in recent decades away from a child protection orientation toward a 'family support' approach evidenced by The National Framework (Commonwealth of Australia, 2021) and its predecessor (Council of Australian Governments, 2009). Like a family support orientation, these frameworks reflect a partnership approach with families that acknowledges their strengths and needs in their broader context (Herrenkohl et al., 2015). A focus on goals pertaining to building parental capacity provides a platform for practitioners to partner with parents and each other in strengthening families.

While the most commonly identified goals (shown in Figure 2. in blue and yellow) were identified as goals in their own right, their interrelatedness was made apparent by the qualitative insights from professionals. For example, *family preservation* was described as contingent upon *child safety* requirements being satisfied. Further, *building parent capacity* can be seen to be underpinned by the goals pertaining to *risk reduction, strengthening child-parent relationship* and *linking the family with community services*. This interrelatedness highlights the centrality of interprofessional collaboration to achieving these goals. Where collaboration is required to *link families with community services* (such as mental health, housing and drug and alcohol support) to *reduce risk* and *build parent capacity* ultimately achieving *child safety* and *family preservation*. The interrelatedness of these goals may support the identification of shared goals across sectors, hence driving collaboration among practitioners whose role it is to keep children safe, preserve families, or build capacity of parents. This may be particularly relevant to fostering collaboration with community services whose role in supporting families known to child protection is less clear, with practitioners recognising mutual benefits of collaborating to address interrelated goals.

Findings from the scoping review and professionals (study 2a) suggest that collaboration among partners, including those from child protection, family support and community services may be enhanced when they recognise the interrelatedness of the needs of all family members, and consider how their work may contribute to positive outcomes for the child as an overarching shared value. For example, findings from professionals indicated that keeping the *best interests of the child* as a shared focus may help overcome divergent priorities. This finding builds on examples identified in the scoping review of overcoming 'opposing' goals and alternate philosophical viewpoints by recognising the interrelatedness of the needs of all family members. For example, residential drug rehabilitation programs for families that respond to a parent's need for support with substance use, while supporting

children alongside their parents - preserving the family (Bosk et al., 2019; Hanson et al., 2015). Additionally, interventions for families experiencing domestic violence exist that are accountable to children's safety needs, as well as supporting the mother and child's relationship (Humphreys et al., 2018; Pennell & Burford, 2000).

The goal of child wellbeing is positioned separately to the other goals in Figure 2. as it pertains to the intrinsic needs of the child (e.g., education, physical and mental health, and behaviour), rather than their care environment as reflected in the other goals. *Child wellbeing* was identified less frequently in the scoping review than other goals, and professionals reported that despite its importance, it was not always able to be prioritised equally against other goals such as safety and addressing parental risk factors. This may reflect ideologies that argue child safety trumps all other goals in work with families known to child protection (Gentles-Gibbs, 2016), or be a symptom of an overwhelmed risk averse system. Nevertheless, child wellbeing is an overarching goal of statutory child protection systems in Australia (Commonwealth of Australia, 2021) and internationally (Geiger & Schelbe, 2021; HM Government, 2018) and needs to be prioritised as such.

As discussed in chapter three (scoping review, Seekamp et al, 2022) and four (professional interviews), child protection and non-government service responses typically focus on addressing the needs and concerns of parents, with the intent to positively influence parental behaviours and circumstances to help them better care for children (Cahill et al., 2020). The apparent lacking proportionate focus on children's wellbeing alongside their parent's needs has rightfully raised criticism (Cahill et al., 2020; Corr & Santos, 2017). There is a need for an equal focus on child well-being alongside child safety and family preservation (Samples et al., 2013), as being safe and with one's family is not enough to ensure positive wellbeing and educational outcomes for children (Karatekin et al., 2014). Australian child wellbeing frameworks such as The Nest (Goodhue, 2021) reinforce this idea,

presenting evidence that for a child to thrive they need their needs met in six key interlocking dimensions (valued, loved and safe; material basics; health; learning; participating; and positive sense of identity and culture). Fittingly, wellbeing has been given more emphasis in child protection legislation in Australia recently including health, mental health and educational outcomes (Jonson-Reid, 2019). This shift in legislative emphasis provides an opportunity for system support for child wellbeing to be prioritised and used as an ultimate indicator of impact of service delivery.

Given the intergenerational patterns of child abuse and neglect (Armfield et al., 2021), a holistic approach that supports children to thrive and grow up to be educated and healthy adults (and likely parents) is a critical strategy of child protection prevention work. Improving wellbeing outcomes for children who come into contact with the child protection system may positively impact intergenerational risk factors for child maltreatment. Research is needed to explore how an approach that balances a focus on the child's care environment as well as their wellbeing (including health, learning, participation and sense of identity and culture) can be ensured. This work should explore assessment, goal setting and service planning with families known to child protection to better understand how this holistic focus can be fostered. Holistic frameworks of child wellbeing may be useful for guiding the development of goals for families known to child protection that consider all the elements of the *best interests of the child,* as well as involvement of practitioners with tertiary training in child development and wellbeing such as occupational therapists and psychologists. Service responses that take this holistic approach will depend on effective collaboration across sectors and with families to adequately respond to the diverse needs of children and their families. Identification of shared goals and the interrelatedness of different goals within families by service providers may support this collaborative work. Critically, the identification of these goals must include family members themselves.

Table 2. below provides a summary of key findings by source from this section that addressed objective one- *exploring shared goals for families known to child protection as an enabler of interprofessional collaboration.*

Table 2. Key findings by source for objective 1

Highlights from section 1	SR	Prof	P	A
Shared goals may enhance collaboration across services at:				
• the overarching service level and	X			
• the practitioner level in work with individual families.	X	X		
Child safety, *family preservation* and *building parental capacity* were identified as common goals across services and may provide a shared focus for enhancing interprofessional collaboration.	X	X		
Acting in the child's best interest				
• underpins all common goals and				X
• was said to support collaboration across the spectrum of services.		X		
Common goals				
• are interrelated and		X		
• recognition of the interrelatedness may support collaboration.				X
Research is needed to explore how goals that balance a focus on the child's care environment (including safety and parent's needs), *and* their wellbeing can be ensured.				X
Parent's involvement in goal setting needs to be better understood as part of work to enhance parental participation.			X	X

SR- scoping review; Prof- professionals; P- parents; A- author deductions.

Section 2. Interprofessional practices

Section two of this chapter addresses objective two of the thesis - exploring *interprofessional practices thought to influence attainment of goals.* Results from study one (Seekamp et al., 2022), 2a, 2b (Seekamp et al., 2023), and three (chapters three, four, five and six respectively), are incorporated reflecting findings from the literature, perspectives of

professionals and parents. This research extends the existing literature by offering rich insights from three sources into specific interprofessional practices across a range of sectors thought to influence outcomes for families.

This chapter section includes four sub-sections:

- engaging families with support
- managing risk
- lead case management
- systems and processes that support collaboration.

Engaging families with support

Engaging families known to child protection with support is known to be challenging (Arbeiter & Toros, 2017; Lehtme & Toros, 2020). Two collaborative approaches were described as useful for engaging families with support. The first approach draws on established practitioner-family relationships and was affirmed as important by professionals (study 2b) and parents (study 3). This approach extends insights into how these relationships may be leveraged to improve service delivery. The second approach described by professionals relies on the statutory power of child protection and was not supported by findings from parents.

The first approach to engaging families endorsed by professionals and parents aligns with existing literature that emphasises practitioner-family relationships as critical to engaging families with support (Lehtme & Toros, 2020; Muench et al., 2017) and calls for collaboration across all sectors including child protection, family support and community services. This approach requires practitioners who have an existing relationship with a family to support the family to build genuine links with new needed services, including acting as a conduit for support while new relationships are developed if needed. This moves practice

beyond the idea of making a referral and relying on the new service to engage the family, or the family to engage with the new service. Findings from parents (study 3) emphasised that service responses that prioritise relationship building help counter their shared history of negative interactions with service providers and overcome their reluctance to engage with support. An interprofessional approach to building relationships could transform how families access support. It would require a shared commitment across all services and sectors to supporting families in ways that recognise practitioner-family relationships as a critical mechanism to engaging families with support and contributing to positive outcomes.

These findings may have particular significance for supporting Aboriginal and Torres Strait Islander families. As described in chapter one, the history of colonisation and reluctance of mainstream services to accept differences in family structure and function between Aboriginal and Non-Aboriginal societies can create barriers for Aboriginal and Torres strait Islander families to engaging with support (Duthie et al., 2019; Oates, 2020). For Aboriginal families to have the practitioner-parent relationships reported to be critical for families to engage with support, better access to bi-cultural approaches to service delivery and Aboriginal Community-Controlled Organisations is required. Increased availability of these practices and services would better enable Aboriginal families to receive support from Aboriginal workers to connect with needed services. This would reflect an equitable approach to relationship-focused collaborations for Aboriginal families.

Given the potential benefits of a shared commitment across sectors to practitioner-family relationships, further work is needed in research and practice to identify what is needed among child protection, family support and community services to implement these approaches. Drawing on White and Winkworth's model (2018), advancing these collaborative practices will require understanding how the willingness and capability of practitioners, as well as system and leadership support can be ensured. As discussed in

chapters five and six, the development of authentic and trusting relationships with families is challenging and takes time. Service models and workloads are required that afford time for this critical work alongside investment in workforce to ensure professional capability across all sectors for relationship-focused work. To ensure equitable access to culturally appropriate and safe relationship-focused support for Aboriginal and Torres Strait Islander families, investment to grow the Aboriginal workforce and services are essential. This will require as promised in the Safe and Supported: Aboriginal and Torres Strait Islander First Action Plan 2023-2026 (Commonwealth of Australia, 2022), funding of Aboriginal Community-Controlled Organisations in a manner that reflects the proportion of Aboriginal children and families known to child protection.

The second collaborative approach to engaging families described by professionals in study 2b conflicts with the relationship-focused approach described above and pertains to collaboration between child protection and family support practitioners. When family support practitioners have difficulty engaging a family referred as part of a differential response, they may seek assistance from child protection. This assistance reflects a *coercive* approach to engagement, where families are compelled to engage with family support via child protection threatening further involvement if they fail to engage. As discussed in chapter five, this collaborative practice was described by professionals as useful for facilitating engagement of families who are reluctant to engage with family support. However, it was acknowledged that this approach was less desirable than relationship-focused authentic engagement as it may hinder the establishment of trusting relationships said to be critical to effective engagement of parents (Lehtme & Toros, 2020; Muench et al., 2017; Seekamp et al., 2023). Despite this approach being counter to the critical relationship-focused orientation, it may have a role to play in differential type responses. When families referred for a differential response resist engaging with these ‘voluntary’ alternate services, there is a risk that they avoid any type of

response – potentially leaving children assessed as having at least moderate risk unsupported (Piper, 2017). These findings suggest that coercive approaches to engaging families may be useful, although they should be used as a last resort and authentic relationship-based approaches should be prioritised.

It is important to consider however, whether there may be a middle ground between authentic relationship-based and coercive approaches to engagement. This middle ground may include involvement of statutory practitioners to compel families to engage with support while demonstrating practices identified by families to support relationships and engagement. For example, practitioners conveying a genuine interest in supporting all members of the family; inviting and listening to the perspectives of family members when identifying issues and supports needed; tailoring service responses to reflect each family's unique circumstances; working alongside, or through practitioners who have an existing relationship with the family; and prioritising and allowing time for relationships to be built.

Managing risk

New insights into collaborative approaches to risk management seen to influence outcomes for families were gained from literature, professionals, and parents (study one, 2a and three). Two key findings regarding collaborative approaches to risk were identified, (i) family support practitioners appear more able to hold risk when the accountability for the risk is shared with child protection via their collaboration and guidance during risk escalations; (ii) community services appear more willing to share risk with shared accountability, provided via clarity that child protection or family support are actively involved with the family. These two key findings are discussed below.

Insights from professionals indicate that family support services have varying thresholds for risk and child protection holds the highest threshold for risk. Reflecting this variation in risk tolerance, findings from the scoping review (Lonne et al., 2014; Tung et al.,

2019) and professionals emphasise that family support practitioners value guidance from child protection when family risk levels escalate beyond the family support service's tolerance. Findings from parents also support this approach, with parents valuing their family support practitioner acting as a conduit between them and child protection following any new child protection notifications. Parents indicated that their family support practitioners were well placed to advocate for them with child protection, potentially avoiding further child protection involvement.

Several benefits from this collaborative approach to risk management were evident from professionals and parents. Support from child protection for family support practitioners during risk escalations was seen to build the capacity and confidence of family support providers to continue to support families through periods of heightened risk. This created benefits for families and child protection, as child protection did not need to take over management of the family – not adding to overwhelming workloads, and families avoided further statutory intervention and increased likelihood of children being removed. It is noteworthy these valued collaborations between child protection and family support were described by professionals as being sought out by family support practitioners informally, rather than reflecting an established collaborative service model. Given the suggested benefits of this collaboration, more formalised opportunities for child protection practitioners to offer consultation to family support services regarding risk management and escalation, despite families not having an open file with child protection should be explored. This may be an effective strategy to better support families with high levels of risk outside of the statutory authority when safe to do so.

New insights into responses to risk by community support services such as health, education, and drug and alcohol support were also presented by professionals and parents in study 2a and three. Community services were found to typically have a low tolerance for risk,

showing a tendency to rely on child protection to manage and respond to families presenting with risk. Insights from professionals indicate that community services often require reassurance from child protection or family support case managers that risks within a family are being managed before they are willing to collaborate and support the family. Adding to this picture, parents conveyed frustration that community services tended to notify child protection concerns through the mandated notification process, but not routinely concurrently offer support, or talk to the family about their concerns.

A reluctance of community services to offer support to families that they report to child protection without involvement of family support or child protection is of concern. In Australia, only a minority of reports to child protection receive some type of formal response (Lonne, Russ, et al., 2021). Therefore, if professionals from community services make a child protection notification and then rely on child protection to respond, these children and their families may be left without support unless their situation reaches the threshold for a child protection response. This issue is also present in other countries with similar protection-oriented child protection systems. In the US there has been criticism of lower risk families screened out of child protection receiving no follow up or support, despite needing prevention services (Waldfogel, 2009). These findings highlight a point in the system where early intervention or prevention efforts that have the potential to re-direct families away from the child protection system can break down.

Community services may tend to rely on child protection to respond to families presenting with high risk for a range of reasons. It may in part be due to community expectations that once child protection issues are reported there will be a response. However, it may also be as Drabble and Poole (2011) found that practitioners' fear repercussions against them by the media or their organisation if there was an adverse outcome. A meta synthesis that explored mandated reporters' experiences with reporting child maltreatment

identified the process of making a notification to be highly stressful (McTavish et al., 2017). Authors of this review call for better support for mandated notifiers including professional debriefing, further training regarding identification and reporting of potential maltreatment, as well as ways of responding to these children and their families. Further, as part of this training, McTavish et al. (2017) highlight the need to emphasise notifiers' moral responsibility to respond to the child or family in need as separate from their responsibility to report maltreatment.

As part of early intervention and prevention approaches to child protection, research is urgently needed to better understand how community services can be enabled to more confidently engage with and support families presenting with risks (alongside making mandatory notifications). Further, to encourage families to engage with any support offered, community service system and practitioner capacity must be built to enable relationship-focused approaches to interacting with families. *Getting It Right for Every Child* (GIRFEC), a policy framework in Scotland that emphasises empowerment, prevention and collaboration offers an example of national level efforts to re-orient universal services to better support families presenting with child protection risks (Scottish Government, n.d.). GIRFEC was designed to improve children's well-being via early intervention, universal service provision, and multiagency coordination across organisational boundaries (Coles et al., 2016). It has a focus on activating early support from social work, health, education, police and housing to avoid issues in families escalating. The framework is administered through documented roles and responsibilities for practitioners across sectors supported by legislation (Scottish Government, n.d.). Practitioners, policy makers and researcher may benefit from insights gained from implementation of this policy framework to guide work to increase involvement of universal services in supporting families with child protection risks.

For countries with mandatory reporting requirements, strategies to build capacity of mandated notifiers (particularly community service providers) to concurrently offer support to families who they may report may be of value. These strategies may include strengthened system support for professionals making notifications as recommended by McTavish et al., (2017), including peer debriefing and mechanisms for communication with colleagues and child protection practitioners. Additionally, training for mandated notifiers to concurrently offer families support alongside making notifications. This should include training for community service practitioners on how to talk about concerns and support with families presenting with risks for maltreatment.

Lead case management

The role of lead case management was described by professionals and parents (study 2a and three) as critical. This role undertaken by family support practitioners was portrayed as fundamental to procuring needed support from community services such as housing, domestic violence, education and mental health support for children and families. Professionals and parents agreed that little if any interprofessional collaboration across sectors would likely occur without this lead case management, potentially leaving families without essential support from community services. This practitioner leadership offers a different perspective of the action area *leadership drives collaboration* from White and Winkworth's model (2018), where leadership for collaboration typically comes from positions of power, driving collaboration at the service/system level. Leadership for collaboration at the practitioner level may be particularly important in the Australian context where findings from this thesis suggest collaboration tends to be ad hoc, relying on practitioners to initiate specific collaborations in response to the unique needs of each family.

The value of practitioner leadership in driving interprofessional collaboration has been previously identified. Drabble and Poole (2011) in their analysis of professionals'

experiences of collaboration between addiction treatment services and child welfare reported the value of leadership at the practitioner level, with individuals helping to initiate specific collaborations. Further, Price-Robertson et al. (2020, p. 5) asserts that collaboration across sectors is always to some extent a 'bottom up 'activity that must be invented and re-invented by practitioners depending on the unique presentation of families. Despite the importance of practitioner leadership in interprofessional collaboration, findings from professionals in study 2a indicate that the role of lead case management is dependent upon individual practitioner expertise rather than being a recognised and defined role and is therefore not consistently implemented. As existing literature has a disproportionate focus on system-level influences on collaboration and lacks explicit guidance for practitioners on this critical element of their work (Price-Robertson et al., 2020), insights into this role are important.

Findings from professionals and parents in this thesis offer much needed guidance for practitioners seeking to facilitate interprofessional collaboration to meet family needs. Key practices of lead case management identified include building trusting relationships with families and together identifying strengths and needs, assertively engaging needed services, driving collaborative thinking and planning, documenting, and communicating plans, and holding practitioners/services accountable to implementing the developed plans in family friendly ways. Given the centrality of lead case management evident in findings of this thesis, action in practice and research is warranted to define this role, clarify what is needed for its implementation, and evaluate its impact in a range of family support settings. Families as stakeholders in collaborations designed to support them must have a voice in this design and evaluation process.

Systems and processes that support collaboration

As discussed in chapter one, in Australia and internationally there is policy support for interprofessional collaboration (Colvin & Miller, 2018; Commonwealth of Australia,

2021; Flaherty, 2018; HM Government, 2018). This suggests an *enabling context exists for collaboration* [action area from the domain *'authority'* (White and Winkworth, 2018)]. However, findings from the qualitative research undertaken as part of this thesis (study 2a, 2b and 3) suggest that in Australia and particularly South Australia, implementation of interprofessional collaboration is predominantly dependent on action at the practitioner level with support for collaboration at the system level not highly evident. The value of leadership and system support for collaboration was evident in findings from the scoping review (Coates, 2017; D'Andrade et al., 2017; Huebner et al., 2017; Lonne et al., 2014) and professionals (Study 2a). These findings mirrored action areas from the domain 'capability' in White and Winkworth's model (2018) to reinforce the following systems and processes as enablers of collaboration - *shared training and development* (Crane et al., 2019; Swenson & Schaeffer, 2018), *common practice models* (Freisthler et al., 2021), *mutual respect and understanding* (Humphreys et al., 2018), *sharing information, and flexible use of resources for innovation* (Lonne et al., 2015; Traube et al., 2015).

The current availability of these system enablers in the Australian context is not clear from findings of this thesis. Individual responses from professionals in study 2a suggest that shared training is happening less frequently than in previous years and while mutual respect and understanding were cited by professionals as critical for effective collaboration, issues of tension and blame between child protection and family support were consistently reported. Information sharing was emphasised to rely on effective lead case management and service model boundaries and timeframes were identified as a barrier to the innovation needed to meet the unique and chronic needs of families. Therefore, while these systems and processes are further affirmed by both the scoping review and professionals as useful for strengthening interprofessional collaboration, how evident they are in the Australian context requires further exploration. To support collaboration in a context where collaboration across sectors

appears to largely be informal, fluid and driven by practitioners, innovations are required that better avail these system supports.

Table 3. below provides a summary of key findings by source from this section that addressed objective two- *interprofessional collaborative practices thought to influence attainment of goals.*

Table 3. Key findings by source for objective 2

Highlights from section 2.	SR	Prof	P	A
Parent-practitioner relationships are critical to engaging families effectively with support.	X	X	X	
To engage families with support and contribute to positive outcomes, a shared commitment across services to practitioner-family relationships is needed.				X
Coercive approaches to engaging families can be helpful with families who are hard to engage.		X		
These approaches should be used as a last resort.		X		
Collaborative approaches to managing risk may offer benefits to child protection, family support practitioners and families.		X	X	X
Lead case management offered by family support practitioners was described as critical to facilitating cross sector collaboration.		X	X	
Establishing shared accountability for risk across services may enable community services to support families with high levels of risk more readily.				X
Research is recommended to explore how the functions of lead case management can be consistently embedded across family support services in Australia.				X
Several systems and process were upheld as important for supporting interprofessional collaboration.	X	X		
Opportunities to strengthen these systems and processes in the Australian context requires exploration.				X

SR- scoping review; Prof- professionals; P- parents; A- author deductions.

Section 3. Collaborative practices between families and practitioners

Section three of this chapter address's objective three of the thesis - *the exploration of collaborative practices between families and practitioners thought to influence attainment of goals from the perspectives of professionals and parents*. This objective acknowledges the need to strengthen participation of parents/caregivers known to child protection in service responses, including identifying their own needs, strengths, and strategies (Gibbons & Connolly, 2021; Muench et al., 2017; Toros et al., 2018). As shown in Table 1., studies 2b (Seekamp et al., 2023) and three, presenting the perspectives of professionals and parents respectively address this objective.

This chapter section includes four sub-sections:

- engaging families
- practitioner-parent relationships
- a tailored approach
- family voice

Engaging parents

Interprofessional practices that facilitate engagement of parents with support were discussed in section two of this chapter, in this section collaborative practices between parents and practitioners that influence engagement are presented. Findings from professionals and parents gathered via study 2b and three align to emphasise that attempts to engage parents with support need to be undertaken with consideration of their history of interactions with services. Findings revealed that many parents have a history of negative experiences with community services including drug and alcohol support, housing, education, health and mental health and child protection. These experiences create scepticism towards services and a reluctance to engage with them. These findings coupled with results from an Australian study exploring experiences of families known to child protection (Khan et al.,

2018) are concerning. Khan et al. (2018) reported that families early help seeking attempts were ignored and undermined, leaving parents frustrated. Together these results suggest practices exist among some community services in Australia that deter families from engaging with support.

Public health approaches to child protection are grounded in early intervention and prevention (Lonne et al., 2019) and aim to enhance outcomes for children by reducing risks in their environments, strengthening protective factors at the individual, family, and community levels (Herrenkohl et al., 2015). Community services such as health, housing, education and drug and alcohol support represent critical elements of a move towards a public health approach to child protection. When families come to the attention of community services, either of their own volition or through other means, the ability of these services to engage and link these families with needed support is critical to the success of early intervention and prevention efforts. In the absence of responses that enable early intervention and prevention, family's needs may escalate funnelling these families towards child protection.

To implement a public health approach to child protection in Australia, there is a need to better understand how community services can be supported to respond to all families in ways that encourage help seeking and engagement with support. This reflects the call from Harries and O'Donnell (2019, p. 248) for a move by all services across the continuum of support to a culture of engagement rather than notification and surveillance. Exploring the perspectives of professionals from these community services may help identify ways forward for building this capacity within community service workforce and systems. Understanding the capacity of these service providers to deliver family-centred practices should form part of this research.

Practitioner-parent relationships

Underpinning the required culture of engagement across services (Harries & O'Donnell, 2019), the importance of relationship-focused approaches is well documented (Lehtme & Toros, 2020; Muench et al., 2017; Navarro, 2014) and perspectives of parents added further weight to this literature. Parents emphasised that until effective practitioner-parent relationships are established, they are likely to remain sceptical and guarded, thereby compromising engagement. Findings from professionals (study 2b) stressed that trusting parent-practitioner relationships can be difficult to establish and take time, particularly in light of parent's past negative experiences. However, the centrality of these relationships to engaging and partnering with parents indicate that they need to be more effectively prioritised in practice.

Insights from professionals and parents in this thesis offer practical strategies for fostering a culture of engagement via practitioner-parent relationships. Affirming existing literature, results from parents and professionals suggest strengths-based practice, listening without judgment and showing genuine care for the family supports the development of relationships (Kemp et al., 2014; Lehtme & Toros, 2020). Additional insights from professionals suggest that avoiding overwhelming families with too many demands, tailoring responses, and using culturally appropriate tools and services, particularly for Aboriginal families, help build practitioner-family relationships, thereby fostering engagement.

Strategies identified in this thesis that support parental engagement align tightly with family-centred practice principles. Family-centred practice highlights the importance of family-practitioner relationships underpinned by strengths-based approaches, tailored responses reflecting each family's unique values, and empowering families to have a say in identifying their goals and service plans (Allen & Petr, 1998; Lietz & Geiger, 2017). Benefits of family-centred practice previously cited including increased satisfaction with services

(Ahn et al., 2018) and attainment of positive outcomes (Toros et al., 2018; Xu et al., 2020) align with findings from parents in this thesis. However, like findings from this thesis and Khan et al. (2018), Lietz and Geiger (2017) report that in the US family-centred practice principles need to be implemented more consistently.

As part of growing a culture of engagement in Australia across child protection, family support and community services, there is a pressing need to better understand the implementation of family-centred practice principles. This includes what family-centred practices are evident in which service types, and what the barriers and enablers of family-centred practice in these contexts are. Workforce training for all sectors, including community services on relationship-focused service delivery as a component of family-centred practice is needed. Providing this training as cross-sector shared training, may offer benefits described in section two above regarding shared training. Further, service systems must support these approaches, allowing practitioners time to build relationships with parents and to support families to develop genuine connections with new needed services to ensure engagement and support.

A tailored approach

Aligning with family-centred practice, a tailored approach to support that reflects the unique profile of each family was highlighted as an important element of partnering with families by professionals and parents in study 2b and three. For parents, a tailored approach appeared to evidence effective partnering where their unique values, needs and strengths had been identified, and specific support offered to reflect these. Parents highlighted that when service responses were tailored, it made them feel understood therefore contributing to them engaging in interventions more deeply.

Findings from professionals showed that they also recognised the importance of a tailored approach to supporting families. For family support practitioners, this was about

being able to offer families the right amount and type of support. However, as previously reported, system constraints including time (Gentles-Gibbs, 2016; Kemp et al., 2014; Michalopoulos et al., 2012) and prescriptive service models that limit practitioner innovation (Gentles-Gibbs, 2016; Marthinsen et al., 2020) were identified by professionals as barriers to offering this 'just right' support. It was stressed by professionals that for families to achieve positive outcomes they typically need family support for a long time, and that some families may always need some level of support. Together, these findings not only highlight tailored approaches with individual families as a potential strategy to enhance participation of parents in service responses, but suggest tailored responses are critical to achieving sustainable positive outcomes for children and their families. Given practitioners and parents appear aware of the value of tailored approaches, next steps require investigation of how systems can better support these tailored responses including long-term support. This is likely to require significantly increased financial investment in family support and a shift in family support service models to being less prescriptive, allowing practitioners to develop service responses that reflect the unique needs of each family.

Family voice

As part of the agenda to increase family member participation in service responses, the need for families to have input into service design and evaluation (beyond their own personal service responses) was highlighted by the results from the scoping review (study 1) and professionals (study 2b). This reflects White and Winkworth's (2018) action area *consumer involvement* referring to the involvement of consumers in design and evaluation of collaborative approaches as key stakeholders in these collaborations. Results from the scoping review, professionals and parents evidence some involvement of consumers in decision making related to their individual service responses. However, a lack of consumer participation in service design and evaluation across each of these studies was evident. While

professionals were found to recognise the input of consumers as important, it was acknowledged that at present there are few mechanisms in place to enable this adequately. These results highlight an important focus for future research and practice - to better understand how families can be enabled to contribute to the evaluation and design of the very service models that are designed to support them.

Table 4. below provides a summary of key findings by source from this section that addressed objective three- *collaborative practices between families and practitioners thought to influence attainment of goals from the perspectives of professionals and parents*.

Table 4. Key findings by source for objective 3

Highlights from section 3.	**SR**	**Prof**	**P**	**A**
Attempts to engage parents with support need to be undertaken with consideration of their history of interactions with services.		X	X	
Strengths-based practice, listening without judgment, showing genuine care, avoiding overwhelming families with too many demands, and using culturally appropriate tools and services may help build practitioner-family relationships.		X	X	
Practices, policies, and service models that genuinely prioritise relationship-building and family-centred practice are required across all sectors.				X
Tailored support encourages participation of parents in service responses and may be critical to achieving positive outcomes.		X	X	
Service systems that better support these flexible responses and long-term support are needed.				X
Opportunities for families to contribute to the evaluation and design of services that are designed to support them are needed.		X		X

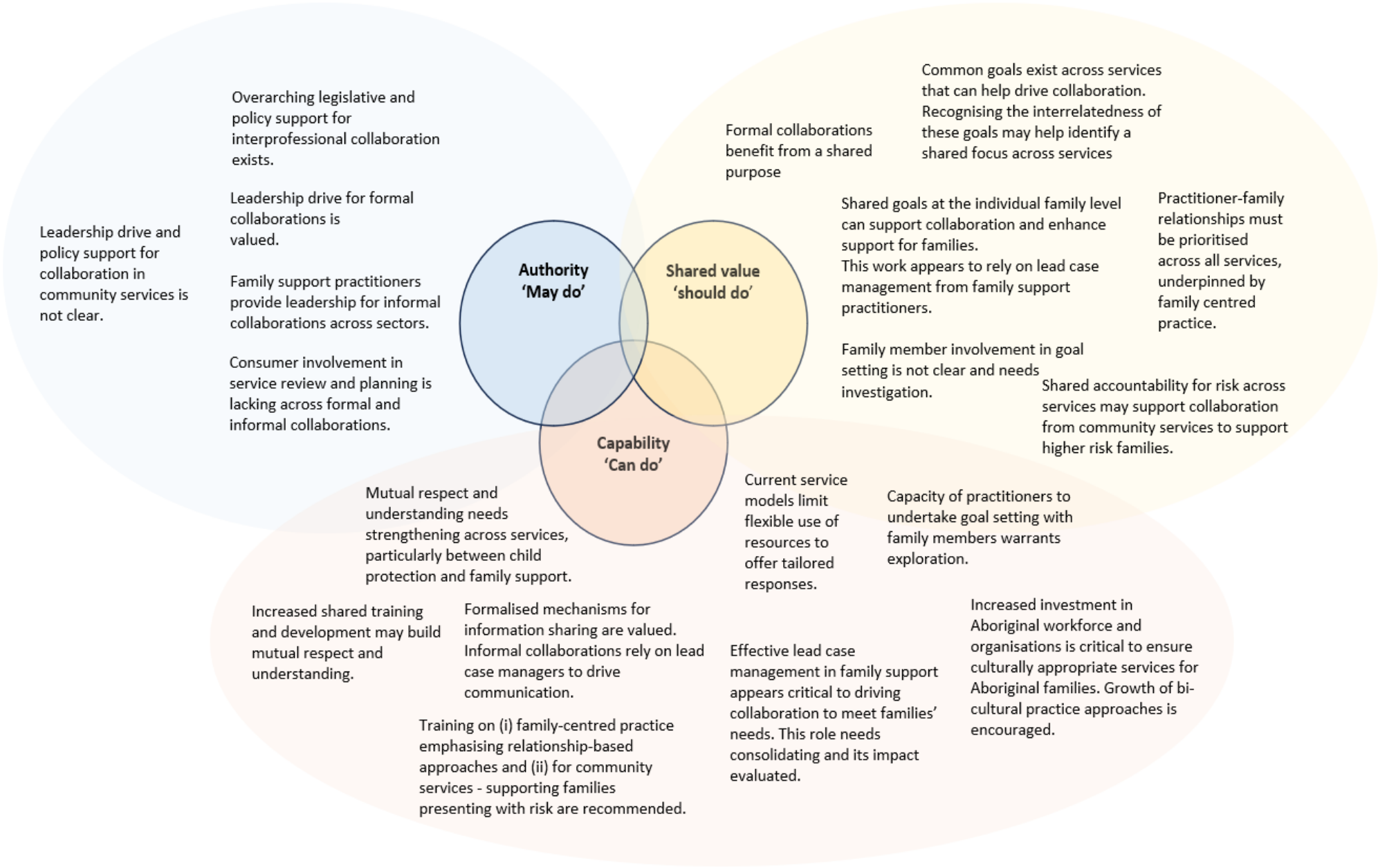
SR- scoping review; Prof- professionals; P- parents; A- author deductions.

Overview of all findings

The three objectives of this thesis have been addressed individually in the above three sections of this chapter. These findings are summarised collectively below in Figure 3.

Insights from this collective overview offer guidance for practice that has reach into each of the objectives of this thesis. White and Winkworth's model (2018) provided a theoretical framework for this thesis and has been used to frame the overview of findings. Figure 3. illustrates the relationship between key findings from this thesis and the three domains of White and Winkworth's model. Findings from this thesis support the applicability of White and Winkworth's model (2018) in the field of child protection, affirming the importance of action areas from the three driver domains 'authority', 'shared value' and 'capability'. As such this model can be recommended as a framework for informing work to analyse and strengthen interprofessional collaboration in this field.

Figure 3. Overview of findings



Section 4. Strengths and limitations of the thesis

Fitting with the ambition of the PhD candidate and the epistemologies of the research, useful and actionable knowledge anchored in respondent experience (Kelly & Cordeiro, 2020, p. 3) was generated from this thesis. The exploratory design provided rich new insights into shared goals as an enabler of interprofessional collaboration and collaborative practices that may contribute to achieving positive outcomes with families. The exploration of collaboration across all sectors involved in supporting families known to child protection addressed a gap in the literature. This provided knowledge that reflects the breadth and complexity of collaboration that is required to meet the diverse needs of families across the spectrum of community services, family support and child protection. Each study contributed unique knowledge to the research objectives offering insights from the literature, professionals, and parents to build a more complete picture. The triangulation of these sources offered additional insights and added credibility to the findings. The use of qualitative research methods to understand the perspectives of professionals and parents in relation to the research questions yielded rich insights into interprofessional collaboration and partnering with parents not afforded by quantitative methods. For study three (parent interviews), the location of the researcher in the office of the family support service one a day a week during data collection facilitated deeper insight into the practice context of family support work and strengthened the candidate's interpretation of findings.

While this thesis offers useful new insights in response to the research objectives, there are several limitations of this work that should be considered. Firstly, results from this thesis highlight several collaborative practices that may contribute to positive outcomes for families, however, the relative contribution of specific collaborative practices to positive outcomes remains unknown. Second, the relatively small sample sizes of professionals and parents and contextualised nature of findings from the qualitative studies mean transferability

of the findings should be carefully considered. Furthermore, as parents were all recruited from one family support agency, the experiences of parents receiving statutory child protection responses, or family support from other services remains unknown. Third, this thesis did not focus on any specific sub-population of parents, such as Aboriginal and Torres Strait Islander, or rural parents, as such issues specific to sub populations who become known to child protection were not explored. Fourth, the exploratory nature of this thesis revealed new rich and contextualised findings in relation to the research objectives, however experimental research is now needed to test findings from this thesis in other contexts. Finally, the voices of children and young people known to child protection were not included in this thesis, leaving a critical perspective unknown.

Future research directions

- As an important element of enabling parental participation in service responses, goal setting with parents as part of child protection and family support work requires further exploration. This should include what practices are currently undertaken and how this practice may be strengthened. This research may include further interviews and/or surveys with family members and professionals involved in child protection and family support work. Additionally, documentary analysis of child protection and family support administrative data/case records may offer a useful approach to this research to enable explorations of (i) goals recorded for individuals and families; (ii) evidence of the extent of family involvement in identifying their goals; and (iii) evidence of the ways in which agencies collaborate to achieve these goals.
- As part of family-centered and child-focused practice, further research in Australia and internationally is required to better understand how children's developmental and wellbeing needs are/can be assessed and supported alongside those of their parents/caregivers.

- Given the suggested value of lead case management in facilitating interprofessional collaboration and parental participation reported in this thesis, this role needs to be better understood and its impact investigated. Specifically, key practices and underpinning knowledge and skills of this role require clarification, as well as how the role can be supported and more consistently embedded across family support services.
- There is a need to investigate how processes and systems known to be supportive of interprofessional collaboration *(i.e., shared training and development, common practice models, mutual respect and understanding, sharing information and flexible use of resources for innovation)* can be provided to better support both informal and formal collaborations in Australia and internationally.
- As part of a public health movement underpinned by early intervention and prevention, there is a need to explore how family-centred practice approaches can be strengthened across community services, family support and child protection. There is a pressing need to understand how community services can be supported to be more responsive to families presenting with risks for child maltreatment, beyond making notifications to child protection. This work may include a review of (i) mandated notification training to include an emphasis on approaches to concurrently supporting and reporting and (ii) support systems including broader training for mandated notifiers.
- Finally, an important focus for future research is to work with families, including children to identify how they can best be enabled to contribute to the evaluation and design of the very services that are designed to support them. Furthermore, the perspectives of children are missing from this thesis and require exploration as a critical perspective to advancing collaborative service delivery for children and their families.

Conclusion and knowledge translation

This thesis sought to better understand (i) shared goals as an enabler of collaboration to support families known to child protection and (ii) collaborative practices between professionals, and between professionals and parents that influence attainment of these goals. Findings from this thesis offer several key messages to inform efforts to enhance interprofessional collaboration and parental participation in the future.

Shared goals exist among services supporting families known to child protection that may facilitate collaboration across services at the overarching service level and the practitioner level in work with individual families. When establishing formal collaborations, the identification of a shared vision and purpose among collaborators is encouraged. Further, the active endorsement and communication of this vision by leadership to staff is recommended to foster buy-in into the collaboration.

Acting in the child's best interests was found to offer a shared overarching goal across services and professionals underpinned mostly by goals related to child safety, improving parental capacity and family preservation. Recognition of the interrelated nature of these goals may strengthen interprofessional approaches to supporting families. Development of shared goals at both the organisational and individual family level must include families drawing upon family-centered practice approaches. Genuine input from families into identifying their goals will require sharing of power between practitioners and families. This power sharing may be challenged by current service models and practice/service cultures. Time will need to be made available to allow genuine relationships with families to be established as a first priority in practice. Further, practitioners will need to genuinely seek and value the perspectives of family members in identifying their needs and issues and then tailor service responses accordingly. To achieve this a move from prescriptive service models and

engrained ways of working with families that pre-determine approaches to service delivery is likely required.

Shared goals identified within this thesis highlight a focus among services supporting families known to child protection on the child's context, or care environment. A proportionate focus is needed on the child's wellbeing and development. This may contribute to efforts to interrupt intergenerational patterns of child maltreatment through supporting these children to achieve better life outcomes. Efforts to achieve this increased focus on wellbeing and development should draw upon holistic frameworks of child wellbeing and the expertise of practitioners who have tertiary training in child development and wellbeing. Further, children should where possible be actively involved in identifying their own needs, strengths and goals. Identifying and responding to the wellbeing and development needs of children known to child protection will require collaboration across a range of sectors including health, education, family support and child protection and should be guided by family-centred practice principles. The identification of shared goals across these services and for individual families may support this collaboration. Further, a shared focus on the best interests of the child should underpin these efforts. Work is likely necessary, particularly among universal services, to clarify the roles of professionals from these sectors to extend their focus beyond reporting children at risk to supporting them and their families.

Lead case management appears critical to driving informal/ad-hoc interprofessional collaboration and participation of parents in these collaborations. Particularly in South Australia, findings from this thesis suggests much of the interprofessional collaboration occurring is informal and dependent upon the role of a lead case manager. Such reliance on lead case management to facilitate collaboration and parental participation needs to be recognised. As such, opportunities for this role to be better defined, supported, and evaluated across child protection and family support services should be sought. To strengthen a public

health approach, consideration of extending this role into the community service sector to support families to access support prior to contact with the child protection system is also worthy of exploration. The GIREC policy framework in Scotland including the role of the 'lead professional' may offer useful guidance for this work.

To support practitioner efforts to facilitate collaboration, systems and processes upheld as useful for supporting collaboration are currently lacking and needed. To encourage mutual respect and understanding across services, opportunities for shared training and development on common practice models should be identified, implemented and evaluated. This training should include relationship-focused practices as part of family-centered practice. Additionally, service models that support flexible use of resources and enable practitioners to tailor service responses to each family are encouraged. This includes increasing the length of time families are able to be offered support to allow genuine practitioner-parent relationships to be built and sustainable changes to be achieved.

Several shared approaches to risk that may be helpful for achieving positive outcomes with families warrant trialling and evaluation in other contexts. These include (i) collaboration between child protection and family support practitioners to engage families who were unable to be engaged by family support practitioners. This collaboration may reduce the chance of families referred to voluntary family support as part of a differential response missing out on support; (ii) child protection practitioners providing guidance to family support practitioners regarding families whose level of risk has escalated considerably despite not having an open child protection file. This may reduce the number of families returning to child protection and increase capacity of family support services to work with risk; and (iii) child protection and family support providing enhanced communication to needed community services about support in place for high-risk families. This may reassure these community services enabling them to more readily offer support to families presenting

with high levels of risk. Additional support and training for mandated notifiers working in community services regarding offering support alongside making a notification is also recommended.

To increase parental participation in service responses a shifting of perspective appears to be required. It is evident that parents want to have input into their service responses. However, it is equally apparent that parents need to be empowered to do this. A shift in practitioner culture from expecting parents to engage with services, to family-centred practices and systems that create a milieu that encourages parental participation is required. Professionals from all sectors must play their part in inviting and orienting families into a network of services that acknowledges and prioritises the critical role that practitioner-parent relationships play in achieving positive outcomes for families.

Strengths-based practice, listening without judgment, showing genuine care, avoiding overwhelming families with too many demands, and using culturally appropriate tools and services may help build practitioner-family relationships. These approaches all reflect family-centred practice principles. To better embed family-centred practices across child protection, family support and community services, accountability for its implementation in service evaluation and reporting is recommended. This may create a needed emphasis on how services are provided to families in addition to what services are provided. Attempts to implement family-centred practice will require ensuring workforce capacity as well as service and policy frameworks that support implementation. Until this system and workforce capability can be built across sectors, lead case management remains a critical mechanism for facilitating collaboration with and for families.

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Appendices

Appendix A Study 1 Statement of authorship

University of South Australia

Statement of Authorship

Title of Paper	Service delivery goals and underlying interprofessional practices: a scoping review to support interprofessional collaboration in the field of child protection.
Publication Status	☒ Published ☐ Accepted for Publication ☐ Submitted for Publication ☐ Unpublished and Unsubmitted work written in manuscript style
Publication Details Relevant reference details	Seekamp, S., Ey, L. A., Wright, S., Herbert, J., & Tsiros, M. D. (2022). Service delivery goals and underlying interprofessional practices: a scoping review to support interprofessional collaboration in the field of child protection. Children and Youth Services Review. https://doi.org/10.1016/j.childyouth.2022.106680
PRINCIPAL AUTHOR	
Name of Principal Author (Candidate)	Sarah Seekamp
Contribution to the Paper Brief description of your work in this publication	Conceptualisation, Methodology, Investigation, Writing-original draft, review and editing.
Overall Percentage (%)	60
Certification	This paper reports on original research I conducted during the period of my Higher Degree by Research candidature and is not subject to any obligations or contractual agreements with a third party that would constrain its inclusion in this thesis. I am the primary author of this paper.
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By signing the Statement of Authorship, each author certifies that: I. the candidate's stated contribution to the publication is accurate (as detailed above); II. permission is granted for the candidate in include the publication in the thesis; and III. the sum of all co-author contribution is equal to 100% less the candidate's stated contribution.	
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Appendix B Study 1 Search terms used in Medline

1	(((family support or family preservation or placement prevention or social or differential response or child* support or prevention or early intervention) adj4 (service* or agency or agencies or department* or program*)) or child welfare or child protection).tw, kf.	73369
2	(child* adj3 (maltreat* or neglect* or abus* or welfare)).tw,kf.	32198
3	child welfare/	22104
4	child abuse/	22850
5	2 or 3 or 4	58460
6	1 and 5	8252
7	((service* or organisation* or organization* or program* or agenc*) adj4 (objective* or goal* or outcome* or indicator* or mission or missions or evaluation or performance measure*)).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]	141643
8	organizational objectives/	20989
9	(multi disciplin* multidisciplin* or inter disciplin* or interdisciplin or inter agency or interagency or multi agency or multiagency or inter professional or interprofessional or collaborat* or cross agency or integrat*).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]	778292
10	7 or 8 or 9	897984
11	6 and 10	1988
12	limit 11 to English language	1949

Appendix C Study 1 Data table

Data Table					
Authors, Year, Title Methodology	**Location**	**Service/Program type(s)**	**Child focused program/service goals**	**Parent/caregiver focused program/service goals**	**Interprofessional practices described as important to achieving outcomes**
			Bolded terms reflect the program goal categories in summary tables 1 and 2.		
Arney et al. (2010) *Mental Health Is One Issue. The Child Is Another Issue. Issues Bounce Back and Clash Against Each Other': Facilitating Collaboration between Child Protection and Mental Health Services.* **Qualitative Interviews**	Australia	**Child protection service-** pilot of a mental health liaison within the child protection office for clients who presented with mental health concerns.	**Safety, Family preservation**	Mental health needs appropriately assessed and supported within the context of determining levels of risk to children of the parent. **(Mental health, risk reduction, family preservation, link with community supports)**	• Mental health nurse placed in child protection office with knowledge across child protection and mental health systems facilitated more efficient access to appropriate services. • Mental health nurse developed knowledge and understanding of mental illness and its impact on parenting among child protection staff to improve service responses for parents with mental illness.
Balestracci (2001) *Intensive family preservation services: Do they live up to their name?* **Quasi-experimental design**	USA	**Family Support-** Yale Intensive Family Program - Intensive family preservation intervention (12-16weeks) for preventing the out-of-home placement of children.	Prevent child removal and hence the trauma of separation and loss. To increase the level of safety and appropriate caregiving. Prevention of long-lasting individual disturbances in behavioural, psychological, or cognitive functioning and symptom formation. **(Family preservation, safety, wellbeing & improved parent child relationship).**	Meet parental needs (both concrete and therapeutic to enable enhanced parenting capacity. **Family preservation** through assessment of needs and tailored response **(Risk reduction, improved parenting skills, improved parent/child relationship, connections to social support and relevant community services, parental wellbeing & concrete needs).**	-

Berzin et al. (2008) *Does family group decision making affect child welfare outcomes? Findings from a randomised control study.* **Randomised controlled study**	USA	**Child protection-** Child protection service using Family Group Decision Making. A child welfare decision-making process in which efforts are made to bring together all parties with an interest in the well-being of the child and his or her family.	Enhanced **safety, permanency/family preservation and wellbeing.**	Family members have a voice in identifying their strengths and needs**. (Family preservation, risk reduction, improved family functioning, links to supports)**	-
Bosk et al. (2019) *Innovations in child welfare interventions for caregivers with substance use disorders and their children.* **Narrative program description**	USA	**SUDs-** 4 services providers that offer SUDs treatment in the context of child welfare concerns. Project Bright -dyadic attachment-based intervention for mothers and children (0-5 years) offered alongside SUD's treatment. C.A.R.E Model integrates trauma informed and parent-infant mental health treatment with SUDs support. Family-Based-Recovery (FBR) - home based dyadic treatment for caregivers and children (0-3years) Mothering from the Inside Out (MIO) 12-week mentalisation-based treatment for mothers offered alongside SUDs treatment.	Project Bright- improved social-emotional development (**wellbeing), improved emotional regulation, parent-child relationship**. C.A.R.E model- **parent-child relationship.** FBR: **family preservation, parent-child relationship**. MIO: attachment **(wellbeing), parent-child relationship.**	Project Bright- **parent-child relationship, improved parenting skills**, including reflective functioning, **enhanced mental health, SUDs support**. C.A.R.E. Model: **SUDs support,** trauma support **(mental health),** improved reflective capacity, relational skills **(improved parenting skills) improved parent-child relationship.** FBR: **SUDs support, parental mental health,** emotion regulation, attunement, reflective functioning **(improved parenting skills), parent child relationship, family preservation.** (MIO): improved maternal reflective function **(improved parenting skills),** mother child	• Communicate with collaborators to advance understanding that children can safely remain with parents with SUDs when provided appropriate clinical support.

				interactions **(Parent-child relationship), SUDs support, maternal mental health.**	
Brown (2017) *A Mindfulness-Based Intervention to Improve Family Functioning among Child Welfare-Involved Families with Substance Use.* **Mixed method & randomised clinical trial**	USA	**SUDs program-** Mindfulness-Oriented Recovery Enhancement adapted for child welfare families (MORE-CW). Assessment of presenting problems, family strength and weaknesses. Orientation to mindfulness, mindful parenting, triggers, and automatic behaviours. Individual sessions of 1 hour in the home are provided weekly.	**Enhance parent/child relationship, safety, wellbeing, and reduced challenging behaviours.**	Reduced drug use by disrupting cycles of automaticity related to drug use. **(SUDs Support)**. Enhance relationships with child, cultivate emotional awareness and self-regulation in parenting, and bring compassion to the parent-child relationship. **(parent/child relationship, improved parent capacity, risk reduction, mental wellbeing)**	-
Browne et al. (2016) *A Randomised Trial of a Wraparound Facilitation Versus Usual Child Protection Services.* **Randomised controlled trial**	Canada	**Child Protection-** Wrap around services via dedicated case management in addition to usual service. Case managers met with families to determine family strengths and needs/goals. With the facilitator's help, a personalised wraparound team is created which may have included include friends, extended family	Improved child functioning, improved development outcomes. **(Wellbeing and improved behaviour)** Child contribute ideas to family plan. Increase links to and participation in community activities. **Safety, family preservation.**	**Improved child and family functioning**, increased family resources, decreased parental stress and caregiver psychological distress **(wellbeing)**. Increase links to and participation in community activities**. (Risk reduction and link to supports, improved parenting skills, concrete needs, family preservation)**	-

		members, and both formal and informal supports.			
Burnson et al. (2021) *The impact of parents anonymous on child safety and permanency.* **Quasi-experimental design.**	USA	**Parenting Program-** Parents Anonymous- parent groups in which parents are encouraged to maintain support for one another outside of the group sessions to foster skill-building and resilience in the home environment. Parents receive a guidebook that details nurturing and parenting strategies, child development guidance, and a program outline.	**Safety,** resilience **(wellbeing), child/parent relationship.**	Reduce parent stress **(enhance the health and mental health of parents)**, **increase social support, reduce risk** of maltreatment (**reduce risk factors)**, and build resiliency in all parents. **Improve family functioning, prevent and intervene in substance use disorders and domestic violence.**	-
Byrne et al. (2012) *Influence of form and timing of social support on parental outcomes of a child-maltreatment prevention program.* **Quasi-experimental design**	Spain	**Parenting Program-** "Apoyo Personal y Familiar" program for at-risk families showing inadequate child-rearing practices. 90 min session per week for 8 months.	**(Safety, parent/child relationship)**	**Enhanced social support,** foster a sense of Personal Agency - related to parenting tasks, internal control over their lives, perception of role difficulty and couple agreement on educational matters. **(Improve parenting skills, enhance parent-child relationship)**	-
Byrne et al. (2014) *Patterns of individual change in a parenting program for child maltreatment and their relation to family and professional environments.*	Spain	**Parenting Program-** "Apoyo Personal y Familiar" program- a multi-site program aimed at increasing parental competence and autonomy among poorly educated	Offer stimulating home environment **(wellbeing)**	Self-efficacy**, parenting skills,** self-control and **wellbeing**/reduced stress, improved home environment **(family functioning).**	-

Non-controlled evaluation		parents at psychosocial risk of child maltreatment.			
Chaffin et al. (2012) *A state-wide trial of the Safecare home-based services model with parents in child protective services.* **Randomised cluster experiment**	USA	**Parenting Program-** Safe Care is a structured behavioural skills training program that focuses on concrete caregiving, household management, and parenting skills.	Reduce future incidents of child maltreatment, increase positive **parent-child interaction**; enhance **safety** at home	To improve **parenting skills** and reduce future occurrences of maltreatment. Develop skills in health care of children, ensuring a safe home and bonding -aiming to increase positive **parent/child relationships (reduced recidivism/risk reduction).**	-
Chaffin et al. (2009) *A Motivational Intervention Can Improve Retention in PCIT for Low-Motivation Child Welfare Clients.* **Randomised controlled trial**	USA	**Parenting program-** Parent Child Interaction Therapy (PCIT) with additional motivational interviewing prior to commencing the PCIT to increase engagement. Typical PCIT protocol (12-14 sessions) was delivered with the addition of a parental self-control and emotional regulation component.	**Improving behaviour, parent- child relationship**	Improving caregivers' expectations, limit-setting skills, and use of safe and effective discipline strategies for reducing non-compliant child behaviour. **(Improving parent- child relationship and growing parenting capacity).**	-
Chahine et al. (2005) *The New York City neighbourhood-based services strategy.* **Action based research**	USA	**Other-** Neighbourhood-based network to improve service coordination and collaboration among key community stakeholders and to shape a tailored multisystem strategy informed by child welfare data. Collaborators included community	Reduce OOHC, if OOHC was essential, children were placed in their own community to maintain connections established and family contact. **(Family preservation, safety),**	Enhanced access to community services **(link to community supports)** to **build their parenting capacities** and avoid the placement of their children in foster care. **(Family preservation)**	• Network governance to promote participation, collaboration, and meaningful client outcomes. • The development of a shared network mission statement tailored to the community it serves. • Establishment of network relationships in which members agree to share resources.

		residents, school personnel, community leaders, police officers, local businesses, judges, law guardians, medical personnel, department for educaiton, faith-based community leaders, substance abuse professionals, and mental health service providers.			• Shared commitments to the community and the coordination of service delivery. • Collaborative alteration of local services to meet the community's needs. • A network evaluation for the monitoring of progress and the pursuit of further improvement in service system for families.
Clark-Duff (2007) *Home-based family assessment and other factors associated with child protection outcome in high-risk families.* **Quasi-experimental design**	Australia	**Family Support-** Voluntary program involving a comprehensive assessment process over 2 weeks- Exploring child and parental needs and strengths form an ecological perspective. Following the assessment, a support plan is developed with the family.	**Safety and family preservation, enhanced child wellbeing.**	**Risk reduction, family preservation, link with support services, increased parenting skills and improved family functioning.**	-
Coates (2017) *Working with families with parental mental health and/or drug and alcohol issues where there are child protection concerns: interagency collaboration.* **Qualitative (interviews)**	Australia	**Child protection, mental health and substance use disorder** (SUD)- Collaboration to provide mental health and SUDs supports to families known to child protection.	Build resilience **(wellbeing), safety, family preservation.**	**Parenting skill building**, enhancing **mental health** and support with **SUD**, **family preservation.**	• Ensure all involved agencies and the family have a shared understanding of the issues that relate to child protection and of what needs to change. • Agency staff have a willingness to learn from each other. • Staff from each agency ensure clarity regarding roles and responsibilities. • Collaboration between agencies in determining/reviewing service models and practices.
Coates and Howe (2015) *Working with Families Who Experience Parental*	Australia	**Child protection, mental health and substance use**	Improve **child safety** and reduce the level of risk of significant harm to the	**Improve parenting capacity** and **family functioning** and **reduce the**	-

Mental Health and/or Drug and Alcohol Problems in the Context of Child Protection Concerns: Recommendations for Service Improvement **Qualitative (interviews)**		**disorder-** Keep Them Safe- Whole Family Team: a service that consists of a multidisciplinary team of mental health and drug and alcohol clinicians who provide an assertive outreach service to the whole family, comprehensive assessments, and a range of individual and family interventions for a period of up to six months.	child/ren. Build child's resilience- (**wellbeing & family preservation**)	**level of risk of** harm to the child/ren. **Address mental health and substance use needs & family preservation.**	
Cole et al. (2021) The impact of the Regional Partnership Grant program on adult recovery and well-being, and child safety, permanency, and well-being outcomes. **2 Experimental Design and 1 randomised controlled trial**	USA	**3 Family Support Programs-** to improve safety, well-being, and permanency outcomes for children at risk of or in out-of-home placements because of caregivers' substance use. **1)** IMPACT Project (Identify Measure and Prevent Addiction and Childhood Trauma) **2)** Family Treatment/Rehabilitation (FT/R) program- New York. **3)** Family Recovery Support (Oregon)	IMPACT Project (Identify Measure and Prevent Addiction and Childhood Trauma)- Improve children's functioning and developmental outcomes, particularly those related to mental health status, recovery from trauma **(wellbeing),** healthy attachment, and social development; and **safety,** wellbeing**, family preservation/permanency**, mental health, reduced challenging behaviour. Family Treatment/Rehabilitation (FT/R) program- New York-**Improve child**	IMPACT Project- Improve the connection to and retention of families in services **(link to services); reduce parents' substance use** and risk for re-referral or involvement in the child welfare system **(risk reduction). Family preservation, mental health, concrete supports.** Family Treatment/Rehabilitation (FT/R) program- New York- **Parenting skills,** reduce harsh discipline, **substance use disorder support, risk reduction, family preservation, improve family functioning.** Family Recovery Support	-

			behaviour, family preservation, safety. Family Recovery Support (Oregon)- Improving **child well-being, safety, family preservation.**	(Oregon)- **substance use disorder support, parent wellbeing, permanency/ family preservation, family functioning & risk reduction.**	
Conley (2007) *Differential response: A critical examination of a secondary prevention model.* **Narrative literature review**	USA	**Family Support-** Another Road to Safety program, involves intensive home visiting and connecting families to local formal and informal resources. Each home visitor conducts a variety of assessments to guide the development of the "Family Care Plan."	Child safety; child growth and development; school readiness; health and wellness; **(safety, wellbeing, improved parent-child relationship, family preservation).**	Co-designed goals with family- (**risk reduction & improved parenting capacity & parent/child relationship**) building family strengths; self-sufficiency; relationships; and nutrition, **connecting family with local services** (**family preservation**).	-
Conley (2008) *An assessment of differential response: Implications for social work practice in diverse communities.* **Mixed methods**	USA	**Family Support-** Another Road to Safety program. A differential response model serving families screened out of investigation. The home visitor maintains a caseload of 7-13 and sees each family for a minimum of one hour a week.	Child safety; child growth and development; school readiness; health and wellness. Overarching goals of safety, permanency, and wellbeing. (**Wellbeing, family preservation, child/parent relationship, safety)**	Enhanced parenting and relationships, self-sufficiency and family preservation. **(Family preservation, parenting capacity, parent/child relationship, links to supports, concrete resources, risk reduction, family functioning).**	-
Conley and Duerr Berrick (2010) *Community-Based Child Abuse Prevention: Outcomes Associated with a Differential*	USA	**Family Support-** Another Road to Safety program, involves intensive home visiting and connecting families to local formal and informal resources. Each	Promote **child safety** and family stability **(family preservation, parent/child relationship**) reduce the likelihood of future child welfare involvement and	Promote family stability, reduce the likelihood of future child welfare involvement. (**Risk reduction, concrete supports, parent/child relationship, family**	-

Response Program in California. **Quasi- experimental design**		home visitor conducts a variety of assessments to guide the development of the "Family Care Plan."	pursue positive child development (**wellbeing).**	**preservation, links to community supports, parenting capacity, family functioning)**	
Cowen (2001) *Effectiveness of a Parent Education Intervention for At-Risk Families.* **Program Evaluation: Secondary analysis of data**	USA	**Parenting Program-** Bavolek Nurturing Program**:** A family systems approach. Skills taught to the parents include handling feelings, communicating needs, developing empathy, taking charge of one's own behaviour, having warm interactions and fun within the family, establishing nurturing routines, gaining self-esteem, learning effective discipline, and giving and receiving healthy touch.	**Improved parent-child relationship.**	Parents will increase their knowledge of age-appropriate developmental capabilities and needs of children. Increase parent's awareness of the child's needs and appropriate methods of behaviour management. **(parent/child relationship, improved parenting capacity)**	-
Crane et al. (2019) *A statewide quality improvement (QI) initiative for better health outcomes and family stability among pregnant women with opioid use disorder (OUD) and their infants.* **Quasi-experimental**	USA	**Other-**Health and Substance Use Disorder collaboration. The model provided integrated, person-centred behavioural health and obstetrical care throughout pregnancy, childbirth, and postpartum periods. Addressed gaps in healthcare and ancillary supports (e.g., housing); and provided evidence-	Improved health at birth. (**Wellbeing, family preservation when safe and safety**)	Reduced drug use, family preservation when safe. **(Substance use disorder support, links to community services and family preservation when safe)**	• Training to support collaboration between providers and case workers from child protective services. • Make service delivery process improvements based on specific feedback from the sites such as simplifying prior authorisation for buprenorphine, clarifying existing resources, and facilitating transportation for health care or related needs or community meetings.

		based protocols for infants born with neonatal abstinence syndrome.			• With support of state and county child welfare leadership increase understanding and collaboration between child welfare, behavioural health, and obstetrical care personnel.
Cunningham and Pergamit (2015) *Housing Matters for Families: Promising Practices from Child Welfare Agencies* **Non-controlled evaluation**	USA	**Child Protection & housing-** Collaboration to assess and meet housing needs as a priority, providing stable homes for welfare known families.	Maintain family unit. (**Family preservation)**	**Increase housing resources** for families involved in the child welfare system, minimise, or prevent the separation of children from their parents **(family preservation).**	• Memorandums of understanding (MOUs) between collaborating agencies describing respective staff's roles and responsibilities. • Regular meetings between agencies • Using dashboard statistics for management and sharing data. • Dedicated staff who receive training from collaborating agencies. • Co-location of staff from collaborating agencies.
Damashek et al. (2012) *Provider Cultural Competency, Client Satisfaction, and Engagement in Home-Based Programs to Treat Child Abuse and Neglect.* **Randomised controlled trial**	USA	**Parenting program-** SafeCare Model, an evidence-based program for parents of children aged 0-5 who are at-risk of/or have been reported for child neglect or physical abuse.	**safety and improved parent/child relationship**	Parents identify symptoms of illness and injury and take appropriate action. Parents identify and secure home hazards that pose a danger to children. Build a **positive parent-child relationship** (**Building parent capacity).**	-
D'Andrade et al. (2017) *The California Linkages Program: Doorway to Housing Support for Child Welfare-Involved Parents.* **Qualitative**	**USA**	**Other-** Collaboration between domestic violence (DV), substance use disorder (SUD) service and child protection agency.	Enhance **child safety and well-being.**	Connect families with supports to meet their needs- including concrete needs (**DV support, SUD support, links to supports, concrete needs, risk reduction**).	• Establish a shared vision between agencies working together. • Pool resources and use them flexibly to meet the identified family needs. • Develop strategies and protocols to encourage collaboration between staff from child welfare and CalWORKs.

					• Ensure staff from each program are aware of the other program's role in strengthening families and meeting program goals on both sides. • Agency leadership must provide a clear vision and training for the collaboration, so staff members know why the collaboration is important and see the value in what the other agency does. • Common goals must be identified by participating agencies. • Provide practices and policies that enable the vision to be attained, including having regular interagency meetings and a data management system that identifies common clients. • Cross agency training- to support worker understanding of roles and responsibilities and the impact of collaboration.
de Melo de Melo and Alarcao (2013) *Transforming Risks into Opportunities in Child Protection Cases: A Case Study with a Multisystemic, In-Home, Strength-Based Model.* **Mixed method**	Portugal	**Family Support-** The Integrated Family Assessment and Intervention Model (IFAIM) assists the child protection system in conducting assessments of parental capacity, family functioning, and caregivers' characteristics affecting parental capacity as well as the family's social and	**Safety** and permanency **(family preservation).**	**Risk reduction, family preservation, family functioning, parenting capacity.**	-

		environmental living conditions. An intervention plan to support the family in making the necessary changes to ensure the child's protection and well-being and increase the chances of positive development.			
de Paul and Arruabarrena (2003) *Evaluation of a treatment program for abusive and high-risk families in Spain.* **Mixed methods**	Spain	**Family support-** Gipuskoa, a family focussed home based program that is usually offered across 24 months available 24/7. Services are offered in collaboration with child protection and other relevant community services. Support includes assessment, case management and treatment.	Preserve **safety,** meet basic needs of children and their families at home. Maintain the family unit **(family preservation), wellbeing** / child development, i**mprove parent/child relationship,** and support anger management **(reduce challenging behaviour).**	Reduce eliminate abusive behaviours **(Improved parenting capacity),** maintain the family unit, improve quality of social interactions **(improved parent/child relationship, family preservation),** address barriers to successful family functioning, e.g., depression and isolation **(mental health). Link to community supports and risk reduction.**	• Gipuskoa case managers wrote reports to child protection services to share progress and outcomes.
Donelan-McCall et al. (2009), *Home visiting for the prevention of child maltreatment: lessons learned during the past 20 years.*	USA	**Parenting program**. Nurse Home Visitation for Prevention of Recidivism of Child Maltreatment. Nurse home visitation every week for 6 months, then every 2 weeks for 6	**Safety**	**Links to supports,** reduced recidivism **(risk reduction), increase parent capacity.**	-

Narrative literature review		months, then monthly for 12 months. Program included intensive family support, parent education about child development, and linkage of family members with other services.			
Faller et al. (2008) *Can Early Assessment Make a Difference in Child Protection? Results from a Pilot Study.* **Quasi-experimental design**	USA	**Family Support-** The Early Assessment Project targeted child protection cases involving children aged 7 years and younger and their families, who were first-time substantiated referrals to CPS.	Children will be in less restrictive placements, enhanced safety, maintenance of family unit. **(Safety, family preservation)**	Reduced subsequent referrals to child protection and fewer terminations of parental rights. **(Family preservation, risk reduction, links to community supports)**	• Multi-disciplinary teams have defined and coordinated roles outlined to ensure all professionals have input in the assessments for all family members. • The multi-d assessment provides an in-depth understanding of the family's strengths and needs and contributes to the child protection worker's recommendations.
Fettes et al. (2020) *Implementation of a trauma-informed, evidence-informed intervention for Latinx families experiencing interpersonal violence and child maltreatment: protocol for a pilot randomised control trial of SafeCare+[R].* **Protocol for a feasibility study and RCT**	USA	**Parenting Program-** SafeCare: a revised version of SafeCare that has a focus on families who have co-occurring domestic violence and child welfare issues. Safecare targets improvement in skills related to home safety, health, and parent-child interaction. This study presents an enhanced version of the SC program, which includes the healthy relationships (HR) curriculum, specifically	Improved home safety. **(Safety, parent-child relationship, and family preservation)**	To help parents recognise abusive patterns, develop healthier relationships **(improve parent-child relationship),** and improve communication skills with a range of adults, including intimate partners, family members, friends, and with their children. Enhanced sense of self and **reduced domestic violence. (Improved parenting skills, risk reduction, family preservation)**	-

		designed for early intervention with family violence.			
Finello et al. (2016) *Home Visiting Programs: What the Primary Care Clinician Should Know.* **Narrative literature review**	USA	**Parenting Program** SafeCare - Safecare targets improvement in skills related to home safety, health, and parent-child interaction.	Prevent child maltreatment **(safety**) and improve health, development, and welfare of children **(wellbeing)**, and **parent–child interactions.**	**Improved parent-child interactions (relationship) and parenting skills.**	-
Fowler and Chavira (2014) *Family Unification Program: Housing Services for Homeless Child Welfare-Involved Families.* **Randomised controlled trial**	USA	**Child protection and housing -** Family Unification Program (FUP), A collaboration between state housing & child welfare to reduce the likelihood of child removal due to poor / inadequate housing.	**Family preservation**	Prevent or mitigate family separation **(family preservation)** solely because of living circumstances and conditions of poverty. Support with required material items **(housing & concrete supports).**	• Formalised partnerships through memorandums of understandings between local public housing authorities and public child welfare agencies. These agreements specify how child welfare agencies will identify eligible families and certify a housing need that threatens parent – child separation.
Freisthler et al. (2021) *Enhancing Permanency in Children and Families (EPIC): a child welfare intervention for parental substance abuse.* **Quasi-experimental**	USA	**Other-** (collab between, university, courts, employment, child protection & health). The Enhancing Permanency in Children and Families (EPIC) program. Child welfare-involved adults who screen positive for substances are matched with a peer recovery supporter. Participants are also incentivised to participate in family treatment drug court, medications for opioid use	Increase resilience and attachment, **improved parent-child relationship** & reduced trauma symptoms in children (**wellbeing).** Reduced length of placement in out of-home care **(family preservation)** and recidivism **(safety)** into the child welfare system.	Reduce abusive and neglectful parenting (**improve parenting**), reduce addiction severity in parents (**sobriety/ substance used disorder support**), and improve permanency outcomes **(family preservation)**	• Procedures to coordinate services between the child welfare system, substance abuse and behavioural health providers, and juvenile/family court in a specified single memorandum of understanding. • All partner agencies agreed to use a shared referral and information management system as the organising body for communication around each case. • Prior to implementation, partner agencies received cross-system training such that workers from each agency became more knowledgeable of key

		disorders and home-based parenting supports are provided.			approaches and systems within each collaborating agency. • Representatives from each system are members of a Steering Committee that meets regularly to resolve any implementation related problems and address barriers.
Gallitto et al. (2020) *Investigating the Impact of the SafeCare Program on Parenting Behaviours in Child Welfare-Involved Families.* **Non-controlled evaluation**	Canada	**Parenting Program-** SafeCare is an evidence-based parenting program designed to reduce the risk of child neglect and prevent its future occurrence. The program is divided into three modules that address household safety, child health, and parent–child interactions.	**Parent/child relationship, family preservation, safety.**	**Parent/child relationship,** provide safe home **(parenting skills),** provide appropriate health care, and reduce child maltreatment. **(Family preservation & risk reduction)**	-
Hammond and McGlone (2013) *Residential family treatment for parents with substance use disorders who are involved with child welfare: two perspectives on program design, collaboration, and sustainability.* **Non-controlled evaluation**	USA	**Child Protection and Substance use disorders-** 2 Programs, both are family-centred services for adults with substance use disorders (SUD) who are involved with child welfare. Wayside's Women's Treatment Centre is a gender-specific residential program for up to 40 women. The program is composed of 90 days in the residential facility, followed by 12 weeks of less intensive treatment and	On Track - **Parent/child relationship, wellbeing family preservation.** Wayside- **Safety, permanency/family preservation and wellbeing, parent/child relationship**	On Track-**reduced substance use/dependence, mental health and wellbeing, family preservation, parent/child relationship,** and self-sufficiency/family sufficiency **(enhanced family functioning). Link to supports.** Wayside- **permanency/ family preservation, substance SUD support, parent/child relationship, link to support services.**	• OnTrack treatment staff accompanied child welfare workers on initial investigations involving drug use allegations and when appropriate, services were offered to parents at that moment. • OnTrack and child protection services developed a shared service plan for each family to coordinate care. • Collaborative visits, supervision and case planning was undertaken by child protection and On Track workers to ensure child safety and caregiver compliance with plans. • Wayside child protection case workers worked closely with Wayside staff to ensure the child's needs were met.

		recovery maintenance. Wayside's Supportive Housing Program provides families in recovery with safe and affordable housing.			• Wayside and child protection case workers communicated regularly to support informed decision making. For example: When the Wayside team felt that the client was ready to spend time with her children, the visits were conducted, under supervision.
Hanson et al. (2015) *Family-Based Recovery: An Innovative In-Home Substance Abuse Treatment Model for Families with Young Children.* **Mixed Methods**	USA	**Child Protection and Substance Use Disorder Support Service collaboration-** Family-Based Recovery (FBR), is an intensive, long-term clinical treatment program that provides substance abuse treatment, individual psychotherapy, parent-child relational support and developmental guidance, and comprehensive case management in the home and community.	A key goal of FBR is to prevent adverse experiences that can affect attachment, emotion regulation, learning capacity, and development. The placement of the child at the time of discharge is a primary child-related outcome measure. **(Family preservation & safety, wellbeing, and parent-child relationship)**	Sobriety, enhancement of the parent-child relationship and reduced parental stress and depression. **(parent/child relationship, mental health support, parent wellbeing, parenting capacity, substance use disorder support, connection to supports, family preservation)**	• Intensive service delivery and close collaboration between FBR and child protection staff allows children to remain in the home while parents receive treatment. • Risks are recognised and shared by both agencies: exposure of children to substances raises concerns for both child protection and FBR treatment providers. • Information is shared between agencies related to risk factors and this has facilitated the establishment of trust among program partners. • FBR, the child protection agency, and parents jointly develop safety plans. • The client and FBR staff inform the child protection authority when a substance use relapse occurs or child safety issues arise, while confidentiality is maintained regarding other aspects of the client's life.
Harder (2005) *Prevention of Child Abuse and Neglect: An Evaluation of a Home Visitation Parent Aide*	USA	**Family Support-** Parent Aide Program: Case management, regular home visits, counselling, and linkage with relevant	**Safety, family preservation**	**Link with community resources** such as housing, childcare, education, health care, employment,	-

Program Using Recidivism Data **Mixed Methods**		services for families referred by CP.		and legal assistance. Replace patterns of abusive behaviour with effective skills for nonviolent parenting Improve parenting skills, problem-solving skills, life skills, and social support. **(Risk reduction, family preservation, build parenting skills)**	
Harnett and Day (2008) *Developing pathways to assist parents to exit the child protection system in Australia.* **Narrative program description**	Australia	**Child Protection-** Family Partnership Model: Based on a relationship-based approach. Involves the following stages in partnership with the family- exploration, understanding, goal setting, strategy planning, implementation, review and ending.	**(Family preservation and safety)**	Enhanced sense of self efficacy as it relates to parenting. **(Risk reduction, enhanced parenting, family preservation, links to support services)**	-
Harnett and Dawe (2008) *Reducing Child Abuse Potential in Families Identified by Social Services: Implications for Assessment and Treatment.* **Quasi-experimental design**	USA	**Parenting Program-** Parents under Pressure Program, PUP: home-based intensive treatment program was designed for multi-problem families referred from CP and addresses needs including- problem child behaviour, parental stress, family relationships, social isolation, and coping with life demands.	**Reduce challenging behaviour, parent/child relationship**	Provide parents with skills to regulate their emotional state, deal more effectively with competing demands, and **engage social support**. **(Parenting capacity, parental mental wellbeing, parent child relationship)**	-

Hubel et al. (2018) *Service needs of adolescent parents in child welfare: Is an evidence-based, structured, in-home behavioural parent training protocol effective?* **Cluster randomised design**	USA	**Parenting Program-** Safe Care: a manualised, structured behavioural parent training intervention that focuses on parent's knowledge of child health, parenting practices and home safety.	**Safety, family preservation, parent-child relationship**	Prevention of recidivism and reduction in risk factors associated with child maltreatment. **(Improved parental capacity, parent child relationship, family preservation)**	-
Huebner et al. (2015) *Sobriety Treatment and Recovery Teams: Implementation Fidelity and Related Outcomes.* **Mixed Methods**	USA	**Child Protection and Substance Use Disorder Service-**The START program is an integrated treatment program for families with co-occurring child abuse and/or neglect and parental substance use disorder that requires collaborative service delivery.	Family unity where possible and **safety (family preservation)**	**Sobriety / reduce substance use. improve parental capacity** to care for children and to engage in essential life tasks. Reduce risks for child maltreatment **(risk reduction)** and re-entry into out-of-home care, **family preservation.**	• Intense collaboration between child welfare and substance use disorder treatment providers, including establishing shared values, common goals, common case plans, and joint responsibility for both parent and child outcomes. • Integrated treatment planning begins during the initial family team meeting where the treatment coordinator participates and begins the substance use disorder assessment. The SUDS treatment providers, child welfare team, and the family explore family strengths and identify needed resources. • The substance use treatment coordinator and providers contribute to decisions about child placement and reunification and share in accountability for child safety and parental capacity. • Child welfare START staff contribute to decisions about substance use

					treatment level of care and share responsibility for engaging and retaining parents in treatment. This shared process is intended to build common case expectations and foster ongoing collaboration
Huebner et al. (2012) *The Impact of Sobriety Treatment and Recovery Teams (START) on Family Outcomes.* **Prospective naturalistic evaluation**	USA	**Child Protection and Substance Use Disorder Service-** START Program with child protection: Parents (mothers and fathers) are provided a range of services to assist them in achieving sobriety, health, and self-sufficiency.	**Safety and permanency (family preservation)**	Reduce family risks for child maltreatment, achieve parental sobriety, avoid child placement in state custody, and reduce service costs. **(Risk reduction, substance use disorder support, family preservation, links to support services, concrete supports, mental health support, DV support, and improved parenting capacity)**	• Each START team includes a specially trained child protection social service worker paired with a family mentor. • To foster integrative service delivery between child protection services and substance use disorder treatment providers, START uses mutually agreed upon tenets; contract expectations; cross-training and joint-training; intensive, monthly, direct-line meetings to deal with issues; and frequent communication about family needs and progress.
Huebner et al. (2017) *Serving families with child maltreatment and substance use disorders: A decade of learning.* **Quasi-experimental design**	USA	**SUDs and child protection-** START is a child-welfare led program designed to provide quick access to intensive substance use disorder treatment that aims to capitalise on the potential readiness to change generated by a child protection report and recognising the urgent needs to keep children safe.	**Safety, family preservation**	**Sobriety: enhanced parenting skills** family unification maintained **(family preservations)**	• Shared data collection systems; regular interprofessional / agency meetings; committed leadership.

Humphreys et al. (2018) *Children Living with Domestic Violence: A Differential Response through Multi-agency Collaboration.* ***Case study and action-based research***	Australia	**Other-** collaboration between child protection, Family Services, the Aboriginal Children's Organisation, and the separate specialist Domestic family violence services for women and men. The organisations collaborate to develop a "rapid" triage based on information from the different organisations' databases and the police referral to assess the risk and determine the appropriate service pathway for engagement with the survivors, children, and perpetrators of family violence.	Reduced child abuse/neglect reports - enhanced child **safety,** and **family preservation.**	**Risk reduction, link with community services, domestic violence support (victim and perpetrator), family preservation.**	• Commitment from managers and workers to develop innovative and better solutions to the service system intervention for domestic and family violence. • Resources were made available by agencies and there was stability in leadership. • Relationships between the partner organisations were built over time at both the practice level and management levels. • A shared vision supported by management in the partner organisations was developed and communicated to staff. • A shared approach to risk assessment was developed. • Information sharing was open and transparent across agencies and was used to problem solve barriers to collaboration and maintain commitment. • Formal structures were put in place for the governance and operation of the triage model to support the development of effective relationships and systems.
Ingram et al. (2015) *Development of an evidence-informed in-home family services model for families and children at risk of abuse and neglect.*	USA	**Family Support-** The Boys Town Family Home Program- The current in-home family services model emphasises (i) a continuous family engagement process; (ii)	**Reduction of child behaviour problems**. Child remains safe from abuse and at home; child remains in school, **(safety, family preservation,**	Develop parenting and life skills and strengthen social support **(build parent capacity, link with support services and social networks).** Child and family risk factors reduced	-

Non-controlled evaluation		practice-based teaching of parenting and other life skills that promote positive parenting and self-sufficiency; and (iii) connecting the family with prosocial support networks (e.g., schools, relatives, and friends) and needed resources to help the family achieve their goals and maintain progress after the services have ended.	**wellbeing, and parent/child relationship).**	**(Risk reduction).** Improved family relationships **(parent/child relationship).** Family remains intact **(family preservation). Substance abuse and/or mental health problems addressed.**	
Ius (2021) *P.I.P.P.I.: The Program of Intervention for the Prevention of Institutionalization: Integrating Intervention, Training, Research, and Policy to Support Families and Professionals.* **Narrative program description**	Italy	**Family Support-** Program of Intervention for Prevention of Institutionalisation (P.I.P.P.I.). Family members and the interdisciplinary team of professionals (social worker, professional home carer, psychologist, teacher, and other social or health professionals) to co-assess the situation, co-plan the intervention, and co-evaluate it.	**Parent/child relationship,** developmental support, education support **(wellbeing), safety, family preservation.**	**Parent/child relationship, parenting capacity, concrete, and social support (links to services), risk reduction, family preservation.**	-
Jouriles et al. (2010) *Improving Parenting in Families Referred for Child Maltreatment.* **Non controlled evaluation.**	USA	**Parenting Program-** The Project Support intervention includes two primary components: (1) teaching mothers child management skills and (2) providing instrumental and	Improve **parent /child relationship, reduce difficult behaviours** & increase positive behaviours.	**Improve parenting capacity** and positive parenting skills- mothers to communicate more effectively with their children and facilitate a more positive and warm	-

		emotional support to mothers.		relationship with their children **(Improve parent/child relationship).**	
Karatekin et al. (2014) *An evaluation of the effects of an integrated services program for multi-service use families on child welfare and educational outcomes of children.* **Quasi-experimental design**	USA	**Family Support-** Partnership for Family Success: Case managers develop a care plan with the parent that is reviewed 6 monthly. Families are supported to access community resources. The case manager visits the families in their homes or other community settings. Includes parent support groups that provide parenting skills and education.	Reducing risk of future maltreatment, reduced school mobility, increase attendance and academic outcomes **(safety, family preservation, parent/child relationship, wellbeing).**	Increase the families' self-sufficiency **(risk reduction, link to supports, concrete supports, family preservations, parent /child relationship, mental wellbeing, parenting capacity).**	• The program has formal and informal agreements with community providers. • For families involved with child protection, child protection has its own case plan that is supported by the Partnering for Family Success (PFS) case manager and incorporated into the PFS case plan.
Lacharite (2014) *Transforming a wild world: Helping children and families to address neglect in the province of Quebec, Canada.* **Narrative program description**	Canada	**Family Support-** An eco-systemic and developmentally based program. Collaborative assessment of the child and family needs and planning of a response. Program includes individualised professional support for the family, direct work with children, parenting groups, individual work with parents related to their personal needs, coaching by lay home visitors from the family's local	Enhanced function in all developmental domains and aspects of life for the child, ensuring the child has good health and **wellbeing. (Safety and family preservation)**	Improved living conditions and access to resources to support family - formal and informal (**links to support**). Sensitive and responsive caregiving, **parenting skills**, enhanced sense of self efficacy **(family preservation).**	• Participation by professionals in an intersectoral partnership, including activities such as training, supervision, time shared and transport to allow a shared responsibility for the child and contributions to be made to optimise the child' development and wellbeing. • Cross agency referrals are viewed as an 'invitation' to these professionals to work with the lead professional and the family. The integrated services rest on this invitational approach of interagency partnerships. • In each territory, a local committee has the function of coordinating the implementation of the programme and

		community and collective family activities.			the interagency partnerships around families. This committee is composed of workers and managers directly involved with the target families.
Lange et al. (2011) *Building a solid partnership: The journey so far', Developing Practice.* **Narrative program description**	Australia	**Child protection and family support-** Child protection and a range of non-government family support agencies- Collaboration to address child abuse and neglect risk factors and preserve family unity.	**Family preservation & safety**	Overarching aim- tackling the conditions and circumstances that put at risk the safety and wellbeing of children and their families. **(risk reduction, family preservation, improve family functioning)**	• Leadership commitment / sponsorship of the collaboration. • Co-designed - agreed practice guidelines for each agency leading to role clarity regarding the collaboration. • Shared understanding and valuing of the work to be undertaken across agencies. • Regular interagency communication to build and maintain relationships. • Quick resolution of cross agency issues through open and respectful communication.
Lawrence et al. (2011) *Multiple Response System: Evaluation of Policy Change in North Carolina's Child Welfare System.* **Mixed methods**	USA	**Family Support-** Differential response system, known as the Multiple Response System (MRS). The program aims to respond not only to the child protection notification, but to understand and address the broader spectrum of needs that might have undermined the caregivers' ability to parent effectively.	**Maintain child safety** and permanency, **(family preservation).**	Address child welfare concerns and prevent future harm to children. **Risk reduction, enhanced parenting capacity, family preservation, links to community services.**	• Collaboration between Temporary Assistance to Needy Families (TANF) program and child welfare included the coordination of joint home visits and case plans, improved communication and information sharing, and inclusion of TANF personnel in meetings as appropriate. This strategy was included to ensure that goals and case plans developed within these two agencies would complement rather than contradict one another.
Leclair Mallette et al. (2021) *Is the Incredible Years parenting programme predictive of case closure*	Canada	**Parenting Program -** Incredible years- group-based programme, delivered in 12 to 20	**Improved parent-child relationship, (improved behaviour & wellbeing).**	Improve the **parent–child relationship**, to increase parents' use of consistent disciplinary; strategies and to improve problem-solving	-

in child protection services for neglect? A quasi-experimental study. **Quasi-experimental study**		weekly sessions by child protection staff.		skills within the family, **(improve parenting capacity and links with supports).**	
Letarte et al. (2010) *Effectiveness of a parent training program "Incredible Years" in a child protection service.* **Non-controlled experimental design**	Canada	**Parenting Program-** The Incredible Years is a manualised program that targets groups of parents over a period of 16 weeks with 2-hour weekly meetings. The topics included: playing with your child, using praise and reward, behaviour management, problem solving, and supporting the child's education.	**Parent child relationship, improved behaviour,** education **(wellbeing)**.	Develop a harmonious **parent–child relationship;** Parents learn and consistently apply effective practices; improve problem solving and communication skills within families and with teachers **(enhanced parent capacity, link with schools/ community supports)**	-
Lonne et al. (2015) *Victoria's Child FIRST and IFS differential response system: Progress and issues.* **Non-controlled program evaluation**	Australia	**Family Support-** Differential response system, with a focus on the Child FIRST and Intensive Family Support (IFS) programme. This program entails a partnership arrangement between child protection services and community-based, not-for-profit agencies to provide a diverse range of early intervention and prevention services.	Improved health and **wellbeing** outcomes. **Family preservation and safety**.	Improved access to early intervention IFS services **(connection to services) Improve family functioning** and avoid statutory involvement **(Family preservation, risk reduction).**	• Clear risk threshold co-developed to delineate where child protection (CP) involvement is required and where Intensive Family Support (IFS) is appropriate. • Liaison workers were identified to communicate between IFS and CP when families risk is approaching CP thresholds. • Top-down implementation support was provided with funded implementation and evaluation. • Clearly documented roles, responsibilities and communication pathways were established.

Maher et al. (2011) *Dosage matters: The relationship between participation in the Nurturing Parenting Program for infants, toddlers, and pre-schoolers and subsequent child maltreatment.* **Quasi- experimental design**	USA	**Parenting Program-** Nurturing Parenting Program for Infants: teaching parents emotional communication and positive parent-child interaction skills, teaching about discipline consistency and time out, and providing parents with the opportunity to practice new skills with children during the training sessions.	**Wellbeing, safety, family preservation, improved parent-child relationship.**	Parents able to demonstrate use of non-violent disciplinary strategies and gains in nurturing parenting beliefs; Gains in the self-worth of parents and parental empathy and meeting their own adult needs in healthy ways. Family unity and reduced rates of abuse and neglect. **(Wellbeing, parenting capacity, child-parent relationship, family preservation)**	-
Marcynyszyn et al. (2011) *Getting with the (evidence-based) program: An evaluation of the Incredible Years Parenting Training Program in child welfare.* **Mixed methods**	USA	**Parenting Program-** Incredible Years- Its curriculum is focused on enhancement of parenting skills, knowledge of child development, positive child behaviour, and parent–child relationships. The program is generally delivered by two group leaders in groups of 10 to 14 parents/caregivers for 2 hours each week over a period of 12 to 14 weeks for lower risk populations.	Enhanced social, emotional, and academic competence and prevention of conduct problems **(reduced challenging behaviours).** Promotion of child social competence, emotional regulation, positive attributions, academic readiness, and problem solving. **(Wellbeing, parent/child relationship)**	Parents develop skills to promote social, emotional, and academic competence of their children. Improved parent-child interactions, building **positive parent-child relationships**, **improved parental functioning (capacity**), less harsh and more nurturing parenting, and increased **parental social support** and problem solving.	-
Marshall et al. (2010) *Comparing differential responses within child*	Canada	**Child Protection-** The family development response (FDR), a differential response model	**Safety, family preservation.**	**Family preservation, risk reduction, links to supports.**	-

protective services: a longitudinal examination. **Quasi-experimental design**		for reports in which an investigation is not required. FDR is a collaborative, solution-focused approach that is tailored to the specific family situation and developmental needs of the child.			
Marts et al. (2008) *Point of engagement (POE): Reducing disproportionality and improving child and family outcomes* **Mixed methods evaluation study**	USA	**Family Support-** Point of engagement (POE) utilises a multidisciplinary team decision making approach that includes the family in the process of selecting and planning for the delivery of needed services. POE actively seeks to engage a range of community-based agencies to meet the family's needs.	Ensuring **safety,** permanency, **well-being** & **family preservation**	**(Risk reduction, connection to services, family preservation)**	-
Millett et al. (2016) *Understanding change among multi-problem families: Learnings from a formative program assessment.* **Mixed Method**	USA	**Family Support-** Pathbuilders is a voluntary, long-term (up to 24 months) intervention combining evidence-based parenting programming, mental health treatment, family coaching, and case management.	**Safety,** metal health, development & education support **(wellbeing).**	**Risk reduction, concrete supports, mental health support, increased parenting skills, links to services.**	-

Millett (2019) *child maltreatment prevention program in child protective services.* **Quasi-experimental design**	USA	**Family support service (FSS) and Child Protection-** FSS operating from within CPS for families screened out. The voluntary program provides families with needed supports to promote safety and well-being of children and families. Caregivers are given supports to increase their parental capacity to meet their children's and family's future needs, remove barriers hindering family functioning and gain access to community based resources.	**Safety family preservation & wellbeing.**	Meet the current, specific needs of the family. **(Risk reduction)** **Increase parental capacity and family functioning** and **gain access to community-based resources**. Support to **meet concrete needs and parental mental health needs, family preservation).**	-
O'Connor et al. (2005) *Nothing about me without me": Leading the way to collaborative relationships with families.* **Narrative program description**	USA	**Other-** Centre on Addiction and Substance Abuse's CASA Safe Haven is an evidence-based, community-driven intervention program in which child welfare agencies; courts and attorneys; staff from substance abuse treatment, mental health, employment, welfare, domestic violence, or other service agencies; and families themselves collaborate to improve outcomes for families	Permanence is the number one priority after child **safety.** If restoring the birth family unit is not possible, caseworkers must make an alternative permanency plan **(Family preservation/permanency, parent/child relationship)**	Goals for the family in five specific areas: substance abuse goals; employment, vocational, or income goals that acknowledge TANF mandates and regulations for parents on welfare; family goals; psychological goals; and medical goals. **(Parenting capacity, links to supports, sobriety, parent /child relationship, risk reduction, family functioning and family preservation)**	• Leadership provides encouragement and support to staff in making decisions, exercising judgment, and working in multidisciplinary teams. • CASA Safe Haven introduces a process facilitator (PF) to guide and direct the process of collaborating systems and agencies. As a neutral facilitator, a PF brings together the service providers working with a family for family group conferences. • In CASA Safe Haven, CASA works with front-line and senior staff to create collaborative relationships that foster new capacities at the family, agency, community, and system levels by building agency capacity and creating

		involved with child welfare and substance abuse.			family-centred policies that allow agencies and families to succeed. • To equip staff with skills and knowledge to strengthen their performance and improve their ability to collaborate with each other, Safe Haven and staff from partner agencies participate in professional development workshops and seminars. • Integrated learning experiences are provided in which staff learn new skills by sharing perceptions, insights, and solutions with colleagues from other systems. Some of the professional development experiences take place during planning and implementation meetings attended by representatives of child welfare and community agencies. These planning meetings both resolve specific programmatic or procedural problems and foster interagency communication about larger systems issues.
Olsen et al. (2015) *Supports for Families Affected by Substance Abuse.* **Quasi-experimental design**	USA	**Substance use disorder service and child protection-** Project Connect offers a comprehensive home visiting program that addresses the needs of child welfare involved, substance affected families. In addition to in-home visits, the program provides	Enhance safety and permanency and strengthen family relationships. Enhance child wellbeing. **(Safety, family preservation, child/parent relationships, wellbeing).**	Build parental resources to help achieve abstinence, support recovery, enhance parental capacity, strengthen family relationships and functioning, and family preservation **(family functioning, substance use disorder support, family preservation, child/parent relationship, link to**	• Project Connect staff are co-located in the state's regional child welfare offices to facilitate relationship building, referrals, and case coordination.

		home-based parent education and parenting groups, using the Nurturing Program for Families in Substance Abuse Treatment and Recovery model.		**community supports, risk reduction, concrete resources, mental health, and domestic violence support).**	
Osofsky et al. (2007) *The development and evaluation of the intervention model for the Florida Infant Mental Health Pilot Program.* **Non-controlled evaluation**	USA	**Parenting Program-** Child-Parent Psychotherapy CPP, which engages both child and parent working together. CPP included relationship-based assessments, child-parent relationship-based psychotherapy, parental psychoeducation, and guidance, and enhanced case management.	Reduce the occurrence and reoccurrence of abuse and neglect **(safety)**, enhance the child's developmental functioning **(wellbeing)**, and increase expeditious permanent placements. **(Parent-child relationship, family preservation)**	Improve responsive parenting. (**Improved parenting capacity, parent/child relationship, mental health, family preservation**)	-
Oxford et al. (2018) *Ensuring Implementation Fidelity of a 10-Week Home Visiting Program in Two Randomised Clinical Trials.* **Randomised Controlled trial**	USA	**Parenting Program-** Promoting First Relationships® (PFR), a 10-week home visiting parenting intervention. Each session includes: rapport building, specific PFR consultation strategies, video reflective feedback, parent–child activities, and informational handouts.	Enhanced **parent/child relationship.**	To help parents become more emotionally available to their children and increase their understanding of their children's social and emotional needs**. (Increase parenting skills and parent-child relationship)**	-
Pasalich et al. (2018) *Does Parents' Own History of Child Abuse Moderate the Effectiveness of the*	USA	**Parenting Program-** Promoting First Relationships Program, a 10-week home visiting	Enhancing toddlers secure base behaviours **(wellbeing, parent-child relationship)**	Enhanced parental sensitivity towards toddler **(parenting skills, parent child relationship)**	-

Promoting First Relationships® Intervention in Child Welfare? **Randomised controlled trial**		parenting intervention. Each session includes: rapport building, specific PFR consultation strategies, video reflective feedback, parent–child activities, informational handouts, and "Thoughts for the Week".			
Peckover and Everson (2014) *Putting Men's Abuse of Women on the Childcare Agenda: An Innovative Specialist Domestic Abuse Project.* **Mixed methods**	England	**Domestic Violence-** The MAZE project supports women and families affected by domestic abuse; with a focus on the abuser's behaviour as the main issue - undertaking direct 1:1 work with children, women, and men	Not stated	Men taking ownership of their violent behaviour. Increase mothers' awareness of the impact of the DV on self and children. **DV support men and women (victim and perp)**	• Shared meetings between MAZE staff and child protection. • Sharing expert knowledge of domestic violence. Leading to clarity about the risks domestic violence poses for children and women and the changes required to reduce risks and enhance safety. • Collaboration on the development and implementation of child protection plans.
Pennell and Burford (2000) *Family group decision making: Protecting children and women.* **Quasi-experimental design**	USA	**Child Protection-** Family group decision making brings together the family in which the abuse or neglect took place with their relatives, friends, and other significant supports to develop a plan to stop the maltreatment. The plan must be approved by the referring authority, which then bears responsibility for its adequate resourcing.	**Safety** of child from domestic violence; family unity **(family preservation)**	**Safety for mother and child from domestic violence.** Family unity if safe **(family preservation, risk reduction, link with supports)**	• Safety serves as a goal for both child welfare and domestic violence program.
Rivera and Sullivan (2015)	USA	**Substance use disorder (SUDs) service and child protection –** SUDs	Avoiding out of home care **(family preservation)** and child abuse & neglect	**Sobriety; enhanced parenting skills;** family unification maintained	-

Rethinking Child Welfare to Keep Families Safe and Together: Effective Housing-Based Supports to Reduce Child Trauma, Maltreatment Recidivism, and Re-Entry to Foster Care. **Quasi-experimental design**		treatment, child welfare & crisis nursey relief collaborate to offer intensive support to the family with constant supervision by case managers. Often includes provision of emergency housing, SUDs treatment and parenting education/support.	**(safety),** child development/ wellbeing **(wellbeing & Improved child/parent relationship).**	**(family preservation);** stable **housing;** reduced repeat abuse/neglect **(risk reduction), improved parent/child relationship.**	
Rodrigo et al. (2006) *Outcome evaluation of a community centre-based program for mothers at high psychosocial risk.* **Quasi-experimental design**	Spain	**Parenting Program-** **"**Apoyo Personal Familiar" (APF) program for mothers referred by child protection. Weekly sessions over 8 months with links to other local supports as required. The program has 5 modules focussing on topics including: family routines, managing children's behaviour, family context needs, parenting under pressure and problem solving.	**Improved parent-child relationship.**	Increase knowledge of child development and education; improve parenting practices; foster personal agency by increasing a sense of self-efficacy, internal control, marital agreement, and accurate role perception **(link to supports, improved parenting skills, parent-child relationship).**	-
Rogers-Brown et al. (2020) *Behaviour change across implementations of the SafeCare model in real world settings.* **Non-controlled evaluation**	USA and Canada	**Parenting program**- Safe care: an 18-session behavioural parenting program that teaches skills in positive parent-child interactions, home safety, and child health.	Improved **safety and parent - child interactions/relationship.**	**Improved parenting a**nd **parent/child interactions** - e.g., responsiveness, tuning into child, warmth.	-

Rostad et al. (2017) *The influence of concrete support on child welfare program engagement, progress, and recurrence.* **Non-controlled evaluation**	USA	**Family support-** Case management and provision of concrete support and home visiting support from a case manager.	**Safety, family preservation**	**(Reduced risk)** of abuse and /or neglect. **(Wellbeing), concrete supports and family preservation.**	-
Saldana (2015) *An Integrated Intervention to Address the Comorbid Needs of Families Referred to Child Welfare for Substance Use Disorders and Child Neglect: FAIR Pilot Outcomes.* **Pilot randomised controlled trial**	USA	**Substance use disorder service-** The Families Actively Improving Relationships Program: is an intensive community-based treatment model. Treatment lasts approximately 8 months, with an initial intense level of contact that is titrated down over time.	**Improved behaviour, (child/parent relationship)**	Enhanced positive parenting settings, non-harsh limits and following through. Development of problem solving and stress management skills. Sobriety **(Build parenting capacity, Sobriety, child /parent relationship)**	-
Schaeffer et al. (2013) *Comprehensive treatment for co-occurring child maltreatment and parental substance abuse: Outcomes from a 24-month pilot study of the MST-Building Stronger Families program.* **Quasi-experimental design**	USA	**Substance use disorder and child protection-** Multisystemic Therapy-Building Stronger Families (MST-BSF), an integrated treatment model for the co-occurring problem of parental substance abuse and child maltreatment among families involved in the child welfare system.	**Safety, permanency (family preservation & parent-child relationship) and wellbeing.**	**Sobriety, enhanced mental health and wellbeing, improved parenting capacity and parent-child relationship.** Family unity **(Family preservation, risk reduction).**	• Child protection caseworkers are trained in MST-CAN and attend key treatment sessions with families. • Child protection caseworkers regularly attend MST-CAN team consultation meetings to coordinate care and ensure that protective service decision making is based on clinical needs and progress. • Administratively, considerable attention is given to forging positive relationships among family members and child protective service (CPS) staff.
Sicotte et al. (2018) *Moderating Role of the Form of Maltreatment Experienced by Children*	Canada	**Parenting Program-** The Incredible Years: program consists of 16 weekly 2-hr sessions and topics such as	**Reduced challenging behaviour, improve parent-child relationship, safety.**	Improve the **parent–child relationship**, increase parents' use of effective, consistent disciplinary	-

on the Effectiveness of a Parent Training Program. **Quasi-experimental design**		playing with one's children, providing them with positive reinforcement, setting clear limits, managing difficult behaviour, and communicating are addressed.		strategies, and improve parents' problem-solving skills **(improve parenting skills).**	
Simon (2020) *An Examination of Needs, Matched Services, and Child Protective Services Re-Report Among Families with Complex Needs* **Non-controlled evaluation**	USA	**Family Support-** services aimed to strengthen families by targeting five protective factors to prevent child maltreatment: parental resilience, social connections, knowledge of parenting and child development, concrete support in times of need, and children's social and emotional competence.	Children's social and emotional competence **(wellbeing), family preservation, safety**	Parental resilience **(wellbeing), social connections,** knowledge of parenting and child development **(parenting capacity)**, **concrete support** in times of need. **Family preservation, risk reduction. Mental health, domestic violence support and substance use disorder support/sobriety.**	-
Stover et al. (2020) *Evaluation of a Statewide Implementation of Fathers for Change: A Fathering Intervention for Families Impacted by Partner Violence.* **Non-controlled evaluation**	USA	**Parenting Program-** Fathers for change has a dual focus on interpersonal violence and child maltreatment and is an intervention that can be offered by child protection services to assess individual family needs and provide services to fathers.	Reduced child maltreatment **(safety), improved parent-child relationship.**	**Reduced interpersonal violence,** improve father-child interactions **(parent/child interaction).** Aims to enhance reflective functioning of parent, increasing awareness of their own emotions and those of their child. **(Improved parenting, reduced recidivism/risk reduction)**	-
Swenson and Schaeffer (2018)	USA	**Family support-** MST (multisystemic therapy)-CAN is a treatment model	Keep families together safely **(family preservation).** Prevent re-	Keep families together safely. **(Family preservation).** Prevent re-	• MST-CAN team members aim to facilitate positive relationships with collaborators and shoulder risk by

A Multisystemic Approach to the Prevention and Treatment of Child Abuse and Neglect. **Narrative program description**		based largely on the Standard MST model. Child protection is the referral source for MST-CAN programs. Two modifications of MST-CAN were developed for the specialty populations of families experiencing physical abuse and/ or neglect plus parental substance abuse (MST-BSF) and intimate partner violence (MST-IPV).	abuse and neglect. (**safety).** Reduce mental health difficulties experienced by adults and children. Increase natural social supports (**wellbeing).**	abuse and neglect. **(Risk reduction & increase parenting skills).** Reduce mental health difficulties experienced by adults and children. **(Mental health)** Increase natural **social supports.**	intensive work on safety in the home and with the family. • CP caseworkers are included as part of the clinical team, developing a sense of shared responsibility for safety, engaging in ongoing consultation to solve problems, meeting with families together, conducting periodic review of goals as a team with the family. • CP staff receive in training on the MST-CAN treatment model. • The family, MST-CAN team, and CPS develop shared goals to help family's complete treatment • MST-CAN team members are in regular contact with CP workers to advocate for the family, to create an inclusive team atmosphere, and to do whatever it takes to keep the family together safely.
Swenson et al. (2010) *Multisystemic Therapy for Child Abuse and Neglect: A randomised Effectiveness Trial* **Randomised controlled design**	USA	**Family support**- Multisystemic Therapy for Child Abuse and Neglect (MST-CAN). Implemented with youth 10-17 years and their caregiver who is known to child protection. Goals were co-designed with family. Each target behaviour was assessed to determine the drivers of that behaviour. The drivers that were the strongest were prioritised for intervention.	**Enhanced youth behaviour and wellbeing -** achievement of developed goals, **safety, family preservation.**	Enhanced **social connectedness, linking with support services**, addressing **mental health** concerns, developing **parenting skills,** child development knowledge and **family preservation.**	• The treatment team worked closely with child protection, rather than with juvenile justice as in standard MST, to foster positive child protection-family relations and ensure that child protection decision making was based on clinical need or clinical progress.

Taban and Lutzker (2001) *Consumer Evaluation of an Eco-behavioural Program for Prevention and Intervention of Child Maltreatment.* **Non-controlled evaluation**	USA	**Parenting Program**- Safe Care is an 18-session behavioural parenting program that teaches skills in positive parent-child interactions, home safety, and child health.	Improved **safety and parent - child interactions.**	Improved **parenting capacity and parent child interactions** -e.g., responsiveness, tuning into child, warmth	-
Temcheff et al. (2018) *Common components of evidence-based parenting programs for preventing maltreatment of school-age children.* **Scoping review**	Canada	**Eight parenting programs** for those known to child protection. Alternative for families, Homebuilders, Incredible years, Multi-systemic therapy for child abuse and neglect (MST-CAN) Project 12 ways Triple P, Parents Anonymous.	Alternatives for Families: Cognitive Behavioural Therapy- **parent/child relationship, safety.** Homebuilders- **parent/child relationship, safety, family preservation, reduce challenging behaviour.** Incredible Years- **increase parent/child relationship, family preservation, enhanced behaviour.** MST CAN- **safety, family preservation.** Nurturing Parenting Program- **none described.** Project 12 ways- **parent/child relationship, reduce challenging behaviour.** Triple P- **decrease challenging behaviour.** Parents Anonymous- **safety, family preservation.**	Alternatives for Families: Cognitive Behavioural Therapy- **increase parenting skills, improve family functioning, improve parent/child relationship, reduce risks for abuse/neglect.** Homebuilders- **parenting skills, family functioning parent/child relationship, social support, reduce risks for abuse/neglect, family preservation.** Incredible Years- **parent/child relationship, parenting skills-** including reducing harsh punishment, **social support, family preservations.** MST-CAN- **parenting skills, social support, reduce risks for abuse/neglect, family preservation.**	-

				Nurturing Parenting Program- **increase parenting skills** and knowledge, increase self-efficacy. Project 12 ways- **parenting skills, parent/child relationship.** Triple P- **parenting skills,** self-efficacy & reducing harsh punishment. Parents Anonymous- **family functioning,** self-efficacy, **reduce risks for abuse/neglect, family preservation**, reduce harsh punishment **(improve parenting skills).**	
Thompson et al. (2013) *Parenting in recovery program: participant responses and case example.* **Qualitative (focus groups)**	USA	**Child Protection & substance use disorder (SUD) support**-The Parenting in Recovery (PIR) program aimed to address parental substance abuse and child well-being among families involved in the child welfare system. The program includes residential substance abuse treatment, parenting classes and in-home visitation, links to services and concrete supports. Children also receive wraparound services based on needs.	Enhanced health and **wellbeing, reduced challenging behaviours, parent-child relationship, safety, permanency/family preservation.**	Recovery from substance dependence **(SUDs support).** Maintaining/regaining custody of their children **(family preservation**). M**ental health support, enhanced parenting skills, strengthened child-parent relationship, link to services, housing).**	-

Traube et al. (2015) *Predictors of Substance Abuse Assessment and Treatment Completion for Parents Involved with Child Welfare: One State's Experience in Matching across Systems.* **Retrospective cohort study**	USA	**Child Protection and Substance use disorder support**- An integrated services delivered by certified drug and alcohol counsellors who are located in each child protection local office. Services include assessment of needs, identification of substance abuse treatment programs, referral to these programs; and assistance with the placement of clients into programs with the appropriate level of care.	**Safety and** permanency, **family preservation**	**Risk reduction,** family well-being; increased reunification, **substance abuse treatment (Family preservation).**	• Co-locating substance use disorder (SUDs) staff in child welfare offices. • Creating joint case plans between child welfare services and SUDs. • Using official committees to guide collaborative efforts. • Offering training and cross-training between agencies. • Establishing protocols and policies for sharing confidential information. • Dedicated funding to increase capacity for substance abuse treatment programs designed to address the specific treatment needs of individuals involved with child welfare.
Trenado et al. (2009) *Protecting the family: support and assistance for families.* **Narrative program Description**	Spain	**Family Support-** Assessment of the family situation including protective factors, family interactions and risk factors. A plan is then developed by the team and presented to the family for agreement and action. Three key intervention processes are used: family guidance (or counselling), family mediation and family therapy.	**Permanency (family preservation) and safety and child-parent relationship.**	Helping the family to better understand its problems and decide how to deal with them **(risk reduction)** and to improve communication and relations within the family **(improve parent - child relationship, family preservation).**	-
Tung et al. (2019) *Characteristics of effective collaboration: A study of Nurse-Family*	USA	**Family Support-** Nurse-Family Partnership (NFP) offered in partnership with child protection services, a	**Family preservation, safety, wellbeing, parent-child relationship.**	**Family preservation, enhanced parenting capacity and parent-child relationship.**	• Mission and methods alignment between the agencies. • Open communication channels between agencies in the form of a

Partnership and child welfare. **Qualitative**		program of pre-natal and infant/toddler home visiting by nurses for vulnerable mothers bearing first children.			consistent contact person at each agency. • Structured educational opportunities to learn about each other's organisations.
Turner et al. (2017) *Summary of comparison between FFT-CW® and Usual Care sample from Administration for Children's Services.* **Quasi-experimental design**	USA	**Family Support-** Functional Family Therapy- FFT-CW® program addresses mental health, substance abuse, domestic violence, and other needs of family members and tailers treatment to their risks. FFT-CW provides two levels of assistance: High Track offers therapeutic therapy in the home and Low Track supports therapeutic therapy out into the community.	Goals are codesigned with youth to address issues threatening permanency, and relate to **wellbeing/mental health, family preservation & safety.**	Goals are codesigned with family to maintain family unity **(family preservation)** and child safety **(risk reduction): develop parenting skills** improve family dynamics and communication **(child-parent relationship)** better **engage with community services** such as allied health establish a safe, stable, and supportive home environment, **support with mental health, substance abuse, domestic violence.**	-
Villodas et al. (2021) *Feasibility and promise of community providers implementing home-based parent-child interaction therapy for families investigated for child abuse: A pilot randomised controlled trial.* **Pilot randomised controlled trial**	USA	**Parenting program –** Parent-child interaction therapy (PCIT): Sessions were conducted weekly in families' homes.	**Improved behaviour, improved parent/child relationship.**	Improving caregivers' expectations, limit-setting skills, and use of safe and effective discipline strategies. (P**arent- child relationship and improved parenting capacity).**	-

Wallace (2021) *Addressing the Needs of Infants and Toddlers Exposed to Maltreatment: Examining the Impact of an Integrated Early Head Start & Children and Youth Services Program.* **Retrospective Cohort study**	USA	**Family Support-** SafeStart is a centre-based program for children who have prenatal or early exposure to drugs. Children are enrolled at the time of referral and the program typically ends when the child turns 3 years of age. Each family has a caseworker and therapeutic coach to support them with parenting and other concrete needs.	Enhance developmental outcomes for children. **(Wellbeing, safety, family preservation)**	Meet **concrete needs** - employment, **housing,** health, & education. Parenting education. **(Build parenting capacity, family preservation, links to supports)**	-
Walton (2001) *Combining Abuse and Neglect Investigations With Intensive Family Preservation Services: An Innovative Approach to Protecting Children.* **Quasi-experimental design**	USA	**Child Protection-** Child protection worker and family preservation worker work together to respond to referral and undertake assessment. Dual focus on investigation and family needs assessment and response, including parental skills training, and developing a network of formal and informal supportive resources. At the end of the investigative period, the team pooled their knowledge in making a case determination.	**Safety and permanency (family preservation).**	**Improve the family's general functioning** as well as its cooperation with the child protection. Connect the family with a network of resources designed to outlive the caseworkers' involvement**. (Links to community supports, risk reduction, family preservation).**	• Child protection investigators were paired with family preservation workers to work together on investigation and response planning.

Weegar et al. (2018) *Perspectives on the implementation of an evidence-based neglect program within child welfare.* **Qualitative study**	Canada	**Parenting Program-** SafeCare® is a parenting program that directly targets risk factors for child neglect among child welfare-involved families with young children (i.e., newborn to 5 years). It is home based and there are three modules, namely home safety, child health, and caregiver-infant/child interaction.	**Safety, family preservation, parent/child relationship.**	**Prevention of recidivism or reduction in risk factors** associated with child maltreatment, **(improved parental capacity, parent child relationship, family preservation**).	-
Whitaker et al. (2020) *Effect of the SafeCare© intervention on parenting outcomes among parents in child welfare systems: A cluster randomised trial.* **Randomised controlled trial**	USA	**Parenting Program-** SafeCare is an 18-session behavioural parenting program that teaches skills in positive parent-child interactions, home safety, and child health.	**Safety, parent/child relationship.**	Seek and sustain **social supports for the family,** good physical and **mental health; and increased functioning levels of family members, risk reduction, parenting capacity, concrete supports, parent/child relationship (family preservation).**	-
Witkin (2013) *Preventing Child Maltreatment and Neglect: New Directions for Successful Engagement and Retention of At-Risk Families.* **Mixed methods**	USA	**Family Support-** Partnership for Families Program, includes a minimum of two home visits per month, a pre and post assessment of family functioning, and approximately 6 months of services. Each family's services are planned and coordinated by the lead agency.	**Increase Parent/child relationship, safety.**	Increase **social supports** for the family. Promote pro-social and nurturing interfamily relationships; good physical and **mental health; and increased functioning levels of family members, risk reduction, parenting capacity/skill building, concrete supports, parent/child relationship**.	-

Zhou et al. (2017) *Evaluation of Positive Parenting Programme (Triple P) in Singapore: Improving parenting practices and preventing risks for recurrence of maltreatment.* **Quasi-experimental design**	USA	**Parenting program-** Triple P: Parents develop a parenting plan and practice their plan with their children. Parents monitor their children's behaviour, and their own behaviour, and reflect on what is working with their parenting plan and what is not working so well.	**Decrease behaviour problems** in children (for families experiencing difficult child behaviours) **Improve parent/child relationship.**	Increase competence in promoting healthy development and managing common child behaviour problems and developmental issues. **(Parenting capacity, Improve parent/child relationship).**	-

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Appendix D Study 1 Summary of studies excluded at full text

212 studies excluded from full text review	
Not known to child protection **44**	(Admon Livny & Katz, 2018) (Mills et al., 2009) (Coleman & Jenson, 2000) (Mokuau, 2002) (Kelleher & Johnson, 2004) (Dumont et al., 2008) (Appleton, 2012) (Russell et al., 2007) (Barlow et al., 2013) (Crusto et al., 2008) (Nations, 2005) (Wise, 2003) (Smith et al., 2012) (Gessner, 2008) (Kaye et al., 2018) (Slesnick & Erdem, 2013) (Yates et al., 2015) (Levine, 2001) (Scott, 2010) (Banwell et al., 2002) (Kumpfer & Magalhaes, 2018) (Silovsky et al., 2011) (Efevbera et al., 2018) (Niccols et al., 2012) (Knox & Burkhart, 2014) (Barlow et al., 2007) (Byrne et al., 2019) (Chartier et al., 2017) (Falconer et al., 2008) (Fergusson et al., 2013) (Geeraert et al., 2004) (Gonzalez & MacMillan, 2008) (Green et al., 2017) (Hoefer & Bryant, 2017) (Jonson-Reid, 2000) (Lo & Cho, 2021) (Lowell et al., 2011) (Mace et al., 2015) (Oppenheim-Weller & Zeira, 2018) (Peckover & Golding, 2017) (Pratt et al., 2000) (Van Dongen et al., 2018) (Weymouth & Howe, 2011)
Not a review of a specific service **43**	(He, 2017) (Cross et al., 2012) (Pecora et al., 2014) (Kovacs & Tomison, 2003) (Littell, 2001) (Littell & Schuerman, 2002) (Weeks, 2021) (Berliner et al., 2015) (Albright et al., 2019) (Post et al., 1997) (Wells & Tracy, 1996) (Littel, 1997) (Ridings et al., 2016) (Smith & Marsh, 2002) (Lessard et al., 2014) (Echlin & Osthoff, 2000) (Cameron & Karabanow, 2003) (Marsh & Smith, 2011) (Millett, 2016) (K. A. Piper, 2017) (Hughes et al., 2013) (D'Andrade et al., 2008) (MacLeod & Nelson, 2000) (Weigensberg et al., 2009) (Kerwin, 2005) (MacPherson, 2010) (Chen & Chan, 2016) (Brandon & Thoburn, 2008) (Casanueva et al., 2008) (Dennis et al., 2015) (Gibson et al., 2015) (Green et al., 2008) (He & Phillips, 2017) (Humphreys et al., 2020) (Lee et al., 2009) (Loman & Siegel, 2012) (McDonald & Rosier, 2011) (Kathryn A. Piper, 2017) (Rogers & Parkinson, 2017) (Samples et al., 2013) (Torres, 2020)
Doesn't describe intended outcomes for children and caregivers of service/program **41**	(Aarons et al., 2014) (Latzman et al., 2019) (Winokur et al., 2015) (Francis, 2008) (Stahlschmidt et al., 2018) (Smith & Mogro-Wilson, 2007) (Banks, Dutch, et al., 2008) (Alaggia et al., 2015) (Lindsey et al., 2002) (Rijbroek et al., 2017) (Banks, Landsverk, et al., 2008) (Harlow & Shardlow, 2006) (Jose & Wetzler, 2019) (Daniel, 2016) (Malik et al., 2008) (Kemp et al., 2014) (Chambers, 2006) (Venables et al., 2015) (Beeman & Edleson, 2000) (Littell & Tajima, 2000) (Oliveros & Kaufman, 2011) (Gladstone et al., 2012) (Huebner et al., 2018) (Campbell, 2002) (Hardy & Darlington, 2008) (He, 2015) (Price et al., 2012) (Osterling & Austin, 2008) (Kyte et al., 2013) (Chambers et al., 2021) (Coll et al., 2010) (Dodge et al., 2019) (Green et al., 2016) (Hebert et al., 2014) (Huebner et al., 2015) (Lalayants, 2010) (Lyons, 2002) (McAlpine et al., 2001) (Rockhill et al., 2015) (Waldfogel, 2009) (Zannettino & McLaren, 2014)
Pre-2000 **47**	(VanBremen & Chasnoff, 1994) (Wolfe & et al., 1988) (Armstrong et al., 1999) (Amundson, 1989) (Little et al., 1991) (Heneghan et al.,

	1996) (Whitney & Davis, 1999) (Choi et al., 1997) (Gershater-Molko, 1999) (Dubowitz, 1989) (Janet E. Findlater & Susan Kelly, 1999) (McCroskey & Meezan, 1998) (Cameron & Cadell, 1999) (De Bernardi, 1995) (Meezan et al., 1997) (Britner & Reppucci, 1997) (Sparks, 2000) (Wolfe & Manion, 1984) (Dore & Harnett, 1995) (Waite, 1988) (Barth et al., 1988) (Rossi, 1992) (Epstein, 1990) (Poertner et al., 1991) (Bidgood & van de Sande, 1990) (Huxley & Warner, 1993) (Templeman, 1999) (Williams-Burgess et al., 1995) (Maluccio, 1998) (Mouzakitis & Goldstein, 1985) (McGeshick, 1995) (Campbell, 1997) (Daro & McCurdy, 1994) (Ketring, 1999) (Magura & Laudet, 1996) (Olsen, 1995) (Azzi-Lessing & Olsen, 1996) (Bath & Haapala, 1994) (Blau et al., 1994) (Carlson, 1997) (Cowen, 1991) (Dore & Doris, 1998) (J. E. Findlater & S. Kelly, 1999) (Glisson & Hemmelgarn, 1998) (Littell, 1995) (Saunders & Goodall, 1985) (Smokowski & Wodarski, 1996)
Wrong service/ program type **22**	(Suchdev-Manchandani, 2006) (Romero et al., 2010) (Kolko et al., 2011) (Landsman et al., 2001) (Gopalan et al., 2021) (Gallagher-Mackay, 2012) (K. A. Piper, 2017) (Mindell et al., 2003) (Charest-Belzile et al., 2020) (Lalayants, 2012) (Perry et al., 2013) (Drabble, 2011) (Jordan et al., 2014) (Duffy et al., 2016) (Dauber et al., 2012) (Carten & Goodman, 2005) (Corr & Santos, 2016) (Dumbrill, 2005) (Fallon et al., 2017) (Fowler et al., 2011) (Pithouse & Lindsell, 1996) (Romero, 2010) (Sawrikar, 2019)
In out of home care or trauma treatment **6**	(Ryan et al., 2008) (Green et al., 2007) (Choi, 2015) (Waxman et al., 2009) (Dakof et al., 2010) (Ungemack et al., 2015)
book / conference abstract **4**	(Leslie & Motz, 2020) (Flaherty et al., 2008) (Stimac & Buljan Flander, 2015) (Saldana, 2015)
Manual duplicate **3**	(Karatekin et al., 2014) (Whitaker et al., 2020) (Turner et al., 2017)
Commentary / viewpoint article **2**	(Gomby, 2007) (Barth, 2012)

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Appendix E Study 2a Statement of authorship

University of South Australia

Statement of Authorship

Title of Paper	Exploring service goals and underlying interprofessional practices for children and families known to child protection
Publication Status	☐ Published ☐ Accepted for Publication ■ Submitted for Publication ☐ Unpublished and Unsubmitted work written in manuscript style
Publication Details Relevant reference details	Seekamp, S., Ey, L. A., Herbert, J., & Tsiros, M. D. (Submitted 2023; currently under review), Exploring service goals and underlying interprofessional practices for children and families known to child protection, Children and Youth Services Review.
PRINCIPAL AUTHOR	
Name of Principal Author (Candidate)	Sarah Seekamp
Contribution to the Paper Brief description of your work in this publication	Conceptualization, Methodology, Investigation, Formal Analysis, Writing-original draft, review and editing.
Overall Percentage (%)	70
Certification	This paper reports on original research I conducted during the period of my Higher Degree by Research candidature and is not subject to any obligations or contractual agreements with a third party that would constrain its inclusion in this thesis. I am the primary author of this paper.
Signature *Signatures will be redacted by the Library at the time of publication*	Sarah Seekamp Digitally signed by Sarah Seekamp Date: 2024.01.03 09:28:28 +10'30'
Date	3-Jan-24
CO-AUTHOR CONTRIBUTIONS	
By signing the Statement of Authorship, each author certifies that: I. the candidate's stated contribution to the publication is accurate (as detailed above); II. permission is granted for the candidate in include the publication in the thesis; and III. the sum of all co-author contribution is equal to 100% less the candidate's stated contribution.	
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Last updated: May 2023

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% Contribution to the Paper			

Appendix F Study 2b Statement of authorship

University of South Australia

Statement of Authorship

Title of Paper	Partnering with families known to child protection in an interprofessional context.
Publication Status	☒ Published ☐ Accepted for Publication ☐ Submitted for Publication ☐ Unpublished and Unsubmitted work written in manuscript style
Publication Details Relevant reference details	Seekamp, S., Ey, L. A., & Tsiros, M. D. (2023). Partnering with families known to child protection in an interprofessional context. Child Abuse and Neglect. https://doi.org/10.1016/j.chiabu.2023.106426
PRINCIPAL AUTHOR	
Name of Principal Author (Candidate)	Sarah Seekamp
Contribution to the Paper Brief description of your work in this publication	Conceptualization, Methodology, Investigation, Formal Analysis, Writing-original draft, review and editing.
Overall Percentage (%)	70
Certification	This paper reports on original research I conducted during the period of my Higher Degree by Research candidature and is not subject to any obligations or contractual agreements with a third party that would constrain its inclusion in this thesis. I am the primary author of this paper.
Signature *Signatures will be redacted by the Library at the time of publication*	Sarah Seekamp Digitally signed by Sarah Seekamp Date: 2024.01.03 09:42:31 +10'30'
Date	19-Dec-23
CO-AUTHOR CONTRIBUTIONS	
By signing the Statement of Authorship, each author certifies that: I. the candidate's stated contribution to the publication is accurate (as detailed above); II. permission is granted for the candidate in include the publication in the thesis; and III. the sum of all co-author contribution is equal to 100% less the candidate's stated contribution.	
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Last updated: May 2023

University of South Australia

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Signature *Signatures will be redacted by the Library at the time of publication*		Date
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Appendix G Study 2a & 2b ethics approval

Sarah Seekamp

From:	no_reply@unisa.edu.au
Sent:	Saturday, 21 August 2021 4:27 PM
To:	Sarah Seekamp; Seekamp, Sarah Louise - heasl001; James Herbert; Lesley-Anne Ey; Margarita Tsiros
Cc:	Human Ethics
Subject:	Human ethics: Application approved

Dear Applicant

Re: Ethics protocol "Exploring child and family centered service goals and interprofessional practices to support attainment of these for children and families known to child protection." (Application ID: 203984)

Thank you for submitting your ethics protocol for consideration. Your protocol has been considered by the E3 Committee Review Group.

I am pleased to advise that your protocol has been granted ethics approval and meets the requirements of the National Statement on Ethical Conduct in Human Research. You may now commence your research.

Please regard this email as formal notification of approval.

Ethics approval is always made on the basis of a number of conditions detailed at http://www.unisa.edu.au/res/forms/docs/humanresearchethics_conditions.doc; it is important that you are familiar with, and abide by, these conditions. It is also essential that you conduct all research according to UniSA guidelines, which can be found at http://www.unisa.edu.au/res/ethics/default.asp

Please note, if your project is a clinical trial you are required to register it in a publicly accessible trials registry prior to enrolment of the first participant (e.g. Australian New Zealand Clinical Trials Registry http://www.anzctr.org.au/) as a condition of ethics approval.

Best wishes for your research.

Executive Officer
UniSA's Human Research Ethics Committee
CRICOS provider number 00121B

This is an automated email and cannot be replied to. Please direct your query to humanethics@unisa.edu.au.

Appendix H Study 2a &2b recruitment email

Dear ……..,

I, Sarah Seekamp, am a PhD candidate with the Australian Centre for Child Protection, University of South Australia (UniSA).

I am currently undertaking a study to explore from the perspective of professionals in the field of child protection and family support:

i) What are important child and family focused goals/outcomes of services that support children and their families known to child protection?
ii) What are the inter-professional and collaborative practices that support attainment of these outcomes?

Interprofessional collaboration has been identified as an expected requirement of child protection and family support practice to enhance the safety and wellbeing of children known to child protection. Shared practice goals are a well-documented enabler of inter-professional collaboration. However, currently there is little clarity in the literature as to what shared practice goals for services that support families and children known to child protection are or should be.

You have been invited to participate as you have been identified as having relevant expertise in this area. Participants who agree to participate in this study will take part in an interview with the researcher that will take between 30-60 minutes at a mutually agreeable time, either face to face, via zoom or telephone.

Your input will contribute to enhancing understanding of child and family-focused goals for services that support families and children known to child protection, as well as inter-professional practices that support attainment of these goals.

Attached is an information sheet detailing the project further, your rights and other important information. Please read this carefully before deciding to participate. This project has been approved by the University of South Australia's Human Research Ethics Committee (203984).

My supervisors and I value your expert contribution and hope to shed further insight in this area with your participation. Please do not hesitate to contact me with any questions you may have. I will contact you via phone in no more than 7 days to check your interest and respond to any question you may have.

Thank you for your time,

Sarah Seekamp, PhD Candidate
Dr. Lesley-Anne Ey, Dr. Margarita Tsiros & Dr. James Herbert (UniSA Supervisors)

University of South Australia

Participant Information Sheet

Project Title:

Exploring child and family-centred service goals and interprofessional practices to support attainment of these for children and families known to child protection.

Project Number: 203984

Chief Investigator: Sarah Seekamp

Supervisors: Dr. Lesley-Anne Ey

Dr. Margarita Tsiros

Dr. James Herbert

Introduction

You are invited to take part in this research project that explores child and family-centred goals of services that support children and their families known to child protection and inter-professional practices that support attainment of these goals. You have been invited to participate as you have been identified as having relevant expertise in this area.

This Participant Information Sheet explains the research project and the processes involved with taking part. Please read this information carefully and ask questions about anything you want to know more about. Participation in this research is voluntary.
If you decide you want to take part in the research project, you will be asked to sign a consent form. By signing it you are telling us that you:

- Understand what you have read.
- Consent to take part in the research project.
- Consent to the use of your information as described.

What is the purpose of this research?

The aims of this research are to explore from the perspective of professionals in the field of child protection and family support:

iii) What are important child and family focused goals/outcomes of services that support children and their families known to child protection?

iv) What are the inter-professional and collaborative practices that support attainment of these outcomes?

Interprofessional collaboration has been identified as essential for, and an expected requirement of child protection and family support practice to enhance the safety and wellbeing of children who have been abused and/or neglected or are at risk thereof. Despite this, implementation of this collaborative approach among child protection and family support services remains a challenge. Shared practice goals are a well-documented enabler of inter-professional collaboration. However, currently there is little clarity in the literature as to what shared practice goals for services that support families and children known to child protection should be. **This study will seek to enhance understanding of child and family-focused goals for services that support families and children known to child protection, as well as inter-professional practices that support attainment of these goals**.

This research is being conducted as part of a PhD by Sarah Seekamp who is receiving a joint scholarship from the University of South Australia and South Australian Department for Child Protection to undertake this research.

What does participation in this research involve?

- Participants who agree to participate will take part in an interview with the researcher that will take between 30-60 minutes.
- After consenting to participate, a suitable time and place for the interview will be determined with the participant. Interviews may be conducted via phone, zoom, or face to face (within COVID-19 guidelines).
- With participant consent, interviews will be audio recorded. The recording and transcript of the recording is raw data and will be kept securely for five years after which time it will be destroyed. To protect participant confidentiality, all potentially identifying information will be removed.
- You will be contacted by the researcher with a summary of your interview to check that your interview has been recorded correctly.
- It is anticipated approximately 10-15 participants will be interviewed.
- At the end of the interview, I will also ask you to recommend other experts in your field who could contribute to the research.
- Data collected in this project may be used in future related projects as part of the researcher's PhD, for which ethics approval will be sought.

What are the possible benefits of taking part?

There will be no personal benefit to participants from participation in this research; however, your participation in this research may contribute to service changes in the future to better meet the needs of parents / caregivers and children receiving support from child protection and family support services.

What are the possible risks and disadvantages of taking part?

It is not anticipated that there are any risks to participation in this study beyond those encountered in everyday life.

Do I have to take part in this research project?

Participation in this research project is voluntary. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage without consequence. If you do decide to take part, you will need to sign a Consent Form.
Should you choose to withdraw from the study, you may opt to have your interview excluded from the study, however, this needs to be done within two weeks after your interview date, prior to data analysis. You may also choose to not respond to questions and/or choose to omit or ask to delete any data supplied.

What will happen to information about me?

By signing the consent form, you consent to the research team collecting and using your interview data for the research project. Any personal information about you will remain confidential both during and after the project and no information which could lead to identification will be released, unless required by law. When reporting findings from the research, participants will be de-identified. Throughout this project, electronic copies of the data will be stored on a password-protected file, on a password protected device only accessible to the researcher and the supervisory team (UniSA supervisors). No other organisation or person will have access to the data collected during the interviews.

Participants have the option to be acknowledged as a contributor to this research in a general statement of acknowledgement in documents reporting findings from the research. If you wish to be acknowledged, you can identify this on the consent form.

What happens when the research project ends?

On the completion of the project participants will be sent a summary of the findings either in hard copy or via email.
Further, upon completion of the project, audiotapes of the interviews and transcripts of the tapes and any other data from the study will be stored securely in the Australian Centre for Child Protection archive for five years. Following this time, all data will be destroyed by a secure document destruction service.

Further information and who to contact.

If you want any further information or if you have any questions concerning this project you can contact the lead researcher- Sarah Seekamp on the details below, or Dr. Lesley-Anne Ey, (Principal Supervisor).

Research contact person

Name	Sarah Seekamp
Position	Lecturer, PhD Candidate, UniSA Allied Health and Human Performance
Telephone	08 86302 2705
Email	sarah.seekamp@unisa.edu.au

Name	Dr. Lesley-Anne Ey
Position	Australian Centre for Child Protection, UniSA Education Futures

Telephone	08 83024600
Email	Lesley-Anne.Ey@unisa.edu.au

This project has been approved by the University of South Australia's Human Research Ethics Committee (Protocol Number: 203984). If you have any ethical concerns about any aspect of the project, or questions about your rights as a participant please contact:

Reviewing HREC approving this research and HREC Executive Officer details

Reviewing HREC name	University of South Australia Human Research Ethics Committee
Telephone	+618 8302 6330
Email	humanethics@unisa.edu.au

Appendix J Study 2a & b consent form

UniSA Allied Health & Human Performance

Human Research Ethics Committee
CONSENT FORM

This project has been approved by the University of South Australia's Human Research Ethics Committee. If you have any ethical concerns about the project or questions about your rights as a participant, please contact the Executive Officer of this Committee, Tel: +61 8 8302 3118; Email:

SECTION 1: CONTACT AND PROJECT DETAILS

Researcher's Full Name:	Sarah Seekamp
Contact Details:	Sarah.seekamp@unisa.edu.au
Supervisor's Full Name:	Dr. Lesley-Anne Ey, Dr. Margarita Tsiros, Dr. James Herbert
Contact Details:	Lesley-Anne.Ey@unisa.edu.au; Margarita.Tsiros@unisa.edu.au; James.Herbert@unisa.edu.au;
Protocol Number:	203984
Project Title:	Exploring child and family-centered service goals and interprofessional practices to support attainment of these for children and families known to child protection.

SECTION 2: CERTIFICATION

Participant Certification

In signing this form, I confirm that:

- I have read the Participant Information Sheet and the nature and purpose of the research project has been explained to me. I understand and agree to take part.
- I understand the purpose of the research project and my involvement in it.
- I understand that I may withdraw from the research project at any stage and that this will not affect my status now or in the future.
- I understand that while information gained during the study may be published, my personal comments will remain confidential, unless required by law.
- I have the option to be acknowledged as a contributor to this research in a general statement of acknowledgement in documents reporting findings from the research. Tick the box if you would like to be listed in the acknowledgments. ☐
- I understand that I will be audiotaped during the interview.
- I understand that data collected in this project may be used in future related projects as part of the researcher's PhD, for which ethics approval will be sought.
- I understand that the audiotape will be transcribed into a written document and will be stored on a password protected document on a password protected computer at the University of South Australia along with the audio file. I will have access to the transcript to check that information is correct. During the project only the research team will have access to the data. I understand that on completion of the project, audio files and transcripts of the interviews will be stored in a secure archive for five years before they are destroyed.

Participant Signature	*Printed Name*	*Date*

Researcher Certification

I have explained the study to the participant and consider that he/she understands what is involved.

	SARAH SEEKAMP	
Researcher Signature	*Printed Name*	*Date*

Appendix K Study 2a & b Interview guide

Interview guide – (Professionals)

1. ***Can you tell me about your work relating to supporting families and children known to child protection?***
   Probe:
   - Who you have worked for, the focus of these roles and services and any key collaborators in this work?

2. ***Reflecting on this work, what do you perceive to be the most important outcomes / goals from work by statutory child protection agencies and/or support services for children and their families?***
   (Ensure both outcomes for children and parents / care givers are explicitly explored)

   Probe:
   - Are there goals /outcomes relating to the impact of these services – i.e., what is different for this child or parent/carer because of these services? For example, child development, personal wellbeing, the services/ supports they have accessed, their experience as a child in their family / relationships).

   - Are there goals / outcomes relating to the way children receive services, their experience of being a client of these services? For example, shared goals for family work, or participation in decision making.

   - Are there goals that relate more to the short term, medium and longer term?

3. ***Are there other specific outcomes / goals for children and their families particularly from <u>collaborative</u> work by statutory child protection agencies and support services for children and families?***
   (Ensure explore both outcomes for children and parents / care givers explicitly)

   Probe:

   Think of a time when you worked inter-professionally with other services (i.e., in Child Protection and worked with a family support service or vice versa), when you were able to achieve outcomes for children and families – what were those outcomes, what contributed to those outcomes.

   OR

   Have you done any projects on interprofessional collaboration in family support – what outcomes was the interprofessional collaboration trying to achieve, what practices did it examine/explore?

4. ***Can you describe collaborative practices between child protection and family support services that are/ could be helpful in achieving the outcomes for children and families you have identified as important?***

5. ***Can you tell me about what may support these collaborative practices and/or has led to good outcomes for children and their families?***

   Prompts to explore domains of Winkworth and White model as enablers of collaborative practice:
   - factors relating to leadership, policy, organisational approach / focus, consumer or stakeholder support or voice.
   - Resources (skills, knowledge, human resources, ways of working, training and development)
   - Value- (Purpose, goals, accountability relating to collaboration).

6. ***Can you describe your experience working in partnership with children and families.***
   Probe:
   - What do you think are important elements of this work?
   - What influences how you work in partnership with families?
   - Can you tell me about how the agency that you work for may influence how you partner with families?

7. **Can you think of a time when you collaborated with other services and families and you were able to achieve positive outcomes for children and families. Please tell me about this work.** (E.g., Child Protection and family support service, or other sectors required to support families such as mental health, or children's services.)

   Probe:
   - What supported this work?
   - Can you describe how families were involved in this collaboration?

   (For participants with research/policy experience)

   Have you work on any projects focused on partnering with families known to child protection and/or interprofessional collaboration in child protection/family support? Can you please tell me about the project and its outcomes.

8. ***Is there anything else you would like to share relating partnering with families known to child protection and collaborative practices that influence this work?***

9. ***Is there anything else you would like to share relating to outcomes for children and families known to child protection and collaborative practices that support attainment of these outcomes?***

Appendix L Study 3 Statement of authorship

University of South Australia

Statement of Authorship

Title of Paper	Participation of parents known to child protection in service responses: Experiences of parents in an interprofessional context,
Publication Status	☐ Published ☐ Accepted for Publication ■ Submitted for Publication ☐ Unpublished and Unsubmitted work written in manuscript style
Publication Details Relevant reference details	Seekamp, S., Ey, L. A., Wright, S., Herbert, J., & Tsiros, M. D. (Submitted 2023: currently under review), Participation of parents known to child protection in service responses: Experiences of parents in an interprofessional context, Children and Youth Services Review.
PRINCIPAL AUTHOR	
Name of Principal Author (Candidate)	Sarah Seekamp
Contribution to the Paper Brief description of your work in this publication	Conceptualization, Methodology, Investigation, Formal Analysis, Writing-original draft, review and editing.
Overall Percentage (%)	70
Certification	This paper reports on original research I conducted during the period of my Higher Degree by Research candidature and is not subject to any obligations or contractual agreements with a third party that would constrain its inclusion in this thesis. I am the primary author of this paper.
Signature *Signatures will be redacted by the Library at the time of publication*	Sarah Seekamp Digitally signed by Sarah Seekamp Date: 2024.01.05 09:19:11 +10'30'
Date	5-Jan-24
CO-AUTHOR CONTRIBUTIONS	
By signing the Statement of Authorship, each author certifies that: I. the candidate's stated contribution to the publication is accurate (as detailed above); II. permission is granted for the candidate in include the publication in the thesis; and III. the sum of all co-author contribution is equal to 100% less the candidate's stated contribution.	
Name of Co-Author 1	Dr Lesley-Anne Ey

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Last updated: May 2023

University of South Australia

% Contribution to the Paper	10		
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Name of Co-Author 3	Dr James Herbert		
% Contribution to the Paper	10		
Signature *Signatures will be redacted by the Library at the time of publication*	James Herbert Digitally signed by James Herbert Date: 2023.12.19 13:35:11 +08'00'	Date	19-Dec-23
Name of Co-Author 4			
% Contribution to the Paper			
Signature *Signatures will be redacted by the Library at the time of publication*		Date	
Name of Co-Author 5			
% Contribution to the Paper			
Signature *Signatures will be redacted by the Library at the time of publication*		Date	
Name of Co-Author 6			
% Contribution to the Paper			
Signature *Signatures will be redacted by the Library at the time of publication*		Date	
Name of Co-Author 7			
% Contribution to the Paper			

Appendix M Study 3 Ethics approval

Sarah Seekamp

From: no_reply@unisa.edu.au
Sent: Saturday, 2 July 2022 9:21 AM
To: Sarah Seekamp; James Herbert; Margarita Tsiros; Seekamp, Sarah Louise - heasl001; Lesley-Anne Ey
Cc: Human Ethics
Subject: Human ethics: Application approved

Dear Applicant

Re: Ethics protocol "Exploring goals of family members from work with Family Support Services and how services can work together to support identification and achievement these goals." (Application ID: 204226)

Thank you for submitting your ethics protocol for consideration. Your protocol has been considered by the E3 Committee Review Group.

I am pleased to advise that your protocol has been granted ethics approval and meets the requirements of the National Statement on Ethical Conduct in Human Research. You may now commence your research.

Please regard this email as formal notification of approval.

Ethics approval is always made on the basis of a number of conditions detailed at https://i.unisa.edu.au/staff/research/research-ethics/human-research-ethics/ethics-management-for-research-projects/ (under the heading 'What are the Standard Conditions of Approval?'). It is important that you are familiar with, and abide by, these conditions. It is also essential that you conduct all research according to UniSA guidelines, which can be found at https://i.unisa.edu.au/staff/research/research-ethics/human-research-ethics/ethics-policies-guidelines/

Please note, if your project is a clinical trial you are required to register it in a publicly accessible trials registry prior to enrolment of the first participant (e.g. Australian New Zealand Clinical Trials Registry http://www.anzctr.org.au/) as a condition of ethics approval.

Best wishes for your research.

Executive Officer
UniSA's Human Research Ethics Committee
CRICOS provider number 00121B

This is an automated email and cannot be replied to. Please direct your query to humanethics@unisa.edu.au.

Appendix N Study 3 Recruitment Procedure



Ethics Approval Project Number: 204226

Chief Investigator: Sarah Seekamp
Supervisors: Dr. Lesley-Anne Ey
Dr. Margarita Tsiros
Dr. James Herbert

Participant recruitment procedure:

- Child and family practitioners (CFPs)/case managers from the family support program will identify potential participants.
- Child and family practitioners (CFPs)/case managers will ensure that parents/caregivers meet the eligibility criteria for the study:

Inclusion Criteria:
Parents/caregivers who are currently or were receiving a service within the last 12 months from the family support program.

Exclusion criteria
As determined by child and family practitioners (CFPs)/case managers, parents/caregivers who either themselves or their family members are experiencing acute stressors that may increase the risk of psychological discomfort or distress. (For example - pending court hearings, or acute mental illness)

- Initial contact with participants will be made by child and family practitioners (CFPs)/case managers.
- The CFP will approach parent(s)/caregiver(s) who meet the inclusion criteria and with the support of the "invitation" (Appendix O) explain the nature and purpose of the study and seek their interest.
- The CFP may leave the 'invitation' with their client for consideration and provide the 'information sheet' (Appendix Q) to the client if their client is interested.
- The CFP may request the researcher contact the client to discuss the study if the client requests this.
- If a client declines to participate, no further invitations to participate in the study will be raised by any practitioner from the family support service.

If you require any further information relating to this research project, please contact Sarah Seekamp on Sarah.Seekamp@unisa.edu.au
Thankyou.

Appendix O Study 3 Invitation

University of South Australia

Invitation

You are invited to take part in a research project

The researcher wants to find out about:

1. Your goals for you and your family members from work with family support services.

2. The ways that you think different services can work together to support you and your family achieve these goals.

Who is the researcher:

Sarah Seekamp – A PhD student with University of South Australia. She has lots of experience working with families and is a mother herself. Sarah hopes to share the voices of families receiving family support services to help guide how services are offered in the future.

What is involved:

An interview with Sarah that takes between 30 and 60 minutes. If you choose to take part, you will decide with Sarah where and when to have the interview.

Participation is voluntary:

You do not have to participate. If you decide to participate, you are free to withdraw at any time. Sarah is separate to (deidentified family support agency) and choosing to participate, or not participate will not affect your services with(de-identified family support agency), or anyone else.

If you choose to participate you will receive a $40 gift voucher.

More information:

You do not have to decide right now. You can talk to Sarah and meet with her to get more information to help you decide. There is a participant information sheet with more detailed information about the project.

If you want more information or to talk with Sarah, tell your Resilient Families Child and Family Practitioner and they will arrange this for you.

This project is approved by The University of South Australia Human Research Ethics Committee – Project Number 204226

Appendix P Study 3 Participant distress/wellbeing protocol

Participant Distress/Wellbeing Protocol

Family Member interviews

The following protocol was developed in consultation with (de-identified Family support provider) and is designed to:

- Minimise the likelihood of any participant experiencing distress from participating in the interview.
- Provide timely and appropriate support in the unlikely event that a participant becomes emotionally distressed during the interview.

Protocol

- To minimize the likelihood of a participant becoming distressed during the interview Child and Family Practitioners (CFP) from the Family support provider (FSP) will identify potential participants who they deem suitable to safely participate.
- As indicated in the consent form, to allow participants to decide if the interview may be distressing for them, they have the option to review the interview guide before consenting to participate.
- The researcher will communicate with the participant's CFP prior to the interview and notify them of the time and place of the interview so that the CFP can make a wellbeing check phone call to the participant following the interview.
- In the event that a participant does become distressed during the interview:
    - The researcher who has significant experience working with vulnerable families will pause the interview.
    - The researcher will provide emotional support and ask the participant whether they would like to cease the interview or continue at a time they feel ready.
    - The researcher will notify the participant that they will call their CFP so that they can provide follow up support. In the event the researcher cannot reach the CFP, they will contact the FSP Team Leader.
    - The researcher will stay with the participant if needed until the CFP, or FSP Team Leader arrives to offer further support.

Appendix Q Study 3 Participant information sheet



Participant Information Sheet

Project Title:

Exploring parent/caregiver goals of work with family support services and interprofessional practices to support identification and achievement of these goals.

Project Number:	204226
Chief Investigator:	Sarah Seekamp
Supervisors:	Dr. Lesley-Anne Ey
	Dr. Margarita Tsiros
	Dr. James Herbert

Introduction

You are invited to take part in this research project that explores your goals of work with family support services and how services can work together to support you to identify and reach these goals. You have been invited to participate as you are receiving a family support service and so have valuable experience to share on this topic.

This Participant Information Sheet explains the research project and what is involved with taking part. Please go over this information carefully and ask questions about anything you want to know more about. Participation in this research is voluntary and you are free to withdraw at any time.

If you decide you want to take part in the research project, you will be asked to sign a consent form. By signing it you are telling us that you:

- Understand this information sheet.
- Consent to take part in the research project.
- Consent to the use of your information as described.

What is the purpose of this research?

The aims of this research are to explore with parents/caregivers who are receiving family support services:

(i) Goals for themselves and their family members from work with family support services.

(ii) The ways that agencies that support these families can/do work together to support them and their family identify and attain these goals.

Many families who are vulnerable and needing support to create positive homes and care for their children are in contact with a number of different services. Research tells us that to effectively support families, these different services must work together. There is a need to find ways to support different services to work together more effectively. When different services identify shared goals for families, services work more effectively together, and families have better outcomes. However, little is known about what these shared goals for families may be, or how they are identified.

This study will provide new information from parents/caregivers about their goals for themselves and their family members from work with family support services and the ways that services can/do work together to support them identify and reach these goals.

This research is being conducted as part of a PhD by Sarah Seekamp who is receiving a joint scholarship from the University of South Australia and South Australian Department for Child Protection to undertake this research.

What does participation in this research involve?

- Participants who agree to participate will take part in an interview with the researcher that will take between 30-60 minutes.
- After consenting to participate, a suitable time and place for the interview will be decided on with the participant. Interviews may be conducted via phone, zoom, or face to face (within COVID-19 guidelines).
- With participant consent, interviews will be audio recorded. The recording and transcript of the recording is raw data and will be kept securely for five years after which time it will be destroyed. To protect participant confidentiality, all potentially identifying information will be removed.
- You will be contacted by the researcher with the option to review a summary of your interview. You may add to, change, or remove parts of your interview at this time.
- Approximately 10-15 participants will likely be interviewed.

What are the possible benefits of taking part?

Your participation in this research may contribute to service changes in the future to better meet the needs of parents / caregivers and children receiving support from child protection and family support services. You will receive a $40 Coles/Myer gift card to compensate you for your time.

What are the possible risks and disadvantages of taking part?

There is a small risk that you may become distressed during the interview while responding to the interview questions. If you are concerned about his possibility, please talk to the researcher, and go over the interview questions before consenting to participate.

There is a small risk that participants may share information that may prompt a notification to child protection. The interview questions are not designed to gather this type of information

and the researcher will endeavour to prompt participants to pause before continuing to share certain information to minimise this risk.

Do I have to take part in this research project?

Participation in this research project is voluntary. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage without consequence. If you do decide to take part, you will need to sign a Consent Form.
Should you choose to withdraw from the study, you may opt to have your interview taken out of the study, however, this needs to be done within two weeks after your interview date, prior to data analysis. You may also choose to not respond to some questions and/or choose to ask to delete any information supplied.

What will happen to information about me?

By signing the consent form, you consent to the research team collecting and using your interview data for the research project. Any personal information about you will remain confidential both during and after the project and no information which could lead to identification will be released, unless required by law. When reporting findings from the research, participants will be de-identified. Throughout this project, electronic copies of the data will be stored on a password-protected file, on a password protected device only accessible to the researcher and the supervisory team (UniSA supervisors). No other organisation or person will have access to the data collected during the interviews.

What happens when the research project ends?

On the completion of the project participants will be sent a summary of the findings either in hard copy or via email.

Further, upon completion of the project, audiotapes of the interviews and transcripts of the tapes and any other data from the study will be stored securely in the Australian Centre for Child Protection archive for five years. Following this time, all data will be destroyed by a secure document destruction service.

Further information and who to contact.

If you want any further information or if you have any questions concerning this project you can contact the lead researcher- Sarah Seekamp on the details below, or Dr. Lesley-Anne Ey, (Principal Supervisor).

Research contact person

Name	Sarah Seekamp
Position	Lecturer, PhD Candidate, UniSA Allied Health and Human Performance
Telephone	08 86302 2705
Email	sarah.seekamp@unisa.edu.au

Name	Dr. Lesley-Anne Ey
Position	Australian Centre for Child Protection, UniSA Education Futures

Telephone	08 83024600
Email	Lesley-Anne.Ey@unisa.edu.au

This project has been approved by the University of South Australia's Human Research Ethics Committee (Protocol Number: 204226). If you have any ethical concerns about any aspect of the project, or questions about your rights as a participant please contact:

Reviewing HREC approving this research and HREC Executive Officer details

Reviewing HREC name	University of South Australia Human Research Ethics Committee
Telephone	+618 8302 6330
Email	humanethics@unisa.edu.au

Appendix R Study 3 Consent form

This project has been approved by the University of South Australia's Human Research Ethics Committee. If you have any ethical concerns about the project or questions about your rights as a participant, please contact the Executive Officer of this Committee, Tel: +61 8 8302 3118; email: humanethics@unisa.edu.au

SECTION 1: CONTACT AND PROJECT DETAILS

Researcher's Full Name:	Sarah Seekamp
Contact Details:	Sarah.seekamp@unisa.edu.au
Supervisor's Full Name:	Dr. Lesley-Anne Ey, Dr. Margarita Tsiros, Dr. James Herbert
Contact Details:	Lesley-Anne.Ey@unisa.edu.au; Margarita.Tsiros@unisa.edu.au; James.Herbert@unisa.edu.au;
Protocol Number:	204226
Project Title:	Exploring parent/caregiver goals of work with family support services and interprofessional practices to support identification and achievement of these goals.

SECTION 2: CERTIFICATION

Participant Certification

In signing this form, I confirm that:

- I have read the Participant Information Sheet and the details of the research project have been explained to me. I understand and agree to take part.
- I understand the purpose of the research project and my involvement in it including the topics to be discussed.
- I understand that I may withdraw from the research project at any time and that this will not have any negative consequences now or in the future nor effect my relationship with (de-identified family support service).
- I understand I have the option to meet the research er before deciding to participate.
- I understand that while information gained during the study may be published and made public, what I have said will remain confidential, unless required by law.
- I understand that what I say will be audio recorded during the interview.
- I understand that I will have the option to review what I have said and add, change, or remove information during the member checking process.

☐ I would like to request a copy of the research report to be provided directly to me upon completion of the study.

- I understand that the audiotape will be transcribed into a written document and will be stored on a password protected document on a password protected computer at the University of South Australia along with the audio file. I will have access to the transcript to check that information is correct. During the project only the research team will have access to the data. I understand that on completion of the project, audio files and transcripts of the interviews will be stored in a secure archive for five years before they are destroyed.

Participant Signature	*Printed Name*	*Date*

Researcher Certification

I have explained the study to the participant and consider that he/she understands what is involved.

Researcher Signature	*Printed Name*	*Date*

Appendix S Study 3 Parent/caregiver interview guide

1. ***Can you please begin by telling me a bit about yourself and your family and your involvement with X (de-identified family support service)?***

2. ***Thinking about when you first began working with X, can you tell me about things you hoped might happen for you from working with them?***

Were there things you hoped you might be able to achieve, or things that you hoped might become different?

3. **Are there things that you also hoped might happen /change for other members of your family from work with X?**

This may include grandparent, partners, children…….

4. **Do you think other members of your family may have had some of their own goals, or thoughts around what they hoped might happen from working with X?**

This may include grandparent, partners, children…….

Explore whether these goals were like those held by the participant or different.

5. **Can you tell me about how your goals for yourself or other family members may have changed over time while working with the X?**

What sort of things lead to those changes?

6. **Sometimes knowing where to start when getting support can be hard and working out goals can be challenging for workers and families.**
   Can you tell me a bit about how you came to work out what it was you wanted to work on/towards?

Was this something that you were clear about from the beginning?

How did workers contribute to working out what your goals, or goals for you family members might be?

Do you feel like you are working on the things that are most important to you?

7. ***I'm interested in the experience of families who are involved with a number of service providers including child protection.***
   Can you tell me about any other services who you are receiving support from or involved with?

What sort of things are those agencies providing support with?

8. ***Can you tell me about how your work with X might relate to what you are doing with those agencies?***
   In what ways – i.e., related goals, sharing information.

9. **Are there things about the way workers from X and/or those other services worked together that made things easier/better for you and your family?**

10. **Are there other ways that workers from X and/or those other services could work together to make things easier/better for you and your family?**
11.

12. **Is there anything else you would like to share with me that we haven't covered?**

(Clarify approach to member checking)