Evaluation of SA Family Group Conferencing

FINAL REPORT

July 2024

Dr Jacynta Krakouer
Dr Eden Thain
Dr Miriam Maclean
Dr Olivia Octoman
Dr Melissa Kaltner

unisa.edu.au/accp

University of South Australia | Australian Centre for Child Protection

Contents

Acknowledgements

We would like to acknowledge the input of our Project Control Group, which was comprised of members from the Department for Child Protection (DCP), Relationships Australia (South Australia) (RASA), and Aboriginal Family Support Services (AFSS). Our Project Control Group assisted through the provision of advice throughout the evaluation period. We appreciate their time and efforts. In particular, we would like to thank Ms Jodie Halliday from DCP for support throughout the evaluation period, which included providing access to essential project background materials, key personnel, targeted recruitment of participants, and dissemination of results.

We would also like to acknowledge the input of our Expert Advisory Group – Professor Leah Bromfield, Professor Melissa O'Donnell and Ms Amy Cleland – and thank them for their advice and input regarding our evaluation.

We thank all participants who took part in our evaluation. We greatly appreciate their time, enthusiasm and generosity in sharing valuable insights to inform our evaluation.

Finally, we would like to acknowledge all families who have participated in the FGC program in South Australia and their strengths and resilience in rearing their children.

Terminology

Within this report, we respectfully use the following terminology to refer to First Peoples in the Australian context: 'Aboriginal', 'Aboriginal and/or Torres Strait Islander' and 'Aboriginal and Torres Strait Islander'.

We use the term 'non-Indigenous' in this report to refer to people who do not identify as either Aboriginal and/or Torres Strait Islander.

Within this report, we also use the term 'provider' to refer to RASA and AFSS as providers of FGC services, and occasionally refer to DCP as 'the Department'.

Cultural safety is also mentioned in this report, predominantly with reference to Aboriginal and/or Torres Strait Islander families. It is important to note that numerous definitions of cultural safety exist, particularly in the international literature, given the term's origins in the Aotearoa New Zealand context among Māori nursing professionals (Papps & Ramsden, 1996; Williams, 1999).

No definition of cultural safety was provided to participants in this evaluation, thus providing them with opportunity and scope to determine what cultural safety means for them. This is particularly poignant for Aboriginal and/or Torres Strait Islander peoples, given that cultural safety is best determined by those who experience how their culture and identity is responded to within organisational and societal contexts. Eckermann et al. (cited in Williams, 1999, p. 213) provides the following definition of cultural safety:

> … *"an environment that is safe for people: where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience, of learning, living and working together with dignity and truly listening."*

We also note the work of SNAICC – National Voice for Our Children, and the Victorian Aboriginal Children's Commissioner at the Commission for Children and Young People in outlining one definition of cultural safety for Aboriginal children in an organisational abuse prevention and child safety context:

> *"Cultural safety for an Aboriginal child means they experience a safe, nurturing, and positive environment, where their unique identity is respected without attack, challenge or denial. In this environment, their voice is heard and valued, and they are free to explore and express themselves, their culture, views and needs."* (Commission for Children and Young People, 2024, p. 4).

List of Abbreviations

ACCO	Aboriginal Community-Controlled Organisation
AFSS	Aboriginal Family Support Services
AHREC	Aboriginal Human Research Ethics Committee
APY (Lands)	Anangu Pitjantjatjara Yankunytjatjara
ACCP	Australian Centre for Child Protection
DCP	Department for Child Protection
FGC	Family Group Conferencing
FLDM	Family-Led Decision Making
KPI	Key Performance Indicator
NSW	New South Wales
NFGC	Ngartuitya Family Group Conference
RASA	Relationships Australia South Australia
SA	South Australia
UCC	Unborn Child Concern
UniSA	University of South Australia

Executive Summary

Family Group Conferencing (FGC) is a strengths-based, family-led process that aims to empower families to make decisions about the well-being of their children (Connolly & Morris, 2012). Applied in a statutory child protection context, FGC can be utilised to enable families to make select decisions about how children's safety and well-being can best be achieved, drawing on the family's knowledge of what will work best for their unique situation (Connolly & Morris, 2012).

In South Australia, FGC, under the *Children and Young People (Safety) Act 2017*, is utilised in a statutory child protection context, with a particular focus on Aboriginal and Torres Strait Islander families and community members, to identify strategies to keep children and young people safe, and where possible, with family and kin. The FGC program in South Australia is an initiative funded by the Department for Child Protection (DCP). The program is delivered by Relationships Australia (South Australia) (RASA) and the Aboriginal Family Support Services (AFSS).

In South Australia, FGCs are considered decision-making meetings that redefine the role of family and professionals in the care and protection of children (DCP, n.d.). FGC is a decision-making forum in which families and professionals come together to decide on and generate family-led solutions to improve the safety and care of children and young people in child protection. It is a statutory requirement that FGCs are considered for all children in the child protection system in South Australia. The *Children and Young People (Safety) Act 2017* Part 3 – 10.1(d) – states:

> *in each case, consideration should be given to making arrangements for the care of a child or young person by way of a family group conference if possible and appropriate.*

The *Children and Young People (Safety) Act 2017* Part 2 -21(1) states that the purpose of a family group conference is to:

provide an opportunity for a child or young person and their family, in accordance with this Part—

(a) to make informed decisions as to the arrangements for the care of the child or young person; and

(b) to make voluntary arrangements for the care of the child or young person that are consistent with sections 7 and 8, as well as this Act generally; and

(c) to review those arrangements from time to time.

Previous evaluations of the FGC model in South Australia, which commenced as a pilot funded in January 2020, have been conducted (see summary of findings in Appendix A). In July 2023, the Australian Centre for Child Protection (ACCP) was commissioned by DCP to undertake an evaluation of Family Group Conferencing in South Australia, originally covering the FGC Program period from 1 January 2020 to 30 June 2023, and subsequently extended to include site data for referrals to 31 January 2024 and follow-up data to 29 February 2024.[1]

This evaluation report contains the findings of the ACCP independent evaluation of the FGC program in South Australia. This report is structured according to the following sections:

- **Project Context.** This section provides a brief overview of the Family Group Conferencing program in South Australia and how it has operated over time since its inception.

- **Project Team and Governance.** This section details the personnel who were involved in the evaluation, and the governance approach used. The evaluation team included personnel affiliated with, or contracted by, the Australian Centre for Child Protection at the University of South Australia, all of whom were experienced researchers holding doctoral qualifications and

[1] Wherever possible the evaluation has covered this period.

together held expertise in relation to child protection, Aboriginal research, quantitative research and qualitative research. The governance of the evaluation project included a Project Control Group comprising membership from DCP, RASA and AFSS, and an Expert Advisory Group comprised of senior child protection experts affiliated with the Australian Centre for Child Protection at the University of South Australia.

- **Evaluation Methods.** This section provides a brief overview of the mixed methods evaluation approach used by the evaluation team, as well as the sources of data that were accessed and analysed. The evaluation focused on implementation and outcomes of the FGC program in South Australia using quantitative and qualitative data. Specifically, we accessed, collected, analysed and triangulated (where possible) the following data to inform our findings:

    - DCP administrative data
    - DCP case files
    - Organisational data held by RASA and AFSS
    - Pre-collected surveys of families, children and professionals administered by RASA and AFSS
    - Surveys, interviews and focus groups of Aboriginal and Torres Strait Islander and non-Indigenous professionals employed at DCP, RASA, AFSS and other services, including the Department of Human Services, who were involved in, or had a vested interest in, the FGC program in South Australia.

  For ease of reading within the main body of the report, full detail of our evaluation methods are contained at Appendices B and C.

  The limitations of our evaluation approach included a lack of direct participation of families and children who have been involved in FGC in South Australia in the evaluation, and insight into sub-group (i.e., short-term orders, UCC, Aboriginal and/or Torres Strait Islander families, outer regional and very remote locations) experiences of FGC dependent on participant knowledge in qualitative data collection (i.e., surveys, interviews, focus groups). Insights into effectiveness by sub-group were thus derived through quantitative data analysis and triangulated with qualitative insights where possible. Families and children's perspectives were captured via the pre-collected surveys administered by RASA and AFSS, as well as information contained in DCP case files [redacted by the authors due to confidentiality reasons], however this resulted in secondary, and indirect, analysis of families' and children's perspectives on their FGC experience/s. Other considerations out of scope for this evaluation included a full economic cost-benefit analysis for the FGC program, and an evaluation of how the broader context within which FGC sits may impact FGC service delivery.

- **Results.** This section outlines the key results from our evaluation. It is structured according to *Implementation* and *Outcomes* results.

    - Implementation results include high levels of satisfaction with the FGC program for professionals involved with FGC, and strong indication of the program being implemented as intended in a strengths-based and family-led manner. Opportunities exist to strengthen the implementation of FGC in South Australia in relation to referrals (which includes training), and timeframes for FGC service access and provision. This may include the expansion of, and increased investment into, the FGC program given findings relating to service demand and caseloads, including for the Unborn Child Concern (UCC) cohort. Importantly however, in our qualitative findings, participants stressed that complete satisfaction with all issues or resolving all problems related to

FGC service delivery was unexpected and would not be a useful metric for an effective program delivered in a complex social services environment.

- Outcomes results from this evaluation show that the FGC program in South Australia is having a positive impact on children and families who are involved in FGC, with high levels of satisfaction for families involved in FGC and strong outcomes related to effectiveness of FGC. Compared to matched comparison groups, it was found that overall, children who have participated in the FGC program are significantly more likely to have a subsequent case closure, significantly less likely to be the subject of future substantiations of child maltreatment, and significantly less likely to be placed in out-of-home care. Outcomes for significant reduced likelihood to be placed in out-of-home care were repeated for most sub-groups, including Aboriginal and/or Torres Strait Islander families, short-term orders and Unborn Child Concern (UCC) sub-groups, but not for families from outer regional to very remote areas. Furthermore, no reduction was found in relation to notifications based on involvement in the FGC program. This finding is aligned with the qualitative results which indicated that opportunities exist for the FGC program in South Australia to work more closely with health, welfare and support services and professionals to implement FGC plans and support families after their FGC service provision has ceased.

Additional quantitative and qualitative findings are contained in Appendices I, J, and K for ease of reading within the main body of the report.

- **Discussion.** This section summarises the evaluation outcomes and provides key insights into areas of interest and consideration. It highlights that overall, our evaluation has found that FGC in South Australia is having positive impacts on children and families involved in the program, particularly in reducing the likelihood of substantiations of child maltreatment and placement in out-of-home care for most children, including Aboriginal and/or Torres Strait Islander children, those on short-term orders and those under the UCC FGC program. Out-of-home care entries were generally in the order of 33% to 150% higher among the comparison groups compared to the FGC groups, including within these sub-groups. However, as noted, this pattern of reduction in out-of-home care placement was not repeated for children and families in outer regional and very remote areas, where the population is largely Aboriginal and/or Torres Strait Islander peoples. This is an area of concern that requires additional attention, including reviewing opportunities for continued provider and local service collaboration, potential funding increases and focus on DCP practice.

  As highlighted in our report, including children's voices was a primary motivator for most frontline professionals in DCP and Provider organisations. The stories shared of children having a true voice in the conference and preparation phase to share their feelings, wants and needs, and the impact this has on families cannot be underestimated. For many, this inclusion and the power that this has in a conference makes the program innately effective in its key goal: To bring families together to discuss the issues impacting their children, which is most effective when listening to the children themselves and including them as a person worthy of choice and determination. These final two points were extremely profound for Aboriginal and Torres Strait Islander participants.

  Opportunities exist to continue to strengthen the FGC program across several facets, including through the provision of training and collaboration between DCP and providers to strengthen the transparency, including the case direction and ‘bottom lines’ that are at the core of DCP’s

safety concerns for families taking part in FGC; sharing risk and embedding the family-led decision ethos into DCP practice across the continuum of child protection work; and, reviewing systemic opportunities to share risk and work with service providers to support the implementation of FGC plans. There is strength in reducing longer-term DCP intervention in families' lives as a result of FGC in South Australia, as shown in this evaluation, but always room for improvement in a statutory context where decision-making, timelines and circumstances can rapidly change and evolve.

Other opportunities to improve the effectiveness of FGC relate to manageable caseloads for FGC Providers, service expansion, and the measures of effectiveness used for the FGC program, including Key Performance Indicators (KPIs) and the limitations of using satisfaction measures as a proxy for success. Improving community awareness of the FGC program in South Australia was also noted participants in this evaluation as important for improved effectiveness, highlighting the need to implement FGC plans in conjunction with services external to DCP and FGC Providers. Participants suggested that increasing knowledge of FGC could be achieved via mediums such as additional referral pathways, media and community awareness raising initiatives.

- **Conclusion.** This section offers the following opportunities for continued, and improved, provision of the FGC program:

1. Continued funding of current providers, RASA and AFSS, given evaluation insights into established relationships, streamlined functioning and evidence of both family satisfaction and effectiveness.
2. A cost-benefit economic analysis to be undertaken by DCP (internally or externally) to inform future funding needs and requirements, particularly with respect to outer regional and very remote FGC service delivery and the potential expansion of the UCC FGC program. This enabler is aligned with our contextual funding considerations outlined in this report.
3. Expansion of the FGC program with consideration to:
    a. The UCC FGC program and associated funding considering the preventative opportunities it presents.
    b. Regional-specific FGC, including potential funding increases and collaboration with local services and/or local service provision in outer regional and very remote areas (including ACCOs and Aboriginal Community-Controlled Health Organisations).
    c. Increased workforce. And,
    d. Training considerations, particularly within DCP.
4. Implementation of uniform training for DCP frontline staff, including child protection practitioners and High-Risk Infant Workers, with a focus on the family-led decision making ethos, transparency and power, and referral clarity and transparency of bottom-lines.
5. Maintain or expand choice for families as part of FGC service provision, including processes, while upholding respect for Aboriginal and/or Torres Strait Islander self-determination.
6. Consideration of workload concerns for providers, with logistical caseload considerations to continue enabling quality FGC provider service provision.
7. For relevant SA government departments to investigate additional referral pathways, particularly as part of the UCC FGC program, including with respect to the Department of Human Services (DHS).

8. Exploration and discussion of external, or whole of government approaches, to increased support for implementation of FGC plans, including for families (such as kin carers) and external services, with a focus on reducing (re)notifications to DCP post-FGC.
9. Consider opportunities for improved DCP practice, including shifting towards offering all families a 'choice' to participate in FGC, thus potentially enabling opportunities for increased family empowerment during child protection processes.

Project Context

In South Australia, like other models of FGC, the FGC model has five stages, including (1) referral of the family; (2) preparation; (3) participation in the FGC (family conference), which includes information sharing, family time, and agreement to the decisions; (4) plan implementation; and (5) review of the plan (see Figure 1).

Figure 1. Five stages of the FGC Service Delivery Model (Department for Child Protection, 2021, p. 9)

The objectives of the SA FGC Program have been outlined by DCP as being to:

- engage children/young people, families, community and DCP in a child-centred, family-led earlier intervention partnership approach,
- produce actions that result in increased safety and stability of care arrangements for the child/young person and
- provide a culturally safe space to facilitate empowerment of Aboriginal and Torres Strait Islander children/young people, their families and communities to make decisions' (DCP, 2023 – Evaluation Specification, p. 14)

Across South Australia, there are two core models of FGC and model variations across services, including:

- The FGC 'Mainstream model':
    - Relationships Australia SA (RASA) FGC service. This includes the Ngartuitya Family Group Conference (NFGC) Service, and a contracted service delivered to families in the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands. Training for this FGC service was undertaken with Sharon from Leeds, with Paul Nixon, and also separately with New South Wales (NSW) Spirit Dreaming. RASA now facilitate an accredited FGC training that is micro-credentialed in this model, and contract APY Lands FGC service provision to independent Aboriginal coordinators who are known and have well-established connections with community in the APY Lands.
    - Aboriginal-specific FGC service via Aboriginal Family Support Services (AFSS), who worked closely with the Aboriginal-owned company, Spirit Dreaming, in NSW to tailor training to AFSS. AFSS now utilise training developed by the NSW Spirit Dreaming team to inform their FGC service provision.
- The Unborn Child Concern (UCC) FGC Model (RASA and AFSS).

FGC commenced delivery on the 1st of January 2020; however, across the life of the service delivery, there have been changes to the delivery and scope of the service, including changes to the clients able to be referred to FGC, referral regions, and the organisations delivering the service. See Figure 2 for a timeline of funding for FGC across RASA and AFSS since 2020 including changes to location and eligibility over time.

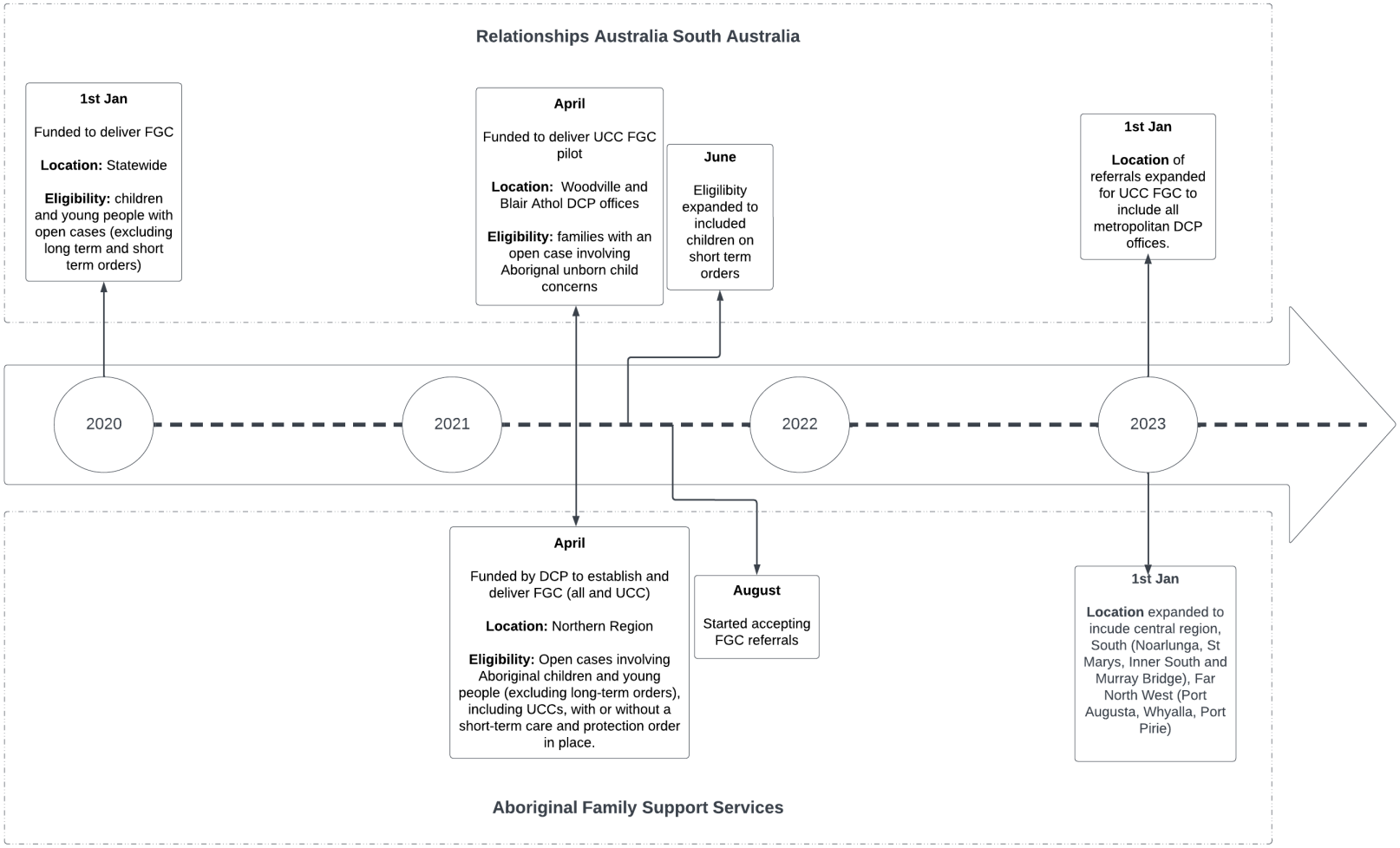

Figure 2. Timeline of FGC including organisation funded, service, location and eligibility since commencement in 2020

Project Team and Governance

This independent evaluation was co-led by two experienced researchers, including one Aboriginal researcher, Dr Jacynta Krakouer (qualitative lead), and one non-Indigenous researcher, Dr Olivia Octoman (quantitative lead) from the University of South Australia (UniSA). Due to unforeseeable delays from external bodies, the lead researchers shifted throughout the project's life – bringing non-Indigenous researcher Dr Eden Thain to lead the project's everyday operations and non-Indigenous researcher Dr Miriam Maclean to complete the quantitative analysis. These researchers worked closely with DCP, AFSS, RASA and the project's Expert Advisory Group and Project Control Group (see Figure 3).

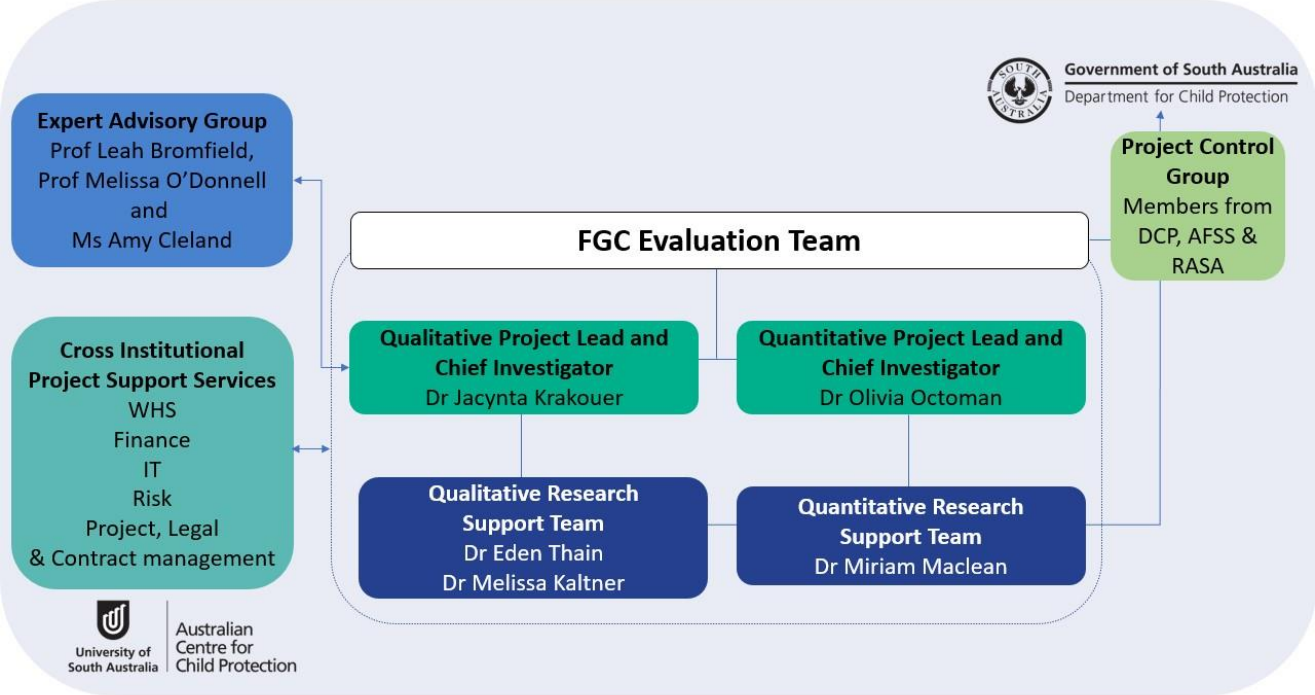

Figure 3. FGC Evaluation Project Team and Structure

The evaluation team maintained an awareness of the sensitivity and emotive nature of the research, especially with respect to Aboriginal and Torres Strait Islander people. Strengthening relationships and engagement with Aboriginal and Torres Strait Islander people, organisations, and communities is fundamental to FGC and was central to our evaluation. Aboriginal and Torres Strait Islander governance was embedded into the evaluation, with our internal Expert Advisory Committee, including ACCP Aboriginal Engagement Strategy Lead, Ms. Amy Cleland, and our external Evaluation Project Control Group, including Aboriginal and Torres Strait Islander staff from within DCP, RASA and AFSS. Our governance approach was not a one-off process but rather a continuous approach throughout the evaluation project and involved key Aboriginal and Torres Strait Islander organisations and leaders providing advice on the evaluation study design, methodology, procedures, analysis, interpretation of results and dissemination of research outputs, including communication of results.

Expert Advisory Group

To ensure excellence in project management and ethics, this project was delivered under the oversight of an Expert Advisory Group. The group provided high-level expertise and direction for the evaluation and the evaluation team. The Expert Advisory Group for the FGC Evaluation Project was comprised of Professor Leah Bromfield, Professor Melissa O'Donnell and Ms. Amy Cleland from UniSA.

FGC Project Control Group

With the support of DCP, a Project Control Group was established to support the evaluation. The Project Control Group included key members from DCP, AFSS and RASA, and a consultant who had worked closely with FGC in South Australia. The Project Control Group brought a wealth of expertise to the service delivery and operations of FGC in South Australia. This group was consulted throughout

the project with key consultations to discuss the methods of the evaluation and feasibility and to present and discuss interim findings to ensure appropriate interpretation of findings, and communication of results.

Evaluation Method

This project aimed to independently evaluate the FGC program in South Australia funded by DCP and delivered by two organisations: RASA and AFSS. The evaluation aimed to ascertain to what extent the FGC program is achieving its intended objectives, to assess the acceptability and effectiveness of the FGC program, and to contribute to improving FGC service delivery by independently evaluating the FGC program and its delivery. An overview of the three stages of the evaluation is provided in Figure 4 below.

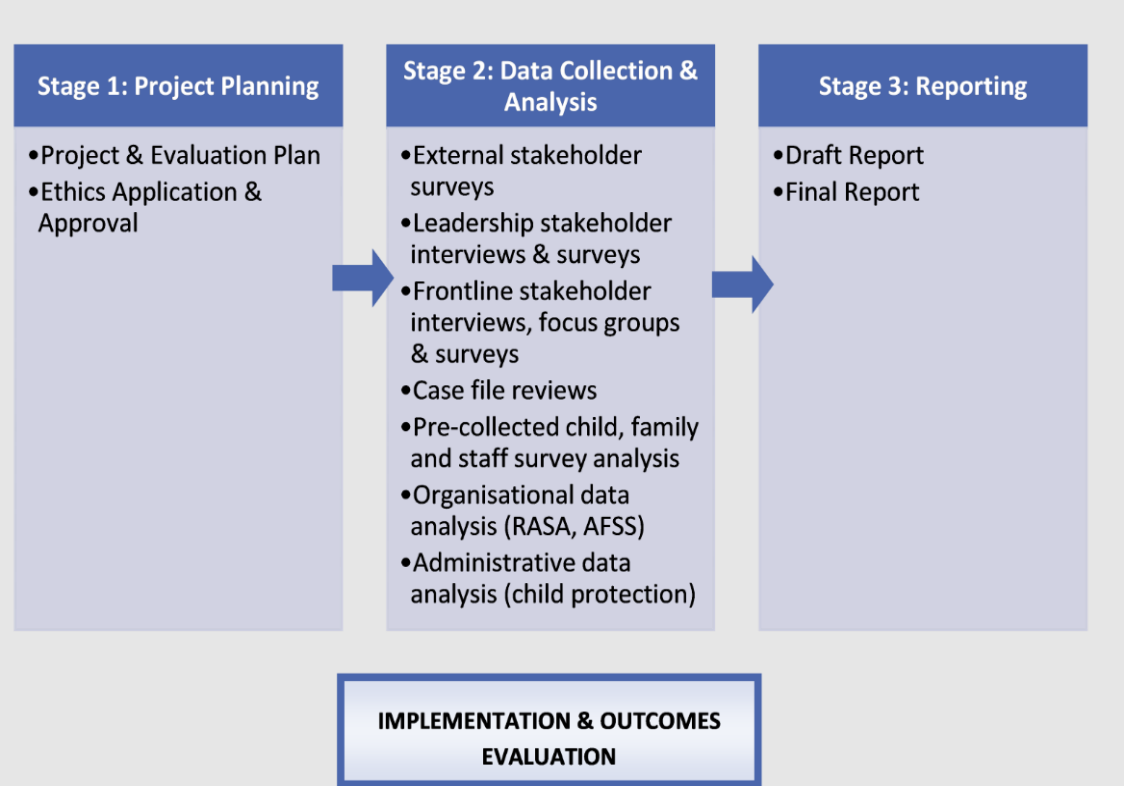

Figure 4. Overview of stages of the evaluation

Stage 1: Project Planning

During this first stage of the evaluation, the evaluation team received and read background information provided by DCP to support developing and refining the Project Plan and Evaluation Framework. The research team met with key stakeholders, the Expert Advisory Group and the Project Control Group, to refine the evaluation approach provided in this document.

The ethics application for this evaluation was submitted to the Aboriginal Health Research Ethics Committee (AHREC) and through the UniSA Human Research Ethics Committee. Unfortunately, due to the high workloads of these external bodies, the project's approval was delayed at an ethics board level. Therefore, a 3-month extension to approval was required for data collection, analysis, and write-up.

Ethics approval for this evaluation project was received from both the Aboriginal Health Research Ethics Committee (AHREC) (AHREC protocol number 04-23-1091) and through the UniSA Human Research Ethics Committee (UniSA project number 205863). These ethical approvals ensured that the project was undertaken to the highest ethical standards for research and evaluation, which is particularly important for vulnerable populations, including children and families involved with child protection systems and Aboriginal and Torres Strait Islander people.

Stage 2: Mixed Methods Data Collection and Analysis

This project used mixed data collection and analysis methods to ensure a robust evaluation that delivered insights into the implementation and outcomes of the FGC program in South Australia. A summary table of the methods used to capture implementation and outcomes data is presented in Table 1.

Table 1. Evaluation methods, sample, and what this data enabled insight into

METHOD	WHO	ENABLED INSIGHT INTO
	Qualitative	
Surveys	• External stakeholders engaged with families involved in FGC, including: • Service providers at schools, birthing hospitals, and intensive family services	• Engagement in FGC and external services • Outcomes for children and families involved in FGC
Interviews and Surveys	• Leadership stakeholders, including: ○ RASA leadership ○ AFSS leadership ○ DCP Leadership	• Referral process • Implementation of FGC, including barriers and enablers • Opportunities for improvement of FGC • Using FGCs to address UCC reports, and with those under short-term orders • Cost of providing FGCs • Outcomes for children, young people and families involved in FGC
Interviews, Focus Groups and Surveys	• Frontline FGC staff, including: ○ RASA Coordinators ○ AFSS Facilitators ○ DCP High Risk Infant Workers and other key staff involved in UCC FGC pilot	• Child and family engagement with FGC • Effectiveness of FGC program • Using FGCs to address UCC reports, and with those under short-term orders • Outcomes for children, young people and families involved in FGC program • Barriers and enablers associated with FGC • Opportunities for improvement of FGC
Case File Reviews	• Randomly selected case files from DCP, with at least one Aboriginal and/or Torres Strait Islander family, and one culturally and linguistically diverse family, selected.	• Reasons for referral into FGC • Child and family engagement with FGC • Effectiveness of FGC program • FGC process across program organisations • Outcomes for children, young people and families involved in FGC

Quantitative		

Pre-collected Surveys	• RASA and AFSS services, including surveys completed by:
	  ○ Children
	  ○ Families
	  ○ Staff
		• Child, family and worker satisfaction with FGC process
		• What worked well and suggestions for improvement

Organisational Data Analysis	• RASA and AFSS services	• Number of referrals received into FGC • Number of families who did not accept connection to FGC and reason • Number of families connected to FGC • Number of completed FGC meetings • Who participated in FGC meetings

Administrative Data Analysis	• Department for Child Protection	• Outcomes following FGC, including:
		  ○ Reports
		  ○ Investigations
		  ○ Substantiations
		  ○ Placement in out-of-home care
		  ○ Closures

Further detail on the qualitative and quantitative methods used in this evaluation can be found at Appendix B. Qualitative Methods and

Appendix C. Quantitative Methods The survey tools, interview and focus group guides used for qualitative data collection as part of this evaluation can also be found at Appendix D. Guide for Interviews with Leadership Stakeholders-Appendix H. Survey for External Professionals.

Results

The results below are structured according to *Implementation Results* and *Outcomes Results.* These sections contain mixed methods findings from quantitative and qualitative data[2] analysed for the evaluation. The qualitative data gives the context in which the quantitative findings can be understood, and likewise, the varied qualitative data provides understanding through triangulation—narrowing broader notions into likely and trustworthy target concepts and themes. Where possible, insights from data from multiple sources have been integrated to demonstrate where qualitative and quantitative findings align.

Before considering these results, it is important to highlight that both providers are spoken about in a uniform manner ("Provider") throughout the qualitative data. This aligns with the data, wherein the two providers involved were unanimous in all but two areas: (1) the referral-in meeting procedure and, (2) how much variance between provider models was tenable and warranted (one arguing for uniformity, the other for divergence and adaptability to meet the needs and preferences of the families served by FGC). The authors of this report are ethically bound to maintain the anonymity of the providers given the sample and population sizes in consideration, as well as this uniformity in answers and analysis. Therefore, further identification of the provider organisation is inappropriate, and is only undertaken in one section under Outcomes Results where provider feedback data was analysed. This split was necessary since the two sources of provider data varied (including in terms of how responses were worded and measured), and thus unable to be merged despite similar family satisfaction outcomes being apparent.

Implementation Results

The implementation results are structured according to two sections:

1. Referrals.
2. FGC Service Provision, with additional considerations provided for:
    a. Case direction and withdrawal.
    b. Unborn Child Concern considerations. And,
    c. Cost of FGCs.

Referrals

The number of referrals[3] received in the FGC program are presented below in Table 2.

Table 2. Summary of referrals, families referred, and children referred

	DCP Referrals of families	Distinct families referred	Distinct children referred
AFSS	176	~151	270
RASA	898	~804	1526
Total	1074	955	1796

**Note that distinct families will be a slight undercount per service, as families referred to both services will only be counted once to ensure the total number of families is correct.*

[2] Please note that some qualitative quotes are presented with errors in grammar or spelling corrected for ease of reading, or elements cut out if the answer had identifying information (marked by ellipses).

[3] To determine the numbers of referrals made to the FGC program, we analysed organizational data. This quantitative data includes data collected by RASA and AFSS (1 January 2020 – 31 January 2024), which is collected as referrals for families, and data collected by DCP, which is provided for individual children (1 January 2020 – 29 February 2024). Families are counted in two ways. When counting referrals, the same family may be counted more than once, if they have been referred to one of the services more than once over the duration of the study, or if they have been referred to both services at different times, particularly if it was not the same child/children as the focus of the referral. Counting referrals provides insight on the workload of the services, as each referral may involve contacting the family and potentially proceeding to a conference. We also report on individual families, to identify how many families have interacted with the service. Reporting on children allows us to examine outcomes for children whose families have participated in FGC, and comparison children.

Key quantitative findings in relation to referrals include that:

- **Just over half (56.4%) of DCP referrals to FGC were for Aboriginal and/or Torres Strait Islander families** (see Table 3, p. 14).
- **Slightly more than half (53.3%) of family referrals resulted in an FGC conference** (see Table 4, p. 15).
- **Referrals were most often made during the child protection investigation phase** (*n*= 557 of 1074 referrals) (see Table 5, p. 15).

Referrals for Aboriginal and Torres Strait Islander families

In relation to referrals made for Aboriginal and/or Torres Strait Islander families:

- Most (97.7%) made to AFSS were for Aboriginal and/or Torres Strait Islander families[4]. Aboriginal and/or Torres Strait Islander status was not yet determined for the remaining families referred to AFSS.
- Almost half (48.3%) of referrals received by RASA from DCP were for Aboriginal and/or Torres Strait Islander families.

Table 3. Aboriginal and Torres Strait Islander Family Referrals

Referrals by Aboriginal and/or Torres Strait Islander origin	AFSS	RASA
Aboriginal but not Torres Strait Islander origin	165	425
Both Aboriginal and Torres Strait Islander origin or Torres Strait Islander origin only	7	9
Neither Aboriginal nor Torres Strait Islander origin	0	453
Not ascertained	4	11
Total	176	898

The survey results of 23 frontline DCP practitioners (including caseworkers, High-Risk Infant workers, Principal Aboriginal Consultants or Practice Leads, and Supervisors or Senior Practitioners) showed that most (*n*=15, 71%) reported that there was no difference when making a referral for an Aboriginal and/or Torres Strait Islander family to FGC.

A small number (*n*=6) of DCP frontline practitioners indicated that some differences were evident, including for referrals to the Unborn Child Concern (UCC) FGC program or in relation to the Aboriginal and Torres Strait Islander Child Placement Principle, as shown below:

- *While all families are considered equally in the FGC process, the Aboriginal Placement Principles clearly establish an objective for how we engage with Aboriginal families. Notably, our efforts should demonstrate participation and partnership. Additionally, there is currently an NFGC HRI role that only focuses on referring Aboriginal UCCs for the NFGC [RASA] process.*

- *As per our practice principles, family-led decision-making is embedded into our practice with cultural families. Not to say Caucasian families are not offered the same opportunity; however, there are fewer community/cultural supports willing to offer their service provision in a CP context, so more often than not, there are no family, community or services who are willing to join the process to support risk mitigation; therefore, a drawn-out process of an FGC is not considered the most suitable option. DCP practitioners can facilitate a similar dynamic with the same practice principles to ensure the decision-making is family-led, where suitable.*

[4] This is to be expected since AFSS is an Aboriginal Community-Controlled Organisation (ACCO) delivering FGC services specifically for Aboriginal and/or Torres Strait Islander children and families. Less than 5 referrals to AFSS were for culturally and linguistically diverse (not Aboriginal and/or Torres Strait Islander) families.

Referrals for Culturally and Linguistically Diverse families

The RASA site data indicated there were also 78 referrals for culturally and linguistically diverse families, which included 17 families who identified as having Aboriginal and/or Torres Strait Islander origin and another culturally and linguistically diverse background.

Outcomes of referrals

As shown in Table 4 (below), 572 referrals resulted in an FGC conference (including 352 recorded as including a review). Withdrawals of referrals by DCP (*N*=234) often reflected a worsening or, in some cases, a significant improvement in family functioning, safety or circumstances such that a different service or intervention was considered more appropriate. The relatively high number of withdrawals may be partly explained by the fact that many referrals occurred during the investigation phase of child protection involvement, so the assessment of the family's needs may change through the investigation process. When the families chose not to engage, in most cases, the reason given for a family not engaging or withdrawing from the service was simply that they did not want to participate in FGC[5].

Table 4. Outcomes of referral

Outcomes of Referrals of Families	AFSS		RASA		Total	
FGC and review convened	37	21.0%	183	20.4%	220	20.5%
FGC convened	50	28.4%	302	33.6%	352	32.8%
Referral/preparation	23	13.1%	60	6.7%	83	7.7%
Declined	21	11.9%	87	9.7%	108	10.1%
Withdrawn by DCP	32	18.2%	202	22.5%	234	21.8%
Withdrawn by family	11	6.3%	40	4.5%	51	4.7%
Withdrawn/declined (unspecified)	2	1.1%	24	2.7%	26	2.4%
Total	176	100.0%	898	100.0%	1074	100.0%

Referrals were most often made during the investigation phase (51.9% of 1074 referrals), as shown in Table 5 (below).

Table 5. Child Protection Phase at Referral

Referrals - Phase at Referral	AFSS		RASA		Total	
Investigation	67	38.1%	490	54.6%	557	51.9%
Protection Order	51	29.0%	122	13.6%	173	16.1%
Protective Intervention	28	15.9%	225	25.1%	253	23.6%
UCC	30	17.0%	60	6.7%	90	8.4%
Not stated	0	0.0%	1	0.1%	1	0.1%
Total	176	100.0%	898	100.0%	1074	100.0%

[5] 15 more specific reasons for families withdrawing from the FGC program were provided. These included: "Family engaged in different services or processes such as mediation"; "Child entering care placement"; "Family relationships or not wanting a meeting with others"; "Change in family circumstances"; "Did not want to travel for a conference"; "Other issues such as housing taking priority"; "Family did not feel properly informed prior to referral"; and, "Withdrew after being informed of risks".

Enablers in referral practices

Our qualitative findings, including interviews with DCP, RASA and AFSS, identified several enablers for current referral practices. These included:

- **The timeliness and quality of referrals**. And,
- **Post-referral communication between DCP and FGC service providers**.

Timeliness and quality of referrals

All parties involved across DCP and providers discussed the high rate they consider families for referral. Given the adaptability of the FGC program, the variety of presenting child protection concerns, timelines, and needs of families were not viewed as issues. Many of those interviewed discussed at length the variety of families they considered either for referral or were seeing in the FGC process. Providers, in particular, were eager to encourage the provision of FGC to more families with different needs. DCP staff were more reticent, given the late or progressed nature of the issues for which families were being referred. Providers discussed this late-stage referral as well but often focused on the strengths of moving towards family-led decision-making, which is unlikely to be available for families before FGC referral.

Providers generally discussed what they were looking for in a quality referral. More on referral qualities are described below; however, two key elements were continually repeated: family empowerment and transparency. Throughout the FGC referral, the focus is on family empowerment to take control of the issues. However, there should also be a consistent focus on transparency and truth-telling of those issues, both from DCP and for the family. This seems to be the impetus for Providers seeking more information on the situation around the child and the plans from DCP staff regarding what investigations and assessments were taking place. Providers highlighted that without such transparency, they were reticent to take on the referrals as this could produce issues throughout the FGC process. Providers did note, however, that workers often still take on referrals that are not complete in their investigation and information-gathering phases.

> *There have been times where we've really had to challenge family and social workers with being transparent about certain information and that is when it really gets tricky because obviously, you're trying to work collaboratively with both, but you have to challenge both at the same time and go right "We know that this is what you talked about in the phone call. You need to talk about it in front of family." (Provider)*

Post-referral communication

Both providers and DCP participants discussed post-referral communication. DCP staff sometimes reported the post-referral communication as an increased workload. While this is true, it is also an attempt to control workload issues for Providers. Providers discussed how both parties need to better understand the bottom lines, plans, and timelines around the family and their child's safety before proceeding with the family group conference. Providers highlighted that there was not much uniformity in the referrals they received but that families are unique, so differences are to be expected.

Therefore, Providers' current practice involves further post-referral communication with DCP workers to clarify the bottom lines, current child safety, and the plans going forward from the DCP workers, such as further investigations and assessments. This information helps providers clarify the suitability, direction, timelines, and needs of that family compared to those otherwise on their workload. Providers were eager to maintain this post-referral communication.

> *… as a team we have open arms. Where DCP workers should ring and say, "What do I need to do next?" and we will be very open to that... (Provider)*

Opportunities for further development for referrals

The opportunities for further development for referrals were in relation to:

- **Timeframes**, including when referrals are made by child protection and the length of FGC service provision.
- **Training**, focusing on improving the clarity of bottom lines and the referral-in meeting which takes place at the commencement of the FGC service, and,

- **Improving the quality of referrals**.

Timeframes

As shown in our methods section (see Appendix B. Qualitative Methods), an online survey, which remained open for one month, was distributed electronically in March 2024 to DCP frontline staff implementing FGC (defined as those involved in the delivery and/or implementation of the FGC program, including caseworkers, High Risk Infant Workers, Principal Aboriginal Consultants (PAC), Practice Leads and Supervisors/Senior Practitioners) to supplement interview and focus group data. In surveys of DCP frontline staff, where 15 completed responses were received and analysed, timeframes for the FGC process were mentioned as a concern.

Table 6. Issues reported for referral process by DCP frontline staff

Common issues for Referrals (as coded by analyst)	Codes	% of responses
Long timeframes / Delays	11	73.33%
Conflicting information (availability and needed consenting parties)	3	20.00%
Referrals rejected	3	20.00%
Needing to both refer and confer about a case (time issue)	1	6.67%
Referral in meeting complications (e.g., family timing)	1	6.67%
Service limitations (i.e., regional)	1	6.67%
Timeframes getting better over time	1	6.67%
Total Responses	15	100%

This may be related to the reality that just over half (51.8%) of referrals made to FGC by DCP occur during the child protection investigation phase, as shown in Table 5 (p. 14).

Specifically, concerning the UCC FGC program, some data contained in surveys of DCP frontline staff highlighted similar timeliness issues, both in long timeframes and in the late stage at which referral is made. This was compounded with extra considerations for referral approvals for non-Indigenous families. The reasons, as coded, were as follows:

Table 7. Challenges for UCC FGC Program as reported by DCP frontline staff

Challenges for UCC (as coded by analyst)	Codes	% of responses
Late pregnancy notice issue - earlier is better	4	20.00%
Time intensive	4	20.00%
The limit to Aboriginal and/or Torres Strait Islander families	3	15.00%
Regional availability	2	10.00%
Mother reluctance	1	5.00%
Need improved cultural considerations	1	5.00%
Several bad experiences	1	5.00%
Staff hesitation	1	5.00%
No challenges	2	10.00%
No experience	4	20.00%
Total responses	20	100%

Some suggestions for improving the provision of the UCC program provided by DCP frontline staff who completed surveys included:

Table 8. Suggestions for improvement of the UCC FGC Program by DCP frontline staff

Suggestions for UCC (as coded by analyst)	Codes	% of responses
Open program to all	5	27.78%
Overall Timeliness	3	16.67%

Earlier family work	2	11.11%
Clarity on roles and responsibilities	1	5.56%
Pre-birth timeliness	1	5.56%
Embed Aboriginal Maternal Infant Care Workers (AMIC)	1	5.56%
No Suggestions	3	16.67%
No Experience	4	22.22%
Total Responses	18	100%

Training

A principal element that returned continuously through the discussion of opportunities for further development was the necessity of consistent and constant training for DCP staff. Providers, in particular, were very sympathetic to the fast-paced nature of staffing changes in the Child protection space. Providers pointed to a lack of consistency in their referrals and also sometimes a misunderstanding of the process – e.g., invitations to all family members for the referral-in meeting. Providers also discussed the potential for training to be embedded beyond or before DCP employment. For example, questioning the level at which educational institutions incorporate family-led decision-making and Family Group Conferencing as an element of helping families with child protection concerns will determine new DCP staff's ability to adapt to the FGC program needs.

> *I would love for DCP… for there to be a lot more practice investment in their existing workers [and] to make this a mandatory [training]. (Provider)*

Both DCP leadership and provider staff knew staffing changes were systemic rather than a specific issue for the FGC program.

All involved raised a particular point about the bottom lines. For DCP, the bottom lines were the key concerns; therefore, they carried the risk for their cases. For providers, the bottom lines were the point at which families could start to take control. Given this separation, at times, it seemed that the bottom lines were not amenable to the family-led decision-making ethos and, therefore, unsuitable for a family group conference. Given the above elements of consistent communication, this was often the point at which providers wished to gain clarity or provide direction to DCP staff for their referrals. Maintaining a clear bottom line that assesses risks while giving families the power and control to choose the direction of solutions to address that concern is paramount to both DCP's and providers' interests.

A more mechanical consideration arose: who leads the referral-in meeting for the Family Group Conferencing process. Two Clear reasons for two separate directions were provided. One direction was that, at the referral-in point, providers should take control of the direction of Family Group Conferencing and lead the meeting to establish themselves as the point of contact for the family. The alternative rationale was that the provider must maintain separation from DCP, but at this point, the relationship is only between the family and the DCP staff; therefore, it is appropriate for the DCP staff to lead. This second point seemed particularly important for Aboriginal and Torres Strait Islander families, given the long histories of community issues with DCP intervention. Therefore, the only outcome from this analysis is that referral-in meetings should be explored more, especially as contextually sensitive as to who is most appropriate to lead these rather than a one-size-fits-all referral-in meeting process. DCP staff, particularly supervisors, raised this as a potential point of confusion for their staff given the complications around training new staff, as commented above.

Improving the quality of referrals

In discussion with Providers, some general elements for quality referrals were mentioned:

Table 9. Qualities of Desirable versus Limiting Referrals

Desirable qualities	Limiting qualities
Clear Bottom Line with Family Choice in how to address the issues	Non-family-oriented bottom line Pre-determined, top-down pathway

Transparency of concern and path forward (investigation and assessment)	Hidden elements (from provider and family)
Suitable timing considering assessment to flexibility (e.g., not after all choices have been made or before safety is established)	Too early (still need assessment)
	Too late (pathway 100% set)
Children are provisionally safe	Not safe / no assessed safety
Family suitably ready, informed and consenting	Family confusion on participatory nature

To provide a rudimentary example, the issue of a mother's drug consumption was provided in a focus group. Participants described a limited referral, which included a bottom line that detailed timelines and outright expectations such as: "*Mother will be free of drug use within the next six weeks utilising X service".* A more desirable referral will state the issue of the mother's drug consumption, that the children must be protected from it, and be clear on timeframes of assessments or other decision-making on the part of DCP but allow the choice of services or outcome of the mother's or children's positioning to be up to the family. The example given by participants described a final family plan; the family would work with the mother to stop any drug consumption in the presence of children, and the mother would receive respite assistance with their children regularly in the care of family members while they would work on their drug issues in a more culturally appropriate way, including culturally appropriate services.

Bottom lines – especially when expansive or detailed – could become a plan told to family:

> *Sorry, the bottom line, that is a massive point of contention between all of us, you know, and I think it would just kind of whether we use them, whether we don't use them, how to structure them… we want it to fit into it like a as sort of a statement, a safety statement and not dot points because we like to have a position that if there's drop points all of a sudden you've got a plan. (Provider)*

The above example underscores the role of DCP staff in upholding the family-led decision-making ethos in the Family Group Conferencing program. This approach allows providers to navigate their processes while ensuring the ethos remains intact, and families are given control. DCP staff consistently acknowledge the importance of considering the risk placed on children and how this risk focus leads staff to address concerns in a very specific way.

FGC Service Provision

This section draws on qualitative findings from surveys, interviews, and focus groups with professionals from DCP, RASA and AFSS. It begins with overall perspectives on delivery of the FGC program. Subsequently, it is structured according to enablers and opportunities for further development within each of the phases of the FGC process, as indicated below:

- Organisational Relationships (Enablers, Opportunities for Further Development)
- Preparation Phase (Enablers, Opportunities for Further Development)
- FGC Conference – Event (Enablers, Opportunities for Further Development)
- Family Plans (Enablers, Opportunities for Further Development)
- Follow-up/Review (Enablers, Opportunities for Further Development)

For further details, please see Appendix K. Additional Survey Results, which contains additional findings from surveys related to FGC service provision.

Delivery of the FGC Program as Intended

- **FGC delivery is largely as intended**.
- Further **discussion on follow-up/Review practices** could be explored.
- **Only slight divergences** which align with Family-Led Decision Making (FLDM) ethos.

As shown in our detailed methods section (see Appendix B. Qualitative Methods), an online survey was distributed to RASA and AFSS frontline providers (defined as those involved in delivering the FGC

program at RASA and AFSS) in March 2024 to supplement interview and focus group data. While the sample size is small (potentially due to the simultaneous offer of participation in interviews and focus groups wherein 10 frontline providers participated – see Appendix B. Qualitative Methods), in surveys of five frontline providers involved in delivering the FGC program, they were asked to assess whether their delivery of FGC was as intended. This means assessing how it linked to their training and the intentions given to them by that training or other information, including documentation. All aspects were rated as intended except for one report on FGC's follow/review aspect, which was rated as 'moderately as intended'.

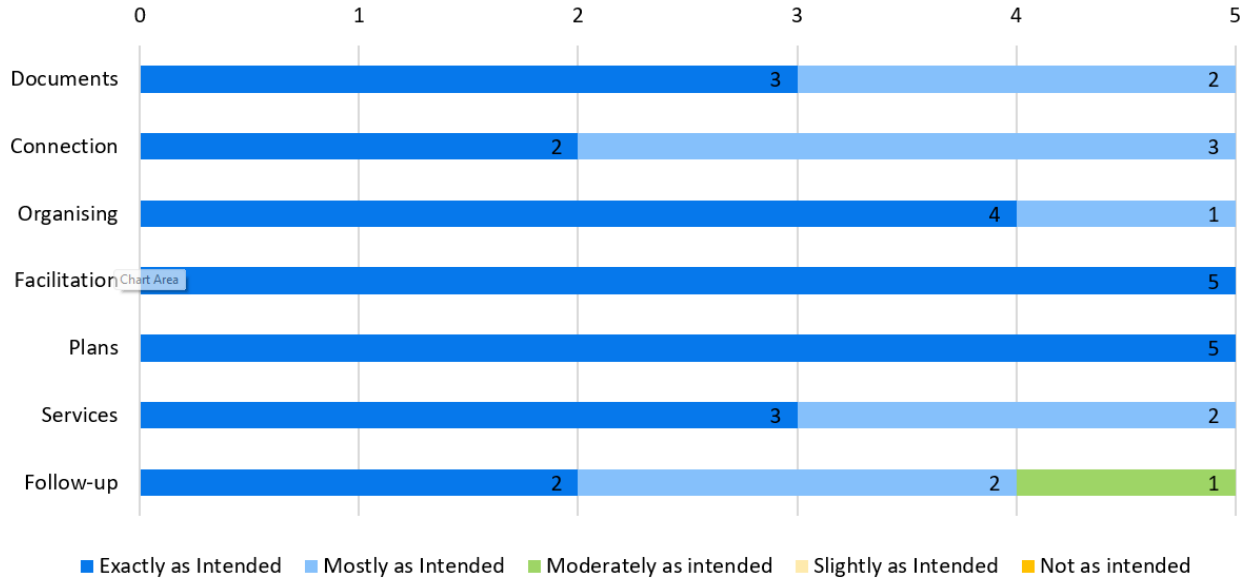

Figure 5. Reports of use/delivery as intended of aspects of the FGC program by Provider frontline staff

Frontline providers were then asked to focus on their most recent FGC and consider attributes of the FGC, including the focus on family strength and family-based solutions over professional solutions, cultural safety, that children are heard, and that the plan is agreed to and addressed the bottom line. Again, the sample rated that most aspects were present, with divergence in professional solutions, which was expected as the family-led decision-making should limit this inclusion, though professionals are present and may suggest some, and there was some lack of knowledge around cultural safety.

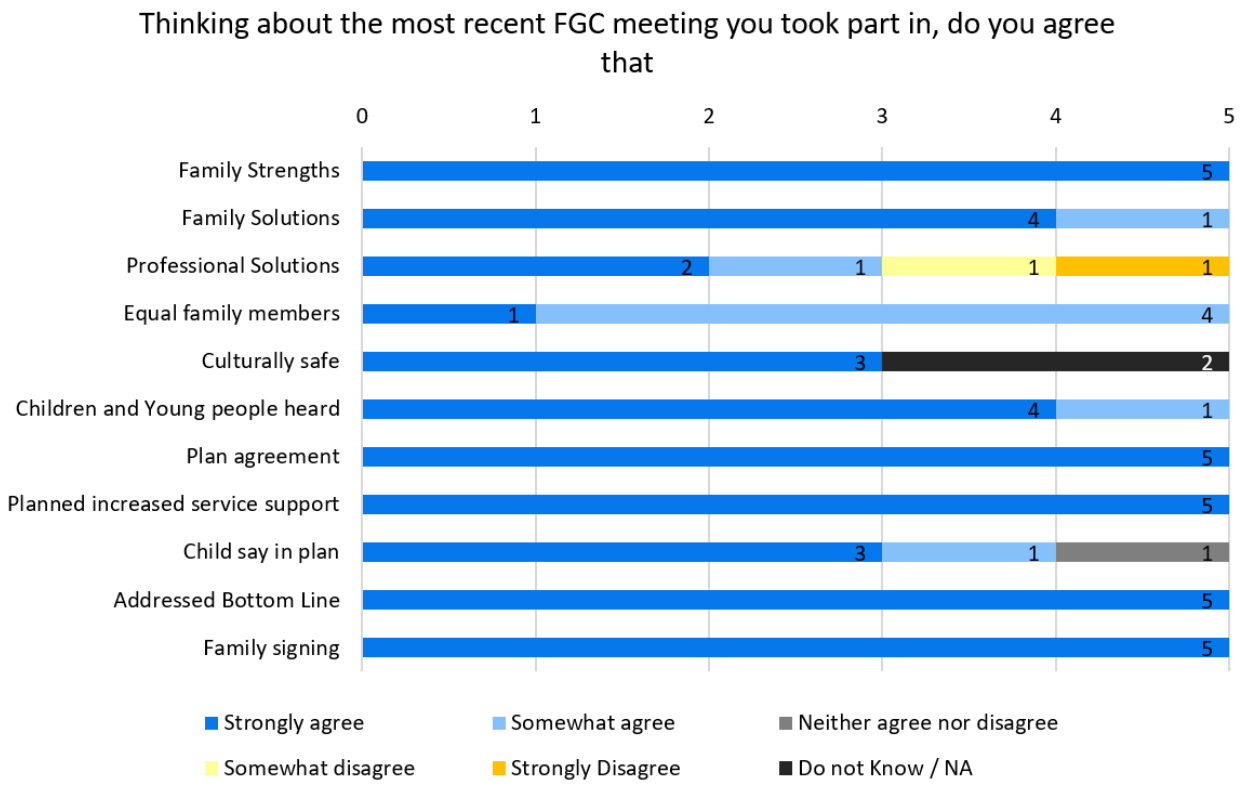

Figure 6. Most recent FGC qualities observed by Provider frontline staff

Organisational Relationships: Enablers

- **Initial relationship needs are met**.
- **Streamlining** is occurring.
- **Relationship management is ongoing**.

All those interviewed consistently noted that the working relationship between all organisations involved in FGC was the core of producing quality work. Particular providers, especially from the leadership cohort, discussed the effort put in at the establishment of the FGC program to begin partnership-based relationships between DCP and providers. Many spoke of these relationships as beyond their establishment phase and that most 'teething' issues are being worked out and streamlined.

> *Well, I think now that it's a bit more developed, everyone sort of knows what we're doing while we're here. So, it's streamlined a bit more of the processes… (DCP)*

While these relationships were commented on as being now established and streamlined, there were still areas of expansion and consideration for the ongoing nature of the relationships. In particular, a few areas are under current consideration or actively in the minds of frontline workers, both for DCP and providers. These included:

- Continuing to establish relationships with the rotating frontline workers for providers and DCP.
- Continuing to build relationships through organisational presence and communication pathways.
- Continuing to establish procedures and protocols and their clarity between organisations.

For providers, there was a focus on these relationships, mostly facilitating a better relationship between DCP and family rather than the providers and family or the providers and DCP. This consistently came back to both the focus of family-led decision-making within the FGC provision and the long historical and cultural context of DCP in families' lives, particularly for Aboriginal and Torres Strait Islander families.

Organisational Relationships: Opportunities for Further Development

- **Maintain identity separation** between Providers and DCP.
- **Clear understanding of the dependencies and context of timelines/timeliness.**
- **Further reinforce family-focused and FLDM-based partnerships between all parties.**

All parties discussed the need for frontline provider staff to be present, particularly those in DCP who are inexperienced in FGC. All parties interviewed or in focus groups commented on the capacity to improve the presence of providers inside DCP offices or in direct communication with DCP workers. Potential costs for iterations of this continued communication, increased communication, or increased presence of providers around, near, or with DCP locations or workers were noted.

One organisational point under discussion was the positionality of the organisations from the families' perspective. Both providers highlight the need to separate their organisation from DCP practices clearly. This is not an easy task, as the providers thought it best that families viewed their provision of FGC as separate from DCP and its involvement in their families. This was particularly profound for Aboriginal and Torres Strait Islander families. The complexity of this separation was discussed, particularly for the transition point of referral-in meetings.

Future targets for developing organisational relationships included fundamental aspects like knowing who to talk to and who to email. Throughout the following and previous data, timelines arose as a particular sticking point around the challenges and possible improvements of the FGC program. In interviews, these largely came from not understanding who to talk to or how to gain the information needed between both parties, often driven by the different timetabling, scheduling, and processes of workers between the organisations. These sometimes could be as simple as someone being on leave and communication lines being disrupted. The need for better understanding and communication was emphasised to improve these situations.

One potential avenue for further relationship development is all parties' shared goals. Both DCP and provider staff emphasised the need to prioritise families as the central point of focus. The safety and productivity of the family, particularly the child, are the primary concerns of all actions. This was presented as a caution against losing sight of this shared direction and adopting a more isolated (us-and-them) view of the provider-DCP relationship, which should be avoided.

> *… because at the end of the day, we're all there for the same reason to keep children safe. And, so, what I've started to realise is that relationship is just as important as the relationships we have with children. If we wanna create change, we need to bring everyone on board and everyone needs to be able to kind of have an understanding of, Yep, we all need to do our bit and do our bit well. (Provider)*

Preparation Phase: Enablers

- **Family choice** in who, what, where, and when throughout.
- **Support to and for children** in the preparation phase.
- Where **"real work"** occurs.

The key consideration for providers was to allow families to highlight those in their networks who needed to be incorporated into the Family Group Conferencing process. Providers spoke of this as the true start of control and family-led decision-making. While the focus was generally on parents, it was important to maintain a focus on bringing in support and addressing an understanding of rupture within relationships, especially given the complexity of the history of the families involved in DCP referrals. In discussions with DCP supervisors, several mentioned that they believed they knew who should be involved in the preparatory phase and invited to the event of the Family Group Conference itself. Providers rejected this idea as being against their training and the ethos of the family-led decision-making models.

The key consideration for providers, on the other hand, was increasing the circle of support for parents and particularly for children; this finding connected again to the central organising concept of transparency, not only between family, DCP and provider but between family members:

> *That's what's effective, that we've widened that circle, that no matter if DCP, because DCP there what nine to five, if DCP are not there. Often when it goes down its at night time and you know… there's*

> *violence or whatever it's the family that are gonna be there and pick up the pieces and often they know more than anybody. So, widening that circle and making sure that everybody knows what's going on for children that's what, to me, is effective and whether they can kick in themselves and go and, you know, take a child from a parent and take them home with them that night. (Provider)*

Providers and ECP staff discussed how the families' control largely affects the preparatory phase. This could present issues, such as if families disconnect or lack engagement with provider staff. But it can also open opportunities to get the work for the family plan done at families' pace:

> *Then, depending on the prep work, they'll either come with a plan where everyone's on board, or they will come with the drafts and then decently step out and allow the family to create a plan. (DCP)*

In this phase, the engagement of child advocates and time with children was particularly important. These spaces were the providers' focus, particularly providers that allowed for in-house child advocates. The discussion of time and knowledge sharing with children were profound and important. Including children's voices before and beyond the event of the Family Group Conference itself was important to all involved and recognised by all those participating in interviews and focus groups.

The preparatory phase work was discussed as not being captured in KPIs, and neither the focus of the funding provision nor the process itself but essentially the spaces in which the complex and needed work was completed.

> *Interviewer:* *… it sounds like the prep work is the real work. The prep works where it all happens.*
>
> *Provider:* *Fully, fully. Yeah. It is the most important part, it truly is, it's the most important part because it and if you get, if you do good prep work, you can just get to the conference day, you start the conference and the family just kick in and do their thing.*

Preparation Phase: Opportunities for Further Development

- **Maintain limited DCP input** in who is involved.
- **Improve communication** between providers and DCP throughout preparation phase.

The opportunities or concerns for the preparatory phase largely revolve around maintaining family control. Communication with families should occur promptly and involve many parties that DCP or providers could identify. The family-led decision-making ethos was stressed as needed throughout this phase, allowing the family to engage with providers as they wanted to and to allow the engagement of family, friends and other services as they requested. Providers, in particular, highlighted the need to allow for this variability, recognising that this may mean that sometimes parties, as identified by DCP or other services involved, may not always be included in the preparatory phase nor in the event itself.

On the other hand, DCP staff raised interesting and important points when considering the communication element during the preparation phase. DCP staff suggested that they could more clearly communicate case direction and new information to providers while providers could communicate the stage and progress of contact with the family, who is contacted in the family and their network, any updates to timelines for contact and any interruptions to contact or further preparation. It was suggested that with this communication, providers and DCP would be more comfortable with interruptions and timeline changes.

FGC Conference – Event: Enablers

- **Preparation work leads** to agreed plans.
- The conferences as an event of **healing and helping relationships**.
- **Addressing needs throughout the family**.

As stated above, the Family Group Conference is often the culmination of much preparation work. Frontline provider staff indicated that without the correct preparatory work, there are cases where families have come together when a plan could not ultimately be agreed upon. Without the necessary preparatory work, a plan may not eventuate. On the other hand, with the correct amount of preparatory work, a family can discuss their needs and establish a plan already well understood by family members, given that they have had time to digest the ramifications and the extent of the issues presented. This ties directly into the need for transparency, highlighted in referrals.

All those interviewed and participating in focus groups commented on the high success and the privilege of attending Family Group Conferences. Many participants spoke out particularly powerful stories in how they displayed family change and the FGC's adaptability to unique contexts. For example, dealing with family members who are otherwise unavailable for conference. Including a mother:

> *And that was awesome… they had family time, obviously, like the whole family went in there and saw Mum, and they have like a little playground and contact rooms and stuff. So, the little boy came along too, and then for the family meeting, obviously like an auntie took the kid out, and we used like one of their education spaces… like put on lunch and everything, so that was quite a cool FGC… And I think it was so much better, obviously, for mum to be present in person because that whole, the whole point of that meeting was like, who's gonna be looking after this boy while Mum [could not], like which family we relying on and who's gonna help mum when she's [available] to, like, get her act together. That was where, like, the best FGC I've ever done. (DCP)*

Family Group Conferencing is also seen as a chance for many families to overcome pain and issues that have existed for a long time. One of the continually repeated ideas was that ruptured relationships could be repaired through the event of a family group conference.

> *Some families have had so much rupture for, you know, decades, and that they can still come together, put that aside, or say you know get things off their chest and say things and cry and apologise and stuff and then you know, get to the point of getting kids in a safe, safe house. So, it's amazing work really. (Provider)*

FGC Conference – Event: Opportunities for Further Development

- **Sharing risk and, therefore, control** from DCP to family.
- **Improve training** for on-the-ground approval in DCP staff.

There was a uniform sticking point in the discussions of conferences. Primarily, the child protection system works to reduce the risk for children at all points within investigation, assessment, and intervention. For DCP workers, this became an issue as their focus had to be on risk assessment and mitigation. That focus sometimes seemed at odds with the family-led decision-making that underpins Family Group Conferencing. Both providers and DCP recognised that a change requires a systemic shift, moving risk from the department to families. But this need exists in a context and a media space where it is uncomfortable for DCP staff to relinquish control. This was described as both a relinquishing of power and an understanding of the risk that everyone holds. The opportunity for further development was to embed family-led decision-making at all department levels and involvement with child protection. This opportunity for further development obviously exists well beyond the program's scope.

> *You know, in that or earlier intervention, I think it's got, I think, the family-led decision as a broader overarching concept. I think that's really important for our work, you know, to empower families where they can to make that, make those decisions and self-determination, obviously for Aboriginal families. But I do agree with you, and I think that's what staff struggle with. (DCP)*

More practically, issues arose around the approval process for plans. In many cases, families, in collaboration with the providers, could develop plans that addressed the needs as they saw them, yet the DCP staff present were cautious, worried, or required further external approval from supervisors to allow a plan to go forward. Both DCP and provider staff recognised this might indicate limitations in the frontline worker training and capability or confidence in applying family-led decision-making. The opportunity here would be maintaining the training level of all participating in Family Group Conferencing for a smooth transition between family plans and the approval by DCP. Again, this is a more systemic opportunity for development than one that is mechanically linked to the program of Family Group Conferencing, but nonetheless, it is a key and necessary element to consider when assessing how functional Family Group Conferencing is.

> *… we were being called out for sending workers who didn't have, I guess the skill set to be able to confidently agree to a plan when they or there's a confidence issue. But there's also maybe the plan wasn't that suitable or wasn't satisfying our bottom line around what we wanted safety to look like. (DCP)*

Family Plans: Enablers

- **Impressive family-provided solutions**.
- **Helping with problems** – but not a magic solution.

Family plans are extended experiences that reach beyond the meeting itself and the approval of DCP. The life and effectiveness of these plans extend through time and into the reviews (see next section).

Participants frequently shared how impressive the level of detail and the steps of the plans were. Families were said to find unique ways to address issues that were not originally thought of in investigative or other intervention pathways.

> *So sometimes I'm really impressed with the amount of detail they put in. With some of the plans, it's been good. (DCP)*

The most particular and recurrent outcome was increased support directly to the child or children. This was often spoken about as an increase in a circle of support or direct eyes on a child that allowed them to remain safe. The stress from Family Group Conferencing providers was that this support came from families rather than the intervention approach by DCP that would see the families not maintain their relationship with their child through removal. This final point is particularly important for Aboriginal and Torres Strait Islander families.

> *When you add the family, you bring that up too. Now that means more eyes on children. The safer children are, so that, to me, is effective. Not only that, it's effective because you're leaving the child within its family structure, which is going to be better, anything that leaves that child within its family or community structure is way better for a child. (Provider)*

With plans and providers, as well as DCP staff focused on improving child safety, the complexity of these issues was consistently returned to. Some discussed that FGC is not a solution for problems that are persistent and often intergenerational. Nor will it address interconnected relational and systemic issues for families. But the plans put in place are good and allow many more people to be involved in the solutions for improving children's safety.

> *… there were some really good plans put in place … we have really good family plans put in place. We're really there, lots of people were invited around the table, so family as well as services were invited and … the work had been done pre-FGC in terms of getting the right people around the table. (DCP)*

Family Plans: Opportunities for Further Development

- Further integration with **external services**.
- **Financial support** for plans inc. kin-based care.
- **Expanding** ongoing review and support.

Opportunities for further development of the plans for Family Group Conferencing were spread throughout the discussions. One of the key outcomes was the recognition that many plans require implementation that involves external services. In some cases, referral pathways can be long, sometimes services have limited capacity, and sometimes the completion timelines of plan-integrated objectives are at the behest of those services. This, again, is an opportunity for further development that reaches beyond the program itself. Appropriate service provision with wrap-around support that extends beyond the Family Group Conference as a single event is necessary to improve outcomes for children. As mentioned above, there is a recognition that the opportunities for further development to see the success of these plans rely on viewing Family Group Conferencing as not the only solution but a step towards family-led decision-making to improve children's safety.

Aligned with the survey results, the results for interviews and focus groups were consistent. Concern was voiced about the lack of financial support for family and kin-based carers, particularly around larger families where a kin-based carer may involve multiple children under their care. Many parties suggested that Family Group conferences need to, in some way, incorporate funds and other financial means or directions, such as integration with Centrelink that will allow kin-based carers or other carers within families to access financial support. This was stressed as a necessity to have appropriate outcomes from family group conference plans.

This was similarly discussed for families with multiple and complex needs. In many cases, the Family Group Conference addresses the main bottom line as presented by DCP: improving the safety of children. However, there is a consistent relational element at play for family group conferences. Other family members and the family as a whole require support, and therefore, ongoing service support, including sometimes continued connection to DCP may be required to support these more complex needs.

The most concrete future development was to view Family Group Conferencing as not a one-and-done event. Rather, family group conferences could be requested by many other parties or families themselves to go over and develop plans to address multiple needs repetitively. This incorporates itself into the discussion around follow-up and reviews (see next section).

> *And again, for families that will need it; like a lot of these families we fully expect that we'll get, it's not just one-and-done. We might get 2, 3, 4 FGCs, but these families deserve as many family group conferences as they need. (Provider)*

Follow-up / Reviews: Enablers

- A **celebration** of success.
- A **chance to pivot** for complications and complexities.

The discussion on follow-ups in reviews was less than for the other sections. Many DCP and provider staff discussed how important and good it was to have follow-ups, but also discussed the limitations in both their provision and their allowance given funding or other workloads. Some said they had not participated in any or had no knowledge. Control remaining with family to ask for a follow-up or to come back to discuss a plan was praised and upheld as a core element that aligns with the ethos of family-led decision-making.

When reviews did happen, they were discussed as a chance to pivot if needed, for example, if a plan was not going according to its original design. Otherwise, families requested reviews as a form of celebration to review and understand the progress that they made and their achievements.

> *But if [DCP] closed, a lot of families still wanna review because they just, I found that a lot of the families actually quite enjoy coming together and celebrating what they have done so far. Yeah, it's more like a celebration. (Provider)*

Follow-up / Reviews: Opportunities for Further Development

- **Other parties to raise reviews**, remove re-notification needs.
- **DCP could maintain contact** to support plans and reviews.

Some provider staff described needing further clarification on what the review process could look like or what an expanded review process could look like. This opportunity for further development would involve treating follow-up and the review process as a core part of the FGC program. Many participants linked this future direction with the view that Family Group Conferencing is not a one-and-done solution.

Reviews similarly require linkages to external services. Some participants suggested that external services may be able to raise reviews or further family group conferences. This suggestion was made to prevent the only pathway to a second FGC being a re-notification to DCP.

Similarly, DCP and provider staff seemed at odds with their views of how Family Group Conferencing and reviews can operate as a systematic measure of children's safety. For example, providers often commented that they wished that DCP would remain in contact with families and be aware of the family's progress to facilitate closer reviews of that progress. DCP staff suggested that reviews should be owned by the family and the providers as DCP cases and workloads require the closure of those cases. All parties agreed that ending DCP in the involvement of families' everyday lives is a benefit but that it may be naive to progress a case to closure with an agreed plan, given the high complexity of the problems under discussion in these plans.

Case direction and withdrawal

- **DCP case direction changes impact** the completion of FGC processes at all stages.

Throughout the interviews, participants indicated that the DCP case direction processes determine the outcomes for FGC. This impacted what was seen as a fit referral:

Provider 1: *[if there are referral issues] feel free to re-refer, but other than that, we generally meet with the family, don't we? In a referral-in meeting and try and explore things and unpack a bit more and see if we can move forward. For a good outcome for the family. But if there's no scope for family, then decision making.*

Provider 3: *Sorry, when the case direction is not clear or they're still in that assessment phase or they haven't completed their investigation. That's a really tricky space. We're still working because you start working with the family. We've had done a couple of times [where that was the issue]. We, so, the beginning working with the family and they have a really clear direction they want to go in.*

This impacted the preparation phase work outcomes – with sudden direction changes impacting the sustainability of family engagement and explaining withdrawals for providers.

> *If it was during the prep, I'd say it's the family withdrawn or there's been child protection, more child protection items where the departments changed their case direction. Usually, it's often we will get them changed case direction. (Provider)*

Providers found that their effectiveness, in the view of DCP, was still determined by the power DCP has in directing family outcomes beyond the FLDM models that directed their work.

> *Once you get to conference, but only half make it to conference throughout the whole time that we've done it, I'm and I'll put it in, put those numbers in my feedback, which makes me go actually there's still a little bit and that's usually the front where all of a sudden DCP has changed case direction and really fast because of not being able to let go of that relinquish power. (Provider)*

This stressed the areas of needed growth for all of FGC as a program:

> *FGC is in its infancy, yeah, so there's been families who haven't had great experiences of a process either it's started and then it's fallen over because DCP has changed case direction or, you know, whatever's happened. So, it's not necessarily something that everyone's loved. We're learning how to do it. (Provider)*

UCC considerations

- **Timeliness of referrals** repeated as a consideration.
- **Possibilities associated with earlier FGC provision,** including more than one conference.

The UCC program was spoken about sparingly throughout interviews. Due to the low number of UCC voices captured, it was also difficult for them to present data without identifying them. Throughout interviews and focus groups, UCC appeared in several of the common conversational points including family consent and willingness to participate:

> *There's only been one referral recently that I rejected without or declined. Sorry without meeting the family 1st, and that was because mum hadn't been contacted. She was pregnant. It was an unborn child concern. But they had no contact details. Because it's a fully consenting process like you can't, you can't even start in a conference unless they say yes. I would like to start this process. (Provider)*

The issues raised in the survey around early UCC intervention were put at odds with the onerous monitoring practices of DCP, that this tendency is receding for some, but this means that case direction changes are sometimes determined by a lack of knowledge on pregnancy and birth.

> *For some, we've got immediate concerns that you can't have an FGC on that day like we've got a newborn and say the newborn is born like, I mean for unborn. Obviously, we try and do FGCs before,*

> *but we've also had someone we don't even know. People are pregnant and then next minute here's a newborn baby. (DCP)*

Otherwise, the UCC program was spoken about by those in leadership as the less developed element of FGC while suggesting the interest and need for expansion.

> *Like there's and, there's a lot that comes with those conferences and we're trying to and then, you know, we did get their unborn child conferences, which is a little bit, you know, the uptake is we were kind of getting there. But yeah, I think that and there has been an appetite to keep funding this space and which is great. (Provider)*

Cost of FGCs (travel, time, and caseloads)

- **Cost of travel, logistics of travel and contexts** of cases impact on performance (timeliness).
- **Team size** impacts on timeliness.
- **Aboriginal and Torres Strait Islander contexts are paramount and aligned with FLDM**.
- Above considerations stressed when considering Provider effectiveness.

Both providers were rather uniform in the limitations they saw from an economic perspective. While there were points in the discussion that providers acknowledged FGC per conference cost seems high at face value, the work around the conferences as events and the number of cases considered were stressed above and beyond this. When costs and funding to the FGC program were a point of conversation throughout interviews and focus groups, markedly often this was a call for more funding and work to be done in the program:

> *I feel like people, you know, we have a lot of turnover in DCP. So I feel like people are bit worried. Should we refer? Should I do an FGC? Should I not? It's not always the first thing they think of, so I think that's just the thing. Over time, that's going to continue to develop, and if that the government probably puts in more funding or continues to fund it well, that will continue to see a lot more positives. (DCP)*

For providers, the workforce-to-workload ratios were the critical consideration for further funding, and as referral numbers increase, more funding and more stability in positions are needed to allow for more work to be done.

> *You know, funding agreements and budgets and recruitment and so in some ways it's really great, but the downside is there's not that many hands to do lots and lots of work (Provider)*

The workload on particular workers was stressed, but this contextually combined with the locality of the families. For example, while a caseload of 8 families was repeated, providers returned consistently to the logistical issues, time, money and planning involved in servicing families across the state:

> *Eight families on your caseload, or five families on your caseload. But two are in [regional], one's in [another regional location], and some of them are [elsewhere]. Down here in metro again planning and the logistics of that… So then do that in eight weeks if you had 20 staff? Potentially you'd be looking at having some regionalised teams. Which then makes you more responsive to that area. You're not having to do as much travel backwards and forwards and around… So, I think logistics become a massive issue and the economy of scale and funding, there's all those challenges involved (Provider)*

The realities of linking funding to effectiveness were a worry point for providers. They were aware that their effectiveness could be reduced to their KPI metrics but stressed the unique contexts of FGC and the need to follow families rather than deliver their service. This was particularly pointed when considering the KPI and, therefore, workload and funding impacts of completing FGC preparatory work for Aboriginal and Torres Strait Islander families, as noted below.

> *Provider 3:* *Our families, they have community obligations that they have to fulfil that and stuff. So, you never know when that's gonna happen. And that just pushes everything. We've got one at the moment. They had to go up to*

community for Sorry Business. Cars broken down and they can't get that back and it's just suffers like nice and yeah, it does push the time frames out a lot. But I mean, we do try.

Provider 1: *We do try and we have sort of made a I don't know if I want this recorded, but we have sort of made a decision as a team that KPI's are important, but they're not as important as cultural safety for our families. So if we when I do my reporting, I do a lot of commentary. You know the commentary box to say why we haven't met them. Because we consider the very good reasons why we haven't met the KPI's. And it's important.*

Provider 2: *But it's important to reflect that because Aboriginal people Aboriginal and Torres Strait Islander people are unique and there are a lot of times, we've got one particular family where, they go on Sorry Business and you know as Aboriginal people we have Sorry Business that could go on for three months, six months, 12 months you know and they trying to get back here. Because they've got housing here. And so it is, they're engaging with some Aboriginal services there to support them and get them back to that. So, we wait and then I, I still got to see these children… but I can wait. And then when we're told when we communicate with that Aboriginal Health Service or community, they say "Yeah, they're coming back now" then we'll go out.*

Provider 3: *But then there's also, because their families and community, and we sort of have to get together with them as well and talk to them and then. Yeah. And so, it can really blow those timelines and KPIs right out the water and then.*

Provider 2: *You know, you know in and then in SA they call it Nunga time, yeah. Nunga time means have you ever heard someone say, "I'll be there in a minute" My friends do this for me. Yeah, so they'll say because they know there's something at 12:00. They will tell me that it is at 11:00. I reckon you're a Nunga like because like our time things. It's not that we're deliberately doing it, but in SA, it's the Nunga time thing they call it, like on Aboriginal time. But it depends on what's happening for the family. And we just work with the families around, OK? Yes, we have KPIs, and we have to follow this family safely on their journey working with them.*

Overall, there is a need to consider the complex contexts at play in the program implementation. Without consideration of these contexts, issues can arise, and the boundaries and markers of an "effective FGC delivery" may be set in a way that does not align with the FLDM and FGC model ethos and practicalities. Providers and DCP staff acknowledged the change in system processes is needed to align to FGC over FGC conformity to DCP historical practice. The results direct towards these costing and funding considerations in further expansion or provision of the service.

Outcomes Results

Satisfaction with FGC

Analysis of the pre-collected[6] family feedback surveys collected by RASA and AFSS showed that overall, families who took part in FGC with both RASA and AFSS were highly satisfied.

Aboriginal Family Support Services (AFSS) FGC Satisfaction

Sixty-four (64) family members completed the AFSS feedback survey about their involvement with the FGC program at AFSS between 22/03/23-23/12/23. These responses were received in relation to at

[6] Our evaluation team received raw data for secondary analysis from surveys that has been designed and administered by RASA and AFSS to families that participated in their FGC service. Some of this survey data had been collected prior to the commencement of the evaluation (hence, the naming of the surveys as 'pre-collected'). See Appendix C. Quantitative Methods for further information.

least 20 distinct families[7] involved in FGC, thus highlighting multiple family member responses for some families. For families involved in the AFSS FGC program who completed the AFSS feedback survey:

- **Most (93.7%) family members were either 'very satisfied'** (*n*=25) **or 'extremely satisfied'** (n=35) with the FGC conference process.
- **Most (95.3%) felt that the process was genuinely supportive of family-led decision making**.
- All (100%) family members agreed that the **conference was 'done in a culturally respectful way'.**
- All (100%) family members agreed that their **FGC was a fair process**.
- All (100%) family members indicated that their **facilitator treated them respectfully** throughout the FGC process.
- All (100%) family members agreed that they had a **clear understanding of the agreement** that was made at the end of the conference.

The pie chart below shows the satisfaction ratings provided by family members who completed the AFSS feedback survey.

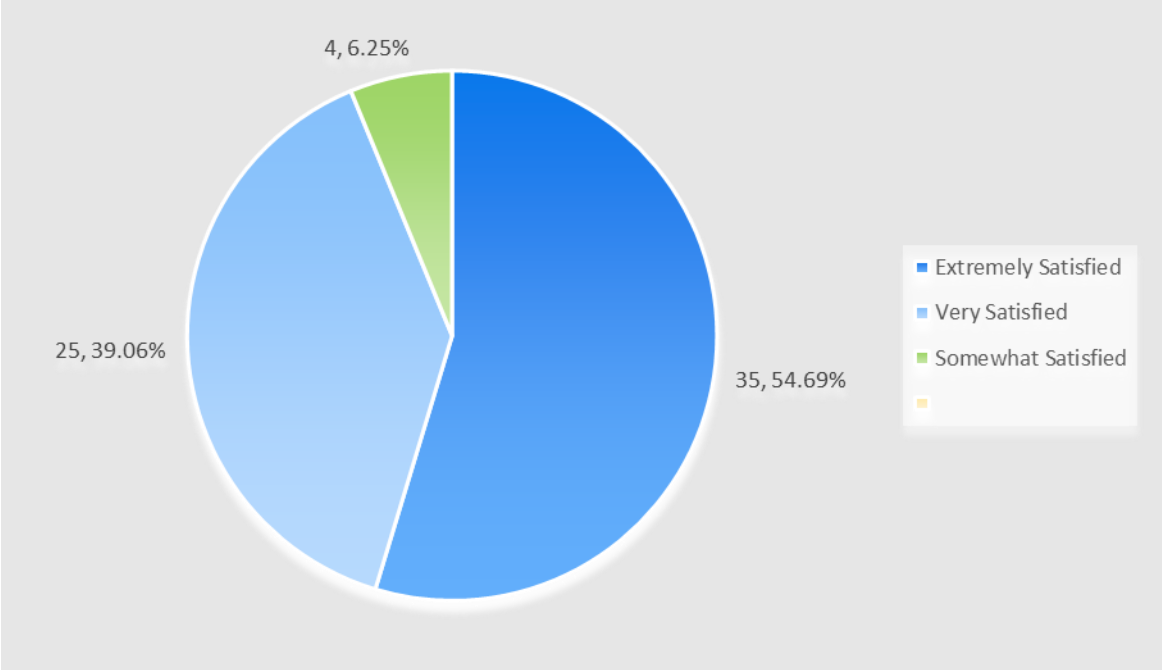

Figure 7. Family Satisfaction with FGC process (AFSS) - How satisfied were you with the conference process?[8]

Relationships Australia South Australia (RASA) FGC Satisfaction

A higher number (*n*=785) of family members or close friends (such as family friends and support people for parents) completed the RASA family feedback survey administered by RASA about their involvement with the Ngartuitya Family Group Conference (NFGC) program (RASA) between 11/01/22-29/1/24. These responses were received in relation to at least 198 distinct families[9] involved in FGC, thus highlighting multiple family member responses for some families. The RASA feedback survey for families included feedback obtained after the NFGC conference (*n*=753), and after the review (*n*=32).

[7] This was calculated based on the client ID numbers linked to the raw data received. This figure does not take into account missing client ID numbers.

[8] Pie chart results displayed as "Count, Percentage".

[9] This was calculated based on the client ID numbers linked to the raw data received. This figure does not take into account missing client ID numbers.

For families involved in the NFGC program who completed[10] the RASA feedback survey after the conference (*n*=753):

- **Most (94.9%) family members indicated that they were satisfied with how the FGC went**, by selecting 'agree' (*n*=331; 44.1%) or 'strongly agree' (*n*=381; 50.8%) on a 5-point Likert scale.
- **Most (94.3%) felt that they were given a fair opportunity to help lead the decision-making process**, by selecting 'agree' (*n*=235; 34.7%) or 'strongly agree' (*n*=404; 59.6%) on a 5-point Likert scale.
- **Most (94.1%) felt like the child's voice was heard and encouraged**, by selecting 'agree' (*n*=209; 31.0%) or 'strongly agree' (*n*=426; 63.1%) on a 5-point Likert scale.675
- **Most (91.4%) felt that their family's culture, and what was important to their family, was recognised, included and respected**, by selecting 'agree' (*n*=225; 33.4%) or 'strongly agree' (*n*=391; 58.0%) on a 5-point Likert scale.
- And **most (93.2%) felt that the child at the centre of the NFGC will be safer** because of decisions made during the FGC process, by selecting 'agree' (*n*=211; 31.3%) or 'strongly agree' (*n*=417; 61.9%) on a 5-point Likert scale.

The pie chart below shows the satisfaction ratings provided by family members who completed the RASA feedback survey after the conference.

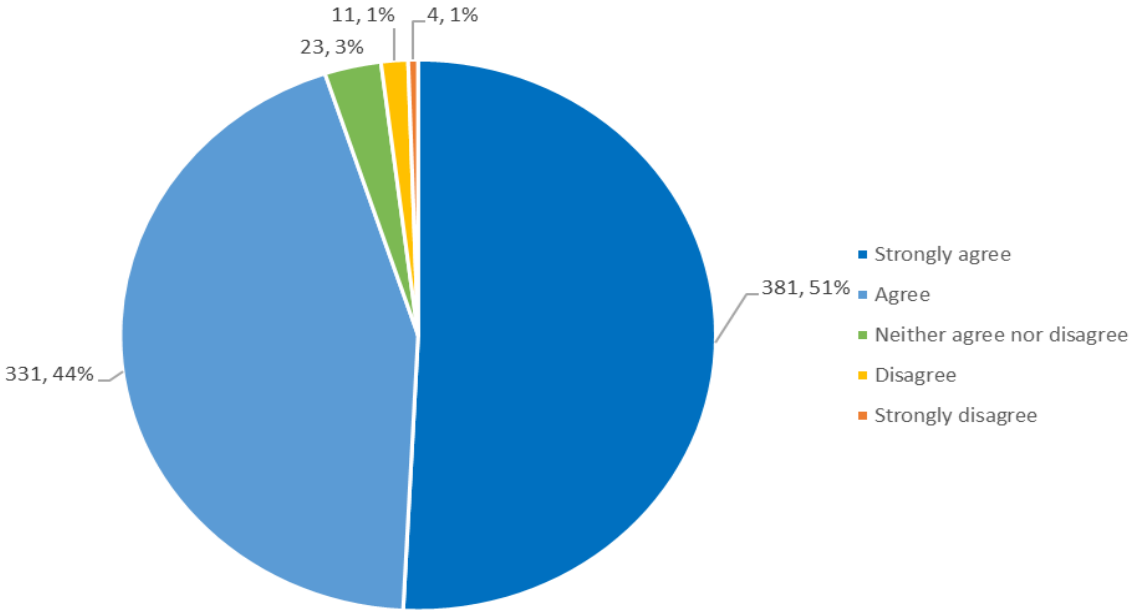

Figure 8. Family Satisfaction with FGC process (RASA) - 'Overall I feel satisfied with how the FGC went'[11]

For families involved in the NFGC program who completed the RASA feedback survey after the review (*n*=32):

- Most (90.6%) indicated that the **child at the centre of the NFGC was safer now because of the decisions made during the FGC process**, by selecting 'agree' (*n*=14; 43.7%) or 'strongly agree' (*n*=15; 46.9%) on a 5-point Likert scale. None indicated disagreement with this statement about the child's safety at the review stage.

[10] Missing responses were excluded from analysis.
[11] Pie chart results displayed as "Count, Percentage".

Effectiveness of FGC

This section draws on quantitative child protection outcomes data used to measure the effectiveness of FGC in reducing rates of notifications, substantiations and placement into out-of-home care. It also draws on interview and focus group data with participants, predominately from DCP, RASA and AFSS, where the effectiveness of FGC was discussed.

To determine the effectiveness of FGC in reducing rates of notifications, investigations, substantiations, placement into out-of-home care and case closures using quantitative data analysis, we used matched comparison groups to enable an understanding and exploration of outcomes for families referred but who did not engage, families who engaged with FGC and families who were never referred to FGC. Detail about the analysis cohort used to determine child protection outcomes is provided in table format at Appendix I. (Please also refer to Appendix B for detail about our child protection administrative data analysis methods).

Child Protection Outcomes – Statistical Analysis

As length of follow-up varied across the children and groups (see Appendix C), cox regression analysis was used to examine whether there was a significant difference between the FGC participants and the two comparison groups in child protection outcomes (rereports, investigations, substantiations, entry to out-of-home care and case closures) at any given point in time (accounting for follow-up time, as well as whether the child was on short term orders at the time of referral, and Aboriginal and/or Torres Strait Islander status). This analysis was only conducted with the main group due to the difference in dates required for the unborn cohort to take into account birth timing (the UCCs and other key subgroups are addressed below).

Results showed that the FGC children were:

- **Significantly more likely to have a re-report after the meeting date than the referred-only group, and no significant difference compared to the matched comparison group.** The referred-only group had 13% less risk of a re-report than the FGC group at any point in time during follow-up (HR = 0.87 [95% CI 0.77-0.98]).

- **Significantly less likely to be the subject of an investigation after the meeting date than the matched comparison group, and no significant difference compared to the referred-only group.** The matched comparison group had almost two times the risk of an investigation at any point in time during following up compared to the FGC group (HR = 1.95 [95% CI 1.74-2.18]).

- **Significantly less likely to have a substantiation after the meeting date than the matched comparison group, and no significant difference compared to the referred-only group.** The matched comparison group had more than two times the risk of a substantiation at any point in time during following up (HR = 2.44 [95% CI 2.15-2.77]) compared to the FGC group.

- **Significantly less likely to enter out-of-home care after the meeting date than both comparison groups.** The referred-only group had 33% higher risk of entering care (HR = 1.33 [95% CI 1.09-1.63]) and the matched comparison group had more than double the risk of entering care (HR = 2.54 [95% CI 2.02-3.18]) at any point in time during following up compared to the FGC group.

- **Significantly more likely to have a case closure after the meeting date than both comparison groups.** The referred-only group had a 60% lower likelihood (HR = 0.40 [95% CI 0.36-0.46)*]) and the matched comparison group had a 45% lower likelihood of having a case closure (HR = 0.55 [95% CI 0.51-0.60]) at any point in time during following up compared to the FGC group.

These results may reflect a higher level of monitoring associated with involvement in FGC and/or services they may be referred to, however a reduction in substantiated abuse or neglect and a reduction in likelihood of entering out-of-home care, and an increase in case closures (overall and earlier as also shown in Appendix I Table 21 and Case closures are presented in Table 22. The majority of children in the UCC FGC group (74.5%) had a case closure in the first 6 months after birth.

Table 22. Time from FGC meeting and from birth to first closure (Unborn Child Concern)

Time from birth to first closure	**FGC Unborn Child Concerns**		**Matched Unborn Child Concerns**		**Referred Only Unborn Child Concerns**	
	Count	%	Count	%	Count	%
4 weeks or less	17	30.9%	57	34.5%	10	28.6%
1-6 months	24	43.6%	28	17.0%	7	20.0%
6-12 months	3	5.5%	5	3.0%	1	2.9%
1-2 years	3	5.5%	2	1.2%	0	0.0%
>2 years	0	0.0%	0	0.0%	0	0.0%
None in timeframe	8	14.5%	73	44.2%	17	48.6%
Total	55	100.0%	165	100.0%	35	100.0%

These quantitative results from the cox regressions are summarised in the table below.

Table 10. Cox regression comparing child protection outcomes FGC main group to comparison groups

	HR (95%CI) Univariable		HR (95%CI) Multivariable	
	Matched group	Referral-only	Matched group	Referral-only
Notifications	1.02 (0.94-1.11)	0.87 (0.77-0.98)*	0.99 (0.91-1.08)	0.87 (0.77-0.98)*
Investigations	1.99 (1.78-2.23)*	1.00 (0.85-1.18)	1.95 (1.74-2.18)*	1.00 (0.85-1.17)
Substantiations	2.50 (2.21-2.84)*	1.14 (0.95-1.36)	2.44 (2.15-2.77)*	1.14 (0.95-1.37)
Entries to care	1.15 (0.94-1.40)	2.68 (2.14-3.36)*	1.33 (1.09-1.63)*	2.54 (2.02-3.18)*
Case closures	0.58 (0.53-0.63)*	0.39 (0.35-.0.44)*	0.55 (0.51-0.60)*	0.40(0.36-0.46)*

*p<0.05

** Confounders included in the model: Aboriginal status, short term orders at referral

***HR: Hazard Ratio, CI: Confidence Interval

Detailed tables are provided in Appendix J showing the timing of first outcomes (notifications, investigations, substantiations, entry to out-of-home care and case closures) for children in the main and UCC FGC cohorts and each of the comparison groups.

Subgroups

- **The pattern of out-of-home care reduction following FGC was repeated for all sub-groups** (including UCC, children on short-term orders at referral and Aboriginal and/or Torres Strait Islander children), **except for children living in outer regional to very remote areas**.

In order to assess outcomes for key subgroups, including UCC, children on short-term orders at referral, and Aboriginal and/or Torres Strait Islander children, additional cox regression analyses were conducted to assess whether the reduction in out-of-home care was consistent across groups of interest. As the issue of difficulties in service delivery to more remote areas arose in the qualitative component of the evaluation, a comparison of out-of-home care outcomes for children in metropolitan and inner regional areas compared to outer regional, remote or very remote areas was included. As higher numbers of statistical tests increase the likelihood of finding significant results by chance, these focussed on out-of-home care outcomes only, as out-of-home care is an important child protection indicator, strongly impacts families, and has a significant economic burden. These analyses confirmed that the likelihood of out-of-home care was reduced for FGC participants among Aboriginal and/or Torres Strait Islander children, and also children on short-term orders at the time of referral, consistent with the overall results presented above. For the UCC children, there was a reduction in out-of-home care compared to the matched comparison group only, however the sample was relatively small. Overall, results were fairly consistent and positive across different client groups of interest. The one exception was children living in outer regional to very remote areas: families in these areas had no significant reduction in out-of-home care associated with FGC participation.

Examples of Case Outcomes

This section has been redacted by the authors due to confidentiality reasons.

Perspectives on Effectiveness of FGC

In interviews and focus groups, participants were asked if FGC was effective. All participants affirmed that it was effective, but they were then further asked why they thought it was effective or what effectiveness meant to them.

Many answers revolved around the end of DCP intervention or investigation with the family. Several participants included claims that many families were no longer in the department's interest and would not need to return to the department's notice. The quantitative analysis below provides more information on this claim. Otherwise, the key element of effectiveness was not removing children, keeping children out of residential care. This was sometimes cited as the main reason that Family

Group Conferencing was effective, even if child protection issues were not entirely resolved. Participants stress that complete satisfaction with all issues or resolving all problems was unexpected and would not be a useful metric for an effective program.

Otherwise, effectiveness was attributed to events and effects of the process itself. For example, many frontline providers staff cited repairing family relationships as a key element of the program's effectiveness. In their words, family repair from rupture was one of the most impactful and important things to see in the preparation and conference phases. Many stories were shared of family members who were otherwise not connected through estrangement or external circumstances, then coming together in the FGC program to resolve issues in unique and important ways.

For others, family choice was the key element for effectiveness. This was particularly profound for Aboriginal and Torres Strait Islander families. Aboriginal participants in interviews and focus groups stressed the long and complicated history of DCP involvement with Aboriginal and Torres Strait Islander families and the need for family choice and control to be at the forefront of their solving of child protection-related issues. This was also seen as a potential repairing pathway for Aboriginal and Torres Strait Islander communities.

Often accompanying the above point was an implication that DCP as a statutory authority and DCP staff, in their everyday interactions with families, need to relinquish power to empower families to solve their own problems. Yet, how this may be achieved with consideration to existing legislation governing DCP practice was not clear. Frontline providers praised DCP staff who engage strongly with Family Group Conferencing for their willingness and confidence in empowering families with this pathway. Both DCP workers and provider frontline staff noted that systemically, DCP as a statutory authority is not in a position where that power can appropriately be relinquished to families to solve problems in their own way. Again, as with previous effectiveness and opportunities points, this critique was framed beyond the FGC program. For some, this was described as "bolting on FGC onto a system that is not appropriate for it", whereas in a family-led decision-making ethos, Family Group Conferencing would be at the centre of all cases. These participants stressed that the effectiveness of FGC, and therefore the results in this evaluation, will be limited more by the systems around FGC than the program itself. The authors acknowledge the limitations of the evaluation to take into consideration all other elements of the system that are impacting this program. A whole system analysis was not the aim or scope of this evaluation.

> *I'd love to do more work with DCP around particular offices, and how we can, the DCP officers that we find are overreaching a bit, like they find they find it hard to let go of that risk and hand it over to family. (Provider)*

Finally, most importantly and most powerfully, including children's voices was a primary motivator for most frontline professionals in DCP and Provider organisations. The stories shared of children having a true voice in the conference and preparation phase to share their feelings, wants and needs, and the impact this has on families cannot be underestimated. For many, this inclusion and the power that this has in a conference makes the program innately effective in its key goal: To bring families together to discuss the issues impacting their children, which is most effective when listening to the children themselves and including them as a person worthy of choice and determination. These final two points were extremely profound for Aboriginal and Torres Strait Islander participants.

These qualitative analyses (surveys, interviews, focus groups) can conclude that the analysis suggests the program is effective beyond its scope in the view of those interacting directly with it.

Opportunities to be More Effective

This section discusses a range of different elements noted by staff as important to improve the effectiveness of FGC as they see it.

First, many staff mentioned community involvement and awareness beyond referral to Family Group Conferencing - as the initial referral discussion by DCP staff is the only community pathway to learn of the FGC program's existence. This opportunity included increasing the knowledge in a community of family group conferences as an option through particular outreach (e.g., media) and further discussion in communities. This also included increasing the range of services and departments that refer to Family Group Conferencing. Almost all participants noted that at least expanding family group

conference referrals to DHS would be an important step to ensure an early intervention element in the Family Group Conferencing processes. Late-stage issues in referral by DCP were mentioned as elements that probably limit effectiveness. Community awareness was particularly important for Aboriginal and Torres Strait Islander communities as there is a need to highlight that Family Group Conference providers are not DCP and, therefore, can speak with and to the community as independent parties or, from the provision by ACCOs, from the perspective of Aboriginal or Torres Strait Islander persons.

Next, the link between family group conferences and services stands out as an area of potential limitation for the FGC program. As mentioned above, many plans rely on services, and much of the knowledge, information and pathways for change rely on external services. Further engagement with these external services to increase their awareness and understanding of the program and assess and understand their ways of working within the program is needed in the future.

A more mechanical element to consider was caseloads. The discussion with leadership and frontline provider staff revealed a consistent maximum caseload for any worker of seven or eight. Beyond this, caseload timelines and the sheer volume of family members spoken to can become untenable. For example, some frontline workers suggested that they speak to 15-20 family members or connected services in a case. With the caseload of eight, 160 people in total would be contacted potentially in one 8-week period. This is a heavy workload because some contacts may not always be available or require multiple contacts.

Several of the management staff from providers suggested that the measures of effectiveness (KPIs), depended on by DCP for general running effectiveness, seemed limited in their scope to assess the work done (see, for example, the workload and importance of the preparation phase). For example, timelines for both referral-in meetings and the completion of conferences rely on DCP staff availability and family availability, which are out of providers' control. Pushing for more control over meetings and the family contact to meet these timelines would go against the family-led decision-making ethos built into the FGC design. Therefore, families have the ability to determine those timelines more than the providers do. Similarly, the timeline targets (%) were mentioned as being too high. All parties did, however, stress that they do not wish for the timelines to be removed, only that the reporting of such KPIs or other effectiveness indicators be understood in their context and with the recognised dependencies. The commentary associated with reporting these KPIs was stressed to be privileged above the number target. Ultimately, for providers, family context came first, and the need to meet timelines came second, consistent with their training, FLDM ethos and external limits such as the needed interaction with DCP staff.

The provider staff also highlighted a high level of DCP dependency on the direction of the conference's completion. Frontline provider staff reported that changes in case direction from DCP or finalisation of assessment, which changed the view of safety for children, were the main reasons an FGC referral would be withdrawn. This led to suggestions around referrals needing transparency on assessment and investigative elements present in the cases and the need for provisional safety. With these two factors, provider staff can be assured that their work will lead to a conference and not look like a failed case due to direction change beyond their control. Leadership staff from providers noted that these sorts of cases should also be noted in reporting.

Throughout all the suggestions above, there was a call for the expansion of the service. This included more staff to take on more cases and expand into other areas or to take on all potential referrals, with many arguing that all families in DCP or other department investigative procedures should be offered a family group conference, as opposed to the current legislative "considered". This was particularly important for regional areas where dedicated teams were required. The logistic pressure on workers based outside these regional areas makes it generally untenable to work on a family's timeline and appropriately meet them in person, as simple issues such as family illness can derail long and costly logistical considerations for this regional work. This then was discussed as impacting the KPIs discussed above.

One of the more contentious opportunities for further development was the notion of choice and variation in the FGC program delivery. As in the survey results (see Appendix K), the leadership of both providers suggested different directions for the FGC program. Some argued that uniformity would

make things simpler for DCP staff and potentially simpler for families, though limited community knowledge exists regardless of the model. While others argued that true choice was required and that a true choice requires differentiation between providers. This point of contention was discussed with providers around the need to facilitate sometimes unique processes and pathways for Aboriginal and Torres Strait Islander families. This variation aligns with the adaptability of Family Group Conferencing, though there is a need for true choice in providing services to specific families. It is a potential strength of further development. For example, providers warned that ACCO providers using the same service model as a mainstream approach may indicate a lack of choice for Aboriginal and Torres Strait Islander people. Expanding the FGC program to more workers or providers would likely include variations beyond this. The opportunity for further development that this evaluation can conclude is that further discussion is needed around what is true choice and how much variability is permittable in this program, both from DCP staff's perspective and to meet the needs of families.

A final area of future development, which links to expansion and variation in the program, is the need for further staff retention and staff qualities. This was discussed by both the DCP and provider staff, particularly the leadership and management staff. For providers, a set of qualities to effectively facilitate the family-led decision-making ethos and family group conferences were potentially in limited supply. This led to some leadership staff discussing the need to have ongoing positions at a good pay rate for the maintenance and retention of these staff – for FGC coordinator or facilitator to be seen "as a career", not only a job. Both providers highlighted that they feel confident in their ability to train new staff but that such training needs to be incorporated into the further development of this program and its provision. The sticking point for DCP in this regard was that high staff turnover or low staff retention leads to providers needing to consistently educate or reestablish relationships for Family Group Conferencing. For DCP, this is a systemic issue, but it impacts the effectiveness of Family Group Conferencing and must be considered in further exploration of its effectiveness.

Altogether, most areas for further development are already areas of discussion between DCP and providers. This evaluation encourages further discussion, exploration, and trial of different avenues and pathways for these developments. These seem only to be pathways to improved effectiveness and sustained workforces to embed family-led decision-making in the DCP process.

Discussion

Our evaluation has highlighted a range of positive impacts associated with the effectiveness and implementation of the FGC program in South Australia. The high levels of satisfaction reported by families to providers is one area of celebration for FGC, along with the strong implementation outcomes reported particularly throughout the qualitative data. FGC in South Australia has moved beyond its initial 'teething' stages, where strong relationships between providers and DCP are evident, while the process itself is predominately implemented as intended, subsequently creating shifts in power imbalances between families and DCP, embedding children's voice into consideration of their own safety and wellbeing, and importantly, placing family empowerment at the centre of practice.

Notably, the significant reduced likelihood of out-of-home care entry following the FGC meeting date for most children (when split by sub-groups) is encouraging, along with other effectiveness outcomes for the main quantitative analysis which highlighted significant reductions in investigations and substantiations. Reducing (re)notifications following FGC however, presents opportunities for further development. Similarly, the finding that the sub-group reduction in out-of-home care entry is not repeated for children in outer regional to very remote areas – who are predominately Aboriginal and/or Torres Strait Islander children – is another area that warrants attention. Consideration of the findings that relate to FGC in the recent Commissioner for Aboriginal Children and Young People's inquiry into the application of the Aboriginal and Torres Strait Islander Child Placement Principle (Lawrie, 2024) is important in this regard.

Improving referrals, sharing risk and strengthening family empowerment

Opportunities exist, as highlighted in our report, to continue to strengthen referral practice for FGC. This is particularly poignant for DCP child protection practitioners, where the family-led decision-making ethos can, at times, conflict with prior training concerning risk mitigation and assessment. Providing transparent reasoning, by DCP professionals, as to what constitutes a genuine risk or safety

concern for children to families and FGC providers is the ongoing task that requires continued focus, attention and training.

Our findings in this regard are in alignment with previous evaluations, including that by Nixon (2022), which noted the need to strengthen the presentation of bottom-lines as part of FGC. To some extent, improving how bottom-lines are written and conveyed by DCP to families and providers requires ceding some power to families to determine how the risk and safety concerns can best be addressed. This is in line with the ethos at the core of FGC: that families know their circumstances best, and can come up with the right solutions, given the opportunity, time and power to do so. Indeed, our evaluation has showcased some of creative family-solutions generated as part of FGC, as long as some of the positive outcomes that FGC can produce. To 'share risk' in a statutory context, as part of FGC, is not an easy feat, but is aligned with the importance of involving children and families in decisions that impact their lives. It is similarly aligned with opportunities to strengthen collaborative practice amongst all involved in, and beyond, FGC processes.

Strengthening collaborative practice

The follow-up and implementation of plans following FGC, as highlighted in our findings, presents an opportunity for further collaborative practice, particularly amongst services. To some extent, this is an issue that is beyond the scope of this evaluation given that it signals broader systemic challenges associated with child and family support and welfare provision and funding, along with considerations associated with mandatory reporting.

Indeed, reducing notifications to child protection is a challenge reflecting the reality of a notify-investigate child protection system. The surveillance of external services following FGC, potentially as part of plan implementation, may result in increased notifications for a range of reasons, including the identification of need for additional support beyond the capacity of the notifier. As highlighted in our findings, opportunities exist to strengthen collaboration with external service providers beyond the FGC process, to encourage others beyond DCP to hold risk and to provide support to families to implement their FGC plans as desired by families. This is a long-term opportunity however, where strengthening prevention and early intervention services and solutions to, and for, families and communities requires an all-of-government approach, as highlighted in policy documents such as the *Safe and Supported: the National Framework for Protecting Australia's Children 2021-2031* (Department of Social Services, 2021).

Early intervention and opportunities afforded by the UCC FGC program

In terms of early intervention opportunities, our findings (in particular, the sub-group UCC quantitative out-of-home care outcomes) show promise in relation to the opportunities the UCC FGC program may afford to preventing infant entry into out-of-home care. Indeed, the long-term costs of placement in out-of-home care for infants (aged under 1) can be potentially significant, with seminal international evidence highlighting patterns of repeat involvement in care proceedings for women, and birthing parents, who have experienced infant removal by child protection (Broadhurst et al., 2015). Peer-reviewed literature highlights the significant window of opportunity that pregnancy affords for change, wherein this unique and optimistic period of time can result in heightened levels of motivation for women, birthing parents and their families to address potential child protection concerns before the birth of a baby (Chamberlain et al., 2022; O'Donnell et al., 2019, 2023).

Consistent with evidence concerning pre-natal child protection involvement, late referral during pregnancy to child protective services is an issue of concern that restricts the opportunity to wrap around supports to the family before the birth of a new baby (O'Donnell et al., 2023). Insight into the provision of more than FGC during pregnancy as part of the UCC FGC program, discussed in qualitative interviews, demonstrates the importance of early intervention and referral during pregnancy.

Used effectively, the UCC FGC program offers the opportunity to address potential child protection concerns – thus informing child protection decision-making post-birth – and provide necessary supports to the family, as well as family empowerment through transparent discussion of DCP's risk concerns to the unborn baby. Certainly, it is an area where leading practice could be established in South Australia, particularly for Aboriginal and/or Torres Strait Islander babies who are subject to increased likelihood of child protection attention, and removal, evident throughout all Australian states and territories (Chamberlain et al., 2022; O'Donnell et al., 2019, 2023). Strengthening collaboration

between providers, DCP, the Department of Human Services, as well as potentially with maternity hospitals, health services and Aboriginal Community-Controlled Health Organisations, is recommended and timely in the UCC FGC space.

Choice and continued service expansion

Finally, the opportunity to continue to offer choice – and self-determination – for families, and particularly Aboriginal and Torres Strait Islander communities, as part of FGC is one that requires reiteration. As indicated previously, the notion of choice and variation in the FGC program delivery was one of contention, where multiple perspectives from DCP and Providers were evident. While uniformity would potentially result in simplicity of process and ease for DCP staff, the importance of unique processes and pathways for Aboriginal and Torres Strait Islander families was emphasised as well. This variation aligns with the adaptability of Family Group Conferencing, and the need for true choice in providing services to specific families.

Part of the strength of FGC is its ability to empower families to make decisions, and for Aboriginal and Torres Strait Islander families and communities, to make decisions as part of culturally appropriate service provision, which may not align with mainstream approaches to FGC. Expanding the FGC program to more workers or Providers would likely include further variations to the FGC service on offer to families and is thus a point for future consideration. Additional examination is needed concerning what constitutes true choice and how much variability is permittable in the FGC program, both from DCP staff's perspective and to meet the needs of families. This is needed in a context where the diversity and complexity of circumstances and experiences of families who interface with the FGC program is apparent, and potentially, most profound for Aboriginal and Torres Strait Islander families who have experienced a long history of disempowerment, and oppression, due to child welfare practice.

Our evaluation has provided insight into the effectiveness of FGC for children on short-term orders, based on quantitative analysis, as well as insight into cost considerations with FGC. These have been discussed and are considered below as part of our suggestions moving forward, where opportunities exist to further assess cost considerations relating to FGC service delivery and the utility of the FGC program for children on short-term orders.

Conclusion

Our evaluation has provided evidence of positive implementation and effectiveness outcomes, as well as opportunities for improvement and expansion of FGC in South Australia. We offer the following opportunities for continued, and improved, provision of the FGC program:

1. Continued funding of current providers, RASA and AFSS, given evaluation insights into established relationships, streamlined functioning and evidence of both family satisfaction and effectiveness.
2. A cost-benefit economic analysis to be undertaken by DCP (internally or externally) to inform future funding needs and requirements, particularly with respect to outer regional and very remote FGC service delivery and the potential expansion of the UCC FGC program. This enabler is aligned with our contextual funding considerations outlined in this report.
3. Expansion of the FGC program with consideration to:
    a. The UCC FGC program and associated funding considering the preventative opportunities it presents.
    b. Regional-specific FGC, including potential funding increases and collaboration with local services and/or local service provision in outer regional and very remote areas (including ACCOs and Aboriginal Community-Controlled Health Organisations).
    c. Increased workforce. And,
    d. Training considerations, particularly within DCP.

4. Implementation of uniform training for DCP frontline staff, including child protection practitioners and High-Risk Infant Workers, with a focus on the family-led decision making ethos, transparency and power, and referral clarity and transparency of bottom-lines.
5. Maintain or expand choice for families as part of FGC service provision, including processes, while upholding respect for Aboriginal and/or Torres Strait Islander self-determination.
6. Consideration of workload concerns for providers, with logistical caseload considerations to continue enabling quality FGC provider service provision.
7. For relevant SA government departments to investigate additional referral pathways, particularly as part of the UCC FGC program, including with respect to the Department of Human Services (DHS).
8. Exploration and discussion of external, or whole of government approaches, to increased support for implementation of FGC plans, including for families (such as kin carers) and external services, with a focus on reducing (re)notifications to DCP post-FGC.
9. Consider opportunities for improved DCP practice, including shifting towards offering all families a ‘choice’ to participate in FGC, thus potentially enabling opportunities for increased family empowerment during child protection processes.

References

Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member checking: a tool to enhance trustworthiness or merely a nod to validation?. *Qualitative Health Research*, *26*(13), 1802–1811. https://doi.org/10.1177/1049732316654870

Braun V., & Clarke V. (2021). *Thematic analysis: A practical guide* [eBook version]. SAGE

Broadhurst, K., Alrouh, B., Yeend, E., Harwin, J., Shaw, M., Pilling, M., Mason, C., & Kershaw, S. (2015). Connecting events in time to identify a hidden population: birth mothers and their children in recurrent care proceedings in England. *The British Journal of Social Work*, *45*(8), 2241–2260. https://doi.org/10.1093/bjsw/bcv130

Chamberlain, C., Gray, P., Bennet, D., Elliott, A., Jackomos, M., Krakouer, J., … Langton, M. (2022). Supporting Aboriginal and Torres Strait Islander Families to Stay Together from the Start (SAFeST Start): Urgent call to action to address crisis in infant removals. *Australian Journal of Social Issues*, *57*(2), 252–273. https://doi.org/10.1002/ajs4.200

Children and Young People (Safety) Act 2017 (SA) (Austl.) Available at: https://www.legislation.sa.gov.au

Commission for Children and Young People. (2024). *Understanding cultural safety for Aboriginal children and young people: a guide for implementing Child Safe Standard 1*. Author: Melbourne, Victoria. Available at: www.ccyp.vic.gov.au

Connolly, M., & Morris, K. (2012). *Understanding child and family welfare: Statutory responses to children at risk.* Palgrave Macmillan: Bassingstoke.

Department for Child Protection (n.d.). *Introduction to Family Group Conferencing Part 1*. Government of South Australia, unpublished presentation.

Department for Child Protection [DCP]. (2021). *Evaluation of Family Group Conferencing Pilot*. Government of South Australia.

Department for Child Protection [DCP]. (2023). *Request for Quote (RFQ) P500 – Family Group Conferencing Evaluation*. Government of South Australia.

Department for Child Protection [DCP] (2023). *Family Group Conferencing program logic*. Government of South Australia.

Department of Social Services. (2021). *Safe and Supported: the National Framework for Protecting Australia's Children 2021-2031.* Commonwealth of Australia. Available at: https://www.dss.gov.au

Lawrie, A. (Commissioner for Aboriginal Children and Young People South Australia). (2024, May). *Holding on to Our Future, the Final Report of the Inquiry into the application of the Aboriginal and Torres Strait Islander Child Placement Principle in the removal and placement of Aboriginal Children in South Australia*. Commissioner for Aboriginal Children and Young People South Australia. Available at: www.cacyp.com.au

Nixon, P. (2022). *'If you want to change outcomes, then change the way decisions are made': Family Group Conferences as emerging practice in Child Protection South Australia – An Action Research Project: Final Report*. Unpublished report.

O'Donnell, M., Lima, F., Maclean, M., Marriott, R., & Taplin, S. (2023). Infant and pre-birth involvement with child protection across Australia. *Child Maltreatment*, *28*(4), 608-620. https://doi.org/10.1177/10775595231186647

O'Donnell, M., Taplin, S., Marriott, R., Lima, F., & Stanley, F. J. (2019). Infant removals: the need to address the over-representation of Aboriginal infants and community concerns of another 'stolen generation'. *Child Abuse & Neglect*, *90*, 88–98. https://doi.org/10.1016/j.chiabu.2019.01.017

Papps, E., & Ramsden, I. (1996). Cultural safety in nursing: the New Zealand experience. *International Journal for Quality in Health care*, *8*(5), 491-497. https://doi.org/10.1093/intqhc/8.5.491

Saldaña, J. (2013). *The coding manual for qualitative researchers* (2nd ed.). SAGE.

Williams, R. (1999). Cultural safety – what does it mean for our work practice? *Australian and New Zealand Journal of Public Health*, *32*(2), 213-214. https://doi.org/10.1111/j.1467-842X.1999.tb01240.x

Appendices

Appendix A. Summary of previous evaluations of the Family Group Conferencing program in South Australia

This section has been redacted by the authors due to confidentiality reasons.

Appendix B. Qualitative Methods

This section will describe the qualitative aspects of the methods used: surveys, focus groups, interviews, and case file reviews.

Qualitative data collection gathered data from participants across three key stakeholder groups:

(1) External stakeholders working with families involved in the FGC program;

(2) Those in leadership positions at DCP, RASA, AFSS; and,

(3) Frontline stakeholders implementing the FGC program at DCP, RASA and AFSS.

In addition to surveys, interviews, and focus groups, a case file analysis was conducted to ascertain contextualised cases, including outcomes for children and families involved in the FGC program.

Data Collection Method: Surveys

An online survey, hosted in Qualtrics, was distributed to external stakeholders working with families who have been involved in the FGC program, frontline stakeholders implementing the program, and leadership (inclusive of financial personnel) to elicit stakeholders' perspectives of the FGC program, including their experiences of the FGC program, their understandings of families' experiences of the FGC program, and outcomes for children and families involved in the FGC program.

The final surveys are attached at the Appendices.

Generally, the survey questions are structured according to the following themes:

- Referral process, including referral from the FGC program to external services.
- Stakeholder involvement in and experiences of the FGC program.
- Family willingness to engage with the FGC program throughout the process.
- Outcomes for children and families involved in the FGC program, including external service engagement following FGC.
- Outcomes for Aboriginal and Torres Strait Islander children and families involved in the FGC program, including external service engagement following FGC. And,
- Stakeholder satisfaction with the FGC program and suggestions for improvement.

The population of possible participants to complete the surveys was identified by DCP, and a list was compiled, including:

- 41 Leadership stakeholders
- 106 Frontline stakeholders
- 19 External service providers were contacted to share the external survey with the appropriate stakeholders.

The final participation rates in the survey met initial expectations for such a participant pool (see Table 11). The time spent on the surveys (by completions) is included, with several outliers of 2-4 hours removed, indicating both an expected participation rate and a high degree of engagement in the survey, including by the length of responses.

Table 11.
Survey responses and time in survey for the three evaluative surveys

	External	Leadership	Frontline
Respondents	24	23 (56%)	37 (35%)
Completes	22	16	28
Incompletes	2	7	9

Average Time (Outliers 2-4+ hours)	24 mins	21 mins	19 mins

This survey approach ensured that a range of stakeholders participated in the evaluation, thus enabling important insights from those working with families before, during, and after their involvement in the FGC program. These insights included how families have engaged with FGC services and external services and what outcomes have been achieved for children and families involved in FGC.

Data Analysis: Surveys

The survey data included both quantitative and qualitative questions (See Appendices). The questions lend themselves to descriptive statistical analysis for the Likert questions and a qualitative content analysis for the open-ended questions. Survey data was primarily used in conjunction with interview and focus group data, given that it added further trustworthiness to the richer-quality information provided in focus groups and interviews. All datasets within this report are best seen as one data set used for triangulation, while these two elements of the qualitative research counterbalance each other and add trustworthiness to each other.

Data Collection Method: Interviews and Focus Groups

Interviews and focus groups with key stakeholders from DCP, RASA and AFSS were undertaken to provide insight into the implementation of the FGC program (past and current), and its outcomes, focusing on referral pathways, cost associated with FGC, the FGC process and its utilisation for UCC reports and children and young people under short term orders.

Interviews and focus groups were semi-structured in-person or online. Questions can be found in full – minus the unique prompting and further conversation of the interviews and focus groups at the end of this document (See Appendices). Interviews and surveys asked about the following themes:

- The implementation of the FGC program over time, including discussion of past and current implementation, as well as implementation fidelity (implementation as intended, alignment of program delivery to the model).
- Current barriers, enablers and opportunities for improvement associated with implementation and service delivery, including discussion of cost and what is working, any challenges that need to be addressed, and where improvements can be made.
- Partnerships and relationships between DCP, FGC service providers and other organisations and communities (including Aboriginal and Torres Strait Islander communities).
- Feedback mechanisms utilised by RASA and AFSS.
- Effectiveness of the FGC program, including targets, processes and the cultural appropriateness of the FGC program for Aboriginal and Torres Strait Islander children and families, as well as:
    - utilising FGC to address UCC reports
    - utilising FGC for children and young people under short-term orders
    - the cost of providing FGCs.
- Thus, interviews and surveys involved discussion of the implementation and effectiveness associated with the FGC program.

Of those identified for recruitment, 30 participated in an interview or focus group; the following sample was interviewed or participated in a focus group (see Table 12, below).

Table 12
Number of interviews or focus groups with number of participants (frontline or leadership), with time and share of time and interviews or focus groups.

	Interviews / Focus Groups	N=	Frontline	Leadership	Hours	per cent of Time	per cent Ints/FGs
DCP	8	14	12	2	7.98	35.30%	44.44%
AFSS	3	9	7	2	6.72	29.70%	16.67%
RASA	6	6	3	3	7.63	33.75%	33.33%

External	1	1			0.28	1.25%	5.56%
Total	18	30	23	7	22.62	100.00%	100.00%

The research team allowed each group to be equally represented in their time to speak to the questions asked; no one group was heard for longer than another in interviews/focus groups despite the pool of available participants being notably fewer than the others. Also, an important divergence did occur; in the context of Aboriginal and Torres Strait Islander participation for this evaluation, longer times were permitted to discuss the context in the discussion – as may have been common if a yarning methodology had been used.

All interviews and focus groups were recorded and transcribed using Microsoft Teams or Office365 transcription tools. These transcripts were de-identified to position them as frontline or leadership and their respective organisations. All other identifiable details were either anonymised or not used to present quotes in this report.

Data Analysis: Interviews and Focus Groups

De-identified transcripts were moved to NVivo, a computer-assisted qualitative data analysis software (CAQDAS), for coding purposes. A single pass of hybrid inductive/deductive eclectic style coding (Saldaña, 2013) was used to organise and analyse the data. Key centrally organising concepts were highlighted based on the evaluation needs or consistent participant use. Those concepts were used to generate thematic aspects to report across the data – akin to the common processes of Reflexive Thematic Analysis (Braun & Clarke, 2021) – with some focus on content analysis-driven frequency considerations for elements that required it (e.g., see below referral qualities conclusions).

The interview and focus group data – as rich and highly contextual – was used as a base for the qualitative methods triangulation. Survey and case data were used to supplement this core analysis, supply a wider population, and base trustworthiness of the conclusions.

The final notable element is that a form of minimal member checking (Birt et al., 2016) was completed using the project control group, allowing the leadership of the organisations represented to confirm the results – no changes were suggested in a preliminary data analysis presentation session.

Data Collection: Casefile Analysis

A casefile analysis was completed to provide insights and examples relating to how the FGC program is applied, how children and families experience it, and the resulting outcomes. Six case files were identified suiting several variables – Aboriginal or Torres Strait Islander, UCC, completed or did not complete the conference - but otherwise randomly chosen within those groupings by the DCP liaison for all relevant documentation to be provided to ACCP staff de-identified.

Data Analysis: Casefile Analysis

De-identified case file review information was summarised and used to understand, using a template form developed by the research team to gather and contrast the following aspects of FGC participation:

- Reason/s for referral to FGC.
- Who was present at the FGC meeting.
- How many family members were present, including whether and how children and young people were involved in the FGC meeting.
- The main goals of the Family Plan.
- Whether a Family Plan review person had been identified at the conference.
- The status of the main goals of the Family Plan at time of the review.
- The skills gained by families following completion of FGC.
- Family relationships, before and after FGC, to ascertain whether family relationships have improved following FGC. And,
- Whether cultural context was addressed, including whether and how cultural sensitivities or other relevant factors were addressed as part of the FGC service.

These cases were used as case-based triangulation of other findings in the evaluation.

Appendix C. Quantitative Methods

This section will describe the quantitative aspects of the methods used. Quantitative approaches were used to analyse organisational data on service use (referrals and meetings), administrative data to examine child protection outcomes, and satisfaction survey data. All data was provided in a de-identified format to maintain the privacy of the families involved. Analysis was conducted using SPSS and Stata software packages.

FGC feedback survey data - satisfaction

Pre-collected feedback and survey data were analysed to explore the outcomes of FGC for children, families, service providers and practitioners. As with the stakeholder surveys, the pre-collected feedback surveys questions lend themselves to descriptive statistical analysis for the numeric data (Likert questions or yes/no responses) and a qualitative content analysis for the open-ended questions. As there were differences between the sites in how the questions were worded and the responses were collected (e.g. Likert satisfaction scales versus a yes/no response), the responses could not be combined and are presented separately for AFSS and RASA.

Organisational FGC data – referrals

Utilising the pre-collected organisational data from DCP, AFSS and RASA, the evaluation team cleaned, analysed and were able to describe the number of referrals, outcomes of referrals, the number of FGC meetings completed, and characteristics of families involved. This information is provided in table format. Where available, families' reasons for withdrawing from FGC were summarised.

FGC administrative data – child protection outcomes

Data

Analysis of the administrative data was used to gain insights into the FGC program's effectiveness in increasing stability for vulnerable children and families and the safety of children and young people after an FGC. Pre-collected organisational data from DCP, AFSS and RASA was merged with DCP datasets covering a range of child protection outcome events. A data extraction was developed with DCP. The quantitative analysis examined child protection outcomes, including notification, investigations, substantiations, entries into out-of-home care and case closures following FGC.

Data from DCP covered the period from January 2020- 29th February 2024, while site data was provided to 31 January 2024. All data was provided in a de-identified format, with ID numbers provided for children and families and mapping files to allow linkage of the datasets. The first FGC conferences were provided in April 2020, continuing to the end of data collection. As a result children whose families participated in FGC in April 2020 have almost four years of follow-up data, while those who participated in FGC in February 2024 may have less than a week of follow-up data.

Quasi-experimental design and comparison groups

Where sample sizes were sufficient for comparison, a *quasi-experimental approach* to this component of the evaluation has been used enabling matched comparison groups to be established with matching child/family indicators selected in collaboration with DCP.

Two comparison groups were used in the study: 1) Referred-only children were children whose families had been referred to FGC but who had not participated in an FGC meeting, and; 2) A matched comparison group was created of children with open child protection cases during the period during which the FGC was in operation and being evaluated, matched on age of the child, Aboriginality, and an indicator of socio-economic area from the Australian Bureau of Statistics. Where possible FGC children were matched at 3:1 to children not referred to FGC. Comparison group children were assigned dates equivalent to the referral and/or meeting dates of children with actual referral or meeting dates, in order to define an equivalent period of follow-up. The referred-only group includes referrals that the providers declined as they were inappropriate referrals, those that DCP withdrew before FGC was held and those where the family declined to participate. As discussed in Appendix J, both the referred-only group and those who participated in the FGC had higher rates of prior child protection involvement than the matched group of children not referred to FGC. Based on higher levels previous child protection involvement (substantiations and short-term orders) among the referred-only and FGC children, the matched comparison group could be considered more likely to have more positive

outcomes, however there are many other unmeasured factors that may influence outcomes. Including both comparison groups is aimed to reduce the limitations of each and provide a more accurate assessment.

The children in the study were further grouped by whether they were the subject of an unborn child concern report (UCC) or were part of the main cohort whose child protection involvement commenced after they were born. Therefore, outcomes are provided for six groups of children: FGC participants with a UCC, referred-only children with a UCC, matched comparison group children with a UCC, FGC main cohort (born prior to child protection contact), referred-only main cohort, and matched comparison main cohort.

Analysis

Quantitative analysis was conducted to examine the outcomes for children/families to identify any impact FGC has had on safety of children and young people (e.g., subsequent reports, investigations, substantiations, entries to out-of-home care and case closures). This included descriptive analyses (tables showing the percentage of children in each group experiencing a particular outcome within each time period of follow-up). For the main cohort, Cox regression analysis was conducted, a statistical technique that compares the likelihood of events occurring over time for two or more groups. This technique takes into account the variation in follow-up time for children who receive a service at different points in time. Additional Cox regression analyses were conducted within the main cohort (children born before child protection contact) to ascertain whether results are similar for subgroups of interest, such as Aboriginal and Torres Strait Islander children, children on short-term orders at the time of referral to FGC, and children from remote or regional areas (based on postcode data and Australian Bureau of Statistics 2017 remoteness areas). Additional cox regression analysis was also conducted for children with UCCs. As conducting higher numbers of statistical tests increases the likelihood of finding statistically 'significant' results by chance and weakens confidence in results, these additional analyses focused on out-of-home care entries, which is a key measure of assessed child safety at home, impacts families greatly, and has an economic cost.

Time to outcome events

The tables and cox regression examine time to first occurrence of a child protection event (such as a report or investigation). For the main cohort, events which occur after the meeting date and by the end of the study (29th February 2024) are counted. For the UCC cohort, follow-up time is primarily counted from the child's date of birth. This is because some child protection events such as entry to out-of-home care can only occur after birth, and there is a need for precision in dates that takes into account birth as child protection interventions happen in a narrower timeframe for newborns (i.e. many events occur within days or weeks of birth) than for older children for whom the meeting date, as the start of the intervention is the most appropriate time to begin follow-up.

Appendix D. Guide for Interviews with Leadership Stakeholders

Interview Topic & Question Guide	
Topic Area	**Potential Questions**
Background information about the FGC program	• Tell me a bit about your role in the FGC program? • Describe your experiences of the Family Group Conferencing program? • What involvement do you have with FGC program staff? • Can you tell me about the different models for FGC service delivery?
Referral process	• How does the referral process for the FGC program work? Is there any difference for Aboriginal and Torres Strait Islander families? • Can you walk me through some examples where referral to the FGC program has worked well? Under what circumstances have referrals to FGC been appropriate? • Can you tell me about any issues that have been encountered with the referral process?
Funding for FGC program	• Tell me a bit about funding for the FGC program. • Can you tell me about any issues that have been encountered with funding arrangements?
FGC program	• Tell me a bit about some of the successes of the FGC program? Can you give me specific organisational examples? • Tell me a bit about some of the challenges associated with the FGC program? Can you give me specific organisational examples?
Child protection involvement	• Can you tell me a bit about how child protection is involved in the FGC process? • Please tell me a bit about any successes or challenges associated with child protection involvement in FGC.
What is working well and additional resources needed	• What is working well with the current referral to or delivery of the FGC program? • What has helped the delivery the FGC program? *Prompt: processes, resources, support etc* • What additional resources are needed to effectively deliver the FGC program as intended?
Challenges and barriers	• Describe any challenges/barriers associated with referral to or delivery of the FGC program?

	• How can these challenges and barriers be addressed?
Effectiveness of FGC program	• Overall, do you think the FGC program is effective? *If yes, why? If no, why not?* • How satisfied are you with the FGC program?
Suggested improvements	• Please describe any suggestions for how FGC can better meet the needs of a diverse range of children, young people and families? *Prompt: Ask about needs of culturally and linguistically diverse children, young people and families; children, young people and families living with disability, and Aboriginal and/or Torres Strait Islander children, young people and families* • Please describe any other suggestions to improve the referral process or delivery of the FGC program?

Appendix E. Guide for Interviews and Focus Groups with Frontline Family Group Conferencing and Other Practitioners

Interview/Focus Group Topic & Question Guide	
Topic Area	**Potential Questions**
Background information about the FGC program	• Tell me a bit about your role in the FGC program? • Describe your experiences of the Family Group Conferencing program? *Prompt: understanding of FGC program* • *For CPP staff:* What involvement do you have with FGC program staff? *Prompt: satisfaction, any issues with engagement.*
Referral process	• How does the referral process for the FGC program work? *Prompt: Child Protection staff involvement, FGC staff involvement* • How do you decide which families should be referred to the FGC program? Is there any difference for Aboriginal and Torres Strait Islander families? • Can you walk me through some examples where referral to the FGC program has worked well? Under what circumstances have referrals to FGC been appropriate? • Can you tell me a bit about circumstances where you have been able to accept a referral to FGC?
Preparation for FGC meeting	• Describe your experiences of engaging with families for (referral to) this FGC program? *Prompt: Ask about engagement with each of the various target families* • What's involved in the preparation phase before an FGC meeting takes place? How long does this usually take? • Can you tell me a bit about times where families have commenced the preparation phase, but haven't proceeded to an FGC meeting and why?
FGC meetings	• How are FGC meetings currently organised? • Describe your experiences of facilitating FGC meetings? • Can you give me some examples about families who have been through the FGC process? • Can you walk me through some examples where an FGC meeting has not been held, and why?
FGC plans	• Tell me a bit about how FGC plans are developed? • What do the plans usually look like, and do they address the protective concerns held by child protection? • Tell me a bit about your experiences of engaging with support services as part of this FGC program?

FGC follow-up	• Can you tell me a bit about the follow-up process after an FGC meeting has been held? • Have families been able to achieve their goals listed on their FGC plans? • What support needs have families had following the FGC meetings? • Can you tell me about times where child protection has either stayed involved, or discontinued involvement, with a family following FGC?
What is working well and additional resources needed	• What is working well with the current referral to or delivery of the FGC program? • What has helped you to deliver the FGC program? *Prompt: processes, resources, support etc* • What additional resources are needed to effectively deliver the FGC program as intended?
Challenges and barriers	• Describe any challenges/barriers associated with referral to or delivery of the FGC program? • How can these challenges and barriers be addressed?
Effectiveness of FGC program	• Overall, do you think the FGC program is effective? *If yes, why? If no, why not?* • How satisfied are you with the FGC program?
Suggested improvements	• Please describe any suggestions for how FGC can better meet the needs of a diverse range of children, young people and families? *Prompt: Ask about needs of culturally and linguistically diverse children, young people and families; children, young people and families living with disability, and Aboriginal and/or Torres Strait Islander children, young people and families* • Please describe any other suggestions to improve the referral process or delivery of the FGC program?

Appendix F. Survey for Leadership Stakeholders

1. What is your role in the FGC program?

Open ended response

2. How long have you been in this role for?

Open ended response

3. What organisation do you work for?

DCP – RASA – AFSS

4. To your knowledge, is the FGC program being delivered consistently?

Yes No Not Sure

If no, why not.

5. Do you have any comments or concerns about referrals into the FGC program?

Open ended response

6. Do you have any comments or concerns about funding for the FGC program? *This can be specific to your organisation or in general.*

Open ended response

7. How does the FGC program work for Aboriginal and Torres Strait Islander children and families?

Open ended response

   a. Do you have any comments or concerns about the FGC program for Aboriginal and Torres Strait Islander children and families?

Open ended response

8. How does the Unborn FGC program work?

Open ended response

   a. Do you have any comments or concerns about the Unborn FGC program?

Open ended response

9. Overall, do you think the FGC program is effective? Yes – No

If yes, why?

If no, why not?

10. What is working well with the current delivery of the FGC program?

Open ended response

11. Describe any challenges associated with delivering the FGC program?

Open ended response

12. Do you have any suggestions to improve the delivery of the FGC program? Yes No

If yes, please describe.

13. Is there anything else you would like to say about the FGC program?

Open ended response

Appendix G. Survey for Frontline Family Group Conferencing and Other Practitioners

1. What is your role in the FGC program?

Open ended response

If Child Protection/High Risk Infant Worker Staff:

2. How do you decide which families should be referred to the FGC program?

Open ended response

3. Is there any difference for Aboriginal and Torres Strait Islander families?

Yes – No

If yes, please describe.

4. Have you encountered any issues with the referral process to the FGC program?

Yes – No

If yes, please describe.

5. What involvement do you have with FGC program staff?

Open ended response

6. In your experience, how willing are families to be involved in a FGC meeting?

Open ended response

7. Can you describe any challenges that you have encountered with the Unborn FGC program?

Open ended response

8. Do you have any suggestions to improve child protection practitioner involvement with the FGC program?

Open ended response

9. Do you have any suggestions to improve the Unborn FGC program?

Open ended response

If FGC Staff:

2. What is your FGC program location?

Open ended response

3. What organisation do you work for?

DCP – DHS – RASA – AFSS

4. How satisfied are you with your current job?

1 = Not at all satisfied 2 = Somewhat unsatisfied 3 = Neutral 4 = Somewhat satisfied 5 = Completely satisfied

5. To your knowledge, how many referrals does each FGC Coordinator/Facilitator currently receive?

Open text, number

6. To your knowledge, what is the current caseload (i.e. number of families) of FGC Convenors?

Open text, number

7. To your knowledge, is the FGC program being delivered consistently?

Yes No Not Sure

If no, why not.

8. How are FGC meetings currently organised?

Open ended response

9. How are FGC plans currently developed?

Open ended response

10. How the FGC program work for Aboriginal and Torres Strait Islander families?

Open ended response

11. How does the Unborn FGC program work?

Open ended response

12. To what extent are the following processes of the FGC pilot being delivered as intended?
Please answer the following questions, where 1 = Not at all as intended, 2 = Slightly as intended, 3 = Moderately as intended; 4 = Mostly as intended; and 5 = Exactly as intended

- The connection process? 1 – 2 – 3 – 4 - 5
- Engaging with families? 1 – 2 – 3 – 4 – 5
- Organising the FGC meetings? 1 – 2 – 3 – 4 – 5
- Facilitating the FGC meetings? 1 – 2 – 3 – 4 – 5
- The development of FGC plans? 1 – 2 – 3 – 4 - 5
- The follow-up of FGC plans? 1 – 2 – 3 – 4 – 5
- Engaging with support services? 1 – 2 – 3 – 4 - 5

13. How effective is the current FGC process in:

Please answer the following questions, where 1 = Not at all effective, 2 = Slightly effective 3 = Moderately effective 4 = Very effective and 5 = Extremely effective

- Reducing child protection systems contact? 1 – 2 – 3 – 4 – 5
- Engaging families? 1 – 2 – 3 – 4 – 5
- Meeting the needs of culturally and linguistically diverse children, young people and families? 1 – 2 – 3 – 4 - 5
- Meeting the needs of children, young people and families living with disability? 1 – 2 – 3 – 4 - 5
- Empowering families to work collaboratively to make decisions? 1 – 2 – 3 – 4 – 5
- Focusing on families' strengths? 1 – 2 – 3 – 4 – 5
- Building on families' strengths? 1 – 2 – 3 – 4 – 5
- Assisting engagement with support networks? 1 – 2 – 3 – 4 – 5
- Strengthening engagement with support networks? 1 – 2 – 3 – 4 – 5
- Assisting engagement with services? 1 – 2 – 3 – 4 – 5
- Strengthening engagement with services? 1 – 2 – 3 – 4 – 5
- Supporting Aboriginal families in building their connection with community and culture? 1 – 2 – 3 – 4 – 5
- Improving safety for children and young people? 1 – 2 – 3 – 4 – 5

14. Do you require any additional assistance to perform your FGC-related duties:

- Before FGC proceedings? Yes No *If yes, please describe.*
- During FGC proceedings Yes No *If yes, please describe.*
- After FGC proceedings? Yes No *If yes, please describe.*

15. What is working well with the current delivery of the FGC program?
Open ended response

16. Describe any challenges associated with delivering the FGC program?
Open ended response

17. Do you have any suggestions to improve the delivery of the FGC program?
Yes No

If yes, please describe.

18. Overall, do you think the FGC program is effective? Yes – No
If yes, why?

If no, why not?

19. Is there anything else you would like to say about the FGC program?
Open ended response

Appendix H. Survey for External Professionals

Background questions

1. What is your role? (open ended response)
2. What is your agency/organisation? (open ended response)
3. Have you been involved in the Family Group Conference (FGC) program? Y/N/Unsure
   a. If so, how? (open ended response)
4. Have you worked with any families who have been referred into the FGC program? Y/N/Unsure
   a. If yes, how many? (open ended response)
   b. If yes, did any of these families include: (select all that apply)
      - Aboriginal and/or Torres Strait Islander people?
      - Parents or children living with disability?
      - People from culturally and linguistically diverse backgrounds (not including Aboriginal and Torres Strait Islander people)?
      - Unsure/ don't remember
5. Have you worked with any families who have attended an FGC meeting? Y/N/Unsure
   a. If yes, how many? (open ended response)
   b. If yes, did any of these families include: (select all that apply)
      - Aboriginal and/or Torres Strait Islander people?
      - Parents or children living with disability?
      - People from culturally and linguistically diverse backgrounds (not including Aboriginal and Torres Strait Islander people)?
      - Unsure / don't remember
6. Have you attended an FGC meeting? Y/N/Unsure
   a. If yes, how many? (response options) 1 – 2 – 3 – 4 or more – Don't remember
   b. If yes, when did this/these meetings take place? (Please include the month and year of the FGC meeting/s) (open ended response)

Pre-FGC meeting (Preparation)

7. Did you have contact with an FGC Convenor before an FGC meeting was held? (if you have taken part in more than 1 meeting, select all that apply) Y/N/Don't remember
   a. If yes, how did this contact occur? (select all that apply) Phone / Email / In-person meeting or visit / Online meeting / Don't remember
   b. If yes, how easy was it to have contact with the FGC Convenor before the meeting? (if you have taken part in more than 1 meeting, select all that apply) 1 = Very difficult, 2 = Difficult, 3 = Not difficult or easy, 4 = Easy, 5 = Very easy, 6 = Don't remember
8. Thinking about the families you work with that are or have been involved in the FGC program, were they: (select all that apply)
   - Involved in your service prior to referral into FGC?
   - Referred to your service as a result of the FGC program?
   - Don't remember
9. (If selected yes to Q6) Prior to the FGC meeting, did you receive an agenda? Y/N
   a. If yes, were you involved in creating the agenda? Y/N/Don't remember
10. (If selected yes to Q6) Did you feel prepared to take part in the FGC meeting/s? (if you have taken part in more than 1 meeting, select all that apply)
    1 = Not at all prepared, 2 = Somewhat prepared, 3 = Prepared, 4 = Definitely prepared, 5 = Don't remember

Experience of FGC meeting

11. Thinking about the most recent FGC meeting you took part in, please indicate how much you agree or disagree with the following statements on a scale of 1-5 where 1 = Strongly disagree and 5 = Strongly agree.

(Select one option – Response options, 1 = Strongly disagree, 2 = Disagree, 3 = Neither disagree or agree, 4 = Agree, 5 = Strongly agree, 6 = Don't know/Not applicable)

The meeting

- I had an active role during the FGC meeting (i.e., actively took part in making decisions, deciding on goals for the agreement/plan)
- The FGC Coordinator/Facilitator supported the family to make decisions
- The FGC meeting focused on families' strengths
- Families came up with solutions during the meeting on their own
- Families came up with solutions during the meeting, with the support of professionals
- Families did not come up with solutions during the meeting
- All family members participated equally in the FGC meeting
- (If applicable) For Aboriginal families or families from other culturally and linguistically diverse backgrounds, the FGC meeting was culturally-safe
- (If applicable) Children and young people had a say during the FGC meeting.
- The FGC Convenor facilitated the meeting well
- I had a passive role during the FGC meeting (i.e., attending as a support person for a child, young person, family member)

The agreement/plan

- The agreement/plan created at the end of the meeting was based on what the family agreed to
- Receiving (more) support from my service/agency was a part of the agreement/plan
- Receiving (more) support from services in general was a part of the agreement/plan
- (If applicable) The agreement/plan included what children and young people said they wanted during the meeting.

Post-FGC meeting (Outcomes)

12. How long has it been since the last FGC meeting you attended? (open ended response)
13. Please indicate your agreement with the following statement:

(Select all that apply – Response options, 1 = Strongly disagree, 2 = Disagree, 3 = Neither disagree or agree, 4 = Agree, 5 = Strongly agree, 6 = Don't know/Not applicable)

The families that I work with have been more engaged with my service following the FGC meeting

14. Overall, how satisfied are you with the current FGC process? (Select one response, response options: 1 = Not at all satisfied, 2 = Somewhat satisfied, 3 = Neutral, 4 = Somewhat satisfied, 5 = Completely satisfied
15. In your opinion, was the FGC meeting effective? Y/N
    b. If yes, why?
    c. If no, why not?
16. Please describe any suggestions to improve the FGC program. (Open ended)
17. Is there anything else you'd like to say about experiences of the FGC program? (Open ended)

Appendix I. Child Outcome Tables

The following tables show the percentage of children within each group who experienced each child protection outcome during the follow-up period, and those that did not experience that outcome within the timeframe of the study. Only the first occurrence of each outcome is counted. For children with unborn child concern reports, follow-up was from birth as some child protection outcomes cannot occur before birth. For the main cohort (born children), follow-up was from the date of the FGC conference or equivalent assigned date for the comparison groups.

As can be seen in Table 13, a higher proportion of the referred-only children (42.1%) had no further notifications during follow-up to the end of the study, compared to 26.1% of the FGC children and 21.0% of the matched group. The FGC children had a slightly higher proportion of children with new notifications early in the follow-up (58.3% combined in the categories first four weeks or one to six months) compared to 50.5% of the referred-only children.

Table 13. Time from FGC meeting to first notification (Main cohort)

Time from meeting to first notification	FGC Children (Main)		Matched Group (Main)		Referred Only (Main)	
	Count	%	Count	%	Count	%
4 weeks or less	191	19.2%	521	18.8%	153	20.9%
1-6 months	389	39.1%	992	35.8%	217	29.6%
6-12 months	95	9.6%	339	12.2%	40	5.5%
1-2 years	56	5.6%	244	8.8%	10	1.4%
>2 years	4	0.4%	93	3.4%	4	0.5%
None in timeframe	259	26.1%	583	21.0%	308	42.1%
Total	994	100.0%	2772	100.0%	732	100.0%

Among the UCC FGC group, a higher percentage of children had notifications during follow-up (83.6%), compared to the matched comparison group (50.9%) and the referred-only group. Increased notifications do not always reflect the level of risk within a family, as involvement with more services often means more 'eyes on the child', with many service providers required to report child safety concerns. Therefore, increases in notifications can be indicative either of higher risk or of higher monitoring, and are best considered in conjunction with indicators such as out-of-home care placement and case closures.

Table 14. Time from birth to first notification (Unborn Child Concern)

Time from birth to first notification	FGC Unborn Child Concerns		Matched Unborn Child Concerns		Referred Only Unborn Child Concerns	
	Count	%	Count	%	Count	%
4 weeks or less	20	36.4%	37	22.4%	9	25.7%
1-6 months	19	34.5%	33	20.0%	13	37.1%
6-12 months	2	3.6%	13	7.9%	2	5.7%
1-2 years	5	9.1%	1	0.6%	1	2.9%
>2 years	0	0.0%	0	0.0%	0	0.0%
None in timeframe	9	16.4%	81	49.1%	10	28.6%
Total	55	100.0%	165	100.0%	35	100.0%

The referral-only group were less likely to reach the end of follow-up without being the subject of an investigation (35.0%) than the FGC group (63.1%) and the matched comparison group (67.0%).

Table 15. Time from FGC meeting to first investigation (Main cohort)

Time from meeting to first investigation	FGC Children (Main)		Matched Group (Main)		Referred Only (Main)	
	Count	%	Count	%	Count	%
4 weeks or less	75	7.5%	151	5.4%	58	7.9%
1-6 months	183	18.4%	528	19.0%	126	17.2%
6-12 months	39	3.9%	376	13.6%	30	4.1%
1-2 years	52	5.2%	455	16.4%	20	2.7%
>2 years	18	1.8%	293	10.6%	8	1.1%
None in timeframe	627	63.1%	969	35.0%	491	67.0%
Total	994	100.0%	2772	100.0%	733	100.0%

Almost half of the UCC FGC group were the subject of an investigation within the first four weeks after their birth. Only around one in four of this group (27.3%) reached the end of follow-up without being the subject of an investigation. Some caution should be applied in interpreting the results from the UCC FGC group as it is a small group (N=55) and therefore a small number of children can make a large change in percentages. Nonetheless, the proportion of UCC FGC children reaching the end of follow-up without an investigation is markedly lower than the referred only group (42.9%) and the matched comparison group (77.6%).

Table 16. Time from birth to first investigation (Unborn Child Concern)

Time from birth to first investigation	FGC Unborn Child Concerns		Matched Unborn Child Concerns		Referred Only Unborn Child Concerns	
	Count	%	Count	%	Count	%
4 weeks or less	25	45.5%	15	9.1%	13	37.1%
1-6 months	10	18.2%	9	5.5%	4	11.4%
6-12 months	3	5.5%	8	4.8%	2	5.7%
1-2 years	2	3.6%	5	3.0%	1	2.9%
>2 years	0	0.0%	0	0.0%	0	0.0%
None in timeframe	15	27.3%	128	77.6%	15	42.9%
Total	55	100.0%	165	100.0%	35	100.0%

Although one in ten of the FGC group had a substantiation of maltreatment within the first four weeks after the meeting, a large proportion (71.5%) did not have any substantiations during the follow-up period.

Table 17. Time from FGC meeting to first substantiation (Main cohort)

Time from meeting to first substantiation	FGC Children (Main)		Matched Group (Main)		Referred Only (Main)	
	Count	%	Count	%	Count	%
4 weeks or less	102	10.3%	78	2.8%	61	8.3%
1-6 months	101	10.2%	446	16.1%	99	13.5%
6-12 months	38	3.8%	375	13.5%	26	3.5%
1-2 years	30	3.0%	487	17.6%	12	1.6%
>2 years	12	1.2%	387	14.0%	1	0.1%
None in timeframe	711	71.5%	999	36.0%	534	72.9%
Total	994	100.0%	2772	100.0%	733	100.0%

Outcomes in this area were less positive for the UCC FGC group, with less than half (38.2%) having no substantiations during follow-up.

Table 18. Time from birth to first substantiation (Unborn Child Concern)

Time from birth to first substantiation	FGC Unborn Child Concerns		Matched Unborn Child Concerns		Referred Only Unborn Child Concerns	
	Count	%	Count	%	Count	%
4 weeks or less	7	12.7%	3	1.8%	6	17.1%
1-6 months	22	40.0%	4	2.4%	10	28.6%
6-12 months	3	5.5%	1	0.6%	3	8.6%
1-2 years	2	3.6%	4	2.4%	0	0.0%
>2 years	0	0.0%	0	0.0%	0	0.0%
None in timeframe	21	38.2%	153	92.7%	16	45.7%
Total	55	100.0%	165	100.0%	35	100.0%

Conversely, the FGC children were the most likely to not enter out-of-home care during follow-up (87.1%), compared to the referral-only group (75.3% and the matched comparison group (84.8%).

Table 19. Time from FGC meeting to first OOHC (Main cohort)

Time from meeting to first OOHC	FGC Children (Main)		Matched Group (Main)		Referred Only (Main)	
	Count	%	Count	%	Count	%
4 weeks or less	18	1.8%	42	1.5%	47	6.4%
1-6 months	62	6.2%	135	4.9%	115	15.7%
6-12 months	26	2.6%	71	2.6%	12	1.6%
1-2 years	14	1.4%	96	3.5%	6	0.8%
>2 years	8	0.8%	77	2.8%	1	0.1%
None in timeframe	866	87.1%	2351	84.8%	552	75.3%
Total	994	100.0%	2772	100.0%	733	100.0%

The table below shows the timing of first entries to care. Given the small number of children who entered out-of-home care, interpretation is limited, however it is positive that only 1 child in the FGC UCC entered out-of-home care during the first four weeks after their birth, particularly given the high number of notifications and investigations during the same time period.

Table 20. Time from birth to first OOHC (Unborn Child Concern)

Time from birth to first OOHC	FGC Unborn Child Concerns		Matched Unborn Child Concerns		Referred Only Unborn Child Concerns	
	Count	%	Count	%	Count	%
4 weeks or less	1	1.8%	5	3.0%	5	14.3%
1-6 months	5	9.1%	0	0.0%	8	22.9%
6-12 months	1	1.8%	2	1.2%	0	0.0%
1-2 years	0	0.0%	0	0.0%	0	0.0%
>2 years	0	0.0%	0	0.0%	0	0.0%
None in timeframe	48	87.3%	158	95.8%	22	62.9%

As shown below, the FGC group had a high percentage of children with a case closure (85.7%), with many occurring in the four weeks after the FGC meeting (28.3%). In comparison, 73.4% of the matched comparison group and 48.6% of the referred-only group had a closure during follow-up.

Table 21. Time from FGC meeting to first closure (Main cohort)

Time from meeting to first closure	FGC Children (Main)		Matched Group (Main)		Referred Only (Main)	
	Count	%	Count	%	Count	%
4 weeks or less	281	28.3%	372	13.4%	75	10.2%
1-6 months	484	48.7%	968	34.9%	202	27.6%
6-12 months	69	6.9%	335	12.1%	52	7.1%
1-2 years	18	1.8%	241	8.7%	22	3.0%
>2 years	0	0.0%	118	4.3%	5	0.7%
None in timeframe	142	14.3%	738	26.6%	377	51.4%
Total	994	100.0%	2772	100.0%	733	100.0%

Case closures are presented in Table 22. The majority of children in the UCC FGC group (74.5%) had a case closure in the first 6 months after birth.

Table 22. Time from FGC meeting and from birth to first closure (Unborn Child Concern)

Time from birth to first closure	FGC Unborn Child Concerns		Matched Unborn Child Concerns		Referred Only Unborn Child Concerns	
	Count	%	Count	%	Count	%
4 weeks or less	17	30.9%	57	34.5%	10	28.6%
1-6 months	24	43.6%	28	17.0%	7	20.0%
6-12 months	3	5.5%	5	3.0%	1	2.9%
1-2 years	3	5.5%	2	1.2%	0	0.0%
>2 years	0	0.0%	0	0.0%	0	0.0%
None in timeframe	8	14.5%	73	44.2%	17	48.6%
Total	55	100.0%	165	100.0%	35	100.0%

Appendix J. Child Protection Outcomes – Analysis Cohort

The children whose families participated in the FGC include a group of children with Unborn Child Concerns (UCC, N=55), and the main cohort (children referred after birth, N = 994). Each of these groups has 2 comparison groups: children referred to the FGC but who did not participate in a conference, and a matched group of children matched on age, socio-economic area, and Aboriginal and/or Torres Strait Islander origin. Although the matched group are comparable on the characteristics used for matching, Table 23 shows that there are further characteristics on which the matched group remain less comparable to the FGC children. For example, the children referred to FGC, whether they participated in the FGC or were referred-only including a history of more child protection involvement such as being on short-term orders at referral or having substantiations prior to the FGC date. Some of the families who did not participate were declined as inappropriate referrals for the FGC service. It is possible that unmeasured differences may exist between groups, for example that families who participate in a service such as FGC may have characteristics such as greater willingness to engage in interventions or better relationships with extended family than families who are referred but decline to participate. Likewise, families who are selected for referral may differ from those not referred in unmeasured ways. Using two different comparison groups is intended to address some of the potential advantages and disadvantages of each of the referred only and the matched comparison.

Table 23. Characteristics of the groups included in the analysis

		FGC Children (Main)		Matched Group (Main)		Referred Only (Main)		FGC Unborn Child Concerns		Matched Unborn Child Concerns		Referred Only Unborn Child Concerns	
		Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
Aboriginal and/or Torres Strait Islander	Yes	472	47.5%	1206	43.5%	390	53.2%	44	80.0%	133	80.6%	35	100.0%
	Not or Not Stated	522	52.5%	1566	56.5%	343	46.8%	11	20.0%	32	19.4%	0	0.0%
Quintile SES	1 - Most Disadvantaged	498	50.1%	1323	47.7%	394	53.8%	31	56.4%	93	56.4%	22	62.9%
	2	112	11.3%	336	12.1%	106	14.5%	4	7.3%	12	7.3%	3	8.6%
	3	145	14.6%	435	15.7%	83	11.3%	12	21.8%	36	21.8%	5	14.3%
	4	113	11.4%	337	12.2%	85	11.6%	3	5.5%	9	5.5%	3	8.6%
	5 - Least Disadvantaged	56	5.6%	148	5.3%	36	4.9%	3	5.5%	9	5.5%	2	5.7%
	Missing	70	7.0%	193	7.0%	29	4.0%	2	3.6%	6	3.6%	0	0.0%
Sex	Female	461	46.4%	1332	48.1%	328	44.7%	24	43.6%	48	29.1%	17	48.6%
	Male	529	53.2%	1433	51.7%	403	55.0%	28	50.9%	51	30.9%	11	31.4%
	Unknown / Not stated	4	0.4%	7	0.3%	2	0.3%	3	5.5%	66	40.0%	7	20.0%
Remoteness	Inner Regional Australia	84	8.5%	260	9.4%	54	7.4%	3	5.5%	13	7.9%	5	14.3%
	Major Cities of Australia	650	65.4%	1752	63.2%	458	62.5%	50	90.9%	109	66.1%	26	74.3%

	Outer Regional Australia	145	14.6%	399	14.4%	144	19.6%	0	0.0%	29	17.6%	4	11.4%
	Remote Australia	29	2.9%	109	3.9%	31	4.2%	0	0.0%	2	1.2%	0	0.0%
	Very Remote Australia	16	1.6%	60	2.2%	17	2.3%	0	0.0%	6	3.6%	0	0.0%
	Missing	70	7.0%	192	6.9%	29	4.0%	2	3.6%	6	3.6%	0	0.0%
Disability flag	No	916	92.2%	2610	94.2%	665	90.7%	55	100.0%	165	100.0%	34	97.1%
	Yes	78	7.8%	162	5.8%	68	9.3%	0	0.0%	0	0.0%	1	2.9%
Phase at referral	Intake	4	0.4%	0	0.0%	9	1.2%	11	20.0%	0	0.0%	0	0.0%
	Investigation	585	58.9%	0	0.0%	419	57.2%	1	1.8%	0	0.0%	0	0.0%
	Protection Order	115	11.6%	0	0.0%	109	14.9%	0	0.0%	0	0.0%	0	0.0%
	Protv Int	289	29.1%	0	0.0%	180	24.6%	1	1.8%	0	0.0%	0	0.0%
	Not referred	0	0.0%	2772	100.0%	0	0.0%	0	0.0%	165	100.0%	0	0.0%
	UCC	1	0.1%	0	0.0%	16	2.2%	42	76.4%	0	0.0%	35	100.0%
On Short Term Order at Referral	No	888	89.3%	2649	95.6%	626	85.4%	55	100.0%	165	100.0%	35	100.0%
	Yes	106	10.7%	123	4.4%	107	14.6%	0	0.0%	0	0.0%	0	0.0%
Prior Substantiation/s	No	136	13.7%	1325	47.8%	124	16.9%	49	89.1%	160	97.0%	29	82.9%
	Yes	858	86.3%	1447	52.2%	609	83.1%	6	10.9%	5	3.0%	6	17.1%
	Total	994	100.0%	2772	100.0%	733	100.0%	55	100.0%	165	100.0%	35	100.0%

Appendix K. Additional Survey Results

This section has been redacted by the authors due to confidentiality reasons.

University of South Australia | Australian Centre for Child Protection

Contact: Lisa McDonald

lisa.mcdonald@unisa.edu.au

Improving the lives of vulnerable children.

unisa.edu.au/accp