

Evaluation



ABORIGINAL AND TORRES STRAIT ISLANDER FAMILY LED DECISION MAKING TRIAL

October 2017



GAME CHANGERS



Acknowledgments

We would like to thank the staff of the Recognised Entities and Aboriginal and Torres Strait Islander community controlled organisations who provided the Family Led Decision Making Trial services, SNAICC the implementation partner, and the departmental staff who generously shared their experience of the trials with us, so we could observe and learn.

We would like to thank the Local Reference Groups, Community members, and families who graciously welcomed us into their world, so we could hear their story and include their voice in this evaluation.

Winangali/Ipsos consortium acknowledges the traditional owners of the water, land and sea. Accumulated knowledge which encompasses spiritual relationships, relationships between people, relationships with the natural environment and the sustainable use of natural resources are reflected in language, narratives, social organisation, values, beliefs, and cultural laws and customs may have been shared with us by the Aboriginal and/or Torres Strait Islander people and/or communities that contributed to this research. We respect that this knowledge is not static like the written word but responds to change through absorbing new information and adapting to its implications. Therefore, we wish to acknowledge Indigenous communities of the four trial sites as joint custodians of their research findings. We would like to thank the Aboriginal or Torres Strait Islander researchers who worked hard to make sure this evaluation was conducted in a culturally sensitive manner including Sharon Barnes, Nancy Bamaga, Deon Davis, and Elizah Wasaga.

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Family-centric cultural practice

The unique difference of the Aboriginal and Torres Strait Islander family led decision making trials (the trial) to the previous ways of working by the Department of Communities, Child Safety and Disability Service (the department) was that **authority was given to families and children/young people to problem solve and led the decision making in a culturally safe space** by using external convenors to the department that were Aboriginal and/or Torres Strait Islander. Culturally safe spaces are created when there is independence, choice, privacy and time but most importantly when done in an “**Aboriginal and/or Torres Strait Islander way**”.

The trial, when implemented as intended has been a catalyst for innovative practice through experimentation. Putting families in the center of practice and giving them choice and doing things in an Aboriginal and/or Torres Strait Islander way can create family centric cultural practice through ground up change. The trial, when not implemented as intended, that is when the independence of the FLDM service providers to work with families was undermined by co-convening with department it disempowered the families, the Aboriginal and/or Torres Strait Islander convenor and the Recognised Entity. **Co-convening got in the way of making a culturally safe space** regardless of how well intentioned the Departmental staff might have been because the power and privilege balance between the two convenors was inequitable.

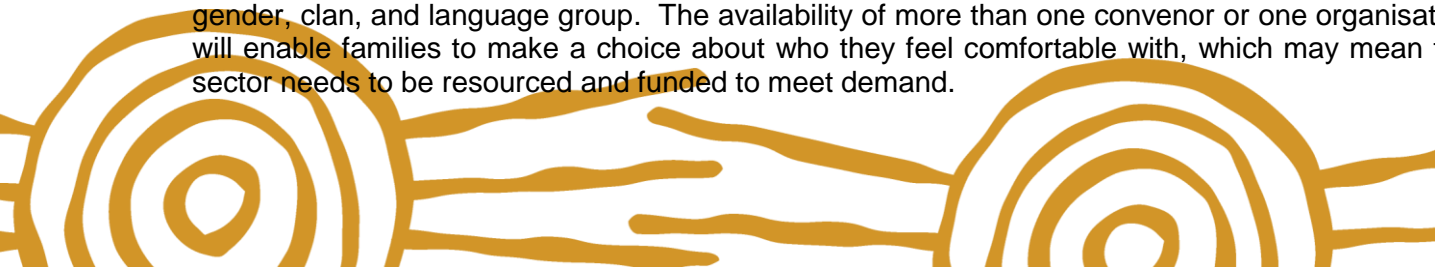
The trial evaluation identifies and explains factors that are generating different outcomes for Aboriginal and Torres Strait Islander families. The information below highlights examples of ‘how the trial was done’ when it generated positive experiences and outcomes for families. These emerging trial factors become practice learnings for family-led decision making in Queensland’s child safety and child and family sector.

Key Learnings

The concept of a ‘culturally safe space’ proved to be a key context for families, connected to triggering the mechanism of ‘belonging’ and ‘welcome’ which, in turn generated particular outcomes, depending on the extent to which it was present or absent.

When families have a say in the process, in a culturally safe space, and things are done in an Aboriginal and Torres Strait Islander way, this is what they see:

- **I am provided with the choice of my convenor.** Their choice could include working with an internal departmental convenor who identifies as an Aboriginal and/or Torres Strait Islander person, or working with an external Aboriginal and/or Torres Strait Islander convenor. Having the fundamental right to access culturally appropriate convenors of their choice would contribute to the restoration of social justice.
- **I can choose a convenor that I feel comfortable with.** Convenors may differ according to age, gender, clan, and language group. The availability of more than one convenor or one organisation will enable families to make a choice about who they feel comfortable with, which may mean the sector needs to be resourced and funded to meet demand.



- **I see trust between our local Aboriginal and/or Torres Strait Islander organisations and the department.** The department needs to trust the local level Aboriginal and/or Torres Strait Islander community controlled organisations to develop different ways of working, because they are the appropriate authority who knows best how to work with their families.

What it means to have a say

Each family is different and should have the choice to do things in a way that will bring out the best results for their family. Having a **say in the process** is important, as it:

- encourages agency, self-determination and trust that it will be an environment in which their family can make decisions;
- ensures families understand the concerns of child safety and address their worries as soon as possible, explained by someone they trust in terms they can comprehend;
- ensures families fulfil their family's commitment to keeping their child/ren safe, healthy and growing to their full potential.

What it means to do things in an Aboriginal and Torres Strait Islander way

It is important to have a whole of community response to child safety. Each child belongs to a family group and each family group is part of a community or communities. When families have independence, choice, privacy and time they can draw on the strengths and supports of their whole family and community to identify responses that will keep children safe and cared for in family, community and culture. This collectivist approach differs from the government process to date that functions in accordance with an individualised 'client' system.

There are deeper connections, spirituality and cultural knowledge needed to support families in decision making. These ways of knowing transcend a lived experience that cannot be taught to non-Indigenous convenors or developed into cultural competency tools.

The trial has demonstrated that when given the opportunity, Aboriginal and Torres Strait Islander communities can have a culturally safe response to child safety. When safe spaces are created, the strength of the collectivist culture will ensure that children and young people have their family and community leading decisions about their safety and wellbeing that are focused on their connection to culture and family (even if not placed in their own family). The trial acknowledged and strengthened the role of whole of community to supporting families to keep children safe and challenged the status quo thinking built into the existing processes and procedures.

If resourcing supported the availability of culturally safe spaces across Queensland it would facilitate the application of the Aboriginal and Torres Strait Islander child placement principle. The intent would be to reduce rates of removal and strengthen cultural connectedness.

“Too many changes in policy but never a change in how much control and choice we have to do it our way, so there is no ownership which mean programs often fail in the end...”



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Executive Summary

The Evaluation of Aboriginal and Torres Strait Islander Practice Reforms (COM0138B) for the Department of Communities, Child Safety and Disability Services (the department) was conducted by Winangali and Ipsos. The evaluation focused on the trial of Aboriginal and Torres Strait Islander Family-Led Decision Making (the trial) in three settings across four sites between 18 April 2016 and 30 June 2017 (with an extension in the Cairns site for Trial 3 until August 2017 to expend all funding). The settings and sites for the trial are:

- Early intervention and family support (EI) (Trial 1 - Ipswich);
- The Investigation and Assessment (IA) process (Trial 2 Mount Isa); and
- The legislated Family Group Meetings (FGMs) process (Trial 3- Cairns, Torres Strait).

Trial activity



Family Group Conferencing

The trial design is grounded in the Family Group Conference (FGC) model. FGC is a family-led decision-making process. Family led decision making or the Family Group Conference Model has been good practice around the world with families from First Nations, and Aboriginal and Torres Strait Islander family led decision making has been adopted as good practice by other states and territories in Australia. The difference between the Trial and the current Family Group Meetings in Queensland is that:

- the meetings in Trial 2 and 3 were co-convened with a Departmental convenor and an Aboriginal and/or Torres Strait Islander independent convenor; and
- the meetings occurred at earlier stages of the child protection continuum in Trial 1 and 2.

The family led decision making incorporates a range of tools for self-assessment, planning, and decision making by the family to respond to the department's worries prior to the department making a decision about the need for protection and the type and length of intervention (if required).

Evaluation aim and approach

This evaluation uses a realist approach to demonstrate the extent to which family-led decision making has worked in this trial because of the way it was implemented and administered as part of the overall intention to test the new practice reforms in Queensland. The evaluation developed a theory to explain the factors that may be generating different outcomes in certain kinds of contexts. The extent to which this trial worked was a matter of "**how it was done**" rather than "**what was done**". What was done was evidenced-based and effective which should create positive results in relation to creating safer outcomes devised by the family (in accordance with the child placement principle priorities e.g. at-home preferred outcome etc.). However, it did not always work as well as expected or to the extent it should for everyone. This was because how it was done did not always happen in a truly "**Aboriginal and/or Torres Strait Islander way**". Understanding the different contexts of what makes a safe place to enabled the evidence based practice to occur or not was investigated. The evaluation uses evidence from qualitative interviews, the analysis of case files, administrative data, performance reports and review of documentation.

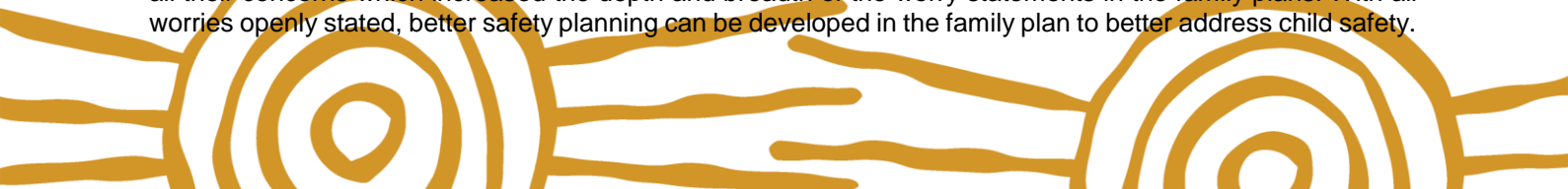
Limitations

This evaluation is a post measurement with families after participation in the trial therefore it is limited in the ability to measure change over time for the family. Conclusions about portability to other sites are therefore necessarily limited. Administration data was often not recorded about the trial – nor did it prove granular enough or sufficiently contextualised to draw detailed conclusions concerning outcomes. Qualitative discussions are of course subjective and wide ranging, so where outcomes discussed in this report are stated by the story teller they may not be adequately explained by administration data. Only a small number of families consented to participate in this evaluation, hence those that did not may have held different views.

What did success look like?

Success was achieved when the trial facilitated a **culturally safe space** for families to meet, and where the Aboriginal and/or Torres Strait Islander convenor truly led the process **their way**. When the Department enabled the process to be independent and acknowledged that the FLDM service providers engage better with families, particularly, when families could see and feel the power shift from Department to Aboriginal and/or Torres Strait Islander convenors it created a culturally safe space.

The concept of a 'safe space' proved to be both multi-faceted, dynamic, and important. This represented a key contextual feature which, under realist philosophy, held real causal power in driving or triggering mechanisms of 'belonging' and 'welcome' that in turn yielded particular outcomes depending on the extent to which it was present or absent. In these **culturally safe spaces** families were more likely to listen, speak up and talk about all their concerns which increased the depth and breadth of the worry statements in the family plans. With all worries openly stated, better safety planning can be developed in the family plan to better address child safety.



Successful outcomes for families were achieved when Aboriginal and/or Torres Strait Islander convenors and the FLDM service providers were truly empowered to do things their way. When they could give families choice in the process, it created agency which supported self-determination and built trust. When preparation time allowed for engagement of wider family networks and community members (whether directly by the convenor contacting others or indirectly by family consulting others themselves) it was done in a way that was culturally sensitive using appropriate protocols and authority. When the explanation of the complex child safety system was done in either their language or using their terms it was better understood by families. When things were done in an **Aboriginal and Torres Strait Islander way** families felt safe, strong and supported to make more informed decisions.

The trial successfully met the following aims being to:

- Promote self-determination and shared decision making at different phases of the child protection continuum;
- Empower families to make informed choices and decisions about what's best for their children, while the department ensures safety concerns are addressed by the process; and
- Develop and trial the capacity of the Recognised Entity to lead decision making and case planning in a culturally sensitive way.

Trial Outcomes

Outcomes for families

The new independent Aboriginal and/or Torres Strait Islander convenor resource supported:

- Privacy for talking, acknowledgement of past pain, release of emotions and time for healing;
- Being understood and not judged;
- Independent and trusted advice; and
- Better understanding of the child safety system and concerns.

The extent to which these supporting factors were present influenced how families felt and whether outcomes were achieved. More positive outcomes were achieved when:

- A space without judgement or 'talking down' was created;
- The family had choice during planning of the meeting;
- There was a focus on the present and keeping children/young people with family and/or kin;
- The department and stakeholders demonstrated respect for their Aboriginal and/or Torres Strait Islander convenor; or
- The process was done in an Aboriginal and Torres Strait Islander way, allowing time to discuss and process information, and the time to reflect and respond through culturally appropriate dialogue.

When the trial worked well, families identified the following outcomes:

- Did not feel alone and under attack, felt that someone believed in them which gave them optimism and motivation to follow the actions in the family or safety plan;
- Trusted that the process was genuine because they were treated with respect and dignity;
- Spoke up about all the concerns and worries;
- Owned their plan and committed to making it work;
- Separated their emotions from the problem solving so they can all work together;
- Felt supported and that they had someone who knew them and their family's story rather than a room of strangers who they perceive are against them;
- Worked with the department not against them because there was a common focus on the child/ren;
- Focused on the child's safety and what they could do to change their behavior;
- Service provision and assistance that may not be specifically for child safety concerns but contribute to the health and wellbeing of the family and child/ren;
- Reconnecting with estranged family members, bringing family together that may have been dysfunctional or realising roles of support within the family; and/or
- Understood and accept the final decision even if they didn't agree with the decision.



Outcomes for FLDM service providers and the department

When the trial worked well, **FLDM service providers** identified the following positive outcomes:

- Family referrals to services to support the health and wellbeing underlying the child safety concerns to develop a longer term approach to improving the child/young person's outcomes, not just an immediate safety plan;
- Family choice in their referral pathway and not being referred to services they were not comfortable with or that were ineffective in the past;
- Seeing families smiling, reconnecting and making plans to stay in touch at the end of a meeting;
- Better practices when working with families and better support to families due to more training in FGMs and child safety procedures and processes;
- Family plans that:
 - are actionable because there are family and child support services or health and wellbeing services available to address sometimes long term or ongoing concerns of the family;
 - are more meaningful and creates optimism for change by the family;
 - include a discussion of all the worries and agreed actions to address them;
 - when reviewed, provide vital reflection time for the family;
 - when reviewed provide reinforcement in taking responsibility and ownership of the family plan and supports further change.
- Pride in the service they were able to provide to families; and/or
- Saw families starting to heal from the pain and trauma of past removals.

When the trial worked, **the department** identified the following outcomes:

- Engagement of families who they had previously not been able to engage;
- Job satisfaction and a sense of achievement when families were working together with them (no longer against them) to implement safety plans;
- A sense of relief when they saw the greater gains in child safety through working appropriately with the family;
- An awakening as to how important genuine cultural authority and knowledge is for families;
- Realisation that they may not have been as culturally competent as they may have thought which opened them to learning and improvement in the way they worked by acknowledging that the Aboriginal and/or Torres Strait Islander convenors were the right people to do that role; and/or
- Appreciation and respect for the "Aboriginal and Torres Strait Islander way of doing things" can't be learnt or copied by non-Indigenous people, and that the importance of identified positions.

Trial Impact

The evaluation developed a theory for the apparent explanatory factors or 'the reasoning' that may be generating quite different outcomes in certain kinds of contexts. The extent to which this trial worked and the impact it had was a matter of "**how it was done**" rather than "**what was done**". Strengthening the ability for Aboriginal and/or Torres Strait Islander convenors and the FLDM service providers to lead the process with authority and respect was the key to gaining successful outcomes with families.

Stage of the child safety continuum

The stage of the child protection continuum in which the trial is being applied is an important context. In the early intervention and secondary services space, FLDM service providers can work independently to keep the family out of the system, potentially making it easier to build trust and optimism through engagement. Earlier intervention along the spectrum is logical and supported in the literature and would have a greater impact on keeping children and young people safer sooner because there is more time to work with families in their way. More time enables more privacy, choice and independence.

In the statutory stage of the child protection continuum the FLDM service provider must work closely with Child Safety making it harder to build trust and optimism with the family by demonstrating independence. The Aboriginal and/or Torres Strait Islander convenors needed to strengthen their capacity and knowledge of the child safety system to work more independently.



Empowerment

Empowerment appears to decline as the trial moves along the child protection continuum, because the independence, authority and power of the FLDM service provider diminishes to the overarching statutory child safety systems. This trial has also identified that where external Aboriginal and/or Torres Strait Islander convenors are used, it may be more successful because the extent to which they have control and are perceived as independent is also greater.

Organisational culture

Where departmental staff are committed and supportive of the trial (that is willing to change and work differently) progress has been made to implement partnership approaches that are more efficient and practical. Where there is resistance to change, or triangular conversations, or unclear communication within the department, time and energy is needed to get everyone on the same page. When departmental staff gave over more control to the Aboriginal and/or Torres Strait Islander convenors they saw greater gains with the families. When departmental staff felt loss adverse, that is they felt handing over control was a greater loss than what they may gain in benefits, it impacted on the Aboriginal and/or Torres Strait Islander convenors ability to create a culturally safe place for families. Unfortunately, poorer outcomes because of the unsafe place reinforced the departmental staffs attitude that then needed to maintain control. Where there is organisational culture of status quo bias departmental staff need to see the greater gains that culturally safe places have for families to change their behaviour.

Implementation challenges and strengths of a shared practice model

The trial had many challenges but the dedication of SNAICC, the departmental staff and FLDM service providers to address them in a collaborative manner was truly inspiring and a strength. There is good will generated in the trial sites for the practice reform vision for Aboriginal and/or Torres Strait Islander families and their communities.

The two biggest strengths for the implementation of the shared practice model were:

- independent third party implementation consultant who could navigate the tensions of differing interpretation between the department and the external FLDM service providers to get everyone on the same page, and
- the commitment of the FLDM service providers and the department staff to work together to resolve issues when they arose.

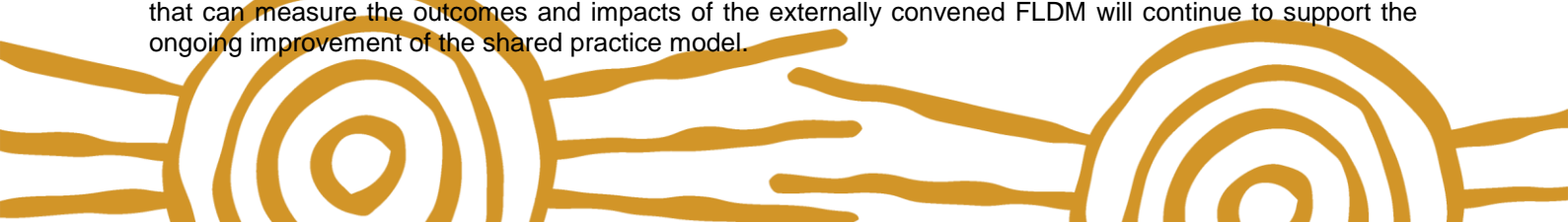
The three biggest challenges for the implementation of the shared practice model were:

- resourcing it adequately so it has integrity and independence aligned with the intent of the model;
- turnover of FLDM service provider staff and departmental staff; and
- changing entrenched individual and organisational cultures in the department to empower the FLDM service providers and families so that they can be independent.

Reflections for future practice

The trial found that external Aboriginal and/or Torres Strait Islander convenors created “culturally safe spaces” and equalising the power to result in more successful Family Led Decision Making practices. The extent to which the department facilitates choice, privacy, independence and the “Aboriginal and/or Torres Strait Islander way” of doing things whether internally or externally, will determine how successful FLDM will be in the future. Ideally, the independence of the convenor is important to see this FLDM process flourish and for families to feel safer and more confident to address the worries and safety concerns of the department. However, this suggests that the FLDM model should not be co-convened as it was in the trial which would need further testing and evaluation.

How well extending the trial to scale up to include more families, or a greater scope of application across the statutory system will depend on supporting and resourcing the model. A monitoring and evaluation framework that can measure the outcomes and impacts of the externally convened FLDM will continue to support the ongoing improvement of the shared practice model.



Introduction

The Winangali Ipsos consortium was contracted by the Department of Communities, Child Safety and Disability Services (the department) to undertake the Evaluation of the Aboriginal and Torres Strait Islander Practice Reforms (the trial). This evaluation is part of the Aboriginal and Torres Strait Islander Practice Reforms project in the context of the Supporting Families Changing Futures reform program which is focused on delivering the right services at the right time to support families and keep children safely at home. The vision for the reform is that:

Queensland children and young people are cared for, protected, safe and able to reach their full potential. Queensland families and communities are empowered to become stronger, more capable, more resilient and are supported by a child and family support system that understands and respects the importance of family, community, and culture.¹

Understanding how the shared practice model resonates with the overall reform vision and the vision of the community is important, as this is a new way of working together for Aboriginal or Torres Strait Islander owned or community controlled organisations and the department. The shift in roles and the integration of new roles through shared practice into the department's child safety processes (particularly Trial 2 and 3) represents what is different in this trial.

Overview of the trial

The trial implemented Family Group Conferencing using a shared practice model aimed at better meeting the needs of Aboriginal and Torres Strait Islander children, young people and families where intervention or support is required by the department or service provider. The focus of the trial is the application of Aboriginal and Torres Strait Islander Family-Led Decision Making (FLDM) at three stages in the child safety continuum in four sites:

- Early intervention and family support (Trial 1 - Ipswich);
- The Investigation and Assessment (IA) process (Trial 2 Mount Isa); and
- The legislated Family Group Meetings (FGMs) process (Trial 3- Cairns and Torres Strait).

Trials 2 and 3 will both test a shared practice model between FLDM Service Providers and Departmental staff. The FLDM service provider will take the lead in activities such as: designing, planning, facilitating or co-facilitating family group meetings; cultural support planning; identifying and assessing carers; transition from care planning, health passport and education support planning, and reviewing current orders using an Aboriginal and Torres Strait Islander family-led decision making approach. The FLDM Service Providers involvement and influence in the meeting and the pre-meeting coordination is important because it is intended that Aboriginal and/or Torres Strait Islander people increase ownership over the whole process.

Evaluation goals

The evaluation intends to:

- Identify implementation challenges and strengths for each trial and location;
- Assess how well each location has achieved the short term objectives of each trial model; and
- Collect cost information associated with each family participating in the trials to contribute to a cost analysis of the project.

Evaluation methodology and methods

The approach taken is grounded in theory such as realist evaluation, participatory action research and implementation science but refined for practicality given how the research is framed and the budget and timeline constraints. The methodology for achieving the required goals of the evaluation is detailed in Appendix A. The evaluation uses evidence from qualitative interviews, the analysis of case files, administrative data,

¹ <https://www.communities.qld.gov.au/gateway/supporting-families>



performance reports and review of documentation. A summary of the evaluation methods is detailed in Appendix B.

Evaluation results

The findings of this evaluation have been progressively supplied to the department for the purpose of action learning. Early identification of resourcing and communication issues were identified and supported the implementation partner and FLDM service providers concerns to be addressed. Whilst the intent of the trial was not to inform the reshaping of the Recognized Entities role or the department's current internal Family Group Conference model, however, over the course of the evaluation preliminary findings have also informed the department's thinking around these broader practice reform agendas.

The evaluation results are based on qualitative data from the following sources: 18 families; 7 convenors; 8 RE staff; 11 departmental staff; 7 professionals and stakeholders; 15 reference group members; 12 case file audits; attendance at knowledge share workshop conducted by SNAICC; participation in working group teleconferences; performance reports and administrative data.

Limitations

This evaluation is a post measurement with families after participation in the trial therefore it is limited in the ability to measure change over time for the family. Results reflect scope and time limitations, approach taken, and the unique contexts of each of the four communities where the trial was undertaken. Conclusions about portability to other sites are therefore necessarily limited. Administration data was often not recorded about the trial – nor did it prove granular enough or sufficiently contextualised to draw detailed conclusions concerning outcomes. Qualitative discussions are of course subjective and wide ranging, so where outcomes discussed in this report are stated by the story teller they may not be adequately explained by administration data. Only a small number of families consented to participate in this evaluation, hence those that did not may have held different views.

The trial was not long enough to include enough cases to understand the success or otherwise and fully test the practice implications and effect on existing legislative arrangements and delegations. The trial did not have the infrastructure, systems and record keeping facilities in place to accurately measure and assess the time and resources taken to undertake a full family-led process. The trial did not have the ability to track cases nor the longitudinal data collection and record keeping ability to monitor and review the efficiency of FLDM at different phases of the child protection continuum.

Structure of the report

This report is structured into six chapters. The first, this introduction provides an overview of the trial and the evaluation. The second chapter provides background information about the trial and the Family Group Conferencing model it was based on, to support the theory of change. This chapter also describes what was done in the trial and how it was implemented. The third chapter focuses on the outcomes of the trial based on a range of data sources. The fourth chapter discusses the implementation and how the trial progressed in the trial journey. The fifth chapter provides a realist analysis seeking to understand how, why and to what extent different kinds of outcomes were achieved for different families. The final chapter discusses possible implications for future practice reforms.



The trial

This section provides background information about the trial and overall aims the Family Group Conferencing model the trial was based on. It also outlines a tentative theory of change and the process used in FLDM. It also sets out how the trial was implemented and the department's investment.

Trial aims

The Aboriginal and Torres Strait Islander family-led decision making trial aims include:

- Promote self-determination and shared decision making at different phases of the child protection continuum;
- Empower families to make informed choices and decisions about what's best for their children, while the department ensures safety concerns are addressed by the process;
- Develop and trial the capacity of the Recognised Entity (RE) and Aboriginal or Torres Strait Islander community controlled organisation' to lead decision making and case planning in a culturally sensitive way;
- Test the practice implications and effect on existing legislative arrangements and delegations;
- Assess the time and resources taken to undertake a full family-led process; and
- Review the efficiency of FLDM at different phases of the child protection continuum.

Evidence based model for the trial

The intervention framework is grounded in the Family Group Conference (FGC) model originating in New Zealand then later adapted in Victoria, Australia. FGC is a family-led decision-making process which focuses on discussing and developing strategies that protect the safety and wellbeing of children and young people primarily through bringing together parents, extended family members, the child/young person, child protection workers and service providers. Family Group Conferences are usually assisted by an impartial third party who makes sure that all participants have a chance to speak and are heard, and that the needs of the child/young person remain at the center.

Conferences aim to empower families to develop strategies that best protect and support the child/young person – whilst also developing relationships between child protection agency specialists and family members within a culturally sensitive environment. Family led decision making meetings leading up to the conference are important to assess and determine whether there is even a need for formal 'protection'. Ultimately the conference aspires to resolve child protection concerns and to help rebuild family ties.

The trial's design replicates the core features of the Victorian FGC model, including:

1. All participants discuss the concerns raised about the child.
2. The family has private time together – this is a mandated element in all the trials. Private time is utilised by the family to develop a culturally appropriate family-based plan that addresses the identified safety concerns in an effort to offset or ameliorate the risk of harm to the child.
3. Agreement is sought as to whether the plan developed by the family addresses the child protection concerns or if the child continues to be in need of protection. If agreement is reached that the plan provides for the child's safety then it is endorsed by the meeting and signed off by the department if relevant.



The FLDM trial

The practice principles adopted in the trial are:

- The child protection agency **recognises the family group as a key contributor and decision maker**. Sufficient time, support and resources must be committed to prepare the family and significant others for their role in the decision making process. Acknowledging the family and significant others as a contributor and decision maker signifies acceptance of family as important to the child or young person. Child Safety always retains the responsibility for ensuring that any decision or plan ensures the child/young person's safety, overall wellbeing and to keep them connected to their culture, families and communities.
- **Family is a culturally defined and informed concept** and who constitutes a child's "family" should be defined as widely as possible. This should include all family, extended family, relatives, family friends, significant others to the child/young person and include members of the family's support network who have something to offer the child and family.
- An **independent worker** who has no case responsibility should be responsible for guiding the FLDM process. Providing an independent coordinator who is charged with creating an environment in which transparent, honest and respectful conversation can occur between the family and child protection agencies signifies a commitment to empowering and non-oppressive practice.
- **Family groups should always have the opportunity to meet on their own**, without non-family members being present, to work through the information they have been given and to formulate a plan to address the safety, wellbeing and belonging needs of the child. Providing family groups with time to meet on their own enables them to apply their expertise and knowledge to the situation in ways that are consistent with cultural decision making practices. Acknowledging the importance of this time and taking active steps to encourage family groups to plan in this way signifies an acceptance of the limits of Child Safety's knowledge and affirms the agencies commitment to ensuring that the best possible plans and decisions are made.
- If a plan developed by the family group **ensures the safety of the child** then the child protection agency should consider that preference is given to the family group's plan over other identified plans and progress the plan (endorse and resource). Accepting the family's plan where it meets the child protection worries and concerns signifies confidence in and a commitment to partnering and supporting families to care for and protect their children and to build the family groups capacity to do so.

Five steps in the process may be considered a theory of action and include:

1. Referrals and information gathering
2. Family engagement and preparation
3. Family-Led Decision Making Meeting
4. Confirming the plan with the department (Trial 2 and 3 only) and family; and
5. Review and feedback.

Key to the evaluation is understanding if the trials have been successfully established in each site and if they are operating as intended in the Work Package Plan and the above Practice Principles and Guidelines. Enhancing the strengths of the FGC model through these evaluation findings should further improve practice reforms and FLDM practice in Queensland.



Theory of change

The evaluation sought evidence of the apparent causal links between the trial resources and the outcomes identified. It did so through these key research questions which expressed key aspects of our theory of change:

- a) Did the new resources combined with different ways of working in the Aboriginal and Torres Strait Islander FLDM trial support change to occur in line with the vision of the reform and the aims of the trial?
- b) Did the explicit focus on Aboriginal and Torres Strait Islander values and decision making processes that acknowledge shared responsibility for caring for children (that is, by parents, extended family, Elders and the community – that supports families to keep the child/young person safe, healthy and reaching their full potential by resolving child safety concerns and assisting in the rebuilding of family ties) contribute to increasing (retaining) Aboriginal and/or Torres Strait Islander child/young people at home safely or with kinship carers, thereby increasing (maintaining) cultural connectedness for the Aboriginal and/or Torres Strait Islander child/young people?; and
- c) Were the key processes supported and stimulated to ensure that meaningful, practical ‘empowerment’ and ‘self determination’ preconditions were in place in each trial site – which were theorized to drive desired outcomes? If so, how did this manifest? Were local Aboriginal and/or Torres Strait Islander families and staff enabled to take control of child protection processes, promoting outcomes that keep children safe and cared for in their family, community and culture. The assumption is that cultural competency and family-centric practices are necessary features of the model.

Our theory of change then necessitates a focus on “*how*” it was done as well as “*what*” was done. This also reflect “*Aboriginal or Torres Strait Islander ways of doing things*” that are difficult to encapsulate in a process, practice or principle document. These elements of how it was done and the extent to which that seemed to yield desired outcomes, are discussed using a ‘realist’ perspective in chapter five. The substantive theories supporting this theory of change consist of intersections between regulatory theory, respect theory, self-determination theory, as well as choice, independence and agency theory. These substantive theories are discussed further in Appendix E.

Site and supplier context

The four sites were selected base on criteria developed in consultation with QATSICPP and the Child Safety Regional Directors from Far North, North and Central Queensland for reflection on local expectations. There were four suppliers in these sites where the trial took place, each with their own unique contexts. The trial sites and suppliers are described by their selection criteria in the following table.

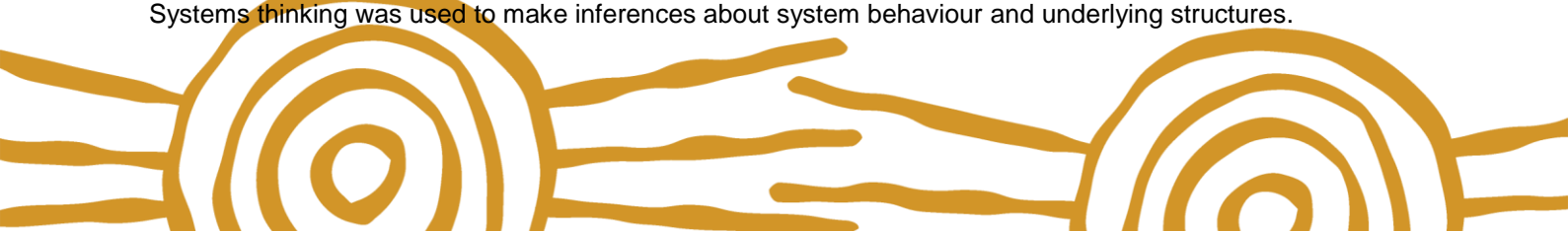
	Trial 1 – Ipswich (South West Qld Region)	Trial 2 – Mt Isa (North Qld Region)	Trial 3 – Cairns (Far North Qld Region)	Trial 3 –Torres Strait (Far North Qld Region)
High number of Indigenous children on child protection orders (CPO) and intervention with parental agreement (IPA). Intake and Assessment (Substantiated/Unsubstantiated). Indigenous children subject to an intake for the first time (at Regional level)*.	IPA: 44 CPO: 297 I&As Substantiated year ending:130 I&As Unsubstantiated year ending:247 Relatively high number of Intakes for the first time. (Regional):485	IPA:55 CPO:171 I&As Substantiated year ending:165 I&As Unsubstantiated year ending: 229 Relatively high number of Intakes for the first time. (Regional):719	IPA:123 CPO: 329 I&As Substantiated year ending:30 I&As Unsubstantiated: year ending: 16 Relatively high number of Intakes for the first time. (Regional):906	IPA:76 CPO:130 I&As Substantiated year ending:19 I&As Unsubstantiated year ending:31 Relatively high number of Intakes for the first time. (Regional):906
Supportive recognised entity/family support service with capability to undertake tasks described and with no or few performance	Kummara Association Inc. (Family Support Service) The region has a well-performing Family	AIDRWA Mount Isa and District Inc. (Recognised Entity) and co-convened with Child Safety	Wuchopperen Health Service Ltd. (Recognised Entity) and co-convened with Child Safety	Port Kennedy Association (Recognised Entity) and co-convened with Child Safety 85% target hours



	Trial 1 – Ipswich (South West Qld Region)	Trial 2 – Mt Isa (North Qld Region)	Trial 3 – Cairns (Far North Qld Region)	Trial 3 – Torres Strait (Far North Qld Region)
issues. 2013/14 performance data.	Support Service (Kummara Inc.) with excellent governance and with pre-existing service delivery frameworks that are aligned to family led decision making.	83% target hours achieved. AIDRWA participated in recent review of FGMs. RE is heavily involved in case planning and FGM participation. The RE has a strong compliance relationship with the contract management team and is considered to be highly accountable for any potential responsibilities as part of a trial.	50% target hours achieved RE workers from Wuchopperan (Cairns and Edmonton CSSC's) have a good relationship and Elders and other leaders in the communities are very cooperative with Child Safety in the Region. Wuchopperan actively take a lead on identifying and reconnecting with kin. Are a large integrated service organisation and have governance and capacity.	achieved. RE workers from Port Kennedy Association (Torres Strait Islands) have a good relationship and Elders and other leaders in the communities are very cooperative with Child Safety in the Region. PKA attend the TI hub almost daily and work with the CSSC closely on genograms.
Capacity of department's FGM convenors to undertake activity within the proposed trials 2&3		Mt Isa CSSC currently has an FGM practice model and tools. AIDRWA Mount Isa and District Inc.	4.5 FTE FGM convenors based in Cairns that work with a high A&TSI population. Have a Principal Team Leader attached to the Office of the Regional Director (as is the Indigenous Practice Leader). The practice is to comprehensively involve families and community members in decision making at all significant points (often family members run the majority of the meeting). For 2013-14 (Sept – Sept) there were approx. 70 of these with approx. 125 Case Plans generated with cases attached to the Torres Strait Islands Hub.	
Supportive relationships with Elders and leaders within the local Aboriginal and Torres Strait Islander community	South west Cultural Enablers network has links to Elders and traditional groups. Elders have participated in training in service centres. Strong partnerships exist with Kambu and Goolburri REs that have allowed community Elders to act as cultural support persons for Cultural Support Plans.	FGM Consultation Group established consisting of Recognised Entity, community legal reps. Members have been invited based on cultural knowledge. Currently CSSC has an Indigenous principal project officer dedicated to assisting with the Indigenous reform strategies, who has existing strong partnerships in the community. Works alongside the Indigenous Practice Leader position.	Benefit of obtaining cultural expertise with two distinct cultural groups to understand the best approach to ATSIFLDM. Opportunity to work with CSSC has connection with Wuchopperen men's group and key community organisations including in Yarrabah.	
Geographic spread – remote, regional and urban.	Urban	Regional	Regional	Remote

Initially only three sites were considered. However, through further consultation and in recognition of the unique differences in culture, geographical remoteness and service delivery challenges the Far North Queensland site was split into Cairns and Torres Strait Islands making four sites.

The trials are set in complex micro and macro systems. Ultimately, systems are made up of people and people behave in different ways influenced by the physical and socio-cultural environments as well as the the motivation reasoning, and ability of the person/families concerned. The evaluation suggests that people behave the way they do in this new “shared practice” system, due to a number of dynamic structural features. Systems thinking was used to make inferences about system behaviour and underlying structures.



Contexts help to describe and understanding the forces and interrelationships that shape the behaviour of the people in the system/communities concerned. In particular, three site and supplier contexts that impacted on the trials:

- 1) the level of clarity and/or consistency about the trial varied due to regional level administration of the trials;
- 2) the capacity of the FLDM service providers and extent to which they could support new convenor roles and a new service model; and
- 3) the extent to which departmental staff truly (not just words but actions) embraced the trial's commitment to shared power and control in the practice space.

These contexts had a significant impact. Some supported the forces or interrelationships to pull together (shape) better and greater outcomes. In others, forces seemed to push groups apart and poorer outcomes were evident. The three significant contexts identified above also varied over time in each site and it was evident that the 'pull' (positive) forces gained momentum and overcome the push forces by the end of the trial period. These contextual factors are discussed in more detail in the chapter on the realist perspective.

Stages of the child protection continuum

There are three different trials occurring simultaneously but in four trial sites as described in the table below.

	Trial 1 – Ipswich	Trial 2 – Mt Isa	Trial 3 – Cairns and Torres Strait
Phase of child protection system	Early intervention where there is no requirement for ongoing departmental contact / intervention	Department has the investigation and assessment process open and statutory protection is likely or being considered	Child Protection Orders or Open Intervention with Parental Agreement is in place (the trial is both for initial case plan development, as well as case plan review)
Primary outcomes sought	Divert families from future departmental intervention Keep children connected to family, community & culture	Reduce entry to out-of-home care Promote rapid re-unification Keep children connected to family, community & culture Increased role of the RE	Identify alternatives to OOHC & culturally appropriate placement options Improve quality of case plans, cultural support plans, and transition from care plans Increased role of the RE To reduce intrusiveness and length of intervention.

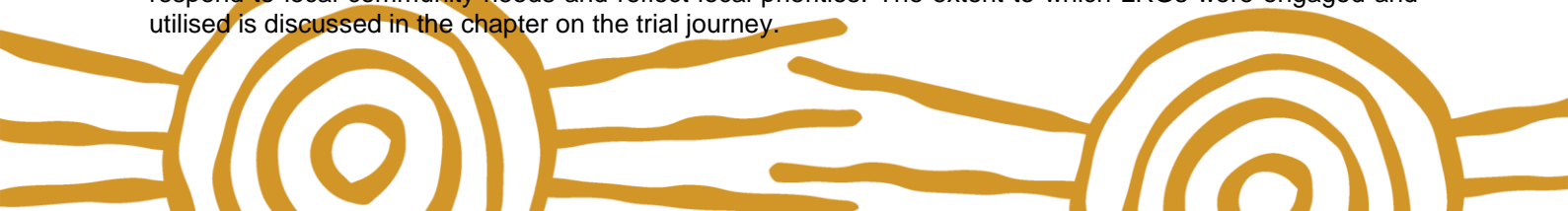
As discussed earlier, the stage of the child on the child protection continuum influenced outcomes. This is discussed further in chapter five on the realist perspective.

Implementation strategy

The trials were implemented within legislative parameters set by the Child Protection Act 1999 prescribing responsibilities of the department and FLDM service providers to operate flexibly within these legislative requirements. Specifically, for Trial 2 and 3 the FLDM service providers were Recognised Entities (RE). SNAICC were commissioned to support implementation and practice from January 2016 to June 2017. Discussion on the challenges and strengths for the implementation of the trials is discussed in the chapter on the trial journey.

Local reference groups

The role of the Local Reference Group (LRG) participating in the Aboriginal and Torres Strait Islander Family-Led Decision Making Trials was intended to bring local knowledge and cultural expertise to the trials and to enable community ownership of the process. SNAICC and FLMD service providers held engagement workshops and meetings during the trial. In the design these groups were viewed as a critical component of the trials - especially to promote self-determination, local community ownership, and the adaptation of trials to respond to local community needs and reflect local priorities. The extent to which LRGs were engaged and utilised is discussed in the chapter on the trial journey.



Investment

The costs for the trial was budgeted for an allocation of \$1.569 million over three years. The costs included the contracting of an implementation consultant, an evaluator and the FLDM service providers, external convenors and internal costs covering training, travel and marketing were also included. The total cost for the trials has not been made available to the evaluation team.

The costs for FLDM service providers allocated in was \$631,236. The total cost of service delivery by the FLDM service providers will be confirmed in 2018 after the finalisation of this report. It is estimated at \$667,923 based on the contracted agreements. Final costs may vary for expenditure and brokerage claims based on audited figures which will not be available until the end of the year.

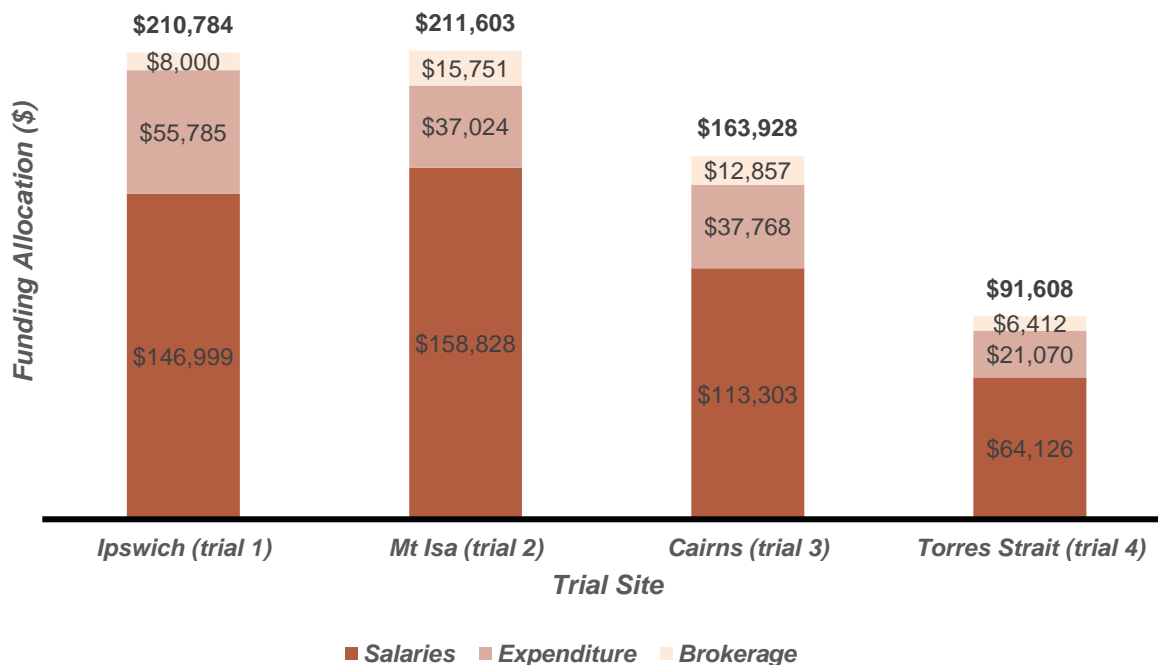
An Investment Specification describes the department's intent of investment and offers guidance to service users and service delivery types on the requirements for services to be delivered, funding allocated and reporting required. An Investment Specification was not developed for the trial, making it difficult for specific guidelines to be adhered to. Due to this lack of specific guidance, the services involved utilised the Families Investment Specification developed by *Child, Family & Community Services Design and Commissioning* in April 2017, to support funding allocation and reporting required for each trial site.

There was variability in how the contract manager and the FLDM service provider interpreted the use of expenditure and brokerage budgets. Brokerage funds were generally used to ensure the outcomes of safety plans/case plans can be appropriately resourced. However, this was vague and open to interpretation. The Work Package 28 Plan defines brokerage as *"use of brokerage funds held within the organisations participating in the trial will aid the scope and potential of support and case plans developed in each trial."*

For example, in the Ipswich trial most of the brokerage money was rolled into the expenditure budget which went towards transport and items that may be considered brokerage. The Torres Strait trial had high transport costs, in some cases too much to expend making the FLDM service provider reliant on using the departmental helicopter flights to visit families across the islands as it was too cost prohibitive to make independent trips. Mt Isa had no transport at the beginning of the trial relying on Taxi's or lifts with the department before increase in expenditure was made to lease a vehicle.



ATSIFLDM Trial Contract Costs



Salary expenses were allocated between 0.5 to 1 Full Time Equivalent. The department resourced a second convenor for trial 2 (Mt Isa) in the last six month of the trial. Discussions on the impact of resourcing is made in the trial journey chapter.

Determining a cost per family is not as simple as averaging the costs spent by the caseload. There were significant scaling up of resources and training required to commence the trial. Secondly, a critical mass or fixed cost is needed to be covered just to run the service, so incremental costs for additional families once economies of scale are met may be smaller depending on the volume of the case load. Thirdly, each family is very different, the engagement, preparation and meeting time required may vary significantly. Some families are easier to engage, and some families are ready sooner than others to hold the meeting.



Trial 1 – Early Intervention

Trial Site 1

The first trial was conducted in Ipswich by Kummara Association Incorporated (Kummara) Family Support Service. As part of the trial, Kummara applied family-led decision making as an early intervention response for assessment and planning. This involved the application of a family group conferencing framework, which is a strengths-based shared practice model that empowers the family to identify their strengths and take the lead in designing a solution to meet their child's needs.

Kummara is an Aboriginal organisation located in Goodna whose policy statement is *Stronger Indigenous Families*. The work and activities that are engaged in by staff, and offered as a service to the local Aboriginal community of Brisbane/Ipswich, involve working closely with Aboriginal and Torres Strait Islander families, women and children. Their underlying method of working takes as its premise the notion of the primacy of the family/community and local consensus style decision making.

The interaction between the schools, Aboriginal Medical Service (Goodna/Ipswich) and RE team is very strong when identifying family needs and ensuring families are provided with as much as they require to ensure the safety and wellbeing of the families. The programs they operate establish very close links to the strong cultural links of ensuring service is offered from babies to elders. The involvement of parents/carers in these programs also demonstrates elements of integrity as Elders who are carers are asked to facilitate Cultural activities for Kummara.

Key phases for implementing Aboriginal and Torres Strait Islander Family-led Decision Making

Referral and
Gathering Initial
information

Engaging with
the Family and
Preparing for
the Meeting

Facilitating the
Aboriginal and
Torres Strait Islander
Family-led Decision
Making Meeting

Sharing and
Supporting the
Plan

Reviewing the
Plan



Up to 12 Weeks

Outcomes

- Divert families from future Departmental intervention
- Keep children connected to family, community and culture



Trial Outcomes



28 referrals received



Case load of 20 families total



19 families exited the service

16

Families benefited from improvements in safety and protection from harm

16

Families benefited from improved life skills

16

Case plans addressed safety needs for the family



1 family exited due to a child protection notification



616 hours applied to the service

Story from the Trial

“Willing, Loving, Caring” Carer

Client XXXX is the grandfather to 3 kids currently in his care.

The grandfather notified the department of his grandchildren’s safety due his daughter’s drug and alcohol abuse, domestic violence, neglect and lack of parental care.

The department referred the family to the service. Outcomes from engaging with the service include:

- A change in the children’s behavior;
- Grandfather has gained the love and trust of the children;
- The grandfather strengthened his role as parent/carer/protector;
- The house is a safe place;
- The children are engaging and learning about their cultural connections; and
- Each child has a private tutor to help with their education.

The family has a very strong network of support in the community, the children are excelling at school and Kummara offer as much support as required.

Trial Strengths

Primacy of place | Importance of family/kin and relationships | Partnership with families and professionals | Consensus decision making | Non-competitiveness | Positive group dynamics | Age and gender recognition and respect | Maintenance of harmonious relations | Non-hierarchical structures | Sharp observational abilities | Aboriginal system of logic and time and space

Kummarra: the conduit between families and service providers

Trial Challenges

- Only 2 Aboriginal and Torres Strait Islander workers out of a team of 9
- Out of 2 convenors, only 1 is Aboriginal and Torres Strait islander – leading to challenges in perceptions of cultural appropriateness when engaging with service providers and families.
- The non-Indigenous convenor and Aboriginal convenor had to learn to work together and work to each other’s strengths.
- Elders were not utilised in the trial
- Elders were recognized within each family group
- Future focus would promote connections with local Elders groups to further build support for families

Trial Learnings

- Circle of Security: providing a cultural insight into behavioural changes for parents, teaching and supporting them in becoming more effective parents. “Secure Base – Safe Haven.”
- There is a strong reference group of community professionals who have maintained linkage to community as well as lengthy working careers in our community they understand the culture of the Child Protection in our Region.
- Families cultural values and beliefs do not differ significantly when moving geographically within the state, region or out of state. Kummara’s approach was to respect and adapt to understand each family’s unique culture and belief system to build on safer outcomes for children and families.

Trial 2 – Investigation and assessment

Trial Site 2

The second trial occurred in Mount Isa by the RE, Aboriginal and Islanders Development and Recreational Women's Association and District Inc. (AIDRWA). This trial applied Aboriginal and Torres Strait Islander family-led decision making before the Department's investigation and assessment was finalised. AIDRWA coordinated and independently convened a family group conference that collaboratively identified and addressed the safety concerns with the family, with the intent of arriving at alternatives to protection, or identifying strategies to minimise the degree and length of any necessary intervention.

Having a service provider with community connections ensured the success of an under resourced trial site. Families engaged more effectively with the RE and all families interviewed appreciated the cultural and personal support the RE office offered to them. Each family had a specific emotional journey and story that had positive outcomes, a very strong word that was impressed during the trial visit is "empowering the families". Sessions were not conducted in the department office, making the meeting more effective as the families chose the venue and who attended. When the Department was used, the families were less trusting and levels of anxiety increased when discussing placements and family plans.

REs were not always provided with the appropriate service support to effectively undertake their jobs during the trial period. Limited transport was an issue for Trial site 2 as the service providers had to use one vehicle between an office of 6 staff members. There was an expectation that convenors would be able to travel to family homes in taxis for meetings, rather than have the safety of an office vehicle. The trial was also unable to cater for the service of regional communities outside Mount Isa. Due to the dynamics of Mount Isa, families don't have a lot of confidence in ATSI specific services to meet family needs identified in the family plans.

Key phases for implementing Aboriginal and Torres Strait Islander Family-led Decision Making

Referral and Gathering Initial information

Engaging with the Family and Preparing for the Meeting

Facilitating the Aboriginal and Torres Strait Islander Family-led Decision Making Meeting

Sharing and Supporting the Plan

Reviewing the Plan



Rapid Response

Outcomes

- Reduce entry to out of home care
- Promote rapid re-unification
- Keep children connected to family, community and culture
- Increased role of the RE

Trial Outcomes



20 referrals received



Case load of 20 families total



20 families were serviced

16

Families benefited from improvements in safety and protection from harm

13

Families benefited from improved life skills

16

Families increased their cultural connectedness



16

Family plans addressed safety needs for the family



4 families exited due to ongoing intervention



641 hours applied to the service

Voices from the Trial

“They [the Department] put a label on us straight away.” Client

“It’s an us and them mentality.” Convenor

“Yeah, before I just had white people and sometimes they don’t understand Aboriginal ways. They were really picky and they didn’t understand where I was coming from, didn’t know what to do, but when they told me that I was referred to Family-led Decision Making I was really happy. They are Aboriginal and understand where I’m coming from – very helpful.” Client

“I don’t want my children’s kids being part of what I experienced, enough is enough.” Client

Story from the Trial

[Client] has been part of the children welfare system for majority of her life, being placed in care as a child, enduring the trauma of being abused there and having limited access to her family. She was brought up in the care of her grandmother later in life and looked forward to the times for respite when she wasn’t in the care of white people. She was physically abused by her carers if she made mistakes, she wasn’t allowed to contact her family at all, and did not attend schooling throughout her early years. She now suffers from severe depression, mental health problems, is a victim of physical violence and is heavily medicated all the time because of the trauma she endured as a child in the child protection system. She has been in violent relationships with previous partners but is currently single. She has 5 children who are in care – due to the Trial and FLDM her children have been placed with her parents in [nearby community]. This placement has alleviated the stress she felt as she was worried that her children would follow her path. The grandparents maintain a strong cultural connection to their country by taking the children hunting, gathering, and learning about their connections to the land. The FLDM meeting was held in a recreation area close to the [nearby community] under some gum trees with Centacare, Departmental staff, and ATSI/FLDM convenors all present. Choice for the meeting location led to a culturally safe venue which influenced a very positive outcome. Undertaking counselling, medical appointments, and having confidence and trusting services have been instilled in the client.

Trial Strengths

- The concept of self-determination, shared decision making and empowering families to make informed choices gave hope to an already discriminative system for Aboriginal and/or Torres Strait Islander families in Mount Isa, it gave hope in developing cultural outcomes that were pertinent to the reconnection of families.
- The Convenors had strong community skills that aided in this process, they were all local community members who were entrenched in the community so the profile of their work did not prevent any problematic issues.
- Trial site 2 has a very strong working group of Elders who are very passionate about the welfare needs of the children in the community and the resources to strengthen families
- A number of key department staff showed a high commitment to the trial and its intended outcomes and a willingness to persist alongside the AIDRWA through a range of challenges. The AIDRWA staff and the Department staff maintained a consistency of regular collaborative practice meetings that was above that achieved in any other trial sites. This reflected in the resolution of a number of issues, increased support for families and stronger practice in the later stage of the trial - this was reflected in an increasing number of families that received support and cases that were completed in the last 6 months of the trial.



Trial Challenges

- Limited training provided to Aboriginal FLDM Convenors.
- Lack of adequate resources to cater for regional communities surrounding Mt Isa where many extended family members live.
- There is inconsistency amongst staff within the department on their need to control the process.
- Not all departmental staff have had cultural training or appreciation of the community dynamics and language groups in the region.
- The technical practice skillset of convenors impacts their responsibilities with report writing, departmental protocols and interpretation of Child Safety systems.

Trial Learnings

- What works in the city does not work in Mount Isa.
- The community adapt to thinking "outside the box".
- The cultural profile is very strong and use of culture can be valuable in learning how it can be implemented in other communities.
- The convenors need to build stronger network links to ALL services/agencies/community groups in and around Mount Isa.
- The township of Mount Isa has at sometimes more than 10 language groups residing in the community which pose the dilemma of it being a transient community and meeting specific cultural needs.



Trial 3 – Legislated Family Group Meetings (FGMs)

The third trial was conducted in two locations — Cairns and the Torres Strait Islands. In this trial, the Department contracted Wuchopperen Health Service and Port Kennedy Association Inc. to test the effectiveness of expanding the role of REs to take the lead in co-convened family group meetings. The Department worked in close partnership with the REs and families to develop family-driven, culturally appropriate case plans. The families need to be decision makers in Trial 3 more than other trial sites because of the stage of the child protection continuum. However, this trial site because of the context of the stage of the child protection continuum was the most challenging for families. In particular families were interested and motivated to see the new way of working with the FLDM service provider, but when it didn't work as expected and the Department continued to lead and control the processes it created disappointment and dissatisfaction. When the trial was not delivered as intended there were quite negative comments. However, when the trial was delivered as intended there were very positive comments.

Trial Site 3

Cairns was a trial site that had challenges in ensuring enough data was collected and families/stakeholders were interviewed because of staff turnover. Therefore, the evaluation had limitations in understanding a broad range of views from families. These evaluation challenges were also trial challenges. In Cairns the transition and staff turnover of convenors became a challenge and impacted the process of the RE obtaining files and case notes from the Department as well as the process of engaging with families referred to the trial. The changes of convenors also impacted the trust that families had in the trial.

Where the department was very protective about the information it shared from case notes (particularly reports from professionals or assessment reports) there was a perception by the RE that decision making would be influenced by what the Department knew. If this information was shared upfront there was more trust between the RE and the Department. Often the process of going back and forth to the Department to obtain this information was not user friendly or efficient and resulted in the families (who told the RE what the department had) losing trust in the process. The extent of this was said to vary depending on Departmental staff and was possibly perceived because of the way referral forms were completed or the time frame in which they had to work with families. Despite this tension arising during implementation Wuchopperen was found to be very capable as a provider to undertake the information gathering tasks and worked collaboratively with the Department to achieve better outcomes.

Key phases for implementing Aboriginal and Torres Strait Islander Family-led Decision Making

Referral and Gathering Initial information

Engaging with the Family and Preparing for the Meeting

Facilitating the Aboriginal and Torres Strait Islander Family-led Decision Making Meeting

Sharing and Supporting the Plan

Reviewing the Plan

Up to 30 Days

Outcomes

- Identify alternatives to OOHC and culturally appropriate placement options
- Improve quality of family plans, cultural support plans, and transition from care plans
- Increased role of RE

Trial Outcomes



63 referrals received



Case load of **32** families total



25 cases were closed

4

Family plan reviews

30

Family Group Meetings convened



22

Families increased their cultural connectedness



576 hours applied to the service

Voices from the Trial

Where the department assumes the quality of a meeting is measured by the number of family members and pressures families to invite extended family:

“They’re saying the only way you’re going to see your kids is through this way ... the whole family thing – you literally have to say yes to every little thing.” Client

Where the department led and controlled the convening instead of the FLDM service provider:

“I feel like I’m getting ambushed, like everyone’s ganging up on me. I’ll just sit back and I’ll agree to everything that I have to. Until I can speak up and there’s someone that I can talk to and I can get out what I really want to say – I’ll do it then.” Client

Where the family appreciated the opportunity to have their say about the worries and not just have the departments views:

“It’s the way the world works, you’ve got to hear two sides of the story, not just one.” Client

Story from the Trial

[Client] has 5 children in his care and was very honest and open in sharing his families story and the lack of duty of care offered to him. He is of Aboriginal decent & and his partner is non-Aboriginal, he has been dealing with anger management problems over the years but did share his family’s story growing up. His mum was deemed homeless, they lived in their family car and travelled around. He and his sister were both removed due to an accident relating to his mum’s car, when asked for their home address he gave his mum’s number plate, he was cuffed then by the police and taken down to the police station where the department was waiting and removed them from their mum’s care, he was 15 at the time. For a few years, he lost contact with his sister and mum as he didn’t have permission to engage with his mum or sister while he was in care. His time in care was traumatic and he created a strong barrier in which trust was an issue because of the broken promises offered to him. When he was told that his family were going to be part of the trial due to his anger management problems there was no engagement with the convenor prior to the conference. His first contact face to face with the convenor was at the conference. At the conference he felt set up because there were 4 Child Safety officers in the meeting, ATSIFLDM convenor, and a support person from the Wuchupperen (RE). Had described the meeting as very hostile, like he was on trial. In the meeting they brought up his past history with him being in care which was a trigger for him, and caused a strong emotional pull to want to walk out of the meeting. The ATSIFLDM convenor did not intervene but rather the RE worker took him outside to settle him, the client was appreciative of that as it was the only reason he walked back into the meeting. This story highlights the necessity for preparation meetings where other families stated they had time to confront past trauma and be emotional in private and not be judged.

Trial Strengths

- The service provider is the lead provider in Cairns for ATSI child welfare.
- Family Group Meetings need FLDM as an alternative method to get better outcomes for families.
- They have a very strong working group of Elders who are very passionate about the welfare needs of the children in the community and the resources to strengthen families.

Trial Challenges

- Files were not handed over from old/new convenors made transitions for clients difficult.
- No resources for the program (Mobile Phone, Vehicle) made engaging families difficult.
- Comparison of wages between FLDM convenor in the Department and the RE is different creating feelings of inequality.
- Elders were not used in the meetings.
- Financial strains on the FLDM service provider.
- The Department and Aboriginal convenors are not seen as equals in the processes, and such limited information is provided about the families to the FLDM service provider.
- The conferences were not always driven by the families. Departmental convenors led rather than FLDM service provider.
- Not all department staff were open to hearing expert advice from SNAICC about how the model could be more effective.

Trial Learnings

- More resources are required to ensure choice, privacy and independence.
- All department staff should undertake local cultural awareness training when supervising ATSI co-workers or co-convening FGM for Aboriginal and Torres Strait Islander families

Trial Site 4

Torres Strait trial site is made up of 15 islands, most of which have very poor telephone reception and have limited transport options to travel to them. The challenges families/stakeholders were engaged relies heavily on when the Departmental staff are available to travel, because there was no funding for the Torres Strait Islander convenor to travel to families across the islands independently.

Contexts of this site that made the trial challenging to deliver were:

- Communication – Phone, Receiving messages;
- Shame, culture and boundaries;
- Family Island hopping; or
- High cost of travelling.

Despite the challenges of the trial Port Kennedy Inc and the Torres Strait Islander convenor felt that over time they were able to address the inequity of power in the roles and relationships with the department to feel more empowered to help their families and communities. They believe the external convenor model is the only way families in their region will have social justice when interacting with the Child Safety System.

There was a lot of work done by Port Kennedy Inc to engage families to participate, building relationship through case by case visits and relationship building with departments and other stakeholder. The Port Kennedy Inc and LGR was very hesitant to release any names to the evaluators because they did not want to jeopardise this trust and confidentiality was their main concern. Three families agreed through Port Kennedy to be interviewed. Feelings of family shame in the community also restricted the evaluators’ engagement with the community as people don’t want others knowing their family business, especially when identifying support people in very small communities.

Key phases for implementing Aboriginal and Torres Strait Islander Family-led Decision Making

Referral and Gathering Initial information

Engaging with the Family and Preparing for the Meeting

Facilitating the Aboriginal and Torres Strait Islander Family-led Decision Making Meeting

Sharing and Supporting the Plan

Reviewing the Plan



Up to 30 Days

Outcomes

- Identify alternatives to OOHC and culturally appropriate placement options
- Improve quality of case plans, cultural support plans, and transition from care plans
- Increased role of RE

Trial Outcomes



18 referrals received



Case load of 16 families total

11

Family plans developed

12

Cases closed with no family plan reviews

11

Families increased their cultural connectedness



12

Family Group Meetings convened



360 hours applied to the service

Voices from the Trial

Where it created safe space:

“ATSIFLDM employs employees who are Indigenous, this makes communication and understanding easier.” Client

Where it created commitment to the family plan:

“I want the Department to leave me and my partner alone, we have picked ourselves up by moving back home.” Client

Where the tension of co-convening was seen by the family:

“The department is trying to separate me and my family and divide the community because we are only a small community and I play a leading role in my family.” Client

Trial Strengths

- Families show interest and move forward with the outcomes.
- The families are the decision makers.
- Outcomes are community based and inclusive of the entire family kinship system.

Trial Challenges

- When the department are present the families are less confident.
- Non-engagement – families don't talk or respond as effectively.
- Self-doubt and lack of self-confidence.
- Limited resources and excessive travel costs to travel to outer islands restricted the conferences from occurring.
- Conferences only occurred when departmental staff was travelling to those islands.
- Time is a challenge when cultural commitments and obligations are a precedent.

Trial Learnings

- The convenor believe strongly in maintaining the cultural integrity and respect for the families involved and this needed to be better understood by the department.
- Confusion around SNAICC role and feelings that they were controlling the trial by the local reference group.
- The local reference group where very hesitant in consenting to release families names due to the historical challenges of having families/children removed from the islands by government.
- The local reference group raised various concerns with funding extension, protection of families cultural rights and obligations, sensitivity of the cases of the families, relationship breaches and having new entities such as SNAICC confuse the community on what structures were already in place.
- The Family Led Decision Making Project is a crucial component to the RE Program for the effective delivery of Family Support Services in the Torres Straits specifically towards the decreasing of the numbers of Aboriginal and Torres Strait Islander children going through the Child Safety System.
- Family Led Decision Program must be acknowledged by the funding agencies as an effective program for the Torres Straits region and this should be demonstrated through the allocation of funding.
- The remote 18 island communities in the Torres Straits are surrounded by water and flights to most of these island communities are expensive and time consuming. Travel costs must be included as a very important part of the project if it is to be effective and directly contributing to the Closing the Gap initiative.
- Port Kennedy is the local NGO already set up and ready to manage and operate the Family Led Decision Making Program with knowledgeable, skilled, passionate, committed and culturally aware/sensitive staff members.

Evaluation findings

There are a number of sources of information about the outcomes of the trial. Outcomes are derived from qualitative data from the in-depth interviews with families, community members, local reference group members, convenors, FLDM service provider staff, departmental staff and professionals and stakeholders. Quantitative data from the 12 case file audits, performance reports and administrative data. Other sources informed theory testing and consolidation such as the program logic workshop, attendance at knowledge share workshop conducted by SNAICC and participation in working group teleconferences. This section discusses how many participated in the trial, some profiles of the families who participated, how they felt about being in the trial and how the trial impacted on FLDM service providers, departmental staff and other stakeholders.

Trial outputs

There were 130 families who were referred to participate in a trial of an Aboriginal and Torres Strait Islander led FLDM meeting across three regions in four sites at three different stages of the child protection continuum. There were 88 families who participated in the Trial. This section discusses the quantitative from performance reports provided by the FLDM service providers from Trial 2 and Trial 3 to their contract managers in the OASIS database. The data for the reporting period of January 2016 to 30 June 2017 has been provided and analysed.

In Trial 1 Ipswich:

- There were 28 referrals received and commenced making a case load of 20 families in total.
- All 20 families were serviced and 19 exited the service.
- There were 16 families with outcomes of improvements in safety and protection from harm, and 16 families with improved life skills.
- There were 16 families whose case plan address safety needs.
- There were 1 family who exited the service as they received child protection notifications.
- 616 hours were applied to the service.

In Trial 2 Mt Isa:

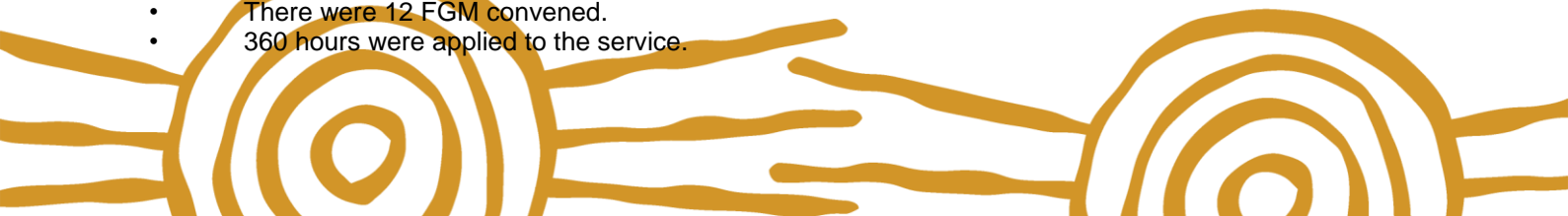
- There were 20 referrals received and commenced making a case load of 20 families in total.
- All 20 families were serviced.
- There were 16 families with outcomes of improvements in safety and protection from harm, 13 families with improved life skills and 16 families increased their cultural connectedness.
- There were 16 families whose case plan address safety needs.
- There were 4 families who exited due to ongoing intervention.
- 641 hours were applied to the service.

In Trial 3 Cairns:

- There were 63 referrals and 32 families participated in the service.
- There were 32 case plans developed of which 22 had cultural plans.
- There were 25 cases closed with 4 case plans reviewed.
- There were 30 FGM convened.
- 576 hours were applied to the service.

In Trial 3 Torres Strait:

- There were 18 referrals and 16 families participated in the service.
- There were 11 case plans were developed of which 11 had cultural plans.
- There were 12 cases closed with no case plans reviewed.
- There were 12 FGM convened.
- 360 hours were applied to the service.



In all trial sites there was less activity in the first half of 2016 and the majority of worker time was spent on meeting with the Local Reference Groups; training related to the trial; support and meetings with SNAICC; and meeting with the department. In Trial 2 (Mt Isa) and Trial 3 (Torres Strait) all of the referrals were able to be recruited into the trial.

In Trial 1 (Ipswich) there were more referrals than those who entered the trial. Referrals that were not serviced either did not meet the criteria for the trial, resolved issues without need of intervention, or the families' needs had changed from referral to engagement. In Trial 3 (Cairns) there was a significantly higher number of referrals compared with other sites, with 41% of referrals accepted into the trial. While Cairns worked with twice as many families as Mount Isa, not all referrals could be accepted. This was said to be due to the time constraints and departmental requirements of only taking a certain number of clients per period (i.e. 6 clients in any 3 month period). Of those who were approached to participate in the trial, there were 5 families that declined the trial. The reasons for the families' non-participation include no contact achieved or no response to contact attempts (2), constant rescheduling and ran out of time (1), wanted to go through Department process (1) and behaviour of the client (1).

In Trial 3 there was staff turnover that stopped the service delivery for the first quarter until new staff were trained. Funding allocation has been extended into the third quarter of 2017 until exhausted.

Case file audits

One of the comments that was consistently stated by convenors was that there was no "typical" family nor was there a "family type" that could be generalised for their trial. Each family was said to be unique and different. This section looks at the circumstances of a small sample of families in the trial by examining the family profiles of 12 families who consented to case file audits. It is hard to know if this group was representative of the overall group characteristics that participated in the trial, because this information is not available. The sample however does highlight the different family types, varying family histories and experience with child safety.

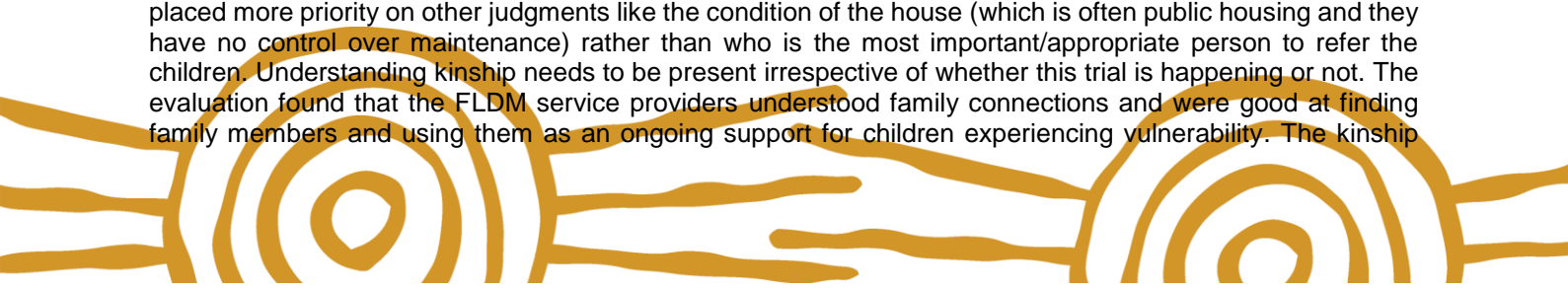
The family plans

The family plans themselves should represent the way the family drafted the plan, and therefore not necessarily sticking to a specific templated idea of how it needs to be documented. The plan formats audited did vary and as such the same information was not present for all cases in the same way. In general, cultural plans were not always a separate statement or document or even stated. It was said that there are times when cultural plans do not need to be stated as they are implied when family remains intact or when extended family are caring for the children. Cultural plans may be embedded in the safety plan or overall plan and were not separated out to a specific response in the case file notes.

"A non-Indigenous person might read that plan and say – where is the culture? – but I read the plan and I can see it woven in there. Don't need to be spelled out all the time for the department. We know it is there just trust us." RE.

"It can be a little bit insulting asking a grandparent – now how you gonna bring up this little one in culture? – it's just how we live day in day out." Aboriginal Convenor.

Families interviewed felt that the department staff (convenors and CSOs) ignored the family connections and placed more priority on other judgments like the condition of the house (which is often public housing and they have no control over maintenance) rather than who is the most important/appropriate person to refer the children. Understanding kinship needs to be present irrespective of whether this trial is happening or not. The evaluation found that the FLDM service providers understood family connections and were good at finding family members and using them as an ongoing support for children experiencing vulnerability. The kinship

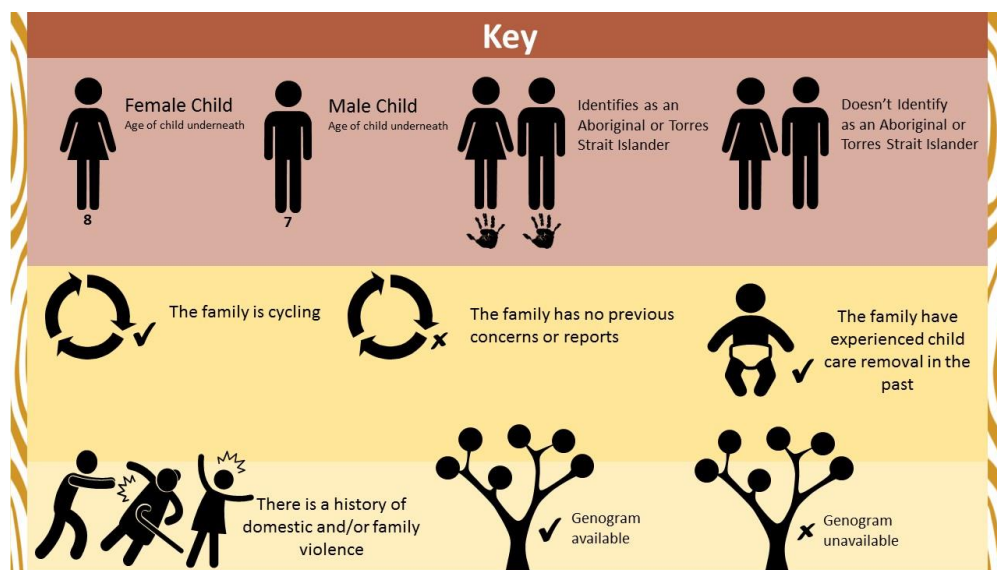


network as a resource to the planning process doesn't come across strongly in the statements for families, because this was one of those "unspoken" and "known" things that the Aboriginal and Torres Strait Islander convenors just apply. However, non-Indigenous convenors were said to labour over the importance of kinship, which was something they didn't really understand well enough to know if it was present.

However, where the family consisted of mixed heritage parents or grandparents, the cultural plans were said to be more important so that specific actions for extended Aboriginal and/or Torres Strait Islander family members were made clear to the non-Indigenous family members.

The cultural plan is a requirement and therefore if not easily distinguishable or identified in the family plan, non-Indigenous people may be difficult to know whether it is missing or present.

For each of the file audits we looked at the following items:



(Note: Not all circumstances are seen in every case)

Trial Site 1

In Trial 1 the file audits were compiled from the FLDM service provider's case notes. Families are referred at an early intervention stage and a case file on ICMS is not yet initiated. In the three cases reviewed the families generally didn't have a genogram completed. There appears to be some consistency with the departmental worries and families worries and suspected harm types. However, as the department were only at referral stage and not involved in the meeting this might explain the discrepancy.

Family plans were created and agreed upon, safety needs completed and importantly the family participating agreed to use services identified in the plan in all three cases. In two of the three cases a cultural support plan was included in the family plan.



One out of three cases resulted in the children being placed in kinship care with the grandparents. Two of the three cases resulted in no change in the care arrangements for the children.

Trial Site 1 **ATSIFLDM – AUDIT SHEET 1**

Context
Children concerned: 9, 7, 8
Family cycling: x
DFV mentioned: ✓
Previous child removal: ✓
Attendee Relationship: Grandparent x2, Mother
Family tree: x

Suspected abuse type
• Anxiety
• Mental harm
• Depression
• Negligence

Department worries
• Abusive behaviour
• Physical abuse

Family worries
• Children's behaviour
• Swearing
• Abusive behaviour
• Malnourished

Family-led Decision Making
• Attend ✓
• Non-attend x

Outcomes
• Plan created & agreed on ✓
• Cultural support needs completed ✓
• Safety needs completed ✓
• FP agrees to use services ✓

Pre-FLDM children in care of biological parent (one or both) → Post-FLDM children go to kinship carer

Trial Site 1 **ATSIFLDM – AUDIT SHEET 3**

Context
Children concerned: 8, 6, 2, 3
Attendee Relationship: Mother, Grandfather
Family tree: x

Suspected abuse type
• Negligence
• Domestic violence
• Unsafe environment

Department worries
• Domestic violence
• Unsafe environment/Child safety
• Negligence
• Mental abuse

Family worries
• Domestic violence
• Unsafe environment/Child safety
• Negligence
• Mental abuse

Family-led Decision Making
• Attend ✓
• Non-attend x

Outcomes
• Plan created & agreed on ✓
• Cultural support ✓
• Safety needs completed ✓
• FP agrees to use services ✓



ATSIFLDM – AUDIT SHEET 4

Trial Site 1

Context

Children concerned: 9, 8, 5, 17

Family cycling:

Attendee Relationship: Mother, Grandmother

Attendee counts: 55, 31

Family tree:

Suspected abuse type

- Health issues
- Neglect
- Drug and alcohol

Department worries

- Domestic violence
- Child care needs
- Neglect
- Drug and alcohol

Family worries

- Domestic violence
- Child care needs
- Neglect
- Transience of family
- Health concerns
- Parenting skills

Family-led Decision Making

- Attend:
- Non-attend:

Outcomes

- Plan created & agreed on
- Cultural support
- Safety needs completed
- FP agrees to use services

Trial Site 2

In Trial 2 audits were compiled from the case file on ICMS. In the four cases reviewed the families generally didn't have a genogram completed.

Domestic and family violence was present for all four cases. There does not appear to be family worries documented in the case plans. In three cases a follow up assessment plan was completed and in the third case the child was not in the care of the parent's post FLDM

In Trial 2 the FLDM service provider maintained some resourcing for each case. The effort to engage families ranged from 6 – 10 attempts to arrange preparation time. The FLDM meeting took 2-3 hours and the brokerage ranged from \$40-\$80

ATSIFLDM – AUDIT SHEET 9

Trial Site 2

Context

Children concerned: 1, 2, 6, 7

Family cycling:

Attendee Relationship: Mother, 2/4 case children

Attendee counts: 24, 2, 1

Physical Condition:

Mental Health Condition:

Previous child removal:

Family tree:

Suspected abuse type

- Negligence
- Health Welfare
- Domestic Violence
- Drug Abuse

Department worries

- Not Documented ??

Family worries

- Documented ??

Family-led Decision Making

- Attend:
- Non-attend:

Outcomes

- Plan for an assessment/follow up assessment
- Safety plan developed with the family

Post FLDM Child Care Arrangements: Biological Parent


Family contacted 7 times for prep meeting



3 hours taken for the FLDM

\$60 Brokerage

ATSIFLDM – AUDIT SHEET 10




Trial Site 2




Context
 Children concerned: 7 (Mother), 11 (Father), 17 (Child)
 DFV mentioned: 
 Attendee Relationship: Mother (44), Father (45)

Suspected abuse type
 • Domestic Violence 
 • Alcohol Abuse 

Department worries
 • Not documented ??







Family worries
 • Not documented ??



Family-led Decision Making
 • Attend 
 • Non-attend 

 Family contacted 6 times for prep meeting
 3 hours taken for the FLDM
 \$80 Brokerage



Outcomes

 • Plan for Assessment/Follow Up 


ATSIFLDM – AUDIT SHEET 11




Trial Site 2





Context
 Children concerned: 3 (Mother), 5 (Father), 8 (Child), 12 (Child)
 Family cycling: 
 Attendee Relationship: Mother (27), Father (26)
 DFV mentioned: 
 Physical Condition: 
 Mental Health Condition: 
 Previous child removal: 
 Family tree: 

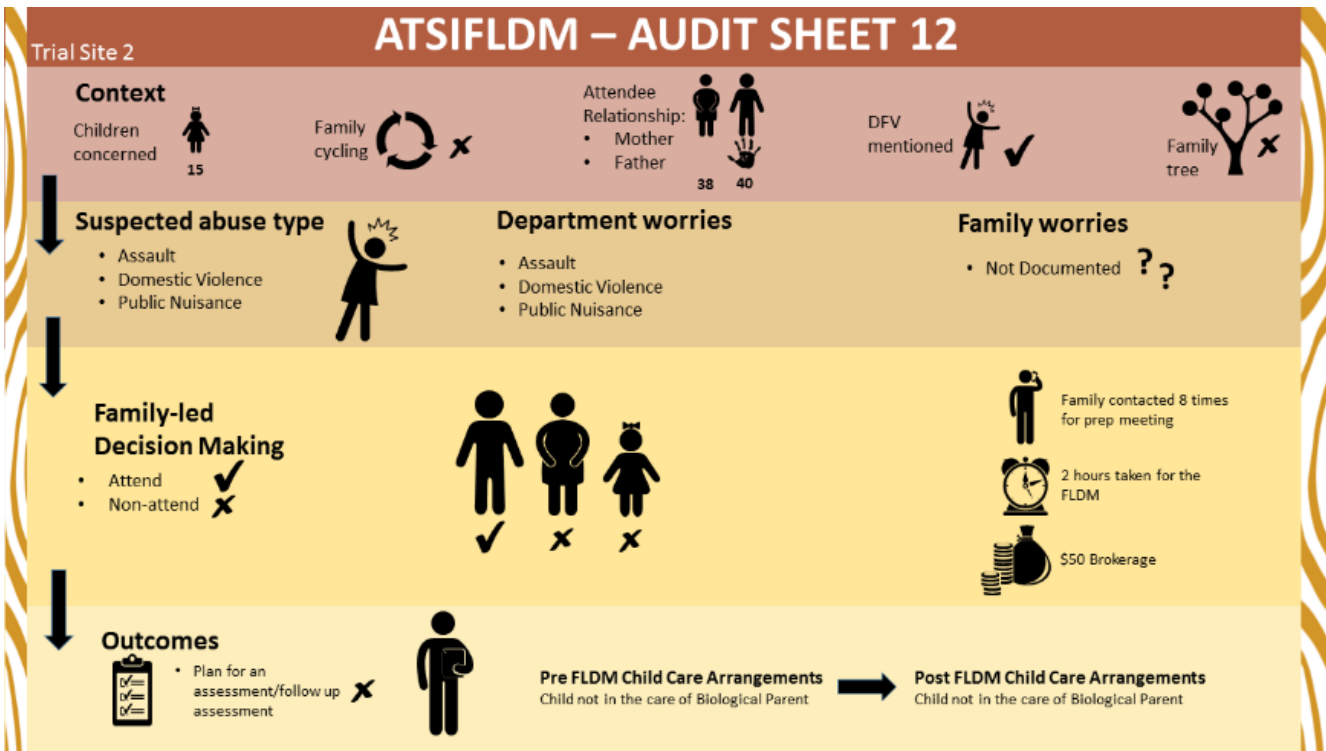
Suspected abuse type
 • Domestic Violence 
 • Children's Safety 

Department worries
 • Domestic Violence 
 • Children's Safety 

Family worries
 • Not Documented ??

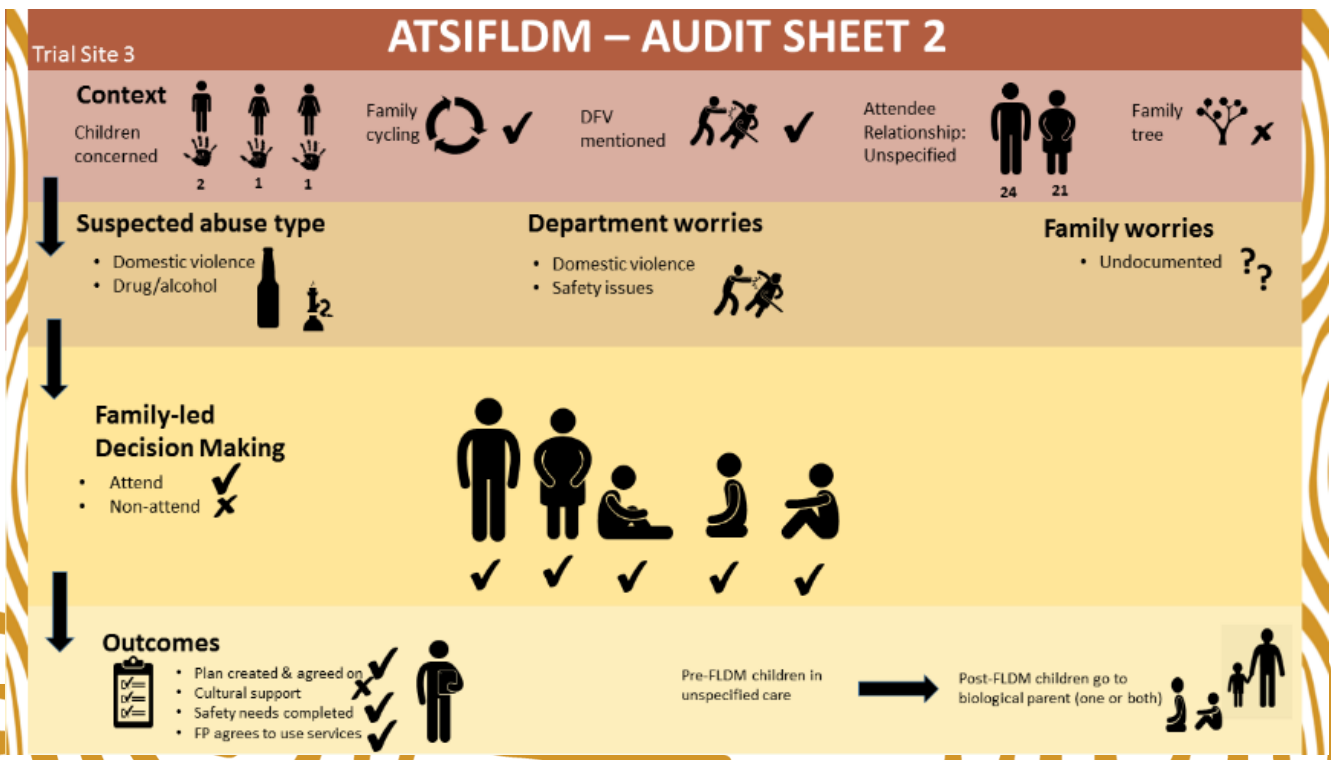
Family-led Decision Making
 • Attend 
 • Non-attend 

 Family contacted 10 times for prep meeting
 3 hours taken for the FLDM
 \$40 Brokerage

Outcomes

 • Plan for an assessment/follow up assessment 

 Pre FLDM Child Care Arrangements: Biological Parent → Post FLDM Child Care Arrangements: Biological Parent's Family (Kinship Care) 



Trial Site 3

In Trial 3 audits were compiled from the case file on ICMS. In the five cases reviewed only 2 families had a genogram completed. Harm types were multiple and more complex for these cases. In two cases the children remained in the care of their family after the FLDM and in one case they went to foster care, another was kinship care and the third was not stated. In two case files the family worries were not stated. There were three cases where family worries include the underlying issues of neglect through poverty.



Trial Site 3

ATSIFLDM – AUDIT SHEET 5

Context

Children concerned: 10 (M), 13 (F), 14 (M)

Family cycling: ✓

Attendee Relationship: Mother (37), Father (41)

Previous child removal: ✓

Family tree: ✓

Suspected abuse type

- Sexual Abuse
- Domestic Violence

Department worries

- Sexual Abuse
- Domestic Violence

Family worries

- None

Family-led Decision Making

- Attend: ✓
- Non-attend: ✗

Outcomes

- Safety needs completed: ✓

Pre FLDM Child Care Arrangements: Biological Parent

Post FLDM Child Care Arrangements: Unknown

Trial Site 3

ATSIFLDM – AUDIT SHEET 6

Context

Children concerned: 5 (M), 6 (F), 8 (M), 11 (M)

Attendee Relationship: Mother (37), Father (39)

Mental Health Condition: Intellectual Disability (11)

Family tree: ✗

Suspected abuse type

- Drugs and Alcohol Misuse
- Dealing
- Neglect

Department worries

- Drug Use
- Dealing
- Neglect
- Child's Behaviour

Family worries

- Expensive Housing
- Limited Support from DCS

Family-led Decision Making

- Attend: ✓
- Non-attend: ✗

Outcomes










- Safety needs completed: ✓
- Cultural Plans Completed: ✗

Pre FLDM Child Care Arrangements: Biological Parent

Post FLDM Child Care Arrangements: Biological Parent









Trial Site 3

ATSIFLDM – AUDIT SHEET 7

Context Children concerned  2 2	Attendee Relationship: • Mother  26 • Father  24	Physical Health Condition  Mental Health Condition 	Family tree 
Suspected abuse type <ul style="list-style-type: none"> • Drug use • Medical Care • Neglect • Sexual Abuse 	Department worries <ul style="list-style-type: none"> • Drugs and Alcohol • Child Care • Safety of Children and Siblings 		Family worries <ul style="list-style-type: none"> • Neglect • Drugs and Alcohol • Children's Behaviour
Family-led Decision Making <ul style="list-style-type: none"> • Attend <input checked="" type="checkbox"/> • Non-attend <input checked="" type="checkbox"/> 			
Outcomes <ul style="list-style-type: none"> • Plan for Assessment/Follow Up <input checked="" type="checkbox"/> • FP Agrees to use Services <input checked="" type="checkbox"/> • Safety needs completed <input checked="" type="checkbox"/> • Cultural Support Plan Completed <input checked="" type="checkbox"/> Pre FLDM Child Care Arrangements: Biological Parent  → Post FLDM Child Care Arrangements: Foster Care 			

Trial Site 3

ATSIFLDM – AUDIT SHEET 8

Context Children concerned  17	Family cycling 	Attendee Relationship: • Mother  38 • Unknown  47	Previous child removal 
Family tree 			
Suspected abuse type <ul style="list-style-type: none"> • Child Behaviour 	Department worries <ul style="list-style-type: none"> • Dealing with reasons why child was adopted 		Family worries <ul style="list-style-type: none"> • Child Behaviour • Aggression • Reconnection to the Family
Family-led Decision Making <ul style="list-style-type: none"> • Attend <input checked="" type="checkbox"/> • Non-attend <input checked="" type="checkbox"/> 			
Outcomes <ul style="list-style-type: none"> • Transition from care needs completed <input checked="" type="checkbox"/> Post FLDM Child Care Arrangements: Kinship Care (not biologically related) 			

Outcomes for families

This section evidences the perceptions, attitudes, feelings and outcomes as described and valued by the families involved in the trial and those who observed the families. The evaluation focused on what was new or different about this specific trial and how this impacted on families.

The new supporting resources that the trial gave to families as stated by them was:

- Privacy to talk without the department present;
- Working with convenors from their culture who understand them and don't judge them like the department;
- Independent advice and information from Aboriginal and Torres Strait Islander people they trust;
- Acknowledgement of past pain, privacy from the department for the release of emotions and time for healing; and
- Learning about the child safety system and understanding what the child safety concerns actually mean (in their own language or way of talking and not in departmental or legal language).

"[Trial] employs employees are Indigenous where it makes communication & understanding easier."

"I don't trust the other services like with personal things, it's bad to tell Child Safety, but this [trial] is ok."



"the issues that we have, we could sort it out ourselves within the family within the home without their [department] involvement."

"Confidentiality is a big issue up here because communities are small and families know when you are being processed by agencies"

How the FLDM trial felt to the family could very much influence whether outcomes were achieved. More positive outcomes were achieved when:

- A safe space was created where the family felt comfortable;
- The family had choice about the planning of the meeting (choice of date, time, location, attendees);
- Verbal and non-verbal communication and mannerisms that demonstrated that the Aboriginal and/or Torres Strait Islander convenor was leading the process, was being respected by other departmental staff and professionals as an equal;
- Pacing the information delivery and giving time to process information without condescending tones and no talking down to families;
- Aboriginal and Torres Strait Islander way of doing things that give time to reflect and release emotions, even humor at odd times, or anger, or silence, but mostly said to be done in "our way";
- Focus on the now problems and issues not shaming on the past issues; and
- Focus on the child/ren and young people staying with family and/or with kin.

"When they told me that I was referred to Family Led Decision Making I was really happy they are Aboriginal they understand where I am coming from, very helpful."

"Cultural activities (ceremonies) needs to be part of the process as it heals clients and exposes children to their own cultural practices as indigenous people learn through culture."



"Working together and being one and talking on the ground before that child is moved. If this is my grandchild, you come and talk to me I'll give you placement."

"We felt better that we spoke to our own people first before talking to those white people."



When families are provided with these new supporting resource factors and how they were applied resulted in more positive outcomes identified as:

- Did not feel alone and under attack, felt that someone believed in them which gave them optimism and motivation to follow the actions in the plan;
- Trusted that the process was genuine because they were treated with respect and dignity;
- Spoke up about all the concerns and worries;
- Owned their plan and committed to making it work;
- Separated their emotions from the problem solving so they can all work together;
- Felt supported and that they had someone who knew them and their family's story rather than a room of strangers who they perceive are against them;
- Worked with the department not against them because there was a common focus on the child/ren;
- Focused on the child's safety and what they could do to change their behavior;
- Service provision and assistance that may not be specifically for child safety concerns but contribute to the health and wellbeing of the family and child/ren;
- Reconnecting with estranged family members, bringing family together that may have been dysfunctional or realising roles of support within the family; and
- Understood and accept the final decision even if they didn't agree with the decision.


"I think it would be very powerful stuff for families getting a chance to have a say."

".. got to a place where I am going to stick to the plan. It's worth doing the program, I took a lot away from it. You have to be open and honest to what your needs are. The funding to provide this service is required. It's what the family needs, other services do not support us."

"I don't like to be judged by my past."

"The support they have, they're like the defender of us, that's how they make me feel. And not fearful, like I can speak more. That's the service that they have for us."

"Feeling like we got this Family Plan we put together ourselves and we can go away and actually put it into practice."



Outcomes for FLDM service providers


This section evidences the perceptions, attitudes, feelings and outcomes as described and valued by the convenors and staff involved in the trial and those who observed them working. The evaluation focused on what was new or different about this specific trial and how this impacted on the FLDM service providers.

This trial was different because the FLDM service providers felt they were given the authority and power to work more actively and directly with the family, shifting away from a primarily advisory role to the department, to essentially developing a family centred approach that is culturally sensitive. In the secondary system, as an early intervention strategy this trial's strengths are in the development of protective strategies. These strategies are based on the transfer of knowledge regarding the thresholds for harm, (i.e "what is safe" from a departmental perspective), whilst working with the strengths of the family (i.e to protect from harm) and focusing on the safety and wellbeing of the child/young person as a common goal.



The new supporting resources that the trial gave to FLDM service providers as stated by them was:

- More independence and authority to work with the family;
- More time in the 'preparation meetings' to build trust, confidence, resilience, optimism, and work with families to identify their strengths;
- More respect for their cultural knowledge and recognition that working with Aboriginal and Torres Strait Islander families' needs to be done differently; and
- More training and support to better understand the child safety legislation and departmental expectations.




"I've got to encourage, I've got to listen to that and I've asked them to tell me, if what I'm asking or what I'm suggesting through my interventions conflicts with their beliefs or practices."


"Yes we're learning, we're trying to translate our jargon to family friendly language that everybody can understand."

How the trial felt to the FLDM service providers could very much influence whether outcomes were achieved. More positive outcomes were achieved when:

- Enough preparation time spent with the family to explain the child protection system and processes, is done in a way which can be understood by families because it is delivered by an independent, trusted informant in their language (either colloquial or traditional) who understands their culture, historical contexts and works to their strengths;
- The FLDM service provider can allocate resources so that it is done to meet specific family needs and support family choice;
- Working privately and independently from the department so that the families' concerns (not just child safety concerns) can be raised and the complex needs of the family can be better addressed;
- A good relationship with the child safety officers (CSO) and the department's convener created productive partnerships and good information sharing which made the convener feel organised, prepared and professional in front of the families;
- Overcoming internalised stigma and racism to challenge external racism and judgemental lines of enquiry by the department; and
- Given equal power in the processes and treated as an equal partner with the convener and allowed to lead the discussions with families.



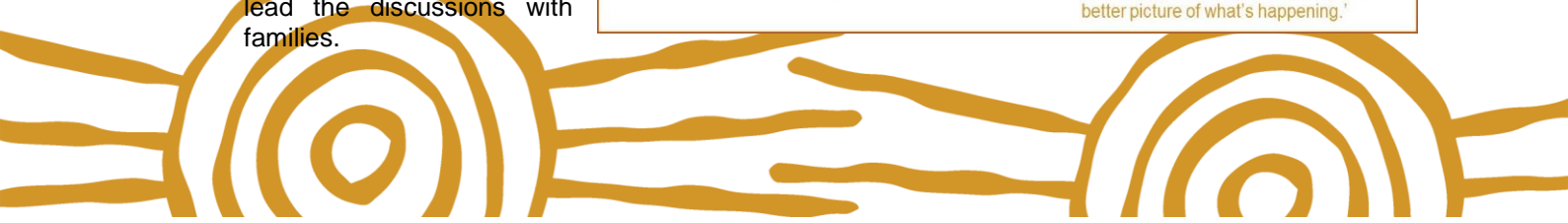
"You had to go over it a couple of times because these families don't understand this stuff."



"It's the first thing, as soon as you're a black person or you're indigenous it's like "Is there any domestic violence at home? Do your parents drink?"

"They put a label on us straight up hey. They put a big stamp on us."

"They [department] just come and talk to us when they should also talk to those other family members as well to get a better picture of what's happening."



When FLDM service providers are provided with these new supporting resource factors and how they were applied resulted in more positive outcomes identified as:

- Family referrals to services with a holistic approach to health and wellbeing that can address the range of issues causing the child safety concerns to developing a longer term approach to improving the child/young person's outcomes, not just an immediate safety plan;
- Discussion about the services ensured that the family had a choice in the referral pathway and not being referred to services they were not comfortable with or that were ineffective in the past;
- Seeing families smiling at the end of a meeting;
- Seeing families reconnecting and making plans to stay in touch at the end of a meeting; and
- Better practices when working with families and better support to families due to more training in FGMs and child safety procedures and processes;
- Family plans that are actionable because there are family and child support services or health and wellbeing services available to address sometimes long term or ongoing concerns of the family, it is more meaningful and creates optimism for change by the family;
- Felt that the safety plans were better because all the worries had been discussed and actions to address them agreed (no hidden surprises that might impact safety later);
- Pride in the service they were able to provide to families;
- Saw families starting to heal from the pain and trauma of past removals; and
- When family plan reviews are conducted, this reflection time is vital to the family. This reflection time provides an opportunity to manage the constant change in families, and to celebrate small incremental change and improvements in child outcomes. The review provides reinforcement in taking responsibility and ownership of the family plan and supports further change. It should be noted that reviews seemed to be rarely conducted – and said to be either a capacity issue, ongoing family plans being revised or prompting by the system was not present because it sits outside department systems and processes in particular to the trials (T3).

Outcomes for the department

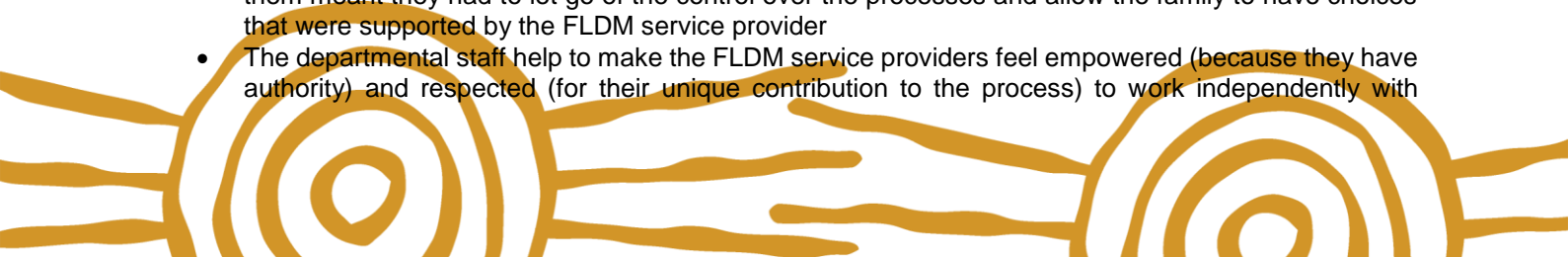
This section evidences the perceptions, attitudes, feelings and outcomes as described and valued by the departmental staff involved in the trial and those who observed them working. The evaluation focused on what was new or different about this specific trial and how this impacted on the departmental staff.

The new supporting resources that the trial gave to the departmental staff (Trial 2&3) as stated by them was:

- Contractual relationship to work with RE's on a different level of authority;
- Seeing cultural advice and support in practice; and
- Additional Aboriginal and/or Torres Strait Islander convenor staff resources.

How the trial felt to the departmental staff (Trial 2&3) could significantly influence whether outcomes were achieved. More positive outcomes were achieved when:

- Clear about roles and responsibility of the FLDM service providers and the role of the department which build trust, privacy and independence from the perspective of the family
- There is a partnership approach between the Child Safety Service Centre and FLDM service provider towards the day to day scheduling of caseload, information management and planning
- Child Safety staff and internal departmental convenors believed in and supported the trial with more than words but more importantly actions
- Child Safety staff and internal departmental convenors trusted the FLDM service provider. Trusting them meant they had to let go of the control over the processes and allow the family to have choices that were supported by the FLDM service provider
- The departmental staff help to make the FLDM service providers feel empowered (because they have authority) and respected (for their unique contribution to the process) to work independently with



- families
- Child Safety staff and internal departmental convenors understood their power and privilege, that they were not independent and the effect their presence may have on families
- The FLDM service providers were resourced to meet the needs, choice and geographical dispersion of some families allowing the true nature of the model (family leading decision making and deciding when/ where/ whom to meet with / independence); and
- When there are no appropriate services to refer family members onto to make family plans meaningful


When departmental staff are provided with these new supporting resource factors and how they were applied resulted in more positive outcomes identified as:

- An awakening as to how important cultural authority and knowledge is (i.e.,not just the rhetoric of the reform but deeper understanding)
- Realisation that they may not have been as culturally competent as they may have thought which opened them to learning and improvement in the way they worked
- Appreciation and respect for the “Aboriginal and Torres Strait Islander way of doing things” can’t be learnt or copied by non-Indigenous people, and that the importance of identified positions
- Engagement of families who they had previously not been able to engage
- Job satisfaction and a sense of achievement when families were working together with them (no longer against them) to implement safety plans; and
- A sense of relief when they saw the greater gains in child safety through working appropriately with the family outweighed the feeling of losing control to the FLDM service provider.

“I had a mum who was empowered enough to do family time on her own, come up with all her hopes and dreams for her child but you have the department dictating to our families what is a family.”

“one of the big strengths here is that we have a practice framework that gives the foundation for all the staff on the common practice that makes therapy work.”

“We had mobile phones so that we can call people, we had the resources to just do stuff without the fear of failing and repercussions.”

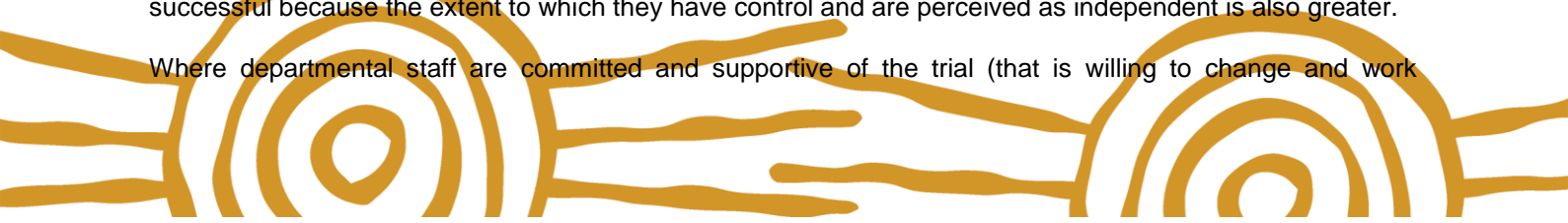


Trial impact

The stage of the child protection continuum in with the trial is being applied is an important context. Trial 1 has a very different context where the community controlled organisation is working on early intervention and not involved in legislative processes led by the department. They can work independently to keep the family out of the system, potentially making it easier to build trust and optimism. In Trial 3, the statutory stage of the child protection continuum means that the FLDM service provider must work closely with Child Safety making it harder to build trust and optimism with the family.

Empowerment appears to decline as the trial moves along the child protection continuum, because the independence, authority and power of the FLDM service provider diminishes to the overarching statutory child safety systems. The legislative requirements of this work are such that Child Safety has a powerful position in the assessment, investigation and management of children identified as in need of protection, with the Courts having ultimate decision making power in the mandate to keep children/young people safe. Earlier intervention along the spectrum is logical and supported in the literature, however it would appear this trial has also identified that where external Aboriginal and/or Torres Strait Islander convenors are used, it may be more successful because the extent to which they have control and are perceived as independent is also greater.


Where departmental staff are committed and supportive of the trial (that is willing to change and work



differently) progress has been made to implement partnership approaches that are more efficient and practical. Where there is resistance to change, or triangular conversations, or unclear communication within the department, time and energy is needed to get everyone on the same page to understand the intentions and details of the trial. In some cases, real shifts in organisational culture were apparent, and in other cases there appears to be still a lot of work to be done to change the status quo within the department. Another learning is that no trial happens in an historic vacuum. Some families carry a lot of pain due to past policies.

The FLDM service providers involved in the trial have had varying levels of success in implementing the trial, however all have felt a strong sense of determination to continue providing external convening services as a way forward to truly healing families in their community. The trial has felt like a success for FLDM service providers. This greatly impacts on the self determination of the FLDM service providers to continue to work with the department to change the way they work to improve child safety outcomes.

‘I need them; the whole community needs them. With 90% children gone you know, who’s going to protect us? That’s why we need this mob here to protect us.’



It all goes back to the days the government intruding into our lives. I feel strongly about that, because of what happened to my parents.



The trial journey

The trial was a journey of emergent spaces between families, FLDM service providers and the department, which remained inherently complex and fluid – even in this small trial in a short timeframe of just over a year and a half. When the shared space emerges as a place of social justice with equality, respect and dignity, positive change can happen for families and communities. This section of the report draws on evidence on the implementation challenges, strengths through primary data collection with families, communities, REs, SNAICC, external stakeholders and the department and secondary data analysis.

The implementation took time and were generally not up and running smoothly for at least six months. In the early stages some of the FLDM service provider was not resourced to the level they needed to be to appear independent of the department. The result is that families were unclear about the roles, responsibility and independence of the FLDM service provider, this was said to erode trust between families and the FLDM service provider. Despite the implementation challenges, the FLDM service providers' management and convenors and SNAICC have shown strength of character, dedication and commitment to working on improving the practices of FLDM and the trial model.

Implementation challenges and strengths

The literature summarized in Appendix C illustrates the use of implementation science learnings to improve the outcomes of evidence based practice models such as the FGM. The trial investment assumed that implementation science using effective implementation strategies from feasibility to fidelity will be used to improve the FLDM model which is an evidence based practice model.

The two biggest strengths for the implementation of the shared practice model were 1) independent third party implementation consultant who could navigate the tensions of differing interpretation between the department and the external FLDM service providers to get everyone on the same page, and 2) the commitment of the FLDM service providers and the department staff to work together to resolve issues when they arose.

The three biggest challenges for the implementation of the shared practice model were 1) resourcing it adequately so it has integrity and independence, 2) turnover of FLDM service provider staff and departmental staff, and 3) changing entrenched individual and organisational cultures in the department to empower the FLDM service providers and families so that they can be independent.

Implementation drivers such as competency, organisation and leadership build the capacity and infrastructure that is crucial for the shared practice model to work. Individuals in the workforce (including age, cultural status, time on the job, training, and level of education) and organisational factors (including organisational culture, communication, and size of agency) may combine to impact the implementation of the practice reforms.

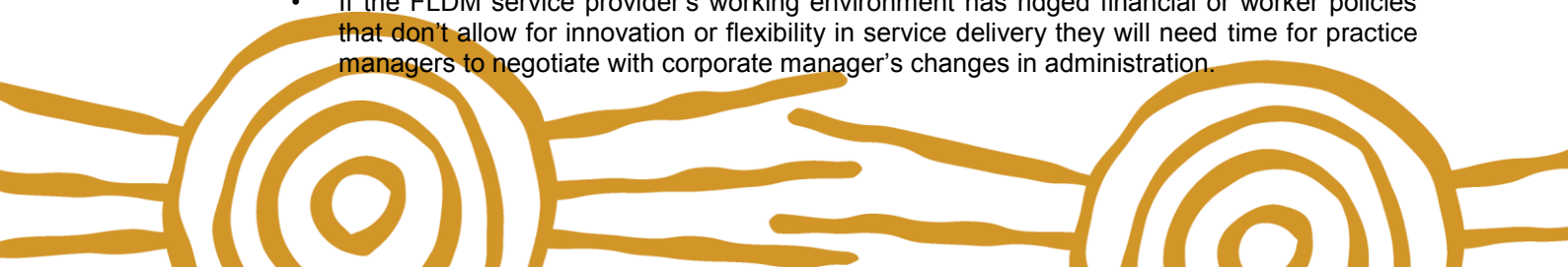
Where successful partnerships were developed between the FLDM service provider and the department they had a clear purpose and shared understanding of the trial. The partnership worked if each party valued the role of the other partner and it was clear who was responsible for each aspect of the trial. This needed to occur on a macro level – way the system worked, but also at a micro level – the way the convenors worked in a meeting with the family. These partnerships took time to develop, and in some cases needed to be developed again as staff changed. Strong partnerships were only an outcome when there were good relationships, essentially the humans in the system could either make the trial work or hinder the extent to which it could work.



Organisational factors

There are a number of organisational factors that appeared to impact on the implementation of the shared practice model in the four trial sites:

- Organisational climate as a result of the broader reforms, including how people interpreted funding requirements and guidelines were additional facilitators or barriers to implementation. That is, when people sought to use the trial for a broader agenda (i.e. reinforcing the internal convenor model or reinforcing RE reforms) it ceased to have fidelity with the practice principles of the trial.
- The implementation of Trials felt very rushed for those involved. The internal departmental communication between the program team, contract managers, child safety teams and procurement prior to engaging the FLDM service providers was not always effective. Not everyone was on the same page, including the FLDM service providers and SNAICC. There seemed to be inconsistent communications about what the rules, roles and responsibilities were, without clear direction on what the trial was to achieve. This created triangular conversations and wasted time, aligning all those involved at the initial stages of the trial. The procurement process limited the ability for open dialogue with the FLDM Service Provider's which would have provided clarity and built or maintained good relationships between the Department and the RE.
- The RE's (trial 2&3) tended to have less power in the negotiations or discussions around clarifying the roles and responsibilities of the trial requirements. This often meant SNAICC were drawn in to be a mediator between the department and the RE's. SNAICC attempted to hold the integrity of the model and trial principles throughout the mediation but were met with a lot of resistance to change.
- The department's readiness to adopt new practices and commitment to a shared practice model supported the implementation. The implementation of the FLDM appear to be more successful in places where there is strong support, or mature implementation due to its longer history of using FGC. However, this still varied by site as different staff turned over in the department.
- Where individuals have changed to a collaborative working style, it facilitates better communication between the FLDM service providers and departmental staff resulting in better preparation for the Family Group Meeting. Child Safety had to change from "telling" to "asking" and similarly the FLDM service providers to "ask" and not wait to be "told". This change was supported through mutual respect and clear understanding for each other's unique role.
- Other contextual factors related to FLDM Service Provider's organisational structure, including ability to handle an increased caseload size, a higher level of need (more complex cases) among families, supervision with lack of consistency and training, along with organisational climate and culture factors such as policy limitations and interactions with outside services and the Department, negatively impact implementation. A key learning about implementing the trials is "speed" at which FLDM service providers can get up and running depends on a number of factors:
 - The stage of the child protection spectrum. FLDM at an early intervention stage requires less time to prepare convenors and build relationships with departmental staff.
 - If the FLDM service provider is not used to dealing with families with multiple complex needs they will need time to change their practice and consider the skillset of convenors.
 - If the FLDM service provider's working environment has ridged financial or worker policies that don't allow for innovation or flexibility in service delivery they will need time for practice managers to negotiate with corporate manager's changes in administration.



- The size and structure of the FLDM service provider. FLDM service providers that have been delivering a range of government funded services have systems and structures in place to manage the contract. They have also developed ways of doing business with government and developed some economies of scale to manage the contractual requirements. The size may also be a factor in the implementation progress of innovation in new practices where smaller agencies and agencies with lower levels of job stress have higher levels of implementation progress.
- Access to suitably skilled staff. The location of the FLDM service providers and the conditions of employment will determine how quickly the appropriate staff can be engaged, trained and working.
- The brand association of the FLDM service providers and child and family services. FLDM service providers that are known by community for delivering services in the sector and have developed a good reputation will engage participants.
- FLDM service providers with formalised practice policies and practice management support will adopt new practices more quickly than those that have to develop their practice policies.

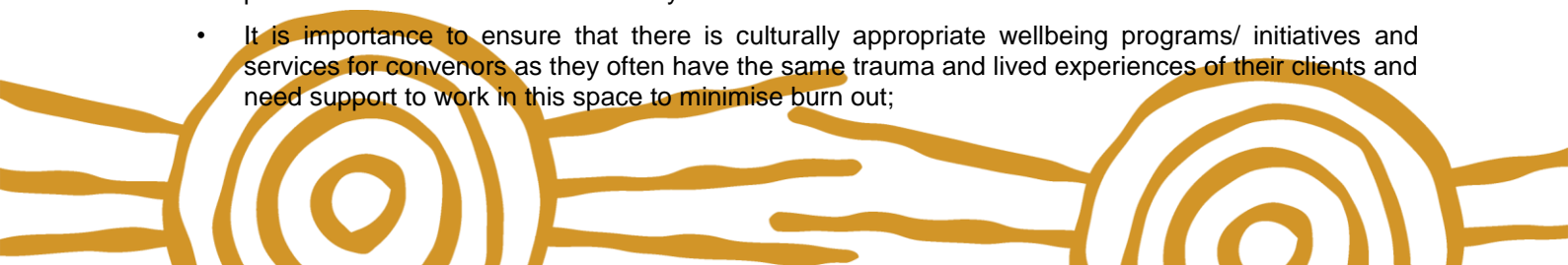
Workforce factors

The Aboriginal and/or Torres Strait Islander convenors of this trial are inspiring in their dedication and stamina as they navigate the challenges of implementing a new model of FLDM. The extent to which the Aboriginal and/or Torres Strait Islander convenors have developed over the journey of this trial was observed. They were truly inspirational in their transformation as witnessed in their presentations at a recent FGM departmental training.

Worker turnover and implementation of practice models are areas of importance as the continuity of the workforce will allow for more experienced workers to innovate and create improvements to the practice. In two of the four trial sites turnover of staff has delayed implementation.

The workforce factors of the convenor that impact on the success of implementation are:

- only 0.5 or 1 FTE convenor funded per site / which meant no contingency for leave or departures;
- convenor role similar to FGM convenor in the Department but not paid equivalent salary making it difficult to attract staff to the role external convenor role;
- convenors were initially female (Trial 2&3) and there was recognition of the need for male workers;
- diversity of language skills may be required for some sites/regions that can't be covered by just one convenor;
- diversity of family connections/relations/conflicts of interest of the convenor may present barriers or limit choice for families with only one convenor in each location;
- home visits may not be safe with one staff member / particularly if no secure transport available to exit the property;
- All on the shoulders of one.....'**must have broad shoulders**'. This is particularly hard for Aboriginal and Torres Strait Islander workers who live in their communities and are part of the families they are working with. The right person with the right cultural standing in the community can carry that burden on broad shoulders. For younger or less acknowledged staff, culturally, they can feel the tension and pressure of their role from community members.
- It is importance to ensure that there is culturally appropriate wellbeing programs/ initiatives and services for convenors as they often have the same trauma and lived experiences of their clients and need support to work in this space to minimise burn out;



The workforce factors for departmental staff and the child safety sector that impact on the success of implementation are:

- Cultural competency to understand and believe in the model. There appeared to be a lot of over confidence in departmental staff's cultural competence which may be described as unconsciously incompetent. This is where departmental staff believed they "could" do the role of the Aboriginal and/or Torres Strait Islander convenors role, or that this external role was not needed. As internal departmental convenors worked more with the Aboriginal and/or Torres Strait Islander convenors and their cultural knowledge increased they became more consciously competent. This is when they started questioning not whether they "could" do the role, but whether they "should" do the role. For example, where an internal departmental convenor felt it was their role to "push" families on choices like who to attend the meetings because the Aboriginal and/or Torres Strait Islander convenors would not "push" because of culture. There was a lack of understanding about why it is not ok to "push" rather than a matter of who does the "pushing". This is an example of where staff have some knowledge and mistakenly think this is enough, but do not have the deeper reasoning to implement the knowledge appropriately.
- Status Quo Bias is present for some internal departmental convenors and Child Safety Team Leaders where they use status quo as a reference point, resulting in any change being felt as a loss. This creates a preference for doing nothing or maintaining prior decisions. Understand the vision of the reform and how this trial aligns with the vision was not always presented as a greater gain, so staff saw any change as a loss to either their status, control or their authority in the eyes of others.
- Reflective Reinforcement or loss aversion is where departmental staff felt disproportionate pain over losses and tend to take gains for granted. This leads us to strongly prefer avoiding losses, rather than acquiring gains. For example, where an internal departmental convenor may have relinquished some degree of control in a family meeting to the Aboriginal and/or Torres Strait Islander convenor and the meeting was a success. The internal departmental convenor felt the loss of control to a greater extent than they saw any gain, and they assumed that the meeting would have been a success anyway if they had been in control.

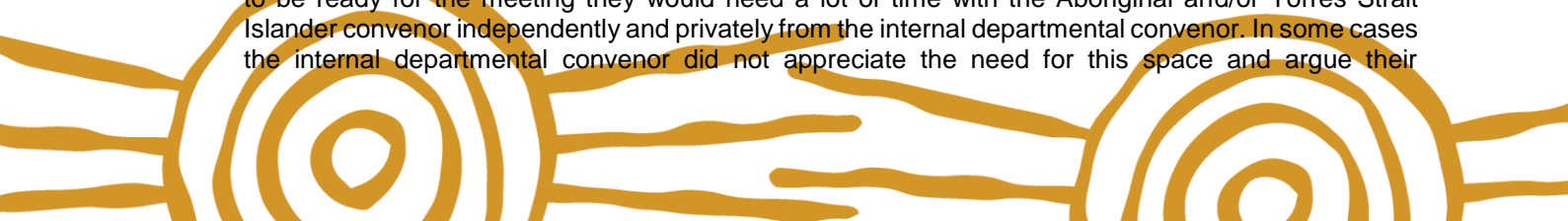
Trial principles versus trial practice

The use of strong implementation partner support and strength based supervision has been viewed as a tool to increase effective implementation. The implementation partner sees themselves as agents of change rather than messengers from the department, this has positive and powerful influences for better practice. In this trial SNAICC are the implementation partner.

During implementation there were challenges when the departmental staff who were learning a new model had a different vision than SNAICC which was based off the principles of the trial and the strong knowledge of the theoretical models of FLDM. When all parties are not on the same page it placed the FLDM service providers in the middle confused by triangular conversations. At the same time the trial evolved and became refined through development which creates confusion for some local reference groups who refer to information provided at initial discussions and meetings which is now superseded.

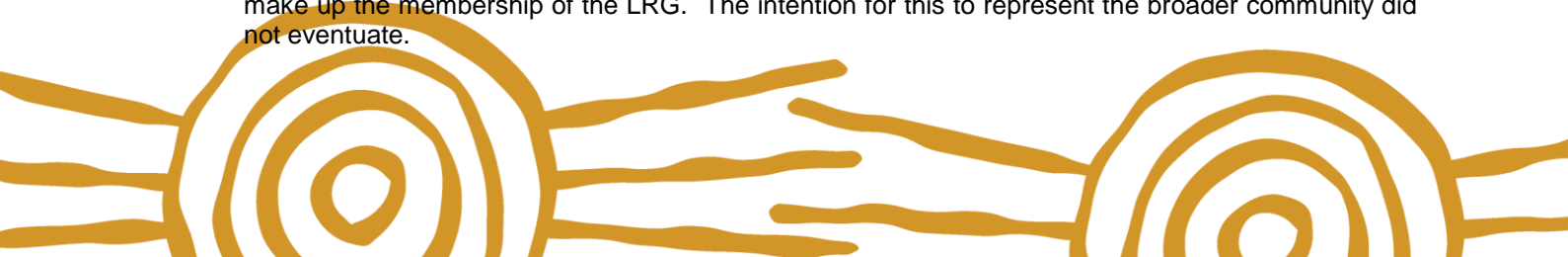
At a practice leader the implementation partner has provided a high level of support, training and space for learning to the FLDM service providers. Despite all good intentions in the trial design, the way it was undertaken in practice did not always align with the trial principles. Whilst the trial design allows for flexibility, creativity and innovation, it was said that there was a constant tension between cultural values or the Aboriginal and/or Torres Strait Islander way of doing things and the departmental expectations. For example:

- The importance of preparation time is a fundamental component of the FGM model, and the need to spend time with families in "Aboriginal and/or Torres Strait Islander way" meant that for some families to be ready for the meeting they would need a lot of time with the Aboriginal and/or Torres Strait Islander convenor independently and privately from the internal departmental convenor. In some cases the internal departmental convenor did not appreciate the need for this space and argue their



interpretation of the “co” role rather than the “led” role. In other cases the departmental expectations were represented in the contract where FLDM service providers did not have the resources or funding to work with families independently.

- The contracting and procurement of the trial as a once off was still interpreted as a commitment to long term change in relationship by the FLDM service providers. The department’s expectation was that they could gear up and down easily with existing staff to deliver this trial. The skill set needed in the convenor role and the cultural authority needed to deliver the trial was underestimated in the way in which the department funded the trial.
- The department’s expectation that a single convenor model would work. However, diversity of convenors is needed to meet cultural protocols (age, gender, clan, language group) and to get the level of engagement needed with a larger group of extended family members (i.e. small groups talking in the big group). In addition, when two convenors visits a family they are better able to engage with and incorporate the child/ren’s wishes and input and families input separately because of the dual resources.
- The department did not always respect and acknowledge cultural authority of leadership to guide and support family choices. Where the “power” of who could decide did not transfer to the family because their choices were overruled by the department it was often due to the department acting with cultural blindness and not giving the FLDM service provider the authority to act. In principle the trial was to Aboriginal and/or Torres Strait Islander **led** – yet it was often department led. Team Leaders or other departmental staff would mandate where and when the meetings were held or not turn up to meeting if they were not held in locations or times that were not convenient to them.
- The family plan is meant to be agreed at the conclusion of the meeting, but where the Team Leaders did not attend or did not agree they would edit and change the family plan post meeting. Areas that they would change were important to the family, which may have been more wholistic support and services planning for ongoing health and wellbeing of the family. Editing the plan undermines the family decisions that they have made to the work towards the actions in the plan. Where it works well is when the family take a copy of the plan and it lives with the family and goes with them.
- Family is culturally defined and informed concept, and who constitutes a child’s “family” should be defined as broadly as possible and include significant others to the child/young person. The department still expects genograms to be done for families yet the genograms cannot be drawn to reflect cultural relationships appropriately. The feedback we received from convenors was that doing genograms or family mapping was useful for engaging the wider support network / reconnecting family members, but the critical factors were how well it is done and by who (an Aboriginal or Torres Strait Islander person that has established trust and rapport with family). The software to draw the genogram in the department limited the ability to show the diversity and complexity of kinship structures, only biological structures.
- A Local Reference Group was proposed to be established at each trial site to maintain the intent of the different trial approaches and to act as a community and cultural reference group. The implementation partner and the FLDM were not sufficiently resourced to nurture a local reference group that would cover the diversity of families and communities in the region. In addition to this there was little communication that clearly identified what the role of the LRG should be in each trial site. SNAICC relied primarily on the advice of local community-controlled organisations as to the membership and process for forming LRG’s at each trial site. The FLDM service providers tended to draw on their current cultural advisors and staff, or other related service providers in the region to make up the membership of the LRG. The intention for this to represent the broader community did not eventuate.



Aspects of a realist perspective

This evaluation uses aspects of a realist approach which assumes that in certain contexts when the trial resources are introduced it will change the 'reasoning' of participants in relation to the desired behavior or outcomes. The evaluation has found that understanding context is key to determining if the trials have been more or less effective with different families depending on their circumstances at different stages of the child protection continuum and a number of other key features as outlined above. There are also different convenors from different organisations in different regions working with different departmental staff who influence the outcomes of the trial depending on range of organizational factors and workforce factors. This section discusses the diversity and complexity of the contexts within the trial.

Specific to this trial the evaluation found that to varying extents change occurred when the following elements were present:

Safe space – The concept of a 'safe space' proved to be both multi-facted, dynamic, and important. This represented a key contextual feature which, under realist philosophy, held real causal power in driving or triggering mechanisms of 'belonging' and 'welcome' that in turn yielded particular outcomes depending on the extent to which it was present or absent.

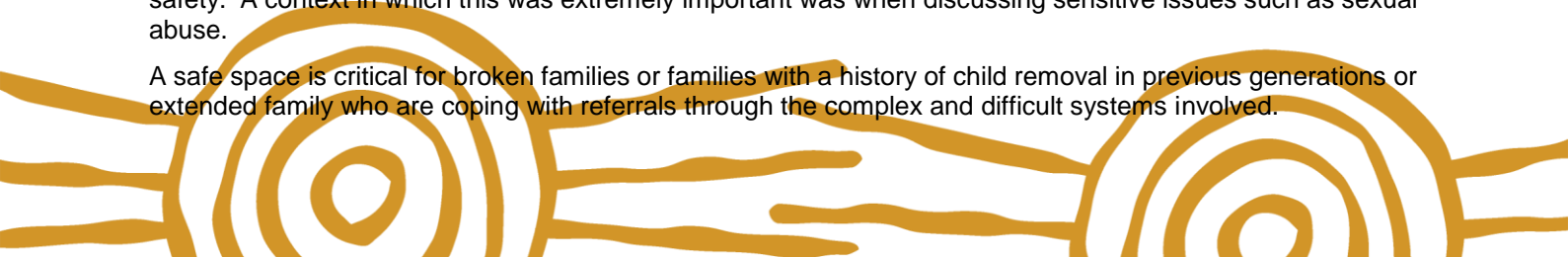
The trial is delivered via a cultural mechanism supported by local FLDM Service providers and Aboriginal and/or Torres Strait Islander convenors. This in turn was enabled through the context of the provision of funding to Aboriginal and Torres Strait Islander FLDM service providers and the training of convenors which then knew how to create a "safe space" for *particular* families. Preparation time was another feature of safety in that it was culturally sensitive, independent from the department, free from judgement and allowed time for healing because there was apparent a joint and deep understanding of trauma and the lived experiences of Aboriginal and/or Torres Strait Islander people. The meeting was also safe when it was held at a location that felt peaceful to the family, this may be on neutral ground for all family members, on country for spirituality, and not in locations that could trigger past trauma like departmental facilities or buildings.

As outlined, the trial created a safe space because there is a way of doing and knowing that is specifically drawn from the cultural connectedness of the convenor and the family. For example, there are times when words are not needed, intuition, respect and a deeper sense of understanding each other is present. This eliminates the need for families to explain, justify or deliberate over what it means to be an Aboriginal and Torres Strait Islander person to non-Indigenous people. When families do not feel misunderstood or judged based on their culture, they were less likely to be defensive and more likely to listen to the concerns of child safety.

Aboriginal and Torres Strait Islander convenors noted that cultural support was embedded throughout family plans through conversations which naturally included strengths or strategies that were based in culture and cultural connections without needing to be addressed by a separate 'cultural support plan'. This is primarily not just about cultural competency of convenors but has a secondary benefit of efficiency. There is efficiency in not needing to create another plan, another document, spending more time on a process that is not well understood by the department and can be belittling for family when it is explicit.

In summary, 'contexts' included the freedom of families to meet in a safe space according to their own wishes, mechanisms of trust were created yielding outcomes including a propensity to active listening, speaking up and talk about all their concerns which increased the depth and breadth of the worry statements in the family plans. With all worries openly stated, better safety planning developed in the family plan to better address child safety. A context in which this was extremely important was when discussing sensitive issues such as sexual abuse.

A safe space is critical for broken families or families with a history of child removal in previous generations or extended family who are coping with referrals through the complex and difficult systems involved.



Choice promotes independence and creates agency – Choice for the family at every stage of the process is important to gain trust in the integrity of the trial. Choice enables an increased level of self-determination when they assume shared responsibility for the decisions during the preparation stage and planning the meeting. Promoting independence to make decisions for what may seem small (what food to eat, where to meet, what time to meet) helps to make independence stronger within the wider context of meeting purpose (who needs to attend, what behavior needs to change, what will make the child safe).

Independence helps families to recognise the value of thinking about them self and their behavior as well as others. Independence contributes to the development of self-esteem, identity and wellbeing. With independence families can begin to understand the responsibilities that go with being an individual and a member of a family. This sense of being a family member is also important to help develop a sense of themselves as individuals—with their own skills, strengths, worries and behaviours.

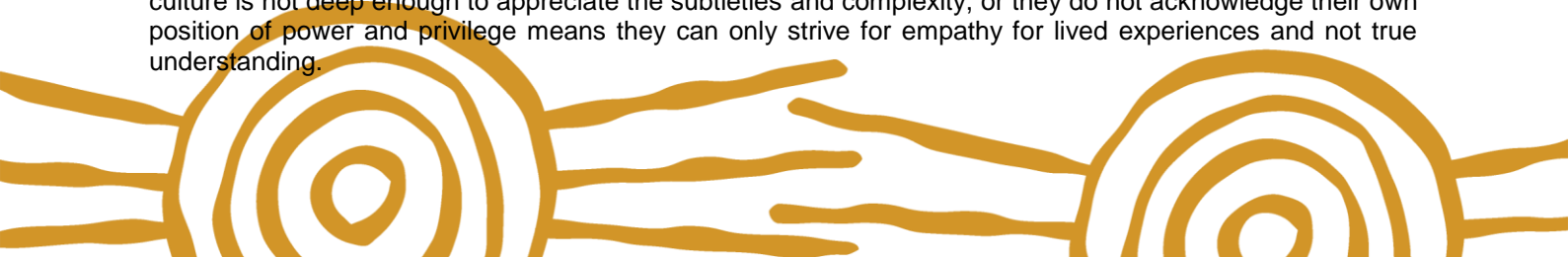
Families have a sense of ‘agency’ when they are independent and feel in control of things that happen around them; when they feel that they can influence decisions. This is particularly important during preparation with small decisions at first to gain trust and self-confidence. This sense of agency for families may take time to develop, particularly those with a history of child removal or who are cycling through the child protection system. Too often these past experiences have treated families as though they are incapable of making decisions or holding valid opinions. The FLDM must listen to and respect family’s words and ideas, and the convenor should model collaboration and cooperation and show recognition for the family’s capabilities. To reach good outcomes in the meeting stage families need to be provided with opportunities to develop the confidence to explore the world around them that they may have been deigning, to ask questions about the child safety legislation or support service, to express ideas, to get things right, but also to understand that you can’t ask a wrong question.

An environment or process without choices quickly becomes institutional; the exact opposite of what the trial wants for families, particularly those with historical legacies and intergenerational trauma of child removal. Some may feel learned helplessness and while families are certainly capable of making many choices, their ability to do so may need to develop over time with guidance and support. The role for convenors is to help families develop the decision-making skills needed to make good choices, to help them to focus on the safety of the child/young person, recognise the options that are available, and to recognise the responsibilities that come with particular preferences, while being a member of family.

When families are given choice which develops independence and agency they are more confident to problem solve and find their own solutions, which are more likely to be sustainable because of the ownership and commitment to the decisions by the family.

Equalising the power – Families look to how the Aboriginal and/or Torres Strait Islander convenors behave and how they are treated by departmental staff in the FLDM meeting to determine how much power they have in the process and will adjust their own behaviour accordingly. When convenors are given equal co-convening power or lead the meeting, are respected for their contribution and listened to by the department, the family are more likely to listen, speak up and feel confident. When convenors are noticeably less powerful in the meeting because of either assumed positions of privilege, lack of empathy, or confusion over the roles of the co-convenors, the families don’t feel safe to speak up and become silenced.

When non-Indigenous co-convenors from the department are over confident in their perception of their cultural capability they overshadow the Aboriginal and/or Torres Strait Islander convenors which diminishes the respect for their cultural authority and the family sees them being undervalued. The undervaluing of the Aboriginal and/or Torres Strait Islander convenors’ cultural authority diminishes the families positioning cultural aspects of their plan as strengths. This is particularly prevalent when the non-Indigenous convenors understanding of culture is not deep enough to appreciate the subtleties and complexity, or they do not acknowledge their own position of power and privilege means they can only strive for empathy for lived experiences and not true understanding.



Time to process – Families need time to process information. Families are often in shock after being confronted by child safety concerns, which can lead to a number of emotional processes from denial to anger to frustration and depression. Some families have difficulty with English, as well as western concepts and may have little understanding of legislative processes, government institutions or regulations. Some families have grown up with violence and substance abuse being normalised and may be confronted with a lot of new information about the negative effects it may have on children. Some families are suffering from intergenerational trauma or post-traumatic stress disorders. All of these circumstances impact on people's cognitive abilities, making it difficult to process information. When families have had enough time to process the information which may be different for each family, they are ready for the meeting – and when families can ask lots of questions in a safe space. When families have not had enough time to process information they feel nervous and less confident about what will happen at the meeting and are more likely to stay silent than to shame themselves by asking questions.

The way information is delivered in either the colloquial language and/or traditional language is specifically done in an Aboriginal and/or Torres Strait Islander way. When this is done it is less condescending and intimidating and easier for families to process.

Time to heal – Families need time to process their emotions. Families will fluctuate through a range of emotions both in preparation time and in the meeting time. It is important that families have the time to express their emotions, acknowledge and share how they are feeling. It is also important that this is done in privacy away from the eyes and ears of the department. Families feel they need to hold it in or control themselves or they will be judged or their reactions will be held against them if departmental staff are present. Having an independent external Aboriginal and/or Torres Strait Islander convenor to help support and guide them through this emotional journey in a safe space that is non-judgemental and non-blaming is vital to start the healing process. For some families bringing your feelings to the surface, drawing in the parts of you that are in denial, remembering the feelings of the past (child removal or abuse and harm) is very difficult. The pain of the past may be far from their present consciousness and it may take some time to connect the reasons for why they are feeling this way. Patience and perseverance of the convenors is vital, as too is a safe place to let these emotions out. If these emotions are not processed the family can't move to a more analytical position ready for decision making. The convenors play a role in healing past pain by helping families to release their emotions, reflect on their behaviours and regain balance to move forward with the process. If this healing is rushed families may not be in the best position to make decisions. Emotional healing also involves letting go of all that is not conducive to a positive emotional environment, the format of the FLDM enables families to put their worries and concerns on the table and focus on what positive actions they can do to change the environment to keep the child safe.

Focused on the safety of the child/ren – bringing families together - Families with a common purpose and goal to focus on the child/ren worked together on the family plan. The family plan articulates the vision for keeping the child/ young person safe, healthy and reaching their full potential. The family plan includes the strategies to protect and develop the child/young person and the services required to achieve their vision. Family plans which are meaningful (align with their vision) and actionable (strategies and services are realistic) are more likely to be owned (commitment) and therefore implemented by the family. Creating the family plan not only resulted in resolving child safety concerns but also assisted in the rebuilding of family ties. Where the Aboriginal and/or Torres Strait Islander convenor worked on resolving conflict through drawing on Elder's advice and knowledge or senior family members they were more likely to bring families together. The Aboriginal and/or Torres Strait Islander convenor could talk to other family members on behalf of the parents to invite and connect them into the process.

Mindset for change - Some department staff seem to have demonstrated a limited mindset, engaging with the FLDM service providers in a fee for service arrangement, where the providers' role is essentially a cultural interpreting service at the Family Group Meeting. It seemed to yield better outcomes when the FLDM service providers feel empowered (because they have authority) and respected (for their unique contribution to the process) to work independently with families and communities to improve child safety. Where departmental staff appear to have little confidence or respect in the cultural knowledge and place more value on knowledge



of the child safety system they undervalue the Aboriginal and/or Torres Strait Islander contribution and role in the process.

Within FLDM service providers there initially seemed to be a tendency to stay in old modes of working and be controlled (often by the control and limitation of resources and processes) by the department particularly in Trial 2 and 3. The FLDM service providers took time to build their confidence to fully embrace the concept of independence and the intention of the trial. Although it also seemed that some individuals, without clarity of the boundaries of their role, or an intimate knowledge of child safety legislation, lacked the confidence, and without resources, lacked capacity to be independent. The extent to which the departmental staff they were working with valued their contribution determined how quickly the FLDM service provider embraced the new way of working.

Program theory

The practice reforms are set in complex micro and macro systems. The Aboriginal and Torres Strait Islander FLDM is a model made up of these systems. Ultimately, systems are made up of structures and people, and people behave in different ways. There are a number of different people in the system: families and communities, RE staff and the Departmental staff. The way a person behaves in a system is influenced by the physical and socio-cultural environment and by the motivation and ability of the person. The theory of change must try to capture the human decision making in the system. The evaluation sought to understand why people behaved the way they did in this new system, and whether changing the system will change behaviour.

This section attempts to start describing and understanding the forces and interrelationships that shape the behaviour of the humans in the system. Aboriginal and Torres Strait Islander FLDM is formed by strategy initiatives with respect to their macro and micro features. Where the structures support the forces or interrelationships to pull together better or greater outcomes are achieved. Where the structures push the groups apart poorer outcomes are achieved.

The following diagram is a way to visualise the push and pull factors in the system that either make the FLDM trial work to achieve outcomes. The macro environment must support the ability to create **safe spaces** and **equalise the power**. The micro environment must **support time to process, time to heal, focus on the safety of the child** and create **mindsets for change**.

Safe spaces are created when there is access to resources, choice, Aboriginal and/or Torres Strait Islander led, informal knowledge systems are recognised, FLDM convenor skills and training, lived experiences of the convenors, and where the meetings are held.

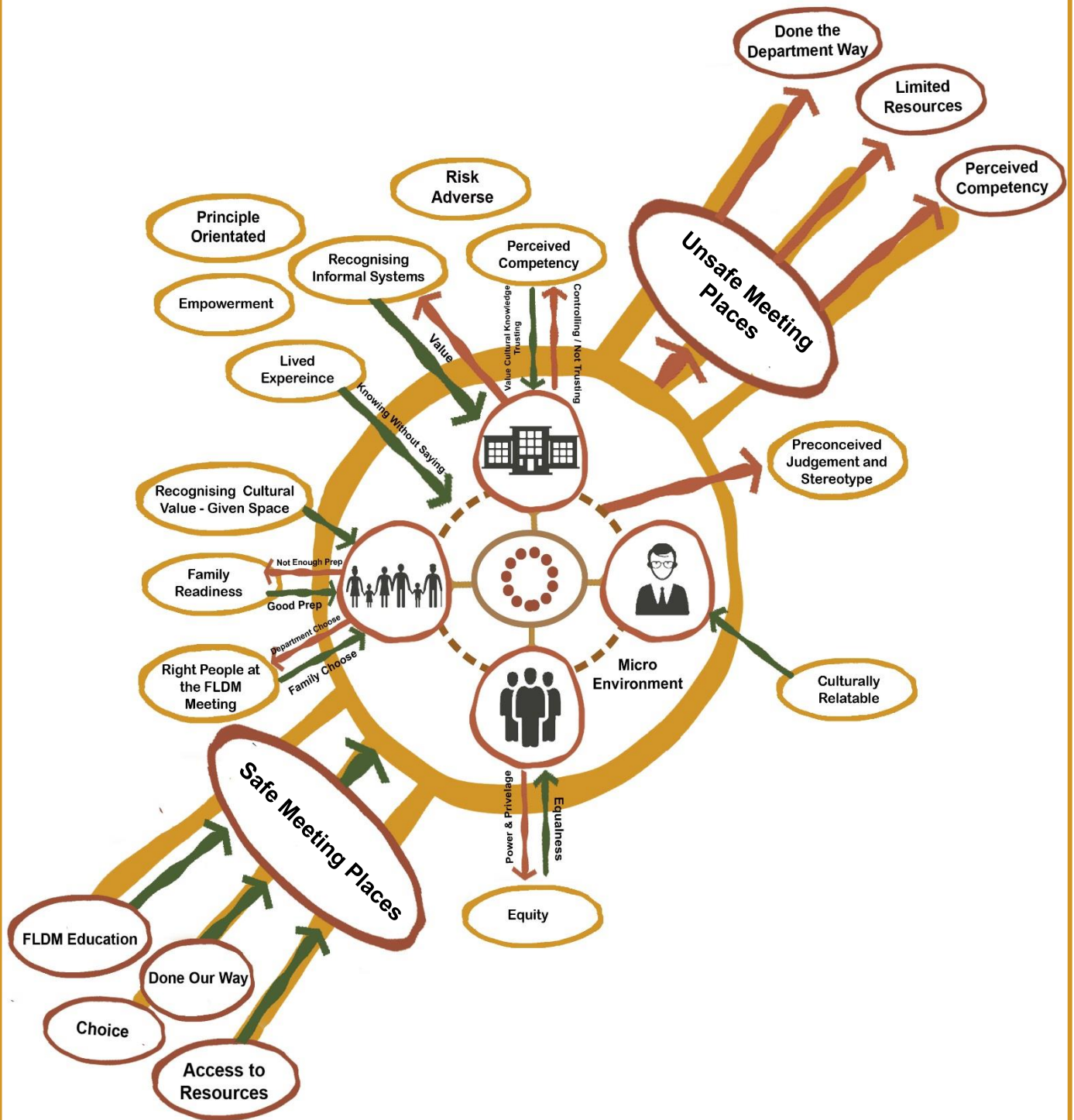
Equalising the power occurs when the right mindsets for change exist. There needs to be empowerment and confidence in the trial, belief that the trial vision is the right way to go, trust that the FLDM service providers can deliver, be orientated by the principles of the trial and have cultural awareness and relatability. When people have status quo bias' or 'loss aversion', they will be fixated on the processes, be culturally blind and/or have preconceived ideas of incompetence, be risk adverse and fail to see the gains because they fear a lack of control.

Within the micro environment it was manifest that to extent to which choice, time, privacy and independence are present determines the extent to which the outcome of the meeting will be successful.

In the center of the diagram is the child/ren. The symbol used represents a child in some Indigenous artwork and for the purposes of our interpretation of the theory using this visualization the child/ren are at the centre and the intended outcome is their safety, wellbeing and ability to grow to their full potential. When everyone is working together towards the centre it pulls people together. The closer all parties are to the center of the diagram the greater the outcomes or success of the meeting.



Macro Environment



Macro Environment



Towards the future practice reforms

The trial theory indicates that there is a need for external providers to assist in creating “safe spaces” and equalising the power to result in more successful Aboriginal and/or Torres Strait Islander Family Led Decision Making. The extent to which the department facilitates choice, privacy, independence and the “Aboriginal and/or Torres Strait Islander way” of doing things whether internally or externally, will determine how successful FLDM will be in the future.

The trial successfully met the following aims being to:

- Promote self-determination and shared decision making at different phases of the child protection continuum;
- Empower families to make informed choices and decisions about what’s best for their children, while the department ensures safety concerns are addressed by the process; and
- Develop and trial the capacity of the Recognised Entity and/or Aboriginal or Torres Strait Islander community controlled organisation’ to lead decision making and case planning in a culturally sensitive way.

The trial was not long enough to include enough cases to understand the success or otherwise and fully test the practice implications and effect on existing legislative arrangements and delegations. The trial did not have the infrastructure, systems and record keeping facilities in place to accurately measure and assess the time and resources taken to undertake a full family-led process. The trial did not have the ability to track cases nor the longitudinal data collection and record keeping ability to monitor and review the efficiency of FLDM at different phases of the child protection continuum. The trial in practice did follow the Aboriginal and Torres Strait Islander Child Placement Principles.

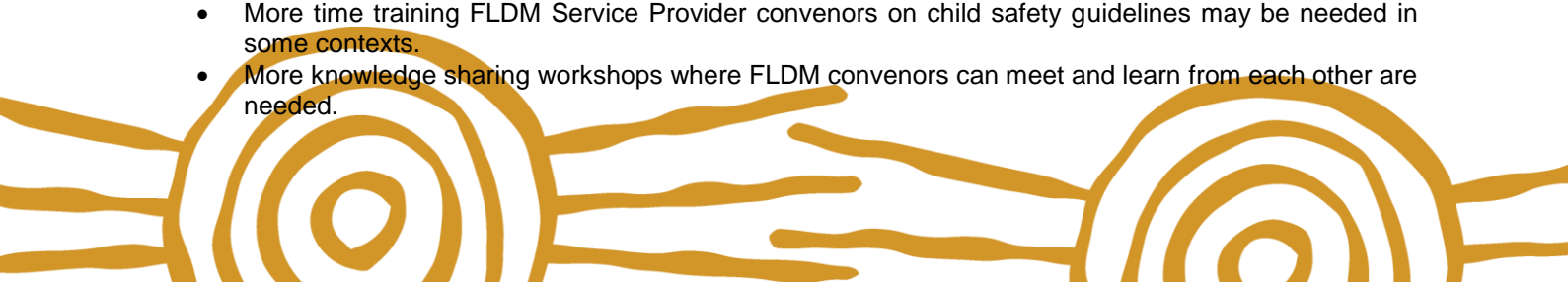
Overall where the trial lost fidelity of the intended model it was evident that organisational culture (status quo bias and loss aversion) drove the lack of communication, collaboration and clarity of the trial purpose. Where the trial regained fidelity of the intended model over the course of the trial, organisational barriers were broken down and the greater gains and successes for families as a collective achievement between FLDM service providers and the department far outweighed any of the personal or loss of control (loss of control) felt by individual staff. This shift in mindset saw the momentum for the trial accelerate towards the end of the trial. Unfortunately now the FLDM service providers are in limbo, enthusiastic and willing to continue delivering this service but no real commitment from the department that this way of working will continue.

Despite the lack of certainty (actual contracted relationships) there are a number of lessons that have been learnt that should be considered if this model was to be continued. There are also considerations for the portability and scale of the trial should it be repeated in Queensland or elsewhere.

Early intervention sites like Trial 1 didn’t need to co-convene with the department and was very effective in cases progressing to child safety notifications. Early Intervention is an ideal place for using an independently led family group conference model to prevent children entering into the child protection system.

Lessons learnt

- Realist theory proved helpful in proposing key ingredients of a successful Aboriginal and Torres Strait Islander family led decision making trial.
- More time training FLDM Service Provider convenors on child safety guidelines may be needed in some contexts.
- More knowledge sharing workshops where FLDM convenors can meet and learn from each other are needed.



- Overall more funding for FLDM convenors to increase caseload capacity, diversity and overcome transport issues is critical to ensuring families have a choice.
- More funding for SNAICC to travel and support FLDM Service Providers may be required to make the trial more successful, particularly when there is staff turnover.
- More support for community engagement and community education that would support the FLDM Service Providers to advocate for the new service and role of the FLDM Service Providers.
- Capacity strengthening with some FLDM Service Providers to manage the contract and administer the service may be required in some contexts.
- Clear and consistent communication about the trial internally and externally. Communications strategy and change management strategy are recommended to improve implementation.
- Clarity around the FLDM Service Provider convenor role in well-defined boundaries would enable more confidence in determining when they can be flexible and adaptable for their unique trial context.
- Co-convening with the department did not always work well to empower FLDM Service Provider and Aboriginal and/or Torres Strait Islander families.
- Pre-employment and succession workforce strategies to build capacity of Aboriginal and/or Torres Strait Islander convenors in the sector.

Portability and scale

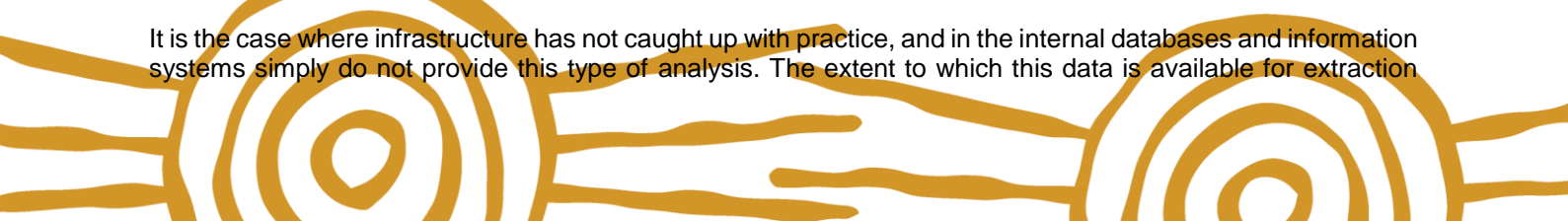
How well the process can scale up to include more families, or a greater scope of application across the statutory system will depend on supporting specific parts of the model:

- Community development principles could be employed to ensure the ground up development of the model – rather than “this is what we want to pay you to do” have the conversation with FLDM service providers about “what is the best way to do this in your community and what support/resources do you need to deliver this service in your location?”
- A workforce pre-employment strategy as a specific strategy under the Indigenous sector employment strategy as part of the overall reforms. This is an additional role, and will require attracting more people to this sector. It has potential to provide employment opportunities, but only if there are pathways to this job. Consider funding a successor who learns under the convenors and grows into the role over time. Consider what Certificate courses or Tertiary courses are needed to cover the wide range of skills this role requires.
- Address the transport disadvantage of Aboriginal and/or Torres Strait Islander families, including with digital transformation of communications and service delivery (webinar conferencing for example).
- There is a need for suitable intensive child and family wellbeing services that can help families fulfill the family plan actions, especially services that provide trauma and healing services.
- Diversity of suppliers and/or convenors to give the families choice and/or may be more culturally appropriate for some people.
- The department and the sector need to share the same vision and have clear communication about roles and the responsibilities.

Monitoring, Evaluation and Learning

This section discusses the key measurement considerations for future monitoring of the outcomes of FLDM. The trials were meant to evaluate the investment compared to the benefits. To do this one must understand all the costs involved and all the gains above the counterfactual. That is, what is the cost of a family in the trial verses the cost of a similar family not in the trial. What were the differences in their outcomes, and what was the differences (progression into tertiary for example) in the cost or burdens on the child protection system. The logic would be that having the trial at early stages of the child protection continuum would decrease the number of families needing child safety interventions and the application of the trial at later stages would result in less out of home placements and more children living safely with family or kin.

It is the case where infrastructure has not caught up with practice, and in the internal databases and information systems simply do not provide this type of analysis. The extent to which this data is available for extraction



and analysis was limited in the trial, but should be considered for future applications of either the Internal FLDM program or external contracting of convenors.

Participant feedback in relation to satisfaction with the process and outcome is important. However it was rarely collected. Considerations for whether the feedback form delivered at the end of the meeting is the most appropriate time for collecting this information. There may need time for reflection on the process, there also may need privacy from the convenor to provide the information confidentially.



Appendix A - Methodology

Ultimately this research project will need to be coherent, feasible and useful by contributing actionable insights for the department, and service providers. The approach taken is grounded in theory but refined for practicality given how the research is framed and the budget and timelines.

The grounded theory that has been incorporated is:

- Realist evaluation (how does it work?);
- Outcome evaluation (did it work); and
- Implementation review (what was done and how can it be done better?).

Outcome evaluation

The data collected through the conduct of the trials and administration data provides objective evidence of “what” may be happening but not the “why” it is happening. Primary data collection will be required to better understand if the trials have worked. Considering the cultural diversity within Indigenous Australia and the heterogeneity of the locations in this study a single research approach may not work. Each location will need to develop the methods and tools to undertake the research that will work in their community. Participatory research methods are geared towards planning and conducting the research process with those people who’s lived experience and actions are under study. Consequently, this means that the aim of the evaluation questions develop out of the convergence of two perspectives—that of science and of practice.

In the best case, both sides benefit from a participatory research process. Jagosh, J. et al. (2012) reviewed 276 publications on participatory research to find that this technique can strengthen partnerships. Also found was that participatory research (1) ensure culturally and logistically appropriate research, (2) enhance recruitment capacity, (3) generate professional capacity and competence in stakeholder groups, (4) result in productive conflicts followed by useful negotiation, (5) increase the quality of outputs and outcomes over time, (6) increase the sustainability of project goals beyond funded time frames and during gaps in external funding, and (7) create system changes and new unanticipated projects and activities.²

The purpose of the outcome research is to:

- Describe the trial model developed at each location and the process of change expected for children and parents as a result of their participation in ATSIFLDM meetings, and how well each trial has achieved the intended model.
- Identify and analyse the varying outputs and immediate outcomes in each trial location, to provide findings that will inform the department on the value of implementing ATSIFLDM practices more broadly.
- Make general comparisons of each trial, the client groups and the effectiveness of each trial in achieving specific immediate outcomes. This should reflect the fact that this project involves different approaches to the application of ATSIFLDM processes, and to different stages of the child safety service continuum, and to different procedures/decision making points within each stage.

² Jagosh, J., Macaulay, A. C., Pluye, P., Salsberg, J., Bush, P. L., Henderson, J., ... & Seifer, S. D. (2012). Uncovering the benefits of participatory research: implications of a realist review for health research and practice. *Milbank Quarterly*, 90(2), 311-346.

- Provide a breakdown of costs per location and/or per family to inform the department on resource requirements of ATSIFLDM practice.

Implementation review

The implementation challenges and strengths for each trial and location will be reviewed for how well each location is working towards achieving the short term objectives of each trial model. The purpose of this report is to assist the department to monitor the implementation and initial performance of the trials. Data will be collected by the services participating in the trials for analysis and reporting. Additional interviews will also inform the implementation review, especially qualitative data.

Key evaluation questions for the implementation review are:

- How were the trials implemented within each location?
- How many families participated in the trial and what were their identified needs?
- What aspects/procedural steps of child protection were ATSIFLDM processes applied to?
- If there is sufficient throughput of circumstances and families at different stages to test ATSIFLDM application the research will cover:
 - Transition from care planning (not all kids are at that age)
 - Child Safety Planning: Not all cases will be OOHC
 - Support Service Cases
 - IPAs
 - Case review of existing cases
 - Reunification planning
 - Health passport and education support plan review.
- Have the trials been successfully established in each location and are they operating as intended?
- How were Aboriginal and Torres Strait Islander agencies supported and resourced to participate to a greater extent in statutory decision making and case planning?
- How were children and families supported and resourced throughout the process leading up to participating in Family-Led Decision Making meetings?
- What were the implementation and practice issues experienced and what strategies have been used to address these?

Realist evaluation

To review how the trials, improve the quality of the Family Group Meeting process to develop family decisions and Family Plans and Individual Case Plans to promote child safety and wellbeing in general and where relevant Cultural Support Planning and transition-from-care planning a realist evaluation will be undertaken. A realist evaluation is a type of theory-based evaluation that seeks to understand 'what works', 'how it works', 'for whom' and 'in which contexts or circumstances' to achieve intended outcomes. It is very useful in complex situations or when tackling 'wicked problems'. Rather than looking for silver bullets, the realist approach expects that what works is different for different people e.g. that the family conferencing for a young parent in a remote community with large family networks will be different to what works for older kinship carers in an urban community with smaller family networks.



Realist evaluation assumes that programs or activities work in certain contexts when the programme activities introduce resources that change the reasoning of participants towards the desired behaviour. Realist evaluation assumes different activities will be more or less effective with different people and families depending on their circumstances. For example, teaching the basics of fishing to a man who already knows how to fish, will not lead to more effective fishing for that man—but it might for others without that knowledge.

A programme delivers a set of activities to a target audience with one or more intended outcomes. These activities introduce resources or change the reasoning of participants—and it is this, rather than the activity per se, that is effective, but only in certain situations. To continue the example, running a fish handling skills workshop is an activity; developing knowledge of fish handling techniques may be the mechanism by which the workshop is effective for increasing employability in aquaculture. It may be effective for some people (e.g. those with low knowledge, and high motivation to apply it) but not others (e.g. those with high knowledge or low motivation to apply it). But there may be other mechanisms at play ‘opportunities to go fishing’ may be the primary mechanism of the workshop for some participants. Here the same workshop activity will not lead to the intended knowledge or employability outcome. So not only is an activity a means of leveraging a deeper causal mechanism that will be effective in certain situations for some end, the same activity may leverage other mechanisms in different contexts for different ends.

A programme of activities with intended outcomes can be represented by one or more theories and displayed in a logic model or as hypotheses. In realist evaluation, whether visual or written, the programme theory is expressed as a series of context-mechanism-outcome (CMO) configurations that may occur at any step in the program logic. These describe how and when program activities fire ‘mechanisms’ (i.e. the deeper causal forces that lie within activities) that lead to different outcomes in different circumstances or contexts. In other words, the mechanisms explain ‘how’ the activities within a programme lead to expected outcomes. The context pertains to ‘for whom’ and ‘in which circumstances’ the mechanism leads to the intended outcomes.

The implications of a realist approach for policy and programmes is to use the knowledge from realist evaluation to support different activities in different contexts. These will fire mechanisms to generate intended outcomes and will deliver a greater ‘bang for the buck’ than rolling out what seems to work on average. Realist evaluation is an approach not a method, it can employ a wide range of qualitative and quantitative social science methods. It will most often use mixed methods to develop and then test CMOs in programme data. In the Practice Reform evaluation, the intended outcomes will be described first, then the activities involved in trials and the possible causal mechanisms they fire in certain contexts to deliver outcomes. We will then seek evidence to expand the list of mechanisms and determine in what contexts they lead to the related outcomes.

The problems of individual agency and sociological structure in social policy are vexed—but in Indigenous communities where the group may take precedence over the individual, it may be more important to focus on family and community as a means towards long term sustainability of the reform objectives. As others have noted, Aboriginal and Torres Strait Islander populations have a complex history of colonisation, institutional racism, mobility and kinship structures and obligations, the realist evaluation has the potential to strengthen the basis for understanding how programs work in this context³.

Manzano (2016) proposes there are three phases in realist interviews theory gleaning, theory refining and theory consolidation.⁴ The first task will be to identify the important mechanisms that enable the trials to work. This is followed by identifying the necessary support factors or contexts for these mechanisms to ‘fire’ that is, to be sufficient for generating a change. It will also involve identifying mechanisms that might lie outside the trials that are important in different contexts for generating the related outcomes. A realist analysis then links context and mechanism to generate statements taking the form of ‘In context ‘x’, mechanism ‘y’ produces outcome ‘z’.

³ Cargo M & Warner L 2013. “Realist evaluation” in action: a worked example of the Aboriginal Parental Engagement Program. Melbourne: Australian Institute of Family Studies. Viewed 14 March 2014.

⁴ Manzano, A. (2016) The craft of interviewing in realist evaluation. *Evaluation*, 22(3) 342-360.

Understanding how an intervention worked, and when it worked will require an understanding of the way the programme affected a person or their environment in such a way that the person (or people) made different choices or, perhaps without being aware of why, performed different behaviours. This knowledge will most likely be drawn from a large number of stories of people who were involved in that intervention, rather than a large suite of measures. A realist perspective will expect an intervention works for some people, but not others. There are three phases used in realist interviews, (1) theory gleaning, (2) theory refining and (3) theory consolidation. The research process will consist of a range of activities in each of these three phases.

Phase 1 Theory gleaning

Before doing participatory research, theory gleaning will look for possible mechanisms for generating outcomes using knowledge of the trials, and any previous literature. Next the programme resources (actions or interventions) that are likely to fire these mechanisms will be identified from the programme manual. Through consultation with program stakeholders and service providers at the logic workshop and through participatory research key outcomes for families that are of “value” to the community will be identified for further testing.

Phase 2 Theory refining

Participatory research with programme stakeholders will be undertaken to identify key activities and the contexts in which these led to different related outcomes, and why? [Answers to the ‘why’ will lead to identification of the mechanisms that are fired by activities]. It will also identify key mechanisms that do not appear to be addressed by the program resources but that appear to be important for generating outcomes important to the community. Interviews with community members and families will be undertaken to understand their trajectories and the factors that have been most important for them in moving towards (or away from) related outcomes—and what they feel would be important for them to make progress. This will use ‘draw the path’ method with a representative sample of participants and other local Aboriginal and/or Torres Strait Islander people in the community.

Phase 3 Theory consolidation

A list of refined context-mechanism-outcome configurations will be tested with key stakeholders for their ability to explain what works for whom under what circumstances and how. These may be further tested by analysis of patterns of outcomes predicted by the CMOs in administrative data sets. Identify key mechanisms that do not appear to be addressed by the trials but that appear to be important for generating outcomes important to the community.

There are four stages to the overall design of the project: Preparation, Desk Research, Fieldwork and Reporting.



Appendix B – Evaluation Methods

The design relies on a detailed scoping meeting and project logic workshop at the beginning of the evaluation. Our experience with other programme evaluations will assist with informing the Department of Communities, Child Safety and Disability Services about concepts and constructs which best measure the impact and benefits of the implementation of the Family-Led Decision Making framework. Indeed, a key to ensuring the project logic and evaluation framework is owned by all stakeholders is to develop it together.

Each trial site will be different and the approach taken at each site may vary, however, by applying some systems thinking to the evaluation it should create the flexibility needed at a local level and the consistency needed at an aggregate level. A realist lens will be adopted to better understand what is working, for who under what circumstances to identify the mechanisms driving the achievement of short term outcomes.

A process evaluation concentrates on the implementation of the project to determine if the intended quantifiable targets and implementation strategies have occurred as planned. Particularly, it can look at the effectiveness of the programme components in achieving early programme outcomes. In the case of the Aboriginal and Torres Strait Islander Practice Reforms, a process evaluation will be particularly important in determining adjustments or improvements because there is an intention to expand beyond the four initial sites to the rest of the state. The trials will have limited time to gather evidence needed to determine if outcomes have been obtained within the evaluation timeframe. Therefore, it is critical that the investigation of the processes is rigorous and robust. Due to the timing of the evaluation report (i.e. less than 12 months after implementation) and potential limitations in the ability to collect data from client groups or participants in the programme, this evaluation should also be considered an early outcome measurement and not an entirely conclusive evaluation of the intended mid-term outcomes. In addition, it may be useful to compare families that only have a FLDM/FGM post I&A for comparisons.

Preparation

The planning and scoping phase of the evaluation will provide preliminary guidance to a more in-depth process for organising the field visits which will occur in Stage Two.

Inception Workshop

Stage one will consist of a dialogue, and workshop with Department staff and relevant stakeholders and service providers. The workshop will include a discussion of approaches to programme evaluation. An important aspect of this phase will be the setting of common expectations of what words like quality, effectiveness, efficiency or appropriate mean. The outcome of the workshop will be a diagrammatic representation of the model which will form the basis of the evaluation framework.

At this meeting the team will discuss access to previous evaluations that may have been done and the availability of secondary data or administrative data.

Evaluation Tools

There are a number of tools that have been developed by the Queensland Family & Child Commission for the workplace self-assessment of services.⁵ These provide a consistent way across the sector of asking about key evaluation constructs in ways that are relevant to the child protection system. Instruments are particularly suited to the child protection context. These tools will be assessed to determine their value for the current evaluation – particularly in terms of assessing positive culture, organisation performance and stakeholder experience of service. These instruments will be augmented to ensure comprehensive coverage of model constructs – finalised during inception discussions.

⁵ <http://www.qfcc.qld.gov.au/workplace-practice-self-assessment-toolkit>



Community Consultation and Consent

Winangali will work in partnership with our local research networks and connections to negotiate access and consent in the communities selected to visit. This task involves obtaining a letter(s) of agreement from the designated or respected leaders of each community to be involved.

A formal letter outlining the project, requesting permission with another returning letter that community leaders (as recognised by the community) can sign to show they have given consent for the research to proceed in their community. This may include formal organisations or authorities and informal leadership structures and representatives recognised by the community to speak for community. By way of example Uncle Eddie in Ipswich and the Torres Strait Authority Board would be consulted and consent given before the evaluation commenced.

The consultants on this project have relationships with these communities and have undertaken many similar projects requiring visits to remote and regional Aboriginal and/or Torres Strait Islander communities. To be successful, a researcher has to be accepted by the organisation or community approached, and must be aware of and understand cultural norms and expectations. A respectful and meaningful evaluation will involve talking to leaders and representatives from as many different key clan or language groups as possible in each of the communities who have used or who were eligible but have not used the service. Having worked in these regions before, our consultants are intimately aware of the local politics, family business and governance structures and have strategies to best navigate a representative evaluation.

Ethics Approval

AIATSIS Research Ethics Committee approved the evaluation approach and research method. Reference EO49 - 21022017

Desk Research

Our suggested evaluation also involves the analysis of administrative data, cost analysis and review of documentation. Document review would include all program manuals, funding agreements, quality assurance procedures, staff training modules, service provider procedures and process documents and other relevant policy documents to describe the program. Cost analysis can be derived from funding arrangements, and/or actual cost data from service providers, and administrative data on the cost of services (or the counterfactual) more generally from the Department. Administrative data may include data recorded by the Family Group Conference coordinators and information extracted from hardcopy referral forms, conference reports and Family Plans. Available data will be determined as part of the inception workshop.

Ideally the administrative data for at least ten families at each Child Safety Service Centre would be analysed to provide case studies. The final sample size for this component of the evaluation will be dependent upon program referral and participation rates.

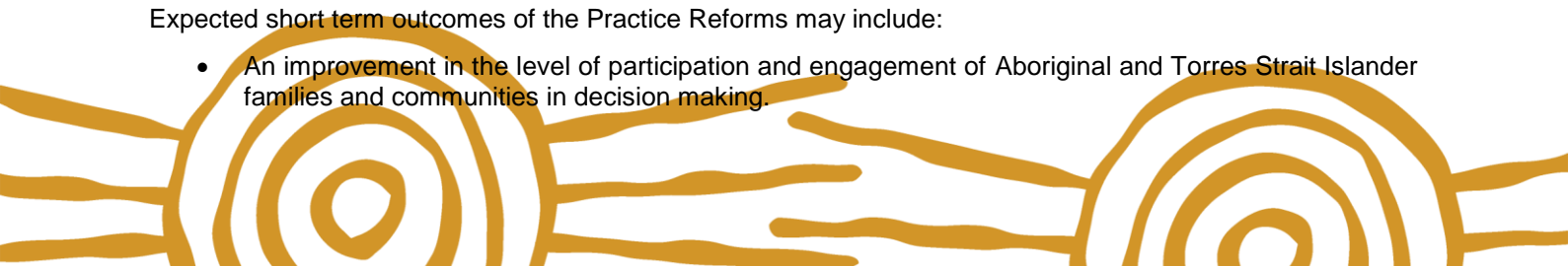
Ideally, the sample will enable a random selection of families within different categories/strata, such as 'aspect' or 'procedures' of the child protection continuum/system the families have been involved in; harm type, urban, regional and remote locations. Once the initial data on the caseload is received a sample plan will be developed, in consultation with the trial sites.

Desk research will predominately be undertaken by Kylie Brosnan. As the only non-indigenous team member she will seek with assistance from her team members to ensure an Aboriginal perspective to the analysis and interpretations has been applied. The most relevant experience for Kylie Brosnan is the conduct of the Implementation Review of the Intensive Family Support Services in the Northern Territory reviewing five sites across three service providers.

Fieldwork

Expected short term outcomes of the Practice Reforms may include:

- An improvement in the level of participation and engagement of Aboriginal and Torres Strait Islander families and communities in decision making.



- The identification of culturally appropriate service responses.
- Greater access to universal and secondary services by Aboriginal and Torres Strait Islander children and families.
- An increased involvement and influence of FLDM Service Providers in providing more culturally appropriate and responsive services. Empowering communities and families to have more ownership throughout the process.
- Better establish and maintain positive cultural connections through improved the quality of the Family Group Meeting process to develop family decisions and Family Plans and Individual Case Plans to promote child safety and wellbeing in general and where relevant Cultural Support Planning and transition-from-care planning a realist evaluation will be undertaken.

Our initial exploration of evaluation methodologies for site specific programs suggests the inclusion of in-depth interviews, conference observations and the analysis of secondary data (see example table below). This represents our initial exploration of methodology which will be refined as part of early discussions with the Department.

In-depth interviews with key stakeholders. In-depth interviews will be undertaken with key professionals involved in the Family Group Conference. Interviews are preferably conducted in person but may need to be undertaken via telephone if they are not available in community at the time of the fieldwork. Aboriginal and/or Torres Strait Islander researchers will undertake interviews with Aboriginal and Torres Strait Islander stakeholders and Non-Indigenous researchers may undertake interviews with other stakeholders as appropriate. These interviews can uncover useful insights and allows a relatively free exchange of information compared with group discussions. This is particularly the case when dealing with confidential or sensitive topics.

As part of the inception workshop the merits of conducting in-depth interviews with parents and family members who participated in a conference or who were eligible but didn't participate will be discussed. Overall stakeholders will include service providers, community members and Departmental staff and other key stakeholders (potentially Police liaison/legal aid/caseworkers).

Planning observations. Local researchers will be involved in the family led decision making environment, observing actual behaviour for an extended length of time, capturing all of the interactions that are part of a conference. Note: Winangali has undertaken Ethnographic research in the Ipswich site's organisation for a project on behalf of the Queensland Family and Child Commission. Observations only occur with full consent of all parties.

Telling the story of the shared practice model: Vignettes is a powerful way to enable participants to describe outcomes, changes in attitudes, behaviours and norms which all help to identify the mechanisms of change. The use of a decorative design or small illustrations can often contain a thousand words and provides a powerful story to inform the evaluation. Personal stories can also provide the audience of the evaluation a practical example to better understand the evidence found in quantitative data. Consent to use any images or stories in published works must be gained, and often this may be denied. However, the power is in helping the evaluation team to develop the framing for the next stage of research.

Participatory Impact Pathway Analysis: Engages participants in predicting how project outcomes can lead to social, economic and environmental impacts through participatory workshops in which project implementers and key community stakeholders construct project impact pathways. In the workshop, participants create a logic model once the underlying impact pathways have been discussed and agreed upon.



Figure 1 Recommended in-depth interview sample

Location	Number of families interviewed	Number of Convenors interviewed	Number of community leaders / local reference group interviewed	Number of Support Services Stakeholders interviewed	DCCSDS Staff	Total number
Ipswich	5	2	2	1 Social Worker 1 School Engagement officer	1 Contract Manager (Partial as new) 1 Practice Leader	13
Mt Isa	7	2	5	3 RE staff 2 Managers of Services	1 Contract Leader 1 Practice Manager 1 Senior Team Leader	22
Cairns	3	2*	0	2 RE staff	1 Contract Manager 1 Practice Leader 1 Senior Team Leader 1 Support Person	10
Torres Strait	3	1*	8 in a Group meeting	3 RE staff 2 Managers of Services	2 Contract Managers	11 + 1 group discussion

* Attempts to interview FGCM convenors who worked on the trial from the department were unsuccessful.

Reporting

Descriptive statistical and thematic analysis will be undertaken in the community. Analysis will include the preparation of case summaries based on participant records; and the analysis of administrative data, accounting summaries, including data extracted from hardcopy records and data extracted from observed groups.

At the conclusion of all community reports a consolidated report aggregating the findings into one evaluation summary will be produced. This report will be reviewed by the Winangali project managers prior to submission to the Department to ensure that the findings reflect the various differences and similarities found across the different communities and sites. A draft will be submitted for review and feedback before the final report. Once the content of the final report has been agreed it will be prepared for Web Accessibility. Winangali will use Ipsos who has produced numerous public reports and has an internal design team skilled in the production to these specific requirements.



Appendix C - Literature on implementation

Implementation occurs in stages:

- Exploration and adoption;
- Installation;
- Initial implementation;
- Full implementation;
- Innovation; and
- Sustainability.

These stages usually occur over two to four years. Implementation science, which is based on the premise that proven intervention must be consistently and systematically implemented, also includes three other frameworks – drivers, cycles and teams. There is no ‘proven intervention’ being systematically implemented, but instead approaches are adapted to the place and context. Therefore, the most relevant framework for the future administration of Aboriginal and Torres Strait Islander FLDM relates to drivers of change: supporting good practice by focusing on organisations and systems that build capacity and internal structure, as well as responding to barriers. From a research perspective, implementation science has been differently defined with the emphasis on methods employed to investigate the integration of evidence into policy and practice, thus, in its intent to investigate and address major bottlenecks (e.g. social, behavioural, economic, management) that impede effective implementation.

In a review of literature, the Parenting Research Centre (PRC) underlines that many previous efforts to implement evidence-based programmes in the family support sector have not reached their full potential. This is due to a variety of issues inherent in both the family support service setting and the implementation process itself. Their report warns:

‘Without addressing these organisational and individual challenges as part of a planned, purposeful and integrated implementation strategy, interventions, even effective ones, may not produce the desired effects for parents and children. Therefore, attention to how a programme is implemented is as important to child, parent and family outcomes as what is implemented’.

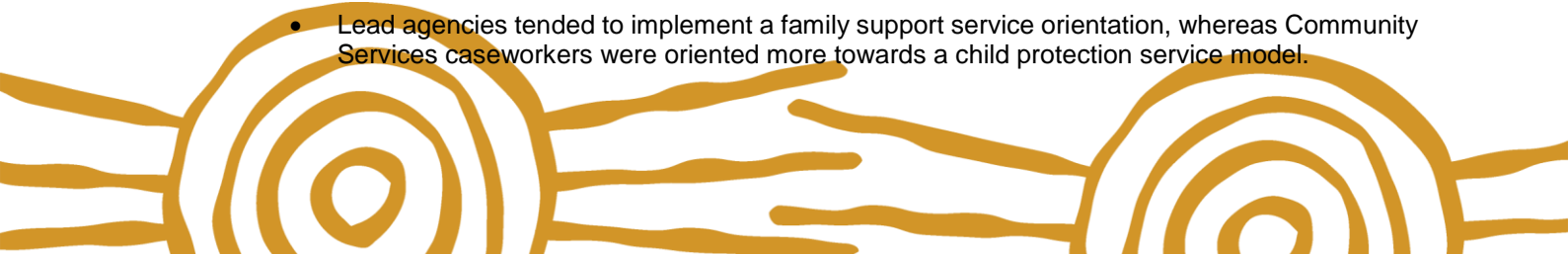
Key considerations identified by the Parenting Research Centre (PRC) include the following:

- Availability of staff with competencies matched to the skills required to implement the programme;
- Capacity to deliver competency-based training which will lead staff to develop the skills and behaviours necessary for a particular task by delineating important components of the task;
- Providing work-based, opportunistic and reflective consultation and coaching to staff;
- Using implementation fidelity measures and programme outcome measures to inform decision-making; and
- Using supportive and facilitative administrative systems to better integrate the practice or programme into the organisation.

Another significant challenge facing services is deciding the extent to which a programme should be adapted, or not, to fit the context. If a programme is adapted, it needs to be considered if this can be done with quality and to good effect, retaining the essential elements of the programme that contribute to its effectiveness. Such an approach seems in keeping with the underlying principles of implementation science in health research. The issue of variability, depending on the context, emerged as a key finding in the evaluation of Brighter Futures in NSW. This variability was related to the client characteristics, the capacity of different services, and on individuals’ commitment and ability to engage in partnerships in the government and non-government sector¹.

Interestingly, the evaluation focused on what was then a ground-breaking partnership between government child protection workers and non-government service providers. They found:

- Lead agencies tended to implement a family support service orientation, whereas Community Services caseworkers were oriented more towards a child protection service model.



- In sites where partnerships were working well, this was due to the initiative and personality of individuals working on the ground rather than being a result of partnerships at the structural or strategic level.
- Within the partnership there remained an inequitable relationship between Community Services and contracted service providers.

The question of how well partnerships work is an important one, and there was evident concern among the non-government sector in the NT about an increased role in delivering child protection services **Error! Bookmark not defined.** To the Board of Inquiry into the Child Protection System in the NT, non-government agencies expressed their concerns about the effects of entering into a contractual arrangement to deliver a service for government that included:

“...inherent risks in becoming involved in a contractual relationship with government as a provider of a service including: restrictions around the sharing of information; perceived threats to the advocacy role of the non-government agency; the refocusing of the mission of the organisation that might threaten to divert it from its core purpose; the administrative cost of complying with reporting requirements which may burden the administrative capacity of the organisation. Related to these is the risk that an organisation may be encouraged to expand beyond its capability.”

In recognition that successful partnerships should have a clear purpose, add value to the work of the partners and be carefully planned and monitored, VicHealthii has produced a resource – the partnership analysis tool. Although the tool is for health promotion, it takes a generic approach and could be employed in other fields of social services. As the importance of collaboration and partnership is underlined as crucial to effective service delivery and is a central tenet of the co-roles in some stages of the child protection continuum, consideration should be given to use this tool or other methods to plan or review current partnerships.

The literature supports the use of implementation science to improve the outcomes of evidence based practice models. The program theory for the trial makes an assumption that implementation science using effective implementation strategies from feasibility to fidelity will be used to improve the FLDM model which is an evidence based practice models. Implementation drivers such as competency, organisation and leadership build the capacity and infrastructure that is crucial for the shared practice model to work. Individual (including age, cultural status, time on the job, training, and level of education) and organisational factors (including organisational culture, communication, and size of agency) may combine to impact the implementation of the practice reforms.



Appendix D – SNAICC Recommendations

Cultural Authority and Leadership

Aboriginal and Torres Strait Islander Family-Led Decision Making (ATSIFLDM) always be led by Aboriginal and Torres Strait Islander staff working for Aboriginal and Torres Strait Islander community-controlled organisations (ATSICCOs).

“Before I just had white people and sometimes they don’t understand Aboriginal ways. They were really picky and they didn’t understand where I was coming from.” – FLDM Participant

“The convenors absolutely need to be sitting in a very neutral space, but again, trying to break down the ‘us and them’ between the department and families and really trying to pull everybody together. I think that’s one of the things that’s absolutely crucial when you think about who you put into the role of being a convenor.” – RE

Rather than co-convening with the Department, co-convening should be undertaken by two convenors within an Aboriginal and Torres Strait Islander organisation, to uphold the process as Aboriginal and Torres Strait Islander led, with Department roles undertaken by Child Safety Officers (CSOs) and Team Leaders where there is statutory involvement.

Develop locally tailored cultural protocols for engaging with family, community, and ATSICCOs and incorporate into DCCSDS staff training to embed ATSIFLDM process across service areas and communities rather than as a single program approach.

“But then once I started to see that sorry business happened so frequently I had those conversations with my family and said “what is it that you want me to do if sorry business is occurring in your community? ... One particular family said to me “just come and visit us when you get here and we will tell you ... You have to ask.” - Re

Cultural Authority and Leadership Cont.

“You would have to put some power into the Aboriginal orgs because if you’re depending on us, the department, to be able to give that power we’re not ever going to be able to do that I don’t think. Not in any meaningful way.”
 – The Department

Resource and empower Aboriginal and Torres Strait Islander organisations to design and lead their own processes of community consultation to inform the approach to ATSIFLDM.

Allow flexibility for local design of ATSIFLDM processes so that ATSICCOs can work with their communities to harness existing local level leadership and decision making processes and reflect the strengths of each community’s and each family’s way of working to resolve issues.

“At the start of the trial it was very much a power struggle even though I wasn’t looking for power struggle or wasn’t looking for the power, it was about how the department held the FLDM and this is how it’s going to be done.”
 - Convenor

“You would have to legislate or you would have to build the power into the structure so that if the family produces the family plan the department has to accept it and has to do what it says and can’t water it down and minimise it in the process”
 – Lead for the Trial

ATSIFLDM should be defined in legislation, policy and program design as a community-led process to empower families, not as a service to the Department or a service tied only to child protection systems processes.



Support Across the Continuum

“When they told me that I was referred to Family Led Decision Making I was really happy they are Aboriginal they understand where I am coming from, very helpful.”
– FLDM Participant

Access to ATSIFLDM should be made available at key decision making points across the care and protection continuum including wherever possible before decisions about removal and alternate care are made (mandatory referral points are legislated), as well as through self-referral and flexibility for service providers to identify points when the process would be beneficial for families.

Ensure processes and resourcing enable a strong early intervention capability for utilising ATSIFLDM in communities, for example within Family Wellbeing Services, or through existing community-led family decision making processes.

“Giving them [convenors] short courses that would empower them to have those opportunities to be able to empower themselves so they can pass it on to us and better be able to protect us. I want them to be very strong.”
– FLDM Participant

“Cultural awareness training and more training for these guys too. And more training in leadership as well. Just stuff about basically how the world is a lot different to how you think it is.” – FLDM Participant

Include in training for Department practitioners a focus on understanding the central importance of family and community empowerment at each and every stage of work with a family. This would include building the knowledge, understanding and capability to transfer responsibility from the Department to enable community-led ATSIFLDM processes.

Limitations of Resourcing and Single Convenors

“We definitely need a male worker ... Even though it’s all sort of changed now, yeah definitely need male workers because culturally you’ve still got to have that. It’s how we’ve been brought up, tradition, with males talk to males.” – FLDM Participant

ATSIFLDM services in any location have a minimum of 3 and preferably more frontline staff to enable a collaborative and supportive staff team environment, co-convening within organisations, and appropriate backfill. It is suggested that service providers have attention to the importance of gender balance and diversity of clan/ language representation in the recruitment of staff teams.

Include within contract delivery requirements and consideration of caseloads the role of ATSICCOs to implement ATSIFLDM using a community development approach with elements including community engagement and collaboration with other providers, ensuring stronger alignment with Human Services Quality Framework (HSQF) standards and community and cultural obligations for organisations and workers.

“We really want our RE and the trial workers to know the community so they should be doing that community engagement”
- RE

“Access to ICMS...when the FGM doesn’t come through and you only have the mum, dad contact details, they wouldn’t have anybody else for support. But that information is documented on ICMS, placement of the child, who’s the carer. So this information isn’t in the FGM file” - Convenor

Ensure equitable resourcing of community-controlled organisations in relation to Departmental Collaborative Family Decision Making (CFDM) teams, taking account of frontline workers, management support, professional development and logistical resources. Given significant resources and Aboriginal and Torres Strait Islander identified positions currently in CFDM, it will likely be necessary to transition resources from the Department to community organisations.

Preparation with Families

DCCSDS draw on trial findings to inform a full assessment of the resourcing requirements for undertaking a thorough preparation phase for ATSIFLDM. The assessment must have regard to greater resourcing needs related to travel costs in remote and isolated locations such as the Torres Strait Islands. Resourcing should recognize that families commonly require three or more preparation meetings prior to an ATSIFLDM meeting to be ready to participate.

“So we told him that we really need our own transport, so he said ok and went out and bought a car. We had mobile phones so that we can call people, we had the resources to just do stuff without the fear of failing and repercussions.” - Convenor

“After we had that meeting everything calmed down a little bit” – FLDM Participant

“The cultural support person is an ongoing intervention worker. So your case worker, your RE and the family should get together and develop that cultural support plan.” - Convenor

DCCSDS review processes, resourcing and timing of cultural support planning to utilise the strengths of the ATSIFLDM process and convenors and to elevate the status of cultural support for children and young people.

Collaborate Practice Development

“The convenors absolutely need to be sitting in a very neutral space, but again, trying to break down the ‘us and them’ between the department and families and really trying to pull everybody together.” – The Department

Local implementation teams are established that include ATSIFLDM convenors / managers and key child safety staff to promote a consistent and collaborative working relationship between the Department and ATSIFLDM service providers. Local implementation teams should establish consistent agendas, and shared accountability to follow-through



Holistic Support and Integration with other Family Supports

The importance of collaboration between ATSIFLDM and Family Wellbeing Services is recognised and incorporated into the design of future models of practice to promote consistent support and family-led practice.

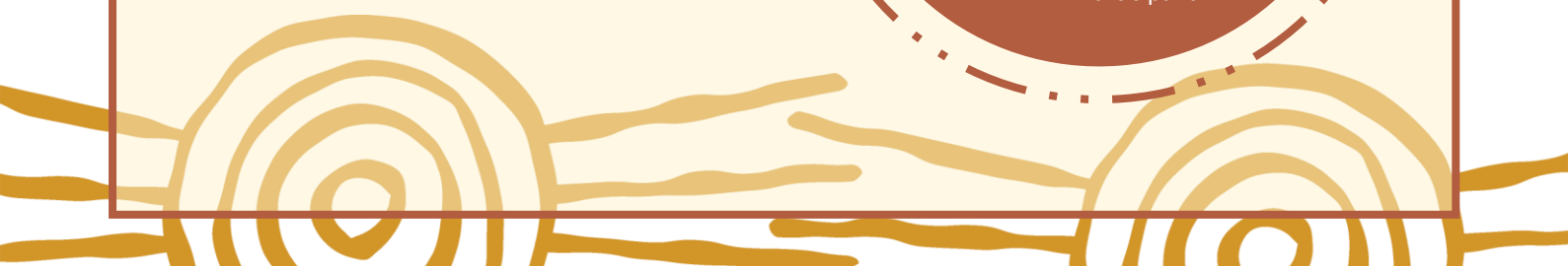
“What we do with this service and ICAP, we attend the network meetings, you’ve got the networks from 0 to 12 then you’ve got the youth networks and we attend those and I’m connected in with the homelessness, the housing network.” - RE

“I think that meeting was kind of a review, there was already a plan in place so we just discussed from our perspective the strengths and the needs and how we might move forward or how we might support the family and other services to move forward.” - The Department

Resourcing of ATSIFLDM recognises functions in building networks and collaboration with a broad range of services that support families to implement their decisions and plans.

Information about ATSIFLDM be shared broadly in communities so that all services and stakeholders are aware of the role that they can play to support families to make decisions and implement plans.

“The challenges are the perceptions of the Child Safety Department, their perception, where they stand within the community. I know they want to keep kids safe and that, but they rock up like the police ... When they come it’s like far out, life’s ended, family’s going to be ripped apart because we just had a little argument.” - FLDM Participant



Holistic Support and Integration with other Family Supports Cont.

“No I haven’t heard a single thing from her [the convenor] at all and the other one, since that meeting there hasn’t been any contact” – FLDM Participant

The processes needed to establish an effective follow-up support mechanism for families to be given strong consideration in the future ATSIFLDM model design. At least one follow-up meeting coordinated by the ATSIFLDM convenor is recommended to support families to implement their plans.

Information sharing protocols and processes are established between ATSICCOs undertaking family decision making to enable appropriate information sharing about families who are transient and spread across broad geographic areas.

“The FDM doesn’t have very much information so I would have to contact Megan and say hey can you have a look on ICMS for this family. Sometimes that can be up to 50 emails a day and if I had access to OCMS I could go right back through history and look at child safety concerns and previous case plans.”
- Convenor



Supporting Practice Excellence

“I think then the second philosophy is a philosophy around having Aboriginal people and Torres Strait Islander people run and lead these forums in a way that’s going to be more culturally appropriate than the department can do.”
- The Department

DCCSDS ensure that appropriate training and capacity development supports are scoped and included in future ATSIFLDM model development in close consultation with QATSICPP.

DCCSDS has significant attention to internal training needs to shift culture and practice and develop readiness for its staff to support and enable ATSIFLDM.

“There was some training that just got rolled out somewhere the other day and I noticed that the CSO said ‘this would be great for the indigenous staff’ and I was like ‘Who already know about grief and loss counselling?’. Perhaps some other people can go.”
- The Department

“The RE is supposed to be there for both the department and the families – like a translator. Those two meetings I had, they didn’t do nothing.”
- Convenor

An independent implementation support role is provided for in any future ATSIFLDM model. This may include elements of intensive implementation support for the establishment phase and ongoing support to promote practice excellence, including through the role of QATSICPP.

DCCSDS resource annual service forums in regional centres across the state to support practice sharing and the development of practice excellence for ATSICCOs and ATSIFLDM convenors.

“I would love to see a better relationship between Child Safety and our workers. I think there should probably be some sort of data system that the information should be fed into.” - RE

Appendix E – Substantive theories

The purpose of this literature review is to support the research team in understanding the theoretical assumptions underpinning the Family Led Decision Making process (FLDM). The relationship between Regulatory Theory, Self-Determination Theory, Choice and Agency and Respect Theory will be established and the degree to which they have been investigated will be presented. This review is not intended to be exhaustive, but rather it will outline essential theoretical material that will allow the research team to apply deep methodological thinking within the context of FLDM. It supported the program logic diagram and has been included for reference.

Regulatory Theory / Punishment Theory

The literature proposes Regulation Theory as the rules imposed by an authoritative body (the regulator) for the purpose of guiding or restraining behaviour. This definition can be further extended to encompass a 'sustained and focused control exercised by a public agency over activities that are valued by a community'. By applying economic incentives, contractual powers, deployment of resources or the supply of information, regulation influences business and social behaviour.

The literature highlights that the question to Punish or Persuade has led to the development of The Pyramid Strategies of Responsive Regulation, encompassing the Regulatory Pyramid and the Enforcement Pyramid. Each present a range of options for the regulator to impose in response to undesirable social behaviour. Regulatory responses are presented in sequential order, carrying more coerciveness for the regulator as they travel up the pyramid. Responsive regulation further requires a contextual understanding of conduct and motivations to ensure that the regulation or sanction given is in keeping with the severity of the conduct.

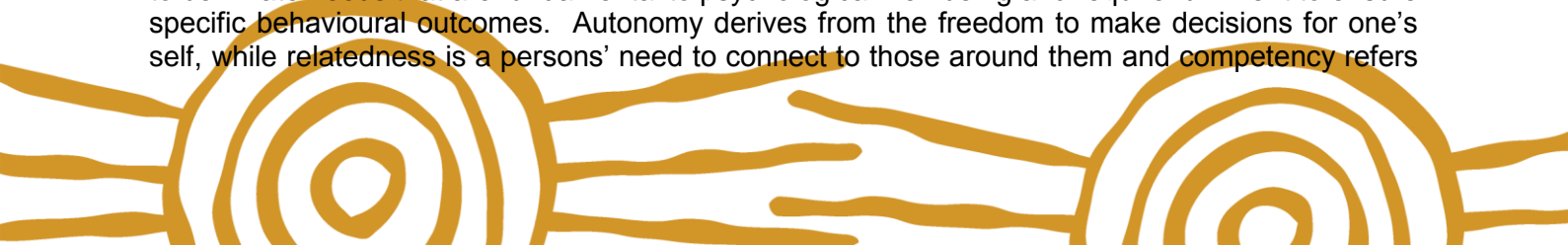
In using the Regulatory Pyramid, the regulator focuses on self-regulation. This initial approach to responsive regulation focuses on persuading against the undesirable social behaviour, preventing the need to move up the pyramid towards more coercive measures.

The Enforcement Pyramid presents measures available to the regulator to sanction breaches. These too are presented in sequential order, with the more severe sanction occurring at the tip of the pyramid. Theorists have noted that compliance is more likely to occur when an individual is faced with a sequence of sanctions as opposed to just one drastic sanction that can be used against them. Whilst the Pyramid Strategies of Responsive Regulation highlights that individuals typically comply with regulation for ethical reasons, the threat of sanction must exist for self-regulation and softer methods to work more effectively.

The literature further discusses the importance of compliance, how the regulator and the regulatee view each other, suggesting that this relationship is not only relevant to the outcome, but has an overall impact on the future legitimacy and trustworthiness for the regulatory system.

Self Determination Theory

Over the years, motivation models have been continuously redefined. Despite this, the concept of fulfilling unmet needs has remained a constant throughout. The evolution of motivation theories has resulted in the more multifaceted social-cognitive motivation that exists today. Self Determination Theory (SDT) focuses its attention on human motivation considering psychological innate needs and the achievement of human growth. Autonomy, Relatedness and Competence are considered to be innate needs that are fundamental to psychological well-being and require fulfilment to ensure specific behavioural outcomes. Autonomy derives from the freedom to make decisions for one's self, while relatedness is a person's need to connect to those around them and competency refers



to the need to feel effective in carrying out an activity.

Motivational style comprises of intrinsic and extrinsic elements that are driven by the degree to which behaviour is self-dependent. Self Determination Theory focuses on motivational styles that sit on a scale of autonomy leading to self-determined intrinsic behaviour. Intrinsic motivation is considered the most autonomous motivational style, whereby activities are engaged in out of interest, thus resulting in a positive influence over lifelong behaviour.

Rational Choice and Agency

Rational Choice theory provides a framework for understanding the way in which aggregate social behaviour derives from individual behaviour (ref). The literature suggests that choices made by individuals are considered to be complete or transitive:

Complete – individual can say which of two alternatives they prefer or that neither is preferred

Transitive – If option A is preferred over option B, Option B is preferred over option C, then A is preferred over option C.

The literature defines an individual with a clear idea of their preferences as a rational agent. The literature further highlights that the individual agent will act consistently in choosing the self-determined best choice of action. The preference of the rational agent will generally provide the individual with the greatest satisfaction as they are made with self-interest in mind.

Respect Theory

Respect theory recognises that respect for others and self-respect are deeply connected. The cyclic relationship of respect and self-respect suggests that it is difficult to respect others if we don't respect ourselves and to respect ourselves if others don't respect us'. The concept of respect features in a range of philosophical contexts including autonomy and agency, justice and equality, moral motivation and cultural diversity.

Respect is said to derive from the theory of value, which can be further categorised into relative value and intrinsic value:

Relative value: value that derives from relation to something else

Intrinsic value: value not derived from relation to something else

The literature suggests that dignity derives from value in relation to something else, therefore respecting a person requires the maxim of treating them as an end and not merely a means just as respecting oneself requires adopting the maxim of treating oneself as an end and not merely a means. Treating an individual with respect recognises an individual's capacity to act morally and makes certain ways of treating them appropriate.

Levels of racism:

- Personal: prejudice or bias. Maintenance of conscious or unconscious attitudes and feelings that whites are superior.
- Interpersonal: Behaviours based on conscious or unconscious biased assumptions about self and others.
- Institutional: An examination of power relationships reveals institutional racism.
- Cultural:
- Modern Racism:

Multicultural strategies are designed to increase the ability of individuals and groups to recognise, understand and appreciate differences as well as similarities.



Appendix F - Implementation

What were SNAICC contracted to do?

Completion of Project Implementation Plan

Project Objectives & Outcomes | Outline all Activities & Deliverables | Project Schedule | Consultation Engagement Sub Plan

Initial Evidence Based Trial Methodology Guidelines for each Trial Site

Input from: the Department | ATSI Organisations | Trial Site Community Stakeholders
 Stakeholder Engagement | Address learnings from Victorian AFLDM model | Operational Processes | Required Resources
 | Stakeholders Roles & Responsibilities | Data Collection
 Review from: Local Reference Groups | the Department | Expert Advisory Group

Implementation of Trials

Pre-trial training: Deliver training program tailored to each site | Deliver information & training material for wider audience

Live Delivery of Trials: Professional supervision and cultural support | Conduct support sessions for service leaders, service providers | Partnership Development | Identify issues | Refine operations | Monitor/Support implementation

Support for Evaluation

Provide information, input and data to evaluator for mid-point and end point evaluations

Final Report

Consultation with trial Stakeholders | Develop a draft summary report | Develop a Final Summary Report

What did SNAICC say they would do?

Milestone 1: Project implementation planning

- Project plan – consultation and sub plan.
- Confirmed membership and terms of reference.
- Establish local project reference groups.

Milestone 2: Trial Methodology Guidelines

- Advise key stakeholders on Victorian AFLDM learnings.
- Draft methodology guidelines for each trial site.
- Complete initial methodology guidelines.
- Develop initial guidelines included in trial methodology.

Milestone 3: Implementation for Trials

- Preparation of training program and materials tailored to each site.
- Training delivery to departmental and service provider staff at each trial site.
- Complete supervision and support sessions for all implementation stakeholders' quarterly.
- Analyse implementation issues to inform trial development and report outcomes.
- Quarterly meetings of local reference groups conducted at each trial site.
- Quarterly meetings of the expert advisory group to discuss and input to project development.
- Complete monthly reports.

Milestone 4: Final Report

Draft and complete the final report summarising the trial from SNAICC's perspective

Milestone 5: Support for Evaluations

Collate and provide data to the evaluator for point 1 and point 2.

What did SNAICC actually do?

Activities

- Worked collaboratively to lead the design and implementation for the trials with the Department of Communities, Child Safety and Disability Services.
- Partnered with Victorian Aboriginal Child Care agency.
- Designed and delivered a 2-day convenor training program.
- Consulted with all trial sites for guidelines and training development.
- 6 meetings of the Expert Advisory Group to enhance the quality of service through input on design, service delivery and cultural considerations.
- Hosted training and information sessions for local organisations, DCCSDS staff and local reference groups at each trial site.
- 6 site visits to each trial site to discuss implementation, address concerns or uncertainties and seek solutions in line with trial guidelines and principals.
- Hosted 10 circle of practice teleconferences.
- Quarterly local reference group meetings to provide cultural knowledge and expertise which SNAICC supported with the Terms of Reference guidance on agendas and participation.
- Regular consultations with expert advisory group from each trial site.
- Ongoing site support through site visits, telephone and email.
- Two progress reports completed.
- Provided support to the evaluator for point 1 and point 2.

Resources Developed

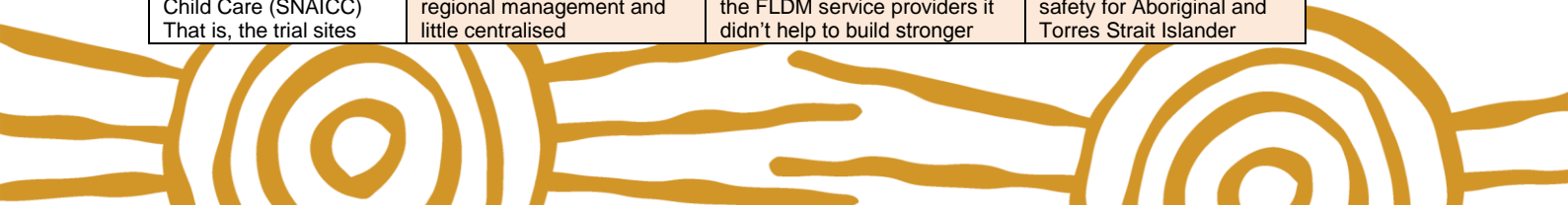
The Eco Map | Family Kinship Tree | Mt Isa: Timeframes, Meeting Process | Questions for Elders | Trial Model Framework developed for Ipswich, Mt Isa, Cairns & Torres Strait | ATSI FLDM Feedback Questionnaire

Appendix G – Learnings

What's new or different about this trial?	Challenges and early tensions	Strengths and successes	Strategies to improve practice
<p>It is a shared practice model between Family Lead Decision Making (FLDM) service providers and departmental staff.</p> <p>That is, there are co-convenors in Trial 3 and department involvement in Trial 2.</p>	<p>When families saw tensions play out in the new shared practice space it undermined the Aboriginal and/or Torres Strait Islander convenors ability to create a safe space for families to talk up and be listened to.</p> <p>Confusion over roles and lack of agreement on what “co-convenor” or “Aboriginal and/or Torres Strait Islander led” truly meant due to overlaps with existing and emerging government language of FGM, FGC, CFDM.</p> <p>This confusion exacerbated as time went on due to significant investment in CFDM and identified positions within the Department over the length of the trials</p> <p>Tendency to stick with status quo and not let go of control to support the principles of the trials for the Aboriginal and/or Torres Strait Islander convenors to lead the process.</p> <p>Relationships between people did not always facilitate good partnerships between the department and the FLDM service providers. Tendancy for department to take over the processes and control the meeting.</p>	<p>Greater success was achieved where the relationship between the departmental convenor and the Aboriginal and/or Torres Strait Islander convenor was one of mutual respect for what each person brought to the table. When there was acknowledgement of the complementary skills that sought to clarify the roles in fluid contexts for different family circumstances the Aboriginal and/or Torres Strait Islander convenor appeared strong and confident leading the process.</p> <p>When families see the Aboriginal and/or Torres Strait Islander convenors being strong and confident, working with the department, they feel they can be strong and confident and talk up and be listened to.</p> <p>Greater success was achieved when departmental convenors handed over full control to Aboriginal and/or Torres Strait Islander convenors.</p>	<p>Building better working relationships between departmental staff and FLDM service providers through clear and consistent understanding of the principles underpinning the practice should be reinforced.</p> <p>Increase the skillset of the Aboriginal and/or Torres Strait Islander convenors to Loss/Gain – human comprehend some of the complexities of the child safety system so they are less reliant on a co-convenor.</p> <p>Increase the cultural relatability of the Child Safety Officers and team leaders so that they can work with Aboriginal and/or Torres Strait Islander convenors without a departmental convenor.</p> <p>Families see, hear and feel everything that occurs in the dynamics between the department and the FLDM service providers.</p>
<p>It was trialed at earlier stages of the child protection continuum than the FGM that legislatively must be held to develop a case plan. That is, there were FLDM at early intervention (Trial 1) and at investigation and assessment (Trial 2).</p>	<p>The resourcing and funding of the trial did not allow for innovation in practice.</p> <p>The risk adversity and lack of trust for the FLDM service providers limited the ability to test creative or new ways of working.</p> <p>The level of departmental involvement increases along the child protection</p>	<p>Working with families sooner rather than later in the child protection continuum (Trial 1) was harder work to engage (no fear yet of the system) but once engaged easier to conduct preparation as more time to work with the families (less complexity and diversionary in nature) and this lead to more commitment to the plan as the family worked free of departmental</p>	<p>Strategies that increase the transparency and access of information between the department and the FLDM service provider to help plan caseloads, initiate engagement quickly with a full understanding to enable better use of preparation time.</p> <p>Strategies that provide</p>



What's new or different about this trial?	Challenges and early tensions	Strengths and successes	Strategies to improve practice
	<p>continuum. Therefore, the early stages have more mechanisms for success such as choice, privacy, independence and time. The later stages are more subjective to how the department works as to whether it will be successful or not.</p>	<p>involvement.</p> <p>Efficiencies and productivity gains were a success of Trial 2 when the department and FLDM started to co-ordinate their efforts and work together.</p>	<p>choice, privacy, independence to the families in later stages of the child protection continuum will assist in making those meetings more successful.</p>
<p>It is an Aboriginal and Torres Strait Islander family-led decision making approach. That is, there is increased focus on cultural safety plans and connection to culture developed through cultural knowledge and strengths based approach that recognises and respects culture.</p>	<p>Where there is no social justice (sense of fairness or just relation between the family and the department) or understanding of the power and privilege that departmental convenors have the ability for Aboriginal and/or Torres Strait Islander convenors to share their cultural knowledge. Where departmental convenors were over-confident in their cultural capability or unconsciously incompetent. This created a lack of awareness about when culture was embedded in safety plans or connectedness was achieved.</p>	<p>Greater success was achieved when there was recognition and respect for the cultural knowledge and contribution of the Aboriginal and/or Torres Strait Islander convenors.</p> <p>Greater success was achieved when Aboriginal and/or Torres Strait Islander convenors were trusted for ensuring that culture was a focus without having to overstate or itemise it for the sake of non-Indigenous departmental staff.</p>	<p>What is "increased cultural competency" mean. And at what point does greater understanding of culture for non-Indigenous departmental staff shift from "because I already know about culture I can work with Indigenous families" to "I know enough about culture to know I shouldn't work with Indigenous families because Aboriginal and/or Torres Strait Islander people are better placed to do so".</p>
<p>The process is led by Aboriginal and/or Torres Strait Islander community controlled organisations and their convenors who are external contractors independent from the department. That is, there is increased cultural safety for families because of the way the work is done.</p>	<p>When the department dictated when and where meetings would be held or limited the choices of the family in the composition of the meeting attendees the ability for the Aboriginal and/or Torres Strait Islander convenor to make the meeting a safe place was compromised.</p> <p>The meeting was safe when it was held at a location that felt peaceful to the family, this may be on neutral ground for all family members, on country for spirituality, and not in locations that could trigger past trauma like departmental facilities or buildings.</p>	<p>Greatest success was achieved when the trial created a safe space because there is a way of doing and knowing that is specifically drawn from the cultural connectedness of the convenor and the family.</p> <p>There are times when words are not needed, intuition, respect and a deeper sense of understanding each other is present. This eliminates the need for families to explain, justify or deliberate over what it means to be an Aboriginal and Torres Strait Islander person to non-Indigenous people. When families do not feel misunderstood or judged based on their culture, they are less likely to be defensive and more likely to listen to the concerns of child safety.</p>	<p>Training should stress that all human interactions (verbal and non-verbal) between the department and the FLDM service provider are witnessed by the family and taken as a cue as to whether there is a safe space. Training should include strategies to make a safe place for families by having agreed ways of working between the departmental staff and FLDM service providers.</p> <p>A safe space is critical for cycling families or families with a history of child removal in previous generations or extended family.</p>
<p>The trial is supported by a practice implementation partner, The Secretariat for National Aboriginal and Islander Child Care (SNAICC) That is, the trial sites</p>	<p>Getting everyone on the same page to have a common understanding of the trial intent and the principles of FLDM had challenges in the context of regional management and little centralised</p>	<p>SNAICC were successful in holding the department accountable to the intent of the trial. When SNAICC became a mediator at times between the department and the FLDM service providers it didn't help to build stronger</p>	<p>To ensure social justice is observed and the intent and interests of families and communities are maintained a third party expert in child and cultural safety for Aboriginal and Torres Strait Islander</p>



What's new or different about this trial?	Challenges and early tensions	Strengths and successes	Strategies to improve practice
<p>were supported by an external expert to implement the practice and strengthen the FLDM service provider's capacity.</p>	<p>administration for consistency or collaboration.</p> <p>Different FLDM service providers had varying operational capacities and SNAICC were funded only to address practice capacity.</p>	<p>relationships between the two.</p> <p>It was however successful in equalizing the power balance to give the FLDM service providers a voice in raising concerns and issues about the integrity of the model and what was working and what was not working.</p>	<p>families should be engaged to support the FLDM services providers. The independence from the department is needed to ensure the practice advice with best practice in FGM models.</p> <p>There may also be a need for external oversight to ensure the integrity of the model. Independent and external evaluation that is transparent is one way to hold integrity in the model.</p>



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