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Seeking Safety

Aboriginal Child Protection Diversion Trials Evaluation Final Report

20 December 2022

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About this Report

This report was commissioned by The Victorian Aboriginal Child Care Agency, The Bendigo and District Aboriginal Co-operative, Njernda Aboriginal Corporation and Goolum Goolum Aboriginal Cooperative.

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About the Authors

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Executive Summary

Victorian Aboriginal children are currently 17 times more likely to be in out-of-home care compared to non-Aboriginal children. This is because Aboriginal children are more likely than non-Aboriginal children to be reported to Child Protection, and because Child Protection cases involving Aboriginal children are more likely to progress to Court and out-of-home care after a decision has been made that a child needs protection.

Aboriginal families and communities are disproportionally affected by traumatic experiences and their associated negative consequences, including unemployment, educational disadvantage, poverty, homelessness, and intergenerational trauma. This puts Aboriginal children at greater risk of adverse childhood experiences and for being reported to Child Protection. Visibility to mandatory reporters and implicit bias in the decisions of mandatory reporters may also contribute to differences in Child Protection reports. Aboriginal people also underutilise mainstream prevention and early intervention services, and avoid working with social service professionals, due to fear of child protection intervention or because mainstream services do not meet their cultural needs.

Historic child welfare legislation, policy and practice has also created a great deal of fear and distrust between Aboriginal people and the government. As a result, encounters with Child Protection creates significant anxiety for Aboriginal families, particularly for those with historical legacies and intergenerational trauma relating to child removal. These factors affect how Aboriginal parents react to a Child Protection investigation and interventions concerning serious child safety concerns. Aboriginal parents may behave in ways that obscure signs of safety or strengths within a family, or cause Child Protection practitioners to view them as uncooperative and see this as further evidence of their problematic parenting, which may precipitate Court action and a removal decision. Parents' fear and distrust of Child Protection also makes it difficult for Child Protection practitioners to develop and sustain supportive relationships with parents as the basis for a protective intervention without a Court order.

A lack of informal supports and culturally safe and culturally relevant family preservation services following a substantiation decision, or difficulties and delays in accessing necessary family and community-based supports, may also contribute to disparities in Court orders and removals after a substantiation decision.

The Aboriginal Child Protection Diversion Trials represent a move from acknowledging the problem of Aboriginal overrepresentation in Victorian child welfare to implementing Aboriginal-led solutions.

Exercising a collective right of Aboriginal people to determine and control their own destiny by exercising autonomy in their own affairs, four Victorian Aboriginal Community Controlled Organisations (ACCOs) developed three program trials to divert children and families away from Child Protection to Aboriginal Community Based Child Protection Mechanisms:

- The Aboriginal-Led Case Conferencing Trial (ALCC) (Victorian Aboriginal Child Care Agency)
- The Aboriginal-Led Aboriginal Family Decision-Making During Open Investigation Program Trial (AFLDM) (Goolum Goolum Aboriginal Cooperative and the Njernda Aboriginal Corporation) and
- The Garinga Bupup Trial (Bendigo and District Aboriginal Cooperative).

The program trials were expecting to bridge the gap between Aboriginal families and access to culturally safe and relevant services and thus prevent Child Protection investigations involving Aboriginal children, Aboriginal child removals and placement of Aboriginal children with non-Aboriginal caregivers.

The evaluation of the trials, conducted by Social Work at the University of Melbourne under Aboriginal leadership, aimed to address questions regarding program effectiveness, acceptability, and feasibility. The evaluation of each of the program trials employed a mixed-methods design, integrating data from different data collection methods, including secondary analysis of Child Protection administrative data, secondary analysis of agency data, parent feedback surveys, and stakeholder interviews and focus groups.

While the sample sizes were small, and it was not possible to follow families for very long after their episode of care, the evaluation provided a strong case for the effectiveness of the ALCC trial and Garinga Bupup in diverting Aboriginal children from Child Protection investigation. The ALCC trial had an 78% diversion success rate, and Garinga Bupup had a 63% diversion success rate. This equates to a $5 and $2 return on every $1 invested respectively. While the AFLDM trials did not demonstrate the same diversion success due to redesign and delayed implementation, pre-conditions for long-term diversion outcomes included in the program logic were evident, as were core components linked to program effectiveness.

Garinga Bupup and the ALCC trial provided more intensive case management than originally intended, but overall, the trials were implemented effectively and with fidelity in their local context. There was also evidence that the pre-conditions for diversion (short- and medium-term outcomes) were in place. There was excellent uptake and use of the trials among Garinga Bupup and ALCC families, and good uptake among AFLDM families in the late stage of implementation following redesign. Parents were very satisfied with their service; they experienced a high-level of personal and cultural safety during care and felt supported by ACCO Convenors/Case Manager. Garinga Bupup mothers showed a high level of trust in the Garinga Bupup Senior Case Manager, and the Garinga Bupup Senior Case Manager also highlighted the close “family-like” relationship that she formed with mothers. There was evidence that the trials improved parents’ self-esteem, self-agency, and personal empowerment, and successfully engaged parents in community-based support to address struggles linked to poverty and disadvantage and exacerbated by social isolation.

The evaluation verified core components or active ingredients that are essential if Aboriginal Community Based Child Protection Mechanisms are to achieve desired outcomes. Safe, empowering and trusting relationships, were enabled by an Aboriginal service provider, voluntary relationships, brokerage, and culturally grounded practices that reflect Aboriginal cultural values of family preservation, respect, honesty, choice, and empowerment and maintain cultural integrity in service delivery. Personal empowerment and openness to change was fostered by honesty about the risk of harm to children and the potential for

statutory action and the integration of Aboriginal traditions and rituals that build a strong Aboriginal identity and reconnection with self, family, and community.

Strong links between Child Protection and the ALCC trial following a Child Protection report (using Lakidjeka as an intermediary) fostered timely case conferencing. Timely connections to services and supports (including natural helping systems) were aided by case conferencing and AFLDM meetings. Intensive case management (spending time) was also necessary in Aboriginal perinatal families to develop trust, strengthen natural supports and reduce barriers to engagement in health and social care services.

The AFLDM experience shows that diversion during a Child Protection investigation is not feasible, and the experience of all trials shows that referring families to Aboriginal Community Based Child Protection Mechanisms is best undertaken at the 'front door' of the Child Protection system (or before an unborn child report in the case of Garinga Bupup). Addressing child safety concerns in the community also involves effective linkages with the statutory Child Protection authorities, to identify and divert families where there are child safety concerns, to mediate statutory Child Protection activities, and to agree a way forward where there are serious child safety concerns warranting a statutory protective intervention, or when ACCOs require support in contacting families.

The Aboriginal Child Protection Diversion Trials incorporated several factors that increased the probability of successful implementation. ACCO practitioner skills were a critical implementation enabler. This included the ability to recognise and respond to parents' personal histories of trauma, discrimination, disempowerment, and the fear of statutory intervention, the ability to mediate between the world of Child Protection and the family, the ability to focus on parents' strength-areas and ability to recognise and respond to child safety concerns. The valuing of Aboriginal self-determination in child welfare and operational capacity and support by Child Protection (Intake) and Community Based Child Protection was also necessary for implementation. Implementation was also supported by ACCO internal structures, systems, policies, and procedures that align with Aboriginal Community Based Child Protection, such as case practice frameworks, policies, procedures, client recording systems and case management supervision. Barriers to service access can

also be mitigated when ACCOs have diverse service offerings and are able to prioritise care to families where child safety concerns are identified.

The evaluation highlighted several considerations for design and process improvement for each trial, such as enhanced stakeholder communication (all trials), stronger links with Child Protection (AFLDM trials), new referral pathways (Garinga Bupup), changes to the inclusion criteria to reach new or wider groups of Aboriginal families (e.g., mothers having subsequent babies - Garinga Bupup - and perinatal Aboriginal families - ALCC), improved access to information on referral commensurate with a Child Protection investigation (ALCC) and brokerage funding (ALCC). There was also agreement among several stakeholders that Garinga Bupup needed additional staff capacity to sustain an intensive case management model that supports mothers/families from the early stages of pregnancy and following birth, meets community demand and accommodates the afterhours nature of the work.

On balance, there is a strong case for robust Aboriginal Community Based Child Protection Mechanisms in Victoria. Community-based management of child protection issues means that Aboriginal people exercise their right to autonomy and control in matters relating to service activity being provided to them, avoid potentially unnecessary removal decisions and harm caused by culturally unsafe encounters with Child Protection, and receive more direct access to culturally safe and culturally relevant services and support.

Evidence that the current activities can divert Aboriginal children from statutory Child Protection authorities, and convergence across all three trials in terms of the theory of change, core elements and enablers, provides a sound basis for recommending:

- Full implementation of all trials.
- Continued improvement that requires no or limited additional resourcing.
- A summative evaluation to verify effectiveness, core components and enablers, including an economic assessment that captures monetary savings and non-monetary benefits.
- Development of a plan to move from model demonstration to full implementation and potential replication, that includes sufficiently documenting the need or problem the

programs address, the program's approach to the problem and its effects, how it works, the settings in which the programs are intended to be used, what is needed to successfully implement the programs in different community settings, and how progress can be assessed.

- Active communication about the programs to ACCOs that might be both 'willing' to, and 'capable' of, replicating the programs, or developing their own local mechanism for Aboriginal Community Based Child Protection based on core components.
- Exploration of the capacity and acceptability of Aboriginal Community Based Child Protection Mechanisms to form part of the building blocks for a new approach to Aboriginal Child Protection announced by the Victorian Premier on 5 December 2022 (https://www.theguardian.com/australia-news/2022/dec/05/victoria-vows-to-overhaul-child-protection-as-yoorrook-justice-commission-begins-public-hearings).

Background

Over recent years much attention has focused on the disproportionate number of Aboriginal children involved in all Child Protection activities, including investigation, protective intervention, and out-of-home care (OOHC) (SNAICC, 2022). In 2021-22, Aboriginal children were 17 times more likely to be in OOHC compared to non-Aboriginal children in Victoria, and the rate of admission to OOHC for Aboriginal children in Victoria was the highest in the nation (AIHW, 2022). Currently, most Aboriginal children in OOHC in Victoria are not in the care of Aboriginal persons or organisations, which may result in a loss of connection to culture.

The Aboriginal Child Protection Diversion Trials were designed and delivered by Victorian Aboriginal Community Controlled Organisations (ACCOs) to prevent Aboriginal families from experiencing a Child Protection investigation and further Child Protection activities, such as child removal. They were developed within the overall context of a reform strategy aimed at increasing Aboriginal self-determination and self-management where child safety concerns are identified in Aboriginal families (Appendix A). Self-determination is a collective right of Aboriginal people to determine and control their own destiny by exercising autonomy in their own affairs and maintaining distinct political, legal, economic, social, and cultural

institutions (Coalition of Aboriginal and Torres Strait Islander Organisations, 2020; UN General Assembly, 2007).

An approach to promote the wellbeing of Aboriginal children and families based on self-determination is required to tackle Aboriginal overrepresentation in Victorian Child Protection with a focus and investment on the underpinning drivers of Aboriginal child removal.

Drivers of Aboriginal Child Removals

Aboriginal overrepresentation in OOHC is caused by factors at the Child Protection report stage and post-substantiation decision phase. That is, there are high disparities in reports of concern to Child Protection, and following a substantiation decision, Aboriginal children have a higher probability of a protection application and removal than non-Aboriginal children.

Colonialism, historical and intergenerational trauma as inflicted by the Stolen Generations has interrupted traditional Aboriginal parenting values and practices and left a legacy of social disadvantage that puts Aboriginal children at greater risk of adverse childhood experiences and for being reported to Child Protection (AIHW, 2022; Child Welfare Information Gateway, 2021; Drake, Jonson-Reid, Kim, and Chiang 2021; Mason, Broadhurst, Ward, Barnett, and Holmes, 2022; HREOC, 1997). Implicit bias in the decisions of reporters, and "visibility bias" are also argued to inflate reporting of Aboriginal children to Child Protection.

Aboriginal people also underutilise mainstream prevention and early intervention services, and avoid working with social service professionals, due to "fear of an interventionist system that drives towards the removal of children without offering sufficient supports to families" (SNIACC, 2022, p.23) or because mainstream services are culturally incongruous. The Aboriginal early intervention system is also insufficiently resourced to provide appropriate supports to prevent contact with Child Protection and state intervention to protect Aboriginal children, especially during the perinatal period.

While Aboriginal families and communities are disproportionally affected by traumatic experiences and their associated negative consequence, there is also evidence that features of the current statutory Child Protection system contributes to disparities in Aboriginal child removals. As the Family Matters 2022 report states "the over-representation of Aboriginal and Torres Strait Islander children in out-of-home care has continued to increase at a higher rate than the overrepresentation of Aboriginal and Torres Strait Islander children in cases of substantiated child neglect or abuse" (SNAICC, 2022, p. 12).

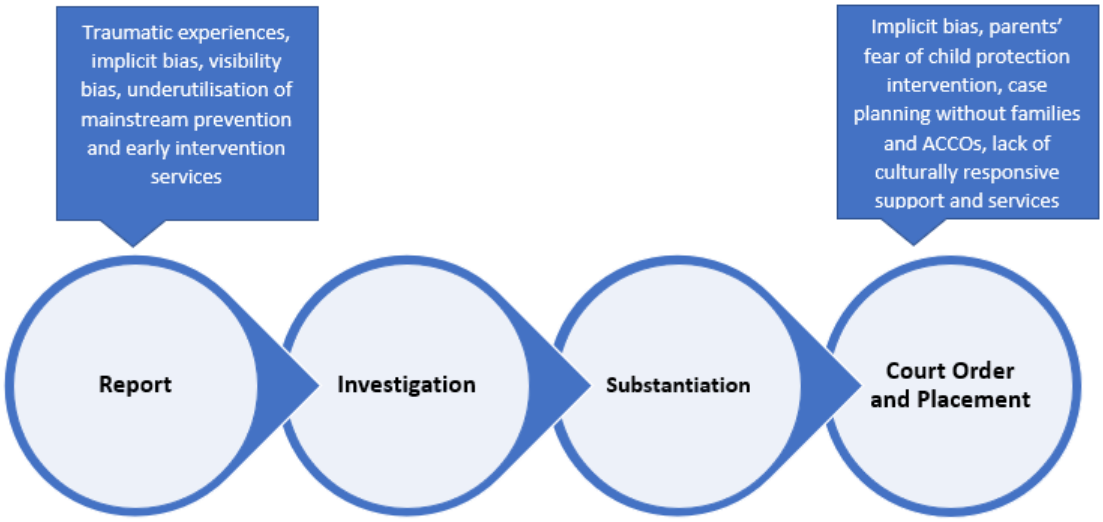
Drawing from the decision-making ecology (DME), studies have shown that caseworkers' personal biases, in addition to case characteristics, play a role in decisions to remove a child from their home (Hollinshead, Currie, Kroll, Feldman, Monahan-Price and Fluke, 2021), and that "illegitimate factors" or implicit racial bias may help to explain why Child Protection authorities are more likely to seek safety for First Nations children through Court orders and removal compared to other children (Keddell, Cleaver, Fitzmaurice, 2021).

Many Aboriginal people also feel anger and hostility toward Child Protection and the agencies and staff associated with Child Protection, and there exists a genuine fear of statutory agencies with the power to remove children (Hinton, 2013; Horejsi, Heavy Runner Craig, and Pablo, 1992). These factors affect how Aboriginal parents react to a Child Protection investigation and interventions concerning serious child safety concerns. Aboriginal parents may behave in ways that obscure signs of safety or strengths within a family, or cause Child Protection practitioners to view them as uncooperative and see this as further evidence of their problematic parenting, which may precipitate Court action and children's progression through Child Protection phases. Parents' fear and distrust also makes it difficult for Child Protection practitioners to develop and sustain supportive relationships with parents as the basis for a protective intervention without a Court order. A lack of informal supports and culturally relevant family preservation services following a substantiation decision, or difficulties and delays in accessing necessary family and community-based supports, may also contribute to Aboriginal overrepresentation following a substantiation decision.

The root causes of Aboriginal overrepresentation in Child Protection are illustrated in Figure 1.

Figure 1:

The Root Causes of Aboriginal Overrepresentation in Child Protection



The Aboriginal Child Protection Diversion Trials

Four Victorian Aboriginal Community Controlled Organisations (ACCOs) have developed three Aboriginal Child Protection diversion program trials to operate either before or during a statutory Child Protection investigation:

- The Aboriginal-Led Case Conferencing Trial (Victorian Aboriginal Child Care Agency (VACCA))
- The Aboriginal-Led Aboriginal Family Decision-Making During Open Investigation Program Trial (Goolum Goolum Aboriginal Cooperative (Goolum Goolum) and the Njernda Aboriginal Corporation (Njernda)) and
- The Garinga Bupup Trial (Bendigo and District Aboriginal Cooperative (BDAC)).

The program trials are funded through the Department of Families, Fairness and Housing (DFFH) Aboriginal Children and Families Innovation and Learning Fund. The program trials aim to:

• Improve parent engagement in culturally responsive services and support to address child safety concerns following a Child Protection report involving an Aboriginal unborn baby/child.
• Prevent the need for Child Protection investigations involving Aboriginal children, Aboriginal child removals and placement of Aboriginal children with non-Aboriginal caregivers.
• Prevent repeat Child Protection reports and investigations involving Aboriginal children.

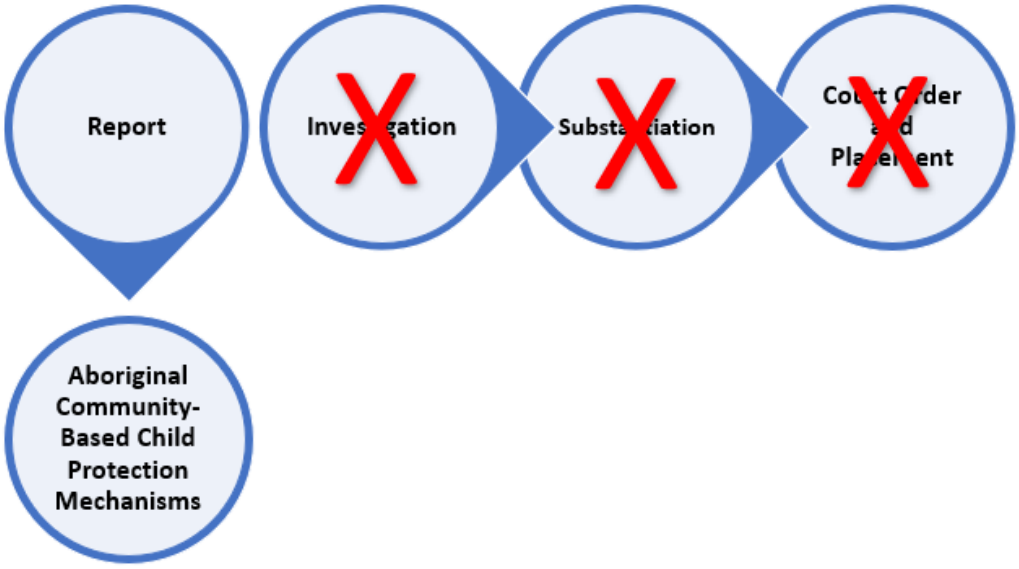
Program Logics, Case Management Approach and Service Blueprints

After detailed service design, each ACCO and Author 1 co-developed a program logic for each program trial, which articulate the inputs, outputs, and outcomes of the implementation process (Appendix B). They were all based on an understanding of the drivers of Aboriginal child removals outlined above and had a similar theory of change; that is, they were expecting to prevent the need for a Child Protection investigation and children's progression through Child Protection phases by creating access to culturally appropriate services and supports following a Child Protection report.[1] To bridge the gap between Aboriginal families and access to culturally appropriate services and supports, Aboriginal Community Based Child Protection Mechanisms (CBCPMs) were put in place. Defined broadly, CBCPMs include all groups or networks at grassroots level that respond to and prevent child protection issues and harms to vulnerable children (Kostelny, Wessells, and Ondoro, 2020) (Figure 2).

[1] Or during an investigation or following a non-substantiation decision in the case of the AFLDM trials.

Figure 2.

Diversion to Aboriginal Community Based Child Protection Mechanisms following a Child Protection Report



The ALCC trial was designed to service a relatively high number of clients for a brief period. Case conferencing was used to develop a family support plan and provide holistic, coordinated, and integrated services across providers. The AFLDM trial also aimed to service a relatively high number of clients for a brief period, using AFLDM meetings to develop a family plan inclusive of natural supports and coordinate services. In both trials, the AFLDM Convenors and the ALCC Convenor were expected to meet with families a few times to resolve issues and act as a link between the parents and other services and supports. Garinga Bupup was a more intensive case management model, where there is a closer relationship with the clients. The Case Manager "walks the pregnancy journey" with the mother over a sustained period and offers them constant support, including ensuring they attend their antenatal appointments. The Garinga Bupup trial also included brokerage funding.

The trials adopted a culturally grounded[2] case practice approach, which integrates traditional cultural activities, practices, customs, interaction styles, symbols, values, and

[2] In culturally grounded interventions, communities design and implement new services from the ground up based on knowledge of the needs and strengths of their people.

beliefs into service delivery. This includes the importance and value of family preservation, extended family, kinship networks, culture, social obligations and community, personal and cultural safety, trustworthiness, respect, empowerment, and choice.[3] ACCO engagements also demonstrate an awareness and understanding of the pervasiveness of trauma, including historical and intergenerational trauma as inflicted on the Stolen Generations, and the negative associations and trauma attached to Child Protection.

The service design for each trial also included consultation with Child Protection if families did not engage in the trial, or if serious child safety concerns could not be managed without support from the statutory agency. The service design for Garinga Bupup, also included pre-birth case conferencing with Child Protection practitioners where necessary for coordination, mitigation, and advocacy purposes. The ALCC trial was also designed to accept referrals from Child Protection Intake after an intake decision in consultation with Lakidjeka.

It was expected that implementation of the program activities would lead to a supportive parent-practitioner relationship, personal empowerment, strong Aboriginal identity, and openness to change and, in turn, connection to culturally appropriate services and supports that would offer safety to children and avoid future investigations, protection applications and removals.

Service blueprinting (Bitner, Ostrom and Morgan, 2008; https://www.vic.gov.au/service-blueprint) was used to present the activities, roles and responsibilities, relationships, and interdependencies of the program trials in a precise and highly specific manner; to make the initial idea more concrete and actionable. Service blueprinting results in a visual picture of the service process that everyone can see and understand. Steps in the service process (the client journey from initial contact to service closure) are mapped out. For each step or stage in the journey, the timeframe, the client's interaction with the service, the actions or tasks undertaken by professionals (seen and unseen by the family) and support processes (tools and systems that support service delivery) are added.

[3] These principles and values overlap with trauma-informed care and relationship-based practice.

Service blueprints were refined over a series of iterations. Author 1 and each ACCO developed a base design involving the service steps on which Child Protection practitioners were able to elaborate and iterate in a series of group conversations and one-on-one meetings. Key design decisions (such as caseload, referral protocols, consultations with Child Protection) were made during design meetings. The final blueprint was used to prepare for implementation by communicating the responsibilities of people across the ACCOs and Child Protection, ensuring that the tools and support infrastructure that need to be developed were ready prior to implementing change.

The three trials are briefly described as follows.

The Aboriginal-Led Case Conferencing Trial

This trial was undertaken by VACCA for 12 months between 27 Sept 2021 and 26 September 2022 in the northeast metropolitan area (NEMA) and the Hume and Merri-Bek area (Banyule, Darebin, Hume, Merri-bek, Nillumbik, Whittlesea, Yarra). Its purpose was to receive reports[4] referred by Child Protection Intake that would otherwise have progressed to a Child Protection investigation. Excluded from the trial were reports where Child Protection assessed that an urgent and immediate investigation was required. Once referred to the trial, a case conference was to be convened to decide on the most appropriate response. A specialist Caseworker (the ALCC Convenor) would engage the family and seek to develop a strategy with the family that would address protective concerns and prevent or minimise the need for a protective intervention.

[4] Reports are usually the entry point for children into the Child Protection System. The notification triggers an intake process where Child Protection practitioners evaluate the report and determine what action to take.

The Garinga Bupup Trial

This trial was undertaken by BDAC in the Central Goldfields, Greater Bendigo, Loddon, Macedon Ranges and Mt Alexander localities. Its purpose was to receive referrals where there were concerns about an unborn Aboriginal child related to their safety and wellbeing after birth early in pregnancy and ideally before Child Protection had opened a case. The aim was for a specialist Case Manager to engage the mother and develop a strategy that would prevent or minimise the need for Child Protection intervention after the baby was born.

The Aboriginal-Led Family-Led Decision-Making Trial

This trial was undertaken by the Goolum Goolum Aboriginal Cooperative (based in Horsham) and the Njernda Aboriginal Corporation (based in Echuca). Its original purpose was to receive referrals from Child Protection where an investigation had commenced but had not yet been completed, with the intention of diverting the matter from the need for further Child Protection involvement. Referrals were also accepted following a non-substantiation decision. This design had to be modified due to a lack of referrals, perhaps because Child Protection more routinely enforced its preferred practice to complete an investigation following the first visit to the family, where possible. The new design focused on receiving referrals from Child Protection Intake via the Aboriginal Child Specialist Advice and Support Service (ACSASS) (in the case of Njernda) and Lakidjeka (Goolum Goolum) services.

To adjust for the lack of referrals from the Child Protection Investigation Team, the AFLDM trial started to accept referrals from the Child Protection Intake Team when cases are closed at intake phase or remain open until a referral has been accepted (wellbeing report), and from Goolum Goolum/Njernda (internal) Family Service, Alcohol and Other Drug (AoD), Early Years (pregnant women) or Healing Programs.

What follows is an overview of the evaluation of the Aboriginal Child Protection Diversion Trials undertaken by Social Work at the University of Melbourne under Aboriginal

leadership[5]. Key findings are outlined and discussed, following by four formative and two summative recommendations.

Evaluation Design and Methodology

The evaluation aimed to address questions relating to effectiveness, acceptability, and feasibility, namely:

1. Was the trial implemented correctly?
2. What were the implementation barriers and enablers?
3. How satisfied were Aboriginal families who received the trial and what features of the trial made a difference?
4. Was the trial successful in achieving its short-, medium- and long-term outcomes?

The evaluation of each of the program trials employed a mixed-methods design, integrating data from different data collection methods. To evaluate the success of the trials in achieving long-term outcomes, child protection case trajectories of "trial children" were compared with "non-trial" children during the implementation period, and child protection case trajectories of all Aboriginal children were compared before and during the trial, using data from the DFFH Client Relationship Information System (CRIS). Other methods used to address the key evaluation questions (KEQs) included parent feedback surveys, secondary analysis of Aboriginal agency client records, and interviews and focus group discussions with implementers/key stakeholders. Each method was analysed separately, then integrated to address KEQs for each trial separately (Appendices C, D and E) and summarised in Table 1 below. Human research ethical clearance for all methods employed in this evaluation was obtained from the University of Melbourne Human Research Ethics Committee (HRE ID #22422).

[5] The responsible researchers were accountable to an Aboriginal Governance Group who was overseeing the evaluation. This Governance Group comprised Aboriginal people from the Victorian Aboriginal Child Care Agency, The Bendigo and District Aboriginal Co-operative, Njernda Aboriginal Corporation and Goolum Goolum Aboriginal Cooperative. The evaluation approach was also developed in co-design with Local Implementation Teams, which included Aboriginal Caseworkers/Convenors from the ACCOs.

Table 1.

Summary of Evaluation Findings

Trial name	Was the trial implemented correctly?	What were the implementation barriers and enablers?		How satisfied were Aboriginal families who received the trial?	What features of the trial made a difference?	Was the trial successful in achieving its ST, MT, and LT outcomes?
		Enablers	**Barriers**			
ALCC trial	Referral from Child Protection intake effective. Targets achieved (n=26). Families held for longer than originally intended, resulting in multiple case conferences and professional care team meetings per case. Referred families (n=37) mostly fitted the inclusion criteria. Families connected to a variety of community services. Five Section 38 consultations completed.	Governance group. Implementation team. Service blueprint. Organisational support (VACCA). Convenor with the appropriate skill and knowledge to implement the ALCC.	Lack of resources (wait times for services, lack of brokerage)[6]. Rules around information sharing between Child Protection, other government departments (e.g., Victoria Police), schools and the ALCC Convenor. ALCC Convenor not having the equivalent powers as Child Protection to be able to request information e.g., corrections orders, L17s.	Very satisfied.	Timely referrals. Support from Aboriginal agency outside Child Protection. Culturally grounded case practice. Proactive, well-executed short-term case management to mitigate the escalation of risk and advocacy across the service system. Strong interface with Child Protection (with Lakidjeka prior to referral, s.38 consultations, and informal consultations).	Very good uptake/utilisation, but not all referred families participated in the trial. High level of cultural safety and engagement. Engagement in community services where there was an identified need. Families rebuilding agency and control over their personal life. Four ALCC children were involved in a re-report (17.4%)[7]. Diversion rate of 78.3% (investigation). Substantially fewer ALCC children were involved in an investigation

[6] Upon identifying this issue VACCA allocated family service brokerage to the ALCC.

[7] Families who did not utilise the ALCC were also re-reported.

Trial name	Was the trial implemented correctly?	What were the implementation barriers and enablers?		How satisfied were Aboriginal families who received the trial?	What features of the trial made a difference?	Was the trial successful in achieving its ST, MT, and LT outcomes?
		Enablers	**Barriers**			
					Ease of referral into VACCA services. Family inclusion in case conferences. Professional care team meetings. Case management based on self-determination (e.g., choice of mainstream/cultural services). Follow-up to ensure referrals led to family involvement.	compared to non-trial children involved in a report during the same period. None of the ALCC children were placed in OOHC, compared to 4.2% of non-trial children. Slight reduction in the % of reports that resulted in an investigation, substantiation and OOHC placement in the trial period compared to the 10 months prior.
Garinga Bupup trial	Referral from community and self-referrals effective. Families fitted the inclusion criteria (early stage of pregnancy, unborn child at risk of future harm), but initially accepted families late in pregnancy and 50% of families were not first-time pregnancies.	Governance group. Stakeholder engagement (Child Protection). Organisational support (BDAC). Implementation team. Caseworker with the appropriate skills and knowledge to	Resources – one case manager insufficient to provide intensive "journey walking" to five+ mothers. Challenges to support women when attending Bendigo hospital for antenatal appointments and for labor and birth.	Very satisfied.	BDAC's knowledge of their community. Culturally grounded, therapeutic approach to engagement. Proactive, well-executed case management. Capacity to communicate child safety concerns and to	Excellent uptake/service utilisation. High level of engagement. Increased utilisation of antenatal care. Engagement in community services where there was an identified need.

Trial name	Was the trial implemented correctly?	What were the implementation barriers and enablers?		How satisfied were Aboriginal families who received the trial?	What features of the trial made a difference?	Was the trial successful in achieving its ST, MT, and LT outcomes?
		Enablers	**Barriers**			
	Higher caseload than originally intended (n=19 families had some engagement with the service). Journey walking extended to hospital stay for birth and after hours/crisis support. Cultural activities implemented as intended (possum skin pelts were made for each baby and Welcome Baby to Country ceremonies took place, although there was some disruption due to COVID-19 restrictions).	implement Garinga Bupup. Service blueprint.			appropriately assess and respond to risk. Journey walking pre- and post-birth. Strong Interface with Child Protection (pre-birth meetings and consultations involving cases open with Child Protection, informal consultations). Low caseload. Brokerage.	Increased cultural understanding and cultural responsiveness at Bendigo hospital. Fewer unborn child reports during the trial than before the trial. Utilisation of Garinga Bupup prevented Child Protection from opening cases during the unborn phase. More reports on Aboriginal babies aged less than one year during the trial than before the trial, however fewer Aboriginal babies aged less than one year entered care during the trial than before the trial. Diversion rate of 62.5% (investigation following birth). Following birth, two Garinga Bupup babies were placed in OOHC (22.2%), although Garinga Bupup remained part of care team and one Garinga Bupup baby was in care under an interim accommodation order for a very short period.

Trial name	Was the trial implemented correctly?	What were the implementation barriers and enablers?		How satisfied were Aboriginal families who received the trial?	What features of the trial made a difference?	Was the trial successful in achieving its ST, MT, and LT outcomes?
		Enablers	**Barriers**			
AFLDM trial	Low number of referrals (n=14) and target of n=30 AFLDMs not achieved (n=5, Goolum Goolum, and n=2, Njernda). Section 38 consultations did not take place on a consistent basis when the family chose not to engage in the trial. AFLDMs implemented as intended.	Governance group. Stakeholder engagement. Organisational support (Goolum Goolum/Njernda). Continuous improvement (re-design). Service blueprint. Implementation team.	Lack of Child Protection impetus to divert Aboriginal children during investigation phase. Poor dissemination of AFLDM trial within Child Protection teams and to Aboriginal families.	Very satisfied.	ACSASS guiding Child Protection on referrals. AFLDM process. Absence of Child Protection during family meetings.	A substantial proportion of non-substantiated families did not consent to referral or were ineligible. Low uptake/conversion of referrals to AFLDMs (56% Goolum Goolum and 40% Njernda). Families that had an AFLDM were connected to services and supports. No difference in Child Protection intervention before and during the trial (but very low numbers of children placed in OOHC).

Synthesis of Findings from the Aboriginal Child Protection Diversion Trials

A synthesis of the separate evaluation findings is presented below to provide a picture of the effectiveness, acceptability, and feasibility of Aboriginal Community Based Child Protection Mechanisms as implemented by VACCA, BDAC, Goolum Goolum and Njernda.

Feasibility: Implementing and Operationalising the Aboriginal Child Protection Diversion Trials

Referral

The referral pathways established for the ALCC trial and Garinga Bupup were implemented as intended.

ALCC Trial.

The ALCC trial accepted referrals from Child Protection Intake. This occurred after the intake decision and consultation with Lakidjeka regarding the appropriateness of referral to the ALCC trial. Parental consent was not required for Child Protection practitioners (intake) to refer to the ALCC trial. Information extracted from the ALCC client records indicates that all (n=37) ALCC families were referred from Child Protection Intake. A VACCA worker said that Child Protection "have been really fantastic ... in referring the cases to [the ALCC trial]", and a Child Protection practitioner said that "VACCA were really responsive" to requests for consultation at intake. Lakidjeka played a major part in prompting referrals and ensuring that referrals met the inclusion criteria and that the ALCC trial was ready to receive referrals.

However, the aim was for the ALCC to contact families within 1-2 days of accepting a referral, and out-of-date, missing, or confusing contact information recorded on the intake report caused delays in contacting parents. A Child Protection practitioner said, "It's really only the intake document that gets sent through. … if that's not updated, then sometimes that's led to complications for [the ALCC Convenor] trying to get in contact with family members and things like that".

Garinga Bupup.

Garinga Bupup accepted referrals from OOHC providers, The Orange Door (TOD) and community, ideally before Child Protection opened a case on an unborn Aboriginal baby. The Garinga Bupup Senior Case Manager said, "A lot of our referrals have come through from self-referrals, community members, internal referrals throughout the BDAC". However, as the program matured, "… the more known it has become, the more outreach we've had regarding our referrals". The Garinga Bupup Senior Case Manager provided an example of how one mother was referred via a BDAC worker, highlighting the role of BDAC's knowledge of their client group:

> She [mother] ran into one of the AFPR [BDAC Aboriginal Family Preservation and Reunification] workers in town and the AFPR then obviously found out she was pregnant and said, "Hey is it okay if I give [Garinga Bupup] your name and number?" ... Mum agreed. And the rest is kind of, history.

AFLDM Trials.

Originally, the AFLDM trial accepted referrals from the Child Protection investigation team if a substantiation decision was not made following the first visit, or if there was an immediate non-substantiation decision and no further action was taken by Child Protection. However, referral from Child Protection Investigation to the AFLDM trial was not successful. A Child Protection practitioner said investigation had started "enforcing the policy of making decisions at the first visit". Child Protection practitioners were also concentrating on their statutory obligations during investigation and were not focused on diversion or dual planning for intervention when conducting first home visits. A Child Protection practitioner said:

> Sometimes we're not very good in the investigation phase at going, "Let's go and do an AFLDM straight away". Instead, we're really focused on the investigation and the concerns and those type of things instead of doing that dual planning about intervention as well at the same time. (Child Protection practitioner)

Child Protection practitioners also saw few "non-substantiated cases sitting in the investigation and assessment phase" (Child Protection practitioner), or reports involving

Aboriginal children that were not substantiated. The CRIS data shows that over ten months of the trial across the two AFLDM trial areas, 119 reports of harm involving Aboriginal children were investigated. Approximately half (n=58) of these investigations were substantiated, which meant these families were not eligible for referral into the program[8]. A Child Protection practitioner also said that certain non-substantiated cases were not referred to the AFLDM trial because parents "refused consent to do the referral … were not in scope for the project due to being ANCOR [Australian National Child Offender Register] reports regarding registered sex offenders … we have not yet finished the investigation … one closed prior to the investigation because the family had moved". In terms of the parents who declined to be referred to the trial, a Child Protection practitioner said that they "Didn't want the agency [i.e., Goolum Goolum] knowing their business".

To adjust for the lack of referrals from the Child Protection Investigation Team, the AFLDM trials started to accept referrals from Child Protection Intake via ACSASS (in the case of Njernda) and Lakidjeka (Goolum Goolum) services when cases are closed at intake phase or remain open until a referral has been accepted (wellbeing report), and from internal Family Service, AoD, Early Years (pregnant women) and Healing Programs.

The referral pathway from Child Protection (Intake) proved to be far more successful than referral from Child Protection Investigation. However, due to the lack of referrals initially, and the need for redesign, over a 12-month period, only 14 families were referred to the AFLDM trials for Goolum Goolum and Njernda combined.

Effort Needed to Sustain Referral Pathways from Child Protection Intake.

While referral from intake was implementable, for both the ALCC trials and the AFLDM trials, Child Protection practitioners said that after initial implementation, their intake teams needed to be reminded about referring families to the trials to sustain the referral pathway.

[8] Business as usual AFLDM meetings should occur for an Aboriginal child within 21 days from substantiation.

Program Targets and Target Group

Program targets for the AFLDM and ALCC trials were 30 for each ACCO. The caseload for Garinga Bupup was five. Both the ALCC trial and Garinga Bupup achieved (or exceeded) program targets. Over a 12-month period, 19 families used Garinga Bupup and 26 families used the ALCC trial. Seven AFLDM meetings were conducted across both AFLDM trials (n=5, Goolum Goolum and n=2, Njernda).

The ALCC trial targeted families requiring immediate and effective intervention to address child safety concerns and avoid statutory action. Evidence from client records and stakeholder testimony shows that ALCC families matched the inclusion criteria, as children were at risk of harm from parental mental illness, family violence, and parental substance misuse and other possibly related concerns such as homelessness, social isolation, environmental neglect, child missing school and inadequate parenting skills. The Garinga Bupup target group was women pregnant with an Aboriginal baby at risk of future harm. First-time mothers were a priority group, and the aim was to identify women early in gestation to provide an opportunity for intervention prior to birth.

The ALCC Convenor said “Generally, people were quite receptive to the trial and giving it a go”. A small number of families accepted into the ALCC trial and did not take part were ineligible (residing outside the service area or were deidentified). However, there were a few families who the ALCC Convenor either couldn’t contact or engage in the program. The ALCC Convenor said, “There were obviously some that declined to participate, which is their right”. It appeared that the families that the ALCC Convenor found hard to contact/engage were reticent to engage with child and family services generally and “are the families we probably could have predicted they [ALCC Convenor] were going to struggle to contact from previous intakes and reports” (Child Protection practitioner).

The profile of mothers who participated in the Garinga Bupup trial mostly matched the inclusion criteria. Garinga Bupup unborn babies were at risk of future harm from serious difficulties requiring intensive case management. The Garinga Bupup Senior Case Manager said, “There was quite a few very high-risk mums. One who had escaped probably one of the worst cases of family violence that I have seen”. Women’s lack of informal support was

highlighted by the Garinga Bupup Senior Case Manager and Child Protection practitioners (Community Based). The Garinga Bupup Senior Case Manager sad, "… we've had other women that have no family support, no real friends that literally are so disconnected and so isolated where I'm in the labour room as a support person while they're birthing". A Child Protection practitioner (Community Based) said, "and a lot of time they're young mothers, they don't have connection to culture, to family – they don't even have a strong friend network …".

On average, mothers were referred into Garinga Bupup in the middle of the second trimester (week 19), allowing a reasonable "intervention window" between the date cases were accepted and the baby's date of birth. However, only half of the Garinga Bupup clients were first time mothers, and early into program delivery, some mothers were accepted into the trial close to their delivery date. This highlights a need for intensive case management for both first-time mothers and those having subsequent babies.

Due to the low numbers and lack of information from client records available for the evaluation, it's difficult to determine the needs of families who took part in an AFLDM meeting. However, the AFLDM Convenor (Goolum Goolum) described one case involving maternal substance misuse and an informal care arrangement with the maternal grandmother, suggesting some AFLDM children were growing up in seriously difficult circumstances (Attachment E).

Case Management and Service Coordination

All three case management models (see above) were successfully implemented, although there were slight departures from the service design in relation to the intensity and length of service for the ALCC trial and Garinga Bupup. For the ALCC trial, the Convenor met with families more times, over a longer period than originally intended because of waiting periods for services such as housing and youth mental health. The ALCC Convenor said, "There's wait lists everywhere. There's a five-year waiting list at the moment [for housing] … and there's a six month wait list for boys to get a mentor …. Mental health support is a big barrier, particularly for teenagers". The mean service episode for the ALCC trial was 121

days. Each case typically involved one or two[9] family-inclusive case conferences to develop a case plan and several professional care team meetings involving services that were engaged in supporting the family.

The mean length of service for Garinga Bupup was 21.5 weeks. However, Garinga Bupup was more intensive than planned, with the Senior Case Manager providing constant, attentive case management, offering support during hospital stays for birth and providing after hours crisis support. The Garinga Bupup Senior Case Manager described an incident involving a mother who was having a mental health episode:

> I found myself starting early in the morning because she'd [mother] had a bad night and her mental health was extremely bad where I'd debated calling Psych Triage. I'd say, "Okay. Look, I'm coming over. We're going to have a coffee, sit down and have a yarn. See what we can talk through". And, around the same time things were escalating with two other mums. So many things seemed to be happening at once. And, as we know, no babies are born between 9:00am and 5:00pm. … So, quite often I have found myself sleeping at the hospital. … I've worked weekends. Where mum's started labour at 6:00am on a Friday morning and we don't have a bub until late Saturday, early Sunday. So, it's been very sporadic with the babies and the times that I'm working. (BDAC Garinga Bupup Senior Case Manager)

Supportive Links with Child Protection

The evaluation established evidence of continuous consultation between the Garinga Bupup Senior Caseworker and the ALCC Convenor with Child Protection practitioners on cases accepted into the trials. For the ALCC, data from VACCA's CSNet client management system indicated that five s.38 consultations[10] were initiated, and a Child Protection report was made by the ALCC Convenor in four cases (approximately one in five cases). The ability to discuss cases with a specialist Child Protection practitioner, glean more information and come up with strategies for families at the point of a re-report was of great assistance to the ALCC Convenor:

[9] Where conferences were convened for mothers and fathers separately.

[10] Registered family services can consult with Child Protection at any time under s.38 of the CYFA.

> I found [the Section 38 consultations with the Child Protection practitioner] really helpful even if it was just discussing the families with [Child Protection practitioner] and then she'd say to me, "But have you tried this? Have you contacted this person? Can you give this a go?" or she could look up that extra information on their computer and come back to me and give me some more information or more strategies. So, to me, that was invaluable. It was really good. It made the difference with some families about whether they went back in or whether I pursue a bit more. (ALCC Convenor)

The Garinga Bupup Senior Caseworker was also very proactive in consulting with Child Protection practitioners when a case was open with the department[11], or when the mother was unclear about Child Protection involvement. A pre-birth meeting was convened in two cases. The Garinga Bupup Senior Case Manager said:

> That's generally a meeting with Child Protection, Bendigo Health, any other support services they may have. Whether that's AoD or mental health or family violence support. Where we all come together with the family around a big table, and we all talk about "These are the concerns that's brought us here today. … This is what each worker is doing. These are our roles. This is what we're accountable for. Is there anything else you need us to be doing for you? What else can we do? What else can your family do? What are you responsible for? What are your strengths?"

For the AFLDM trials, a risk-based consultation should have been initiated if a family chose not to engage in the AFLDM trial to determine a course of action (e.g., re-report to Child Protection Intake or support to contact the family). While there was evidence that s.38 consultations had occurred, not all Child Protection practitioners "had that interface with [the Goolum Goolum or Njernda trial convenors]".

Implementation Enablers

The Aboriginal Child Protection Diversion Trials incorporated several factors that increased the probability of successful implementation.

[11] For example, where the unborn child had older siblings open with Child Protection (part of sibling group).

Aboriginal Leadership and Organisational Support

Within ACCOs, there was strong and effective leadership, an innovation culture, and internal structures, systems, policies, and procedures that aligned with the trials, such as case practice frameworks, policies, procedures, client recording systems and case management supervision. ACCO internal programs also provided referral pathways for Garinga Bupup and the AFLDM trials, and enabled families to connect with services in a timely way. The ALCC Convenor said, "The other valuable relationship to the program has been with VACCA's Family Services Team. It was great to be able to have that support immediately available for families". An Aboriginal governance structure was also established prior to implementation. The Governance Group was chaired by an ACCO staff member, and all four Aboriginal agencies were represented in the group.

Implementation Planning

There was considerable planning before implementation. As discussed above, service blueprinting was undertaken, and program logics were developed for each trial. Governance and accountability structures, including a Governance Group and Local Implementation Teams, were also outlined before implementation.

Implementation Teams

During implementation, teams were established at the local level to oversee, support, and attend to implementation managed by a dedicated Project Coordinator. Local Implementation Teams met on a fortnightly basis initially, then moved to monthly.

Continuous Improvement.

Feedback provided during implementation team meetings provided important information about the operation of the trials to track progress and support continuous improvement. This was most apparent for the AFLDM trials, which were not receiving referrals from Child Protection (Investigation) during the initial stage of implementation. Feedback was used to make changes to the referral pathway to improve the service design.

Child Protection Engagement and Support.

Child Protection was involved in the Aboriginal Child Protection Diversion Trials as a funder and implementer (Child Protection practitioners (intake) referred families to the ALCC and AFLDM trials and conducted risk-based consultations with ACCO Case Manager/Convenors). The Aboriginal Child Protection Diversion Trials were funded through a DFFH Aboriginal Learning and Innovation Grant, and as stated at the outset, the trials were developed within the overall context of a reform strategy aimed at increasing Aboriginal self-determination and self-management where child safety concerns are identified in Aboriginal families. Consequently, there was a high level of commitment from Child Protection for diversion of Aboriginal children away from Child Protection and encouraging community-based resolutions. Even despite faults in the initial design of the AFLDM trials, a Child Protection practitioner said, "we definitely need an intervention [diversion] program". A Child Protection practitioner involved in the implementation of the ALCC trial also said:

> I think the biggest thing for me is that a family is getting every opportunity to avoid a Child Protection response, to have Child Protection knocking on their door for maybe the fifth, sixth time. That we are creating a pathway for them that, hopefully, does not involve a government body coming and landing on their doorstep.

As an implementer, Child Protection was in involved as a partner in the design and delivery of the trials under Aboriginal leadership and joined the Local Implementation Teams to help oversee and support the implementation process. During the design process, Child Protection help develop strategies to address pre-identified implementation barriers. For example, they recognised that Child Protection practitioners (Community Based) had limited capacity to support the ALCC Convenor during the trial and nominated a Child Protection specialist who was supporting implementation of the Aboriginal Children in Aboriginal Care (ACAC) program to perform this function instead.

The ACCOs also said that Child Protection was very supportive operationally. The Garinga Bupup Senior caseworker said, "The advocacy for this program has been so strong from Child Protection and they have put a lot of faith into my assessment and support around the families". As mentioned above, the ALCC Convenor said that Child Protection practitioners

(intake) were “really fantastic” referring cases into the ALCC trial, and the ability to discuss cases with the Child Protection specialist was of great assistance as well.

Staff with Skills and Knowledge to Manage Cases Where There Are Child Safety Concerns

Successful implementation of the trials was attributed to the skills and experience of ACCO Case Manager/Convenors. Aboriginal families targeted for diversion are cases where there are current concerns for children’s safety, requiring a timely and effective response to manage and reduce risk of harm to children.

In relation to the ALCC trial, a Child Protection practitioner said that “It needs to be an experienced person in that position. They’ve got to be comfortable with going and knocking on a door, potentially, and saying, “Hi, how are you going? Haven’t got you on the phone”. A VACCA worker also said, “you need somebody that shows initiative with getting the work done”.

A Child Protection practitioner also indicated that they needed to have confidence that the Garinga Bupup Senior Case Manager could appropriately manage cases where there is a risk of harm to children, saying “before this program, we wouldn’t have sat with that level of risk, because there’s no eyes in there, whereas you’ve got [Garinga Bupup Senior Case Worker] in there – she’s quite experienced, especially with working with pregnant women …”. The Garinga Bupup Senior Caseworker also said that “a really strong sense of risk assessments and risk to children is something that has to be understood to work in a program like Garinga Bupup”.

Implementation Barriers

While implementation of the trials was enabled in important ways, there were some challenges to implementation because of a lack of stakeholder engagement and resources.

Some Stakeholders Not Informed of the Trial Pre-Implementation

Garinga Bupup and the AFLDM trials did not engage all stakeholders essential to implementation during the preparation and planning stage. For Garinga Bupup, Bendigo Health (provider of pregnancy and postnatal care services in the Garinga Bupup service

area) was not involved in design, and relevant staff did not have good awareness of the trial initially. This, combined with visitor restrictions relating to the COVID-19 pandemic, created challenges for the Garinga Bupup Senior Case Manager to support women's contact with antenatal care, and during labour and birth:

> There were some challenges unfortunately due to the visitor restrictions through COVID in our atrium. We had to iron out some of our processes to facilitate [the Garinga Bupup Senior Case Manager] attending with women through the antenatal phase but also through birthing because we felt it's incredibly important that [she] is present when the women wish for her to be there. Otherwise, this wouldn't have been a concern in normal times, the challenges with their only facilitating one support person through the antenatal phase and birthing suite. But we were able to facilitate [Garinga Bupup Senior Case Manager]'s attendance. We issued her with the exemption pass to be able to permit her into the hospital to be with women. I think if it had been not a global pandemic and we didn't have visitor restriction in place, it would've been more seamless. We did get there in the end. But I think we did cause some unrest initially. (Bendigo Health Worker)

It was also mentioned during focus group discussions that Aboriginal communities served by Goolum Goolum and Njernda were not informed about the AFLDM trials, and that this may have contributed to reticence about agreeing to a referral. For example, a Child Protection practitioner reflected that Njernda and Goolum Goolum need to be "providing families with more information about the pilot".

Insufficient Resources

It was also apparent during the implementation phase that Garinga Bupup and the ALCC trial could have benefited from additional resources. During interviews and focus group discussions, it was mentioned that there was no one to step in for the Garinga Bupup Senior Caseworker when she was unavailable. Several people also mentioned that Garinga Bupup did not have capacity to meet demand, and that there were several pregnant women who were on a waiting list for the service.

CRIS data shows that in the ten months between 1 November 2021 and 31 August 2022, 24 Aboriginal children aged less than one year were the subject of a Child Protection investigation in the Garinga Bupup service area. During this period, ten unborn Aboriginal children were reported to Child Protection. Five of eight Garinga Bupup babies also had a CRIS number, indicating considerable overlap between Child Protection and Garinga Bupup cohorts. Taken together, these data suggest that there is relatively large number of Aboriginal babies aged less than one year investigated by Child Protection who are neither reported to Child Protection as an unborn child nor involved with Garinga Bupup. Although it is uncertain whether safety concerns were present during pregnancy or not, it supports the idea that there is unmet demand for an expanded perinatal diversion program in the Bendigo region.

Child Protection practitioners and the Garinga Bupup Senior Caseworker proposed similar team structures for an expanded future Garinga Bupup program:

> I think it would work best … to have myself, another two [case] managers, and a case support [worker]… So, that – it would be like, a three-week rotating roster between myself and the other two managers. So, we would have a week of being on call each. (Garinga Bupup Senior Case Manager)

> I would say that at least two more staff would be really handy, because then I think you would see that change in the intervention, because you'd have a team – when you're talking about a team and you're talking about being at the hospital all the time and being within the Department and other service agencies, then your voice gets heard across the Bendigo region, and then the program may have that bit more of an impact with the intakes or reports coming through, because we're all aware of this program, but I'd be really mindful of who else within the Bendigo region is really aware and understands fully what this program is. (Child Protection practitioner)

The ALCC Convenor also said that brokerage would enhance engagement, support, and outcomes for Aboriginal families on the cusp of a Child Protection investigation:

> It would be handy I think for that initial visit to have a brokerage component to the program so you can go out with a $50 food voucher. That will always get you in the

> door. Or, if there's immediate needs, if there is that waiting period, that we are able to support them financially for a little bit before they're picked up by another program. I think that's important because generally, as we know, when families are reported to Child Protection, financial strain is one of the biggest things that I've noticed. (Aboriginal-Led Case Conference Convenor)

The ALCC Convenor said, "There's wait lists everywhere. There's a five-year waiting list at the moment [for housing] … and there's a six month wait list for boys to get a mentor …. Mental health support is a big barrier, particularly for teenagers". Another VACCA worker agreed that "Youth mental health is probably the most standout one for wait times". A VACCA worker said, "if the referrals were accepted sooner, then we would have less families going back to or entering the Child Protection system. A Child Protection practitioner said, "Having the resources in the community. That was a bit of a barrier, particularly earlier on".

Acceptability: Family Experience of the Aboriginal Child Protection Diversion Trials

A client feedback form was developed for each trial to capture feedback about the client's emotional and cultural safety and satisfaction during their episode of care. For the ALCC trial and Garinga Bupup, emotional and cultural safety was measured using the same six items rated on a 5-point Likert scale (higher scores indicate higher emotional and cultural safety). Sample items include "I felt comfortable and at ease" and "My caseworker considered my cultural needs". As shown in Table 2 below, the mean scores for both programs were 4.5, indicating that parents felt a high level of emotional and cultural safety during their episode of care.

Table 2.

Emotional and Cultural Safety

	Number	Mean (Standard Deviation)	Minimum	Maximum
Garinga Bupup	6	4.5(.3)	4.3	5.0
ALCC trial	11	4.5(1.2)	1.0	5.0

Note: Range 1-5, higher scores indicate higher emotional and cultural safety.

For the AFLDM trials, emotional and cultural safety during the AFLDM meeting were measured using eight items rated on a 5-point Likert scale. Items included “Things were done in an Aboriginal way” and “I did not feel judged based on my culture”. The mean score from the two completed forms was 5.0, also showing a high level of emotional and cultural safety during the AFLDM meetings. AFLDM Convenors said the absence of Child Protection practitioners made Aboriginal families feel comfortable during the meetings. The Goolum Goolum AFLDM Convenor said that one mother felt that “having everyone present around the table made her feel very supported”. An Aboriginal process also created an emotionally and culturally safe context for Aboriginal family members to attend meetings, acknowledge concerns, and identify ways that they could support children’s safety and wellbeing. The Njernda AFLDM Convenor indicated that the AFLDMs resulted in family plans that “identified family members who could provide support”, such as “providing respite” for a mother with five children.

The Client Satisfaction Questionnaire (CSQ-8) was included on the ALCC and Garinga Bupup feedback forms (Larsen, Attkisson, Hargreaves, and Nguyen, 1979) by permission of the copyright holder. This is an eight-item scale rated on a 4-point Likert scale (higher score indicates higher satisfaction). Response descriptors vary. The mean score for Garinga Bupup and the ALCC trial was 3.8 and 3.6 respectively, indicating high satisfaction with both programs (Table 3). For the AFLDM trials, satisfaction with the AFLDM meeting was measured using eight items developed specifically for the evaluation rated on a 4-point Likert scale (higher score indicates higher satisfaction). Items include “Did the Convenor do a good job of running the meeting?” and “Are you satisfied with how much you were

listened to?". Response descriptors vary. The mean score for the two completed feedback forms was 4.0, again indicating high satisfaction.

Table 3.

Service Satisfaction

	Number	Mean (Standard Deviation)	Minimum	Maximum
Garinga Bupup	6	3.8(.4)	3.0	4.0
ALCC trial	11	3.6(.5)	2.3	4.0

Note: Range 1-4, higher scores indicate higher satisfaction.

Effectiveness: Outcomes from the Aboriginal Child Protection Diversion Trials

Diversion from Child Protection Investigation

The aim of the ALCC trial was to divert Aboriginal families from a Child Protection investigation immediately following a Child Protection notification that met the threshold for further action. Garinga Bupup aimed to avoid Child Protection opening a case pre-birth and conducting an investigation following birth. The original aim of the AFLDM trials was to divert Aboriginal children from progression through Child Protection phases (protection application and OOHC), promote community-based resolutions to child safety concerns and, if care was necessary, ensure compliance with the Aboriginal and Torres Strait Islander Child Placement Principle (placement hierarchy) (SNAICC, 2017). In the redesign, the AFLDM trial also aimed to divert Aboriginal children from Child Protection investigation and encourage family- and community-based responses to child safety issues and needs.

The ALCC achieved a diversion rate of 78.3%. That is, of the 23 ALCC children followed in CRIS until 31 August 2022, five were investigated. A substantially lower proportion of ALCC children were involved in an investigation between 1 November 2021 and 31 August 2022

compared to non-trial (reported) Aboriginal children[12] during the same period (5(21.74%) compared to 344(34.2%))[13]. None of the five ALCC children who were assessed as requiring further investigation were placed in OOHC, compared to 4.2% of non-trial children[14] (Appendix B).

Garinga Bupup achieved a diversion rate of 62.5%. That is, three of eight Garinga Bupup children were subject to an investigation following birth (five investigations avoided). All three investigated Garinga Bupup babies were substantiated, and two entered care, although one baby was placed in care under an interim accommodation order for a very brief period before being returned to the custody of the mother (Table 4).

It is difficult to establish a comparison group since Garinga Bupup accepted community referrals (as opposed to referrals from Child Protection), and not all unborn reports to Child Protection meet the threshold for further action. However, over ten months of the trial (1 November 2021 – 31 August 2022), there were eight non-trial children[15] involved in an unborn report to Child Protection. Four of these children were involved in a report to Child Protection following birth (and an additional child was involved in two s.38 consultations). All four non-trial children aged less than one year involved in a report were investigated (a diversion rate of 50%). The four investigations resulted in three protection applications and one OOHC entry (see Table 4 below).

[12] Non-trial Aboriginal children are Aboriginal children reported to Child Protection during the CRIS observation window (1 November 2021 to 31 August 2022) who did not take part in the ALCC trial.

[13] When comparing investigation rates of trial and non-trial children, it's important to note that all ALCC children met the threshold for further action, while most notifications (64% nationally) are dealt with by other means (AIHW, 2022).

[14] It should be noted that some ALCC children may have been involved in an investigation prior to their involvement in the ALCC program.

[15] Non-trial children are unborn Aboriginal children reported to Child Protection during the CRIS observation window (1 November 2021 – 31 August 2022) who were not part of Garinga Bupup.

Table 4.

Comparison of Garinga Bupup Children and Non-Trial Children Reported to Child Protection as Unborn Children

	Open case during pregnancy	Unborn child report	Child report	Investigation	Substantiation	OOHC
Garinga Bupup Children	8	5	3(37.5%)	3(37.5%)	3(37.5%)	2(25.0%)
Non-trial children involved in an unborn child report	Unknown	8	4(50.0%)	4(50.0%)	3(37.5%)	1(12.5%)

Due to a lack of parental involvement[16] in the evaluation, it was not possible to follow up children involved in the AFLDM trial to determine whether they were subsequently involved in a Child Protection investigation. However, aggregate CRIS data suggests that there was no difference in the proportion of reports that progressed to investigation over ten months during the evaluation period (1 November 2021 to 31 August 2022) and for the first ten months of the 12 months prior (1 November 2020 to 31 August 2021) (34.3% and 33.1% in the Goolum Goolum area and 37.9% and 32.9% in the Njernda area). However, during interviews with AFLDM Convenors, there was evidence that families were following Family Plans developed during the AFLDM meetings and were resolving child safety concerns without support or involvement from Child Protection. The Njernda AFLDM Convenor said that “clients are still engaging with the supports I've put in place for them”. The Goolum Goolum Convenor highlighted one Family Plan that had avoided a Child Protection investigation. In this case the Family Plan involved a voluntary Aboriginal kinship care arrangement with contact by agreement, and ongoing support from the Goolum Goolum alcohol and drug worker.

[16] Parental consent was required to access CRIS data for individual cases.

Return on Investment from the Aboriginal Child Protection Diversion Trials

While there are considerable non-monetary benefits of diversion from Child Protection and implementation of Aboriginal CBCPMs, the economic costs of the Child Protection system are significant. In 2020-21, government expenditure on all protective intervention and care services was $1.27bn (SCRGSP, 2022, Table 16A.8). The annual Report on Government Services (RoGS) sets out the costs for different Child Protection activity groups for Victoria (https://www.pc.gov.au/ongoing/report-on-government-services/2022/community-services/child-protection). The application for the Aboriginal Children and Families Innovation and Learning Fund Grant also included (conservative) costs for delivery of the trials for a 12-month period.

Assuming conversion rates from one Child Protection phase to the next, set out in Appendix G[17], and that the cost of each Child Protection phase for an Aboriginal child is the same as for the average child, and if Child Protection case trajectories do not involve subsequent reports and investigations, every ten investigations prevented by the ALCC potentially saves $370,350. As the ALCC trial prevented 18 investigations in 10 months, or on a projected basis, 22 investigations in 12 months, the annual cost savings is potentially $777,735. The total cost of the ALCC trial for 12 months was $162,459. This means that the ALCC program can yield a $5 return per $1 invested.

For Garinga Bupup, the same assumptions regarding costs per phase and case trajectories were applied, although return on investment was calculated in terms of unborn reports prevented, due to the lack of time to follow-up Garinga Bupup babies after birth. The calculated savings in preventing ten unborn reports was $192,965. On a projected basis, Garinga Bupup prevented 17 unborn reports in 12 months[18], indicating an annual cost

[17] Broadly that there is one OOHC placement for every 10 investigations, or .5 placements for every 10 Child Protection intakes.

[18] Over the first seven months of the trial, only five Garinga Bupup children had a CRIS number after three months following the Garinga Bupup acceptance date (indicating an unborn child report). CRIS data also indicates that there were 12 fewer unborn children reported to Child Protection during 10 months of the trial (n=10) compared to the 10 months immediately prior (n=22).

savings of $328,041. The total cost of the Garinga Bupup trial for 12 months was $159,500. This means that Garinga Bupup can yield a $2 return per $1 invested.

Achievement of Outcomes During the Trials

While the three trials implemented slightly different case management models, the theoretical path towards diversion was very similar. All three trials anticipated diversion from Child Protection investigation would follow safe, empowering and trusting relationships between parents and ACCO Convenors/Case Manager, parental empowerment/openness to change and connections to culturally safe and responsive services and supports.

Safe, Empowering and Trusting Relationships

A feature of the Aboriginal Child Protection Diversion Trials that distinguishes them from Child Protection was the ability of ACCO Case Manager/Convenors to establish safety and meaningful engagement with parents, whereas fear and distrust of Child Protection often makes it difficult for Child Protection practitioners to develop and sustain supportive relationships with Aboriginal parents. A Child Protection practitioner involved in the implementation of Garinga Bupup highlighted this point, saying "It's about making the mother feel comfortable, and they don't want Child Protection in there telling them, whereas if they've got [Garinga Bupup Senior Case Manager] addressing any concerns that we may have, the meeting runs so much smoother".

Feedback from parents highlight their positive experiences with ACCO Case Manager/Convenors. Two Garinga Bupup mothers provided a response to the open-text question about positive experiences included on the client feedback form. Both mothers expressed gratitude for the Garinga Bupup Senior Caseworker, saying "our caseworker was amazing" (id#1) and "love my worker" (id#2). Several parents also commented on the ALCC Convenors' engagement approach saying, "[ALCC Convenor] made me feel safe and my feelings valid" (id#11), "so kind and lovely and so helpful with everything" (id#8), "very supportive and understanding" (id#4), and "really supportive" (id#5).

All the women referred to Garinga Bupup accepted the service. A Child Protection practitioner said:

> I don't think she's [Garinga Bupup Senior Case Manager] had any disengage, to be honest, even the one that we had come through as a report once mum birthed – despite the Department having to go and intervene legally, that young mum still reached out to [Garinga Bupup Senior Case Manager], still wanted her to be a part of the care team, so despite that outcome, they were still wanting to engage.

The Garinga Bupup Senior Case Manager completed an 11-item survey on nine Garinga Bupup family's engagement with the program. Items include "[mother] sees that her family needed some support" and "[mother] believes BDAC is supporting her family to get stronger" rated on a 5-point Likert scale (high scores indicating greater engagement). The mean engagement score for the nine cases was 4.5, indicating a very high level of engagement with the service. During interview, the Garinga Bupup Senior Case Manager said:

> All my mums have engaged beautifully. They've all been fantastic. I haven't had one that hasn't wanted to engage. I haven't had a mum yet that hasn't been appreciative and thankful for the support that we've been able to provide for mum. Not just through pregnancy but making sure the baby has all the baby needs.

The Garinga Bupup Senior Caseworker also highlighted the close "family-like" relationship that she formed with mothers, saying "It all has a big family feel about it. Everybody feels connected, welcome and supported".

Features of the Trials that Fostered Safe, Empowering and Trusting Relationships

There were several features of the trials that enabled safe, empowering, and trusting relationships, including voluntary relationships and an Aboriginal service provider, culturally grounded practice encounters, and brokerage.

Voluntary Relationships and an Aboriginal Service Provider

Many Aboriginal people fear, and distrust Child Protection and the agencies and staff associated with Child Protection. Child Protection cases are involuntary, and opposition to

Child Protection involvement makes it difficult for Child Protection practitioners to develop and sustain supportive relationships with parents in casework so that steps can be taken to reduce risk to the child. ACCOs, on the other hand, do not pose a threat to parents like Child Protection, and there is not the inherent power imbalance. ACCOs also deliver services that integrate practices that are commensurate with Aboriginal values, beliefs, and worldviews, which affords them a beginning level of cooperation as the basis for building helpful relationships.

Culturally Grounded Practice Encounters.

Participants in the qualitative interviews and focus group discussions connected practices based on the Aboriginal cultural values of respect, choice, and empowerment with the development of safe, trusting, and empowering relationships.[19]

Spending Time.

Respect includes taking time, and ACCO practitioners allow time to build trust and meet families where they are at, working at the family's pace. Child Protection practitioners highlighted the role that spending time had in developing and sustaining trusting relationships between the Garinga Bupup Senior Case Manager and mothers:

> [Garinga Bupup Senior Case Manager has] really spent that time forming that relationship, that trust – a lot of the time, she's been in the birthing suite with these mums, and I just think back to my birth – that's some big trust, having a service in the birthing suite with you while you're having your baby. I just think that speaks volumes for the relationships she's formed with these mums … . (Child Protection practitioner)

[19] Yarning as an approach to communication was also evident in the Garinga Bupup Senior Case Manager's response to an incident involving a mother who was having a mental health episode, where:

> I found myself starting early in the morning because she'd [mother] had a bad night and her mental health was extremely bad where I'd debated calling Psych Triage. I'd say, "Okay. Look, I'm coming over. We're going to have a coffee, sit down and have a yarn. See what we can talk through".

> One of the reasons that [the Garinga Bupup Senior Case Manager]'s been so successful is that she's walked alongside these women for extended periods of time … I think the vital role is that [the Garinga Bupup Senior Case Manager]'s always the constant. (Child Protection practitioner)

Work outside regular daytime hours, and the extended hours, was also observed by the Aboriginal Health Liaison Worker:

> [Garinga Bupup Senior Case Manager] was there for her for the birth as well and ran off three- or four-hours' sleep. It was a 20-something hour day for her, and she was back the next day providing support with some food and accommodation for the person who was able to look after her young son for the night.

Support Based on Choice and Empowerment.

Across all trials, support was based on choice and empowerment, which means services supported parents' ability to make their own choices, or decisions regarding their family's path away from Child Protection and use a strengths-focused perspective that leverages from existing resources. The Garinga Bupup Senior Case Manager said a key aim of the service was to build empowerment for women pregnant with an Aboriginal baby, recognising that fear of Child Protection and mainstream services affected their engagement with health and social care. The Garinga Bupup Senior Case Manager said:

> I think over time being able to empower and show women that they are a great mum, or they are doing a great job, or they have nothing to fear because you're not doing anything wrong. You're doing all these wonderful things. So, even if the hospital did ring and say, "I'm worried about mum's mental health report" we can always say, "But mum's engaged with the mental health worker or she's gone to the GP for a mental health plan".

The ALCC Convenor demonstrated choice in service delivery by mentioning that whether families were connected to cultural or mainstream services was their choice, saying "I think we were [successful in engaging cultural services] for those who wanted it. Some families didn't want to be engaged with cultural services. They were happy to go mainstream and

preferred that, which was their choice. So, where they wanted it, I think we worked pretty well towards that".

Brokerage.

Being able to tailor a response to the mother's practical needs, helped to create a relational connection between the Garinga Bupup Senior Case Manager and mothers. The Garinga Bupup Senior Case Manager said, "just being able to take mum up to the Big W and let them choose new outfits for bub. To me, that's highly rewarding, and I think it's really positive rapport building as well with the families".

As indicated above, the ALCC Convenor also said that brokerage would enhance engagement, support, and outcomes for Aboriginal families on the cusp of a Child Protection investigation.

Aboriginal Cultural Practices and Rituals.

Each trial also included traditional Aboriginal cultural practices, and ritual participation in service delivery, including the gifting of a possum skin cloak, Welcome to Country ceremonies (Garinga Bupup) and decision-making processes grounded on the traditional community such as the involvement of extended family and Elders (ALCC trial and AFLDM trial). The ALCC trial also actively linked families into cultural services to enable discovery of identity and/or support and nurture already established cultural connections.

As well as creating comfort in service settings and fostering supportive relationships, incorporating Aboriginal cultural rituals and customs in service delivery, reconnects families to traditional childrearing responsibilities, fosters a strong Aboriginal identity, and strengthens cultural connections which, in turn, has been associated in the literature with becoming or being empowered (Dudgeon, Bray, Blustein, Calma, McPhee, Ring, and Clarke, 2022; Tsey, Whiteside, Haswell-Elkins, Bainbridge, Cadet-James, and Wilson, 2010).

Self-Determination and Openness to Change

Culturally attuned engagements with ACCO Case Manager/Convenors described above provide parents the experience of safety, authentic connection, and an understanding of their strength areas.

There was evidence of demonstrable impact of the trials building self-determination, or belief in one's ability to exert control over life circumstances, and openness to change and the outcomes identified in the literature that have been associated with becoming or being empowered including increased self-worth and hope. Two mothers provided specific examples of improvements since the Garinga Bupup Program. These were "my partner has reached out to his extended family and culture because of the experience with BDAC" (id#1), and "support, confidence, and self-esteem" (id#5). The Garinga Bupup program also improved one mother's confidence in interactions with Child Protection. A Child Protection practitioner said that the Garinga Bupup Senior Case Manager "... helps the mum feel, I suppose, empowered to be able to have particular conversations with the Department …".

The ALCC Convenor said that "having parents realise that they can make a change themselves" was one of the most rewarding aspects of the trial. The ALCC Convenor also provided examples of how the trial was supporting families to rebuild agency and control over their personal life:

> I think for a lot of families it was about knowing where to go for help too. I can't tell you how many times I've had people say to me, "I didn't realise that VACCA had all those services". So, it's about that education and then empowering them to reach out for that support which a lot of them did. If we'd closed or they'd ring me and ask for something I'm like, "If you give this person a call, they'll be able to help you," and they would. There were some people that said to me it was great that I empowered them to be able to ask for help, that there's nothing shameful about asking for help and that it's better to ask for help in the first instance than have everything fall apart and then end up with a report. (ALCC Convenor)

Features of the Trials that Fostered Self-Determination and Openness to Change.

Honesty About Risks to Children.

In addition to establishing trustworthiness, Garinga Bupup and ALCC implementers both said that honesty about the risks to children, was central to parents' acceptance and conscious awareness of the need for change to avoid Child Protection involvement and keep children safe:

> I find that being honest and being direct. And I suppose in some sense there's some bottom lines around you know, we have this program, and the program design is this. But without this program and if you're not attending your appointments and we're not doing these things, chances are that Child Protection may become involved. And I don't want to see you go down that track. I feel that's what's keeping the transparency within the program. I think that's what keepings families engaged. (Garinga Bupup Senior Case Manager)

> The ALCC program … can engage with the families and say, these are the things you need to do, A, B and C, so Child Protection can back off and then we're all here to support you to do this. I think that was a real positive. (VACCA Family Services Worker)

> I think being honest, telling them about the program, telling them what the idea of the program was and how we were trying to prevent them entering an investigation phase with Child Protection. I think just being honest about it was the best way and encouraged that engagement … . Not promising them anything you cannot deliver. I constantly heard that. "Are you going to promise all this stuff that you're not going to deliver like they have before"? (ALCC Convenor)

Connections to Services and Supports

Feeling empowered, Aboriginal families were connected to services and supports aimed at reducing risks to children. For the ALCC, families were referred to VACCA Family Services, VACCA Family Violence program, VACCA Koori Families and First Educator program, VACCA Wilam Housing, Noogal Clinic, Austin Health CYMHS, Barreng Moorop, VACCA Koorie Kids,

Navigator program, Elizabeth Morgan House, schools, and public hospitals, AoD service (detox/rehab), NDIS, and Dardi Munwurro (youth service).

A Child Protection practitioner also commented on the ability of the ALCC Convenor to connect families to services:

> I think once they've engaged, then that's been really quite strong in terms of the connections and the support they've afforded. I know that they've had Family Services. I know they've worked with the VACCA family violence program. So, there's a whole range of things under their umbrella, which makes it really easy then to coordinate. I know if I'm sitting at VACCA, I can go to [the ALCC Convenor]. [The ALCC Convenor will] go, "Hang on. We can go and grab the family support services person," and you can all sit in the same space and talk. I think having that connection has been really good. I do think that [the ALCC Convenor] been able to make those referrals to services which have resulted in engagement. (Child Protection practitioner)

A Bendigo Health Worker observed better engagement in antenatal care because of the continuity of support provided by the Garinga Bupup Senior Case Manager, saying "I think with [the Garinga Bupup Senior Case Manager], women were far more engaged in antenatal care, much more willing knowing that they had somebody as a consistent support person and that continuity".

The Bendigo Health Worker went on to say that there was better "attendance at appointments, ultrasounds and pathology" and "that those tests and interventions were far better received in terms of labour management for all women, again, having that consistent continuity of your support person or care provider". In the postnatal phase, the same Bendigo Health Worker felt that "knowing that there was a circle of safety around women and babies certainly made the midwifery staff feel that there were supports in place".

The Aboriginal Health Liaison Worker (Bendigo Health) provided an example of the support provided by the Garinga Bupup Senior Case Manager during labour and birth, saying "She [mother] was so grateful for [the Garinga Bupup Senior Case Manager]'s support and I

honestly don't think she would have stayed in hospital if it wasn't for [the Garinga Bupup Senior Case Manager]'s support.

Features of the Trials that Fostered Connections to Services and Supports.

In addition to self-determination and openness to change, there were several aspects of the trials that fostered connections to services and supports, including case conferences/AFLDMs, connections to internal ACCO programs, and proactive casework to support families to take steps toward change and ensure that referrals had been followed through.

Case Conferences and Aboriginal Family-Led Decision-Making Meetings

Case conferences and AFLDM meetings were effective coordination processes to develop family plans and connect parents to services and support. Each ALCC case typically involved one or two[20] family-inclusive case conferences to develop a case plan and several professional care team meetings involving services that were engaged in supporting the family. The AFLDM trials also engaged Aboriginal extended family and community members in resolving problems and supporting families. As above, the two AFLDM families who provided feedback were very satisfied with the AFLDM meetings, as was one mother who provided feedback about the Garinga Bupup pre-birth case planning meeting. All three families found the meetings, which were Aboriginal led, emotionally and culturally safe, respectful, inclusive, and non-threatening.

Links to Internal Programs and Services.

Aboriginal perspectives on healing reflect the essence of holism, or the interconnectedness of life's dimensions, and ACCOs aim to provide a holistic service, often delivering a range of culturally appropriate health, social and emotional wellbeing, family violence and drug and alcohol services that can address a range of issues causing child safety concerns. As discussed above, connections with ACCO internal programs, such as VACCA Family Services, supported timely access to services that parents needed.

[20] Where conferences were convened for mothers and fathers separately.

Case Coordination Activities.

Several stakeholders indicated that Convenors/Case Manager needed to be very proactive in their engagement efforts with parents and consulting Child Protection when there were serious safety concerns. In terms of connecting parents with services and supports, stakeholders said that Convenors/Case Manager also needed to proactively undertake coordination activities, such as directly arranging access to services, reducing barriers to obtaining services, establishing linkages, and following through with service providers to ensure families are receiving a service.

Discussion

Aboriginal families and communities are disproportionally affected by traumatic experiences and their associated negative consequence, including disruption in healthy family functioning, which puts Aboriginal children at greater risk of adverse childhood experiences and investigation by Child Protection. However, Victorian Aboriginal children, like First Nations children Australia-wide, have a higher probability of a protection application and removal following a substantiation decision than non-Aboriginal children. This disparity is caused by factors in the decision-making ecology of Child Protection practitioners, including implicit biases, and case factors, such as difficulties developing and sustaining supportive relationships in Child Protection practice, parents' lack of acceptance, and conscious awareness of the need for change and lack of access to culturally relevant family and community-based supports that would offer safety to children.

If CBCPMs were available where child safety concerns were identified in Aboriginal families, then implicit racial bias, would not impact removal decisions, and harm caused by culturally incongruous encounters with Child Protection would be avoided, and Aboriginal families would feel safe and empowered to accept the need for change and receive access to culturally relevant services more directly. CBCPMs would also mean that Aboriginal people exercise their right to autonomy and control in matters relating to service activity being provided to them.

The Aboriginal Child Protection Diversion Trials were three CBCPMs designed and delivered by Victorian ACCOs to prevent Aboriginal families from experiencing a Child Protection investigation and further Child Protection activities, such as protective intervention. They were expecting to divert families from a Child Protection investigation and create access to culturally relevant services and supports that would reduce risks to children.

While the sample sizes were small, it was not possible to follow families for very long after their episode of care, and cost savings were based on estimated, rather than actual conversion rates from one Child Protection phase to the next, the evaluation provided a strong case for the effectiveness of the ALCC trial and Garinga Bupup in diverting Aboriginal children from Child Protection investigation. The ALCC trial had an 78.3% diversion success rate, and Garinga Bupup had a 62.5% diversion success rate. This equates to a $5 and $2 return on every $1 invested respectively. While the AFLDM trials did not demonstrate the same diversion success due to redesign and delayed implementation, pre-conditions for long-term diversion outcomes included in the program logic were evident, as were core components linked to program effectiveness.

Garinga Bupup and the ALCC trial provided more intensive case management than originally intended, but overall, the trials were implemented effectively and with fidelity in their local context. There was also evidence that the pre-conditions for diversion (short- and medium-term outcomes) were in place. There was excellent uptake and use of the trials among Garinga Bupup and ALCC families, and good uptake among AFLDM families in the late stage of implementation following redesign. Parents were very satisfied with their service; they experienced a high-level of personal and cultural safety during care and felt supported by Convenors/Case Manager. Garinga Bupup mothers showed a high level of trust in the Garinga Bupup Senior Case Manager, and the Garinga Bupup Senior Caseworker also highlighted the close “family-like” relationship that she formed with mothers. There was evidence that the trials improved parents’ self-esteem, self-agency, and personal empowerment, and successfully engaged parents in community-based support to address parenting struggles linked to poverty and disadvantage and exacerbated by social isolation.

The evaluation verified core components[21] or active ingredients that are essential if CBCPMs are to achieve desired outcomes. Safe, empowering and trusting relationships, were enabled by an Aboriginal service provider, voluntary relationships, brokerage, and culturally grounded practices that reflect the values of family preservation, respect, honesty, choice, and empowerment and maintain cultural integrity in service delivery. Personal empowerment and openness to change was fostered by honesty about the risk of harm to children and the potential for statutory action and the integration of Aboriginal traditions and rituals that build a strong Aboriginal identity and reconnection with self, family, and community.

Strong links between Child Protection and the ALCC trial following a Child Protection report (using Lakidjeka as an intermediary) fostered timely case conferencing. Timely connections to services and supports (including natural helping systems) were aided by case conferencing and AFLDM meetings. Intensive case management (spending time) was also necessary in Aboriginal perinatal families to develop trust, strengthen natural supports and reduce barriers to engagement in health and social care services.

The AFLDM experience shows that diversion during a Child Protection investigation is not feasible, and the experience of all trials shows that referring families to Aboriginal CBCPMs is best undertaken at the point of Child Protection intake (or before an unborn report in the case of Garinga Bupup). Addressing child safety concerns in the community also involves effective linkages with the statutory Child Protection authorities, to identify and divert families where there are child safety concerns, to mitigate statutory Child Protection activity, and to agree a way forward where there are serious child safety concerns warranting a statutory protective intervention, or when ACCOs require support in contacting families.

The Aboriginal Child Protection Diversion Trials incorporated several factors that increased the probability of successful implementation. ACCO practitioner skills were a critical

[21] Indispensable elements of an intervention or implementation plan, which cannot be changed without undermining it. All core components should be delivered with fidelity.

implementation enabler. This included the ability to recognise and respond to parents' personal histories of trauma, discrimination, disempowerment, and the fear of statutory intervention, the ability to mediate between the world of Child Protection and the family, the ability to focus on parents' strength-areas and ability to recognise and respond to child safety concerns. The valuing of Aboriginal self-determination in child welfare and operational capacity and support by Child Protection (Intake) and Community Based Child Protection was also necessary for implementation. Implementation was also supported by ACCO internal structures, systems, policies, and procedures that align with Aboriginal CBCPMs, such as case practice frameworks, policies, procedures, client recording systems and case management supervision. Barriers to service access can also be mitigated when ACCOs have diverse service offerings and are able to prioritise care to families where child safety concerns are identified.

Design Improvements and Strategies to Mitigate Implementation Barriers

The evaluation highlighted several considerations for design and process improvement for each trial. The ALCC Convenor said that the program needed the same information as a Child Protection (Investigation) if it was to operate as a viable alternative, such as access to the L17 referrals made by Victoria Police officers who have attended a family violence incident and intervention orders (IVOs). It was also suggested that the ALCC program could expand its target group to women pregnant with an Aboriginal baby. The ALCC Convenor also said that brokerage would enhance engagement, support, and outcomes for Aboriginal families meeting the threshold for Child Protection investigation.

Including mothers having subsequent babies as a priority group (in addition to first-time mothers) and accepting referrals from Child Protection (Intake and Community Based Child Protection), were identified enhancements to the Garinga Bupup program. There was also agreement among several stakeholders that Garinga Bupup needed additional staff capacity to sustain an intensive case management model that supports mothers/families from the early stages of pregnancy and following birth, meet community demand and accommodate the afterhours nature of the work.

As mentioned above, the AFLDM trials underwent a redesign process to improve referrals into the program. To adjust for the lack of referrals from the Child Protection Investigation Team, the AFLDM trials started to accept referrals from Child Protection (Intake) via ACSASS (in the case of Njernda) and Lakidjeka (Goolum Goolum) services when cases are closed at intake phase or remain open until a referral has been accepted (wellbeing report), and from internal Family Service, AoD, Early Years (pregnant women) and Healing Programs.

For all trials, better dissemination about the programs was recommended. For the AFLDM trials, making families aware of the program, highlighting its autonomy from Child Protection, was considered necessary going forward to improve receptivity. For Garinga Bupup, there were perceived benefits in building a relationship with GPs and formalising the relationship with Bendigo Health, to establish strong referral pathways from pregnancy care providers.

Conclusion and Recommendations

There is a strong case for robust Aboriginal CBCPMs in Victoria. Community-based management of child protection issues means that Aboriginal people exercise their right to autonomy and control in matters relating to service activity being provided to them, avoid potentially unnecessary removal decisions and harm caused by culturally incongruous encounters with Child Protection, and receive more direct access to culturally safe and relevant services and support.

This evaluation found that Aboriginal community-based responses to child protection issues can stop up to 80% of statutory investigations in the short-term if programs include core elements such as supportive links with Child Protection, ACCO practitioners with the right skills and experience, case practices that integrate, or are commensurate with Aboriginal cultural values, and culturally congruent mechanisms for case planning and case coordination that fit to local context, such as case conferencing or more traditional models for exploring and settling matters, such as AFLDM meetings. Success is also dependent on

the right circumstances surrounding the implementation effort, particularly commitment to self-determination for Aboriginal people.

Evidence that the current activities can divert Aboriginal children from statutory Child Protection authorities, and convergence across all three trials in terms of the theory of change, core elements and enablers, provides a sound basis for the following formative and summative recommendations for consideration by stakeholders.

Recommendations

Recommendation 1:

VACCA, Goolum Goolum and Njernda should seek additional funding for full implementation of the ALCC trial and AFLDM trials into subsequent years, and BDAC should seek funding for full implementation of Garinga Bupup with additional staff capacity to meet local demand, and sustain an intensive case management model, including afterhours support.

Recommendation 2:

Stakeholders should consider suggestions for continued improvement that require no or limited additional resourcing, such as enhanced stakeholder communication (all trials), stronger links with Child Protection (AFLDM trials), new referral pathways (Garinga Bupup), changes to the inclusion criteria to reach new or wider groups of Aboriginal families (Garinga Bupup and ALCC), improved access to information on referral commensurate with a Child Protection investigation (ALCC) and brokerage funding (ALCC). Child Protection should ensure that ACCOs are able to continue consulting with Child Protection under s.38 of the CYFA and that referral pathways between Child Protection (Intake) and ACCO programs remain viable through continuous internal dissemination.

Recommendation 3:

Fully implemented programs should be subject to a summative evaluation to verify effectiveness, core components and enablers. The evaluation should include an economic assessment that captures monetary savings[22] and non-monetary benefits.

Recommendation 4:

Key stakeholders should review the original programs and create a plan to move to from model demonstration to full implementation and potential replication. This includes sufficiently documenting the need or problem the program address, the program's approach to the problem and its effects, how it works (including core components and the purpose that they serve), the settings in which the programs are intended to be used, what is needed to successfully implement the programs in different community settings (e.g., the responsibilities of different professionals and organisations involved in implementing the programs, professional development requirements[23], infrastructure, and systems requirements), and how progress can be assessed.

Recommendation 5:

VACCA, BDAC, Goolum Goolum and Njernda should develop a communication plan and actively communicate information about the programs to ACCOs that might be both 'willing' to, and 'capable' of, replicating ALCC, Aboriginal-Led AFLDM and Garinga Bupup, or developing their own local mechanism for Aboriginal Community Based Child Protection based on core components.

Recommendation 6:

VACCA, BDAC, Goolum Goolum, Njernda and Child Protection should explore the capacity and acceptability of Aboriginal community ownership in the identification, prevention and

[22] Savings associated with a reduction in notifications investigated, seeking a court order and placement https://www.pc.gov.au/ongoing/report-on-government-services/2022/community-services/child-protection.

[23] ACCOs should consider professional development and other requirements needed to sustain the programs, specifically where they can obtain professional development resources and support for Convenors/Case Managers, such as training programs and mentoring/coaching models.

responding to child protection issues through Aboriginal Community Based Child Protection Mechanisms as the building blocks for a new approach to Aboriginal Child Protection announced by the Victorian Premier on 5 December 2022 (https://www.theguardian.com/australia-news/2022/dec/05/victoria-vows-to-overhaul-child-protection-as-yoorrook-justice-commission-begins-public-hearings).

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Appendix A: Victorian Policy Context

The Victorian Government's commitment to advancing self-determination in child welfare for Aboriginal Victorians is detailed in the following agreements, policy documents and Aboriginal programs.

The Roadmap for Reform: Strong Families, Safe Children outlines the government's reform of the Child Protection and family services system and includes a commitment to Aboriginal self-determination around decision-making and care for vulnerable Aboriginal children and young people. More information is available on the Roadmap for Reform website

Wungurilwil Gapgapduir: Aboriginal Children and Families Agreement and Strategic Action Plan: a landmark partnership between Aboriginal community, Government and community service organisations to advance self-determination and commit to better outcomes for Aboriginal children and their families. It outlines a strategic direction to reduce the number of Aboriginal children in out-of-home care by building their connection to culture, Country and community. More information is available here.

Beyond good intentions: Creating a fair, just and restorative Victorian child and family welfare service system for Aboriginal and Torres Strait Islander children, the *Beyond good intentions statement* was developed in 2013, led by Berry Street, the Victorian Aboriginal Child Care Agency (VACCA), MacKillop Family Services and the Centre for Excellence in Child and Family Welfare. The statement aims to address how best to support self-determination for Aboriginal families and communities in Victoria and 'to move beyond good intentions to better outcomes'. Read more about the Beyond good intentions statement on the Centre for Excellence in Child and Family Welfare website https://www.cfecfw.asn.au/beyond-good-intentions.

Koori kids: growing strong in their culture: Available on the Aboriginal communities page of the Commission for Children and Young People (CCYP) website <https://ccyp.vic.gov.au/upholding-childrens-rights/aboriginal-communities>

Always was, always will be Koori children: The report of an investigation into the circumstances of 980 Aboriginal children and young people in out-of-home care in Victoria. See in particular finding 5 and recommendation 5.3. The report is available on the Always was, always will be Koori children page of the CCYP website.

Korin Korin Balit-Djak: serves as a 10-year plan to revolutionise Victoria's health and human services' work with Aboriginal communities. The Korin Korin Balit-Djak plan details how the Department of Health will work with Aboriginal communities, community organisations, other government departments and mainstream service providers – now and into the future – to improve the health, wellbeing and safety of Aboriginal people in Victoria. More information is available here.

Aboriginal Children in Aboriginal Care program (ACAC)

Self-determination underpins the ACAC program. Aboriginal people, who know what is best for Aboriginal children, should be responsible for the safety and protection of Aboriginal children. By placing the responsibility for the protection and care of Aboriginal children with Aboriginal agencies, the ACAC program allows organisations to do things differently to make a difference in the lives of Aboriginal children and families.

Section 18 of the *Children, Youth and Families Act 2005* (CYF Act) enables the Secretary of the Department of Families Fairness and Housing (the department) to authorise the principal officer of an Aboriginal agency to perform specified functions and powers conferred on the Secretary in relation to an Aboriginal child or young person or the sibling of an Aboriginal child authorised to the Aboriginal Community Controlled Organisation (ACCO) on subject to a protection order. The ACAC program is the departmental program that operationalises that legislative provision.

The ACAC program recognises the needs of Aboriginal children are best met by Aboriginal community services that are culturally attuned. ACCOs are also best placed to reconnect Aboriginal children and families to culture where there has been a disconnection. Currently two ACCOs are fully authorised to provide ACAC:

- The Victorian Aboriginal Child Care Agency (VACCA) was authorised in November 2017
- Bendigo and District Aboriginal Cooperative (BDAC) was authorised in January 2019.

Two ACCOs are in pre-authorisation phase of ACAC operating 'as if' authorised under section 18 of the CYF Act:

- Ballarat and District Aboriginal Cooperative (BADAC)
- Njernda Aboriginal Corporation (Njernda)

With an additional two ACCOs selected for pre-authorisation in 2021. These include:

- Rumbalara Aboriginal Co-operative (Rumbalara)
- Gippsland and East Gippsland Aboriginal Co-operative Ltd (GEGAC)

Aboriginal Response to Child Protection Reports program

The 2020-21 Victorian State Budget provided $11.6 million over four years to expand ACAC through developing and piloting an Aboriginal response to reports to Child Protection about the safety and wellbeing of Aboriginal children and young people where an investigation is required.

This new approach aims to pilot culturally informed investigations of Child Protection reports and offer culturally appropriate support for families, with the aim of strengthening Aboriginal families and reducing the over-representation of Aboriginal children in Child Protection and care.

Appendix B.

Aboriginal Child Protection Diversion Trials Program Logics

Figure 1.

Garinga Bupup Evaluation Program Logic

Problem Statement	Inputs	Outputs: Activities	Outputs: Participation	ST Outcomes	MT Outcomes	LT Outcomes
Despite evidence of the importance of a safe intrauterine environment from the earliest stages of pregnancy, the adverse effects on the foetus of antenatal maternal stress and the opportunities for therapeutic intervention during pregnancy, the Loddon service system is primarily geared towards supporting child safety once a baby is born. The failure	• Senior caseworker (1.0EFT) • CSNet • Governance (Local Implementation Team and Governance Group) • ACCO policies, proformas and assessment tools • Culturally responsive workers, practices, and practice frameworks[24]	• Referrals from Orange Door, community or OOHC provider to BDAC allocation committee • BDAC allocation committee referrals to vulnerable unborn Aboriginal baby trial • Home visits/client interactions • Support plans	• First time pregnancies involving an Aboriginal baby (caseload of 5)	• Engagement in casework early in gestation • Family trust • Working relationship • Family receptivity • Cultural safety	• Connection to culturally responsive services to address child safety concerns • Engagement in antenatal services and other services to address risk of future harm to unborn baby	• Diversion from unborn child report to Child Protection and progression through child Protection phases following birth • Reduction in child safety concerns

[24] These include four practice components of relationship first, being with families/journey walking, wrap-around service coordination and professional collaboration.

Problem Statement	Inputs	Outputs: Activities	Outputs: Participation	ST Outcomes	MT Outcomes	LT Outcomes
to relationally support families during pregnancy is a missed opportunities to proactively equip parents for parenting, develop their understanding of the critical stages of development both in utero and in the early stages of life, and how these are impacted by their behaviour and choices. Failure to wrap around and impart wisdom to these families has resulted in re-reports, investigations, and removals of children in the most formative years of life.	• Brokerage funding	• Journey walking (e.g., supported contacts with Bendigo hospital, MCH visits etc.). • Pre-birth conferences • Consultations with professionals (referrals etc.) • Risk-based consultation with Child Protection • Welcome Baby to Country[25] and possum skin pelt[26] at birth.				

[25] Welcome Baby to Country is an important part of Aboriginal society so that everyone in the Community knows this Child and knows where this Child comes from and belongs.

[26] Possum skin cloaks are one of the most sacred expressions of traditional south-eastern Aboriginal peoples.

Figure 2.

Aboriginal-Led Case Conferencing Trial Program Logic

Problem Statement	Inputs	Outputs: Activities	Outputs: Participation	ST Outcomes	MT Outcomes	LT Outcomes
Child Protection can progress to investigation based on limited information or historical information contained in Child Protection case management files. The investigation process is not a mechanism of safety, and it creates significant anxiety for Aboriginal families. Unnecessary investigation can deepen Aboriginal families' fear and mistrust of Child Protection. The investigation process can also delay access to culturally appropriate services and increase the risk of a protective intervention.	• ALCC convenor (1.0EFT) • Team Leader Lakidjeka • Child Protection Specialist – Aboriginal Children in Aboriginal Care and Aboriginal Initiatives position (s38 consultations) • CSNet • Governance (Local Implementation Team and Governance Group) • VACCA policies, proformas and assessment tools • Culturally responsive workers, practices, and practice frameworks	• Referral from Child Protection intake to ALCC Trial • Culturally responsive case practice • Aboriginal-led case conferences (*N*=30) • ALCC convenor-family interactions • Support plans • Culturally safe referrals • Contacts with family and professionals • Risk-based consultation with Child Protection	Aboriginal children notified to Child Protection that met a threshold for further action.	• Family trust • Working relationship • Family receptivity • Cultural safety • Cultural strengthening	• Connection to culturally responsive services to address child safety concerns	• Diversion from Child Protection investigation and progression through Child Protection phases and re-reports (further contact with Child Protection) • Reduction in child safety concerns

Figure 3.

Aboriginal-Led Aboriginal Family-Led Decision-making Trial

Problem Statement	Inputs	Outputs: Activities	Outputs: Participation	ST Outcomes	MT Outcomes	LT Outcomes
Referral to AFLDM post substantiation decision is too late. Child Protection practitioners may have established the case plan direction before there is an opportunity to convene an AFLDM meeting, restricting the input of Aboriginal family and community in developing solutions and facilitating placement in line with the hierarchy of placement options outlined in the ATICPP. In the standard co-convenor	• AFLDM trial convenor (1.0EFT) • CRIS/SP client management system • Governance (Local Implementation Team and Governance Group) • ACCO policies, proformas and assessment tools • Culturally responsive workers, practices, and practice frameworks	• Referral from Child Protection investigation to AFLDM trial • Aboriginal-led AFLDMs (target n=30) • AFLDM convenor-family interactions • Support plans • Consultations with professionals • Risk-based consultation with Child Protection	Aboriginal families with children subject to a Child Protection investigation	• Family trust • Working relationship • Family receptivity • Cultural safety • Cultural integrity of AFLDM meetings (who attends, dialogue) • Informal family support	• Culturally safe referrals • Engagement in culturally responsive services to address safety concerns	• Diversion from progression through Child Protection phases • Compliance with the ATICPP placement hierarchy • Reduction in child safety concerns

Problem Statement	Inputs	Outputs: Activities	Outputs: Participation	ST Outcomes	MT Outcomes	LT Outcomes
approach, Child Protection practitioners retain the power to make case plan decisions. The lack of independence of Aboriginal convenors can undermine the cultural integrity of the process, limiting the extent to which outcomes of the meeting are successful.						

Appendix C

“That’s some big trust … .”

Evaluation Findings from the Garinga Bupup Trial

Table 1.

Summary of Findings from the Garinga Bupup Trial

Was the trial implemented correctly?	What were the implementation barriers and enablers?		How satisfied were Aboriginal families who received the trial?	What features of the trial made a difference?	Was the trial successful in achieving its ST, MT, and LT outcomes?
	Enablers	Barriers			
Referral from community and self-referrals effective. Families fitted the inclusion criteria (early stage of pregnancy, unborn child at risk of future harm), but initially accepted families late in pregnancy and 50% of families were not first-time pregnancies. Higher caseload than originally intended (n=19 families had some engagement with the service). Journey walking extended to hospital stay for birth and after hours/crisis support.	Governance group. Stakeholder engagement (Child Protection). Organisational support (BDAC). Caseworker with the appropriate skills and knowledge to implement Garinga Bupup. Service blueprint.	Resources – one case manager insufficient to provide intensive "journey walking" to five+ mothers. Challenges to support women when attending Bendigo health for	Very satisfied.	BDAC's knowledge of their community. Culturally grounded, therapeutic approach to engagement. Proactive, well-executed case management. Capacity to communicate child safety concerns and to appropriately assess and respond to risk. Journey walking pre- and post-birth.	Excellent uptake/service utilisation. High level of engagement. Increased utilisation of antenatal care. Engagement in community services where there was an identified need. Increased cultural understanding and cultural responsiveness at Bendigo Health. Fewer unborn child reports during the trial than before the trial. Utilisation of Garinga Bupup prevented Child Protection from opening cases during the unborn phase.

Was the trial implemented correctly?	What were the implementation barriers and enablers?		How satisfied were Aboriginal families who received the trial?	What features of the trial made a difference?	Was the trial successful in achieving its ST, MT, and LT outcomes?
	Enablers	**Barriers**			
Cultural activities implemented as intended (possum skin pelts were made for each baby and Welcome Baby to Country ceremonies took place, although there was some disruption due to COVID-19 restrictions).	Implementation team.	antenatal appointments and for labour and birth.		Strong Interface with Child Protection (pre-birth meetings and consultations involving cases open with Child Protection, informal consultations). Low caseload. Brokerage.	More reports on Aboriginal babies aged less than one year during the trial than before the trial, however fewer Aboriginal babies aged less than one year entered care during the trial than before the trial. Following birth, two Garinga Bupup babies were placed in OOHC (22.2%), although Gariga Bupup remained part of care team and one Garinga Bupup baby was in care under an interim accommodation order for a very short period.

BDAC Client Information System Data

The Garinga Bupup Senior Case Manager was intended to carry a caseload of five. Across the 12-month evaluation period (15 November 2021 to 14 November 2022) 19 families had some engagement with the service. Of these, eight consented to the evaluation.

Demographic and Service Profile of Garinga Bupup Families

Client data supplied by BDAC for the entire 12-month trial period indicated that approximately half of the Garinga Bupup cases involved first-time pregnancies. The mean age of mothers (*M*=25 years) reflects this. While one mother was accepted into the program following birth, overall, there was a reasonable "intervention window" between the date cases were accepted and baby's date of birth (*M*=12 weeks). For cases that had closed at the time of the analysis, the service episode averaged 22 weeks (Table 2).

Table 2.

Demographic and Service Profile of Garinga Bupup Families

	Number	Mean (Standard Deviation)	Minimum	Maximum	Number (Per cent)
Maternal age	7	24.5(4.6)	18	31	NA
First pregnancy	8				4(50.0)
Stage of pregnancy at referral (weeks)	6	19.0(9.2)	10	36	NA
Length of service (weeks)	4	21.5	7	36	NA
Window between date case accepted and baby's date of birth	7	11.9	0[27]	30	NA

[27] Indicates case was accepted after birth.

Client Feedback Forms

Safety, Satisfaction and Change Among Garinga Bupup Families

Nine feedback forms were completed by Garinga Bupup families concerning eight children[28]. Analysis of these data shows a very high level of satisfaction and safety experienced by families during their service, as well as improvements in areas such as confidence and self-esteem since their involvement with BDAC.

Table 3.

Safety, Satisfaction and Change Among Garinga Bupup Families

	Number	Mean (Standard Deviation)	Minimum	Maximum
Safe environment (Range 1-5, 6 items)	6	4.5(.3)	4.3	5.0
Service satisfaction (Range 1-4, 8 items)	6	3.8(.4)	3.0	4.0
Client outcomes (Range 1-5, 10 items)	5	4.2(.5)	3.6	4.9

Positive Experiences

Two mothers provided a response to the open-text question about positive experiences included on the client feedback form. These included “feeling supported and protected during our hospital stay” (id#1) and “so much general support along the way” (id#2). Both participants expressed gratitude for the Garinga Bupup Senior Case Manager, saying “our caseworker was amazing” (id#1) and “love my worker” (id#2).

Examples of Improvements Since the Garinga Bupup Program

Two mothers provided specific examples of improvements since the Garinga Bupup Program. These were “my partner has reached out to his extended family and culture

[28] In one case, both the mother and father completed a feedback form.

because of the experience with BDAC" (id#1), and "support, confidence, and self-esteem" (id#5).

Pre-birth Case Planning Meeting

One mother provided feedback about the pre-birth case planning meeting designed to capture subjective feelings of safety (8 items, scale 1-5) and satisfaction with the meeting (nine items, scale 1-4). Mean scores were 5.0 and 4.0 respectively, indicating that the mother experienced the meeting as culturally safe and nonthreatening, and was very satisfied with the meeting, including the way she was talked to, the influence she had on the case plan and the way the convenor ran the meeting.

Worker Perceptions of Client Engagement

The Garinga Bupup Senior Case Manager completed an 11-item survey on nine Garinga Bupup family's engagement with the program. Items include "[mother] sees that her family needed some support" and "[mother believes BDAC is supporting her family to get stronger". The analysis of these responses indicates a very high level of engagement with the service (Table 4).

Table 4.

Worker Perceptions of Client Engagement

	Number	Mean (Standard Deviation)	Minimum	Maximum
Client engagement (range 1-5, 11 items)	9	4.5(.4)	4.0	5.0

Findings from the Client Relationship Information System Data

The following results are based on an extract of data from the Child Protection Client Relationship Information System (CRIS) between 01 November 2020 and 31 August 2022 for relevant cases in the Central Goldfields, Greater Bendigo, Loddon, Macedon Ranges and Mt Alexander localities (the Garinga Bupup trial area).

Child Protection Case Trajectories of Garinga Bupup Babies

Unborn Child Reports

Four Garinga Bupup unborn babies of mothers who had been accepted into the Garinga Bupup program between 15 November 2021 and 31 May 2022 (the first seven months of the trial) were the subject of an unborn child report after a minimum of three months following the Garinga Bupup acceptance date. Three Garinga Bupup unborn babies were also the subject of an unborn child report prior to the Garinga Bupup acceptance date) (Table 5).[29]

Table 5.

Unborn Child Reports on Garinga Bupup Unborn Babies After a Minimum Three-Months following Acceptance into the Program[30]

Garinga Bupup unborns: referrals accepted November 2021 to May 2022	Number	%
Cases with a CRIS number in scope	5	100.00%
Cases with CP unborn report prior	3	60.00%
Cases with at least one CP report/unborn report following	4	80.00%
Cases with at least one report before and after	2	40.00%

Reports on Garinga Bupup Babies Aged Less Than One Year

The diversion rate for Garinga Bupup was 62.5% (investigation following birth). Over the first 10 months of the trial (01 November 2021 – 31 August 2022), reports were made on three of the eight Garinga Bupup babies following birth. In all three cases, this resulted in an investigation with a substantiation outcome, and two babies were placed in care, although one baby was placed in care under an interim accommodation order for a very brief period before being returned to the custody of the mother.

It is difficult to establish a comparison group since Garinga Bupup accepted community referrals, and not all unborn reports to Child Protection would necessarily meet the

[29] These data were supplied by BDAC and cross-referenced with CRIS data.

[30] The low number of cases is explained by the exclusion of referrals received after 31 May 2022 (to allow for post-closure tracking), and by the fact that many referrals to Garinga Bupup/BDAC were community referrals with no Child Protection contact and therefore no CRIS number.

threshold for further action, resulting in an open Child Protection case, for example. However, over the same period (01 November 2021 – 31 August 2022), there were eight non-trial children involved in an unborn report to Child Protection. Four of these children were involved in a report to Child Protection following birth (and an additional child was involved in two s.38 consultations). All four non-trial children aged less than one year involved in a report were investigated (a diversion rate of 50%). The four investigations resulted in three protection applications and one OOHC entry.

Comparison of Child Protection Reports Prior to and During the Garinga Bupup Trial

There were approximately one-third fewer unborn reports to Child Protection over the first ten months of the trial (n=10) compared to the ten months preceeding the trial (n=22). However, the number of reports on Aboriginal babies aged less than one year was higher during the trial (n=40) compared to the 10 months prior (n=31) (Table 6).

Table 6.

Unborn Child Reports and Reports on Babies Before and During the Garinga Bupup Trial

BDAC/Garinga Bupup area. Reports on unborns and babies		
Report type	**Nov 2020-Aug 21**	**Nov 2021-Aug 2022**
Unborn child reported to Child Protection	22	10
Report to Child Protection on child aged under 1	31	40

Comparison of Aboriginal Babies Aged Under One Year Entering Care Before and During the Garinga Bupup Trial

Despite the higher number of reports on Aboriginal babies aged less than one year during the trial compared to before the trial, over approximately the first ten months of the trial (15 November 2021 – 31 September 2022), there were fewer Aboriginal babies aged less than one year placed in OOHC (n=5) compared to the first ten months of the twelve months prior (n=8) (Table 7 and Table 8). This equates to 25.8% of reports resulting in care before the trial compared to 12.5% of reports resulting in care during the trial.

Table 7.

Case Trajectories of Aboriginal Babies Aged Under One Year Before the Garinga Bupup Trial

All reports of Aboriginal children aged <1: 1 Nov 2020 to 31 August 2021					
CP event	**Number**	**% of reports**	**Number of children**	**% of children**	**Average per child**
Report	31	100.00%	30	100.00%	1.03
Investigated	20	64.52%	20	66.67%	
Substantiated	14	45.16%	14	46.67%	
Placed in OOHC	8	25.81%	8	26.67%	

Table 8.

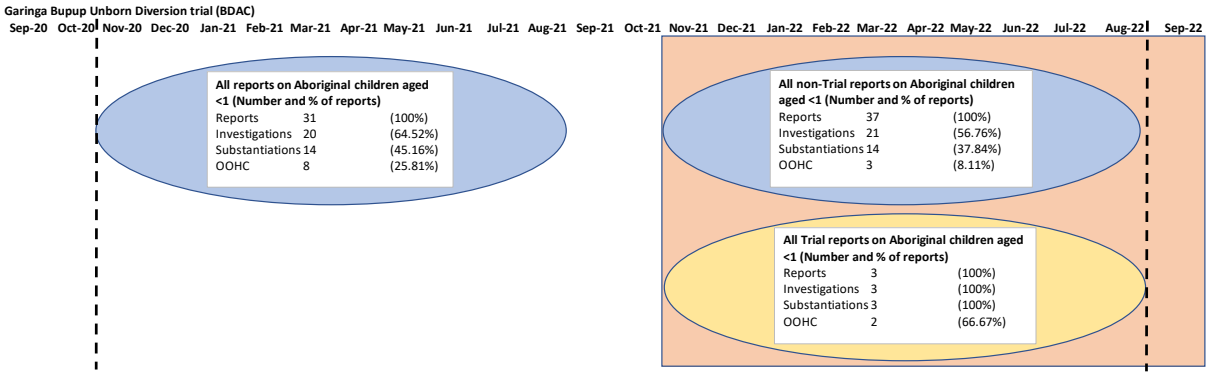
Case Trajectories of Aboriginal Babies Aged Under One Year During the Garinga Bupup Trial

All reports of Aboriginal children aged <1: 1 Nov 2021 to 31 August 2022					
CP event	**Number**	**% of reports**	**Number of children**	**% of children**	**Average per child**
Report	40	100.00%	30	100.00%	1.33
Investigated	24	60.00%	23	76.67%	
Substantiated	17	42.50%	17	56.67%	
Placed in OOHC	5	12.50%	5	16.67%	

A summary of all the CRIS data relating to Aboriginal babies aged less than one year are presented in Figure 1 below.

Figure 1.

Comparison of Aboriginal Babies Aged Under One Year Before and During the Garinga Bupup Trial



Narrative Summary of Interviews and Focus Group Discussions

Three individual interviews and one focus group discussion were conducted with professionals involved in the implementation of Garinga Bupup, including the Garinga Bupup Senior Case Manager, staff at Bendigo Health, and Child Protection practitioners.

BDAC and Community Members Main Referrers

The Garinga Bupup Senior Case Manager said, "A lot of our referrals have come through from self-referrals, community members, internal referrals throughout the BDAC". However, as the program matured, "… the more known it has become, the more outreach we've had regarding our referrals". The Garinga Bupup Senior Case Manager provided an example of how one mother was referred via a BDAC Worker:

> She [mother] ran into one of the AFPR [BDAC Aboriginal Family Preservation and Reunification] workers in town and the AFPR then obviously found out she was pregnant and said, "Hey is it okay if I give [Garinga Bupup] your name and number?" ... Mum agreed. And the rest is kind of, history.

Participants in the interviews and focus group discussions pointed out that Child Protection and Bendigo Health were not referrers. A Child Protection practitioner said, "Community Based [Child Protection] didn't do any direct referrals into Garinga Bupup". The Aboriginal Health Liaison worker at Bendigo Health mentioned that midwives did not refer to the program, saying, "I guess we both weren't aware of each other at that point or weren't aware of each other enough to know the referral part there". In relation to referrals from health services, the Garinga Bupup Senior Case Manager also mentioned that "We don't get many referrals from GPs or anything along those lines which I think, is still another thing that we need to investigate more and build a working relationship with our GPs throughout Bendigo".

Women/Families have Diverse and Intensive Support Needs

Participants in the interviews and focus group discussions highlighted the intensive support needs of women referred to the Garinga Bupup program. The Garinga Bupup Senior Case Manager said that a lot of the women "had Child Protection involvement and had other

children removed or children removed then reunified. And then mum was pregnant with another baby ... A lot of them weren't first time mums". Child Protection practitioners similarly observed that "They've [mothers] got children either already in the system or Child Protection open on children who are at home with them" and that "several cases involved siblings that were open with Child Protection, so unborn [child] was part of a sibling group".

Women's lack of informal support was highlighted by the Garinga Bupup Senior Case Manager and Child Protection practitioners. The Garinga Bupup Senior Case Manager sad, "… we've had other women that have no family support, no real friends that literally are so disconnected and so isolated where I'm in the labour room as a support person while they're birthing". A Child Protection practitioner said, "and a lot of time they're young mothers, they don't have connection to culture, to family – they don't even have a strong friend network …".

The Garinga Bupup Senior Case Manager said that "There was quite a few very high-risk mums. One who had escaped probably one of the worst cases of family violence that I have seen". Speaking more generally about the mothers who were accessing the Garinga Bupup program, the Garinga Bupup Senior Case Manager said:

> Not one family that I've worked with yet have I just been able to solely focus on pregnancy … . I've had to wear multiple hats and work in multiple different areas. Whether that be in family violence, mental health, AoD. Everything and anything. I've even done budgeting and grocery shopping with mums.

Success in Building Client Trust, Engagement and Empowerment

All the women who were referred to Garinga Bupup accepted the service. A Child Protection practitioner said:

> I don't think she's [Garinga Bupup Senior Case Manager] had any disengage, to be honest, even the one that we had come through as a report once mum birthed – despite the Department having to go and intervene legally, that young mum still reached out to [Garinga Bupup Senior Case Manager], still wanted her to be a part of the care team, so despite that outcome, they were still wanting to engage.

The Garinga Bupup Senior Case Manager said:

> All my mums have engaged beautifully. They've all been fantastic. I haven't had one that hasn't wanted to engage. I haven't had a mum yet that hasn't been appreciative and thankful for the support that we've been able to provide for mum. Not just through pregnancy but making sure the baby has all the baby needs.

Several participants spoke about the success that the Garinga Bupup Senior Case Manager had in building a trusting working relationship with women as a foundation for engagement in Garinga Bupup and other services, often when they would not accept help from Child Protection and mainstream family services:

> [Garinga Bupup Senior Case Manager has] really spent that time forming that relationship, that trust – a lot of the time, she's been in the birthing suite with these mums, and I just think back to my birth – that's some big trust, having a service in the birthing suite with you while you're having your baby. I just think that speaks volumes for the relationships she's formed with these mums …". (Child Protection practitioner)

> In the beginning, she [mother] was sitting in IFS [Intensive Family Services]. So, she was Intensive Family Support. She wouldn't engage with the worker, didn't want a bar of any services, any supports, hated everybody. You know, nobody ever done anything to help her. So, her case manager come to me and said, "Look, she's actually pregnant. I'm not getting anywhere. Can you come out and work with her, so you know whether she'd get along with you?". (BDAC Garinga Bupup trial Senior Case Manager)

> My understanding from the Garinga Bupup Senior Case Manager and from case managers is that the mums are really happy. I know she advocated and got a mum a house the other day, so I'd be pretty happy about that if I was that mum, but yeah, I haven't heard anything negative. I think it's all been positive, and she's able to get them into the services that they're identifying that they need supports from. (Child Protection practitioner)

A Bendigo Health worker observed better engagement in antenatal care because of the continuity of support provided by the Garinga Bupup Senior Case Manager, saying “I think with [the Garinga Bupup Senior Case Manager], women were far more engaged in antenatal care, much more willing knowing that they had somebody as a consistent support person and that continuity”.

The Bendigo Health worker went on to say that there was better “attendance at appointments, ultrasounds and pathology” and “that those tests and interventions were far better received in terms of labour management for all women, again, having that consistent continuity of your support person or care provider”. In the postnatal phase, the same Bendigo Health worker felt that “knowing that there was a circle of safety around women and babies certainly made the midwifery staff feel that there were supports in place”.

The Aboriginal Health Liaison worker provided an example of the support provided by the Garinga Bupup Senior Case Manager during labour and birth, saying “She [mother] was so grateful for [the Garinga Bupup Senior Case Manager]'s support and I honestly don't think she would have stayed in hospital if it wasn't for [the Garinga Bupup Senior Case Manager]'s support.

The Garinga Bupup Senior Case Manager said a key aim of the service was to build empowerment for women pregnant with an Aboriginal baby, recognising that fear of Child Protection and mainstream services affected their engagement with health and social care. The Garinga Bupup Senior Case Manager said:

> I think over time being able to empower and show women that they are a great mum, or they are doing a great job, or they have nothing to fear because you’re not doing anything wrong. You’re doing all these wonderful things. So, even if the hospital did ring and say, “I’m worried about mum’s mental health report.” We can always say, “But mum’s engaged with the mental health worker or she’s gone to the GP for a mental health plan”.

The Garinga Bupup Senior Case Manager described a case where a woman felt empowered to access antenatal care without her support:

> That's been a real highlight for me seeing families change. … Some of them are at the point where they're happy to go to the antenatal appointment without me. If I can't get there, they will say "No, it's okay. Mum's going to take me, or I can take a taxi, or I'll be fine". And, they'll go on their own. I think that's wonderful that they've built the relationship. They knew the girls at the front desk. They're starting to know some of the obstetricians, some of the midwifes. I think that's positive.

As a Bendigo Health worker observed, "If women are engaged with care and they feel safe, they feel welcomed, they're going to be far more open I suppose to sharing information and not closing down and what could be perceived as hiding information". A Child Protection practitioner also said that "… a lot of these mums are really hesitant because they are about to birth, they've got children either already in the system or Child Protection open on children who are at home with them, and they're really worried that we're going to come up and take their baby from hospital".

Maternal empowerment also appeared to improve interactions with Child Protection. A Child Protection practitioner mentioned that the Garinga Bupup Senior Case Manager "... helps the mum feel, I suppose, empowered to be able to have particular conversations with the Department, and she's a really strong advocate for the mums with the Department as well".

Improved Cultural Responsiveness in Mainstream Antenatal Care

A positive, unanticipated outcome of the presence of the Garinga Bupup Senior Case Manager at Bendigo Health has been, according to the Aboriginal Health Liaison Worker, "a broadening and opening minds of the midwives" in relation to "what it looks like for an Aboriginal woman to birth at the hospital … It might mean once upon a time a midwife might have seen the fact that the mum might not want to breastfeed as a lack of connection, or maybe they look negatively on that as a care aspect. We're finding that's changing".

Success in Preventing an Open Child Protection Case During the Unborn Phase

Child Protection practitioners were clear that certain cases did not progress from intake because the Garinga Bupup program was involved with the family. A Community Based Child Protection practitioner said:

> There had been a request for me to review one for us to manage, and I pushed that back to intake and said, "Can you please liaise with Garinga Bupup to see if it's already open, because otherwise we would be doing the same thing …".

Another Child Protection practitioner said, "the ones that have come across from intake definitely have closed and we haven't seen them reopen, and I think that's all because the [Garinga Bupup Senior Case Manager] is in and working with these families".

The Garinga Bupup Senior Case Manager described how she was able to work with one mother when Child Protection was open on older siblings to support reunification and prevent an unborn child report:

> So, I reached out to mum. I formed a really good relationship with her and she's now looking at having her older two children reunified to her care. They've been out of her care now for nearly two years while she's been working on her challenges for the last 18, 19 months. So, she's now clean. She's not using at all. She now has a beautiful little home. She can have … both the two boys in and the newborn baby in. Child Protection are currently in a voluntary space and they're planning on closing. They have no interest in opening an unborn report on mum.

There was another example where "Garinga Bupup were involved, so Child Protection closed with Garinga Bupup in place and being able to liaise via Section 38". (Child Protection practitioner)

However, Child Protection involvement was necessary in certain cases. The Garinga Bupup Senior Case Manager said, "There have been a few times … where the risk's been too great and there's been too many concerns … for mum or the family, the unborn, or the newborn, where Child Protection has had to be involved".

Success in Diverting Aboriginal Babies from Court Following Birth

In addition to preventing Child Protection from opening a case during the unborn phase, a Child Protection practitioner said that "I definitely think there's less interventions – probably not interventions, not the word – I think there's less legal interventions". (Child Protection practitioner).

Features of Garinga Bupup Linked to Success

Several aspects of the Garinga Bupup program were key to achieving the outcomes just described. This includes relational connection, honesty, and openness with families about child safety concerns, and strong connections between Garinga Bupup and Bendigo Health and Child Protection. In every respect, these elements were dependent upon the qualities and skills of the Garinga Bupup Senior Case Manager.

Relational Connection

Garinga Bupup incorporates the Aboriginal value and concept of relational connection or "walking the journey", which was identified as a vital element to a range of positive outcomes for mothers and perinatal Aboriginal families. A Child Protection practitioner observed that "one of the reasons that [the Garinga Bupup Senior Case Manager]'s been so successful is that she's walked alongside these women for extended periods of time … I think the vital role is that they're the constant – [the Garinga Bupup Senior Case Manager]'s always the constant".

In the case of vulnerable Aboriginal perinatal women, walking the journey requires "massive heart" (Aboriginal Health Liaison Worker). It is also an extremely demanding task, requiring the Senior Case Manager to be with the mother after hours during times of crisis and/or during labour and birth. The Garinga Bupup Senior Case Manager described an incident involving a mother who was having a mental health episode:

> I found myself starting early in the morning because she'd [mother] had a bad night and her mental health was extremely bad where I'd debated calling Psych Triage. I'd say, "Okay. Look, I'm coming over. We're going to have a coffee, sit down and have a yarn. See what we can talk through". And, around the same time things were escalating with two other mums. So many things seemed to be happening at once.

> And, as we know, no babies are born between 9:00am and 5:00pm. … So, quite often I have found myself sleeping at the hospital. … I've worked weekends. Where mum's started labour at 6:00am on a Friday morning and we don't have a bub until late Saturday, early Sunday. So, it's been very sporadic with the babies and the times that I'm working. (BDAC Garinga Bupup Senior Case Manager)

Work outside regular daytime hours, and the extended hours, was also observed by the Aboriginal Health Liaison Worker:

> [Garinga Bupup Senior Case Manager] was there for her for the birth as well and ran off three- or four-hours' sleep. It was a 20-something hour day for her, and she was back the next day providing support with some food and accommodation for the person who was able to look after her young son for the night.

In addition to keeping a flexible work schedule, being able to tailor a response to the mother's practical needs, helped to create a relational connection between the Garinga Bupup Senior Case Manager and mothers:

> Being able to work with a family and making sure they have everything they need for the baby … just being able to take mum up to the Big W and let them choose new outfits for bub. To me, that's highly rewarding, and I think it's really positive rapport building as well with the families. … But even just for them to be able to reach out if they need a taxi voucher to get to an appointment. It all has a big family feel about it. Everybody feels connected, welcome and supported. I suppose this is the first environment that I've worked in where that's the case. You're able to support families on multiple different levels. (Garinga Bupup Senior Case Manager)

Honesty and Transparency About Child Safety Concerns

Honesty and respect are other Aboriginal values that are reflected in the Garinga Bupup practice approach. Transparency about safety concerns, and the necessity of change to avoid Child Protection involvement, was considered integral to helping mothers to engage in services and support when this was delivered within a motivating and strengths-based (empowerment) approach, and mothers were supported to take steps towards change:

> I find that being honest and being direct. And I suppose in some sense there's some bottom lines around you know, we have this program, and the program design is this. But without this program and if you're not attending your appointments and we're not doing these things, chances are that Child Protection may become involved. And I don't want to see you go down that track. I feel that's what's keeping the transparency within the program. I think that's what keepings families engaged. (Garinga Bupup Senior Case Manager)

Connections between Garinga Bupup and Child Protection

Strong connections between Garinga Bupup and Child Protection were essential to the delivery of the Garinga Bupup program. This was achieved through pre-birth conferences and regular consultation meetings. While pre-birth meetings were structured into Garinga Bupup' design, consultation meetings evolved over the course of the trial.

Family-inclusive Conferencing.

In two cases, the Garinga Bupup Senior Case Manager convened a pre-birth meeting:

> When we get to the prebirth space, that's generally a meeting with Child Protection, Bendigo Health, any other support services they may have. Whether that's AoD or mental health or family violence support. Where we all come together with the family around a big table, and we all talk about "These are the concerns that's brought us here today". … This is what each worker is doing. These are our roles. This is what we're accountable for. Is there anything else you need us to be doing for you? What else can we do? What else can your family do? What are you responsible for? What are your strengths? What are you going to bring to the table?" (Garinga Bupup Senior Case Manager)

The pre-birth conference/meeting had several aims, including ensuring communication and coordination among professionals/across organisations, supporting openness about child safety concerns with the mother/family, and addressing mothers' feelings of fear and powerlessness in interactions with Child Protection practitioners. The Garinga Bupup worker said:

> I think it also alleviates a lot of the fear … and a lot of the unknown for our families that we work with. … You know, I suppose in the back of their head, they're always [thinking], "What if Child Protection takes the baby? What if Child Protection say this?" So, I think it's a really nice way for us all to come together and have those really open conversations. They kind of walk away going – or if there are still some concerns they go, "Right. I've got to pull my finger out. You know, I really do have to engage with this. Or I really have to do that". (Garinga Bupup Senior Case Manager)

The Garinga Bupup Senior Case Manager went on to say that the pre-birth meeting is a way that the mother/family and an Aboriginal agency can influence Child Protection assessments and decisions, especially by highlighting the protective and preventative role of parents and family members:

> I've had Child Protection come into the meeting as well to voice their concerns, around the reports or the information they've received. And, then that gives us the opportunity to counteract those concerns and those reports and show all the positives and the strengths. (Garinga Bupup Senior Case Manager)

A Child Protection practitioner also said that these meetings are safer, and have better outcomes when led by the Garinga Bupup Senior Case Manager:

> It's about making the mother feel comfortable, and they don't want Child Protection in there telling them, whereas if they've got [Garinga Bupup Senior Case Manager] addressing any concerns that we may have, the meeting runs so much smoother.

The Aboriginal Health Liaison Worker also highlighted the advocacy roles that the Garinga Bupup Senior Case Manager plays in relation to Child Protection:

> It is a natural thing in her [Senior Case Manager] role to take the stance of protective of mother, baby, family to create those outcomes. … [Garinga Bupup Senior Case Manager] and I are probably very similar in the way we will advocate for our patients when maybe they don't have the confidence to speak up or are not sure of their choices from a health care perspective.

Regular Consultation with Community Based Child Protection.

The Garinga Bupup Senior Case Manager was also very proactive in consulting with Community-Based Child Protection where a case was open with the Department[31], or where the mother was unclear about Child Protection involvement:

> [Garinga Bupup Senior Case Manager] and I catchup monthly. We have a regular monthly catchup, just so she has the opportunity. She knows she can consult with [us] at any point, but I suppose it was just an opportunity for her to touch base, and if she did have any other questions on any of these families, she can talk to us about that. (Child Protection practitioner)

> There have been times when I've been able to have a brief consult with Child Protection … Just being able to ask, "Is there Child Protection involvement? I'm not too sure. Mum has said that it's okay to give you a call and have a yarn because she's not too sure who her case manager is". … Informal conversations like that. (Garinga Bupup Senior Case Manager)

Another Child Protection practitioner highlighted the importance of regular consultations to strengthen the connection between Garinga Bupup and Child Protection:

> I think, since setting up these monthly catchups, the relationship between [Garinga Bupup Senior Case Manager] and the Department has strengthened. She'll reach out on the ones that she is working on where the Department is open, like on Wednesday – I reached out to the Case Manager and we're doing a pre-birth planning meeting together, which [Garinga Bupup Senior Case Manager]'s going to lead and the Department will attend, but she's going to be leading that. I think, without that kind of connection in, it does make it tricky.

The positive relationship that developed between Child Protection and Garinga Bupup was evident when a Child Protection practitioner said, "I think [Garinga Bupup Senior Case Manager] and I have caught up outside of that [monthly meetings] as well. I'm at BDAC for other reasons, so if I see her, I always say, "G'day – do you need anything while I'm here?"

[31] For example, where the unborn child had older siblings open with Child Protection (part of sibling group).

Support for Antenatal Care

The Garinga Bupup Senior Case Manager said that being able to support mother's contacts with antenatal care prevented unnecessary reports when mothers presented at hospital to birth:

> I think probably another factor is the relationship with Bendigo Health and having families supported there. All too often women were turning up to birth and had no prior antenatal care. And, obviously, that's a red flag to Child Protection. And, then that initiates a Child Protection response. But what people weren't realising was the fear of services. (Garinga Bupup Senior Case Manager)

Recognising and Responding to Risk

The ability of the Garinga Bupup Senior Case Manager to recognise child safety concerns, communicate these to mothers/families, assess risk, and act to protect unborn children at risk of future harm, was a foundational requirement of the role:

> I think a really strong sense of risk assessments and risk to children is something that has to be understood to work in a program like Garinga Bupup. Because at the end of the day, as much as we want our families to stay together, if that risk is too great, if you can see that the child's not safe, Child Protection needs to be involved … I think it's really important that anybody that does work in the Garinga Bupup space or working with young, vulnerable people such as babies, you need to be able to complete robust risk assessments and be brave enough to let a family know that "This isn't okay. I'm going to have to let Child Protection know". And, make that phone call. (Garinga Bupup Senior Case Manager)

A Child Protection practitioner highlighted the Garinga Bupup Senior Case Manager's capacity to clearly communicate child safety concerns to mothers/families:

> Something I suppose that we would see as a risk – she can really talk to that, and I think that's what makes the difference. So, she can articulate that for these mums where, when you're pregnant, you're hormonal, you've got Child Protection saying, "Hey, this needs to change. That needs to change –" [Garinga Bupup Senior Case Manager] – I think she just has a different way about explaining things to mums, and

> actually saying, “Hey, well, you’re actually doing that, and this is how we’re going to show Child Protection that you’ve addressed that concern,” so I just think she works differently, and in this particular service, she has the capacity to do that, which I think is amazing. I just wish there was more of her…”. (Child Protection practitioner)

The Garinga Bupup Senior Case Manager also conveyed the benefits of being able to translate Child Protection concerns to mothers/families:

> Sometimes families don’t like to communicate with Child Protection, or they don’t absorb what Child Protection is saying because they feel so stressed. Whereas I can come in and explain, “Well, I can tell you this”. … And I think that’s been a beneficial thing for the families because I can cut through the jargon used by Child Protection and explain to the families, “So, when Child Protection are saying this, they mean this. This is going to be the expectation. So, going forward, you’re going to have to do this”. (BDAC Garinga Bupup trial Senior Case Manager)

The Garinga Bupup Senior Case Manager went on to describe how she works with mothers/families who are involved with Child Protection:

> I always explain, the last thing that Child Protection wants to do is remove people’s children. They don’t want to do that. But they have to with some families. If we are honest with Child Protection, I can support you in that space. If you’re feeling worried, you can call me. I can be there with you if Child Protection is conducting a home visit. We can talk to them together and I’ll support you to talk to them. Because I think sometimes when people are fearful of Child Protection walls go up and, before you know it, you’re coming off as refusing to engage.

Child Protection Trust in Garinga Bupup Assessment and Intervention

Child Protection practitioners said that because of the Garinga Bupup Senior Caseworker’s experience and proactive engagement with Child Protection, they were able to trust her assessment and close cases following birth that would have otherwise remained open:

> The Department, before this program, we wouldn’t have sat with that level of risk, because there’s no eyes in there, whereas you’ve got [Garinga Bupup Senior Case Worker] in there – she’s quite experienced, especially with working with pregnant

> women, so you can trust her assessment, and she does reach out, I think, because she's worked hard on forming those relationships. She's formed the relationship with the hospital and just other service delivery agencies in Bendigo. You know that what she says, she's going to do, and there's that follow-through, so I think having that there's a bit of peace of mind for Departmental staff, knowing that someone's got eyes on this baby, because a lot of time, we send mums home and it's either Maternal Child Health Nurse or Family Services, and it's not as intensive as what [Garinga Bupup Senior Case Worker]'s offering these mums. (Child Protection practitioner)
>
> Because [Garinga Bupup Senior Case Manager]'s involved, depending on the family, the risk is probably looked at as a bit less than what we would if [Garinga Bupup Senior Case Worker] wasn't involved, because we know it's an intensive service, and as [Child Protection practitioner] said, up to six months …". (Child Protection practitioner)
>
> This program has really changed, I think, the Department's response to these mums and these unborn babies. I really think it's really changed our view and having this program and knowing that they're in pre-birth and post-birth makes a huge difference. (Child Protection practitioner)

The Garinga Bupup Senior Case Manager also acknowledged the confidence that Child Protection had in her assessment and intervention:

> The advocacy for this program has been so strong from Child Protection and they have put a lot of faith into my assessment and support around the families. If I'm saying, "Mum is doing this. Mum is doing that. Or my recommendation would be this", Child Protection aren't pushing against me. They're going, "Okay. So, what do you need us to do for you?" So, that's worked well for the program so far. (Garinga Bupup Senior Case Manager)

Ongoing Monitoring and Support Following Birth

As indicated in the quotes from Child Protection practitioners above, the fact that Garinga Bupup works with mothers/families perinatally (that is, following birth as well as pre-birth), shapes Child Protection decisions and actions if there is an open case at/following birth:

> The other thing that adds, I guess, further value in terms of [the Garing Bupup trial] is that it's not just that unborn phase that [the Garinga Bupup Senior Case Manager] is working with them either, so yes, there's that leadup, but then there's also that additional support up to that six-month, 12-month – depending on when they opened – that continues to provide the support, so in terms of making Child Protection decisions, … there's ongoing monitoring, there's ongoing support, there's ongoing engagement, so that then may, or may not, depending on risk, family to family, reduce the likelihood of it progressing further in the program, because we know that the intensive support's in there". (Child Protection practitioner)

Challenges to Support Women at Bendigo Health

Bendigo Health was not involved in the Garinga Bupup co-design, so the program was not well socialised among hospital staff when implementation commenced. This, combined with visitor restrictions relating to the COVID-19 pandemic, created challenges for the Garinga Bupup Senior Case Manager to support women's contact with antenatal care, and during labour and birth:

> There were some challenges unfortunately due to the visitor restrictions through COVID in our atrium. We had to iron out some of our processes to facilitate [the Garinga Bupup Senior Case Manager] attending with women through the antenatal phase but also through birthing because we felt it's incredibly important that [she] is present when the women wish for her to be there. Otherwise, this wouldn't have been a concern in normal times, the challenges with their only facilitating one support person through the antenatal phase and birthing suite. But we were able to facilitate [Garinga Bupup Senior Case Manager]'s attendance. We issued her with the exemption pass to be able to permit her into the hospital to be with women. I think if it had been not a global pandemic and we didn't have visitor restriction in place, it would've been more seamless. We did get there in the end. But I think we did cause some unrest initially. (Bendigo Health Worker)

At the beginning of the trial, communication, and decision-making (such as making a report to Child Protection) was also not happening in a multidisciplinary approach:

> We all learned lessons that it's important to have the key people around the table, a consumer included, to ensure that we've got all the facts. We've got all the knowledge, and we've shared our knowledge to know that "This is what we're going to do. This is our plan. Are you comfortable with that?" (Bendigo Health worker)

To improve communication and cooperation between Bendigo Health and Garinga Bupup, a representative from Bendigo Health was invited to monthly stakeholder meetings convened by the BDAC Director of Families, Healing, and Response. The Garinga Bupup Senior Case Manager was also invited to pregnancy care meetings at Bendigo Health "to learn of any issues or concerns that have been raised through those meetings or channels and just iron out if there were any flags that were raised in that particular meeting for Aboriginal women" (Bendigo Health worker).

Adjustments to Strengthen and Sustain Garinga Bupup into the Future

There was consensus among participants in the interviews and focus group discussions that Garinga Bupup had altered pre-birth Child Protection in the greater Bendigo area in a significantly positive way, and should be continued:

> I think just recognising that this is a massive gap in our service that we don't have a continuity model for Aboriginal women. This is an amazing piece of work that could be extended. (Bendigo Health Worker)

Accepting Referrals from Pregnancy Care

Several participants in the interviews and focus group discussions mentioned that there is heavy demand for the Garinga Bupup program, and that referrals could be accepted from other sources, especially pregnancy care. The Aboriginal Health Liaison Worker said, "I would love to see some work put in with how do we find these mums? There are so many mums that are at risk of just social issues outside of it but having Child Protection involved".

The Aboriginal Health Liaison Worker mentioned that "not all Aboriginal people in the Bendigo area go to BDAC for their medical help, which also then leaves a gap for referral". The Bendigo health worker indicated that referrals could come directly from the Bendigo Health midwives:

> For [Garinga Bupup Senior Case Manager] to receive referrals directly from midwifery staff here, I think it's a great idea. I'd be very happy and open. I'd be concerned around the amount of referrals that poor [Garinga Bupup Senior Case Manager] might get bombarded with. Obviously, we're here to support. We also have the Aboriginal health liaison officers here to assist as required". (Bendigo Health worker)

The Aboriginal Health Liaison Worker agreed that it's "definitely worthwhile" … formalising that [referrals] a bit more".

Additional Garinga Bupup Caseworkers

As the Bendigo Health worker mentioned, the one Garinga Bupup Case Manager does not have the capacity to accept an increase in referrals. Several people mentioned that it would be beneficial to have more Garinga Bupup caseworkers.

> It's all been super positive. If there was at least one more of her, if not more, that would be great. … I think it's a brilliant program. I hope that it continues, and I know that it is so valued in our community with the mums that I've had come through and this body of work isn't wasted. It is definitely used in a positive way, for sure. (Aboriginal Health Liaison worker)

> Child Protection practitioner 1: "I think she's done a really, really good job. As I said, I would advocate for another one of her. I think that would even make more of an impact".
> Child Protection Practitioner 2: "Couple of her would be good".
> Child Protection practitioner 1: "Actually, yeah, a couple would be really, really, handy".

> [Garinga Bupup Senior Case Manager] definitely sees demand, and I know their [BDAC] bridging program holds other mums who she could definitely pick up, but she doesn't have the capacity to. I know she wants to, but she wouldn't be giving them the service that she would want to, and the time, and what they deserve, realistically. So, yeah, definitely, I would say that at least two more staff would be really handy, because then I think you would see that change in the intervention, because you'd have a team – when you're talking about a team and you're talking about being at the hospital all the time and being within the Department and other service agencies, then your voice gets heard across the Bendigo region, and then the program may have that bit more of an impact with the intakes or reports coming through, because we're all aware of this program, but I'd be really mindful of who else within the Bendigo region is really aware and understands fully what this program is. (Child Protection practitioner)

There was also mention of the need for a senior worker to manage the Garinga Bupup caseworkers, who can step in when caseworkers are unavailable to provide continuity of care:

> I don't know whether having someone like a manager or something that sat over a couple of staff that held the cases, so that when, e.g., one of them was off sick, it wasn't then just lumping it onto the other worker to then manage all ten for a week or a week and a half, or while they were taking three weeks' holiday or whatever it may be. It meant that that then – Team Manager or whatever kind of over-sat some of those things and could help juggle things, yeah. (Child Protection practitioner)

> I think you need another senior worker, or as [my colleague] said, a senior worker and two Case Managers. (Child Protection practitioner)

> The way that I've explained how I think it would work best to [my manager] would be to have myself, another two [case] managers, and a case support [worker]… So, that – it would be like, a three-week rotating roster between myself and the other two managers. So, we would have a week of being on call each. (Garinga Bupup Senior Case Manager)

Strengthening Connections with Bendigo Hospital

As well as establishing a referral pathway between Bendigo Health and Garinga Bupup, and continuing weekly pregnancy care meetings with the Garinga Bupup Senior Case Manager, a Child Protection practitioner observed that:

> There's a little bit more work there to be done, and not just by BDAC – the hospital probably needs to step that up a little bit more, to be honest, because then they might fully understand the program and be more confident in what the program is delivering.

From the perspective of the Aboriginal Health Liaison Worker, this involves defining role boundaries when the mother is attending antenatal care and staying in hospital for labour and birth, and following discharge from hospital:

> When they're [mothers are] not in the hospital … our role ceases from there. Do we do a follow up call to see how they are? Sure. But, once you're not in the hospital, our role stops and [the Garinga Bupup Senior Case Manager] … picks back up again. I do think it would be good to formalise some of those boundaries, not because it's an issue, but more because especially for staff changes in our office. (Aboriginal Health Liaison worker)

> [Garinga Bupup Senior Case Manager] might have a mother that she might think would be appropriate for a referral that we can keep an eye on as well or help out when she's here. I think some kind of formalising would be great. Wouldn't have to be anything too crazy, but I think just knowing who does what and when and how that can best work together. I know for the rest of my team I've taken quite a lead on the women's ward and the children's ward, but for others, and we do have new staff coming in, it would be great for anyone to pick this up and be able to provide that as well. (Aboriginal Health Liaison Worker)

> I do think that there is some work that we can all do together, but I am mindful of while they're in a hospital setting, we have a role ourselves to play, and then [the Garinga Bupup Senior Case Manager] has hers as well. She does a lot of that, don't

> get me wrong, but I would love to see more emphasis on creating it all outside, prior and post, and then while we're here we could do it together. (Aboriginal Health Liaison Worker)

Strengthening Connections Between Child Protection Intake, ACSASS and Garinga Bupup

A Child Protection practitioner said that there was an opportunity to strengthen the interface between Child Protection Intake, ACSASS and Garinga Bupup, to prevent Child Protection opening cases unnecessarily if the ACSASS worker knew which families were working with Garinga Bupup:

> That was always really hard, and I think the interface, I suppose, between [Child Protection] intake and the program [Garinga Bupup], and I guess that's what I always encouraged – before coming to me [CBCP], if you've got an Aboriginal baby and you're having a consult with ACSASS, then you need to be asking, "Are they engaged with Garinga Bupup?" because that then gives you some insight, and I guess that interface, I think, for me is still kind of not there … if they're an unborn or a baby that is working with [Garinga Bupup Senior Case Manager], and if it doesn't need to sit with us [Child Protection], then we absolutely don't want it to sit with us. (Child Protection practitioner)

> So, if we were calling [ACSASS] about an unborn and they had access to [the Garinga Bupup Senior Case Manager]'s list, they would automatically be able to inform that information. I don't think you're going to reduce the reports, regardless of [Garinga Bupup Senior Case Manager] working with these mums, because anyone could report … It's stopping the next phase after intake, I think, is the biggest thing. (Child Protection practitioner)

Appendix D

Evaluation Findings from the Aboriginal-Led Case Conferencing Trial

Table 1.

Summary of Findings from the Aboriginal-led Case Conferencing Trial

Was the trial implemented correctly?	What were the implementation barriers and enablers?		How satisfied were Aboriginal families who received the trial?	What features of the trial made a difference?	Was the trial successful in achieving its ST, MT, and LT outcomes?
	Enablers	**Barriers**			
Referral from Child Protection intake effective. Targets achieved (n=26). Families held for longer than originally intended, resulting in multiple case conferences and professional care team meetings per case.	Governance group. Implementation team. Service blueprint. Organisational support (VACCA). Convenor with the appropriate skills and	Lack of resources (wait times for services, lack of brokerage)[32]. Rules around information sharing between Child Protection, other government departments, schools	Very satisfied.	Timely referrals. Support from Aboriginal agency outside the statutory Child Protection system. Culturally grounded approach to engagement that is strength-based, builds self-determination/agency, and listens to client voice.	Very good uptake/utilisation, but not all referred families participated in the trial. High level of cultural safety and engagement. Engagement in community services where there was an identified need.

[32] Upon identifying this issue VACCA allocated family service brokerage to the ALCC.

Was the trial implemented correctly?	What were the implementation barriers and enablers?		How satisfied were Aboriginal families who received the trial?	What features of the trial made a difference?	Was the trial successful in achieving its ST, MT, and LT outcomes?
	Enablers	**Barriers**			
Referred families (n=37) mostly fitted the inclusion criteria. Families connected to a variety of community services. Five Section 38 consultations completed.	knowledge to implement the ALCC.	and the ALCC Case Convenor. ALCC Convenor not having the equivalent powers as Child Protection to be able to request information e.g., corrections orders, L17s.		Proactive, well-executed short-term case management to mitigate the escalation of risk and advocacy across the service system. Strong interface with Child Protection (with Lakidjeka prior to referral, Section 38 consultations, and informal consultations). Ease of referral into VACCA services. Family inclusion in case conferences. Professional care team meetings.	Families rebuilding agency and control over their personal life. Four ALCC children were involved in a re-report (17.4%)[33]. Substantially fewer ALCC children were involved in an investigation compared to non-trial children involved in a report during the same period. None of the ALCC children were placed in OOHC, compared to 4.2% of non-trial children.

[33] Families who did not utilise the ALCC were also re-reported.

Was the trial implemented correctly?	What were the implementation barriers and enablers?		How satisfied were Aboriginal families who received the trial?	What features of the trial made a difference?	Was the trial successful in achieving its ST, MT, and LT outcomes?
	Enablers	**Barriers**			
				Case management based on self-determination (clients exercise their right and control over service delivery, such as choice of mainstream/cultural services. Follow-up to ensure referrals led to family involvement.	Slight reduction in the % of reports that resulted in an investigation, substantiation and OOHC placement in the trial period compared to the 10 months prior.

Data from VACCA's CSNet Client Information System

Data from VACCA's CSNet Client Information System was available for the 12-month trial period - 27 Sept 2021 to 26 September 2022. During this time, the ALCC received 37 referrals from Child Protection Intake. Of those families, 26 participated in the trial (70.3%). Of these 26 families, 19 agreed to participate in some part of the evaluation.

Child Protection Reports on Aboriginal-Led Case Conferencing Children

Data from VACCA's CSNet system indicated that five Section 38 consultations were initiated, and a report was made by the ALCC Convenor in four of 19 cases (21.1%). In these four cases, the ALCC service closed with the family on or close to the report date as Child Protection planned to investigate.

Length of Service and Conferencing

At a mean of 121 days, ALCC service episodes were longer than designed/anticipated. Each case also typically involved one or two[34] family-inclusive case conferences to develop a case plan and several professional care team meetings involving services that were engaged in supporting the family (see Table 1 below).

Table 1

Data from VACCA's CSNet Client Information System: Length of Service and Conferencing

Service Characteristic		Number	Per cent	Mean (Standard Deviation)	Minimum	Maximum
Length of service (days)		19		121.4(64.9)	28	251
Conferencing	Family inclusive case conference/s only	6	31.6	NA	NA	NA
	Professional care team	1	5.3	NA	NA	NA

[34] Where conferences were convened for mothers and fathers separately.

	meeting/s only					
	Family inclusive case conference and professional care team meeting/s	12	63.2	NA	NA	NA

Reasons for Referral into the Aboriginal-Led Case Conferencing Trial

Reasons for referral into the ALCC trial were wide ranging and included factors which intensify the complexities of parenting, such as psychological problems, family violence, homelessness, inadequate parenting skills, and parental substance misuse. Home environment/environmental neglect, and child missing school were also reasons for referral.

Connections to Services and Supports

Services and supports that families were referred to, or who were already supporting families included, VACCA Family Services, VACCA Family Violence program, VACCA Koori Families and First Educator program, VACCA Wilam Housing, Noogal Clinic, Austin Health CYMHS, Barreng Moorop, Koorie Kids, Navigator program, Elizabeth Morgan House, schools, and public hospitals, AoD service (detox/rehab), NDIS, and Dardi Munwurro (youth service).

Feedback Forms

Eleven of the ALCC families completed a feedback form designed to measure safe environment for the delivery of care, client engagement in the ALCC program and overall satisfaction with the service. Results from the analysis show a very high level of client engagement, cultural safety, and service satisfaction (Table 2).

Table 2.

Client Feedback

	Number	Mean (Standard Deviation)	Minimum	Maximum
Client engagement in the ALCC (range 1-5, 11 items)	11	4.5(1.0)	1.6	5.0
Safe environment (range 1-5, 6 items)	11	4.5(1.2)	1.0	5.0
Client satisfaction (range 1-4, 8 items)	11	3.6(.5)	2.3	4.0

Positive Experiences

Eight of the 11 participants who completed a feedback form completed the open-ended item on positive experiences. Several participants commented on the ALCC Convenors' strengths-based, relational approach saying, "[caseworker] made me feel safe and my feelings valid" (id#11), "so kind and lovely and so helpful with everything" (id#8), "very supportive and understanding" (id#4), and "really supportive" (id#5). No negative experiences were reported.

Findings from the Child Protection Client Relationship Information System Data

The following results are based on an extract of data from the Child Protection Client Relationship Information System (CRIS) between 1 November 2020 and 31 August 2022 for relevant cases in Banyule, Darebin, Hume, Merri-bek/Moreland, Nillumbik, Whittlesea, Yarra (the ALCC trial area). The CRIS observation period for the ALCC trial was ten months between 1 November 2021 and 31 September 2022.

Child Protection Re-Reports Following Acceptance into the Aboriginal-Led Case Conferencing Trial

Thirteen[35] ALCC families who had been accepted into the ALCC program between 1 November 2021 and 31 May 2022 (approximately seven months of the trial) consented to researchers accessing CRIS data for evaluation purposes. Three (23.08%) children from these 13 families were re-reported to Child Protection within a minimum three-month follow-up period (Table 1)[36].

Table 1.

Child Protection Re-Reports Following Acceptance into the Aboriginal-Led Case Conferencing Trial between November 2021 and May 2022[37]

VACCA ALCC Trial cases: referrals accepted November 2021 to May 2022	Number	%
Cases with a CRIS number in scope	13	100.00%
Cases with at least one Child Protection report prior	13	100.00%
Cases with at least one Child Protection report following	3	23.08%
Cases with at least one report both before and after	3	23.08%

Case Trajectories of Aboriginal-Led Case Conferencing Trial Children Compared to Non-Trial Children

A substantially lower proportion of ALCC children were involved in an investigation between 1 November 2021 and 31 August 2022 compared to non-trial Aboriginal children[38] during the same period (21.74% compared to 34.2%). None of the ALCC children were placed in OOHC, compared to 4.18% of non-trial children.[39] (Table 2 and 3).

[35] The low number of cases is explained by the exclusion of referrals received after 31 May 2022.

[36] As reports involving ALCC children were not investigated, consecutive reports for non-ALCC children were not examined due to lack of comparability.

[37] These data were supplied by VACCA and cross-referenced with CRIS data.

[38] Non-trial Aboriginal children are Aboriginal children reported to Child Protection during the CRIS observation window (1 November 2021 to 31 August 2022) who did not take part in the ALCC trial.

[39] It should be noted that some ALCC children may have been involved in an investigation prior to their involvement in the ALCC program.

Table 2.

Case Trajectories of Aboriginal-Led Case Conferencing Children

All Trial reports of Aboriginal Children: 1 Nov 2021 to 31 August 2022					
CP event	**Number**	**% of reports**	**Number of children**	**% of children**	**Average per child**
Report	23	100.00%	17	100.00%	1.35
Investigated	5	21.74%	4	23.53%	
Substantiated	1	4.35%	1	5.88%	
Placed in OOHC	0	0.00%	0	0.00%	

Table 3.

Case Trajectories of Non-Trial Children

All non-Trial reports of Aboriginal children: 1 Nov 2021 to 31 August 2022					
CP event	**Number**	**% of reports**	**Number of children**	**% of children**	**Average per child**
Report	1005	100.00%	687	100.00%	1.46
Investigated	344	34.23%	332	48.33%	
Substantiated	133	13.23%	132	19.21%	
Placed in OOHC	42	4.18%	42	6.11%	

Comparison of Child Protection Reports and Child Protection Services 10 Months Prior to the Aboriginal-Led Case Conferencing Trial and During the Aboriginal-Led Case Conferencing Trial

There was a 21.5% increase in the raw number of Child Protection reports during the ALCC trial period (n=1,028) (1 November 2021 to 31 August 2022) compared to the prior year (n=846) (1 November 2020 to 31 August 2021), perhaps at least partly because of the gradual lifting of COVID-19 restrictions. There was a slight reduction in the proportion of reports that resulted in an investigation, substantiation and OOHC in the ALCC trial period compared to the comparison 10-month period (Table 4 and Table 5).

Table 4.

Aboriginal Child Report Outcomes Prior to the Aboriginal-Led Case Conferencing Trial

All reports of Aboriginal children: 1 Nov 2020 to 31 August 2021					
CP event	**Number**	**% of reports**	**Number of children**	**% of children**	**Average per child**
Report	846	100.00%	594	100.00%	1.42
Investigated	289	34.16%	272	45.79%	
Substantiated	140	16.78%	137	23.06%	
Placed in OOHC	56	6.62%	56	9.43%	

Table 5.

Aboriginal Child Report Outcomes During the Aboriginal-Led Case Conferencing Trial

All reports of Aboriginal children: 1 Nov 2021 to 31 August 2022					
CP event	**Number**	**% of reports**	**Number of children**	**% of children**	**Average per child**
Report	1028	100.00%	704	100.00%	1.46
Investigated	349	33.95%	336	47.73%	
Substantiated	134	13.04%	133	18.89%	
Placed in OOHC	42	4.09%	42	5.97%	

Figure 1 and Table 6 below illustrates the higher proportion of ALCC children who were closed from intake following a report (that is, no further Child Protection service during the CRIS observation period), and the lower proportion who were closed following investigation, substantiated (no OOHC) and placed in care compared to non-trial children and all children in the preceding ten months.

Figure 1.

Case Trajectories of Aboriginal-Led Case Conferencing Trial Children, Non-Trial Children and All Aboriginal Children Prior to the Trial

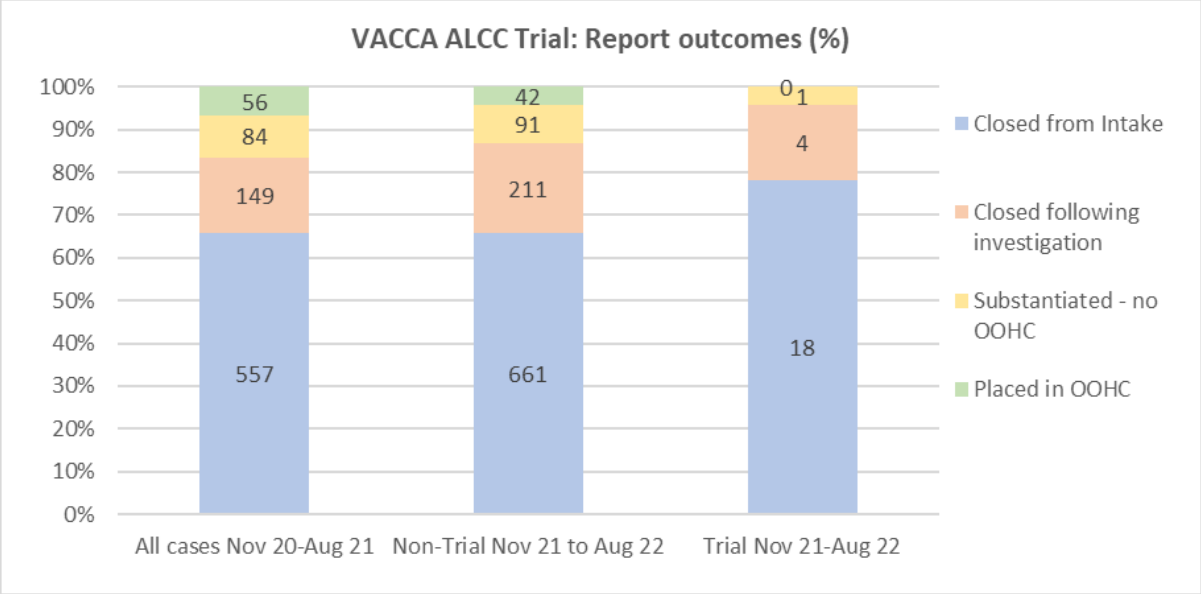


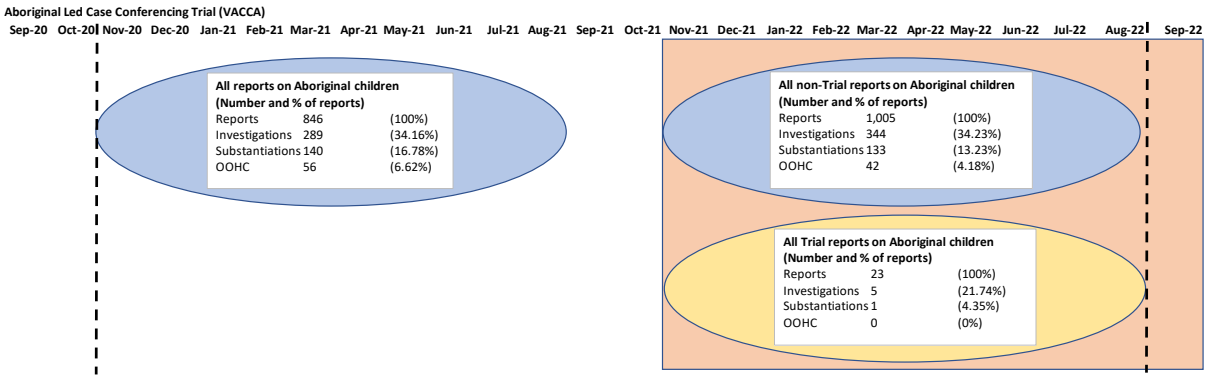
Table 6.

Case Trajectories of Aboriginal-Led Case Conferencing Trial Children, Non-Trial Children and All Aboriginal Children Prior to the Trial

Report Outcomes	All cases Nov 20-Aug 21	Non-Trial Nov 21 to Aug 22	Trial Nov 21-Aug 22
Closed from Intake	557	661	18
Closed following investigation	149	211	4
Substantiated - no OOHC	84	91	1
Placed in OOHC	56	42	0
Total reports	*846*	*1005*	*23*

Figure 2.

Comparison of Aboriginal Children Pre- and During the Aboriginal Led Case Conferencing Trial



Narrative Summary of Interviews and Focus Group Discussions

Two interviews and two focus group discussions were held with professionals involved in the implementation of the ALCC trial, including the ALCC Convenor, representatives from Lakidjeka and VACCA Family Services and Child Protection practitioners.

Referral Pathway from Child Protection Intake Mostly Successful

The referral process from Child Protection intake was mostly effective, particularly at the beginning of the trial. A VACCA worker said, "[Child Protection] have been really fantastic as well in referring the cases to [the ALCC trial]".

Consultation between Child Protection intake practitioners and Lakidjeka intake (Northern Region) before a referral helped to ensure appropriate and timely referrals, and ALCC program readiness to accept a new referral:

> Having intake completed within the region and on the same the team has allowed for [us] to have discussions prior to accepting the referral from Child Protection. It allowed [Aboriginal-Led Case Conference Convenor] to push back at times and ask questions to get more information. (Aboriginal-Led Case Conference Convenor)

> I think the relationship is important to be able to say, "Yeah. Look, this one sits a bit funny, but how about we try?". (Child Protection practitioner)

A Child Protection practitioner also commented on the responsiveness of VACCA in relation to requests for consultation at intake:

> Organising the initial consults, VACCA were really responsive, called back straight away. One of mine, the second one, there was some hesitation around it, but the family were involved with VACCA, and it was reported that she would consult with the workers and get back to me by a certain time. That had occurred. The follow-up and the consults were really easy to organise, and there was a really quick response. (Child Protection practitioner)

A straightforward referral process was also enabling, according to a Child Protection practitioner:

> The process [of referral from Child Protection intake to the trial] actually is really quite easy, which I think is really important. Especially with those cases that could potentially go either way, to investigations or across, it does need to be timely, otherwise things can escalate really quickly. To add to that referral process, it is really easy. It's great that you don't have to fill in another form, all these long questionnaires. (Child Protection practitioner)

However, towards the end of the trial, the ALCC Convenor said, "there's a few that aren't quite fitting the criteria". It appeared that Child Protection intake practitioners were not clear that the ALCC was intended to divert families from an investigation; that is, if the ALCC program didn't exist, then the case would progress to an investigation. A VACCA worker said, "It's fantastic that we've had [Lakidjeka intake] in that space to guide them in what is

appropriate and what is not, but sometimes there's a bit of a gap on what is appropriate to refer to the program and whether it meets the criteria".

A Child Protection practitioner said that although there was internal communication about the trial initially, the program needs constant dissemination to sustain the referral pathway:

> We probably need to do some more work internally with our Child Protection staff because I think we let them know that these programs are happening and we had [Aboriginal-Led Case Conference Convenor] attend our huddle, so an all-Child Protection forum, then leadership meetings with our investigation team, but that was months ago when all the initial changes were occurring. So, I think unless we're constantly prompting, the only other real prompt comes from ACSASS, and sometimes intake don't get to speak to our ACSASS team.

Most Families Receptive to the Aboriginal-Led Case Conferencing Trial, but Some Families Hard to Engage

As indicated above, 26 of 37 families referred to the ALCC participated in the trial. There were several reasons why families did not take part in the trial, including families not residing in the service area and one family being deidentified after the referral was made. The ALCC Convenor said that one family preferred to work with Child Protection because they had the power to enforce a family violence intervention order:

> We've had families that have gone on and asked for Child Protection to enforce certain things such as enforce an IVO [intervention order] against their former partner, whereas I can't enforce any of that. That's not what my role was. So, I think some of them were more comfortable in having someone do that hard work for them that I couldn't do because it wasn't part of the role. (ALCC Convenor)

Most families that were referred to the ALCC were receptive and engaged in the program. The ALCC Convenor said "Generally, people were quite receptive to the trial and giving it a go" and went on to say that "most of the families I've worked with are real keen for it to continue and would recommend it to any family". However, several participants identified that there were a few families who the ALCC Convenor either couldn't contact or could not

engage in the program. The ALCC Convenor said, “There were obviously some that declined to participate, which is their right”.

A Child Protection practitioner said, “When you think back to the initial intake document, there’s probably some signs in there that we were going to find it really hard to engage those people to start off. Those ones are the ones that are probably coming back into Child Protection”. Another Child Protection practitioner made a similar observation, saying that “the families that they’re [ALCC program] struggling to contact are the families we probably could have predicted they were going to struggle to contact from previous intakes and reports”.

It appeared that the families that the ALCC Convenor found hard to engage were experiencing chronic issues from current and historic traumatic events. A Child Protection practitioner said “We’ve had a few young mums living with grandparents who’ve done exactly the same thing with them. Those repeated patterns. They are more chronic, more difficult families to work with. They always have been”.

A Child Protection practitioner made a connection between difficulty engaging parents in the ALCC trial and their avoidance of working with social service professionals due to concerns that it makes them visible to Child Protection:

> I think there’s been feedback about one young mum recently said, “But, if I work with the services, they’ll make a report to Child Protection”. It’s like, “No. It’s the opposite way. We’re going to come and knock on your door because you’re not working with these services, and you’ve got little babies”. (Child Protection practitioner)

Diversion from Investigation Achieved in Some Cases

There was strong support from Child Protection for giving families the opportunity to work with VACCA to avoid an investigation if possible:

> I think the biggest thing for me is that a family is getting every opportunity to avoid a Child Protection response, to have Child Protection knocking on their door for maybe the fifth, sixth time. That we are creating a pathway for them that, hopefully, does

> not involve a government body coming and landing on their doorstep. If it does result in that, that we've given it its best shot to not have that happen. Where there's really nothing else that we could have done, probably, to avoid that. (Child Protection practitioner)

> It's given us another option, which is really valuable in bringing community together. I know with my first referral; the family hadn't had a lot of exposure also to Aboriginal services. So, I think that was a great pathway to be linked in with those services. (Child Protection practitioner)

A Child Protection practitioner observed positive outcomes for families who the ALCC Convenor was able to engage, saying "I think where [the ALCC Convenor] has been able to get in and get the network around the family, she's actually had some really good results with that". Another Child Protection practitioner also commented on the ability of the ALCC Convenor to connect families to services:

> I think once they've engaged, then that's been really quite strong in terms of the connections and the support they've afforded. I know that they've had Family Services. I know they've worked with the VACCA family violence program. So, there's a whole range of things under their umbrella, which makes it really easy then to coordinate. I know if I'm sitting at VACCA, I can go to [the Aboriginal-Led Case Conference Convenor]. [The Aboriginal-Led Case Conference Convenor will] go, "Hang on. We can go and grab the family support services person," and you can all sit in the same space and talk. I think having that connection has been really good. I do think that [the Aboriginal-Led Case Conference Convenor] been able to make those referrals to services which have resulted in engagement. (Child Protection practitioner)

The ALCC Convenor also mentioned that whether families were connected to cultural or mainstream services was their choice, saying "I think we were [successful in engaging cultural services] for those who wanted it. Some families didn't want to be engaged with cultural services. They were happy to go mainstream and preferred that, which was their choice. So, where they wanted it, I think we worked pretty well towards that".

The Aboriginal-Led Case Conference Convenor described a family where diversion was achieved successfully:

> There was one family that I helped very early on, and I remember there was a whole lot of things happening at that time. We're trying to get services for people, and I think I was carrying probably about 15 families at that stage because I couldn't get them into services. This particular family got the help that they needed, and I remember coming back to the office and saying to [VACCA worker], "If that's the only one that works out of all of this, I'm happy". One family was diverted away. Mum's doing really well. There hasn't been a re-report. Mum's getting the help that she needs and being able to have her child with her while she gets that help, for me that's a win-win. (ALCC Convenor)

A VACCA worker also noticed a decrease in the number of children subject to a Child Protection intervention and entering care, which was attributed to families being diverted at the 'front door' of the Child Protection system:

> We saw a decrease in the number of families being referred into Child Protection or progressing through the Child Protection system, which was good. It made us a lot quieter as my normal role, which is really good. But, it had an after effect also. The cultural support planning team, we had a chat to them about the impacts with seeing less families coming through the Child Protection system and they even had an impact with referrals to their service because families weren't progressing through the Child Protection system. (VACCA Worker)

A Proportion of Families Receiving the Aboriginal-Led Case Conferencing Trial Re-Reported to Child Protection

As discussed above, the ALCC Convenor was unable to engage some of the families that were accepted into the ALCC trial, and it was often these families who came back into Child Protection[40]. A change in family circumstances when a baby was involved also prompted a re-report. A Child Protection practitioner said "it's primarily that, as I said, the risk has increased. So, babies, where there's been a family violence incident or something like that,

[40] These children were not followed up in the CRIS data as they were not included in the ALCC trial cohort.

and we've had to get something happening urgently. We've done a couple of those with babies". In one case the ALCC referred a family back to Child Protection because, in addition to the reasons for referral, the family was uncontactable and the ALCC Convenor was alerted to a red flag in the Child Protection system.

Factors that Contributed to Positive Outcomes

There were several practice elements that enabled positive outcomes for families, which are discussed below. It was noted, however, that implementation of these practices was dependent on the skills and qualities of the ALCC Convenor:

> I think the success probably comes down to having the right person in that position as well. I'm going to say it. [Aboriginal-Led Case Conference Convenor is] a similar age to me. Maybe that mature age. Coming from the wise perspective of having worked in different agencies, worked around, not being new to the role, I think, is probably really critical. It needs to be an experienced person in that position. They've got to be comfortable with going and knocking on a door, potentially, and saying, "Hi, how are you going? Haven't got you on the phone". (Child Protection practitioner)

> [The ALCC Convenor] works independently without really much support or guidance from myself as her team leader, which is fantastic. I think if we had anybody else that does need more assistance or hands-on help, then it would – you need somebody that shows initiative with getting the work done. (VACCA Worker)

Engagement Based on Honesty

The perceived diversionary impact of the ALCC programs was connected to the ALCC Convenor's ability to engage families then work with them to address child safety concerns:

> The ALCC program … can engage with the families and say, these are the things you need to do, A, B and C, so Child Protection can back off and then we're all here to support you to do this. I think that was a real positive. (VACCA Family Services Worker)

The ALCC Convenor said honesty and transparency about the aims of the trial and what it was able to deliver helped to engage families:

> I think being honest, telling them about the program, telling them what the idea of the program was and how we were trying to prevent them entering an investigation phase with Child Protection. I think just being honest about it was the best way and encouraged that engagement … . Not promising them anything you cannot deliver. I constantly heard that. "Are you going to promise all this stuff that you're not going to deliver like they have before"? (ALCC Convenor)

A conversation about the trial happened at the first visit, before the case conference. A VACCA worker said "So, we thought it was beneficial to be open and honest from the start on why we were there, and better to have those conversations up front and face to face".

Building Self-Determination

The ALCC Convenor said that "having parents realise that they can make a change themselves" was one of the most rewarding aspects of the trial. The ALCC Convenor also provided examples of how the trial was supporting families to rebuild agency and control over their personal life:

> I've had people that I have helped come back, call me to ask me questions or, "I've looked but can I go somewhere else? Can you suggest where I can get more help?" or something has changed, and they just wanted to check in with me. So, that's been good that they've got that point of contact. Obviously, that's worked, that you can contact VACCA at any time. (ALCC Convenor)

> I think for a lot of families it was about knowing where to go for help too. I can't tell you how many times I've had people say to me, "I didn't realise that VACCA had all those services". So, it's about that education and then empowering them to reach out for that support which a lot of them did. If we'd closed or they'd ring me and ask for something I'm like, "If you give this person a call, they'll be able to help you," and they would. There were some people that said to me it was great that I empowered them to be able to ask for help, that there's nothing shameful about asking for help and that it's better to

ask for help in the first instance than have everything fall apart and then end up with a report. (ALCC Convenor)

Supporting Families to Make Change

The ALCC Convenor said that supporting families to make change, as opposed to simply outlining safety concerns and what action the family needs to take, set the ALCC trial apart from Child Protection:

> It's not just making those referrals. It's making sure that those referral pathways have contacted the families, have done that initial home visit or intake, and giving them a clear timeline of what is going on. I think a lot of the time people go into their homes. They tell them, "Right, these are the concerns. You've got to do this". Okay, that's great, but by when? And, what's going to happen if I don't? I suppose also give them the opportunity to make the choices about what services they want to connect with. Don't tell them who they're going to connect with. "Would you prefer to go with one of the ACCOs or would you prefer to go mainstream? Is there a service that you're working with that you want to continue to work with, but you've just fallen out of contact with them?" I think you've just got to be honest and direct…, and then give them an opportunity to input into that. (ALCC Convenor)

A VACCA Family Services Worker described how the ALCC Convenor mentored her when taking over a family:

> [ALCC Convenor] would make sure that the Family Services Case Worker, which are us, are taking over and then she would help us – she would support us for a few weeks with me, because some of the families, they had intensive needs and requirements. She would fill me in with what the family has needed. In some cases, if the family wasn't really engaging with me but they were engaging with her instead, what she would do was, for a client, what we did was we did a joint meeting. Because the client was able to engage with her and request things from her, but she wasn't really doing that with me. After having that joint meeting, together with her, the client started to pick up my calls and she also started to message me as well. I think she just felt more comfortable with both of us being there. Then, she also started to build that rapport with me. (VACCA Family Services Worker)

> Working with [ALCC Convenor] was really helpful because I'm quite new in this role, it's been four months and although I am able to do everything on my own and refer my clients to the right supports, [Aboriginal-Led Case Conference Convenor] is always there as an extra support for me, other than my team leader. I always know if something is wrong and I can't really solve the situation, I just go to [ALCC Convenor], debrief with her, and she always guides me on what to do, where to apply or she gives me phone numbers and say, "You can contact this agency for more support". She's always there for me. (VACCA Family Services Worker)

Case Conferencing

The case conference itself was seen to be an effective way of engaging a care team to support families to address child safety concerns, with the added benefit of enhancing parents' receptivity to services and support:

> [The case conferences were] very useful – Were able to ensure everyone was aware of the concerns and what was being done to address them. At times also helped the family engage better as they knew services were working together to support the family. It helped with services not doubling up with support and there was earlier awareness when the family's situation changed. [ALCC Convenor]

> Most of the families had or required support from multiple services some who were not even aware the family was working with other supports. [The case conference] allowed the care team to be pulled together and provide a wraparound service to the family. [ALCC Convenor]

Section 38 Consultations with Child Protection

The ability to discuss cases with Child Protection, glean more information and come up with strategies for families on the cusp of a re-report was of great assistance to the ALCC Convenor:

> I found [the Section 38 consultations with Child Protection] really helpful even if it was just discussing the families with [Child Protection practitioner] and then she'd say to me, "But have you tried this? Have you contacted this person? Can you give

> this a go?" or she could look up that extra information on their computer and come back to me and give me some more information or more strategies. So, to me, that was invaluable. It was really good. It made the difference with some families about whether they went back in or whether I pursue a bit more. (ALCC Convenor)

Barriers to Responsive Practice

Service Availability and Wait Times

A Child Protection practitioner and VACCA Workers said that lack of services and wait times for services contributed to re-reports. The ALCC Convenor said, "There's wait lists everywhere. There's a five-year waiting list at the moment [for housing] … and there's a six month wait list for boys to get a mentor …. Mental health support is a big barrier, particularly for teenagers". Another VACCA Worker agreed that "Youth mental health is probably the most standout one for wait times". A VACCA Worker said, "if the referrals were accepted sooner, then we would have less families going back to or entering the Child Protection system. A Child Protection practitioner said, "Having the resources in the community. That was a bit of a barrier, particularly earlier on".

VACCA Family Services seemed to be the exception to the rule. The ALCC Convenor said, "The other valuable relationship to the program has been with VACCA's Family Services Team. It was great to be able to have that support immediately available for families".

Out-of-date Contact Information on Referral

In the ALCC blueprint, the Child Protection intake report was included in the referral (not redacted). Out-of-date, missing, or confusing contact information recorded on the intake report caused frustration for the ALCC Convenor and caused delays in contacting parents[41]:

> I think the other frustrating thing was on the intake reports, and I'm sure it's the way it's produced, is that sometimes you can have a child who has their contacts listed as five different mobile numbers. Well, which one do I call? There are addresses withheld so then I have to contact them again. You've withheld it on the report.

[41] The plan was to contact families within 1-2 days of accepting a referral.

> What is the address of the family or what's the phone number of the family, or the numbers are incorrect? I would've thought at intake, if you're taking any intake about the family, you're checking all this information as you're going. And, it may just be the way it's reported on the intake record but I spend a lot of time sometimes chasing up that information. Sometimes it can take me a week or two to get that information. So, that's two weeks that have gone past that I haven't been able to engage with a family. (ALCC Convenor)

> It's really only the intake document that gets sent through. … if that's not updated, then sometimes that's led to complications for [Aboriginal-Led Case Conference Convenor] trying to get in contact with family members and things like that. [Aboriginal-Led Case Conference Convenor is] normally back to State-wide Services and said, "Can someone give me more current contact details?" (Child Protection practitioner)

Future Adaptations

Referral of Expectant Aboriginal Families

During the trial, referrals came from Child Protection intake – State-wide Services. The ALCC Convenor said, "I'd encourage it [ALCC] to include pre-birth as well". She went on to say:

> I think that there's been a few referrals that have come through that I think if the family were supported prior to the birth may not have resulted because pre-birth is a voluntary space, but once the baby's born, then you have to be involved. So, I think that if it could be supported pre-birth then you're going to have a better outcome at birth and also moving forward, because the supports are already in place before the baby's born.

The ALCC Convenor gave an example of how better connections between an ACCO, and birthing hospitals pre-birth could assist Aboriginal perinatal families:

> We had one recently that was an unborn report which they'd tried to refer through. Obviously, we didn't have the scope to take unborn. But I knew the social worker at the hospital, and I was having a discussion with her about another family, and I said, "Look, I know that this one's coming through. When the baby's born, it's going to be

> referred to me but, in the meantime, can I send you a referral form to Family Services and to the Koorie Families as First Educators program, plus the Wilam housing program? Can you fill them out? I'm happy for you to send them back to me and I'll send them on but at least then there's services for when mum has the baby already in place." So, we did that. Mum had the baby a week later and she was already connected in with all the services. (ALCC Convenor)

Consultation and Information Sharing with Child Protection

Due to capacity issues within Community-Based Child Protection, it was decided during service blueprinting that the ALCC would consult with the Child Protection specialist who was supporting implementation of the Aboriginal Children in Aboriginal Care (ACAC) program. However, the Child Protection specialist said "moving forward … does it sit with me, as the Child Protection specialist, or does it sit with community-based in the future, where they do the consults there".

The ALCC Convenor said that "not being able to access that same kind of information [as Child Protection has] was frustrating at times". She recommended clarity around information sharing, and better access to Child Protection histories:

> I think the clarity around information sharing or lack of because I don't hold the same powers as Child Protection. So, if we're talking about this as an alternative to going to investigation it should be, as far as I see it, on the same level as an investigation power.

As well as access to "the L17s [referrals made by Victoria Police officers who have attended a family violence incident], IVOs [intervention orders]", the Aboriginal-Led Case Conference Convenor would like access to "more information from Child Protection through that intake space … the amount of information that is exchanged as a part of that referral process".

Material Assistance

The ALCC Convenor also said that brokerage would enhance engagement, support, and outcomes for Aboriginal families on the cusp of a Child Protection investigation:

> It would be handy I think for that initial visit to have a brokerage component to the program so you can go out with a $50 food voucher. That will always get you in the door. Or, if there's immediate needs, if there is that waiting period, that we are able to support them financially for a little bit before they're picked up by another program. I think that's important because generally, as we know, when families are reported to Child Protection, financial strain is one of the biggest things that I've noticed. (ALCC Convenor)

Dissemination About the Program

The ALCC Convenor identified ways to avoid Child Protection reports involving Aboriginal children. The ALCC Convenor said, "I think that if it [ALCC] is to continue and I'm allowed to continue in the role, that is something that I would push is getting out there in the community and making them aware that the service is there, what it's about, different ways of supporting the families". The ALCC Convenor described the practice when interfacing with mandatory reporters, such as school principals or maternal and child health nurses, to avoid unnecessary Child Protection reports involving matters of neglect, developmental or emotional harm[42]:

> For me, now with every care team meeting I have that involved the primary school or a secondary school or a maternal child health nurse, one of the things I always say in these care team meetings is that to avoid a report to Child Protection you also can reach out to VACCA and refer to Family Services. You can contact VACCA and see whether that family is already being supported by Family Services. Arrange a care team meeting. Ask the family if they want to be linked in with support services before picking up the phone to Child Protection. So, that's been my little song that I sing every meeting in the hope that that can divert some of these families because some of the issues aren't that big. They could be addressed that way as opposed to a report to Child Protection. (ALCC Convenor)

[42] If a mandatory reporter believes a child needs protection from sexual abuse or physical injury, the law requires them to report to child protection unless they believe that someone else has already reported the matter.

The ALCC Convenor also observed that intervention when families access VACCA's emergency relief services could prevent a future Child Protection report:

> The other thing I'd suggest is that is there the possibility of a triage when people are ringing for emergency relief at VACCA or any other service. Rather than just saying, "Yeah, no worries, we'll send you out a $100 food voucher or a fuel voucher," or whatever, "Can you tell me a little bit about what's going on? Can we refer you to any other services within VACCA?" rather than just giving them that. Having a conversation to find out what's going on because I've noticed with the referrals, and it's only through looking on our program, that generally three to six months before a report coming through from Child Protection, they've reached out for support from VACCA for emergency relief. (ALCC Convenor)

Attachment E:

Evaluation Findings from the Aboriginal-Led Aboriginal Family-Led Decision Making Trial

Figure 1.

Summary of Findings from the Aboriginal-led Aboriginal Family-Led Decision-Making Trial

Was the trial implemented correctly?	What were the implementation barriers and enablers?		How satisfied were Aboriginal families who received the trial?	What features of the trial made a difference?	Was the trial successful in achieving its ST, MT, and LT outcomes?
	Enablers	**Barriers**			
Low number of referrals (n=14) and target of n=30 AFLDMs not achieved (n=5, Goolum Goolum and n=2, Njernda). Section 38 consultations did not take place on a consistent basis when the family chose not to engage in the trial. AFLDMs implemented as intended.	Governance group. Stakeholder engagement. Organisational support (Goolum Goolum/Njernda). Continuous improvement (re-design). Service blueprint.	Lack of impetus to divert Aboriginal children during investigation phase. Poor dissemination of AFLDM trial within Child Protection teams and to Aboriginal families.	Very satisfied.	ACSASS guiding Child Protection on referrals. Culturally grounded AFLDM process. Absence of Child Protection during family meetings.	A substantial proportion of non-substantiated families did not consent to referral or were ineligible. Low uptake/conversion of referrals to AFLDMs (56% Goolum Goolum and 40% Njernda). Families that had an AFLDM were connected to services and supports. No difference in Child Protection intervention before and during the

Was the trial implemented correctly?	What were the implementation barriers and enablers?		How satisfied were Aboriginal families who received the trial?	What features of the trial made a difference?	Was the trial successful in achieving its ST, MT, and LT outcomes?
	Enablers	**Barriers**			
	Implementation team.				trial (but very low numbers of children placed in OOHC).

Data from Njernda and Goolum Goolum's Client Information Systems

During the trial period - 5 October 2021 to 04 October 2022 (Goolum Goolum) and 18 October 2021 to 17 October 2022 (Njernda) - five families were referred to the AFLDM trial in the Njernda area, and two AFLDM's took place (40%). In the Goolum Goolum area, nine families were referred to the AFLDM trial and five AFLDM's took place (56%).

Feedback Forms

Two families consented to take part in the evaluation, and two feedback forms were completed. The feedback forms were designed to be completed by families after the AFLDM to capture their subjective feelings of emotional and cultural safety during the meeting (8 items, scale 1-5), satisfaction with the meeting (nine items, scale 1-4), and engagement with the AFLDM program (11 items, scale 1-5). The mean scores for the three scales were 5.0, 4.0 and 5.0 respectively, indicating very high safety, satisfaction, and engagement.

Findings from Client Relationship Information System Data

Comparison of Child Protection Reports and Child Protection Services in the Goolum Goolum and Njernda Areas Over Ten Months During the Trial and Ten Months Prior.

Child Protection data were compared for ten months during the trial period (1 November 2021 to 31 August 2022) and for the first ten months of the 12 months prior (1 November 2020 to 31 August 2021).

In the Goolum Goolum area, the overall number of children placed in OOHC was very small over both time periods (four and six respectively), suggesting no difference in Child Protection intervention (Table 1 and Table 2). In the Njernda area, 11 children were placed in OOHC prior to the trial, and eight children were placed in OOHC during the trial (Table 3 and Table 4).

Although unrelated to the trial, in the Goolum Goolum area prior to the AFLDM trial, approximately 70% of Child Protection investigations resulted in a substantiation outcome. During the trial, the substantiation rate dropped to 48% (Table 1 and Table 2). In the Njernda area, the substantiation rate before and during the trial was stable at 49% (Table 3 and Table 4). In Victoria in 2020-21, the substantiation rate for all children was 54.5% (AIHW, 2022, Supplementary Table

S3.3)[43]. According to data presented in the 2022 Report on Government Services (Data Table 16A.1), the substantiation rate for Victorian Aboriginal children in 2020-21 was 58.6% and the rate for non-Aboriginal children was 53.9% (https://www.pc.gov.au/ongoing/report-on-government-services/2022/community-services/child-protection).

Table 1.

Case Trajectories of Aboriginal Children in the Goolum Goolum Area[44] Prior to the Aboriginal-led Aboriginal Family-Led Decision-Making Trial

All reports of Aboriginal children: 1 Nov 2020 to 31 August 2021					
CP event	**Number**	**% of reports**	**Number of children**	**% of children**	**Average per child**
Report	134	100.00%	101	100.00%	1.33
Investigated	46	34.33%	41	40.59%	
Substantiated	32	23.88%	28	27.72%	
Placed in OOHC	4	2.99%	4	3.96%	

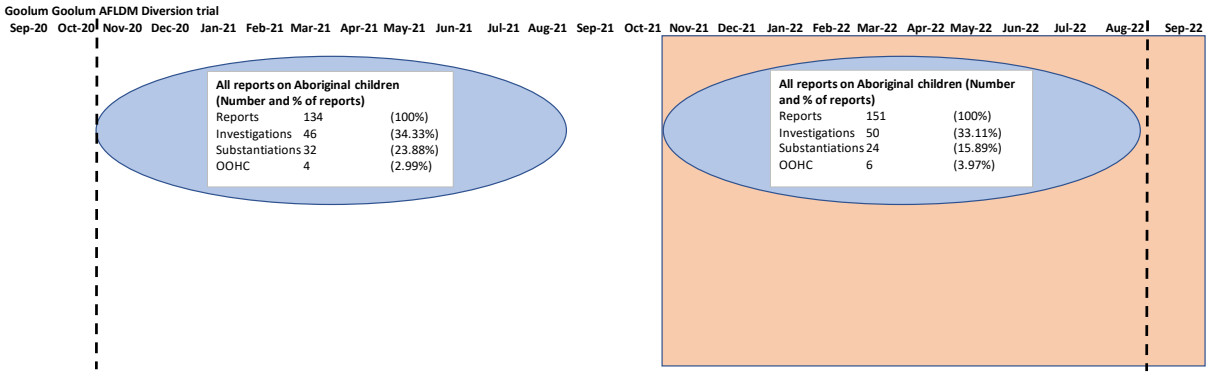
Table 2.

Case Trajectories of Aboriginal Children in the Goolum Goolum Area During the Aboriginal-led Aboriginal Family-Led Decision-Making Trial

All reports of Aboriginal children: 1 Nov 2021 to 31 August 2022					
CP event	**Number**	**% of reports**	**Number of children**	**% of children**	**Average per child**
Report	151	100.00%	114	100.00%	1.32
Investigated	50	33.11%	48	42.11%	
Substantiated	24	15.89%	24	21.05%	
Placed in OOHC	6	3.97%	6	5.26%	

Figure 1.

Comparison of Aboriginal Children Pre- and During the Aboriginal Led Aboriginal Family-Led Decision-Making Trial (Goolum Goolum)



[43] In 2020-21, 16,130 children were substantiated from 29,582 finalised investigations.

[44] Hindmarsh, Horsham, Northern Grampians, West Wimmera and Yarriambiack.

Table 3.

Case Trajectories of Aboriginal Children in the Njernda Area[45] Prior to the Aboriginal-led Aboriginal Family-Led Decision-Making Trial

All reports of Aboriginal children: 1 Nov 2020 to 31 August 2021					
CP event	**Number**	**% of reports**	**Number of children**	**% of children**	**Average per child**
Report	251	100.00%	167	100.00%	1.50
Investigated	95	37.85%	83	49.70%	
Substantiated	47	18.73%	44	26.35%	
Placed in OOHC	11	4.38%	11	6.59%	

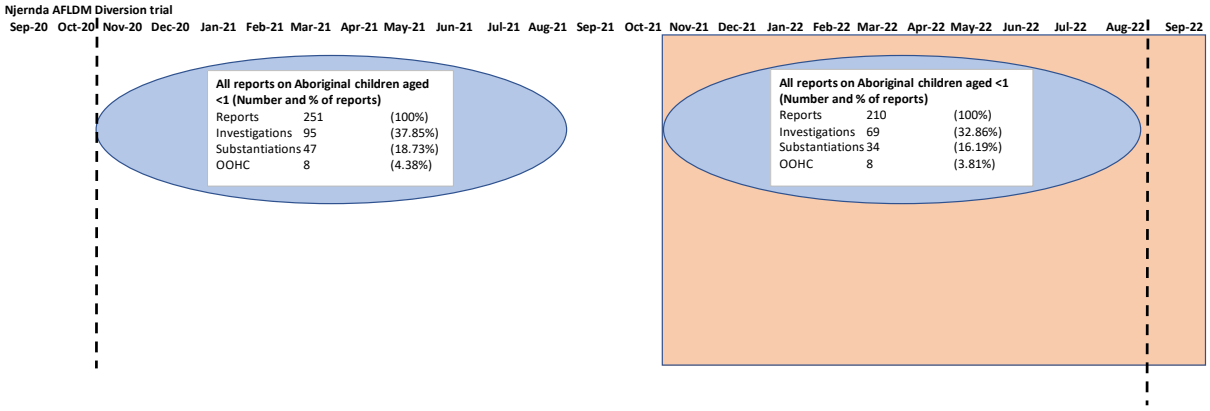
Table 4.

Case Trajectories of Aboriginal Children in the Njernda Area During the Aboriginal-led Aboriginal Family-Led Decision-Making Trial

All reports of Aboriginal children: 1 Nov 2021 to 31 August 2022					
CP event	**Number**	**% of reports**	**Number of children**	**% of children**	**Average per child**
Report	210	100.00%	162	100.00%	1.30
Investigated	69	32.86%	66	40.74%	
Substantiated	34	16.19%	33	20.37%	
Placed in OOHC	8	3.81%	8	4.94%	

Figure 1.

Comparison of Aboriginal Children Pre- and During the Aboriginal Led Aboriginal Family-Led Decision-Making Trial (Njernda)



[45] Campaspe.

Narrative Summary of Interviews and Focus Group Discussions

One interview and two focus group discussions were held with professionals involved in the Njernda and Goolum Goolum AFLDM trials, including the Njernda AFLDM Convenor, and Child Protection practitioners in both areas. The Goolum Goolum AFLDM Convenor provided written responses to interview questions.

Very Few Referrals from Child Protection Investigation

The AFLDM trial was designed to arrange Aboriginal-led AFLDM meetings if a substantiation decision had not been made by Child Protection following the first visit, or if there was an immediate non-substantiation decision and no further action was to be taken by Child Protection. However, the AFLDM trials received a very low number of referrals from the Child Protection Investigation Team.

Child Protection practitioners said that they "weren't actually receiving any referrals that could go across to either of the programs because of the eligibility criteria". A Child Protection practitioner explained that around the time of the trial, Child Protection had started "enforcing the policy of making decisions at the first visit. It's always been a department policy but it's something that the area has really focussed in making those decisions whether to substantiate, or close, or do follow ups".

In addition to Child Protection completing investigations following the first visit, Child Protection practitioners saw few "non-substantiated cases sitting in the investigation and assessment phase", or reports involving Aboriginal children that were not substantiated (Child Protection practitioner). A Child Protection practitioner explained, "unfortunately a high proportion of Aboriginal and Torres Strait Islander families have substantiated harm … There were 27 cases that could have been referred and 16 of those were – harm was substantiated".

A Child Protection practitioner also said that non-substantiated cases were not referred to the AFLDM trial because they [parents] "refused consent to do the referral … were not in scope for the project due to being ANCOR [Australian National Child *Offender* Register] reports regarding registered sex offenders … we have not yet finished the investigation … one closed prior to the investigation because the family had moved". A Child Protection practitioner said that families

with no desire to use the service “Didn’t want the agency [i.e., Goolum Goolum] knowing their business”.

Referrals from Child Protection Intake a More Feasible Approach

To adjust for the lack of referrals from the Child Protection Investigation Team, the AFLDM trial started to accept referrals from the Child Protection Intake Team when cases are closed at intake phase or remain open until a referral has been accepted (wellbeing report), and from Goolum Goolum/Njernda (internal) Family Service, AoD, Early Years (pregnant women) or Healing Programs.

The Njernda ACSASS worker felt that it was appropriate to refer families from Child Protection intake:

> I think the amount of intakes that we do get … you get the feel of, yeah, this would suit this program. You know, there's some concerns there but there's not enough for an investigation and you don't want it to go to investigation. So, you would – ultimately, you would want the family to have that support and come together as a family … . (Njernda ACSASS worker)

The Lakidjeka and ACSASS (Njernda) programs had a key role in identifying suitable Aboriginal families for the AFLDM trial following the re-design, and the Njernda ACSASS worker indicated that the Njernda AFLDM Convenor actively consulted the ACSASS worker about referrals:

> [Njernda AFLDM convenor] would come and ask me any questions … if he wasn't sure about the – you know, about … who to invite. 'Cause not everyone's listed in – you know, in the profile as well … and… if it's been in … a number of times we would have that information. So, we would, you know, let him know who to contact … who would be appropriate to contact. (Njernda ACSASS worker)

A Child Protection practitioner indicated that Child Protection Intake stopped thinking about the trial after some time had lapsed, and that referrals were mainly prompted by the ACSASS teams, saying “sometimes [Child Protection] Intake don’t get to speak to our ACSASS team”. A Child Protection practitioner said:

> We probably need to do some more work internally with our Child Protection staff because I think we let them know that these programs are happening and we had [AFLDM

convenors] attend our huddle, so an all-Child Protection forum, then leadership meetings with our investigation team, but that was months ago when all the initial changes were occurring. (Child Protection practitioner)

Challenges Engaging Families in the AFLDM Trial After Referral

In addition to families who did not consent to a referral to the AFLDM trial, or were ineligible for the trial, it appeared that the AFLDM Convenors had difficulty engaging some families. A Child Protection practitioner was familiar with five families who were referred to the Njernda AFLDM trial. Of these, the Child Protection practitioner said, "I believe three have had an AFLDM occur. The other two, I know [the Njernda AFLDM convenor] was trying to get in touch with the family but wasn't having any luck at that point in time. So, I don't know since then …". Referring to the Goolum Goolum AFLDM trial, another Child Protection practitioner from the investigation team said "we only were able to refer three families. And, as I understand, all of those … declined to participate in the program".

The Njernda AFLDM convenor said that, regarding families who didn't want to engage with the AFLDM trial, "they didn't actually say they didn't want to be involved, they just didn't … answer their phones or anything".

Section 38 Consultations Not Initiated on a Consistent Basis if a Family Chose Not to Engage

Child Protection practitioners indicated that if a family chose not to engage in the AFLDM trial, a risk-based consultation should be initiated to determine a course of action (e.g., re-report to Child Protection intake or support to contact the family). However, a Child Protection practitioner said, "I haven't had that interface with [the Goolum Goolum or Njernda Trial convenors]" and that "I think if all of that was in place, maybe we'd see some other results".

Aboriginal Families Engaged with AFLDM Process and Following Family Plans

The absence of Child Protection practitioners made Aboriginal families feel comfortable during the meetings. The Goolum Goolum AFLDM convenor said that one mother felt that "having everyone present around the table made her feel very supported". An Aboriginal process also created an emotionally and culturally safe context for Aboriginal family members to attend meetings and identify ways that they could support children's safety and wellbeing. The Njernda AFLDM

convenor indicated that the AFLDMs resulted in family plans that "identified family members who could provide support", such as "providing respite" for a mother with five children.

It also appears that the families are following Family Plans developed during the AFLDMs. The Njernda AFLDM Convenor said that "clients are still engaging with the supports I've put in place for them". The Goolum Goolum convenor highlighted one family plan that had avoided a Child Protection investigation. In this case the Family Plan involved a voluntary Aboriginal kinship care arrangement with contact by agreement, and ongoing support from the Goolum Goolum alcohol and drug worker.

Diversion is More Feasible at the 'Front Door' of Child Protection

The low number of referrals from Child Protection Investigation suggests this is not an optimal point in the Child Protection process to divert Aboriginal families. Several Child Protection practitioners reinforced the point that the opportunity for prevention at the investigation phase did not materialise. A Child Protection practitioner said, "It's very clear that that cohort of families following an investigation is just not there really for the support that they thought they had identified". Another Child Protection practitioner said that the AFLDM trial "it's not so much for me about diverting from Child Protection because they're already in Child Protection when I do the referral". Another Child Protection practitioner said:

> I think the thought was that there was a gap in service following an investigation for cases that weren't substantiated. And, what we found is that that number was quite small in the end. So, that resulted in a small amount of referrals. (Child Protection practitioner)

There was also a sense that referral at the investigation phase was difficult because Child Protection practitioners are not focused on diversion or referral when conducting first home visits:

> Sometimes we're not very good in the investigation phase at going, "Let's go and do an AFLDM straight away". Instead, we're really focused on the investigation and the concerns and those type of things instead of doing that dual planning about intervention as well at the same time". (Child Protection practitioner)

Future Adaptations

Although the trial did not successfully identify and redirect Aboriginal families at the investigation phase, there was commitment to the Aboriginal family meeting model, and the idea of

establishing an Aboriginal Community Based Child Protection Mechanism. There was also a strong sense that “we definitely need an intervention [diversion] program. There probably needs to be some tweaking regarding these (AFLDM trial] programs”. (Child Protection practitioner)

Consistent with the opinion expressed above that investigation is the wrong point in the Child Protection process for diversion, a Child Protection practitioner suggested that ACCOs should intervene with families earlier, saying:

> So, earlier intervention, more focus on diversion at the intake phase or from the community level, through family services and child first referrals from that point. Yeah. Just before it gets to my team. (Child Protection practitioner)

A Child Protection practitioner also reflected that the trial needed to be better disseminated among Child Protection staff and that Njernda and Goolum Goolum need to be “providing families with more information about the pilot”.

Finally, as highlighted above, a stronger interface between Child Protection and the AFLDM programs would create opportunities for problem solving and joint working, and ensure children are re-reported if families chose not to engage in the program and there are significant unmanaged child safety concerns.

Attachment F

The AFLDM Child Protection Diversion Trial Re-Design

Problem statement

A significant number of Aboriginal children in the Loddon and Wimmera South-West Areas are frequently reported to Child Protection. These children are growing up in circumstances which diminish their sense of safety, stability, and wellbeing. Ongoing family problems place children at increased risk of removal and loss of connections with family, community, and culture.

Community services are setup to respond to a crisis, rather than helping to support families through difficult life situations over the long term. Community services stop seeing parents before they are ready, and families cannot access support when they need it to prevent a crisis from occurring. A Child Protection investigation undermines parents' confidence and readiness to interact with support services.

The trial

The AFLDM trial will work flexibly and promptly to arrange AFLDMs for Aboriginal families to provide culturally appropriate information gathering, support and decision-making at times when families need it. This will keep change and healing in process and children safe. AFLDMs will respond to difficult life situations before they escalate into a crisis requiring a Child Protection response. Where possible, Elders will be involved in AFLDMs to provide information, participate in decision-making, and strengthen responsibilities to help raise children within kinship systems.

Families will be referred to the AFLDM trial to help them transition out of a Goolum Goolum/Njernda (internal) Family Service, AoD, Early Years (pregnant women) or Healing Program, or when a situation arises while receiving an ACCO service where decisions need to be made about children's care and safety and kinship support systems mobilised.

The AFLDM trial will also follow-up with families referred by the Child Protection Intake Team when cases are closed at intake phase or remain open until a referral has been accepted (wellbeing report). The Lakidjeka and ACSASS (Njernda) programs will have a key role in identifying Aboriginal families who are suitable for the AFLDM trial. The AFLDM trial will also accept referrals

from the Child Protection investigation team during open investigation as per the original trial design.

Expected outcomes

The efficacy of family group conferencing as a diversionary mechanism is well recognised in other Australian jurisdictions and internationally. The AFLDM trial will enhance connections between parents, ACSASS/Lakidjeka and other ACCO programs and services to ensure families have access to culturally appropriate supports when they need it. The AFLDM process will provide a context of care where Aboriginal people feel safe and supported, empowered, culturally connected and ready to have safe conversations about difficult topics and plan for safe lifestyle choices and children's care and safety. AFLDMs will make decisions about children's care and safety arising from difficult life situations and reduce or prevent a crisis from occurring leading to a Child Protection response. AFLDMs will strengthen responsibilities to help raise children within kinship systems and increase parents' natural supports. AFLDMs during open investigation are also expected to lead to diversion from protective intervention and greater compliance with the ATICPP placement hierarchy if children are removed.

Appendix G

Calculation of Cost Savings from the Aboriginal Led Case Conferencing Trial and Garinga Bupup

The 2022 Report on Government Services (RoGS) includes costs for different Child Protection activity groups for Victoria (https://www.pc.gov.au/ongoing/report-on-government-services/2022/community-services/child-protection). Table 16A.25 in the supporting material gives the following costs for 2020-21:

Intake	$454
Investigation	$2,252
Protective Intervention	$6,700[46]
Obtaining court order (PA)	$5,115
Supervising court order	$16,890[47]
OOHC	$270,240[48]

The costings below assume that each ten investigations lead to one OOHC placement.

Every 10 unborn reports prevented (Garinga Bupup/BDAC pilot) therefore potentially saves:

Child Protection intervention phase	Costs/units	Total cost
10 Child Protection intakes	$454 x 10 =	$4,540
5 investigations	$2,252 x 5 =	$11,260
3 protective interventions	$6,700 x 3 =	$20,100
1 Court order via PA	$5,115 x 1 =	$5,155
1 Court order supervision	$16,890 x 1 =	$16,890

[46] RoGS does not specify an amount, but notes that roughly the same proportion of expenditure is devoted to both investigations and protective interventions (no court). Since only about a third of investigations become protective intervention with no court, it follows that the unit cost for protective interventions must be about three times the cost of an investigations.

[47] RoGS does not specify an amount but states an overall cost as 6.6% of total Child Protection costs. This is about 50% higher than the overall cost of investigations. Since five investigations result in a Court order, this means that the unit cost of supervising a court order is about 150% of the cost of 5 investigations = $16,890.

[48] RoGS states that OOHC accounts for 49% of total Child Protection costs. This is roughly 12 times the cost of all investigations. However, if each 10 investigations lead to one OOHC placement, the unit cost is roughly 120 x the cost of an investigation = $270,240.

0.5 OOHC	$270,240 x 0.5 =	$135,120
All phases cost savings		***$192,965***

Every 10 investigations prevented (ALCC/VACCA pilot) potentially saves:

Child Protection intervention phase	Costs/units	Total cost
10 investigations	$2,252 x 10 =	$22,520
5 protective interventions	$6,700 x 5 =	$33,500
2 court order via PA	$5,155 x 2 =	$10,310
2 court order supervisions	$16,890 x 2 =	$33,780
1 x OOHC	$270,240 x 1 =	$270,240
All phases cost savings		***$370,350***

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