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Research Centre
for Children and
Families

Family Connect and Support Program

Evaluation
Final Report

Research Centre for Children and Families

Curijo Pty Ltd

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Acknowledgement of Country

The Department of Communities and Justice and The Research Centre for Children and Families acknowledge the Traditional Custodians of the various lands on which we work and where Family Connect and Support services are delivered.

We pay respects to Elders past, present and emerging, and recognise and celebrate the diversity of Aboriginal peoples and their ongoing cultures and connections to the lands and waters of NSW.

We acknowledge that the historical context of government intervention when it comes to child protection, has had a significant and detrimental impact on Aboriginal and Torres Strait Islander individuals' connection to country, land, culture, health, and sense of belonging. We recognise that when not addressed in a culturally safe way, current government systems and supports surrounding family support services can perpetuate the intergenerational trauma experienced by Aboriginal and Torres Strait Islander individuals and communities.

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Project team

The Research Centre for Children and Families at The University of Sydney, in partnership with Curijo Pty Ltd, was commissioned by the NSW Department of Communities and Justice (DCJ) to evaluate Family Connect and Support (FCS). Funding and resourcing for the evaluation was provided by DCJ.

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Glossary of key terms

Aboriginal Participation Plans (APPs): Family Connect and Support providers are expected to prepare Aboriginal participation plans, which outline how the provider is engaging with local Aboriginal Community Controlled Organisations (ACCOs) and how they are upskilling their staff in working with Aboriginal families.

Benefit Cost Ratio: Based on cost-benefit analysis (see below), benefit cost ratio is calculated. For the purposes of this evaluation, these figures indicate how many dollars NSW Government save, for every dollar spent on FCS services, in terms of avoided costs of later statutory child protection involvement of families served by FCS and the cost attributed to their personal benefits of avoided child protection involvement.

Culturally and Linguistically Diverse (CALD): The term 'culturally and linguistically diverse' is used to identify a person's international country of birth, ancestry, country of birth of parents, language spoken and religious affiliations. For reporting purposes, country of birth and main language spoken at home are the two questions used to record a client's CALD status.

Case: The term 'case' refers to the household unit or family who receive FCS services. For reporting purposes, cases act as 'containers' as they group sessions together, and link client and session data to location and program activity data.

Client: Clients are any person who receives a service as part of the FCS program that is expected to lead to a measurable outcome. They may be within a target group for the FCS program, such as a child aged 0-5 years, or child or young person affected by mental illness.

ChildStory: ChildStory is the NSW Department of Communities and Justice information management system for children and young people who are in out-of-home care or have been reported to child protection services. It is one of the sources of the data analysed in the outcomes evaluation.

Cost-benefit analysis (CBA): Cost-benefit analysis is a systematic method for evaluating and comparing the costs and benefits of a program. CBA in this evaluation is guided by the DCJ Benefits Menu outlining the financial costs of client outcomes (2024 version 1.0).

Data Exchange (DEX): The Data Exchange is the reporting platform used for Family Connect and Support. It is a web-based platform hosted by the Commonwealth Department of Social Services. Recording client data in DEX was not required for FCS providers until February 2022.

Department of Communities and Justice (DCJ): The NSW Department of Communities and Justice is the statutory child protection agency responsible for providing children and young people across the state safety and protection from risk of harm, abuse and neglect. DCJ also provides early intervention support to vulnerable families through a variety of funded programs including the Family Connect and Support (FCS) program.

Dosage: The amount of service the family receives, in terms of number of sessions and number of weeks engaged in the FCS service.

Family Connect and Support (FCS): Family Connect and Support is a free and voluntary service for children, young people and families who need support, anywhere in New South Wales. FCS offers referrals, practical support, information and advice and case coordination. See ‘service elements’ for description of the FCS model.

FCS Common Assessment Framework (CAF): The FCS Common Assessment Framework provides a consistent approach for FCS services when assessing children, young people and families’ strengths and needs. The FCS CAF has been designed to align with the DCJ Aboriginal Case Management Policy, which introduces the key elements for culturally aware and responsive ways of working with Aboriginal children, families, and communities.[1]

FCS Common Assessment Tool (CAT): The FCS Common Assessment Tool is an assessment tool for practitioners conducting comprehensive assessments that are family led and culturally aware and responsive. The CAT should be used alongside the CAF, when families require the support of a comprehensive assessment.

Family Referral Service (FRS): The FRS program was the NSW Ministry of Health managed precursor to FCS. It was introduced in 2010 and rolled out statewide through 11 service providers in 2013. In January 2021, it transferred to DCJ management, was redesigned and renamed Family Connect and Support.

Helpline report: An assessment of information about suspected child protection concerns to the Child Protection Helpline is made to determine if a child or young person is at risk of harm from abuse and/or neglect. Reporters to the Helpline may be mandatory reporters (those whose role or position mandates they share safety concerns about a child, including Health, Education, Police, etc.), or members of the public. Helpline practitioners make assessments using the Screening and Response Priority tool (SCRPT) to identify if the information received meets the legislative threshold for suspected risk of significant harm (ROSH). Helpline staff assess types of alleged child abuse and neglect (e.g., emotional abuse, physical abuse, sexual abuse, neglect) and the family’s issues identified by reporters as impacting on the safety and wellbeing of the child (e.g., carer mental health, domestic violence and drug/alcohol use by carer). The assessment made at the Helpline also determines the response time required for caseworkers to make contact and begin a face-to-face assessment with a family (e.g., less than 10 days).

Investigation: A face-to-face investigation of a helpline report, using the Safety and Risk Assessment tool (see entry for Safety and Risk Assessment), to determine whether intervention with the family is required.

National Disability Insurance Scheme (NDIS): The NDIS is a program, funded and administered by the Commonwealth of Australia, that provides information and referrals, links to services and activities, individualised plans, and funded supports to people assessed as having a permanent disability.

NSW Human Services Outcomes Framework: The NSW Human Services Framework is a cross-agency framework that promotes the wellbeing of NSW people and communities through seven specific domains. The domains are:

[1] https://dcj.nsw.gov.au/service-providers/oohc-and-permanency-support-services/aboriginal-case-management-policy.html

- **Social & community**: All people in NSW are able to participate & feel culturally and socially connected.
- **Empowerment**: All people and communities in NSW are able to contribute to decision making that affects them and live fulfilling lives.
- **Safety**: All people in NSW are able to feel safe.
- **Home**: All people in NSW are able to have a safe and affordable place to live.
- **Education & Skills**: All people in NSW are able to learn, contribute and achieve.
- **Economic**: All people in NSW are able to contribute to, and benefit from, our economy.
- **Health:** All people in NSW are able to live a healthy life.

Out-of-home care (OOHC): Statutory out-of-home care is when the NSW Children's Court makes an order allocating parental responsibility for a child or young person to the Minister for Community Services. The order requires the child or young person to live with a person who is not their parent and in a place that is not their parental home, such as foster or residential care.

Provider (or service provider): Providers are agencies which are contracted by DCJ to deliver FCS services. Seven non-government organisations hold service delivery contracts with DCJ to deliver the FCS program, some of which partner with other non-government organisations to deliver services through sub-contracting arrangements.

Referrers: FCS engages with organisations that make **inbound referrals**, by referring families into the FCS program. FCS, also makes **outbound referrals** for the families they serve to service providers in their local areas. Inbound referring agencies include community services, health services, educational services, justice/legal services, and child protection. Outbound referrals include services for family support, mental health, material wellbeing and basic necessities, money, and social or community housing.

Risk of Significant Harm (ROSH): A concern report that meets the statutory threshold of risk of significant harm (ROSH). In assessing a child/young person concern report to determine if it meets the statutory threshold of risk of significant harm, caseworkers in the Child Protection Helpline apply the Structured Decision Making (SDM) and Screening and Response Priority (SCRPT) tools to determine the level of response category (e.g., less than 10 days). A child or young person is at ROSH if the circumstances that are causing concern for their safety, welfare or wellbeing are present to a significant extent. This means it is sufficiently serious to warrant a response by a statutory authority irrespective of a family's consent.

Safety and Risk Assessment (SARA): The Safety and Risk Assessment is a Standard Decision Making© assessment framework used by a DCJ caseworker in a face-to-face investigation to assess a child protection (ROSH) report and whether intervention with the family is required.[2]

SCORE survey: The Standard Client/Community Outcomes Reporting (SCORE) survey is an outcome reporting tool that helps report the impact of service delivery and is entered through the DEX reporting platform. Per the decision of DCJ, utilising the SCORE survey in

[2] DCJ retired the SDM Risk Assessment and SDM Risk Reassessment tools in September 2024. This does not have implications for the evaluation as the FCS evaluation was complete by this time.

FCS is currently not mandatory for FCS providers and there is a low level of completion for FCS clients.

Service types: The FCS program includes several service types (also referred to as service activities), which are recorded in the Data Exchange (DEX) for reporting purposes. These are the activities service providers deliver directly to clients and specified in contracts. These include:

- **Active holding -** Where an outbound service is at capacity or not yet accessible, FCS service providers will maintain contact and provide support to the client family.
- **Brokerage -** Support is given in the form of brokerage to assist clients with their immediate needs.
- **Case plan completed** - Session is created to indicate that a case plan has been developed for a client.
- **Family capacity building -** FCS provider brings together family members (including extended family and kin) and/or others.
- **Family group conferencing -** Members of a family's informal support network meet to discuss presenting issues, needs and strengths, and jointly develop a family-centred and led plan that supports the family to achieve their goals.
- **Information/advice/referral –** Front-line staff provide immediate and thorough information and advice to clients and address their needs prior to any significant assessment being undertaken. A referral is supporting client families by connecting them with other services.
- **Intake/assessment –** FCS provider conducts an initial or comprehensive assessment of a client's strengths and needs.
- **Referral received** - Session to be created when the FCS provider receives a referral for client.

Session: A session is an interaction between the FCS service provider and a case or client. This may be in person or via phone/video conference. For reporting, a session records what service was delivered and when, and which clients attended.

Substantiation: A determination made after DCJ's legally mandated field assessment. The Safety and Risk Assessment, part of the NSW Structured Decision Making suite of tools, is used to determine whether a child has experienced 'actual harm' or is at 'risk of harm' following a ROSH report, to classify the report as either 'substantiated' or 'not substantiated'. A substantiation indicates there is sufficient reason to believe the child has been, is being, or is likely to be abused, neglected or otherwise harmed.

Target groups (also referred to as priority cohorts): While any family with a child aged 0 to 18 years may receive FCS services, the priority groups for service delivery are: Aboriginal children, young people and their families, children aged 0 – 5 years, and children and young people affected by mental illness. FCS providers are expected to make proactive efforts to engage these priority groups.

Section 1—Executive summary and recommendations

Background

Family Connect and Support (FCS) is a voluntary support service for vulnerable children, young people and families in New South Wales (NSW), funded by NSW Department of Communities and Justice (DCJ). FCS services are delivered statewide, by seven non-government organisations (NGOs), also referred to as service providers, with some of these NGOs subcontracting with additional NGOs. Statewide reach is achieved by delivering services at specified sites and using strategies to reach clients in other geographical locations, including through appropriate outreach and/or mobile services. FCS provides a tiered response based on family needs and includes the following core service elements: information and advice, comprehensive assessment, proactive outreach, short-term case planning and coordination, and active holding. The FCS program aligns with the broader direction of the NSW government to invest early in services and programs for vulnerable children, young people, and families.

In January 2021, FCS replaced the NSW Family Referral Service (FRS). FRS was introduced as a key initiative under the *Keep Them Safe* reforms[3], arising from the *Special Commission of Inquiry into Child Protection Services in NSW*[4]. FRS was introduced in 2010 and managed by the NSW Ministry of Health as a voluntary service. The program was rolled out statewide across 11 Family Referral Services in April 2013. The NSW Ministry of Health commissioned an evaluation of the FRS program in 2013. The evaluation identified a range of service benefits including reports from 7 in 10 clients that FRS supported them to access services they most needed[5]. A systematic review of the out-of-home care (OOHC) system in NSW, by David Tune AO PSM (the Tune Review)[6], was conducted in 2015. The Tune Review made some important observations about the way government relates to children and families experiencing vulnerabilities relevant to the redesign of FRS into FCS[7].

Evaluation of the FCS program

In partnership with Curijo Pty Ltd, the Research Centre for Children and Families (RCCF) at the University of Sydney was commissioned by DCJ to undertake a comprehensive evaluation of the FCS program. The purpose is to understand whether the FCS program provides an effective soft entry point into the service system for vulnerable families and how service delivery is correlated to future child and family outcomes. The evaluation explores the impact and outcomes of the program since it transitioned from FRS to FCS in January 2021.

The evaluation aims to understand the connection between FCS support in preventing a child, young person and/or family's issues from escalating. The focus is on:

- the effectiveness of FCS' program design;
- (unintended) implementation outcomes for families;
- comparison of the service delivery activities to achieved family outcomes;

[3] NSW Government. *Keep Them Safe: A shared approach to child wellbeing* is the response to the Report of the Special Commission of Inquiry into Child Protection Services in NSW, led by the Honourable James Wood, AO, QC, released in November 2008.
[4] Wood J (2008). *Special commission of inquiry into child protection services in NSW: Volume 2*. Sydney: NSW Government.
[5] KPMG (2013) *Evaluation of Family Referral Services: NSW kids and families*, Government Advisory Services.
[6] Tune (2015) *Independent review of out-of-home care in New South Wales final report*.
[7] NSW Government. *Keep Them Safe: A shared approach to child wellbeing* is the response to the Report of the Special Commission of Inquiry into Child Protection Services in NSW, led by the Honourable James Wood, AO, QC, released in November 2008

- appropriateness of FCS' culturally aware and responsive approaches to Aboriginal and Culturally and Linguistically Diverse (CALD) families; and
- comparability of the program benefits to program cost and social investment return.

The evaluation offers insights into the new program design, what is working well, and outcomes families achieve. The evaluation findings will be used to support decisions about program continuation, expansion and policy and practice decisions.

FCS Evaluation approach

The evaluation of the FCS program consists of three parts:

1. **Process evaluation** - How well was FCS program designed and implemented to achieve client outcomes?
2. **Outcome evaluation -** What outcomes has FCS program achieved for clients?
3. **Economic evaluation -** Do benefits for clients who access FCS outweigh the cost of the program?

Details of the methodology for each evaluation component can be found in Section 2.

FCS Evaluation questions

The key evaluation questions aim to explore how the program has been designed and implemented. This includes the consideration of unintended outcomes of implementation. A range of qualitative and quantitative methods are used to answer the following evaluation questions:

Implementation

1. What were the key activities within the FCS service which providers engage in?
2. What service usage were observed per case?
3. What proportion of services involved a referral of at least one client within a case?
4. Who received active holding or brokerage or family capacity building and how much time was spent on these service activities?
5. How many families were engaged in FCS who are defined as priority cohort and/or with complex needs (multiple issues)? How well did the program reach and engage priority cohorts?
6. How many cases were closed because of unmet needs?
7. How many cases reached the 16 weeks duration threshold?
8. How have the key features of the FCS service model been implemented?
9. Were there any gaps to the design of the FCS model?
10. What were the barriers and facilitators of implementation?

Service design and delivery

11. How did the different supports delivered (e.g. active holding, brokerage) work together to support clients?
12. Were the services flexible and responsive to client and community needs?
13. Was there meaningful client and community engagement by services?
14. Were clear client pathways through the service system developed and used?
15. Were enduring partnerships between services formed?
16. What role has FCS played in building the capacity of referrers to make appropriate referrals and adopt a shared responsibility of risk?

17. What role has FCS had in providing leadership locally and acting as a service connector for families and within the broader service system?
18. Were services culturally aware and responsive?

FCS client satisfaction

19. Were clients satisfied with their FCS provider?
20. How could client feedback be collected on an ongoing basis to inform the FCS program?

Client outcomes

21. Did utilisation of the FCS service *causally* reduce children's and young people's statutory child protection involvement, specifically risk of significant harm and risk of substantiations of significant harm?
22. Which clients benefited most from the FCS services (e.g., Aboriginal versus non-Aboriginal clients; rural versus urban clients; clients served by large and small providers)?
23. What was the relative benefit in terms of risk reduction of a case plan completion, a service referral, active holding or brokerage, and family capacity building?

Economic analysis

24. What was the average cost per provider, cost per case, and cost per session in the financial year 2022-2023?
25. Did the FCS program save costs by reducing risk of harm to children and young people?

In addition, the evaluation team was asked to consider whether evidence from the evaluation could inform recommendations about the program model and service delivery. The evaluation team was asked to make evidence-informed recommendations including: *reporting on outcomes data*, including top questions to ask clients in order to assess client satisfaction and change from program participation as well as other specific client cohorts that should be reported upon; *FCS providers*, including the benefits of smaller vs bigger service delivery organisations; the *FCS program model* and whether changes should be made for greater effectiveness; and *eligibility for FCS* and whether eligibility criteria should be modified. The evaluation considers these topics and makes recommendations where possible based on the data.

FCS Evaluation stages

Stage 1: The interim report[8] provided evaluation findings on implementation of the program, such as fidelity to the model and perspectives of FCS staff and key stakeholders. A series of consultations were conducted with FCS staff and stakeholders to gather their insights into the implementation of the model. Online consultations were held with each FCS provider and in some cases their sub-contracted NGO partners, with 80 FCS staff participating. In addition, 83 FCS staff (representing 58% of all staff employed in the program) completed a survey, with participation by caseworkers or case managers, team leaders, intake workers, and staff in other roles (e.g., administrators). See interim report for full details on FCS stakeholder and staff consultations.

[8] https://www.familyconnectsupport.dcj.nsw.gov.au/content/dam/dcj/familyconnectsupport/documents/family-connect-and-support-fcs-evaluation-interim-report-july-2023.pdf

Online consultations with organisations providing inbound referrers to the FCS program and receiving outbound referrals from the FCS program were completed with 54 stakeholders, which included 9 CALD stakeholders or representatives of CALD services and 10 Aboriginal stakeholders representing Aboriginal Community Controlled Organisations (ACCOs) (see interim report for full details). Feedback from Aboriginal key stakeholders was also reported in a stand-alone consultation summary[9].

Stage 2: The final report consists of new analyses of interviews with families who had received services from FCS providers and the outcome and economic evaluation. Administrative child protection data from ChildStory and routinely collected FCS program data from Data Exchange (DEX) were analysed to assess the impact of FCS on reducing risks for children. While subject to low completion, the report also includes findings on client satisfaction from family surveys (SCORE) completed within DEX[10].

The FCS final evaluation report is structured into 8 sections, these are:

1. Executive summary and recommendations
2. FCS program and evaluation overview
3. Summary of FCS staff and stakeholder consultations
4. Cultural awareness, confidence and responsiveness
5. Families' perspectives of FCS
6. Outcomes evaluation
7. Costs and benefits of FCS
8. Conclusion

Key findings

Examining data collected from FCS staff, stakeholders and clients, as well as findings from the outcomes and economic evaluation components, the following key findings were made about the FCS program and client outcomes.

Unique and necessary in the service sector

There was a strong consensus across all of the consultations that FCS fills a critical gap in the service system. Stakeholders consistently affirmed the need for the program and suggested that if the program did not exist, a critical referral pathway and service for families would be lost. The capacity of the FCS program to work with families according to their varying needs and issues was viewed as rare across the sector, and highly valued. Families were highly appreciative of FCS and would recommend the service to other families facing challenges.

Flexible and responsive to families

[9] https://familyconnectsupport.dcj.nsw.gov.au/content/dam/dcj/familyconnectsupport/documents/FCS_Evaluation_-_Aboriginal_Sector_Consultations.pdf

[10] The Standard Client/Community Outcomes Reporting (SCORE) survey is an outcome reporting tool that helps report the impact of service delivery. It should be noted that FCS agencies reported issues with the SCORE survey and there was a decision made by DCJ that requesting completion of family surveys was not compulsory for FCS agencies. This resulted in low completion rates. For more information about the SCORE survey, see: https://familyconnectsupport.dcj.nsw.gov.au/documents/FCS_Data_Collection_and_Reporting_Guide.pdf

Agencies making referrals to FCS and FCS staff reported that the flexibility of the program was one of its key strengths. The flexibility in the model allowed staff to address the needs of families in responsive and purposeful ways. The broad eligibility criteria facilitated easy access to the program for families. Home visiting and telephone engagement were identified as components of FCS service delivery that facilitated family engagement. The specific skills of FCS staff included active listening, providing information in a clear and appropriate way, demonstrating empathy, adopting a trauma-informed approach, being honest and transparent, and offering their broad knowledge about local services. Using these skills, FCS providers broke down fears families might have about engaging with a support service and encouraged them to participate. The family-led and strengths-based approach, adopted by FCS providers, encouraged families to identify their own needs and goals. Families reported positive experiences in receiving supports tailored to their needs.

Active community partners

In regional and rural areas, it was considered important that FCS providers proactively engage with other programs offering health and family support services. Agencies appreciated the efforts FCS providers made contributing to community functions, such as social tenant barbeques or events for children during school holidays, as these provided opportunities to form informal networks and build trust with community. Examples of good practice included FCS caseworkers attending antenatal services to introduce themselves to families and provide information about FCS to Aboriginal women who have to leave Country to attend maternity and birthing care. Some services also provided positive feedback about how FCS services were able to work with Aboriginal families using culturally aware and responsive practices. They emphasised that this was more apparent in FCS providers that have Aboriginal workers in key roles including intake, casework and management. FCS services that have Aboriginal staff were considered to be better able to build relationships with local Aboriginal communities and develop referral pathways. They were also reported to be more likely to participate in proactive outreach activities to build trust with Aboriginal communities.

Outcomes findings reinforced that the FCS model appears less effective in more rural areas, due to fewer local services being available to families. In addition, with limited staff covering vast geographic distances, it was not always possible to assign two staff members to make home visits for proactive outreach. In these geographic contexts, it was particularly critical for FCS providers to build relationships with other local providers to facilitate client access to outbound referrals.

Helpful for navigating local services

A common feature of FCS reported by families who participated in interviews was that FCS workers were welcoming and non-judgmental, provided practical assistance, and proactively advocated on their behalf. FCS case coordination relieved clients of repeating their story, and reliving traumatic experiences, with a range of different service providers. Families found the array of support services within their local community confusing or overwhelming to access, and commented on how the FCS program helped them navigate the service system. Several participants reported that they found it hard to ask for help and appreciated the warm and caring response from their FCS worker. Respondents agreed that the FCS worker had helped them when they really needed it, and this had a significant impact on their lives.

Successful in reaching key client groups

FCS service providers agreed that they conduct assertive outreach to engage families, and particularly those in priority cohorts[11]. The analysis of the DCJ administrative child protection data and FCS program data (from January 2021 to end of June 2023) revealed that FCS is reaching the priority population cohorts. Two out of five clients (40.5%) served belonged to priority cohorts, which is defined as clients who identify as Aboriginal; children younger than 5 years of age; or clients who have a dependent younger than 18 years of age who was referred for mental health. More than one in seven clients were recorded to have a disability. Observed at the case level, more than one in two cases (52.0%) included a client from a priority cohort. The majority of clients (53.4%) entered FCS through a referral made by an education agency (22.4%), a health agency (16.0%), or a justice agency (15.0%). Only 6.3% were referred by a child protection agency and 12% were self-referred or referred by friends or family.

The FCS Common Assessment Framework (CAF) acknowledges that complexity will affect the needs of each case[12]. Some measures of needs were recorded, albeit imprecisely, upon entry into the FCS. The most common primary reason for seeking assistance was for issues of family functioning (31.6%), mental health, wellbeing and self-care (24.5%), personal family safety (22.1%), and housing (7.6%). Very few families entered the FCS because they needed assistance for material wellbeing, financial resilience, physical health or employment matters.

Associated with positive outcomes

Analysis of administrative child protection data[13] from ChildStory linked with FCS program data from DEX suggested positive outcomes for families who engaged with FCS. A model was estimated for children who entered and exited FCS between February 2022 and January 2023 and who were then followed in the administrative child protection data until August 2023. As the program was not rolled out through a randomised controlled trial, which would have allowed for clean causal evaluation, the evaluation relied on more technically challenging statistical methods and stronger model assumptions. To deal with self-selection into FCS, the evaluation was conducted with all FCS child clients who entered program in the nominated window. The treatment group was identified as clients who exited FCS when their needs were met and was compared to clients who also benefitted from some services from FCS but exited for other reasons, which is referred to as `needs unmet'. Clients in the comparison group exited FCS for a variety of reasons (quit the service, deceased, moved away, higher assistance needed, assistance no longer needed, no longer eligible, other).

Clients in the treatment group[14] were part of cases that received approximately 100 sessions and stayed in the system for 83 days, while clients in the control group[15] were part of cases that received on average 50 sessions and stayed in the system for 48 days. Cases with clients

[11] While any family with a child aged birth to 18 may receive FCS services, the priority groups for service delivery are Aboriginal families, families with children aged 0-5 years, and young people affected by mental illness.
[12] https://familyconnectsupport.dcj.nsw.gov.au/documents/family-connect-and-support-common-assessment-framework.pdf
[13] The evaluation did not include removal and placement in out-of-home care as an outcome because of the short window of client follow-up
[14] The treatment group was identified as clients who exited FCS when their needs were met and was compared to clients who also benefitted from some services from FCS but exited for other reasons, which is referred to as `needs unmet'.
[15] Clients in the comparison group exited FCS for a variety of reasons (quit the service, moved away, higher assistance needed, assistance no longer needed, no longer eligible, other).

in the treatment group were significantly more likely to receive an external referral, brokerage, active holding and family capacity building than the control group.
Clients in the treatment and control group differed in their history of contact with the child protection system pre-FCS. In the treatment group, 47% of clients never had contact with the child protection system, while in the control group only 36% of clients never had contact.
The treatment and control group were similar in terms of their underlying motivation and need for accessing the FCS program, as both groups are referred and initially engaged in FCS, but differed in the intensity of services received and the duration of their time spent in FCS. Differences in case complexity, needs and latent risk of harm are controlled for in the estimation model. A series of robustness checks was conducted to test for reliability of estimates by changing the definition of the control group, sample restrictions and additional controls.

Post-FCS, families who were recorded as exiting FCS with their needs met, compared to families in the control group who exited with unmet needs[16] (holding other things constant), had a 7.7% lower risk of contact with the child protection system. Children in the treatment group were also significantly less likely to receive a ROSH report post-FCS by 7.4% relative to the control group. Children in the treatment group children were furthermore significantly less likely to be investigated for an allegation of maltreatment by 10.7% and 17.2% less likely to be substantiated for maltreatment. They were also 37% less likely to be substantiated for exposure to domestic violence. Substantiation for exposure to domestic violence was examined as an outcome because Family Connect and Support staff reported that they frequently worked with families experiencing domestic and family violence. Overall, treatment effects were statistically significant at conventional significance levels.

These numbers mean that if the children in the control group – those for whom the FCS did not meet their needs– had received an FCS treatment that would have met their needs, then:

- 1 out of 13 children – would have avoided contact with the statutory child protection system
- 1 out of 13.5 children – would have avoided a ROSH report
- 1 out of 9.3 children – would have avoided an investigation
- 1 out of 5.8 children – would have avoided a substantiation
- 1 out of 2.7 children – would have avoided substantiated exposure to domestic violence.

There were no statistically significant differences in interaction effects between treatment and sub-group indicators (Aboriginal vs non-Aboriginal; urban vs remote; small vs larger providers). However, statistical insignificance does not necessarily mean insignificance from a practice perspective. Large standard errors may have caused statistically insignificant interaction effects, even though the absolute size of the interaction effect may have implied large magnitude differences between the groups considered.

That was the case in this evaluation. When translating the interaction effects into risk reduction estimates for each group, it was found that reduction in risk for avoided substantiation was greater *in magnitude* for Aboriginal children (-27.4%) than non-Aboriginal children (-19.1%); for clients in urban areas (-28.4%) than clients in more rural

[16] Due to issues with data availability and to avoid self-selection bias, it was not feasible to compare families who received FCS to families who did not receive FCS. This means that the outcomes evaluation did not compare those families who received with FCS those who did not, but rather compared families who received FCS and completed the service with their needs met to families who completed the service without their needs met.

areas (-8.3%); and clients served by smaller providers (-23.7%) than clients served by larger providers (-15.2%).
These tentative findings align with reports from FCS providers covering large rural areas about the challenges of connecting families with services due to limited availability of services. Benefits of FCS participation was not linked to receipt of specific service types, but rather were linked with having needs met or having a case plan completed. Smaller providers may be better equipped to cater directly to the needs of their clients.

The important insight is that FCS clients who exited the program with their needs met were less likely to engage with the statutory child protection system at a later date. When FCS workers and services could address families' needs, it was worth the effort. However, FCS service providers may not be able to meet all the needs of families, given the scope of FCS and limited availability of local services.

Positive investment comparing costs to benefits

Drawing upon these findings, calculations were made about the benefit-to-cost ratio[17]. According to annual financial statements supplied with by all FCS providers for the 2022/23 financial year, DCJ spent $19.9 million on the FCS program inclusive of DCJ administrative costs, or 0.12% of the total expenditures of DCJ ($16.5 billion). FCS service provider expenditure for 2022/2023 was $19.7 million. The average cost per FCS case was $3,167, with a range varying from $2,109 to $6,069 per case[18]. The mean cost per session was $61.80, with a minimum of $10.40 and maximum of $147.10. The average session that provided information/advice/referral lasted for 20 minutes. This average cost of $61 is less than the total cost of seeing a GP for a 20-minute visit ($84 Medicare rebate for a 20-minute GP visit plus out-of-pocket costs)[19], showing FCS to be at the lower end of the possible price schedule of comparable services from other government departments.

The Benefit Cost Ratio (BCR) calculations suggest that FCS was cost beneficial. A BCR greater than one indicates that the investment is socially worthwhile. The BCRs calculated under different scenarios and assumptions ranged between 1.1 (using the most conservative estimate and highest cost observed) and 4.9 (using the least conservative estimate and the average costs observed). For every dollar spent on a successful FCS case, there is a social return of between $1.10 and $4.90. These numbers indicate that FCS has quantifiable social benefits measured by the monetarised value of avoided pain, suffering and trauma (experienced by the child) and the avoided costs to government attributable to expected reduced service use.

[17] To calculate the benefits in relation to program costs, the *DCJ Benefits Menus 2024 v. 1.0* was utilised. For the purposes of this analysis, avoided costs were calculated. The calculation includes only specific avoided costs for the outcome under discussion (e.g., substantiation of a ROSH report), not cumulative costs (e.g., avoidance of ROSH and then substantiation of ROSH).
[18] Costs per case vary based on the number of clients entered into the DEX database by providers. Only clients who explicitly agreed to their information being recorded in DEX are included in this calculation. Therefore, organisations with higher costs per client partially reflects their stringency on data entry.
[19] Medicare benefit item 00306 - $168, typical patient pays $182.

Recommendations

Based on the evaluation findings and suggestions made by families who have received FCS services, community stakeholders and FCS staff, **20 recommendations** were made regarding three areas of the evaluation:

- *Eight recommendations* were made to improve reporting, collection of outcomes data, and opportunities for causal evaluation;
- *Six recommendations* were made to enhance service delivery while maintaining the strengths of the FCS model, and enhance provider performance; and
- *Six recommendations* were made to promote culturally aware and responsive practice with Aboriginal and CALD clients.

A. Improve reporting, outcomes data, and causal evaluation opportunities

For future evaluations as well as ongoing reporting to inform continuous program improvement, the following recommendations are made in terms of collecting data on the FCS program and planning evaluation timeframes:

Recommendation 1: Collect client satisfaction data independently rather than having FCS workers collect this data

It is likely that there is a social desirability bias in how current client satisfaction data are collected. The client survey should be completed independently by the client and not be collected by the FCS caseworker, or provider, as this may bias the results. The current client survey could be replaced with a short survey that is sent by text to families via their phone or email and collected through Qualtrics or another survey database. The questions should be focused on their satisfaction with the service they received and any resulting improvement in the issues prompting the referral to FCS.

Recommendation 2: Select a set of priority measures for baseline data collection and follow-up

To enable ongoing monitoring and future evaluation, FCS providers should collect the same data at baseline (before the intervention starts) and at follow-up (e.g., during the intervention and at completion of the service provision). Based on cross-cutting themes of how FCS was able to help families as reported by FCS staff, stakeholders and clients and from desktop review of referral reasons and case plans, the following top five questions for collecting client self-assessment are recommended:

a. My mental health is good
b. I feel my family and I are safe
c. I am reasonably comfortable/have enough money to get by
d. I feel connected to my community
e. I am living in housing that is suitable for my family needs.

These measures correspond to the NSW Human Services Outcomes Framework safety, economic, home, health and social & community domains. Given the brief (16 week) duration of services, there is little reason to think that FCS programs would be able to make

changes in education and skills. While changes in the home domain are very difficult to achieve, housing is clearly a widespread issue, with limited availability of affordable housing and long waitlists for social housing. The client interviews acknowledged that FCS providers could do little to address housing issues; however, clients did express appreciation of the efforts FCS staff made, connecting them with social housing providers, writing support letters and assisting them with housing applications. In addition, asking clients about their experiences with the FCS service could contribute to the NSW Human Services Outcomes Framework domain of empowerment. The following measures from the current SCORE survey (listed below) are meaningful for assessing clients' experiences of FCS service provision and should be retained and asked at the start and end of service provision:

- I feel better able to deal with issues,
- I know about the available support services,
- I know how to access these services.

Recommendation 3: Collect more detailed and varied data on priority cohorts

FCS has three identified priority groups: Aboriginal families; families with children aged 0–5 years; and young people affected by mental illness. Based on FCS program data, two in five clients fit within these cohorts and more than one in two cases include a client within this category.

There are other client groups with significant vulnerabilities that should also be considered. *Safe and Supported, the National Plan for Protecting Australia's Children 2021-2031*, identifies four priority groups:

- Aboriginal and Torres Strait Islander children and young people experiencing vulnerability;
- Children and young people with a disability and/or parents with disability experiencing disadvantage or who are vulnerable;
- Children and young people who have experienced abuse or neglect, including children in out-of-home care and young people transitioning to adulthood and leaving out-of-home care;
- Families with multiple and complex needs defined as having a combination of mental health issues, alcohol and drug misuse, domestic and family violence, disability, social exclusion, poverty, housing uncertainty, unemployment and underemployment.

FCS already prioritises Aboriginal families, families with young children and vulnerable young people experiencing mental health issues. FCS could additionally prioritise families experiencing multiple and complex needs, including parents and children with disabilities. From the interviews with families and consultations with FCS service providers, families particularly need support with getting a diagnosis when they have a child showing potential signs of disability or struggling with challenging behaviours.

A recent report using the NSW Human Services Data Set identified that 33% of children who were reported to the NSW Child Protection Helpline had experienced parental domestic and family violence (DFV) or DFV alongside parental mental health issues or parental substance

use issues[20]. Based on the feedback from FCS workers, they are already working with families who fit the profile of having multiple and complex needs.

In order to track other client cohorts such as these noted above, additional options should be added to DEX for referral reasons. This includes adding flags for mental health (child/young person or parent), domestic and family violence, drug and alcohol misuse, homelessness, unemployment, parental disability, and financial stress or crisis. In DEX, there is already a field for a client's primary reason for seeking assistance, whether the client is eligible for NDIS, and whether the client has a disability (and type). However, some of this information needs to be more specific. Gathering additional information about the referral reason can be useful to assess client complexity and inform the development of protocols for how to work with clients with particular needs.

Recommendation 4: Record data about families' needs

The outcomes evaluation has identified that FCS is effective in reducing subsequent child protection involvement in the short-term when families' needs are met at the time of case closure relative to families whose needs were not met. We recommend adding a data collection field for FCS providers to indicate after assessing families' needs at intake, using the Common Assessment Tool (CAT), whether the program is positioned to meet those needs. As indicated in the process evaluation, often it is not possible to connect families with the service referrals they need due to scarcity of services, particularly in rural areas. According to FCS providers, some families' needs are beyond the scope of assistance they can provide. Reporting the likelihood of being able to meet a family's needs as a binary (yes/no) or using rating scale (e.g. 1 very unlikely to 5 very likely), would provide information on the types of families' needs that are not the right fit for FCS and should receive a different type of response (e.g., statutory).

It would also be helpful to collect data on families' needs to indicate the types and amount of service the family requires. The length of engagement with an FCS client depends on the complexity of their needs. The higher the needs that a client has, the more contact time they are likely to have. This makes it difficult to assess the outcomes of treatment amount, because of this pre-existing relationship to complexity. In other words, regardless of the amount or quality of FCS service they receive, a family with more complex needs is more likely than a family facing fewer challenges to have future child protection involvement. It would be helpful for FCS providers to document reasons why families require more engagement with FCS and longer service delivery periods, so this can be taken into account when assessing service outcomes. This could involve a revision to the weighted referral system, which many FCS providers found confusing. In this context, it would also be important to collect information on the total number of children in the household and their needs, even if they do not attend a session.

In addition, it is important for FCS workers to record all family members on intake. Information was not consistently entered about child clients. This is likely because FCS visits took place while children were attending school, and FCS staff recorded data about the family members who attended FCS sessions. However, it is important to track the children

[20] Luu, B., Wright, A. C., Schurer, S., Metcalfe, L., Heward-Belle, S., Collings, S., & Barrett, E. (2024). *Analysis of linked longitudinal administrative data on child protection involvement for NSW families with domestic and family violence, alcohol and other drug issues and mental health issues* (Research report, 01/2024). ANROWS.

involved in FCS cases and their needs to ensure that adequate services are provided for the whole family and to enable outcomes evaluation.

Recommendation 5: Require consistent DEX data entry

DCJ should ensure that consistent data collection and reporting is required through DEX when new contracts are enacted. FCS agencies were not required to enter client data in DEX until February 2022, and the evaluation therefore did not have full data from the commencement of the program in January 2021. This delay in the data entry requirement compromised the reliability of the evaluation, as some families were not entered into DEX as having received a service between January 2021 and February 2022, when they had indeed received an FCS service. This measurement error has likely resulted in an underestimation of the effectiveness of FCS. Entering client data in DEX could be linked to payment of contract.

In addition, required reporting should include information on when a record only reflects an intake, and when a record indicates an accepted referral. This would enable practitioners and data analysts to clearly identify clients who have regularly and meaningfully engaged with FCS. This would also enable identification when an FCS service could not be provided due to lack of capacity. Data entry should also indicate when core casework has ended and a period of follow-up has begun, in order to identify cases that have truly closed.

Recommendation 6: Allow for a longer follow-up period for evaluation

To be able to make statements about the medium and longer-term effectiveness of the FCS program, there needs to be adequate time for the FCS service to mature. For future evaluations, there should be an extended timeframe, to be able to monitor client outcomes. In this evaluation, clients in FCS can only be reliably followed from February 2022. Follow-up data in the statutory child protection system is only available until August 2023. At most, clients in the service can only be followed for a year and a half, and most clients for a much shorter period of six months, which is a limited timeframe for observing child protection involvement outcomes. For future evaluations, it is recommended that cohorts of clients be observed for more than one year and ideally for two years or more, so that impacts on longer-term outcomes such as removal and entry into out-of-home care can be assessed. This recommendation is therefore to commission program evaluations three to five years after program initiation.

Recommendation 7: Record information on services provided to families and link to child protection records

A major complication in this evaluation was the inability to observe which clients had also received services through the FRS program, which ended in January 2021. As FCS and FRS were similar in objectives and structure, any comparisons over time rely on the assumption that clients in FCS have not already benefitted from services provided through FRS for the time period when the FCS client was observed in the pre-treatment period (the time period before the FCS service was observed). This implies that theoretically clients might have received similar treatments in both the pre-treatment period (FRS) and in the treatment period (FCS). If information on FRS clients had been available, then the evaluation team could have controlled for it. In the absence of this information, the evaluation team had to assume that no other service had been received pre-FCS, which is a poorly substantiated assumption. It is

critical that all FCS agencies collect data on all cases they serve, to allow for robust evaluation of program outcomes.

Recommendation 8: Roll out new programs in ways that enable robust evaluation through randomly assigning people to treatment/control groups and bring evaluators into the program design and rollout phase

As previously noted, the FCS program was rolled out across the whole of NSW in January 2021 and followed the statewide rollout of the FRS program, which had a similar service delivery model. This means that it was not possible for the evaluation team to observe a natural experiment, where some families received the service while other similar families did not, for reasons that were random such as geographic residence. In the future, an evaluation should be considered from the beginning of the development of new social programs, so that they can be implemented in ways that enable people to be randomly assigned to treatment or control groups (i.e., a randomised control trial). Those assigned to control groups can be prioritised to receive the program after a period of follow-up, as for example in a stepped-wedge cluster randomised trial design[21]. Two options for rollout are recommended. First, a staggered rollout design makes a program available incrementally to random subsets of people, such as by geographic location. This would enable tracking a set of families who were eligible to receive the intervention with a group who were not yet eligible, with differences between the groups due to chance. This is how the pilot of the National Disability Insurance Scheme was evaluated. Second, a lottery can be conducted through which all people who want a particular social program can register their interest, then be randomly allocated to the program, with the remainder of the group constituting the control group. Then both groups can be tracked over time to measure outcomes. In the United States, the Oregon Health Insurance Experiment[22] used this model to analyse outcomes for those who were able to enrol in publicly funded health insurance after being uninsured, compared to those who remained on the waitlist. The new Australian Centre for Evaluation[23], within the Australian Government Treasury, is advocating for increased use of randomised control trials in the delivery of government-funded services, to answer causal questions regarding whether government programs work and how well they work. It is furthermore recommended to bring in evaluation teams at the beginning of designing a program and its rollout structure. This would ensure that minimum requirements for reliable evaluations are embedded into the program logic.

B. Service delivery

The major takeaway from the FCS program evaluation is resounding endorsement from families who have received services, key community stakeholders and FCS staff, coupled with evidence of positive outcomes for families who exit with their needs met and positive return on investment. The following recommendations would enhance the program model by maintaining or strengthening service delivery.

Recommendation 9: Advocate for greater investment in early intervention

[21] Hemming, K., Haines, T. P., Chilton, P. J., Girling, A. J., & Lilford, R. J. (2015). The stepped wedge cluster randomised trial: rationale, design, analysis, and reporting. *British Medical Journal (The BMJ), 350*.
[22] Finkelstein, A., Taubman, S., Wright, B., Bernstein, M., Gruber, J., Newhouse, J. P., ... & Oregon Health Study Group, T. (2012). The Oregon health insurance experiment: evidence from the first year. *The Quarterly Journal of Economics*, *127*(3), 1057-1106.
[23] Australian Government, The Treasury (n.d.). *Impact evaluation.* https://evaluation.treasury.gov.au

DCJ staff refer families to the FCS program when families are reported to the Child Protection Helpline but do not meet the threshold for statutory intervention. They are also referred in cases of low-level ROSH (less than 10 days) where they meet other FCS eligibility and are within the 30% cap on DCJ referrals to FCS. There is not an adequate supply of services with sufficient intensity and expertise for families who are not allocated for statutory child protection intervention, but have children at a high-level of risk[24]. Consistently identified service gaps include: housing, mental health services (psychologists and counsellors), domestic and family violence services, intensive family case management, paediatric and allied health for children including speech therapy, and clinical assessments for neurodevelopmental conditions (e.g., autism spectrum disorder). These shortages are particularly problematic in rural areas. Many of the types of supports that families require are not available due to geographic gaps in service delivery or oversubscription to these services. For example, due to caps on Brighter Futures and other Family Preservation programs, FCS staff reported through focus groups that it was frequently not possible to connect families with the longer-term support they need. Moreover, the outcomes evaluation found tentative evidence that the FCS program may have been less effective for families in rural areas, where there are fewer services to which families may be referred. Although this finding was not statistically significant, it was significant from a practice perspective. These findings speak to the need for analysis of the current ecosystem of family support services in NSW and targeted funding to increase the capacity of local services to take on new clients.

Recommendation 10: Allocate higher priority to FCS referrals

FCS providers have more limited scope in making service referrals than DCJ statutory staff, such as to fee-free psychology services or intensive family support services. For example, intensive family services are primarily occupied with statutory referrals, limiting access from FCS referrals. The NSW Family Preservation program only allocates 10% of their capacity to community referrals[25]. To get support for families, FCS providers reported they feel under pressure to report families via the Child Protection Helpline to reopen their case, but this is perceived as damaging trusting relationships and resulting in potential overreach in terms of statutory response.

Recommendation 11: Support FCS staff to maintain and develop specific skills

Evaluation of the implementation of the FCS model, including consultations with FCS staff and stakeholders as well as interviews with families, identified that a core set of skills was essential to delivering the model. These included active listening, communicating clearly and appropriately, demonstrating empathy, adopting a trauma-informed approach, being honest and transparent and using a friendly tone of voice and sense of humour, where appropriate. These skills assisted in breaking down fears families might have about engaging with a support service. By adopting a family-led and strengths-based approach, FCS providers encouraged families to identify their own needs and goals. It is important for FCS programs to keep these skills in mind when hiring new staff and when providing professional development opportunities.

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[24] Beaton, R. (2022) *Collaboration workshop: Child Wellbeing Units and Family Connect and Support services*. Insight Consulting Australia.
[25] Ibid.

Recommendation 12: Consider longer timeframes for some cases

The standard 16-week service delivery period can be too short when there are long wait times for referrals, or families are facing additional challenges, such as court proceedings. The flexibility of the FCS program could include an option to automatically extend the timeframe for specific families to address ongoing issues or to allow additional time for complex cases. Of the 9,242 FCS cases for which case start and case end date was available, 11% received FCS services for more than 16 weeks. A set of criteria could be developed for flagging families who may benefit from additional FCS support. Longer timeframes to enable active holding may also be required in rural areas due to limited services.

Recommendation 13: Raise awareness of FCS through social media and community promotion

Families can be reluctant to seek help early. A positive experience for families receiving an FCS service was associated with the provision of practical assistance, and proactive advocacy on their behalf. FCS case coordination relieved families from the burden of repeating their story with a range of different service providers and reliving traumatic experiences. The FCS program is highly valued in that it can assist families to navigate a confusing and complex service system. Consultations with FCS stakeholders and interviews with families suggested that there are missed opportunities to promote FCS within local communities. This could include distributing FCS brochures in universal settings (e.g., childcares, schools) as well as posting to social media and community bulletin boards with simple and clear messages about the voluntary assistance provided by FCS, so families can self-refer if needed.

Recommendation 14: Celebrate and reward the best performing service providers

This evaluation revealed that there was great variety across providers in terms of average cost per case, average time spent on cases and clients, and referrals made to external organisations and service providers. Some providers made very strong efforts to record client data into the DEX, other providers were very low-cost even though they engaged deeply with their clients. Some providers were exceptionally successful in making referrals and completing cases when the needs of their clients were met. Even though the purpose of this evaluation was not to study provider differences in effectiveness, some providers stood out as exceptional performers. The high-performance providers should be celebrated by the NSW Department of Communities and Justice. One recommendation is to offer financial incentives to providers who successfully enter all client data into DEX, or who manage to keep high priority or vulnerable clients engaged with the system. Examples of such incentives have been trialed widely in the health care service sectors. It is furthermore recommended to commission an inquiry into best practice for provider payment for performance and incentive payments for providers who consistently deliver quality services and achieve positive client outcomes.

C. Culturally aware and responsive practice

Consultations with Aboriginal and CALD stakeholders were consistent with general stakeholder consultations, in highly valuing FCS and its role within the sector and the support provided to families. These consultations informed recommendations on ways that FCS

services can enhance the services they deliver to Aboriginal and CALD families and build partnerships within their communities.

Recommendation 15: Develop culturally appropriate referral pathways

Feedback from Aboriginal and CALD stakeholders indicated that referral pathways with FCS could be strengthened. This could facilitate more collaborative work between FCS and Aboriginal and multicultural services and improve the appropriateness of services with which families are connected. Aboriginal and CALD stakeholders recommended the development of culturally appropriate referral pathways between organisations and suggested that more case conferencing meetings were needed to work collaboratively in supporting families.

Recommendation 16: Engage early with Aboriginal Community Controlled Organisations (ACCOs) to support families

The impact of past policies and practices continues to have repercussions for Aboriginal communities and families. In consultations with ACCOs, stakeholders expressed that Aboriginal families may avoid FCS providers because they are funded by DCJ. Early engagement with ACCOs can help to bridge this divide and build trust with Aboriginal family members, to achieve proactive outreach with Aboriginal families and practice in ways that are culturally aware and responsive with families.

Recommendation 17: Build and maintain relationships and partnerships with a range of service providers

Relationships within local services are important across FCS regions to foster an effective inbound and outbound referral system. Common strategies included attending interagency meetings, organising and attending community events, and undertaking targeted visits to universal settings such as early childhood centres, schools and other service providers. Good communication was noted by stakeholders to facilitate the ease of two-way referrals.

Recommendation 18: Ensure FCS staff practice in ways that are culturally aware and responsive in their staff management and collaborations

Aboriginal services reported that FCS providers that had Aboriginal staff were observed to be appreciative of the community obligations for Aboriginal people and the importance of cultural awareness, confidence and responsiveness when working with Aboriginal families. However, Aboriginal services expressed concerns that when only one Aboriginal worker was employed within an FCS service, they needed support to avoid burnout. Some Aboriginal agency representatives reported that FCS providers would reach out to them to fill gaps in their cultural awareness, confidence and responsiveness, including family finding.

Recommendation 19: Review Aboriginal Participation Plans

Aboriginal Participation Plans (APPs) should be reviewed to verify they are based on authentic relationships with ACCOs and that FCS providers are taking the appropriate actions to implement them. There have been reports from some Aboriginal services that they had not been contacted by the FCS provider in their area and they were unaware that they were included in their APP. A lack of proactive engagement with Aboriginal services

may result in the escalation of family issues and lead to a higher risk of Aboriginal families entering the child protection system. Interagency meetings were noted by Aboriginal and CALD stakeholders as a good forum for exchanging information, both about families and what services could offer, and enabling regular communication for relationship building.

Recommendation 20: Change how data is collected on cultural diversity

This recommendation straddles the categories of improved reporting and culturally aware and responsive practice. Whether a family is designated as CALD is currently defined in the FCS program data in terms of whether they speak a language other than English as their main language in their home and born in another country. However, the Australian Bureau of Statistics considers that cultural and linguistic diversity involves several elements, including birth country and ancestry, and that a single variable to define a group as CALD is inadequate[26]. FCS staff indicated that they were uncomfortable with the current way that data is collected about families' cultural diversity. Instead of only the current measures, consideration should also be given to including several other measures, including parents' countries of birth, year of arrival in Australia and first language spoken, as well as language spoken in the home and country of birth.

[26] Australian Bureau of Statistics (2022). *Standards for statistics on cultural and language diversity*. https://www.abs.gov.au/statistics/standards/standards-statistics-cultural-and-language-diversity/latest-release

Section 2 – Family Connect and Support & evaluation overview

Family Connect and Support overview

Background

In January 2021, the Family Referral Service (FRS) transferred from the NSW Ministry of Health to the NSW Department of Communities and Justice (DCJ). Building on FRS, the FCS service model was informed by the Stronger Communities Insights data and stakeholder consultations. Feedback about the FRS program emphasised its value in identifying, engaging, and referring families to services before their situation escalated.

The FCS program has attempted to address some of the challenges with FRS identified by the *Their Futures Matter* Access System Redesign process, undertaken in 2018[27]. These included:

- Lack of coordination or data sharing between government agencies (schools, police, child protection);
- No common assessment tool;
- Limited access to DCJ funded programs, or statutory support to work with high-risk families;
- No meaningful reporting on family outcomes;
- Lack of consistency between FRS providers; and
- Insufficient services to meet the needs of families.

The FCS program builds on the FRS model and provides more service elements and practice guidelines to reflect contemporary family needs in NSW (see Table 1 for a comparison of the two programs). The need to redesign and build on the work of FRS was identified through extensive sector consultations. It showed that FRS was a valued program and with the redesign to the FCS model, key features and strengths of FRS remained in the FCS model, such as:

- Assessment of family strengths and needs to inform service responses;
- Provision of information and advice to help families navigate the service system;
- Warm referrals to services to link families with appropriate supports in their local area;
- Follow-up of referrals to ensure families were engaged with the services they needed;
- Active holding of families where there is a service gap or waiting time to access services;
- Provision of timely and comprehensive feedback to inbound referrers about the outcome for the family referral;
- Flexible use of brokerage funds to address immediate family needs;
- Assertive outreach methods to engage isolated families; and
- Voluntary, non-statutory program for families in NSW experiencing vulnerability.

[27] Their Futures Matter (2018) *Access system redesign evidence review.* NSW Government: Sydney.

Table 1 Differences between the FRS and FCS programs

Maintained in FRS and FCS	Enhanced under FCS	New features in FCS
• **Family strengths and needs assessed to inform service response.** • **Information and advice provided to help them navigate the service system.** • **Families connected to services through warm referrals linking them with appropriate local support services.** • **Referrals are followed up to ensure they are appropriate and sustainable.** • **Timely and comprehensive feedback provided to inbound referrers about the outcomes.** • **Brokerage funds used flexibly to address immediate family needs.** • **Assertive outreach including home visiting and cold calling to reach isolated families.** • **A voluntary program delivered state-wide to any family in NSW experiencing vulnerability.**	• Expanded active holding to keep families engaged and connected when there are service gaps or blockages. • Emphasis on using the active holding period to provide practical support, home visits and more active follow up with outbound referral agencies. • Families assessed at ROSH (less than 10 days) can be referred to the FCS in any location in NSW. • The FCS service model introduced a 30% cap on inbound referrals received from DCJ Community Service Centres (ROSH less than 10 days) to ensure service delivery remains primarily focused on the prevention and early intervention. • Service timeframe has been extended from 12 weeks to 16 weeks to ensure family needs are met. • Family strengths and needs are holistically assessed in the FCS model to inform case planning and coordination. • Community of practice and local leadership groups made up of FCS representatives, meet regularly to support operational aspects and promote good practice.	• Introduction of family-led decision making to leverage off informal supports and resources. • Increased focus on outreach into universal settings to support referral pathways and decrease barriers to service access. • Increased focus on innovation and flexible service delivery to respond to large scale disasters and emergencies and to reach isolated families. • Co-designed Common Assessment Framework, universal referral forms, case plans and practice tools to increase consistency across FCS. • Redesigned and centrally managed program wide website. • Outcomes-based reporting and service delivery aligned to the domains of the Human Services Outcomes Framework. • FCS services delivered under a Human Service Agreement. • Funding and resource allocation model reflects current demographics and community need. • Updated service targets, compliance, and accountability measures.

FCS has been refined by the lessons learned from the implementation of the original FRS service model. Some of the changes to the model include:

- Broader inclusion criteria alongside assertive outreach targeted to priority groups including Aboriginal families, families with children aged 0–5 years, and children and young people affected by mental illness;

- Increased consistency across the FCS program through the co-designed CAF[28] and a universal referral form (used by DCJ for referrals to FCS), case plans and practice tools;
- Enhanced flexibility in the range of support offered and greater efforts to connect families with a wide range of services;
- Redesigned and centrally managed program-wide website with new referral functionality;
- Alignment of service domains to the NSW Human Services Outcomes Framework, through outcomes-based reporting and service delivery, to measure positive impact on the lives of vulnerable families;
- Revised service targets, compliance, and accountability measures; and
- Development of disaster and emergency responses (in the context of large-scale disasters) to enable outreach to isolated families through innovative and flexible service delivery.

FCS is a statewide, voluntary service for children, young people and families which provides a soft entry point and connection to the service system for families who may be experiencing vulnerabilities or who require some level of support before issues escalate. It is an early intervention service that helps families identify their strengths and address underlying issues and needs from a holistic perspective.

Families are referred to FCS from a range of sources; for example, DCJ may directly refer families to FCS from the Child Protection Helpline where it is considered that a families' need may be better met by an FCS service[29]. Other referral sources to FCS include: Child Wellbeing Units (CWU); health and human service providers; and family and community sector agencies, including schools.

The program aims to intervene early and prevent family issues from escalating and becoming more complex. FCS provides an assessment of needs and supports children to remain safe and well in their family, to avoid the need for statutory intervention. The services provided through FCS include comprehensive assessment, active outreach, short-term case planning and coordination. Where services are not immediately available, FCS may offer active holding, to keep the family engaged until supports are available.

FCS Weighted Referral System

The weighted referral is the assessment of complexity of services required by a family reflected in how much time FCS workers will spend, being a low, medium, or high-level case. The weighting includes the Remoteness Index of Australia (ARIA+), which allows a 16% loading for greater travel time and insufficient services in regional areas (see Figure 1). The weighting enables costing for the allocation of hours according to the complexity and duration of the service provided. The unweighted referrals are the number of clients to which an organisation is expected to provide services.

[28] NSW Government and Parenting Research Centre (2022, April). *Family Connect and Support Common Assessment Framework.* https://familyconnectsupport.dcj.nsw.gov.au/documents/family-connect-and-support-common-assessment-framework.pdf
[29] In the transition from FRS to FCS, the FCS model introduced a 30% cap on inbound referrals received from DCJ Community Service Centres (ROSH less than 10 days) to ensure service delivery remains primarily focused on prevention and early intervention.

Figure 1 Weighted referral allocation method

The costing weighting is applied to the FCS program according to the formula in Table 2. It should be noted that a family assessment that is under 2 hours in duration, and which does not result in an outbound referral, is not counted towards an agency's referral target.

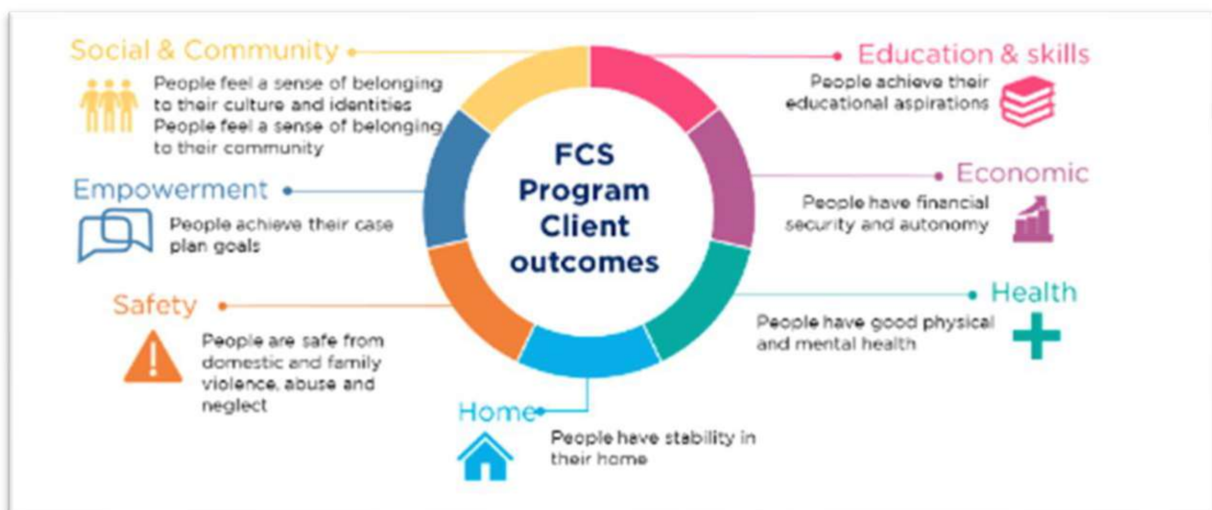
Table 2 Costing weighting formula

Referral Complexity	Minimum time	Maximum time	Cost weight
Low	2.0 hours	5.0 hours	0.5
Medium	5.0 hours	15.0 hours	1.2
High	15.0 hours	35.0 hours	3.4

FCS Minimum Data Set

There is a minimum data set that all providers must report on, using the DEX platform[30]. This data set includes client details and demographic data, service delivery data and client outcomes data. The full list of data that must be reported is provided in the FCS Data Collection and Reporting Guide[31]. There are seven long-term outcomes that the FCS program is expected to contribute to for children, young people, families, and communities in NSW. These are aligned with the NSW Human Services Outcomes Framework and described in Figure 2.

Figure 2 FCS Program client outcomes



[30] Reporting on the FCS program using DEX became required from 1 February 2021, including DEX Protocols. All service providers are required to report to DCJ on a quarterly basis and have 15 days to upload their reports in DEX from the end of the quarter.
[31] https://familyconnectsupport.dcj.nsw.gov.au/documents/FCS_Data_Collection_and_Reporting_Guide.pdf

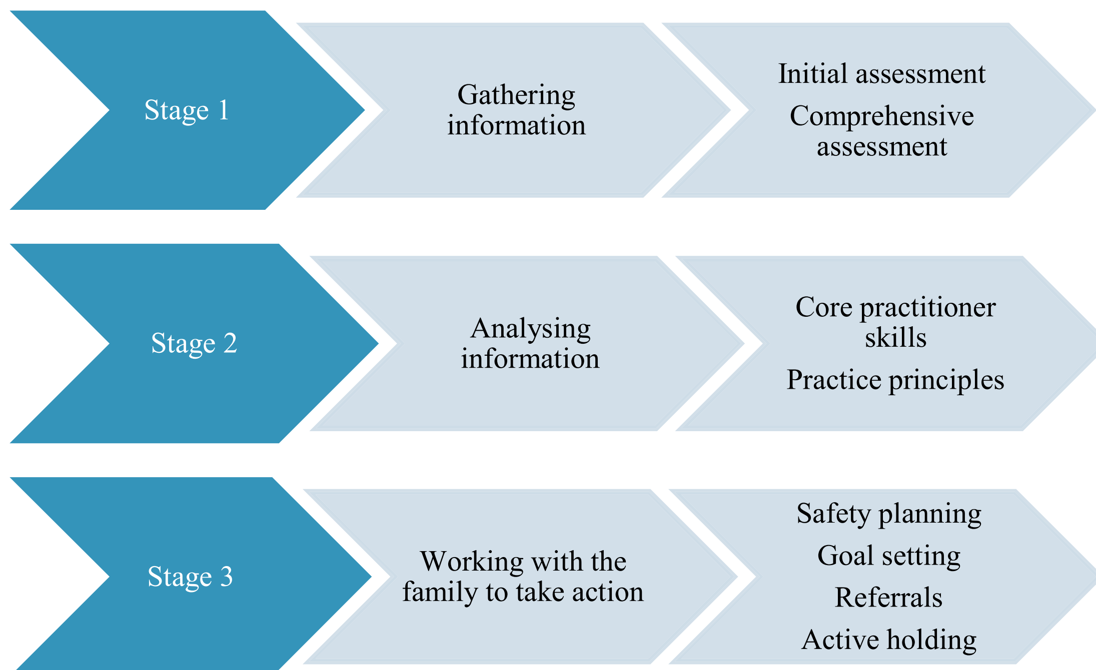
Additional fields have been added to enable the reporting of multiple referrals and demographic data about the family unit. DEX records clients as individuals, or as group clients (families). Children are recorded as clients if they were present when a service was delivered, or the service provided was targeted towards the child. Both DCJ and providers have access to FCS program data reports via DEX so they can be used for performance monitoring, and for future service forecasting.

Once client data is entered into the DEX database, a Statistical Linkage Key (SLK) is automatically generated, which enables it to be matched over time and programs. FCS program data contributed to the analysis for the evaluation of the program outcomes, along with administrative child protection data from ChildStory.

FCS Common Assessment Framework (CAF)

DCJ commissioned the Parenting Research Centre (PRC) to develop the CAF[32] to provide a framework for the key program principles and to create a common language and core skills required by FCS workers. The CAF emphasises the importance of strong engagement and assessment skills. The FCS CAF has been designed to align with the Aboriginal Case Management Policy, which introduces key elements for culturally aware and responsive ways of working with Aboriginal children, families, and communities[33]. The common assessment process outlined in the CAF includes 3 stages (see Figure 3).

Figure 3 Process outlined in the FCS Common Assessment Framework



Eight domains, aligned with FCS Program Logic outcomes (See Appendix Table 1), are identified within the CAF that FCS workers can explore with families.

The CAF is designed to provide FCS workers with a template for assessing the strengths and needs of families who are seeking support from the FCS program. FCS workers are

[32] https://dcj.nsw.gov.au/content/dcj/familyconnectsupport/family-connect-and-support-home/resources/assessment-resources.html
[33] https://dcj.nsw.gov.au/service-providers/oohc-and-permanency-support-services/aboriginal-case-management-policy.html

encouraged, where appropriate, to have conversations with families instead of a structured interview. The CAF provides a template for practitioners to record family observations and to help them to identify and prioritise areas where families most need assistance. FCS workers should refer to the CAF for guidance around safety planning, goal setting, case planning, making referrals and active holding.

FCS Common Assessment Tool (CAT)

DCJ engaged Curijo to lead the process of developing a CAT, to align with the domains of the CAF. It aims to embed Aboriginal voices into the assessment process and support greater consistency in intake and assessment for families who access FCS.

The CAT was developed through a co-design process led by Curijo in 2022/23 utilising practice and quality expertise within FCS providers, including frontline staff, and practice and quality experts. An underlying principle for the CAT development was the need to be open and flexible to broader opportunities that may arise to link the CAT across the child and family service continuum.

A preliminary version of the CAT was rolled out for user testing in mid-2023 and the final version was launched in November 2023. Evaluation of the CAT is beyond the scope of this evaluation. FCS workers can also refer to the CAT Guide[34] to seek examples of questions which may support conversations with families during this process.

FCS Aboriginal Participation Plans

FCS providers are expected to complete an Aboriginal Participation Plan (APP) for their district, as a contractual requirement. A template developed by DCJ was provided to guide the process, with the intention that the APPs be living documents that could be adapted in response to community circumstances. The expectation was that the APPs would be developed in consultation with local Aboriginal organisations and stakeholders, and DCJ representatives. The APPs are reviewed quarterly by the provider, and annually by DCJ through the contract management process. The plans also outline what steps FCS providers are taking to build the cultural competence of their staff, such as education and training and participation in local cultural events and forums.

[34] https://dcj.nsw.gov.au/content/dcj/familyconnectsupport/family-connect-and-support-home/resources/assessment-resources.html

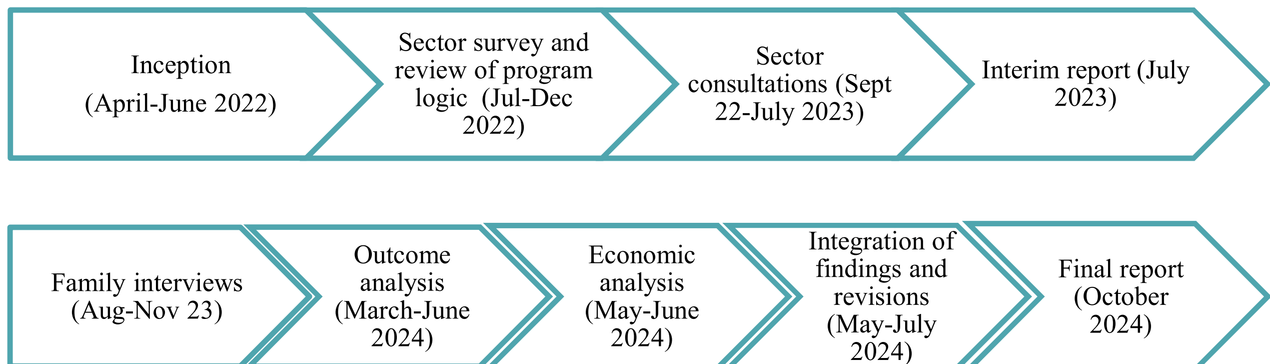
Evaluation overview

Evaluation timeline and deliverables

During the evaluation's initial phase, the following components of the evaluation were completed (see Figure 4 for all steps of the evaluation timeframe):

1. Establishment of the Steering Committee terms of reference and membership, including representation from: RCCF, Curijo, DCJ districts, Transforming Aboriginal Outcomes, Family and Community Services Insights, Analysis and Research (FACSIAR) and the Early Intervention team.
2. Preparation of the evaluation plan including key evaluation questions and methodologies.
3. Development of a communication and recruitment strategy for evaluation stakeholders and participants.
4. Submission of the ethics application to University of Sydney Human Research Ethics Committee (HREC).
5. Review of the FCS program logic, based on consultations with FCS providers.

Figure 4 Evaluation timeframe



Steering Committee

The FCS Evaluation Steering Committee was established to ensure the project is informed by key stakeholders, policy, and practice considerations. Quarterly meetings were chaired by the project sponsor (DCJ) with secretariat support provided by the RCCF evaluation team including agendas, minutes, and meeting papers. The Steering Committee met regularly throughout the evaluation, providing a forum for progressing the key deliverables and specific components of the study.

Evaluation plan

The FCS Evaluation Plan was developed in consultation with the FCS Project team in DCJ and submitted in August 2022. Feedback from DCJ was incorporated and the FCS Evaluation Plan was finalised. The FCS Evaluation Plan provided a living document of the overarching evaluation strategy, timeframes, and key deliverables for the project. The Evaluation Plan included a risk assessment of the key challenges that were likely to arise during the course of the evaluation, and the mitigation strategies for managing issues as they occur. The

evaluation and risk management plan were periodically reviewed and updated to reflect developments with the project and any emerging issues as they arose.

Communication Strategy

A communication strategy was developed to encourage the engagement of key stakeholders in the evaluation process. The Steering Committee provided advice to the evaluation team on the communication and recruitment strategy for different audiences involved in the FCS evaluation, as well as assisted, where appropriate, with the dissemination of recruitment messages. Participants were informed about the study through print and electronic media.

A specific component of the communication strategy was culturally aware and responsive outreach and engagement with Aboriginal and culturally diverse families, communities, and agencies. An essential theme for the evaluation was to determine whether the implementation of FCS is culturally aware and responsive for Aboriginal families, and other culturally diverse families, and the degree to which it is an effective program for safely diverting children from involvement with statutory child protection. To encourage the engagement of ACCOs and families, targeted consultations were conducted by Curijo. Partnership with Curijo has ensured that the evaluation questions and methods are culturally sensitive and meaningful, so the Aboriginal and CALD families and agencies felt safe to participate.

Communication strategies to recruit families to participate in the evaluation included the use of video messages to provide simple and clear messages, and summaries with infographics to convey key messages and encourage community engagement.

Ethics Review

The Evaluation Plan was submitted to the University of Sydney Human Research Ethics Committee (HREC) and approved in August 2022 [2022/512]. The data collection methods complied with the University Data Management requirements, to ensure participant sensitivity and safety, as well as the secure transfer and storage of all data collection.

RCCF partnered with Curijo to contribute their extensive experience in consultancy and evaluation of organisations and programs providing targeted early intervention and family services. Curijo is a highly respected Aboriginal-owned organisation experienced in engagement with diverse stakeholders. Curijo lives, respects and demonstrates the values, principles and protocols outlined in NIAA's IAS Evaluation Framework and NHMRC's Guidelines Framework, specifically, *Ethical Conduct in Research with Aboriginal and Torres Strait Islander Peoples and Communities*[35]. Curijo provided guidance for engagement with Aboriginal and CALD families and communities, to gain their trust and conduct culturally appropriate data collection and analysis.

Evaluation limitations

Despite best efforts and intentions, there are several major limitations of this evaluation. These include the brief implementation period, data quality issues, challenges establishing a suitable control group, and the absence of outcomes data other than administrative child protection data, as SCORE survey data was incomplete due to issues with the instrument which led DCJ not to require this form of data collection.

[35] https://www.nhmrc.gov.au/about-us/resources/ethical-conduct-research-aboriginal-and-torres-strait-islander-peoples-and-communities

Brief implementation period

There was a short time period between implementation of the service (in January 2021) and the evaluation timeframes (which commenced in 2022). Administrative child protection data was only available until August 2023. Due to data quality issues in FCS program data collection in DEX, a treatment sample of families who received FCS services could be followed for a post-treatment period of 6 to 18 months. This is a short time period for potential child protection issues to arise, particularly removal and entry into out-of-home care, so short-term outcomes of ROSH and substantiated ROSH are the focus of the outcomes evaluation.

Data quality issues

FCS program data collection was only mandated in February 2022. This means that the data entry in DEX before that date was incomplete. This complicated the research methodology as those in the control group may indeed have been in the treatment group and could therefore underestimate the treatment effect. Some data fields were poorly recorded; for example, based on feedback from FCS staff who participated in the evaluation about their discomfort identifying families as CALD, this group is likely underreported. In addition, there was significant inconsistency among providers in terms of how diligently they recorded data. Some providers did not consistently record children in their cases in DEX and one provider did not record the referrals they made in DEX[36].

Difficulty establishing a suitable control group

There is no ideal control group available since the FCS service is voluntary. The FCS service was not randomised and the rollout did not happen in stages across locations. Therefore, a control group cannot be chosen from a sample of individuals who did not receive FCS in a given year and month. In addition, a control group cannot be formed from cohorts before 2021, as these cohorts may have benefitted from FRS. As FRS data was not recorded in DEX and not available for analysis purposes, it is unknown which clients previously benefitted from this service. It cannot be ruled out that some families in the control group or treatment group may have benefitted previously from FRS. The evaluation methodology attempted to rule this out as much as possible by focusing on a cohort of children who benefitted from FCS one to two years after FCS replaced FRS, and by conditioning the analysis on outcomes pre-FCS. Conducting the analysis this way is an effort to control for potential benefits families may have received if they participated in FRS.

Collection of client outcomes and feedback

Due to problems with the SCORE survey and the decision by DCJ to no longer require it from late 2022, these data were only used to a very limited extent. Client outcomes were very poorly recorded and therefore not used in the evaluation. Data on client satisfaction is limited and is the only measure included in the evaluation.

[36] DCJ is working with these providers to rectify data reporting issues.

Section 3 – Summary of FCS staff and stakeholder consultations

The FCS Evaluation Interim Report[37] provided mid-point evaluation findings on implementation of the program. The Interim Report details findings about fidelity to the FCS model and perspectives of FCS staff and key stakeholders from inbound and outbound referring agencies, including Aboriginal and CALD stakeholders. Feedback from Aboriginal sector representatives is also reported in the Aboriginal Sector Consultations summary[38].

A high-level summary of the interim report findings is reported in this section. This includes revisions to the FCS program logic based on consultations with FCS staff, insights about program documentation from the desktop review, and key findings on FCS implementation facilitators and inhibitors from workforce and sector consultations. For detailed discussion of these findings and data collection instruments (FCS workforce survey, FCS focus group discussion guides, and stakeholder focus group/interview guides), please refer to the FCS Evaluation Interim report.

FCS program logic

The first set of consultations organised through the evaluation focused on the FCS program logic. In total, 38 FCS staff members representing the seven FCS service providers (with their consortia partners where relevant) participated in online consultations about their views on the draft FCS program logic model. Consultation questions focused on the following topics: core components and flexible activities of the FCS model; goals of the FCS program; impact of the FCS program with children, young people and families; short, medium and long-term outcomes they expect to see with children, young people and families who participate in FCS; and differences in potential outcomes based on the culture of the children, young person and families.

There was broad agreement among FCS providers that the program aims to improve client outcomes across a range of domains aligned with the NSW Human Services Outcomes Framework and therefore that the goals currently ascribed to the program are appropriate. The majority of suggested changes discussed by FCS providers pertain to the core components and flexible activities column of the program logic. Their feedback informed a set of recommendations for the revision of the FCS program logic, to ensure that the program aims and objectives are aligned with the core activities being delivered by the FCS service providers.

As a result of this feedback, DCJ made a number of changes to the FCS program logic. The program logic has been simplified, and more closely aligned with the activities and services provided by the FCS program (see Appendix Table 1). The outcomes are now more immediate and linked to the program goals and impacts. A one-page infographic has been designed to provide an accessible, easy to read fact sheet about the FCS program[39] .

Desktop Review

A desktop review of key FCS documents was conducted to assess gaps in model design and operational protocols. A review of the program specifications, referral protocols, FCS service

[37] https://familyconnectsupport.dcj.nsw.gov.au/documents/family-connect-and-support-fcs-evaluation-interim-report-july-2023.pdf
[38] https://familyconnectsupport.dcj.nsw.gov.au/content/dam/dcj/familyconnectsupport/documents/FCS_Evaluation_-_Aboriginal_Sector_Consultations.pdf
[39] https://familyconnectsupport.dcj.nsw.gov.au/documents/DCJ-FCS-Program-Evaluation.pdf

agreements, FCS APPs, intake document templates and other documentation relevant to delivery of FCS was conducted. The review provided context for the evaluation, with the collation of all the relevant information underpinning the program's operation and program management. Overall, it was identified that there was a comprehensive suite of protocols and procedures to support the implementation.

It was noted that all FCS providers had developed comprehensive APPs that detailed how providers were engaging with local Aboriginal Elders, communities, and service providers. The strength of the plans included the identification of who is responsible for leading each initiative, linked to timeframes and status updates. APPs that stood out as potential models were comprehensive in identifying Aboriginal services encompassed by the plan, as well as clearly defining actions and accountabilities.

A key finding that stood out about FCS documentation, from the desktop review and FCS staff consultations, was that some FCS staff found the weighted referral system confusing. In addition, some felt more time should be allocated to the assessment and case planning process. It was not clear if the service tier should be determined by the complexity of the family issues, or the number of hours spent with the family during intake. As noted by FCS staff and stakeholders, it takes time to build rapport with families and gain their trust, which did not always fit within the program timeframes.

Another challenge raised in the desktop review and FCS staff consultations was reporting on capacity development within the local service system. This unique component is highly valued by FCS staff, yet some expressed that they cannot adequately report on this work within the current reporting framework. Significant time and effort were invested into building relationships across the referral network and upskilling other organisations. Consideration should be given to how to capture and measure this component of the program in the reporting system.

Workforce and sector consultations

The process evaluation investigated FCS design and implementation, using the following data collection approaches:

- **Workforce surveys** with FCS service provider staff to identify issues with implementation, perceptions of engagement and partnerships among services, between September and November 2022. All FCS staff were invited and encouraged to participate. The survey was administered online using Qualtrics survey software. A total of 83 FCS program staff, representing approximately 58% of the FCS workforce, completed the survey. The sample consisted mostly of caseworkers or case managers (54%) and team leaders (22%), as well as intake workers, managers, and other roles (e.g. administrators, coordinators, program workers). There were 24 FCS staff who identified as CALD (29%), with only two working in an identified CALD role, and 13 FCS staff (16%) who identified as Aboriginal and/or Torres Strait Islander. See the interim evaluation report for a complete demographic breakdown of the participant sample.
- **FCS provider consultations** with each FCS provider and in some cases sub-contracted partners, between September and November 2022. Each FCS provider was invited to participate in an online focus group discussion that explored the experiences

of program staff with implementing the program including what works well and what could be improved. In total, 80 FCS staff participated across 9 online consultations.
- **Stakeholder consultations** with organisations that make inbound referrals to FCS or receive outbound referrals from FCS, between November and December 2022. Each FCS provider provided the evaluation team with a contact list of its key stakeholders, including Aboriginal and CALD referral service stakeholders. Service providers represented included government (DCJ, Child Wellbeing Units in Police and Education, NSW Health and NSW Education) and non-government organisations delivering family support services. A total of 54 stakeholders were consulted, including 40 participants from mainstream inbound and outbound referral services, 9 CALD stakeholders or those representing CALD services, and 10 Aboriginal stakeholders who work in ACCOs. The consultations with ACCOs were completed in 2023, with a stand-alone summary published to the Family Connect and Support website in November 2023[40].

The findings from the workforce and sector consultations, including the workforce survey, staff and stakeholder focus groups and family interviews, have been consolidated to respond to the implementation evaluation questions. These include:

- FCS implementation facilitators and program strengths
- FCS implementation barriers and challenges
- Program design gaps

FCS implementation facilitators and program strengths

A number of factors were identified by FCS staff and stakeholders as supporting effective implementation of the FCS program. These included elements of the FCS model and qualities of service delivery, as well as skills and knowledge demonstrated by FCS staff.

Flexible model design

The FCS program specifications have enabled considerable flexibility in the way the model is delivered by FCS providers across the state. Stakeholders noted this flexibility allows providers to meet the specific needs of the diverse local communities and families they service. For example, FCS responds to families in moments of personal crisis, such as car accidents, and communities in need including those affected by bushfires, floods and during COVID-19 lockdowns. FCS staff likewise considered the flexibility of the program as one of its key strengths. Flexibility in the model allows staff to respond to the needs of families in responsive and purposeful ways. They highlighted how they were able to offer outreach and engagement options to families, working with them in ways that suit them best, whether in person, by phone or text, or by email.

Broad eligibility criteria

Respondents considered that FCS's broad eligibility criteria facilitated easy access to the program for families. The majority of FCS staff (93%) who completed the survey agreed that the FCS eligibility criteria is broad enough for families in need of the FCS program to access it and that most inbound referrals they received were for families eligible for the program (85%). Most FCS staff (75%) agreed that the exclusion of families who are already engaged with the statutory child protection system from the FCS program is appropriate. However, a

[40] https://familyconnectsupport.dcj.nsw.gov.au/documents/FCS_Evaluation_-_Aboriginal_Sector_Consultations.pdf

quarter of respondents disagreed or were unsure about whether families who are already engaged with the statutory child protection system should be ineligible to receive the FCS program. FCS stakeholders also identified the program's broad eligibility criteria as a key strength of the program. Stakeholders appreciated that most referrals to FCS were accepted and that the FCS eligibility criteria were less rigid than that of other programs.

Expertise in local service sector

FCS providers were perceived, including by themselves, to hold up-to-date information about services in their regions that can meet the varying needs of families. Almost all FCS staff agreed or strongly agreed (96%) that they had a good understanding of the local services able to meet the needs of their clients. Almost all FCS staff (99%) reported that they advocated for client access and acceptance into external services. FCS staff shared that they developed service directories and update them on a regular basis. In this way, they played a key role within communities as local service sector experts. Stakeholders described FCS knowledge and expertise in the local service system as invaluable and a key strength of the program. Many stakeholders discussed the difficulty they experienced with trying to keep up with available services in their areas. This was particularly the case for inbound referrers in regional and remote locations, and state-wide services with limited knowledge of what is on offer in specific communities. These inbound referrers positioned FCS as their go-to referral for families and appreciated that FCS providers could use their expertise to make appropriate referrals for families on their behalf. Stakeholders also highly valued opportunities they had to liaise with FCS staff about available services to meet family needs. They described how FCS staff shared their knowledge and expertise of local services, which in turn gave them ideas of how to support families and contributed to strong collaborative working relationships.

Capacity to engage families

Consultations with FCS staff and stakeholders suggested that the FCS program has strong capacity to engage families. Home visiting and telephone engagement were identified as components of FCS service delivery that facilitate family engagement. The ability of the FCS program to provide home visits was viewed as a key facilitator of family engagement in the program. FCS staff discussed how their capacity to meet families in their homes or other community locations assisted them to develop good working relationships with families that supported their engagement in the program. Stakeholders frequently identified the home visiting component of the program as a core strength and enabler of effective family engagement. The home visiting services offered by FCS were highly valued, including cold call home visits following a referral, as this gave families an additional opportunity to engage in the program if they did not answer initial phone call attempts. Home visits were also important for collecting information about a family's situation, particularly in instances where referring services were unable to attend the home. The practice of home visiting is consistent with findings of the *Preventing Child Maltreatment: Evidence Review*[41] on the DCJ evidence portal, which identified engagement through home visiting (and other forms of engagement, such as phone calls) as a core component of evidence-informed programs that can prevent child maltreatment and improve parenting knowledge, skills, and behaviours.

[41] The Department of Communities and Justice and the Centre for Evidence and Implementation conducted an evidence review on parenting programs that seek to prevent child maltreatment. Key findings available at: https://evidenceportal.dcj.nsw.gov.au/content/dam/dcj/evidence-portal/documents/preventing-child-maltreatment/preventing-child-maltreatment-what-works.pdf

Highly skilled intake and phone-based communication

The FCS program involves over-the-phone service delivery, including intake and triaging. The FCS program is voluntary and therefore FCS intake workers require a high level of skills to engage families. FCS staff noted the rapid pace at which intake workers were able to establish rapport, trust, and feelings of safety with families. Stakeholders perceived FCS staff as possessing specific skills that facilitated effective phone-based work. These skills included active listening, sharing information in a clear and appropriate way, demonstrating empathy, adopting a trauma-informed approach, being honest and transparent, and using a friendly tone of voice and sense of humour, where appropriate. FCS staff reported that these skills assisted to break down fears families might have about engaging with a support service, encouraging them to participate.

Family-led decision making

Throughout consultations, FCS providers discussed how they adopted a family-led and strengths-based approach in their work with families. This included encouraging families to identify their own needs and goals. FCS staff were generally positive about the assessment tool they use to conduct family assessments, with 64% of FCS staff who completed the workforce survey reporting satisfaction with the tool. Workforce survey respondents also highly agreed (92%) that their meetings with families were strengths-based and encouraged family decision-making and responsibility. FCS staff were also positive about their engagement of families in the development of their case plan. Most staff (88%) agreed or strongly agreed that they actively involved families in the development of their case plan. However, FCS staff made clear that they did not deliver Family Group Conferencing, with most FCS staff disagreeing or strongly disagreeing (59%) or being unsure (34%) that they deliver Family Group Conferencing. Similarly, most FCS staff disagreed or strongly disagreed (54%), or were unsure (30%), that they refer families to external Family Group Conferencing programs. On the basis of consultations with FCS staff, the FCS logic model was revised to describe 'Family-led decision making' as an FCS service or activity, rather than Family Group Conferencing.

Active holding

Active holding involves the FCS provider monitoring a family's circumstances and providing practical support, home visits and follow-up with service providers, while suitable services are being arranged. In this way, they stay connected to a family while they are waiting for a service or support to become available. Active holding was viewed by staff and stakeholders alike as a strength of the program, given systemic service gaps in the social welfare sector. FCS staff were generally positive about their ability to undertake active holding with families until they were able to access external services to which they had been referred. Most FCS staff (91%) agreed or strongly agreed that they were able to maintain communication with families until they were able to access a suitable service. Likewise, most FCS staff (81%) felt they were supported to provide short term case management to address immediate needs until families could access a suitable service. Active holding was called out by Aboriginal stakeholders as a highly valued component of the FCS service model that along with brokerage funding, helped families get back on their feet without creating dependence on the FCS provider.

Free, voluntary, and non-statutory early intervention support

The cost-free and voluntary nature of the FCS program is broadly viewed as facilitating access to the program and affording families choice in whether they participate. This was viewed by both FCS staff and stakeholders as a strength of the program. FCS staff indicated that less stigma was attached to voluntary, non-statutory services, assisting families to feel comfortable to seek support. They described how their work assisted families to build their support-seeking capacities, which can prevent escalation to the statutory child protection system. Where families might later come into contact with statutory child protection and OOHC systems, FCS staff suggested that their work equipped families with knowledge and skills to navigate these systems.

Likewise, stakeholders recognised the important role FCS played as a non-statutory pathway that supports families in a non-punitive way. Anecdotal feedback from stakeholders suggested that early intervention support from the FCS program could prevent the escalation of family needs and result in a reduction of re-reports to the statutory child protection system. Stakeholders viewed this type of early intervention as a critically important service option for Aboriginal families specifically, with the potential to contribute to a reduction in entries to care for Aboriginal children.

Filling a gap in the service system

Both inbound and outbound referral stakeholders of the FCS program repeatedly applauded the program for filling a critical gap in the service system. Stakeholders consistently affirmed the need for the program and suggested that if the program did not exist, a critical referral pathway and service for families would be lost. In particular, stakeholders described how the FCS program assisted to alleviate capacity issues affecting their services, ensuring that families receive a service when they are not able to allocate resources or had long waitlists. Stakeholders highly valued the ability of the FCS program to provide support to families in the interim, including an assessment of their needs and making referrals to appropriate services. It was clear that FCS is a highly valued program in the social service sector across NSW, contributing a unique service delivery offering that is not duplicated.

Implementation barriers and challenges

Several barriers to effective implementation of the FCS program were identified. These were largely outside the control of FCS providers, in terms of systemic gaps in services to which they can refer families, including a lack of access to DCJ outbound referrals, as well as challenges they faced grappling with families' complexity and managing risk. Resourcing constraints and limited timeframes made implementing aspects of the FCS model difficult, particularly assertive outreach.

Systemic service system gaps

Systemic and pervasive service gaps were identified as a key barrier to effective implementation of the FCS program. The workforce survey highlighted accessible and timely service information and referrals as the most challenging program component to deliver. In line with this, the majority of survey respondents were dissatisfied with the length of time it takes for services to make outbound FCS client referrals (63%). In comparison, FCS workforce survey responses were mixed in relation to referral pathways. In response to whether they were satisfied with the referral pathways they can offer FCS clients into local services and supports, 42% of respondents disagreed or strongly disagreed that they were satisfied, 39% agreed or strongly agreed that they were satisfied, and 19% were unsure.

During consultations, FCS program staff frequently reported difficulty with providing appropriate, accessible, and timely outbound referrals to FCS clients due to systemic service gaps. FCS stakeholders also acknowledged systemic service gaps were a barrier to delivering the FCS program and other programs in the early intervention context. Reported problems included that there were limited services available that met the needs of clients; capacity issues affecting availability of appropriate services; and extensive waiting lists for client acceptance into appropriate services. Commonly reported service gaps in critical human service systems and wellbeing domains included:

- Housing and homelessness;
- Domestic and family violence support services;
- Mental health support for children and adults, including psychologists and counsellors;
- Children's health and allied health services including paediatricians, disability support and occupational therapy; and
- Longer-term early intervention case management services.

Service gaps were consistently reported by all FCS providers; however, these gaps were more pronounced for FCS providers servicing regional and remote communities. Inability to appropriately refer families to longer-term services meant they frequently exceed the 16-week FCS program timeframe, impacting both client uptake and engagement. When they continue to actively hold clients beyond the 16 weeks program duration threshold, it puts pressure on staff workloads and their ability to accept inbound referrals.

Family complexity and managing risk

A key barrier to FCS service delivery identified by staff and stakeholders was the increased complexity of family needs and high-risk levels associated with cases that are referred and accepted into the FCS program. In the workforce survey, FCS staff respondents indicated that complexity of family needs (68%) and time (66%) were among the biggest challenges they experienced in delivering the model. During consultations, both FCS staff and stakeholders suggested that the complexity of family needs have been increasing over time, impacting the level of risk that FCS providers are holding. FCS staff indicated that inbound referrals from the Child Wellbeing Units (CWUs)[42] and DCJ could increasingly be characterised as high risk due to the complex nature of the family's needs. They suggested that family complexity should be considered when making decisions about worker caseload targets or limits and resource allocation. FCS staff questioned whether they were best placed to respond to referrals for complex and acute reasons such as domestic and family violence, homelessness, and significant mental health concerns. This was due to the ongoing child safety risks associated with such referrals and the lack of appropriate and available outbound referral pathways.

FCS staff expressed concerns about their role and capacity to manage the high level of risk as a voluntary, non-statutory service. FCS staff stated that when they reported complex cases back to DCJ, they were not deemed high risk enough to qualify for acceptance back into the statutory child protection system. At the same time, families were being assessed by

[42] Child Wellbeing Units (CWUs) are located in the three key agencies employing mandatory reporters: the NSW Department of Education, the Ministry of Health and NSW Police. The purpose of CWUs is to support their workforce and build capacity, in order to support mandatory reporters to better respond to concerns relating to the safety, welfare and wellbeing of children and young people.

outbound referral support services as too high risk. As such, families become 'stuck' with FCS in the absence of a statutory response or appropriate intensive and longer-term case management services. The increased complexity associated with families with whom they are working and level of risk they are managing has led FCS staff to question whether FCS service delivery is moving out of the early intervention space altogether.

Collaborative work between FCS and CWUs has commenced to develop a shared understanding of risk and better ensure appropriate CWU referrals are made. DCJ convened workshops in 2022 and 2023, which brought together all statewide CWUs (Police, Health, and Education) and all FCS providers in order to strengthen the working relationships and arrangements between them. FCS providers working with 'high risk' families was a key theme that emerged through the workshop and potential solutions were discussed. The FCS program currently accepts DCJ referrals that are screened in as requiring a less than 10-day response. These referrals stem from ROSH reports that have been screened as lower risk and therefore have longer response times than higher risk referrals requiring a less than 72-hour or less than 24-hour response. DCJ stakeholders indicated that the screening process lacked accuracy in effectively assessing risk and explained how cases requiring a less than 10-day response could often involve more significant risks and concerns than those screened in at higher risk with shorter response times. This resulted in FCS providers working with families with complex needs and a higher risk level than their screening suggested. Both FCS staff and stakeholders acknowledged that families were being referred to FCS because their case was not allocated by DCJ, despite the complexity of family needs and the underlying risks involved. During evaluation consultations, FCS staff and CWU stakeholders expressed interest in continuing this shared work to manage the risk level of referrals.

Limited access to referral pathways for DCJ-funded services

A significant gap in the service system design identified throughout consultations is access to referral pathways to DCJ funded services. As discussed above, limited outbound referral accessibility and managing risk associated with complex cases were identified as barriers to effective implementation of the FCS program. Limited access to DCJ referral pathways for complex cases exacerbated these issues. FCS providers commonly reported the need for access to DCJ referral pathways to intensive family preservation services, long-term case management services, counselling for children and young people, and other specialist programs. FCS providers indicated that the categorisation of their outbound referrals as community referrals was problematic given the small caps on community referrals for these services when compared to allocation for DCJ referrals. FCS providers also reported that they often had no option but to make a report to the DCJ Child Protection Helpline in the hopes of getting families referred into the services they needed. This also had varied outcomes dependent on DCJ resourcing and capacity and was viewed as ethically problematic by FCS staff. Damage to relationships between FCS staff and families was reported as well as increased levels of stress experienced by the families as a result of child protection reports.

Limited access to early intervention services in local areas also shaped referrals of families to FCS, meaning that organisations are likely to refer families to FCS when they cannot directly refer them to longer-term family preservation programs. Inbound referrers reported similar access limitations to DCJ referral pathways. In lieu of being able to make direct referrals to family preservation services, they were left with little choice but to refer to the FCS program in circumstances where FCS might not be the most appropriate service for the family. FCS providers received many inbound referrals from DCJ and both FCS staff and stakeholders described how these referrals were often a result of DCJ capacity and resourcing issues. As

such, the lack of access to DCJ referral pathways was characterised as a significant service and system gap, given the level of families' needs.

Program timeframe constraints

Overall, the allocated timeframe for delivering the FCS program was viewed as a challenge by FCS program staff. Workforce survey results indicate that staff were slightly more likely to disagree (45%) than agree (43%) with the sufficiency of the 16-week timeframe for FCS service delivery. More staff disagreed (48%) that 2 weeks for FCS service delivery with low complexity families was sufficient than those who agreed (30%). Some FCS staff who completed the workforce survey indicated that insufficiency of time and resources impacted their ability to conduct a holistic, whole-of-family assessment that is strengths-focused with 39% disagreeing they had sufficient time, 39% agreeing, and almost a quarter being undecided (23%). Another factor that impacted timeframes is outbound referral service waitlists and delays in accepting FCS clients, requiring the provision of the active holding component, to ensure families were supported in the interim. During consultations, many FCS staff mentioned how limited outbound referral service availability impacted their capacity to deliver the program within the 16-week timeframe. FCS staff explained how this resulted in extension requests and delays to ending engagement with FCS clients, putting a strain on FCS resources. Approximately half of FCS staff (54%) agreed or strongly agreed that they were satisfied with the process for requesting extensions on timeframes when needed.

Resourcing constraints

Limited resourcing for staff has had an impact on the ability of FCS providers to deliver the proactive outreach component of the FCS program model. Some FCS agencies self-fund additional FCS positions to deal with caseloads. When asked whether they have adequate time and capacity to reach families via phone and home visits, just over half of FCS staff (55%) agreed or strongly agreed that they had adequate time and capacity. In-person cold calls and home visiting were a highly valued component of the FCS program among stakeholders, yet FCS staff reported that their capacity to conduct these important proactive outreach activities was severely hindered by limited staff time and capacity. Staff safety is a significant consideration when making decisions about delivering proactive outreach with limited resources. Because they may only have resources to allocate one staff member, for reasons of staff safety, in-person cold calls and home visits are not carried out. While all FCS providers reported resourcing constraints in relation to the number of funded positions available to service their program catchment areas, FCS providers responsible for regions that covered large geographical areas with dispersed populations faced the greatest resource challenges. Managing resources and allocating staff time and costs for travelling across large geographical distances was not always feasible and carried the risk of time wastage if families are not home.

Limited brokerage funding

Brokerage funding for each family is not determined by the program, but decided by each FCS provider based on their budget. FCS staff were more positive about the flexibility of funding than the amount of funding available. Most staff (62%) felt that the level of brokerage funding was insufficient. However, FCS staff viewed the flexible nature of brokerage funding more favourably, with 60% agreeing that brokerage funds were flexible enough to offer different types of practical support and meet the immediate needs of clients. During consultations, both FCS staff and stakeholders advocated for increased brokerage

funding to respond to the immediate needs of families. It was suggested that the size of families should be taken into consideration when allocating brokerage funds and that more funds may be needed to meet the needs of those from communities that experience widespread vulnerabilities.

Difficulties with data collection and reporting requirements

There were mixed views about whether the Department of Social Services' DEX platform adequately reflected FCS service delivery. Almost half of FCS staff (48%) agreed or strongly agreed that it did, while 34% disagreed or strongly disagreed, and 17% were unsure. Survey participants also indicated that reporting information in DEX was time consuming and duplicated information they already inputted into their internal reporting or other systems, which contributed to this burden. FCS staff indicated a range of concerns about data entry, including concerns about the appropriateness of personal information gathered about families, such as sexual orientation and level of education. FCS staff also raised concerns about whether data collected and reported about CALD families adequately and accurately captured their cultural diversity. Some FCS staff were critical of the way that CALD families were being identified based on the language they speak, rather than how they identify culturally. Additional reasons given for disagreeing that information entered into DEX adequately reflected service delivery included that some aspects of service delivery were not included in reporting requirements, particularly relating to intake and coordination roles and difficulties with errors in the DEX system.

FCS staff were asked in the workforce survey and during consultations whether they conducted the SCORE client survey[43]. Nearly two-thirds of survey respondents indicated 'Yes' (64%), nearly a third indicated 'No' (31%), and 5% were not sure. When asked about any issues experienced with the client survey, the most common response was dissatisfaction with the questions included in the survey (52%). FCS staff expressed concerns about the appropriateness of the language used in the client survey, describing the wording of questions as inappropriate with the potential to cause offence and jeopardise relationship building efforts with families. Additional concerns included timing of when it was administered (48%), frequency for conducting the client survey (33%) and the length of time needed to complete the survey (37%). Approximately one third (29%) of respondents reported 'other' challenges with the survey, with many reporting that families were unwilling to participate. FCS staff suggested that the client survey should be externally and independently administered rather than administered by a program staff member who worked closely with the family in order to ensure families were better positioned to openly and honestly respond to the survey.

[43] Due to FCS staff concerns about the SCORE client survey, DCJ made it non-compulsory to administer.

Section 4 – Cultural awareness, confidence and responsiveness

Consultations were conducted with 10 Aboriginal service providers[44] and 9 CALD stakeholders or those representing CALD services, through online interviews that explored their perceptions and satisfaction with the FCS program. Findings from the stakeholder consultations with Aboriginal stakeholders and relevant parts of workforce consultations are reported in *Family Connect & Support Evaluation – Aboriginal Sector Consultations*[45] and the interim evaluation report[46] and summarised in this section.

Throughout the sector consultations, strengths and challenges were identified in relation to cultural awareness, confidence and responsiveness of services delivered by FCS providers. Overall, FCS providers were viewed to value the cultural knowledge and expertise of staff, community organisations, stakeholders, and leaders. Aboriginal services valued the individual responses tailored to families and assistance FCS provided to Aboriginal families experiencing issues with housing or household financial pressures. A core area for improvement for FCS providers identified by Aboriginal and CALD stakeholders was the need to build and develop their culturally appropriate referral pathways.

Strengths of FCS programs

Valuing cultural knowledge and expertise

FCS staff reported that they highly valued the cultural knowledge and expertise that Aboriginal FCS staff bring to their roles. Non-Aboriginal FCS staff explained that they frequently used the cultural support offered by their Aboriginal colleagues through formal cultural consultations and informal exchanges of knowledge, advice, and ideas for engaging and supporting Aboriginal families. FCS staff were similarly appreciative of the unique skills and expertise that their CALD colleagues brought to their roles. They discussed how CALD colleagues were able to speak with families in-language to overcome language barriers and build rapport. They were also able to provide interpreter assistance for team members. One provider discussed how a CALD staff member was involved in developing a cultural consultation template that staff members could use to seek out information about cultural needs and nuances of diverse families from CALD staff members of the same cultural background. They explained how this information could help to build understanding about cultural differences among staff members on an ongoing basis.

Some FCS providers also leveraged the knowledge and expertise of Aboriginal and CALD workers from external organisations to fill gaps in their cultural capability. Aboriginal and CALD stakeholders provided examples of instances where their local FCS provider had utilised their organisations, or particular staff within their organisations, for cultural consultations. It was noted that staff in Aboriginal services had provided useful assistance to FCS caseworkers for Aboriginal family finding, genealogy and other areas. There was agreement between Aboriginal organisations and FCS providers that fostering good relationships contributed to families receiving FCS services that were culturally aware and responsive.

[44] FCS agencies provided a list of Aboriginal Community-Controlled Organisations (ACCOs) with which they received inbound or made outbound referrals. From this list, 52 ACCOs were contacted; 39 declined to participate with no reason given; 3 declined on the basis that they had not received a referral from an FCS provider.
[45] https://familyconnectsupport.dcj.nsw.gov.au/documents/FCS_Evaluation_-_Aboriginal_Sector_Consultations.pdf
[46] https://familyconnectsupport.dcj.nsw.gov.au/documents/family-connect-and-support-fcs-evaluation-interim-report-july-2023.pdf

Cultural awareness, confidence and responsiveness in practice with families

FCS staff who completed the workforce survey indicated high levels of agreement (78%) about having access to culturally appropriate information about services that they could share with families. Most respondents (92%) also reported that they had strategies to reach out to families in a culturally appropriate way. FCS staff were generally confident in their ability to practice cultural awareness and responsiveness and were generally satisfied with the relevant training they had received. About two-thirds of respondents agreed or strongly agreed that training they had received provided sufficient information about culturally aware and responsive practices with CALD families (67%) and Aboriginal families (69%). However, when compared to other areas of workforce training, levels of satisfaction were low, indicating a potential area for improvement to staff training.

Aboriginal stakeholders provided positive feedback about the FCS services working with Aboriginal families in ways that were culturally aware and responsive. It is important to note that not all stakeholders were able to provide feedback about culturally aware and responsive approaches adopted by FCS providers when working with families, because they reported that they did not have direct knowledge of approaches taken. However, some feedback from stakeholders collected during consultations indicated that some FCS providers were culturally aware and responsive with Aboriginal families. Aboriginal stakeholders emphasised that culturally aware and responsive practice stemmed from having Aboriginal workers in key roles including intake, casework, and management, who were also able to participate in proactive outreach activities to build trust with Aboriginal communities.

Aboriginal stakeholders also noted that the FCS model delivered important support to families. They particularly called out the flexible model design as an improvement in the FCS model when compared to FRS. Aboriginal stakeholders also expressed appreciation for the FCS activities of brokerage and active holding, as supportive of families without creating ongoing dependency of the family on the agency. Aboriginal service providers expressed it was important that FCS providers followed up with families after making referrals to support services to ensure they were able to access the supports they needed.

Some CALD stakeholders also provided positive feedback about the capacity of some FCS providers to engage in culturally aware and responsive ways with CALD families. This feedback pertained to the ability of individual workers to consider the cultural needs of families. Other feedback pertained to the openness of whole teams to seek out and receive further culturally specific information about families.

Proactive outreach with Aboriginal communities

FCS staff pointed out the critical work of Aboriginal colleagues to promote the program and build relationships with local Aboriginal communities. Aboriginal staff likewise highlighted the targeted proactive outreach activities they undertook in order to build trust with Aboriginal communities and develop referral pathways with Aboriginal organisations. Proactive outreach activities included attending Aboriginal interagency meetings, community events and meetings with Aboriginal services. One Aboriginal stakeholder provided positive feedback about the proactive outreach activities that an FCS provider had undertaken, which included family events for child protection and NAIDOC week. Having FCS coordinators attend community functions, such as social housing tenant barbeques or school holiday events for children, provided further opportunities to form informal networks and build trust with communities.

FCS providers were observed by stakeholders to be committed to conducting proactive outreach with Aboriginal families and communities. This was identified as being critically important by FCS stakeholders, as some families may mistrust FCS since it is funded through DCJ. They stressed that early engagement with Aboriginal organisations can help bridge this divide, to build trust with Aboriginal family members.

In regional and rural areas, it was considered important that FCS providers proactively engaged with other service providers who were offering child and family services. For example, Aboriginal women may have to leave Country to attend maternity and birthing care. Aboriginal service providers recommended that FCS caseworkers attend these clinics as a way to introduce themselves to families and provide information about available services. Pre-school centres were also considered to be useful places to meet with mothers and provide information about available supports. Engaging in this type of outreach was also a way to reduce the need to travel long distances to meet with families in more remote communities.

While APPs are expected from each FCS provider, there were significant differences in terms of the comprehensiveness and specificity of plans. APPs that had clearly defined actions and accountabilities for engagement with local service providers, communities and Elders stood out. Model APPs could be shared amongst FCS services, particularly with newly commissioned services. In some instances, Aboriginal service providers who had been listed in APPs reported that they had not been contacted by the FCS service and were not aware that they were included on the APP. There may be a need for accountability checks on APPs, to confirm that they have been completed in consultation with local Aboriginal service providers. FCS providers who employed Aboriginal staff were observed to be better positioned to build relationship and conduct proactive outreach to local Aboriginal services providers.

Challenges

Limited culturally appropriate referral pathways

FCS staff who completed the workforce survey expressed some dissatisfaction with their Aboriginal and CALD service referral pathways, indicating that there is room for improvement. There were slightly higher levels of satisfaction with their referral pathways with ACCOs and other culturally appropriate support services for Aboriginal families than their referral pathways with multicultural services and other culturally appropriate support services for CALD families. One-third of respondents (33%) agreed or strongly agreed that they were satisfied with their Aboriginal referral pathways, compared to under one-third (27%) for CALD referral pathways. Satisfaction with CALD referral pathways was lower, with 45% disagreeing or strongly disagreeing that they were satisfied, compared to 39% for Aboriginal pathways. During consultations, FCS staff discussed challenges with culturally appropriate referral pathways. This included a lack of Aboriginal services in specific regions for outbound referrals, a lack of interpreters and CALD staff at outbound referral services, and concerns about the skillset of workers at outbound referral services to practice cultural awareness and responsiveness with CALD families.

Aboriginal stakeholders provided mixed feedback about the effectiveness of their referral pathways with FCS. One Aboriginal stakeholder reported that referrals were being made between their own programs while another Aboriginal stakeholder reported that no referrals were being made to their service. Another Aboriginal stakeholder reported that outcomes for

Aboriginal families could be improved if referrals to their service were made earlier, to avoid escalation of issues that could lead to child protection involvement. Overall, Aboriginal stakeholders suggested that there was room to improve the referral pathways between their service and FCS.

CALD stakeholders also provided mixed feedback. Some CALD stakeholders reported that they received very few or no referrals from FCS. One stakeholder explained that when they did receive referrals from FCS, it was apparent that families had been referred to relevant multicultural services. They pointed out that this was an indication that the FCS provider had a good awareness of appropriate multicultural services to which to connect CALD families and suggested that this may be the reason why they did not receive referrals from FCS, as linking CALD families with relevant multicultural services would typically be a role their service fills.

Section 5 – Families' perspectives of FCS

Overview

Family members who received FCS services were recruited to participate in interviews to inform the evaluation. FCS providers were asked to provide information about the evaluation and an invitation to participate in an interview to families exiting the FCS program, and to families who had exited the program in the previous 6 months. People who were interested were provided with a one-page flyer about the evaluation, and a Participant Information Statement (PIS) explaining what would be involved should they participate, including how their privacy and confidentiality would be protected. The flyer and PIS form provided a link to register for an interview.

Families were offered 1 hour online or telephone interviews, to seek their views on the service they had received from FCS. To be eligible, individuals needed to be 16 years of age or older, and to have received the FCS program within the previous 6 months. At the end of the interview, participants were offered a $60 grocery voucher to thank them for their time.

Participants were asked a series of questions about the FCS service they had received, including their views on relationships with FCS staff, their experiences of developing a family plan and whether FCS connected them with services and perspectives on culturally aware and responsive practice (see Appendix 2 for a complete list of interview questions).

The aim of these interviews was to explore the research question:

> *How well was the FCS program designed and implemented to achieve client outcomes?*

The key findings from the family interviews are linked to workforce and sector consultation findings where relevant.

Family recruitment and characteristics

Families were recruited for interviews from mid-October until the end of November 2023. In total, 18 people participated in an interview. Of these, 5 participants identified as Aboriginal, 3 were fathers, 13 were mothers, and 1 was a grandmother caring for her grandchildren. None of the people interviewed identified as coming from a CALD background. Most participants had recent contact with the FCS program, with four identifying they were currently in contact, and most others had been in contact in the previous few months, with only two reporting that they had been in contact 6-7 months prior. The participants came from different locations, including urban, regional, and rural settings, and received services from 5 of the 7 FCS providers.

Although the number of interviews was small (n=18), they captured families' experiences of FCS across a variety of service providers and geographic locations. The respondents had experienced a wide range of complex and challenging circumstances that led to their referral to an FCS service. The interviews indicated that FCS providers were accepting referrals of high-risk families and were managing to de-escalate these risks with direct support, as well as through referrals to other services. The overall view amongst respondents was that FCS workers were welcoming and non-judgmental, provided practical assistance by helping them navigate the service system and proactively advocate on their behalf. The common feature of

the interviews was that all respondents reported a positive experience with the FCS service; the help they received had been targeted to their specific needs, and the assistance provided had been of benefit to them and their children.

Key themes and findings

Referral to and knowledge of the FCS program

In line with the broad eligibility criteria, most of the interview participants had been referred to FCS by an agency such as the school that their children attended; health service, or housing support service. This aligned with findings from the FCS workforce survey that the great majority of staff agreed that most referrals to the program are appropriate for the service. One had received a recommendation from a family member who worked in an FCS service in another region. A few respondents were not sure how they came to be in contact with the FCS provider.

> *"I've got three girls…. I've become their full-time mum and dad sort of thing. And we have to start with nothing and we sort of... we made it happen by ourselves. You know and I wasn't sure what support was out. The school realised because [child] was wearing the same clothes every day." –* Parent interview 1

There was a general view that most families were not aware of the availability of the FCS program prior to their referral. Several participants suggested that information about FCS services be promoted on social media. Others thought that information brochures should be available in shopping centres, Centrelink offices, and medical centres.

> *"Most people don't know about the FCS service. Should be more information on social media." -* Parent interview 7

Housing instability as a leading reason for referral

Most families had a wide range of issues with which they needed assistance, however, a common feature across all interviewees was housing stress and instability. All parents reported a range of difficulties with housing including:

- Lack of affordable private rental properties;
- Living in cramped quarters as more suitable accommodation was not available;
- Available accommodation being temporary; and
- Long waiting list for social housing.

The limited availability of social housing, affordable private rentals and other forms of housing support was a key feature contributing to the stress for vulnerable families. One single mother reported that she shared a one-bedroom apartment with her daughter because she had a secure long-term lease, even though she wanted to move to another area and get a more suitable home. Participants recognised that FCS was not a housing provider; however, families appreciated their assistance they provided in helping them to prepare and submit housing applications, including the provision of support letters for housing providers. Some mentioned that their FCS caseworker actively advocated on their behalf to place them on a priority housing waiting list.

Support and advocacy

Participants valued the assistance from FCS caseworkers to help them access and navigate other agencies. As noted by FCS staff and stakeholders, FCS workers' deep knowledge of

local services enabled them to assist families to access the help they needed. Practical support, such as helping them to apply for Centrelink payments, obtain birth certificates and access NDIS support, made a real difference for families. Many families did not know what payments and support they were entitled to and found the process of navigating the service system daunting. They praised their FCS caseworker for advocating on their behalf and helping them complete and submit applications.

> *"She ...was amazing... Just her knowledge. And she would sit at the computer because I can't sit at the computer ...and she would sit at the computer and do all the paperwork for me. That helps so much."* - Parent interview 10
>
> *"You know, she linked me with the social worker at Centrelink. And straight away, she said (Centrelink social worker) Look, I'm gonna put you on a carers' payment because I know you're stuck. You can't work at the moment."* - Parent interview 1

Families provided examples of how FCS providers offered them support tailored to their needs, demonstrating family-led decision making. One mother had been overcharged by their childcare provider, who disputed the claim and refused to provide a refund. The FCS worker was able to intervene and demonstrate that she was owed a refund. She was offered three-months free childcare in lieu of a repayment. A grandmother who was caring for her grandchildren commented on an FCS worker who negotiated with the school about an overdue payment and then helped her grandson to apply for a scholarship.

In line with commentary from stakeholders, families also described how the engagement skills of FCS providers, including empathy and transparency, encouraged them to accept services. A number of participants reported that they found it hard to ask for help; however, the warm and caring response from their FCS worker helped them to accept that they needed support. All respondents agreed that their FCS worker had helped them when they really needed it, and this had a significant impact on their lives. They would recommend FCS to other families in need and would go back and ask for help if they needed it in the future.

> *"It does make you feel a lot better knowing that someone's there to advocate and help you. You know, guide you through things."*— Parent interview 10

Whole-of-family case coordination

Whole-of-family case coordination was also recognised and valued by families. FCS workers completed the referrals and briefed the other services about the family circumstance, which relieved them of the burden of reliving traumatic experiences. Qualities of services that they noted also made a difference included providing person-centred service and delivering the right help at the right time.

> *"Yeah, it takes away that burden because she puts me in contact with the people she's already ... writes the referral letters with brief needs and concerns ... So, you don't have to repeat yourself over and over. With the risk that you know the service might not even be able to help after you have told them."*— Parent interview 10

Brokerage and financial support

Most participants reported receiving financial support from their FCS provider. As observed by stakeholders and FCS staff, small amounts of brokerage often relieved families' stress by meeting an immediate need. The type of funding most frequently mentioned was for purchasing groceries, either directly or through providing grocery vouchers the family could use to buy essentials. One participant mentioned receiving backpacks for their children with

school supplies. A mother recounted a story of when she and her daughter were ill, but she hadn't been able to cancel the home visit with the FCS worker. When the FCS worker arrived, she said: "*send me a list of what you need [at the grocery store].*" The FCS worker did the shopping for her and she put another grocery voucher at the bottom of the shopping bag. However, another woman commented that the FCS worker had met the participant at the grocery store and rather than providing grocery vouchers, the worker paid for the shopping, which they had found humiliating.

FCS funds were also used to help families with emergency payments and to access services they needed, including driving lessons and counselling for their children. FCS helped some families to access vouchers and discounts from other agencies, such as school vouchers from Service NSW and Centrelink payments. Families suggested the provision of other forms of financial support, such as fuel vouchers to help with the cost of getting to appointments.

FCS referrals to support services

Families also raised warm referrals as an important part of their FCS service experience. This is in line with the FCS workforce survey finding that the majority of FCS always introduce clients to the referral agency. Several of the respondents spoke about the efforts FCS staff made to connect them to other support services, such as giving them the opportunity to comment on what was included in support letters. Families also valued the process of active holding, appreciating when FCS kept them informed about the referrals made and advised them about who would contact them. Some spoke about their FCS worker providing a personal handover, taking them to meet the staff at the outbound referral service and introducing them to their new worker.

A few respondents described how their worker would make the initial contact with other agencies so that they did not need to repeat their story.

> *"I found with Family Connect and Support I rang up, told her my circumstances. Yeah, you know, and they got back to me straight away. You know they've done intake. They took details when they referred me on. It wasn't me repeating myself again. It was the lady* [FCS worker] *who actually done the intake took the information and then passed it on to the next person. Yeah, that's so important."* – Parent interview 10

The comprehensive knowledge of FCS providers about local services, which was highly valued by stakeholders, was also echoed by families. Respondents appreciated how knowledgeable FCS workers were about the resources within the local area. Families commented on how the FCS program helped them navigate the services in the community and described this as "removing the burden" of reaching out cold to family services. The understanding FCS workers had about service criteria and how they laid the groundwork by contacting the service and providing support letters as needed, was a relief to families who found the array of services confusing or overwhelming, particularly when they were already under stress.

> *"When you're a single parent, there is a lot of stuff out there, like there are a lot of resources out there to help. But if you don't know, you don't know. And it was lovely to speak to somebody like that because she said, look, I have the ability to help."* – Parent interview 5
>
> *"…[*The FCS worker*] said that she has lots of ways to get resources and lots she knows. She knew lots of different things and she just said, look, I think this would really benefit you. I'm just gonna refer you on to them."* – Parent interview 4

Illustrating how FCS facilitated early access to services to promote family functioning, one mother spoke about how her FCS worker helped her realise she had a drinking problem, and referred her to a drug and alcohol service, which she described as a "*game changer.*" The FCS caseworker also helped her to access holiday care for her son while she received treatment. Following treatment, the FCS worker connected her with a family preservation service, which was enhancing her resourcefulness in meeting her family's needs and helping her to keep her son from entering OOHC.

> "*I was really impressed with the program, like literally. Saved my life for me that made the difference between me keeping, or not keeping my kids.*" – Parent interview 8

Demonstrating service flexibility, one mother discussed how the FCS worker helped her to overcome issues related to a lack of transport, by arranging driving lessons, and providing transport for her to attend appointments and court appearances.

Client perspectives on FCS caseworkers

The most common terms used by the respondents to describe their FCS caseworker were *warm, respectful,* and *understanding.* These comments aligned with feedback from FCS stakeholders that FCS staff were highly skilled in engaging families in services. Several participants mentioned feeling that they could trust their FCS workers, and that their children also felt comfortable and safe with them. Some had initially been anxious about contacting FCS, fearing that their children could be removed from their care. However, the FCS staff had been kind and welcoming, going out of their way to be helpful. In the same vein, stakeholders also observed that FCS staff demonstrated qualities such as empathy, honesty and transparency that encourage families to open up, and accept services. One person commented his worker went *"above and beyond"* (interview 10) and this was reflected in the general sentiment that the FCS worker genuinely cared and would do what was necessary to help the family get the support they needed.

> *"It was such a beautiful warm environment and everybody in there was very dedicated. My problems were never a problem. My problems were there for her to like help."* – Parent interview 6
>
> *"And having that bit of extra support then enables you to, you know, achieve the things that you wanna do. And like you said, you're really, you're feeling organised and yeah."* – Parent interview 9

FCS clients shared examples about how their FCS workers provided culturally aware and responsive care. An Aboriginal mother commented on how her (non-Aboriginal) worker took her to a Yarning Circle, attending the first session with her to make sure she felt comfortable there. Another Aboriginal woman spoke about how her FCS worker helped her connect to an Aunty program. She was able to meet an older woman who reminded her of her Nan and helped her connect to Country.

The welcoming and non-judgmental approach of the FCS workers helped vulnerable parents overcome their reluctance to ask for help. Respondents commented on feeling comfortable accepting help from FCS, even though they had experienced difficulties in accessing services in the past.

> *"They just sort of asked if we needed help, which I really did."* – Parent interview 1
>
> *"You're really treated like an individual who is vulnerable. They get to know you, they're genuine and they will try to support you, in whatever it is that you need and nothing is ever too much."* – Parent interview 6

Most respondents stated that they would be happy to recommend FCS to other parents. Others expressed appreciation that they could re-refer themselves to their FCS provider if they needed help again in the future.

FCS challenges

Throughout the interviews, there was only one direct complaint made about the FCS service, from a mother who was embarrassed when the FCS worker paid for her groceries, rather than provide her with shopping vouchers. However, this parent also praised the support that FCS provided, including assistance with unpaid school fees, arranging for the children to see a counsellor, and preparing support letters for social housing and NDIS assessments.

While participants were satisfied with their experiences of the FCS program, they identified gaps in services, especially in regional and rural areas, and long wait lists for some programs, as problems that limited their ability to receive help as a family. Access to secure affordable housing was the most pressing issue impacting all families interviewed. Respondents acknowledged that FCS providers were limited in being able to address this issue, other than through advocacy, support letters and referrals to housing providers. Single parents struggled with the costs of essentials like daycare and found it difficult to meet the costs of activities for their children, such as swimming lessons, sports membership fees, or dancing lessons. This aligned with comments from FCS staff that brokerage was not sufficient to help families access private services that could help meet their goals, such as greater community inclusion.

Most respondents were satisfied with the FCS service timeframe; however, some felt that the length of time for the FCS service should be more flexible. It was noted that, there can sometimes be long wait times for referrals to other services or delays with court dates that can extend the duration of support needed from FCS. It was noted by a few family members that FCS workers offered to keep the case open until the family had started with the new service, in case they needed further follow-up.

Client recommendations

The main recommendation that the respondents raised about the FCS program was the need for greater awareness of the program in the community. Several respondents thought that FCS should be promoted through social media. Others suggested that information about FCS services should be provided in places where families go regularly, such as community notice boards in shopping centres and brochures made available in medical centres and Centrelink offices. One parent commented that the service *"is very known but hard to explain,"* suggesting that participants might be given a short description of the service so they could explain it to others through word-of-mouth. Some parents considered it was important that any community information about FCS should make it clear that FCS was separate to child protection and OOHC services, even if they were based with a provider who also delivered OOHC.

Participants also made comments about the broader family support and early intervention programs available to vulnerable families. Some felt it was unfair that their children missed out on participating in recreational activities because of their financial situation and thought more should be made freely available. In particular, one parent noted that there should be free access to swimming lessons for children living in coastal areas. Respondents noted that FCS could not solve all of their problems, however, they appreciated the assistance that FCS provided.

Case studies

Four composite case studies were prepared for in-depth insights into the FCS services. FCS providers were asked to send de-identified referral forms, brokerage requests and case file notes to the evaluation team. These materials were analysed to identify common themes across reasons for client referrals to FCS, service components provided to families (including reasons for brokerage if relevant) and early outcomes noted in the case file notes. As such, none of these composite case studies are based on a single real case. These key themes illustrate a range of typical experiences of clients served by FCS, including facilitators and barriers to service delivery.

Case study 1

Background

Carrie was referred to FCS by the CWU. A neighbour reported a domestic violence assault against Carrie to the Child Protection Helpline. Carrie is a young Aboriginal woman and mother of two children under 6 years old. She had a childhood history of child protection involvement and her mother had been subject to domestic violence, and as a result, she had been placed in the care of a maternal aunt.

The FCS program made several attempts to contact Carrie. They made two unanswered phone calls and sent text messages. On the third attempt, Carrie responded. She indicted she had poor mental health and fear of judgement, which made her withdraw from help. After the FCS worker explained they could help her by linking her to services, Carrie agreed to an initial meeting.

FCS actions

The FCS worker collaborated with Carrie to develop a family plan. Her strengths included her concern for her children and focus on keeping them safe. Carrie received support from her Aunty with whom she was living. Carrie was separated from her children's father because of his violence and had an AVO in place. Her additional challenges included limited social and community connections, anxiety and depression, and financial stress.

The FCS worker connected Carrie to support services, including a referral to Brighter Futures for longer-term support. She was able to access free counselling through victims' services, to help her process her experiences of domestic violence and childhood trauma. The FCS worker completed the paperwork for Carrie to receive Family Tax Benefit A and B, to provide her with a consistent income. While waiting for these benefits to come through, the FCS worker provided her with grocery vouchers. The worker also assisted her with filling out applications for childcare, noting that there were long waitlists in her area. The FCS worker arranged for Carrie to attend a supported playgroup, where she could connect with other mums and enable her children to enjoy the social and emotional benefits of playing with other children. Carrie did not drive so her Aunty was transporting her to the supported playgroup. At Carrie's request, her FCS worker arranged for her to access a low-cost drivers education program so that she could learn to drive and increase her independence.

Outcomes

Carrie's case closed with FCS when Brighter Futures accepted her case. She reported feeling more confident about caring for her children and accessing community supports. She was aware that she could self-refer to the FCS provider if she needed support in the future.

Case study 2

Background

Yasmin self-referred to the FCS program, following the suggestion from a friend. She and her husband Bijan had four children and were living in an overcrowded home with relatives. They were experiencing financial strain and had to leave their private rental because Bijan had recently lost his job. They had been on the social housing waitlist for several years and were hoping to go on the priority housing list given their current circumstances.

FCS actions

Yasmin and Bijan met with the FCS worker to develop a family plan. They identified that their family had many strengths, including their strong marriage, their work ethic, and Yasmin's proactive efforts to access supports. They had no child protection history and they were supported by relatives who looked after the children some of the time.

Their goal was to move into their own housing and to receive support for their youngest child to attend preschool. The FCS worker wrote a letter of support for priority housing and reached out to the local community and mosque who offered to send a food hamper.

The FCS worker identified that they were eligible for Centrelink benefits and helped them prepare their application. They were also assisted with a rental application. The FCS worker gave them grocery vouchers and provided them with information about the local sources of cheap and free food. FCS also provided them with fuel vouchers, enabling the family to save more of their income.

Outcomes

The family were offered a range of supports to ease their financial situation and assist them to apply for Centrelink benefits and access early learning centres. The FCS worker also made referrals to local parenting support groups to reduce their isolation and expand their support networks. The family continued to wait for social housing; however, they appreciated the support letters provided by the FCS worker.

Case study 3

Background

Paul is a single father who was referred to FCS by the school his children were attending. He was concerned because both of his children's teachers had suggested that he seek developmental assessments due to potential neurodivergence and behaviour issues. The older child had difficulty sitting quietly and following instructions. The younger child was non-verbal and did not interact with other children. Both children had to be continually supervised, as they were considered to be a flight risk, meaning that they might run away and become endangered. As a result, Paul could not go out in public because the children would become distressed, which included doing their grocery shopping as 'Click and Collect.' Paul was having difficulty coping as he did not have time for his own self-care and exercise. The school had been assisting him by arranging for the school psychologist to undertake developmental assessments of the children so he could apply for NDIS support packages.

FCS actions

Paul was grateful to receive support from the FCS worker. The FCS worker referred him to the local family support program, which helped him establish routines, boundaries, and behaviour management strategies with the children.

FCS assisted Paul to apply for the Centrelink Carer Allowance, as he was unable to work due to his parenting responsibilities. To provide Paul with more support, the FCS worker also helped him to obtain a cleaner through the NSW Home Care program.

Outcomes

The family support program, together with support from the school, provided strategies for managing the children's behaviour issues, and supported them within their schools with behaviour support plans. FCS also assisted Paul with accessing early intervention services for his younger child. Paul has engaged with a local parenting group, which eased his isolation and provided him with peer support. The Centrelink Carer Allowance and Home Care assistance provided him with financial support and some respite from his carer's duties.

Case study 4

Background

Janine is an Aboriginal mother with two children who was experiencing homelessness in rural NSW. She was struggling with the lack of available support services in her area and was unhappy about drug and alcohol use in the local community. She decided to move with her sons to another regional town after her cousin suggested that there was more support available there. She self-referred to FCS after hearing positive reports about the program from family members.

FCS actions

The FCS worker connected her to an ACCO, which arranged a place for her at a shelter and then assisted her to apply for housing support. After one month, she was allocated a home to move into. The FCS worker arranged for her to obtain the household items she needed to set up a home, such as bedding, clothes and household goods. The FCS worker also organised for Janine to receive some home support with cleaning and cooking. She took Janine to appointments with doctors and helped her to apply for Centrelink payments.

The FCS worker helped her to enrol her sons at school and arranged for them to be assessed by the school psychologist, who diagnosed them with ADHD. They are now on medication and have a NDIS plan.

Although the worker was not Aboriginal, Janine felt she was respectful and non-judgmental. The FCS worker also connected her to an Aboriginal women's group.

Outcomes

Janine was grateful for the support that was provided noting that she didn't expect things to happen so quickly. She also appreciated the way that the FCS worker helped her to think about her goals and plans, so she was able to identify what her priorities were. The advocacy provided helped Janine to receive priority attention from services, and Janine was impressed by the effort FCS went to for her and her children.

Section 6 – Outcomes evaluation

The outcome evaluation explored the impact and outcomes of the program since it transitioned from FRS to FCS in January 2021 (see Section 2 for a detailed description of the changes to the program design undertaken during the transition). The modifications to the FCS program design aimed to align the program with the broader direction of the NSW government to invest early in services and programs for vulnerable children, young people, and families. While FRS was much more varied in terms of the types of services that a family might receive, FCS has a more consistent model that is delivered across providers (See Appendix Table 1 for a description of the model). FCS is therefore a package of services that is more flexible and comprehensive than the service offered under FRS.

Outcome evaluation scope and data

The quantitative component of the evaluation of the FCS program sought to answer questions that could be mapped onto four domains as outlined in Table 3 Outcome evaluation domains. The evaluation linked FCS program data from DEX with administrative child protection data from ChildStory.

Table 3 Outcome evaluation domains

Domain	Questions
1. Implementation	• What were the key activities within the FCS service which providers engage in? • What service usage was observed per case? • What proportion of services involved a referral of at least one client within a case? • Who received active holding or brokerage or family capacity building and how much time was spent on these activities? • How many families were served in FCS who are defined as priority cohort and/or with complex needs? • How many cases were closed because of unmet needs? • How many cases reached the 16 weeks duration threshold?
2. Client satisfaction	• Were clients satisfied with the FCS provider? • What recommendations can be made regarding data collection for the future?
3. Client outcomes	• Did utilisation of the FCS service *causally* reduce children's risk of significant harm and risk of substantiations of significant harm? • Which clients benefited most from the FCS services? (e.g. Aboriginal versus non-Aboriginal clients; rural versus urban clients, clients served by large and small providers?) • What was the benefit in terms of risk reduction of a case plan completion, an actual service referral, active holding, brokerage, and family capacity building?

4. Economic analysis	• What was the average cost per provider, cost per case, and cost per session in the financial year 2022-2023? • What were the greater economic benefits of FCS?

Overview of data sources

FCS program data from the Department of Social Services Data Exchange (DEX)

Analysis of FCS program data (from DEX) provided an overview of client profiles and demographics, engagement with FCS target groups, types of services delivered, intensity and length of service engagement and the key referral sources, mapped to DCJ districts to discern regional variations. These data had records from January 2021 to end of June 2023.

DCJ administrative child protection and out-of-home care data from ChildStory

The evaluation team linked FCS program data to the administrative child protection data. Data were made available from January 1999 to September 2023. The main outcome variables were indicator variables for child protection involvement, including: Report of Significant Harm (ROSH), investigation using the Safety and Risk Assessment (SARA) tool, and substantiation of alleged harm or neglect (see Table 4 for variables).

Economic cost data

Economic cost data were derived from the 2022-2023 financial statements of the seven service providers contracted by DCJ to deliver the FCS program.

Table 4 Variables for outcomes analysis

Data source	Variables
DCJ: Child Protection Reports	Date Child Protection Helpline report received Primary issue reported Flag for risk of significant harm (ROSH) report Safety Assessment: Safety decision Risk Assessment: Final risk level
DCJ: Child and Family services	Referral to Brighter Futures Referral to IFS/IFP (Intensive Family Support/Intensive Family Preservation)
DCJ: Persons File	Month and year of birth Gender Indigenous status Country of birth Language
DCJ: Relationship mapping	Person ID Related person ID Relationship type

Data issues and limitations

FCS services were introduced in January 2021. The program used a transitional approach to support all providers to become familiar with DEX and work through data quality questions and issues. Data records appeared to have been entered regularly from July 2021. However, FCS services were not required to record client data in DEX until February 2022, meaning data entry in DEX before this date was incomplete. This complicated the research methodology as there may have been some bias in data recorded before client data entry was required. For example, FCS providers may have recorded data on families who did better in the program and therefore the program effects could be overestimated. Alternatively, those in the control group may have been in the treatment group and thus the treatment effect may be underestimated. This also affected the ability of the evaluation to measure program outcomes, as data need to be reliably recorded both before and after the intervention.

Since reliable data on each FCS case in DEX were only available from 1 February 2022, the outcome evaluation is restricted to clients who entered and exited FCS between 1 February 2022 and 31 January 2023. This allowed for the RCCF evaluation team to follow a cohort of children who entered FCS and to gain insights about their contact with the statutory child protection system between 6 months (for late FCS entrants in January 2023) and 18 months (for early entrants in February 2022).

SCORE survey data were not consistently recorded by FCS providers. FCS service providers notified DCJ about their concerns with the survey instrument, which was perceived as potentially insensitive and off-putting to clients (see discussion in Section 3 on the workforce consultations and surveys). As a result, DCJ indicated that SCORE survey completion was not required. This guidance was consistent with the observation that service providers collected more than three times as many questionnaires from clients at the beginning of FCS in 2021 than in 2023. For those data that were collected, it is difficult to rule out bias, as it is possible that the survey collection was selective and that FCS providers only offered the survey to clients who were explicitly satisfied with FCS or who experienced good outcomes. If this is the case, it could lead to an overestimate of the effectiveness of FCS. Therefore, use of SCORE data is limited to analysing client satisfaction, to glean some lessons that may be applied to future efforts to assess client satisfaction.

Causal identification of the impact of the FCS program

The main challenge in evaluating the FCS program was the appropriate choice of a control group with which to compare FCS recipients. The FCS program was not randomised and the rollout did not happen in stages across locations, which meant a control group could not be chosen from a sample of individuals who did not receive FCS in a given year and month. In addition, there were other key challenges in establishing a credible control group for the causal evaluation of the FCS program regarding client outcomes:

1. Selective participation in FCS: Some clients self-referred into the FCS service, while others were referred into the program by others. Given the voluntary nature of FCS, there was self-selection into the program. This choice to voluntarily participate was likely to be linked to unobservable factors (e.g., need), which were also related to the outcomes considered in the evaluation (e.g., child protection involvement).
2. Systematic variation in the intensity of the treatment: Some clients received a greater level of support from FCS providers (e.g., a greater number of sessions, more time spent on each session, and more service referrals) than other clients. The intensity of support that clients received during their time spent in FCS depended on many

factors, including the complexity of their case and the availability of services. For instance, clients in urban areas may be more likely to be referred to more appropriate services than clients in more rural areas, where services may be lacking.

3. FCS replaced FRS, excluding historic comparison cohorts: FRS was superseded by FCS without interruption. A control group cannot be formed from cohorts before 2021 (as these cohorts may have benefitted from FRS). Therefore, it was not possible to compare FCS clients (who received the service post January 2021) with an historical cohort of families with similar characteristics pre-2021, because families may have received FRS services (which is similar to FCS) but there is no data available on which families received FRS.

Due to these difficulties in finding a credible control group, there are limitations in the conclusions that can be drawn from the impact analyses. The statistical model described below goes into more detail about the self-selection problem laid out above.

Empirical framework, treatment definition and statistical model

With these challenges in mind, the evaluation team has taken a pragmatic approach to derive a control group from the *whole population of FCS clients with children (aged 0-17)*, who entered the FCS program and who could (potentially) be followed longitudinally in the statutory child protection system. To deal with selective participation in the FCS program, both treatment and control groups were child/youth clients (aged 0 – 17) who were referred or self-referred to FCS at least once. Outcomes on both groups were sourced from the statutory child protection. The greater economic benefits are calculated as reduced risk of harm to the child.

Treatment and control group

The treatment and control groups were derived from the entirety of child clients who entered FCS between 1 February 2022 and 31 January 2023[47]. Treatment was defined by exiting FCS when "needs were met", sourced from a variable in the FCS program data that indicated the exit reason from FCS.

1. *Definition 1: Binary measure - FCS met client needs*

- Treatment group: FCS clients who exited with needs met, as indicated in the FCS program data (exit reason code) by 'exited FCS when needs were met' (treatment = 1);
- Control group: FCS clients who exited FCS for all other reasons: cannot assist, deceased, higher assistance needed, moved, no longer assisted, no longer eligible, client quit the service, other reasons (treatment=0)[48].

This treatment definition ensures that all clients, independent of whether they are in the treatment or control group, have (self) selected into the FCS program. This is a benefit because *both treatment and control groups were identified as in need of the service* and were willing to *seek the service*. This definition overcomes the methodological concerns on systematic selection into the program outlined above.

[47] FCS program data were reliably entered by 6 out of 7 providers since February 2022. FCS program data before this date were deemed potentially incomplete.
[48] The FCS program data also lists in the exit reason code as "client deceased". In the estimation sample there is not a single client who was deceased.

This definition of treatment and control introduced new risks. It resulted in *differential lengths of time spent in the program between the treatment and the control group*. It may well be that clients in the treatment group have specific needs and case complexities that made it easier for the system to meet their needs. Ideally, the control group should include only clients who wanted to engage with FCS, but the provider did not have the resources or capacity to help them at that point in time. However, the control group also included clients who quit the service, moved away or exited for undisclosed reasons. These clients may have had less motivation to complete the full program, even though they may have benefitted from it the most.

This additional self-selection problem is addressed in various ways. First, a statistical model is used that can control for *observable differences* in the data between treatment and control groups, including case complexity and length. A balance of covariates table is provided to demonstrate that this is necessary (Appendix Table 5 Balance of covariates between treatment and control groups). Differences in *unobserved characteristics* were controlled for by utilizing the longitudinal nature of the available administrative child protection data. Precise knowledge of the exact start and end date of the FCS program not only allowed for identifying the client's exact duration in the FCS program, but also constructing measures of children's risk of harm *before, during and after* FCS participation. Second, a series of sensitivity checks to the treatment effect estimates was provided in which alternative control group or sample definitions were applied.

The statistical model

A primer on causal identification and self-selection issues

At starting point, a simple statistical model is considered that related data on a child's risk of harm (*RoH*) to data on a child's participation in the FCS program (*In FCS=1 if yes, =0 if no*) in a linear way:

Equation 1

$$RoH = \alpha + \beta InFCS + e.$$

In Equation **1**, α measured the average risk of harm in the population, β measured the relationship between FCS participation and risk of harm and **e** measured all other factors that remain unobserved.

As described above, the FCS program was not rolled out as part of a randomised controlled trial, or through other means that produced some randomness in who received FCS and who did not. Therefore, it was not easy to estimate reliably the true impact of the FCS program (which may be positive, negative or neutral). The main problem with statistically linking a child's risk of harm after their family received the FCS program, relative to those who did not participate in FCS, was that there were likely unobserved factors (here captured in **e**) that impacted both the outcome (here: RoH) and the treatment of interest (here: FCS).

In the context of this evaluation, it was most likely that each child has a *latent risk of being exposed to harm*, that is generated by the complexity of the *family's circumstances* and *parental behaviours, attitudes and needs*. This latent risk of harm is likely to affect both

selection into FCS (selective referral) and selective FCS completion, but also the probability of being harmed in any time period considered, including the period post-FCS participation. Without prior knowledge about the direction of the relationship between a child's unobservable latent risk of harm and FCS referral and completion, we cannot predict the direction of the likely biases of β.

To deal with this selection problem, a more complex statistical model was applied to reduce likely biases produced in β. First, selection into FCS is dealt with by focusing the analysis on all children who were referred into FCS (as described in the treatment and control group definition section). The treatment effect of FCS is therefore identified through variations in the treatment intensity. Some participants received enough services so that their needs were met (treatment group), while some participants received some services, but not enough so that they exited without their needs met (control group). In Equation **2** $FCS^{Met\ Needs}$ takes the value 1 for the treatment group, and 0 for the control group.

Equation 2

$$RoH = \alpha + \beta\ FCS^{Met\ Needs} + \boldsymbol{e}.$$

In this specification, self-selection into FCS was controlled for, but additional selection into completing the FCS program so that their needs were met may still be left in the error term ***e***. To deal with selective completion of FCS, the evaluation used a *value-added* model that has been applied extensively in the human capital development literature where children are exposed to a variety of parenting behaviours[49]. The approach is useful in settings where *all children receive some form of treatment but at varying degrees* and where *multiple measurements of outcomes are available*: in the future ($t+1$), concurrently, when treatment was given (t), in the past ($t-1$) and in the very first time period a child is observed ($t=0$).

In the context of this evaluation, these RoH outcome data are not only available after FCS completion ($t+1$), but also during FCS (RoH_t), directly before FCS (RoH_{t-1}), and all periods before the FCS program was introduced in January 2021 - i.e. the initial conditions of a child's exposure to harm ($Sum(RoH_0)$). The adjusted statistical model is as follows:

Equation 3

$$RoH_{t+1} = \alpha + \beta\ FCS^{Met\ Needs}{}_t + \gamma_1 RoH_t + \gamma_2 RoH_{t-1} + \gamma_3 Sum(RoH_0) + X'\mu + e.$$

In Equation **3**, the outcome variable is RoH_{t+1} and the control variables are:

[49] These models come from a literature that seeks to identify the causal impact of parental time inputs on children's cognitive or non-cognitive achievement, but in empirical settings where past parental time inputs, innate ability of the child, and other important factors (e.g. parental attitudes) are not observed at all or observed only partially. To overcome statistical problems of self-selection into greater levels of parental time inputs into the child's skill production function, such value-added models recommend making use of availability of lagged measures of children's achievement, or available lagged measures of parental time inputs (if available). These models usually proxy innate ability with parental background information. Depending on the exact specification, the models identify the causal impact of parental time inputs into their child's skill production function with the assumption that the impact of all observed and unobserved inputs decline over time (at a geometric rate). Such assumptions imply that the impact of parental time input at age 3 has a stronger impact on children's skills at age 5 than at age 7. For an overview of the value-added models, see Fiorini, M. and Keane, M.P. (2014). How the allocation of children's time affects cognitive and noncognitive development. *Journal of Labor Economics*, vol. 32, no. 4, pp. 787–836. https://doi.org/10.1086/677232. The seminal work on these models come from Todd, P.E. and Wolpin, K.I. (2003), On the specification and estimation of the production function for cognitive achievement. *The Economic Journal*, 113: F3-F33. https://doi.org/10.1111/1468-0297.00097

- Lagged dependent variable, RoH_t, measured during the FCS window (while services were received).
- Lagged dependent variable, RoH_{t-1}, measured before FCS started.
- Initial conditions, $Sum(RoH_0)$, a cumulative measure of the child's exposure to the statutory child protection system before FCS was introduced in 2021.

Figure 5 describes the logic of the identification approach. See Appendix 2 Quantitative analysis, Equation 4 for a technical description of the statistical model. The columns in the top panel (blue shaded arrows) describe five time periods relative to the potential treatment window (white-shaded column). The short-term outcomes are depicted in the light pink column. The longer-term outcomes are depicted in the yellow column. The pre-treatment periods are depicted in the two light green columns. The timelines of the treatment group are depicted as orange arrows (middle panel) and the timelines in the control group are depicted as green arrows (bottom panel).

As clients in the treatment group were likely to have different case complexities and histories in their contact with the statutory child protection system (relative to clients in the control group due to risk of harm related selection into program intensity), the model controlled for the whole history of the child protection contact pre-FCS (immediately before, a period called $t-1$, and the years before FCS was implemented in 2021, a period referred to as t_0) and within the FCS window (referred to as period t).

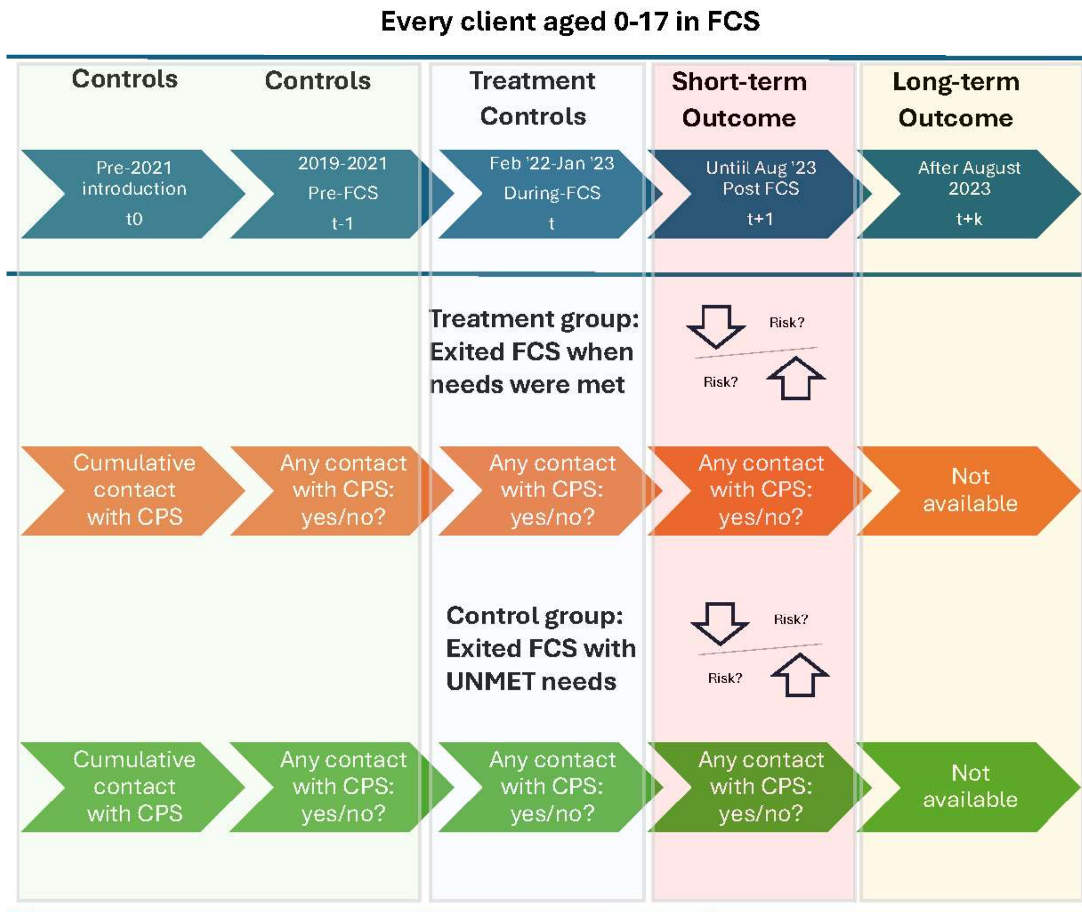
Furthermore, the model controlled for a variety of characteristics (**X_t'**) that may proxy for potential complexity of the case, the needs of clients, and the resources available to the providers to meet the needs of their clients. Specifically, the model controlled for:

- Case specific characteristics: provider fixed effects (inherent qualities of the FCS provider that are unlikely to change over time but might affect the client outcome), timing of the FCS program (start month), whether case involves a priority cohort, the number of sessions, the number of clients in a session, primary reason for seeking assistance recorded at screening, who referred the case to the FCS provider, and case complexity (whether case involved a disability and either one of the following reasons for seeking assistance: employment, housing, mental health, personal and family safety).[50]
- Child client specific characteristics: gender, Aboriginal status, whether client has a disability recorded at entry and type, age at first session.

All of these controls are observed in period t.

[50] Some clients have numerous, chronic and interrelated problems. Such families do not constitute a homogenous group. Complex needs may also not be indefinite, they may change over time. These families need individualised, tailored and flexible approaches to assist them. It is thus imperative that service providers acknowledge, record and address such complexity. Recent research has shown that families with complicated needs typically have five or more disadvantages including living with poverty, unemployment, poor quality housing and disabilities (Social Exclusion Taskforce, UK 2007). Other definitions would include mental health problems and substance abuse problems. We have attempted to measure such complexity by combining indicators of needs (Housing, Employment, Mental health, and Disability). In total, there were 553 children in FCS who were part of a complex case (3.5% of the entire child client sample).

Figure 5 Statistical model logic



A comparison of outcomes in period *t+1* between treatment and control group was therefore conditional on observable characteristics that proxy case complexity and history with the statutory child protection system. Medium to longer-term outcomes of the FCS program would be interesting, however no outcomes data was available post August 2023. Longer term outcomes could be studied in a follow-up evaluation.

Assumptions for the model to yield a causal effect and limitations

The estimate β in Equation **3** would identify the causal impact under the assumption that lagged measures of the outcome variable (risk of harm), and the initial endowment in risk of harm are reliable proxies for a child's *latent risk of harm* that may affect the intensity of a client's FCS participation, and that no other remaining unobserved confounders exist that affect both the outcome and FCS intensity[51]. In other words, if we assume that a child's previous contact with the statutory child protection is a good indicator of their overall risk of harm which might influence the benefits they receive from FCS, and there are no other hidden factors affecting both the risk and participation in FCS, then the coefficient β in

[51] Technical derivations demonstrate that this model furthermore assumes that the impact of FCS inputs decline geometrically over time, which means that FCS given at age 5 has a strong impact on a child at age 7 but a weaker impact at age 9. Implicit in the model is also that the declining impact of FCS is the same for each age group when FCS was delivered. See Todd and Wolpin (2003) for more details. As this evaluation is only focused on the short-run effects, and not on the longer-term dynamic impact, this assumption is considered immaterial for the reliability of the estimation results.

Equation **3** would show the true causal effect of how FCS completion with needs met impacted later statutory child protection involvement. This means the estimated coefficient on β can be interpreted as causal under the *conditional independence assumption*. In technical terms this refers to the assumption that the covariance between the error term **e** and the treatment variable FCS is zero, conditional on control variables. This means that there are no remaining unobserved factors that influence both treatment status and the outcome of interest.

This is a strong assumption and should be treated with caution. However, several arguments speak in its favour. First, selective participation in FCS was dealt with by following the trajectories of *all child clients who were FCS clients*. Both treatment and control groups either self-identified or were a priori identified in the system as a potential beneficiary of FCS. Clients made efforts to be screened into the system. The system also considered the clients as eligible for the service. This implies that clients both in the control and treatment group must have had some comparable characteristics at entry into FCS. In the results section, we provide evidence on similarities and differences between the two groups.

The model deliberately refrained from comparing children within the FCS program to children who were never part of FCS, as selection into FCS is likely to be systematic, with little overlap in characteristics that describe the two groups (see results section for evidence on the differences)[52]. The focus on children with different intensities of participation in the FCS program to define treatment and control group status eliminates the risk that unobservable factors that are linked to a child's risk of harm also determine entry into FCS.

Second, although the intensity or length of participation in the FCS program may be related to underlying risk factors, the statistical model also takes advantage of some expected randomness in the system to successfully cater for the needs of clients. Some FCS cases will exit due to decisions made by the child's parents (case-specific characteristics), other cases will exit early due to system error or system capacity constraints (provider- or area-specific characteristics).

By controlling for provider fixed effects, case characteristics, and lagged measures of the outcome variable (risk of harm), which proxy for the latent risk of a child to be harmed, it is not unreasonable to assume that there are no other systematic but unobservable factors that could affect both risk of contact with the statutory child protection system and the risk of exiting FCS with unmet needs.

Finally, one could argue that complexity of the case will be a defining factor of successful treatment and the risk of contact with the statutory child protection system. All regression estimates are adjusted by controlling for reasonable proxies of complexity, such as the primary reason for seeking support from the FCS provider, whether the case reached the 16 week limit, the number of sessions in a case, the number of clients in a case, whether the case involved a priority cohort, whether the client has a disability, and whether the case can be

[52] The RCCF team in collaboration with FACSIAR explored alternative estimation models. For instance, a difference-in-difference model was considered in which all children with at least one child protection record were followed over time. This approach would have had to rely on a sample of children with regular contact in the child protection system, some of whom benefitted from FCS and others who did not. The evaluation team considered this approach as not ideal, as selection into FCS is random, and it would have focused on children with very high risks of harm. FCS had the effect of reducing contact with statutory child protection, and that caused a systematic change in the composition of the treatment group that could be followed over time in the child protection system. Over time, the children in FCS, who were still observed in the administrative child protection data, were most likely children at greatest risk of harm, for whom FCS could not provide alternative services that could cater for the needs of the child outside the child protection system. Preliminary estimation results can be provided upon request but have to be considered with high levels of caution.

considered as complex[53]. To allay all remaining concerns about the composition of the control group, robustness checks were provided to the main estimation results.

There is some confidence that the statistical model yielded a causal impact of the effect of the FCS program for families who exited with needs met compared to families who exited with their needs not met.

Alternative treatment and control groups

In addition to the preferred definition of treatment and control group (Definition #1 treatment group families who exited with needs met, control group families who exited with their needs not met), alternative treatment and control group definitions have been applied in the analyses. These indicated the type of activities that were completed during FCS. These were defined through a description of the service type that clients received in any of their sessions. They aimed to capture the effectiveness of different components of FCS. While each offered different insights, they also had some level of bias.

2. Definition 2: Case involved as completed case plan. Where clients' needs are assessed as more complex, and/or a range of service responses are required, service providers work with the family to develop a family case plan. Plans are family-led, strengths-based and identify appropriate timeframes, resources and supports.
    a. Treatment group: An FCS client's case involved at least one session where the service type stated, "case plan completed" (treatment=1).
    b. Control group: None of the sessions of an FCS client's case involved the service type "case plan completed" (treatment=0).

3. Definition 3: Referral to an external provider
    a. Treatment group: At least one client in the case received a referral to an external provider (treatment=1).
    b. Control group: None of the clients in the case received a referral to an external provider (treatment=0).

4. Definition 4: Case involved 'brokerage'. Brokerage is a service type that can be used for families where presenting issues can be quickly addressed through practical assistance and where services and support are not otherwise available[54].
    a. Treatment: FCS client had included a record of brokerage (treatment=1) in at least one session.
    b. Control group: FCS client had no record of brokerage recorded in any session for the duration of the case (treatment=0).

5. Definition 5: Case involved 'active holding', which can be used where an outbound referral service is at capacity or not yet accessible. FCS service providers will actively maintain contact and provide support to the client family while they are waiting for services to become available.

[53] As noted above, some clients have numerous, chronic and interrelated problems. We have attempted to measure such complexity by combining indicators of needs (Housing, Employment, Mental health, and Disability). In total, there were 553 children in FCS who were part of a complex case (3.5% of the entire child client sample).
[54] FCS service providers use brokerage funds to ensure: the timely and effective engagement of families, and the management of presenting issues through the purchase of services or goods that address the immediate needs of a child or young person at risk of entering the statutory child protection system, where these services or goods are not otherwise available.

    a. Treatment group: At least one session in a case included a record of active holding (treatment=1).
    b. Control group: none of the sessions in a client's case involved active holding (treatment=0).

6. Definition 6: Case involved 'Family capacity building'. Family support activities provided during case planning and coordination, which involve undertaking activities to implement the case plans of individual clients (child/ren, young person or family), aimed at enhancing parent/child relationships, increasing family connectedness and reducing child distress. These can include among other home visits and mediation.
    a. Treatment group: At least one session in a client's case included a record of family capacity building (treatment=1).
    b. Control group: None of the sessions of the FCS client's case involved service type Family capacity building. (treatment=0).

For each of these alternative treatment and control definitions, the same causal identification assumptions and caveats hold as for the preferred treatment and control group definition.

Outcome measures

Client outcomes (if observed in the statutory child protection system at all) were observed in the statutory child protection system data over different time periods. Clients were (potentially) observed before FCS, during FCS and after they have received an FCS service. The timing of FCS can be identified precisely as the FCS program data has exact start and end dates of FCS for each recorded case. This allowed for the construction of a history of contact with the statutory child protection system relative to the start and end date of the FCS service.

Multiple outcomes were constructed in the administrative child protection data for three time periods: *pre-treatment*, which refers to statutory child protection system contact before FCS service; *treatment*, which refers to the time window when the clients entered FCS and then exited FCS; and *post-treatment*, which refers to statutory child protection system contact in the short-term after FCS (6 to 18 months post-treatment).

Each outcome is a dummy variable that takes the value 1 if the contact occurred at the indicated time period and 0 otherwise. These are:

i) Any contact with statutory child protection system (=1 if yes, =0 otherwise).
ii) Any report of risk of significant harm (ROSH) (=1 if yes, =0 otherwise).
iii) Any record of an investigation (=1 if yes, =0 otherwise).
iv) Any record of substantiated maltreatment if investigated (=1 if yes, =0 otherwise).
v) Any record of substantiated exposure to domestic violence if investigated (=1 if yes, =0 otherwise).

Substantiation for exposure to domestic violence has been examined as an outcome because Family Connect and Support staff reported that they frequently worked with families who have complex needs, including domestic and family violence. The CAF indicates that families may be considered to have complex needs where there is domestic violence and

child protection involvement[55]. Other research on families with complex needs in NSW has found that domestic and family violence is often indicated when reports are made to the Child Protection Helpline[56]. Therefore, the evaluation examined whether families' involvement with FCS was associated with substantiated exposure to domestic violence for families who exited FCS with needs met, compared to families who exited the program with needs unmet.

Results

Population of individuals and families recorded in FCS program data in DEX

Client characteristics

In total, there were 32,102 FCS clients and support persons observed in the FCS program data. Due to a known reporting error which the FCS program team is working to rectify, the age of a portion (2.8%, N=900) of clients was misrecorded. These clients were omitted from further analysis[57]. Summary statistics were provided in Appendix Table 2, where column (1) refers to the full sample; column (2) refers to the adult sample; and column (3) refers to the child/youth sample. When describing the sample of FCS clients, it is important to note that data quality issues affect the accuracy of these statistics.

From this sample, 1 in 4 of the adult clients were male, and 1 in 2 clients were male in the child sample of clients (ages 0-17). More than 1 in 4 clients (27.5%) were recorded as Aboriginal. The average age at the first session was 38 for adult clients and 8.6 years for children. Only a small fraction of the adult clients (3%) was recorded as identifying as CALD. Since FCS staff mentioned in consultations that they were uncomfortable recording someone as CALD based off the language they spoke rather than their cultural background, the percentage of CALD clients was likely underreported. For the majority of clients (96.5%), the main language spoken at home was English. Where it was recorded (N=19,531 clients), almost all adult clients had not completed more than a secondary education (82.9%) and less than 1 in 20 had a tertiary education (4.8%). Slightly less than 1 in 8 clients reported a disability (13.0%) and less than 1 in 20 clients (4.6%) qualified for packages from the National Disability Insurance Scheme (NDIS). Two out of five clients were reported to be part of the FCS priority cohorts (40.5%). Almost 2 in 3 child/youth clients were reported to be part of the priority cohort (59.0%)[58].

[55] NSW Government (2022). *Family Connect and Support Common Assessment Framework. An early intervention and prevention approach.* Parenting Research Centre.

[56] Luu, B., Wright, A. C., Schurer, S., Metcalfe, L., Heward-Belle, S., Collings, S., & Barrett, E. (2024). *Analysis of linked longitudinal administrative data on child protection involvement for NSW families with domestic and family violence, alcohol and other drug issues and mental health issues* (Research report, 01/2024). ANROWS.

[57] The DEX database was provided in separate CSV files for client information, session information, attendance information, and assessment of outcomes. Client number of observations vary across these different CSV files. For instance, in the FCS program data client characteristic file, there are 32,102 individual clients, while in the FCS session CSV file, there are 32,103 clients. Of these 32,102 clients, 668 clients were support persons in FCS. In the child FCS sample, 262 individual clients were considered to be support person. For one client, the case ID is missing.

[58] Priority cohorts are defined as clients who are either Aboriginal, or less than 5 years of age, or less than 18 years of age and were referred to FCS because they required assistance for their mental health as primary reason for seeking assistance.

Case characteristics

Number of Cases, Sessions and Clients

Summary statistics on FCS cases are reported in Appendix Table 2 Summary statistics on FCS cases.

In total, there were 13,693 cases that were observed in the FCS program data. The majority of cases (>53%) had entered FCS through a referral made by the education system (22.4%), the health care system (16.0%), and the justice or legal system (15.0%). Only 6.3% of cases were referred by a child protection agency, and 12% were self-referred (including via friends or family). In more than 1 out of 2 cases (52%), at least one client was reported as being part of a priority cohort. In more than 1 in 20 cases, the case was considered complex (5.8%), which included clients with disability and one of the core need requirements (employment, housing, mental health).[59] At entry into FCS, service providers recorded the primary reason for seeking assistance. In almost 1 out of 3 cases, the primary reason for assistance was family functioning (31.6%). The other most common reasons were mental health, wellbeing and self-care (24.5%), and personal and family safety (22.1%).

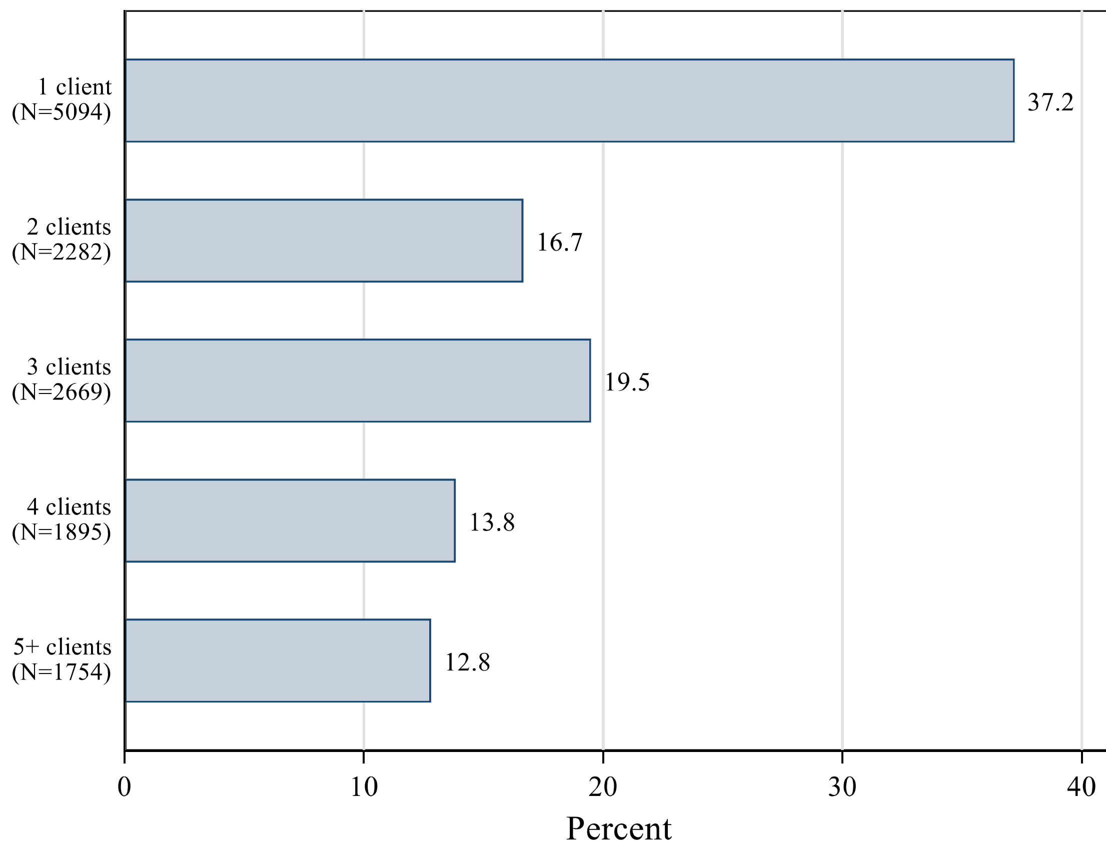
Within each case, there were multiple sessions, and within each session there was either one or multiple clients recorded (the assumption being that this reflects family members). In total, the FCS program data recorded 233,107 individual sessions and 527,786 case-client-session observations[60]. On average, there were 38.5 sessions per case-client, while the median session number was 20. The mean number of sessions per case-client in the bottom 25th percentile was 8, while the mean number of sessions in the top 25th percentile was 45. Delivery organisations varied greatly in the number of sessions within each case, with the smallest average number of sessions per case-client being 12.6 and the largest average number of sessions per case-client being 76.3.

The average number of clients per session was 2.6, with a minimum of 1 and a maximum of 12 (including a support person). In more than 1 out of 3 cases (37.2%), there was only one client listed in the data (see Figure 6). In 16.7% of all cases there were 2 clients, and in 19.5% of all cases there were 3 clients, and in 13.8% of all cases there were 4 clients. In 12.8% of all cases there were 5 or more clients.

[59] Recent research has shown that families with complicated needs typically have five or more disadvantages including living with poverty, unemployment, poor quality housing and disabilities (Social Exclusion Taskforce, UK 2007). Other definitions would include mental health problems and substance abuse problems. We have attempted to measure such complexity by combining indicators of needs (Housing, Employment, Mental health, and Disability). In total, there were 553 children in FCS who were part of a complex case (3.5% of the entire child client sample)

[60] There were 2,781 clients in the session data, with client ID equal to 0, even though the session had a recorded date and ID. These clients were omitted from the analysis.

Figure 6 Clients per case by category (in percent)



Note: In total, there were 13,693 cases. The graph depicts the percent of cases with 1 client only, 2 clients, 3 clients, 4 clients or 5 or more clients.

Data on minutes spent per case were available for 11,231 cases. On average, providers spent 499 minutes per case or 8.3 hours. The median number of minutes was 285 minutes (4 hours and 45 minutes). There is great variability in time spent per case per provider, with a minimum of 329 minutes per case on average for one provider and a maximum of 736 minutes per case on average for another provider[61]. The average number of minutes for cases that exited after one session was 36 minutes (N=43 for which data on minutes per session was available). The mean assistance per session was 28.8 minutes, while the extreme values were 0 minutes and 31,695 minutes. The median session time was 20 minutes.

Service types per session and case

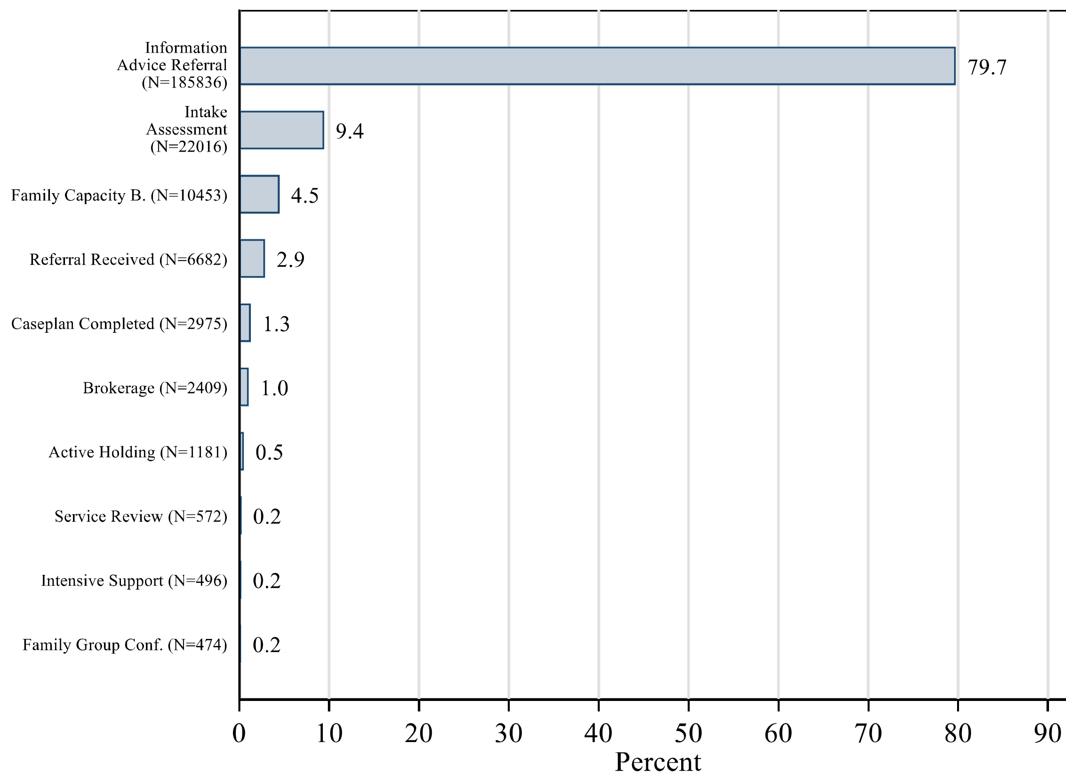
The FCS model is characterised by several service types (see Appendix Table 1), which are prescribed in response to the type of case. There were 233,094 FCS session observations, with recorded service types delivered (See Figure 7). The most common service type (or service activity) recorded in a session was “information, advice, or referral” (79.7%) (N=185,836). This type of service is usually delivered to cases of low complexity.

[61] Information on minutes spent on assistance per session was provided for 194,193 sessions. Minutes per session were only recorded for intake/assessment (N=21,088), information/advice/referral (N=148,602), family capacity building (N=9,165), brokerage (N=2,036, and Family Group Conferencing (N=463). Total number of minutes per case were calculated as the sum of all recorded minutes within one case across all sessions.

In 9.4% of sessions, “intake/assessment” was provided. Less than 5% of sessions featured “family capacity building” (N=10,453). In 1.3% of all sessions (N=2,975), a case plan was completed. A case plan is set up to support a family explore and reflect what is important to the individual or family and the change they seek to make.

The service types “active holding” and “brokerage”, both of which are used when the case is of high complexity and in the presence of service gaps, occurred only in 0.5% (N=1,181) and 1.0% (N=2,409) of all sessions. In 2.9% of all sessions, the session was recorded as referral received (N=6,682).

Figure 7 Service types per session



Note: Data available on 233,094 session observations.

Additional information was available on the number of referrals made to an external provider that were provided in a session. It should be noted that issues with the accuracy of recording outbound referrals were identified for two FCS service providers, so reported statistics are likely to be underestimated. Overall, 1 in 5 clients (N=6,357 out of N=31,205) received at least one referral to an external provider. For a very small number of clients, a referral was made to an internal provider (N=355 or 1.1%).

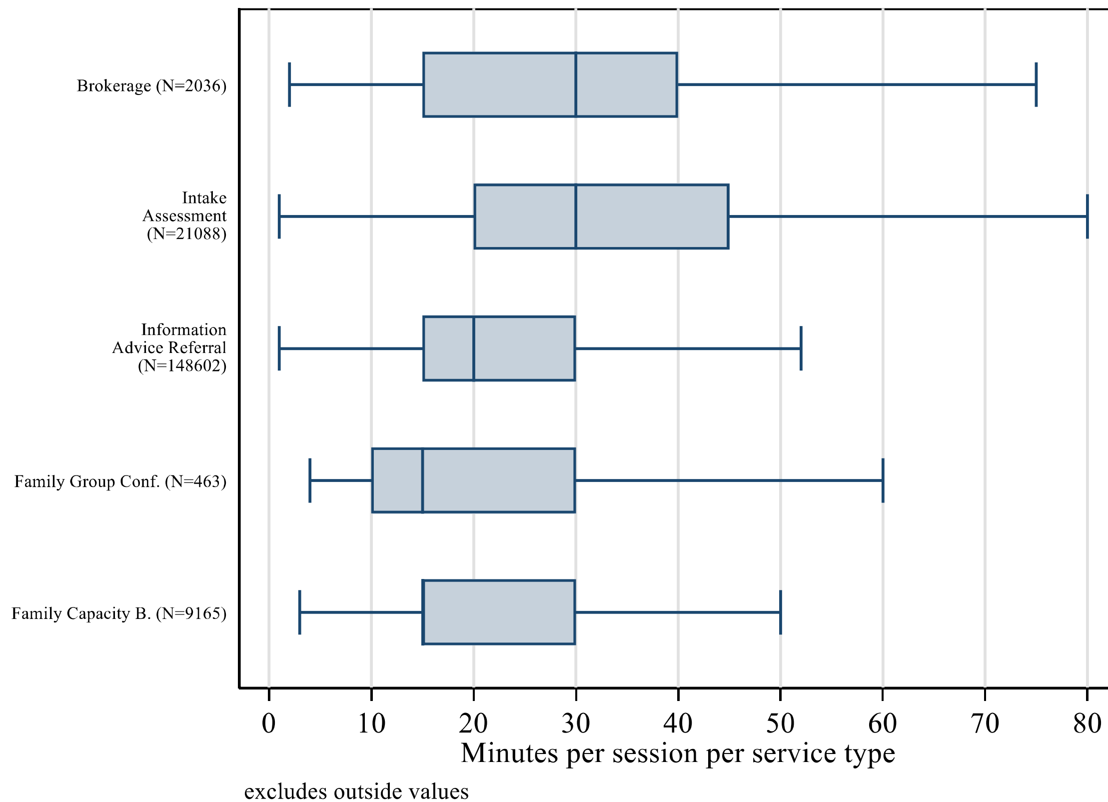
Time spent on service types

Data were recorded on minutes of time allocated across a range of service types (see Figure 8). The median time FCS service providers spent on each service type was:

- Intake and assessment – 30 minutes
- Information, advice and referral – 20 minutes
- Brokerage – 30 minutes

- Family capacity building – 15 minutes.

Figure 8 Minutes spent per service type



Note: Data on minutes per service type were recorded in 181,354 sessions The graph depicts a box plot, which depicts the interquartile range within the box (25%-75% of the distribution) and the whiskers indicate variability outside the upper and lower quartiles. The horizontal axis describes minutes per session. Vertical lines within the box demark the median. For legibility, this graph excludes extreme values. Numbers in parentheses reflect count (N).

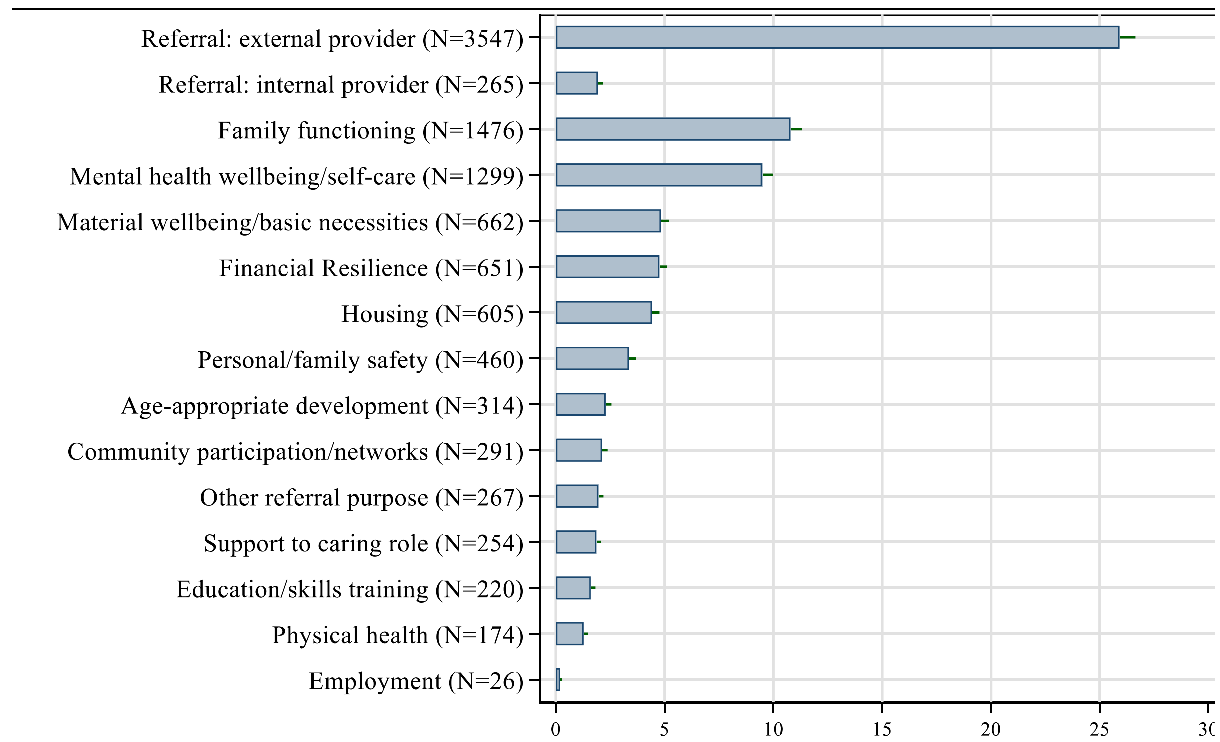
Outbound service referral types in sessions and per case

When collapsing the information by case, in 25.9% of all 13,693 cases (N=3,547) a referral was made to a service that was provided by a different organisation and in 1.9% cases a referral was made to another service offered within the same organisation (N=265) (See Figure 9). The most frequent outbound referral type per case was made for the purposes of (1) Family functioning (10.8%, N=1,476), (2) Mental health, wellbeing, and self-care (9.5%, N=1,299), (3) Material wellbeing and basic necessities (4.8%, N=662), (4) Financial resilience (4.8%, N=651) and (5) Housing (4.4%, N=605). Very few referrals were made for the purpose of Support for caring role (1.9%, N=254), Education and skills training (1.6%, N=220), and Physical health (1.3%, N=174). Almost no referrals were made for the purpose of Employment (0.2%, N=26).

There was again a large degree of variation in the probability of making a referral by provider. One provider only made referrals in 4.8% of all cases, while another made referrals in 43.2% of all cases.

The average and median wait time for a referral was 54.1 days and 42 days, respectively, with broad variation across providers (mean waiting time ranging from 6 to 45 days). This was likely due to availability of local services across FCS catchment areas, which was noted by FCS providers and stakeholders to vary greatly by region.

Figure 9 Any referrals made in a case and type of referrals made

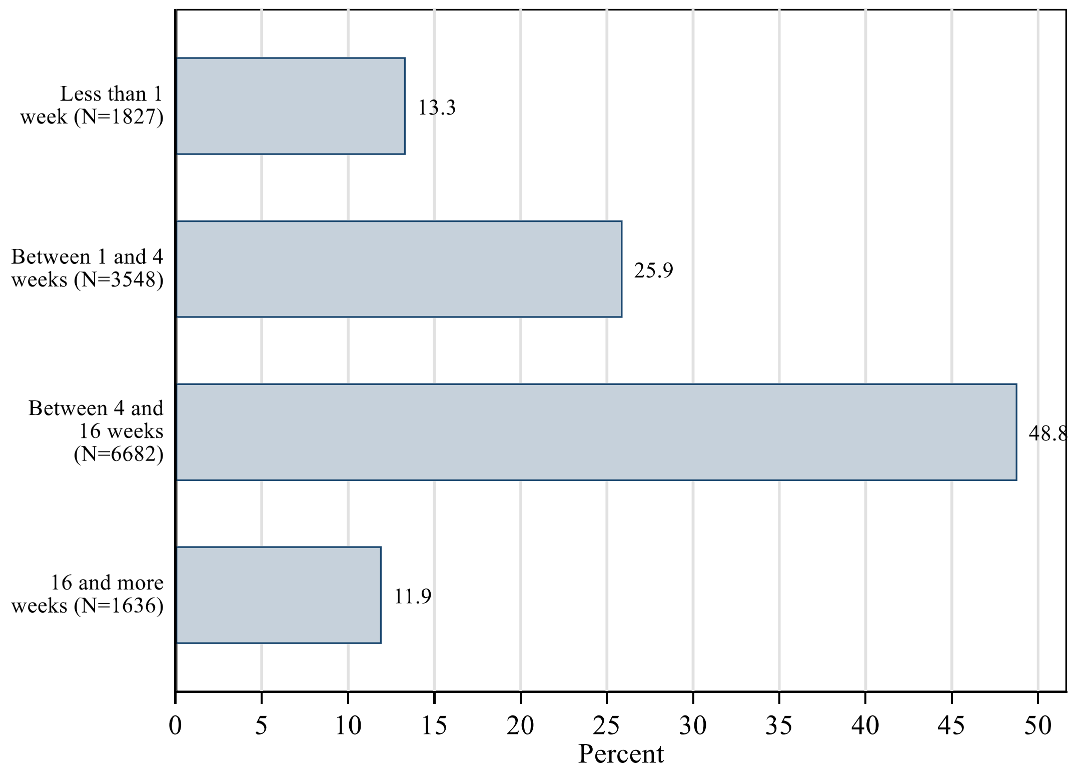


Note: The figure depicts the number and percent of the 13,693 cases where at least 1 referral was made. Parentheses report the number of observations.

Duration of cases

In 9,242 cases, the case was completed (with start and end dates available for each case). For these cases, a duration of the case could be calculated. The mean duration between the first session and the last session was 52.4 days (7.5 weeks). In 13.3% of cases, the duration was less than 1 week. In 25.9% of all cases, the case was open between 1 and 4 weeks. In 48.8% of all cases, the case was open between 4 and 16 weeks. In 11.9% of all cases, the case was open beyond the 16-week time limit (see Figure 10).

Figure 10 Length of a case until closure



Note: Data were available for 13,693 cases. Figure depicts the percent of cases with duration: Less than 1 week, Between 1 and under 4 weeks, between 4 and under 16 weeks, and 16 and more weeks.

Exit reasons and met and unmet needs

For 8,743 cases, data were available on the exit reason. In the majority of FCS cases, the client exited because their needs were met (40.5%, N=3,545) or they no longer needed the service (18.3%, N=1,604). In 17.8% of cases, the client quit the service (N=1,558). In almost 10% of cases, other reasons for exit were listed but not specified (N=868). In 6.4% of cases, FCS could not assist (N=559). In 2.9% of cases, the client was no longer eligible for FCS (N=256), and in 2.6% of cases higher level assistance was needed (N=224). Very few cases ended because the client moved away (1.5%, N=127) or became deceased (N smaller than 5, exact number suppressed to avoid possibility of identification) (see Figure 11).

This suggests that there were a host of different reasons why clients in cases exited FCS. One in three cases ended because clients perceived they no longer needed the service (without having their needs met) or because they quit the service. One in eight cases ended because of system constraints (e.g., eligibility criteria, higher level of assistance, inability to help). One in ten cases ended for reasons that did not fit any of the listed categories. These distinctions are important information for service providers, as some of these constraints can be controlled by the provider (e.g., system constraints). Whether or not needs were met at the end of the FCS case required detailed information on the needs of the clients. This information should be collected at intake for each new FCS case. Whether FCS met the needs of the clients is a critical outcome of the FCS service provision and can be used as a marker for the effectiveness of the FCS program.

Figure 11 Exit reason for each case

Note: Data on exit reason were available for 8,743 cases. Numbers in parentheses report the number of cases.

Case complexity

FCS works with a range of families in situations with varying degrees of complexity. Some FCS providers may deal with more complex cases than others. Whether a provider can help the client(s) to meet their needs will depend on the complexity of clients' needs and the potential diversity of services required to meet such needs. No official definition of complexity has been used in the DEX data entry, but it has been suggested that multiple and complex issues may refer to domestic and family violence and/or contact with the statutory child protection system[62]. However, complexity could also be described by the number of clients involved in a case, the purpose of a referral into FCS, or whether one of the clients in a case has a disability.

In the FCS program data, there were 4,206 out of 32,101 clients who were recorded with at least one disability (13.3%). The most common disability was of a psychiatric nature (N=2,761 or 8.6%)[63]. Only 1,299 clients were NDIS eligible (4.0%).

When considering disability per case, a disability was recorded in four out of ten cases (N=5,621, 41.0%). Of these, 2,603 cases did not state the type of disability. The most common explicitly stated disability was a psychiatric disorder (N=2,468, 18.0%). Of the 13,693 cases, 1,143 included a client with NDIS eligibility (8.3%).

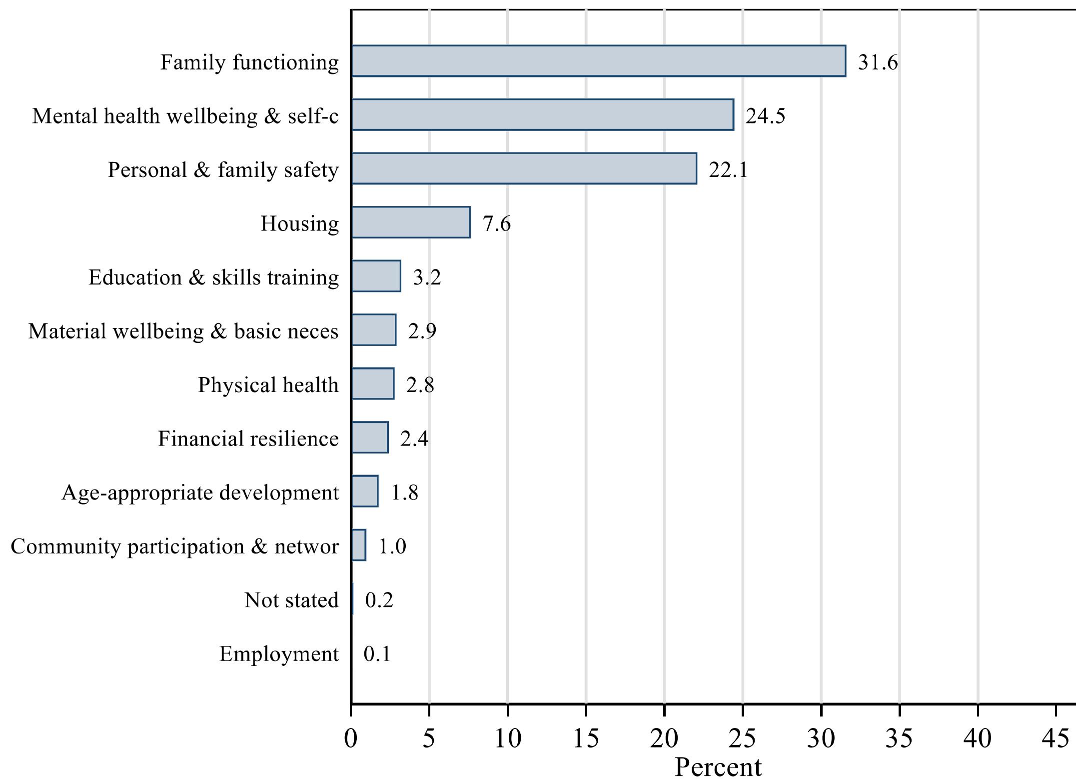
A definition of complexity could also be derived from data on the primary reason for seeking assistance. Figure 12 demonstrates that the top three primary reasons why assistance was sought was family functioning (31.6%), mental health, wellbeing and self-care (24.5%) and personal and family safety (22.1%). Housing, where the client is seeking to improve their housing stability or address the impact of poor housing on their independence, participation and wellbeing was listed in 7.6% of cases as the primary reason for seeking assistance[64].

[62] See NSW Government (2022). *Family Connect and Support Common Assessment Framework. An early intervention and prevention approach*. Parenting Research Centre.

[63] Another 4,096 clients were observed in the disability records, although their disability was not stated, or they were not asked the question. Therefore, this group may or may not have a disability.

[64] The Data Exchange recorded a primary reason but not a secondary reason for seeking assistance, albeit this was recommended. However, service providers included detailed data on all reasons for which assistance was sought. In 17.2% of all cases only one reason was listed. In 35.7%, 2 reasons were listed. In 30.4% of the cases 3 reasons were listed, in almost 9% of cases 4 reasons were listed.

Figure 12 Primary reason for assistance



Note: Data on primary reason for assistance at entry of FCS were available for all 13,693 cases.

Complexity of a case was likely to involve multiple issues, including either one of the high priority issues (need for housing, need for employment, need for mental health and wellbeing, need for personal and family safety), and a disability. In total, there were only 2,074 cases (15.1%) with both a disability and either one of the priority reasons to seek assistance.

Alternatively, complexity could be defined as a case where the referral into FCS came from a health, justice, or child protection agency. Referral source was the person or agency responsible for referring a client to an organisation. The source of referral was important in mapping client pathways and access points. Among 13,693 cases, 15% of cases were referred into FCS by the justice system or legal service provider, 16% by a health care provider and 6.3% by child protection services. The majority of cases were referred to FCS by the education system (22.4%), community services (13%), and self-referral (12%) (Appendix Figure 3 Summary Statistics on FCS cases). (See Section 1, Executive Summary and Recommendations).

Given the multitude of ways to measure complexity and the limitations of the data, the evaluation team was unable to land on a standard definition of case complexity. However, a standard definition of complexity would be desirable. This question could be further considered and refined through FCS data collection and monitoring processes and future evaluations; this is addressed in the recommendations (See Section 1, Executive Summary and Recommendations).

Client satisfaction

The SCORE client survey included questions about client satisfaction. As noted earlier, DCJ communicated to FCS providers that SCORE completion was optional from late 2022 (see

discussion on data used in evaluation in this section and FCS workforce consultations), meaning that data are incomplete and potentially biased. Nevertheless, data were collected on 1,184 clients: 334 clients in 2021, 587 clients in 2022 and 263 clients in 2023, up until June 2023. These data were examined to inform potential future efforts at capturing client satisfaction.

Client satisfaction was high overall, and satisfaction scores improved between 2021 and 2023. By 2023, 4 out of 5 clients (80%) agreed with all three satisfaction statements:

(1) The service provider was able to deal with my issues (71% in 2021 vs. 80% in 2023)
(2) I was satisfied with the service (81% in 2021 vs 78% in 2023)
(3) The service staff listened to and understood my issues (73% in 2021 versus 80% in 2023)

Effectiveness of FCS in reducing risks for vulnerable families

For the outcome analyses, administrative child protection data were used, with the samples restricted to contact with the statutory child protection system between 1 January 2019 and 29 August 2023 (the latest extract date available). Individual information on cumulative statutory child protection system contact prior to 2019 and since 1999 (earliest year of data available) was merged to each child's observation.

In total, there were 16,042 children in FCS who were under the age of 18 years at the time of the service (age recorded at first session). Children with reported birth years before 2003 were dropped from the sample (as these are not considered children), as well as children born in 2024 (no follow-up data), yielding a sample of 15,984 children (7,900 cases).

FCS client data can be reliably analysed for service entries since February 2022. Before that date, data entry into DEX was not obligatory for providers. For the purpose of this evaluation, a sub-sample of child clients was defined as clients who entered FCS between 1 February 2022 and exited by 31 January 2023. This analytical sample definition ensures that measurement error and incompleteness was minimised and that child client outcomes can be followed over a time period of 6 to 18 months. This leaves a sample of 6,874 FCS child clients observed in 3,498 cases (see Table 5). The average age at entry into FCS was 8.6 years.

Table 5 shows the percentage of children in FCS in contact with the statutory child protection system before, during and after they exited FCS. Overall, risk of contact with child protection services (any contact, any ROSH, any field assessment, any substantiation) was higher before child clients entered FCS than post-FCS. One could argue that this is so by definition because the time window considered for the analysis was greater pre-FCS. However, this is still true when restricting the time window to 12 months before and after FCS. In this case, 42.5% of child clients had contact with the statutory child protection system in the year before they started FCS. During FCS, 18.9% had contact with the statutory child protection system, and only 35.8% had contact with statutory child protection system within a one-year window post-FCS. This is preliminary evidence that FCS may have diverted clients away from the statutory child protection system. However, Table 5 alone is not evidence for the effectiveness of the FCS program.

Table 5 Percentage of FCS children with statutory child protection system contact, before, during and after they exited FCS

	Before FCS started	During FCS window	After FCS was completed
	(1)	(2)	(3)
Sample: FCS Entry and exit between February 2022 and January 2023			
Any statutory child protection system contact	52.4	18.9	34.9
Any ROSH	46.2	13.7	30.0
Any Field assessment	21.8	3.2	9.4
Any substantiation	12.2	1.5	5.3
Any statutory child protection system contact +/- 12 months	42.5	18.9	35.8
Observations	**6,874**	**6,874**	**6,874**

Note: Analytical sample includes all FCS child clients who entered the exited FCS between 1 February 2022 and 31 January 2023. Pre-FCS period includes all child protection system records starting 1 January 2019 and ended 8 August 2023 (last available data point). SD is standard deviation.

How do children in FCS who have contact with the statutory child protection system differ from children in the system who do not enter FCS?

Child clients in FCS were significantly different from children in the statutory child protection system who have no record of involvement in the FCS program (Appendix Table 4). Significant differences are reported for significance levels of 5% or smaller ($p<0.05$). FCS child clients were significantly more likely to be female and younger in age at their first contact, and they were significantly less likely to have a missing record on Aboriginality status. They have had significantly fewer total number of ROSH reports (2.7 vs 3.1) and helpline issues (9.1 vs 13.6) at the time of each report, and fewer investigations (3.4 vs 4.1) and substantiations (0.5 vs. 0.7) following each report in a period before FCS was introduced (before 2021). They were also reported to the statutory child protection system for different reasons. They were, for instance, twice more likely to be reported because their carer had a mental health issue (0.7% vs 0.3%), and more likely to be reported for emotional abuse (19.3% vs 16.4%) and neglect (26.2% vs. 21.2%), but less likely to be reported for sexual abuse (11.5% vs 18.8%). They were less likely to be reported to the Child Protection Helpline by a private school staff member (2.7% vs 5.3%), and more likely to be reported by police (20.2% vs 17.1%).

When estimating a multivariate model of the risk of contact with the statutory child protection system for FCS child clients (relative to non-FCS clients), it was found that FCS clients, who are reported to the Child Protection Helpline pre-treatment, were significantly at greater risk of being reported as ROSH by 1.3 percentage points (ppt) ($p<0.01$). Although they were less likely to be investigated for alleged maltreatment than children who were not part of FCS, they were at greater risk of being substantiated for maltreatment, although this difference was only significant at the 10% level (by 1.6 ppt, $p<0.10$).

It was concluded that child clients in FCS who had some records in the statutory child protection system were very different from children not in FCS who had contact with the statutory child protection system[65].

It is for this reason that this evaluation did not compare children in FCS with children not in FCS. This would have required focusing on a sample of children with regular contact with the statutory child protection system and on treatment and control groups that were very different in their long-term risk of experiencing harm and contact with the statutory child protection system.

How do children in the treatment and control group differ at FCS entry?

The evaluation focused on a comparison of 5,934 FCS child clients with needs that were met (treatment group) with FCS child clients that exited the FCS program for other reasons (control group). Both groups can be assumed to be similar in their underlying characteristics and motivations to seek assistance, although they may have differed in their reasons for seeking assistance. Additional analyses demonstrate that the treatment and control groups were similar with respect to some characteristics and different with respect to other characteristics at entry into FCS (Appendix Table 5). For instance, the treatment and control groups' children were similar in their sex composition (Male, p=0.5072, Female: p=0.436) and whether their case involved a priority cohort (p=0.1990). However, children in the treatment group were slightly younger (8.3 vs 8.8 years), the case was more complex in terms of needs involving disability and either housing, mental health or employment (6.6% vs 3.3%), and they were more likely to have a learning disability (7.3% vs 4.2%). Cases in the treatment group were more likely to seek assistance for housing (9.3% vs 5.5%) and less likely to seek assistance for personal and family safety (20.3% vs. 34.0%). They were more likely to have self-referred into FCS (18.0% vs 6.6%) or been referred by the education system (24.5% vs 20.7), but less likely to have entered the FCS program through referral by the justice system (8.9% vs 16.0%) or through a community organisation (9.6% vs 18.6%). There was no difference between the treatment and control groups in terms of being referred into FCS by the statutory child protection system (6.5% vs 6.1%, p=0.518), even though the treatment group children had significantly lower risk of contact with child protection services in the past 12 months leading up to their FCS entry than children in the control group (37.8% vs 48.8%). Children in the treatment group were more likely to never have a record in the statutory child protection system than the control group (46.5% vs 36.5%). The treatment and control groups also significantly differed in the delivery organisation of their case and location.

The conclusion of this balance of covariates test between the treatment and control groups is that it is important to control for variables that capture these observable differences. The estimation models presented in the next section control for such observable differences.

Differences in intensity of FCS treatment between the treatment and control groups

Children in both the treatment and control groups received some services offered by FCS (Appendix Figure 4 Balance of covariates between treatment and control groups). They differed by the length of program participation and activities undertaken. Cases in the treatment group had 100 sessions and stayed in the system for 82 days on average, while cases in the control group had 50 sessions and stayed in the system for 48 days on average. While 1 in 4 cases in the treatment group stayed in the system for 16 weeks or beyond, less

[65] Estimation results provided upon request from the authors of this report.

than 1 in 10 cases in the control group did so. Two out of three cases in the treatment group benefitted from an external referral to a service provider, while only one in six cases in the control group did so. Cases in the treatment group also benefitted more from any of the available service components such as active holding (6.3% vs 1.1%), family capacity building (25.2% vs 12.2%), and brokerage (16.7% vs 4.0%). Therefore, the treatment effects of FCS presented in the next section have to be understood within the context of differences in service intensity.

Estimated treatment effects

Estimated treatment effects are reported in Table 6 for the main treatment definition (column (1)). The treatment effect reflects differences in the intensity of program participation. Alternative treatment definitions (columns (2)-(6)) reflect a client's receipt of specific service components. The final estimation sample was 5,934 child clients for whom complete information was available on outcomes, treatment status and control variables. Standard errors were clustered (by case) and adjusted for heteroskedasticity. These are reported in parentheses.

Table 6 Estimated treatment effects for five outcomes and six treatment definitions

	Treatment definitions					
Outcomes:	Exited with needs met	Case plan completed	Case received a referral	Brokerage	Active holding	Family capacity building
	(1)	(2)	(3)	(4)	(5)	(6)
Panel A: Any statutory child protection system contact	-0.046^{***}	-0.033^{*}	-0.003	-0.022	-0.009	0.003
	(0.016)	(0.019)	(0.017)	(0.025)	(0.049)	(0.020)
Control group mean	0.591	0.573	0.579	0.553	0.553	0.555
Percent change	-7.7	-5.7	-0.5	-4.0	-1.6	0.5
Observations	5934	5934	5934	5934	5934	5934
Panel B: Any ROSH	-0.038^{**}	-0.016	-0.011	-0.034	-0.030	-0.012
	(0.016)	(0.019)	(0.017)	(0.024)	(0.045)	(0.020)
Control group mean	0.52	0.509	0.507	0.487	0.487	0.485
Percent change	-7.4	-3.1	-2.1	-6.9	-6.2	-2.5
Observations	5934	5934	5934	5934	5934	5934
Panel C: Any invest.	-0.027^{**}	-0.017	-0.026^{**}	-0.009	0.027	-0.025^{*}
	(0.012)	(0.012)	(0.012)	(0.019)	(0.033)	(0.013)
Control group mean	0.256	0.244	0.24	0.233	0.232	0.234
Percent change	-10.7	-7.0	-10.8	-3.8	11.6	-10.9
Observations	5934	5934	5934	5934	5934	5934
Panel D: Any Subst.	-0.025^{***}	-0.011	-0.009	-0.008	0.027	-0.017^{*}
	(0.009)	(0.010)	(0.009)	(0.014)	(0.029)	(0.010)
Control group mean	0.147	0.14	0.138	0.132	0.133	0.134
Percent change	-17.2	-7.5	-6.7	-5.9	20.6	-13
Observations	5934	5934	5934	5934	5934	5934
Panel E: Any Subst. DV	-0.014^{**}	-0.004	-0.004	0.006	-0.004	-0.016^{***}

	(0.005)	(0.006)	(0.004)	(0.009)	(0.005)	(0.005)
Control group mean	0.037	0.035	0.035	0.034	0.033	0.033
Percent change	-37.0	-10.2	-10.9	16.6	-11.8	-47.1
Observations	5934	5934	5934	5934	5934	5934

Note. Any invest. is any investigation and Any Subst. is any Substantiation. Each panel and column report the estimated coefficient on the treatment variable obtained from a separate regression model. All outcomes are binary variables (no=0, yes=1). Estimation sample includes all children (ages 0-17) in the FCS program who entered and exited the program between 1 February 2022 and 31 January 2023. Administrative child protection data were sourced from years 2019 to August 2023. Long term history of contact with the statutory child protection system was sourced since 1999. Each model controls for lagged values of the dependent variable (any contact with the statutory child protection system just before FCS, any contact during FCS); child characteristics (gender, Aboriginal status, age at first session, whether child has a disability and the type of disability, total number of ROSH and total number of Substantiations before FCS was introduced in January 2021, 0 if no contact with the statutory child protection system pre-FCS introduction) and case characteristics (Sessions per case, clients per case, whether case reached 120 days, start month of case, whether case belongs to priority cohort, delivery organization, main reason for referral into FCS, and source of referral, case is considered as complex). Each column reports coefficient on treatment indicator (0,1). Full estimation results are provided by authors upon request. Clustered standard errors (by case ID) in parentheses.
* *p < .10,* ** *p < 0.05,* *** *p < 0.01.*

Treatment (1): FCS cases which met the needs of clients

Children in the treatment group were 4.6 percentage points (ppt) less likely to have a contact with the statutory child protection system post-FCS than clients in the control group, holding other things constant (Table 6, Panel A). This estimated treatment effect is statistically significant at the 1% level (p<0.01). As the control group had a mean risk of contact with the statutory child protection system before their FCS started of 59.1%, this treatment effect implies a reduction of risk by 7.7%. Children in the treatment group were also significantly less likely to receive a ROSH report post-FCS by 3.8 ppt (p<0.05), or 7.4% less likely relative to the control group mean pre-FCS of 52.0% (Table 6 Panel B).

Children in the treatment group were significantly less likely to be investigated for an allegation of being maltreated by 10.7% (Table 6, Panel C, -2.7 ppt, p<0.05, control mean pre-FCS 25.6 %) and 17.2% less likely to be substantiated for maltreatment relative to the control group mean (Table 6, Panel D, -2.5 ppt, p<0.01, control mean pre-FCS 14.7%). They were also 1.4 ppt (p<0.05) less likely to be substantiated for exposure to domestic violence (Panel E). Relative to the control group mean of 3.7%, this treatment effect implies a reduction of risk by 37.0%.

These numbers mean that if the children in the control group – those for whom FCS did not meet their needs – had received an FCS treatment that met their needs, then:

- **1 out of 13 children –** would have avoided contact with the statutory child protection system
- **1 out of 13.5 children –** would have avoided a ROSH report
- **1 out of 9.3 children –** would have avoided an investigation
- **1 out of 5.8 children –** would have avoided a substantiation
- **1 out of 2.7 children –** would have avoided substantiated exposure to domestic violence.

These findings are reliable under the assumptions of the statistical model, as laid out in the statistical model and assumptions sections.

Treatment (2): FCS cases where the case plan was completed

No statistically significant treatment effects were found when comparing clients whose case plan was completed, with clients whose case plan was not completed (column (2), Table 6). The only noteworthy difference is that those whose case plan was completed were 3.3 ppt less likely to have had any contact with the statutory child protection system than those whose case plan was not completed. This estimate is statistically significant only at the 10% significance level. The treatment effect implies a reduction in risk by 5.7% relative to the pre-treatment control group mean of 57.3%.

Treatments (3)-(6): Components of the FCS model

There is no strong evidence that specific components of the FCS program were more or less effective than others:

***Any referral*:** Referrals on their own made no significant difference to the outcomes of children, with the exception that children where at least one referral was made in the case were 2.6 ppt less likely to be investigated for alleged maltreatment ($p<0.05$, Table 6, Panel C). Relative to the pre-treatment control group mean of 24%, this treatment effect implied a reduction in risk of 10.8%, or 1 in 10 avoided an investigation.

***Any brokerage, any active holding, any family capacity building*:** There was no evidence that these sub-components on their own were successful in reducing the risk of contact with the statutory child protection system. There was, however, one notable exception. Children who received family capacity building were significantly less likely to be substantiated for exposure to domestic violence in their home. The reduction was estimated as -1.6 ppt ($p<0.01$). Relative to the control group mean of 3.3% pre-FCS, this implied a reduction of 47.1% or 1 in 2 avoided substantiations for domestic violence. This is a positive outcome, as family capacity building aims directly at supporting parents to build positive connections within the family.

To conclude this section, it was assessed that program effectiveness is really about whether the FCS provider was able to meet the needs of the clients and not so much whether they provided specific components of the FCS service model. If these needs were laid out (early in their engagement with FCS) in a case plan, and if this case plan was completed, then FCS was likely to be successful in reducing the risk of a child's risk of harm (as measured by investigations and substantiations). Some positive insights were also gained about the effectiveness of family capacity building in reducing the risk of exposure of children to domestic violence.

Sensitivity checks to the main estimate of interest

In this section, a sensitivity check is presented to demonstrate that the estimates are not spurious. These checks were performed for the most important outcome: reduced risk of substantiated maltreatment (Table 6, column (1), Panel D). The aim of this exercise was to show that the presented treatment effect is not sensitive to model assumptions, sample definitions, additional controls and control group definitions. A summary of this exercise is presented in Appendix Table 6.

Eight different alternative model specifications were tested. These were:

(1) Control for other inputs into FCS

(2) Use alternative estimation sample (entries into FCS in financial year 2021-2022)
(3) Drop clients who quit FCS
(4) Drop clients who say assistance was no longer needed
(5) Drop clients who needed higher assistance
(6) Drop clients who exited FCS for "other reasons"
(7) Drop clients who were no longer eligible
(8) Drop clients who exited FCS for any reason that indicates client motivation (quit, moved and other reasons)

The benchmark estimate was -0.025 ppt, significant at the 1% level of significance. The treatment effect is bound between -0.19 (estimate model with sample of clients who entered FCS and exited between 1 July 2021 and 30 June 2022, not statistically significant) and -0.37 (drop all clients who exited FCS through self-selection). In seven out of eight alternative model specifications, the treatment effect is still statistically significant at the 5% level or better. It is concluded that the treatment effects of interest (substantiated maltreatment) are robust and not driven by specifics of the model or the control group definition.

Heterogeneity in FCS treatment effects

Who benefitted most from the FCS program? In this section, we explore if the treatment effect of the FCS program on substantiated maltreatment was moderated by observable characteristics that allow classification of clients into sub-groups. This is referred to as testing for the 'heterogeneity'[66] in the treatment effect. Subgroup analyses are presented for the main treatment effect of interest: the impact of FCS (when needs were met) on the risk of substantiated maltreatment.

Heterogeneity in treatment effect is calculated by Aboriginality status (one of the priority groups of FCS), by urbanity of the region (a proxy for the availability of other services), and the size of the provider (a proxy for the economies of scale of the service provider)[67]. Groups are defined as follows:

- Aboriginal status: Status of the child client within a case (yes=1, no = 0).
- Urbanity: Postcode in which the main client of the case resides. Clients in postcodes within the Sydney, Central Coast, Newcastle and Lake Macquarie, and the Illawarra region are coded as clients living in more urban areas (yes =1, no=0; missing postcode is coded as 2), and clients living in all other regions are coded as living in more rural regions[68].

- Size of the provider: Whether the case is managed by one of the two largest providers (yes=1), versus case is managed by any of the other providers (no=0).

The main results are summarized in Table 7. We fail to reject the null hypothesis of a 'zero interaction effect' for all three group comparisons and both outcomes, with p-values all greater than 0.05. This means that overall, there was no statistically significant difference in the treatment effect between any of the three group comparisons and the outcome of interest (see

[66] Heterogeneity means that there is variability in the data. So, if one brings together different studies for analysing them or doing a meta-analysis, there will be differences found.
[67] To obtain estimates on potential heterogeneities in the treatment effect, the benchmark model is re-estimated but includes interactions of the treatment indicator with indicators of Aboriginal status (defined by the status of the main client of the case), or urbanity, or size of the provider).
[68] Postcodes and regions categorized from www.nsw.gov.au/education-and-training/resources/smart-and-skilled-regions

Panel A).

However, subtle differences emerged by subgroups when allowing for a comparison of differences in magnitude which are meaningful from a practice perspective. Even though there is no statistical significance in the estimated interaction effects, most likely because of large standard errors, the size differences are large. In Panel B, the magnitude of the estimated treatment effects (and their standard error) for each sub-group is presented. While the estimated treatment effect was -2.6 ppt (p<0.01) for non-Aboriginal child clients, it was -5.6 ppt (p<0.01) for Aboriginal child clients (column (1)). This suggests that, even though the group differences were estimated imprecisely, it may well be that FCS was more effective in reducing risk of maltreatment for Aboriginal children than for non-Aboriginal children. The percent reduction in the risk of maltreatment (relative to the mean risk of maltreatment for each group) was -27.4% for Aboriginal clients and -19.1% for non-Aboriginal clients.

While in non-urban areas FCS was not effective in reducing maltreatment risk (-1.3 ppt, not statistically significantly different from zero), it significantly reduced maltreatment risk by 3.86 ppt (p<0.01) in urban areas. In terms of percent reduction in the risk of maltreatment, these numbers indicate that the risk change is only -8.3% in non-urban areas and -28.4% in urban areas, a large difference.

Lastly, the treatment effect was larger in magnitude in absolute terms for providers of smaller size (-3.7 ppt, p<0.10), than in large providers (-2.2 ppt, p<0.05). In terms of risk reduction in maltreatment, these numbers translate into a percent risk reduction of -23.7% for smaller providers and -15.2% for larger providers. This also appears to be a large difference in absolute terms.

While the analyses did not yield statistically significant differences in the impact of FCS by policy-relevant sub-groups, which may be due to the smaller sample sizes, this suggests there were some important trends in treatment effects for subgroups that are revealed only when scrutinizing the magnitude of the impact. In line with key findings from workforce and stakeholder consultations, FCS may have been more effective for clients in urban areas because there are more services available to which FCS can refer clients. Therefore, the needs of the clients can be met faster or more comprehensively. Smaller providers may be better equipped than larger providers to deal with case complexity and thus provide a more tailored approach that reduces greater risks of harm.

Table 7 Heterogeneity analysis – impact of FCS on substantiation by sub-groups

	(1)	**(2)**	**(3)**
	Aboriginality status	by Urban	By size of provider
Panel A: Estimated coefficients of the treatment effect and interaction effect			
FCS met needs	-0.026***	-0.013	-0.037*
	(0.009)	(0.017)	(0.021)
FCS Interaction term with:	Aboriginal status	Urban area	Large provider
	-0.030	-0.026	0.014
	(0.020)	(0.019)	(0.023)

Panel B: Calculated marginal effects for each sub-group			
Estimated treatment effect for:	Non-Aboriginal	Non-urban	Smaller provider
	-0.026***	-0.013	-0.037*
	(0.009)	(0.017)	(0.021)
Mean	0.136	0.156	0.159
Percent change	-19.1	-8.3	-23.7
Estimated treatment effect for:	Aboriginal	Urban	Large provider
	-.0562***	-.0386***	-.022**
	(.0201)	(.011)	(.010)
Mean	0.205	0.136	0.145
Percent reduction	-27.4	-28.4	-15.2
Observations	**5934**	**5934**	**5934**

Note: Table reports coefficients obtained from an extension of the benchmark model used in Table 6, column (1), panel D. The outcome variable is substantiated maltreatment. The treatment is whether FCS met the clients' needs. The treatment indicator is interacted with Aboriginal status (column (1)), whether the client lives in an urban region (column (2)), and whether the client is served by a large provider (column (3)). Panel A reports estimated coefficients of the treatment effect and of the interaction effect between treatment and sub-group (Aboriginal client, urban area, large provider). Panel B reports the calculated treatment effect for each of the two sub-groups. They are interpreted in terms of percentage point reductions in terms risk reduction of substantiated maltreatment. Standard errors were calculated using the delta method using STATA lincom command.

Section 7 – Costs and benefits of FCS

It has been shown in the previous section that FCS was effective in reducing the risk of (substantiated) maltreatment. In this section, cost-benefit calculations are presented for the outcome of maltreatment, as this outcome is considered of greatest policy relevance. These are based on a comparison of the moneterised benefits of reduced maltreatment risk (reduction of the risk of substantiated maltreatment, which also includes ROSH substantiation) with the monetarised cost of delivering the program. Calculations are based on the recommendations of the NSW Government Guide to Cost-Benefit Analysis (2023)[69].

The treatment effect reported in Table 6 (column (1), Panel D) was used as the basis to calculate monetarised benefits of FCS. The costs of the FCS program were calculated with data on program costs sourced from FCS agency financial acquittals in Financial Year 2022/2023, including caseworker or manager involvement in referrals; brokerage costs for families as a result of an FCS assessment; and FCS data collection and entry.

Cost Analysis

Financial Expenditures

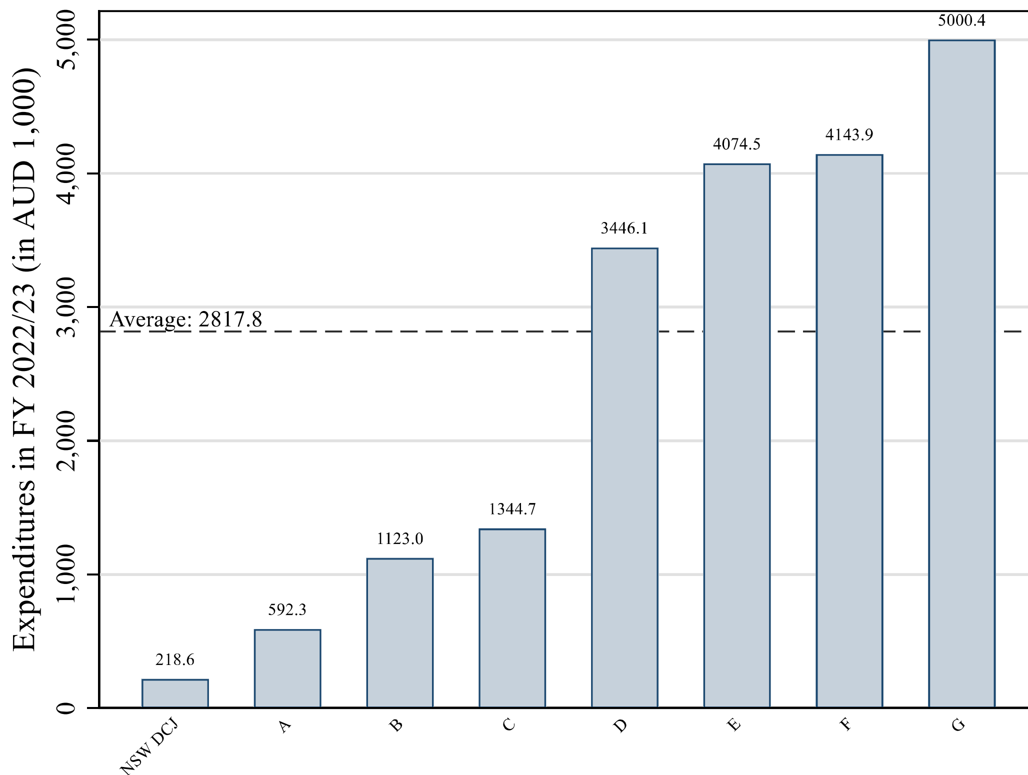
The FCS program is funded by DCJ through block funding. Annually, the seven contracted agencies receive a transfer in line with the previous year's funding. The FCS program expenditure for service provision in FY 2022/2023 was $19.9 million or 0.12% of the total DCJ expenditure ($16.5 billion). FCS providers spent $19.7 million on the FCS program. Program management costs (salaries and on-costs) for DCJ were $214,615 per annum (excluding GST) and $4,000 was spent on DEX licensing (excluding GST).

For the purpose of this evaluation and analysis, FCS provider expenditure records were relied on. Expenditure records differ from the FCS budget in that they represent what FCS providers report as their actual expenditure, whereas the budget is what is paid by DCJ to FCS providers.

The average expenditure per provider per annum was $2,817,818. Almost two out of three dollars (63%) spent were administered by the three largest contracted service providers. The largest provider had an annual expenditure of $5,000,381, and the smallest provider had an annual expenditure of $592,255 (Figure 133) (service provider names anonymised–A-G).[70]

[69] NSW Government Treasury Guidelines (2017), p. ii, downloaded from https://www.treasury.nsw.gov.au/finance-resource/guidelines-cost-benefit-analysis.
[70] Funding amounts vary as providers have different geographical and client number coverage.

Figure 133 Annual reported expenditures for administering FCS in financial year 2022/2023, by agency and provider



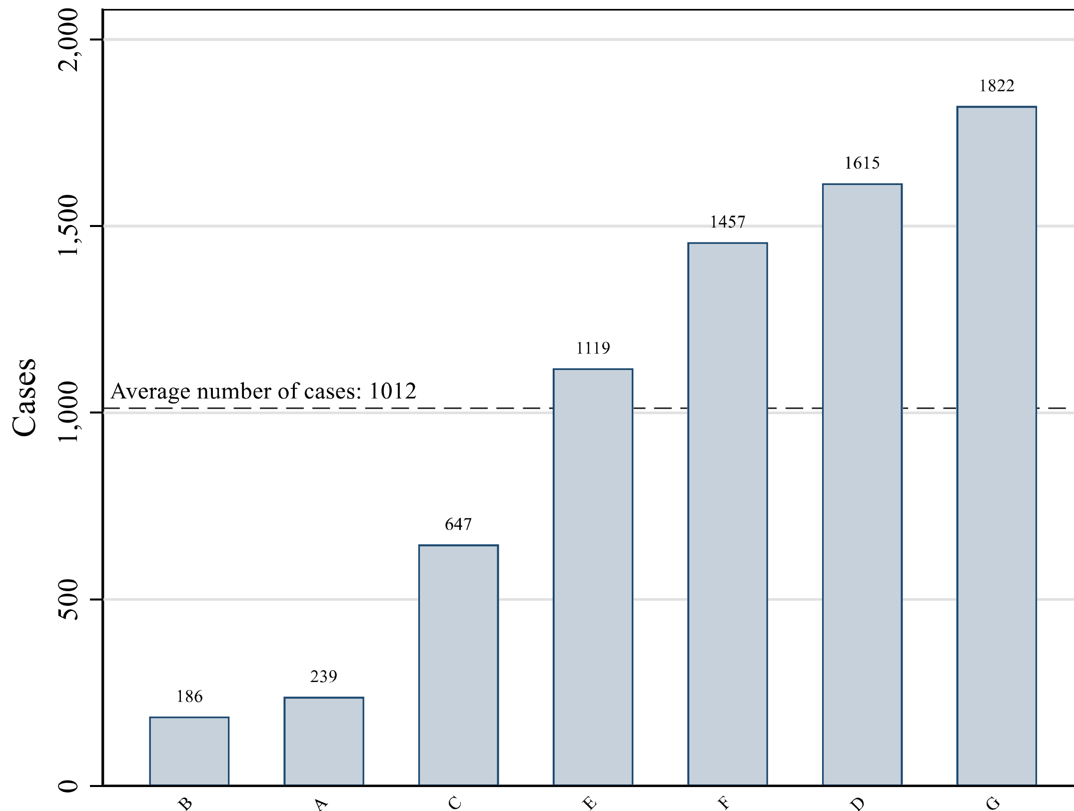
Note. All numbers are expressed for the FY 2022/2023 in $1,000. Expenditures were derived from the FCS providers' annual financial year statements for 2022/2023. Program management costs for DCJ were included as well, where $214,615 per annum (excluding GST) was spent on salaries and on-costs and $4,000 was spent on DEX licensing costs (excluding GST). In total, expenditure for the FCS program was $19.9 million in the financial year 2022/2023, or 0.12% of the annual expenditures of DCJ which reported $16,529,682,000 or $16.5 billion in the Financial Year 2022/2023. The dashed line displays the average expenditure across all providers ($2,817,800). Department of Communities and Justice 2022-23 Annual Report. 2022-23: Volume 2 Audited Financial Statements https://dcj.nsw.gov.au/resources/annual-reports.html. It should be noted that the annual budget of the NSW Government was $116.3 billion. DCJ's expenditures make up 14.2% of the NSW Government total budget.

Cost per case

Costs have been calculated per overall case (including the overhead central administrative costs) and individually for each of the seven providers. The average cost per case was calculated using the expenditure statements of each provider for FY 2022/2023 and the number of cases each provider recorded for the same financial year.

Overall, there were 7,085 cases managed by all providers combined in the FY2022/2023. Providers varied greatly in the number of cases they handled. The largest provider handled 1,822 cases and the smallest provider handled 186 cases (Figure 144, service provider names anonymised–A-G). The average number of cases per provider was 1,012.

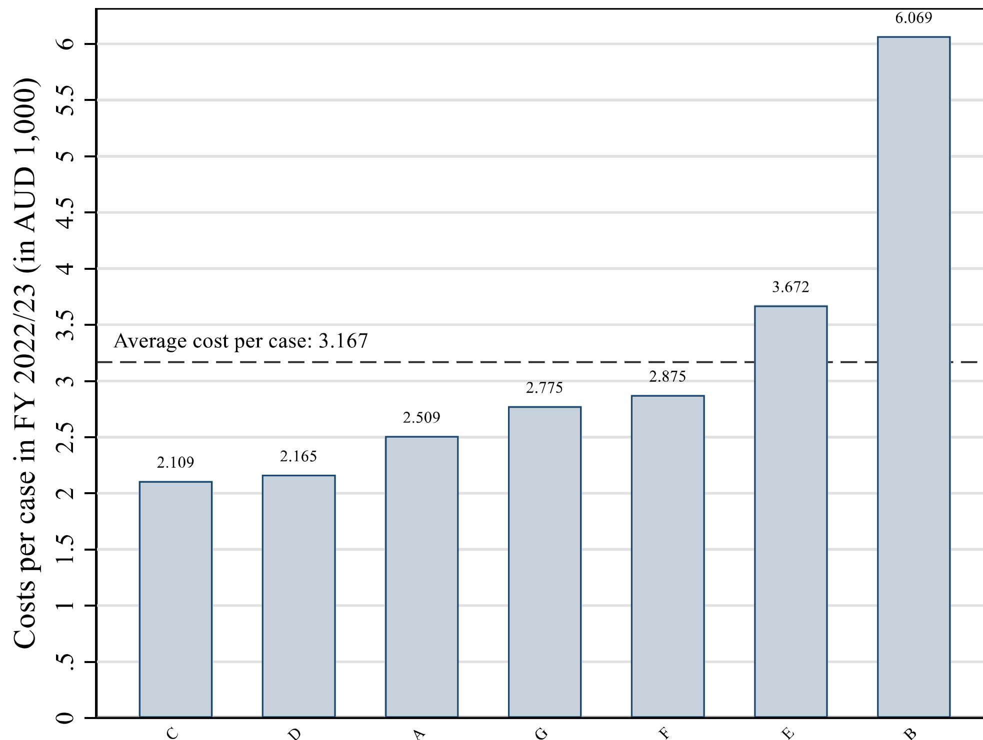
Figure 144 Number of cases in financial year 2022/2023, by provider



Note: This figure reports the number of cases for each provider during the financial year 2022-2023. Dash horizontal line reports the average number of cases across all providers in the same financial year.

By dividing the total expenses (the sum of all expenses for all providers plus the expenses for overhead costs for DCJ) by the total number of cases that were handled by all providers in FY 2022-2023, an average cost per case was $2,814. When allowing for variability in average cost per case across providers, the average cost per case, which was calculated as the average across seven providers, was $3,167 (Figure 155, service provider names anonymised–A-G). The highest cost per case provider was estimated to be $6,069 and the lowest cost per case was $2,109. Two providers had costs per case above the mean, while the remaining providers had costs per case below the mean costs per case of $3,167.

Figure 155 Average costs per case in financial year 2022-2023, by provider



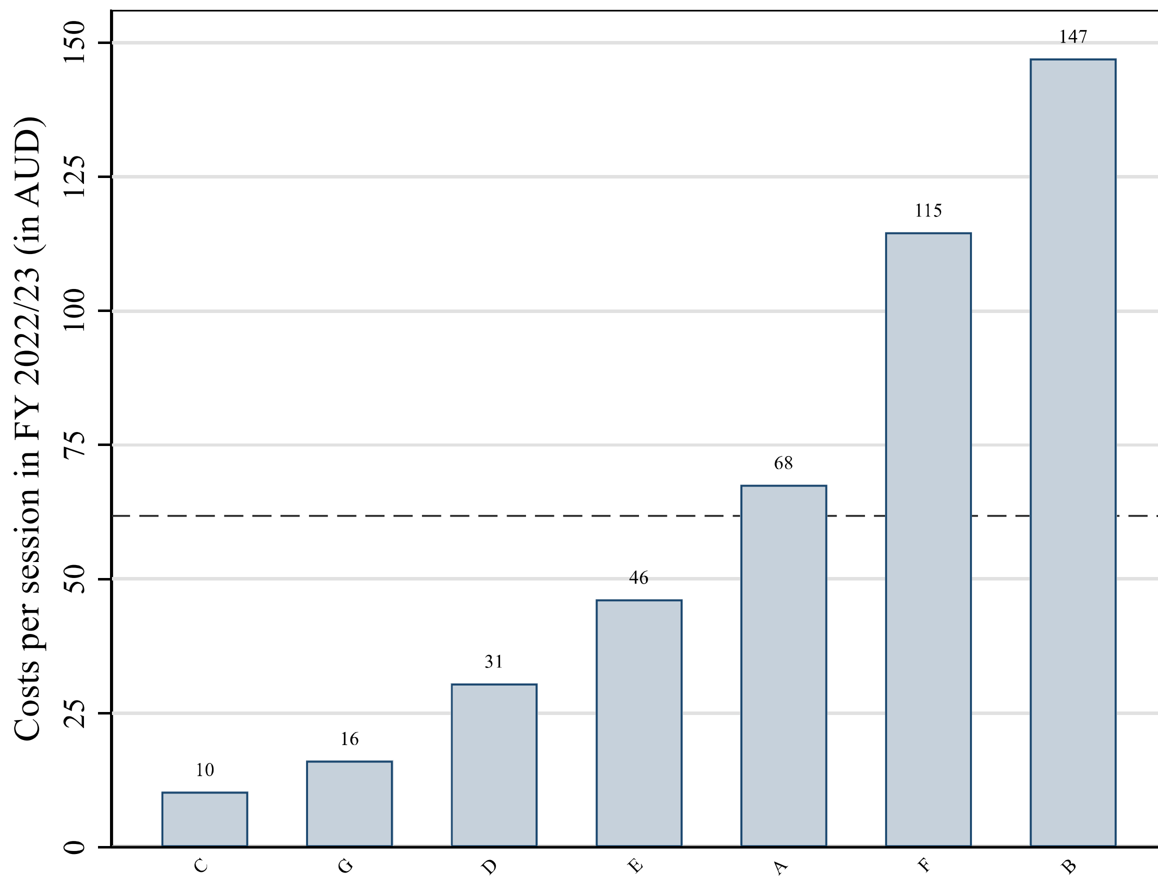
Note: Reported are average costs per case for each provider in $1,000 for FY 2022/2023. Expenditures were derived from the FCS providers' annual financial year statements for 2022/2023 and the number of cases for each provider were calculated for the same financial year. The average cost per case is calculated by averaging the average costs per provider across all seven providers. .

Both treatment and control groups produced costs. To calculate the net cost of FCS delivery and meeting client needs, it is required to generate estimates of the average cost of the treatment group (exited FCS when needs were met) and the average costs of the control group (exited FCS for any other reason). These estimates were produced by calculating the average cost per session and then multiplying this average cost by the average number of session that treatment and control groups offered.

The average number of sessions overall was 89.9, but in the control group it was 49.9 and in the treatment group it was 100.7. The average cost per session across all providers was $61.80, with a minimum of $10.40 and a maximum of $147.10. Three providers had average cost per sessions above the mean of $61.80, while four providers had average costs per session below the mean (Figure 166, service provider names anonymised–A-G).

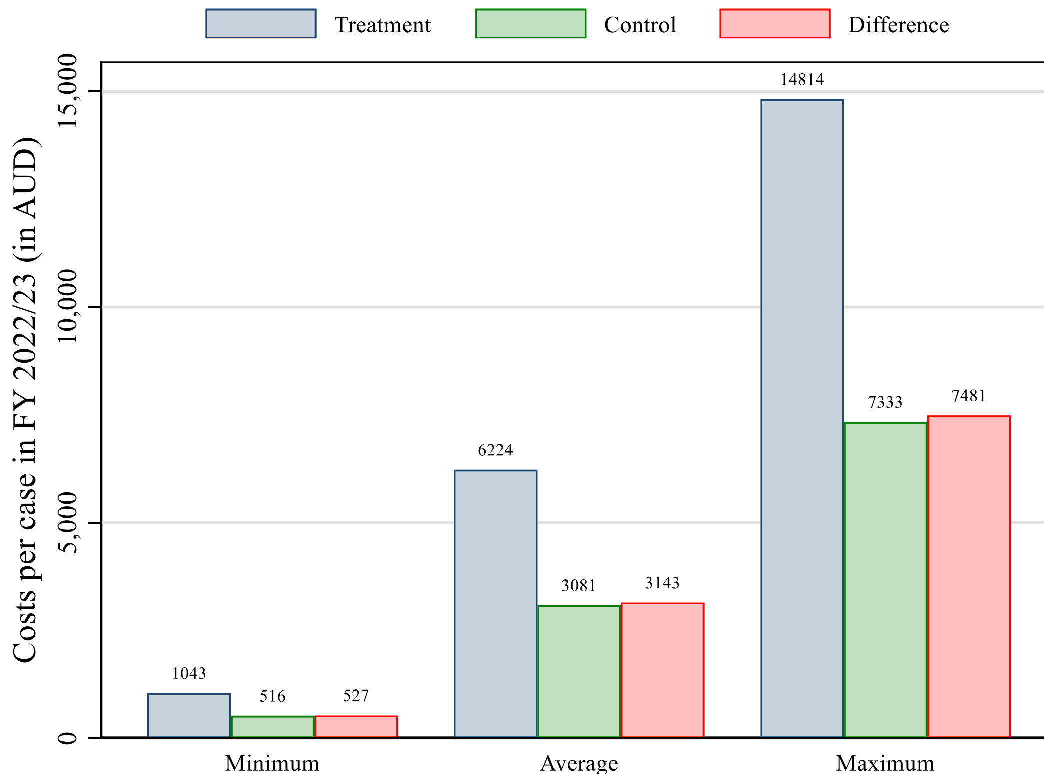
The average cost per case in the treatment group – calculated as the product of 100.7 (rounded) and $61.80 (rounded) – was $6,224 (rounded to the nearest dollar). The average cost per case in the control group – calculated as the product of 49.9 and $61.80 – was $3,081 (rounded). The net cost of delivering FCS successfully, which was defined as meeting the needs of the client, was $3,143 (rounded), which is the difference between $6,224 and $3,081 (Figure 177). The net minimum cost was $527, and the net maximum cost was $7,481. Any inconsistencies are due to rounding errors.

Figure 166 Average costs per session in financial year 2022-2023, by provider



Note: Reported are costs per session rounded to the nearest dollar. The average number of sessions per case across all seven providers was 89.9 with a standard deviation of 70.3, a minimum average number of sessions per case of 25.1 and a maximum average number of sessions per case of 203.8. The average cost per session was calculated as dividing the average cost per case by the average number of sessions per case (across providers and within providers).

Figure 177 Average costs per case by treatment and control group, and average difference in cost per case in financial year 2022-2023



Note: The average cost per case for treatment and control groups was calculated as the average cost per session multiplied by the average number of sessions provided per case of the treatment group (100.7 sessions) and per case of the control group (49.9 sessions). Difference was calculated as the difference in average cost per case of treatment group and the control group. Minimum and Maximum refers to the average cost per case for the provider with minimum costs and the provider with maximum costs, respectively. The difference reports the net cost for achieving a specific outcome through FCS, acknowledging that both the treatment and control groups in FCS incur costs. The costs per case in the control group are about 50% of the costs in the treatment group. Reported costs are in dollars. Any inconsistencies are due to rounding.

Benefit values

The overall economic benefit of the FCS program has been estimated. These benefits are referred to as the total social benefit. The economic evaluation compares the economic cost of the FCS program to its overall economic benefit that emerged through the program's impact on (substantiated) maltreatment risk. The FCS program was estimated to reduce the risk of substantiated maltreatment for clients who exited the FCS program with their needs met, relative to clients who exited the FCS program for other reasons. Economic benefits could accrue both to the system by avoiding costs due to reduced service use and to the client by improving their Quality Adjusted Life Years through the potential reduction in the risk of posttraumatic stress disorder[71].

[71] From the DCJ Benefits Menu: "This is the pain and suffering costs avoided for each incident of trauma resulting in ROSH. Post-traumatic stress disorder is a known potential consequence of child abuse. This pertains to the injury suffered by the child who is subject to abuse." (p. 87)

For the purpose of this evaluation, avoided costs were partially derived from the most current DCJ Benefits Manual (April 2024) and from estimates directly provided by the FACSIAR Economic Evaluation team[72]. These data were used to calculate the Benefit Cost Ratio, according to the NSW Government Guide to Cost-Benefit Analysis[73].

The focus is on the benefit value outcomes recorded in the child protection outcome group and therefore associated with the Safety domain of the NSW Human Services Outcomes Framework[74]. Specifically, avoiding an incident of substantiated maltreatment has a calculated per person per lifetime benefit value in terms of avoided costs to government ($22,659) attributable to expected reduced service use[75] and greater economic benefits to an individual ($44,102) due to avoided trauma[76]. Hence, the overall monetary benefit of avoiding substantiated maltreatment is estimated to be $66,761 per person per lifetime.

Benefit Cost Ratio (BCR)

The BCR of the FCS service is the ratio of the sum of the present value of benefits to the sum of the present value of costs (see p. 97 NSW Treasury Guidelines). A BCR greater than one indicates that benefits outweigh costs:

$$BCR = \frac{\sum_{t=0}^{T} \frac{B_t}{(1+r)^t}}{\sum_{t=0}^{T} \frac{C_t}{(1+r)^t}}$$

In this BCR definition, B_t is the FCS program's benefits less disbenefits (if any) in year t expressed in real terms (i.e., excluding inflation). C_t is the FCS program's costs in year t expressed in real terms (i.e., excluding inflation). r is the real social discount rate (usually assumed to be 0.05), and T is the number of years in the analysis period. Because the evaluation only allows for short term impact evaluation and because only one year of service provision is used as the basis for evaluation, the BCR are calculated for the current time period t=0[77].

This evaluation includes in B_t the avoided costs and the broader economic benefits to the community (arising usually from positive spillovers) that arise from avoiding one case of substantiated maltreatment (see Box 7, NSW Treasury Guidelines). C_t includes all recurrent, capital and ancillary costs of running the FCS program in a given financial year, which are derived from the full expenditure statement of each service provider. The benefits were calculated as the reduced risk of (substantiated) maltreatment in the child population affected by FCS, a number derived from the economic impact analysis. The costs were calculated as the net costs of moving the control group from exiting FCS without having their needs met to exiting FCS with their needs met.

[72] *Source:* FACSIAR Economics (April, 2024). *DCJ Benefits Menu: The financial value of client outcomes*. Sydney: NSW Government.
[73] NSW Government Treasury Guidelines (2017), p. 19, https://www.treasury.nsw.gov.au/finance-resource/guidelines-cost-benefit- analysis
[74] This framework can be accessed at: https://dcj.nsw.gov.au/about-us/nsw-human-services-outcomes-framework.html
[75] This benefit is calculated as the expected avoided cost of future service use. The avoided cost measure is based on a similar calculation as the Menu item SA19 in the 2024 (April) DCJ Benefits Menu. It uses a class of "Family Action Plan or Intensive Preservation" (FAPIP) as proxy for substantiated risk of significant harm available in Child Protection Investment Model. The value is $22,659 and is calculated as the difference (in 2023 dollars) between the discounted expected costs for FAPIP ($30,310 * 1.17 = $35,364) and for a single ROSH report ($10,943 * 1.17 = $12,803). Numbers were provided by the FACSIAR Economics and Evaluation team on 6 August 2024 via email.
[76] This benefit reflects the avoided pain, suffering and trauma resulting from substantiated child abuse. It applies to children with a substantiated instance of child abuse only. It does not apply to children at ROSH.
[77] This implies that the denominator $(1+r)^t$ will become 1.

According to the treatment estimates reported in Section 6, FCS was effective in reducing risk of substantiated maltreatment by 17.2% for those whose needs were met. This treatment effect suggested that for every 5.8 cases, one case of substantiated maltreatment would have been avoided (100/17.2=5.8). The monetarised benefits due to avoided costs and greater economic benefits of one avoided case of substantiated maltreatment is $66,761.

Table 8 presents the BCR for different scenarios of costs and impact estimates that achieve a reduction of one case of substantiated maltreatment. The calculations using the benchmark estimate are presented in column (1), the calculations using the most conservative estimate and least conservative estimate, derived from the sensitivity checks (Appendix Table 6), are presented in columns (2) and (3), respectively. BCRs are presented both using the average net costs and the maximum net costs.

Calculations reveal that the BCR is bounded between 1.1 (most conservative estimate based on the maximum costs observed) and 4.9 (least conservative estimate based on average costs observed). The BCRs are bounded between 3.7 and 1.5 when using the benchmark impact estimate (Panel F, Table 8).

Thus, the results show that for clients whose needs were met in FCS, compared against clients who received some FCS, but whose needs could not be met, FCS was cost effective. The BCR is always greater than 1, with a range of 1.1 and 4.9. This means that every dollar invested in FCS is expected to yield a positive social benefit of between $1.10 and $4.90.

Table 8 Benefit cost ratio calculation for successfully meeting the needs of a client in FCS: Reduced risk of substantiated maltreatment

	Benchmark estimate	**Most conservative estimate**	**Least conservative estimate**
Panel:	**(1)**	**(2)**	**(3)**
[A] FCS treatment effect in percent (%) change	-17.2	-12.8	-23.0
[B] Number of FCS cases needed to reduce 1 event in the child protection or OOHC system Calculated as: 100% | [A]	5.8	7.8	4.3
[C] Net costs per unit FCS ($)	3,143	3,143	3,143
[Net maximum cost ($)]	[7,481]	[7,481]	[7,481]
[D] Total costs for delivering FCS needed to avoid substantiation ($) Calculated as: [B] × [C]	18,229 [43,392]	24,515 [58,352]	13,515 [32,168]
[E] Total social benefits per child per lifetime ($)	66,761	66,761	66,761
[F] Benefit Cost Ratio	**3.7** **[1.5]**	**2.7** **[1.1]**	**4.9** **[2.1]**

[Most conservative BCR based on maximum observed costs] [a] Calculated as: [E] | [D]			

*Note: Social benefits are calculated from the estimated treatment effects of FCS on risk of substantiation (*Table 6*, column (1), Panel D). Estimates are based on a follow-up of 6-12 months post-FCS. Estimates must be considered in the short run, while social benefits are calculated on a lifetime basis. Net costs per case were calculated as the difference between average costs in the control group and average costs in the treatment group calculated for the financial year 2022-2023. [a]Numbers in brackets are based on net maximum (*$7,481*) costs (difference between treatment and control group when FCS was delivered by the highest cost provider).*

Section 8 – Conclusion

Overall, the qualitative and quantitative components of the FCS evaluation found there is strong and consistent evidence that the FCS program is performing well and meeting family needs. The evaluation affirmed FCS as a critical referral pathway and service for families. FCS is a highly valued program across NSW, offering a unique service delivery that is not duplicated by other programs.

The process evaluation, based on surveys, interviews and focus groups across FCS staff, stakeholders and clients, reported the core strengths of the FCS program to be its flexible model design, broad eligibility criteria and active holding component. FCS is seen as a critical element for a well-functioning child and family services system, that can prevent issues from escalating to the point of child removal. Providing families with free, voluntary and non-statutory early intervention support fills a gap in the service system. Stakeholders also valued the role FCS providers played in their unique and extensive knowledge of local service sectors across NSW.

The consultations conducted during the evaluation indicated that the program changes made during the transition from FRS to FCS have made a positive difference. The key benefits were associated with the broader inclusion criteria for service eligibility, introduction of more flexibility in the range of support offered, and greater effort made to connect families with a wider range of services. Flexibility of the program was noted as one of its key strengths as it allows staff to respond to the needs of families in targeted and purposeful ways. When referral services were unable to allocate resources, or have long waitlists, they highly valued the ability of the FCS program to provide support to families in the interim, including an assessment of their needs.

Advocacy and case coordination were features of the program that were highly valued by families. Being relieved of the need to repeat their story with a range of different service providers, and potentially reliving traumatic experiences, was described as lifting a burden from them. Providing a timely non-statutory pathway, when families most need it, can have a significant impact which can assist in diverting families from more intrusive interventions. While some families commented that the timeframe for the FCS service should be more flexible due to long wait times for services, this could put pressure on FCS staff workloads and their ability to accept inbound referrals if they continue to actively hold clients beyond the 16-week program duration threshold.

The main challenge for the FCS program, raised by everyone consulted, is the systemic and pervasive service gaps in early intervention and specialist services. Long waitlists and limited service availability impacted on the ability of FCS to effectively refer families to the supports they needed. Brokerage funds were deemed insufficient to source and sustain private services for clients when public services were not available. These service gaps were more pronounced for FCS providers servicing regional and remote communities. Any further roll-out of the FCS program should be considered within the context of the available services within the catchment area and the capacity of the local early intervention service system.

Evidence from the outcomes evaluation indicates that families who receive FCS services and exit with needs met (compared to families who exit FCS services without needs met) are less likely to have contact with the statutory child protection system within the 6-18 month window of observation. An analysis was conducted with 5,934 FCS child clients who entered

and exited FCS between February 2022 and January 2023. Children in cases with needs met were 7.7% less likely to have a contact with statutory child protection system post-FCS; 7.4% less likely to be reported as ROSH at the Helpline; 10.7% less likely to be investigated for an allegation raised at the helpline; 17.2% less likely to be substantiated for maltreatment; and 37% less likely to be substantiated for exposure to domestic violence. All treatment effects were statistically significant at least at the 5% significance level. A series of robustness checks ensured that the estimates were insensitive to sample definitions, additional controls and control group definitions, which provides some assurance that the impact estimates are not spurious.

The benchmark estimate suggests that for every 5.8 FCS cases, which manage to help clients to meet their needs, one child client will avoid (substantiated) maltreatment in the short term. This number is relatively robust, varying across alternative models between 4.3 FCS cases (least conservative estimate) and 7.8 FCS cases (most conservative estimate).

The evaluation also assessed whether specific service components – including case plan completed, information, advice or referral, brokerage or active holding – of the FCS model were effective in reducing risk of harm. This exercise showed that there were almost no statistically significant impacts on risk of harm reductions by individual service components. This finding suggests the positive outcomes for families were attributable to the program as a whole, rather than a specific service type. The only exception was that receipt of family capacity building, a service type that helps families to establish better relationships within their families, appeared to have reduced a child's risk of exposure to family violence. The treatment effects were not small in effect size, suggesting that helping families to strengthen their relationships has, at least in the short term, quantifiable benefits in terms of children's safety.

There were no statistically significant differences in interaction effects to indicate that FCS has differential effects by sub-group indicators (Aboriginal vs non-Aboriginal; urban vs remote; small vs larger providers). However, statistical insignificance does not necessarily mean there are not meaningful differences from a practice perspective. Large standard errors and small sample sizes of the subgroups may have caused statistically insignificant interaction effects, even though the absolute size of the interaction effect may have implied large magnitude differences between the groups considered.

This was the case in this evaluation. When translating the interaction effects into risk reduction estimates for each group, it was found that reduction in risk for avoided substantiation was greater *in magnitude* for Aboriginal children (-27.4%) than non-Aboriginal children (-19.1%), for clients in urban areas (-28.4%) than clients in more rural areas (-8.3%), and clients served by smaller providers (-23.7%) than clients served by larger providers (-15.2%).

These tentative findings align with reports from FCS providers covering large rural areas about the challenges of connecting families with services due to limited availability of services. Benefits of FCS participation were not linked to receipt of specific service types, but rather were linked with having needs met or having a case plan completed. Smaller providers may be better equipped to cater directly to the needs of their clients.

Using the benchmark impact estimates for risk of substantiation, and the cost and benefit estimates, it was estimated that FCS was cost effective for families whose needs were met

when considering the downstream benefits of reduced substantiated maltreatment. The average cost per case across all providers, including the overhead costs to DCJ, was $3,167 per case. The range for these costs were from a minimum value of $2,109 and to a maximum value of $6,069 per case. The costs of operating the FCS program is within the ballpark of the operating costs reported by KPMG for the FRS program (part of the *Keep Them Safe* initiative)[78]. KPMG found that that the FRS program cost $4,010 per family that accessed an outbound service provider, with considerable variation in the cost within and across service categories. For instance, information-only service costs ranged between $201 and $1,734; the cost for a simple referral (to one provider) ranged between $780 to $3,326; and complex referral costs ranged between $1,482 and $3,206. Within FCS, each session was estimated to cost on average $61.80, with a minimum of $10.40 and a maximum of $147.10, which is cheaper than the average service cost under FRS and cheaper than the average cost of a standard Medicare rebated visit at the GP ($84).

The Benefit Cost Ratio calculations suggest that for every dollar spent on FCS, there is a return of investment of $3.70 (based on average costs) or $1.50 (based on maximum costs). Allowing for conservative and less conservative estimates, the calculations generate BCRs that range between 1.1 and 4.9. These numbers say that FCS has quantifiable social benefits measured by the monetarised value of reduced pain (experienced by the child) and the avoided costs to government by reducing costs for staff members to prevent further harm to children at risk.

Are these estimates reliable? The impact and economic analysis has to be understood within the context of the statistical model and its strong assumptions made to derive these conclusions. The statistical model controlled for a child's latent risk of being harmed in a variety of ways. But the proxies used for innate risk may be noisy or weak. Although a range of estimates were presented, the evaluation team recommends caution in interpreting the results as strictly causal. The presented BCRs are considered as upper bounds, which means they represent the maximum possible impact. It is strongly recommended that future program evaluations are planned before a new program is implemented. Program rollout strategies should be chosen based on internationally recognized ways that facilitate a more reliable strategy for causal impact evaluation (e.g., randomized controlled trial, lotteries to grant access to scarce resources).

Importantly, the overall conclusion from this mixed-method evaluation is that the FCS program seems to be functioning well overall to achieve its intended goal of supporting children, young people and families and preventing their issues from escalating to the point of statutory child protection involvement. Fine-tuning the model should include consideration of how families with complex needs are served. FCS providers hold significant risk yet have limited access to referral pathways to DCJ-funded services, and this should be addressed. Greater resource allocation to the FCS program would enable providers to better meet the needs of clients, including by enhancing staff capacity for assertive outreach and meeting immediate client needs through brokerage funding. However, service outcomes are reliant on FCS providing families with referrals to services that can meet their needs, and these social services are unevenly distributed throughout the state.

It is critically important for NSW Government to consider broader investments in the infrastructure of family preservation and other support services across the state, including in

[78] KPMG Government Advisory Services (2013). *Evaluation of the Family Referral Services: NSW Kids and Families.* https://www.health.nsw.gov.au/parvan/childprotect/Documents/frs-evaluation-report.pdf

rural and regional areas, so that FCS providers can make timely and appropriate outbound referrals to local services. Such investments have the potential to keep children safe, families intact and communities strong by effectively resourcing and supporting families.

Appendices

Appendix Table 1 Program logic (August 2022)

CURRENT SITUATION	ACTIVITIES AND SERVICES	EVIDENCE	OUTPUTS	THEORY OF CHANGE	CLIENT OUTCOMES
The number of child protection helpline reports continues to rise and less than one-third of children reported at Risk of Significant Harm (ROSH) receive a face-to-face assessment (Donnelly Inquiry, 2017; Tune Review 2016). Reviews of the NSW child protection system between 2008 and 2019 consistently highlight that there is inadequate investment in early intervention services to support families to address their complex needs and vulnerabilities to prevent contact with statutory child protection and entries into OOHC (Wood 2008; Tune Review 2016; Donnelly Inquiry 2017; Family is Culture 2019). The following cohorts (Stronger Communities Investment Unit 2018 Insights Report) are more at risk of entering the NSW statutory child protection system. • Aboriginal children, young people & their families • Children aged 0-5 years • Children and young people affected by mental illness Commonwealth and NSW Governments have committed to reduce overrepresentation and increase access to early intervention for Aboriginal families (Closing the Gap, 2020; FACS Aboriginal Outcomes Strategy, 2017-2021). In addition, families with vulnerable young children 0-5 and young people affected by mental illness have been identified as priority populations (Stronger Communities Investment Unit 2018 Insights Report). Families have needs that cross government silos (e.g. economic, health, housing, education, safety) and attempts to coordinate services across agencies have failed to improve their outcomes (Tune Review, 2016). The current service system is complex and difficult to navigate, with inconsistencies in service provision and entry points across geographic locations. This makes it difficult for families to access the supports available to them (TFM Access Services Redesign, 2019).	**Proactive outreach** • Outreach into universal settings, home visits and cold calling to better reach families. • Anyone who presents to FCS will be provided with support if they are not already engaged with the statutory child protection system. **Holistic assessment** • Timely needs and strengths-based assessment. • Whole-of-family lens, trauma-informed and culturally safe. • Tiered support model tailored to client needs. **Timely and warm referrals** • Intake and referral gateway into local services and supports, with support to navigate the system. • Culturally appropriate information and referrals. • Advocating for client access to services, arranging services and introducing clients to the referral agency. • Active outbound contact with families and/or outbound agencies to learn if family's needs have been met/whether further support is required. **Active holding & flexible brokerage** • Check ins and support to families, including practical supports and use of brokerage, home visits, follow up with services – until a suitable service can be accessed. • Brokerage funding where presenting issues can be quickly addressed through practical assistance. **Family-led decision making** • Meetings with families are strengths-based and encourage family decision-making and responsibility about the services with which they engage • Informal supports within the family as well as formal supports are identified and engaged in partnership with the family • Referral to a formal Family Group Conference or convening a Family Group Conference where appropriate. **Whole-of-family case coordination and planning** • Dedicated case coordination and a single point of contact for the family. • Individualised, single case plan that can move with the family. • Case conferencing meetings with the family's service providers to facilitate coordination of service provision.	Available evidence on effective and targeted early intervention can significantly impact the developmental outcomes, and in turn, life trajectories of children, families and communities. Research shows that enablers of success and specific service features of interventions include: soft entry points; flexible approaches that respond to individual needs; strengths-based approaches; and community- driven and culturally appropriate design'. Consultations with the child and family sector, in the FCS redesign process, highlighted the effectiveness of identifying, engaging and referring families to services before their situation escalates. The FCS model builds upon the strengths of the longstanding NSW Family Referral Services, that were implemented as part of the Keep Them Safe Reforms. These strengths include: * Information & advice to help family's navigate the service system * Warm referrals * Brokerage funds * Assertive outreach The core component 'Engagement' is critical to preventing child abuse and neglect (DCJ Evidence Portal: Preventing Child Maltreatment Evidence Review). Engagement activities include building trust and being flexible in delivery to meet the needs of clients. How services engage with families is crucial to ensuring parents/carers participate and remain in a program. In the case of FCS, families' support needs are meet and they are effectively engaged and connected with the appropriate services through warm referrals. Evidence shows 'Engagement' is most effective when practitioners also: * Build a positive relationship with families by fostering a trusting and caring partnership built on empathy respect and open communication, and *Actively work with families to overcome barriers to their participation(DCJ Evidence Portal: Preventing Child Maltreatment Evidence Review 2022). Engagement is important in ensuring families receive referral to other support services that	• Number of families effectively contacted by the service/ service type received. • Number of client responses delivered across the response type 1 to 4 based on case complexity and time engaged with service. • Number of clients reached from priority target groups. • Number of outbound referrals to a variety of referral agencies. • Number of families who receive an assessment. • Number of families who have accessed brokerage. • Number of families who are satisfied with the service they receive. • Number of case conferencing meetings convened. • Number of clients who needed and received active holding and short-term case management. • Number of community outreach activities delivered e.g., attending interagency meetings, attending community events. • Number of clients who were ineligible and received a referral to another appropriate service. • Number of practical supports provided through brokerage and/or appropriate referral (by type of support required e.g., education. DFV, finance, housing, and health)	Through early access to service and support, families can build their own capabilities to meet their goals and safely care for their children. This is achieved by increasing a family's knowledge of services and supports that may help their ability to engage in appropriate services, leading to increased empowerment and family functioning.	**Families engage with Family Connect and Support.** **Families identify their needs, through assessment considering the 8 NSW Human Services Outcomes Framework domains (economic, family relationships, education and skills, safety, home, health and empowerment).** **Families are provided with culturally appropriate service information and referrals.** **Families have increased knowledge of the services and supports available to them.** **Families have improved resourcefulness to meet their needs.** **Families are empowered to engage with services which support their needs.** **Families feel heard, understood and respected when engaging with the FCS.** **Children are safe within their families with reduced risk of entry into the child protection system.** **Families, children and young people's mental health and wellbeing are improved.**

		provide: case management; parental education, coaching and modelling; parental self-care and personal development; and building supportive relationships and social networks (DCJ Evidence Portal: Preventing Child Maltreatment Evidence Review).			

[i] Their Futures Matter (TFM), 2018, *Access Systems Redesign: Evidence Review.*, Sydney: State of NSW.

Appendix 1 FCS Evaluation - Interview guide for families

Introduction/consent

- We are evaluating the Family Connect and Support service. The Family Connect and Support is a free and voluntary service that aims to connect families with the right services and supports at the right time. I want to talk to you about the support you received as part of the service.
- The NSW Department of Communities and Justice funds non-government organisations to deliver the Family Connect and Support service. They are also funding this research study.
- This is an independent evaluation of the Family Connect and Support service which means our evaluation team has been employed by the Department to do the evaluation for them.
- Our interview is completely private and confidential. No one else will know you took part in an interview. No one at the organisation you received the Family Connect and Support service from and no one at the NSW Department of Communities and Justice will know you took part. The only time I might need to tell anyone else what you've said is if you were to tell me that you or anyone else is unsafe. I would talk this over with you before I did anything about it.
- Interview will take about an hour.
- You can take a break or stop at any time – I will check that you are OK to continue every now and again.
- I'd like to record the interview, so that I can really listen to you instead of having to take notes and afterwards, we can be sure that we have a true record of what you have said. Is this OK?

Obtain signed and verbal consent.

Introduction screener

1. Before we start, do you identify as Aboriginal or Torres Strait Islander? Are you living on Country? [If yes, use version for Aboriginal families]
2. Do you identify as being from a culturally diverse background?
    - Do you speak another language at home? Which language? [Offer interpreter]
    - Were you born overseas? Which country were you born in?
    - [If yes to any of the above, use version for CALD families].

Interview guide for non-Aboriginal, non-CALD families

1. Could you tell me the name of the organisation that provided you with the Family Connect and Support service?
2. Could you tell me what you think the Family Connect and Support service provides to families?
3. Could you tell me a little bit about your family e.g. do you have any children living with you?
4. What were the main reasons you started working with the Family Connect and Support service at [organisation]? (Prompts: financial, education, safety, housing, health and mental health, understanding how to receive support). Did any other issues come up around this time?
5. Could you tell me a little bit about how you became involved in the Family Connect and Support service at [organisation]? (Prompts: were you referred and by who? Did an FCS worker reach out to you directly by phone, or visit you in your home?) How long were you involved with FCS? (Prompt: Did you think that was long enough? Why?)
6. Was the FCS service able to help you to address your concerns and connect you with appropriate support? If so, how?
   (Prompts: timely support, accessible referral services)
7. Did you make a family plan?
   1. Did a worker at [organisation] involve you and your family and support network in developing the plan? What was that like?
   2. Do you think the goals in the plan were achievable? Was the timeframe long enough to achieve these goals?
   3. How were you supported to reach your goals? (e.g. did worker check in with you regularly? Did you have a meeting to identify supports? Did they help you pay for something you needed at the time?)
8. What kind of information were you given about how you could connect with support services in your community? (Prompt: Format – e.g. leaflets, contact numbers, verbal advice, advice in writing; Domain of support – e.g. health, housing, education, family violence)
   1. Was this information relevant for you and your family?
9. Did a worker at [organisation] refer you to or organise any other services for you?
   1. Where did they refer you to? (What kind of services)
   2. How useful were these referrals?
   3. How did you get in touch with the other service? Did the FCS worker arrange this for you? (E.g. gave you a written referral, introduced you to a worker at the other service, held a meeting between you and the other service?)
10. What was your experience like at the service you were referred to? (e.g. were you able to get the support you wanted? Were there any wait times to get into the service? Did the FCS worker stay in touch with you while you were waiting? How

would you describe your relationship with staff in the service? (Prompts: feeling heard and understood, respected)

    1. Was your relationship with staff different to any previous experiences you have had? Are there any ways it could be improved?

11. Was there anything you were frustrated with when using the FCS service? Are there any ways you think the service could be improved?
12. Did the service help you meet any of your goals or address your concerns? (Economic, education and skills, safety, home, health (physical and mental), community and empowerment).
    1. Can you tell me about any positive changes that have happened since you used the Family Connect and Support service? (Prompts: learning where and how to get support, practical or emotional support)
    2. Did the service help you to achieve any positive changes?
    3. What helped to support you? How was it different to other support you have received before? What else could have helped?
13. Would you feel more confident to reach out for support in the future? (Prompts: knowing where and how to get support, knowledge of local services in your area, knowing I can come back to FCS if I need help)
14. If you needed to, would you use the FCS service again in the future?
15. Would you recommend this service to other families? Why, why not?
16. Do you think families in your community know about FCS? Can you think of any ways they could find out about it?
17. What do you think would be the best way of getting feedback from families about their experiences with FCS and any changes they experienced as a result of the service? (Prompts: Type – short survey, interview; method – text message, phone call, in-person; who – FCS worker or someone else).
18. Preferred gift card and email address

Interview guide for Aboriginal families

1. Could you tell me the name of the organisation that provided you with the Family Connect and Support service?
2. Could you tell me what you think the Family Connect and Support service provides to families?
3. Could you tell me a little bit about your family e.g. do you have any children living with you?
4. What were the main reasons you started working with the Family Connect and Support service at [organisation]? (Prompts: financial, education, safety, housing, health and mental health, understanding how to receive support). Did any other issues come up around this time?
5. Could you tell me a little bit about how you became involved in the Family Connect and Support service at [organisation]? (Prompts: were you referred and by who?
    1. Did an FCS worker reach out to you directly by phone, or visit you in your home?)
    2. How long were you involved with FCS? (Prompt: Did you think that was long enough? Why?)
6. Was the FCS service able to help you to address your concerns and connect you with appropriate support? If so, how?

(Prompts: timely support, accessible referral services, culturally aware and responsive)

7. Did you make a family plan?
    1. Did a worker at [organisation] involve you and your family, kinship and support network in developing the plan? What was that like?
    2. Do you think the goals in the plan were achievable? Was the timeframe long enough to achieve these goals?
    3. How were you supported to reach your goals? (e.g. did worker check in with you regularly? Did you have a meeting to identify supports? Did they help you pay for something you needed at the time?)
8. What kind of information were you given about how you could connect with support services in your community? (Prompt: Format – e.g. leaflets, contact numbers, verbal advice, advice in writing; Domain of support – e.g. health, housing, education, family violence)
    1. Was this information relevant to you and your family?
    2. Did you feel like the information given to you was culturally aware and responsive?
9. Did a worker at [organisation] refer you to or organise any other services for you s?
    1. Where did they refer you to? (What kind of services)
    2. How useful were these referrals? (Prompt: Were these culturally aware and responsive)
    3. How did you get in touch with the other service? Did the FCS worker arrange this for you? Did that work for you? (E.g. gave you a written referral, introduced you to a worker at the other service, held a meeting between you and the other service?)
    4. What was your experience like at the service you were referred to? (e.g. were you able to get the support you wanted? Were there any wait times to get into the service? Did the FCS worker stay in touch with you while you were waiting?
10. How would you describe your relationship with staff in the service? (Prompts: feeling heard and understood, culturally responsive and respected)

    1. Was your relationship with staff different to any previous experiences you have had? Are there any ways it could be improved? (e.g. was an Aboriginal staff member available)
    2. Did staff ask you about your culture? Did they demonstrate respect for your culture?

11. Was there anything you were frustrated with when using the FCS service? Are there any ways you think the service could be improved?
12. Did the service help you meet any of your goals or address your concerns? (Economic, education and skills, safety, home, health (physical and mental), community and empowerment).
    1. Can you tell me about any positive changes that have happened since you used the Family Connect and Support service? (Prompts: learning where and how to get support, practical or emotional support)
    2. Did the service help you to achieve any positive changes?
    3. What helped to support you? How was it different to other support you have received before? What else could have helped?
13. Would you feel more confident to reach out for support in the future? (Prompts: knowing where and how to get support, knowledge of local services in your area, knowing I can come back to FCS if I need help)
14. If you needed to, would you use the FCS service again in the future?
15. Would you recommend this service to other families? Why, why not?
16. Do you think families in your community know about FCS? Can you think of any ways they could find out about it?
17. What do you think would be the best way of getting feedback from families about their experiences with FCS and any changes they experienced as a result of the service? (Prompts: Type – short survey, interview; method – text message, phone call, in-person; who – FCS worker or someone else).
18. Preferred gift card and email address

Interview guide for CALD families

1. Could you tell me the name of the organisation that provided you with the Family Connect and Support service?
2. Could you tell me what you think the Family Connect and Support service provides to families?
3. Could you tell me a little bit about your family (Prompts: do you have any children living with you? Do any other family members live with you? How long have you lived in Australia? What type of visa do you hold?)
4. What were the main reasons you started working with the Family Connect and Support service at [organisation]? (Prompts: financial, education, safety, housing, health and mental health, understanding how to receive support). Did any other issues come up around this time?
5. Could you tell me a little bit about how you became involved in the Family Connect and Support service at [organisation]? (Prompts: were you referred and by who?)
    1. What is your understanding about your involvement with FCS? (Prompt: do you know why you were referred there?)
    2. Did an FCS worker reach out to you directly by phone, or visit you in your home? What was that like?
    3. Were you offered an interpreter?
    4. How long were you involved with FCS? (Prompt: Did you think that was long enough? Why?)
6. Was the FCS service able to help you to address your concerns and connect you with appropriate support? If so, how? (Prompts: timely support, accessible referral services, culturally aware and responsive)
7. Did you make a family plan?
    1. Did a worker at [organisation] involve you and your family in developing the plan? What was that like?
    2. Do you think the goals in the plan were achievable? Was the timeframe long enough to achieve these goals?
    3. How were you supported to reach your goals? (e.g. did worker check in with you regularly? Did you have a meeting to identify supports? Did they help you pay for something you needed at the time?)
8. What kind of information were you given about how you could connect with support services in your community? (Prompt: Format – e.g. leaflets, contact numbers, verbal advice, advice in writing; Domain of support – e.g. health, housing, education, family violence)
    1. Was this information relevant to you and your family?
    2. Was this information culturally aware and responsive? Was any of the information they gave you culturally inappropriate or insensitive?
    3. Did you understand all the information that was given to you?
    4. Do you think any of the information could have been better communicated to you?
9. Did a worker at [organisation] refer you to or organise any other services?
    1. Where did they refer you to? (What kind of services)
    2. How useful were these referrals?
    3. How did you get in touch with the other service? Did the FCS worker arrange this for you? Did that work for you? (E.g. gave you a written referral, introduced you to a worker at the other service, held a meeting between you and the other service?)

   4. Were the services you were referred to culturally aware and responsive?
   5. Do you know of any culturally-specific services that could have better supported you and your family?
   6. What was your experience like at the service you were referred to? (e.g. were you able to get the support you wanted? Were there any wait times to get into the service? Is there anything important for you about your culture that you wish the service knew)

10. How would you describe your relationship with staff in the service? (Prompts: feeling heard and understood, culturally responsive and respected)
    1. Was your relationship with staff different to any previous experiences you have had? Are there any ways it could be improved? (e.g. was an Aboriginal staff member available)
    2. Did staff ask you about your culture? Did they demonstrate respect for your culture?
11. Was there anything you were frustrated with when using the FCS service? Are there any ways you think the service could be improved?
12. Did the service help you meet any of your goals or address your concerns? (Economic, education and skills, safety, home, health (physical and mental), community and empowerment).
    1. Can you tell me about any positive changes that have happened since you used the Family Connect and Support service? (Prompts: learning where and how to get support, practical or emotional support)
    2. Did the service help you to achieve any positive changes?
    3. What helped to support you? How was it different to other support you have received before? What else could have helped?
13. Would you feel more confident to reach out for support in the future?? (Prompts: knowing where and how to get support, knowledge of local services in your area, knowing I can come back to FCS if I need help)
14. If you needed to, would you use the FCS service again in the future?
15. Would you recommend this service to other families? Why, why not?
16. Do you think families in your community know about FCS? Can you think of any ways they could find out about it?
17. What do you think would be the best way of getting feedback from families about their experiences with FCS and any changes they experienced as a result of the service? (Prompts: Type – short survey, interview; method – text message, phone call, in-person; who – FCS worker or someone else).
18. Preferred gift card and email address

Appendix 2 Quantitative analysis

The Estimation Model

The statistical model can be described as follows:

Equation 4

$$Y_{i,c,p,t+1} = \alpha + \beta FCS_{i,c,p,t} + Client'_i\gamma + Provider'_p\delta + Case'_c\delta + \theta_1 Y_{i,c,p,t} + \\ + \theta_1 Y_{i,c,p,t-1} + \varepsilon_{i,c,t+1,p}.$$

The variable $Y_{i,c,p,t+1}$ measures the outcome of interest for child client i, at time *t+1, in case c,* at provider p. This outcome is a binary indicator of whether the child had contact with the statutory child protection system post-FCS (any contact, ROSH report, investigation, substantiation, substantiation for domestic violence). The binary indicator variables $FCS_{i,c,p,t.}$ measures treatment, which takes the value 1 if the client was treated (e.g., exited FCS with needs met) in time period *t,* and 0 otherwise (e.g., exited FCS with unmet needs). The characteristics that are specific to the client have been controlled for, the case, the provider, and the client's past dynamics in the statutory child protection system. These are as follows:

1. $Client'_i$: Whether client is female (0, 1); whether client is coded as Aboriginal (0, 1), age at session of FCS (range 0-17); whether client has a disability and which type of disability (if available), and long-term cumulative exposure to the statutory child protection system (total number of substantiations, total number of ROSH reports since 1999).
2. $Provider_p$: indicator variables for the agency that delivered FCS
4. $Case'_c$: Whether case involved a priority cohort, whether case is complex, (any disability in case and any of the three concerns: employment, mental health, housing); sessions per case, clients per case, whether case reached the maximum of 16 weeks, and indicator variables for the start month of FCS, and the primary reason for seeking assistance.
5. Statutory child protection contact dynamics $Y_{i,c,p,t}$, $Y_{i,c,p,t-1}$: Had contact with system during and before FCS, respectively.

Of main interest is the estimate on β, which describes the causal relationship between FCS treatment and the outcome of interest under the assumption that treatment is not related to any remaining unobservable factors that are captured in the error term $\varepsilon_{i,c,t+1,p}$. The estimated coefficient on β can be interpreted as causal under the *conditional independence assumption*. This assumption states that there are no unobservable factors captured in $\varepsilon_{i,c,t+1,p}$ that correlate both with treatment and the outcome of interest.

Appendix Table 1 Summary Statistics of clients in the FCS program

	(1)	(2)	(3)
	Client population		
	All	**Adults**	**Child/Youth**
	Mean or Proportion (Std. dev.)	**Mean or Proportion (Std. dev.)**	**Mean or Proportion (Std. dev.)**
Male	0.382	0.254	0.501
	(0.486)	(0.435)	(0.500)
Aboriginal	0.275	0.240	0.307
	(0.446)	(0.427)	(0.461)
CALD	0.018	0.030	0.006
	(0.132)	(0.172)	(0.078)
Youth (< 18 years)	0.516	0.000	1.000
	(0.500)	(0.000)	(0.000)
Birth year	1998.737	1983.549	2012.926
	(16.876)	(10.750)	(5.056)
Age at session	22.879	38.086	8.638
	(16.929)	(10.893)	(4.947)
Any disability	0.135	0.113	0.157
	(0.342)	(0.316)	(0.363)
Learning disability	0.032	0.012	0.051
	(0.176)	(0.110)	(0.219)
Disability, type not stated	0.129	0.141	0.118
	(0.336)	(0.348)	(0.322)
Psychiatric disability	0.088	0.082	0.093
	(0.283)	(0.275)	(0.291)
Sensory disability	0.014	0.002	0.025
	(0.117)	(0.045)	(0.156)
NDIS eligible	0.046	0.031	0.059
	(0.209)	(0.174)	(0.236)
Priority cohort	0.405	0.207	0.590
	(0.491)	(0.405)	(0.492)
Client is support person	0.016	0.017	0.016
	(0.127)	(0.128)	(0.127)
Client state is NSW	0.999	0.999	0.999
	(0.035)	(0.036)	(0.034)
Education: pre-primary	0.124	0.001	0.233
	(0.330)	(0.026)	(0.423)
Education: primary	0.246	0.006	0.457
	(0.430)	(0.079)	(0.498)
Education: secondary	0.550	0.829	0.303
	(0.498)	(0.377)	(0.460)
Education: certificate 1-4	0.025	0.052	0.001
	(0.156)	(0.223)	(0.031)
Education: some other education	0.033	0.064	0.006

	(0.179)	(0.245)	(0.075)
University education	0.022	0.048	0.000
	(0.148)	(0.213)	(0.014)
Born in Australia	0.861	0.813	0.905
	(0.346)	(0.390)	(0.293)
If migrant: arrival year	2011.549	2010.882	2017.750
	(9.905)	(10.103)	(4.459)
Main language: English	0.965	0.954	0.975
	(0.184)	(0.209)	(0.157)
Observations	**31206**	**15080**	**16102**

Note: Client population excludes 900 observations for whom birth information was incorrectly recorded as being born before 1930. The client DEX data pool does not provide information on whether the client is a carer and or an adult. The adult client sample is defined as clients age 18 and older at the time of the session. The child/youth client sample is defined as clients who are younger than age 18 at the time of the session. Education data available for 19,531 clients. Migration year available for 206 clients.

Appendix Table 2 Summary statistics on FCS cases

Variable	Mean or proportion	Available sample
	(1)	(2)
Household composition		
Couple	0.007	8,822
Family	0.384	8,822
Group	0.052	8,822
Group 2	0.008	8,822
Homeless	0.005	8,822
Not stated	0.058	8,822
Single	0.018	8,822
Sole parent	0.556	8,822
Clients/sessions		
Clients per case	2.575	13,693
Sessions per case	38.541	13,693
Any client in case in priority cohort	0.519	13,693
Case is complex	0.058	13,693
Days in system (incl. cases not yet closed)	52.353	13,693
Case in system: Less than a week	0.133	13,693
Case in system: 1-4 weeks	0.259	13,693
Case in system: 4-16 weeks	0.488	13,693
Case in system: More than 16 weeks	0.119	13,693
Who referred to FCS?		
Self/Family/Friends	0.120	13,693
Child protection	0.063	13,693
Justice Legal	0.150	13,693
Education	0.224	13,693
Health	0.160	13,693
Community	0.130	13,693
Other party/agency	0.129	13,693
All other sources	0.025	13,693
Primary reason for assistance sought in FCS		
Not stated	0.002	13,693
Employment	0.001	13,693
Education, skills, or training	0.032	13,693
Housing	0.076	13,693
Personal and family safety	0.221	13,693
Mental health/wellbeing and self-care	0.245	13,693
Age-appropriate development	0.018	13,693
Community participation and networks	0.010	13,693
Physical health	0.028	13,693
Financial resilience	0.024	13,693
Family functioning	0.316	13,693
Material wellbeing/basic necessities	0.029	13,693
Service provider		
Provider 1	0.203	13,590
Provider 2	0.279	13,590

Provider 3	0.028	13,590
Provider 4	0.200	13,590
Provider 5	0.173	13,590
Provider 6	0.085	13,590
Provider 7	0.033	13,590
Activities in FCS		
Any external referral	0.259	13,693
Any internal referral	0.019	13,693
Case plan completed	0.179	13,693
Any active holding	0.045	13,693
Any family capacity building	0.137	13,693
Any intensive support	0.013	13,693
Any brokerage	0.098	13,693
Total minutes spent per case	498.5	11,231
Exit reason		
Cannot assist client	0.065	8,743
Deceased client	0.001	8,743
Higher assistance needed	0.026	8,743
Moved away	0.016	8,743
Needs were met	0.408	8,743
Assistance no longer needed	0.185	8,743
No longer eligible	0.029	8,743
Other reason for exit	0.101	8,743
Client quit the service	0.178	8,743

Appendix Table 3 Comparison of children with and without FCS contact with records in the statutory child protection system

Variables	Not in FCS	In FCS	p-value	Nr. obs.
	(1)	(2)	(3)	(4)
Male	0.4797	0.4913	0.1670	347261
Female	0.4697	0.4882	0.0270	347261
Gender undefined	0.0506	0.0204	0.0000	347261
Non-Aboriginal	0.5389	0.6365	0.0000	342027
Aboriginal	0.1527	0.2363	0.0000	342027
Aboriginal status missing	0.3083	0.1272	0.0000	342027
Total number of ROSH reports	3.0583	2.6894	0.0000	350582
Total number of helpline issues	13.5743	9.1257	0.0000	350582
Total number of investigations	4.1160	3.4007	0.0000	350582
Total number of substantiations	0.6591	0.5465	0.0000	350582
Total number of items in helpline	1.0241	1.0277	0.2150	348222
Total number of issues within investigation	1.4894	1.5496	0.1020	53487
Age at contact	8.8529	8.1196	0.0000	348222
Contact year	2020.4	2020.3	0.0150	348222
Contact month	6.0127	5.9342	0.1650	348222
Child at risk due to own behaviour	0.0710	0.0630	0.0550	337390
Carer has mental health issues	0.0026	0.0069	0.0020	337390
Carer: other issues	0.0016	0.0020	0.6100	337390
Domestic violence	0.0581	0.0653	0.0870	337390
Carer drug alcohol abuse	0.0046	0.0040	0.5840	337390
Emotional abuse	0.1635	0.1934	0.0000	337390
Reason missing	0.0053	0.0061	0.5580	337390
Neglect	0.2117	0.2619	0.0000	337390
No harm or risk	0.0304	0.0228	0.0030	337390
Other issues	0.0084	0.0069	0.3050	337390
Physical abuse	0.2243	0.2223	0.7750	337390
Prenatal report	0.0304	0.0304	0.9950	337390
Sexual abuse	0.1879	0.1148	0.0000	337390
Any investigation	0.1818	0.2082	0.0000	348222
Any substantiation	0.1709	0.2247	0.0000	117597
Any domestic violence substantiation	0.0834	0.1223	0.0010	63404
Catholic/Independent schools	0.0526	0.0274	0.0000	348194
Childcare/Preschool	0.0326	0.0216	0.0000	348194
FACS	0.0507	0.0554	0.2150	348194
NGO	0.1070	0.1159	0.0960	348194
NSW Education	0.2391	0.2487	0.1880	348194
NSW Health	0.1112	0.1213	0.0670	348194
NSW Police	0.1713	0.2019	0.0000	348194

Non-mandatory reporters	0.1562	0.1523	0.5240	348194
Other health	0.0255	0.0241	0.5910	348194
Other mandatory	0.0538	0.0314	0.0000	348194

Appendix Table 4 Balance of covariates between treatment and control groups

Variables	Control	Treatment	p-value	Nr. obs.
	(1)	(2)	(3)	(4)
Demographics				
Male	0.4996	0.5072	0.5670	5934
Female	0.4988	0.4884	0.4360	5934
Other sex definition	0.0016	0.0044	0.0740	5934
Non-Aboriginal	0.6178	0.6665	0.0000	5934
Aboriginal	0.2523	0.2106	0.0000	5934
Aboriginal indicator missing	0.1300	0.1229	0.4220	5934
Age at session	8.8230	8.3326	0.0000	5934
Case involved priority cohort	0.5585	0.5752	0.1990	5934
Case is considered as complex	0.0330	0.0663	0.0000	5934
Any disability	0.1597	0.1974	0.0000	5934
Learning disability	0.0424	0.0728	0.0000	5934
Disability: not stated	0.0350	0.0373	0.6490	5934
Physical disability	0.0137	0.0250	0.0030	5934
Psychiatric disability	0.1059	0.1158	0.2370	5934
Sensory disability	0.0227	0.0478	0.0000	5934
Primary reason for assistance				
Not stated	0.0027	0.0061	0.0660	5934
Employment	0.0005	0.0004	0.8530	5934
Education and skills training	0.0358	0.0211	0.0010	5934
Housing	0.0547	0.0926	0.0000	5934
Personal and family safety	0.3395	0.2027	0.0000	5934
Mental health wellbeing and self-care	0.1877	0.2111	0.0290	5934
Age-appropriate development	0.0263	0.0320	0.2040	5934
Community participation and networks	0.0038	0.0110	0.0030	5934
Physical health	0.0301	0.0391	0.0700	5934
Financial resilience	0.0052	0.0215	0.0000	5934
Family functioning	0.2982	0.3247	0.0330	5934
Material wellbeing and necessities	0.0153	0.0377	0.0000	5934
Service provider				
Provider 1	0.4159	0.4778	0.0000	5934
Provider 2	0.4033	0.3225	0.0000	5934
Provider 3	0.0093	0.0254	0.0000	5934
Provider 4	0.0000	0.0000		5934
Provider 5	0.0044	0.0176	0.0000	5934
Provider 6	0.1324	0.1566	0.0100	5934
Provider 7	0.0347	0.0000	0.0000	5934
Region				
Sydney	0.3000	0.3642	0.0000	4982
Central Coast	0.0795	0.0921	0.1270	4982

North Coast & Lake Macquarie	0.0938	0.0963	0.7630	4982
Illawarra	0.1064	0.1260	0.0380	4982
Richmond	0.0000	0.0000		4982
South Highland	0.0446	0.0540	0.1420	4982
Hunter Valley	0.1258	0.0995	0.0040	4982
Mid North Coast	0.0068	0.0079	0.6480	4982
Coffs Harbour	0.0010	0.0021	0.3380	4982
Capital Region	0.0165	0.0259	0.0290	4982
Central West	0.0139	0.0318	0.0000	4982
Riverina	0.0110	0.0000	0.0000	4982
New England	0.1704	0.0953	0.0000	4982
Murray Region	0.0281	0.0000	0.0000	4982
Far West	0.0023	0.0048	0.1650	4982
Who referred to FCS?				
Self/Family/Friends	0.0662	0.1795	0.0000	5934
Child protection	0.0607	0.0649	0.5180	5934
Justice Legal	0.1595	0.0891	0.0000	5934
Education	0.2074	0.2457	0.0010	5934
Health	0.1176	0.1729	0.0000	5934
Community	0.1855	0.0957	0.0000	5934
Other party/agency	0.1773	0.1229	0.0000	5934
All other sources	0.0257	0.0294	0.4030	5934
Service intensity				
Sessions per case	49.8616	100.7319	0.0000	5934
Number of clients per case	4.1557	4.1729	0.6920	5934
Number of days case is in the system	48.3434	82.5072	0.0000	5934
Days in system: Less than 1 week	0.1059	0.0254	0.0000	5934
Days in system: Between 1 and 4 weeks	0.2607	0.0926	0.0000	5934
Days in system: Between 4 and 16 weeks	0.5450	0.6231	0.0000	5934
Days in system: 16 and more weeks	0.0884	0.2589	0.0000	5934
Case had at least one external referral	0.1609	0.6577	0.0000	5934
Case had at least one internal referral	0.0036	0.0136	0.0000	5934
Ever had active holding in case	0.0107	0.0632	0.0000	5934
Ever Family Capacity Building in case	0.1223	0.2519	0.0000	5934
Brokerage ever in case	0.0399	0.1676	0.0000	5934
Why exited the case?				
Cannot assist	0.1228	0.0000	0.0000	5934
Higher assistance needed	0.0629	0.0000	0.0000	5934
Moved away	0.0252	0.0000	0.0000	5934
Needs were met	0.0000	1.0000		5934
No longer assistance needed	0.2380	0.0000	0.0000	5934
No longer eligible	0.0334	0.0000	0.0000	5934
Other reason	0.1450	0.0000	0.0000	5934
Client quit FCS	0.3726	0.0000	0.0000	5934

Child protection contact				
FCS child has no record in the child protection	0.3557	0.4651	0.0000	5934
Total number of substantiations pre-FCS	0.6008	0.4594	0.0020	5934
Total number of ROSHs pre-FCS	2.9070	2.3405	0.0010	5934
Any statutory child protection system contact pre-FCS-since 2019	0.5907	0.4800	0.0000	5934
Any statutory child protection system contact 12 months before FCS entry	0.4876	0.3778	0.0000	5934
Any ROSH before FCS entry	0.5201	0.4234	0.0000	5934
Any Investigations before FCS entry	0.2564	0.1856	0.0000	5934
Any substantiation before FCS entry	0.1475	0.1022	0.0000	5934
Note: Treatment and control group are defined as Needs met when exiting FCS and all other reasons when exiting FCS. P-value refers to a test of equality of means between treatment and control group. A p-value<0.05 is considered as benchmark for rejecting the null hypothesis of no differences.				

Appendix Table 5 Sensitivity checks on estimated FCS treatment effects

	Model specification								
	(1)	**(2)**	**(3)**	**(4)**	**(5)**	**(6)**	**(7)**	**(8)**	**(9)**
FCS	-0.025***	-0.026**	-0.019	-0.025**	-0.027***	-0.019**	-0.029***	-0.024***	-0.037***
	(0.009)	(0.012)	(0.015)	(0.011)	(0.010)	(0.009)	(0.010)	(0.009)	(0.013)
Mean	0.147	0.147	0.148	0.158	0.156	0.141	0.147	0.143	0.162
% change	-17.2	-18	-12.8	-16.1	-17.4	-13.4	-19.6	-16.9	-23
N	5934	5934	2787	4572	5064	5704	5404	5812	3950

Note, each column represents a different estimation model. Column (1) refers to the benchmark model presented in Table 6, column (1), Panel D. The outcome is whether the child experienced maltreatment that was substantiated during an investigation. $^{*}p < .10$, $^{**}p < 0.05$, $^{***}p < 0.01$ *Robustness checks are as follows:*
(1) Benchmark
(2) Control other inputs into FCS
(3) FY2122 Sample
(4) Drop quitters from FCS
(5) Drop clients who say assistance no longer needed
(6) Drop clients for whom higher assistance was needed
(7) Drop other reasons
(8) Drop no longer eligible
(9) Drop all self-selection (Movers, Quitters, Other reasons)
Clustered standard errors in parentheses