

EVALUATION OF THE RESILIENT FAMILIES SERVICE



NSW TREASURY

MID-TERM REPORT

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ARTD Consultancy Team

Sue Leahy, Fiona Christian, Alexandra Ellinson, Francis Matthew-Simmons, Florent Gomez-Bonnet

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Abbreviations and acronyms

Control Child	Child in a Control Group family matched to an Index Child
CSC	FACS Community Service Centre
CYP	Child/ren and young people
EIP	Evidence Informed Practice
FACS	NSW Department of Family and Community Services
Index Child	Youngest child in a family at the time of referral to the RF service
OOHC	Out-of-home care
Out-of-home care placements	Identifies the number of distinct placements (excluding respite, placements with parents and multiple placements with the same carer) that CYP was subject to. This includes non-statutory placements.
Region 1	Eastern Sydney CSC areas, Central Sydney CSC areas, Burwood CSC areas and Lakemba CSC areas.
Region 2	Bankstown CSC areas, Campbelltown CSC areas, Fairfield CSC areas, Liverpool CSC areas, and Ingleburn CSC areas.
RF service	Resilient Families service
RF site	Resilient Families service delivery site (Rosebery, Campbelltown or Liverpool)
RPF	Resilience Practice Framework (or, the Framework)
ROSH	Risk of Significant Harm
SARA	Safety and Risk Assessment
SBB pilot	NSW Government Social Benefit Bond pilot
SROH	Secondary Risk of Harm
Statutory out-of-home care entries	Identifies the number of out-of-home care periods for CYP where statutory care was identified at any point in the care period.
TBS	The Benevolent Society

Executive summary

In November 2013, ARTD was engaged by NSW Treasury to evaluate Resilient Families (RF), an intensive support service delivered by The Benevolent Society (TBS) to families in Greater Sydney where there are concerns about the safety and wellbeing of children. The service is funded under the NSW Government's Social Benefit Bond (SBB) pilot, in which private investment is applied to achieve targeted social outcomes, in this case a reduction in demand for acute child protection services.

The purpose of the evaluation is to assess the implementation and outcomes of the RF service over its first three years of operation, from 2013 to 2016. It is also to assess the appropriateness of the measures in use for calculating the bond payment. This is the second of three evaluation reports. This Mid-term Report looks at achievements and challenges in the implementation of the service in the first fourteen months of its operation. During this period the RF service was delivered in three TBS sites—Rosebery, Liverpool and Campbelltown—that cover two NSW Department of Family and Community Services (FACS) Regions. The report also presents early outcomes data and prepares the groundwork for how outcomes will be measured in the Interim evaluation in early 2016.

Key findings

The RF service has been successfully established and is moving towards a mature stage of implementation. Families participating in RF appear to present with varying risk profiles and levels of client need, ranging from low to high. RF is providing a flexible, responsive service focussed on developing positive changes in behaviour, though less intensive than anticipated. It is too early to assess outcomes, but while there is no evidence yet that the service is effective for the overall cohort, there are early indications the service has been effective for high needs families who complete the service.

Detailed summary of findings

In the table below we map our findings against the evaluation questions within the process, outcomes and economic evaluation components. These are set out against the program logic and show the main structure of the report.

Evaluation question	Mid term finding
Process evaluation	
Chapter 2 How well are targeted clients being identified and referred to the program?	The process is being implemented as intended but while some families present with low functioning and substantial prior contact with the child protection system, others have limited prior contact

Evaluation question	Mid term finding
	and may be below the threshold for an intensive intervention.
Chapter 3 To what extent is the service being delivered as intended?	The RF service is developing towards a mature stage of implementation. The data show it to be a flexible, evidence-informed service providing families with links to external services and building their social supports.
<ul style="list-style-type: none"> ▪ Are planned timeframes for assessment, review and program duration being met? 	There are delays in the referral and engagement processes that mean the service is not delivered with a sense of immediacy, one of the underpinning theoretical principles for intensive services.
<ul style="list-style-type: none"> ▪ What is the nature and intensity of the service being delivered, e.g. individually targeted, which evidence-based practices are being employed? 	Our evidence indicates TBS is delivering a flexible, evidence-informed service, underpinned by the Resilience Practice Framework (RPF) (see 1.2). Most or all families have received the service during the difficult hours of 4-6pm, and some families also received the service in the early morning or early evening periods. At the time of reporting, the RF service remains less intensive than expected given caseloads, and while the intended pattern of an intensive 12 weeks at the start of the service is starting to emerge at the Rosebery site, overall this pattern is not strongly evident.
<ul style="list-style-type: none"> ▪ How well are participants being linked into relevant services and making broader social and community connections? 	TBS staff are working with families to develop social connections and other natural supports. RF families are being referred to a range of external services, though largely children's services and health services and relatively few referrals to housing, domestic violence or men's services.
<ul style="list-style-type: none"> ▪ What affects the individualisation of plans? 	A Resilience Assessment Tool is being used to assess individual family strengths and needs.
<ul style="list-style-type: none"> ▪ Is the program sufficiently well-resourced and supported, including staff skills and professional support and development, clear guidelines, etc.? 	The majority of RF staff survey respondents (7 of 9, n=10) feel supported by TBS: overall, and especially in relation to the professional supervision and internal learning and development support they receive. Respondents felt they had been less well supported in relation to their induction to RF and external learning and development, two of the establishment challenges identified in the Preliminary Report. With increased learning and support around the Framework and more time to apply it in practice, TBS staff are more positive and

Evaluation question	Mid term finding
<ul style="list-style-type: none"> How do the processes for joint working between TBS and FACS differ from business as usual, including regular data provision, and to what effect? 	<p>confident in their use of the RPF.</p> <p>Working relationships between local TBS and FACS staff are reported by TBS staff to be positive and mostly effective, but variable. Some staff have suggested working arrangements could be improved by ensuring more FACS Community Service Centre (CSC) staff know about and understand the RF service. Relationships are less well developed in Region 2 compared with Region 1.</p>
<ul style="list-style-type: none"> To what extent has TBS developed a culture of learning and adaptation in delivering the program? What has facilitated this, and what are the outcomes? 	<p>TBS is responding to Preliminary evaluation recommendations with efforts to improve the quality of program data, address issues of integration in the two Region 2 sites and work on relationships with FACS.</p>
<p>Outcomes evaluation</p>	
<p>Chapter 4 What are the outcomes of the RF service for participants?</p>	<p>In this report, our purpose is to lay the groundwork for the outcomes evaluation, firstly establishing the comparability of the Index and Control cohorts, and then outlining ways in which outcomes will be measured in the next report. The populations for the report are small and the data collection period is short so we have not undertaken statistical testing. Trends may be seen as indicative, but not robust.</p>
<ul style="list-style-type: none"> Do Index Children have less contact with the child protection system than the comparison group? 	<p>Index Children have received slightly more Helpline reports and had more Safety and Risk Assessments (SARAs) commence in the measurement period than Control Children (n=120). The greater number of reports for Index Children may in part be explained by 'surveillance bias', which cannot be understood reliably but indicates that increased contact with services means families will be reported more often. Positively, there were fewer entries into statutory out-of-home care for Index Children than Control Children.</p>
<ul style="list-style-type: none"> What changes in functioning and wellbeing are seen for Index Children and their families? What new skills and behaviours have parents/ carers learned? 	<p>Outcomes for the small number of families for whom we have TBS Resilience Outcomes baseline and review 1 assessment scores (n=13) show a range of small, positive changes across assessment items and a few minor declines. The greatest improvement between baseline and review 1 was in the 'Increasing Safety' outcome area, which has been the main focus of TBS's work with families to date.</p>

Evaluation question	Mid term finding
<ul style="list-style-type: none"> Who does the program appear to work best for? 	<p>The early evidence indicates that families with highest risk and needs profiles showed greatest gains.</p> <p>When we link FACS outcomes data to TBS service data about service participation we also observe that families who had completed the service and exited with goals met (n=7), and families continuing to receive the service during the evaluation period (n=25), experienced no entries into out-of-home care, received fewer reports to the child protection Helpline and had fewer SARAs commence than families who had discontinued the service through moving away or disengaging (n=9).</p>
<ul style="list-style-type: none"> How appropriate are the measures in place for the bond payment? 	<p>The early data shows there is a good alignment between the bond measures and TBS assessment of families at entry, but there is less alignment in them as measures of change. However, this is based on a very small sample at this stage (n=13). The use of reports may be problematic because families participating in RF may be more likely to be reported than those who do not have such a high level of contact with the service system. The use of SARAs may be similarly affected.</p>
Economic evaluation	
Chapter 5 Does the program offer value for money?	Actual costs are comparable to similar programs in NSW, although costs per family are slightly higher than budgeted.

Recommendations

The recommendations below focus on further development of the service and optimising the outcomes for families. They address the key issues emerging from the Mid-term evaluation: ensuring families with appropriate risk profiles are referred, achieving immediacy in the referral process, maintaining a focus within RF on key practice areas, continuing activity to improve data quality and building relationships among TBS and CSC staff.

We recommend that:

1. TBS and FACS review referred cases where families are perceived to be under the threshold for an intensive service, to identify the factors impacting on decisions to refer these cases, e.g. eligibility criteria, FACS knowledge about or confidence in the service; and identify actions that could be taken to address factors impacting on low risk families being referred e.g. adjustment in the process for identifying families and/or a process for ongoing review where TBS assesses referred families as low needs.

2. In the event that lower risk families continue to be referred to RF, TBS update program documentation to explicitly describe the service as flexible in terms of intensity, and ensure caseloads are adjusted to reflect different intensities and durations; within this model allow individual staff to develop expertise in different styles of work, crisis, motivational, long-term, etc.
3. FACS consider whether there can be greater account of immediacy in the process of filtering eligible families to refer.
4. TBS and FACS continue to work together to increase knowledge about the RF service among CSC staff, especially in Region 2, with the aim of developing a shared understanding of information to be shared through the referral process and meet TBS timeframes for completing joint initial home visits.
5. TBS continue to review practice in relation to the intensity of the service and in working with families at home to model effective routines and behaviours.
6. TBS to continue work to build the accuracy, consistency and completeness of the data in key areas such as service referrals, social connections, intensity and duration of service and application of the RPF.

1. Resilient Families and its evaluation

1.1 A Social Benefit Bond pilot

The Resilient Families (RF) service is an intensive family support intervention provided to families where there are concerns about the safety and wellbeing of children. The Benevolent Society (TBS) established the service as part of the NSW Government's Social Benefit Bond (SBB) pilot, in which private investors provide up-front funding to service providers to deliver improved social outcomes.

The funds provided under a SBB are intended to expand social investment into prevention and early intervention approaches that otherwise may not receive sufficient resourcing. The direct financial incentive to achieve an agreed outcome is expected to drive service delivery, innovation, and help reduce the demand for government expenditure on acute and crisis services. If outcomes are delivered, the cost saving to government can be used to pay back the investor's principal and provide a return on investment. The return on the investment is dependent on the degree of improvement in social outcomes and the precise structure of the SBB.

The TBS SBB pilot is one of the first two SBB pilots in Australia. It is an opportunity to trial new ways of working between the NSW Department of Family and Community Services (FACS) and the non-government sector. Under the model, families are identified through a centralised process within FACS, rather than within local Community Service Centres (CSCs). The pilots also bring a strong focus on outcomes rather than defined service specifications, and a more robust approach to measuring outcomes.

1.2 Resilient Families service

The RF service commenced working with clients in October 2013. It will be operational for five years and aims to support between 300 to 400 families over this period.

The objectives of the RF service are to:

- support parents to create a safe and stable family environment
- improve parenting capacity and family functioning
- reduce the number of reports of Risk of Significant Harm (ROSH) and the number of SARAs commenced
- prevent entries in out-of-home care.

Key features of the RF service are:

- a primary focus on engaging families and building relationships
- providing practical and therapeutic supports
- client-centred service provision that uses flexible work arrangements—including outside business hours and an after-hours call service for emergency contact—and access to flexible funds
- an initial 12 weeks of high-intensity support, followed by 9 months of less intensive service, including a planned step-down approach to exit the family (plus an option for families to choose to re-engage at the end of the 12-month period)
- working in close collaboration with FACS.

Resilience Practice Framework

The service is based on a Resilience Practice Framework (RPF), which TBS developed in partnership with the Parenting Research Centre based on a review of evidence around ‘what works’ in supporting and promoting resilience in children.¹ By clearly articulating the outcomes and practices associated with resilience, the RPF establishes a unifying approach to service delivery across a number of TBS child and family programs—including the RF service.

There are four main components of the RPF. Among these are a set of 42 Evidence Informed Practices (EIPs) and a Resilience Assessment Tool used at the start of the service and each three months to develop and review case plan goals and outcomes in five areas.

1. Increasing Safety
2. Secure and Stable Relationships
3. Increasing Self-efficacy
4. Improving Empathy
5. Increasing Coping/ Self-regulation.

Evidence Informed Practices

Evidence Informed Practices (EIPs) introduce a ‘common elements’ approach to service delivery. This approach hypothesises that it is not a program as a whole that works, but rather the common elements or practices within programs that work, when implemented in the right context to achieve identified behavioural outcomes.

TBS has identified 42 practices shown empirically to positively affect behaviour,² and aligned these to the 5 resilience outcomes within the RPF. Most are quite simple, can be easily taught (e.g. giving descriptive praise, time-out and self-monitoring), and have outcomes that are immediately observable. Accordingly, they are seen as a useful way to share practices that reduce behavioural and psychological problems, improve wellbeing, and achieve public

¹ Parenting Research Centre and The Benevolent Society (2013) Resilience Practice Framework.

² See D. Embry and A. Biglan, ‘Evidence-based Kernels: Fundamental Units of Behavioural Influence’, *Clinical Child Family Psychology Review*, v11, page 96, 2008.

health goals. These practices can achieve goals in a way that reduces reliance on implementing programmatic, and often costly, interventions.

A Homebuilders approach

More broadly, the RF service is based on Homebuilders: a model of support developed in the 1970s in the United States of America.³ Premised on crisis as a motivator for behavioural change, Homebuilders targets families within the child protection system who are at a point where out-of-home care is likely without significant change in parental behaviours and the safety of the environment for the children. There are no wait lists and the intervention starts immediately after referral.

Key dimensions of Homebuilders' services are that they are time-limited, intensive (six to eight hours per week with families) and home-based, providing practical and therapeutic support, including household routines, cleanliness and safety. The model brings a strengths-based, holistic and culturally appropriate approach to address a structured assessment of needs, problem behaviours and other safety and wellbeing concerns. There is some evidence to suggest that family preservation services are most effective for highest risk families.⁴

1.3 The evaluation

The purpose of the evaluation is to assess the implementation and outcomes of the RF service over its first three years of operation. It is also to assess the appropriateness of the measures in use for calculating the bond payment.

The key evaluation questions, which shape the structure for this report, are below.

- How well are targeted clients being identified and referred to the RF service?
- To what extent is RF being delivered as intended?
- What are the outcomes of the RF service for participants?
- How appropriate are the measures in place for the bond payment?
- Does the RF service offer value for money?

The more detailed evaluation questions are provided in Appendix 1.

The evaluation covers the RF service from October 2013 to 2016. The evaluation is delivering three reports over this period:

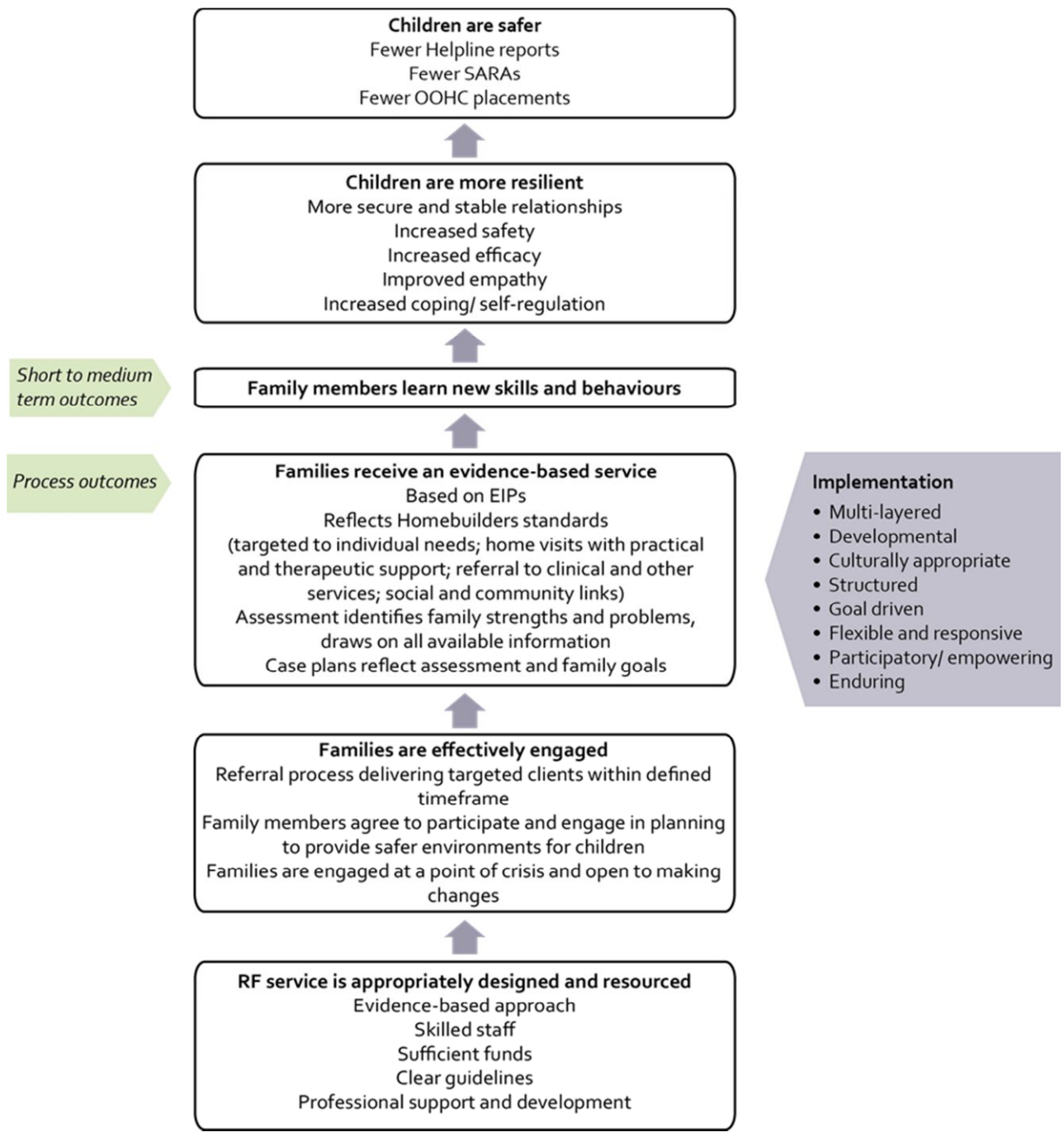
- Preliminary (December 2014)
- Mid-term (this report)
- Final (March 2016).

³ Institute for Family Development, (2013). Homebuilders standards 3.0. Washington: Institute for Family Development, www.institutefamily.org/programs_ifps.asp

⁴ Tully, L. (2008) Family Preservation Services: Literature Review, Centre for Parenting and Research, NSW Department of Community Services, 2008; IFBS Evaluation Early Findings, internal FACS report.

Each report is addressing process, outcomes and economic components, though the emphasis across these reports shifts from implementation to outcomes and brings a more detailed analysis of costs. This Mid-term Report looks at how the implementation of the RF service has progressed since the Preliminary Report and prepares the groundwork for the outcomes evaluation in early 2016 by outlining the data that will be available and how it can be analysed to answer evaluation questions.

Figure 1. The Resilient Families service program logic



1.3.1 Method

We are using a theory-based, mixed-methods design to collect evidence against the evaluation questions. The methods are detailed in Appendix 2. In summary, this report draws on the following data.

- Survey of TBS staff (n=9)
- Interview with TBS program manager (n=1)
- Interviews with FACS staff (n=2, only Region 1)
- Program costs and administrative data provided by TBS and FACS
- Remediated, aggregate TBS service monitoring data covering the period 8 October 2013 to 29 November 2014
- Unit record TBS service monitoring and client assessment data covering the period 8 October 2013 to 29 November 2014
- Remediated, aggregate TBS client numbers covering the period 8 October 2013 to 30 December 2014
- Unit record FACS data covering periods prior to and since service participation.

1.3.2 Confidence in the findings

We are confident the evaluation is collecting a robust set of evidence that will enable us to answer the evaluation questions. We have seen improvements in some key areas of the TBS dataset since the Preliminary Report, though we know that further work has been done since this dataset was extracted so we cannot be totally confident about that data's accuracy or completeness. We have recommended key areas for further quality improvement effort within TBS. The TBS survey data reflects a high response rate (9 of 10 staff) and qualitative comments bring good insights about service delivery in some areas and filled some data gaps in the previous report.

We have established that the Index and Control Groups are closely matched so we can confidently compare the two groups in the outcomes analyses. The outcomes analysis population for this report is small so we have not undertaken statistical testing and trends may be seen as indicative but cannot be relied on at this stage. The outcomes analysis draws on different combinations of TBS and FACS data. The FACS data was provided over a number of months with each dataset a snapshot, so there are complications in the analysis and reporting of outcomes that we will rectify for the next report by changing the plan for data provision.

We were only able to identify FACS staff in Region 1 who were willing to participate in an interview, so there is a gap in FACS' perspective from Region 2.

2. Are targeted families being referred?

This chapter addresses the evaluation questions concerned with the referral process: how well it is working and whether targeted families are being referred to the service.

The process for referring families to the RF service is different from FACS' usual model. When TBS has a vacancy they notify FACS to request a referral. Instead of cases being identified within a local CSC, the referral process is managed centrally, through a system-generated list of eligible children and a process of checking records with the local CSC to get an up-to-date understanding of each family's circumstances. Families are then referred directly to TBS for intake into the RF service.

The process is operating largely as intended, but not all families being referred may be at sufficiently high risk to require an intensive service. A two-pronged response is proposed: working towards only high risk families being referred, while also defining the service model more flexibly in terms of intensity and duration in response to family need.

2.1 Family characteristics

2.1.1 Family demographics

By the end of November 2014, 69 families had commenced the service. Taking into account an initial start-up period, this indicates TBS and FACS are tracking well toward a planned target of 70-90 families per year over 5 years.

Three-quarters of families (n=36) have a two-carer structure, with the majority of Primary Carers women between 18 years to 57 years, and an average age of 31.3 years. One-quarter (24%) of Primary Carers have HSC or a post-school qualification, although there is variation across sites. Employment is highest at Roseberry (23%), but overall less than 15% of Primary Carers are employed and the main source of income is government benefits.

Index Children range from unborn⁵ to almost six years old at assessment, and are on average aged 1.9 years (n=49). Children in this cohort are almost equally distributed by gender across the RF service as a whole, but mostly male in Campbelltown (75%), and female in Roseberry (66%) and Liverpool (63%). Four of the Index Children are Aboriginal: three are in the RF service at the Roseberry site.

⁵ Reports to the Helpline can be made about an unborn child. Some of these children then become potential matched pairs, and their families can be referred to the service before the Index Child is born. In some cases TBS will start working with the family.

The most common housing type for families is public housing—for almost half of the families in Liverpool and a third of the families at the Campbelltown and Rosebery services (n=36). A third of the families at the Rosebery service lived in crisis accommodation. One-fifth (21%) of families had moved three times or more in the past twelve months. Most speak English at home. Only four identify as Aboriginal (Table 23, Appendix 3).

2.1.2 Needs and risk profiles of Primary Carers of Index Children

The Resilience Outcomes Tool baseline indicates Primary Carers (n=35) faced greater difficulties than the general population at the time they entered the RF service. On the K-10—a simple measure of psychological distress generally used as a brief screening tool—these carers scored an average of 18.2, compared to an average of 14.5 for the Australian population,⁶ indicating an increased level of psychological distress (Table 1). Primary Carers also scored 61.8 on the Personal Wellbeing Index, which is lower than the Australian average of approximately 73.7 – 76.7.⁷

Table 1. Baseline results for Primary Carer wellbeing

Survey	RF sample		Comparative sample	
	N	Mean (S.D.)	N	Mean
K-10	35	18.2 (6.5)	8,841	14.5
Personal Wellbeing Index	35	61.8 (21.5)	-	73.7-76.7

Source: TBS RF assessments database, n=36, missing data=1.

As children, almost half (n=27) of the Primary Carers had been the subject of a NSW Child and Young Person (CYP) concern or child protection report themselves, from 1 to 41 reports each and an average of 9.4 reports. Fifteen of these Primary Carers had been the subject of a Risk of Significant Harm (ROSH) report or other referred report as a child. The number of ROSH or referred reports they had received ranged from 1 to 35, with an average of 11.1 reports.

2.1.3 Needs and risk of Index Children

Within the small sample to date, Index Children referred to RF faced greater difficulties than the general child population, as measured by their baseline score for the Strengths and Difficulties Questionnaire (SDQ) using the Resilience Outcomes Tool (n=12). At baseline,

⁶ Slade, T., Grove, R., Burgess, P. (2011). Kessler psychological distress scale: normative data from the 2007 National Survey of Mental Health and Wellbeing.

⁷ Meade, R., and Cummins, R. (2010). What makes us happy? Ten years of the Australian Unity Wellbeing Index. Melbourne: Australian Unity: Deakin University.

Index Children scored 10.7 on the total difficulties scale of the SDQ (Table 2). This is compared to an 'average' score of 8.2 among the normative population, indicating greater difficulties among the RF population.⁸

Table 2. Baseline results for Index Children’s wellbeing

Survey	RF sample		Comparative sample	
	N	Mean (S.D.)	N	Mean
Strengths and Difficulties Questionnaire-Total difficulties	12	10.7 (4.9)	910	8.2

Source: TBS RF assessments database, n=36, with only 12 children old enough for SDQ.

Child protection profile

Index Children had been the subject of an average of 4.2 Helpline reports in the 12 months prior to their families’ participation in the RF service (Table 37, Appendix 6). For analysis, we have aggregated the data on these children into 4 groups according to their number of Helpline reports in the 12 months prior to RF (Table 3). One group had only one report in this period—and this report would have led to their referral to RF. In contrast, the 16 Index Children in Group 4 had been subject to between 6 and 13 reports each in the 12 months prior to RF, reflecting a much higher risk profile.

Table 3. Helpline reports for Index Children in the 12 months prior to RF

	Number of Helpline reports in 12 months previous (includes trigger report)	Number of Index Children
Group 1	1 report	14
Group 2	2 or 3 reports	13
Group 3	4 or 5 report	16
Group 4	6 to 13 reports	16
	Total	59

Source: FACS data for matched Index Children, n=60, one child did not have a Helpline report in the previous 12 months.

All 60 matched Index Children had at least one SARA conducted prior to referral to the RF service; again, the majority of these assessments were commenced at the time of referral.

⁸ Mellor, D. (2005). 'Normative data for the Strengths and Difficulties Questionnaire in Australia' Australian Psychologist, 40(3), pp.215–222.

Seven children had one additional SARA in the twelve months prior to referral (Table 39, Appendix 6). The outcome of the Safety Assessments immediately prior to referral (the first of two components of the SARA) was 'Safe with plan' (90%) or 'Safe' (10%) (Table 40, Appendix 6). The Risk Assessments (the second component of the SARA) immediately prior to referral were assessed as 'high' (62%) or 'very high' (17%) in the majority of cases, and one-fifth were assessed as moderate (22%) (Table 41, Appendix 6). None of the matched Index Children had been in out-of-home care in the 12 months prior to commencing RF (Table 42, Appendix 6).

2.2 Results of the referral criteria and process

The process is being implemented as intended, though the data above show referred families have presented with a mix of risk profiles. This is consistent with earlier descriptions given by TBS staff, that some families have high needs and are reluctant to engage with the service, and others less so.

High needs families include carers with a history of negative experiences with child protection services and lack of understanding or acknowledgement of child protection concerns. Some family members can be defensive towards, or not trust the supports offered and/or are resistant to change. Strategies for engaging these families suggested by TBS are given in the next chapter (see 3.1).

On the other hand, TBS staff described some lower risk families who are not at crisis point and feel that an intensive service like RF is too intrusive for them. There are also families who already have supports in place for whom the service is not useful.

There are a number of great wraparound services meeting their needs. We have agreed with the mum to do an assessment and if by the end of this we don't see a place for us, then that could be an outcome. (TBS staff, survey response)

These lower risk families may be below the threshold for an intensive intervention. While around one-quarter of the Index Children (16 of 59) had been reported between 6 and 13 times in the 12 months prior to commencing RF, for another quarter (14 of 59), the report associated with the referral was the first report made about the Index Child in the previous 12 months. Given the average age of these children is 1.9 years, it is possible and even likely that for some Index Children this could have been the first report made about them.

The SARA undertaken at the time of referral was the first such assessment for the majority of the Index Children (52 of 59), and the outcome of all Risk Assessments was 'moderate' in one-fifth (21%) of cases. The data about Primary Carers as children and their TBS assessment scores show a similar variation.

The risk level of participants is important for two reasons. Firstly, there is evidence that the model may be most effective for high needs families (see 1.1). Early analysis of outcomes from RF is consistent with the literature. Namely, the same outcomes (in functioning and

reduced reports) were seen for families with lower functioning and higher levels of prior contact with the child protection system, as higher functioning families with less prior contact (see Table 11), meaning gains were greater for the higher needs group. This has important implications for economic analysis, as benefits are optimised where there is greatest scope for improvement. Families declining the service also impacts on the economic analysis (see 5.2).

The evidence that some families being referred are below the risk threshold for an intensive service is not conclusive, but is sufficient, given the importance of the issue, to warrant further investigation and action. We propose the following strategies.

1. Work towards referring high risk families

- Review internally within FACS and with TBS to establish the cases of concern and identify the factors impacting on decisions to refer these cases e.g. eligibility criteria, FACS knowledge about or confidence in the service.
- Identify actions that could be taken to address factors impacting on low risk families being referred, with a view to minimising these cases e.g. adjustment in the process for identifying families and/or a process for ongoing review where TBS assesses referred families as low needs.

If systemic or other factors cannot be easily changed, then another approach should be taken.

2. Adopt a flexible service model according to level of need

- In the event that lower risk families continue to be referred to RF, update program documentation to explicitly describe the service as flexible in terms of intensity and ensure caseloads are adjusted to reflect different intensities and durations
- Develop a flexible caseload model that reflects different intensities and durations; within this model allow individual staff to develop expertise in different styles of work, crisis, motivational, long-term, etc.

3. Is RF being implemented as intended?

This chapter is concerned with implementation—the timeframes, quality of service and operating environment for RF.

Timeframes

There are delays in the referral and engagement processes that mean the service is not delivered with a sense of immediacy, one of the underpinning theoretical principles for intensive services.

Quality of service

TBS describe the key features of the service as its flexibility, openness to listen to families and focus on their strengths and positive behaviour change. It is delivered in family homes at critical times of the day when staff can work with family members to implement EIPs, and model and teach new behaviours and routines.

RF families are being referred to health and children’s services and 12% of the time spent in applying EIPs is in social mapping, in which TBS helps families build broad social connections. The service is individually targeted and focussed on areas of need, identified in baseline assessments.

Operating environment

TBS staff feel well supported overall, and in particular in their professional supervision and learning and development. They were less positive about access to external learning, and equivocal in their views about support by TBS in relation to equipment and facilities and organisational systems

Joint working between TBS and FACS staff is mostly positive and productive, though varies on an individual basis, and staff turnover within CSCs means ongoing communication and relationship building are needed. Relationships are most developed in Region 1, where the program is delivered most closely as intended.

TBS is responding to Preliminary evaluation recommendations with efforts to improve the quality of program data, address issues of integration in the two Region 2 sites and work on relationships with FACS.

3.1 Meeting planned timeframes

Overall, the process of engaging families with the service is slower than expected. The initial joint home visit can be difficult to arrange, and it is taking longer than expected to complete assessments. The needs of different families are one main reason described by TBS staff for this. On the one hand, some families are difficult to engage because of their high levels of need and challenging behaviours. On the other hand, there are families with lower needs who can be difficult to engage because they do not feel they need the service.

3.1.1 Assessment

Initial home visit

The assessment process commences with an initial home visit or meeting with the family. Ideally this is a joint home visit where both TBS and FACS staff visit the family at home to explain the service, their respective roles and expectations. TBS and FACS staff⁹ have both described this initial meeting as important for communicating a shared view of risks and safety concerns to families, and TBS staff indicated that FACS attendance is helpful in getting families to engage with the service.

The TBS Service Model and Operating Guidelines outline a timeframe of seven days between initial contact and the initial home visit or meeting to occur. In practice this is proving challenging, especially in Region 2, where it has taken an average of 12 and 13 days to hold these meetings, and in individual cases up to five and seven weeks (25 and 37 business days) to meet with families.

The concern is that intensive services are designed to be offered to families at a time of crisis when family members are most likely to be receptive to change (see 1.2). The eligibility criteria that families have a SARA commence in the past 35 days¹⁰ means there will often already be a delay between the initial incident triggering the intervention, and the service response.

The RF Operations Manual¹¹ specifies that FACS may request that the family attends a meeting just with TBS, and in these cases uses key messages and a program brochure to promote the program to families. At least anecdotally, this requirement does not seem to be widely known or understood by all TBS or FACS staff. Given the importance of both joint attendance and timeliness, it would be preferable for FACS to prioritise these meetings whenever feasible. When not, they should communicate this to TBS in an agreed, timely way and TBS should proceed with the initial meeting within the seven days as specified in the RF Operating Manual. FACS staff should make every effort to make the initial visit, given the referral is to an intensive service and their attendance can be a key factor in family engagement.

Completing needs assessment

Following the initial home visit, TBS completes the Resilience Assessment Tool with the family and develops a case plan ('Family Support Plan'). TBS determines the resilience outcomes and EIPs that will be important in their work with the family.

⁹ Note this only includes FACS staff from Region 1.

¹⁰ Operations Manual for the TBS Social Benefit Bond Pilot p 13.

¹¹ Operations Manual for the TBS Social Benefit Bond Pilot p 30.

Completing family assessments is taking longer than expected in both Regions. The TBS RF Service Model and Operating Guidelines indicate that this assessment is to be completed within 30 days, but in practice this is taking an average of 59 days, though with considerable variation—from 10 to 230 days (Table 27, Appendix 4). This seems to be because of the challenges involved in engaging families, related in part to their risk profiles, both low and high, for different reasons, as described in chapter 2 (2.2).

TBS staff suggest the following practices are important or helpful when engaging harder to reach families.

- **Intervening at a time of crisis:** referring families at a time of crisis, and ensuring a swift intake process so that initial visits and assessments occur when the need for the service is clear.
- **CSC staff establishing expectations about the RF service:** presenting families with a clear expectation that FACS' statutory concerns are to be addressed by participating in the service; FACS' participation at the initial home visit helps with this.
- **TBS staff giving clear information about the RF service:** communicating that TBS is independent of FACS and explaining the purpose of the service, how often they will visit, and the structure of service delivery over time.
- **TBS staff meeting families 'where they are at':** offering support that meets families' immediate needs and that recognises cultural differences.
- **TBS staff providing material or hands on support:** incentives for participating appear to support engagement.

3.2 Nature and intensity of the RF service

In the Preliminary Report we assessed the RF service against the standards for Homebuilders.¹² This showed the RF service to be consistent in key dimensions: values-base; service provision in a natural environment; single, specific target population; time-limited intervention (albeit much extended); and delivered by individual caseworkers operating within a team. Two particular areas we looked at in detail for the Mid-term evaluation are the hours of the day that the service is being delivered and the pattern of service intensity.

3.2.1 Service delivered at critical times of day

Intensive home-based services are delivered flexibly at different times during the day, including early mornings and late afternoon periods. This enables caseworkers to engage with all family members. It also provides opportunities to teach, model and support positive new behaviours and routines appropriate for these critical times of day.

Data collected through the TBS staff survey shows that all or most TBS staff visited families at home between the hours of 4-6pm and 'some' or 'a few' families were visited at other key

¹² The RF service reflects many key characteristics consistent with Homebuilders standards¹² for service design and implementation.

times, including early mornings. TBS should continue to monitor practice in this area, including looking at practice around morning routines to enhance school and early childhood service attendance.

Table 4. Critical times the service is delivered

	All families	Most families	Some families	A few families	No families	Total	Missing
Weekdays 7-9am	0	1	4	3	0	8	0
Weekdays 4-6pm	2	3	1	2	0	8	0
Weekdays 6-8pm	0	0	3	4	1	8	0
Weekdays after 8pm	0	0	0	2	5	7	1

Source: TBS staff survey n=8.

3.2.2 Intensity and pattern of service

Service intensity

While the TBS RF Service Model Operating Guidelines do not define intensity, caseloads suggest these would be similar to Homebuilders, which provides six to eight hours of face-to-face time per week.

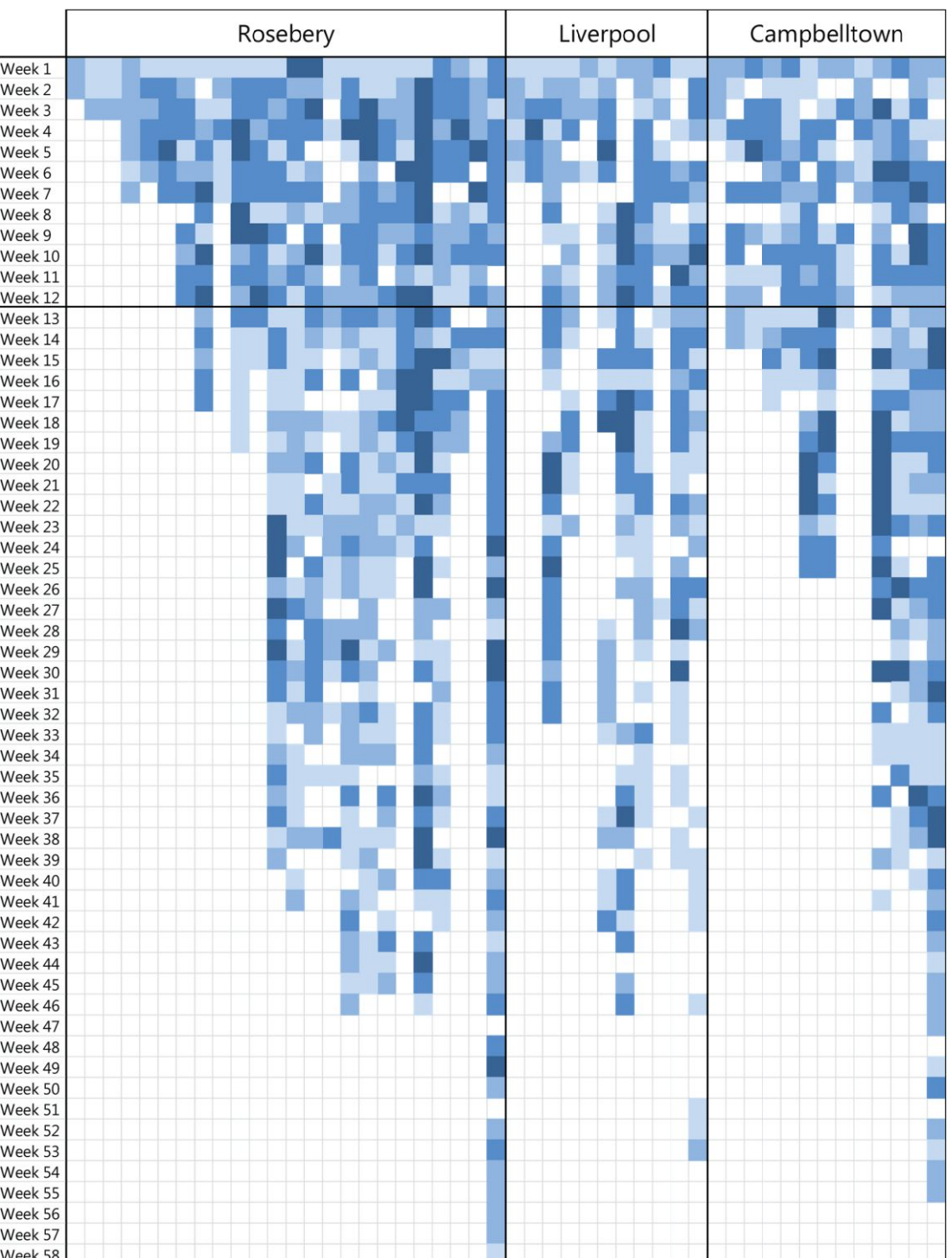
The current service data show RF clients had received an average of 1.3 visits per week in the first 12 weeks in the service, for an average duration of just less than 2 hours (Table 28, Appendix 4). There is a lot of variation within the data, with some families averaging one meeting every four weeks, while others average three meetings a week, over durations varying from twenty minutes a week to five hours per week. This aligns with earlier discussion of the mixed needs and risk profiles that families are presenting with.

Since the Preliminary Report, TBS has been working with staff to improve the quality of service data so we cannot be totally confident in it at this stage. We will continue to monitor this aspect of the service, given its implications for economic analysis.

Service pattern

The RF service model outlines an initial 12 weeks of high-intensity support, followed by 9 months of less intensive service, including a planned step-down approach to exit the family. Below (Figure 2) we show the intensity of the service received by each family each week during the first 12 weeks and subsequently. We can see a more intensive pattern in the first 12 weeks of service starting to emerge in the Rosebery service, although overall patterns are not strongly aligned to the RF service model.

Figure 2. Hours of service per week for each family



Source: TBS RF program database; n=49 (1 missing)

3.3 Links to relevant services and making broader social and community connections

3.3.1 Links to services

There were 64 referrals to external services made for the 49 families in the data.¹³ Over half were referrals to a children’s service or health service (Table 5). Given data on family housing status (Table 24, Appendix 3), and reported and assessed issues (Table 25 and Table 26, Appendix 3), referrals to housing, domestic violence and men’s services are lower than might be expected. Two-thirds of the recorded referrals to external services were made for families at the Rosebery service; it is unclear whether this reflects a difference in practice or a difference in how staff are recording information about practice.

The data show that TBS staff have improved how they record practice in this area since the Preliminary Report, though we still cannot be sure of its completeness. TBS should continue to work with staff to monitor practice, with a view to encouraging staff to use specialist resources where appropriate and available.

Table 5. Referrals to external services by service type

Service type	N	Per cent
Childcare/ playgroup/ school holiday	21	33%
Health services	18	28%
Parenting support	6	9%
Mental health services	5	8%
Financial support or counselling	5	8%
Local community services (not specified)	4	6%
DV/ trauma support	2	3%
Housing	2	3%
Men's group	1	2%
Total	64	100%

Source: TBS RF program database, n=49; families can have more than one referral.

¹³ 49 families accepted the referral to the service and consented to the evaluation; see Table 16, Appendix 3.

3.3.2 Building of social connections and natural supports

The principle for including wider family members and people from a family's social and community network in family plans is based on the fact that these people or connections will remain part of the family's environment after formal agency involvement, and some will have a long-term commitment to the children and young people in the family. It can be difficult for service providers to access or engage natural supports, and previous research shows these supports tend to be under-represented in family plans.¹⁴

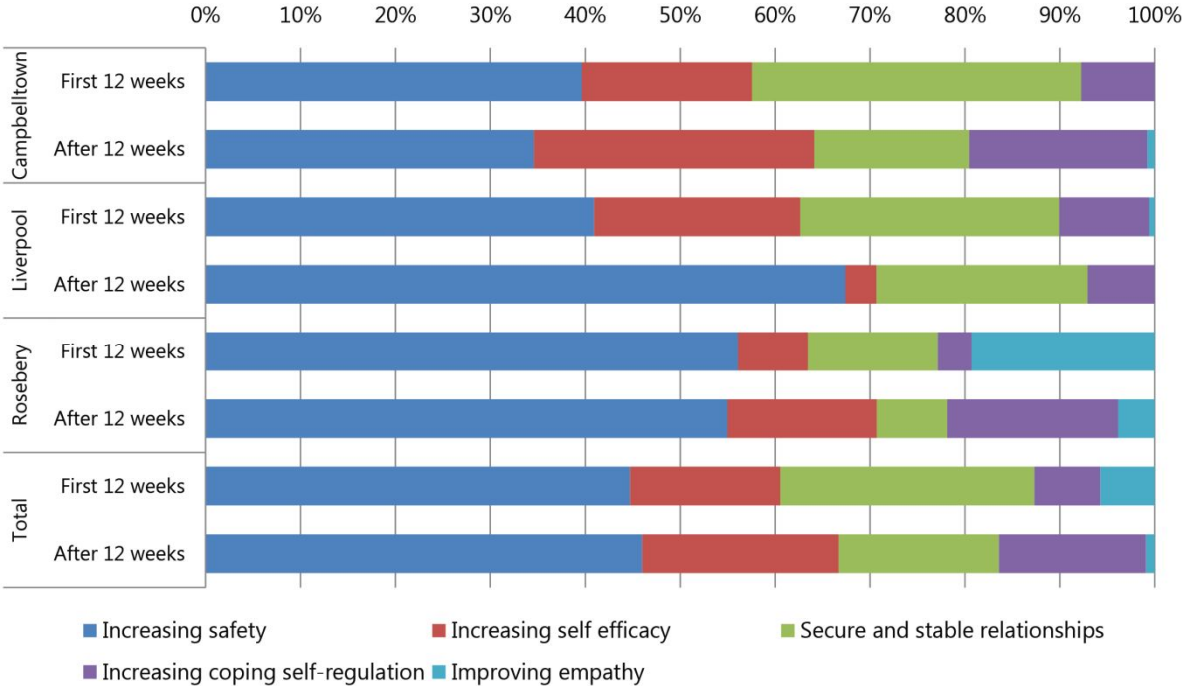
In the RF service, TBS staff help families to build these connections through social mapping, as part of the 'Increasing Safety' domain in the RPF. Social mapping accounted for 12% of the time spent in this domain in the first 12 weeks of service, and 22% of the time after the first 12 weeks. This equates to 5% of all time spent on EIPs in the first 12 weeks, and 10% of all time on EIPs after the first 12 weeks. In the next report, TBS may be able to provide benchmarks for these findings. Our initial assessment is that these proportions seem reasonable, and show an improvement in the monitoring data since the Preliminary Report. In the next report, we will bring a client perspective to this aspect of the service through our interviews with family members. Given the importance of social connections for families, we recommend TBS also continues to guide and monitor practice in this area.

3.4 Individualising plans

At an individual family level, practice is focussed on areas of need, identified in baseline assessments and reviews. TBS staff describe the key features of the service as its flexibility, openness to listen to families and focus on their strengths, and positive behaviour change. Figure 3 shows that most time in the first 12 weeks and subsequently is spent on 'Increasing Safety' (45% in the first 12 weeks and 46% in the period following). This was the case at all three services, though some differences can be seen.

¹⁴ Bruns, E.J., Walker, J.S., Adams, J., Miles, P., Osher, T.W., Rast, J., VanDenBerg, J.D. & National Wraparound Initiative Advisory Group (2004). Ten principles of the wraparound process. Portland, OR: National Wraparound Initiative, Research and Training Centre on Family Support and Children's Mental Health.

Figure 3. Percentage of time spent on EIPs focused on each Resilience Outcome



Source: TBS RF program database.

3.5 Program resourcing and support

In the Preliminary Report we documented the early stage of the RF service, noting a number of challenges especially for staff in a new service developing within a wide-scale organisational practice change. We reported that some staff found learning how to apply the new RPF difficult. For some, their experience had been negatively impacted by delays in training or insufficient integration of RF into TBS’s broader organisational systems and culture at a localised level.

For this report, most TBS staff survey respondents indicated feeling well supported by TBS overall (6 of 9). In particular, staff indicated they ‘always’ or ‘mostly’ felt well supported in the professional supervision they were receiving (7 of 9); organisational induction to TBS (6 of 9); and in the ongoing learning and development provided by TBS (6 of 9).

Consistent with the preliminary data, fewer staff felt ‘always’ or ‘mostly’ supported in their induction and initial training for the RF service (3 of 9), or in ongoing learning and development provided externally (2 of 9). And they were equivocal in their views about support by TBS in relation to equipment and facilities (5 of 9) and organisational systems (4 of 9).

3.6 Joint working between TBS and FACS

The centralised referral process within the RF pilot brings something of a different element to the usual FACS and NGO service provider relationship. Just under half (4 of 9) of the TBS staff survey respondents reported their working relationship with FACS to be 'always' or 'mostly' effective. Three commented positively on the:

- long-standing nature of these relationships
- FACS' staff openness to learning about RF
- FACS' staff co-operative approach.

Other TBS respondents reported their relationship with FACS staff as only 'sometimes' effective. Respondents describe a lack of awareness of the service as most problematic. Looking at the 69 referrals to RF among FACS overall caseload across 9 CSCs helps explain the challenges of effective communication and relationship building. With frequent changes in CSC staff and roles (as perceived by TBS staff), and a dense service network of local programs and services, it is not surprising that not all CSC staff know about the RF service in any detail until they are impacted directly.

Most TBS staff we surveyed (6 of 9) made suggestions as to how the referral process could be improved, and most suggestions were around improving information sharing with FACS, building FACS' staff knowledge of the RF service and improving processes involved for working together. The issues raised were similar across the two Regions, but were more consistently expressed in Region 2. Two staff thought that FACS needs to provide clearer or more detailed information about referred children and family members, and another TBS staff member pointed to a high degree of variability among FACS staff in the level of documentation provided. In interviews, FACS staff have previously spoken about variability in the information available in each individual case. While the requirements for information sharing are outlined in the Operations Manual for the TBS SBB pilot,¹⁵ more communication between FACS and TBS about these requirements for staff may be helpful.

In the Preliminary Report, we recommended FACS and TBS work on relationship building at the local level, including looking at structured approaches to working together such as regular meeting forums. As described below (see 3.8), TBS and FACS have developed, and are implementing a strategy to address these issues.

The current data suggest an ongoing focus on building local CSC staff knowledge and understanding of RF process would be beneficial to continue developing effective pathways and working relationships. TBS reports having visited FACS Regions on different occasions to present information about the RF service to staff but feel they have limited capacity to influence the relationship, especially in relation to joint working arrangements.

¹⁵ Operations Manual for the TBS Social Benefit Bond Pilot p10.

3.7 Differences across sites

The main differences to have emerged so far are around the processes for joint working between TBS and FACS, particularly around the referrals and assessment process. As reported above, TBS and FACS have been implementing strategies to improve working relationships and processes since the period of data collection for this report.

3.8 Culture of learning and adaptation

TBS responded comprehensively to the Preliminary evaluation findings through a Practice Improvement Plan addressing each of the recommendations. Actions within this plan have been completed during the Mid-term evaluation period. The plan reflected five key aims, each outlined below, with a summary of activity undertaken.

1. **Increase the consistency and accuracy of the RF data:** TBS staff were trained in RF database entry and the Resilience Outcomes Tool; the manual for data entry was updated; monthly audits of data entry commenced weekly.
2. **Increase staff skills and confidence using the Resilience Assessment Tool:** TBS staff were given an opportunity to provide feedback to TBS' review of the Resilience Assessment Tool; group coaching sessions were established; a new learning and development plan for new and existing staff covering induction processes (RPF and TBS), the RPF and mandatory training, was developed.
3. **Increase the intensity of service delivery:** Learning circle session on intensity was planned; weekly audits of intensity data commenced.
4. **Continue to build the relationship between TBS and CSCs:** Plan includes establishing a structured approach to communication with FACS and a standard 'Questions and Answers' sheet about the RF service for CSC staff. These actions were planned for 2015 so are outside the scope of this report.
5. **Increase the regional integration of RPF:** During the current evaluation period, TBS had commenced planning to relocate the Campbelltown RF service to Liverpool to improve integration and engagement of TBS staff with other TBS programs and staff; and to address and resolve site level administrative issues.

The impact of some of this work can be seen in the current data, for example in the improvement in service data for service referrals and social connections. The next stage of the evaluation will reflect the two-site service structure and we will look at outcomes in terms of regional differences for the Interim report.

4. Are client outcomes being achieved?

This chapter examines the extent to which outcomes are being achieved for clients to date, and lays the groundwork for the outcomes evaluation, outlining ways in which the outcomes can be measured in the Interim report in 2016.

Early findings show that the Index Children have received slightly more Helpline reports and had more SARAs commence in the measurement period than Control Children, though fewer statutory out-of-home care entries. TBS data show some improvements in functioning and wellbeing among the Index Cohort. When we link TBS and FACS data, we observe that among this small, early cohort, greatest gains were made by families with highest risk profiles.

4.1 Reduced contact with the child protection system

4.1.1 Outcomes for all children in the cohort

The ultimate outcome of RF is that children are safer. The success criteria in the program logic (reflecting the SBB structure) is whether the Index Children have less contact with the child protection system than the Control Children, namely in the numbers of:

1. reports to the Helpline
2. SARAs commenced
3. entries into statutory out-of-home care.¹⁶

Comparison of the Index and Control Children on demographic variables, the number and risk level of Helpline reports prior to referral, the number and outcomes of SARAs prior to referral and the child protection histories of Primary Carers, show the two groups to be highly comparable (see Appendix 6).

The outcomes cohort for this report involves 60 Index Children and their matched pair (n=120). During this initial period of analysis the Index Children (Table 6):

- received slightly more Helpline reports than Control Children (116 compared to 98 reports)
- had more SARAs commence (24 SARAs and two Secondary Risk of Harms (SROHs)¹⁷) compared with 15 SARAs and 1 SROH for the Control Group
- experienced fewer statutory out-of-home care entries (8 entries into statutory out-of-home care for Index Children, compared to 10 entries for the Control Group).

¹⁶ Operations Manual for the TBS Social Benefit Bond Pilot p4, p10.

¹⁷ Another form of FACS assessment also counted within bond measure.

Table 6. Outcomes for all children in cohort

Outcome area	Index	Control	% difference
Reports	116	98	18% more for Index
SARAs	26	16	63% more for Index
Statutory OOHC Entries	8	10	20% fewer for Index

Source: FACS data, n=120 (60 Index and 60 Control).

When we look more closely at the population using TBS data about service participation we can see that families who had met their goals or were continuing in the service performed better on the bond measures than families who had exited through moving away or disengaging. They received fewer reports to the Helpline, had fewer SARAs commence and none had experienced any entries into care.

4.1.2 Reports to the Helpline by sub-group

In the period prior to commencing RF, 40 of the 41 Index Children had been the subject of 204 Helpline reports, an average of 5 per child. Since commencing RF, 24 of these children have been the subject of 86 Helpline reports, an average of 3.6 per child. The total number of children reported to the Helpline decreased by 40% and the total number of reports declined by 58%.¹⁸ The largest change in the number of reports was seen for the children in the group where families met their goals (79%), and the least in the group that exited (42%) (Tables 7 and 33).

Table 7. Change in reports to the Helpline for RF children by service participation

Group	1. Goals met	2. Continuing	3. Exits
Outcome	79% reduction	46% reduction	42% reduction
	Children in 4 of these 7 families had no reports after commencing the service. Total reports for this group fell by 79%, from 33 to 7, and the average number of reports per reported child fell by 2.4 reports, from 4.7 to 2.3.	Reports decreased by 46%, from 24 to 13. Total reports fell by 59%, from 121 to 50, and the average number of reports for those being reported decreased from 5.0 to 3.9 reports.	Eight of the nine children had Helpline reports. Total reports fell by 42%, and the average number of reports per child fell from 5.6 to 3.6 reports.

Source: TBS RF program database and FACS data, n=41.

¹⁸ The preliminary analysis in this report does not control for the differing lengths of time children were in the measurement period prior to or during service, as date of birth data was not available for any Control Children or some Index Children. Average duration in pre and post measurement periods was less than 12 months for all groups and sub-groups compared (see Tables 14 and 15 in Appendix 2).

4.1.3 Safety and Risk Assessments by sub-group

There has been a large decrease in the number of children who are the subject of a SARA commence since commencing RF, but a small increase in the average number of SARAs for each child involved. In the 12 months prior to commencing RF, 47 SARAs had been commenced for 40 of the 41 Index Children, an average of 1.2 per child. Since commencing RF, SARAs have been commenced for only 13 of these children, but with an increased average of 1.5 SARAs commenced. The total number of children for whom SARAs were commenced decreased by 68% and the total number of SARAs commenced decreased by 57% (Tables 8 and 34).¹⁹

Table 8. Change in SARAs commenced for RF children by service participation

Group:	1. Goals met	2. Continuing	3. Exits
<i>Outcome</i>	78% reduction	75% reduction	20% reduction
	Children in 5 of the 7 families that met their goals had not had a SARA commenced since starting in RF. The average number of SARAs commenced decreased from 1.3 to 1.	The number of children in families continuing in the program who had SARAs commenced decreased by 75%, from 24 to 6. Total commencements fell by 64%, from 28 to 10, but the average number of SARAs for those with commencements increased from 1.2 to 1.7 SARAs.	Five of the nine children in the families that discontinued the program had SARAs commenced after beginning the program. Total SARAs commenced fell by 20%, but the average number of SARAs commenced per child rose from 1.1 to 1.6.

Source: TBS RF program database and FACS data, n=41.

4.1.4 Out-of-home care entries by sub-group

None of the 41 Index Children in the evaluation cohort had a statutory out-of-home care entry prior to commencing RF. Six children had a total of six statutory entries after commencement (Tables 9 and 35).²⁰

¹⁹ ²⁰ The preliminary analysis in this report does not control for the differing lengths of time children were in the measurement period prior to or during service, as date of birth data was not available for any Control Children or some Index Children. Average duration in pre and post measurement periods was less than 12 months for all groups and sub-groups compared (see Tables 14 and 15 in Appendix 2).

Table 9. Change in statutory entries for RF children by service participation

Group	1. Goals met	2. Continuing	3. Exits
<i>Outcome</i>	No statutory entries	16% with statutory entry	22% with statutory entry
	None of the 7 children whose families met their goals were placed into statutory out-of-home care.	Four of twenty-five of the children continuing in the program had a statutory entry.	Two of nine children whose families had exited the program had a statutory entry.

Source: TBS RF program database and FACS data, n=41.

4.2 Improvements in wellbeing

4.2.1 Improvements in individual scales

We next look at outcomes in functioning and wellbeing measured through the TBS Resilience Outcomes Tool. The tool includes a range of survey items, of which we are drawing on three of the key measures (see Box 3). The target age for the child-focussed survey, the Strengths and Difficulties Questionnaire, means it only applies for a small sub-set of the Index Children.

Box 3	Resilience Outcomes Scales
	<ul style="list-style-type: none"> ▪ Strengths and Difficulties Questionnaire (SDQ): The SDQ is designed as a brief behavioural screen questionnaire about 4-17 year olds, and can be used for a variety of purposes, including evaluation. The version used in RF is the Parent 4-10 version. The SDQ contains 5 subscales, and a 'Total Difficulties' score, which provides an overall measure of problems. ▪ K-10: The K-10 is a simple measure of psychological distress, used as a brief screening tool. It contains 10 questions about emotional state. ▪ Personal Wellbeing Index (PWI): The PWI has been developed to measure an individual's subjective quality of life, or wellbeing. It contains one overall measure, and seven additional items which are summed to produce an overall score.²¹

The population for the analysis is small, comprising the 13 families for whom we had baseline and review 1 scores available²². We first used the assessment scores to measure changes between baseline and review 1 within each instrument. There are a range of small, positive changes across assessment items and a few minor declines.

²¹ All standardised measures included in the Resilience Outcomes Tool (ROT) were scored according to their existing published manuals. Data had already been recoded where necessary by TBS (i.e. where individual variables had to be reversed due to the question format). A number of items were removed from the tool since the earlier versions, impacting the resilience outcomes and how they were calculated. Other items were added or altered.

²² Note that most items have some missing data; the number of respondents is stated with each description.

4.2.2 Improvements in resilience outcomes

To explore the same data when grouped according to TBS Resilience Outcomes, we created an outcome score for each of the five resilience outcomes. The biggest changes were seen in the 'Increasing Safety' and 'Increasing Self-efficacy' outcomes. There were small increases in each of the resilience outcomes scores between baseline and review 1, indicating an improvement in outcomes as measured by the tool. The majority of items show some improvement (though little can be made of these differences within the current size of the population). Greatest changes were seen in 'Increasing Safety' (Table 10).

The 'Increasing Safety' outcome area has been the main focus of TBS's work with families to date. Areas of greatest change in this area were in Primary Carers being able to cover a \$500 emergency expense, being less likely to feel they need but can't get support, and feeling more satisfied with life as a whole. They were also more likely to have been homeless or given up food or other necessities to pay rent or mortgage in the past year (Table 32).

Table 10. Resilience outcomes scores, change from baseline and review 1

Resilience Outcome	N	Baseline score	Review 1 score	Change
Increasing Safety	13	-0.051	0.183	+0.235
Secure and Stable Relationships	13	-0.097	0.033	+0.130
Improving Coping and Self-regulation	13	-0.052	0.080	+0.132
Increasing Self-efficacy	12	-0.124	0.216	+0.228

Source: TBS RF assessment database, n=13 Note: There was no data available for the improving empathy outcome.

Declines in some survey scores are consistent with TBS' expectations that some outcomes 'get worse' as families become more comfortable with their caseworker, have more awareness of parenting practices, and better understand what their parenting practices could be.²³

4.3 TBS' observations of family benefits

When surveyed about the extent that families receiving the RF service have benefited from it, TBS staff indicated that families benefited 'mostly', and three indicated that families benefited 'always'. No staff felt that families only benefited 'sometimes' or 'rarely'. All staff provided reasons for their rating. In both Regions, although more frequently in Region 1, staff presented positive stories about families where parents/ carers engaged with the service,

²³ This is known as the Dunning-Kruger effect. See Kruger, Justin; Dunning, David (1999). "Unskilled and Unaware of It: How Difficulties in Recognizing One's Own Incompetence Lead to Inflated Self-Assessments". *Journal of Personality and Social Psychology* 77 (6): 1121–34.

leading to improvements in parenting practices and the home environment that benefited children, and which made practical supports available to help through times of crisis. They believe families leave the service as more capable parents, better linked in with supports and with improved relationships with their children. They also described gains in the children's relationships and education, and improvements in their behaviour and presentation, and the home environments as safer, more predictable and more stable.

TBS staff who were surveyed commonly associated a family's 'willingness to receive a service and engage on some level', or to 'acknowledge child protection concerns' with achieving better outcomes. Consistent with this, staff working in both Regions qualified their views about benefits for families who were not well engaged with the service. In these cases, the more minimal direct benefits include having access to immediate, practical assistance ('even if they have not learnt something, they possibly would have benefited practically in one way or another to help them at that current time'). Three staff across both sites also commented that, if a family did not engage at all, then a referral to the RF service still means that risks are identified and documented and that this can support statutory agencies to evidence and action child protection concerns.

4.4 Appropriateness of the bond measures

The bond payment uses a reduction in contact with the child protection system to measure outcomes. The use of reports to the Helpline can be problematic, as children of participating families might have been more likely to be reported as being at risk of harm than comparison group families because they were subject to greater scrutiny and increased interaction with service providers. We know for example, that at least 30 of the Helpline reports were made by TBS while working with RF families. This is known as surveillance bias and is likely to be greater in contexts of mandatory reporting, such as in NSW.²⁴ It can help explain negative findings, though not reliably.

Similarly, the use of SARAs as a measure may be problematic because CSC staff may be more, or less likely to complete an assessment following a report to the Helpline due to a family's participation in RF. In the next report we will compare the number of reports made about Index Children prior to a SARA commencing, to the number of reports made about Control Children before a SARA.

Our analysis will look at a more detailed set of FACS data to better understand the appropriateness of the bond measures and outcomes for children in participating families, including: ROSH and Non-ROSH status of Helpline reports; reported issues; the outcome of safety and risk assessments; and all entries into out-of-home care (see Appendix 5).

²⁴ 2010, SPRC, Brighter Futures Final Evaluation Report <http://apo.org.au/node/23443>.

We will also look at the association between child protection outcomes used for SBB payment purposes and outcomes measured through the TBS Resilience Framework. In the table below we divide the small cohort for whom we have TBS outcomes data (n=13) into two groups according to their baseline assessment score. The group with lower assessed baseline functioning also had more child protection reports prior to starting the service. This table also shows that the reduction in reports was greater for the higher risk group, and functioning improvements were similar. This suggests good alignment between the measures in family presentations, but less in change scores²⁵.

Table 11. Report history and outcomes by resilience baseline assessment outcome

Baseline resilience assessment	Ave. reports pre	Ave. ROSH reports pre	Average total reports during	Average ROSH Reports during	% with statutory entry	Change in outcome index at review 1
Outcome index less than 0 Indicates lower baseline score (n=7)	6.9	3.7	1.9	0.9	14% (n=1)	+0.29
Outcome index greater than 0 Indicates higher baseline score (n=6)	4	2.3	2	0.8	17% (n=1)	+0.32

Sources: TBS RF assessments database and FACS; n=13.

²⁵ The preliminary analysis in this report does not control for the differing lengths of time children were in the measurement period prior to or during service, as date of birth data was not available for any Control Children or some Index Children. Average duration in pre and post measurement periods was less than 12 months for all groups and sub-groups compared (see Tables 14 and 15 in Appendix 2).

5. Does RF offer value for money?

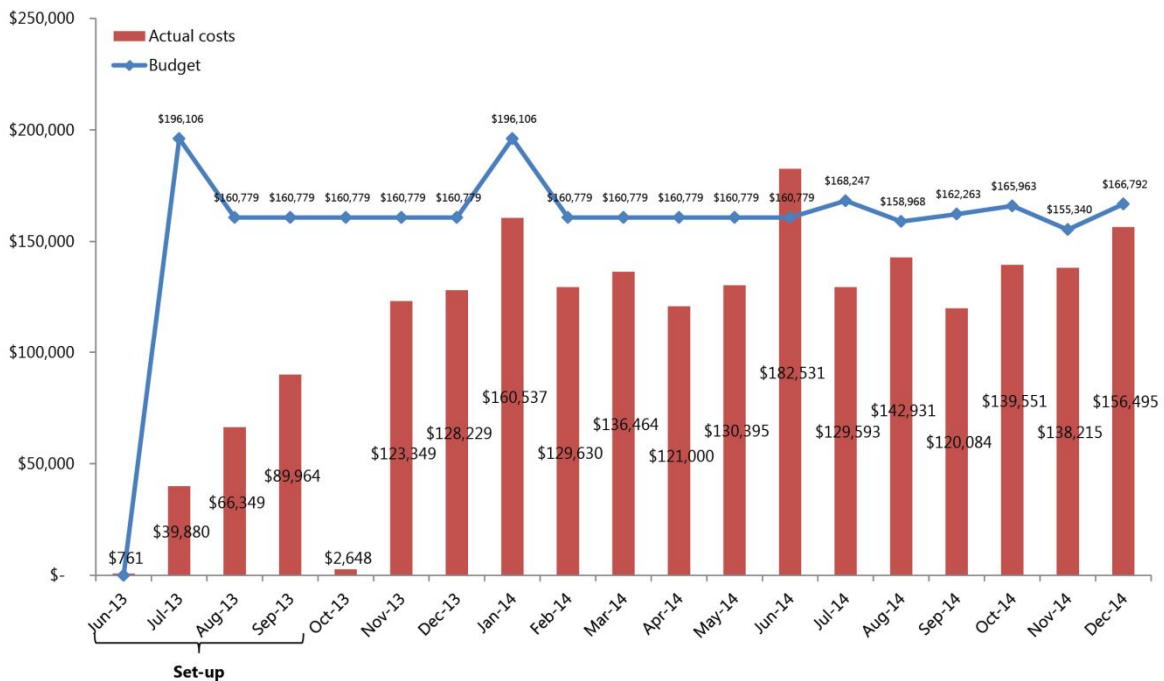
The economic component of this evaluation assesses the value for money of the RF service, comparing actual costs against the initial budget, and the average cost per RF family to that of other similar services.

The total program costs are lower than budgeted which can be accounted for by the start-up period. The average cost per family is higher than budgeted due to a lower number of families commencing the service than expected.

5.1 Budgeted and actual costs

The RF service has been allocated a \$10 million budget over five years, based on a SBB mechanism. Figure 4 presents the actual costs of the service against the budget, by month from June 2013 to December 2014. It shows an initial start-up period to October 2013, when costs associated with service delivery commenced, and these have remained fairly even. To the end of December 2014, the actual costs of the program were \$2,138,605, compared to a budget of \$2,977,572 for the period. This represents 28% less spent than initially planned.

Figure 4. Resilient Families services budget and actual costs, June 2013–December 2014



Source: TBS cost data, June 2013 to December 2014.

5.1.1 Distribution of costs

The distribution of costs shows that staff costs account for almost two-thirds of program costs (62%). Of the amount spent on staff costs, 53% went to caseworkers' salaries, 16% to supervisors/ team leaders and 10% to management. Another one-fifth (21%) was allocated to TBS shared corporate services costs.

5.2 Cost per family

The average cost for the 59 families participating in the RF service up to December 2014 is \$36,248, which is 45% over the initial funding of \$25,000 but is still comparable to budgeted costs in other intensive support programs (Table 12). There were 11 families decline the service (see Table 13), which is impacting on this result. In the next report we will explore cost drivers in more detail and seek further data on the actual costs in other identified programs.

Table 12. Comparison of funding for RF service with similar programs in NSW

Program	Service level	Annualised budget	Annualised target no. families	Avg. funding per family
Resilient Families	Intensive	\$2,000,000	80	\$25,000
Intensive Family Based Service	Intensive	\$3,200,000	88	\$36,364
Intensive Family Support	Intensive	\$6,113,027	170	\$35,959
Intensive Family Preservation	Intensive	\$3,980,443	98	\$40,617

Sources: TBS and FACS.

6. Conclusion and recommendations

This chapter reflects on the key findings from the Mid-term outcomes and process findings and discusses the key issues to have emerged: risk/ needs profile of families, immediacy of referrals, key practice areas, ongoing data improvement and relationship building among TBS and CSC staff.

6.1 Progress with implementation

The Mid-term evaluation has shown the RF service to have moved to a more established stage of implementation. It appears to be a flexible service, responsive to client needs. It is underpinned by an evidence-informed practice framework, which TBS staff are becoming more comfortable with, and finding helpful in informing and structuring their practice. TBS has responded to each of the evaluation Preliminary Report's recommendations to improve data collection, examine practice, address integration issues and keep a focus on building relationships with CSC staff.

6.2 Priorities for ongoing focus

While the service is becoming more mature, the Mid-term findings highlight some areas for further discussion and follow up. In many cases these build on issues first identified in the Preliminary Report.

Targeting high needs families

In chapter 2 we discuss the profile of participating families based on evidence that some families being referred are below the risk threshold for an intensive service. We propose two strategies—firstly, working towards ensuring that high risk families are referred. In the event this is not feasible due to systemic or other constraints, we propose that TBS develops a framework for segmenting clients according to need, and adjust caseloads accordingly.

Achieving greater immediacy in the referral process

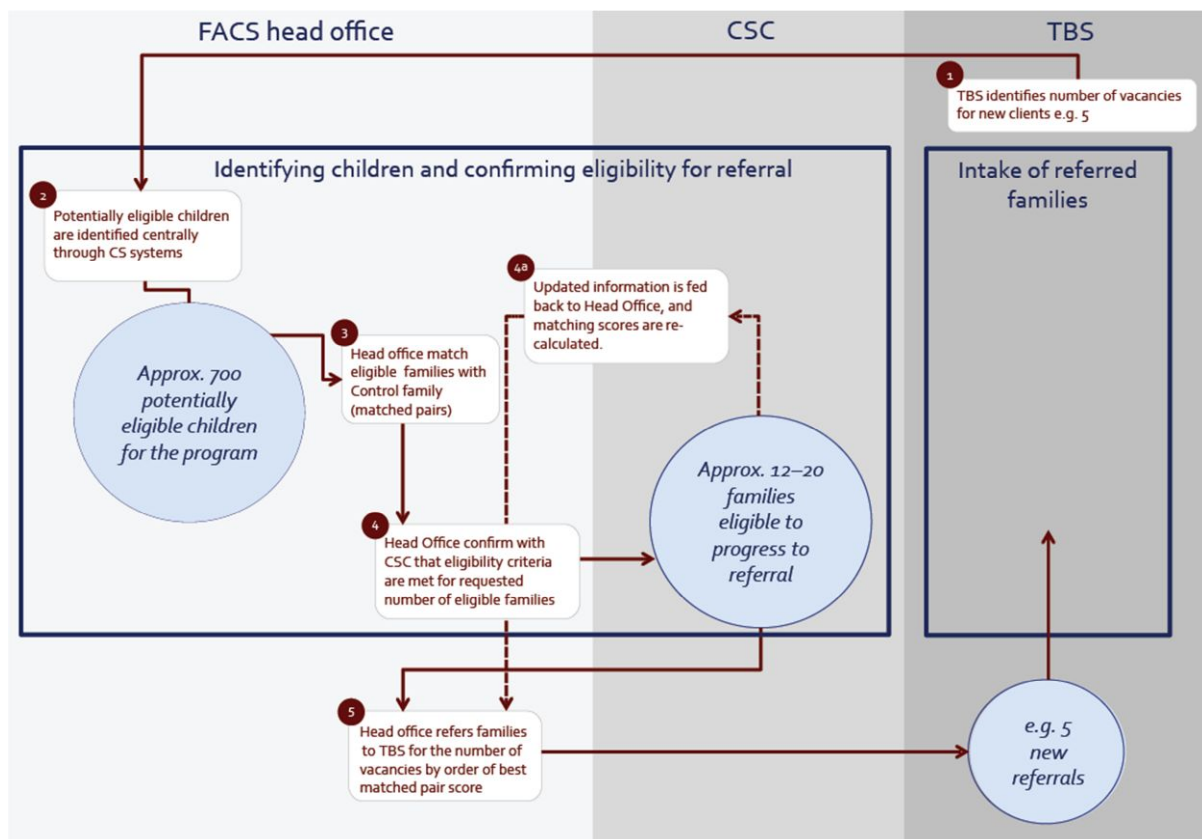
As described earlier and outlined in the RF program logic, the service model is underpinned by the theory that crisis acts as a motivator for change. In the report we identify two barriers to achieving immediacy in the RF referral process.

One is the eligibility criteria for families to have a SARA commence up to 35 days prior to referral. A diagrammatic representation of the process for identifying families shows a high number of eligible families are initially identified, and then filtered through a process of

matching and information checking with the CSC. It may be possible to factor in the immediacy of the intervention for individual families, in this process.

The second barrier to immediacy is that it is taking longer than planned, in some cases, to complete the initial home visit after making contact with families. We recommend that TBS and FACS continue to work together on this issue, with the aim of improving CSC staff understanding of the importance of immediacy within the model.

Figure 5. Centralised referral process from FACS to TBS



Maintaining a focus on key practice areas

TBS should continue to focus on areas of casework of particular significance for outcomes, including a home-based service, delivered flexibly and at key times of the day, making links to external services as needed, building social connections and natural supports, and delivering an initially intensive, then tapering service.

Continuing data improvement efforts

TBS should also continue its activity to support understanding and build consistency in recording practice within the RPF, and where possible, provide benchmarks for the application of the RPF.

Continuing to build relationships between TBS and CSC staff

Overall, relationships between TBS and CSC staff are positive and effective, but under half (4 of 9) reported their working relationship with FACS to be 'always' or 'mostly' effective. As a theme in TBS feedback in both evaluation reports this warrants further discussion. The challenges seem greatest in Region 2, where we were unable to interview any staff so do not understand the issue from their perspective.

TBS is working on a joint strategy toward more structured forums for communication with FACS. These actions were planned for 2015 and will be reported on in the next report. We also recommend FACS review CSC staff access to information about RF from a FACS operational perspective.

6.3 Recommendations

On the basis of the Mid-term findings we recommend the following.

1. TBS and FACS review referred cases where families are perceived to be under the threshold for an intensive service, to identify the factors impacting on decisions to refer these cases, e.g. eligibility criteria, FACS knowledge about or confidence in the service; and identify actions that could be taken to address factors impacting on low risk families being referred, e.g. adjustment in the process for identifying families and/or a process for ongoing review where TBS assesses referred families as low needs.
2. In the event that lower risk families continue to be referred to RF, TBS updates program documentation to explicitly describe the service as flexible in terms of intensity, and ensure caseloads are adjusted to reflect different intensities and durations; within this model allow individual staff to develop expertise in different styles of work, crisis, motivational, long-term, etc.
3. FACS considers whether there can be greater account of immediacy in the process of filtering eligible families to refer.
4. TBS and FACS continue to work together to increase knowledge about the RF service among CSC staff, especially in Region 2, with the aim of developing a shared understanding of information to be shared through the referral process and meet TBS timeframes for completing joint initial home visits.
5. TBS continues to review practice in relation to the intensity of the service and in working with families at home to model effective routines and behaviours.
6. TBS to continue work to build the accuracy, consistency and completeness of the data in key areas such as service referrals, social connections, intensity and duration of service and application of the RPF.

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Appendix 1: Evaluation questions

Process 1. How well are targeted clients being identified and referred to the program?

- What are the characteristics of participants in terms of their needs and risk level? Are these as expected?
 - Do the referral criteria or processes need to be revised or refined? Is the matching process resulting in high risk groups of clients not being referred, or lower risk clients being over represented in the program or over-servicing of those referred?
-

2. To what extent is the service being delivered as intended?

- Are planned timeframes for assessment, review and program duration being met?
 - What is the nature and intensity of the service being delivered, e.g. individually targeted, which evidence-based practices are being employed?
 - How well are participants being linked into relevant services and making broader social and community connections?
 - What affects the individualisation of plans and what are caregivers' experiences of the process? What helps and what hinders?
 - What is effective in helping families access and build natural supports and what are the barriers?
 - Is the program sufficiently well-resourced and supported, including staff skills and professional support and development, clear guidelines, etc.?
 - How do the processes for joint working between TBS and FACS differ from business as usual, including regular data provision, and to what effect?
 - To what extent has TBS developed a culture of learning and adaptation in delivering the program? What has facilitated this and what are the outcomes?
 - What differences can be observed across sites and what are the implications of any differences for clients and program outcomes?
-

Outcomes 3. What are the outcomes of the RF service for participants?

- Do Index Children have less contact with the child protection system than the comparison group?
 - What changes in functioning and wellbeing are seen for Index Children and their families? What new skills and behaviours have parents/ carers learned?
 - Who does the program appear to work best for?
 - Which service components appear to be most important for achieving
-

benefits?

- Are there other observable outcomes not reflected through key outcome measures?
-

4. How appropriate are the measures in place for the bond payment?

- What is the association between child protection outcomes used for SBB payment purposes and outcomes measured through the TBS Resilience Framework?
-

Economic 5. Does the program offer value for money?

- What are the actual (versus budgeted) costs of the program?
 - How do these costs compare to similar programs in NSW and in other jurisdictions?
-

Appendix 2: Methods

Design

We are using a mixed-methods design to collect evidence against the evaluation questions. In summary, the data sources used in this report are as follows.

- Survey of TBS staff (n=10, 9 responses: 8 complete, 1 partial)
- Interviews with FACS staff (n=2, Region 1 only)
- Program costs and administrative data provided by TBS and FACS
- Remediated, aggregate TBS service monitoring data covering the period 8 October 2013 to 29 November 2014 (informs the referral analysis)
- Unit record TBS service monitoring and client assessment data covering the period 8 October 2013 to 29 November 2014 (informs the client profile and service delivery analyses)
- Remediated, aggregate TBS client numbers covering the period 8 October 2013 to 30 December 2014 (informs the cost analyses)
- Unit record FACS data covering periods prior to and since service participation (informs client profile and outcomes analyses).

Quantitative data sources

The analysis of families and their outcomes draws on seven datasets, five from FACS and two from TBS, as described below.

TBS RF data

TBS RF Client details database—a custom built Excel database that details a client’s entry into the service, the type, frequency and duration of service they receive, and reasons for and supports in place around their exit from the service. This database was provided on 5/12/2014, and we undertook some cleaning to make it complete to 29/11/2014. This database contains the records of the 49 Index Children and their families who were referred between 17/10/2013 and 20/11/2014, commenced in the service and consented to participate in this evaluation.

TBS Assessments data

TBS Assessments database—an SPSS data file containing the results of the Resilience Outcomes Tool for each family. This tool measures the five resilience outcomes as defined by TBS. This database included records for 36 families overall, each of which have some baseline data, and 13 of which also have data from the first review. This database was provided on 11/12/2014.

FACS demographic data

An Excel spreadsheet containing the Index/ Control status and pair identifier, measurement period start and end dates, and key bond matching criteria data for each of 60 Control and 60 Index Children, and one unmatched Index Child. The measurement period start date for these Index Children ranges from 17/10/2013 to 29/10/2014. This set includes data for the 11 Index families who refused the RF service and the 9 families who accepted the service but refused the evaluation, excludes data for 6 excluded pairs, and does not have data for 4 families referred to TBS close to or shortly after 29/10/2014.

FACS reports data

A spreadsheet of all reports for each of the CYP in the Intervention and Control Groups as detailed above from 12 months prior to their measurement start date until 12 December 2014. It includes all non-cancelled contact records where CYP is a subject of the record and contact record meets standard counting rules for definition of a 'report', detailing the start date, ROSH/ Non-ROSH outcome and primary reported issue for each report. It was extracted from CIW Production on 12/1/2015, and we undertook some cleaning to make it complete to 29/11/2014. The contact start date for the reports ranges from 16/11/2012 to 25/11/2014.

FACS Safety and risk and secondary assessments data

A spreadsheet of all secondary assessments undertaken for each CYP in the intervention and Control Groups from 12 months prior to their measurement start date until 12 December 2014. It includes all non-cancelled Secondary Assessment Stage 2 records where CYP is a subject of the record, and excludes records where safety assessment element = Draft, and details assessment type, dates, assessed issues, and safety and risk outcomes. It was extracted from CIW Production on 12/1/2015 and we undertook some cleaning to make it complete to 29/11/2014. SAS2 start dates range from 21/01/2013 to 24/11/2014.

FACS out-of-home care data

A spreadsheet of out-of-home care information for CYP in the Intervention and Control Groups as detailed above from 12 months prior to their measurement start date until 29 November 2014. It includes only primary placements that commence on or before 29/11/14, and excludes cancelled placements and those with parents or respite placements. The list details the total number and duration of out-of-home care placements in the 12 months before and during the measurement period, the number of these placements which included a statutory care entry, the date of the first placement post-measurement start date, and whether the child was in care at the measurement start date. It was extracted from CIW Production on 16/3/2015. Measurement period start dates range from 30/08/2013 to 16/10/2014.

Child protection and out-of-home care data for the Primary Carers of the above described Index and Control Children from when they were themselves a child. This data includes records only for those who were resident in NSW as a child, and covers time periods with differing reporting and care frameworks and practices. The data includes the number of child and young person concern/ child protection reports, the number of ROSH or Referred reports, and the total number of days in care in all care periods, for each instance in which the parent was the subject. It was sourced from the Child Protection historical SPSS database as of 30 June 2014, and was provided on 14 April 2015.

Linking datasets






The data was provided over five months, from November 2014 to April 2015. TBS and FACS enter and exit families from their systems at different times, and treat groups of families in different ways in terms of data capture and reporting, reflecting the families' trajectories through the two different systems, and the different purposes of each data collection. In Table 13 below we map out data sources and populations to define the cohorts used in the report. The families described in the first four rows make up the 60 families in the Index Cohort. Other cohorts are shown through shading and colour highlights explained in the legend below Table 13.

Table 13. Analysis of cohorts by data sources

Description	N cases referred to TBS	Data source				
		FACS child CP data	FACS Carer CP data	TBS program data	TBS baseline assess data	TBS first review data
Families who have been in the program long enough for a first TBS review.	13	✓	✓	✓	✓	✓
Families who have NOT been in the program long enough for a first TBS review.	19	✓	✓	✓	✓	
Families for which baseline assessment has not yet been completed.	8	✓	✓	✓		
11 families that declined the service and 9 families that declined the evaluation.	20	✓	✓			
1 unmatched Index Child. ^	1	✓	✓	✓	✓	
1 early exit from RF.	1		✓	✓	✓	
1 early exit from RF; 1 new client with match to be finalised on birth.	2			✓	✓	
New clients to TBS, including 1 new client with match to be finalised on birth.	5			✓		
1 early exit in FACS data, with no reference in TBS data (possibly seen as refused by TBS).#	0		✓			
1 to be finalised on birth (no data).#	0					
Total cases included by data source	69	61	63*	49	36	13

*Not all carers had child protection (CP) data as a child; this figure assumes that the records were searched for all 61 Index Children; data was provided for an additional 2 children, who had been early exits. CP data includes Helpline reports, SARAs commenced and number and duration of OOHC placements. ^Unmatched Index Children will be included in the final analysis. # These families make a total of 71 cases known to the evaluation but are not included as referred clients in any analysis.

Key

-  60 matched Index Children (and their 60 matched Control Children), used in comparisons of Index and Control Children on Helpline reports, SARAs and OOHC histories and outcomes.
-  41 families with FACS and TBS program data, used in analysis of Helpline reports, SARAs and OOHC placements by service status.
-  49 families with TBS program data used to describe service users' basic demography and service use patterns, duration and intensity.
-  36 families with TBS assessments data used to describe service users detailed demography and baseline resilience profiles.
-  13 families who have had a resilience review used to analyse child protection and resilience outcomes by baseline resilience assessment.

Quantitative analysis

Index and Control Children and the bond calculation cohort

The Index and Control Child data provided for this report includes 60 Index Children and their 60 Control counterparts and one unmatched Index Child. It excludes 10 families: 3 families TBA on birth, 3 families who were early exit from treatment area, and 4 families with insufficient observations. The bond payment calculation is based on an 'intention to treat' model and will be conducted on all Index Children referred to RF, with the following exceptions:²⁶

- Index Children who are not yet born and hence not yet matched at the date of extraction (TBA on birth)
- Index Children whose families have moved away from the catchment areas for the service within 3 months of referral (early exit from treatment area)
- Index Children that are Index Children whose initial Safety Assessment decision has been reversed, such that they are outside the criteria for the RF service, or are removed by FACS into out-of-home-care ('Unsafe')
- Index Children who have been referred to RF within the six weeks prior to data extraction (insufficient observations).

The outcomes evaluation combines these data with the more detailed set of child protection data, together with TBS assessment and service data, to better understand the outcomes being achieved and help assess the appropriateness of the bond measures. For this report, we explore outcomes through four sets of analysis, each drawing on different combinations of data.

Four sets of outcomes analysis

1. Comparison of Helpline reports, SARA commencements and out-of-home care entries for children referred to the program (Index Children) and a matched Control Group (Control Children) (n=60 Index and n=60 Control; total n=120).
2. Analysis of the Helpline reports, SARA commencements and out-of-home care entries for children in the program, augmented by TBS data about RF service participation (n=41).
3. Analysis of resilience outcome change scores for RF clients who have completed a baseline assessment at entry and review 1 at about 4 months (n=13).
4. Analysis of resilience outcome change scores for RF clients who have completed a baseline assessment and review 1 augmented by Helpline reports, SARA commencements, out-of-home care entries and TBS RF service data (n=13).

²⁶ Operations Manual for the TBS Social Benefit Bond Pilot p 25.

Preliminary results

The final analysis looks at child protection data and TBS service data for these 13 families. We divide the cohort into two groups according to their baseline assessment score. The group with lower assessed baseline functioning also had:

- more child protection reports prior to starting the service
- received a more intensive service
- child protection outcomes comparable to those with higher baseline functioning.

While the population is too small to draw conclusions, the data provide a positive indication the service is working well for high needs families, in terms of the service response and its impact.

The key outcomes measured reflect the goals of the SBB pilot to prevent reports to the Helpline, SARAs commenced and placements into out-of-home care.

Tables comparing pre and post measurement periods for comparison groups and sub-groups

The preliminary analysis in this report does not control for the differing lengths of time children were in the measurement period prior to or during service, as date of birth data was not available for any Control Children or some Index Children. Average duration in pre and post measurement periods was less than 12 months for all groups and sub-groups compared, as shown below (Tables 14 and 15).

Table 14. Pre and post measurement periods for Index and Control Children

Group	N	% unborn and under 1 year at commencement	Mean months of service or measurement period
Index	60	42%	8.25
Control	60	42%	10

Source: FACS data, n=120.

Table 15. Pre and post measurement periods for RF families by service status

Group	N	% unborn and under 1 year at commencement	Mean months of service or measurement period
Continuing in program	31	52%	7
Family met goals	7	43%	10
Family discontinued	11	44%	9.75

Source: TBS RF program database data, n=49.

Appendix 3: Client referral data

Referral process

In total, 69 families were referred to the RF service. Of these, 58 commenced and 11 declined. Of the 58 who commenced, 49 agreed to participate in the evaluation. Almost half the referrals were for Rosebery, with the other half evenly distributed across the two service locations in Region 2.

Table 16. Total referrals by service location

TBS SBB pilot Region	Service location	Commenced service and consented to evaluation	Commenced service and did not consent to evaluation	Declined service	Total referred
Region 1	Rosebery	25	2	2	29
Region 2	Campbelltown	13	2	6	21
	Liverpool	11	5	3	19
Total referrals		49	9	11	69

Source: Remediated TBS RF data from period 8 October 2013 to 29 November 2014.

Timeframe for fulfilling referral requests

Two-thirds of referrals were completed within the initial 10-day target and the remaining third within the secondary target of 20 days. The 12 unfulfilled vacancies in the RF service occurred in the first 3 months of operation.

Table 17. Vacancies declared by TBS and referral outcome

Number of vacancies	Count	Per cent
Vacancies met by referral within 10 days	54	64%
Vacancies met by referral between 10 and 20 days	18	21%
Vacancies met by referral over 20 days	0	0%
Unfulfilled vacancies	12	14%
Total vacancies notified	84	100%

Source: Remediated TBS RF data from period 8 October 2013 to 29 November 2014.

Family and carer characteristics

Table 18. Primary Carer characteristics

Primary caregiver characteristics		Campbelltown	Liverpool	Rosebery	Total
	n	10	9	17	36
Age at referral	Average (mean)	32.6	32.8	29.5	31.3
	Missing data	2	0	3	5
Gender	Male	10%	0%	8%	6%
	Female	90%	100%	92%	94%
	Missing data	0	0	4	4
Employment situation	Employed full time	0%	0%	15%	6%
	Employed part time	10%	0%	0%	3%
	Employed casual	0%	0%	8%	3%
	Full time carer/parent	70%	56%	62%	63%
	Unemployed	20%	44%	15%	25%
	Missing data	0	0	4	4
Main source of income	Wages or salary	0%	0%	14%	6%
	Child support or maintenance from ex-partner	0%	0%	7%	3%
	Government benefit, pension or allowance	100%	100%	79%	91%
	Missing data	0	0	3	3
Highest level of education achieved	Less than HSC or equivalent	90%	57%	74%	76%
	HSC or equivalent	0%	29%	17%	14%
	Post-school qualification	10%	14%	8%	10%
	Missing data	0	2	5	7

Source: TBS RF baseline assessment, n=36.

Table 19. Secondary Carer characteristics

Secondary caregiver characteristics		Campbelltown	Liverpool	Rosebery	Total
n		8	8	11	27
Age at referral	Average (mean)	38.1	30.3	40.8	37.2
	Missing data	1	2	1	4
Gender	Male	88%	75%	90%	85%
	Female	13%	25%	10%	15%
	Missing data	0	0	1	1
Employment situation	Employed full time	0%	20%	13%	10%
	Employed casual	29%	20%	38%	30%
	Full time carer/parent	29%	20%	13%	20%
	Unemployed	43%	40%	38%	40%
	Missing data	1	3	3	7
Main source of income	Wages or salary	33%	40%	25%	32%
	Government benefit, pension or allowance	67%	60%	63%	63%
	No income source	0%	0%	13%	5%
	Missing data	2	3	3	8
Highest level of education achieved	Less than HSC or equivalent	83%	50%	33%	64%
	HSC or equivalent	0%	50%	33%	18%
	Post-school qualification	17%	0%	33%	18%
	Missing data	2	6	8	16

Source: TBS RF baseline assessment n=36, 9 families do not have a Secondary Carer.

Table 20. Type of housing

	Campbelltown	Liverpool	Rosebery	Total
n	9	7	15	31
Own or am paying off house/ flat	11%	14%	13%	13%
Public housing	33%	43%	27%	32%
Private rental house/ flat/ unit	33%	29%	27%	29%
Stay with family or friends	11%	14%	7%	10%
Caravan	0%	0%	0%	0%
Crisis/ temporary housing	11%	0%	27%	16%
Homeless	0%	0%	0%	0%
Missing	1	2	2	5

Source: TBS RF baseline assessment data, n=36.

Table 21. Language spoken at home by service location

	Campbelltown		Liverpool		Rosebery		Total	
	n	%	n	%	n	%	n	%
English	9	90%	8	89%	15	88%	32	89%
Chinese languages	1	10%	0	0%	1	6%	2	6%
Turkish	0	0%	0	0%	1	6%	1	3%
Other (not defined)	0	0%	1	11%	0	0%	1	3%
Total	10	100%	9	100%	17	100%	36	100%

Source: TBS RF baseline assessment data, n=36.

Index Child characteristics

Table 22. Average age and gender of Index Children across sites

Age at referral	Campbelltown	Liverpool	Rosebery	Total
n	9	9	15	33
Average age	2.0	1.7	2.0	1.9
Gender				
n	8	8	15	31
Male	75%	38%	33%	45%
Female	25%	63%	66%	55%
Missing	1	1	0	2

Source: TBS RF baseline assessment data n=36, 3 unborn children excluded.

Table 23. Aboriginal or Torres Strait Islander

Identifies as ATSI	Campbelltown	Liverpool	Rosebery	Total
n	9	9	14	32
No	100%	89%	79%	88%
Yes	0%	11%	21%	12%
Missing	0	0	1	1

Source: TBS RF baseline assessment data n=36, 3 unborn children excluded.

Table 24. Number of times the family has moved house in past 12 months

	Campbelltown	Liverpool	Rosebery	Total
n	10	9	14	33
Not at all	50%	67%	50%	55%
Once	0%	11%	7%	6%
Twice	20%	11%	21%	18%
Three times	10%	11%	7%	9%
Four times or more	20%	0%	14%	12%

Total	100%	100%	100%	100%
Missing	0	0	3	3

Source: TBS RF baseline assessment data, n=36.

Table 25. Primary reported issue of Index and Control Children after service commencement

Primary reported issue	Index	Control
Inadequate Supervision for age	11%	8%
Risky of physical harm/ injury	11%	7%
Emotional state of carer	10%	2%
DV Child/n exposed to violence	9%	4%
Drug abuse by carer	8%	12%
Risk of sexual harm/ injury	7%	15%
Risk of Psychological harm	7%	6%
Physical: other	6%	6%
Physical: Hit, kick, strike	4%	2%
Inadequate shelter or homeless	3%	5%
No Harm or Risk issues	3%	5%
Neglect: Hygiene	3%	4%
DV- Domestic Violence	3%	3%
Psychiatric disability, carer	3%	2%
Alcohol abuse by carer	3%	0%
CYP is danger to self/ others	2%	0%
Sexual: indecent acts/ molest	2%	0%
Sexual Penetration	1%	2%
Prenatal Report	1%	1%
Suicide risk/ attempt of carer	1%	1%
Inadequate Clothing	1%	0%
Inadequate Nutrition	1%	0%
Physical: Strangle/ suffocate	1%	0%
Drug use by child or young person	0%	6%

Primary reported issue	Index	Control
Legal Guardianship issues	0%	2%
Alcohol use by child or young person	0%	1%
Carer in prison	0%	1%
Medical treatment not provided	0%	1%
Neglect EDU: Habitual Absence	0%	1%
Unauthorised OOHC arrangement	0%	1%

Source: FACS data, n=120 (60 Index and 60 Control).

Table 26. Primary assessed issue for Index and Control Children

Primary assessed issue	Index	Control
Emotional state of carer	27%	0%
DV, Child exposed to violence	15%	6%
Inadequate Supervision for age	12%	0%
Alcohol abuse by carer	8%	0%
DV, Domestic Violence	8%	0%
Risk of sexual harm/injury	8%	6%
Drug abuse by carer	4%	6%
No Harm or Risk issues	4%	31%
Physical: Hit, kick, strike	4%	0%
Physical: other	4%	6%
Risk of physical harm/injury	4%	0%
(blank)	4%	13%
Drug use by child or YP	0%	6%
Legal Guardianship issues	0%	6%
Physical disability of carer	0%	6%
Psychiatric disability, carer	0%	13%
Grand Total	100%	100%

Appendix 4: Implementation of RF data

Table 27. Days from referral to commencement of Resilience Assessment Tool by service

Location	Families N	Mean	Standard deviation	Minimum	Maximum	N Missing (Not commenced)
Campbelltown	10	48	26	10	88	3
Liverpool	9	53	23	29	89	2
Rosebery	20	68	61	23	230	5
Total	39	59	47	10	230	10

Source: TBS RF program database, n=49.

Table 28. Average weekly number and duration of face-to-face meetings with clients per week

Period	Measure	Type of interaction	Families N	Mean	Standard Deviation	Minimum	Maximum
First 12 weeks	Number	Face-to-face	47	1.3	0.6	0.25	3
	Duration	Face-to-face	47	1.93	1.34	0.31	8.9
After 12 weeks	Number	Face-to-face	29	0.94	0.52	0.2	2.18
	Duration	Face-to-face	29	1.63	1.27	0.37	5.23

Source: TBS RF program database, n=49; 2 families were yet to have their first meeting with the service.

Appendix 5: Extended outcomes data

Bond data analysis

The data in this section looks at a more detailed set of FACS data concerning RF participants during the service. It includes:

- ROSH and Non-ROSH status of Helpline reports
- reported issues
- outcome of safety and risk assessments
- all entries into out-of-home care.

Reports to the Helpline

Since commencing the service, Index Children have been the subject of 116 reports, while Control Children have been the subject of 98 reports within the same period (Table 29). This is a difference of 18 reports, or an increase of 18% in the number of reports for the Intervention Group compared to the Control Group. Index Children had a higher proportion of reports that were ROSH reports than those in the Control Group (56% Index vs. 44% Control).

Table 29. Helpline reports by proportion ROSH and Non-ROSH during service

	Number reports	% Non ROSH	% ROSH	Total
Index	116	44%	56%	100%
Control	98	51%	49%	100%
Total	214	47%	53%	100%

Source: FACS data, n=120 (60 Index and 60 Control).

In the period during service, children in the Control Group were more likely than children in the Intervention Group to have risk of sexual harm/ injury (15% Control vs. 7% Index) or drug abuse by carer (12% Control vs. 8% Index) as the primary reported issue. Index Children were more likely than their matched Control to have primary risks of domestic violence/ child exposure to violence (9% Index vs. 4% Control), emotional state of carer (10% Index vs. 2% Control) or risk of physical harm/ injury (11% Index vs. 7% Control). Inadequate supervision for age was the primary reported issue for similar proportions of both groups (11% Index vs. 8% Control) (Table 25, Appendix 3).

Safety and Risk Assessments

Through the evaluation data we also know that safety outcomes for Index Children have been predominantly ‘Safe with plan’ (42% Index vs. 33% Control), whereas those for Control Children have been predominantly ‘Safe’ (47% Control vs. 38% Index). Similar proportions of both groups have a safety outcome of ‘Unsafe’ (19% Index vs. 20% Control) (Table 30).

Table 30. Safety outcome of SARAs during service

	Safe	Safe with plan	Unsafe	Total
Index	38%	42%	19%	26
Control	47%	33%	20%	15

Source: FACS data n=120 (60 Index and 60 Control) Note: One Control SARA did not have a safety outcome recorded.

Risk assessments were completed for 25 of the 26 SARAs commenced for the Index Children and for 12 of the 16 SARAs commenced for the Control Children. A greater proportion of risk assessment outcomes were ‘very high’ or ‘high’ for Index Children than for Control Children (92% Index vs. 83% Control). The remaining risk assessment outcomes were ‘moderate’ for Control Children (17%) and ‘moderate’ (4%) or ‘low’ (4%) for the Index Children (Table 31).

Table 31. Risk outcome of SARAs during service

	Very high	High	Moderate	Low	Total
Index	36%	56%	4%	4%	25
Control	33%	50%	17%	0%	12

Source: FACS data n=120 (60 Index and 60 Control) Note: One Index and 4 Control SARAs did not have a risk outcome recorded.

Primary assessed issues for Control and Index Children were quite different (Table 26, Appendix 3). Index Children were more likely to have domestic violence/ child exposed to violence (23% Index vs. 6% Control) or emotional state of carer (27% Index vs. 0% Control) as the primary assessed issue. Control Children were more likely to have no harm or risk issues (31% Control vs. 4% Index) or psychiatric disability of carer (13% Control vs. 0% Index) as the primary assessed issue.

Entries to out-of-home care

Four of the Control Children were in care at the time of commencement of the measurement period and three of these children continued in that placement until data extraction. When comparing the average number of days in placements for all children who were in or commenced a placement after entry into the program or measurement period, Index

Children had fewer days on average in out-of-home care (145) than Control Children (191) (Table 32). Index Children also have a lower average number of placements (1.5) than Control Children (1.8) in the period after entry or measurement, comparing those who were not in continuous placements, and a lower number of statutory out-of-home care placements (8 Index vs. 10 Control).

Table 32. Out-of-home care data during service

	Children with subsequent placements not in OOHC at start	Number of OOHC placements	Care days	Statutory care entries	Mean days	Mean OOHC placements
Index	10	15	1449	8	145	1.5
Control	12	22	2865	10	191	1.8

Source: FACS data n=120 (60 Index and 60 Control).

Outcomes by service outcome analysis

Table 33. Reports to the Helpline before and during service by service outcome*

	Prior to service			During service			Change			
	Number of children reported	Number of reports	Mean reports per child	Number of children reported	Number of reports	Mean reports per child	Decrease in children reported	Decrease children reported %	Decrease in number of reports	Decrease reports %
Family met goals	7	33	4.71	3	7	2.33	4	57%	26	79%
Continuing in program	24	121	5.04	13	50	3.85	11	46%	71	59%
Family discontinued	9	50	5.56	8	29	3.62	1	11%	21	42%
Total	40	204	5.1	24	86	3.58	16	40%	118	58%

Source: TBS RF program database and FACS data, n=41.

The proportion of ROSH and Non-ROSH reports was consistent for all groups before the program, at about 40% Non-ROSH and 60% ROSH. After commencing the program, the proportion of Non-ROSH reports increased by 16% for the children in families that had met

their goals, by 8% for the families that had discontinued, and it remained unchanged for the children continuing in the program²⁷.

Table 34. SARAs commenced before and during service by service outcome*

	Prior to service			During service			Change			
	Number of children with SARA(s)	Total SARAs	Mean SARAs per child	Number of children with SARA(s)	Total SARAs	Mean SARAs per child	Decrease in children with SARA(s)	Decrease children with SARAs %	Decrease in number of SARAs	Decrease SARAs%
Family met goals	7	9	1.29	2	2	1	5	71%	7	78%
Continuing in program	24	28	1.17	6	10	1.67	18	75%	18	64%
Family discontinued	9	10	1.11	5	8	1.6	4	44%	2	20%

Source: TBS RF program database and FACS data, n=41.

Table 35. Out-of-home care placements before and during service by service outcome*

	Placements post			Care days post			Statutory care Entries post		
	Number of CYP with placements	Total placements	Mean placements per CYP	Number of CYP in care	Total care days	Mean care days per CYP	Number of CYP with SC entries	Total SC entries	Mean SC entries per CYP
Family met goals	0	.	.	0	.	.	0	.	.
Continuing in program	5	7	1	5	501	100	4	4	1
Family discontinued	2	4	2	2	392	196	2	2	1

²⁷ * The preliminary analysis in this report does not control for the differing lengths of time children were in the measurement period prior to or during service, as date of birth data was not available for any Control Children or some Index Children. Average duration in pre and post measurement periods was less than 12 months for all groups and sub-groups compared, see Tables 14 and 15 in Appendix 2.

Total	7	11	2	7	893	128	6	6	1
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Source: TBS RF program database and FACS data, n=41.

TBS outcomes data analysis

Strengths and Difficulties Questionnaire (SDQ)—The SDQ measures the psychological attributes of children in five areas (Box 4). Seven families had completed the SDQ at both baseline and at review 1. There was an increase in scores, indicating worsening outcomes over time in four of the subscales. This means that these seven Primary Carers felt that their children were exhibiting greater difficulties at review 1 than when they started RF.

Box 4 Strengths and Difficulties Questionnaire (SDQ)

The SDQ questionnaire classifies psychological attributes into 5 subscales: emotional symptoms, conduct problems, hyperactivity, peer problems, pro-social behaviour. The first four of these subscales can also be summed to generate a 'total difficulties score'; an overall measure of the difficulties that the child faces. There are also cut-off scores for each of the subscales, and if children are scored above these this is considered evidence of a problematic area.

Kessler-10—The K-10 is a simple measure of psychological distress generally used as a brief screening tool. The 12 Primary Carers who had completed the K-10 at both baseline and at review 1 had an average baseline score of 16.8, slightly elevated from the general Australian population. There was a very small increase in the mean score for these families to 17.7 at review 1, indicating a slight increase in distress among Primary Carers at this point.

Box 5 K 10

Within the K-10, possible scores range from 10 (low distress) to 50 (very high distress), with the average population level score being 14.5.

Personal Wellbeing Index (PWI)—The 12 RF families with scores at baseline and review 1 scored 63.8 at baseline, showing lower wellbeing among RF families than the general population. The mean PWI score of this group increased to 66.1 at review 1, indicating an improvement in subjective wellbeing among this group. However, this is still substantially below the average Australian score for this measure.

Box 6 Personal Wellbeing Index (PWI)

The PWI has been developed to measure an individual's subjective quality of life, or wellbeing. The measure produces a score out of 100, with a higher score indicating greater subjective wellbeing. The average score among Australians is between 73.7 and 76.7.

Resilience outcomes

To explore the same data when grouped according to TBS Resilience Outcomes, we created an outcome score for each of the five resilience outcomes. These were calculated by standardising the different survey items (creating 'z-scores' using the mean and standard deviation of each variable at baseline), and then finding the average (mean) of all the standardised scores within each outcome.

The outcome which TBS staff spent most time and where change was greatest was 'Increasing Safety'. Change scores for the items in this area are below.

Table 36. Increasing Safety measures: baseline and review 1

Item	Question/ subscale	N	Measure	Baseline	Review 1	Change
Family Resource Management	'During the past year, have you been homeless or had to give up food or other necessities to pay your rent or mortgage?'	11	% No	73%	63.6%	-9.4%
	'If an emergency struck today and you needed \$500 to get you through, would you be able to manage on your current savings?'	12	% Yes	41.7%	58.3%	+16.6%
PFS	Social Support	12	Mean	5.2	6.1	+0.9
LSAC	'How often do you feel that you need support but you can't get it from anyone?'	11	% Often/ Very often	10%	0%	-10%
PFS Knowledge of Parenting	My child misbehaves just to upset me	11	Mean	5.5	5.7	+0.2
	When I discipline my child I lose control	11	Mean	6.0	6.2	+0.2
PWI	'How satisfied are you with your life as a whole?'	12	Mean	59.2	75.0	+15.8
	PWI (7 items)	12	Mean	63.8	66.1	+2.3
LSAC	Carer connectedness	12	Mean	3.7	4.1	+0.4
	Child connectedness	11	Mean	3.2	4.3	+1.1

Source: TBS RF assessment database; n=13.

Appendix 6: Comparative description of Index and Control Children

The analysis below examines the outcomes of the matching process to date (n=120), to determine if the outcomes comparison between Index Children and the matched Control Children is justifiable and future use appropriate. The analysis shows a high level of comparability across the two groups. Although there are a small number of cases not matched at the individual level (e.g. where either the Index or Control Child is Aboriginal and the other not, and vice versa in a second case), globally the two cohorts are matched on nearly all key characteristics. Control Children have slightly more prior ROSH reports, with an average of 2.59 ROSH reports (of a total average of 4.71 reports) compared to 2.53 ROSH reports (from a total of 4.24 reports) made about Index Children in the year prior to entry. The two groups had a similar number of SARAs commenced (67 for Intervention vs. 69 for Control), though 6% of the Control Group were 'Unsafe' (vs. 0% Index). On the other hand, 18% of Index Children have a very high risk assessment, vs. 9% of Control Children.

Eligibility and matching criteria

Each Index Child and a group of potential Control Children are directly matched on qualifying criteria that include the out-of-home care history and SARA history of all children, including those aged over 16, of the Primary Carer, and the age category of the youngest child²⁸. In 82% of families of both the Index and Control Children, none of the children of the Primary Carer had a prior out-of-home care placement. Similarly, in 90% of families of both the Index and Control Children, the children of the Primary Carer had been subject to nil or one prior SAS2 or SARA. For both groups, 6.7% of children were unborn at commencement as Index or Control Child, 35% were under 1 year, 31.7% were 1 to 2 years, and 26.7% were aged 3 to 5 years.

Potential matched pairs are next scored on criteria that include family size and Indigeneity to refine the Index and Control match. The resultant groups are identical in terms of Indigeneity, with 6.7% of Index and Control Children being Aboriginal, although eight pairs are not a direct match. Family size is matched on a categorical classification, and the composition of the Intervention and Control Groups varies a little here, as seven pairs are not exactly matched. Whereas 78.3% of Index Children are from families with 0, 1 or 3 resident children, 71.7% of Control Children are in this category. Larger proportions of Control Children are in families of 2 (13.3% vs. 11.7%), and 4 or more resident children (15% vs. 10%). It is hard to know from these categories if there is an overall difference in average family sizes between the Intervention and Control Groups.

²⁸ Operations Manual for the TBS Social Benefit Bond Pilot p 14-18.

Prior child protection and out-of-home care experiences of Index and Control Children

Although there are slight variations in report, SARA and out-of-home care experiences of the Index and Control Children, overall the two groups appear comparable on these measures.

Reports pre, ROSH, Non-ROSH

In the 12 months prior to the program, the Index Children had a slightly lower total (250) and average (4.24) number of reports than the Control Group (total 273 and average 4.71), but a higher proportion of reports for the Index Children were ROSH (59% vs. 55%) (Tables 37 and 38).

The most frequent primary reported issues were the same for both groups, in similar proportions: DV/ DV Child exposed to violence (24% of Index reports, 21% of Control reports); Drug abuse by carer (15% Index, 12% Control); Inadequate supervision for age (8% Index, 7% Control); Physical: Hit, kick, strike (5% Index, 8% Control); and Prenatal report (6% Index, 9% Control).

SARAs pre, number and outcomes

All Index and Control Children had been the subject of a SARA as part of their entry into the program or Control Group. Seven of the Index Children and eight of the Control Children had also been the subject of an additional SARA in the prior 12 months. Index Children had been the subject of an average of 1.12 SARAs, compared to 1.15 for Control Children (Table 39).

The safety assessment outcome for the SARA immediately preceding referral for the Index Children was 'Safe with plan' for 90% and 'Safe' for 10%. None were 'Unsafe', as required by program guidelines. For the Control Group, 80% were assessed as 'Safe with plan', 14% were 'Safe', and 7% were assessed as 'Unsafe' (Table 40).

The risk assessment outcome for the SARA immediately preceding referral for the Index Children was very high for 17%, high for 62%, and moderate for 22%. For the Control Group, 8% had a risk assessment of very high, 65% were high, 25% were moderate, and 2% were assessed as low risk (Table 41).

The most frequent primary assessed issues were mostly the same for both groups, in similar proportions: DV/ DV Child exposed to violence (27% of Index reports, 33% of Control reports); Drug abuse by carer (22% Index, 22% Control); Inadequate supervision for age (10% Index, 12% Control). However, 10% of Index Children had Emotional state of carer as the primary assessed issue, compared to 3% of Control Children.

Out-of-home care pre – days and placements

Four of the Control Group children each had one out-of-home care placement prior to being matched with an Index Child. Each of those placements had involved a statutory care entry, and the average duration was 25 days. Three of those placements continued into the post-matching measurement period. None of the Index Children had an out-of-home care placement prior to being referred to RF (Table 42).

Primary Carer as a child

A slightly higher proportion of the Primary Carers of the Index Children were the subject of CYP concern or child protection report²⁹ as children, compared to the Primary Carers of Control Group children (45% vs. 38%). However, the Primary Carers of the Index Children had a slightly lower average number of reports (9.4 vs. 10.8).

Fifteen of the Primary Carers of both the Intervention and Control Groups had been the subject of a ROSH or referred report³⁰ as a child. The average number of ROSH or referred reports was almost the same (11.1 reports Index vs. 11.2 reports Control).

Six of the Primary Carers of the Index Children were in out-of-home care as children, compared to eight of the Primary Carers of the Control Children. The average number of days in out-of-home care was higher for the Control Group Primary Carers (1,997 days) than for the Intervention Group Primary Carers (833 days).³¹

Tables comparing Index and Control Children

Table 37. Helpline reports by proportion ROSH and Non-ROSH preceding commencement of measurement period

	Number reports	% Non ROSH	% ROSH	Total
Index	250	41%	59%	100%
Control	273	45%	55%	100%
Total	523	43%	57%	100%

Source: FACS data n=120 (60 Index and 60 Control).

²⁹ Child/ young person concern reports relate to the period from 24 January 2010 onwards. Child protection reports relate to data for the period to 24 January 2010.

³⁰ ROSH reports relate to the period from 24 January 2010 onwards. Reports referred to a CSC/ JIRT for further assessment relate to the period from 1 July 2001 to 30 June 2014. Child protection Helpline began operating in 2001–02. Child protection records prior to the introduction of Helpline do not include ROSH/ referred reports. Therefore the records in this table are limited to the period 2001– 02 to 2013– 14.

³¹ This data excludes: 1. placements where children and young people have returned to previous carers; and 2. children and young people that had a non-permanent placement for less than 7 days.

Table 38. Total and average number of ROSH and Non-ROSH reports preceding commencement of measurement period

		Valid number	Mean	Standard deviation	Minimum	Maximum	Sum	Missing
Index	Non-ROSH	39	2.64	1.55	1	6	103	21
	ROSH	58	2.53	1.9	1	10	147	2
Control	Non-ROSH	43	2.86	2.52	1	12	123	17
	ROSH	58	2.59	1.63	1	8	150	2

Source: FACS data n=120 (60 Index and 60 Control),

Table 39. Total and average number of SARAs commenced preceding commencement of measurement period

	Number of CYP	Mean SARAs	Standard deviation	Minimum	Maximum	Total SARAs	Missing
Index	60	1.12	0.32	1	2	67	0
Control	60	1.15	0.36	1	2	69	0

Source: FACS data n=120 (60 Index and 60 Control).

Table 40. Safety outcome of SARA immediately preceding commencement of measurement period

	Safe	Safe with plan	Unsafe	Total
Index	10%	90%	0%	60
Control	14%	80%	7%	60

Source: FACS data n=120 (60 Index and 60 Control).

Table 41. Risk outcome of SARA immediately preceding commencement of measurement period

	Very high	High	Moderate	Low	Total
Index	17%	62%	22%	0%	60
Control	8%	65%	25%	2%	60

Source: FACS data n=120 (60 Index and 60 Control).

Table 42. Out-of-home care data preceding commencement of measurement period

	Children in OOHC placements at start	Care days	Statutory care entries
Index	-	-	-
Control	4	99	4

Source: FACS data n=120 (60 Index and 60 Control).