EVALUATION OF THE RESILIENT FAMILIES SERVICE

NSW TREASURY

INTERIM REPORT

MAY 2016

ARTD CONSULTANTS
strategy & evaluation

Acknowledgments

This work was completed with the assistance of the Evaluation Working Group, comprising staff from NSW Treasury, NSW Department of Premier and Cabinet, NSW Department of Family and Community Services and The Benevolent Society.

We would also like to thank the key informants from the Resilient Families service and NSW Department of Family and Community Services. We thank them for their time and insights and trust that their views are adequately represented in this report.

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Abbreviations and acronyms

AIFS	Australian Institute for Family Studies
Control Child	Child in a Control Group family matched to an Index Child
CSC	FACS Community Service Centre
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 OOHC placements (excluding respite, placements with parents and multiple placements with the same carer) that Child 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
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 OOHC	Identifies the number of out-of-home care (OOHC) periods for Children 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 complete the Stage 1 evaluation of 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, the outcome is a greater reduction in contact with the child protection system for children in families who receive the service, than a matched pair cohort of Control Children whose families receive a business-as-usual response from the NSW child protection system.

The purpose of the Stage 1 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 performance through the bond payment. We draw on primary data collected from TBS and RF family members and secondary data from TBS and the NSW Department of Family and Community Services (FACS). This is the final Stage 1 report. Stage 2 will cover the final two years of the pilot.

Key findings

The RF service reflects many of the characteristics of an intensive service, but is delivered with lower intensity, longer duration and with less immediacy in the referral process. A proportion of families participating appear to be under the threshold for an intensive service, a central theme in the report because of its relevance for program fidelity, family engagement, service intensity and ultimately performance under the SBB. The report discusses how the eligibility criteria and centralised referral mechanism may be contributing to the risk levels of families who are participating, as well as to delays in the timeliness of service delivery. It also highlights areas for service improvement.

The outcome evaluation has found that for the subset of families for whom we have TBS outcomes data (n=59) the service is associated with increased family functioning and wellbeing outcomes. But for the population as a whole (n=172), RF is not performing strongly under the SBB mechanism. Within the Stage 1 evaluation measurement period the Index Children whose families received the RF service (n=86) received more reports to the FACS Helpline than the Control Children (223 compared with 173) and had more Safety and Risk Assessments (SARAs) commence (52 compared with 35). In contrast, for the third SBB measure, Index Children experienced slightly fewer statutory out-of-home care (OOHC) placements than Control Children (15 compared with 18).

The population is too small and arguably too short a timeframe has passed for conclusions to be made about outcomes. There are also some questions around the measures and scope to refine these.

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	Finding
Process evaluation		
Chapter 2	**How well are targeted clients being identified and referred to the service?**	
	How well are targeted clients being identified and referred to the program? 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?	Between October 2013 and June 2015, 107 families were requested by the RF service and 94 were referred, which was under the planned number of 70-90 families per year. The referral process has matured in its implementation at a local level as relationships have developed and FACS staff developed a better working understanding of the RF service. There are two main concerns, each relating to the centralised referral mechanism. 1. **Risk level.** The referral process is generating families with a range of risk profiles, including some who appear to be under the threshold for an intensive intervention. This means some families who may not otherwise are receiving an early intervention service, but this may also be undermining performance under the bond structure. 2. **Timeliness.** The theory of change underpinning intensive services is that clients will be most receptive to change at a time of crisis, so it is important to engage them at this point in time. The RF intervention commences on average 5.2 weeks after FACS commence the SARA, which becomes part of their eligibility for RF, meaning the critical engagement period may have passed by the time families are introduced to the RF service.
Chapter 3	**To what extent is the service being delivered as intended?**	
	Are planned timeframes for assessment, review and program duration being met?	Previously reported delays in the referral and engagement processes remain, which mean the service is not delivered with a sense of immediacy once families enter the program. This is an issue for program fidelity, although the timeframes are not mandated, given the intent for flexibility in the service design. The average service duration is about nine months, shorter than the 12 months anticipated. This may relate to the lower than planned needs of some families.
	What is the nature and intensity of the service being delivered e.g. individually targeted?	The service is delivered through Family Support Plans, which reflect family strengths and needs and address FACS safety concerns. The flexible and individually-targeted nature of the service is evidenced through interviews with TBS staff and Primary

	Evaluation question	Finding
	Which evidence-based practices are being employed?	Carers, and through service data that shows some relationship between the risk levels that families present with and the intensity and duration of the service they receive. However, families receive an average of eight hours of service per month, which is less than expected for an intensive service. Staff use the TBS Resilience Practice Framework (RPF) to guide their practice, though it does not appear to be fully embedded at this stage as staff are not always certain of how their practice should be recorded within the framework. The largest area of focus of TBS's work with families under the RPF was on 'Increasing Safety' (which corresponds with the area of greatest improvement in the TBS Resilience Outcomes Tool). TBS staff and Primary Carers each described and provided examples of how the service is strengths-based.
	How well are participants being linked into relevant services and making broader social and community connections?	TBS staff help families to build social and community connections through *social connection mapping* within the Increasing Safety outcome in the RPF. There are no benchmarks available to accurately interpret the data on this activity, but from our interviews with Primary Carers we would suggest in some cases more focus is needed in this area. There were 143 individual referrals made for the RF family members, an average of 1.7 per family, the majority of which were to health or children's services. The number of referrals to housing, domestic violence and mental health services was low given the prevalence of these issues among participating families, but there are a range of factors to take account of in considering this finding. Firstly there is evidence through the Evidence Informed Practices (EIP) data collection that TBS staff are working with families in these areas directly. As well, some families enter with key service links already in place and for some of these families the goal is to reduce the number of services in their lives, not make more referrals. The family members we spoke with seem to have been linked to the services they needed, though there were too few involved to allow us to generalise from their experience.
	Is the program sufficiently well-resourced and supported, including staff skills and professional support and development, clear guidelines, etc.?	The RF service appears well resourced. Staff receive one-on-one professional supervision, and regular training. They value being able to spend what they describe as 'more time' with RF families, compared to other family support programs they have worked with. They also value the brokerage which enables them to provide material support to address crisis needs (e.g. rent payments, health services), build skills (e.g. parenting teaching dolls) and develop independence and resilience (e.g. driving lessons), although the economic analysis shows expenditure on client services to be substantially less than budgeted.

	Evaluation question	Finding
		There is also an ongoing challenge in recruiting and retaining qualified staff which, anecdotally, may in part reflect salary levels.
	How do the processes for joint working between TBS and FACS differ from business-as-usual, including regular data provision, and to what effect?	TBS staff have reported that the relationship between TBS and FACS staff in referring Community Service Centres (CSCs) has matured over time, they believe through increased confidence of CSC staff to refer and pass on case management responsibility to the RF service. Regular changes in staff within both organisations make maintaining these relationships an ongoing challenge. Another challenge is the variation in practice described by TBS staff and RF clients and lack of opportunity available to TBS to raise practice questions within CSCs due to the requirement to deal with all concerns through a centralised process within FACS. Changing this requirement would mean TBS could discuss practice issues more informally and earlier, which in turn could support relationship building at the local level.
Outcomes evaluation		
Chapter 4	**What are the outcomes of the RF service for participants?**	
	What changes in functioning and wellbeing are seen for Index Children and their families? What new skills and behaviours have parents/ carers learned?	There have been improvements in functioning and wellbeing for Index Children and their families over time. On intake, families were functioning more poorly and showed lower wellbeing when compared to the general population. By the time families exited the RF service, many were functioning at a normative level. Primary Carers we spoke with were very positive about how the service had helped build their skills, confidence and self-sufficiency.
	Do Index Children have less contact with the child protection system than the comparison group?	During the Stage 1 measurement period Index Children, compared to Control Children, had more Helpline reports (223 compared with 173) and more SARAs commence (52 compared with 35) but slightly fewer entries into OOHC (15 compared with 18). For Control Children to be selected they had a SARA commence in the measurement period, which means they had an active child protection response instead of referral to the RF service. At this point it seems that the FACS intervention is providing a similarly effective intervention as RF, at least in the short term. More information about the type of intervention that the Control Group received during the measurement period would help to explain the improvement they made.
	Who does the program appear to work best for?	There are no clear patterns emerging regarding differences in effectiveness for different cohorts in the RF service at this early stage.

	Evaluation question	Finding
		Those families at lower risk at entry into RF had fewer Helpline reports, and fewer SARAs commenced when compared to those at high or very high risk, though differences between the groups are not statistically significant at this point. Those at very high risk had greater relative improvements in functioning and wellbeing as measured through the RPF, compared to those at moderate risk. Families who exited with case plan goals met were, on average, subjects of fewer Helpline reports and fewer SARAs commenced than others. The sample sizes are not large enough to draw strong conclusions from these findings.
	How appropriate are the measures in place for the bond payment?	Having multiple measures in place helps to make the measures more robust overall, because any one measure may be unreliable. Entry into statutory OOHC is the strongest and most appropriate measure, as a placement involves external validation through the court process. Helpline reports are a good measure that should be retained with some refinement to take account of possible observation bias. We also have some concerns about SARAs commenced as a reliable measure because it is subject to context and capacity within individual CSCs at given points in time. This is mitigated to some extent by Index and Control Children being allocated within the same CSC, and SARAs commenced may in fact be a good indicator of safety concerns. The appropriateness of this measure should be explored in more detail in future reports.
Economic evaluation		
Chapter 5	How do the costs of RF compare to other programs?	The average actual cost for the 81 families participating in the RF service up to June 2015 is $38,053, 52 per cent over the initial budgeted cost per family of $25,000, but still comparable to (or under) the funded cost per family for other intensive family service programs in NSW. A majority of costs are fixed so are not expected to vary much with the number of families supported, and there is an under-spend in client expenditure (brokerage costs). Therefore the cost per family is likely to reduce with an increase in the number of families.

Conclusions and recommendations

The RF service is associated with increased safety and wellbeing for children and their families but is performing relatively poorly under the SBB mechanism because decreases seen in the contact with the child protection system for RF families, is similar to or less than the decrease seen for Control Children. This suggests that a FACS business-as-usual response is as effective as the RF service, at least in the short term. The evaluation has highlighted a number of issues that may help improve performance, including revising the referral mechanism and improving practice in key areas of service delivery. These are reflected in the recommendations below. Other recommendations are aimed at better understanding the service that Control Children and the families are receiving to help interpret future findings, and considering possible revisions to the SBB measures to enhance their reliability.

Recommendation 1. Review the centralised referral mechanism, including the selection and matching process, to improve the timeliness of referrals and better target the service to those families most likely to benefit from an intensive service. In reviewing the process, consider a direct pathway to the RF service from referring CSCs.

Recommendation 2. Develop a strategy within TBS for ongoing review and improvement in the following areas of service delivery.

1. Reducing timeframes for engaging families and completing family case plans.
2. Increasing service intensity, especially in the first three months of the service.
3. Focusing on social connections in the implementation of Family Support Plans.
4. Optimising the use of external and specialist resources of potential benefit to families.
5. Seeking to manage the duration of involvement by families to more closely align with the initial intention of program participation for 12 months and ensure the longer term throughput nature of the program.
6. Embedding the RPF into practice.

Recommendation 3. Revise the TBS SBB Operations Manual so that practice discussions can be held in the first instance with relevant TBS and CSC managers, and only escalated to SBB contract managers where these cannot be resolved locally.

Recommendation 4. Extend data collection around the TBS SBB to provide aggregate level information about service activity for Control Children and their families.

Recommendation 5. Discount Helpline reports made in the first six months of the measurement period for each Matched Pair.

Recommendation 6. Expand the analysis of SARAs commenced in the final evaluation stage to develop a more detailed understanding of the appropriateness of this measure.

1. Resilient Families and its evaluation

1.1 Background and context for Resilient Families

In NSW, the *Children and Young Person (Care and Protection) Act 1998* stipulates that the protection of children is shared by the government, families and non-governmental agencies. When a child is at risk, however, it is principally the NSW Department of Family and Community Services (FACS) that intervenes on behalf of that child. FACS currently delivers and funds a number of services designed to address safety and wellbeing in the family environment to prevent children and young people from escalating within the children protection system, and entering out-of-home care (OOHC).

In 2013–14 there were 18,192 children in OOHC in NSW. This figure has grown steadily since 2002 and is currently double the number in the next highest state.[1] While the purpose of the statutory care system is to prevent or minimise the impact that neglect and abuse have on a child's development, it is costly to provide, and there is evidence that children and young people in OOHC generally have higher rates of physical, developmental and emotional problems, and lower rates of education than others.[2] The NSW Government, like other governments in Australia, is aiming to shift investment in child protection towards prevention and early intervention services.

1.1.1 Social impact investment and social benefit bonds

Social benefit bonds (SBBs) are a form of social impact investment, a recent approach to driving change towards improved social outcomes. SBBs—and social impact investment tools more broadly—are designed to achieve outcomes in a way that shares the risks and benefits between government and the private sector. In a SBB, a non-government investor supplies the capital for a new social program and, if this program is deemed successful according to agreed measures, the government repays the initial investment plus an agreed amount of interest. The return on investment is dependent on the degree of improvement in social outcomes, and the precise structure of the bond. A principal advantage of this approach is that it can expand the level of upfront investment available for prevention and early intervention activities, freeing up government funds to be used in other areas. Moreover, the direct financial incentive to achieve an agreed outcome under a bond can be expected to drive service delivery and innovation and, ultimately, help to reduce the demand for government expenditure on acute crisis services and tertiary, curative interventions.

Currently, there are a limited number of proven social impact investment models that exist, and theoretical models can struggle to inspire investor confidence. There are conflicting perspectives on how to evaluate particular social programs (e.g. whether to measure money saved or costs avoided); and many of the outcomes of social interventions are difficult to quantify. For a SBB to succeed there must be sufficient capacity across the government and non-government organisations to accommodate new social programs. Valid and reliable indicators must also be established to accurately measure the success of the social investment.

[1] Australian Institute of Health and Welfare, *Child protection in Australia 2013-2014*, 2015
[2] Osborn, A. and Bromfield, L., 'Outcomes for children and young people in care', Australian Institute of Family Studies, 2007

The Social Benefit Bond pilots in NSW

Two SBB pilots are currently underway in NSW, and are the first of their kind in Australia. These pilots aim to test the capacity of SBBs to sustainably increase funding for prevention and early intervention programs and catalyse the development of the social investment sector. Both pilots are operating in the child protection system and trial new ways of working between FACS and the non-government sector. They bring a strong focus on outcomes, rather than defined service specifications, and employ a more robust approach to measuring these outcomes.

To appropriately facilitate the implementation of social impact policy, the NSW Government has created the Office of Social Impact Investment and is working in conjunction with the NSW Social Impact Investment Expert Advisory Group.

The Benevolent Society (TBS) is delivering the Resilient Families (RF) service under one of these SBB pilots. The RF service commenced working with families in October 2013. It aims to support between 300 and 400 families over the five years of its operation.

1.2 The Resilient Families service

The RF service is designed as an intensive family support intervention where there are concerns about the safety and wellbeing of children which, if not addressed, are likely to result in removal of the children concerned. Families are eligible for referral to the service if they have at least one child less than six years old who is living at home and has been assessed by FACS as at Risk of Significant Harm (ROSH) but 'Safe with Plan'.

The RF Service Model Operating Guidelines describe how the service is to be client-centred, focused on engaging families and building relationships, and providing both practical and therapeutic supports. Other key features involve:

- using flexible work arrangements and contact hours, and access to flexible funds
- delivering an initial 12 weeks of high-intensity support, followed by 9 months of less intensive service with a planned step-down approach towards exit (plus an option for families to re-engage at the end of the 12-month period)
- working in close collaboration with FACS.

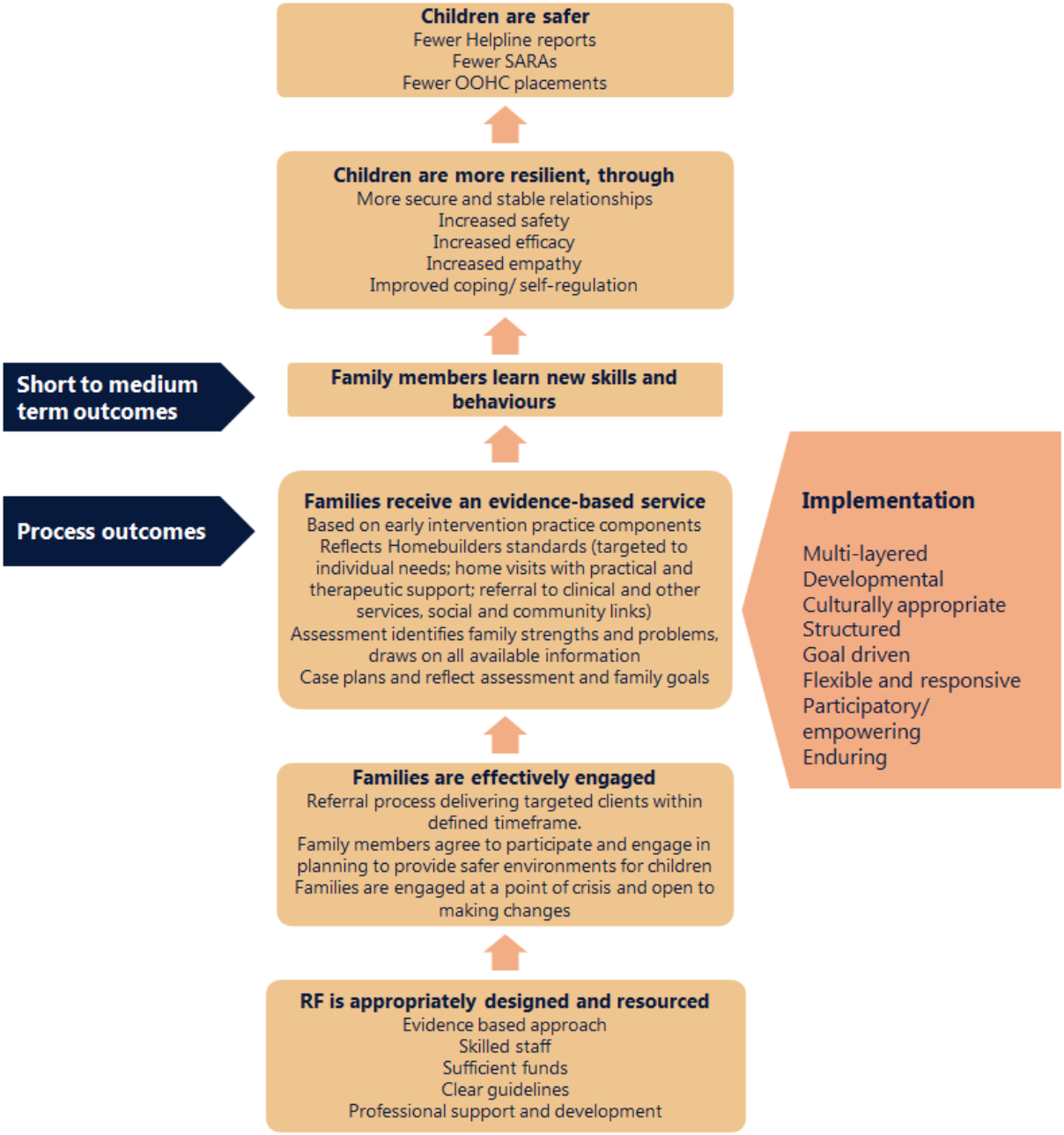
The RF service objectives are to strengthen family functioning and relationships, and ensure children's safety and wellbeing. This involves achieving the five resilience outcomes identified in the Resilience Practice Framework (see 1.2.1).

For the purpose of the SBB calculation, the outcomes of the RF service are measured through the number of:

1. reports to the Helpline
2. Safety and Risk Assessments (SARAs) commenced by FACS
3. entries into statutory OOHC.

These outcomes that contribute towards the objective of children being safer are reflected in the RF service delivery logic (Figure 1). The logic diagram does not include outcomes for Control Group Families within the SBB mechanism, which is part of the operating context for the RF service.

Figure 1. The Resilient Families service program logic



Source: ARTD Consultants

1.2.1 The Resilience Practice Framework

The RF service is based on the Resilience Practice Framework (RPF), which TBS developed in partnership with the Parenting Research Centre. The RPF is informed by evidence around 'what works' in supporting and promoting resilience in children,[3] and identifies six domains in a child's life that are associated with resilience: secure base, education, friendships, talents and interests, positive values and social competencies. Five resilience outcomes are also identified in the RPF.

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

The RPF is accompanied by a Resilience Assessment Tool, which includes a Resilience Outcomes Tool—which are used at the start of the service to develop a Family Support Plan, and then applied every three months to review progress towards goals and outcomes—as well as guidelines to support practice and initial engagement. The practice guidelines outline 42 Evidence Informed Practices (EIPs) for workers to use to build parenting skills and resilience in children and families. 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.

1.2.2 Developed from the Homebuilders approach

The RF service was established in view of Homebuilders, a model of support that developed in the 1970s in the United States of America.[4] Premised on crisis as a motivator for behavioural change, Homebuilders' services target families within the child protection system who are at a point where OOHC 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.

The Homebuilders 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. Key dimensions of Homebuilders services are that they are home-based, time-limited, intensive (six to eight hours per week with families), and provide practical and therapeutic supports, including around household routines, cleanliness and safety. There is some evidence to suggest that family preservation services of this kind are most effective for highest risk families.[5]

1.2.3 Designed to enable the measurement of bond outcomes

For the purposes of the SBB calculation on the RF service, outcomes for children in the service ('Index Children', the youngest or unborn child within an Index Group Family) are compared to outcomes for similar children in Control Group Families. Index Children and Control Children are matched closely on

[3] Parenting Research Centre and The Benevolent Society, *Resilient Practice Framework*, 2013
[4] Institute for Family Development, *Homebuilders Standards 4.0,* 2014
[5] Tully, L., *Family Preservation Services: Literature Review,* Centre for Parenting and Research, 2008; IFBS Evaluation Early Findings (internal FACS report)

a one-to-one basis ('Matched Pairs'). Control Group Families meet RF eligibility criteria and would have been referred if they lived in an 'Agreed Location'.[6]

To recruit and establish these two groups, referrals to the RF service go through a centralised process within FACS rather than being managed at the local CSC (see 2.2 for more detail). This allows FACS to run an automated tool to select the Matched Pairs. Control Group Families are not aware that they have been selected in this process and the services that they receive do not change as a result. They are removed from the Control Group if they are referred to another intensive service and a substitute family is allocated, where appropriate.[7]

Intention-to-treat

The TBS SBB pilot uses an intention-to-treat (ITT) design. This means that those families of Index Children who decline the service are still counted as part of the Index Group. ITT designs aim to estimate the effects of programs as they are offered, or as assigned, and ignores any noncompliance or withdrawal that occur following the random allocation. Other evaluation designs (non-ITT) may measure the effects of a program only on those who receive an intervention, and are often termed 'treatment on the treated' designs. The main weakness of an ITT design is that if subjects who did not actually receive an intervention are included as subjects who did receive an intervention, this may indicate little about the effectiveness of that intervention. However, the main benefit of an ITT design is that it reflects a practical scenario, as non-compliance and dropouts are a reality for any program, and difficult to identify within the control.

1.3 The evaluation

The purpose of the Stage 1 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 TBS SBB payment.

Five key evaluation questions, listed below, have shaped the collection of evidence and analysis for Stage 1. A more detailed list of evaluation questions is in Appendix 1.

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

This Interim Report is the third report, and final in the planned series of Stage 1 reports:

- Preliminary Report (December 2014)
- Mid-term Report (June 2015)
- Interim Report (May 2016).

[6] Region 1 or Region 2, as defined in the TBS SBB Operations Manual.
[7] Substitutions have occurred in all cases to date.

The report covers families who participated in the RF service from October 2013 to the end of June 2015 (for whom remediated data was made available in December 2015).

1.3.1 Methods

We used 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:

- a group interview with TBS staff in each region (n=6)
- an interview with TBS program manager (n=1)
- interviews with Primary Carers who have exited the service (n=5 [one parent asked us to use a pre-recorded video interview as data for the evaluation])
- unit record TBS service monitoring and assessment data from 8 October 2013 to 30 June 2015 (n=59)
- unit record FACS data covering periods prior to and since service participation from 8 October 2013 to 30 June 2015 (n=172)
- remediated, aggregate TBS client numbers from 8 October 2013 to 30 June 2015 provided directly by TBS for the economic evaluation; includes families who did not consent to the evaluation but other counting rules are not known (n=81)
- program costs and administrative data provided by TBS (June 2013 to June 2015) and FACS

We obtained ethics approval from The University of Sydney Human Research Ethics Committee in April 2014 to conduct this evaluation [no. 2014/339].

Analyses using risk levels and service status

In this report we examine the outcomes as delivered through the SBB structure by comparing the child protection outcomes for RF Index Children with Control Children (and their respective families).

As well as looking at outcomes for the population overall (n=172), we look at outcomes for a smaller cohort of families who consented to participate in the evaluation and for whom we have functioning and wellbeing outcomes as measured by the TBS Resilience Outcomes Tool, and data about the service they received (n=59). Within this smaller population (n=59), we undertake more detailed analysis of child protection outcomes by looking at outcomes based on family level of risk and on service status (goals met, exited or continuing).

Level of risk

In the Mid-term Report we suggested that a proportion of referred families could be considered 'lower risk', and potentially less appropriate for an intensive service. To investigate this issue, in this report we looked at the outcomes of families according to their risk level on entry into the program. Chapter 2 outlines how risk level was examined in three different ways.[8]

1. Number of previous reports to the Helpline for Index Children
2. Presence of predictive risk factors (sourced from literature)
3. Outcome of the Risk Assessment in the SARA undertaken at the time of referral to the RF service

[8] For a detailed explanation of how these three measures of risk were used, see Appendix 2.

We tested each method by looking for relationships between the service delivered and outcomes achieved according to low and high risk within each definition (see 2.2.2). We found the strongest relationship with the third method—the risk outcome in the initial SARA. This was then used as a key variable in reporting on service intensity (Chapter 3) and in reporting on outcomes (Chapter 4).

Service status

In the Mid-term Report we found that families in the RF service who had either met their goals or were continuing in the service were tracking better—no entries into OOHC, fewer reports to the Helpline and fewer SARAs commenced—than those who had exited the service early (i.e. before meeting their goals). To see whether this pattern has continued, we repeated this analysis for this report (Chapter 4).

1.3.2 Confidence in the findings

We are confident the evaluation has collected a sufficiently robust set of evidence to enable us to support the conclusions we have made, recognising the following limitations: 1) the total population within the bond structure is relatively small (n=172 made up of 86 Index Children and 86 Control Children); and 2) the population who consented to participate in the evaluation for who we have detailed service data and measured functioning and wellbeing assessment data is smaller still (n=59 at baseline, 28 at Review 1, 17 at Review 2 and 11 exited).

A detailed 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—shows the two groups to be highly comparable.[9]

Strong participation of TBS staff in focus groups has provided the evaluation with an understanding of the delivery of RF in practice, the characteristics of RF families, and TBS staff perceptions of the client experience. Interviews with Primary Carers have added to our understanding of the nature and quality of the service, perceived outcomes and motivations for engaging.

Both the Preliminary Report and Mid-term Report included recommendations regarding ongoing data collection quality improvement effort within TBS. TBS has made ongoing efforts to improve data quality, though as the current data set is limited to the period ending June 2015, in many cases this effort will not have impacted on its quality or completeness of data for this report.

[9] ARTD Consultants, *Resilient Families Evaluation Mid-term Report*, 2015

2. Referral process

This section addresses the evaluation questions about how well the referral process is working including the characteristics (needs and risk levels) of family members and whether any refinements need to be made to the referral criteria or processes.

Key findings

Referrals are tracking just below planned numbers and local relationships (between TBS and FACS) have matured over time. There remain two key issues, both of which relate to the centralised referral mechanism.

1. **Timeliness.** The average period between FACS commencing a SARA (part of the RF eligibility) and a family being referred to the service is approximately five weeks. This is inconsistent with the RF program theory, in which crisis is the key motivator for family members to make changes.
2. **Risk level.** The referral process is generating families with a range of risk profiles, some under the threshold for an intensive intervention. This means families who may not ordinarily access such a comprehensive service are receiving one, but the service is not always reaching its intended target group.

2.1 Referrals are tracking just below planned numbers

TBS are tracking just below the planned target of requests for referrals of 70–90 families per year over five years, taking into account an initial start-up period. In total, 107 families were requested by the RF service up to June 2015 (that is, over 21 months since October 2013). Of these, 13 requests were unfulfilled, five families were excluded from the program after referral, 77 commenced the service and 12 declined. Of the 77 who commenced, 62 agreed to participate in the evaluation but three are not included in the data set for technical reasons (Table 1).

Table 1. Total referrals by service location

Region	Commenced service and consented to evaluation	Commenced service and did not consent to evaluation	Declined service	Sub-total in bond calculations	Excluded after referral	Unfulfilled	Total referred
Region 1	33	2	3	38	2	1	41
Region 2	29	13	9	51	3	12	66
Total	62*	15	12	89*	5	13	107

Source: TBS remediated, aggregate TBS client numbers
*Note: includes 3 children not in this evaluation report: 1 unmatched Index Child, 1 unborn child and 1 child with insufficient observations

2.1.1 Local processes have matured

There were some initial challenges in establishing the referral process in 2013 and 2014. These related to building an understanding about the RF service within CSCs, raising awareness about the new referral process, coming to an agreed understanding about information sharing, and achieving planned timeframes.

These challenges have been largely addressed through maturing relationships and the process adaptations by TBS reported in earlier reports, such as the process for arranging the initial home visit. In 2015, TBS staff noted an overall improvement in the referral process since the earlier evaluation reports. According to TBS staff, some inconsistences in practice remain at the local level with the amount of information attached to referrals continuing to vary, though FACS have earlier noted that some variation will be inherent in the process.[10]

2.2 Key concerns relate to the centralised referral mechanism

The referral process for the RF service is different to FACS' usual model of business. Under normal circumstances, referrals to family support services would be made within a local CSC. In RF, the referral process is managed centrally: once FACS is notified by TBS of a vacancy, eligible children are identified from a system-generated list, and a matching tool pairs Index Children with similar children, who then become Control Group Families. The records of Index Children are then checked with the relevant CSC to develop an up-to-date understanding of their family's circumstances before referral directly from FACS to TBS for intake to the service (see Figure 12, Appendix 3). This centralised referral process allows FACS to match families receiving the RF service with similar families in the child protection system for the purpose of the evaluation and SBB calculation.

While the referral mechanism is being implemented as intended, there are two issues of concern. Each has been raised in previous evaluation reports. Further analysis in the current report confirms earlier observations and suggests some action is warranted. The first is the timeliness of the RF service in making contact with families following their crisis, and the second is the characteristics of referred families and whether their needs match with the design and intended intensity of RF service delivery. These issues are examined in greater detail below.

2.2.1 Timeliness of the referral process is an issue

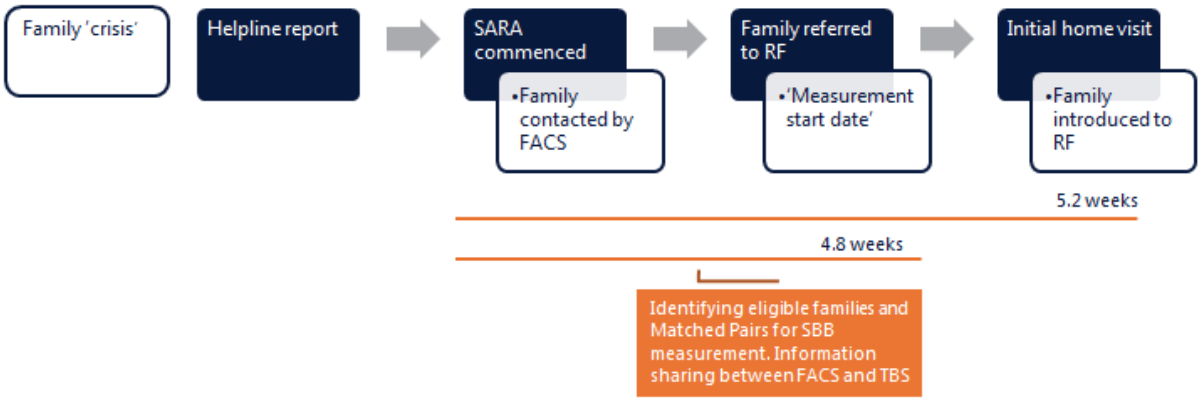
Intensive services such as RF should be offered to families as close to their time of crisis as possible, when family members are most likely to be receptive to change. Research indicates that the sooner a family can be engaged after crisis, the greater the likelihood of engaging with the family, and facilitating positive behavioural changes. Recognising this, the RF service model stipulates a number of timeframes that should be met during the referral and assessment process to ensure that services are timely.

[10] ARTD Consultants, *Resilient Families Evaluation Mid-term Report*, 2015, p19

The delay between the family crisis and the service response

The figure below outlines the timeframes involved in the key milestones between the point in time which may be construed as a 'crisis' in the context of the program theory (an incident or event that led to a report to the Helpline and subsequent SARA commencement)[11] and a referred family being introduced to the RF service.

Figure 2. Time between family crisis and the service response



Source: Image developed by ARTD Consultants using TBS Service monitoring data and FACS SARA and Secondary Assessments data

In previous reports we examined the time between a family being referred to RF and the initial home visit. There have been some adaptions around streamlining FACS attendance at the home visit to address earlier reported issues around delays (see 3.1).

For this report we looked at the overall time from SARA commencement to initial home visit. This shows a range from 2.7 weeks to 23 weeks (i.e. over 5 months) with an average of 5.2 weeks (Table 21, Appendix 3). However, of the 5.2 week period between the commencement of the SARA and the initial home visit, 4.8 weeks was accounted for by the period of handover from FACS to TBS (culminating in the 'measurement start date', see Table 22, Appendix 3).

This suggests that, although continued effort to decrease the time period between referral and home visit is warranted, the more substantial issues are structural. It is probable that a large part of the delay is due to the steps involved in identifying and matching pairs for the SBB measurement, which as described above, involves families being identified for referral through a centralised process within FACS, and checking the currency of information with the relevant CSC.

TBS staff indicated the delay was unhelpful in their efforts to engage families, although one staff member noted that families with a long history of involvement with the child protection system may not recognise a particular reported incident as a 'crisis', and so the timeliness of the intervention may be less material for these families. It is not clear what scope remains for TBS or FACS to reduce this timeframe.

[11] The eligibility criteria that families have a SARA commence in the past 35 days (Operations Manual for the TBS Social Benefit Bond Pilot pg.13).

2.2.2 Families present with a range of risk levels

Understanding the characteristics of families and the complexity of their needs is important to identify who is receiving and most likely to be benefiting from supports, and to assess whether a service is effectively targeted and implemented.

The demographic data (Appendix 4) shows that families in the RF service present with a range of backgrounds, but overall reflect a number of characteristics associated with structural disadvantage. For example, two thirds of Primary Carers do not have HSC or a post-school qualification and Centrelink payments are the main source of income for the majority (85%). Almost a third of families present with a housing difficulty: either in crisis or temporary housing (14%) or staying with family or friends (16%). And one fifth (20%) of families had moved three times or more in the past 12 months.

'Carer concern' (37%) was the most commonly assessed issue in the SARAs in the 12 months prior to entering service. This included all issues related specifically to substance abuse, physical or psychiatric disability and emotional issues and financial problems. Neglect was the second highest category (20%) and included issues around inadequate shelter or homelessness. The next highest were physical abuse (14%) and psychological harm (13%), both of which include exposure to domestic violence (see Table 36, Appendix 6).

In previous reports, we identified a concern that not all families referred to RF have risk levels that warrant an intensive intervention. Staff in Region 1 estimated that up to one in five families they work with do not require an intensive service. Prenatal cases in the period prior to birth were cited as one example of this, and another was families for whom information and awareness-raising were sufficient to promote changes in the required behavioural change. Staff from Region 2, however, felt that in the majority of cases the referred families are appropriate for the RF service once their needs and issues are fully uncovered, which they explained might take a couple of months after the initial assessment and once the family had developed a trusting relationship with the worker.

To investigate this issue of risk levels among RF families further for this report, we used the available child protection data to explore the risk levels in different ways. Three key definitions were used, the number of previous reports to Helpline for Index Children, the absence of predicative risk factors, and the outcome of the Risk Assessment in the SARA undertaken at the time of referral to the RF service.

Using each of the three approaches to defining risk (Box 1), we identify a diverse risk profile of families across the RF cohort. The distribution of families with different levels of risk was found to be similar for each of the three definitions although within the first two definitions the Index Group presented with a slightly higher risk profile. According to all three definitions (and for both Index and Control Groups), at least one in five families have lower than expected risk presentations.

- 21% of Index Children (n=18) have been the subject of none or one prior Helpline report
- 31% of Index Children (n=27) have none or one of the five identifiable risk factors that are predictive of contact with the child protection system
- 22% of Index Children (n=19) had a 'moderate' risk assessment outcome relating to the SARA undertaken at the time of referral to the RF service.

This analysis indicates that there are likely to be lower risk families for who the high intensity of service that the RF service offers may be unsuitable. Challenges around delivering an intensive service in view of this issue are explored in Chapter 3.

Box 1: Three ways to define the risk profiles of RF Index Children and their families

1. Prior reports to the Helpline

Of the 86 families in the Index Group, 21% had been the subject of only one prior report and so could be considered relatively low risk category (though this report may lead to a high risk assessment outcome), while at the high end of the spectrum, 27% had 6 or more reports. The distribution is similar for the Control Group except for a slightly higher proportion with 2- 3 reports.

Table 2. Number of total Helpline reports, prior to RF, Index and Control Group

	Index	Control
N	**86**	**86**
0 or 1 reports	21%	23%
2 or 3 reports	24%	27%
4 or 5 reports	28%	28%
6 or more reports	27%	22%
Total	100%	100%

Source: FACS reports data

2. Absence of predictive risk factors

We examined the presence of predictive risk factors for involvement in the child protection system among the Index and Control Group. Five risk factors were identified from a list developed by AIFS and for which we have data on families: parental substance abuse, family conflict or violence, mental health problems/ parental psychological disability (all reported 12 months prior); a history of child abuse and neglect, and large family size (more than 3 children). Using this definition of risk level, 31% of Index Group Families and 41% of Control Group Families have 0 or 1 of these predictive risk factors.

Table 3. Number of predictive risk factors present, Index and Control Group

	Index		Control	
	n	%	**n**	%
0 or 1 risk factors ('low risk')	27	31%	35	41%
2 or more risk factors	59	69%	51	59%
Total	86	100%	86	100%

Source: FACS demographic data, FACS reports data, FACS SARA and Secondary Assessments data

3. SARA risk outcome

We measured the final risk outcome of the initial SARAs, which were commenced prior to entry into the program (except when Index Children were unborn at the time of referral). This shows that risk outcomes among the Index and Control Groups were very similar, and in both groups 22% had an assessed risk outcome of 'moderate'.

Table 4. Final risk outcome of initial SARA, Index and Control Group

	Index		Control	
	n	%	**n**	%
Low risk	0	0%	1	1%
Moderate risk	19	22%	19	22%
High risk	54	63%	55	64%
Very high risk	13	15%	11	13%
Total	86	100%	86	100%

Source: FACS SARA and Secondary Assessments data

2.3 Discussion of referral process

We have identified two structural issues relating to the centralised referral mechanism which result in delays and a proportion of low risk families participating in the service.

These have implications for service delivery: how well TBS staff can engage families and how intensively they can work. There are also potential implications for performance under the SBB, as the service is not being targeted to those it is intended for and because there is less scope for the service to reduce contact with the child protection system among families with lower risk profiles, especially in relation to OOHC entries.

It is not clear to the evaluation how the centralised referral mechanism is leading to these results, but they are sufficient to warrant further review. In doing so, some consideration should be given to establishing an additional pathway to the RF service. Ideally this might involve a community pathway and self-referrals, as this might generate referrals from families most willing to engage in the service. Another option—potentially more feasible within the current pilot—would be to establish a direct referral pathway from participating CSCs. This could potentially address issues of both risk level and timing. Families most likely to benefit from an intensive service might be more easily identified by CSC staff. If these families were identified through CSC allocation meetings and the family referred as soon as a Safety Assessment was completed, this is likely to result in a more appropriate and rapid service response. This assumes a matched control could be identified after this point, and it is not clear if, or to what extent, this might be problematic. On balance, consideration needs to be given to improving the referral mechanism to optimise the conditions for the service to operate and the performance under the SBB mechanism.

3. Delivery of the Resilient Families service

This section of the report examines the delivery of the RF service to the 59 families who consented to participate in the evaluation, and other aspects of implementation.

Key findings

The RF service continues to be delivered flexibly. The timeframes for assessment and review are on average slower than planned, service duration is shorter and the service is less intensive.

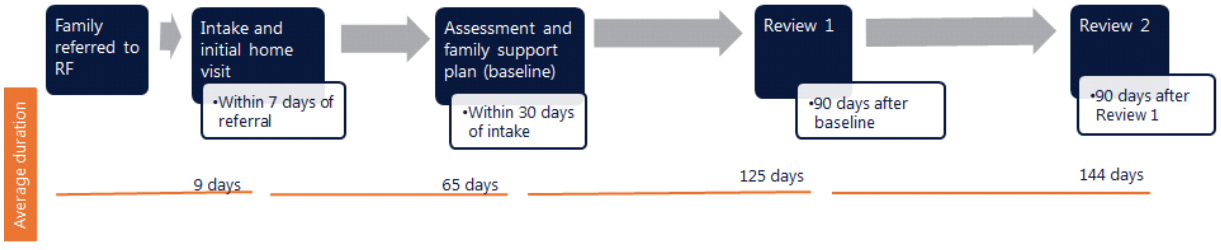
Family Support Plans are designed around family needs and largely designed to address safety concerns. The largest area of focus of TBS's work with families under the RPF was on 'Increasing Safety' although within this not much time was spent on establishing social and community connections. Referrals to external services appear to be low given the presenting needs of clients.

Staff feel the service is well resourced and that overall relationships with local FACS staff have matured, although the centralised process for resolving case management issues is not helping these to develop.

3.1 Delivery timeframes are longer than planned and service duration is shorter

The RF service model puts in place a number of key timeframes for delivery and assessment, and specifies a 12-month service duration (with the option for families to be re-referred). These timeframes are couched within operating guidelines that support flexibility and responsiveness to family needs. In practice, the timeframes are longer than planned (Figure 3). TBS staff report this is in response to family engagement or need.

Figure 3. Timeframes for assessment and review



Source: Image developed by ARTD Consultants using TBS Service monitoring data and TBS Assessment data

Initial home visit

To engage families in the service quickly, the RF Service Model Operating Guidelines state that initial contact should be made with families within seven business days of their referral being received by TBS. Initial contact with families is usually in the form of a home visit. The average number of days between referral and initial contact was 9.4 days, indicating some delays (Table 23, Appendix 3).

The TBS SBB Operations Manual also outlines conditions around the initial home visit, which ideally involves FACS attending the home jointly with TBS. FACS attendance is considered particularly helpful by TBS in motivating families to engage with the service. Fifty-seven of the 59 families in the evaluation sample received a joint home visit. Among the Primary Carers that we interviewed, most spoke about receiving a joint home visit and emphasised FACS involvement as a driver of their decision to participate in the service.

Assessment, planning and review

After families have entered into the RF service, they complete a comprehensive assessment using the Resilience Assessment Tool and Resilience Outcomes Tool, and complete a Family Support Plan with a TBS worker. The planned timeframe for completing a support plan with assessment is 30 days from initial home visit. In practice the average number of days between initial contact and the completion of the Resilience Assessment Tool including a Family Support Plan was 65 days (Table 24, Appendix 3).

Overall, TBS staff observed that engagement is taking longer than planned—delaying the completion of the initial assessment and Family Support Plan—and that 90 days after this can be too soon to start reviewing progress towards goals in the plan. Increasing the intensity of the service may help reduce this period, though this may in turn make engagement in a voluntary service more difficult.

Program duration

The RF service model provides for a 12-month service but this is not a strict requirement: there is scope for families to exit before this time if their goals are met, or to continue in some cases.

Of the 42 families that completed or exited the RF service, the average duration of service was 9.1 months. There was also a large range in duration for this group of families, from less than one month of service to 21 months. When we look at service duration by the risk profile of families (see Box 1), we see a lot of variation but those presenting with moderate risk (n=8) had a shorter service period (average 6.7 months) than others. Variation in service period was greatest for families in the high risk group (Table 5).

Table 5. Length of service (months) for completed and exited RF clients

Final risk outcome (SARA)	N	Months	S.D.	Minimum	Maximum
Moderate	8	6.7	4.1	1.8	13.8
High	28	9.8	5.4	0.9	21.3
Very High	6	9.3	6.5	3.2	20.0
Total	42	9.1	5.3	0.9	21.3

Source: TBS Service monitoring data and FACS SARA and Secondary Assessments data

3.2 A tailored, family-centred service is delivered using evidence-informed practices

The evaluation evidence suggests that RF is delivered flexibly, in alignment with the needs of clients, but with less intensity than was originally intended.

3.2.1 Service planning is responsive to family needs, and takes into account FACS goals

The first step for TBS in planning the service for each family is the completion of the Resilience Assessment Tool (with the family), and the development of a case plan (termed a 'Family Support Plan' in RF). From this, TBS then determines the resilience outcomes and EIPs that will be important in their work with family members. To facilitate this process, TBS staff described that listening to the family to better understand their story, their motivations and their strengths, was helpful in encouraging families to take part in the service planning.

TBS staff also commented that when plans are designed from a strengths perspective to help the family achieve their own goals, this can also address child protection concerns. For example, a family might set a goal to go on a family holiday but to achieve this, the parents would need to address other issues such as gambling.

Box 2: Karen's[+] engagement and support planning with the RF service

Karen was referred to the RF service at a difficult time in her life when she was experiencing depression and she felt that things were, 'going badly downhill, I thought I'd lose everything.' Initially, Karen had low expectations about how the RF service could help her: she was concerned that it would only create more challenges. She was, however, pleasantly surprised when her TBS worker started to help her develop a support plan that broke down the 'big problems' into smaller, achievable tasks.

Although Karen felt that accepting help was strange—she had left home at 14 years old and was used to doing things on her own—the support plan was relevant to her needs. For example, the TBS staff gave her tips to play and communicate better with her young child with autism, as well as strategies to improve how she copes when the home environment is stressful. The worker also assisted her with practical tasks, such as fixing her resume, and connecting her with a new psychiatrist. Karen attributed the usefulness of the support plan and activities with the TBS worker to the time that the worker spent listening to her and understanding how she thinks. [+]*Pseudonym*

TBS staff reported that the FACS and RF assessment goals were generally aligned, as actions within the Family Support Plan were largely focused on addressing safety concerns and risk factors. For the Primary Carers we spoke with, FACS goals appear to have been the key motivator to engage with the service. However, another Primary Carer interviewed indicated that the service provided was so focussed on FACS goals she did not feel the service was responsive to her needs, for example in developing social supports and connections.

3.2.2 The intensity of service is less than planned

Understanding the duration and intensity of the service is critical to understanding how outcomes are achieved, the cost-effectiveness of service provision, and the opportunity costs for taking on further clients. Intensity of service (as measured by contact hours per week) is not defined by the TBS RF Service Model Operating Guidelines, however Homebuilders services generally provide six to eight hours of face-to-face time per week.

The previous evaluation reports suggested that the RF service was being delivered less intensively than planned, with fewer visits and less time spent with clients overall. In our previous report, we also noted that the overall service intensity did not follow a 'step down' pattern—an initial 12 weeks of high-intensity support, followed by 9 months of less intensive service—as indicated by the RF Service Model.

Service intensity is measured here in two ways: the number of visits/ interactions that TBS staff had with Index Children and their families per month, and the total number of hours spent with families per month. Index Children and their families received an average of 12 visits per month whilst in the program, for an average total duration of just over 8 hours per month (Table 6). There was a large variation within the service, with some families averaging approximately one visit per week, while others averaged five per week. The number of hours ranged from 30 minutes a week (2.4 hours per month) to five hours per week (24.6 hours per month).

There is some relationship between service intensity and the risk level of families at the time they enter the service. Those at moderate risk had fewer average interactions with RF per month (10.4 interactions), than those at high (12 interactions) or very high risk (13.1 interactions). They also had fewer contact hours per month (7.8 on average), compared to those at very high risk (9.2 hours on average). Whilst the data suggests some variation in service intensity according to the risk level of families, there is a very high level of variation in service intensity *within* each of the risk cohorts, which contributes to the finding of non-significant differences between the groups.

Table 6. Number of interactions with clients per month, all clients, according to risk level

		Number of interactions per month			Hours per month		
Final risk outcome (SARA)	**N**	**Average**	**Minimum**	**Maximum**	**Average**	**Minimum**	**Maximum**
Moderate	10	**10.4**	5.6	18.2	**7.8**	3.5	13.0
High	38	**12.0**	3.4	20.7	**7.9**	2.4	24.6
Very High	10	**13.1**	6.0	22.2	**9.2**	5.0	13.8
Total	58	**11.9**	3.4	22.2	**8.1**	2.4	24.6

Source: TBS Service monitoring data, FACS SARA and Secondary Assessments data
Note: SARA missing for one family

The data presented in Table 6 highlights two findings: firstly that the average level of service intensity is lower than what might be expected for an intensive service, and secondly, there is a high level of variation in service intensity.

The lower level of average intensity (12 interactions, and eight hours per month) is suggestive of a service that may be flexible according to the need, but is not reflective of an intensive service. TBS staff commonly remarked that they try to be as flexible as they can be in engaging and working with families, recognising that in doing so, they may not meet expectations for an intensive service.

TBS staff reported that a major emphasis in their work with families is to build resilience, with an implicit goal of families being less likely to need to see caseworkers. For example, some TBS staff said that for some of the lower risk families, being flexible in regards to intensity is more empowering and a strength of the service: 'part of my support is to leave it to her [the client]…because it is not about the amount of support in the home, but the quality.' Some of the RF Primary Carers we interviewed also described this (Box 3).

Box 3: Natalie's[+] experience of the RF service and its intensity

Natalie is a single mother with a couple of children who recently separated from a violent relationship and whose newborn child has a number of medical issues associated with being born some months premature.

Natalie said that, during the early days in the RF service, FACS stayed involved in her case to ensure that her youngest child attended medical appointments. Natalie and her TBS worker agreed to a plan where the TBS worker would visit her home once a week for about 1 or 2 hours, and attend medical appointments for the child with her, which was important to Natalie because the TBS worker helped her ask the right questions and understand the advice. During home visits, the TBS worker gave her strategies around communicating better and strengthening relationships with all her children. Natalie said that she was happy with this level of involvement. Although she felt that the TBS worker didn't visit her home a lot, this was ok: they had a strong relationship and Natalie felt that the agreed plan was enough to meet her needs and those of her children. [+]*Pseudonym*

3.2.3 The Resilience Practice Framework is useful, but accurate data collection remains a challenge

To direct the specific activities that caseworkers undertake with clients, the RPF identifies 42 distinct practices[12] that have been empirically shown to positively affect behaviour.[13] These practices are included in the RPF as Evidence Informed Practices (EIPs), and each has been aligned with one of the five resilience outcomes within the RPF. Staff are required to record their activity according to the EIPs, and nominate which of these they have been working on.

Most EIPs are designed to be quite simple, 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

[12] The RF service is based on the Resilience Practice Framework (RPF), which TBS developed in partnership with the Parenting Research Centre.

[13] D. Embry and A. Biglan, 'Evidence-based Kernels: Fundamental Units of Behavioural Influence', *Clinical Child Family Psychology Review,* 2008(11), p96

useful way to share practices that reduce behavioural and psychological problems, improve wellbeing, and achieve public health goals.

Overall, TBS staff felt that the RPF along with the EIPs is a useful tool to help guide service delivery. However, they also reiterated that being responsive to the needs of families was paramount (it is not clear whether these two approaches are at odds). Staff remarked that with some families it was possible to use the resilience outcome areas in the framework and EIPs explicitly, but with others they could not. This depended on the attitudes and literacy level of the family. Staff said they would sometimes 'work backwards' by mapping what they did with a family back to an outcome area and a particular EIP. This suggests that ongoing staff training and support is needed to continue to embed the RPF and accompanying EIPs into practice.

Of the hours that were recorded against a resilience outcome, the most frequently addressed outcome was Increasing Safety (33%)—which aligns to the area of greatest improvement in wellbeing as measured through the Resilience Outcomes Tool (see 4.1.4). The second area of greatest improvement within the tool was Increasing Coping and Self-Regulation, which is not shown to be a focus of the work in the data below (Table 7).

Over a third (38%) of the hours spent with families were not recorded against a resilience outcome or EIP. This is consistent with feedback from TBS staff, who noted that many aspects of their work did not align to a particular EIP. The main focus of the activities recorded within this category were case assessments/ case planning meetings with FACS (23%), housing (16%), parenting and psychoeducation (15%), health/ mental health (14%), and practical assistance with things such as budgeting and developing routines (13%).

Table 7. Time spent on resilience outcomes

Resilience outcome	Total hours	% of Total hours
Increasing Safety	460	33%
Secure and Stable Relationships	199	14%
Increasing Self-efficacy	102	7%
Increasing Coping/ Self-regulation	102	7%
Improving Empathy	12	1%
Other	534	38%
Total	1409	100%

Source: TBS Service monitoring data

3.2.4 Focus on social and community connections needed

Improving connections with family members and community is an important part of the service, as these people/ connections will remain part of the family's environment after formal agency involvement has ended, and some will have a long-term commitment to the children and young people in the family.[14]

In the RF service, TBS staff help families to build these connections through *social connection mapping*, an EIP within the Increasing Safety outcome in the RPF. The time recorded against this EIP was relatively small (10%), equating to 3% of all time spent on EIPs. There are no benchmarks available to accurately interpret this data, but one client we spoke with said that, having now left the service, she feels somewhat isolated and does not have social connections in place to support her over the longer term. This would suggest more focus is needed in this area of TBS's work with some families.

3.2.5 Most referrals are made to child or health related services

Referrals to other services are also recorded by TBS staff. There were 143 referrals to external services made for the 59 families in the data (Table 8), an average of 1.7 per family. That the majority of these were to a health or children's services (playgroup, child care) seems appropriate. In contrast, the number of referrals to housing, domestic violence and mental health services appear relatively low, given the prevalence of these issues for participating families (see 2.2.2).

Table 8. Referrals to external services by service type

Type of external service	Number of referrals	%
Health	36	25%
Playgroup/ Childcare	33	23%
Mental Health	21	15%
Local community services	17	12%
Parenting Support	15	10%
Financial Support or Counselling	7	5%
Housing	7	5%
Drug and Alcohol	4	3%
DV Support	3	2%
Total	143	100%

Source: TBS Service monitoring data

[14] Bruns, E.J. et al., *Ten principles of the wraparound process*, National Wraparound Initiative, 2004

The data overall is difficult to interpret and does not necessarily present a true picture of the suite of services around the families. For example, some families enter the service already connected to other services, or it may be a goal to reduce the number of services some families are receiving. In addition, we can see in the category of work listed as 'other' in the EIP data (see 3.2.3) work with families around housing and psychoeducation as key areas of focus. TBS report that families often enter the RF service with little insight or awareness of the impact of domestic violence or their alcohol and other drug use, and as such are initially resistant to use an external service. The psychoeducation reflects the work they do with family members to increase their understanding in these areas.

Among the RF Primary Carers who we interviewed, referrals or assistance with referrals to health services for carers and children (in particular, to GPs, counsellors and psychiatrists), and referrals to parenting and playgroups (including those offered by TBS) were most often cited. Not all RF Primary Carers who we spoke to described having received referrals to other services when asked.

TBS staff reported challenges in accessing some external services—mainly due to waitlists for appointments. Wait lists tended to be a bigger issue for services that were more likely to be accessed through the public health system (such as occupational therapy and speech therapy). When there was a critical/ urgent need (for example, for a psychiatrist) then this could be paid for by the RF service (using brokerage funds), rather than the client waiting in public system.

Finally there may also be inconsistencies in the way TBS staff are entering information about referrals to external services.

3.3 The program is well resourced and staff are well supported

Feedback from TBS staff indicates that the RF service is well resourced. Staff are able to provide material support to address crisis needs (e.g. rent payments), build skills (e.g. using parenting resources) and develop independence and resilience (e.g. driving lessons). TBS staff also value being able to spend more time with families than in other programs.

There is a strong practice management framework around the delivery of the RF service. All staff receive one-on-one clinical supervision on a fortnightly basis, and each team participates in monthly group coaching with the TBS Practice Support Manager. TBS staff also have access to a continuous learning program within TBS, and are regularly undertaking new and updated training in key practice areas. One staff member mentioned they would like better access to externally provided training, but overall, staff feel well supported in their practice, learning and development.

An ongoing challenge for the RF service has been retaining staff in each site. This has impacted on capacity to request referrals and therefore achieve service targets. However, it not clear what additional efforts can be made by TBS to retain TBS staff, if anecdotal reports indicating that staff are leaving to higher paid and more senior roles are accurate.

3.4 Relationships between TBS and FACS staff have strengthened overall

TBS staff have reported that the relationships between TBS and FACS staff in CSCs at the local level have matured and improved over time, particularly in Region 1. TBS staff report a significant level of trust has now been built and many FACS staff appear to have more confidence to refer families and pass case management responsibility to the RF service. Regular staff turnover within both TBS and FACS means that maintaining and developing this relationship remains an ongoing challenge.

The stronger relationships are based on good interpersonal relationships between individual RF and FACS CSC staff. Where concerns were raised by TBS staff they were concentrated around the practice of individual CSC workers. The TBS SBB Operations Manual outlines processes for communication and resolving issues with clients and between agencies. The process is a change from business-as-usual by requiring resolution through contract managers, rather than through local CSC managers and RF Team Leaders. Local relationships would be better supported if this was revised. The centralised process prevents more informal practice discussions between TBS and CSC managers that occur in other funded programs, and that are seen to help build shared understandings and develop local relationships.

4. Outcomes for families

This chapter examines outcomes for families, drawing on the TBS Resilience Outcomes Tool and FACS child protection data. It also discusses the appropriateness of the measures used for the purpose of the bond payments.

Key findings

The Resilience Outcomes Tool shows improvements in the functioning and wellbeing of Index Children and their families over time. Our interviews with Primary Carers support this; they described a number of ways in which they and their children were better off because of the service.

Similarly, there were also reductions in Index Children's contact with the child protection system over time, with fewer Helpline reports, and fewer SARAs. There were also reductions in these two measures for Control Children, but Control Children received slightly more entries into OOHC.

Results for the total bond population—which includes 86 Index Children and their matched Control Child (total n=172)—show that during the measurement period, Index Children:

- received a greater number of Helpline reports than Control Children (223 compared to 173 reports)
- had a greater number of SARAs commence than Control Children (52 compared to 35 commencements)
- experienced fewer statutory out-of-home care entries than Control Children (15 compared to 18 entries).

Overall, we have found that entries into statutory OOHC is the strongest and most appropriate measure and that Helpline reports is a good measure that should be retained with some refinement. We have some concerns about the reliability of SARAs commenced and suggest more analysis of this measure in the next evaluation stage.

4.1 RF families show improved wellbeing and functioning

The wellbeing and functioning of Primary Carers and Index Children are measured through the TBS Resilience Outcomes Tool, which is completed by Primary Carers on entry and exit from the service and at regular intervals whilst they are receiving services. The tool includes a range of survey items. In our analyses we draw on the three standardised measures used in these tools (Box 4). For this report we look at three scales in particular, two relating to Primary Carers and the third for the Index Child.

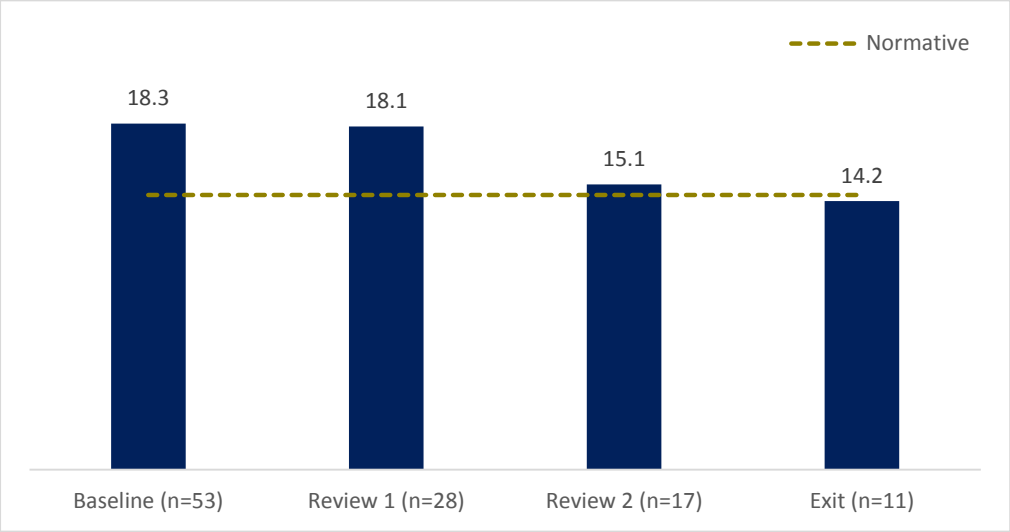
Box 4: Resilience Outcomes Scales

- **K10**: The Kessler-10 (K10) is a measure of psychological distress, used as a brief screening tool. It contains 10 questions about emotional state.
- **Personal Wellbeing Index (PWI)**: The PWI measures 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.[15]
- **Strengths and Difficulties Questionnaire (SDQ)**: The SDQ is designed as a brief behavioural screen questionnaire that can be used for a variety of purposes, including measuring outcomes. The version used by the RF service is the Parent 4-10 version, where it is used for children 3+. The SDQ contains a 'Total Difficulties' score, which provides an overall measure of problems.

4.1.1 Primary Carers report less distress

Primary Carers showed a large decrease in their overall level of psychological distress, as measured by the K10. At baseline, carers (n=52) scored an average of 18.2, compared to an average of 14.5 for the Australian population.[16] However, Primary Carers who completed assessments at Review 1, Review 2, and exit from the program, showed a decreased level of distress compared to baseline. The 17 Primary Carers assessed at Review 2 scored an average of 15.1, and the 11 assessed at exit scored 14.2, making them comparable to the general population (Figure 4).

Figure 4. Primary Carer Kessler-10 scores, over time



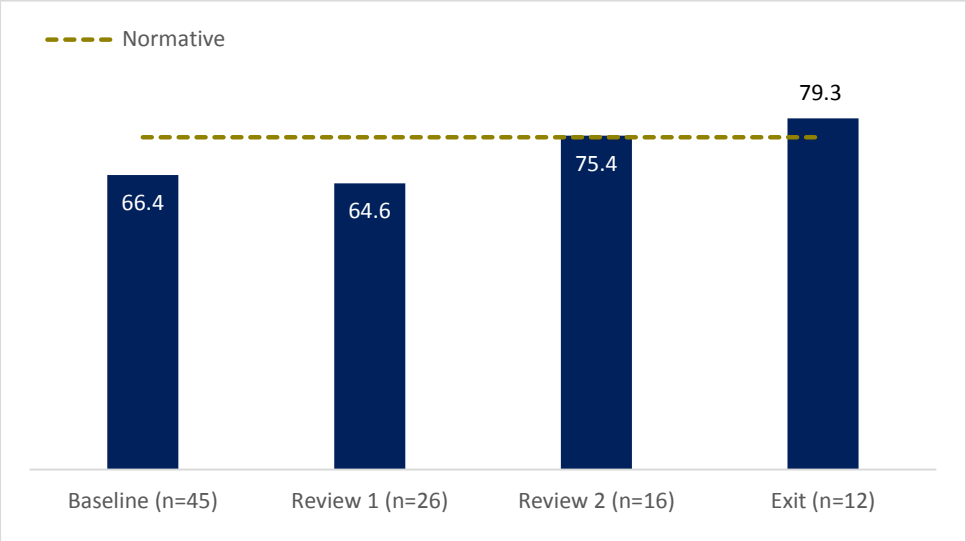
Source: TBS Assessment data

[15] All standardised measures included in the Resilience Outcomes Tool 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.
[16] Slade, T., Grove, R., Burgess, P., 'Kessler psychological distress scale: normative data from the 2007 National Survey of Mental Health and Wellbeing', 2011

4.1.2 Primary Carers report improved wellbeing

Improvements were also seen in the wellbeing of Primary Carers as measured using the Personal Wellbeing Index (PWI, see Appendix 5). At baseline, Primary Carers scored 66.4 on the PWI (measure is out of 100), lower than the Australian average of approximately 73.7 – 76.7.[17] For those assessed at Review 1, this had declined slightly to 64.6 on average. However, scores on the PWI then increased, with the 12 Primary Carers assessed at exit from the program reporting a greater level of personal wellbeing compared to the average Australian (Figure 5).

Figure 5. Primary Carer Personal Wellbeing Index scores, over time



Source: TBS Assessment data

Results from the interviews with RF Primary Carers show how improvements in wellbeing were experienced by some clients, including in the domain of mental health and with respect to having greater confidence as a parent and improved relationships with their children (Box 5).

Box 5: Natalie's[+] increased confidence and skills as a single parent

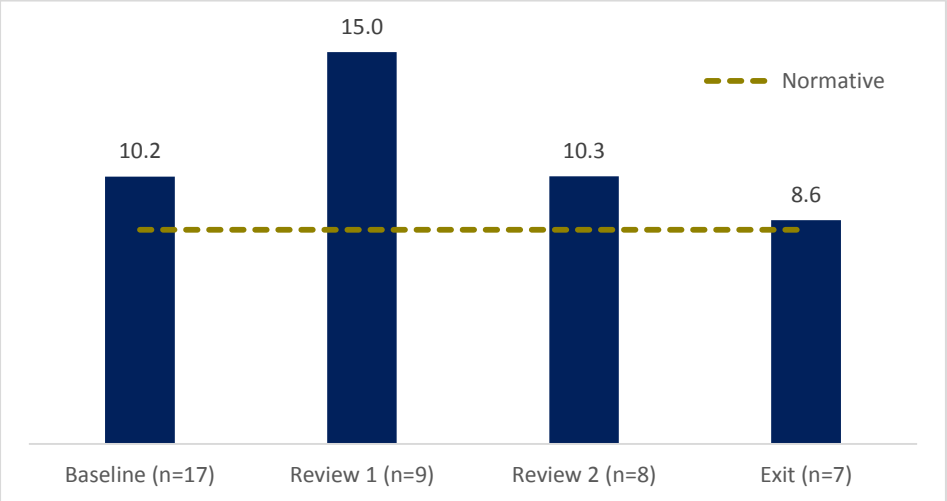
Natalie said that she is parenting differently today, because of the RF service. She feels much closer to her kids, is communicating with them better, and is more open and understanding towards their needs. She also said that she has 'come out of her shell', feels less dependent on the father of her children—who she separated from following a violent incident—and now has more confidence as a single parent. [+]*Pseudonym*

[17] Meade, R., and Cummins, R., 'What makes us happy? Ten years of the Australian Unity Wellbeing Index', 2010

4.1.3 Index Children face fewer social and emotional difficulties

Index Children (n=17)[18] at baseline faced greater difficulties (average score 10.2) than the general child population (normative score 8.2),[19] as measured by the SDQ (maximum score=40, full scale is in Appendix 5). At Review 1, more difficulties were reported for Index Children, (average score 15). However, similar to the pattern seen for Primary Carers, after Review 1 there was a large decrease in the difficulties faced by Index Children. Those who were assessed at exit scored an average of 8.6, comparable to the general population.

Figure 6. Primary Carer SDQ Total Difficulties Subscale scores, over time



Source: TBS Assessment data

Interviews with families also touched on the improvements seen in the children taking part in Resilient Families (Box 6).

Box 6: Karen's[+] improved relationship with her son and safer home environment

A month after completing 12 months of the RF service, Karen feels pretty stable, has a new job, and is happy with her new psychiatrist. Karen reports spending more time with her young son who has autism, because 'my head is in the game now' and because the home environment is less stressful for him. Over the past year, his development, speech and behaviour have improved markedly: he is 'the happiest kid now', and Karen said that others have remarked on his growth too. [+]*Pseudonym*

[18] The target age for the child-focused survey, the SDQ, means it applies for a small sub-set of the Index Children.
[19] Mellor, D., 'Normative data for the Strengths and Difficulties Questionnaire in Australia', 2005

4.1.4 Families show greater resilience over time

The Resilience Outcomes Tool includes questions that align specifically with each of the five TBS resilience outcome areas. We created an 'outcome score'[20] for four of the areas (sufficient data were not available for the Improving Empathy outcome) and then computed an overall 'outcome index'.

There were steady increases over time for families in each of the resilience outcome areas, from baseline to exit. Improvements were greatest in the Increasing Safety and Increasing Coping/ Self-regulation areas. There was also a steady improvement in the overall outcome index (Figure 7). As with the results of individual scales, the combined analyses shows greatest improvement at Review 2 and exit, following only small improvements in the earlier stages. The improvements shown at Review 1 and Review 2 are inconsistent with the increase in reports to the Helpline over the same period (Figure 8). On some indicators though, most notably the SDQ (Figure 6), and to a lesser extent the PWI (Figure 5) there was an initial decline in wellbeing between baseline, and Review 1, before an improvement in later reviews, which is consistent with the pattern in reports (see 4.2).

[20] The responses to each survey item were standardised by converting them to 'z-scores' using the mean and standard deviation of each variable at baseline.

Figure 7. Change in resilience outcomes (higher score indicates better outcomes)

Source: TBS Assessment data

4.1.5 Greatest improvement is seen for highest risk families

We also examined the improvements on the outcome index according to the risk level of families at intake (as measured by their initial SARA). The results indicate that those at very high risk at intake had worse functioning at baseline, scoring -0.42 on the outcome index, but those in that group who were assessed at Review 1, 2 and exit, showed a greater level of improvement on average, relative to the other groups. At this stage, the sample sizes are too small to draw definitive conclusions (Table 9).

Table 9. Resilience outcomes scores, changes over time by initial risk level

Risk level (initial SARA)		Baseline	Review 1	Review 2	Exit
Moderate	n	9	5	2	3
	Outcome index	0.03	0.36	0.19	0.43
High	n	32	20	10	8
	Outcome index	0.10	0.15	0.24	0.40
Very high	n	9	6	4	1
	Outcome index	-0.42	-0.06	0.47	1.02

Source: FACS SARA and Secondary Assessments data and TBS Service monitoring data, n=50, missing data=1

4.2 RF families had less contact with the child protection system over time

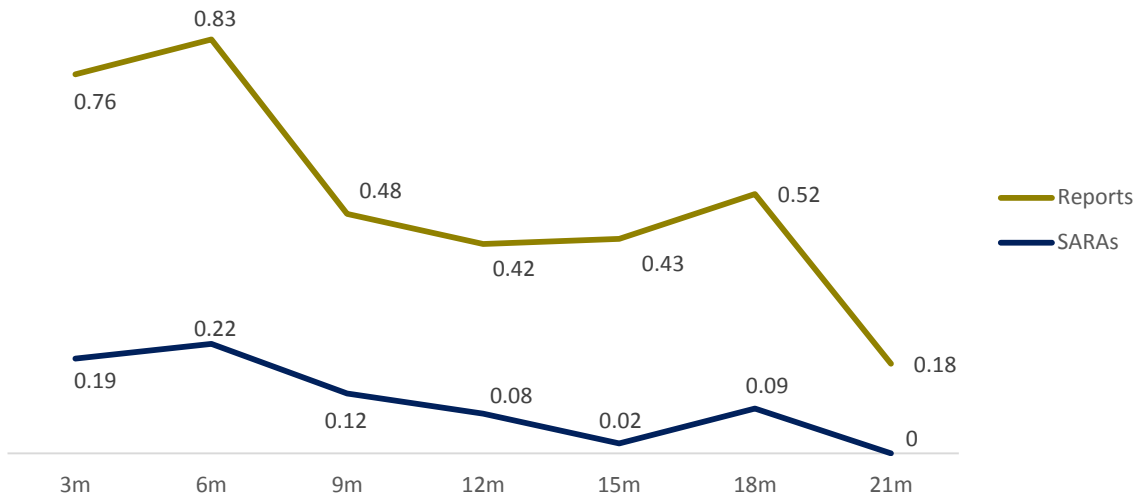
The key objective of the RF service is that children are safer, and this is indicated within the bond structure by reduced contact with the child protection system and measured through:

- reports made to the Helpline
- SARAs commenced
- entries into statutory out-of-home care.

Helpline reports and SARAs

The average number of Helpline reports in which Index Children were the subject, and the number of SARAs commenced for these children, decreased over time. Importantly, there was an initial increase in the number of reports and, to a lesser extent, in the number of SARAs, in the period three to six months after entry (Figure 8).This is consistent with the slow and small gains in functioning and wellbeing in the first six months of service period (see 4.1).

Figure 8. Average number of Helpline reports and SARAs commenced for Index Children per three months since RF service entry



Source: FACS reports data and FACS SARA and Secondary Assessments data

Helpline reports by service outcome

Looking at the number of Helpline reports by service status shows that Index Children whose families met their RF case plan goals were on average, reported less often than those still in the program, those who had exited for other reasons and those who declined the service (Table 10).

Table 10. Number of Helpline reports during measurement period for Index Group by service outcome

Service outcome	N	Average number of reports	S.D.	Minimum	Maximum
Family met goals	10	3.3	3.0	1	9
Continuing in program	14	3.6	3.2	1	12
Exited program	19	5.1	4.3	1	17
Declined RF	7	3.9	4.3	1	13
Total	60	3.7	3.5	1	17

Source: TBS Service monitoring data and FACS reports data

SARAs by service outcome

Similarly, there was an average of one SARA commenced during the measurement period for Index Children whose families met their RF case plan goals, compared to 1.7 for those still in the service and 1.9 for those who exited for other reasons. There was also only one SARA commenced for the four families who declined the service (Table 11).

Table 11. Number of SARAs during measurement period for Index Group by service outcome

Service outcome	N	Average number of SARAs	S.D.	Minimum	Maximum
Family met goals	6	1.0	0	1	1
Continuing in program	7	1.7	1.1	1	4
Exited program	14	1.9	1.0	1	4
Declined RF	4	1.0	1.0	1	1
Total	35	1.5	0.9	1	4

Source: TBS Service monitoring data and FACS SARA and Secondary Assessments data

Out-of-Home Care

Of the 86 Index Children, 15 (17%) entered into statutory OOHC. These children spent a total of 4,156 days in OOHC placements (statutory and non-statutory).

Looking at statutory placements by service status shows fewer placements for those who exited with goals met (5%) than those still receiving the service (13%) or who exited without goals met (33%). Index Children in a quarter of the families who declined the service received a statutory OOHC placement (see Table 42, Appendix 7).

4.3 Similar changes are seen for Control Group Families

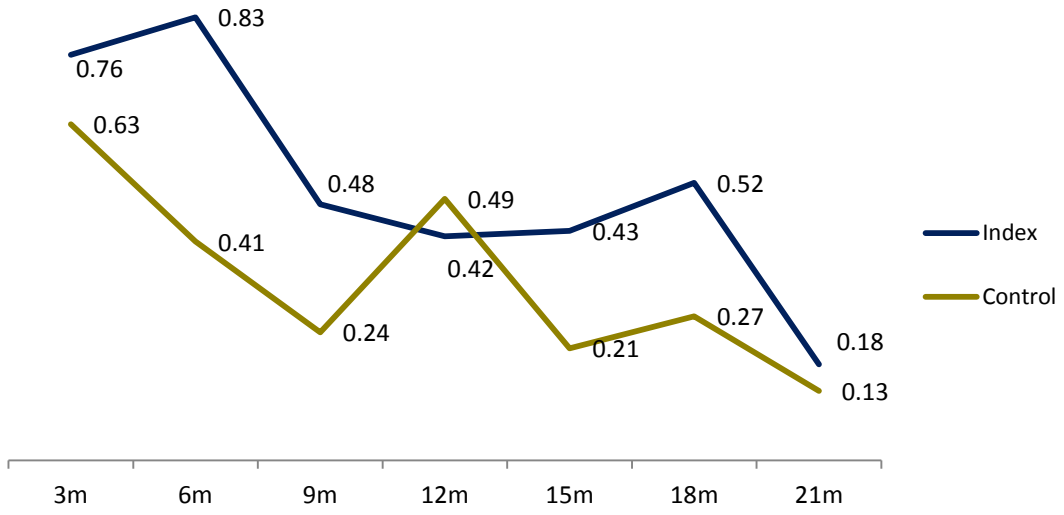
Under the TBS SBB experimental method, program impact is measured by looking at the differences in child protection outcomes between the group of Index Children and group of matched Control Children, who receive a business-as-usual FACS child protection service.

4.3.1 Helpline reports decreased for Index and Control Children

Comparing Helpline reports for the Index and Control Groups show a similar decrease in reports over time, from the beginning of the measurement period. Of note, the increase in the number of reports seen for the Index Group in the second three month period (three to six months after entry) does not occur for the Control Group: the average number of reports for Control Group is significantly lower

during this period. This may provide evidence of observation bias within the reports data impacting the Index Group. It may also reflect the lengthy period shown for engaging RF families.

Figure 9. Average number of reports per three month period, Index and Control Group



Source: FACS reports data

The performance outcome within the bond mechanism is the overall number of reports made during the measurement period. Index Children were the subjects of more reports (both ROSH and non-ROSH) to the Helpline (223 reports in total) than Control Children during the measurement period (173 reports total). Reports where the child was considered to be at risk of significant harm (ROSH) were also more frequent among the Index Children (125) than Control Children (93) (Table 12).

Table 12. Number of Helpline reports, Index and Control Group

	Index Group		Control Group	
	Total no. of Reports	Average per child	Total no. of Reports	Average per child
ROSH reports	125	1.5	93	1.1
Total Helpline reports	223	2.6	173	2.0

Source: FACS reports data, n=172 (86 Index and 86 Control)

Helpline reports by RF service status and risk level

We further examined the number of Helpline reports by their risk level, as measured by their SARA at entry. As might be expected, there were fewer reports during the measurement period for families at moderate risk, compared to those assessed with a SARA risk outcomes of high or very high. This was the case for both the Index Group and the Control Group. Variation was greatest among very high risk families within the Index Group and high risk within the Control Group (Table 13).

Table 13. Number of Helpline reports for Index and Control Children, by SARA risk outcome

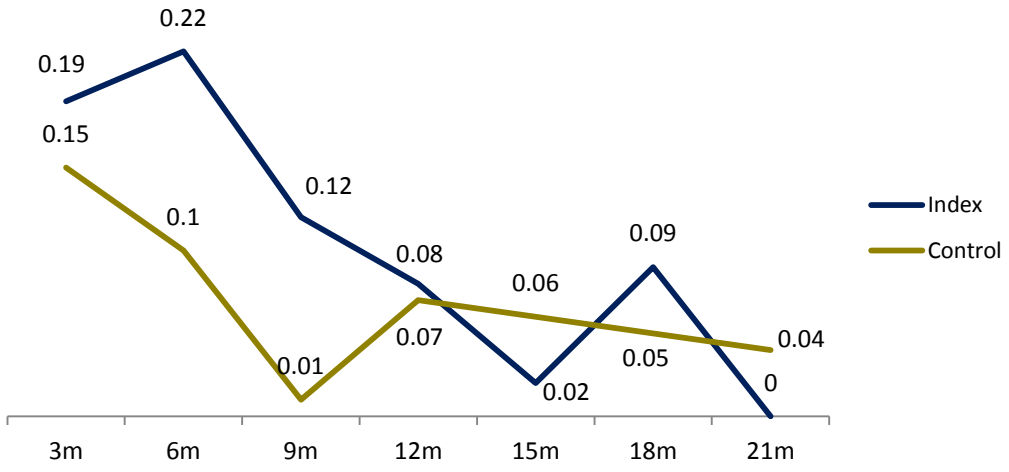
	Final risk outcome (SARA)	N	Average number of reports	S.D.	Minimum	Maximum
Index	Moderate	10	1.6	1.1	1.0	4.0
	High	38	4.1	3.2	1.0	13.0
	Very High	12	4.3	5.1	1.0	17.0
	Total	60	3.7	3.5	1.0	17.0
Control	Moderate	11	2.4	1.4	1.0	6.0
	High	38	3.3	4.5	1.0	26.0
	Very High	7	3.1	2.3	1.0	8.0
	Total	56	3.1	3.8	1.0	26.0

Source: FACS reports data, n=172 (86 Index and 86 Control) and FACS SARA and Secondary Assessments data

4.3.2 Fewer SARAs were commenced over time for Index and Control Group Families

Similar to the trend in Helpline reports, an overall decline in the average number of SARAs commenced was observed for both Index and Control Group Families. Also, as observed in the number of reports for Index Children, the number of SARAs commenced for this group increased in the three to six month period after entry.

Figure 10. Average number of SARAs commenced per 3 month period, Index and Control Group



Source: FACS SARA and Secondary Assessments data

Overall, there were 35 Index Group Families who were the subject of 52 SARAs in total during the program, compared to 27 Control Group Families who were the subject of 35 SARAs (Table 14).

Table 14. SARAs during the measurement period, Index and Control Group Families

	Index	Control
Number of families	86	86
Number of families with SARAs during measurement period	35	27
Total number of SARAs commenced	52	35
Average SARAs per family	1.5	1.3

Source: FACS SARA and Secondary Assessments data

SARAs commenced by risk level

Looking at SARAs commenced for both Index Group and Control Group Families by their risk level, we found a different pattern in the two groups. For Index Families there was a relationship between the risk status of their initial SARA, and the number of subsequent SARAs that were commenced. Families found to be at moderate risk initially had an average of one SARA commenced, whilst very high risk families had an average of two SARAs commenced. This relationship was not repeated in the Control Group, with no clear relationship between their initial risk level, and the number of SARAs commenced during the measurement period. Those at moderate risk had an average of 1.3 SARAs commence, whilst those at very high risk had an average of 1.2 SARAs commence (Table 15).

Table 15. Number of SARAs during RF for Index and Control Group, by SARA risk outcome at entry

	Final risk outcome (SARA)	N	Average number of SARAs commenced*	S.D.	Minimum	Maximum
Index	Moderate	4	1.0	0.0	1.0	1.0
	High	25	1.4	0.8	1.0	4.0
	Very High	6	2.0	1.3	1.0	4.0
	Total	35	1.5	0.9	1.0	4.0
Control	Moderate	4	1.3	0.5	1.0	2.0
	High	17	1.4	0.9	1.0	4.0
	Very High	6	1.2	0.4	1.0	2.0
	Total	27	1.3	0.7	1.0	4.0

Source: FACS SARA and Secondary Assessments data
Note: For families with a SARA commenced

4.3.3 Fewer entries into statutory OOHC for Index Children

The strongest indicator that a child is unsafe is their entry into statutory OOHC, and accordingly this performance outcome is most heavily weighted in the TBS SBB pilot. This is also appropriate given the significant cost savings associated with avoidance of statutory care.

The Index Group had fewer entries into statutory OOHC (n=15), compared to the Control Group (n=18), a 17% difference. The total number of days spent in OOHC placements was also less for the Index Group (Table 16).

Table 16. Number of entries into statutory OOHC, Index and Control Children

	Index	Control
Number of children	86	86
Number of statutory OOHC entries	15	18
Proportion of children with statutory OOHC entries	17%	21%
Total number of days in care*	4,156	5,820

Source: FACS out-of-home care data
*Note: Includes all care types

Analysis of OOHC entries according to the risk level of Index and Control Group Families showed that there was little difference between the two groups, with the majority of entries coming from families found to be at high risk in their initial SARA (Table 17).

Table 17. Number and proportion of statutory OOHC entries during RF service for Index and Control Children, by SARA risk outcome at entry

	Number of statutory OOHC entries			
Final risk outcome (SARA)	**Index**		**Control**	
	N	**%**	**N**	**%**
Moderate	0	0%	1	5%
High	11	20%	11	20%
Very High	4	31%	6	55%
Total	15	17%	18	21%

Source: FACS SARA and Secondary Assessments data and FACS out-of-home care data

4.4 Discussion of outcomes

Primary Carers reported improvements in family wellbeing and functioning consistent with the resilience assessment data, and there have been fewer Helpline reports and SARAs commenced for Index Children and their families over the measurement period to date. Furthermore, Index Children have had fewer entries into statutory OOHC than Control Children overall, the strongest measure of safety out of the child protection outcomes.

Whilst the resilience assessment data shows improvements over time, in some instances this improvement was not linear. On the SDQ (Figure 6) and to a lesser extent the PWI (Figure 5) there was an initial decline in wellbeing between baseline and Review 1, followed by an improvement in later reviews. This pattern is consistent with TBS' expectations that some outcomes appear to worsen as families become more comfortable with their caseworkers, have more awareness of parenting practices, and better understand what their parenting practices should be.[21] TBS also report that increasing family capacity for reflection and trust impact on how they self-report against survey items. This finding is to some extent consistent with the trend in reports to the Helpline and number of SARAs commenced for the Index Group, but not for the Control.

Confounding the positive results for Index Group Families, there are similar improvements among Control Group Families in regards to Helpline reports and SARAs commenced, making it difficult to draw conclusions around the overall effectiveness of the RF service. There are a number of potential explanations as to why the Index Group Families may not have performed as well as the Control Group Families on these two outcomes, and why the Control Group has improved over time.

Index Children may have experienced higher numbers of reports than Control Children due to an observation bias. This relates to the fact that the Index Group are receiving a home-based intensive service from TBS who are mandatory reporters in the child protection system, whereas the Control Group are unlikely to be receiving the same level of service. Therefore, the Index Group are under a greater amount of observation, with more opportunities for them to be reported.

There is some evidence of this in the average number of Helpline reports and SARAs commenced over time; for the Index Group, there was an initial increase in both of these indicators (three to six months after entry), before a larger decline. For the Control Group, there was no such increase. This may be due to the fact that the Index Group are having more opportunity for their problems to be observed. Another explanation might be the lengthy period it is taking for TBS to complete family assessments, as safety and risk factors may be escalating during this period before case plans are in place.

In addition to the initial increase for the Index Group on these two indicators, there was also a clear improvement in the Control Group over time. We see two likely explanations for this, both resulting from the intervention they receive through the SARA. Although Control Group families are excluded if they enter into another intensive family service, this group does receive a FACS' business-as-usual response which consists of having a case plan opened, and a SARA commenced. The safety and risk assessment processes identify key safety issues and risk concerns, and the case will remain active within FACS until these are sufficiently addressed or the children involved are placed into OOHC. We

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

know through the substitution process (see 1.2.3) that these families will not be receiving an intensive case management service, but it is not clear beyond this (in the available data) what services the Control Group Families are receiving. Gaining a more comprehensive understanding of the services the Control Group is receiving might help in understanding any differential or additional outcomes associated with RF service.

In addition, Control Group families may be motivated to alter their behaviour due to being 'on the radar' of FACS. This is supported by the evidence that the likelihood of further FACS involvement appears to be a major motivating factor for families to participate in the RF service. This explanation is supported by a body of research into the phenomena of *measurement reactivity*, where individuals change their behaviour as a result of being aware that they are under observation.[22] This is often observed in research studies, where the process of assessment itself has some kind of intervention effect. In the case of RF, it is likely that such an effect would be even stronger, as the implications are much greater for families in the event of 'poor' performance.

Finally, there is the question of longer term outcomes for families, and the sustainability of the improvements seen within both groups. If TBS is working more deeply through the RF service than a FACS business-as-usual response, it might be expected that the Index Group would show better and more sustained performance on all measures over time, not just statutory OOHC placements. This should be evident by the end of the five year pilot. Arguably, the population is too small and too short a timeframe has passed for certain improvements to be shown or conclusions to be made at this point.[23]

4.5 Appropriateness of performance measures

There are three TBS SBB measures. Multiple indicators of child safety are used to avoid a reductive assessment of outcomes, and to test for congruence in the directionality of outcomes—this can mitigate the risk of problems with data quality, or with the reliability or validity of a single measure. Each TBS SBB measure can also be assessed for appropriateness in its own terms.

Overall, we have found that entries into statutory OOHC is the strongest and most appropriate measure and that Helpline reports is a good measure that should be retained, though refined. We suggest that SARAs commenced maybe less reliable, and more analysis should be undertaken around this.

Entries into statutory OOHC

Entry into statutory OOHC is the strongest indicator in the child protection system that a child is unsafe. As statutory OOHC placements involve an assessment of the case in the judicial system, the safety status of the child is independently verified. These two features indicate that statutory OOHC placements are an appropriate SBB measure. In future trials, consideration could be given to taking into account the number of days in a statutory placement within the performance measure. The implications of this should be considered in the Stage 2 evaluation.

[22]French, D.P and Sutton., 'Reactivity of measurement in health psychology: how much of a problem is it?', *British Journal of Health Psychology*, 2010, 15(3)
[23]ARTD Consultants and RMIT, *Choosing Appropriate Designs and Methods for Impact Evaluation*, 2015

Helpline reports

Helpline reports are a well-established measure in the child protection system that are widely understood within a system of mandatory and non-mandatory reporting to indicate suspicion that a child is at risk or unsafe. This provides a sound reason to use the measure alongside others, though some refinement may be warranted to address the observation bias that appears to be occurring for Index Children (see 4.4). To reduce the impact of this bias, the bond calculation could discount reports made for both the Index and Control Children in the first six months of service when the issue is greatest.

Another option could be to discount Helpline reports made by TBS concerning the Index Group, but there is a risk that this approach introduces a new bias by discounting a mandatory reporter for one group and not for another—that is, FACS reporters for the Control Group that receives a FACS intervention.

SARAs commenced

SARA commencement as a TBS SBB measure captures more information about the risk and safety status of a child than a Helpline report can provide as it reflects a decision by FACS to prioritise the case for attention. But the SARA commencement is the most problematic because the decision to commence a SARA is affected by the capacity of a CSC at any time. Selecting Index and Control Children from the same CSC addresses this to some extent, but practice variation within FACS generally may also impact on the reliability of this measure.

To examine the reliability of SARAs as a measure we looked at the relationship between reports and SARAs commenced. We found that not all reports are followed by a SARA, and not all SARAs are preceded by a report. More than half the reports were followed at some point by a SARA for children in the Index Group (61%), compared to less than half for Control children (43%). This difference is statistically significant. A report for an Index Child was twice as likely to be followed (at some point) by a SARA as a report for a Control Child.

At the same time, for those for whom a SARA was commenced following one or more reports, the mean number of reports prior to the SARA was greater for Index Children (2.8) than for Control Children (2.2).

Overall what this analysis suggests is that there are likely to be differences across CSCs and at different points of time as to when a SARA is completed, suggesting further analysis is needed to determine the reliability of the measure more clearly.

5. How do the costs of Resilient Families compare?

The economic evaluation examines the actual costs of the RF service and how they compare against the initial budget and other similar services.

Key findings

The average actual cost for the 81 families participating in the RF service up to June 2015 is $38,053, 52% over the initial budgeted cost per family of $25,000, but is still comparable (or under) the funded cost per family within other intensive family service programs in NSW.

The majority of costs are staff costs, which can be considered as fixed costs, i.e. not likely to vary much with the number of families supported. There is underspend in client expenditure (brokerage costs). The cost per family is likely to reduce or be contained as the number of families increases.

5.1 Budgeted and actual costs

The RF service was allocated $10 million over five years. The budget was initially set in March 2013 with the expectation that the program would start operating from 1 July 2013 with funding of $2 million per annum.

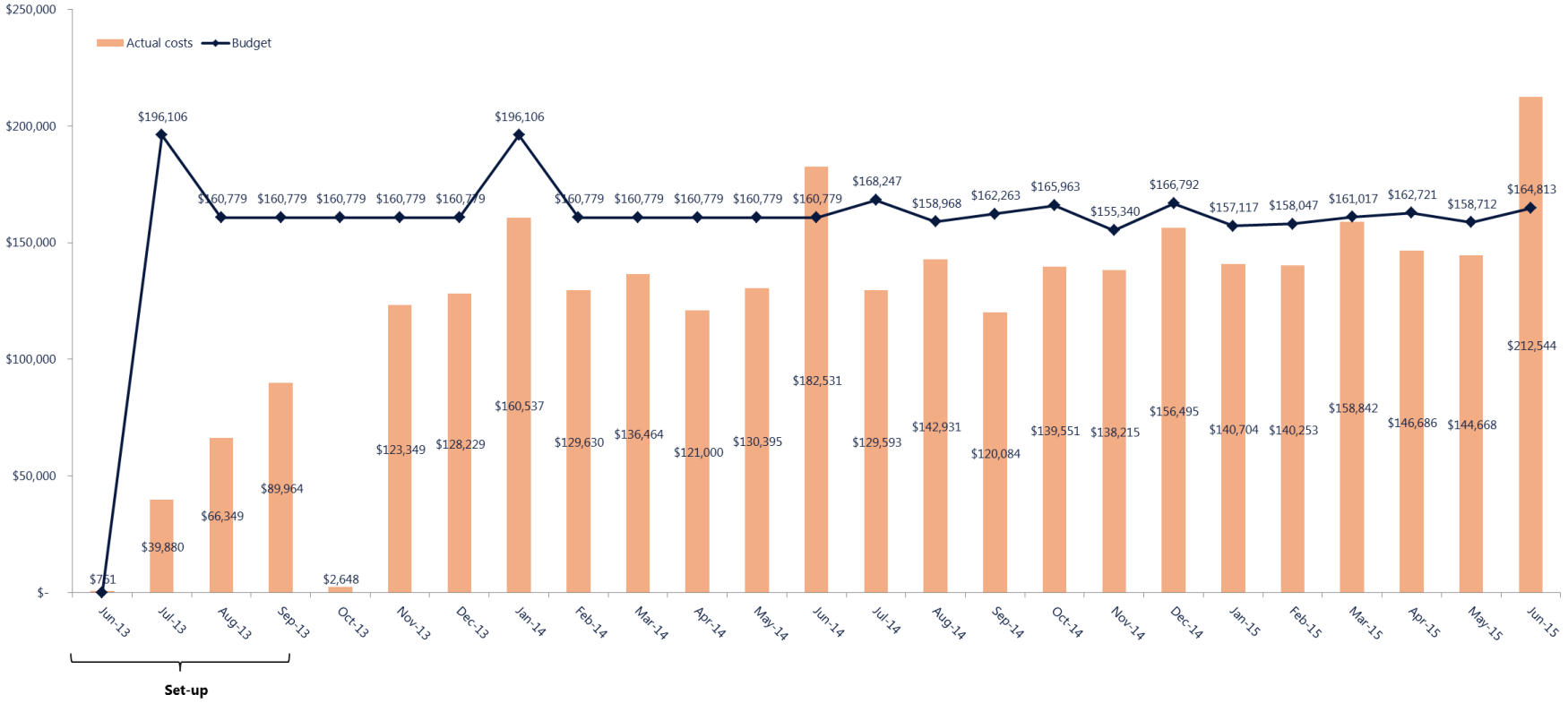
While TBS started incurring costs for the service from June 2013, the actual delivery started in October 2013, as shown in the 'set-up' phase (June to September 2013) in Figure 11. Costs associated with service delivery since that time have remained fairly even. To the end of June 2015, the actual costs of the program including the start-up period were $3,082,301, compared to a budget of $3,939,999 for the period. This represents 22% less spent than initially planned.

Table 18. Budget and actual costs of RF service by financial year

	2013-14	2014-15
Budget	$2,000,001	$1,939,999
Actual	$1,311,737	$1,770,565

Source: TBS cost data

Figure 11. Detailed budget and actual costs of RF service by month, June 2013–June 2015



Source: TBS cost data

5.1.1 Distribution of costs

The distribution of costs shows that the majority of costs are largely fixed and as such they are not likely to vary much with the number of families supported. Staff costs account for almost two thirds of program costs (62%). Of the amount spent on staff costs, 50% went to caseworkers' salaries, 16% to supervisors/ team leaders and 9% to management. Another one fifth of the overall costs (21%) were allocated to TBS shared corporate services costs. This is higher than an industry benchmark identified in a 2012 Nous study where an average of 11.1 per cent of NGOs organisational expenditure was spent on corporate functions (HR, payroll, fleet, finance and IT).[24] However, TBS report that the amount spent on shared services are similar to other NGOs of similar sizes, while the 2012 Nous study included a majority of small NGOs—no benchmark information was available for NGOs of a similar size. TBS also specified that the methods used to calculate shared services cost is based on revenues and not operating expenditure, which contributes to an over-allocation of shared services in the early years where revenues were higher than actual costs. Any relative over-allocation of shared services in the early years are expected to be offset by a relative under-allocation in the later years and balance out over the five years of the project. TBS report there to be no major variances to budget to date and expect the underspent budget early in the program to be offset in later years.

Client costs were the largest area of underspend

The largest area of underspend was in the category of client expenditure (Table 19). We understand the budget included an amount for child care costs that have been largely met instead through child care benefits. TBS also reported that the staff have shown significant resourcefulness in securing discounts and donations instead of buying new goods. This is consistent with the model of sustainability TBS are working towards, in which they are teaching families different ways of sourcing goods through the service.

[24] Nous Consulting, *Not-for-Profit back-of-house function benchmarks 2010–2011*, Public Summary Report, 2012

Table 19. RF service client expenditure budget versus actual, June 2013 to June 2015

	Budget	Actual
Client Consumables Recoverable		$1,838
Client Consumables Not Recoverable	$227,000	$41,914
Client Costs Brokered/Outsourced	$298,814	$41,612
Internal Brokerage		$425
Client External Catering	$6,000	
Groceries		$665
Translation/ Interpreting Services	$6,000	$9,630
Totals	$537,814	$96,084

Source: TBS cost data

5.2 Cost per family

The average cost per family is calculated for the 81 families participating in the RF service up to June 2015.[25] This cost is $38,053, which is 52 per cent over the budgeted amount of $25,000. This is partly accounted for by the lower than planned numbers commencing the service. The cost per family is likely to reduce with an increase in the number of families supported, as the majority of costs are largely fixed and not likely to increase in the same proportion as the number of families.

Although the budgeted cost per family for the RF service ($25,000) is much lower than other intensive family support programs funded by FACS (Table 20), the actual average costs per family for RF ($38,053) are also comparable to budgeted costs of other programs.[26]

Table 20. 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	$6,596,313	164	$40,221
Intensive Family Preservation	Intensive	$4,297,453	93	$46,209

Sources: TBS and FACS program administration data

[25] This figure is provided by TBS as the actual number of families supported in the identified period. It includes families who did not consent to the evaluation but we do not have other information about the counting rules.
[26] We only have access to budgeted, not actual expenditure for other programs.

6. Conclusion and recommendations

This chapter draws conclusions based on key findings of the Stage 1 evaluation and identifies recommendations for the improvement of the TBS SBB pilot referral mechanism, the RF service and the bond measures.

6.1 Targeting and referring families

The evaluation evidence suggests that the centralised referral mechanism which establishes the Index and Control Groups for bond measurement purposes involves a lengthy recruitment, selection and matching process. The overall time from SARA commencement to initial home visit is 5.2 weeks, with 4.8 weeks of this time accounted for by the process within FACS to identify and refer families. This undermines the key principle of immediacy in referrals within the Homebuilders model. A second factor is that the process is generating a proportion of families (about one fifth) who are low risk according to a range of risk measures.

These two factors are concerns for the delivery of the RF service because intervening at the time of a crisis is known to motivate change and the intensity at which TBS can work is limited. The proportion of low risk families means there is less scope to reduce contact with the child protection system, especially in relation to OOHC entries.

These concerns warrant a review of the referral mechanism and consideration of an additional, more direct pathway into the RF service (see 2.3).

Recommendation 1. Review the centralised referral mechanism, including the selection and matching process, to improve the timeliness of referrals and better target the service to those families most likely to benefit from an intensive service. In reviewing the process, consider a direct pathway to the RF service from referring CSCs.

6.2 Nature and quality of delivery

As previous research shows that intensive programs that adhere closely to the Homebuilders model are most effective (see 1.2.2), the Stage 1 evaluation of RF has drawn largely on Homebuilders standards to assess the RF service. Our evidence suggests on many (particularly qualitative) dimensions, the RF service reflects many key Homebuilders principles, such as being a holistic, individually-targeted and strengths-based service. There are limitations to a fidelity assessment of RF given that the service differs from Homebuilders in key design aspects, including duration and intensity. While Homebuilders provides a minimum of eight face-to-face hours with clients over five to six weeks, RF by design, delivers a less intensive service (based on staff of ratio differences) over a period of up to a year. In practice it is even less intensive than planned.

We build on our findings throughout the Stage 1 evaluation in recommending the areas of the RF service that should the subject of focussed improvement effort.

Recommendation 2. Develop a strategy within TBS for ongoing review and improvement in the following areas of service delivery.

1. Reducing timeframes for engaging families and completing family case plans.
2. Increasing service intensity, especially in the first three months of the service.
3. Focusing on social connections in the implementation of Family Support Plans.
4. Optimising the use of external and specialist resources of potential benefit to families.
5. Seeking to manage the duration of involvement by families to more closely align with the initial intention of program participation for 12 months and ensure the longer term throughput nature of the program.
6. Embedding the RPF into practice.

The evaluation also considers the extent to which local working arrangements between TBS and FACS staff have impacted on the implementation of RF. TBS staff believe that overall, relationships with CSC staff have improved as they have matured and these staff have become more familiar with the service. Where challenges exist they are mostly with a small number of staff and relate to case plans and other practice issues. The SBB Operations Manual requires any escalation of concerns through a centralised process in FACS. This means the TBS Manager is unable to have the kind of practice discussion with other managers in CSCs that occur in other funded programs and help to build shared understandings and working relationships.

Recommendation 3. Revise the TBS SBB Operations Manual so that practice discussions can be held in the first instance with relevant TBS and CSC managers, and only escalated to SBB contract managers where these cannot be resolved locally.

6.3 Outcomes achieved

The Interim evaluation shows relatively poor performance to date under the SBB mechanism. Importantly, this is because the Control Children are experiencing a similar pattern of declining contact with the child protection system as Index Children (apart from a spike in contact for the Index Group in the first three to six months after entry), not because RF is failing to achieve its stated outcomes. Consistent with the decrease in contact we also see improvements in functioning and wellbeing for Index Children and their families, but comparative data is not available for the families of Control Children to see if the same patterns exist.

The reasons for the spike in contact for the Index Children are not fully understood. Observation bias, a result of mandatory reporters having frequent home-based contact with families, is likely to be a contributing factor. Another may be the extended periods of time being taken to complete family assessments, which means problems are not being effectively addressed in this initial period.

The Control Group, who by definition have a SARA commenced, receive an intervention from FACS through which major safety issues and risk concerns are identified and the case will remain open until these are adequately addressed.

We know from the small sample of family members we interviewed that their main motivation to participate was to address FACS safety concerns and minimise contact with the statutory system, and we can reasonably expect the same to be true of families of Control Children. We can also expect the case plan goals and activities to be similar for both groups. It appears a FACS business-as-usual response achieved through the SARA process achieves a similar, and in some cases, greater impact than the RF service.

It is possible that TBS may be working more deeply through the RF service than a FACS business-as-usual response. This may help explain performance on the third measure, entries into statutory out-of-home care (OOHC), in which fewer placements were seen for Index Children than for Control Children. If this is the case, we might also expect the Index Group to show better and more sustained performance on all three measures over time.

Recommendation 4. Extend data collection around the TBS SBB to provide aggregate level information about service activity for Control Children and their families.

6.4 Appropriateness of measures

There are a number of questions around the appropriateness of the measures, such as issues around observation bias and reliability.

Entry into statutory OOHC is the strongest and most appropriate measure because this requires the safety status of the child is independently verified through the court system.

Helpline reports are a well-established measure and within a system of mandatory and non-mandatory reporting are understood to indicate safety concerns. It appears there is some level of observation bias occurring in first three to six months of the service. To address this, the bond calculation could be revised to discount reports made for both the Index and Control Children in the first six months.

SARAs commenced appear to be problematic as a measure because they are more affected by context than other measures. We found that not all reports are followed by a SARA, and not all SARAs are preceded by a report. Reports for Index Children were more likely to be followed by a SARA than reports for Control Children, but for those where a SARA commenced, Index Children received more reports. We think the analysis is consistent with our broader understanding that there are likely to be differences across CSCs and at different points of time as to when a SARA is completed. More detailed analysis may help determine the appropriate of SARAs as a measure in future projects.

Recommendation 5. Discount Helpline reports made in the first six months of the measurement period for each Matched Pair.

Recommendation 6. Expand the analysis of SARAs commenced in the final evaluation stage to develop a more detailed understanding of the appropriateness of this measure.

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Appendix 1: Evaluation questions

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

- 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 linked into relevant services and making broader social/ 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?

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?

5. How do the costs of RF compare to other programs?

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

Appendix 2: Methods

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 data

Service monitoring 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 contains the records of the 59 Index Children and their families who were in the service between 8 October 2013 and 30 June 2015, commenced in the service and consented to participate in this evaluation.

Assessment data

TBS Resilience Outcomes Tool database—an SPSS data file containing the results of the Resilience Outcomes Tool for each family. This database includes records for 51 families overall, each of which have some baseline data, and 13 of which also have data from the first review. This database covers consenting families in the program between 8 October 2013 and 30 June 2015.

The tool includes a range of survey items, and is designed to measure the five resilience outcomes as defined by TBS. We reported results from three standardised measures contained within the tool, and also the results for the resilience outcomes.

FACS data

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 86 Control and 86 Index Children. This database covers families in the program between 8 October 2013 and 30 June 2015, 12 Index Families who refused the RF service and the 15 families who accepted the service but refused the evaluation.

FACS reports data

A spreadsheet of all reports for each of the children in the Index and Control Groups as detailed above from 12 months prior to their measurement start date until 30 June 2015. It includes all non-cancelled contact records where a child 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.

FACS SARA and Secondary Assessments data

A spreadsheet of all Secondary Assessments undertaken for each child in the Index and Control Groups from 12 months prior to their measurement start date until 30 June 2015. It includes all non-cancelled Secondary Assessment Stage 2 records where a child is a subject of the record, and excludes records where the 'Safety Assessment = Draft'. It details assessment type, dates, assessed issues, and safety and risk outcomes.

FACS out-of-home care data

A spreadsheet of OOHC information for children in the Index and Control Groups from 12 months prior to their measurement start date until 30 June 2015. It includes only primary placements that commence on or before 30 June 2015, 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.

FACS historical child protection data

Child protection and out-of-home care data for the Primary Carers of the 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 2015.

Quantitative analysis

Index and Control Children and the bond calculation cohort

The Index and Control Child data provided for this report includes 86 Index Children and their 86 Matched Control counterparts and one unmatched Index Child. It excludes eight families: two families TBA on birth, four families who were early exit from treatment area ('Agreed Locations'), one family excluded due to a change in the Safety Outcome (SARA) and one family with an unmatched Index Child. The bond payment calculation is based on an 'intention to treat' model and will be conducted on all Index Children referred to the RF service, with the following exceptions:[27]

- 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)

[27] NSW Treasury, 'Operations Manual for the TBS Social Benefit Bond Pilot' v2.1 2015, p 25.

- 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') in a certain period of time
- Index Children who have been referred to the RF service 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 SBB measures.

Analysis of risk levels

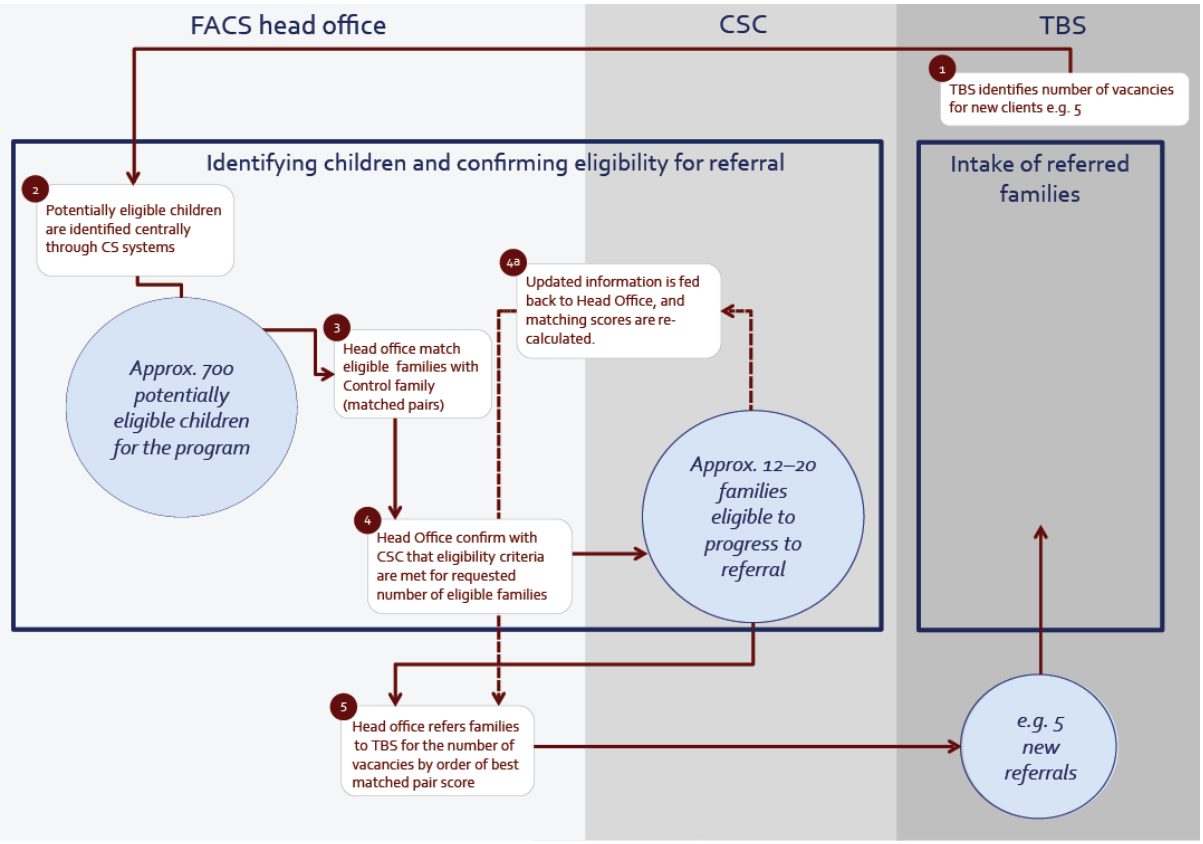
1. **Number of previous reports to Helpline for Index Children.** This was categorised as 0-1, 2-3, 4-5, and 6 or more reports.
2. **Presence of predictive risk factors.** We examined the presence of certain risk factors among both the Index and Control Groups, and calculated which families could be considered at 'low risk'. The list of risk factors used was developed by the Australian Institute of Family Studies (AIFS)[28], which lists 33 risk factors for involvement in the child protection system. Of these 33, we had data for all Index and Control Children on five factors:
    - parental substance abuse (reported issue 12 months prior to entry)
    - family conflict or violence (reported issue 12 months prior to entry)
    - mental health problems/ parental psychological disability (reported issue 12 months prior to entry)
    - history of child abuse and neglect (>1 child on last SARA pre and no history of OOHC or SARAs for siblings, or child > 1 and total reports pre < 2)
    - large family size (if the number of children on last SARA in matching process was greater than 3)

    Families were categorised as either having 0 or 1 of these risk factors present (this was the 'low risk' group), or having 2 or more present.
3. **Outcome of the Risk Assessment undertaken at the time of referral to RF.** SARAs contain a risk assessment tool which is used to determine the likelihood of future abuse or neglect of a child. Families are classified into low, moderate, high and very high risk groups.

[28] Australian Institute of Family Studies, 'Risk and Protective Factors', 2013

Appendix 3: Referral and assessment process

Figure 12. Centralised referral process from FACS to TBS



Source: ARTD Consultants

Timeframes

Table 21. Number of weeks from date of SARA commenced to initial home visit

Child age	N	Average weeks	S.D.	Minimum	Maximum
Unborn	6	-0.1	10.1	-20.6*	6.9
Under 1 year	23	5.4	2.3	2.7	14.0
1-2 years old	13	5.2	1.9	2.9	9.1
3 years or older	17	6.7	4.6	3.0	23.1
Total	59	5.2	4.6	-20.6	23.1

Source: TBS Service monitoring data and FACS SARA and Secondary Assessments data
Note: includes families in the program who consented to the evaluation; * RF commenced working with one child five months before it was born, at which date their SARA commenced.

Table 22. Number of weeks from date of SARA commenced to measurement start date

	N	Average weeks	S.D.	Minimum	Maximum
Control	86	4.7	3.3	0.29	18.6
Index	86	4.8	3.7	0.00	18.9

Source: FACS SARA and Secondary Assessments data
Note: measurement start date is "Date Child was referred to TBS, or if the Child is an unborn Child the later of its DOB or the DOB of its Matched child". Unborn Children had a mean of 12.6 weeks, compared to a mean of 4 weeks for other children.

Table 23. Number of days from referral to initial contact with family

	N	Average number of days	Standard Deviation	Minimum	Maximum
Region 1	32	7.5	15.4	1	91
Region 2	27	11.7	8	2	37
Total	59	9.4	12.6	1	91

Source: TBS Service monitoring data

Table 24. Number of days from initial contact to completion of Resilience Assessment Tool

	N	Average days from initial contact to completion of assessment	S.D.	Minimum	Maximum
Region 1	32	71.5	79.6	14	349
Region 2	27	57.8	79.0	6	378
Total	59	65.4	78.8	6	378

Source: TBS Service monitoring data and TBS Assessment data

Table 25. Number of days between assessment and reviews

Time point 1	Time point 2	N	Average time (days)
Baseline	Review 1	30	125
Review 1	Review 2	15	144
Review 2	Exit	6	143
Baseline	Exit	11	358

Source: TBS Service monitoring data and TBS Assessment data

Appendix 4: Family and carer characteristics

Table 26. Characteristics of RF Primary Carers

		Region 1	Region 2	Total
	n	32	27	59
Age at referral	Average (mean)	30.6	33.08	31.81
	Missing data	8	4	12
Gender	Male	13%	4%	9%
	Female	88%	96%	91%
	Missing data	8	4	12
Employment situation	Employed full time	10%	0%	5%
	Employed part time	0%	4%	2%
	Employed casual	5%	0%	2%
	Full time carer/ parent	48%	61%	55%
	Studying	5%	0%	2%
	Unemployed	29%	35%	32%
	Other	5%	0%	2%
	Missing data	11	4	15
Main source of income	Wages or salary	17%	0%	9%
	Child support or maintenance from ex-partner	4%	0%	2%
	Government benefit, pension or allowance	74%	96%	85%
	No income source	4%	4%	4%
	Missing data	9	4	3
Highest level of education achieved	Never attended school	6%	0%	3%
	Less than HSC or equivalent	61%	72%	66%
	HSC or equivalent	22%	10%	15%
	Post-school qualification	12%	19%	15%
	Missing data	14	6	20

Source: TBS Assessment data, n=59 Note: percentages have been rounded and may not total to 100%

Table 27. Characteristics of RF Secondary Carers

		Region 1	Region 2	Total
n		32	27	31
Age at referral	Average (mean)	37.52	34.43	36
	Missing data	16	12	28
Gender	Male	94%	88%	91%
	Female	6%	13%	9%
	Missing data	16	11	27
Employment situation	Employed full time	17%	21%	19%
	Employed casual	25%	14%	19%
	Full time carer/ parent	8%	21%	15%
	Unemployed	42%	36%	38%
	Other	8%	7%	8%
	Missing data	5	2	7
Main source of income	Wages or salary	29%	38%	33%
	Government benefit, pension or allowance	64%	62%	63%
	No income source	7%	0%	4%
	Missing data	3	3	6
Highest level of education achieved	Less than HSC or equivalent	66%	67%	66%
	HSC or equivalent	17%	11%	13%
	Post-school qualification	17%	22%	20%
	Missing data	11	7	18

Source: TBS Assessment data, n=59, 9 families do not have a Secondary Carer

Note: percentages have been rounded and may not total to 100%

Table 28. Types of housing of RF families

	Region 1	Region 2	Total
n	24	20	44
Own or paying off house/ flat	17%	15%	16%
Public housing	38%	25%	32%
Private rental house/ flat/ unit	17%	30%	23%
Stay with family or friends	13%	20%	16%
Caravan	0%	0%	0%
Crisis/ temporary housing	17%	10%	14%
Homeless	0%	0%	0%
Total	100%	100%	100%
Missing	8	7	15

Source: TBS Assessment data
Note: percentages have been rounded and may not total to 100%

Table 29. Language spoken at home by RF families

	Region 1		Region 2		Total	
	n	%	n	%	n	%
English	23	71.9%	25	92.6%	48	81.4%
Arabic	1	3.1%	0	0%	1	1.7%
Bengali	2	6.3%	0	0%	2	3.4%
Chinese languages	3	9.4%	1	3.7%	4	6.8%
Tagalog (Filipino)	1	3.1%	0	0%	1	1.7%
Turkish	1	3.1%	10	0%	1	1.7%
Vietnamese	1	3.1%	0	0%	1	1.7%
Other (not defined)	0	0%	1	3.7%	1	1.7%
Total	32	100%	27	100%	59	100%

Source: TBS Assessment data, n=59
Note: percentages have been rounded and may not total to 100%

Table 30. Number of times RF family has moved house in past 12 months

	Region 1	Region 2	Total
n	22	23	45
Not at all	64%	48%	56%
Once	5%	13%	9%
Twice	14%	17%	16%
Three times	9%	13%	11%
Four times or more	9%	9%	9%
Total	100%	100%	100%
Missing	22	23	14

Source: TBS Assessment data, n=59

Note: percentages have been rounded and may not total to 100%

Index Child characteristics

Table 31. Average age and gender of Index Children

Age at referral	Region 1	Region 2	Total
n	28	26	54
Average age	2.27	1.88	2.08
Missing	0	0	0
Gender			
n	23	22	45
Male	43%	45%	44%
Female	57%	55%	56%
Total	100%	100%	100%
Missing	5	4	9

Source: TBS Assessment data n=54, 5 unborn children excluded

Table 32. Aboriginal or Torres Strait Islander status of Index Children

Identifies as ATSI	Region 1	Region 2	Total
n	28	26	54
No	75%	92.3%	83.3%
Yes	25%	7.7%	16.7%
Total	100%	100%	100%

Source: TBS Assessment data n=54, 5 unborn children excluded

Appendix 5: RPF scale items

Personal Wellbeing Index

The following questions ask how satisfied you feel, on a scale from 0 to 10. Zero means you feel completely dissatisfied. 10 means you feel completely satisfied. And the middle of the scale is 5, which means you feel neutral, neither satisfied nor dissatisfied.

Table 33. PWI survey items

Item	Rating
How satisfied are you with your standard of living?	0 - 10
How satisfied are you with your health?	0 - 10
How satisfied are you with what you are achieving in life?	0 - 10
How satisfied are you with your personal relationships?	0 - 10
How satisfied are you with how safe you feel?	0 - 10
How satisfied are you with feeling part of your community?	0 - 10
How satisfied are you with your future security?	0 - 10

Source: International Wellbeing Group, Personal Wellbeing Index–Adult, 2013

Strengths and Difficulties Questionnaire

For each item, please mark the box for 'Not true', 'Somewhat true' or 'Certainly true'. Please give your answers on the basis of the child's behaviour over the last six months.

Table 34. SDQ survey items

Item	Rating
Considerate of other people's feelings	0 (Not true), 1 (Somewhat true), 2 (Certainly true)
Restless, overactive, cannot stay still for long	0, 1, 2
Often complains of headaches, stomach-aches or sickness	0, 1, 2
Shares readily with other children (treats, toys, pencils etc.)	0, 1, 2
Often loses temper	0, 1, 2
Rather solitary, tends to play alone	0, 1, 2

Item	Rating
Generally obedient, usually does what adults request	0, 1, 2
Many worries, often seems worried	0, 1, 2
Helpful if someone is hurt, upset or feeling ill	0, 1, 2
Constantly fidgeting or squirming	0, 1, 2
Has at least one good friend	0, 1, 2
Often fights with other children or bullies them	0, 1, 2
Often unhappy, downhearted or tearful	0, 1, 2
Generally liked by other children	0, 1, 2
Easily distracted, concentration wanders	0, 1, 2
Nervous or clingy in new situations, easily loses confidence	0, 1, 2
Kind to younger children	0, 1, 2
Often lies or cheats	0, 1, 2
Picked on or bullied by other children	0, 1, 2
Often volunteers to help others (parents, teachers, other children)	0, 1, 2
Thinks things out before acting	0, 1, 2
Steals from home, school or elsewhere	0, 1, 2
Gets on better with adults than with other children	0, 1, 2
Many fears, easily scared	0, 1, 2
Good attention span, sees work through to the end	0, 1, 2

Source: Youth in Mind, 'SDQ: Information for researchers and professionals about the Strengths & Difficulties Questionnaires', 2014

Appendix 6: Reported and assessed issues

Following consultation with FACS and TBS, assessed and reported issues from SARAs and Helpline reports were categorised according to groupings and decision trees within the Mandatory Reporter Guide. The reported and assessed issues are in the tables below and the categorisations are shown in Table 39 .

Table 35. Reported issues in the 12 months prior to the RF service

Category of reported issue	Index	Control	Total
Physical abuse	24%	24%	24%
Neglect	17%	17%	17%
Sexual abuse	2%	4%	3%
Psychological harm	18%	16%	17%
Children danger to self or others	2%	1%	2%
Relinquishing care	1%	1%	1%
Carer concern	27%	22%	24%
No risk or harm issues	2%	3%	3%
Pre-natal report	7%	13%	10%
Total	353	363	716

Source: FACS reports data

Note: percentages have been rounded and may not total to 100%

Table 36. Assessed issues in the 12 months prior to the RF service

Category of assessed issue in SARA	Index	Control	Total
Physical abuse	14%	22%	18%
Neglect	20%	17%	18%
Sexual abuse	1%	1%	1%
Psychological harm	13%	15%	14%
Carer concern	37%	37%	37%
No risk or harm issues	11%	7%	9%
Pre-natal report	4%	1%	3%
Total	153	166	319

Source: FACS SARA and Secondary Assessments data
Note: percentages have been rounded and may not total to 100%

Table 37. Reported issues during the RF service

Category of reported issue	Index	Control	Total
Physical abuse	24.7%	22.5%	23.7%
Neglect	18.8%	21.4%	19.9%
Sexual abuse	7.6%	11%	9.1%
Psychological harm	15.7%	14.5%	15.2%
Children danger to self or other	2.7%	1.2%	2.0%
Relinquishing care	0.4%	2.3%	1.3%
Carer concern	22.9%	20.8%	22.0%
No risk or harm issues	7.2%	4.6%	6.1%
Pre-natal report	0%	1.7%	0.8%
Total	223	173	396

Source: FACS reports data
Note: percentages have been rounded and may not total to 100%

Table 38. Assessed issues during the RF service

Category of assessed issue in SARA	Index	Control	Total
Physical abuse	15.1%	13.7%	14.5%
Neglect	19.2%	9.8%	15.3%
Sexual abuse	6.8%	5.9%	6.5%
Psychological harm	13.7%	5.9%	10.5%
Relinquishing care	0%	1.9%	0.8%
Carer concern	37.0%	33.3%	35.5%
No risk or harm issues	6.8%	27.5%	15.3%
Pre-natal report	1.4%	1.9%	1.6%
Total	73	51	124

Source: FACS SARA and Secondary Assessments data

Note: percentages have been rounded and may not total to 100%

Table 39. Assessed and Reported Issue Categories[29]

Assessed and Reported Issue Categories	Assessed and Reported Issues	
Physical abuse	DV - Domestic Violence	Physical: Poisoning
	DV, Child/ren harmed intervening	Physical: Strangle/ suffocate
	Physical: Hit, kick, strike	Physical: Throwing baby/ child
	Physical: other	Risk of physical harm/ injury
Neglect	Alcohol use by child or YP	Inadequate Supervision for age
	Drug use by child or YP	Medical treatment not provided
	Failure to Thrive, non-organic	Neglect EDU: Habitual Absence
	Inadequate Clothing	Neglect EDU: C/YP Not Enrolled
	Inadequate Nutrition	Neglect: Hygiene
	Inadequate Shelter or homeless	
Sexual abuse	Child inappropriate Sexual behaviour	Sexual Penetration
	Risk of sexual harm/injury	Sexual: Indecent acts/ molest
Psychological harm	DV Child/ren exposed to violence	Psychological mistreatment
	Persistent caregiver hostility	Risk of Psychological harm
Child danger to self/ others	Child is danger to self/ others	Suicide risk for child
Relinquishing care	Carer in prison	Legal Guardianship issues
	Child/ren or YP/s abandoned	Unauthorised OOHC arrangement
Carer concern	Alcohol abuse by carer	Financial problems of carer
	Developmental disability, carer	Physical disability of carer
	Drug abuse by carer	Psychiatric disability, carer
	Emotional state of carer	Suicide risk/ attempt of carer
Unborn child	Prenatal Report	

Source: FACS reports data

[29] This is not a complete list of all possible reported and assessed issues, but a categorisation of those present in the data sets.

Appendix 7: Child protection outcomes by service outcome

Table 40. Reports to the Helpline for RF children by service outcomes

	Exited with goals met	Exited early	Continuing	Declined RF
Number (families)	19	24	16	12
Number of families with reports	10	19	14	7
% of families with reports	52%	79%	88%	58%
Average number of reports	3.3	5.1	3.6	3.9

Source: TBS Service monitoring data and FACS Reports data
Note: service status is unknown for 15 families who did not consent to the evaluation

Table 41. SARAs commenced for RF children by service outcomes

	Exited with goals met	Exited early	Continuing	Declined RF
N (families)	19	24	16	12
Number of families with SARAs commenced	6	14	7	4
% of families with SARAs commenced	32%	58%	44%	33%
Average number of SARAs commenced per family	1.0	1.9	1.7	1.0

Source: TBS Service monitoring data and FACS SARA and Secondary Assessment data
Note: service status is unknown for 15 families who did not consent to the evaluation

Table 42. Statutory OOHC entries for RF children by service outcomes

	Exited with goals met	Exited early	Continuing	Declined RF
Number of families	19	24	16	12
Number of families with statutory OOHC entries	1	8	2	3
% of families with statutory OOHC entries	5%	33%	13%	25%

Source: TBS Service monitoring data and FACS out-of-home care data
Note: service status is unknown for 15 families who did not consent to the evaluation

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