

EVALUATION OF THE RESILIENT FAMILIES SERVICE



NSW OFFICE OF SOCIAL IMPACT INVESTMENT

FINAL REPORT

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Abbreviations, acronyms and key terms

Control Child	Child in a Control Group family matched to an Index Child
CSC	DCJ Community Service Centre
EIP	Evidence Informed Practice
DCJ	NSW Department of Communities and Justice
Helpline report	A report made to NSW DCJ Child Protection Helpline
IFPS	Intensive Family Preservation Service
Index Child	Youngest child in a family at the time of referral to the RF service
ITT	Intention-to-treat
K10	Kessler-10
OOHC	Out-of-home care. As a SBB performance measure, OOHC refers to statutory out-of-home care. It does not include supported care, voluntary care, temporary care or respite care.
PEEM	Parent Empowerment and Efficacy Measure
PWI	Personal Wellbeing Index
RF service	Resilient Families service
RPF	Resilience Practice Framework
ROSH	Risk of Significant Harm
SARA	Safety and Risk Assessment
SBB	Social Benefit Bond
SDQ	Strengths and Difficulties Questionnaire
TBS	The Benevolent Society

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Executive summary

The Benevolent Society Social Benefit Bond

The Resilient Families (RF) service is an evidence-based, intensive family preservation service delivered by The Benevolent Society (TBS). The service is designed to address concerns about the safety and wellbeing of children that, if unaddressed, are likely to result in their entry into statutory out-of-home care (OOHC).

The RF service was funded in 2013 for five years through the NSW Government's Social Benefit Bond (SBB). A SBB is a financial instrument that pays a return based on the achievement of agreed social outcomes. Performance of the RF service in the TBS SBB was measured through the level of contact with the child protection system that Index Children experienced during the measurement period relative to matched Control Children. Specifically, the number of:

- entries into statutory OOHC¹
- child protection reports to the Helpline from police and health professionals
- Safety and Risk Assessments (SARAs) commenced² by the Department of Communities and Justice (DCJ) (formerly the Department of Family and Community Services)

In total, 354 families were referred to the RF service from the commencement of the program in October 2013 to the end of June 2018 (the SBB measurement period). Of these families, 303 were eligible in the SBB population for outcomes measurement.

The evaluation

ARTD Consultants were engaged by the NSW Office of Social Impact Investment to evaluate the implementation and outcomes of the RF service and to assess the appropriateness of the TBS SBB measures. The evaluation was undertaken in two stages, using a theory-based, mixed-methods design with process, outcomes and economic components.

The process evaluation was the focus of Stage 1, examining the implementation and costs of the RF service and laying the groundwork for the outcomes evaluation; firstly, establishing the comparability of the Index and Control Cohorts, and then outlining ways in which outcomes would be measured.

In Stage 2 the focus of the evaluation shifted to outcomes measurement, while continuing to monitor key implementation factors including targeting; family engagement; and service

¹ Defined as 'statutory' OOHC i.e. excluding supported care, voluntary care, temporary care or respite

² Excluding those made in the first six months (180 days) of the measurement period

focus, timeliness, duration and intensity. Stage 2 also included a case file review to better understand the DCJ business-as-usual service being provided to Control families.

The outcomes evaluation used the intention-to-treat (ITT) method used by the SBB performance framework. This means that families of Index Children who declined the service were still counted as part of the Index families.

This report is the second Stage 2 report; the fifth and final evaluation report. For this report, we analysed data across the total measurement period (July 2013–18) and drew on discussion and analysis from previous evaluation reports. This report draws on:

- **DCJ data** for Index (n=303) and Control (n=303) Children—partial demographics, OOHC, Helpline reports, SARAs commenced and secondary assessments, and historical child protection data³
- **TBS data** for families who consented to their data being used in the evaluation (n=167)— child and carer demographics, reported issues, service activity and outcomes data from the TBS Resilience Outcomes Tool
- **Interviews** with Primary Carers (n=17).

An overview of prior evaluation findings is provided, where relevant, throughout the report. All previous reports can be found on the NSW Office of Social Impact Investment website: <https://www.osii.nsw.gov.au/tools-and-resources/evaluation-of-the-social-impact-investment>.

We are confident in the evaluation conclusions, which are based on a largely consistent set of evidence that emerged during the five years of the evaluation. However, small populations and incomplete data still limit the extent to which some of the findings can be generalised, specifically relating to service activities and outcomes measured through the TBS Resilience Outcomes Tool. Also, families who completed the TBS Resilience Outcomes Tool and who agreed to be interviewed had successfully completed the service and are unlikely to reflect the views of all families, particularly those who declined the service or exited early.

Key findings

Profile of the evaluation population

In total 354 families were referred to the RF service during the TBS SBB measurement period, but due to exclusions defined within the SBB instrument, the population for measuring performance under the SBB consists of a total of 303 Index Children and 303 matched Control Children. The evaluation drew on DCJ data for all of these Children. Of the 354 families referred, 245 families agreed to participate in the RF service and 167 consented to their TBS data being used for the evaluation.

³ As administrative data provided by the Department this did not require participant consent so covers the total SBB population.

Among the 167 families who agreed to receive the RF service and consented to their TBS data being used for the evaluation, the average age of Index Children was 1.6 years old. Just over half (58%) were male, over one-third (36%) were from culturally and linguistically diverse backgrounds and almost one-fifth (19%) identified as Aboriginal and/or Torres Strait Islander. The average age of Primary Carers was 33 years, and almost all (93%) were female. Families' most common reported issues in referrals were child exposure to domestic and family violence (38%) and substance abuse by a carer (29%).

DCJ assessment data was available for all 303 families and showed the population included families with a range of risk profiles—37% were assessed as low or moderate risk in their SARA completed prior to their measurement start date ('commencement SARA'), 45% as high risk, and 17% as very high risk.

Process evaluation

The 354 family referrals to the RF service over the measurement period meant the target of 300–400 families under the SBB was reached. However, **there were two ongoing issues related to the referral process**: providing a timely service response; and targeting families with an appropriate risk level. These issues are important given the service has been found to work best with high-risk families, and when delivered as soon as possible after a crisis point.

RF workers effectively engaged and worked with families, including families from diverse backgrounds. They provided a trusted, non-judgemental service based on individualised case planning. The focus of their work was on increasing safety and stable relationships, delivered largely in family homes. Families highly valued the qualities and skills of RF workers with whom they developed positive, trusting relationships. They also valued the opportunities to develop more harmonious home environments, routines and relationships and to connect with community supports and services.

The **service duration and intensity were as planned**—the average length of service was 11 months, with a slightly longer service for higher-risk families and families who were seen to have achieved their case plan goals. Most Primary Carers reported feeling ready or partly ready to exit the service when they did. Service intensity also appeared to step down as planned, though there was substantial missing data.

Outcomes evaluation

TBS resilience outcomes

TBS developed the Resilience Outcomes Tool to measure family wellbeing and functioning. The data showed generally positive trends from initial assessment to case closure, but the small and varying numbers of post-baseline assessments meant findings are not often generalisable to the whole cohort.

We examined **outcomes of three individual validated measures** used as part of the TBS Resilience Outcomes Tool—the Kessler-10 (K10), Personal Wellbeing Index (PWI), and the Strength and Difficulties Questionnaire (SDQ Parent 2-4 version; SDQ Parent 4–10 version). These showed statistically significant ($p < .05$) reductions in Primary Carers' psychological distress, and statistically significant ($p < .05$) improvements in personal wellbeing. Index Children's levels of difficulties also decreased, but these changes were not statistically significant ($p > .05$).

We also examined the **outcomes of the Resilience Outcome Domains**, which were measured by combining multiple wellbeing tools and survey items. We found generally positive trends in all Domains, with statistically significant ($p < .05$) improvements in Increasing Safety and Improving Coping/ Self-regulation. Interviews with Primary Carers also highlighted the impact of the RF service on wellbeing and family functioning.

TBS SBB performance outcomes

The outcomes evaluation also compared contact with the child protection system, using each of the three TBS SBB performance measures, for the 303 Index Children in the evaluation population with those of the 303 matched Control Children who received a business-as-usual response delivered or coordinated by DCJ. We found that the RF service:

- was **effective in reducing the likelihood of OOHC placements**, with 18⁴ fewer Index Children compared to Control Children entering care during the measurement period.⁵ This difference was statistically significant ($p < .05$) and driven by a higher number of entries into care by the children in the Control Group in the first three months of the measurement period
- had the **greatest impact in reducing OOHC entries for high-risk families**, as seen through a range of risk lenses— commencement SARA risk level, carers' and siblings' OOHC history and families' prior SARAs—and in cases where the Index Child was unborn at the time of referral
- had a **limited impact on the number of Helpline reports** received for Index Children relative to Control Children. While the total number reduced over time, Index Children received more Helpline reports in the first nine months after RF service start than Control Children over the same period. After nine months, both groups received a similar and declining number of reports. This finding was consistent with previous evaluation reports, which noted that Index Children may have experienced higher numbers of reports than Control Children due to surveillance bias (i.e. the number of helpline reports is linked to the level of contact with service providers)
- had a **limited impact on the number of SARAs commenced** for Index Children relative to Control Children. Similar to Helpline reports, Index and Control Children had an absolute reduction in the number of SARAs commenced over the measurement period.⁶

⁴ The evaluation calculations refer to the total number of *children* who entered OOHC after the RF service start. This differs to the TBS SBB calculations, which counted total number of *entries* and found one Control Child with two entries in the measurement period.

⁵ Date the Index Child was referred to the RF service or if unborn, the latter of the date of birth or the date of birth of its Matched Control.

⁶ October 2013 to the end of June 2018.

However, more SARAs were commenced for Index Children during the first nine months after RF service start than Control Children. After nine months, a similar and declining number of SARAs were commenced for both groups.

These findings were also consistent with previous evaluation reports, which pointed to the greatest impact of the RF service being in preventing OOHC entries (rather than Helpline reports and SARAs commenced) and gains being greatest for high-risk families. The implications of these findings are central to our assessment of the appropriateness of TBS SBB performance measures.

Assessment of the TBS SBB performance measures

The appropriateness of the TBS SBB performance measures has been discussed throughout the evaluation. We have concluded that statutory entries into OOHC was the strongest and most appropriate performance measure for the SBB. This is because it directly measures the goal of the service, involves external verification through court orders required for removal, and is associated with greatest cost savings. The measure is binary, which has the advantage of being straightforward and providing an absolute indication of success. In future projects with similar aims, it could be enhanced by incorporating a continuous measure i.e. number of days in OOHC, as this would indicate the level or degree to which outcomes are being achieved and associated system costs.

The number of helpline reports and SARAs commenced were less reliable measures. Helpline reports are well-established indicators of child safety but can be subject to surveillance bias, in which Index Children might have been more likely to be reported as being at risk of harm than Control Children because they were subject to greater scrutiny and increased interaction with service providers. SARAs reflect a decision by DCJ to prioritise the case for attention, but are to some extent subject to policy and practice contexts. Given that Index Children had statistically significantly fewer entries into OOHC than Control Children but similar numbers of Helpline Reports and SARAs commenced, neither measure were useful in demonstrating the success of the RF service in meeting its key goal: to prevent entries in OOHC.

TBS are now delivering the RF service under a new TBS performance-based contract, following conclusion of the SBB in late 2018. The new contract uses statutory entries into OOHC as the sole performance measure that is paid on, reflecting these findings.

Conclusions and recommendations

Targeting the RF service

The RF service prevented entries into OOHC for 18 more Index Children than Control Children during the measurement period. It was particularly successful in working with families with high and complex needs, for whom intensive family preservation services were designed to support, but who are often difficult to engage and work with in a sustained way. The RF

service was also effective in engaging and working with families of Index Children unborn at the time of referral.

The evaluation found, however, that the RF service reached families with a range of risk profiles, some that did appear to have high or complex needs. The evaluation has also been concerned with the timeliness of the referral process, given the importance of intervening close to a family crisis, when families will be most motivated to change behaviours. For the RF service to target high-risk families in a timely way, additional eligibility criteria that indicate risk, such as carers' and siblings' prior contact with OOHC, could be used to help prioritise families for referral.

The service had the greatest impact in reducing entries to OOHC in the first three months. However, given the complex needs of many families, the 12-month period that the RF service provides is appropriate, as it is likely to be a key factor in sustaining outcomes.

We recommend that DCJ:

1. continue to invest in the RF service as an option for families where children are at high risk of entering care
2. more closely target the RF service to high-risk families by introducing additional eligibility criteria that indicate risk, such as carers' and siblings' prior contact with OOHC
3. more closely target the RF service to families with unborn children
4. continue working with TBS to improve timeliness of service commencement
5. maintain the length of service for high-needs families.

Delivering the RF service

The RF service is an evidence-informed service, which the evaluation found was implemented largely as intended and consistently with the service design. It was delivered mostly in-home with a focus on safety, parental coping skills, positive parenting skills and linking family members to the services and supports they need. There is a case for ensuring the RF service is delivered flexibly, including early mornings and evenings, as these are often good times for teaching and modelling new skills and behaviours. There is also room for TBS to offer families more opportunities to develop social connections and other natural supports important for sustaining changes made through the RF service.

There were several gaps in the TBS data that limited the reliability of our understanding of service delivery and our ability to measure outcomes through TBS Resilience Outcomes Tool.

We recommend that TBS:

6. continue to deliver the RF service as a holistic, in-home service with a focus on safety, parental coping skills, positive parenting skills and linking family members to the services and supports needed
7. continue to focus on helping family members build positive social connections and supports, and consider offering opportunities, such as centre-based activities, to assist

with this, especially for higher-risk families and new parents with limited positive supports in place

8. continue to focus on the quality and completeness of service data in key areas to support ongoing monitoring and service improvements
9. continue to use validated tools to inform family plans and demonstrate outcomes.

Measuring TBS SBB performance

The service had the greatest impact in reducing entries to OOHC in the first three months, and families continued to show improvements in wellbeing and family functioning beyond this point. The outcomes in preventing OOHC entries were consistent with the positive trends in family wellbeing and functioning shown through individual validated measures administered by TBS (PWI, K10 and SDQ) and the feedback from Primary Carers. But they were not consistent with performance measured through the number of Helpline reports and SARAs commenced.

We recommend that in the future, when implementing similar social impact investments, the NSW Government:

10. use the number of entries into statutory OOHC as the primary measure
11. consider using the number of days in OOHC as an additional, continuous measure
12. only use Helpline reports and SARAs for monitoring purposes and not as a performance measure for OOHC services
13. continue to use monitoring and evaluation alongside bond calculations.

1. Evaluation of the Resilient Families service

Overview

The Resilient Families (RF) service was funded through The Benevolent Society (TBS) Social Benefit Bond (SBB), undertaken in 2013 as one of the first two social impact investments in NSW. The TBS SBB aimed to test and facilitate the development of the social investment sector. As part of the TBS SBB, the RF service has a strong focus on achieving outcomes—strengthening family functioning and wellbeing to reduce their contact with the child protection system.

TBS delivered the RF service over the five-year TBS SBB measurement period. It is an intensive family preservation service designed to address concerns about the safety and wellbeing of children that, if unaddressed, are likely to result in their entry into statutory OOHC. RF casework practice is guided by an evidence-based Resilience Practice Framework (RPF) and 42 supporting Evidence Informed Practices (EIPs).

ARTD was engaged by the NSW Office of Social Impact Investment to conduct the Stage 1 and 2 evaluations of the RF service. Stage 1 made recommendations about improvements to the program and the TBS SBB performance measures. The Stage 2 evaluation was designed to continue monitoring RF implementation; deepen the analysis of outcomes for RF families according to the SBB performance measures; and provide an assessment of the benefits and appropriateness of TBS SBB measures.

A theory-based, mix-methods evaluation design was applied, which incorporated the intention-to-treat (ITT) design within the TBS SBB structure with more detailed sub-cohort analyses that aimed to better understand the characteristics of families and how evenly benefits were distributed.

1.1 Social benefit bonds: a new approach to investment

Social benefit bonds (SBBs), which are a form of social impact investment, are a recent approach to driving change towards improved social outcomes. SBBs 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 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 structure of the SBB.

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. The focus on outcomes, as distinct from service outputs, allows for greater service innovation, which can deliver better outcomes and ultimately reduce demand for government expenditure on acute crisis services and tertiary, curative interventions.

SBBs are growing worldwide, as an innovative financial instrument that can align public and private interests while addressing complex social problems.⁷ However, to date there is limited empirical evidence of the effectiveness of SBBs in improving social outcomes^{8,9} and conflicting perspectives on how to evaluate particular social programs. Central to the success of SBBs, is defining measurable, explicit, valid and reliable outcomes metrics.¹⁰ Careful evaluation and monitoring are also critical to accurately measure the success of the investment, promote accountability, help keep projects on track, and enable necessary adjustments based on learnings.¹¹

Social Benefit Bonds in NSW

In 2013, the NSW Government pioneered Australia's first two SBBs. At the time of reporting, eight social impact investments have gone to market in NSW. The NSW Office of Social Impact Investment is leading the NSW Government's Social Impact Investment Policy to trial new ways of working between the government and the non-government sector.

The TBS SBB was a \$10 million joint venture between The Benevolent Society, Westpac Institutional Bank and the Commonwealth Bank. It was the first SBB in Australia to mature (in July 2018), delivering capital-protected investors a 6% return on investment and capital-exposed investors a 10.5% return.¹² The RF service was subsequently funded through a two-year performance-based contract with the NSW Department of Communities and Justice (DCJ).

⁷ Fraser, A., Tan, S., Lagarde, M., & Mays, N. (2016). Narratives of Promise, Narratives of Caution: A Review of the Literature on Social Impact Bonds. *Social Policy & Administration*, 52(1), 4-28.

⁸ Fraser, A., Tan, S., Lagarde, M., & Mays, N. (2016). Narratives of Promise, Narratives of Caution: A Review of the Literature on Social Impact Bonds. *Social Policy & Administration*, 52(1), 4-28

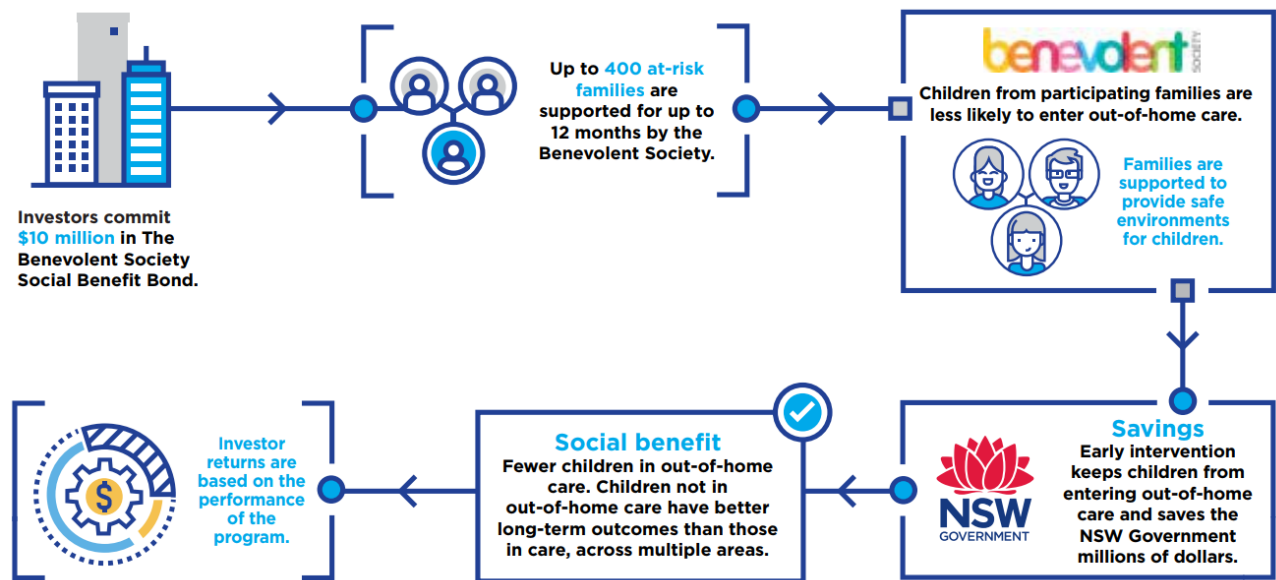
⁹ Edmiston, D., & Nicholls, A. (2017). Social Impact Bonds: The Role of Private Capital in Outcome-Based Commissioning. *Journal Of Social Policy*, 47(01), 57-76. doi: 10.1017/s0047279417000125

¹⁰ Berndt, C., & Wirth, M. (2018). Market, metrics, morals: The Social Impact Bond as an emerging social policy instrument. *Geoforum*, 90, 27-35.

¹¹ Chamaki, F., & Jenkins, G. (2018). Social Impact Bonds: Implementation, Evaluation, and Monitoring. *International Journal of Public Administration*, 42(4), 289-297.

¹² The Benevolent Society. (2018). *Social Benefit Bond Investor Financial Report*.

<https://www.benevolent.org.au/about-us/innovative-approaches/social-benefit-bond>.

Figure 1. TBS SBB: Creating safer homes and keeping children out of care

Source: The NSW Office of Social Impact Investment. (2018). TBS SBB.

<https://www.osii.nsw.gov.au/initiatives/sii/the-benevolent-society-bond/>

1.2 Evidence base for intensive family preservation services

SBBs are commonly cited as tools that 'create a space for service experimentation and innovation' by focusing attention on the achievement of outcomes, and redistributing part of the financial risk to private investors.¹³ At the same time, programs funded through SBBs are typically evidence-informed to ensure that all stakeholders have a degree of confidence that the target outcomes can be achieved.

An intensive family preservation service (IFPS), the RF service was established in view of Homebuilders, a model of support developed in the 1970s in the United States of America.¹⁴ Family preservation programs that demonstrate fidelity to the Homebuilders model were for some time most strongly associated with positive outcomes.¹⁵ Across more recent literature, IFPSs that tend to be associated with better outcomes share some key features—though no single model emerges as the most effective overall, as IFPSs are usually targeted and employ individualised family planning. Broadly, the literature suggests that IFPS interventions be:

- **timely:** referral and intake occur immediately after a 'crisis' (often within 24 hours) to best motivate behaviour change

¹³ Edmiston, D., & Nicholls, A. (2017). Social Impact Bonds: The Role of Private Capital in Outcome-Based Commissioning. *Journal Of Social Policy*, 47(01), 57-76. doi: 10.1017/s0047279417000125

¹⁴ Institute for Family Development. (2014). *Homebuilders Standards 4.0*. <http://www.institutefamily.org/pdf/HOMEBUILDERS-Standards-4-0.pdf>

¹⁵ Tully, L. (2008). *Research Report: Family Preservation Service Literature Review*. NSW Department of Community Services.

- **accessible:** service is offered so that assistance (or on-call help) is on hand when it is needed
- **home-based:** service is primarily delivered in the home—although it is usual for there to be scope for centre- or community-based activities to support this activity.^{16, 17, 18}

While the evidence base is growing, the literature also highlights the importance of flexibility in IFPS delivery so that it is responsive to changing family contexts. Timeliness, accessibility, being home-based and of appropriate intensity, and individual family planning, all speak to interventions that are delivered to families responsively yet in view of evidence-based principles, rather than programmatically according to defined service specifications.

There is some evidence that family preservation services may be most effective for higher-risk families, reflecting the underlying premise of Homebuilders that crises act as a motivator for change.¹⁹ A 2017 meta-analysis that assessed 156 home visiting interventions aimed at reducing child maltreatment found that interventions ‘targeting specific high-risk groups have greater effect sizes than those that targeted a general population’.²⁰ This is consistent with a study that found that IFPS’ were effective in preventing placement for multi-problem families.²¹ More broadly, the literature suggests that the quality and length of relationship between those being supported and those providing support are strongly related to positive outcomes.²²

1.3 The Resilient Families service

The RF service is an intensive family support intervention designed to address DCJ concerns about the safety and wellbeing of children that, if not addressed, are likely to result in their entry into care. TBS commenced working with families in the RF service in October 2013. They aimed to support between 300 and 400 families over the five years of its operation from one of two Sydney regions, covering nine DCJ Community Service Centres (CSCs):

- Region 1: CSC areas of Eastern Sydney, Central Sydney, Burwood and Lakemba
- Region 2: CSC areas of Bankstown, Macarthur, Fairfield, Liverpool and Ingleburn.

¹⁶ Institute for Family Development. (2014). *Homebuilders Standards 4.0*.

¹⁷ Tregeala, S., L Voight, (2013). What intensity of service is needed to prevent children’s entry into out of home care, *Developing Practice, Issue 34*, 31–43.

¹⁸ Schweitser, D., et al. (2015). ‘Building the Evidence Base for Intensive Family Preservation Services’. *Journal of Public Child Welfare*. 9(5). 423–443.

¹⁹ Tully L. (2008). Research Report: Family Preservation Service Literature Review. NSW Department of Community Services.

²⁰ Channa M.W., Geert Jan J.M. Stams, Miranda S. Bek, Esther M. Damen, Jessica J. Asscher, Peter H. van der Laan. (2012). A meta-analysis of intensive family preservation programs: Placement prevention and improvement of family functioning, *Children and Youth Services Review* 34(8), 1472–1479

²¹ Channa M.W., Geert Jan J.M. Stams, Miranda S. Bek, Esther M. Damen, Jessica J. Asscher, Peter H. van der Laan. (2012). A meta-analysis of intensive family preservation programs: Placement prevention and improvement of family functioning, *Children and Youth Services Review*, 34, 1472–1479.

²² Young, T. and Poulin, J. (1998) The helping relationship inventory: A clinical appraisal *Families in Society*, 79(2), 123-133.

As part of the TBS SBB, families were referred to the RF service through a centralised process managed by DCJ. This enabled a matched Control Group to be established alongside Index families, against which TBS SBB performance could be measured (see section 1.3.2).

Families were eligible for referral to the RF service if they had at least one child less than six years old who was living at home and had been assessed by DCJ as at risk of significant harm (ROSH) but 'Safe with Plan'. This assessment indicated one or more dangers present for the child that, without effective preventative action (like the RF service), the planned arrangement for the child would be OOHC. The child could remain in the home so long as planned safety interventions mitigated the identified danger(s).

1.3.1 The RF service model and key components

The Resilient Families Service Model Operating Guidelines describe the RF service as a therapeutic, evidence-informed service designed to provide long-term, intensive, in-home support to families. Key features of the service include:

- a home-visiting focus, with most contact occurring in the family home
- both practical and therapeutic supports
- an initial 12 weeks of high intensity support (4–6 hours per week), often focused on safety planning and stability, followed by 9 months of less intensive service and a planned step-down towards exit (plus an option for families to re-engage within 12 months of exiting from the service)
- an on-call service to provide emergency contact/ crisis support after business hours
- working in close collaboration with DCJ.

In view of the focus on delivering outcomes embedded through the SBB, the Operating Guidelines do not present detailed service specifications around casework activity—although some detail has been added over time—but instead highlight how practice is informed by the RF service approach, which is based on TBS' Resilience Practice Framework (RPF).

The Resilience Practice Framework

TBS developed the RPF in partnership with the Parenting Research Centre.²³ The RPF is informed by evidence around what works in supporting and promoting resilience in children and identifies six domains that are associated with resilience: a secure base, education, friendships, talents and interests, positive values and social competencies.

The RPF is supported by six practice guidelines that, together, outline 42 Evidence Informed Practices (EIPs) for workers to use in building parenting skills and resilience in children and families. EIPs introduce a 'common elements' approach to service delivery. This approach hypothesises that it is the common elements within programs that work, when implemented in the right context, to achieve identified behavioural outcomes. EIPs are quite simple and

²³ The Resilience Practice Framework can be found and downloaded here: <https://www.benevolent.org.au/about-us/professional-resources/child-and-family/child-family>.

easily taught (e.g. giving descriptive praise or time-out strategies) and can be easily disseminated without relying on a programmatic intervention.²⁴ By articulating the practices associated with resilience outcomes, the RPF unifies the service delivery approach across all of TBS' child and family programs, including the RF service.

Resilience outcomes

The RPF is accompanied by a Resilience Assessment Tool, which is used to develop a Family Support Plan, and a Resilience Outcomes Tool that is applied every four months to review progress towards goals and outcomes. Five Resilience Outcome Domains are identified:

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

1.3.2 Performance measures for the TBS SBB

The TBS SBB performance measures were designed to measure the impact that the RF service has on overall child safety as compared to DCJ's business-as-usual child protection interventions, excluding other intensive management programs. Outcomes are measured through the level of contact that Index Children experience relative to Control Children during the measurement period²⁵ in three areas (see Figure 2):

- number of children entering statutory OOHC—weighted at 66% of the total performance improvement percentage
- number of child protection reports to the Helpline from police and health professionals—weighted at 17% of the total performance improvement percentage
- number of SARAs commenced by DCJ—weighted at 17% of the total performance improvement percentage.

²⁴ Chorpita S. et al. (2015). Identifying and selecting the common elements of evidence-based interventions. *Mental Health Services Research*. 7(1). 5–20.

²⁵ TBS SBB Operations manual defines the measurement period from when a child is referred to the program, or joins the control group, to the date of data extraction or the date a child exits the SBB due to changed circumstances.

Figure 2. TBS SBB performance measures

Outcomes for children in the RF service ('Index Children', the youngest or unborn child within an Index family) were compared to outcomes for similar children in a matched Control Group. The process for identifying and matching Index and Control Children was managed by DCJ and detailed in the TBS SBB Operations Manual. Eligible Index Children and Control Children were matched closely on a one-to-one basis ('Matched Pairs'), using an automated and centralised DCJ referral mechanism. Matching criteria related to the child's age, family OOHC history, SARA history, time since the relevant SARA was commenced and Indigenous status.

Control Group families met RF service eligibility criteria and would have been eligible for referral if they lived in Region 1 or Region 2, or if necessary, Region 3 (covering the CSC areas of Auburn, Blacktown, Hawkesbury, Mt Druitt, Parramatta, Penrith, St Mary's, and St George). They were not aware that they had been selected and the services they received did not change as a result i.e. DCJ's business-as-usual child protection response applied. If they were already receiving a service that was equivalent or substantially equivalent to the RF service, or referred to one during the measurement period, they were removed from the Control Group and a substitute family was allocated.

Small changes to the TBS SBB outcome measurement framework were made in late 2016 in response to recommendations from the Stage 1 evaluation and an independent review of the framework (see Chapter 6).

Intention-to-treat design

The TBS SBB used an ITT design. This means that families of Index Children who declined the service were still counted as Index families for measurement and evaluation purposes. ITT designs aim to estimate the effects of programs as they are offered, or as assigned, and

ignore any non-compliance or withdrawals that occur following the random allocation. 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 a control group. It also prevents providers from selecting clients who they believe are most likely to achieve positive outcomes, though this was not possible through the TBS SBB centralised selection process, which required TBS to engage with all referred families. The main weakness is that subjects who did not actually receive an intervention are included along with those who did, which limits what can be known about the effectiveness of that intervention.

1.4 Evaluating the Resilient Families service

ARTD Consultants was engaged by NSW Treasury in 2013 to conduct the Stage 1 evaluation of the RF service, and again in 2016 by the newly formed NSW Office of Social Impact Investment to complete Stage 2. There were five evaluation reports completed across the two stages. This report is the second Stage 2 report; the fifth and final report.

The overarching purpose of the evaluation has been to examine the implementation and outcomes of the RF service over its five years of operation and assess the appropriateness of the TBS SBB performance measures. The evaluation also contributes to evidence about interventions in the child protection context, as well as evidence around the development, implementation and measurement of social impact investments that the NSW Government can use to progress its Social Impact Investment Policy.

Both evaluation stages used a theory-based, mixed-method design, though the specific methods and focus of each evaluation report evolved over time as the service matured and stakeholder needs evolved. We obtained ethics approval from The University of Sydney Human Research Ethics Committee to conduct Stage 1 of the evaluation in April 2014 [no. 2014/339]. This was extended to cover Stage 2 in December 2016.

Stage 1

Stage 1 focussed on process evaluation components. It examined the implementation of the RF service including the: RF service model and the extent to which it reflected the literature on successful interventions; processes for referring and engaging families; characteristics of the families being referred; nature of the service being delivered; supports and resources provided to staff delivering the RF service; and joint working between TBS and DCJ staff. Stage 1 also lay the foundations for the outcomes evaluation: identifying the population for measurement, determining the comparability of the Index and Control groups, and developing and testing analytical approaches.

Stage 1 delivered a Preliminary Report (December 2014), a Mid-term Report (September 2015) and an Interim Report (May 2016).

Summary of Stage 1 evaluation findings

Overall, the Stage 1 evaluation found the RF service to be associated with increased safety and wellbeing for children and their families and reduced contact with the child protection system over time. However, the service was found to be performing relatively poorly under the SBB mechanism because reductions in contact with the child protection system for Index Children were similar to or less than those for Control Children. In contrast, the RF service was associated with decreased rates of OOHC placement, with fewer Index Children placed in OOHC compared to Control Children. The numbers involved were too small to draw any conclusions about these findings.

A detailed analysis of family risk profiles showed that at least one in five had a lower than expected risk profile and may not have been suitable for a high-intensity service. Reports discussed how the TBS SBB eligibility criteria and the centralised referral mechanism may have been contributing to this, as well as to delays in service commencement.

Stage 1 made recommendations to improve performance, including revising the referral mechanism and improving practice in key areas of service delivery. It also suggested discounting reports to the Helpline in the first six months of service participation and further analysis to better understand the appropriateness of SARAs as a measure.

Stage 2

In Stage 2 the focus of the evaluation shifted to the outcomes evaluation, using sub-group analysis to explore outcomes by the risk profile and level of service participation. Stage 2 continued to monitor key implementation issues identified for further analysis and/or monitoring, such as the timeliness and intensity of the service, engagement of families and the focus of the service. It also included a case file analysis to better understand the business-as-usual service being delivered to families of Control Children.

Specifically, the purpose of Stage 2 was to:

- **continue monitoring the progress of RF service implementation** between 2016 and 2018, to further develop our understanding of key factors identified in the Stage 1 process evaluation components such as the timeliness of referrals, the intensity and focus of the service and the experience of families
- **update the analysis of RF client outcomes and TBS SBB performance outcomes** to include outcomes up to 2018 and reach summative conclusions about the effectiveness of the service, including who it worked best for
- **update the assessment of the appropriateness of the TBS SBB performance measures**, to reflect learnings over the five years and inform future performance outcome measures.

A summary of the key findings and recommendations from previous evaluation reports are provided in relevant sections throughout the report. All previous reports can be found on the NSW Office of Social Impact Investment website: <https://www.osii.nsw.gov.au/tools-and-resources/evaluation-of-the-social-impact-investment>.

1.4.1 Program logic

Like Stage 1, the logic model for the Stage 2 evaluation outlines the RF service logic—implementation assumptions, process outputs and resilience outcomes—and locates these in the broader context of the TBS SBB, and against the likely child protection responses received by the Control Group (see Appendix 1).

1.4.2 Key evaluation questions

The key questions addressed by the evaluation were:

1. **What does RF service implementation look like in Stage 2?**
 - a) What are the features of service delivery and casework practice?
 - b) How does this service compare to that received by families in the Control Group?
2. **What are the outcomes of the RF service for families, and what are the outcomes for Control Group participants?**
 - a) What changes in functioning and wellbeing are seen for the Index families?
 - b) Do the Index families have less contact with the child protection system than the Control?
 - c) What might explain divergent patterns within and between the TBS SBB performance measures for Index and Control Groups?
 - d) Are the TBS SBB performance measures sufficiently robust?

1.4.3 This report

This final evaluation report uses the following structure.

- **Chapter 1: Evaluation of the Resilient Families service.** Provides an overview of the evaluation.
- **Chapter 2: Who received the service?** Describes the client population and profile.
- **Chapter 3: What was delivered?** Describes key service characteristics and factors in the RF service implementation.
- **Chapter 4: What were the resilience outcomes?** Reports on the wellbeing and family functioning outcomes measured through the TBS Resilience Outcomes Tool.
- **Chapter 5: What were the TBS SBB performance outcomes?** Reports on the child protection outcomes measured under the TBS SBB.
- **Chapter 6: How appropriate were the TBS SBB performance measures?** Assesses the appropriateness of the TBS SBB performance measures.
- **Chapter 7: What did we learn?** Provides final reflections, conclusions and recommendations.

1.4.4 Methods

For this report, we drew on the following data. A full description of the methods can be found in Appendix 2.

Table 1. Overview of evaluation methods for final report

Data source	Focus	Sample	Report chapters
DCJ demographic data	Demographics of Index and Control Group families	303 Index Children and 303 Control Children	Chapter 2
TBS service monitoring data	Demographics, service activities, and EIPs of Index families	167 Index families that consented to their TBS data being used for the evaluation	Chapters 2 and 3
TBS assessment data	Resilience Outcomes of Index families	167 Index families that consented to their TBS data being used for the evaluation	Chapter 4
DCJ reports data	Helpline reports made for Index and Control Children	303 Index Children and 303 Control Children	Chapter 5
DCJ SARA data	SARAs commences for Index and Control Children	303 Index Children and 303 Control Children	Chapter 5
DCJ OOHC data	OOHC entries for Index and Control Children	303 Index Children and 303 Control Children	Chapter 5
DCJ historical child protection data	OOHC experiences of parents of Index and Control Children	303 Index Children and 303 Control Children	Chapters 2 and 5
Primary Carer interviews	Experiences and outcomes of Primary Carers who had exited the RF service	17 Primary Carers, completed between March 2015 and November 2018	Chapters 3 and 4

1.4.5 Confidence in the findings

We are confident the evaluation is based on a sufficiently robust set of evidence to support the conclusions made. The TBS SBB performance measures are robust and there is enough service implementation data for results to show broad patterns, despite there being relatively small populations within the TBS assessment data and missing service activity data.

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—conducted in the Stage 1 evaluation shows the two groups to be highly comparable, supporting our confidence in the outcomes analysis.

The process and outcomes findings were developed over five iterations of data collection and analysis. Trends developed iteratively and consistently over the course of the evaluation, giving us further confidence in our conclusions.

Data limitations relate to our assessments of the following.

- **Demographic data:** other than Indigenous status, demographic data was not included in the DCJ data set so the description of children and carers relied mostly on the 167 families who consented to their TBS data being used for the evaluation.
- **Service activities and intensity:** there was substantial missing TBS service activity data, which prevented us from drawing reliable conclusions about the focus of service activities and service intensity.
- **Resilience outcomes:** the Resilience Outcomes Tool was not administered to all families at the initial assessment, and there were notable decreases at later time points, in part due to families not staying in the service long enough for multiple review points (4-monthly) or not being willing to be re-assessed. This may have led to positive bias towards those who completed the tool at program exit and the small populations made statistical analysis of change at the individual family level unreliable.
- **Family Strengths and Difficulties Questionnaire (SDQ) data:** given that the SDQ is only administered to children over two years old, and the average age of Index Children was 1.6 years old, this tool could not be used for most families, resulting in a small number of families completing the tool and difficulty detecting statistically significant changes in scores.
- **Entries to OOHC by various risk lenses:** the relatively small proportion of Index and Control Children entering OOHC during the measurement period prevented us from examining the factors associated with OOHC entries using multiple regression. While broadly positive trends were found, these were not always generalisable to the whole cohort; although small numbers in OOHC entries reflect a positive finding for the service.
- **Family interview data:** interviews were conducted with Primary Carers who agreed after successfully completing the service, so are unlikely to reflect the views of all families, particularly those who declined the service or exited early.

Numbers in the report may differ slightly from those used in annual reporting or TBS SBB calculations due to different data extraction dates and/or counting rules for the data provided to ARTD Consultants for the evaluation.

2. Evaluation population and profile

Key findings

The population for measuring performance under the SBB consisted of 303 Index Children and 303 matched Control Children for whom we have DCJ data. However, the population for understanding demographics, RF service activity and resilience outcomes consisted of the 167 families who consented to their TBS data being used in the evaluation.

The average age of Index Children from families who consented to their TBS data being used in the evaluation (n=167) was 1.6 years, just over half (58%) were male, over one-third (36%) were from culturally and linguistically diverse backgrounds and about one-fifth (19%) identified as Aboriginal and/or Torres Strait Islander. The average age of Primary Carers was 33 years, and almost all (93%) were female. Families' most common reported issues were child exposure to domestic and family violence (38%) and substance abuse by a carer (29%).

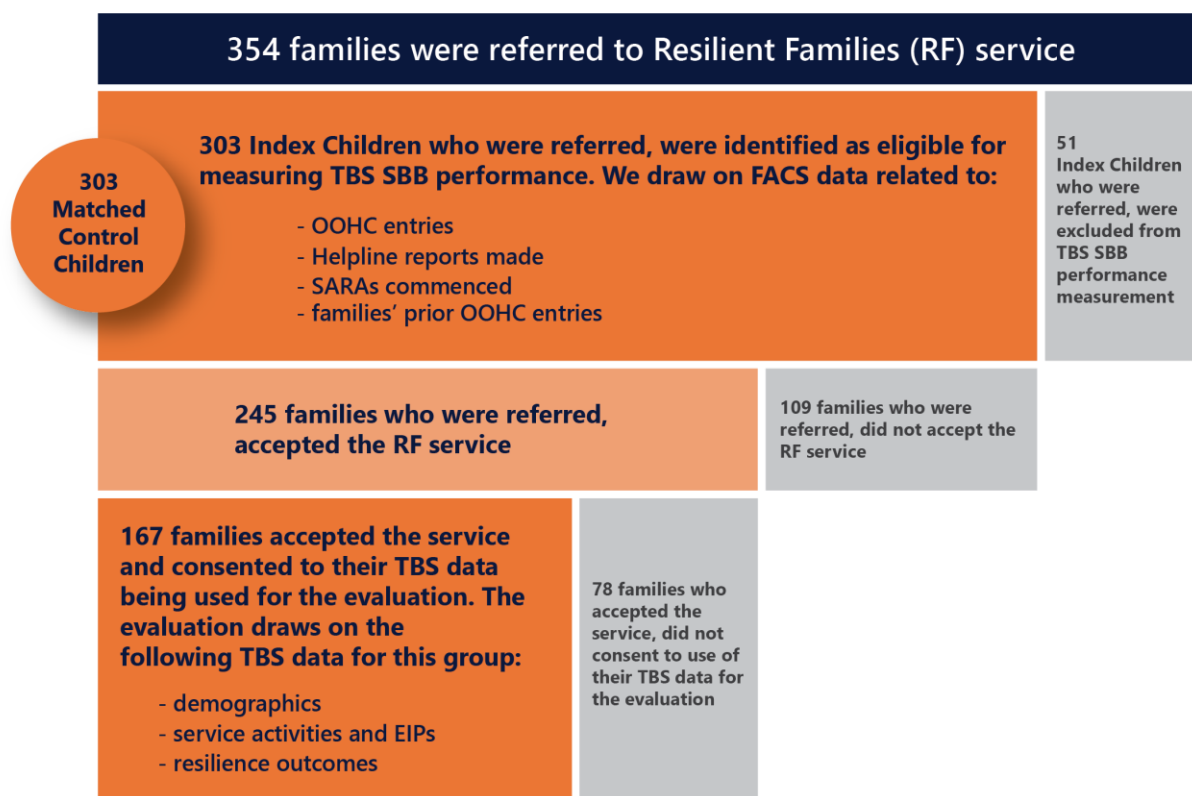
Families in the outcomes evaluation population (n=303) were assessed as having a range of risk profiles—37% were assessed as low or moderate risk in their commencement SARA, 45% as high risk, and 17% as very high risk.

2.1 Populations of participating families

There were 354 families referred to the RF service during the TBS SBB measurement period. Of those referred, 303²⁶ Index Children were also eligible for measuring TBS SBB performance, each with an identified Primary Carer and a matched Control Child. Of those referred, 245 families accepted the service and 167 consented to their TBS data being used for the evaluation.

Figure 3 below outlines the TBS SBB and evaluation populations.

²⁶ Due to exclusions defined within the TBS SBB Operations Manual, 51 of the 354 families referred were excluded from the Index Group.

Figure 3. Total evaluation population

Source: TBS service monitoring data, DCJ demographic data

2.2 Profiles of participating families

The profile of participating families is drawn from both DCJ and TBS data:

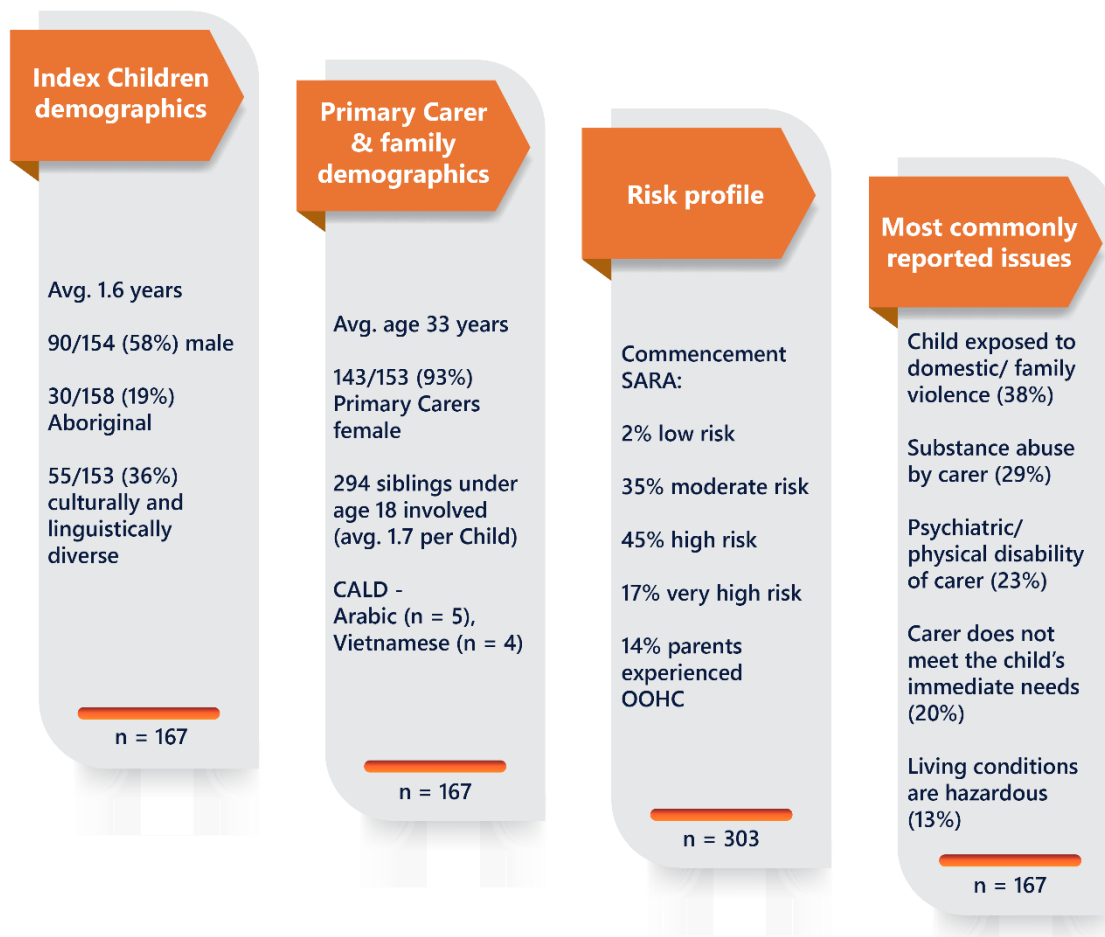
- **DCJ** provided data for the total evaluation population of **303** Index Children and Control Children and their Indigenous and born/ unborn status, their Primary Carers characteristics and contact in the child protection system.
- **TBS** provided demographic, outcomes and service data for **167** Index Children, carers and their families from the population who accepted the referral and consented to their TBS data being used for the evaluation (see section 2.1).

We draw on these two data sources throughout the report and the numbers for analysis within the report change depending on which of these two data sets are relevant and available (and data completeness in each case). See Table 1 in Section 1.4.4 for more details on each data source and how it was used in the evaluation.

The profiles of families who were excluded (n=51), did not accept the service (n=109) or accepted the service but did not consent to their TBS data being used in this evaluation (n=78) (grey shaded boxes in Figure 3) are out of the scope of the evaluation.

Key characteristics of families within the evaluation population based on the data available from these two data sources are summarised below (see Figure 4).

Figure 4. Index Child and family characteristics



Source: TBS service monitoring data, DCJ demographic data

Index Children

The average age of Index Children was 1.6 years at the time of referral (n=164²⁷). Of the 42 unborn children among the total population (n=303), 36 of these cases were among the TBS population (n= 167), indicating RF workers were effective in engaging this cohort.

Across both service regions, over half (58%) of the Index Children were male. Over one-third (36%) were from a culturally and linguistically diverse background and just under one-fifth (19%) were identified as Aboriginal and/or Torres Strait Islander (n=167). This is slightly higher than the proportion of Index Children identified as Aboriginal and/or Torres Strait

²⁷ Data on age is missing for two Index Children within the TBS consenting population and TBS noted that one child was excluded from measurement as the child was unborn at the time of referral and was born post-Resilient Families involvement.

Islander in the DCJ demographic data provided (15% of 303 children), also a positive indication of TBS workers engaging these families.

Primary Carers and families

Almost all Primary Carers (n=167) were female (93%) and their average age was 33 years—the most common age category was 26–35 (43%), followed by 36–45 (33%); only one-fifth (20%) were 16–26 years old. Most (88%) families had a ‘two carer or more’ family structure. There were 294 siblings under the age of 18 listed for the 167 Index Children, an average of 1.7 siblings each.

Seventy-one Primary Carers were from a culturally and linguistically diverse backgrounds. The most common language spoken at home was English, but those who identified as speaking another language spoke Arabic (n=5), Vietnamese (n=4), Khmer (n=3), Spanish (n=2), Tagalog (n=2), Turkish (n=2), Bengali, Cantonese, Greek, Macedonian, Mandarin, Maori, Russian, Urdu, Croatian, and African languages.

Risk profiles

Given the research evidence that family preservation services are most effective for high-risk families (see section 1.2) it is important to understand the risk levels of the RF service participants. It is also important for informing who is most likely to engage with the program and who is mostly likely to benefit, so the service can be targeted effectively and implemented efficiently. We have considered the risk profile of families participating in the service throughout the evaluation, from a range of perspectives, and discuss this further in section 3.2.1.

For this final evaluation, we used DCJ data (n=303) to examine the risk profile of participants through three lenses. The first was the assessed risk level of children in their SARA completed prior to their individual measurement start date (referred to in this report as the ‘commencement SARA’). Over one-third (37%) of Index Children were assessed as at low or moderate risk, 45% were assessed as high risk, and 17% as very high risk in their commencement SARA.

The second lens was intergenerational contact of families with the child protection system by considering parents’ OOHC history. There were 41 Index Children with at least one parent²⁸ with a history of OOHC (14%); on average they spent just over three years in care.

Finally, we looked at contact with the child protection system of siblings;²⁹ specifically, the number of Helpline reports and SARAs commenced prior to the measurement period. We

²⁸ Where the child had multiple parents with a history of OOHC, the parent with the greatest number of days in OOHC was included in the dataset.

²⁹ The term ‘sibling’ refers to any children of the Primary Carer under 18, who may not always have a sibling relationship to the Index or Control Child.

recognise these lenses are inter-related, for example, the history of children's parents and siblings would be a factor in assessments of risk.

Most common reasons for referral

There were 294 reasons for referral listed in the SARAs' reported issues in the commencement SARA for the 167 Index Children in the TBS dataset. The top reported issues were:

- child exposed to domestic and family violence (38%)
- substance abuse by carers (29%)
- psychiatric/ physical disability of carer (23%)
- carer does not meet the child's immediate needs (20%)
- living conditions are hazardous (13%).

3. Service implementation

Key findings

While the target number of families (300–400) to be referred to the RF service during the five-year measurement period was met, there were two ongoing issues related to the referral process:

- **targeting families with an appropriate risk level**—based on the current eligibility criteria, the central referral mechanism generated families with a range of risk profiles, some who appeared under the threshold for an intensive service.
- **providing a timely service**—there were ongoing delays in service commencement, particularly for high-risk families. While timeliness improved over the measurement period, there is scope to improve this further.

RF workers effectively engaged and worked with families, including families from diverse backgrounds. They provided a trusted, non-judgemental and committed service and conducted inclusive and individualised case planning. Data show the focus of their work was on the Increasing Safety and Secure and Stable Relationships Resilience Outcome Domains, almost always within the family home and at critical times of the day.

The service dosage was as planned. The average length of service was 11 months, with a slightly longer service for higher-risk families and families who achieved their case plan goals. Most carers reported feeling ready or partly ready to exit the service when they did. Service intensity also appeared to step-down as planned, though there are substantial missing data.

3.1 Assessing the implementation of the RF service

To assess the implementation of the RF service, we first reviewed the fidelity of the model against the Homebuilders' standards.³⁰ This analysis informed key factors subsequently monitored throughout the evaluation—targeting, timeliness, service focus, duration and intensity—along with the experience of families and the quality of their relationship with their RF worker.

³⁰ ARTD Consultants. (2014). *Evaluation of the Resilient Families Service Stage 1 – Preliminary Report*.

Previous evaluation findings on the RF service implementation

The Preliminary Report (Report 1) found the RF service to be highly consistent with the Homebuilders standards for implementation activity in design and practice, which cover aspects such as family involvement in goal setting and service planning, concrete and therapeutic services, using a range of teaching approaches to promote safety, collaboration and advocacy for clients.

It also assessed the RF service as highly consistent with most Homebuilders standards for program structure but with some key differences—the timeframe to make initial contact, the intensity and duration of the service duration and 24-hour availability of staff.

These findings informed the core components of the RF service implementation to monitor through the subsequent evaluation reports:

- the referral process, including which families were targeted and service timeliness
- how RF workers engaged and interacted with families
- the nature of the service provided
- the length and intensity ('dosage') of the service provided.

3.2 Referral process

The process for referring families to the RF service represented a shift from DCJ's usual model. Under the new model, TBS notified DCJ to request a referral when they had a vacancy. Instead of cases being identified within a local CSC, the referral process was managed centrally, through a system-generated list of eligible Index Children and a process of checking records with the local CSC to get an up-to-date understanding of each family's circumstances. Families were then referred directly to TBS for intake into the RF service.

Using the centralised referral mechanism, 354 families were referred to the RF service, reaching the target to support between 300–400 families during the five-year SBB measurement period. However, over the course of the evaluation, there were two issues related to the RF service referral process—targeting families with an appropriate risk level and providing a timely service—discussed throughout previous evaluation reports and summarised below.

3.2.1 Targeting families

We examined the risk level of RF participants throughout the evaluation to assess whether the service was effectively targeted and to identify who was benefiting most from the supports provided.

Previous evaluation findings on targeting families

The first two evaluation reports provided early indications that some of the families referred to the service may have been below the threshold for an intensive intervention. TBS interviews and survey data suggested there was wide variation in levels of need and functioning among the families participating, and that some lower-risk families who were not at a crisis point felt that an intensive service like the RF service was too intrusive.

There are issues with cases being allocated that do not meet threshold for our intervention and should have been referred to less intensive support services. (RF staff survey respondent)³¹

DCJ data at this time confirmed these views; the Mid-term Report (Report 2) showed that the Helpline report associated with the referral to the RF service was the first report made in the previous 12 months for around a quarter of Index Children (14 of 59), and the commencement SARA was the first SARA undertaken for most (52 of 59).³²

To investigate risk levels among RF families further, in the Interim Report (Report 3) we used DCJ data to explore the risk levels using three definitions: number of prior reports to the Helpline; absence of predictive risk factors; and outcome of the commencement SARAs. The distribution of families with different levels of risk was found to be similar for each of the three definitions (see Appendix 3) and within each, at least one in five families had lower than expected risk presentations:

- 21% of Index Children (n=18) had been the subject of none or one prior Helpline report
- 31% of Index Children (n=27) had none or one of the five identifiable risk factors 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.

The analysis showed that there were likely to be lower-risk families for whom the high intensity of the RF service may be unsuitable, with potential to undermine performance under the TBS SBB.

The Stage 2 Progress Report (Report 4) considered risk profiles in the context of the high number of families who had declined the service: almost as many families had declined the RF service (n=40) as had completed and met their goals (n=42), and others exited early (n=22). Two broad groups of families were identified as most difficult to engage in the service:

- families with a low risk profile who may not have needed an intensive intervention, who tended to decline the service from the outset, especially if they were already involved in other services, or exited early in response to the intensity of the RF service
- families with deeply entrenched poor parenting skills and behaviours, sometimes large families in which unsafe practices have established over many years or generations alongside the removal of multiple children, and a history of commencing and then disengaging with voluntary services.³³

The final evaluation confirmed that families with a range of risk profiles were generated through the centralised referral mechanism, some potentially under the threshold for an intensive service. Over one-third (37%) were assessed in their commencement SARA as low or moderate risk and less than one-fifth (17%) were assessed as 'very high risk' (see Table 2).

³¹ Response to the TBS staff survey reported in: ARTD Consultants. (2015). *Evaluation of the Resilient Families Service Stage 1 – Mid-Term Report*.

³² ARTD Consultants. (2015) *Evaluation of the Resilient Families Service Stage 1 – Mid-term report*.

³³ ARTD Consultants. (2017) *Evaluation of the Resilient Families Service Stage 2 – Progress report*.

Table 2. Commencement SARA risk level for Index Children

Last SARA risk level	N	%
No prior SARA	5	2%
Low	5	2%
Moderate	107	35%
High	135	45%
Very High	51	17%
Total	303	100%

Source: DCJ SARA and secondary assessment data

It is likely that the SARA risk level of some families could have been mitigated by the referral to the RF service itself (as this would reduce the risk rating). However, the overlap in time periods for the risk assessment (which takes place up to over 28 days after the commencement SARA) and the referral to the RF service (which takes an average of 24 days after the commencement SARA), means not all ratings would have been affected.

Also, the data for the 43 families referred to the RF service but excluded from the population for measurement was not included in the analysis. Many of these families may have been initially assessed as high or very high risk and excluded due to a later assessment that the child was unsafe.

Nonetheless, almost two-thirds of families (62%) within the population had a risk assessment of high or very high, and TBS have highlighted this was a major positive result of using the centralised mechanism. It prevented TBS workers from 'turning away' families whose needs appeared too high risk or complex. This is particularly important given evaluation findings that the service worked best with this group (see Chapter 5).

3.2.2 Service timeliness

IFPSs are predicated on crisis as a motivator for change, so timeliness is a key design feature. Referral and intake processes should occur immediately after a point of 'crisis' when family members are most likely to be receptive to change.³⁴ In line with this, the RF Service Model and Operating Guidelines state that initial contact with families should occur within seven business days of TBS receiving a referral, ideally, in the form of a joint home visit between DCJ, TBS and the family.

³⁴ Tregala, S., L Voight. (2013). What intensity of service is needed to prevent children's entry into out of home care. *Developing Practice, Issue 34*, 31-43.

Previous evaluation findings on service timeliness

The Preliminary Report (Report 1) found that 80% of referral requests by TBS were met with a referral within the planned timeframe, but the timeframes for TBS contacting families was longer than the planned; 7 business days in two of the three sites. This trend continued in Report 2.

The Interim Report (Report 3) showed an average of 4.8 weeks from DCJ commencing a SARA to referring to the RF service and 5.2 weeks from the SARA commencement to the initial home visit. It recommended that DCJ and TBS review their respective processes and identify opportunities to improve engagement timeframes.

An independent review of the prioritisation, referral and matching tool completed in 2016 simplified the matching process and prioritised cases for referral based on the recency of the SARA commencement date.

In the Stage 2 Progress Report (Report 4) DCJ and TBS noted they were focussing more on joint working so that the initial home visit could be arranged more swiftly. The Report showed that delays remained an issue; with an average of 4.2 weeks between the date that the SARA commenced and when families were referred to the RF service, and 5.5 weeks to the home visit.

The final evaluation analysis found that delays in service commencement continued, with an average period of 6.3 weeks between the DCJ commencement SARA and the initial home visit (see Table 3). This included six families with a substantial delay (over 10 weeks) in the time between their referral date and the date of the first visit. Excluding these families reduced the average time from 6.3 weeks to 5.3 weeks.

Delays in service commencement were found to be worse for higher-risk families. The average period between commencement SARA and initial home visit was 5 weeks for low-risk families, 6.5 weeks for moderate-risk families, 6 weeks for high-risk families and 7 weeks for very high-risk families (see Appendix 4, Table 14).

Table 3. Average service timeliness over measurement period

Timeliness	Avg. weeks
SARA to referral	3.4
Referral to initial visit	2.9
Total	6.3

Source: TBS Service monitoring data

Note: For re-referred families, the re-referral date was used for calculations

The delays can, in part, be explained by the steps involved in identifying and matching pairs for the TBS SBB measurement through the central referral mechanism, as well as efforts to conduct home visits jointly with DCJ, which takes time to coordinate. Notably, joint visits were not a requirement of the SBB arrangement, but a best endeavours agreement based on advice that joint visits increased family engagement.

Looking at timeliness by year shows the delays seen between 2014–2016 improved in 2017 (see Table 4).

Table 4. Average weeks of service by calendar year

Year	SARA to referral	Referral to initial visit	Total avg. weeks
2013	3.0	1.7	4.7
2014	3.8	4.1	7.9
2015	3.9	2.4	6.4
2016	3.4	3.1	6.4
2017	2.8	2.0	4.7

Source: TBS Service monitoring data

Improvements in timeliness are likely due both to TBS' responses to previous evaluation findings and changes to the centralised referral process made after the Stage 1 evaluation, which resulted in eligible families being prioritised according to the recency of the SARA associated with their referral.

3.3 Engaging and building relationships with families

The RF Service Model and Operating Guidelines outline how the service is expected to work with families. Key features include a focus on engaging and building relationships, recognising families' strengths and engaging them as genuine partners in change; and providing a flexible, home-based service to all members of the family.

3.3.1 Engaging families

Ideally, initial contact happens during a joint home visit between DCJ, TBS and the family. The purpose of this visit is to engage and build relationships with the family and provide them with information about the RF service—its purpose, model and relation to DCJ.

Interviews with Primary Carers (n=17) indicated that most had some initial concerns about the service when they were first engaged, including not understanding what it would entail, concerns about having someone come into their home and feeling judged, fears that their children could be removed, and recollections of previous negative experiences with service agencies.

I was unsure because I didn't know what was going on, didn't know who the person was, didn't know if I'd like it, if I'd trust her. – Primary Carer interview

Four older kids have been in care with DOCS. So that took a lot a lot of trust away ... when I hear something like that I think I go, nah I don't want nothing to do with you. – Primary Carer interview

A few described having limited choice in their decision to engage because DCJ recommended or referred them to the service, during times of crisis.

Overall, however, Primary Carers described their experience of the RF service as positive and reported feeling happy that they chose to engage. Most said they chose to engage because they were experiencing hardships and saw the RF service as an opportunity to receive support. This aligns with the literature that suggests that offering families instrumental supports is sufficient to facilitate engagement.³⁵

I took part because I was pregnant, and I can't drive, and it was very stressful with the things that happened to me. And I wanted to know what can I do to fix the relationship ... how can I stop things happening again? How can I not live in the very bad environment? – Primary Carer interview

Building trust with RF workers also supported engagement.

At first, I wasn't sure about it—I didn't understand what it was. But after a couple of home visits I actually enjoyed it, and realised they weren't going to take my children away, it was about keeping my children in my care. – Primary Carer interview

Engaging with families from diverse backgrounds

During the measurement period, the RF service was successful in engaging families who are culturally and linguistically diverse (36%) or identified as Aboriginal and/or Torres Strait Islander (19%) families (n=167). TBS reported tailoring their approach to effectively engage these groups. This included:

- being open-minded and learning about culture and family structures
- ensuring family support plans reflected cultural considerations
- leveraging relationships with TBS workers from similar cultural backgrounds
- leveraging relationships with local services, such as Aboriginal Community Controlled Organisations, where there was limited internal cultural knowledge.

Translation/Interpreting Services were also the most common type of service/good purchased using brokerage funding. However, TBS reported that not being able to choose their preferred interpreter was, at times, a barrier to effective engagement and relationship building.

³⁵ Landers A, McLuckie, Cann R, Shapiro V, Visintini S, MacLaurin, Trocme N, Saini M, Carrey N. (2018). A scoping review of evidence-based interventions available to parents of maltreated children ages 0-5 with child welfare service. *Child Abuse and Neglect* 76.

3.3.2 Building relationships with families

The importance of building a trusting and positive relationship between families and workers is well established.³⁶ The literature suggests that the quality and length of relationship between those being cared for, and those providing, is one factor that may be most strongly related to positive outcomes. A number of studies have demonstrated that this relationship, which they term the 'therapeutic alliance', is one of the best predictors of outcomes for clients, regardless of the nature of the therapeutic approach or intervention.³⁷

In line with this, a key feature of the RF service model is engaging with families and building relationships. Primary Carers interviewed described their RF worker as having qualities considered important for engaging clients in child protection casework.³⁸ Most spoke extremely highly of their RF worker, describing them as kind, patient, amicable, non-judgmental and genuinely committed to providing support. About half of those interviewed specified that there was 'nothing I didn't like' about their worker. The quality of individual relationships between RF workers and families also attests to the importance of face-to-face contact in establishing good trust and rapport.

The case worker didn't judge, she was very understanding, she listened to me and was not judging; she was always very nice; she never told me what to do—we talked together about what to do. – Primary Carer interview

Many felt that their worker understood their specific needs and offered tailored advice and solutions to address these. Several also noted that they appreciated their worker's relationship with their child/ren. A few also reflected that although they were initially nervous or suspicious, they were quickly reassured and felt able to trust their worker.

Very warm, welcoming, she got on floor and interacted well with kids. Like how she interacted with them ... Really understanding and helpful. Could trust her. – Primary Carer interview

It's just really surprised me that people can help each other—it's not like because of the job, she really cared about me. She wrote down the schedule for my kids. She did a lot of research, just sharing the knowledge about managing kids. – Primary Carer interview

Only three interviewed Primary Carers described negative experiences with RF workers. One found it difficult having their worker change three times in a short timeframe, though they spoke highly of the worker they ended up with. One felt they were getting conflicting advice from the DCJ and RF workers and that she would have liked more 'help in the house'. And

³⁶ Gladstone J, Gary Dumbrill, Leslie B, Koster A, Young M & Ismaila A. (2014). Understanding worker-parent engagement in child protection casework. *Children and Youth Services Review*. 44-56.

³⁷ Young, T. and Poulin, J. (1998) The helping relationship inventory: A clinical appraisal. *Families in Society*, 79(2),123-133.

³⁸ Gladstone J, Gary Dumbrill, Leslie B, Koster A, Young M & Ismaila A. (2014). Understanding worker-parent engagement in child protection casework. *Children and Youth Services Review*, 34, 57.

one said that their RF worker was initially very helpful and supported her to find a job. However, over time the worker's approach became too 'personal', 'she was trying to be a parent ... she was making allegations and stuff, it wasn't good'. This Primary Carer also thought that the RF worker did not fully understand their history or situation.

3.4 Service focus

The literature on effective intensive family preservation services indicates that case planning should be strengths-based and individualised and engage families through trusting relationships with caseworkers.³⁹ In line with this, the RF Service Model and Operating Guidelines state that workers should create family support plans in a collaborative and inclusive manner, so that families feel ownership over their goals. Plans should be developed in the first 30 days of service, and address families' priority needs and goals, including practical and therapeutic supports. Based on this, TBS determines the Resilience Outcome Domains and EIPs that will be important in their work with family members.

Previous evaluation findings on the RF service implementation

Overall, previous evaluation reports described the RF service as a flexible, home-based service, delivered through Family Support Plans, which reflected family strengths and needs and addressed DCJ's safety concerns. The flexible and individually targeted nature of the service was evidenced through interviews with TBS staff and Primary Carers.

TBS survey data showed that many families received the service during the critical hours of 4–6pm, and some in the early morning or early evening periods. The process of engaging families with the service was slower than expected, but TBS were working with families to develop social connections and refer family members to a range of services.

At an individual family level, practice was focussed on areas of need, identified in baseline assessments and reviews. TBS staff described the key features of the service as its flexibility, openness to listen to families and focus on their strengths, and positive behaviour change.

RF workers grew more confident applying the RPF to teach parenting and behavioural skills, and to support a focus on safety. Interviews with family members indicated TBS were establishing and maintaining strong and effective relationships with family members.

The final evaluation found that Primary Carers felt they had a say in what went into their plan and that their voice was heard. All but one Primary Carer described being involved in developing their plan. Primary Carers said they discussed their situation and needs with their RF worker, who supported them to identify their goals and activities and write up a plan that reflected these. Only a few mentioned that DCJ required certain activities to be included in the plan.

³⁹ MacVean, M., Sartore G., Mildon, R., Shlonsky, A., Majika, C., Albers, B., Falkiner, J., Pourliakas, A., & Devine, D (2015). *Review of the evidence for intensive family models, 'Appendix 2'*, prepared by the Parenting Research Centre and the University of Melbourne on behalf the NSW Department of Family and Community Services.

It was me and my partner, we both said it and the RF worker listened and wrote it down and helped us if we needed any more ideas into the plan, but it was mostly us. – Primary Carer interview

Me and my partner sat down and spoke about what we needed ... spoke about the routine and what we needed in the house. She wrote it up on a chart thing ... went through all our ideas of what we thought we needed support with. – Primary Carer interview

One did not think their plan reflected their needs and goals—they felt that the service was separating them from their family, rather than keeping them together.

Supporting plans through brokerage

Several carers said their RF workers provided financial support, including purchasing household goods and food and supporting them to pay school/ playgroup/ university fees.

Financially (helped us). One time they helped with school fees and with a wardrobe for the children. – Primary Carer interview

Budgeting—she told me not to spend on things I don't need, and to spend on things I need. So basically, save on what you don't need. – Primary Carer interview

The most common service/ good purchased through brokerage funding was Translation/ Interpreting Services, following by in-home support materials.

3.4.1 Providing a home-based, flexible service to all family members

The literature indicates that key features of effective IFPSs are being home-based (i.e. primarily delivered in the home, with scope for centre- or community-based activities) and accessible (i.e. offer a 24/7 service or on-call option). It also highlights the importance of flexibility in delivery in response to changing family contexts.⁴⁰

In line with this, the RF Service Model Operating Guidelines state that the majority of service contact should occur in the home and at critical times of the day—early mornings and late afternoons. This enables caseworkers to engage with all family members and provides opportunities to teach, model and support positive new behaviours and routines. The service also incorporates 'on-call' phone support, for out-of-hours emergency and crisis support.

Interviews with Primary Carers indicated the focus of the RF service was on the interaction of the RF workers with Primary Carers and their children within the family home. This is supported by TBS data, which shows that 85% of interactions between workers and families

⁴⁰ Institute for Family Development. (2014). *Homebuilders Standards 4.0*. <http://www.institutefamily.org/pdf/HOMEBUILDERS-Standards-4-0.pdf>; Tregeala, S., L Voight. (2013). What intensity of service is needed to prevent children's entry into out of home care. *Developing Practice, Issue 34*, 31–43.

were face-to-face, which TBS staff indicated occurred in the family home.⁴¹ In a previous report (Report 3), TBS also indicated having visited most families between the challenging hours of 4–6pm and some families in the morning between 7–9am and early evenings.⁴²

TBS also indicated that the RF service focused on engaging all members of the family in case planning and delivering supports and services—particularly men/ fathers in the family. Interviews with Primary Carers supported this. Engaging men was observed to be particularly important when working with families from culturally and linguistically diverse backgrounds.

Interviews with some Primary Carers showed they valued connecting with parents experiencing similar problems.

3.4.2 Focusing on safety and secure relationships

TBS workers used the RPF and EIPs to guide their work with families. The Resilience Outcome Domain most commonly worked on was Increasing Safety (22%) (see Table 5). EIPs within this domain include making safety plans, positive discipline strategies, injury prevention and child proofing, child supervision and health care, and increasing social connections.⁴³ This focus aligns with the statistically significant ($p < .05$) improvements seen in Increasing Safety (see section 4.3).

Table 5. Total hours spent on Resilience Outcome Domains

Resilience outcome domain	N	%
Increasing Safety	867	22%
Secure & Stable Relationships	422	11%
Increasing coping self-regulation	277	7%
Increasing Self-efficacy	213	6%
Improving empathy	54	1%
Other	2,036	53%
Total hours	3,869	100%

Source: TBS Service monitoring data

More than half (53%) of activities were not recorded against a Resilience Outcome Domain or EIP, so categorised as 'other' (see Table 5). The top 'other' activities were intake/ assessment

⁴¹ ARTD Consultants. (2017). *Evaluation of the Resilient Families Service Stage 2 – Progress Report*.

⁴² ARTD Consultants. (2016). *Evaluation of the Resilient Families Service Stage 1 – Interim Report*.

⁴³ Parenting Research Centre and The Benevolent Society (2013) *Resilience Practice Framework: Guide 4: Increasing Safety*.

(18%), housing (11%), advocacy/ support (8%), psychoeducation (7%), review (6%), and information/ advice/ referral (6%) (see Appendix 3, Table 18).

Interviews with Primary Carers tended to emphasise work undertaken within the Secure and Stable Relationships Domain. They described TBS workers focusing on new parenting skills and techniques, including how to interact with children and manage their behaviour, strategies and techniques for mindfulness and coping, and developing household routines.

Mindfulness, I was a stress head, I wasn't coping with stress a lot and so they gave me mindfulness activities, just basically helped and aided with the stress relief. At the beginning it was a bit weird because you're used to a certain way of dealing with stress and all of a sudden someone's telling you to try something different. But towards the end it was very good, and I still use those practices now. – Primary Carer interview

We're really bad with routine in the family. Shocking with routine [She] made up a big chore chart with me and put the kids name on it and stuff like that so I'm stoked that I went ahead with it. – Primary Carer interview

They also described RF workers engaging children through skill-building games and supporting children to manage their behavioural issues, including anger management.

She did a lot of work with one of my boys with anger management issues. She tried to teach him how to deal with his anger.... She played a lot of games to teach the kids how to work as a team, because they're always against each other because everything's a big competition in my house. So, she taught them how to work as a team, work together. – Primary Carer interview

Building social connections

The literature indicates that connections with family members and community is an important part of the service, as these 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. It can be difficult for service providers to access or engage natural supports, and previous research shows these supports tend to be under-represented in family plans.⁴⁴

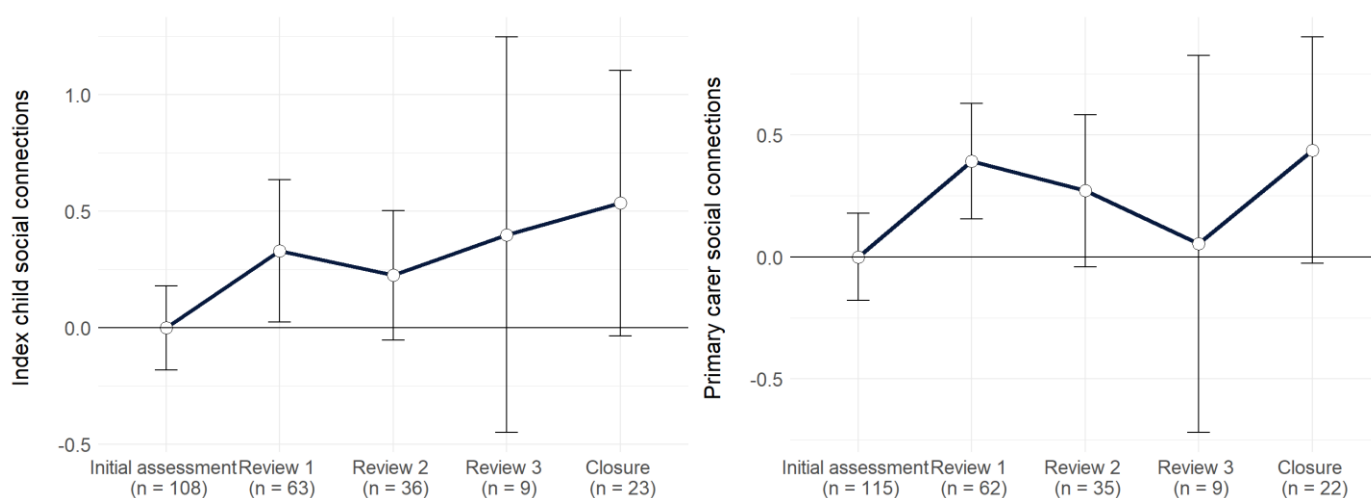
In the RF service, workers helped families to build these connections throughout the service period, particularly when preparing to exit. The RF Service Model and Operating Guidelines state that a successful exit process is one where families feel safe and supported independent of the RF service. To build social connections, TBS workers help families complete *Social Connections Mapping*, an EIP within the Increasing Safety RPF domain. However, time recorded against this EIP was relatively small (13%), equating to 3% of all time spent on EIPs.

⁴⁴ Bruns, E.J. et al. (2004). *Ten principles of the wraparound process*. National Wraparound Initiative.

Data on social connectivity is drawn from the Community Links subscale used in the Longitudinal Study of Australian Children,⁴⁵ which was embedded within the Resilience Outcomes Tool (see Figure 5). It shows slight increases in social connectivity of Index Children and the Carers from initial assessment to case closure, though this change is not statistically significant.

Similar positive but not statistically significant changes were found when analysing the Personal Wellbeing Index (PWI) questions related to community connectedness and personal relationships.

Figure 5. Primary Carer and Index Child social connections



Source: TBS Assessment data

Interviews with carers also pointed to ways in which parents valued building social connections. A few spoke highly about external referrals that provided group settings for parents or their child/ren to connect and socialise.

At the women's group, I'm not the only one who is going through this ... when I got in there I don't want to talk to everyone but when everyone started talking my mind opened up and you're not the only one. – Primary Carer interview

They connected us to a play group It was good just to be able to sit there with mums and their babies. For my child to have fun and feel like she's got other children around her, it definitely helped. – Primary Carer interview

Others described feeling ready to exit the service because they had social supports in place, including school or playgroup networks, a counsellor, a social worker, family or friends,

⁴⁵ Australian Institute of Family Studies. (2003). *Growing Up in Australia: The Longitudinal Study of Australian Children*. Melbourne: Australian Institute of Family Studies.

connections to drug and health services; and an understanding of who to call if they need support, such as services that can provide support managing bills or buying food.

3.4.3 External referrals

The RF Service Model Operating Guidelines state that the coordination of referrals to services and specialist assessment is key to supporting families to meet their goals. They also state that helping families to establish formal and informal community links and build their skills and confidence to engage with external services will support a more successful exit process. This is supported in the literature, which points to the importance of ensuring families have their concrete, clinical and therapeutic needs met for them to engage a service.⁴⁶

From the data available, TBS workers appear to have made limited external referrals, though we understand there was an issue in how referrals were recorded in the dataset. The data available indicated that a wide range of appropriate referrals were made; the five most common referrals types were to mental health (19%), health/ medical/ disability (17%), play groups and child care (12%), education (11%) and housing (8%) (see Appendix 4, Table 18). Previous evaluation reports raised questions about how well external referrals aligned to families' reported issues, particularly domestic and family violence (38%) and substance abuse by carer (29%). However, TBS indicated that these issues were often recorded as part of safety plans so not captured in referral data.

Interviewed Primary Carers explained that RF workers suggested a range of external services and programs for them to consider and many took up referrals made. Seven said they were referred to playgroups or childcare services and five said they were referred to housing services, including the Rent Choice Start Safely program. Other services mentioned were parenting and behavioural management programs, counsellors/ psychologists, speech therapists for their child/ren and a women's group.

Generally, Primary Carers found these referrals useful, particularly the housing supports and those services that provided group settings for parents or their child/ren to connect and socialise (see section 3.4.2).

She referred me to [Community Housing Provider]. I took up the housing, it made a huge difference. – Primary Carer interview

Some Primary Carers did not receive any referrals, explaining that the focus of the RF service was working together with the RF worker. Some chose not to take up the referrals made.

She was gonna refer me to a... I don't know if it was a therapist or a counsellor or something like that, once again it's my trust issues so I said no. – Primary Carer interview

⁴⁶ Tully L. (2008). Research Report: Family Preservation Service Literature Review. NSW Department of Community Services.

3.5 Service length and intensity

The RF service was designed to provide support to families for up to 12 months, starting with high-intensity, home-based supports and stepping down the intensity over time to support families to exit. This is much longer than the Homebuilders standards of six weeks, but there is some evidence in the broader literature to suggest that longer program durations are more effective.⁴⁷

3.5.1 Service duration

For those families with exit data recorded (n=160), the average length of time in the service was 9 months—ranging from one to 32 months. This includes 18 families who were re-referred into the service after exiting, whose time in the service was based on their second referral date.⁴⁸ Families who exited the service with their Case Plan goals achieved (n=97) received on average 9.2 months of service (see Table 6).

Table 6. Average months of service by closure reason

Closure Reason	N	Months (average)
Case Plan Goals Achieved	97	9.2
Family Disengaged	27	7.0
Ineligible	21	6.8
Entry into OOHC	12	10.3
Family Relocated	2	15.4
Family Declined	1	2.6
Total	160	8.7

Source: TBS Service monitoring data

Note: 'Ineligible' refers to families whose eligibility changed after referral to RF. Reasons for exclusion include families where the initial Safety Assessment decision was revised, that there were insufficient observations for the Index Child, when no suitable matched child on risk factors was identified, or where the Index Child entered care between the referral and first meeting.

The length of time in the service was highest for families with a high-risk commencement SARA—moderate-risk families engaged for an average of 7.6 months, high-risk families for 9.7 months, and very high-risk families for 7.9 months (see Appendix 4, Table 19).

⁴⁷ Tully L. (2008). Research Report: Family Preservation Service Literature Review. NSW Department of Community Services.

⁴⁸ TBS data only allowed for time in service to be calculated from the second referral data for re-referred families.

Readiness to exit the service

About half of the Primary Carers interviewed felt they were ready to exit the service at the time they did. A couple noted they felt equipped to manage their lives independently and a couple reflected that although they would have liked to continue working with their RF worker, they felt they were on track and other families should have the opportunity to benefit from the service.

Felt she helped me with everything I could be helped with, ready to tackle it on my own and that someone else should benefit from her support. – Primary Carer interview

Several Primary Carers had mixed views about whether they were ready to exit, reflecting that while they had made progress and had some post-RF service supports in place, they also had unresolved situations they would like further support managing, such as housing and financial issues, DCJ and court cases, and behavioural issues with their children.

A few did not feel ready to leave at all, explaining that they would have benefitted from more time with their worker. Two reflected that while their child/ren's behaviour improved in the company of the RF worker, this was not the case when they left. And one suggested that the duration of the service be tailored to the number of children in the family (i.e. a longer service for families with more children).

I just think that maybe having her a bit longer I could have gotten a bit more out of the service... yeah like I saw changes as well but like kids are always different when people are around aren't they? If she had stayed longer, our routine might have been better than what it is now. I just think, like I said, if it was a family of 2 kids, then yeah perfect, but with 7 children... I think it needs to cater for how many kids. – Primary Carer interview

One Primary Carer thought the service went on for too long.

3.5.2 Service intensity

The RF Service Model and Operating Guidelines state that the RF service starts with a period of high-intensity support before gradually stepping down the number of weekly contact hours with families over time in preparation to exit. Ideally, the service provides face-to-face contact for:

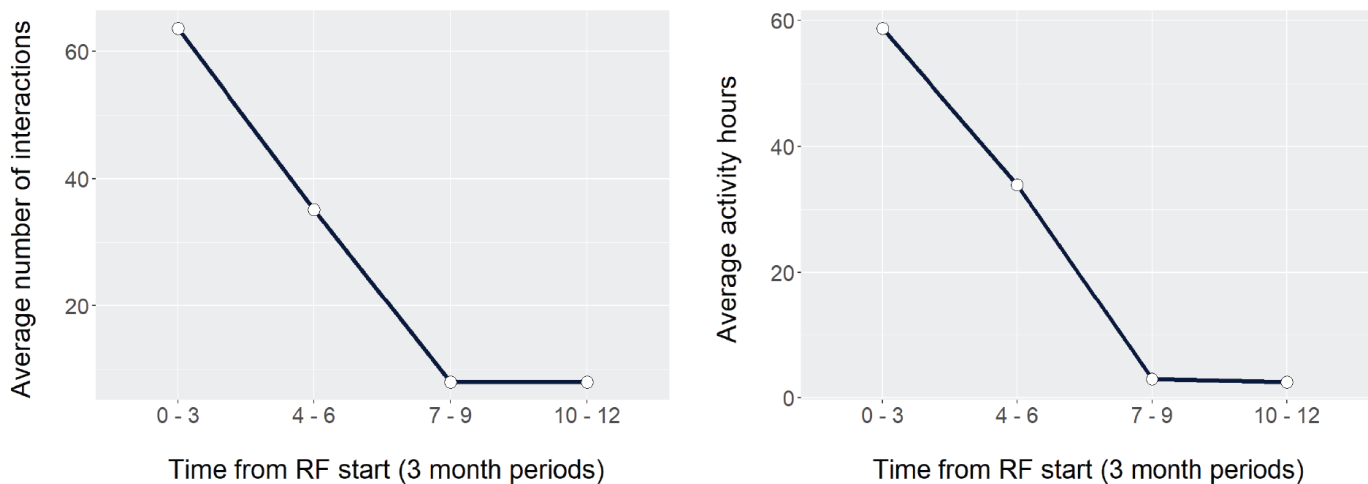
- 4–6 hours per week for the first 0–4 months from referral
- 2–4 hours per week for 4–8 months from referral
- 1–6 hours per fortnight for 8–12 months from referral.

The step-down approach was designed to ensure the RF service addressed immediate safety, provided stability and reduced risk to the children while building the independence of families and their capacity to maintain changes. The exit process for families is designed to ensure that progress can be maintained once the intervention has finished.

While longer in duration, the RF service is designed to be lower in intensity than the Homebuilders standards of six to eight contact hours per week. However, in the broader intensive family preservation literature, how intensity is defined (and the degree to which it is specified) varies and can relate to program structure, duration, and target group.⁴⁹

In line with the step-down approach, service intensity in the RF service decreased over time (Figure 6). The number of interactions and activity hours were much lower than expected, though TBS have indicated a substantial proportion of service activity hours is missing, noting this is part of a broader organisational practice issue, which they are continuing to work to improve.

Figure 6. Average number of interactions and hours of service per family for their first year of service



Source: TBS Service monitoring data

Building on previous report findings, it is positive that in the first three months, service intensity was highest for families with a high-risk commencement SARA (see Table 7), though there was substantial missing data. It is unclear why families commencing with a very high-risk SARA received a less intensive service in the same period, but it may be more difficult to sustain the engagement of these families.

⁴⁹ ARTD Consultants. (2017). *Evaluation of the Resilient Families Service, Stage 2 – Progress Report*.

Table 7. Hours of service activity for the first three months of service by commencement SARA risk level

Commencement SARA	N	Mean	Max.	Min.
Moderate	28	31	106	5
High	34	38	114	3
Very High	12	32	78	4

Source: TBS Service monitoring data

Primary Carers interviewed had mixed views on whether the RF service was of a sufficient intensity to meet their support needs. Five Primary Carers felt the frequency of visits from RF workers and the step-down model of support was appropriate and sufficient.

At the start, Kay visited 3 times a week, then dropped off the 2 and 1. That made sense—when it was 1 day it was almost finished. – Primary Carer interview

However, three felt the service provided was not sufficient, and would have preferred more intensive support.

4. Resilience outcomes

Key findings

Data from the TBS Resilience Outcomes Tool showed generally positive trends from initial assessment to case closure in family wellbeing and functioning, but the small numbers of post-baseline assessments meant findings were not often generalisable to the whole cohort. Interviews with Primary Carers also highlighted the positive impact of the RF service of wellbeing and family functioning.

Individual validated measures showed that as a group, there were statistically significant ($p < .05$) reductions in Carers' psychological distress (Initial Assessment: $n = 113$, Closure: $n = 22$); and statistically significant ($p < .05$) improvements in personal wellbeing (Initial assessment: $n = 113$, Closure $n = 21$). On average, Index Children's (Initial Assessment: $n = 34$; Closure: $n = 6$) levels of difficulties also decreased, but these changes were not statistically significant ($p > .05$).

Resilience Outcomes Domains showed statistically significant ($p < .05$) improvements in Increasing Safety and Improving Coping/ Self-Regulation, but small numbers meant findings in the remaining Domains were not statistically significant ($p > .05$). As well, the process of standardising and combining the tools resulted in resilience outcome scores that were less sensitive to change than the individual tools.

4.1 Measuring resilience

TBS developed the Resilience Outcomes Tool to measure the wellbeing and functioning of families they work with. The Tool comprises a range of validated measures and items from other surveys, which Primary Carers self-reported against on entry to the RF service (baseline), again at regular intervals during the service (Review 1 and 2), and at exit.

These measures were combined to align with and measure each of the TBS Resilience Outcome Domains, identified in the RPF (see section 1.2). This data brought another perspective on the impact of the RF service for families, beyond the child protection outcomes measured through the SBB.

We reviewed baseline and change scores for participants within three of the individual survey tools and for each domain within the Resilience Outcomes Tool, made up of multiple survey items. We also analysed the Primary Carer interview data to understand changes in skills and behaviours from a participant perspective.

Previous evaluation findings on resilience outcomes

The Preliminary Report (Report 1) presented baseline assessment data indicating that, on average, families starting the RF service showed higher levels of distress, lower levels of wellbeing and higher levels of difficulties than the general population, a finding that continued in later reports.

The Mid-term Report (Report 2) showed improvements from baseline to Review 1, with greatest improvement in the Increasing Safety domain, which had been the main focus of TBS's work with families, though the number of families included in the analyses were noted as very small.⁵⁰

In the next two reports we continued to find that families were functioning more poorly and showed lower levels of wellbeing compared to the general population at baseline. As more families completed the tools across their time in the service, we continued to observe the change in scores seen in earlier reports.

While previous results were positive, they did not reach statistical significance due to the small number of families with post-baseline measurements.

4.2 Individual validated measures

For this report, we individually examined the outcomes of three validated measures used as part of the Resilience Outcome Tool:

- Kessler-10 (K10): to measure Primary Carers' psychological distress
- Personal Wellbeing Index (PWI): to measure Primary Carers' subjective quality of life
- Strength and Difficulties Questionnaire (SDQ Parent 2–4 version and SDQ Parent 4–10 version): to measure Index Children's level of difficulties.

Overall, these individual measures showed positive trends for Index Children and Primary Carers towards Australian normative population scores⁵¹ from initial assessment to case closure. However, numbers for post-baseline assessments were variable and notably lower than the number that completed the initial assessment⁵², so findings were not always generalisable to the whole cohort (see Appendix 2 for further discussion).

Multiple factors are likely to have contributed to the small numbers of families completing post baseline assessments. Firstly, not all families were engaged with the service for the full 12 months of service delivery (average length of service was 11 months), with Review 3 reflective of the 12-month assessment period. Secondly, families who had a poor experience at initial assessment (e.g. having language/ comprehension difficulties, becoming distressed etc.) were less likely to complete subsequent reviews. Thirdly, assessments were only available in English. This made it difficult for Culturally and Linguistically Diverse families (36%) to

⁵⁰ When there is substantial variability in scores, larger sample sizes are required to detect if differences are statistically significant. With small sample sizes, not finding a statistically significant difference does not necessarily mean that there is no effect, just that there currently is not enough evidence to make that claim.

⁵¹ Normative data is calculated through administering a tool or scale to a large representative sample of the population. This allows for the distribution or prevalence of scores (i.e. mean, standard deviation) within a population to be estimated. We have included Australian normative scores for measures where available, as they provide further context and aid interpretation by allowing for the scores of Primary Carers and Index Children to be compared to the broader Australian population.

⁵² For example, K10/ PWI Initial Assessment: n = 133; Closure: n = 21/ 22. See Appendix 4 for a complete list of sample sizes across validated tools and Resilience Outcomes.

engage without the support of an interpreter. Fourthly, the SDQ is only administered to children over two years old and the average age of Index Children was 1.6 years. Finally, the number of measures included in the Resilience Outcomes Tool may have contributed to assessment fatigue and difficulties collecting data post-baseline.

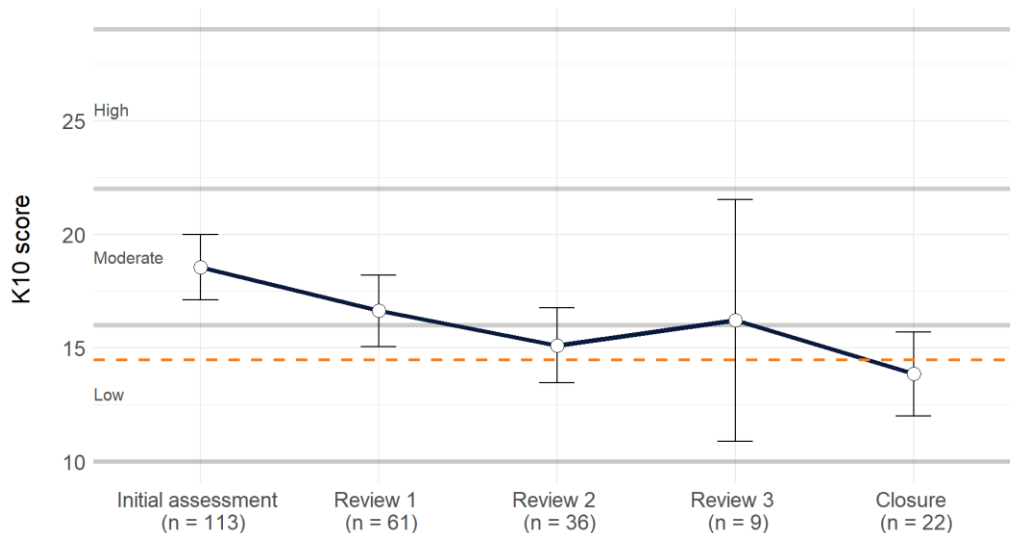
For all validated measures, the figures below show changes in the average scores of Index Children and Carers across assessment time points. Australian normative scores are shown by the orange dotted line across all time points, for comparison purposes. The grey lines reflect clinically notable bands of scores where available (see Appendix 2 for detailed methods, and Appendix 4, Table 23 for detailed reporting of statistically significant findings.)

Kessler-10

The K10 is used as a brief screening tool to measure the psychological distress of Primary Carers. It contains ten questions about emotional state, contributing to the Improving Coping/ Self-Regulation Resilience Domain.

K10 scores showed a statistically significant ($p < .05$) decrease in Carers’ psychological distress from initial assessment to case closure, surpassing the Australian normative score⁵³ by case closure (see Figure 7). On average, Primary Carers were at moderate risk of anxiety and depressive disorders at initial assessment. At case closure, carers were on average at low risk of psychological distress.⁵⁴

Figure 7. K10 scores over time



Source: TBS Assessment data

⁵³ Slade, T., Grove, R., & Burgess, P. (2011). Kessler psychological distress scale: normative data from the 2007 Australian National Survey of Mental Health and Wellbeing. *Australian and New Zealand Journal of Psychiatry*, 45(4), 308–316.

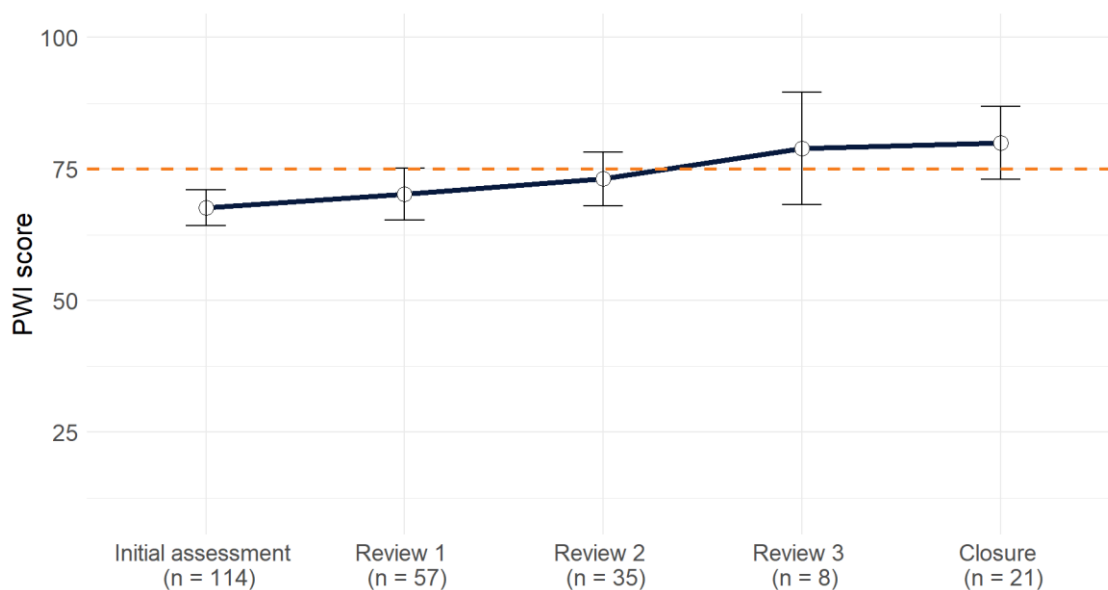
⁵⁴ An additional analysis of the 22 clients who completed the closure assessment found at Initial Assessment an average score of 14 (SD:5). This was slightly lower than the cohort as a whole, but there was substantial variability in scores.

Personal Wellbeing Index

The PWI is used to measure Primary Carers' subjective quality of life, or wellbeing. It contains one overall measure, and seven additional items which are summed to produce an overall score. The PWI contributed to the Increasing Safety Resilience Domain.

PWI scores showed statistically significant ($p < .05$) improvements in Carers' personal wellbeing from the initial assessment to case closure, surpassing the Australian normative score⁵⁵ by case closure (see Figure 8).⁵⁶

Figure 8. PWI scores over time



Source: TBS Assessment data

Strengths and Difficulties Questionnaire

The SDQ is a brief behavioural screening questionnaire that can be used for a variety of purposes, including measuring outcomes. The RF service used the Parent 2–4 version and the Parent 4–10 version, both aimed at children two years and older. The SDQ contributed to the Secure and Stable Relationships, Improving Empathy and Improving Coping/ Self-Regulation Resilience Domains.

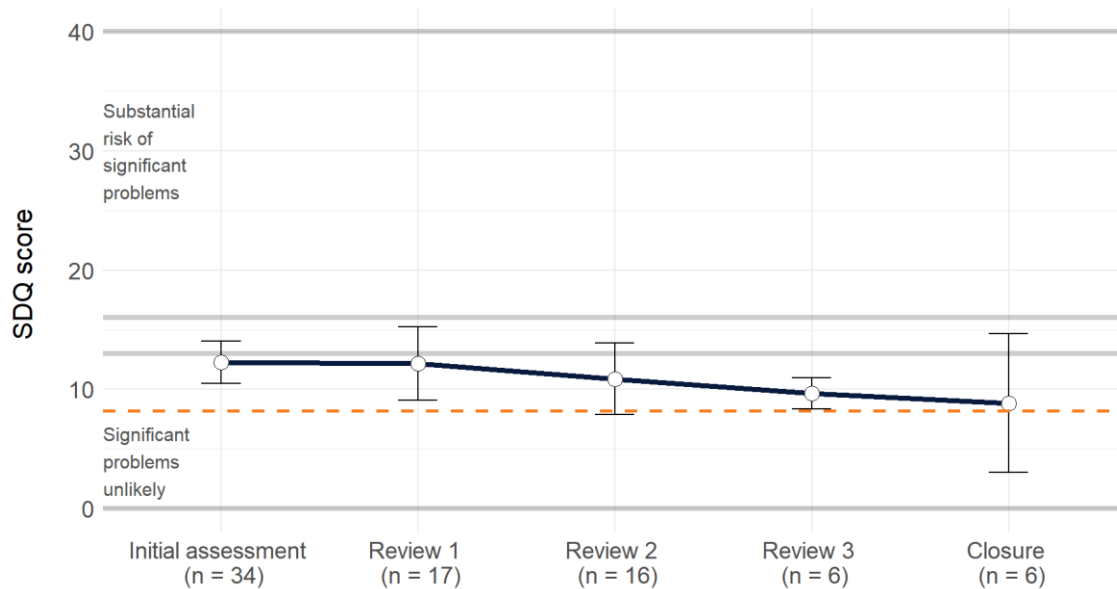
SDQ total difficulties scores showed that children in the RF service faced higher levels of difficulties than the general child population at initial assessment. This decreased over time,

⁵⁵ Australian Unity. (2015). What makes us happy? Fifteen years of the Australian Unity Wellbeing Index. *The Australian Unity Wellbeing Index*.

⁵⁶ An additional analysis of the 21 clients that completed the closure assessment found at Initial assessment an average score of 69 (SD:17). This was broadly consistent with the cohort as a whole, but there was substantial variability in scores.

with average scores in line with Australian normative scores⁵⁷ by case closure. These changes were not statistically significant ($p > .05$) (see Figure 9). The averages for these scores were within the range associated with clinical problems being unlikely.⁵⁸

Figure 9. SDQ total difficulties scores over time



Source: TBS Assessment data

4.3 Resilience Outcome Domains

The TBS Resilience Outcomes Tool comprised a range of validated measures and questions from multiple tools designed to measure child and carer wellbeing.⁵⁹ These were combined to align with and measure each of the Resilience Outcome Domains, 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 decision to use a wide range of tools to measure the Resilience Outcomes Domains was part of an organisation-wide commitment by TBS to implement the RPF and increase

⁵⁷ Mellor, D. (2005). Normative data for the Strengths and Difficulties Questionnaire in Australia. *Australian psychologist*, 40(3), 215-222.

⁵⁸ An additional analysis of the six clients that completed a closure assessment found that at Initial assessment an average score of 12 (SD: 7). This was broadly in line with the cohort as a whole, but there was substantial variability.

⁵⁹ 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.

outcomes measurement. The intent was to use the data to inform casework practice and monitor changes from baseline, as well as to inform research and evaluation. However, following the TBS SBB, TBS have changed their practice and now only collect family outcomes data using the SDQ, PWI, K10 and the Parent Empowerment and Efficacy Measure (PEEM). The evaluation findings support this decision, as the process of standardising and combining the tools resulted in resilience outcome scores that were less sensitive to change than the individual tools (see Appendix 3 for further discussion).

The data showed generally positive trends in all Resilience Outcomes Domains (see Appendix 3), with statistically significant ($p < .05$) improvements in the Increasing Safety and Improving Coping/ Self-regulation Domains between initial assessment and case closure. But small numbers in post-baseline assessments for the remaining Resilience Outcomes Domains meant findings were not generalisable to the whole cohort.

4.4 New skills and behaviours

Interviews with Primary Carers supported the positive trends shown through the validated measures, highlighting the impact of the RF service on wellbeing and family functioning. Several reflected broadly on learning new parenting techniques and approaches, including improved communication skills and strategies for engaging with their children, and having greater confidence as a parent.

I dealt with raising my daughter a certain way—a really different way to how I was taught with the RF program. Not much communication, not much talking, not much engaging, not much positive praise. So, the lady that worked with me, she taught me quite a few positive tips and techniques to use. – Primary Carer interview

A few said they learnt about how parents' behaviour can impact on their children, recognising children should not be exposed to violence and can adopt or learn the behaviours they see. A few also felt that they are now in a much better mental state because of the RF service.

Got me on my feet. I was ready to give up, I was so down, don't think I would have pulled up from this one, think I would have lost everything. – Primary Carer interview

Several described improved family dynamics. They said they now have a better relationship with their child/ren, who appear happier. One Primary Carer said the main change was being able to 'keep her baby'.

We're a family again and it's wonderful, we go to parks more, we go out more, baby is always having fun, she is happy and smiling and healthy. – Primary Carer interview

I have a better relationship with my kids, like we were always close but now I can sit down with my four-year-old and he can read to me whereas before he would get a book and go lay in his room because I was busy. – Primary Carer interview

Several Primary Carers felt that establishing routine at home was a key change. They explained that prior to the RF service, they had limited structure and inconsistent ways of managing household chores. Putting in place a clear routine, including using chore charts, has helped Primary Carers feel more able to manage their household, and also benefitted their children.

Putting a home routine into place. Before that everything was happening willy-nilly in the house. ... Because of her we now have structure—a chore chart, they all have a say in what they want to do. This has really helped. ... they're calmer, have routine, if something changes they're not getting anxious. – Primary Carer interview

I let them get away with a lot and she helped me explain to them that now that this is our house, we have to have a routine. Now I have learnt to stabilise my time between being a mum, doing the housework and running around after the kids and also one on one time with both the kids. – Primary Carer interview

A few explained that prior to the RF service, they could get easily frustrated or 'snap', but that they learnt new techniques to regulate their emotions and respond to frustrations more effectively.

I'd get annoyed if they made a mess. Now take a deep breath, close eyes, take time out. – Primary Carer interview

A few also said they had now stopped using drugs/ alcohol because of the RF service, and one reflected that the RF service 'was a stepping-stone to get a job'.

Only one Primary Carer did not think they learnt or achieved enough through the RF service in the time allowed.

5. TBS SBB performance outcomes

Key findings

The evaluation found that Index Children's contact with the child protection system reduced over time across all three measures: statutory OOHC entries; Helpline reports; and SARAs. Index Children were significantly ($p < .05$) less likely than Control Children to enter OOHC, but there were only small differences between the Index and Control Children in the number of Helpline reports made and SARAs commenced.

The RF service had the greatest impact for higher-risk families, as seen through a range of risk factors—assessed risk level in commencement SARAs, parents' OOHC history, families' prior SARAs, and siblings' experience of OOHC. This impact was seen to occur during the first three months of service.

5.1 Measuring TBS SBB performance outcomes

The outcomes evaluation compared contact with the child protection system for the total TBS SBB population of 303 Index Children referred to the RF service with those of the 303 matched Control Children who received a business-as-usual child protection response delivered or coordinated by DCJ. Contact was measured through:

- statutory entries into OOHC
- reports made to the Helpline by police and health professionals
- SARAs commenced by DCJ.⁶⁰

Previous evaluation findings on the TBS SBB performance outcomes

The TBS SBB performance outcomes data was first analysed in the Mid-term Report (Report 2). The results for this small population showed that Index Children had experienced fewer statutory OOHC entries (8 entries into statutory OOHC for Index Children, compared to 10 entries for Control Children), but received slightly more Helpline reports and had more SARAs commenced in the measurement period than Control Children.

The Report also lay the groundwork for the outcomes evaluation by establishing the comparability of Index and Control Children. A detailed analysis of all relevant data fields showed the two groups to be highly comparable.

The Interim Report (Report 3) also showed that Index Children experienced slightly fewer statutory OOHC entries than Control Children (15 compared with 18); but received more Helpline reports and had more SARAs commenced. The report noted that the population was too small and too little time had passed for conclusions to be made about these outcomes.

To help understand Stage 1 findings that Control Children were experiencing a similar reduction in contact with the child protection system as Index Children, the Stage 2 Progress Report (Report 4) included a case file analysis using a random sample of 50 Control and 89 Index families. This revealed that Control families had received a similar number of interactions per month as Index families, but

⁶⁰ See section 1.3.2 for detailed definitions.

unlike the RF service, most business-as-usual DCJ contact was not face-to-face. Notably, about a third of the Control Group families were involved in another family support service during the measurement period, including some that shared features similar to the RF service. These factors were seen to help explain the similar overall performance of the two groups in Stage 1.

The Stage 2 Progress Report showed that families of Index Children performed slightly better on all three measures, but none of the differences were yet statistically significant. It showed early indications that the RF service worked best for very high-risk families, and outcomes were poorest for those that exited the service early.

5.2 Entries into OOHC

Entries into OOHC for the TBS SBB were defined as ‘statutory’ OOHC i.e. excluding supported care, voluntary care, temporary care or respite. Overall, Index Children (n=303) experienced fewer OOHC entries than Control Children (n=303) and the service worked best for higher-risk families, as seen through a range of risk lenses.

5.2.1 Total entries into OOHC

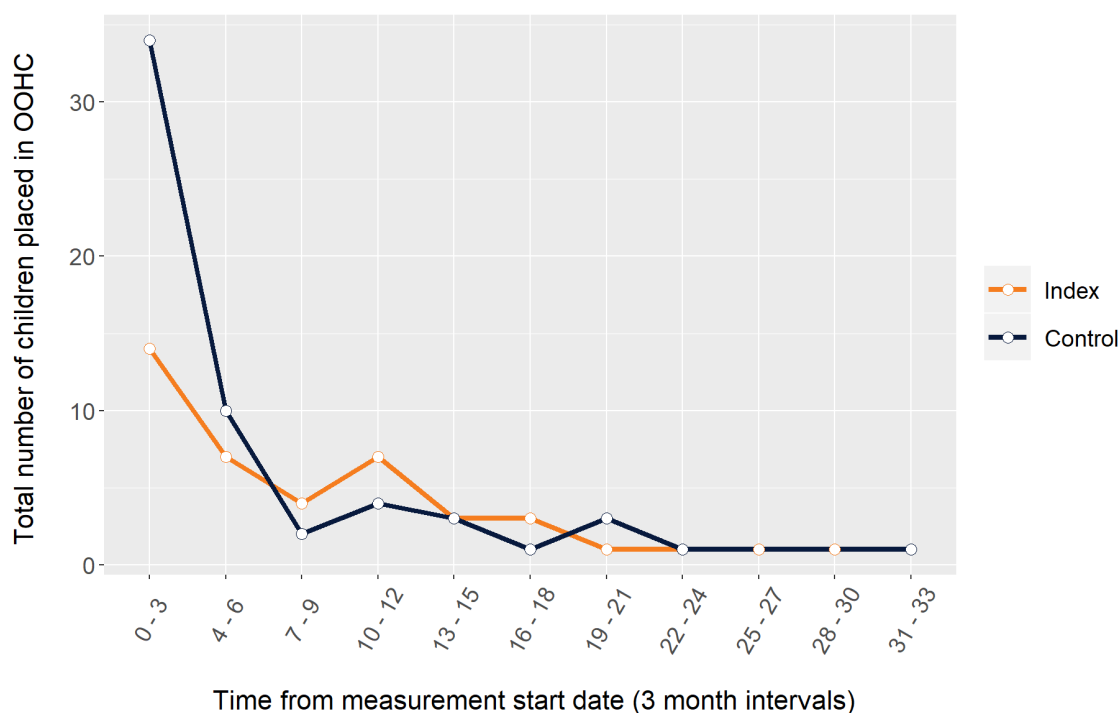
In total, 18 fewer Index Children entered OOHC after starting the RF service than Control Children (see Table 8). The evaluation calculations refer to the total number of *children* who entered OOHC. This differs to the TBS SBB calculations, which counted total number of *entries* and found one Control Child with two entries in the measurement period.

Table 8. OOHC entries during measurement period

	N of children	% of group
Index	41	14%
Control	59	19%

Source: DCJ OOHC data

The difference in the number of children entering care is statistically significant ($p < .05$ —see Appendix 2 for methods of statistical analysis) and driven by a higher number of entries into care by the children in the Control Group in the first three months of the measurement period. After three months, Index and Control Children entered care at similar rates (see Figure 10). This is in line with crisis intervention theory, which, as discussed, suggests that family preservation programs will be more effective when engaging families intensively close to the time of crisis.

Figure 10. OOHC entries per three-month period for Index and Control Children

Source: DCJ OOHC data

5.2.2 Entries into OOHC for higher-risk families

The RF service had greatest impact for higher-risk Index families compared to Control families. Here, risk is understood in a number of ways:

- assessed risk level in the SARA completed prior to the measurement start date ('commencement SARA')
- parents' OOHC history
- families' number of SARAs prior to the measurement start
- siblings' experience of OOHC prior to measurement start.

While these lenses provide different ways of thinking about risk, they are not independent and there is overlap among families in these groups. For example, Index and Control Children who had a parent or sibling with a history of OOHC, and families with two or more prior SARAs, were more likely to be assessed at very high risk than those who did not have these experiences (see Appendix 4, Table 32 Table 33 and Table 34).

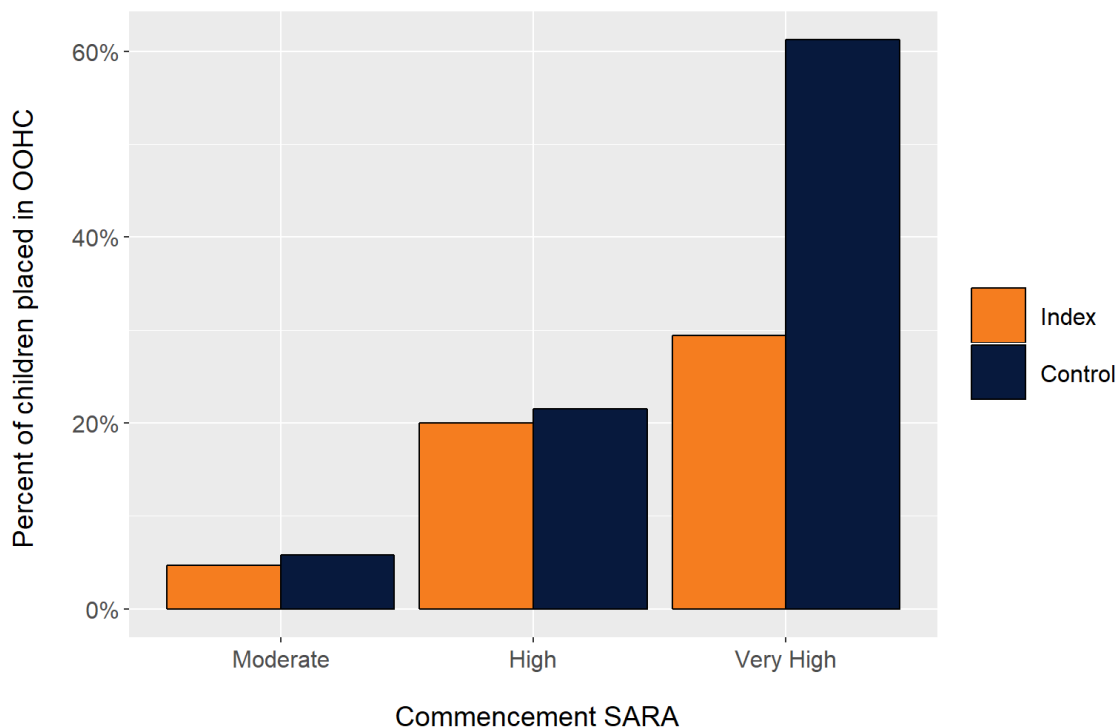
Index Children assessed at very high risk

The RF service had greatest impact for Index Children assessed at very high risk in their commencement SARA. Around half (51%) of Control Children assessed at very high risk entered OOHC during the measurement period, compared to just over one-quarter (26%) of Index Children (see Figure 11). This difference is statistically significant ($p < .05$).

There were no statistically significant differences in the number of Index and Control Children entering OOHC assessed at low, moderate or high risk.

TBS indicated that RF workers were particularly motivated to support higher-risk families or families 'in crisis', in order to prevent children entering care and have a positive impact on those who were most vulnerable. This suggests that interventions close to the time of crisis not only motivate behavioural change among families, but also workers.

Figure 11. Percentage of Index and Control Children placed in OOHC by commencement SARA risk level



Source: DCJ OOHC, SARA and secondary assessments data

Parents of Index Children with a history of OOHC

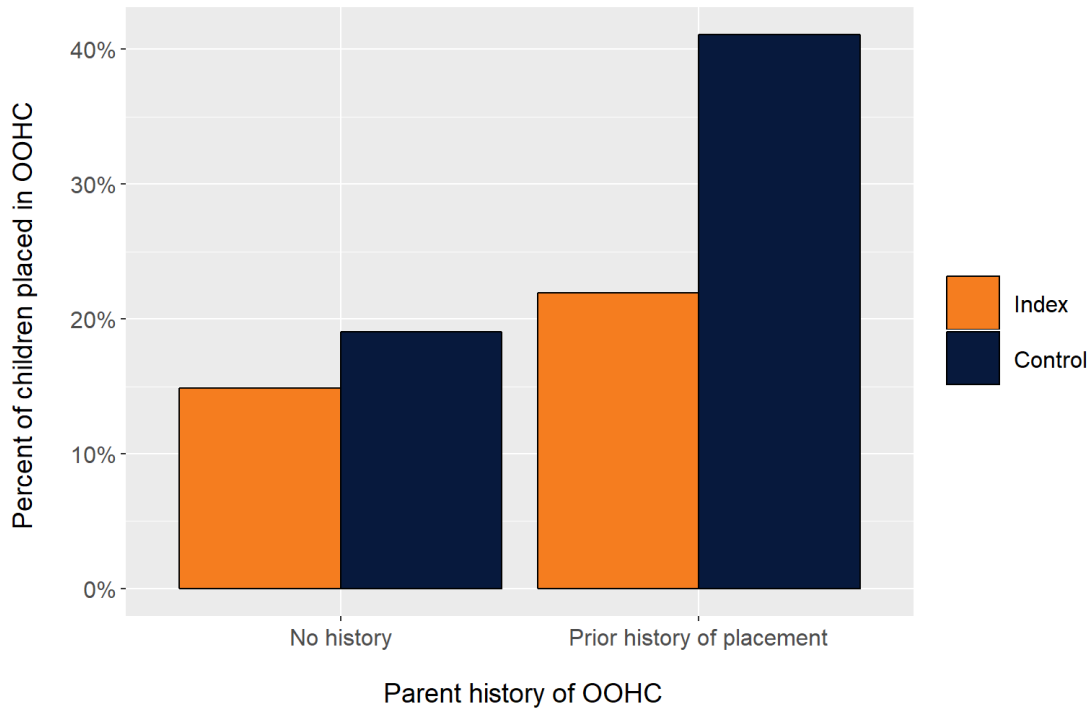
The RF service worked well for parents with their own history of OOHC.⁶¹ More than one-third (36%) of Control Children of parents with a history of OOHC entered care during the measurement period, compared to just over one-fifth (22%) of Index Children—though this difference is not statistically significant ($p > .05$) (see Figure 12).

TBS indicated that workers were extremely motivated to 'break the cycle' of system contact by supporting families with intergenerational child removal trauma. They reported that as

⁶¹ Where the child had multiple parents with a history of OOHC, the parent with the greatest number of days in OOHC was included in the dataset.

these families had previous experiences of the OOHC system, workers could explain the intent of the RF service in a way that resonated.

Figure 12. Percentage of Index and Control Children placed in OOHC by parent history of OOHC



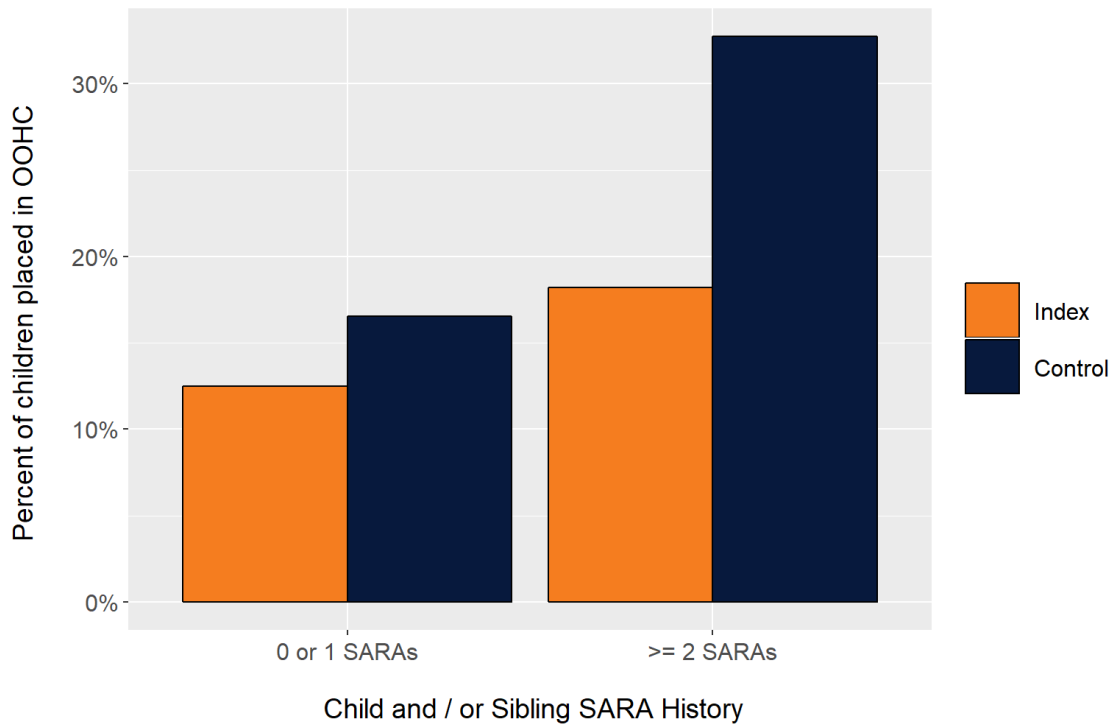
Source: DCJ OOHC and historical child protection data

Families with prior SARAs

About one-third (33%) of Control Children in families who had been subject of two or more prior SARAs entered OOHC during the measurement period, compared to 18% of Index Children (see Figure 13). This difference is not statistically significant ($p > .05$) but is consistent with other findings that the service was most effective for families with highest levels of contact with the child protection system prior to the RF service.

Index and Control Children whose families had no or one prior SARA, entered OOHC after the measurement start date at similar rates.

Figure 13. Percentage of Index and Control Children placed in OOHC by the number of SARAs received by these children and/or their siblings



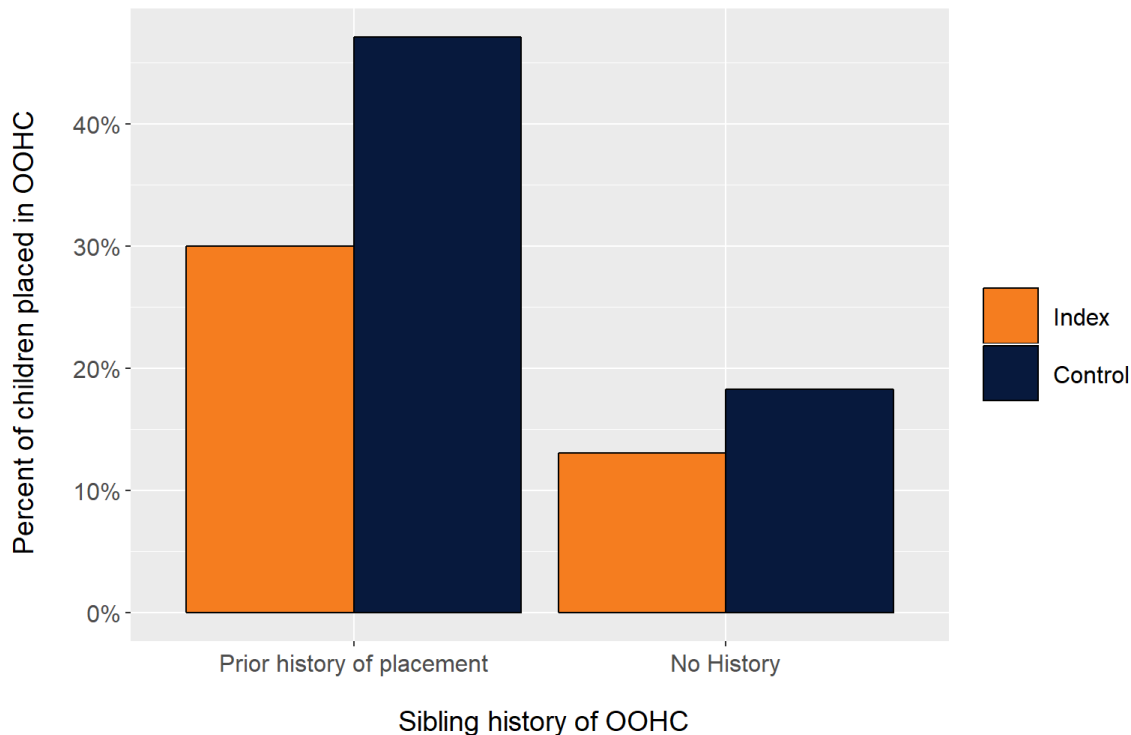
Source: DCJ OOHC and demographic data

Siblings of Index Children with a history of OOHC

The RF service worked well for children with siblings who had entered care prior to the measurement start date. Almost half (45%) of Control Children with siblings with a history of care entered OOHC during the measurement period, compared to less than one-third (30%) of Index Children (see Figure 14). This finding was not statistically significant ($p > .05$).

Index and Control Children with siblings with no prior history of OOHC placements enter OOHC after the RF service start at similar rates.

Figure 14. Percentage of Index and Control Children placed in OOHC by sibling history of OOHC



Source: DCJ OOHC and demographic data

5.2.3 Entries into OOHC for unborn children

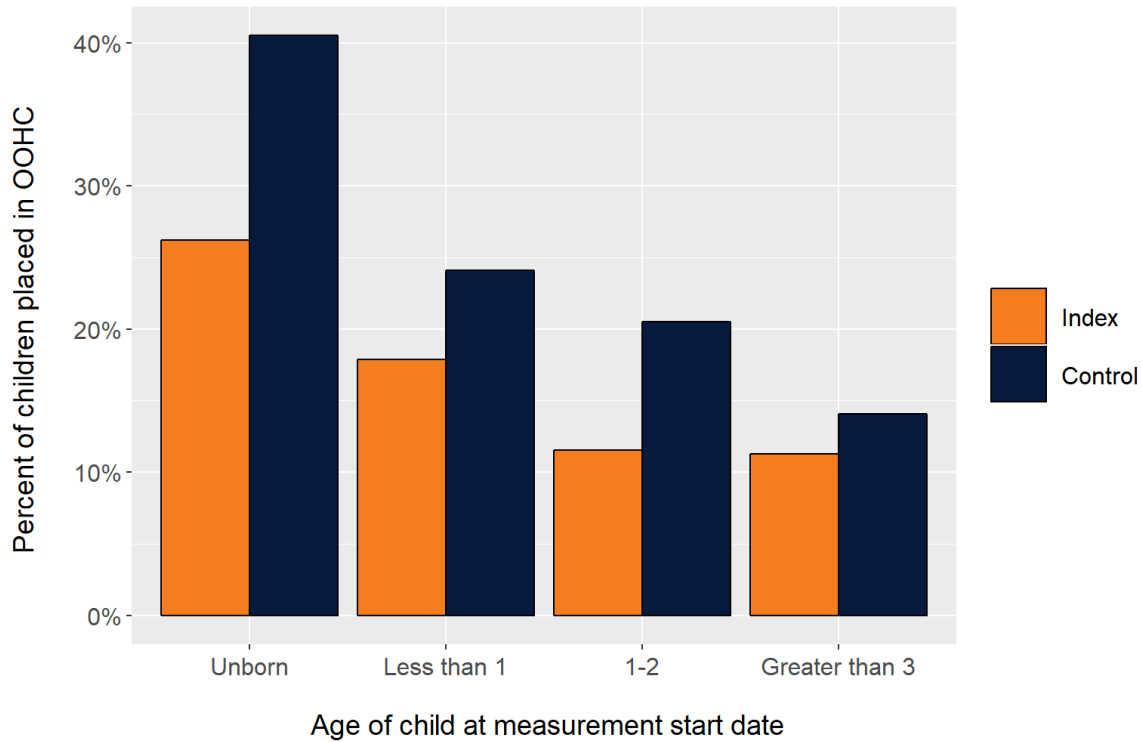
As well as higher-risk families, the RF service was found to work well in cases where the Index Child was unborn at the time of referral. We found that 40% of Control Children who were unborn at the start of the RF service entered OOHC during the measurement period, compared to 26% of Index Children, though again, this difference was not statistically significant ($p > .05$).

The impact of the RF service on preventing OOHC entries decreased with the age of the child. Index Children older than three years at the RF service start entered OOHC at similar rates to Control Children (see Figure 15).

TBS indicated that there was some professional anxiety when working with unborn and very young children, as there is a higher risk of these children entering OOHC, particularly where Primary Carers have previously had other children removed. This motivated workers to focus their efforts to prevent entries to OOHC. They also reported that for unborn children, being referred several months before the child's due date gave workers more time to prepare the family and reduce risks.

We note, however, that the measurement period for children unborn at the time of referral started at the time of birth. This means TBS would have worked with the Primary Carer for some time before the measurement period, which may have contributed to positive findings.

Figure 15. Percentage of Index and Control Children placed in OOHC by age at measurement start date



Source: DCJ OOHC and demographic data

5.3 Helpline reports and SARAs commenced

Overall, the RF service was found to have a limited impact on the other SBB performance measures: number of child protection reports to the Helpline⁶², and number of SARAs⁶³ commenced. Index and Control Children received similar numbers of Helpline reports and SARAs commenced over the measurement period. These numbers reduced overall for both groups over time, a positive indication that service contact had declined for Index families, but not a positive outcome under the SBB, which measures performance based on difference between the Index and Control Groups.

5.3.1 Helpline reports

Both Index and Control Children had an absolute reduction in the number of child protection reports to the Helpline over time. The pattern in reports for each group changed somewhat over the measurement period, and the performance measure was adjusted between Stages 1

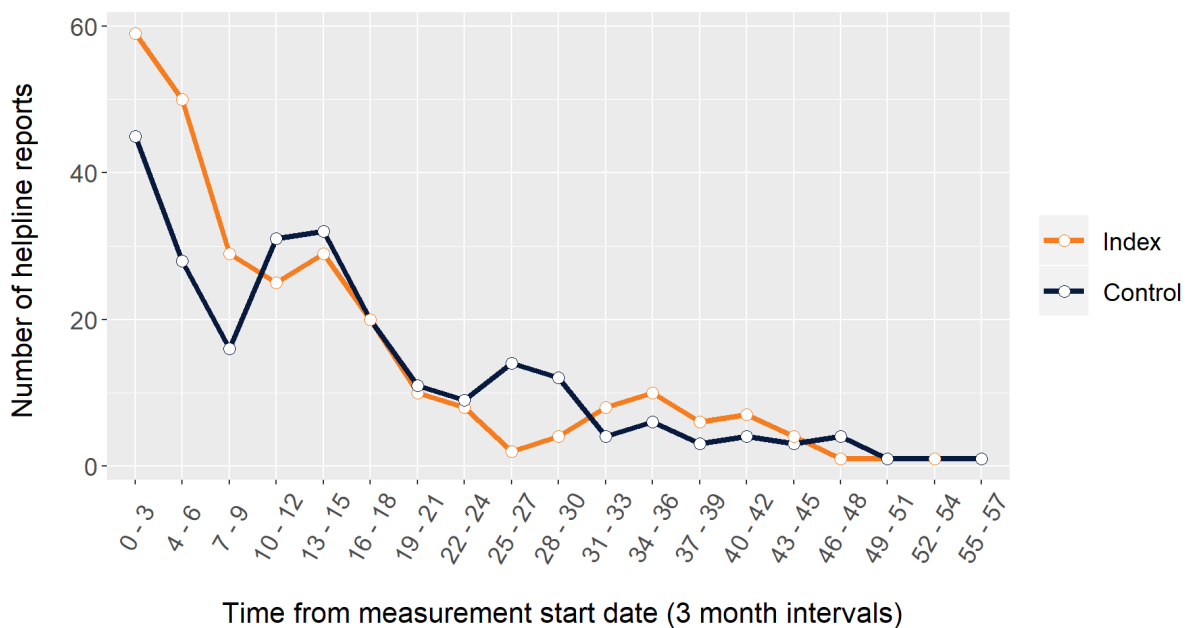
⁶² Child protection reports for the TBS SBB are defined as all reports to the Helpline from police and health professionals including reports by Health, NSW, Health Child Wellbeing Unit, NSW, Interstate or Private Health, Aboriginal Community Health Service, Medical General Practice, Police, NSW, Police Child Wellbeing Unit, NSW, Interstate / Federal Police excluding those classified by DCJ as ‘information only’ (Winning, K. (2016) TBS SBB Operations Manual V4 p21.)

⁶³ SARAs for the TBS SBB are defined as SARAs commenced by DCJ, excluding those made in the first six months (180 days) of each child’s referral to the service.

and 2 (see Chapter 6). Across the total measurement period, based on the revised measure, Index Children received more Helpline reports than Control Children (see Appendix 4, Table 29).

This difference was most notable during the first nine months of the measurement period. After nine months, both groups received a similar and declining number of reports (see Figure 16).

Figure 16. Helpline reports for Index and Control Children per three-month period from start of the RF service



Source: DCJ Reports data

Slightly more Index Children than Control Children were reported to the Helpline over the measurement period and the rate of reports per child was similar across both groups (see Table 9). This finding is consistent with analysis in previous evaluation reports, which noted that Index Children may have experienced higher numbers of reports than Control Children due to surveillance bias, in which Index Children might have been more likely to be reported as being at risk of harm than Control Children because they were subject to greater scrutiny and increased interaction with service providers (see section 6.1).

Table 9. Number of Helpline reports for Index and Control Groups

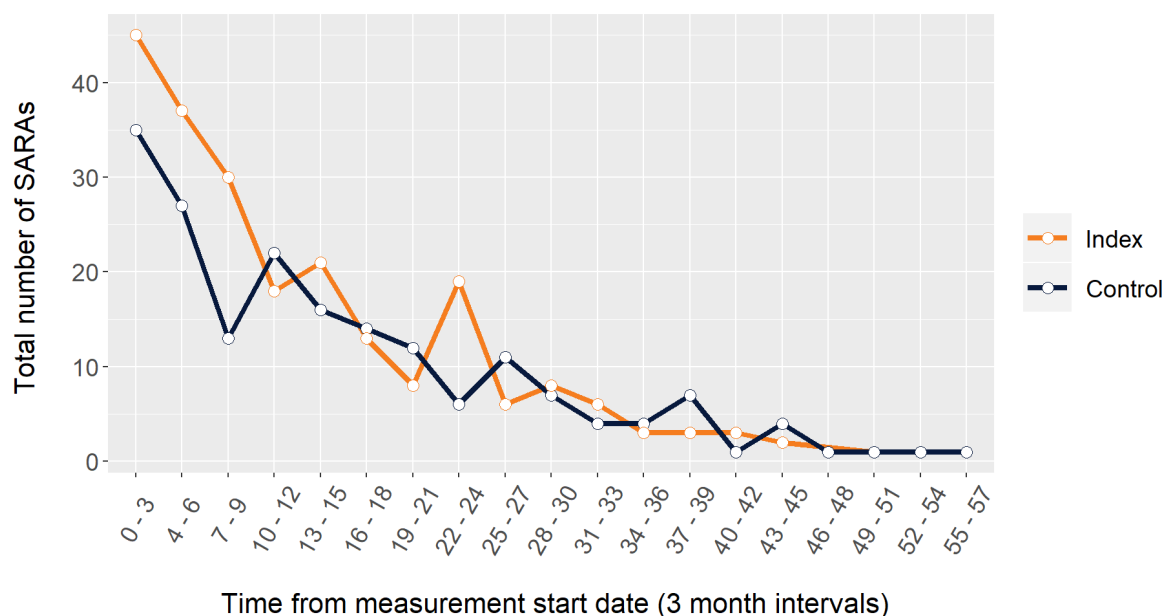
	Any Report		Reports After Start	
	N with reports	% with reports	N	Mean per child
Index	210	69%	978	3.2
Control	198	65%	867	2.9

Note: DCJ reports data. Mean does not include children who received zero Helpline reports.

5.3.2 SARAs commenced

As with the number of Helpline reports, there were more SARAs commenced for Index Children than Control Children (see Appendix 4, Table 30). Both Index and Control Children had an absolute reduction in the number of SARAs commenced over the measurement period. However, more SARAs were commenced for Index Children during the first nine months after the RF service started than Control Children. After nine months, a similar and declining number of SARAs were commenced for both groups (see Figure 17).

Figure 17. Number of SARAs for Index and Control Children per three-month period from start of the RF service



Source: DCJ SARA and secondary assessments data

The finding that after the first 180 days of RF service a similar and declining number of SARAs were commenced for both Index and Control Children has been consistent across all prior evaluation reports, and the use of SARAs as a measure is discussed further in the following chapter (see section 6.1).

6. TBS SBB performance measures

Key findings

The framework for measuring TBS SBB performance used three measures—statutory entries into OOHC, Helpline reports and SARAs commenced—to understand the impact of the RF service on child safety as compared to DCJ business-as-usual child protection interventions. Entries into OOHC were weighted most heavily, as preventing entries is the primary goal of the RF service and involves the greatest system costs. Helpline reports and SARAs were additional, proxy measures of child safety.

We found statutory entries into OOHC was the strongest and most appropriate performance measure; it directly measures the goal of the service, involves external verification through court orders required for removal, and is associated with greatest cost savings. The measure is binary and could be enhanced by incorporating a continuous measure i.e. number of days in OOHC, as this would indicate the level or degree to which outcomes are being achieved and associated system costs.

Helpline reports and SARAs commenced were less reliable measures. While these both showed a reduction in contact for the Index families over the measurement period, a similar reduction was also seen for the Control Children. So, although each showed a decline in contact with the system that could be expected if the RF service was being effective in preventing entries to OOHC, they did not demonstrate a successful outcome within the TBS SBB context (as the SBB payments were based on measured differences between the two groups), despite there being statistically significant differences between the two groups in entries into OOHC.

Helpline reports may be subject to surveillance bias, but changes made to the performance framework that aimed to address this made no observable difference in the pattern of reports over time. There is reasonable evidence suggesting the commencement of a SARA may be influenced by the context. While these two measures may be useful for monitoring purposes, they were not useful or sufficiently robust for measuring the outcome of the RF service.

6.1 Assessing the TBS SBB performance measures

The literature recognises the importance of defining explicit, measurable performance outcomes at the start of any SBB, but notes that the measures selected will vary greatly depending on what the service is aiming to achieve.^{64, 65}

⁶⁴ Berndt, C., & Wirth, M. (2018). Market, metrics, morals: The Social Impact Bond as an emerging social policy instrument. *Geoforum*, 90, 27–35. doi: <https://doi.org/10.1016/j.geoforum.2018.01.019>.

⁶⁵ Chamaki, F., & Jenkins, G. (2018). Social Impact Bonds: Implementation, Evaluation, and Monitoring. *International Journal of Public Administration*, 42(4), 289-297. doi: <https://doi.org/10.1080/01900692.2018.1433206>.

There is limited evidence about the number of measures that should be used in a SBB. Often, it is difficult to definitively measure social outcomes, and so proxy measures can indicate success, and sometimes *multiple* proxy measures are used.⁶⁶ The use of multiple measures can prevent a reductive assessment of outcomes, and test for congruence in the directionality of outcomes, mitigating the risk of problems with data quality, or with the reliability or validity of a single measure. In other cases, however, success can be clearly and discretely measured through a single measure.

There is also limited evidence about whether performance measures should be 'binary' (e.g. a child does or does not enter OOHC) or 'continuous' (e.g. the number of reports to a Helpline). There is some indication that binary measures are more straightforward⁶⁷, providing an absolute indication of success⁶⁸. At the same time, continuous measures can indicate frequency, indicating the level or degree to which outcomes are being achieved and associated system costs.

The framework for measuring TBS SBB performance outcomes was designed to understand the impact of the RF service on child safety as compared to DCJ business-as-usual child protection interventions. It was designed with multiple measures (one binary and two continuous), each relating to a reduction in contact with the child protection system and with varying system costs. The number of children entering OOHC was weighted most heavily for the TBS SBB calculations (see section 1.3.2), as the most serious indicator of children at risk and the most costly outcome to government. Helpline Reports and SARAs commenced were also considered important indicators of a child's safety, with associated system costs.

In early 2016, the TBS SBB was reviewed to ensure the outcome measurement framework was appropriate and the right measures were being used to determine performance. The review led to changes in the measurement of Helpline reports and SARAs: only Helpline reports made by NSW police and health reporters were to be counted to reduce the likelihood of surveillance bias in reporting; and only SARAs from six months after the measurement start date were counted.

To assess the appropriateness of each of the TBS SBB performance measures, we considered:

- usefulness—the practicality of the measure in demonstrating the success of the RF service
- reliability and robustness—the extent to which the measure is consistent and accurate.

Previous evaluation findings on the appropriateness of the TBS SBB performance measures

A reduction in entries into OOHC reflects the primary goal of the RF service and previous reports have suggested this is the strongest of the TBS SBB performance measures. Analysis of outcomes measured through the TBS SBB performance measures in the Mid-term and Interim Reports (Reports 2 and 3)

⁶⁶ Office of Social Impact Investment. (2019). *Social impact investments*. <https://www.osii.nsw.gov.au/initiatives/sii/>

⁶⁷ OECD. (2016). *Understanding Social Impact Bonds*. <http://www.oecd.org/cfe/leed/UnderstandingSIBsLux-WorkingPaper.pdf>.

⁶⁸ Social Finance. (2015). *Technical guide: Designing Outcome Metrics*.

found that while Index Children had experienced fewer statutory OOHC entries, they received more Helpline reports and had more SARAs commenced than Control Children.

The Reports suggested that Index Children may have experienced higher numbers of Reports than Control Children due to surveillance bias.⁶⁹ This relates to the Index families being under a greater amount of observation due to the intensive, home-based RF service and referrals to other parts of the service system to address family support goals. There were likely to be more opportunities for Index Children to be reported than Control Children, who were unlikely to be receiving the same type of service. We indicated the use of Helpline Reports as a performance measure could be problematic for this reason and we recommended discounting reports made for Index and Control Children in the first six months of service, when the issue appeared greatest.

Similarly, the use of SARAs was questioned as a measure due to a concern that they may have been subject to the context and/or capacity of individual CSCs at a given point of time. To investigate this, we looked at the relationship between reports and SARAs commenced and found that not all reports were followed by a SARA, and not all SARAs were preceded by a report. More than half the reports were followed at some point by a SARA for children in the Index families (61%), compared to less than half for Control Children (43%). This difference was 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). The analysis indicated that SARAs were not a sufficiently robust measure to be used for calculating performance outcomes.

In response to learnings from across the SBB, the current TBS performance-based contract uses OOHC as the outcome measure that is paid on.

6.2 Entries into OOHC

Statutory entries into OOHC was the strongest TBS SBB performance indicator. It:

- reflects the primary goal of the RF service
- is a strong and established indicator that a child is unsafe
- relies on an independent verification of the safety status of the child by the courts through the process of making a statutory order
- can be used as a binary measure, so counting is straightforward and reliable.

TBS are now delivering the RF service under a new TBS performance-based contract that uses statutory entries into OOHC as the sole performance measure that is paid on, reflecting this finding.

Considering the number of *days* in statutory care could provide an additional, continuous measure that would align to the real costs of statutory placements. We know, for example, that for the TBS SBB, Index Children who received a statutory entry to OOHC entered care an average of 39 days later than Control Children (see Appendix 4, Table 36).

⁶⁹ Social Policy Research Centre. (2010), *Brighter Futures Final Evaluation Report*, <http://apo.org.au/node/23443>.

6.3 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 concern that a child is at risk or unsafe. On this basis, the number of Helpline reports is a relevant, proxy indicator of child safety, with associated system costs.

However, the RF service was found to have a limited impact on the number of Helpline reports under the TBS SBB. An evaluation without an experimental design would assess the overall reduction in Helpline reports as a positive outcome. Under the TBS SBB however, the similar number of reports found for Index and Control Children suggested that Helpline reports were not a strong indicator of the success of the RF service, relative to business-as-usual. While Index Children received similar numbers of Helpline reports to Control Children, they had statistically significant ($p < 0.05$) fewer entries into OOHC, indicating Helpline reports are not useful in predicting entries to care.

Further, previous findings suggested that Helpline reports may be subject to surveillance bias, leading to changes to only count reports made by NSW Police and health reporters. To assess the impact of this change, we compared reports to the Helpline by health and police reporters to those by all reporters. We found that the pattern of reports did not differ—patterns seen in the reports for both Index and Control Children were highly similar, whether all reports were counted or just those from the two identified sectors. We also know (from the case file analysis conducted in Report 4) that Control Children received a higher-intensity business-as-usual service than initially expected. This indicated that Control Children could be under a similar level of surveillance bias.

Overall, we have concluded that the number of Helpline reports may be useful for monitoring purposes, but not useful as a performance measure in similar SBB contexts.

6.4 SARAs commenced

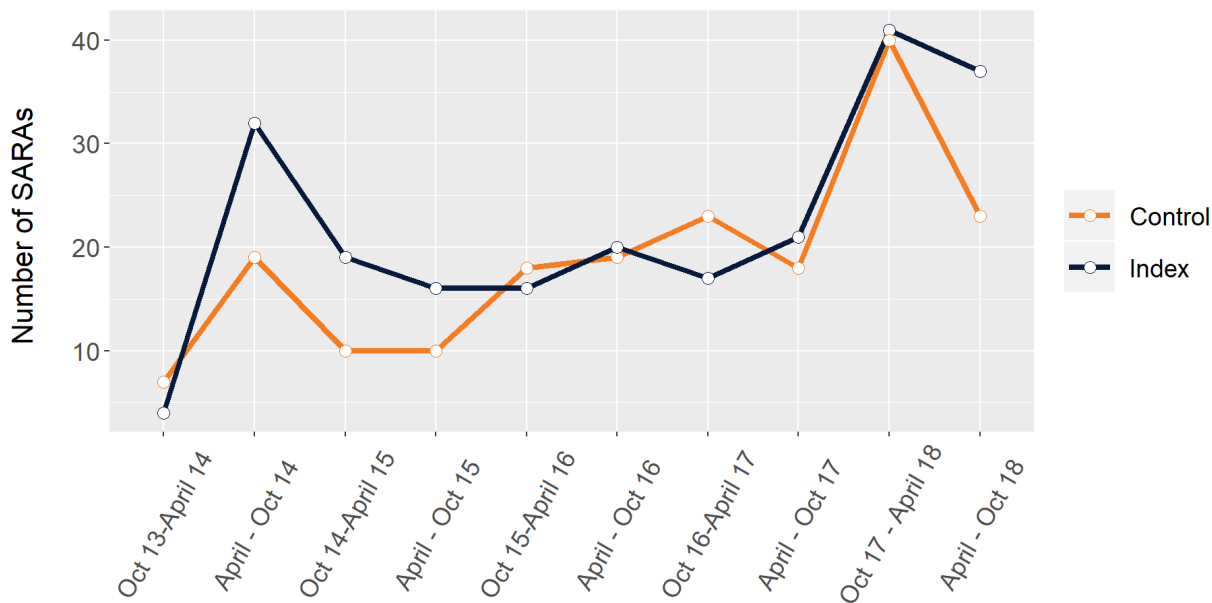
SARAs capture more information about the risk and safety status of a child than a Helpline report can provide, as they reflect a decision by DCJ to prioritise the case for attention. Like Helpline reports, the number of SARAs commenced is a relevant, proxy indicator of child safety, with associated system costs.

However, the RF service was found to have a limited impact on the number of SARAs commenced—while the total number reduced over time, Index Children received similar numbers as Control Children over the measurement period. Like Helpline reports, this suggests that it is not a useful indicator of the success of the RF service, relative to business-as-usual, nor a useful predictor of whether the primary goal of the service is achieved i.e. preventing entries into OOHC.

Further, previous findings have suggested that the number of SARAs commenced is a problematic performance measure because practice and/or context may influence when a SARA is completed. To confirm the extent to which SARAs can be discretionary, we mapped the number of SARAs completed at six-month intervals over the whole measurement period

(see Figure 18) and observed two timepoints where there was a notable difference between Index and Control Groups in the number of SARAs commenced.

Figure 18. Number of SARAs across TBS SBB measurement period



The first was across the first year of the RF service. This may have been due to the increase in the intake of clients early in the program. The second was in the last 12 months of the TBS SBB, when the number of SARAs for both Index and Control Groups increased notably between April and October 2017, after which the number for Control Children decreased rapidly, more so than for Index Children. The increase may relate to an intensive period for referrals to ensure the SBB achieved its target number of families; and/or to preparatory work being undertaken within DCJ for the introduction of new client management system Child Story, which involved case worker training and remediation relating to SARAs over this time.

Overall what this analysis indicates is that a range of factors can impact on when a SARA is commenced. Therefore, while useful for monitoring purposes, we do not recommend using the number of SARAs commenced as a performance measure in future, similar SBB contexts.

7. Conclusions and recommendations

7.1 Targeting the RF service

IFPSs are designed to support families with high and complex needs, for whom the service system has not always been effective in improving outcomes. The RF service was found to be successful in preventing entries into OOHC for these families. Specifically, the RF service was found to reduce the likelihood of entering OOHC during the measurement period for children with:

- **a SARA risk assessed as very high**—26% of Index Children compared to 51% of Control Children entered OOHC
- **a sibling who has a previous experience of OOHC**—22% of Index Children compared to 36% of Control Children entered OOHC
- **a carer who has a previous experience of OOHC**—18% of Index Children compared to 33% of Control Children entered OOHC.

The RF service was also shown to be notably successful in working with families where the child was unborn at the time of referral, with fewer OOHC entries observed for this group. Successful interventions with this group are important in breaking intergenerational cycles of contact with the child protection system.

Current NSW reforms to the child protection system recognise that individualised, family-based responses, with local key workers providing support and coordination, are the best mechanisms for improving life outcomes and changing high-cost life trajectories for children and families with complex needs.⁷⁰ Given the alignment of the RF service with this reform direction, and its success working with high-risk families, we recommend DCJ continue to invest in the RF service as an option for families where children are at risk of entering care.

The evaluation found, however, that the RF service reached families with a range of risk profiles, not all of which were identified as having high or complex needs. On this basis, there is an opportunity for DCJ to consider narrowing the eligibility criteria to ensure RF is targeted to families for whom it has been shown to be most effective. This would mean families who are invited to participate would be those most likely to succeed and would make optimal use of program resources.

The evaluation has also been concerned with the timeliness of the referral process, given the importance of intervening close to a family crisis, when families will be most motivated to change behaviours. This should be a continuing focus of the referral process.

⁷⁰ Tune, D. (2016). *Independent Review of Out of Home Care in New South Wales – Final Report*.

Currently, referral to the RF service is based on the outcome of a SARA safety assessment. Risk levels are determined independently of the referral, up to 28 days later. For the RF service to target high-risk families in a timely way, we recommend introducing additional eligibility criteria to the referral process such as carers and siblings with prior contact with OOHC. The eligibility criteria could also prioritise unborn children, given TBS' success engaging and working with this group.

The service had the greatest impact in reducing entries to OOHC in the first three months, but families continued to show improvements in wellbeing and family functioning beyond this point. Given the time required to address complex needs and entrenched behaviours, we recommend the service continues to be offered to families for 12 months.

We recommend that DCJ:

1. continue to invest in the RF service as an option for families where children are at high risk of entering care
2. more closely target the RF service to high-risk families by introducing additional eligibility criteria that indicate risk, such as carers and siblings with prior contact with OOHC
3. more closely target the RF service to families with unborn children
4. continue working with TBS to improve timeliness of service commencement
5. maintain the length of service for high-needs families.

7.2 Delivering the RF service

The RF service is an evidence-based service which the evaluation has found was implemented largely as intended and consistently with the service design.

TBS staff were effective in engaging families with unborn children at risk and many families with high and complex needs who are often hard to reach and engage in services. Family plans were developed based on a holistic, structured assessment of family strengths, values, skills, and needs. Family members reported feeling their voice was included in developing plans to address safety concerns and highly valued the qualities and skills of RF workers with whom they developed positive, trusting relationships.

The RF service was delivered mostly face-to-face in family homes, a key strength of the service. This is consistent with a recent systematic review that found that home visits with high-risk families were the only form of intervention where there was significant evidence demonstrating a reduction in child abuse being achieved.⁷¹ While the service was delivered to some families outside of business hours, when focussing on high-risk families, there may be more room for a stronger focus on delivering the service in the early morning and early evening periods, important times for teaching and modelling new routines and behaviours.

⁷¹ Levey E, Gelaye B, Bain P, Rondon M, Borba C, Henderson D, Williams M. (2017). *A systematic review of randomized controlled trial of interventions designed to decrease child abuse in high-risk families*. *Child Abuse & Neglect* 65. 48–57.

The emphasis within the RF service on safety, parental coping skills, positive parenting skills and linking family members to the services and supports they need should remain the focus of the service. TBS staff also worked with families to develop social connections and other natural supports and should continue this. Providing opportunities for families to connect with each other through centre-based activities could be helpful for some families, especially higher-risk families needing to establish more positive relationships and supports that can help them sustain changes made through the service.

There were several gaps in the TBS data that limited our understanding of service delivery. For example, data on service intensity and service referrals, and our understanding of outcomes as measured through the Resilience Outcomes Tool. TBS has focussed on improving data completeness in key areas throughout the measurement period. We recommend they continue these efforts in order to collect more complete data to enable ongoing monitoring of service delivery and family outcomes.

We recommend that TBS:

6. continue to deliver the RF service as a holistic, in-home service with a focus on safety, parental coping skills, and positive parenting skills and linking family members to services and supports
7. continue to focus on helping family members build positive social connections and supports, and consider offering opportunities, such as centre-based activities, to assist with this, especially for higher-risk families and new parents with limited positive supports in place
8. continue to focus on the quality and completeness of service data in key areas to support ongoing monitoring and service improvements
9. continue to use validated tools to inform family plans and help demonstrate outcomes.

7.3 Measuring TBS SBB performance

The five-year TBS SBB has provided learnings for the NSW Government, TBS and the sector more broadly. The RF service has a clear aim: to prevent entries into OOHC. This means it is possible to discretely measure success through a single performance measure—number of children entering OOHC. The number of days in OOHC could be used as an additional, continuous measure that would give additional information about the degree of achievement, directly related to potential cost savings.

Reports to the Helpline and SARAs commenced were additional indicators of child safety, but not essential to understanding the success of the service under the SBB. The reduction in Helpline reports and SARAs commenced experienced by Index and Control Children was associated with the prevention of OOHC entries for significantly more Index Children than Control Children, suggesting these are not as useful measures. Partially influenced by practice and policy contexts, SARAs commenced were found to be the least robust measure.

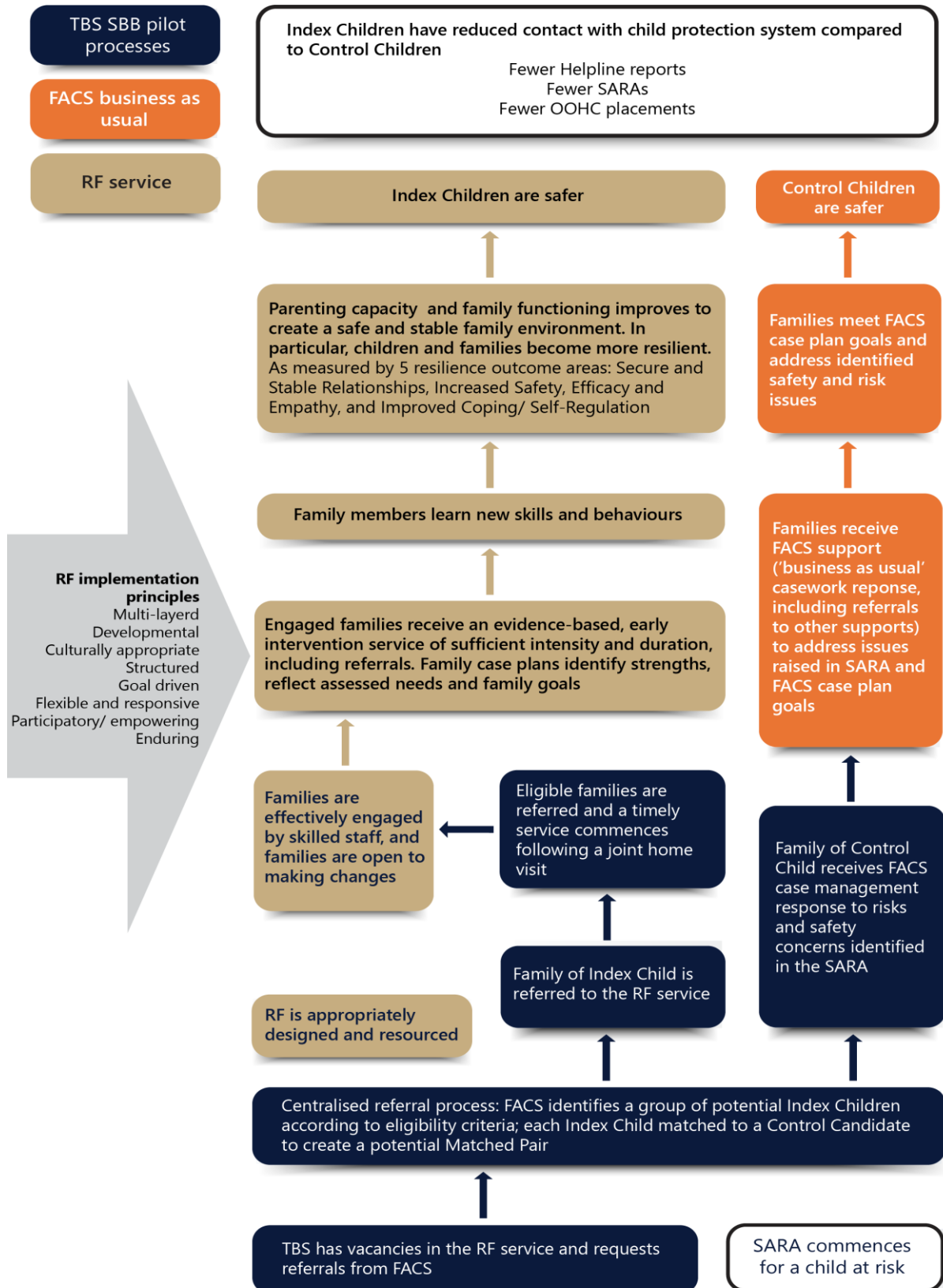
The evaluation has provided a clear understanding of who the program is working best for and why. It has also identified real-time learnings and improvements and explored the appropriateness of the performance measures themselves.

We recommend that in the future, when implementing similar social benefit investments, the NSW Government:

10. use the number of entries into statutory OOHC as the primary measure
11. consider using the number of days in OOHC as an additional, continuous measure
12. only use of Helpline reports and SARAs for monitoring purposes and not as a SBB performance measure for OOHC services
13. continue to use monitoring and evaluation alongside bond calculations.

Appendix 1. Program logic

Figure 19. Resilient Families TBS SBB program logic



Appendix 2. Methods

Data Sources

TBS data

Service monitoring data

Purpose: To understand the delivery of the RF service. To describe the types of families that engage with the RF service. To examine the intensity and frequency of service delivery for families. To examine activities in relation to the Resilience Outcomes Domains.

Scope: The TBS client details database is a custom-built database that has been extracted to Excel. It 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 system was transitioned to a new client data management (CDM) system that collected this data from 1 July 2016. This database includes separate reports for client demographic data, service activities, and EIPs. Records are from October 2013–July 2018.

Sample: The client data extract includes records of 165 of the 167 families that consented to their TBS data being used for the evaluation. The service activities report includes records of 104 of the 167 families that consented to their TBS data being used for the evaluation, and the EIP report includes records of 97 of the 167 families that consented to their TBS data being used for the evaluation.

Assessment data

Purpose: To examine if the RF service can produce changes in wellbeing and functioning across the five Resilience Outcomes Domains that can be detected through validated measures and other tools.

Scope: The TBS Resilience Outcomes database is an Excel spreadsheet that contains the results of the Resilience Outcomes Tool for families in the program between October 2013 to July 2018 who consented to their TBS data being used for the evaluation. This tool includes a range of survey items, designed to measure the five Resilience Outcomes Domains.

Sample: This database includes records for 132 families (out of 167 total consenting families), with baseline data for 119 families, Review 1 data for 65 families, Review 2 data for 37 families, Review 3 data for 10 families, and exit data for 23 families. We understand these are planned to be completed at four-month intervals. However, for many families this was not possible, resulting in the small numbers of completed review data for the second and subsequent reviews.

DCJ data

Demographic data

Purpose: To describe the demographic make-up of Index and Control Children and their families. To examine the relationship between demographic factors and other SBB measures.

Scope: An Excel spreadsheet containing the Index/ Control status and pair identifier, measurement period start and end dates, and key TBS SBB matching criteria data. This data includes records for all Index and Control children from October 2013 to July 2018.

Sample: This Excel spreadsheet includes records for each of the 303 Control Children, 303 Index Children, 2 Unmatched Index Children, and 3 Unborn children in the Index and Control Groups (unmatched and unborn children were excluded from analysis).

Reports data

Purpose: To examine the Helpline reports made regarding Index and Control Children during the measurement period. To compare the number and frequency of Helpline reports made about children in these groups. To examine the rate of Helpline reports made regarding Index and Control Children across the measurement period.

Scope: A spreadsheet of all the reports for each of the children in the Index and Control Groups from 12 months prior to their measurement start date until July 2018. It includes all non-cancelled contact records where a child is a subject of the record and contact record meets standard counting rules for the definition of a 'report', detailing the start date, ROSH/ non-ROSH outcome, primary reported issue for each report, and a identifier for reports to be considered under the changes to the Helpline report counting rules (i.e. Health/ Police).

Sample: This Excel spreadsheet includes records for each of the 303 Control Children, 303 Index Children, 2 Unmatched Index Children, and 3 Unborn children in the Index and Control Groups (unmatched and unborn children were excluded from analysis).

SARA and secondary assessments data

Purpose: To examine SARAs undertaken for Index and Control Children during the measurement period. To compare the number of SARAs received by Index and Control Children during the measurement period. To examine the change in SARAs undertaken for Index and Control Children across the measurement period.

Scope: A spreadsheet of all SARAs and Secondary Assessments undertaken for each child in the Index and Control Groups from 12 months prior to their measurement start date until July 2018. 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.

Sample: This database includes records for each of the 303 Control Children, 303 Index Children, 2 Unmatched Index Children, and 3 Unborn children in the Index and Control Groups (unmatched and unborn children were excluded from analysis).

Out-of-home-care data

Purpose: To examine differences in the number of Index and Control Children who are placed into OOHC during the measurement period. To examine the rates of OOHC entries for Index and Control Children across the measurement period. To examine the impact of demographic and risk factors on rates of OOHC entry in Index and Control Children.

Scope: A spreadsheet of OOHC information for Index and Control Children from 12 months prior to their measurement start date to July 2018. It includes only primary placements that commence on or before July 2018 and excludes cancelled placements and those with parents or respite placements. The list details the total number and duration of OOHC placements in the 12 months prior 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.

Sample: This Excel spreadsheet includes records for each of the 303 Control Children, 303 Index Children, 2 Unmatched Index Children, and 3 Unborn children in the Index and Control Groups (unmatched and unborn children were excluded from analysis).

Historical child protection data

Purpose: To describe the OOHC experiences of parents of Index and Control Children. To examine the intergenerational impact of OOHC placements. To compare the relationship between intergenerational experiences of OOHC on Index and Control Children being placed in OOHC during the measurement period.

Scope: Child protection and OOHC data for parents of the Index and Control Children from when they were themselves a child. This data includes records only for those who were a resident in NSW as a child and covers times 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. Where the child had multiple parents, the parent with the greatest number of days in OOHC was included. Where no parents had days in OOHC, the parent with the most ROSH reports was included. Number of ROSH reports and days in OOHC placement for the child's parent between 87/88 and 30th June 2017 were included. This data was sourced from the KiDS/ CIW production environment as of November 2017.

Sample: This Excel spreadsheet includes records for a parent for each of the 303 Control Children and 303 Index Children.

Primary Carer interviews

Purpose: To understand Primary Carers' experience of the RF service and their perceptions of its impact.

Scope: Interviews focused on Primary Carer's overall experience of the service, the referral, engagement and case planning process, their relationship with the RF worker, activities and referral made, the impact of the service on families, and readiness to exit.

Sample: A convenience sampling method was used. ARTD received a list of Primary Carers from TBS who had exited the RF service and consented to be contacted about being interviewed. Potential interviewees were contacted through their provided phone numbers, and emailed information sheets and consent forms. Participants who preferred to give verbal consent were able to do so.

In total, 17 interviews were arranged and completed between March 2015 and November 2018. The sample included families from both Region 1 and Region 2. Interviews were conducted both over the phone and face-to-face, depending on their preference. Interviewees were compensated for their time.

Data Management

Exclusions

Analysis excluded two unmatched Index Children, and 3 unborn Index and 3 unborn Control Children from DCJ datasets. Of the 354 families referred to the RF service, 303 Index Children were identified for measuring TBS SBB performance—the 43 Children outstanding, who were not part of the TBS SBB population, were also excluded from analysis from all TBS datasets.

Counting rules

The SBB counting method for Helpline reports and SARAs was changed in late 2016 following recommendations from the Stage 1 evaluation and an independent review. These changes altered only Helpline reports and SARAs commenced *during* the measurement period, not *before* entry to the service or the Control Group. Helpline reports were only counted if they were made by Police or health professionals. SARAs were excluded from analysis if they occurred within the first 180 days (six months) of the measurement period for both Index and Control groups.

To determine the Helpline reports to be included in analysis of reports during the RF service, ARTD was provided with a data set which included report contact identifiers where the report was initiated by police or health professionals. An indicator variable was then added to the

primary data set to identify the source of the report and if it should be included in the analysis.

Our analysis included all SARAs commenced after the measurement start date. This differs from the analysis used to determine performance of the RF service under the TBS SBB, which required calculating the date that was 180 days after the measurement period start date and creating an indicator variable that clearly identified SARAs that were commenced after the calculated date. This indicator was used to include or exclude SARAs from the SBB analysis, whereas all SARAs commenced after the measurement start date were included in our analyses.

Variable definition/ calculation

Commencement SARA

To examine the risk profile of Index and Control Children as they entered the measurement period, we calculated a 'commencement SARA' risk level for all Index and Control Children. This risk level was calculated using the final SARA risk assessment that was commenced prior to the child's measurement start date from the DCJ SARA and Secondary Report dataset. This method for examining the level of risk of children as they enter the measurement period was tested in the Interim Report from the Stage 1 evaluation and was found to be the best method for assessing level of risk.

Commencement SARAs relating to eligibility and referral to the program for unborn children may be different to one just before measurement start date, as unborn start dates were allocated once a child was born and a new report and/or the SARA is likely to have occurred close to or at birth which would be different from the 'eligibility' SARA.

Resilience Outcomes subdomain scores

In addition to a number of complete validated tools (K-10, PWI, SDQ), the Resilience Outcomes Tool included a range of items from multiple tools for each of the five resilience outcomes subdomains. There are multiple ways that these items can be combined to create subdomain scores. We used a two-step process in which scores for each tool within a subdomain were first standardised against the group baseline by calculating z-scores, then summed across participants to create a combined item subdomain score. This combined item subdomain score was then standardised against the group scores at baseline by calculating z-scores, such that increases in scores from zero at later assessment time points reflects improved functioning as assessed by the tools associated with that subdomain.

Quantitative Analysis

For all quantitative analyses, data cleaning, dataset merging, restructuring, and variable calculation was conducted in Tableau Prep. Descriptive analyses, producing tables, crosstabs

and charts describing frequencies and proportions was conducted in R. Where sample sizes were sufficient, statistical analyses were carried out in both R and SPSS.

Population and client profile

We used descriptive statistics to examine the demographic profile of Index Children and their Families using the DCJ demographics and TBS Service monitoring datasets.

TBS SBB Performance Measures

We used descriptive statistics to examine the frequency of TBS SBB performance measures (Helpline reports, SARAs, statutory OOHC entries) across Index and Control Children.

We completed a time-series analysis using each child's measurement start date to calculate the number of days from their measurement start date that each Helpline report/ SARA/ statutory OOHC entry occurred. These were then binned into three-month intervals to examine changes in the frequency of these outcomes across the measurement period.

Chi-squared tests were used to test the statistical significance of differences in the number of Index and Control Children that entered OOHC during the measurement period, and differences in the number of children in these groups entering OOCH in the first three months of the measurement period.

Crosstabs were used to examine the impact of risk lenses (commencement SARA, sibling OOHC history, family SARA history, intergenerational experiences of OOHC) on Index and Control Children entries into OOHC during the measurement period. We then performed multivariate analyses using chi-squared tests to examine the statistical significance of these comparisons.

We also performed logistic regression tests and survival analyses to further examine the impact of these risk lenses on TBS SBB performance measures. The results from these analyses were broadly consistent with the descriptive and multivariate analyses outlined above. We did not report these findings in this report as no additional notable findings were observed using these analyses to examine Helpline reports and SARAs, and we found that the relatively low incidence rate of OOHC entries and the sample sizes of the groups associated with the risk lenses made observing reliable differences associated with covariates difficult. Further information regarding these analyses can be provided upon request.

Resilience outcomes

For the individual validated tools (K-10, PWI and SDQ), scores were calculated according to instructions provided for each tool. Normative scores were included in figures to illustrate how Index Children and Carers' experiences compare to the general population.

Independent samples t-tests were used to compare population differences in the validated tools and resilience subdomain scores using pairwise comparisons across assessment occasions. Adjustments for multiple comparisons was made using the Bonferonni correction.

The small number of families that had completed data at initial assessments and later reviews timepoints prevented us from using more rigorous analyses of change, as very few families had completed the ROT on multiple occasions. As a result, these results are not generalisable given relatively small proportion of scores collected who consented to the evaluation.

Service delivery

Used descriptive statistics to characterise the risk profile of Index families and the frequency and duration of service activities experienced by families. Descriptive statistics were also used to examine the timeliness of service, and changes in these measures over the duration of the RF service. It should be noted that relatively few families had activity data recorded in the TBS Service monitoring data. As a result of this, our findings from the analysis of service activity data may not be representative of the program as a whole.

Measures of social connectivity for Index Children and Primary Carers were drawn from the Community Links subscale used in the Longitudinal Study of Australian Children, which was embedded within the Resilience Outcomes Tool. These items were standardised using the process described above. Independent samples t-tests were used to compare the social connectivity scores across the different assessment timepoints.

Qualitative Analysis

Interviews with Primary Carers were recorded with participants consent, transcribed and analysed, using a grounded theory approach. We developed a coding framework based on the data collected, the program logic, and the evaluation questions to identify key themes. We then used Nvivo qualitative analysis software, starting with a small sample of transcripts to check inter-coder reliability and identify any adjustments needed. We then proceeded from open coding (applying initial codes to condense data), to axial coding (refining, organising and linking codes), to selective coding (reviewing previous coding and elaborating major themes).⁷² We ran queries on coded data to answer key questions and developed written summaries of key themes, which were integrated into the report where relevant. Direct quotes were used to illustrate themes and give voice to participants.

⁷² Strauss, A., & Corbin, J. M. (1990). Basics of qualitative research: Grounded theory procedures and techniques. Thousand Oaks, CA, US: Sage Publications, Inc.

Appendix 3. Three methods for defining risk

1. Prior reports to the Helpline

Of the 86 families in the Index families, 21% had been the subject of only one prior report and so could be considered relatively low risk, while at the high end of the spectrum, 27% of this group had six or more reports.

Table 10. Number of total Helpline reports, prior to the RF service, 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: DCJ reports data

2. Absence of predictive risk factors

We examined the presence of predictive risk factors for involvement in the child protection system. Five risk factors were identified from a list developed by the Australian Institute of Family Studies 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 families and 41% of Control Group Families have 0 or 1 of these predictive risk factors.

Table 11. 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%

	Index		Control	
	n	%	n	%
2 or more risk factors	59	69%	51	59%
Total	86	100%	86	100%

Source: DCJ demographic, reports 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 12. 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: DCJ SARA and Secondary Assessments data

Appendix 4. Additional data tables

Population and client profile

Table 13. Age of Primary Carers

Age Range	Total N	%
16–25	29	20%
26–35	61	43%
36–45	47	33%
46–55	4	3%
56–65	2	1%
Total	143	100%
Missing	30	

Source: TBS Service Monitoring data

Service delivery

Table 14. Average service timeliness over measurement period by commencement SARA risk level

Commencement SARA	SARA to referral	Referral to initial visit	SARA to initial visit
Low	4.0	1.0	5.0
Medium	3.3	3.2	6.5
High	3.3	2.7	6.0
Very High	3.9	3.1	7.0

Source: TBS Service monitoring data, DCJ SARA and secondary assessments data

Table 15. Frequency and hours spent on activities categorised as 'Other' evidence informed practices

Activity	Number of Interactions	Hours	%
Intake/Assessment	87	293.4	18

Activity	Number of Interactions	Hours	%
Housing	67	182.0	11
Advocacy/Support	74	129.6	8
Review	65	103.9	6
Information/Advice/Referral	82	99.9	6
Medical	38	74.4	5
Centrelink	30	70.9	4
Education/Skills Training	58	65.4	4
Mental Health	33	62.3	4
Case conference	37	59.5	4
Counselling	15	55.6	3
Child care/preschool	51	54.5	3
Initial meeting - Client	57	52.2	3
Financial/Budgeting	44	51.8	3
Legal	33	42.2	3
Initial meeting - DCJ	48	38.4	2
Psychoeducation - DV	27	35.0	2
Recreational activity	20	33.1	2
Closure	29	28.0	2
Psychoeducation - Other	26	27.4	2
Psychoeducation - MH	24	17.7	1
Psychoeducation - AOD	23	15.1	1
Family Capacity Building	11	8.2	1
Physical Health	14	7.8	0
Psychoeducation - Attachment	16	6.3	0
Psychoeducation - Trauma	12	6.2	0
Immigration	1	6.0	0

Source: TBS Service monitoring data

Table 16. Personal Relationships domain of PWI

	Initial Assessment	Review 1	Review 2	Review 3	Closure
N	114	57	35	8	21
Mean	6.6	6.6	7.4	8.5	8

Source: TBS Assessment data

Table 17. Community Connectedness domain of PWI

	Initial Assessment	Review 1	Review 2	Review 3	Closure
N	112	57	35	8	21
Mean	6.8	6.7	7.3	7.9	7.6

Source: TBS Assessment data

Table 18. External referrals

Referral	Count	%
Mental Health	89	19%
Health / medical / disability	77	17%
Playgroups and childcare	56	12%
Education	53	11%
Housing	38	8%
Financial support and employment services	32	7%
Legal Services	25	5%
Parenting Groups	19	4%
Statutory Child Protection	16	3%
Paediatric Clinic	14	3%
Mentoring Program	11	2%
Financial Counselling	10	2%
Domestic Violence Group	9	2%
Occupational Therapy	7	2%

Relationship Counselling	4	1%
Men's behaviour change group	2	0%
Male Inclusion Support	1	0%
Refugee Services	1	0%
Total	464	100%

Source: TBS Service monitoring data

Table 19. Length of time in program by commencement SARA risk level

Commencement SARA	N	Mean
No Prior SARA	19	9.0
Low	1	1.6
Moderate	48	7.6
High	73	9.7
Very High	26	7.9

Source: TBS Service monitoring data, DCJ SARA and Secondary Assessments data

Resilience Outcomes

Table 20. Changes in K10 scores over time

	Initial Assessment	Review 1	Review 2	Review 3	Closure
N	113	61	36	9	22
Mean	18.5	16.6	15.1	16.2	13.9

Source: TBS Assessment Data

Table 21. Changes in PWI scores over time

	Initial Assessment	Review 1	Review 2	Review 3	Closure
N	114	57	35	8	21
Mean	68	70	73	79	80

Source: TBS Assessment Data

Table 22. Changes in SDQ scores over time

	Initial Assessment	Review 1	Review 2	Review 3	Closure
N	34	17	16	6	6
Mean	12.3	12.2	10.9	9.7	8.8

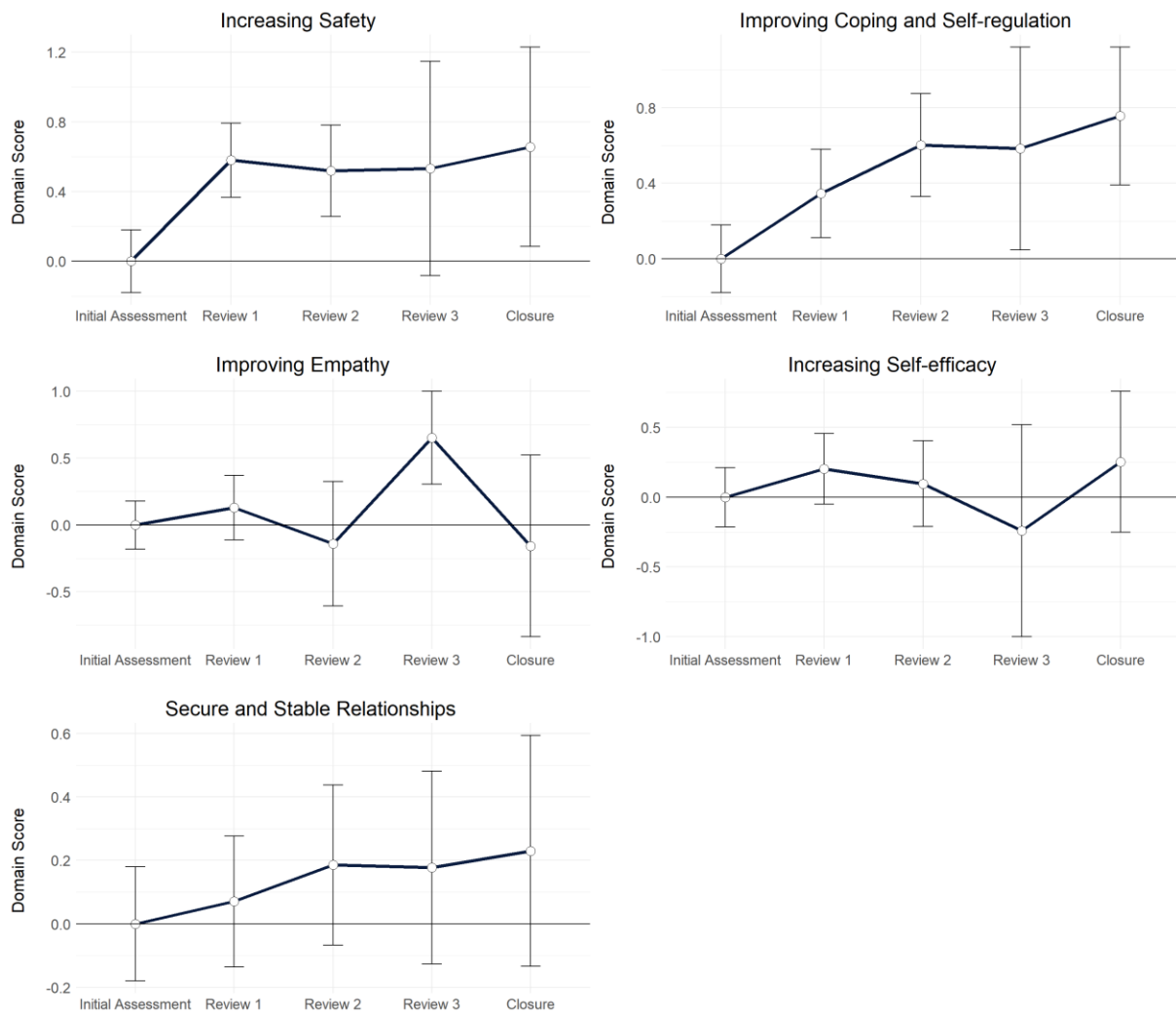
Source: TBS Assessment Data

Table 23. Complete statistical results and effect sizes for statistically significant analyses of differences in scores on the validated measures across assessment time points.

Test	Statistic	df	Value	p	Effect size (Cohen's d)
K10: Initial Assessment vs. Closure	Independent samples t-test	133	2.74	.007	.742
PWI: Initial Assessment vs. Closure	Independent samples t-test	133	-2.87	.005	.712

Source: TBS Assessment data

Figure 20. Changes in Resilience Outcomes Domain scores across assessment periods.



Source: TBS Assessment data

Table 24. Changes in improving empathy scores over time

	Initial Assessment	Review 1	Review 2	Review 3	Closure
Mean	0	0.1	-0.1	0.7	-0.2
Std. dev.	1	1	1.4	0.6	1.7
N	92	52	33	9	21

Source: TBS Assessment Data

Table 25. Changes in increasing coping and self-regulation scores over time

	Initial Assessment	Review 1	Review 2	Review 3	Closure
Mean	0	0.3	0.6	0.6	0.8
Std. dev.	1	1	0.8	0.9	0.9
N	117	64	36	9	23

Source: TBS Assessment Data

Table 26. Changes in increasing safety scores over time

	Initial Assessment	Review 1	Review 2	Review 3	Closure
Mean	0	0.6	0.5	0.5	0.7
Std. dev.	1	0.9	0.8	1	1.4
N	119	65	36	9	23

Source: TBS Assessment Data

Table 27. Changes in secure and stable relationships scores over time

	Initial Assessment	Review 1	Review 2	Review 3	Closure
Mean	0	0.1	0.2	0.2	0.2
Std. dev.	1	0.8	0.8	0.5	0.9
N	118	64	36	9	23

Source: TBS Assessment Data

Table 28. Changes in increasing self-efficacy scores over time

	Initial Assessment	Review 1	Review 2	Review 3	Closure
Mean	0	0.2	0.1	-0.2	0.3
Std. dev.	1	0.9	0.9	1.1	1.1
N	86	46	32	8	18

Source: TBS Assessment Data

TBS SBB Performance Measures

Table 29. Number of Helpline reports of Index and Control Children

	Helpline reports			Children
	N	Mean per child	N with reports	% with reports
Control (n = 303)	867	2.9	198	65.3
Index (n = 303)	978	3.2	210	69.3

Source: DCJ Reports data

Table 30. Number of SARAs commenced for Index and Control Children

	SARAs			Children
	N	Mean per child	N with SARA	% with SARA
Control (n = 303)	187	0.6	117	38.6
Index (n = 303)	223	0.7	130	42.9

Source: DCJ SARA and secondary assessments data

Table 31. Commencement SARA Risk levels of Index and Control Children by Age

Group	Commencement SARA	Unborn	Less than 1	1-2	Greater than 3
Control	Low	2.4%	0.9%	5.4%	1.5%
	Moderate	19.5%	34.9%	29.7%	29.2%
	High	48.8%	46.2%	54.1%	53.8%
	Very High	29.3%	17.9%	10.8%	15.4%
Index	Low	2.5%	0.9%	-	4.3%
	Moderate	32.5%	37.8%	36.4%	34.3%
	High	37.5%	48.6%	44.2%	45.7%
	Very High	27.5%	12.6%	19.5%	15.7%

Source: DCJ demographic, SARA and secondary assessments data

Table 32. Commencement SARA Risk levels of Index and Control Children by sibling history of OOHC placement

Group	Commencement SARA	Prior history of placement	No History
Control	Low	-	3%
	Moderate	-	36.3%
	High	63.3%	47.7%
	Very High	36.7%	13.1%
Index	Low	-	2%
	Moderate	16.7%	39.6%
	High	50%	44.4%
	Very High	33.3%	14%

Source: DCJ demographic, SARA and secondary assessments data

Table 33. Commencement SARA Risk levels of Index and Control Children and/or sibling SARA history.

Group	Commencement SARA	>= 2 SARAs	0 or 1 SARAs
Control	Low	-	3%
	Moderate	3.8%	35.9%
	High	53.8%	49.6%
	Very High	42.3%	11.5%
Index	Low	-	2%
	Moderate	18.9%	39.6%
	High	47.2%	44.9%
	Very High	34%	13.5%

Source: DCJ demographic, SARA and secondary assessments data

Table 34. Commencement SARA Risk levels of Index and Control Children by parent history of OOHC

Group	Commencement SARA	No Parent OOHC history	Parent OOHC history
Control	Low	3%	-
	Moderate	34.1%	13%
	High	50.4%	50%
	Very High	12.5%	37%
Index	Low	1.9%	-
	Moderate	34.9%	42.5%
	High	46.9%	35%
	Very High	16.3%	22.5%

Source: DCJ demographic, SARA and secondary assessments data

Table 35. Complete statistical results and effect sizes for statistically significant analyses of differences in the number of OOHC entries between Index and Control groups and across levels of the risk lenses.

Test	Statistic	df	Value	p	Effect size (Cramer's V)
Group x OOHC entry	Chi-squared	1	3.88	.049	.080
Very High Risk: Group x OOHC entry	Chi-squared	1	6.91	.009	.263

Source: DCJS demographic, SARA, secondary assessments, OOHC and historical child protection data

Table 36. Complete statistical results for survival analysis comparing the differences in days to out-of-home-care entry for Index and Control Children.

Test	Statistic	df	Value	p	Difference in mean survival time (Index – Control)
Days from start to OOHC entry	Log-Rank	1	5.23	.022	39

Source: DCJ OOHC data

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