EVALUATION OF THE RESILIENT FAMILIES SERVICE (SOCIAL BENEFIT BOND PILOT)

NSW TREASURY

EVALUATION STAGE 2 – PROGRESS REPORT

REPORT 4

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ARTD CONSULTANTS
strategy & evaluation

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Abbreviations and acronyms

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

Executive summary

The Resilient Families service and the Social Benefit Bond pilot

The Benevolent Society (TBS) is delivering the Resilient Families (RF) service, an intensive family support intervention 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.

The RF service commenced in October 2013 and aims to support between 300 and 400 families in identified locations across Sydney over the five years of its operation. The RF service provides support to families by applying the Resilience Practice Framework, which brings an evidence-informed approach towards strengthening family functioning and wellbeing across five outcome areas.

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

The RF service is funded through the TBS Social Benefit Bond (SBB) pilot, one of two pilots currently underway in the NSW child protection sector that aim to test and facilitate the development of the social investment sector. Child protection system outcomes for the performance of the RF service in the TBS SBB pilot are measured through the level of contact that Index Children experience relative to Control Children. Specifically, the number of:

- child protection reports to the Helpline from police and health professionals
- Safety and Risk Assessments (SARAs) commenced by Family and Community Services (FACS), excluding those made in the first six months (180 days) of each child's referral to the service
- entries into out-of-home care (OOHC), defined as 'statutory' OOHC i.e. excluding supported care, voluntary care, temporary care or respite.

The evaluation

Stage 1

In 2013, ARTD Consultants was engaged by NSW Treasury to evaluate RF service implementation and outcomes over the first three years of its operation, and to assess the appropriateness of TBS SBB performance measures. Stage 1 used a theory-based, mixed-methods design and delivered a Preliminary Report (December 2014), a Mid-term Report (September 2015) and an Interim Report (May 2016).

The Stage 1 evaluation found the RF service to be associated with increased safety and wellbeing for children and their families but performing relatively poorly under the SBB

mechanism, because decreases seen in the contact with the child protection system for RF families, was similar to, or less than the decrease seen for Control Children. The Stage 1 evaluation identified recommendations to help improve performance, including revising the referral mechanism and improving practice in key areas of service delivery. It also suggested areas in which the bond performance measures could be refined to improve confidence in what is being measured.

Stage 2 approach and data sources

In July 2016, ARTD Consultants was engaged to complete Stage 2 of the RF evaluation, covering the final two years of its operation. The purpose, methods and scope of Stage 2 are similar to the first stage. The main difference is that the evaluation is also examining the service received by the Control Group, to gain an understanding of their performance relative to the Index Group, and refined measures are in place.

This Progress Report is the first of two Stage 2 reports covering the period from commencement on 8 October 2013 to 30 June 2015. Stage 2 continues the Stage 1 design to examine the RF service and outcomes and TBS SBB performance. The performance outcomes are measured with an intention to treat analysis of FACS data as planned within the bond structure. Our method involves sub-cohort analyses to gain insights about these. The RF service outcomes and process evaluation components are examined using TBS service and monitoring data. The data collected and/or provided to the evaluation for this Progress Report is summarised below.

Performance outcomes

- FACS Index and Control Group performance data (n=400)
- FACS Index and Control Group demographic data (n=400)

RF service and outcomes

- RF population, consented to the service and evaluation (n=106)
- RF resilience outcomes and assessment data (n=95)
- TBS case file review (n=89)
- FACS case file review of administrative and outcomes data for Control Group families (n=50)
- RF Primary Carer interviews (n=4)
- RF staff survey (n=9)
- FACS Community Service Centre (CSC) staff focus groups/ interviews (n=5)
- Peer reviewed literature on effective intensive family preservation services

We are confident the evaluation has collected sufficiently robust evidence to support the conclusions drawn. The TBS SBB population has increased such that the significance of outcomes between Index and Control Groups can be tested although the population is too small to test any sub-cohort analyses. There are some limitations in the RF service and outcomes data, noted in the Chapter 2 of this report.

Key findings

The Index Group experience less contact with the child protection system according to TBS SBB performance measures, though as in Stage 1, the Control Group experiences a similar reduction in system contact. For this report, the Index Group performs slightly better on all three measures, but none of the differences are statistically significant at this stage. The most promising difference is in number of statutory OOHC entries, which fewer in the Index Group (27) compared to the Control Group (35) have experienced.

Families that have completed the RF service have reduced contact with the system and those that exit early have the poorest outcomes. Very high risk RF families have half the rate of entry into OOHC (22%) compared to very high risk Control Group families (44%); despite the low numbers involved this is a positive finding.

There are some similarities in the service received by the Control Group (FACS' business-as-usual child protection response), which may partly explain their similar TBS SBB performance—especially a comparable average number of monthly interactions per client. While there are differences in the focus of casework practice received by families in each group, both FACS and TBS refer to external supports that often complement direct service delivery. A key difference is that RF families receive considerably more face-to-face contact. This may contribute to more sustainable outcomes, potentially reflected in the Index Group's performance on the OOHC measure.

Features of RF delivery, such as targeting intensity to family risk and using the Resilience Practice Framework (RPF), have strengthened; and based on the small number of FACS staff we spoke with, working relationships with FACS CSCs appear to have improved. A notable number of families decline the RF service (40) or exit early (22). Among these are two main groups of families:

- families with relatively low risks and who may also already be engaged with other supports
- families with a prolonged history of child protection system interactions and poor service engagement.

There is most scope to improve outcomes in reducing the number of families who decline or exit without other supports in place appears. Reducing commencement delays is also likely to promote families' motivation to engage—which is challenging in a voluntary service context.

Priority areas for TBS to focus their practice and data collection in the final stage of the pilot are in social mapping; delivering and/or referring for assistance with family violence, drug and alcohol and mental health issues; and ensuring the Resilience Assessment Tool is completed with more families.

1. Resilient Families Social Benefit Bond pilot

This chapter provides context for the NSW Government's piloting of social benefit bonds as a way of investing in intensive family support services to achieve child protection outcomes; presents an overview of the Resilient Families (RF) service model, including the Resilience Practice Framework and resilience outcomes measurement; and describes the design of The Benevolent Society (TBS) Social Benefit Bond (SBB) pilot through which the RF service is being delivered, and its outcomes measured.

Summary

TBS is delivering the RF service, an intensive family support intervention 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.

The RF service is funded through TBS SBB pilot, one of two pilots currently underway in the NSW child protection sector that aim to test and facilitate the development of the social investment sector.

The RF service commenced in October 2013 and aims to support between 300 and 400 families over the five years of its operation. As part of the SBB pilot, the RF service has a strong focus on delivering to achieve outcomes—strengthening family functioning and wellbeing to reduce their contact with the child protection system—and RF casework practice is informed by the evidence-based Resilience Practice Framework.

1.1 A new approach to investing in child protection outcomes

The NSW Department of Family and Community Services (FACS) delivers and funds services to address safety and wellbeing concerns in families and prevent children and young people from entering out-of-home care (OOHC). When a child is at risk, FACS has a statutory responsibility to intervene on behalf of that child.

The number of children in OOHC in NSW has grown over the past decade.[1] The NSW Government, like other Australian governments, is aiming to shift investment in child protection towards prevention and early intervention activities.

1.1.1 The Social Benefit Bond pilots in NSW

Social benefit bonds are a form of investment designed to achieve outcomes in a way that shares the risks and benefits between government and the private sector. This approach expands upfront investment in prevention and early intervention, freeing up government

[1] The Tune review released in 2016 found that the number of children and young people in OOHC in NSW doubled over previous 10 years. Refer to NSW Family and Community Services, *Their Futures Matters: A new approach*, NSW Government, November 2016.
At the end of June 2015, the number of children in OOHC in NSW was 16,834 (excluding children and young people on finalised third-party parental responsibility orders). Australian Institute of Health and Welfare, *Children in Care,* CFCA Resource Sheet, October 2016.

funds for other areas, and creates a financial incentive to achieve outcomes, which is expected to drive service delivery and innovation.

Two SBB pilots are underway in NSW and are the first of their kind in Australia. The Office of Social Impact Investment—established as a joint office between the NSW Department of Premier and Cabinet and NSW Treasury—is leading the NSW Government's Social Impact Investment Policy, working with the NSW Social Impact Investment Expert Advisory Group. Both SBB pilots are operating in the child protection system and trial new ways of working between FACS and the non-government sector.

TBS is delivering the Resilient Families service under one of these SBB pilots, the 'TBS SBB Pilot'.

1.1.2 Innovation that builds on evidence about 'what works' in effective family preservation interventions

Intensive family preservation services (IFPS) are designed to keep children and young people safe, and to prevent entries into OOHC, by strengthening family functioning and child wellbeing. These types of interventions have been widely studied for their effectiveness through systematic reviews/ meta-syntheses as well as program-level evaluations.

Across the literature, IFPS that tend to be associated with better outcomes share some key features—even though no single model emerges as the most effective overall, since IFPS are usually targeted to groups/ cohorts and employ individualised family planning. Broadly, these features suggest that interventions are:

- *timely* i.e. referral and intake occurs immediately after a 'crisis' (often within 24 hours) to best motivate behaviour change
- *accessible* i.e. offer a 24/7 service so that assistance (or on-call help) is on hand when it is needed
- *home-based* i.e. primarily delivered in the home—although it is usual for there to be scope for centre- or community-based activities to support this activity. [2]

There is also much literature about the importance of *intensity,* but how intensity is defined (and the degree to which it is specified) varies and can relate to program structure, duration, and target group. Some studies have found that effective IFPS have six to fifteen hours of contact a week and are time-limited i.e. provide one to four months of service.[3] The widely-regarded and studied Homebuilders model requires six to eight hours of contact a week, concentrated within four weeks. Also evidence-based, the Multisystemic Therapy for Child Abuse and Neglect (MST-CAN) approach recommends that intensity varies from three times

[2] Institute for Family Development, Homebuilders Standards 4.0, 2014; Tregeala, S., L Voight, 'What intensity of service is needed to prevent children's entry into out of home care', Developing Practice Issue 34, Bernados, 2013; Schweitser, D., et al, 'Building the Evidence Base for Intensive Family Preservation Services' *Journal of Public Child Welfare*, 9:5, 423–443, 2015

[3] Schweitzer et al., 2015

a week to daily contact as required for six to nine months.[4] Finally, some intensive programs working prenatally with mothers, and which have a much longer duration (e.g. two years), specify one-hour weekly visits prior to and in the first six weeks after birth, followed by fortnightly visits for the next 18 months, and then monthly for the final six months.[5] On the whole, what this indicates is that the appropriate level of intensity is a critical component, but precisely what this is depends on the program and family context.

In addition to these features of IFPS interventions, there is evidence around case planning approaches and casework practices that work well when applied to these models. In summary, these include:

- intake assessments that identify risks, safety concerns and family needs
- family support planning that reflects assessed risks, concerns and needs within a strengths-based approach that is individualised to incorporate family goals
- family engagement that is grounded in a trusting relationship with the caseworker
- interventions structured towards achieving goals with a focus on in-home safety, but delivered flexibly to:
  - provide both practical and therapeutic supports
  - build parenting skills, education and behaviour change/ management techniques
  - improve the quality of parent–child interactions and communication
  - support links to other services so that whole-of-family issues are addressed
  - encourage positive connections to wider family, friend and community networks that can provide support after formal services withdraw.[6]

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

1.2 The Resilient Families service

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

[4] California Evidence-based Clearinghouse for Child Welfare, 'Multi-systemic Therapy for Child Abuse and Neglect', 2016

[5] MacVean M., et al., 'Review of the evidence for intensive family models', prepared by the Parenting Research Centre and the University of Melbourne on behalf of FACS, 2015

[6] MacVean et al, 2015; Tregeala and Voigt, 2013

The RF service commenced working with families in October 2013. It aims to support between 300 and 400 families over the five years of its operation. It is available to identified families across nine FACS Community Service Centres (CSCs), grouped into two regions:

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

TBS provides the RF service to families living in these two regions through two service locations: the Rosebery service for families in Region 1 and the Liverpool service for families in Region 2.

As part of the TBS SBB pilot, families are referred to the RF service through a centralised process managed by FACS. This enables a Control Group to be established alongside the Index Group of RF families, against which SBB outcomes can be measured.

1.2.1 Service model and key components

The Resilient Families Service Model Operating Guidelines describe RF 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/ 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 after 12 months)
- an on-call service to provide emergency contact/ crisis support after business hours
- working in close collaboration with FACS.

In view of the focus on delivering outcomes embedded through the SBB pilot, 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 approach, which is based on TBS' Resilience Practice Framework.

The Resilience Practice Framework

TBS developed the Resilience Practice Framework (RPF), in partnership with the Parenting Research Centre. 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 easily taught (e.g. giving descriptive praise or time-out strategies), and can be easily disseminated without relying on a programmatic intervention.[7] 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 outcomes are identified in the RPF:

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

1.2.2 Performance measurement for the TBS SBB pilot

Child protection system outcomes for the performance of the RF service in the TBS SBB pilot are measured through the level of contact that Index Children[8] experience relative to Control Children (see below) during the measurement period[9]. Specifically, the number of:

- child protection reports to the Helpline from police and health professionals[10]
- Safety and Risk Assessments (SARAs) commenced by FACS, excluding those made in the first six months (180 days) of each child's referral to the service
- entries into out-of-home care (OOHC), defined as 'statutory' OOHC i.e. excluding supported care, voluntary care, temporary care or respite.

Outcomes for children in the RF service ('Index Children', the youngest or unborn child within an Index Group Family) are compared to outcomes for similar children in Control Group Families. Index Children and Control Children are matched ('Matched Pairs'). The pilot uses an

[7] Chorpita S. et al., 'Identifying and selecting the common elements of evidence based interventions', Mental Health Services Research, 7(1), 2015, pp.5–20

[8] Definition for the intervention group within the TBS SBB Operations manual

[9] TBS SBB Operations manual defines the measurement period in some detail. In summary it is 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 pilot due to changed circumstances.

[10] TBS SBB Operations manual defines reports as "Helpline 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 FACS as 'information only'" V4 p21

intention-to-treat (ITT) design. This means that those families of Index Children who decline the service are still counted as part of the Index Group.[11]

Control Group Families meet RF eligibility criteria and would have been referred if they lived in Region 1 or Region 2. Control Group Families are not aware that they have been selected and the services they receive do not change as a result i.e. FACS business-as-usual (BAU) child protection response applies. If they are already receiving case management that is equivalent or substantially equivalent to RF, they are to be removed from the Control Group and a substitute family allocated.

Some changes to the establishment of the Control Group and the calculation of SBB outcomes were made in late 2016 in response to a review of the pilot and recommendations from Stage 1 of the evaluation. (Data in Appendix 8 shows TBS SBB outcomes according to both counting rules).

[11] 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 the control. The main weakness is that subjects who did not actually receive an intervention are included along with those who did, and which limits what can be known about the effectiveness of that intervention.

2. Evaluating Resilient Families

This chapter outlines the approach and findings of the Stage 1 evaluation and describes the scope and methods for Stage 2. More detail on the methods used for this Progress Report is in Appendix 1.

Summary
The Stage 1 evaluation found the RF service to be associated with increased safety and wellbeing for children and their families, but performing relatively poorly under the SBB mechanism. This is because decreases seen in the contact with the child protection system for RF families was similar to, or less than, the decrease seen for Control Children. It identified a number of recommendations to help improve performance, including revising the referral mechanism and improving practice in key areas of service delivery. It suggested areas in which the bond performance measures could be refined to improve confidence in what is being measured.

The Stage 2 evaluation is designed to continue monitoring RF implementation (including costs), deepen the analysis of outcomes for RF families according to the SBB measures (enabled by a larger population), and provide an assessment of the benefits and appropriateness of TBS SBB measures. A theory-based, mix-methods design incorporates the ITT design within the TBS SBB structure with more detailed sub-cohort analyses that aim to better understand the characteristics of families within the pilot and how evenly benefits are distributed.

2.1 Stage 1 evaluation

ARTD Consultants was first engaged by NSW Treasury in 2013 to evaluate the implementation and outcomes of the RF service over the first three years of its operation, and to assess the appropriateness of measures for calculating the performance through TBS SBB payment. During the Stage 1 evaluation, ARTD delivered a Preliminary Report (December 2014), a Mid-term Report (September 2015) and an Interim Report (May 2016).

Box 1: Key findings from Stage 1 (Interim Report) [12]

The RF service was found to reflect a family-centred approach to planning and the tailored use of evidence-informed practices. It was also being delivered with lower intensity and longer duration than similar models, and with less immediacy.

RF families showed increased family functioning and improved wellbeing during their engagement with the service. Families were also found to have reduced contact with the child protection system over time—but similar to the reduction observed in the Control Group. Performance under the SBB measures was not consistent: while Index Children (n=86) experienced slightly fewer statutory OOHC entries compared to Control Children (15 compared with 18), they also received more reports to the Helpline (223 compared with 173) and had more SARAs commence (52 compared with 35). The population was too small and too little time had passed for conclusions to be reached about these outcomes. The evaluation also raised questions around the appropriateness of some measures and identified scope to refine these.

[12] http://www.osii.nsw.gov.au/assets/office-of-social-impact-investment/files/TBS-Evaluation-Interim-Report-2016.pdf

A detailed analysis of RF family risk profiles showed that at least one in five had lower than expected risk presentations, and may not have been suitable for a high intensity service. The report discussed how TBS SBB eligibility criteria and the centralised referral mechanism may have been contributing to this, as well as to delays in service responsiveness. These factors have been relevant for understanding RF service delivery, especially its intensity, family engagement, and ultimately SBB performance.

The evaluation also noted that the average cost of the RF service ($38,053) was more than budgeted but comparable to the funded cost per family of other intensive family services in NSW.

The Stage 1 evaluation was approved by The University of Sydney Human Research Ethics Committee in April 2014 [no. 2014/339]. Approval was extended in 2016 to cover Stage 2. A Reference Group led by NSW Treasury with representatives from FACS and TBS provided guidance to the evaluation.

2.2 Stage 2 evaluation

In July 2016, ARTD Consultants was engaged by NSW Treasury to complete Stage 2 of the RF (TBS SBB) evaluation, covering the final two years of its operation and concluding in February 2019. Like Stage 1, the Stage 2 evaluation includes process and outcomes components and a financial/ cost analysis. Accordingly, the purpose of Stage 2 is to:

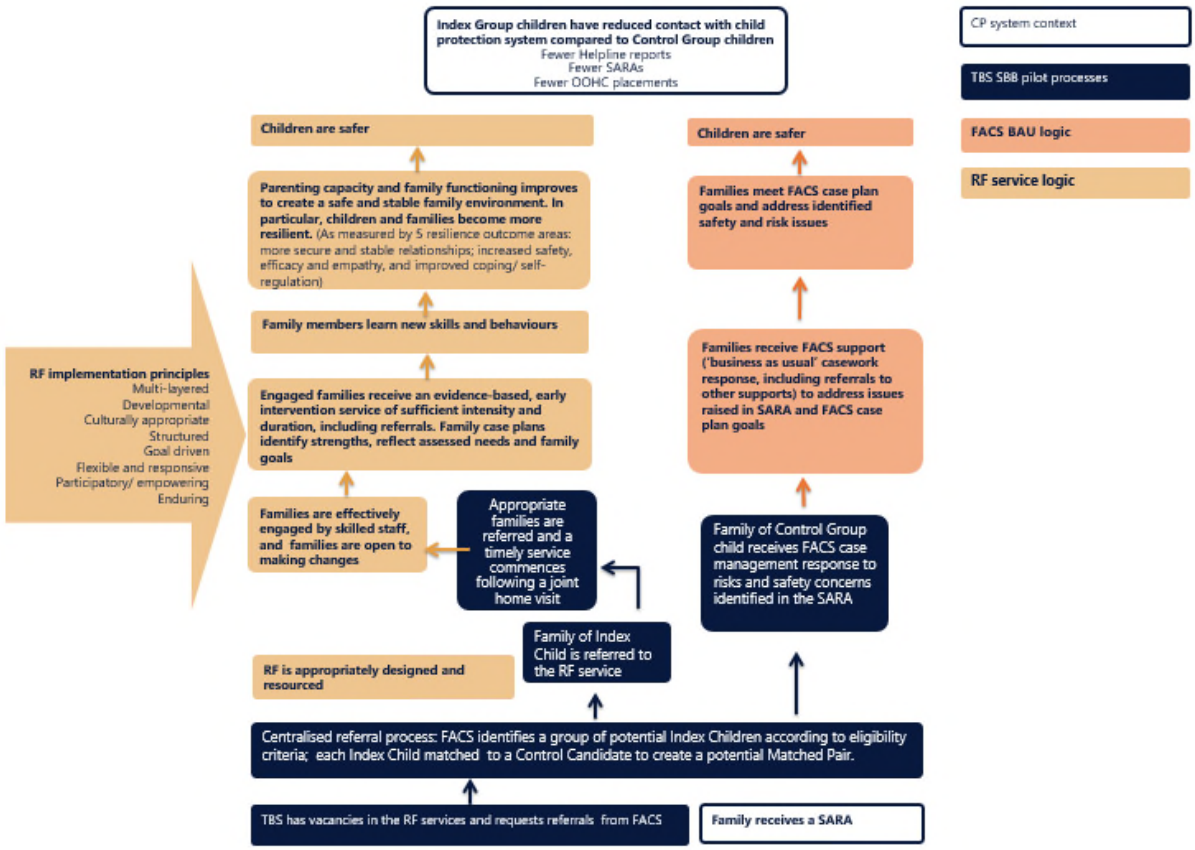
- continue monitoring the progress of RF implementation between 2016 and 2018
- update the Stage 1 analysis of RF outcomes and TBS SBB outcomes to include outcomes up to the end of Year 5 (2018)
- provide an updated assessment of the benefits and appropriateness of TBS SBB measures
- update the cost analysis and consider the cost effectiveness of the RF service.

The evaluation also aims to contribute evidence about early 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.

2.2.1 Logic model of the RF service and the TBS SBB pilot

As with the logic model developed for the Stage 1 evaluation, the model for Stage 2 outlines the RF service logic—implementation assumptions, process outputs and resilience outcomes—and locates these in the broader context of the pilot, and against the likely child protection response received by the Control Group ('FACS BAU logic').

Figure 1. Resilient Families service and TBS SBB pilot logic



2.2.2 Key questions

The Stage 2 evaluation questions, and key investigation domains, are summarised below.

What are the outcomes of the RF service for families (Index Group), and what are the outcomes for Control Group participants? i. Does Index Group have less contact with the child protection system than the Control? ii. What changes in functioning and wellbeing are seen for the Index Group? iii. Is there evidence of sustained outcomes for RF families, and what might explain this? iv. What might explain divergent patterns within and between the bond outcomes for Index and Control Groups? Are the current bond measures sufficiently robust? v. What might explain the observed differences between the Resilience outcomes and bond outcomes for Index children?	Progress Report (i–ii); Final Report (i-v)
What does RF program implementation look like in Stage 2? i. What are the features of service delivery and casework practice? ii. How does this service compare to that received by families in the Control Group?	Progress Report and Final Report
To what extent is RF cost effective? i. What are the actual (versus budgeted) costs of the program? ii. How does the cost of RF compare to similar programs in NSW, including (if feasible pending data) the cost of FACS' business-as-usual response?	Final Report

2.3 Methods

Stage 2 continues the theory-based, mixed-methods design and methods used in Stage 1, with the addition of a case file review involving a sample of Control Children.

2.3.1 Outcomes evaluation

There are two components to the outcomes evaluation: performance outcomes under the TBS SBB; and outcomes measured through TBS Resilience Assessment Tool, synthesised with descriptive data from RF family members and program staff. All administrative and monitoring data used are cumulative from Stage 1 and cover the period from the start of the TBS SBB in October 2013 to the end of December 2016.

TBS SSB performance outcomes

In **Chapter 3** we report on the performance outcomes as defined in the bond structure, using the prescribed ITT design that compares the difference in child protection system contact between the Index Group (n=200) and Control Group (n=200), measured in the number of:

- child protection reports made to the Helpline by police or health professionals
- Safety and Risk Assessments (SARAs) commenced by FACS, excluding those made in the first six months (180 days) of each child's referral to the service
- entries into out-of-home care, defined as 'statutory' OOHC.

For this group we tested all differences for significance using independent t-tests and chi-squared tests but as there are no differences at a .95 confidence level we do not report the results.

In **Chapter 4** we examine the performance results in more detail. We look at the timing of reports and SARAs for children who received them and use a sub-cohort analysis to explore differences in performance outcomes in two ways:

1. child assessed risk level (low, medium, high, very high, based on last SARA prior to entry to RF). We report on 197 Index children and 196 Control Children (with 7 missing cases)
2. family service participation for Index Children only (completed with goals met, continuing, early exit, declined, based on RF monitoring data). We report on 131 children. We exclude the 54 families who did not consent to the evaluation, and another 15 with missing service status data. Where we cross-tabulate service status by risk level, the number decreases to 129 children, as two have missing data for the last SARA.

The sub-cohort populations are described below. We do not test for significance in differences between these cohorts due to their small size.

In **Chapter 4** we also report on a randomly selected subset of 50 Control Children, and compare their levels of service received under 'business as usual' with that of the subset of 89 Index Children for who we have relevant service data. Case file data was summarised into counts of interactions (phone, text, face-to-face), the focus of the interaction (safety, housing

etc.) and the number and type of referrals. This approach was designed to develop comparable data sets on features of service delivery in both settings that we could quantify and describe.

RF outcomes

In **Chapter 5** we examine RF outcomes measured through the TBS Resilience Assessment Tool. We report the resilience outcome data for the 94 children for whom we have one or more assessments; the actual number varies for each measure and time period.

Items in the Resilience Outcomes Tool use standardised measures drawn from validated instruments or instruments for which there is normative data; such as the Kessler-10; Personal Wellbeing Index; Strengths and Difficulties Questionnaire; Protective Factors Survey; General Self Efficacy Scale; and Longitudinal Study of Australian Children Study.

We also report on the four family member interviews completed to highlight how families experienced key changes observed through the RPF data.

2.3.2 Evaluation sub-cohort populations

To understand outcomes for children in the Index Group in more detail, the evaluation uses two sub-cohort analyses. Available data for TBS SSB Index and Control populations and the RF service populations are mapped in Appendix 1.

SARA risk level

The data on risk level at referral to the service as assessed in the SARA prior to entry show the RF service is likely to be working mostly with families who initially presented with moderate to high risks, plus a smaller proportion of families with very high risks. Just over half of the families are categorised as high risk, almost one-third of families are at medium risk and a further eighth at very high risk. The risk profiles of Index and Control families, as indicated by their last SARA prior to commencing the service, are very similar.

In the Interim Report, it was observed that about one in five families had a moderate risk profile, one that may be considered lower than expected for a referral to an intensive intervention with potential for this to limit the overall performance of the RF service.[13]

[13] This finding was based on a detailed analysis of families' risk profiles according to the total number of prior Helpline Reports and the absence of predictive risk factors, in addition to the risk outcome of the initial SARA. In the Interim Report, 19 of 86 families (22%) had a moderate initial SARA risk outcome (Interim Report, section 2.2.2).

Table 1. TBS SBB Pilot population, total and by SARA outcome

Risk level of final SARA prior to RF ('initial SARA')	Index	Control	Total
Low	3	3	6
Medium	59	55	114
High	108	113	221
Very High	27	25	52
No risk level (missing data)	3	4	7
Total SBB population	**200**	**200**	**400**

Source: FACS SARA and Secondary Assessments data

Family service participation

For the 129 RF families we have RF service data for, we look at whether the family engaged with RF and met their goals ('completed RF'), is continuing in the service, exited the service early, or declined it from the outset).

Almost as many families have completed RF and met their goals (n=42) as families that declined RF (n=40).

It is important to recall that, although about half of all families referred to the RF service either declined or exited early, these families are not excluded from the Index Group according to the SBB's ITT design. Relatedly, TBS conducted a supplementary analysis of the reasons why families decline or exit RF early.

Table 2. RF families by service participation status

Service status	N families
Completed RF (met goals)	42
Continuing	26
Exited early	23
Declined	40
Total	131
Unknown – did not consent to evaluation	54
Unknown – missing service data	15

Source: TBS Service monitoring data and FACS reports data

2.3.3 Process evaluation

In **Chapter 6** we examine the implementation of the RF service. We draw on TBS monitoring and other data to examine the implementation of the RF service, and its delivery to the 106 families we have service data for. For this component of the evaluation we draw on:

- TBS service monitoring data (n=106)
- RF staff survey (n=11 of 17)
- Family member interviews (n=4)
- FACS CSC staff member interviews (n=X)

2.3.4 Summary of Stage 2 evaluation data sources

The evaluation data collection is shown below, with the data used for this Progress Report indicated, and additional or updated data that will be included in the final stage.

Table 3. Stage 2 data sources and reporting

Focus	Data source	When data is reported
TBS SBB performance	FACS Index and Control Group - FACS Helpline Report data - SARA and Secondary Assessment data - Out-of-home care data	▪ Progress report: Oct 2013–Dec 2016 (aged[14] data to 31 Dec 2016) ▪ Final Report
Resilient Families service and outcomes	TBS RF service monitoring data	▪ Progress report: Oct 2013–Dec 2016 (aged data to 31 Dec 2016) ▪ Final Report
	TBS RF resilience outcomes and assessment data	▪ Progress report: Oct 2013–Dec 2016 (aged data to 31 Dec 2016) ▪ Final Report
	Interviews with Primary Carers who have exited the service	▪ Progress Report (n=4) ▪ Final Report (n=12 in total)
	Survey of TBS RF caseworkers and team leaders	▪ Progress Report (n=11) ▪ Final Report
	Focus groups with FACS CSC staff in both Regions	▪ Progress Report (n=5) ▪ Final Report
	Focus groups with RF staff	▪ Final Report
	Literature scan on intensive family interventions	▪ Progress Report ▪ Final Report

[14] Aged data is data that has been extracted from a system after sufficient time has passed that it can reasonably be expected that all records are up-to-date

Focus	Data source	When data is reported
	FACS Index and Control Group demographic data	▪ Progress report: Oct 2013–Dec 2016 (aged data to 31 Dec 2016) ▪ Final Report
	FACS Control Group case file review	▪ Progress report (n=50)
	Literature scan on outcomes measures	▪ Final Report
Cost analysis	TBS RF costs data	▪ Final Report
	FACS costing manuals; data on similar programs	▪ Final Report

2.3.5 Confidence in the findings

We are confident the evaluation has collected a sufficiently robust set of evidence to support the conclusions made.

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 Stage 1 of the evaluation shows the two groups to be highly comparable. Data in Appendix 6 show the two groups to very similar on reported and assessed issues of concern.

The number of children in the study has increased since Stage 1 to allow for statistical testing of the whole population but it is not yet large enough to allow for testing in the sub-cohort analyses (see below).

The second of the two sub-cohort analyses is limited by only having service participation data for families in the Index Group but it is nonetheless useful to examine outcomes between families on the basis of their service participation.

There are also limitations in the RF service monitoring and resilience outcomes data, owing to the size of the population: it includes only families who agree to participate in the service and consent to be involved in the evaluation (n=106). Post-baseline Resilient Assessment Tool data is notably incomplete. The RF service populations are shown in **Error! Reference source n ot found.**.

Additionally, TBS initiated new data collection and storage systems from 1 July 2016. The quality of the data (e.g. consistency in recording information on casework practices and referrals) has improved, reflecting TBS' work to incorporate recommendations from Stage 1 of the evaluation. It is possible to match individuals in the data across both systems, but not all data items can be compared directly. Of note, practice records data cannot be directly compared as the level of detail and categories vary between the data sets. We needed to re-categorise some items to enable analysis.

Eleven of the 17 RF workers participated in a staff survey. Many of these respondents gave detailed qualitative feedback which has enhanced our understanding of RF practices and service delivery context, though the views of almost one-third of staff are missing. Focus groups with RF are scheduled for the next evaluation stage.

Focus groups and/or interviews with FACS CSC staff (n=5, including in Region 1 and Region 2 CSCs) provided good information about local interactions between FACS and RF, which is broadly consistent with reports in the RF survey. Because of the small number involved these data have been used cautiously to illustrate, rather than generalise.

Interviews with Primary Carers (n=4) were conducted over the phone as preferred by carers, with each interview lasting approximately 45 minutes. These interviews contribute to our confidence in the findings by adding to our understanding of the nature and quality of the service, perceived outcomes and motivations for engaging families. This builds on our understanding of the experiences of five other families who were interviewed during Stage 1. Though again, due to the small number involved we do not generalise from this data.

3. Performance (TBS SBB) outcomes

This chapter describes the performance outcomes as measured through the TBS SBB design. It reports on the three performance outcomes for the total population of Index Children referred to the RF service and compares these with those of the Control Children who receive a business-as-usual child protection response delivered or coordinated by FACS.

Key findings
Results for the SBB population (n=400) show that during the measurement period (October 2013 – end December 2016), Index Children had slightly less contact with the child protection system than Control Children but none of these differences are statistically significant. The data show that Index Children:

- received fewer Helpline Reports compared to Control Children (111 compared to 122 reports)
- had fewer Safety and Risk Assessments compared to Control Children (52 compared to 60 SARAs)
- experienced fewer out-of-home care entries compared to Control Children (27 compared to 35 entries).

3.1 Helpline reports

The Index Group received slightly fewer Helpline reports than the Control Group (111 compared to 122 reports, see Table 4) and the difference in the average number of reports (0.56 compared to 0.61) is small and not significant. As a child can receive more than one report, Table 4 also shows the number of children reported. Overall, slightly fewer Index Group children were the subject of a report than Control Group children (58 children compared to 60 children).

Table 4. Number of Helpline reports, Index compared to Control Group

	Reports		Children	
	N	Mean per child	N with reports	% with reports
Index (n=200)	**111**	0.56	58	29%
Control (n=200)	**122**	0.61	60	30%

Source: FACS reports data
Note: The mean includes children with no Reports (zeros were excluded from calculations in Stage 1)

3.2 Safety and Risk Assessments

Fewer SARAs were commenced for the Index Group than for the Control Group (52 compared to 60 assessments, see Table 5). The difference in the average number of SARAs (0.26 compared to 0.30) is also not statistically significant. As a child can receive more than one SARA, Table 5 also shows the number of children with an assessment commenced.

Overall, fewer Index Group children were the subject of a SARA than Control Group children (31 compared to 39 children).

Table 5. Number of SARAs, Index compared to Control Group

	SARAs		Children	
	N	Mean per child	N with SARA	% with SARA
Index (n=200)	**52**	0.26	31	16%
Control (n=200)	**60**	0.30	39	20%

Source: FACS SARA and Secondary Assessments data

Note: The mean includes children with no SARAs (zeros were excluded from calculations in Stage 1)

3.3 Out-of-home care entries

There were fewer statutory OOHC entries among the Index Group than the Control Group (27 compared to 35 entries, see Table 6). Overall, slightly fewer Index group children had a statutory entry than Control Group children (27 compared to 35 children), but the difference in proportion is not statistically significant.

Table 6. Number of OOHC entries, Index compared to Control Group

	OOHC entries		Children	
	N	Mean per child	N	% with entry
Index (n=200)	**27**	0.14	27	14%
Control (n=200)	**35**	0.18	35	18%

Source: FACS out-of-home-care data

Note: The mean includes children with no entries (zeros were excluded from calculations in Stage 1)

4. Exploring performance outcomes

In this chapter we explore the performance outcomes reported in Chapter 3. We examine the timing of the reports and SARAs for the Index and Control Groups and complete two sub-cohort analyses to assess whether outcomes are different according to: the assessed risk levels of children; or their family's participation status in the service. We also examine the nature of the service received by Control Group families (FACS' business-as-usual) and the extent to which this is similar or different to the RF service.

Key findings

- Both groups experience an absolute reduction in contact with the child protection system across Helpline and SARA measures over time. This trend was first reported in the Interim Report and indicates that both interventions reduce safety risks to children.
- Families that complete the RF service perform stronger than the Control Group overall, and particularly in experiencing fewer OOHC entries.
- Families that exit the RF service early have especially poor child protection outcomes across all measures and have a slightly higher risk profile.
- Families that decline the RF service perform similarly to the Index and Control Groups on Helpline and SARA measures, but not as well as with OOHC entries—there is some evidence that a fair proportion of families that decline the RF service may have already been engaged in other family services but there is a negative outcome for others.
- Very high risk Index Group families perform particularly well on OOHC measures. These families have half the rate of entry into OOHC (22%) compared to very high risk Control Group families (44%). Across other child protection measures such as Helpline Reports and SARAs, however, differences in outcomes across risk levels are small.
- There are some similarities between the FACS service received by the Control Group and the RF service—particularly the average number of interactions per month. Also, about a third of Control Group families are engaged in another family support service, including some general family support services and those with similarities to RF e.g. a therapeutic and practical in-home support focus. A key difference is that 75 per cent of contact received by FACS clients is by phone, email or text whereas 85 per cent of RF contact is face-to-face.

It is also relevant to note that the overall risk profile of the families in RF is similar to that reported in Stage 1. That is, there is a range of risk levels among families referred and this range includes a notable proportion with fairly moderate risks, lower than what might be expected for an intensive intervention.

4.1 Contact with the child protection system over time

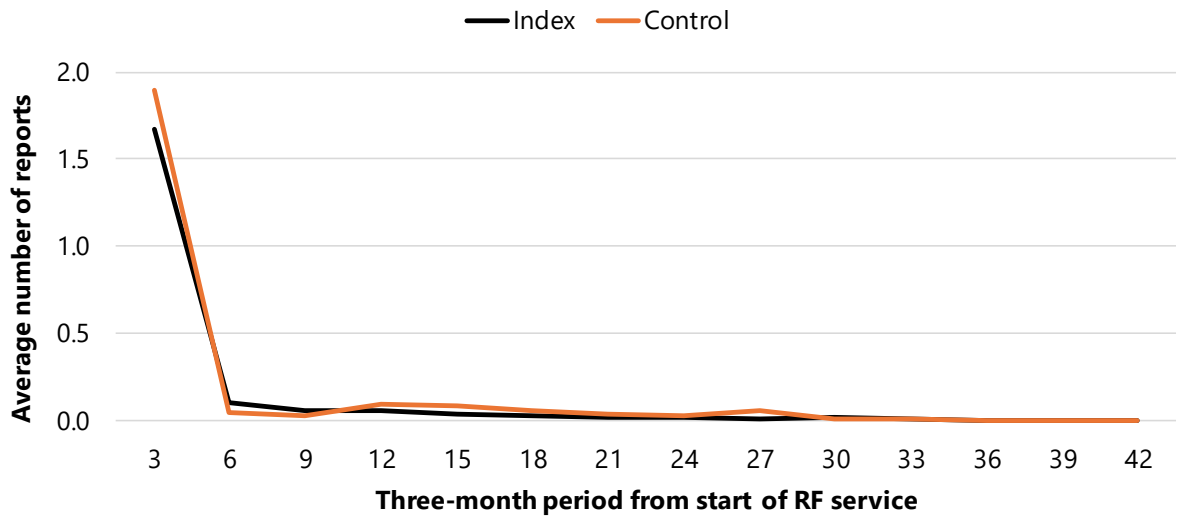
The reduced contact with the child protection system over time shows the continuation of a positive trend for both the Index and Control Group, which was first identified in the Stage 1 Interim Evaluation Report. It is informative to first consider the extent to which these groups experience reduction in child protection system contact over time.

4.1.1 Contact with the child protection system reduces at a similar rate for Index and Control Groups

Helpline reports

Most Helpline reports for both Index and Control Groups occur in the first three months, following the measurement start date (Figure 2).[15] There is a dramatic decrease in reports in the second three months for both groups. After this time, Index Group mean reports decline steadily and are marginally lower than Control Group reports over the first two years of service. By 36 months, average reports are effectively zero (rounding from three decimal places).

Figure 2. Average Helpline reports per three months, Index and Control Groups (n=200 in each group)



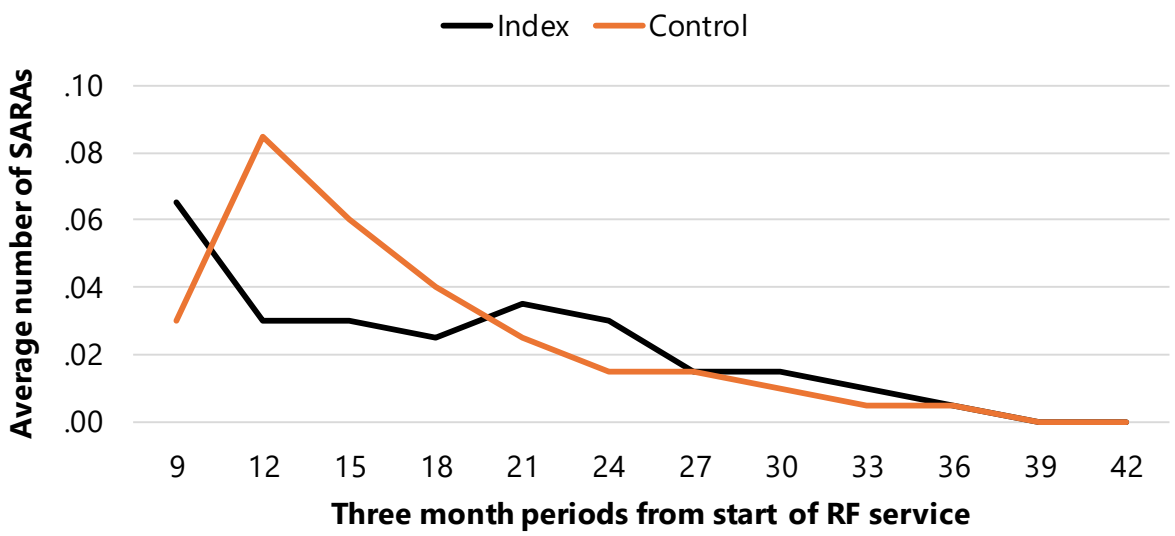
Source: FACS reports data
Note: New counting rules applied, including only Police and Health reporters.
Data under current and previous counting rules are shown in Figure 12, Appendix 8.

SARAs

The number of SARAs commenced are not counted during the first six months after each child's measurement start date but after this period, at 181 days. Index Children initially have a slightly higher average number of SARAs commence at this time, which then decreases in the 9- to 12-month period, while matched Control Group children see an increase in SARAs in the same period. Mean SARA numbers then remain similar for both groups, and decline steadily over time (Figure 3).

[15] This is the date at which Index Group families are referred to the RF service, or the date at which matched families are allocated to the Control Group for measurement.

Figure 3. Average SARAs per three-month period, Index and Control Groups (n=200 in each group)



Source: FACS SARA and Secondary Assessments data
Note: New counting rules excluding SARAs made in the first 180 days
Data under current and previous counting rules is shown in Figure 13, Appendix 8.

4.2 Risk profiles and service participation status

Next we examine outcomes using two sub-cohort analyses which look at outcomes by: Index Children's risk level as assessed in the SARA prior to entry; and their families' service participation status (see 2.3.2).

4.2.1 Profile of population by risk level and family participation

Most Index Children were assessed on entry to the RF service as moderate or high risk. Looking at service completion by risk level (Table 7) shows:

- 62 per cent of families that have completed the RF service entered with either high (41%) or very high risks (21%) and the remainder moderate risk (38%)
- of families with children assessed as very high risk, more have completed the RF service (9) than exited early (5) or declined (3)
- families that started the RF service but exited early (n=22), had a slightly higher risk profile than others: Index Children were assessed as high risk (73%) or very high risk (23%)
- families that declined the RF service from the outset (n=40) had a slightly lower risk profile: most Index Children were assessed as moderate (40%) or high risk (48%); the two low risk Children in the population are also in this group.

Table 7. Service status of Index Children by risk level

Risk level (initial SARA, prior to referral)	N		Completed RF (met goals)	Continuing in RF	Exited RF early	Declined RF
Low	2	N	0	0	0	2
		%	0%	0%	0%	5%
Moderate	40	N	16	7	1	16
		%	38%	28%	5%	40%
High	67	N	17	15	16	19
		%	41%	60%	73%	48%
Very high	20	N	9	3	5	3
		%	21%	12%	23%	8%
Total per service status	129	N	42	25	22	40
		%	100%	100%	100%	100%

Source: TBS Service monitoring data and FACS reports data
Note: Service status is unknown for 54 families who did not consent to the evaluation, 15 families missing service status data, two additional families missing SARA data.

4.2.2 Families that complete the RF service perform better than the Control Group and families that decline or exit early

The following three tables show child protection outcomes for the Index Group as a whole, and according to RF families with different service statuses, and compares this to the Control Group. There is TBS service status data for 131 families.

Children in families that exit the RF service early have more Helpline Reports

Children in families that exit the RF service early receive more Helpline reports (35%) than others (Table 8). This is consistent with the high and very high assessed risk levels for the Index Children in these families (see Table 10) and with the evidence supplied by TBS (Box 1) that some families disengage in reaction to an escalating event (see Table 9).

It is also evident in Table 8 that children in the families that decline the RF service are the least likely to have been the subject of a Helpline report i.e. children with reports make up 20 per cent of this group. It is possible that, after having been referred to RF and declined the service, families are affected by that experience and modify behaviour to avoid further reporting. Or, as suggested in TBS analysis, some families have other supports in place at the time of the referral and others do not believe there are concerns (see Box 1). While it seems that an intensive intervention may not have been warranted for these families, this does not

apply to all families that decline the service – others (20%) continue to have child protection system contact and would likely benefit from support.

Table 8. Helpline reports for families by RF service status, and overall for Index and Control Group

Service status	N children	% children with reports	Average number of reports	S.D.	Min	Max
Completed RF	42	24%	0.5	1.2	0	7
Continuing	26	27%	0.6	1.1	0	4
Exited early	23	35%	0.8	1.3	0	4
Declined	40	20%	0.3	0.7	0	3
Total*	131	25%	0.5	1.1	0	7
Total RF (Index Group)	200	29%	0.56	1.1	0	7
Total Control	200	30%	0.61	1.2	0	6

Source: TBS Service monitoring data and FACS reports data
*Note: Service status is unknown for 54 families who did not consent to the evaluation, 15 families missing service status data

Box 1: Reasons why some families exit RF early and why some decline from the outset

- **Of families that exit RF early,** disengaging with the view that they no longer need support is the most common reason, stated by about 40 per cent. Generally, this is not a view shared by TBS and many attempts to engage families were made before exit. About one-fifth (22%) of families disengaged following an escalating event, such as a ROSH report or another event requiring RF to intensify their focus on an issue that the family would find particularly challenging (e.g. addressing mental health concerns). Other reasons given include families relocating or becoming uncontactable.
- **Of families that decline RF,** already being engaged with support services (other than FACS) was the main reason, stated by 40 per cent. About one-quarter (25%) of families that decline said they do not consider their family to have concerns. Some families provided no reasons for declining.

Source: Secondary data provided by TBS based on their analysis of declining and exiting families (n=59).

Children in families that exit the RF service early have more SARAs

Children from around one in five Index Group families had a SARA commenced (i.e. on average 0.3 SARAs commenced), but the average ranges notably among RF families according to service status (Table 9).

Children in families that exit RF early are the most likely to be the subject of a SARA—the average number of SARAs commenced in this group is 0.9. Also, 39 per cent of families that exited early had a SARA commence for the Index Child, compared to 21 per cent of all RF families, and just 4 per cent of those families continuing in the service (Table 9). This suggests

that continued support from the RF service is associated with fewer SARAs commencing, while families that disengage before having addressed all the child protection concerns continue to be reported and assessed at higher rates.

Families that decline the RF service perform better than those that exit early in terms of SARAs commenced, and about the same as those that complete the RF service (Table 9). This is similar to the pattern noted for this group in relation to Helpline reports (see Table 8). Again, this pattern may reflect that some families who decline services have other supports in place and/or have comparatively lower child protection concerns for whom an intensive intervention is not most suitable—but about one-fifth have needs and risk factors such that they continue to have child protection system contact.

Table 9. SARAs for Index Children in RF families by service status, and overall for Index and Control Group

Service status	N	N children SARA commenced	% children with SARAs	Average number of SARAs	S.D.	Min	Max
Completed RF	42	8	19%	0.3	0.8	0	4
Continuing	26	1	4%	0.1	0.4	0	2
Exited early	23	9	39%	0.9	1.5	0	5
Declined	40	8	20%	0.3	0.5	0	2
Total*	131	26	20%	0.3	0.9	0	5
Total RF (Index Group)	200	31	16%	0.3	0.8	0	5
Total Control	200	39	19%	0.3	0.7	0	3

Source: TBS Service monitoring data and FACS SARA data

*Note: Service status is unknown for 54 families who did not consent to the evaluation, 15 families missing service status data

Children in families that met their RF goals or are still in the service receive few OOHC entries

OOHC entries are uncommon among families that have met their RF goals. In only two of the 42 families that have completed the RF service has the Index Child been placed in OOHC (Table 10). Families that are still in the RF service also experience fewer OOHC entries, and a similar average number of entries as the total Index Group and the Control Group (0.1 and 0.2 respectively, Table 10).

Families that exit RF early have considerably more OOHC entries than any other group: 0.4 entries on average, accounting for 39 per cent of exiting families (Table 10). This confirms that some families are exiting RF where child protection risks remain.

Families that decline the RF service from the outset also have relatively more OOHC entries than those that engage with the service. Unlike the strong performance of this group of families on Helpline and SARA measures, when it comes to OOHC entries their performance drops relative to families that complete or are continuing in RF (i.e. 18% of children compared to 5% and 8% respectively), and is more similar to the Index and Control Groups overall. This suggests these families may have benefitted from engaging with the RF service.

Table 10. Statutory OOHC entries for Index Children by service status, and totals for Index and Control Group

Service status	N	N children with OOHC entries	% children with OOHC entries	Average number of entries
Completed RF	42	2	5%	0
Continuing	26	2	8%	0.1
Exited early	23	9	39%	0.4
Declined	40	7	18%	0.2
Total*	131	20	15%	0.2
Total RF (Index Group)	200	27	14%	0.1
Total Control	200	35	18%	0.2

Source: TBS Service monitoring data and FACS out-of-home care data
*Note: Service status is unknown for 54 families who did not consent to the evaluation. 15 families missing service status data. Due to rounding to one decimal, some averages equal zero.

4.2.3 Very high risk Index Group families have fewer OOHC entries compared to very high risk Control Group families

Fewer OOHC entries among very high risk families is where the Index Group performs most strongly compared to the Control Group. That is, as highlighted in Table 11, 22 per cent of Index Group children within the very high risk category had an OOHC placement compared to 44 per cent of Control Group children in that category.

When looking at other child protection measures for very high risk families, the Control Group performs slightly more strongly i.e. lower mean SARAs (0.12 for Control Group compared to 0.44 for Index Group); and lower mean Helpline (0.56 for Control Group compared to 0.78 for Index Group).

Table 11. Number of reports, SARAs and statutory OOHC entries by risk level, comparing Index and Control

			Risk level (initial SARA)			
			Moderate	High	Very high	TOTAL
Helpline Reports	**Index**	N children	59	108	27	194
		Mean reports	0.22	0.69	0.78	0.55
	Control	N children	55	113	25	193
		Mean reports	0.49	0.61	0.56	0.61
SARAS	**Index**	N children	59	108	27	197
		Mean SARAs	0.07	0.33	0.44	0.26
	Control	N children	55	113	25	196
		Mean SARAs	0.15	0.39	0.12	0.28
Statutory OOHC	**Index**	N entries	2	19	6	27
		% that entered OOHC	3%	18%	**22%**	14%
	Control	N entries	3	19	11	33
		% that entered OOHC	5%	17%	**44%**	17%

Source: TBS Service monitoring data and FACS reports data,
Note: Low risk is excluded from this table as there are no reports, SARAs or entries. Children with no risk level on their initial SARA are also excluded as they cannot be categorised.

4.3 Features of FACS' child protection response

Both the Index Group and the Control Group are performing well as their contact with the child protection system reduces over time. Also, among the Index Group are sub-groups of RF families that engage with the service, meet their goals, and have the best child protection system outcomes compared to other families. But it is plausible that, within the Control Group, there are also families that engage with FACS' business-as-usual child protection response and have similarly good outcomes.

To understand the similarly strong performance of the Control Group, the evaluation reviewed FACS' business-as-usual response to describe the nature of the service received by these families. Data in the following section is drawn from a random sample of 50 Control Group clients, and 89 RF families for which the evaluation has TBS service EIP/ practice data.

4.3.1 The Control Group receives a similar number of interactions each month as families in RF, but most FACS contact is *not* face-to-face

FACS clients in the Control Group receive a similar average number of interactions (phone calls, emails, text, face-to-face contact or case management without client present) per month, compared to families in the RF service: 3.5 compared to 3.7 interactions (Table 12). This average (calculated over a period from referral to case closure/ data extraction), like any service, is likely to include different levels of intensity at different times. Also over the period measured here, each FACS client had on average more interactions (53.5) compared to RF families (38.9); noting that this total includes all types of interactions e.g. face-to-face, phone, email or text.

Table 12. Average interactions (all types) per month and per client, Control and Index Groups

	FACS clients in Control Group (n=50)	RF families in Index Group (n=89)
Average interactions per month*	3.5	3.7
Average interactions per client	53.5	38.9

Source: TBS Service Monitoring Data (based on 89 cases of EIP practice data) and FACS Case File data, which includes a small number of outliers including four cases with over 200 interactions.
*Note: Average interactions is calculated over the time from referral (i.e. referral to RF for Index Group or allocation to Control Group for FACS clients), to the time that *either* a case was closed or the data extraction date, 31 Dec 2016 for RF and 30 June 2016 for Control Group (whichever is earlier. This time is 15.4 months for the Control Group and 10.6 for the Index Group on average. This duration is the most similar point of comparison available for both groups. It is *not* the same as the 'service duration' used to calculate RF intensity (see section 6.1).

While on average FACS clients appear to receive more interactions, there are notable differences in the types of contact, as shown in Table 13 below. Three-quarters (75%) of FACS contact with their clients was by phone, email or text whereas 85 per cent of TBS contact with RF families was face-to-face.

Table 13. Types of interactions with families, FACS casework compared to RF service

	FACS clients in Control Group (n=50)	RF families analysed in Index Group (n=89)
Interaction type	**% of total 2,590 interactions**	**% of total 3,458 interactions**
Call/ email/ text	75%	11%
Face-to-face	17%	85%
Case management without client	9%	4%
Total	101%	100%

Source: TBS Service Monitoring Data and FACS Case File data. Note: percentages have been rounded; missing type data for 85 FACS interactions. This gives a maximum 3.3% uncertainty for the Control Group interaction type percentages in the above table. Excluded 94 Families who declined RF or did not consent to the evaluation, 17 families missing EIP data

The quality of individual relationships between RF workers and families who were interviewed for the evaluation attests to the importance of face-to-face contact in establishing good trust and rapport.

> *The workers were lovely and helpful, especially when they came to pick us up and take us to an appointment and even come over to have a chat. They were really friendly and just nice people. We were really happy to be working with them.* (RF family member, interview)

> *I'm not big on meeting new people so the first few times were a bit iffy letting a stranger near my kids but once I got to know my personal case worker it was so much easier to talk and explain exactly what I needed help with and where I was feeling low… She [the RF worker] did really well; towards the end the kids were even calling her by name and loved when she was coming over. My kids, when they got used to her, constantly wanted to play with her and have her join in their games; but because she was there to see me, our appointments would often run late because she would take the time to sit down and draw with my four year old or talk to my two year old she didn't just ignore them and worry about why she was there.* (RF family member, interview)

It is plausible that this positive engagement facilitated by face-to-face contact supports the sustainability of family outcomes, and encourages families to reach out for additional support if needed after exit. At this stage and within current timeframes, however, this effect is not apparent in the data.

Focus of FACS practice and referrals

General case management accounts for about one-fifth (18%) of practices that occur during FACS interactions with clients—noting that practices are recorded *within* interactions such that multiple practices can be recorded for a single client interaction. FACS casework tends to have a fairly even spread across key domains such as housing, health, family support, mental health, alcohol and other drugs, and domestic violence. As could be expected, there were few

instances of FACS practice described as involving a focus on parenting skills, counselling or behavioural skills.

Table 14. Areas of FACS' focus practice

	FACS (n=50)	
	Count	%
General case management	887	18%
Safety	467	9%
Housing	459	9%
Health	431	9%
Family support	375	7%
Mental health	341	7%
AOD	332	7%
Domestic violence	244	5%
Parenting skills	218	4%
Education	194	4%
Child protection and safety	176	4%
Home visit	145	3%
Finance	134	3%
Legal/court	133	3%
Childcare	128	3%
Other	357	6%
Total	5021	101%
Missing	848	-
Grand total	5869	-

Source: FACS Case File data
Note: percentages have been rounded
Categories that returned a result of <3% and assigned to 'Other' include: cultural support, disability, referral, brokerage, employment, immigration, child counselling skills, liaising with other services, behavioral skills
Child removal & OOHC referral categories merged with Child protection and safety category. The total numbers of 'practices addressed' for FACS (Table 14) differ from interactions (Table 13) due to different recording methods used by FACS and TBS: FACS records multiple 'practices' that are addressed over the course of a single interaction with a client, whereas TBS only records a single practice per interaction.

Of the 50 FACS clients in the review sample, almost two-thirds (n=29) had at least one referral during the measurement period, and in total, 54 referrals were made. Forty-four per cent (n=24) of these referrals were to a parenting and/or family support service (Table 55, Appendix 8), including to Brighter Futures and a specialist therapeutic child protection service. Fourteen referrals to a family support service were accepted, indicating that about one-third (28%) of Control Group families received support services including generalist family support services and those with some features similar to RF, such as a therapeutic

and/or practical focus. In addition, 20 per cent (n=11) of referrals were made to a health/ medical service, and just under ten per cent to a domestic violence support service.

5. Family experience and wellbeing

This chapter describes the changes for families measured through the TBS Resilience Outcomes Tool, comprised of a range of validated scales and standardised items from other surveys which Primary Carers self-report against at entry to RF (baseline) at regular intervals during the service (Review 1 and 2) and at exit. The numbers involved in post-baseline assessments are small but we draw on our interviews with family members to highlight their experiences in areas of measured change.

Key findings

Families in the RF service are assessed using the Resilience Outcomes Tool to monitor changes in their functioning and wellbeing over time: at entry, at four-monthly intervals and at exit. The data is incomplete and the populations are small, especially at exit. In this sense we cannot generalise the positive findings to the broader population. But by exploring data from key items in the tool together with the experiences of RF families who were interviewed (four in the lead up to this report, and five in Stage 1), some of the positive change observed can be understood in more detail.

Greatest gains were seen the Increasing Safety and Increasing Coping/ Self-Regulation domains (Figure 8).

5.1 RF family wellbeing and functioning

In addition to the child protection system outcomes, the wellbeing and functioning of Primary Carers and Index Children are measured through TBS Resilience Outcomes Tool, which is completed by Primary Carers on entry and exit from the service and at approximately four month intervals whilst they are receiving services.

Our analysis of the survey items draws on key items from the standardised measures that use validated scales and/or have normative data: the Kessler-10 (K10) measure of psychological distress; the Personal Wellbeing Index (PWI) that measures subjective quality of life; and the 'total difficulties score' in the Strength and Difficulties Questionnaire (SDQ) Parent 4–10 version. In this section, we look closely at selected measures from these validated scales, as well as questions drawn from the Longitudinal Study for Australian Children (LSAC) to measure change in social connections. See Appendix 5 for detail on these measures.

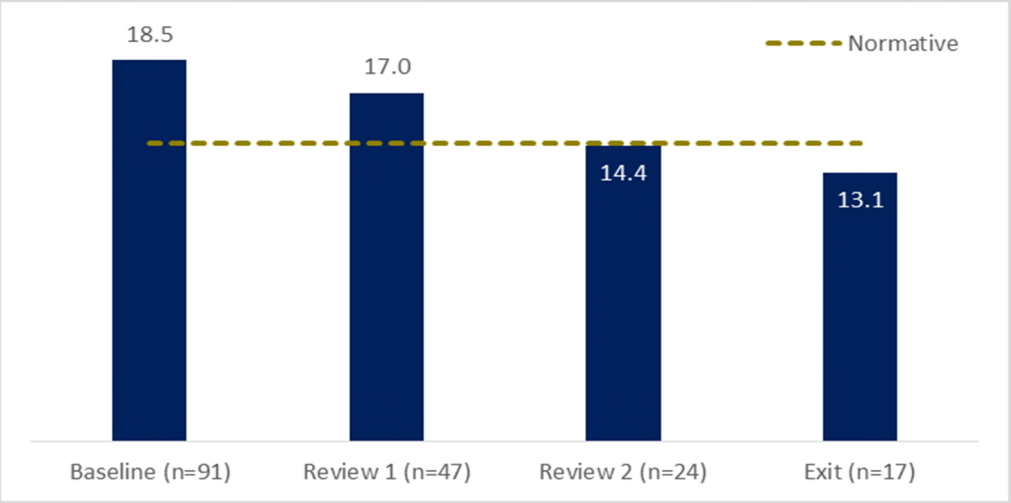
5.1.1 Primary Carers experience less distress

At baseline, Primary Carers (n=91) scored an average of 18.5 on the K10, higher than the average of 14.5 for the Australian population.[16] By Review 2, RF families were similar on

[16] Slade, T., Grove, R., Burgess, P., 'Kessler psychological distress scale: normative data from the 2007 National Survey of Mental Health and Wellbeing', 2011

average to the Australian population and at exit RF families (n=17) were reporting even lower distress (13.1) than the Australian average (Figure 4).

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



Source: TBS Assessment data

Reductions in distress was emphasised by each of the Primary Carers we spoke to for this report (n=4), building on themes identified from families spoken to in Stage 1. Primary Carers often described learning therapeutic techniques for managing stress and other difficult emotions, and it was common for changes in how well parents manage their own stress to be associated with better parenting and being able to communicate more positively and patiently with children.

Box 2: Mikayla learnt how to manage her stress and communicate better with her children

Before Mikayla got in contact with her RF worker, she describes herself as a 'stress head'. She had been finding it difficult to cope with the removal of her daughter less than a year ago as well as challenges during her current pregnancy. With the RF worker, she set up a support plan to address the issues that led to her daughter being removed so that she was best prepared to take care of her son, who was soon due to be born.

Mikayla's favourite thing about the RF service was the understanding and patience she received from RF workers. She learned a lot of useful exercises including mindfulness and techniques to handle stress. These tools helped her to feel more relaxed and less reactive when challenges occurred.

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; I still use those practices now.

By helping Mikayla to manage stress, she was also able to learn new ways of communicating with her son that were more positive and less driven by feelings of anxiety. She was happy with how the RF workers patiently taught her to respond differently to how she had previously, and could see the impact that it made on her newborn son and their relationship.

'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 with my son which has carried on for my daughter as well.'

Since exiting the program, Mikayla has continued to use the techniques she learned with her RF workers and is applying them to her relationship with her daughter who is in OOHC. She feels that she is able to relate more calmly to people around her, communicate more clearly and so is better able to cope with challenges in the future.

'It's good to…know how to deal with things in a positive way instead of burying it and using it in a negative way like how I've done before. So it's a good thing, dealing with things that come up in life and handling it in a more positive way.'

Reported reductions in psychological distress tend to relate more strongly to direct supports offered by RF workers than to the involvement of other services. Only one carer interviewed in this Stage spoke about being offered a referral to a mental health service, which she declined, '*I didn't think I needed it because I was already doing counselling beforehand.'* A different carer noted that she was already working with a psychologist attached to a custody case for her first child. This carer described how RF support helped her to engage more deeply with the psychologist, and to sustain this engagement, *'I continue to see a psychologist as well, where I talk about what I've learnt and those techniques I got from the RF program. So it's not something I've done and then just stopped.'*

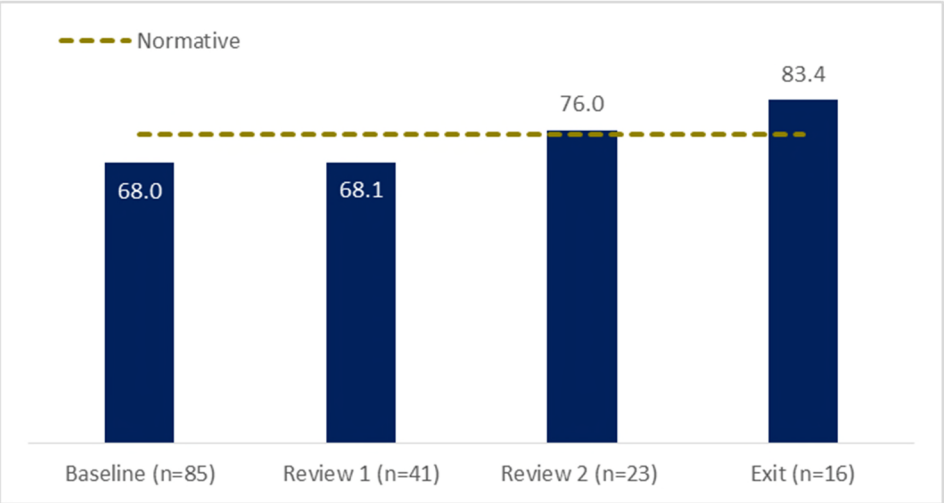
Although only a small interview sample, these observations are consistent with TBS reports that many families are already engaged with services at the time of their referral – especially mental health but also drug and alcohol and domestic violence services. This also contributes to understanding the referral data, which seems low for some types of services (see 6.1.2).

5.1.2 Primary Carers experience improved wellbeing

At baseline, Primary Carers scored 68.0 on the PWI (out of a total of 100), lower than the Australian average of 73.7 – 76.7.[17] RF families' wellbeing on average increased slightly at Review 1 and by Review 2 was similar to the Australian average (76.0). For the 16 RF families assessed at exit, their average personal wellbeing (83.4) was greater than the Australian average (Figure 5).

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

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



Source: TBS Assessment data

In addition to improvements in wellbeing related to reduced psychological distress, it is evident from interviews with Primary Carers that their wellbeing is enhanced when RF workers provide practical assistance with day-to-day activities, and around establishing routines in the home. These kinds of support are often described has having a calming effect, easing tensions and bringing stability to the family environment.

Box 3: Amber received practical supports which created a calmer home environment for her and her children

Amber was connected with her RF worker during a big time of transition in her life: moving out from her parents' home with her two kids for the first time. She was not feeling confident to manage the everyday tasks that her parents had previously taken care of, and she knew there was a risk that her kids would be removed if she couldn't manage.

'I've always had my dad as my shoulder and my rock, helping me with my young kids being a young mum. So going from having dad helping and taking care of me it was good to have someone come around and tell me that I was doing an alright job and seeing that I could do it on my own.'

Amber and her RF worker looked at what tasks her father usually took care of and made a plan for how she could do those things independently. In particular, the RF worker helped Amber learn to budget for her family, referred them to a housing program and helped them get set up in their new home.

Now, Amber feels more confident as a mother, and with support from the RF program has developed better parenting skills and boundaries with her kids. She feels that the relationship with them has changed from best friend to mother, which has helped her cope with her responsibilities, manage her finances, and keep the family going smoothly.

"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. 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. With their help, I've become much more efficient.'

Since exiting the program, Amber knows how to get more support with finances or groceries if she needs it, or how to seek counselling support if she's feeling down. However, the skills she has learned through the RF program mean that Amber has not needed that extra help so far.

Another carer explained how the practical support of her RF worker around establishing routines has made it easier for her and her partner to get to regular drug and alcohol appointments at the local hospital.

> *I am still linked in with RPA drug and health services, I was with them before (that's how I met with RF) but I'm still linked in with them…I go to RPA every day and the nurses come and have a chat with me and stuff like that.* (Primary Carer, interview)

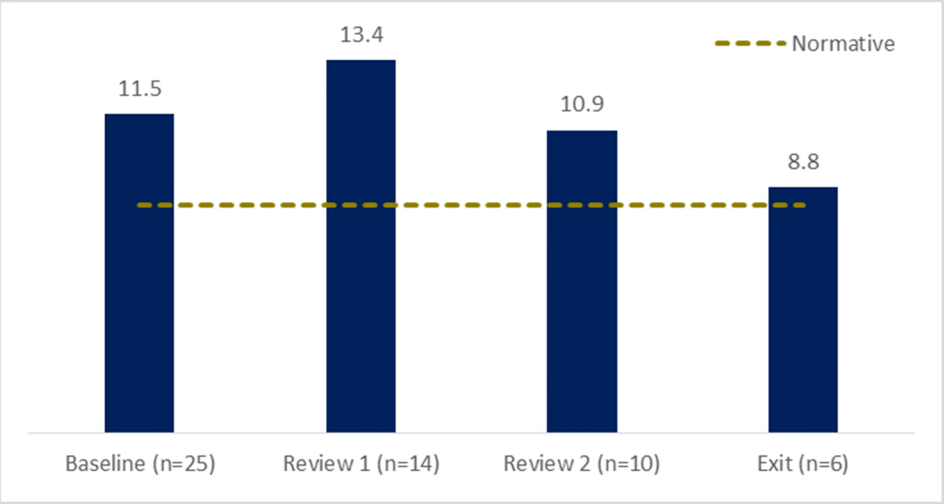
Some carers also spoke about stopping harmful or risky behaviours and how making these changes has not only improved the quality of their relationships but also boosted their sense of confidence and self-esteem. For example:

> *[My plan was…] to stop smoking cannabis which I stopped and I haven't gone back to that. And I'm very proud about that.* (Primary Carer, interview)

5.1.3 Index Children face fewer social and emotional difficulties

Index Children at baseline faced greater difficulties on the SDQ survey (average score 11.5) than the general child population (normative score 8.2).[18] While more difficulties were reported for Index Children at Review 1 (average score 13.4)—a pattern which can reflect increased awareness among Primary Carers of the problems that children are facing—after this time there was a large decrease in the difficulties Index Children reportedly face. Those who were assessed at exit (n=6) scored an average of 8.8, comparable to the general population (Figure 6).

Figure 6. Primary Carer reports on child Strengths and Difficulties Questionnaire, total Difficulties Subscale scores, over time



Source: TBS Assessment data

[18] Mellor, D., 'Normative data for the Strengths and Difficulties Questionnaire in Australia', 2005

Several carers interviewed in the lead up to this report had previously had children removed from their care. It emerged in speaking with these parents that the RF service has helped them to create a safer home environment and better family relationships such that they appreciate how their youngest child is in a relatively better position to experience healthy developmental outcomes. Some parents, for example, spoke about their youngest child being happier and more content day-to-day.

> *….my baby's getting older and runs around and she's a very happy little girl and I just love spending time with her.* (Primary carer, interview)

Others spoke about how their children interact more positively with each other now, and how children also have better emotional regulation such that they do not experience distress in response to ordinary situations.

> *When my two year old is sick, the four-year-old now understands that I can't spend as much one on one time with him so he will go play by himself. And then when his brother is asleep he'll say can we play mummy? So, it's really helped keep the whole family and lifestyle.* (Primary Carer, interview)

In addition to direct supports, the wellbeing of children in the RF service was also observed to have improved in view of referrals to other services that were made/ supported by RF workers.

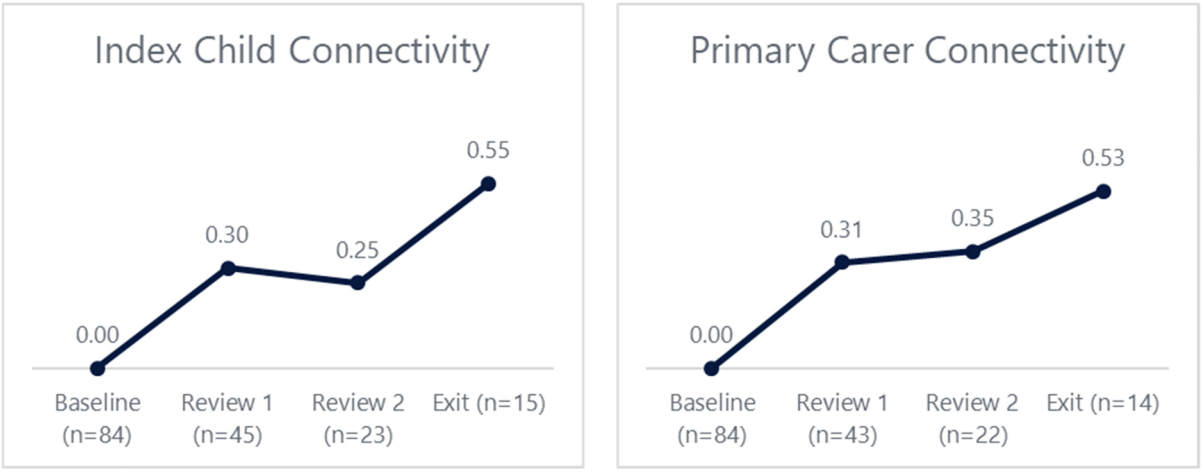
> *In one family, the toddler has severe autism and was already linked with the community centre, but now the RF worker has linked them in further. So the toddler is in four days a week childcare, two days a week in specialist care and although he's still non-verbal, he can smile now and look you in the eyes which has helped a lot. That psychoeducation around what the needs are, helping mum come to terms with the diagnosis and supporting her to reach out, is huge.* (FACS CSC caseworker, focus group)

5.1.4 Index Children and Primary Carers increase their social connections

Index Children and Primary Carers improve connections to family and friends and community during their engagement with the RF service (Figure 7).

Drawing on questions in the Resilience Outcomes Tool which ask about the frequency of contact with family, friends and community members, it is evident that Primary Carers report increased social contact for themselves and for their child over time.

Figure 7. Index Child and Primary Carer social connections between review stages



Source: TBS Assessment Data

Evidence from some of our interviews with families helps us to understand these trends qualitatively.

Box 4: Elodie and her child were connected to local recreational and community supports

Elodie and her partner entered the RF service just before the birth of their daughter. Elodie described the first couple of meetings with the RF worker as 'a bit scary' because she wasn't sure whether their daughter would have to go into care, but after she found out that their daughter would go home with them, she was very happy to have the worker there and felt no concerns about engaging with the service.

'I was really happy, and RF were there and they were happy to take us on…we were just really happy to be with them because not that many people get the chance to participate in Resilient Families.'

In addition to supporting existing referrals to health services, the RF workers helped Elodie make new connections: getting her and her daughter involved in a play group; enrolling and paying for her daughter to be part of Gymbarroo (a physical activity based childhood learning and development program); and suggesting opportunities for her and her partner to get more involved in the local community broadly.

'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.'

Since her family exited the program, Elodie still makes use of these connections, continuing to attend the drug and alcohol clinic, play group and Gymbarroo. These relationships have also helped her stay away from negative influences in her life.

'[I'm] much more calmer and easier, and I handle things in a very good way and still looking after the baby really well, making sure to stay away from bad people but to surround ourselves with positive, happy people that are doing well themselves.

She feels happy that RF helped her family 'be a family again', as her and her partner have much less conflict, go out more, and are no longer at risk of having their daughter removed.

While all carers who were interviewed indicated that direct family relationships had strengthened, only one (illustrated above) commented on social connections beyond this when prompted e.g. '*support wise, it's mainly my family and my partner*.' On the whole, this seems consistent with evidence from other sources that social connections is an area where the RF service could continue to focus practice (see section 6.1.2)

5.2 RF families and resilience

Although the changes observed through the TBS tool are for a small sub-set of the population, they are consistent with positive feedback we received from TBS and FACS staff about the effectiveness of the RF service in working with families.

> *RF is able to invest time into families that no other services can so you can carry out meaningful work with the families. (RF worker, survey)*

> *Four kids in the family—they all had different needs. They [the RF caseworker] were in the home 3 times a week, they would spend one time with the youngest, one time with mum, and one with the other kids to build skills and resilience. That helped mum, being so intentional, because of the nature of her kids' needs she couldn't see her kids as individuals because she was so overwhelmed with the issues. So this helped her see them as individuals and spend one on one time with them. (FACS CSC caseworker, focus group)*

The Resilience Outcomes Tool includes questions that align with each of the five TBS resilience outcome areas. We created an 'outcome score'[19] for four of the areas (sufficient data was not available for the Improving Empathy outcome) and then computed an overall 'outcome index'. Steady increases are seen for families from baseline to exit in each of the resilience outcomes areas (Figure 8). The greatest improvements were in the Increasing Safety and Increasing Coping/ Self-regulation domains.

As in the cases of the individual measures examined above (K10, SDQ, PWI and Connectivity), the Review 2 and Exit stages showed the greatest improvements from the baseline survey for all measures in Figure 8. These improvements are consistent with the decreasing number of reports clients receive as they continue through the RF service, though the small numbers mean it is not possible to generalise from the results.

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

Figure 8. Change in resilience outcomes (higher score indicates better outcomes)

Source: TBS Assessment Data

6. Resilient Families service delivery

This chapter reports on the implementation of the RF service, exploring the intensity, use of the RPF and joint working with FACS. It highlights both strengths and improvements, and ongoing challenges and priorities.

Key findings

- RF service intensity has increased to an average of 9.5 hours per client per month and high risk families receive an average 11 hours of contact per month, suggesting the service is being delivered with some flexibility according to need. Qualitatively, there is evidence that RF workers are adapting the service to meet family needs as these needs change over time, while addressing FACS' risk and safety concerns.
- RF workers are applying the RPF with more confidence to teach parenting and behavioural skills, and to support a focus on safety. This is encouraging as RF workers have received training and other professional support from TBS around this. Service monitoring data supports these improvements with an increase in casework time captured under specific resilience outcome domains. It also appears that external referrals are often made to complement areas of practice—although further exploration is needed around some of these data and its recording.
- Joint working and information sharing between TBS and FACS has reportedly improved, facilitated by updates to RF service guidelines that clarify expectations roles/ responsibilities, and by the increasing level of awareness about the service among local CSCs. There are also instances of collaborative casework approaches that continue throughout much or all of the time a family is engaged in the RF service—while there is no systematic data on how often this occurs, when it does TBS and FACS CSCs are mostly positive about how this helps to support family outcomes. (6.1.3)
- There is scope for the RF service to continue to enhance how it engages with *some* families, noting the group that either decline RF from the outset or exit the service early are most likely to experience an OOHC entry (see 4.2.4). In part, achieving improvements would involve an ongoing focus on specific practice domains, especially supporting social connections, and prioritising training around strategies to maintain family engagement in the context of recurring crises or escalations.
- The centralised matching and referral process used to establish a relevantly similar Index and Control Group means that RF families are not individually selected for their unique or particular suitability to the service. Insofar as this process appears to generate a group that includes some families with a range of other supports in place and/or with relatively moderate risks, engaging families who are best placed to benefit from the service is, to some, a challenge within the TBS SBB.
- There are delays in service commencement, about a month between the initial SARA and referral to RF, and on average about two weeks between referral and the initial joint home visit. This is longer than usual for an IFPS, where immediacy is an important feature (see 1.12). Changes to the matching process made between Stages 1 and 2 may impact on reducing delays in the future but this has not yet translated to shorter (average) times for family contact.
- Priority areas for TBS to focus their practice and data collection over the final 12 months are in social mapping; delivering and/or referring for assistance with family violence, drug and alcohol and mental health issues; and ensuring the Resilience Assessment Tool is completed with more families.

6.1 Strengths and improvements

The RF service is in the fourth year of delivery. When it started in October 2013, the RF service was new—in design and organisational practice framework (and bond context) and with new staff responsible for its delivery. There is good evidence today that service delivery has developed to a more mature stage, particularly in terms of its internal capacity to deliver a quality service but also, and increasingly, in its external relationships. This is summarised neatly by a respondent to the TBS RF survey who commented, based on a recent case file audit, that:

> *…it is evident when looking over cases in RF first year, that the program has grown in its engagement with families, its commitment to engage (never give up). As time goes on, FACS becomes more familiar with the model of service delivery, this is creating positive relationships. This also extends to health professionals and education.* (RF staff survey respondent)

These developments are also reflected in the updated RF Service Operating Guidelines (revised in 2016) that clarified some aspects of the RF approach—such as expectations around intensity, professional supervision and joint working with FACS—without being overly prescriptive. Messages about the priority of a client-centred and outcomes-focused service remain clear and, as explored in the following sections, shape and inform RF practice.

6.1.1 Delivery is increasingly targeted and focused

RF is an intensive family support intervention but, in line with research of effective IFPS, it is also a flexible service that responds to changing family needs (see 1.1.2). In other words, the level and pattern of intensity set out in the RF Service Operating Guidelines—commencing with 0–4 hours of contact per week in the first 12 weeks (up to 16 hours per month) followed by incrementally stepping down to about 1–6 hours per fortnight (2 to 12 hours per month) in the last 8 to 12 months—are intended to guide rather than drive practice.

Building on Stage 1 findings,[20] it is positive that intensity has become a bit more targeted towards the high and very high risk families, and increased overall. Total average intensity has increased since the Interim Report (capturing an additional 18 months of data), from 11.9 to 12.4 interactions per month and the average hours of contact per client each month has increased too, from 8.1 hours to 9.5 hours. Most of this increase has occurred for very high risk families who are now receiving on average 15.7 interactions and 11 hours of contact per month (Table 15). This provides growing evidence that service intensity is likely to be appropriate i.e. perhaps not as high as other intensive programs, but as noted the cohort includes families that have a relatively moderate risk profile.

[20] In Stage 1, RF service intensity seemed low but the significance of this on outcomes was unclear—it was plausible, and consistent with feedback, that this may relate to the finding that about a fifth of families had a risk profile lower than expected to warrant a high intensity intervention. Also, this intensity pattern was not structured (from most intense, reducing over time) but highly variable, but the small number of families in the service at that time made it difficult to determine if this variation was appropriately related to risk levels.

Table 15. RF service intensity (time with or about clients per month, by risk level)

								Interim report	
Final risk outcome (SARA)	**Number of interactions with or about per month**				**Hours per month**			**Interactions per month**	**Hours per month**
	N	**Avg**	**Min**	**Max**	**Avg**	**Min**	**Max**	**Avg**	**Avg**
Moderate	16	**9.7**	2.0	17.7	**9.0**	4.4	18.2	10.4	7.8
High	31	**12.3**	3.2	23.0	**9.1**	2.7	26.4	12.0	7.9
Very High	14	**15.7**	0.4	30.6	**11.0**	0.2	22.5	13.1	9.2
Total	61	**12.4**	0.4	30.6	**9.5**	0.2	26.4	11.9	8.1

Source: TBS Service monitoring data ('meetings' data), FACS SARA and Secondary Assessments data (SARA missing for one family; Interim Report Table 6. Excluded 94 Families who declined RF or did not consent to the evaluation, 45 families have missing data

Note: RF service intensity is calculated using the time from intake to exit. This is a different (shorter) period in Table 12 where Control and Index Group were compared (i.e. time from referral to case close or 31 Dec 2016 for Index and 30 June 2016 for Control)

RF workers have also noted that, to engage some families—especially those with more moderate risks and safety concerns—it can be helpful to start with less intensity and gradually build this up as trust in the service grows. By this time, other issues may have surfaced and parents/ carers have a richer understanding of what RF can offer to support them.

> *The program is overwhelming at first when 2-3 visits are required per week. It's better to ease families into the service at a manageable pace for them and then increases intensity when they are feeling less overwhelmed by the change from engaging with a new service. Also, being genuine and transparent in your support helps families to trust the service.* (RF workers, survey)

In some focus groups with FACS CSC staff, caseworkers also commented on the appropriateness with which RF workers adapt service intensity to meet family needs.

> *In comparison to other NGOs, RF gets that families' needs change day by day. There might be some existing set up, like the worker going in twice a week for parenting lessons, but they are aware that they might need really basic, practical support and that could change weekly as well. So, I like that they can alter their approach because some services are quite rigid and want to stick to the agreed goals but that won't work so well for the family.* (FACS CSC caseworker, focus group)

The improved targeting of intensity to risk is also consistent with evidence about the capacity of RF workers to align goals in the Family Support Plans with risk and safety concerns identified by FACS. All FACS CSC staff in interviews/ focus groups expressed high levels of

confidence in the skills of RF workers to achieve this, and many spoke of RF workers as '*on the same page re child protection concerns.*'

Likewise, RF workers consider that families' goals usually align well or very well with issues identified by FACS (Table 50, Appendix 6), and express a sophisticated understanding of the process of working with and engaging families to achieve alignment.

> *Sometimes goals in the first support plan may differ from the SARAs because you want the plan to be client-centred and based on what they identify as needs. As work together progresses, clients are usually able to self-identify the risks and incorporate those concerns into goals. They are also more open to suggestions for addressing those risks once a relationship has developed with the worker.* (RF staff survey respondent)

> *They tailor their approach to the situation so that if it changes, they change what they are doing. So, they match us (FACS) much more in the way we think and our process, their communication is so good.* (FACS CSC staff, focus group)

Yet a challenge for the RF service remains in attempting to increase intensity with some families at times of crisis, when risks or safety concerns escalate, especially in a voluntary service context. This was noted by TBS as one of the leading reasons why families exit the service (see Box 1), and is explored further in section 6.2.

6.1.2 The RPF is being used with more confidence, which brings a sharp focus on outcomes

RF workers are increasingly confident using the Resilience Practice Framework (RPF) to inform their work with families. When asked in the survey how the RPF helps guide practice, RF workers most often commented on its holistic, flexible, strengths-based features and on how it focuses their activity on achieving measurable, short-term outcomes and longer-term changes. Workers also note that it provides a helpful degree of structure and brings evidence to how they work with families, both therapeutically and around practical parenting skills.

> *That it's outcome based so both you and the families are able to see the changes. The framework is able to guide you at times in supporting your family with what is required to make changes.* (RF staff survey respondent)

> *It is very flexible and adaptable [it works when] you have practitioners who are brave to try new and creative strategies in delivering the principles of the practice.* (RF staff survey respondent)

This growing confidence is consistent with 10 of the 11 survey responses from RF staff about the training they have received around using the RPF: five of these staff always and another five mostly feel supported in this. Most staff also report feeling supported in relation to the induction/ training for the RF service, ongoing professional supervision and internal learning opportunities provided by TBS (**Error! Reference source not found.** and Appendix 7).

The TBS RF monitoring system indicates that RF workers are better able to use the RPF to guide their activity, and record this time accurately. While the volume of paperwork and admin time around data entry continues to be cited by workers as difficult to manage, it is positive that slightly more time is being captured under an identified outcomes domain, and less time allocated to 'other' (i.e. 'other' is down from 38% over the Oct 2013–2016 period to 34% over the 2013-Dec 2016 period, Table 16). Also, about a third of time continues to focus on Increasing Safety, which further supports the evidence noted in 6.1.1 that RF workers also align their practice with issues identified by FACS in SARAs.

Table 16. Time spent on resilience outcomes

Resilience outcome	Total hours	% of total hours	Interim Report — % of total hours
Increasing Safety	1028	32%	33%
Secure and Stable Relationships	507	16%	14%
Increasing Coping/ Self-regulation	315	10%	7%
Increasing Self-efficacy	243	7%	7%
Improving Empathy	58	2%	1%
Other	1110	34%	38%
Total	3261	100%	100%

Source: TBS Service monitoring data; Interim Report Table 7

This focus on resilience outcomes reinforces the reports made by families who were interviewed after exiting from the service about the changes they have sustained (see 5.1), and observations from RF workers about the changes they are seeing in families,

> *Change—seeing change occur, watching individuals grow and gain a voice thus becoming their own advocate. Breaking barriers down, seeing safety created with in the family unit by the family members. Being able to walk away.* (RF staff survey respondent)

> *When you see a client able to access supports on their own and acknowledge where they were when FACS first started to where they are now and take responsibility for their choices and actions and understand how that impacts children and their safety.* (RF staff survey respondent)

Likewise, FACS CSC staff gave examples of families for whom they had observed achieve good outcomes through the RFs service.

> *I got a closure report from RF after five months, and it seems the family exited with good outcomes. We were happy this this.* (CSC casework manager, interview)

> *We were recently sent a closure report, end of last year. We could see progress in parenting skills, only after four or five months. This was positive.* (CSC casework manager, interview)
>
> *There was one mother with five kids and had all previous children removed, and a history of not engaging with services. She worked well with RF and has kept this child.* (CSC casework manager, interview)

Main areas of practice focus

RF casework practice has a particularly strong focus on behavioural skills and parenting skills, together accounting for about a third of all interactions (17% for each). Safety is also a key area of focus, accounting for 14 per cent of practice focus. Thirteen percent of time is allocated to general case management (similar, or though less than for FACS clients, which is at 18%), which includes activities such as case planning, assessment and review, as well as organisational and liaison work with or for clients.

The service monitoring data, reflected in Table 17, suggests a relatively limited direct focus on some domains such as mental health, alcohol and other drugs (AOD) and domestic violence; although it has been reported by TBS that this can, in part, be attributed to how these activities are classified and recorded. TBS have advised that work related to AOD and domestic violence may also be reflected as liaison and advocacy activity, as well as legal/ court work (especially for domestic violence related support involving Police or around Apprehended Violence Orders. Also, the strong focus on safety (14%), such as time developing safety plans, is likely to embed support for families to address these concerns, as well as mental health concerns around suicide.

Table 17. Areas of practice focus, RF service

	TBS (n=89)		Examples/types of activities in Practice Category
	Count	%	
Parenting skills	593	17%	Basic child healthcare, parenting groups, creating effective family rules, learning to better interact with children
Behavioural Skills	576	17%	Adult problem-solving skills, understanding consequences, controlled breathing, setting goals for success
Safety	497	14%	Social connection maps, developing a safety plan
General case management	447	13%	Case meetings, phone calls, assessments, transport, initial meeting with client
Family support	265	8%	Family time, family routines, family support plan
Child protection and safety	137	4%	Supervising children, injury prevention and child proofing, OOHC contact and child removal
Counselling	134	4%	General psychoeducation, mental strategies, mindfulness
Health	133	4%	General medical, exercise, medical professional appointments, muscle relaxation
Housing	131	4%	Housing support
Liaising with Govt Dept or other services	97	3%	Any unspecified/joint meeting with government agencies or other services, chiefly with FACS
Engagement and connection	87	3%	Recreational activities, praising effort and persistence, engaging with clients
Other	361	10%	
Total	3458	100%	

Source: TBS Service Monitoring EIP Data
Note: Categories that returned a result of <3% were assigned to 'Other'. Excluded categories are: education, domestic violence, finance, legal/court, mental health, childcare, AOD, home visit, cultural support, disability, referral, brokerage, employment, immigration, child counselling skills and Brighter Futures. Child removal & OOHC referral category merged with Child protection and safety category.

Also—and as noted in relation to the FACS practice data (section 4.3.1)—these areas of practice focus do not necessarily cover all the forms of support that families in the RF service receive at any time, and external services often appear to complement the areas of practice focus. Of note, almost all RF families (89 of 106 total RF clients who consented to the evaluation) received a referral, and on average about four referrals per family were made (388 referrals in total). This is about twice as many referrals, on average per client, compared to those in the Control Group (Table 56, Appendix 8).

The RF referral data (Table 18) shows well over one third of referrals were made to either a health/ medical/ disability service (24%) or a mental health service (16%), which may also include AOD supports and may account for the apparently low number of referrals in the AOD category (as does the possibility that FACS has referred families to other services prior to their engagement with RF). More exploration of how TBS delivers AOD and domestic violence support is needed to account for the data below, especially given the likely need for these supports among the Index Group.

Also of note, over one-third of referrals were to services with likely direct economic benefits: playgroup/ childcare (14%), education (13%) or financial support and employment (11%).

Table 18. Referrals to external services by TBS

		TBS (n=89)
Type of external service	**Count**	**%**
Health/Medical/Disability	92	24%
Mental Health	62	16%
Playgroup/Childcare	56	14%
Education	51	13%
Financial Support and Employment	43	11%
Housing	27	7%
Parenting and Family Support	25	6%
Other Professional Services	11	3%
Local Community Services and Youth	8	2%
DV Support	5	1%
AOD Services	5	1%
Other	3	1%
Total	388	100%

Source: TBS Service Monitoring Data.
Note: Excluded 94 Families who declined RF or did not consent to the evaluation, 17 families missing referral data

RF workers responding to the staff survey reflected on several challenges, especially service system issues, that they encounter which can affect the referral of RF families to other supports. The costs to families is the greatest challenge reported, considered by almost all respondents as 'always' or 'often' a challenge, particularly in the context of long waiting lists for Medicare-funded services. Service availability—especially in South Western Sydney (Region 2)—and their accessibility for families with limited English also pose a challenge, more so than family preferences about services (Table 52, Appendix 7).

> *Support services not being able to support the level of risk we work with. Childcares, schools, police and housing are not skilled in trauma, the impact on parenting capacity and children.* (RF staff survey respondent)

TBS has also noted scope to improve RF workers' data entry practice around referrals, and that when families are already engaged with other services at the time of referral to RF, these supports are not routinely captured in the data collection.

6.1.3 TBS and FACS relationships have grown and these facilitate service delivery and family outcomes

As part of the TBS SBB pilot, RF service delivery involves new ways of working between FACS and the non-government sector. During the first years of the RF service, challenges around joint working and information sharing were reported, partly due to the need to embed and refine the operation of the centralised referral mechanism, and also simply due to the small numbers of families referred to RF and hence limited exposure to/ awareness of the service among FACS CSC staff. In 2017, the evidence is now showing that joint working and information sharing has continued to improve and that each are generally positive about these processes.

Both RF workers and CSC staff speak highly about the effectiveness of joint home visits—or at least, an initial joint meeting which is also considered satisfactory if a home visit cannot be coordinated.

> *The initial joint home visit provides a good opportunity for case handover and expectations to be clear for the families. It has also been really useful in relationship building between RF and FACS as FACS become more familiar with are program (approach, style, service delivery).* (RF staff survey respondent)

> *[The] initial meeting works well so that when we refer we don't just refer and close but go and visit – together with benevolent society to make sure the family understands the program and engages. It means we can have a frank conversation with the family about what FACS is concerned about.* (FACS casework manager, interview)

Ongoing information sharing is also considered to be going well. While this can depend on the quality and consistency of individual working relationships in some locations, overall both RF workers and CSC staff have expressed the view that processes are more embedded and this has occurred alongside the growing reputation of the RF service. The updated RF Service Model Operating Guidelines also outline expectations around information sharing more clearly. The amount and quality of information provided to RF workers at the time of referral has reportedly improved, and this assists in family support planning.

This view that joint working and information sharing has improved over time is evident in the most recent RF staff survey when compared to the 2014 survey results (Table 19).

Table 19. RF staff reports of how well joint working and information sharing processes with FACS are working

	Joint working and information sharing processes*			
Survey year	**Very well**	**Well**	**Not so well**	**Not at all well**
2017	15%	76%	9%	0%
2014	11%	63%	15%	11%

Source: TBS Staff Survey, February – March 2017
Note: *Combined response to questions asking about joint working related to: (1) Referrals to the RF service; (2) The initial joint home visit or meeting with RF staff and CSC staff; (3) Information sharing with CSC's about families to support client intake to the RF service. Table 49 in Appendix 7 presents this disaggregated data by question.

Information sharing and joint working are seen to be supported when CSCs exercise discretion around the point at which their FACS case plan for the family is closed.

> *My practice as a manager is to keep cases open a bit longer maybe than others might because I want the family to engage.* (FACS casework manager, interview)

> *First, we [FACS] were doing a lot of work with the mother plus working with a child around school refusal and lacking self-confidence, so we did that in tandem with Resilient Families where we would get together and work with the boy, and at the same time the RF worker would go and work with the mum around DV because she had a better rapport with her.* (FACS caseworker, focus group).

CSC staff have reported that they may keep a case plan open for at least the first month after referral to RF—and tend to also visit the family during this period—and potentially keep it open for a couple of months after that. In one CSC, it appears to be usual practice to keep the FACS case open for the duration of the RF service, but it is not known how widespread this practice is across CSCs more generally.

Importantly, not closing the case plan too soon after the initial home visit is not seen by FACS or by RF as indicating a lack of trust in the capacity of the RF service to manage risks, but rather as a mutually helpful arrangement that can support family engagement with a voluntary service. Both TBS and FACS CSC staff have also noted FACS cases tend to be kept open longer where mothers are referred prenatally e.g. three months before the birth, and then six months afterwards.

6.2 Challenges and priorities

As a relatively new although maturing service, there is scope for the RF service to continue to improve how it engages with families and the work that it does to ensure that the positive outcomes are sustained. Also, the RF service is attached to an innovative SBB pilot—which involves, among other features, that families are identified through a centralised referral process so that an Index and Control Group can be established—and this structure has some consequences on the service's delivery context and potentially for the performance

outcomes. Insights that can be drawn for the further development of social investment policy are outlined below, and the lessons from these will be confirmed in the Final Report.

6.2.1 Delays in commencement may be impacting on engagement

Intensive services such as RF should be offered to families as close to their time of crisis as possible, when family members are most likely to be receptive to change. The sooner a family can be engaged after crisis, the greater the likelihood of engaging with the family, and consequently facilitating positive behavioural changes (see 1.1.2). In recognising this, the service model identifies timeframes during the referral and assessment process to promote a timely intervention.

In the Interim Report, two main contributors to service commencement delays were identified:

- a delay between the time of family crisis and referral to RF
- a delay between the referral to RF and initial contact (preferably a joint home visit).[21]

The Stage 1 evaluation recommended, in view of this finding, that FACS and TBS review their respective processes and identify opportunities to reduce engagement timeframes. In response, the Joint Working Group commissioned an independent review of the matching tool formula (used to match children in the Index and Control Group prior to referral), replacing this with a more simplified process of matching families based primarily on SARA recency.[22] FACS and TBS have also been focussing more on joint working so that the initial home visit can be arranged more swiftly.

Current evidence, however, shows that delays in service commencement remain. There is, on average, about a month between the date that the SARA was commenced and when families were referred to RF or allocated to the Control Group for measurement i.e. 4.2 weeks for the Index Group and 3.7 weeks for the Control Group (Table 20). While time has reduced since the Interim Report, potentially due to the simplified matching process, a month remains longer than usual for an intensive service response where an immediate referral response is a critical feature of the model (see 1.1.2). There is also an earlier period, between the SARA commencement date and the Helpline report that indicates the family 'crisis', although this timeframe is not known.

[21] ARTD Interim Report, section 3.1

[22] Matching based on SARA recency was introduced to replace a highly specified "matching tool" formula under which could be difficult and time consuming to find a match within the pool of potentially eligible Control Group families.

Table 20. Number of weeks from date of SARA commenced to measurement start date (referral)

	N children	Mean weeks	Standard Deviation	Min	Max	Missing	Interim Report Mean weeks
Index	198	4.2	4.07	0	23	2	4.8
Control	196	3.7	3.36	0	21	4	4.7

Source: FACS SARA and Secondary Assessment data.
Note: The measurement start data is the date a child is referred to RF, or if unborn the later of its date or birth or the date of birth of its matched child. Unborn children (n=6) have a mean of 9 weeks (12.6 in the Interim Report). Missing SARA date data for 2 Index and 4 Control children.

It should be noted in relation to Table 20 that FACS starts to identify families eligible for referral periodically, following a request for referrals from TBS in view of its service capacity. FACS must make a valid referral within 10 days of TBS making this request. The timing of these requests and the number of families requested at any time may also impact on how quickly eligible families are identified and matched.

Next, there is a period between the referral ('measurement start date') and when RF families are first contacted about the RF service. This reflects the time taken for local CSCs and RF workers to share information and arrange an initial joint home visit, or similar. To engage families in the service quickly, the RF Service Model Operating Guidelines state that initial contact should be made with families within seven business days of the referral being received by TBS.

In practice, making contact within this time frame is not being achieved. Delays observed in the Interim Report have almost doubled with average times increasing from 9.4 days to 17.4 days (Table 21). Individually, for different families, the time to be contacted varies widely, and although some outliers have been removed to account for exceptional circumstances, it appears that delays remain an issue overall.

Table 21. Number of days from referral (measurement start date) to initial contact with family

	N	Average number of days	S.D.	Min	Max	Interim Report average number of days
Region 1	35	16.5	25.0	3	115	7.5
Region 2	50	17.9	16.7	0	88	11.7
Total	85	17.4	20.4	0	115	9.4

Source: TBS Service monitoring data, two outliers removed (values 190 and 231, in Region 1)
Excluded 94 Families who declined RF or did not consent to the evaluation, 21 families missing data

These delays are not consistent with reports about improving working relationships, noted in section 6.1.3. So while there is collaboration between TBS and FACS, other issues may be contributing to this and the evaluation can continue to explore possible structural factors at play.

There is no data on timeframes between the measurement start date and an equivalent 'initial contact' date for families in the Control Group. Insofar as these families are likely to already be engaging with FACS' business-as-usual child protection response, and there is not necessarily this step of arranging an initial joint home visit with another non-government organisation, it is plausible that contact occurs more swiftly for the Control Group on average.

6.2.2 Engaging some families in a voluntary context is a challenge

Establishing and sustaining a trusting relationship with families to work with them on child protection issues requires considerable casework skill and expertise. Overall in this stage and Stage 1, the evaluation has found RF workers to be experienced practitioners, with TBS investing in their professional development and practice supervision. The Primary Carers who we have interviewed (a sample that included families who had exited the program, most having met all their goals) gave evidence of establishing good rapport and trust. In only one case did a participant highlight some relationship-based issues; but their family engaged with and completed RF nevertheless.

Box 5: Ryan found that the caseworker relationship could be difficult to navigate

Ryan described how as a family member he was usually around when the RF worker came to the house, and so he took part in these sessions. He reflected on how he and the Primary Carer felt unsure about agreeing to RF because, *'we're pretty private people…concerned about what their opinions of us would be'*, but they went ahead because they needed help to care for the young children. Ryan described how at first the relationship with the RF worker started well, but over time some tensions emerged.

'At first it was good because, I actually can't remember the caseworker's name but she was pretty good…[then] it kind of became a bit of a drag…it seemed more personal, like she seemed to be in a competition of some sort. She would get really personal and [Primary Carer] is a very stubborn woman. So it was good at the start but it got too in-depth.'

It seems unclear whether the RF worker had quite the level of rapport and trust needed to engage everyone in more challenging conversations around changing behaviours. While Ryan liked the RF worker and felt she was *'was a good person'*, he partly attributed these tensions to the worker not fully understanding their lived experience.

'I don't think she really understood because she didn't come from our kind of background. She put her own life into ours. It's like someone who came from money talking to someone who is bankrupt – they just can't understand.'

Despite this, they stayed involved with the service until *'it was gradually phased out'*. By the end he felt that they had received lots of practical support in managing the household and he was glad that the RF worker encouraged him to apply for work as he now has a job.

We know that almost as many families completed RF and met their goals (n=42) as families that declined RF (n=40) and that 22 families exited early (Table 7). In bringing evidence about the service status and risk profiles of these families and their child protection outcomes (section **Error! Reference source not found.**) together with information from surveys and i nterviews with TBS and FACS, it appears that there are two broad groups of families that are most difficult to engage in the RF service.

Families with relatively low risks and who may also already be engaged with other supports

First, are families with a risk profile that may not warrant an intensive intervention, as identified in the Interim Report[23] and again described in section 4.2.1. These families tend to decline RF from the outset, especially if they are already involved in other services, or disengage in response to the intensity of RF and then exit early. When asked about key challenges in engaging families, RF workers responding to the survey, consistent with reports in Stage 1, often reflected on this group.

> *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)
>
> *Referrals are received for families that do not need an intensive service. This is very time wasting because we're still required to work with the family and complete an assessment before closing rather than give the service to a family who really needs it.* (RF staff survey respondent)
>
> *From my experience to date I believe it's the level of intensity. I think that families are not used to having that level of professional support so can find it difficult to engage to that level. However, I believe that this can be overcome with being flexible with families and not forcing the required hours upon them.* (RF staff survey respondent)

As evident from the comments above, RF staff attempt to engage these families by working flexibly and adjusting the level of intensity accordingly. This also explains data related to the intensity of the RF service which is moderate on average, although has been increasing especially among the higher risk families with better targeting (see 6.1.1).

This flexible response seems appropriate and, insofar as the TBS SBB referral mechanism continues to generate a cohort that includes a proportion of more moderate risk families, arguably there is scope for TBS to focus professional support/ supervision around innovative and tailored engagement strategies for this group. Nonetheless, the work involved in engaging families who may not be the best fit for the service may continue to present a barrier to the RF service being able to focus resources where they are needed most. It may

[23] This group was identified in Stage 1 following a detailed analysis of RF family risk profiles which found about a fifth of families have a profile that may not warrant an intensive intervention (see Interim Report, section 2.2.2).

limit the potential performance of the service insofar as these families have 'less room' to make improvements.

Families with a prolonged history of child protection system interactions and poor service engagement

Second, are those families described by FACS and TBS as having 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. These are also families that have a history of commencing and then disengaging with voluntary services, and are likely to be reflected in Table 7 among the high and very high risk families that exit RF early.

To an extent there is scope for the RF service to better engage this group to prevent their exits, but it also reflects what FACS caseworkers describe as the reality for some families that repeatedly do not engage with a voluntary service. CSC staff (who are often very familiar with these families owing to their child protection history) usually feel it is appropriate that the RF service attempt engagement first, but consider that limited success is not necessarily a reflection on the skills of RF workers. In fact, referral back to FACS following concerted efforts to engage with these families may be seen as a sign that the child protection system as a whole has responded appropriately in context.

> *RF had no real stick to enforce the plan, so we stayed involved and now it's come back to us. But the RF worker was very skilled at working with the family—it's not that the caseworker was not skilled, I have great respect for that worker, it is more structural around being a voluntary service.* (FACS casework manager)

> *There are some families where 'everything' is a problem, multilayered and intergenerational, especially those with multiple older children/ large sibling groups, these are the ones who get referred back. These families need the 'stick' of a statutory agency: they will only work superficially with a voluntary service to get distance from FACS but will not engage deeply.* (FACS casework manager)

Voluntary services like RF that are designed to provide early intervention responses to children at risk of OOHC entry are thus challenged to engage families where the most current crisis precipitating referral reflects long-term issues.

The RF service, with the resources to provide an intensive and extended response where there is more opportunity to build a deeper therapeutic relationship, is arguably best suited t to engage with these families to change behaviours. However, as widely acknowledged in the child protection literature, achieving this quality casework relationship is both one of the most important and most challenging aspects of a successful intervention.

Sometimes advice to an organisation in this situation would be that they enhance their specialised practice to focus on just one or a couple of areas (e.g. around working with family

members with dual AOD/ mental health diagnoses; who are leaving violent relationships; or who are from a culturally diverse background). And then, that they explicitly target the service, which may involve reaching out to find the families most likely to benefit through local service/ referral networks. But in the context of the holistic RF service model and TBS SBB pilot, which embeds a process of centralised referrals, there does not appear to be scope for such refined targeting as a strategy to manage these types of family engagement issues. As noted in section 6.2.1, however, there is scope to improve the timeliness of the intervention after a family crisis and it is plausible that this will have an impact on the motivation to engage.[24]

Again, and insofar as this structural challenge remains for RF, continuing to strengthen joint working with CSCs remains an important component of delivery. It is promising that these relationships have been developing well (6.1.3). It is through responsive and high-quality information sharing that the complexity and subtly of a family's child protection context can be communicated in a way that will best enable RF workers to plan an effective engagement strategy. Also, this can help to build a mutual understanding between FACS and TBS of when keeping the FACS case open, and perhaps arranging additional joint home visits, may be needed to ensure a family's engagement with the RF service.

It is also worth noting that an area of professional practice where RF workers consider they are least supported is around 'ongoing learning and development by external organisations' (Figure 11, Appendix 7). This may represent an opportunity for TBS to scope the relevance of some external training that builds skills/ knowledge related to specialised family engagement. Relatedly, a couple of RF workers feel there are limitations in how well the RPF can be implemented in the midst of some family crises i.e. in a particularly 'unstable' or 'chaotic' home environment. In these cases, workers draw on their '*experience and knowledge of crisis management, which isn't in the Framework*.' To the extent that this assessment of the RPF is accurate, ensuring that workers have these crisis management skills may also be an area for further training.

6.2.3 An ongoing focus on opportunities to build social connections is needed

The Stage 1 evaluation highlighted the importance of improving connections with family members as well as with local communities/ social networks so that these bonds remain once the RF service and/or FACS involvement ends.[25] Yet it was noted in the Interim Report that 'social connections mapping', one of the EIPs within the Increasing Safety domain of the Resilience Outcomes Tool, accounted for just 3% of all time recorded on EIPs. Updated data

[24] In relation to this point, FACS has observed that greater immediacy may impact on risk assessments i.e. that services that intervene with greater immediacy may be challenged to capture all the risks, which can take time to emerge.

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

analysed in this report shows that this proportion is unchanged (i.e. 3% or 76 of 2777 hours recorded up to April 2017).

However, TBS report that RF workers have received practice support around focusing on social connections, and it is positive that relevant survey items in the Resilience Outcomes Tool show an increase in Primary Carer and Index Child connectivity to family, friends and community over time (see 5.1.4). From interviews with families that have exited the RF service, activity to build social connections does not appear as a strong theme. Although in the cases where it has occurred, the carer has responded positively and reports that these connections are being sustained. Focus groups with RF workers in the final evaluation stage can explore this issue in more detail.

A FACS CSC manager also commented that something that may strengthen the RF service, which they would consider a benefit for some families, would be more opportunity for families to engage in TBS' centre-based activities. TBS has offered a limited number of centre-based activities. The suggestion is not to change the primarily in-home model of support, but rather to supplement the service offerings—especially for those carers, including some identified in interviews, who experience social isolation when caring for newborns or young children who are not yet in school. New social connections can be particularly important for helping parents develop and sustain new relationships and behaviours.

7. Conclusions

There is good evidence from the Resilience Outcomes Tool and interviews with families, RF workers and FACS CSC staff, about positive impacts that result for families engaging with the service. The combination of therapeutic and practical supports, delivered flexibly with a level of intensity that is adapted to meet family needs/ risks, while still responding to safety concerns identified by FACS, contribute to these outcomes.

These positive outcomes are reflected in the performance of the Index Group under the TBS SBB pilot—contact with the child protection system has reduced over time across Helpline, SARA and OOHC measures. This reduced contact is, however, only slightly less than that experienced by the Control Group who receive a business-as-usual child protection response delivered or coordinated by FACS. The service received by the Control Group is similar in some ways to that received by RF families—especially in the average number of interactions received by clients per month. A key difference is that RF families receive far more face-to-face contact. Face-to-face contact is key to building good rapport and trust with RF workers, necessary in a voluntary context. Whether this improves the sustainability of outcomes compared to the Control Group is not yet established, but the number of statutory OOHC entries for the Index Group, though not significant, is a positive sign.

Both Index and Control Group families may also be engaged in other support services before they are referred, and continue this engagement. Notably, about a third of Control Group families are involved in another family support service, including some that share features similar to RF. These factors contribute to an explanation of the similar overall performance of the two groups: referrals account for what appear to be differences in the focus of direct casework practice. RF referrals, for example, are commonly made to health/ medical/ disability and mental health services. But, more exploration of this for both groups, and RF data recording practices, is needed to understand this dynamic more fully.

Where the RF service appears to be having the most relative impact, compared to the Control Group, is in preventing OOHC entries among very high risk families. This is promising for the RF service, although the total number of families in this very high risk sub-cohort is small, limiting the strength of this conclusion. It is also noteworthy that the Index Group includes a fair proportion of fairly moderate risk families—this was explored in detail in the Stage 1 evaluation which identified about one-fifth of families with a risk level that may not warrant an intensive intervention, and it does not appear the overall risk profile of the Index Group has changed greatly since this time. The centralised referral mechanism, which only features in the TBS SBB, could be creating a practice challenge for caseworkers to engage families, some for whom another family support service might be a better fit, and limiting performance under the bond structure.

It is also important to consider that at least 20 families have disengaged from the RF service early. Families that exit early have the poorest overall child protection system outcomes and

unlike those who initially decline because they are already engaged in other services, families that exit before their goals are met appear to have unmet child protection issues which results in subsequent Helpline reports and SARAs. Under the intention-to-treat design, these results are included in Index Group performance.

Addressing the issue of early exits by better engaging these families—especially when their disengagement occurs in reaction to an attempt to escalate intensity—appears to be where there is the most scope for the RF service to improve overall outcomes, and TBS SBB performance. Focusing on social connections mapping and exploring scope for more centre-based activities could promote engagement for some families. Continuing to work with FACS to reduce the time between referral to the initial joint home visit is also likely to promote service engagement across the board. Although, there could be some structural limitations to how much these delays can be reduced in view of time to administer the TBS SBB centralised selection, matching and referral processes. More broadly, the challenge of engaging families in a voluntary service is a feature of the RF delivery context, as a non-government service. FACS CSC staff have commented that, in some cases, it is an appropriate child protection system response (rather than a shortfall of the RF service) for disengaged families to exit RF and return to FACS case management.

The positive outcomes for families in the RF service considered alongside the similarly strong performance of the Index and Control Groups points towards the importance of the cost comparison in the final evaluation stage. The final stage will also update the analysis of resilience outcomes for RF families and child protection system outcomes for Index and Control Groups. It will explore features of the RF service and its delivery in the TSB SBB context, as they relate to these outcomes.

Appendix 1. Methods

Quantitative data

Quantitative data used in the evaluation consists of two data sets provided by TBS and five provided by FACS. The contents, date ranges and case numbers in each file are summarised below. Mapping of valid numbers and missing data is shown below.

TBS data

Service monitoring data

The TBS RF client details database—a custom built Excel database that details a client's entry into the service, the type, frequency and duration of service they receive, and reasons for and supports in place around their exit from the service. This system was transitioned to a new CDM system that collected this data from 1 July 2016 to 31 December 2016 (and continuing). Together, these databases contain the records of the 106 Index Children and their families who were in the service between 8 October 2013 and 31 December 2016, and consented to participate in this evaluation.

Assessment data

The TBS Resilience Outcomes Tool database—an SPSS data file containing the results of the Resilience Outcomes Tool for consenting families in the program between 8 October 2013 and 31 December 2016. This database includes records for 95 (out of 106 total consenting RF clients) families, with baseline data for 94 families, Review 1 data for 49 families, Review 2 data for 24 families and exit data for 17 families. We understand these are planned to be completed at four-month intervals. Due to inconsistent data regarding family progression across reviews stages, some families have data for later reviews but not earlier ones. This explains why we have 95 families with assessment data, but baseline data for 94 families.

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

There are two ways in which index scores such as these can be calculated (Sanson et al., 2005).

- Option 1 is to identify cut-off scores for each variable which indicate a problem status; in essence, reducing variables to dichotomous measures. The index score(s) are then calculated by identifying the number of variables where a problem status exists.
- Option 2 is to retain variables in their continuous form (e.g. a 1 to 5 scale), but to standardise them as to make them comparable. Subdomain and domain scores can then be computed as the sum of the standardised scores. This was the approach taken in

developing the Outcome Index for the Longitudinal Study of Australian Children (Sanson et al., 2005).

The approach taken here was to use cut-off scores to indicate where attention may be needed (Option 1). The major limitation of this method is that it can involve essentially arbitrary decisions about where cut-off scores should lie for each variable. In this instance, where there was an existing scoring framework that indicated low functioning for a particular item (e.g. for the SDQ), that was retained. Where there was no such framework, low functioning was indicated by scoring in the bottom quartile for each individual item, *or* by specific responses to individual questions. In cases of low functioning on each item, individuals scored 1, otherwise they scored zero. Scores for low functioning within each domain were then summed to determine an overall index score for each outcome.

FACS data

Demographic data

An Excel spreadsheet containing the Index/ Control status and pair identifier, measurement period start and end dates, and key bond matching criteria data for each of 200 Control Children, 200 Index Children and two Unmatched Index Children (unmatched children were excluded from analysis). This database covers families in the program between 8 October 2013 and 31 December 2016.

FACS reports data

A spreadsheet of all reports for each of the children in the Index and Control Groups as detailed above from 12 months prior to their measurement start date until 31 December 2016. It includes all non-cancelled contact records where a child is a subject of the record and contact record meets standard counting rules for definition of a 'report', detailing the start date, ROSH/ non-ROSH outcome and primary reported issue for each report. A data set containing contact identifiers for reports to be considered under the new counting rules was also provided.

FACS SARA and Secondary Assessments data

A spreadsheet of all SARA and Secondary Assessments undertaken for each child in the Index and Control Groups from 12 months prior to their measurement start date until 31 December 2016. It includes all non-cancelled Secondary Assessment Stage 2 records where a child is a subject of the record, and excludes records where the 'Safety Assessment = Draft'. It details assessment type, dates, assessed issues, and safety and risk outcomes.

FACS out-of-home care data

A spreadsheet of OOHC information for Index and Control Group children from 12 months prior to their measurement start date to 31 December 2016. It includes only primary placements that commence on or before 31 December 2016, and excludes cancelled

placements and those with parents or respite placements. The list details the total number and duration of out-of-home care placements in the 12 months before and during the measurement period, the number of these placements which included a statutory care entry, the date of the first placement post-measurement start date, and whether the child was in care at the measurement start date.

FACS historical child protection data

Child protection and OOHC data for the Primary Carers of the Index and Control Children from when they were themselves a child. This data includes records only for those who were resident in NSW as a child, and covers time periods with differing reporting and care frameworks and practices. The data includes the number of child and young person concern/ child protection reports, the number of ROSH or Referred reports, and the total number of days in care in all care periods, for each instance in which the parent was the subject. It was sourced from the Child Protection historical SPSS database as of 31 December 2016.

Figure 9. RF Index evaluation population data, RF service and assessment data

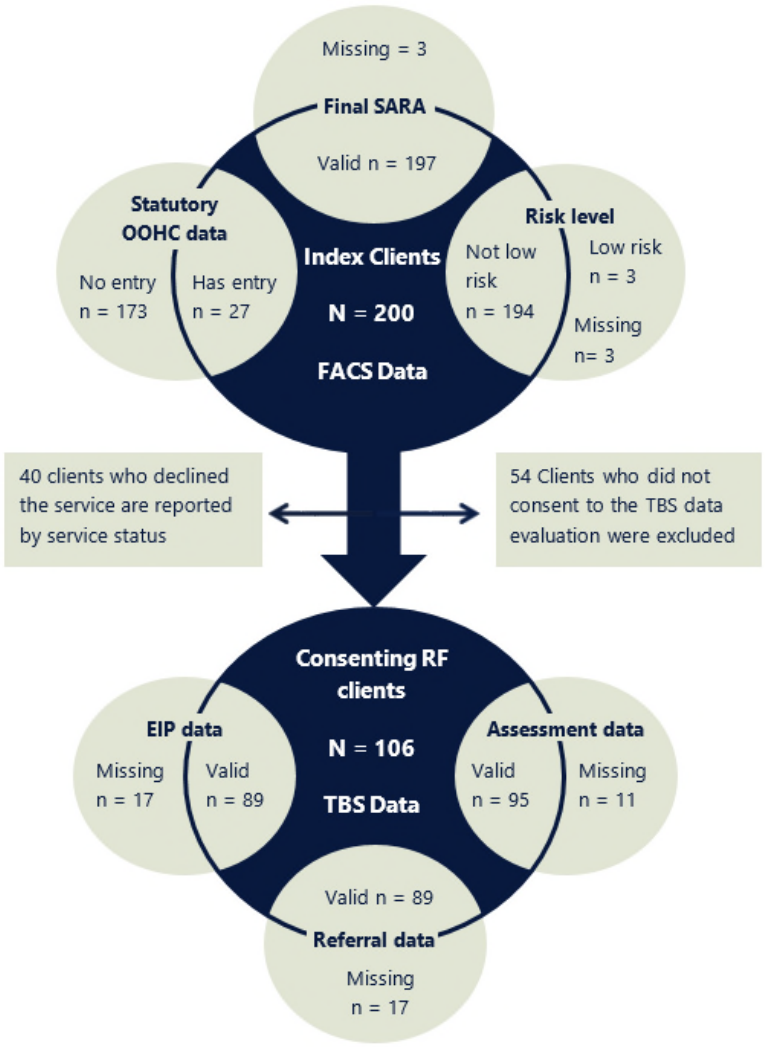
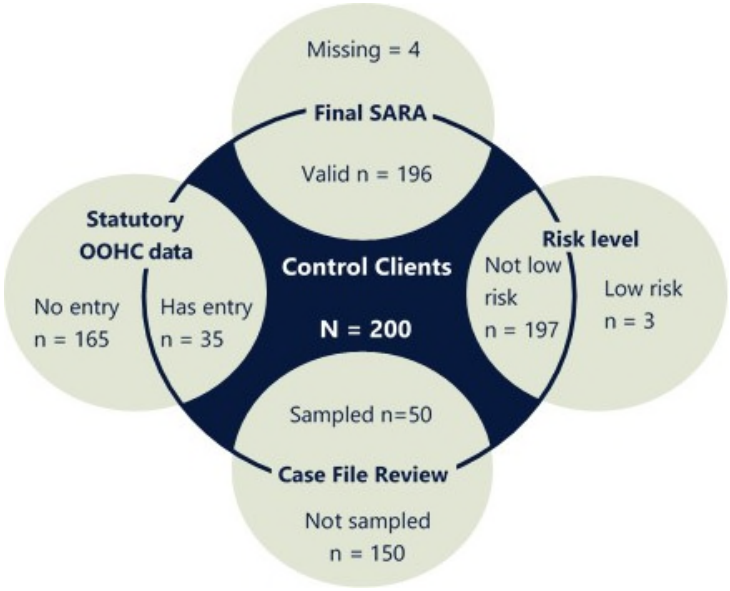


Figure 10. FACS Control evaluation population data



Quantitative analysis

Index and Control Children and the bond calculation cohort

The Index and Control Child data provided for this report includes 200 Index Children and their 200 Matched Control counterparts and two unmatched Index Children. The bond payment calculation is based on an 'intention-to-treat' model and will be conducted on all Index Children referred to the RF service, with the following exceptions:[26]

- Index Children who are not yet born at the date of extraction (TBA on birth)
- Index Children (and their matched Control child) whose families have moved away from the catchment areas for the service within 3 months of referral (early exit from treatment area)
- Index Children (and their matched Control Child) whose initial Safety Assessment decision reassessed as Unsafe and are removed by FACS into OOHC in a certain period of time
- Index Children (and their matched Control Child) who have been referred to the RF service within the six weeks prior to data extraction (insufficient observations).

The outcomes evaluation combines these data with the more detailed set of child protection data, together with TBS assessment and service data, to better understand the outcomes being achieved and help assess the appropriateness of the SBB measures.

[26] NSW Treasury, 'Operations Manual for TBS Social Benefit Bond Pilot' v4.0, 2017.

Statistical analysis

As with previous reports, most of the statistical analysis is descriptive. However, we also introduced a small amount of significance testing, looking at if the differences between the Index and Control groups could be greater than might occur by chance alone. We compared the mean number of Helpline reports, SARAs and statutory OOHC entries for Index and Control groups using 2 sample t-tests. We compared the proportion of Index and Control groups with Helpline reports, SARAs and statutory OOHC entries using Chi-squared tests. None of the differences tested in means or proportions were significantly different at the 95 per cent confidence level (i.e. where $p<0.05$).

Counting rules [updated 2016]

The SBB counting method for Helpline reports and SARAs was changed in late 2016 following recommendations from the Stage 1 evaluation. These changes altered only report and SARA measurement during the measurement period, not before entry to the service or the Control Group. Helpline reports during were only counted if they were reports from police or health professionals. SARAs were excluded from analysis if they occurred within the first 180 days (six months) of referral to the RF service or entry into the Control Group.

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.

Analysing SARAs 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 analysis.

Analyses using risk levels and service status

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

As well as looking at outcomes for the population overall (n=200), we look at outcomes for a smaller cohort of families who consented to participate in the evaluation and for whom we have functioning and wellbeing outcomes as measured by the TBS Resilience Outcomes Tool, and data about the service they received (n=106). Within this smaller population we undertake more detailed analysis of child protection outcomes by looking at outcomes based on family level of risk and on service status (goals met, exited or continuing).

Level of risk

In this report, we looked at the outcomes of families according to their risk level on entry into the program. Risk outcome by final SARA risk assessment at the time of referral to the RF service was used as the key variable in reporting on service outcomes. This method was tested in the Interim Report from the Stage 1 evaluation and found to be the best method for assessing level of risk.

Case file analysis

Casefile data collection was completed during March to May of 2017 and covered case notes from August 2013 to the end of June 2016. In consultation with FACS and using TBS data collection systems as a model, ARTD developed an Excel database to record casefile notes (recording phone calls, meetings, texts, emails, home visits and other forms of contact), referrals and involved services, and brokerage. Control Group children were randomly sorted into a list, with the first 25 children with a matched Index child from each region included in this analysis: total sample size, n=50.

Over the course of several days, our consultant visited the FACS head office to collect data. Data collection was conducted orally, as the FACS staff member read out the date, casefile note type, and main subject(s) of all interactions between FACS and the selected Control Group child within the measurement period, which was entered into the database on a separate computer by our consultant. To maintain confidentiality, no names or places were mentioned or shown to our consultant, and subjects were kept at a high level such as 'health' or 'disability support'. In this way, the type and intensity of casework and services under business as usual could be generally established.

To develop comparable data sets, relevant variables from TBS service data and the FACS case file review were combined into a single data set then coded to a common set of categories, developed iteratively from the analysis. The new categories were then transferred back into the original data sets, and the counts of activities and referrals by new category were taken. Of the total TBS clients who consented to the evaluation (n=106), 89 TBS clients had EIP data and were included in the case file analysis.

Qualitative sources and analysis

Family interviews

ARTD received a list of RF participants from TBS who had consented to be contacted about being interviewed about their experience with the program. To provide the most accurate recollections possible, only participants whose case closure dates fell within 2016 or 2017 were targeted for this round of interviews.

Potential interview participants 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. Following several calls over three months, four interviews were arranged and completed—the sample included families from both Region 1 and Region 2. All preferred to be interviewed over the phone, rather than face-to-face. Interviews were recorded with participants consent, transcribed and analysed to find common or striking themes.

FACS CSC staff focus groups/ interviews

FACS CSC staff were invited to participate in focus groups, one in each region, through a central FACS contact. This was to ensure a hands-off approach to recruitment. Focus groups were recommended to the evaluation as the preferred approach. Multiple invitations and reminders were extended however participation was low. We understand this is, in part, due to staff changing roles and in some locations the relatively small number of current staff who have been directly involved in referral and information sharing processes.

Five staff from across three CSCs (one in Region 1 and two in Region 2) agreed to participate. This group included a mix of CSC managers and caseworkers. Interviews were 45 minutes to 1 hour by phone, and the face-to-face focus group was 1.5 hours. Interviews and focus groups were recorded and notes were taken to enable a thematic analysis.

RF staff survey

The RF staff survey was distributed to workers through a generic online link set up by ARTD and emailed to workers by TBS' evaluation officers. Although this approach did not allow for individual follow up of non-completes, it was the preferred approach in view of the small number of staff and to alleviate concerns about staff being identified.

Of the 17 potential respondents, nine Senior Child and Family Workers and two Team Leaders took part. We analysed the data in Excel, linking questions to those asked in the 2014 survey. We compared these data, although there are limitations in the strengths of conclusions that can be drawn from this due to the low number of participants. We also analysed qualitative response thematically, using Nvivo.

Appendix 2. Referral, assessment and service timeframes

Table 22. Number of weeks from date of SARA commenced to initial home visit

Child age	N	Average weeks	S.D.	Minimum	Maximum
Unborn	6	9.0	10.0	3.0	29.0
Under 1 year	35	5.4	3.1	2.0	15.0
1-2 years old	12	5.4	4.8	2.0	19.0
3 years or older	23	7.6	6.6	3.0	33.0
Total	76	6.9	6.1	2.0	33.0

Source: TBS Service monitoring data and FACS SARA and Secondary Assessments data
Excluded 94 Families who declined RF or did not consent to the evaluation, 30 families missing data

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

	N	Average number of days	Standard Deviation	Minimum	Maximum
Region 1	37	26.5	48.9	3	213
Region 2	50	17.9	16.7	0	88
Total	87	21.6	34.3	0	213

Source: TBS Service monitoring data
Excluded 94 Families who declined RF or did not consent to the evaluation, 19 families missing data

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

	N	Average days from initial contact to completion of assessment	S.D.	Minimum	Maximum
Region 1	29	31.8	42.5	6	182
Region 2	37	30.4	53.3	0	317
Total	66	31.0	48.5	0	317

Source: TBS Service monitoring data and TBS Assessment data
Excluded 94 Families who declined RF or did not consent to the evaluation, 40 families missing data

Table 25. Number of days between assessment and reviews

Time point 1	Time point 2	N	Average time (days)
Baseline	Review 1	42	128
Review 1	Review 2	21	134
Review 2	Exit	8	138
Baseline	Exit	16	326

Source: TBS Service monitoring data and TBS Assessment data
Table includes data from 95 families with assessment data.
Excluded 94 Families who declined RF or did not consent to the evaluation,11 families missing assessment data.
Note: table categories have families that overlap.

Table 26. Length of service (months) for completed and exited RF clients

Final risk outcome (SARA)	N	Months	S.D.	Min	Max	Interim report (2013-16) Months
Moderate	17	6.4	4.8	0.0	19.0	6.7
High	32	9.2	4.8	1.0	21.0	9.8
Very High	14	9.4	5.2	3.0	20.0	9.3
Total	63	8.5	5.0	0.0	21.0	9.1

Source: TBS Service monitoring data and FACS SARA and Secondary Assessments data
Excluded 94 Families who declined RF or did not consent to the evaluation, 43 Families missing data

Table 27. Number of EIP interactions with clients per month, all clients, according to risk level

	Number of EIP interactions per month				Hours per month		
Final risk outcome (SARA)	N	Average	Minimum	Maximum	Average	Minimum	Maximum
Moderate	20	**4.4**	0.4	10.8	**3.2**	0.3	9.1
High	38	**7.5**	0.6	78.0	**4.6**	0.2	33.4
Very High	14	**4.9**	0.2	11.0	**4.2**	0.1	10.2
Total	72	**6.2**	0.2	78.0	**4.1**	0.1	33.4

Source: TBS Service Monitoring EIP and Meetings Data, FACS SARA and Secondary Assessments Data
Excluded 94 Families who declined RF or did not consent to the evaluation, 34 Families missing data, SARA missing for one of the families missing data

Table 28. Number of meetings with clients per month, all clients, according to risk level

		Number of meetings per month			Hours per month		
Final risk outcome (SARA)	**N**	**Average**	**Minimum**	**Maximum**	**Average**	**Minimum**	**Maximum**
Moderate	16	**9.7**	2.0	17.7	**9.0**	4.4	18.2
High	31	**12.3**	3.2	23.0	**9.1**	2.7	26.4
Very High	14	**15.7**	0.4	30.6	**11.0**	0.2	22.5
Total	61	**12.4**	0.4	30.6	**9.5**	0.2	26.4

Source: TBS Service Monitoring Activity Data, FACS SARA and Secondary Assessments Data
Excluded 94 Families who declined RF or did not consent to the evaluation, 45 Families missing data, SARA missing for one of the families missing data

Appendix 3. Family and carer characteristics

Table 29. Characteristics of RF Primary Carers

		Region 1	Region 2	Total
	n	42	50	92
Age at referral	Average (mean)	30.88	32.77	31.90
	Missing data	0	1	1
Gender	Male	2%	12%	8%
	Female	98%	88%	92%
	Missing data	1	0	1
Employment situation	Employed full time	10%	0%	4%
	Employed part time	3%	0%	1%
	Employed casual	6%	0%	3%
	Full time carer/ parent	48%	63%	57%
	Studying	0%	0%	0%
	Unemployed	32%	37%	35%
	Missing data	11	9	20
Main source of income	Wages or salary	13%	0%	5%
	Child support or maintenance from ex-partner	0%	2%	1%
	Government benefit, pension or allowance	81%	95%	89%
	No income source	6%	2%	4%
	Missing data	10	8	19
Highest level of education achieved	Never attended school	0%	5%	3%
	Less than HSC or equivalent	68%	64%	65%
	HSC or equivalent	16%	18%	17%
	Post-school qualification	16%	14%	14%
	Missing data	17	12	29

Source: TBS Assessment data

Excluded 94 Families who declined RF or did not consent to the evaluation, 14 families missing data.

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

Table 30. Characteristics of RF secondary carers

		Region 1	Region 2	Total
n		42	50	92
Age at referral	Average (mean)	36.87	36.56	36.72
	Missing data	5	15	20
Gender	Male	95%	87%	91%
	Female	5%	13%	9%
	Missing data	4	12	16
Employment situation	Employed full time	20%	36%	28%
	Employed part time	8%	0%	4%
	Employed casual	4%	20%	12%
	Full time carer/ parent	4%	12%	8%
	Unemployed	52%	28%	40%
	Other	12%	4%	8%
	Missing data	17	25	42
Main source of income	Wages or salary	31%	43%	37%
	Government benefit, pension or allowance	58%	57%	57%
	Self-employed	4%	0%	2%
	No income source	4%	0%	2%
	Missing data	16	27	43
Highest level of education achieved	Less than HSC or equivalent	61%	56%	58%
	HSC or equivalent	23%	22%	23%
	Post-school qualification	16%	22%	19%
	Missing data	29	32	61

Source: TBS Assessment data

Excluded 94 Families who declined RF or did not consent to the evaluation, 14 families missing data.20 families do not have a Secondary Carer

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

Table 31. Types of Housing for RF Families

	Region 1	Region 2	Total
n	34	41	75
Own or paying off house/ flat	18%	5%	11%
Public housing	32%	27%	29%
Private rental house/ flat/ unit	26%	37%	32%
Stay with family or friends	9%	12%	11%
Caravan	0%	0%	0%
Crisis/ temporary housing	9%	12%	11%
Homeless	3%	0%	1%
Other	3%	2%	3%
Total	100%	100%	100%
Missing	8	9	17

Source: TBS Assessment Data

Excluded 94 Families who declined RF or did not consent to the evaluation,31 families missing data.

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

Table 32. Language spoken at home by RF families

	Region 1		Region 2		Total	
	n	%	N	%	n	%
English	38	90%	43	84%	81	88%
Arabic	1	2%	3	6%	4	4%
Khmer	0	0%	1	2%	1	1%
Chinese languages	0	0%	1	2%	1	1%
Turkish	1	2%	0	0%	1	1%
Urdu	1	2%	0	0%	1	1%
Vietnamese	1	2%	0	0%	1	1%
Other (Unspecified African and Middle Eastern Languages)	0	0%	2	4%	2	2%
Total	42	98%	50	100%	92	99%

Source: TBS Assessment data

Excluded 94 Families who declined RF or did not consent to the evaluation, 24 families missing data

Note: percentages have been rounded and may not total to 100%, data refers to primary languages only

Table 33. Number of times RF family moved house in past 12 months

	Region 1	Region 2	Total
n	31	40	71
Not at all	61%	40%	49%
Once	16%	18%	17%
Twice	3%	20%	13%
Three times	10%	15%	13%
Four times or more	10%	8%	8%
Total	100%	101%	100%
Missing	10	8	18

Source: TBS Assessment data
Excluded 94 Families who declined RF or did not consent to the evaluation, 35 families missing data
Note: percentages have been rounded and may not total to 100%

Table 34. Average age and gender of Index Children at referral

Age at referral	Region 1	Region 2	Total
n	33	45	78
Average age	2.16	1.97	2.05
Missing	0	0	0
Gender			
n	33	44	77
Male	52%	55%	53%
Female	48%	45%	47%
Total	100%	100%	100%
Missing	0	1	1

Source: TBS Assessment data,
Excluded 94 Families who declined RF or did not consent to the evaluation, 28 families missing data
6 unborn children excluded

Table 35. ATSI status of Index Children

Identifies as ATSI	Region 1	Region 2	Total
n	33	44	77
No	70%	77%	74%
Yes	27%	20%	23%
Unknown	3%	2%	3%
Total	100%	99%	100%

Source: TBS Assessment data, 6unborn children excluded

Excluded 94 Families who declined RF or did not consent to the evaluation, 28 families missing data

6 unborn children excluded

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

Appendix 4. Child protection system

Helpline Reports

Table 36. Helpline Reports by service status for Index Children, and RF and FACS as a whole

Service status	N	% families with reports	Average number of reports	S.D.	Minimum	Maximum
Family met goals	42	24%	0.5	1.2	0	7
Continuing in program	26	27%	0.6	1.1	0	4
Exited program	23	35%	0.8	1.3	0	4
Declined RF	40	20%	0.3	0.7	0	3
Total*	131	25%	0.5	1.1	0	7
Total RF	200	29%	0.56	1.1	0	7
Total Control	200	30%	0.61	1.2	0	6

Source: TBS Service monitoring data and FACS reports data
*Service status is unknown for 54 families who did not consent to the evaluation, 15 families missing service outcome data

SARAS

Table 37. Number of SARAs during measurement period for Index Group by service status

Service status	N	N families with SARA commenced	% families with SARAs	Average number of SARAs	S.D.	Min	Max
Completed RF (met goals)	42	8	19%	0.3	0.8	0	4
Continuing	26	1	4%	0.1	0.4	0	2
Exited early	23	9	39%	0.9	1.5	0	5
Declined	40	8	20%	0.3	0.5	0	2
Total	131	27	21%	0.3	0.9	0	5
Total RF (Index Group)	200	31	16%	0.3	0.8	0	5
Total Control	200	39	20%	0.3	0.7	0	3

Source: TBS Service monitoring data and FACS reports data
Service status is unknown for 54 families who did not consent to the evaluation, 15 families missing service outcome data

OOHC Entries

Table 38. Statutory OOHC entries for RF children by service status

	Exited with goals met	Continuing	Exited early	Declined RF	Total*	Total RF	Total Control
Number of families	42	26	23	40	131	200	200
Number of families with statutory OOHC entries	2	2	9	7	20	27	35
% of families with statutory OOHC entries	5%	8%	39%	18%	15%	14%	18%
Average number of entries (all families)	0.0	0.1	0.4	0.2	0.2	0.1	0.2

Source: TBS Service monitoring data and FACS out-of-home care data
*Service status is unknown for 54 families who did not consent to the evaluation. 15 families missing service outcome data

Appendix 5. RPF scale items

Resilience Outcomes Scales

K10: The Kessler-10 (K10) is a measure of psychological distress, used as a brief screening tool. It contains 10 questions about emotional state.

Personal Wellbeing Index (PWI): The PWI measures an individual's subjective quality of life, or wellbeing. It contains one overall measure, and seven additional items which are summed to produce an overall score.[27]

Strengths and Difficulties Questionnaire (SDQ): The SDQ is designed as a brief behavioural screen questionnaire that can be used for a variety of purposes, including measuring outcomes. The version used by the RF service is the Parent 4-10 version, where it is used for children 3+. The SDQ contains a 'Total Difficulties' score, which provides an overall measure of problems. The maximum score is 40.

Social connections: Two questions in the Resilience Outcomes Tool, drawn from the Longitudinal Study for Australian Children and World Values Survey, ask about the frequency of Primary Carer and Index Child contact with families, friends and community. Z-scores are used as a measure of change from the baseline, with higher scores indicating a higher level of change from the baseline.

Table 39. Resilience outcome scores, changes over time by initial risk level

Risk level (initial SARA)		Baseline	Review 1	Review 2	Exit
Moderate	n	24	11	4	4
	Outcome index	0.04	0.34	0.88	1.06
High	n	49	28	13	10
	Outcome index	0.04	0.33	0.23	0.64
Very high	n	19	10	7	3
	Outcome index	-0.09	0.26	0.79	0.81

Source: FACS SARA and Secondary Assessments data and TBS Assessment data
Excluded 94 Facombinedmilies who declined RF or did not consent to the evaluation, 11 families missing data

[27] 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.

Appendix 6. Reported and assessed issues

The tables in this appendix use the new counting rules only (Police and Health reports).

Table 40. All reported issues in the 12 months prior to the RF service

	Index		Control	
Category of reported issue	Number	Percent	Number	Percent
Physical abuse	174	24%	177	22%
Neglect	153	21%	130	16%
Sexual abuse	21	3%	25	3%
Psychological harm	114	16%	124	16%
Children danger to self or others	23	3%	8	1%
Relinquishing care	6	1%	2	0%
Carer concern	162	22%	182	23%
No risk or harm issues	17	2%	17	2%
Pre-natal report	64	9%	134	17%
Total	734	100%	799	100%

Source: FACS reports data

Table 41. Assessed issues in the 12 months prior to the RF service

	Index		Control	
Category of assessed issue	**Number**	**Percent**	**Number**	**Percent**
Physical abuse	84	21%	122	29%
Neglect	99	25%	85	20%
Sexual abuse	1	0%	2	0%
Psychological harm	12	3%	13	3%
Relinquishing care	2	1%	2	0%
Carer concern	132	33%	145	34%
No risk or harm issues	52	13%	39	9%
Pre-natal report	13	3%	13	3%
Children danger to self or others	1	0%	0	0%
Total	396	100%	421	100%

Source: FACS SARA and Secondary Assessments data

Table 42. Reported issues during the RF service

	Index		Control	
Category of reported issue	**Number**	**Percent**	**Number**	**Percent**
Physical abuse	48	44%	50	41%
Neglect	21	19%	12	10%
Sexual abuse	8	7%	7	6%
Psychological harm	4	4%	7	6%
Children danger to self or others	0	0%	2	2%
Relinquishing care	0	0%	1	1%
Carer concern	23	21%	38	31%
No risk or harm issues	5	5%	2	2%
Pre-natal report	0	0%	3	2%
Total	109	100%	122	100%

Source: FACS Reports data

Table 43. Assessed issues during the RF service

	Index		Control	
Category of assessed issue	**Number**	**Percent**	**Number**	**Percent**
Physical abuse	5	12%	8	13%
Neglect	15	35%	6	10%
Sexual abuse	0	0%	2	3%
Psychological harm	0	0%	2	3%
Relinquishing care	0	0%	0	0%
Carer concern	16	37%	24	38%
No risk or harm issues	2	5%	13	21%
Pre-natal report	0	0%	0	0%
Children danger to self or others	5	12%	8	13%
Total	43	100%	63	100%

Source: FACS SARA and Secondary Assessments data

Table 44. Assessed and reported issue categories[28]

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

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

Appendix 7. TBS RF staff survey data

TBS RF staff who responded to the survey include nine Senior Child and Family Workers and two Team Leaders (Table 46). Nearly three-quarters (73%) of survey respondents were based at the Liverpool site (Table 47). Of the staff surveyed, six had worked for TBS for 13 months or less and the longest time someone has been a staff member was 42 months (Table 48).

Table 45. Response rates of TBS RF staff

Site	Staff invited	Number of respondents	Response rate
Liverpool	9	8	89%
Rosebery	8	2	25%
Total	17	10	59%

Source: TBS Staff Survey, February – March 2017

Table 46. Reported TBS RF staff roles

Role	Number	Percent
Team Leader	2	18%
Senior Child and Family Worker	9	82%
Total	11	100%

Source: TBS Staff Survey, February – March 2017

Table 47. TBS site that RF staff work from

Site	Number	Percent
Liverpool	8	73%
Rosebery	2	18%
Rosebery, but I also receive some referrals from Liverpool	1	9%
Total	11	100%

Source: TBS Staff Survey, February – March 2017

Table 48. How long staff have been working in the RF service?

Duration	Number	Percent
Less than 3 months	1	9%
3 – 6 months	0	0%
6 – 12 months	4	36%
12 – 18 months	3	27%
18 – 24 months	1	9%
More than 24 months	2	18%
Total	11	100%

Source: TBS Staff Survey, February – March 2017

Table 49. How RF staff report processes are working

	Very well			Well			Not so well			Not at all well			Total
	n	2017 %	2014 %	n	2017 %	2014 %	n	2017 %	2014 %	n	2017 %	2014 %	n	2017 %
Referrals to the RF service	3	27%	0%	6	55%	67%	2	18%	22%	0	0%	11%	11	100%
The initial joint home visit or meeting	2	18%	22%	9	82%	67%	0	0%	11%	0	0%	0%	11	100%
Information sharing with CSC's	0	0%	11%	10	91%	56%	1	9%	11%	0	0%	22%	11	100%

Source: TBS Staff Survey, February – March 2017

Table 50. How closely are families' RF service goals usually aligned to the risk and safety issues identified in FACS' Safety and Risk Assessments?

	2014 Survey		2017 Survey	
	Number	Percent	Number	Percent
Very well	3	33%	3	27%
Well	6	67%	7	64%
Not so well	0	0%	1	9%
Not at all well	0	0%	0	0%
Total	9	100%	11	100%

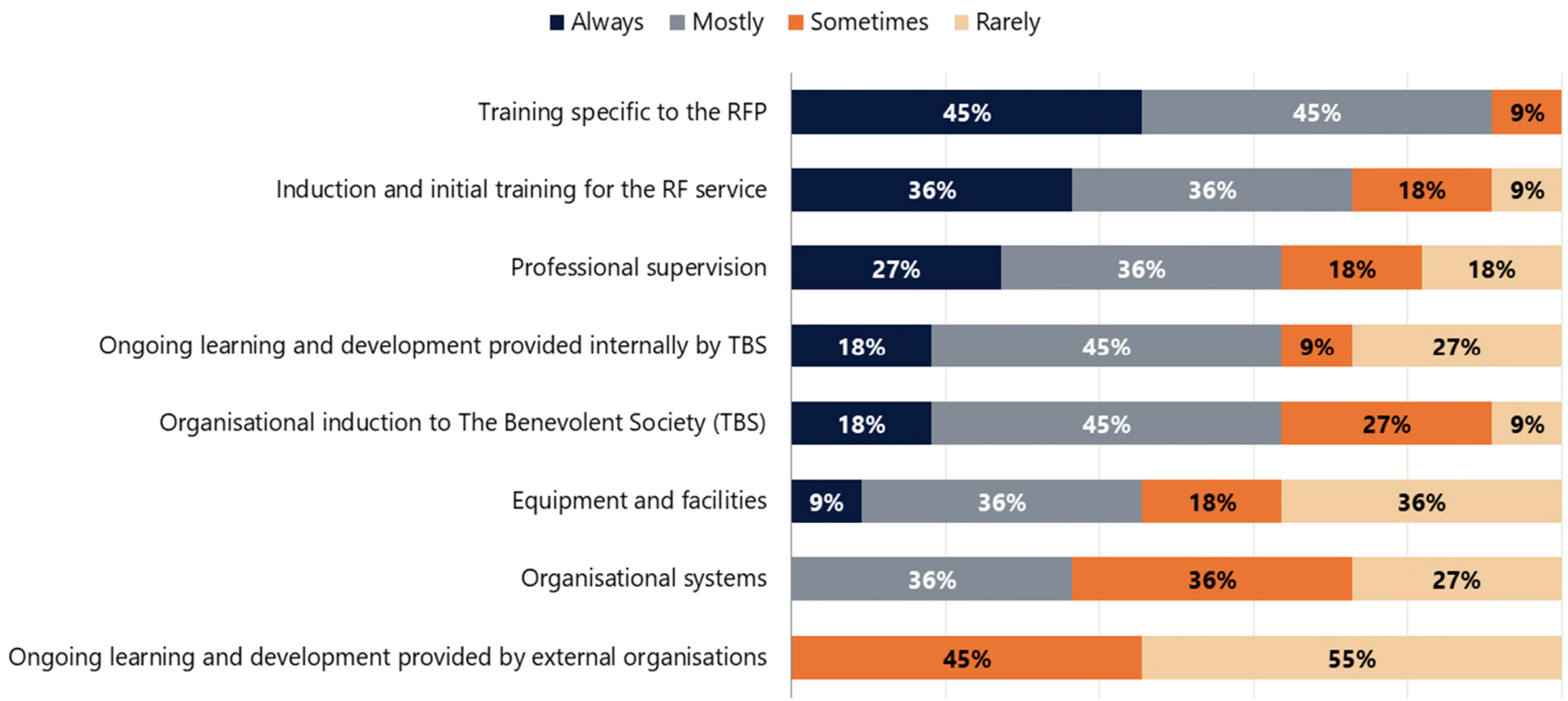
Source: TBS Staff Survey, February – March 2017

Table 51. TBS feelings of organisational support by year

	Always			Mostly			Sometimes			Rarely			Total
	2017		2014	2017		2014	2017		2014	2017		2014	2017
	n	%	%	n	%	%	n	%	%	n	%	%	n	%
Training specific to the RFP	5	45%	NA	5	45%	NA	1	9%	NA	0	0%	NA	11	100%
Induction and initial training for the RF service	4	**36%**	22%	4	36%	11%	2	18%	11%	1	9%	44%	11	100%
Professional supervision	3	27%	**33%**	4	36%	44%	2	18%	11%	2	18%	0%	11	100%
Organisational induction to The Benevolent Society	2	18%	**44%**	5	45%	22%	3	27%	0%	1	9%	22%	11	100%
Ongoing learning and development provided internally by TBS	2	18%	**44%**	5	45%	22%	1	9%	0%	3	27%	22%	11	100%
Equipment and facilities	1	9%	22%	4	36%	33%	2	18%	11%	4	36%	22%	11	100%
Organisational systems	0	0%	11%	4	36%	33%	4	36%	11%	3	27%	33%	11	100%
Ongoing learning and development provided by external organisations	0	0%	22%	0	0%	0%	5	45%	33%	6	55%	33%	11	100%

Source: TBS Staff Survey, February – March 2017

Figure 11. To what extent do you feel supported in the following areas?



Source: TBS Staff Survey, February – March 2017

Table 52. To what extent have the following potential challenges affected the referral of RF families to other support services?

	Always a challenge	Often a challenge	Sometimes a challenge	Never or rarely a challenge		Total	Missing
	%	%	%	%	n	%	n
Costs to a family	40%	50%	0%	10%	10	100%	1
The availability of a service in the local area	10%	50%	40%	0%	10	100%	1
The convenience of a service to the family (its accessibility)	10%	50%	30%	10%	10	100%	1
Family preference	0%	30%	30%	40%	10	100%	1

Note: No TBS staff selected the "Don't know" response option so it was excluded from the table. One staff member did not respond to this question

Appendix 8. Control Group case file review

Table 53. Average number of interactions, measurement time, and interactions per month of FACS and TBS clients.

	FACS (50 clients)	TBS (89 clients)
Average interactions per client	53.5	38.9
Average measurement time (months)	15.4	10.6
Average interactions per month	3.5	3.7

Source: TBS Service Monitoring EIP Data and FACS Case File data.
Note: 'measurement time' refers to time elapsed between referral to either FACS or TBS and the point when the client exited the service. Where a client is continuing within either service, the last date of data collection was used. This is *not* the same as the duration used to calculate the service intensity of RF (section 6.1)

There are limitations in a direct comparison of practices between the FACS Control Group sample and families in the RF service due to different data recording practices, and in view of the database systems set up to record activity. To develop comparable data sets, as far as possible, relevant variables from TBS service data and the FACS case file review were combined into a single data set, then coded to a common set of categories, developed iteratively from the analysis. The new categories were then transferred back into the original data sets, and the counts of activities and referrals by new category were taken.

Table 54. Practices addressed by FACS and TBS with both <3% removed

	FACS (n=50)		TBS (n=89)	
	n	%	n	%
General case management	887	18%	447	13%
Behavioural Skills	10	0%	576	17%
Parenting skills	218	4%	593	17%
Safety	467	9%	497	14%
Housing	459	9%	131	4%
Health	431	9%	133	4%
Family support	375	7%	265	8%
Mental health	341	7%	36	1%
AOD	332	7%	25	1%
Domestic violence	244	5%	39	1%
Education	194	4%	76	2%
Child protection and safety	176	4%	137	4%
Home visit	145	3%	11	0%
Finance	134	3%	38	1%
Legal/court	133	3%	37	1%
Childcare	128	3%	28	1%
Engagement and connection	83	2%	87	3%
Liaising with Govt Dept or other services	75	1%	97	3%
Counselling	22	0%	134	4%
Other	167	3%	71	2%
Total	5021	100%	3458	100%
Missing	848	-	0	-

Source: TBS Service Monitoring EIP Data and FACS Case File data. Excluded categories are: cultural support, disability, referral, brokerage, employment, immigration, child counselling skills and Brighter Futures.

Table 55. Referrals to external services by TBS and FACS

	FACS (n=29)		TBS (n=89)	
Type of external service	n	%	n	%
Parenting and Family Support	24	44%	25	6%
Health/Medical/Disability	11	20%	92	24%
Mental Health	4	7%	62	16%
Playgroup/Childcare	4	7%	56	14%
Financial Support and Employment	1	2%	43	11%
DV Support	5	9%	5	1%
Other Professional Services	4	7%	11	3%
Education	0	0%	51	13%
Housing	0	0%	27	7%
Local Community Services and Youth	0	0%	8	2%
AOD Services	0	0%	5	1%
Other	1	2%	3	1%
Total	54	100%	388	100%

Source: TBS Service Monitoring Referral Data and FACS Case File Data.

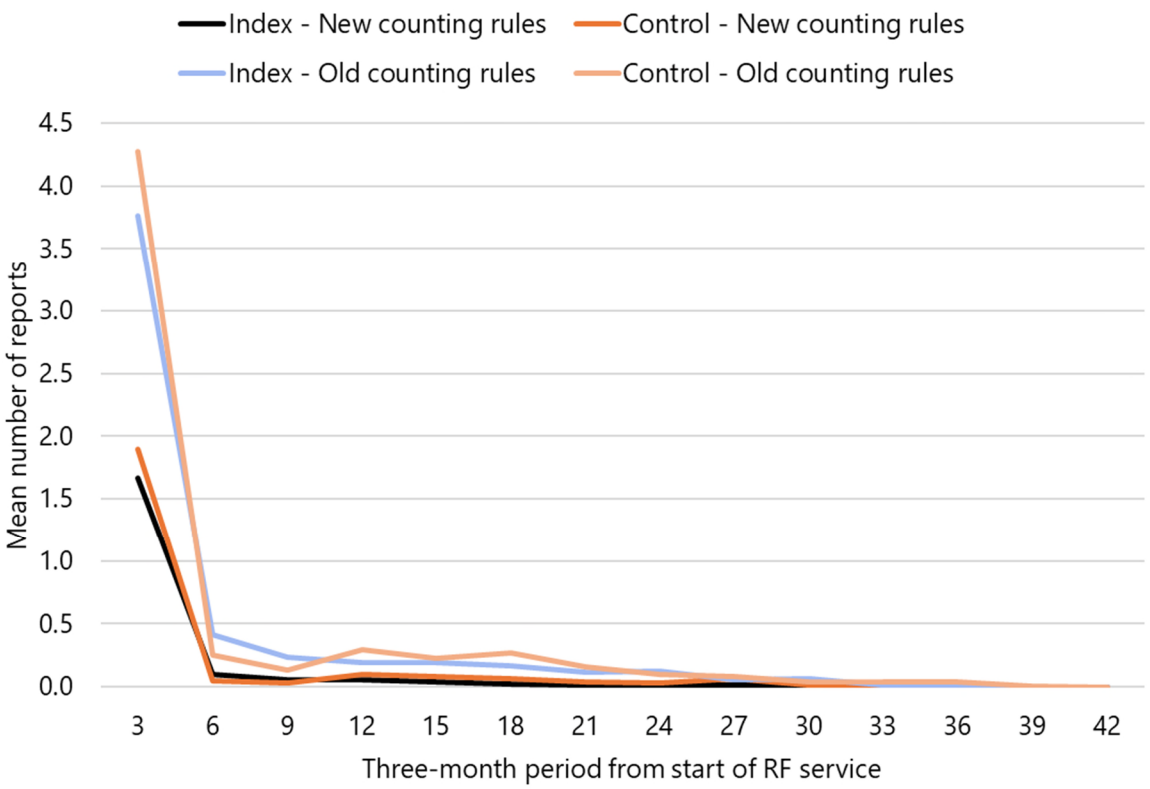
Table 56. Average number of referrals to external services for TBS and FACS clients

	FACS	TBS
Number of clients	50	89
Number of referrals	54	388
Average referrals per client	1.1	4.4

Source: TBS Service Monitoring Referral Data and FACS Case File Data.
Note: Missing referral data for 17 TBS clients.

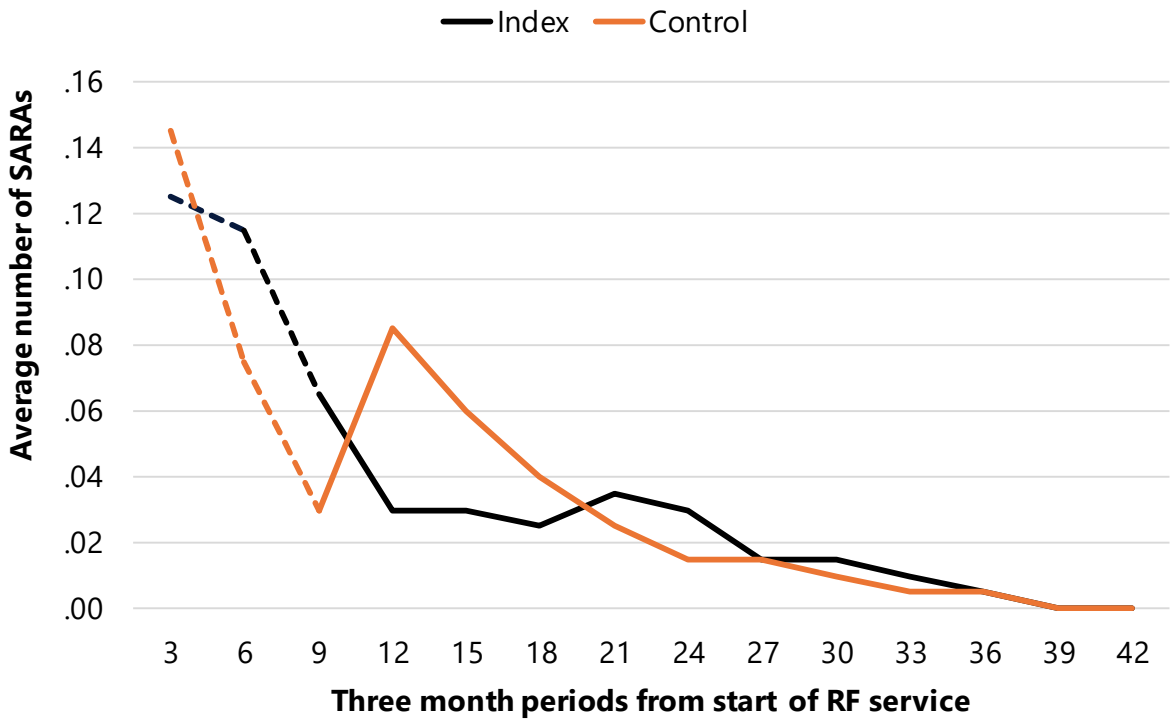
Appendix 9. Comparison of SBB measures on old and new counting rules

Figure 12. Average number of reports during service, three-month intervals



Source: FACS Reports data

Figure 13. Average number of SARAs during service, three-month intervals



Source: FACS SARA and Secondary Assessments data
Note: Dashes in the first two time-periods indicate time-periods that were not included in the new counting method.

Table 57. ROSH and total reports during service

	Old count rules								New count rules							
	Index				Control				Index				Control			
	N reports	Mean	N CYP with reports	Total N	N reports	Mean	N CYP with reports	Total N	N reports	Mean	N CYP with reports	Total N	N reports	Mean	N CYP with reports	Total N
ROSH reports	261	1.31	113	200	239	1.20	116	200	69	.35	58	200	67	.34	60	200
Total reports	474	2.37	113	200	447	2.24	116	200	111	.56	58	200	122	.61	60	200

Source: FACS Reports data

Table 58. Mean SARAs table and number with comparison

	Old count rules		New count rules	
	Index	Control	Index	Control
Number of children	200	200	200	200
Number of SARAs	100	104	52	60
Proportion with SARA	50%	52%	26%	30%
Mean	0.50	0.52	0.26	0.30
Minimum	0	0	0	0
Maximum	7	5	5	3

Source: FACS SARA and Secondary Assessments data

When counting reported and assessed issues, the analysis does not look only at primary reports or assessments, but consolidates all issues.

Table 59. All reported issues in the 12 months prior to RF service (not altered by counting changes)

	Index		Control	
Category of reported issue	N	%	N	%
Physical abuse	174	24%	177	22%
Neglect	153	21%	130	16%
Sexual abuse	21	3%	25	3%
Psychological harm	114	16%	124	16%
Children danger to self or others	23	3%	8	1%
Relinquishing care	6	1%	2	0%
Carer concern	162	22%	182	23%
No risk or harm issues	17	2%	17	2%
Pre-natal report	64	9%	134	17%
Total	734	101%	799	100%

Source: FACS Reports data
Note: Percentages may not add to 100% due to rounding

Table 60. Assessed issues in the 12 months prior to RF service (not altered by counting rule change)

	Index		Control	
Category of assessed issues	N	%	N	%
Physical abuse	84	21%	122	29%
Neglect	99	25%	85	20%
Sexual abuse	1	0%	2	0%
Psychological harm	12	3%	13	3%
Relinquishing care	2	1%	2	0%
Carer concern	132	33%	145	34%
No risk or harm issues	52	13%	39	9%
Pre-natal report	13	3%	13	3%
Children danger to self or others	1	0%	0	0%
Total	396	99%	421	98%

Source: FACS SARA and Secondary Assessments data
Note: Percentages do not sum to 100% due to rounding

Table 61. All reported issues during the RF service (old and new count rules)

	Old count rules				New count rules			
	Index		Control		Index		Control	
Category of reported issue	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Physical abuse	117	25%	106	24%	48	44%	50	41%
Neglect	103	22%	88	20%	21	19%	12	10%
Sexual abuse	44	9%	39	9%	8	7%	7	6%
Psychological harm	69	15%	67	15%	4	4%	7	6%
Children danger to self or others	14	3%	5	1%	0	0%	2	2%
Relinquishing care	5	1%	18	4%	0	0%	1	1%
Carer concern	92	19%	108	24%	23	21%	38	31%
No risk or harm issues	25	5%	10	2%	5	5%	2	2%
Pre-natal report	3	1%	5	1%	0	0%	3	2%
Total	472	100%	446	100%	109	100%	122	101%

Source: FACS Reports data
Note: Percentages may not sum to 100% due to rounding

Table 62. Assessed issues during RF service (old and new count rules)

	Old count rules				New count rules			
	Index		Control		Index		Control	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Physical abuse	30	19%	37	22%	5	13%	8	15%
Neglect	37	24%	20	12%	15	39%	6	11%
Sexual abuse	6	4%	4	2%	0	0%	2	4%
Psychological harm	7	5%	5	3%	0	0%	2	4%
Relinquishing care	0	0%	3	2%	0	0%	0	0%
Carer concern	55	36%	53	32%	16	42%	24	44%
No risk or harm issues	19	12%	42	25%	2	5%	13	24%
Pre-natal report	0	0%	1	1%	0	0%	0	0%
Total	154	100%	165	99%	38	99%	55	102%

Source: FACS SARA and Secondary Assessments data
Note: Percentages may not sum to 100% due to rounding

Table 63. Number of Helpline Reports by RF service outcome, new and old count rules

	Old count rules						New count rules					
Service outcome	N	% families with reports	Average number of reports	S.D.	Minimum	Maximum	N	% families with reports	Average number of reports	S.D.	Minimum	Maximum
Family met goals	42	98%	5.9	5.5	0	32	42	24%	0.5	1.2	0	7
Continuing in program	26	88%	5	5.3	0	20	26	27%	0.6	1.1	0	4
Exited program	23	100%	10.7	7.3	1	30	23	35%	0.8	1.3	0	4
Declined RF	40	95%	4.1	4.9	0	23	40	20%	0.3	0.7	0	3
Total	131	94%	6	6	0	32	131	25%	0.5	1.1	0	7

Source: TBS Service monitoring data and FACS Reports data

Table 64. Number of SARAs during service by RF service outcome, new and old count rules

	Old count rules						New count rules					
Service outcome	N	% families with reports	Average number of reports	S.D.	Minimum	Maximum	N	% families with reports	Average number of reports	S.D.	Minimum	Maximum
Family met goals	42	26%	0.5	0.9	0	4	42	19%	0.3	0.8	0	4
Continuing in program	26	19%	0.3	0.7	0	3	26	4%	0.1	0.4	0	2
Exited program	23	57%	1.4	1.8	0	7	23	39%	0.9	1.5	0	5
Declined RF	40	28%	0.4	0.7	0	3	40	20%	0.3	0.5	0	2
Total	131	31%	0.6	1.1	0	7	131	26%	0.3	0.9	0	5

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

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