



EVALUATION OF THE BENEVOLENT SOCIETY'S RESILIENT FAMILIES SERVICE

Evaluation plan

17 April, 2014

Abbreviations and acronyms

CSC	Community Services Centre
FACS	Family and Community Services NSW
KiDS	Key information and Directory System
RAT	Resilience Assessment Tool (including Review and Reanalysis Tool and Family Support Plan)
RF	Resilient Families
ROSH	Risk of Significant Harm Report
ROT	Resilience Outcomes Tool
SARA	Safety and Risk Assessment
SBB	Social Benefit Bond
TBS	The Benevolent Society

1. Background

1.1 Synopsis

ARTD Consultants is evaluating The Benevolent Society's Resilient Families (RF) service for the NSW Treasury.

The RF service is an intensive family preservation intervention using evidence-based practices for building resilience within families where there are concerns about the safety and well-being of children. The service is funded through the Benevolent Society Social Benefit Bond pilot.

The purpose of the evaluation is to assess the implementation, effectiveness and cost-effectiveness of the RF service in achieving benefits for families. The evaluation will also assess the alignment of child protection outcomes used for bond payment purposes with a more comprehensive assessment of family resilience outcomes.

The scope of the evaluation is RF services provided to participating families across three TBS sites within two agreed locations (each covering a number of FACS Community Service Centres) in greater Sydney. The evaluation runs from October 2013 to January 2016.

Methods include the analysis of child protection data provided by Family and Community Services NSW (FACS), administrative data and resilience outcomes/assessment data provided by The Benevolent Society (TBS), and interviews with program managers, FACS staff and a sample of parents/ carers receiving the service.

1.2 This document

This document is the Evaluation Plan. Its purpose is to outline the evaluation framework, method and processes for data collection, analysis and reporting. The Plan is consistent with the methods the deliverables and timeframe for the evaluation outlined in the December 2014 Project Plan. It has been developed following detailed consultations with NSW Treasury, FACS, Department of Premier and Cabinet and TBS.

This Plan is currently under review by the Human Ethics Research Committee at The University of Sydney. The scope and timing of activities outlined here assumes our ethics application will be approved by the Committee meeting on 06 May 2014 and that we will be notified of the outcome within 10 working days.

The data management and sharing arrangements outlined in this Plan, and which have been submitted as part of the ethics application, will be formalised in an agreement between ARTD and FACS.

If, in formalising these arrangements there are impacts on the project resources or timeframe (Appendix 4) we will discuss with the Working Group any implications this might have on the scope or timing of evaluation activities, or the on ethics approval (e.g. if we need to submit a modification).

1.3 Social Benefit Bonds—a new financial tool for improving social outcomes

1.3.1 New funding infrastructure

A Social Benefit Bond (SBB) is a financial instrument through which private investors provide up-front funding to service providers to deliver improved social outcomes. If outcomes are delivered, the cost saving to government can be used to pay back the investor's principal and provide a return on investment. The return on the investment is dependent on the degree of improvement in social outcomes and the precise structure of the SBB.

This new type of financial instrument directs private capital towards public benefit by establishing partnerships between investors and the non-government sector for the delivery of measurable outcomes. The additional funds provided under a SBB can expand social investment into innovative prevention and early intervention approaches that otherwise may not receive sufficient resourcing. Moreover, the direct financial incentive to achieve an agreed outcome is expected to drive service delivery, and reduce the demand for government expenditure on acute and crisis services.

The focus on robust outcomes measurement necessitated by this model of financing also ensures accountability and transparency in government funding. Not only are SBBs more attractive to investors if backed by a strong evidence base that indicates proposed interventions will be successful, but this evidence base provides government with locally relevant data for future social policy making.

The NSW Government provided for Australia's first SBB in the 2011-2012 Budget. In March 2012 the government selected three tenderers: Mission Australia and partners, to develop a recidivism pilot; and The Benevolent Society, Westpac and Commonwealth Bank of Australia, and UnitingCare Burnside, to develop two out-of-home care pilots. These proponents entered a joint development phase with the NSW Treasury and sponsoring agencies (the Department of Attorney General and Justice and the Department of Family and Community Services) to establish financial instruments, service arrangements and approaches for evaluation.

1.3.2 The Benevolent Society SBB—financing a service to keep families safely together

The NSW Government signed a contract with The Benevolent Society (TBS) for Australia's second social benefit bond, the TBS SBB pilot. The service is an intensive

family preservation intervention for families where there are concerns about the safety and wellbeing of children.

The RF service objectives are to

- support parents to create a safe and stable family environment
- improve parenting capacity and family functioning
- reduce the number of reports of risk of significant harm
- prevent placements in out-of-home care.

The RF service commenced in October 2013 and is financed through the bond for five years. The service is available for up to 400 families across two agreed regions.

- Region 1: Eastern Sydney CSC areas, Central Sydney CSC areas, Burwood CSC areas and Lakemba CSC areas
- Region 2: Bankstown CSC areas, Campbelltown CSC areas, Fairfield CSC areas, Liverpool CSC areas, and Ingleburn CSC¹.

TBS provides the RF service to families living in these two regions (covering the nine CSCs) through three of their service locations:

1. Rosebery service, for families in Region 1
2. Campbelltown service, for families in Region 2
3. Liverpool service, for families in Region 2

The RF service will be provided to identified families in these locations with at least one child aged less than 6 years, living at home, and, with a FACS assessment of all the known dangers, current protective abilities, safety interventions and any other information available, that indicates the child is at Risk of Serious Harm but 'Safe with Plan'. This indicates there are one or more dangers present for the child concerned, and that without effective preventive services, the planned arrangement for the child/young person will be out-of-home care. The child is able to remain in the home as long as the safety interventions outlined in their Plan mitigate the identified danger(s)².

For the SBB pilot, the youngest in a family at the time of referral to RF is classified as the index child for the purpose of measuring outcomes and bond payments. Using the matching tool, this child is matched to a child in a similar family not receiving RF and these matched children form the basis of the intervention and control groups for bond payment and the evaluation.

¹ Note the the LGAs of Camden and Wollondilly are excluded

² FACS and Children's Research Centre *The Structured Decision Making System Policy and Procedures Manual, Implementation version, March . 2011*

1.4 TBS Resilience Practice Framework—identifying evidence-informed practices to deliver resilience outcomes

The RF service operates within a broader practice framework that TBS has developed, in partnership with the Parenting Research Centre, around the concept of resilience. This Resilience Practice Framework provides a unifying approach to TBS’s service delivery and is applied in a number of their child, family and community programs—including the RF service.

Building resilience is a way of supporting children and families who have experienced adversity or who are vulnerable to poor developmental outcomes. The definition of ‘resilience’ used in the Framework is: strength in the face of adversity—the capacity to adapt and rebound from stressful life events strengthened and more resourceful.³ TBS also refers to “resilience” in terms of a child achieving normal developmental goals and milestones under difficult conditions.⁴

The Resilience Practice Framework locates 42 evidence-informed practices (EIPs) within five outcome domains.

1. Secure and stable relationships
2. Increased safety
3. Improved coping/self-regulation
4. Increased efficacy
5. Increased empathy.

Appendix 1 contains the full list of the 42 EIPs aligned to these five outcome domains.

The Resilience Practice Framework is informed by recent approaches to understanding how and why evidence-based programs work.

1.4.1 Using a common elements approach to understand “what works” in program implementation

The 42 EIPs were aligned to resilience outcomes using a ‘common elements approach’⁵. This approach combines findings from the significant body of research about effective programs for children and families, and distils “what works” into common elements or practices (e.g. giving descriptive praise). This approach takes the perspective that it is not a program-as-a-whole that works, but common elements or practices within programs that work, when implemented in the right context to achieve identified outcomes.

³ This definition is well established in the literature. It is drawn from B. Daniel and S. Wassell, *Assessing and Promoting Resilience in Vulnerable Children*, Jessica Kingsley Publishers, 2002.

⁴ The Benevolent Society, *Practice Guide 2: Infants at risk of abuse and neglect*, pg10.

⁵ This approach was developed by S. Chorpita et al., Identifying and selecting the common elements of evidence based interventions: A distillation and matching model”, *Mental Health Services Research*, 7(1), 5-20, 2005.

Each of the EIPs is a procedure that has been empirically shown to affect behaviour. It can be described as a ‘fundamental unit of behavioural influence’⁶ i.e. it will not be effective if broken into component parts, but it is a powerful mechanism for influencing behaviour when applied with an array of effective practices.

Most EIPs are quite simple, can be easily taught and have outcomes that are immediately observable. For example, timeout, written praise notes, self-monitoring, and psychological strategies such as nasal breathing. Accordingly, they are seen as a useful way of disseminating effective practices that minimise behavioural and psychological problems and improve wellbeing, and to achieve public health goals in a way that reduces reliance on programmatic, and often costly, interventions.

1.4.2 Using the Resilience Practice Framework to select and apply EIPs

Applied to the Resilience Practice Framework, TBS Senior Child and Family Workers make an informed selection about which EIPs to use, for whom and in what circumstances. This selection is informed following client intake assessment using the Resilience Outcomes Tool, which links identified needs to specific EIP interventions.

By framing these 42 EIPs within the five resilience outcome domains that reflect common elements of practice, caseworkers are guided to select and implement EIPs with defined goals in mind. In this way, TBS aims to achieve five key resilience outcomes for families (parents and children) participating in the Resilient Families service.

1.4.3 Understanding family engagement in case planning and their relationship with workers in resilience-building contexts

Engaging families in case planning and building a trusting relationship between workers and families—based on recognition of each family’s strengths—is critical to successful child and family services. Achieving this can require a significant shift in how services are delivered. Effective leadership is thus important to support professionals as they move away from risk-aversion and find innovative ways to work with families⁷.

Active engagement of clients in case planning appears to be related to positive outcomes, as does building on and working with the existing supports and strengths within families. Members from the wider family and people from a family’s social and community network will remain part of their environment after formal agency involvement, and some will have a long-term commitment to the children and young people in that family. It can be difficult for service providers to access or engage natural

⁶ D. Embry and A. Biglan, ‘Evidence-based Kernels: Fundamental Units of Behavioral Influence’, *Clinical Child Family Psychology Review*, v11, p.96, 2008. Providing consequences for behaviour and establishing antecedent stimuli for behaviour are two primary mechanisms by which kernels work.

⁷ Morgan and Disney, *Latest Research Evidence on Integrated Programs for Young People at Risk*, 2006

supports, and previous research shows these supports tend to be under-represented in family case plans⁸.

The literature suggests that professionals can find it challenging to work within a strengths-based approach, and may be more familiar operating from a deficit model of assessment.

Another dimension that has come into increased focus in recent years is the nature of the relationship between workers and their clients, described by Young and Poulin⁹ as the 'therapeutic alliance'. These authors describe this alliance as one of the best predictors of outcomes for clients, regardless of the particular therapeutic approach or intervention.

⁸ Bruns, E.J., Walker, J.S., Adams, J., Miles, P., Osher, T.W., Rast, J., VanDenBerg, J.D. & National Wraparound Initiative Advisory Group (2004). Ten principles of the wraparound process. Portland, OR: National Wraparound Initiative, Research and Training Centre on Family Support and Children's Mental Health

⁹ Young, T.M and Poulin, J.E, 'The helping relationship inventory: A clinical appraisal', *Families in Society*, 03/011998, Vol. 79 No.2; p. 123

2. Methods

The evaluation involves an outcomes, process and economic evaluation. It is being undertaken in four stages with the development of an evaluation plan (this document) and the delivery of three reports.

- Stage 1 Planning
- Stage 2 Preliminary report
- Stage 3 Mid-term report
- Stage 4 Interim report (final report is outside the scope of the current study)

We have submitted this version of the Evaluation Plan for ethics approval. From these stages, we will report on each component—process, outcomes and economic focus on outcome and process (including economic) evaluations.

2.1 Program logic as framework

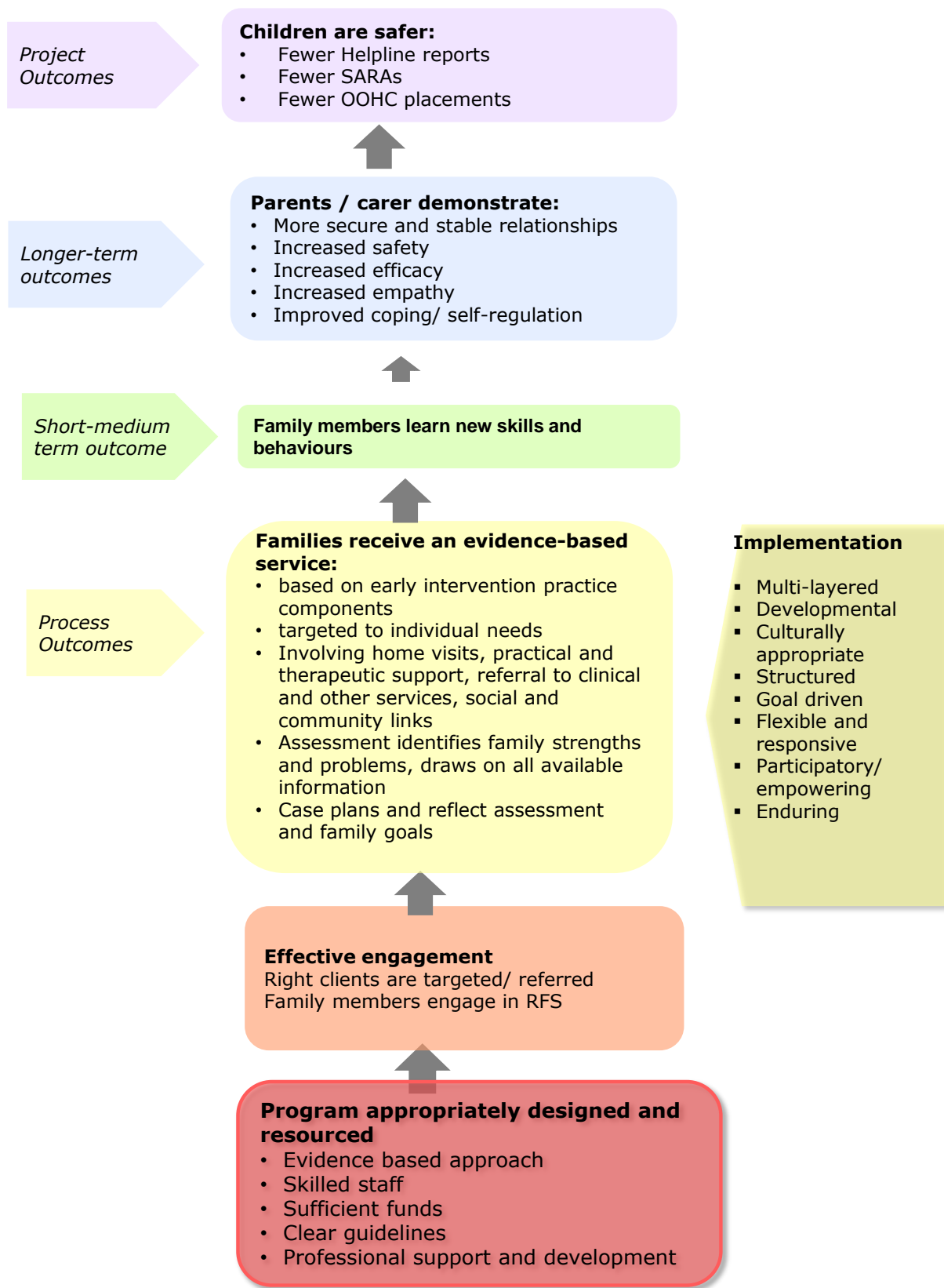
Program logic provides an analytical framework for outcomes evaluation. It is essentially a visual representation of key causal relations that are understood to be operating within an intervention (Figure 1).

The approach used is the ‘outcomes hierarchy’. At the top are the broad policy outcomes to which the program aims to contribute. At the bottom are the resources and activities that are expected to achieve this, through generating a series of ‘immediate’ and then ‘intermediate’ outcomes. The diagram also shows other factors which may influence the program.

The logic shows the RF service to have a relatively simple strategy. A well designed and resourced program supports effective implementation, families will engage in a multi-layered, home-based service that teaches family members new skills and behaviours.

The outcomes for parents are greater capacity to adapt and rebound from stressful life events strengthened and more resourceful, and for their children to have reduced contact with the statutory child protection system—observed through fewer Helpline reports, Safety and Risk Assessments/Secondary Assessments and out-of-home care placements.

Figure 1 Resilient Families Program Logic



2.2 Key evaluation questions

The evaluation questions (see Table 1) address both short and longer-term outcomes in the logic hierarchy.

Table 1. Key evaluation questions

Component	Evaluation question	
Outcomes	1. What are the outcomes of the RF service for participants?	
	i. Do index children have less contact with the child protection system than the comparison group?	
	ii. What changes in functioning and wellbeing are seen for index children and their families? What new skills and behaviours have parents/ carers learned?	
	iii. Who does the program appear to work best for?	
	iv. Which service components appear to be most important for achieving benefits?	
	v. Are there other observable outcomes not reflected through key outcome measures?	
	2. How appropriate are the measures in place for the bond payment?	
	vi. What is the association between child protection outcomes used for SBB payment purposes and outcomes measured through the TBS Resilience Framework?	
	Process	3. How well are targeted clients being identified and referred to the program?
		vii. What are the characteristics of participants in terms of their needs and risk level? Are these as expected?
viii. Do the referral criteria or process need to be revised or refined? Is the matching process resulting in high risk groups of client not being referred, or lower risk clients being over represented in the program or over-servicing of those referred?		
4. To what extent is the service being delivered as intended?		
i. Are planned timeframes for assessment, review and program duration being met?		
ii. What is the nature and intensity of the service being delivered e.g. individually targeted, which evidence-based practices are being employed?		
iii. How well are participants being linked into relevant services and making broader social and community connections?		
iv. What affects the individualisation of plans and what are caregiver's experiences of the process? What helps and what hinders?		
v. What is effective in helping families access and build natural supports and what are the barriers?		
vi. Is the program sufficiently well-resourced and supported, including staff skills and professional support and development, clear guidelines etc.?		
vii. How do the processes for joint working between TBS and FACS differ from business as usual, including regular data provision, and to what effect?		
viii. To what extent has TBS developed a culture of learning and adaptation in delivering the program? What has facilitated this and what are the outcomes?		

-
- ix. What differences can be observed across sites and what are the implications of any differences for clients and program outcomes?

Cost Analysis

5. Does the program appear to offer value for money?

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

2.3 Methods and data sources

The evaluation is a mixed method design drawing on secondary program data and three sources of primary data. The methods are designed to address the key evaluation questions. The focus and scope of data collection and analysis for the outcomes and process, including economic evaluation follow.

Table 3 provides an overview of data sources against the evaluation questions.

The methods are described below in relation to the outcomes, processes and economic evaluations.

2.4 Outcomes evaluation

The outcomes evaluation draws largely on secondary data from FACS and TBS. Primary data will be used to guide and help interpret findings from the outcomes analysis.

2.4.1 Population

The evaluation population is families who receive the service through the three TBS sites (Rosebery, Campbelltown and Liverpool) during the period October 2013 to end June 2015 and consent to being involved in the evaluation. We anticipate this will be up to 200 families.

The intervention group comprises the youngest child in each participating family (index child), whether or not that child has been the subject of the child protection report.

Each index child is matched according to agreed criteria to form the study control group. A primary carer is identified for matching and outcomes measurement processes. The criteria are defined in the Operations Manual for the TBS Social Benefit Bond Pilot (pages 13–14).

2.4.2 Data sources

The outcomes evaluation relies largely on secondary data collected by FACS and TBS. New data collected by ARTD will be used to guide and help interpret findings from the

outcomes analysis. There are three main sources of secondary data, some specified, and others described broadly in the TBS SBB Operations Manual.

The data items have been selected to have minimum resource impact on FACS, TBS and participants, while ensuring that we can adequately address evaluation questions.

1. FACS matching and bond measures data

The FACS data items used for matching the intervention and control groups and for determining outcomes for the purpose of the bond are specified in the Operations Manual.

The evaluation uses the same data to measure service outcomes as will be used to calculate bond payments. The measures reflect the key program outcomes for reduced contact with the child protection system, seen through fewer:

- child protection Helpline reports
- Safety and Risk Assessments (SARAs)/Secondary Assessments
- entries into statutory out-of-home care .

The matching data will be used to

- provide key demographic information about the population
- establish the comparability of the two groups (and determine implications for analysis)

These FACS data items are below.

Table 2. FACS matching and bond measure data items

Matched pairs	Intervention group	Control group
<ul style="list-style-type: none"> ▪ Pair identifier for the two records (using the protocol: year of referral/number of referral and I for Index Child or C for Control Group Child e.g. the first referral in 2013 would be: 13/001I and 13/001C) ▪ Whether the Child is an Index Child or Matched Child ▪ Child’s date of birth (for Index Child only)¹⁰ ▪ SARA record creation date ▪ OOHC history of mother (Category) 	<ul style="list-style-type: none"> ▪ Pair identifier ▪ Measurement Period commencement date ▪ Measurement Period end date (if applicable) ▪ Number of Helpline Reports on the Child during the child’s Measurement Period to the Measurement Period end date or the date of the report (whichever is earlier) ▪ Number of SARAs to which the Child has been subject during the child’s Measurement Period to 	<ul style="list-style-type: none"> ▪ Number of Helpline Reports on Children in the Control Group during each Child’s Measurement Period to the Measurement Period end date or the date of the report or the date that provides an equivalent period for the Index Child (whichever is earlier) ▪ Number of SARAs to which children in the Control Group have been subject during each child’s Measurement

¹⁰ We request that FACS provide us with the age (years and months) of the Index Child. This is to ensure data is not identifiable and to meet our obligations under ethics approval.

Matched pairs	Intervention group	Control group
<ul style="list-style-type: none"> ▪ SARA history of mother (Category) ▪ Age of youngest Child (Category) ▪ Number of Children covered by the SARA used in the matching process ▪ Family size (Category) ▪ Indigeneity ▪ RF Region number ▪ CSC ▪ Suburb: Airs, Claymore or Other ▪ Measurement Period commencement date 	<ul style="list-style-type: none"> the Measurement Period end date or the date of the report (whichever is earlier) ▪ Number of times the Child entered OOHC during the child’s Measurement Period to the Measurement Period end date or the date of the report (whichever is earlier) 	<ul style="list-style-type: none"> Period to the Measurement Period end date or the date of the report or the date that provides an equivalent period for the Index Child (whichever is earlier) ▪ Number of times Children in the Control Group have entered OOHC during each Child’s Measurement Period to the Measurement Period end date or the date of the report or the date that provides an equivalent period for the Index Child (whichever is earlier)

2. FACS other data

Also referenced in the Operations Manual (Chapter 11.2) though not itemised, are a range of measures of potential interest to the evaluation. Most are beyond the capacity of FACS databases to provide and we will use a small targeted set of items that are most important for understanding outcomes and can be provided with a reasonable level of reliability.

FACS data we use—other than the bond outcomes data—serves to add to our understanding in two areas:

- risk level of index children (prior reports and SARAs, OOHC periods)
- characteristics of control group parents (reported issues in past 12 months and, if available, age at birth of first known child[tbc])

We will examine both child protection and ROT outcomes in relation to these variables to help answer evaluation questions about who the service is most effective for, or could be improved for.

3. TBS Resilience Outcomes data

As with the FACS data, the evaluation uses the same TBS data as TBS does to measure safety and wellbeing outcomes.

The tool for this measurement is the TBS Resilience Outcomes Tool (ROT), which is used by SCFWs to inform individual case planning and assessment. The tool comprises a range of validated scales, or sub-scales.

- Strengths and Difficulties Questionnaire (SDQ)
 - Peer Problems
 - Emotional symptoms
 - Conduct problems
 - Hyperactivity
- Protective Factors Survey (PFS)
 - Knowledge of Parenting

- Nurturing & Attachment
- Family Functioning
- Social Support
- Concrete Support
- Longitudinal Study of Australian Children (LSAC)
 - Parenting
 - Family and Relationships
 - Community links
 - Health and wellbeing
- Parenting Sense of Competence Scale
- Personal Wellbeing Index (PWI)
- Home Physical Environment
- K10 Scale
- Family Resource Management

See detail in Appendix 2.

2.4.3 Data format and linkage

We plan to receive all data in unit record form, with a unique identifier that links all FACS and TBS data sets at the individual level. Within the major analysis the data will not be personally identifiable.

For families who we interview and who consent to us linking their qualitative and quantitative data (see Section 2.5.2), we will access their data in an identifiable form and analyse these records separately, as a sub-set of the FACS and TBS secondary outcomes data.

2.4.4 Analysis

All quantitative analysis will be undertaken using IBM SPSS statistics v22 (SPSS). We plan on using both parametric and non-parametric statistics as data sets usually contain categorical and metric data, and metric data may not meet the assumptions of parametric testing. The following analyses will be conducted.

- High level results (family stability and parenting measures, substantiated reports, OOHC placement) will be compared across the program and control group by analysis of variance (ANOVA, planned contrasts and t-tests) of mean numbers of reports at periods before and after interventions. Duration of effect will be measured and compared using survival analysis.
- The impact of the number and type of vulnerabilities in participating families on service use and results (both child protection outcomes and family resilience outcomes) will be analysed by tests of multiple regression.
- The contributions to high-level results for participating families of the number, types and intensity of practices/ services accessed will also be analysed by multiple regression.

- Finer detailed analysis, for example, by family demographics, goal achievement, will be undertaken as allowed by the data set and suggested by initial analyses.

We will focus the reporting of statistical outcomes on estimating the effect (i.e. measuring the outcomes) and then providing a measure of confidence around that measure¹¹.

We will identify the pattern of outcomes in the numbers of Helpline reports; Safety and Risk Assessments (SARAs)/Secondary Assessments and entries into statutory out-of-home care. We will compare this to the pattern for children in a matched control group as evidence that changes for index children can be attributed to RF.

We will also measure changes in parent/ carer and child wellbeing and safety using the validated scales within the TBS Resilience Outcomes Tool and progress with case plan goals.

The size of the population demands that major analyses are undertaken at the level of the RF service, but we will look at differences across TBS sites with a view to better understanding the context for service delivery, or any compounding factors that may be impacting on outcomes, for example demographic or service characteristics that may be associated with particular sites and/ or outcomes.

We will draw on data about family and program characteristics collected through the process evaluation to understand factors relating to outcomes—both family and service characteristics. We will triangulate secondary outcomes data with primary carer interview data, to explore and help support or explain our findings.

We will seek to understand the motivations for family members to engage, factors that are important to family members in staying with the service and what helps or hinders their ability to learn new skills and behaviours.

Alignment of outcomes

The third component of the outcome evaluation is to examine the relationship between child protection and resilience outcomes. It is likely that outcomes will be mixed, within and across FACS and TBS data, but misalignment will be examined and all sources of evidence available will be used in seeking to understand what may be behind inconsistent findings and identify the most reliable measures for implementation of the model in future.

¹¹ Cumming, G. (2012). *Understanding The New Statistics: Effect Sizes, Confidence Intervals, and Meta-Analysis*. New York: Routledge

2.5 Process evaluation

The process evaluation will use a mix of secondary and primary data to understand the RF service implementation and client characteristics. The data will include such aspects as the focus of practices, RF staff training/support and program intensity.

Implementation will be considered in view of contextual factors at a local level and in view of service structures. Both secondary and primary sources of data will be used.

2.5.1 Secondary data sources

TBS service tools

TBS uses a range of program tools to assess families, monitor the service they receive and the progress they make toward their goals. We have identified data items from these tools that we will employ for the process evaluation. Items we will use are detailed in Appendix 3. We will use these data to describe the

- demographics of index children, their primary carers and other family characteristics e.g. family structure, housing
- service characteristics e.g. EIPs, intensity, duration, EIPs, services referred to
- effectiveness of processes for referral, joint working and support for staff in delivering RF.

2.5.2 Primary data sources

There are three sources of primary data to be collected.

Semi-structured exit interviews with primary carers (n=20)

We plan to interview a sample of parents/ carers following their exit from the service. The purpose of the interviews is to better understand the reasons behind the results achieved through RF and to capture more qualitative results not recorded in the secondary data.

Interview participants will be the primary carer of the youngest child who meets referral eligibility criteria.

We will use a semi-structured interview approach to guide participants through key stages of their experiences. This will enable them to talk freely about their experience while the interviewer collects the necessary information. The interviews will cover:

- family context
- perceptions about the service (when initially referred and now they have been involved for a while)
- relationship with the Senior Child and Family Worker
- what about the way the project works is important to them
- what they liked/ did not like about the program
- what they found useful/ not useful about the program

- suggestion for changes/ improvements to the program
- impact if any, increases in support networks, changes in feelings about accessing mainstream services/ knowledge of which services to access when, parenting skills, family functioning
- service gaps—services families needed but that were not provided.

Participants and selection

As referral to the RF service occurs on a rolling basis and service duration is 12 months, families will be interviewed at least 12 months (but no more than 16 months) from their entry date to the service.

The sample size is 20: approximately 6-7 primary carers from each TBS site.

We will use a quota sampling approach, to ensure our sample captures the diversity within the program in terms of parent/ carer characteristics. We will aim to include a minimum number of families from each of the following the groups.

- Aboriginal
- CALD (including at least 2 requiring a translator)
- Disability
- Sole parent
- 4 or more children
- Young (under 21)

We will confirm the target number of primary carers in each group after we have received TBS data about the characteristics of program participants. The sample is not intended to be representative of all families in the RF service or of families within each group. We will examine the data for patterns in relation to parent characteristics, but these will not be the focus of our analysis or reporting. The stories that families tell will be used to illustrate their experience of the service and support the explanation and interpretation of measured outcomes where relevant. The sampling approach will ensure these stories reflect the diversity of the population.

The sample will exclude

- primary carers who do not give consent to TBS for their client data and resilient assessment outcomes data to be used for research and evaluation purposes¹²
- primary carers who do not give consent for TBS to provide ARTD with family details
- primary carers who TBS (e.g. their Senior Child and Family Worker (SCFWs)) reports are vulnerable at the time of exit from the service and for whom the interview is likely to elicit distress

¹² On entering the RF services, primary carers can consent to their personal information being used by TBS for internal research purposes and for external evaluation. TBS received ethics approval for this study from the Cerebral Palsy Alliance Human Research Ethics Committee (period July 2013 to July 2016: no. 2013-07-03). This approval and consent, however, does not extend to ARTD conducting family interviewing and linking this with secondary outcomes data. ARTD is seeking additional ethics approval through The University Of Sydney Human Ethics Research Committee for this component (as well as program staff and FACS staff interviews)

- primary carers for whom TBS (e.g. their SCFW) reports a family member may pose a safety risk to ARTD researchers conducting interviews at the time of exit from the service.

Consent procedure

TBS will seek consent to provide ARTD with primary carer names, contact information, characteristics (to inform our sampling quota) and entry date for all families who meet the inclusion criteria. TBS and ARTD will agree on a timetable to provide these details to ARTD e.g. in August 2014, January 2015 and July 2015.

ARTD will contact primary carers approximately nine months after entering the program, prioritising those who meet agreed quotas. We will invite them to participate in the interview and ask their permission to link their interview and program data.

Primary carers who agree to an interview in principle over the telephone, or are interested and would like consider information in writing, will be sent this information and consent “pack” by post or email. The pack will contain a Participant Information Sheet and Consent Form. The information in this pack will be explained over the phone before the family agrees to participate. Once the materials are received in the post, families will be able to consider them in more detail and telephone ARTD if they have any further queries.

ARTD will obtain verbal agreement for interviews directly from the primary carer over the telephone (preferred method) or email. Consent will be confirmed in writing at the time of interview.

The consent form will make clear the distinction between consent for participation in the primary carer interview and consent for ARTD to use and access personal information.

In relation to the primary carer interview, information in the pack will inform potential participants that

- interviews will be conducted by face-to-face (unless preferred otherwise) at a location local to the family. Interviews will last approximately 45 minutes.
- the interview is voluntary, their decision to participate will not affect their access to family support services or their relationship with any organisation, including TBS and FACS.
- the interview will be audio recorded but is confidential and will be stored securely—nothing they say will be shared with their caseworker, TBS or FACS—and they will not be identifiable in any reports
- there are no risks to themselves or their families if they wish to participate
- they can request a translator so the interview can be conducted in their spoken language
- they can request that the interview be conducted by an Aboriginal person
- they can inform ARTD if they have a disability and need assistance to participate

- participation in an interview is valued and will be recognised with a \$50 voucher to acknowledge their input and time
- they can contact ARTD consultants via telephone or email if they have any questions or concerns
- ARTD will follow up contact (with telephone number provided on consent form, preferred, or email) to arrange or confirm the time and date for interview.

In relation to allowing ARTD to access and use personal information, potential participants will be informed that

- with permission, ARTD will access information about the family that has been collected as part of participation in the RF service, which includes information about case plan assessments and goals and the family's contact with the child protection system.
- allowing ARTD access to this personal information is voluntary: if they choose not to allow this or to withdraw at any time, there will be no impact on their access to family support services or their relationship with any organisation, including TBS and FACS.
- their personal data will remain confidential and no identifying information will be shared unless a child safety issue is identified
- their personal data will be stored securely, and they will not be identifiable in any reports
- their participation by providing this data is valued
- there are no risks or rewards for providing ARTD access with this data.

It will also be explained in the initial telephone call and in the “pack” that a primary carer may choose to be interviewed but decline consent for ARTD to access and use personal data. This is their choice and in this case we will still conduct the interview. We will not access personal data for primary carers who do not participate in interviews.

During the initial contact that ARTD makes with primary carers who agree to participate, we will also propose the location and a suite of possible dates and liaise with them to identify the most suitable day/time. We will endeavour to conduct the interview within three weeks of initial contact from the primary carers.

During initial or follow up correspondence with ARTD, potential participants can indicate whether they require a translator (if not already known) or other measures to ensure the interview culturally appropriate and accessible. If a primary carers can only participate if the interview is conducted at their home, ARTD will accommodate this, taking necessary safety precautions, or we will indicate a preference for a telephone interview.

Once information and consent “packs” have been provided and explained to screened primary carers, and any questions answered to their satisfaction, neither the TBS caseworkers nor FACS program staff will have a role in obtaining consent.

In cases where TBS have indicated a translator is needed, ARTD will use a translator to contact the primary carer and explain participation and consent procedures over the

phone. Importantly, we will also send the pack to these primary carers, in case they have a friend or family member who can also explain the materials, which will give them more time to make an independent assessment of about whether or not they would like to participate. We will also provide time for the translator present on the day of the interview explain and confirm participants understanding of consent, and obtain written or verbal consent, if preferred.

This method of recruitment will ensure that families' SCFW is unaware of whether the primary carer has consented to participate or not, ensuring that participation is confidential. We will also ask the TBS Research Manager to provide the file identifier for those primary carers who consent to the data linkage component.

A \$50 Coles/ Myer voucher to thank participants will be sent to those interviewed. We do not believe this amount is high enough to coerce unwilling primary carers to participate.

We understand there is some potential for primary carers to become upset during the interview. Our researchers are very skilled in interviewing vulnerable populations and are trained in working in this context. But if a participant appears to need additional support following the interview we will discuss with them the option of contacting their SCFW or an independent support service such as Lifeline.

Our researchers are not mandatory reporters but understand that child safety is a priority and if any concerns are identified we will make a report to the Child Protection Helpline (132 111).

Data collection

Interviews will be conducted face-to-face unless a family would prefer to be interviewed by telephone. Interviews will last approximately 45 minutes.

ARTD will work with TBS and FACS to identify a suitable location to conduct interviews in each region. These will be suggested to primary carers and the most convenient location agreed on. Considerations will include a site that is:

- local to the family (no more than 15 min drive) and well connected to public transport
- private so the primary carer's confidentiality will not be compromised
- safe for families and ARTD researchers
- culturally appropriate
- accessible to people with disability
- suitable for young children, if present during interview.

In our experience, a local child health centre or a facility in the council library is generally appropriate.

We have designed the interview questions to gather feedback from consenting family members on the factors that impact their family's engagement and participation in the RF service and their perception of the impacts the service has had for their family.

Data entry, storage, analysis and reporting

With the permission of the participants, we will audio record the interviews. The recording will be transcribed and stored in password-protected MS Word documents, only accessible by the evaluators. The audio file will be permanently deleted once analysis has been completed. The data will then be transferred to NVivo, a computer software program for coding and analysing qualitative data. Access to this database will only be by the evaluation team.

We will analyse the data qualitatively using NVivo software, and, with the consent of primary carers, link each family's secondary outcomes data to their interview data. By triangulating the quantitative and qualitative data for this sub-set of the population we will be better able to explain the data set overall.

Reporting will be at the aggregate level and will not identify any individual participant.

Group interviews with program staff (n=9, one per site per stage)

We will interview staff from each TBS program site (based on an understanding there 3 are sites involved) in small groups. These interviews will gather structured information on implementation and on how families are reacting to/ engaging with the project. At this stage we expect these interviews to cover

- training and support
- contextual and service system factors impacting on implementation
- referral processes (from and to CSCs at the beginning and end of involvement with family)
- families' engagement with the program (characteristics of those who don't engage vs those who do)
- working relationships with other relevant local services
- early indications about how the program is working for families
- what is it about the project they think families like/ find useful
- suggestions for changes/ improvements.

Participants and selection

All program staff at the three sites will be invited to participate. We anticipate this will include a RF Team Leader and 3 SCFWs. Participation in the interview is voluntary and the SCFWs employment will not be affected if they choose not to participate.

Data collection instrument

The group interview is expected to take about 1-2 hours. We have designed the questions to gather feedback from SCFWs on the factors that impact on their delivery of the RF service.

The interviews will be conducted at three points in time. We are planning for these to occur around April/ May and October 2014 and mid/ late 2015. We will work with TBS in setting the approach for the interviews i.e. exact timing, time of day, location etc.

Consent

ARTD will work with the TBS Senior Manager, Research and Evaluation to facilitate the consent process in a way that minimises the risk of real or perceived coercion.

An email invitation (with Participant Information Sheet and Consent Form attached) will be distributed to program staff by the TBS research manager, on behalf of ARTD. The information contained will state that:

- group interviews will be conducted by face-to-face at the TBS service or another appropriate site where they are based, and will take 1-2 hours.
- the interview is voluntary and they can withdraw at any time
- the interview, and notes taken, are confidential—nothing they say will be reported to senior TBS or FACS staff, and individuals will not be named (or otherwise identifiable) in any reports
- there are no risks to themselves if they wish to participate and no costs requiring reimbursement
- there are no benefits or rewards for participating.
- participation in an interview is valued
- they can contact ARTD consultants via telephone or email if they have any questions or concerns
- ARTD will contact them directly (with telephone number provided on consent form and/or via phone or email) to confirm the time and date for interview.

Written consent will be obtained when participants sign the Consent Form and give it to ARTD on the day of the interview. Alternatively, they may scan/email or fax it to ARTD before the interview.

Data entry, storage, analysis and reporting

Notes will be taken by the interviewer during the interview. These notes will be transcribed and stored in password-protected MS Word documents, only accessible by the evaluators. The data will then be transferred to NVivo, a computer software program for coding and analysing qualitative data. Access to this database will only be by the evaluation team.

Reporting will be at the aggregate level and will not identify any individual participant by name or indirectly by their role/position in an organisation.

FACS staff interviews (n=2-3 per region, per stage)

We will conduct individual interviews with key FACS staff with knowledge or oversight of the TBS SBB pilot. These interviews will cover

- referral criteria and process
- the approach to program delivery
- processes for joint working with TBS
- perceived outcomes for clients
- any learnings for future delivery
- contextual factors affecting program implementation (e.g. adverse events, high service demand, lack of providers for particular services).

Participants and selection

Participants will be identified by FACS District Directors, who will identify staff with relevant experience with the program to participate.

Consent

ARTD will work with the relevant FACS Director to facilitate the consent process in a way that minimises the risk of real or perceived coercion.

An email invitation (with Participant Information Sheet and Consent Form attached) will be distributed to the relevant FACS staff by the FACS Directors, on behalf of ARTD. The information contained will state that:

- individual interviews will be conducted by telephone and will take about 30minutes
- the interview is voluntary and they can withdraw at any time
- the interview, and notes taken, is confidential—nothing they say will be reported to FACS staff and individuals will not be named (or otherwise identifiable) in any reports
- there are no risks to themselves if they wish to participate and no costs requiring reimbursement
- there are no benefits or rewards for participating
- participation in an interview is valued
- they can contact ARTD consultants via telephone or email if they have any questions or concerns
- ARTD will contact them directly (with telephone number provided on consent form and/or via phone or email) to confirm the time and date for interview.

Data entry, storage, analysis and reporting

Notes will be taken by the interviewer during the interview. These notes will be transcribed and stored in password-protected MS Word documents, only accessible by

the evaluators. The data will then be transferred to NVivo, a computer software program for coding and analysing qualitative data. Access to this database will only be by the evaluation team.

Reporting will be at the level of agency/ organisation and will not identify any individual participant by name or indirectly by their role/position in an organisation.

2.6 Cost Analysis

The cost analysis will identify the costs of program implementation and service delivery at a program and family unit level¹³. The analysis will draw on two sources of data:

1. **TBS data**—RF costs, including caseworker salary information and an estimation of hourly cost of team leader supervision.
2. **Other program data**—we will examine the costs of similar programs, taking into account the duration and intensity of service within these. We will include FACS funded programs (Brighter Futures, IFP/ IFPS, IFBS) where possible as well as some from other jurisdictions. ARTD will identify relevant programs from other jurisdictions and NSW Treasury will approach relevant organisations to obtain cost and service data.

¹³ An economic analysis will be done in a later evaluation that compares all of the SBB pilots using the same methodology.

Table 3. Key evaluation questions and data sources: secondary and primary sources

Evaluation questions	SECONDARY DATA						PRIMARY DATA		
	FACS		TBS				ARTD		
	Bond measures	Other	Resilience Outcomes Tool	Initial Contact	Re-Analysis Tool and FSP	RF Service & other data	Parent interviews	SCWF interviews	FACS interviews
OUTCOMES									
1. What are the outcomes of the program for participants?									
Do index children have less contact with the child protection system than the comparison group?	✓								
What changes in functioning and wellbeing are seen for index children and their families? What new skills and behaviours have parents/ carers learned?			✓		✓	✓	✓	✓	
Who does the program appear to work best for?	✓	✓	✓	✓	✓		✓	✓	✓
Which service components appear to be most important for achieving benefits?					✓	✓	✓	✓	
Are there other observable outcomes not reflected through key outcome measures?		✓	✓		✓		✓	✓	✓
2. How appropriate are the measures in place for the bond payment?									
What is the association between child protection outcomes used for SBB payment purposes and outcomes measured through the TBS Resilience	✓	✓	✓						

Evaluation questions	SECONDARY DATA						PRIMARY DATA		
	FACS		TBS				ARTD		
	Bond measures	Other	Resilience Outcomes Tool	Initial Contact	Re-Analysis Tool and FSP	RF Service & other data	Parent interviews	SCWF interviews	FACS interviews
Framework?									
PROCESS									
3. How well are targeted clients being identified and referred to the program?									
What are the characteristics of participants in terms of their needs and risk level? Are these as expected?	✓	✓		✓	✓	✓	✓	✓	✓
Do the referral criteria or process need to be revised or refined? Is the matching process resulting in high risk groups of client not being referred, or lower risk clients being over represented in the program or over-servicing of those referred?	✓	✓		✓	✓	✓		✓	✓
4. To what extent is the program being delivered as intended?									
Are planned timeframes for assessment, review and program duration being met?						✓		✓	✓
What is the nature and intensity of the service being delivered e.g. individually targeted, which evidence-based practices are being employed?					✓	✓	✓	✓	
How well are participants being linked into relevant services and making broader social and community connections?			✓		✓	✓	✓	✓	✓

Evaluation questions	SECONDARY DATA						PRIMARY DATA		
	FACS		TBS				ARTD		
	Bond measures	Other	Resilience Outcomes Tool	Initial Contact	Re-Analysis Tool and FSP	RF Service & other data	Parent interviews	SCWF interviews	FACS interviews
Is the program sufficiently well-resourced and supported, including staff skills and professional support and development, clear guidelines etc?						✓		✓	
How do the processes for joint working between TBS and FACS differ from business as usual, including regular data provision, and to what effect?								✓	✓
To what extent has TBS developed a culture of learning and adaptation in delivering the program? What has facilitated this and what are the outcomes?						✓		✓	
What differences can be observed across sites and what are the implications of any differences for clients and program outcomes?	✓	✓	✓	✓	✓	✓	✓	✓	✓
COST ANALYSIS									
5. Does the program appear to offer value for money?									
What are the actual (versus budgeted) costs of the program?						✓			
How do these costs compare to similar programs in NSW and in other jurisdictions?		✓							✓

3. Reporting timeframe and milestones

This section details the data, approach and timeframes for each of the three reports. The milestones and deliverables reflect the approach and methods described in the previous sections.

3.1 Three reporting stages

Reporting in the RF evaluation develops in three progressive stages.

A preliminary report will be delivered in July 2014. It will contain a limited data set and focus on process evaluation and understanding the service clients. It will describe the baseline for the TBS outcomes data.

A mid-term report completed will report on the first set of FACS remediated data covering implementation to end June 2014. This will enable a preliminary assessment of alignment, through comparison of FACS data with a second wave of TBS outcomes data. The report will update the process and economic evaluation analyses.

The interim report (the final deliverable for this evaluation project) will update process, outcomes and economic evaluation components, building on the analysis in each stage and refining our understanding of the evidence to answer the evaluation questions.

The data sets and more detailed description of the data and focus for each report are below.

3.1.1 Preliminary report

Data sources

- TBS Resilience Outcomes data
- TBS service data
- Program staff interviews
- FACS staff interviews
- Economic data for RF, other programs

Process for and focus of reporting

The preliminary report will focus on process evaluation, including descriptions of implementation, contextual factors working arrangements, highlighting opportunities for improvement. We will examine client and characteristics, implementation processes, joint working and service costs.

The preliminary report will also provide the baseline for the TBS outcomes analysis.

Prior to writing the preliminary report we will present preliminary findings to the Evaluation Working group and facilitate a discussion about the implications of the findings. We will gather the insights of the key stakeholders within the group to inform the focus for reporting.

We will synthesise the information from the analysis of quantitative and qualitative data analysis to tell the story of the RF service’s early implementation

Table 4. Preliminary report milestones and deliverables

Stage	Milestones and deliverables	Due date
Preliminary report	Receive TBS service and outcomes data and FACS economic data	May 2014
	Process, TBS outcomes and cost data collection and analysis	May to June 2014
	Workshop	Mid/ late July
	Draft Preliminary report	Mid-August 2014
	Final Preliminary report	End August

3.1.2 Mid-term report

Data sources

- FACS bond measures data
- FACS other data
- TBS Resilience Outcomes data
- TBS service data
- Program staff interviews
- FACS staff
- Parent interviews
- Costs data– TBA, other programs

Process for and focus of reporting

The second report will provide the baseline for the FACS outcomes analysis using the first 12 month remediated FACS data report and any completed parent interviews. It will also update the process and economic analyses and the TBS outcomes analysis.

Prior to writing the mid-term report we will present preliminary findings—including alignment between FACS and TBS outcomes—to the Evaluation Working group and facilitate a discussion about the implications of the findings and focus for reporting.

Following the workshop, we will prepare a draft report that addresses each of the evaluation questions. We will then refine this report based on feedback from the Evaluation Working group.

Table 5. Mid-term report milestones and deliverables

Stage	Milestones and deliverables	Due date
Mid-term report	Process and outcomes data collection (TBS and FACS), update cost analysis	August – November 2014
	Receive FACS and TBS data	Early October 2014
	Workshop	Early December 2014
	Draft Mid-term report	End December 2014
	Final Mid-term report	Early Feb 2015

3.1.3 Interim report (final deliverable)

Data

The final report for the project will draw on all available sources of data.

- FACS bond measures data
- FACS other data
- TBS Resilience Outcomes data
- TBS service data
- Family interviews
- Program staff interviews
- FACS staff
- Cost data – RF, other programs

Process for and focus of reporting

This report will present the findings of the process, outcomes and economic evaluations to end 2015. It will directly address the objectives of the evaluation and to the extent that the available data allows, and reach conclusions on:

- the benefits for clients
- variation in the achievement of different outcomes for different client groups and the factors that influenced this
- whether the proxy measures used for payments in the SBB arrangement were an adequate indicator of the social benefits the bonds were intended to achieve
- how the program could be improved to increase benefits
- the cost effectiveness of the service delivery model
- any unintended consequences.

Prior to writing the interim report we will present preliminary findings to the Evaluation Working group and facilitate a discussion about the implications of the findings and focus for reporting.

Following the workshop, we will prepare a draft report that addresses each of the evaluation questions and refine this based on feedback from the Evaluation Working Group.

The information in the evaluation report will be used to assess the achievements of the program to 2016 and the likely extent of outcomes by 2020; the scope for changing program settings or making improvements to delivery; and changes to the evaluation.

The report will provide the basis for revised evaluation plan for the final evaluation 2016 to 2018.

Table 6. Interim report milestones and deliverables

Stage	Milestones and deliverables	Due date
Interim report	Process, outcomes and cost data collection and analysis (TBS and FACS) Receive FACS and TBS data	August – November 2014 Early October 2014
	Workshop Draft Interim report	End November 2015 End December 2015
	Final Interim report	January 2016

Appendix 1 Resilience framework

Table 7. Evidence-informed practices aligned to resilience outcome domains

Resilience outcome domains	Evidence-informed practices (42)
Secure and stable relationships	<ul style="list-style-type: none"> Descriptive praise Attending to your child Engaging an infant Family routines Family time Following your child's lead Listening, talking and playing more Teachable moments
Increasing safety	<ul style="list-style-type: none"> Tangible rewards Effective requests Creating effective child and family rules Developing a safety plan Injury prevention and child proofing Basic child health care Implementing natural and logical consequences Reducing unwanted behaviours–planned ignoring Reducing unwanted behaviours–time out Social connections maps Supervising children
Increasing self-efficacy	<ul style="list-style-type: none"> Setting goals for success Praising for effort and persistence Identifying negative thinking traps Challenging negative thinking Strategies to challenge negative thinking traps
Improving empathy	<ul style="list-style-type: none"> Tuning in: identifying a child's emotions Naming a child's emotions Modelling empathy Praising empathy Using emotions as a teaching opportunity Emotion coaching
Increasing coping/ self-regulation	<ul style="list-style-type: none"> Promoting better sleep routes (infant) Promoting better sleep routines (toddler and young child) Promoting better sleep routines (adolescent and adults) Problem solving (child) Problem solving and decreasing aggression (younger child) Problem solving (adult and family) Active relaxation – progressive muscle relaxation Active relaxation- mindfulness and visualisation Active relaxation–physical exercise (child) Active relaxation–physical exercise (adult) Active relaxation–controlled breathing (child) Active relaxation–controlled breathing (adult)

Appendix 2 TBS Resilience Outcomes Tool measures

Table 5 presents information about the measures are being used by TBS to measure child and family outcomes and their alignment to resilience outcomes.

Table 8. Scales used within TBS Resilience Outcomes Tool

Information	Completed by	Resilience Outcome	Decision to Use
<p>Strength and Difficulties Questionnaire</p> <p>The Strengths and Difficulties Questionnaire (SDQ) is completed by parents/carers for children aged three years and over. This is a UK measure that has been adapted for Australian use. It assesses a child’s social-emotional wellbeing and emergent behavioural problems. It consists of 25 items completed by parents/carers. Items fall under five scales: emotional symptoms scale, conduct problems, hyperactivity scale, peer problems scale, and pro-social scale. These scales measure changes in children’s cognitive development, social competence and emotional regulation. The SDQ is available in over 30 languages and is widely used in epidemiological, developmental and clinical research, as well as in routine clinical and educational practice</p> <p>The SDQ calculates a total score representing extent of overall difficulties, as well as five subscales representing degree of strengths or difficulties in; emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems and pro-social behaviour.</p>	<p>Completed by caregiver for children/young people aged 3yrs+</p>	<p>Secure and Stable Relationships</p> <p>Improving Empathy</p> <p>Improving coping/self-regulation</p>	<ul style="list-style-type: none"> • The SDQ is a validated measure that is used widely to assess children’s social-emotional wellbeing • The SDQ has normative population measures. This means we can compare the results to the broader population • The SDQ has been used across a large number of internal/external evaluations (Fostering Young Lives, Scarba & PIEC)
<p>Protective Factors Survey (PFS)</p> <p>The Protective Factors Survey is a pre–post tool designed for use with caregivers receiving child abuse prevention services. The survey results are designed to provide a snapshot of families, changes in families’ protective</p>	<p>Completed by caregiver</p>	<p>Secure and Stable Relationships</p> <p>Increasing Safety</p>	<ul style="list-style-type: none"> • The PFS is a validated measure which has been listed as an evidence-based tool • The PFS focuses on protective factors, which is in line with strengths based practice.

Information	Completed by	Resilience Outcome	Decision to Use
<p>factors and areas where workers can focus on increasing family protective factors.</p>		<p>Increasing Self Efficacy</p>	
<p>Longitudinal Study of Australian Children Study (LSAC)</p> <p>The LSAC questions have been adapted from the ‘Growing Up in Australia: The Longitudinal Study of Australian Children’. This is a long-term research project following a large group of children and their families over the years as they grow and learn. Using questions from this survey allows us to compare the results to other children in Australia.</p> <p>Individual items and scales making up the LSAC are mostly sourced from existing instruments.</p>	<p>Completed by caregiver</p>	<p>Secure and Stable Relationships</p> <p>Increasing Safety</p> <p>Increasing Self Efficacy</p> <p>Improving coping/self-regulation</p>	<ul style="list-style-type: none"> • LSAC questions have been adapted from a national longitudinal survey. This means that results can be compared to the broader population • LSAC questions have been included in a large number of internal evaluations (Scarba, EYC, CEYC, C4C)
<p>Personal Wellbeing Index (PWI)</p> <p>This is a 10-item questionnaire intended to yield a global measure of distress based on questions about anxiety and depressive symptoms that a person has experienced in the most recent 4 week period.</p>	<p>Completed by caregiver</p>	<p>Increasing Safety</p>	<ul style="list-style-type: none"> • The PWI is a validated tool that has been used widely in Australia. As such population norms are available • The PWI is a tool that can be used across the life span (i.e child and family caregivers and CADs clients) • It has previously been use in the internal evaluation of CADS and PHaMs
<p>Parenting Sense of Competence Scale (PSOC)</p> <p>This scale comprises 16 questions measured on a 6 point scale as rated by the caregiver. It was created to assess perceived parental competence by measuring satisfaction with parenting and perceived self-efficacy. In this scale, satisfaction is reflective of parental frustration, anxiety and motivation and efficacy is reflective of competence, problem solving ability and capability in a parenting role.</p> <p>Responses are made on a 6-point scale of agreement or disagreement and the scores are added to create a total scale and two separate subscales: a</p>	<p>Completed by caregiver</p>	<p>Increasing Self Efficacy</p>	<ul style="list-style-type: none"> • PSOC is a validated tool with available normative data

Information	Completed by	Resilience Outcome	Decision to Use
<p>satisfaction subscale and self-efficacy subscale.</p>			
<p>Kessler 10</p> <p>The K10 Kessler Psychological Distress Scale is a standardised screening tool for clinically significant depressive and anxiety disorders. The K10 Kessler Psychological Distress Scale is available as a self-administered survey in several language translations.</p>	<p>Completed by caregiver</p>	<p>Improving coping/self-regulation</p>	<ul style="list-style-type: none"> • The K10 is a validated tool that has been used widely in Australia. As such population norms are available • The K10 is a measure that can be used across the life span (i.e. child and family caregivers and CADs clients) • It has previously been use in the CADS evaluation
<p>Home Physical Environment</p> <p>The Home Physical environment is a practitioner based observation of the home. Use a separate sheet (at the back of the tool) for observation ratings for each home observed (e.g. if there is a shared care arrangement it may be appropriate to complete for each home where the child/ren spend significant time).</p>	<p>SCFW observation</p>	<p>Increasing Safety</p>	<ul style="list-style-type: none"> • The Home Physical Environment was previously included in the Brighter Futures Assessment Tool
<p>Family Resource Management</p> <p>Two questions relating to family financial circumstances</p>	<p>Completed by caregiver</p>	<p>Increasing Safety</p>	<ul style="list-style-type: none"> • Included to provide information about family economic security

Appendix 3 Secondary data items and sources

Table 9. Key evaluation questions and data items: secondary data

Evaluation questions	SECONDARY DATA			
	FACS	Other	TBS	
	Bond matching and bond measures		Resilience Outcomes Tool	Initial Contact Re-Analysis Tool and FSP RF Service & other data
OUTCOMES				
What are the outcomes of the program for participants?				
Do index children have less contact with the child protection system than the comparison group?	Schedule 3 data relating to index child/ control: <ul style="list-style-type: none"> - Reports to Helpline - Safety and Risk Assessments - entries to Statutory OOHC Schedule 2 matching data <ul style="list-style-type: none"> - Child age - Family size - Indigenous status - Out-of-home care/ SARA history of mother 			
What changes in functioning and wellbeing are seen for index children and their families? What new skills and behaviours have parents/ carers			<u>Family on entry, 3 months and exit:</u> Protective Factors Survey General Self Efficacy	<u>Family on entry, 6 months and exit:</u> Resilience Analysis Assessment domain Support plan:
				<u>Index child:</u> Danger identified by FACS in SARA <u>Index child:</u> Update reports date and

Evaluation questions	SECONDARY DATA					
	FACS		TBS			
	Bond matching and bond measures	Other	Resilience Outcomes Tool	Initial Contact	Re-Analysis Tool and FSP	RF Service & other data
learned?			SDQ (3-10) LSCA items Caregiver Health and Wellbeing K10 scale Personal Wellbeing Index Home physical Environment Family Resource Management		- 3 highest strengths - 3 priority needs - Resilience outcome goal Progress toward goal	reason for: - ROSH - SARAs Helpline
Who does the program appear to work best for?	As above (Q1) Out-of-home care/ SARA history of mother	<u>Index children/control:</u> Child protection history, all prior: - reports to Helpline - SARAs - OOHC placements <u>Primary carer/control:</u> - Reported issues, each report, past 12 months - Age at birth of first known child (if known)	As above	<u>Family</u> Primary carer (y/n), age, gender Secondary carer (y/n), age, gender Number of children in household Type of home (own, rent etc) House moves in past 12 months Other services involved(school/ child care, GP, CS) Family affiliations Other important traditions Interpreter required <u>Primary & secondary carers</u> Highest level of education Employment situation Main source of income <u>Primary carer</u> Indigenous status Language spoken at home Country of birth CALD <u>Index child</u>	As above	- <u>Secondary carer</u> Indigenous status Relationship to index child

Evaluation questions	SECONDARY DATA					
	FACS		TBS			
	Bond matching and bond measures	Other	Resilience Outcomes Tool	Initial Contact	Re-Analysis Tool and FSP	RF Service & other data
				Child participation in education Estimated number days non-attendance		
Which service components appear to be most important for achieving benefits?					<u>Family, on entry, 6 months and exit:</u> Resilience Analysis Assessment domain Support plan: - 3 highest strengths - 3 priority needs - Resilience outcome goal Progress toward goal	<u>Client meetings</u> Date Type Duration Practitioner skill Outcome Practice Practice duration <u>Client cancellations</u> Notice? Reason <u>Practice details</u> Date Outcome Practice <u>External services</u> Type of service Name of service
How appropriate are the measures in place for the bond payment?						
What is the association between child protection outcomes used for SBB payment purposes and outcomes measured through the TBS Resilience Framework?	As above	As above		As above		

Evaluation questions	SECONDARY DATA					
	FACS		TBS			
	Bond matching and bond measures	Other	Resilience Outcomes Tool	Initial Contact	Re-Analysis Tool and FSP	RF Service & other data
PROCESS						
How well are targeted clients being identified and referred to the program?						
What are the characteristics of participants in terms of their needs and risk level? Are these as expected?	Matching data as above	<u>Index children/control:</u> Child protection history, all prior: - reports to Helpline - SARAs - OOHC placements		<u>Index child</u> Child participation in education Estimated number days non-attendance	As above	<u>Index child:</u> Danger identified by FACS in SARA <u>Index child:</u> Update reports date and reason for: - ROSH - SARAs - Helpline
Do the referral criteria or process need to be revised or refined? Is the matching process resulting in high risk groups of client not being referred, or lower risk clients being over		<u>As above</u>				
To what extent is the program being delivered as intended?						
Are planned timeframes for assessment, review and program duration being met?						<u>Referral process dates</u> Referral received Allocation received Initial contact meeting
What is the nature and intensity of the service being delivered e.g. individually targeted, which evidence-based practices are being employed?				<u>Family, on entry, 6 months and exit:</u> Resilience Analysis Assessment domain Support plan: - 3 highest strengths - 3 priority needs - Resilience outcome goal Progress toward goal		<u>Client meetings</u> Date Type Duration Practitioner skill Outcome Practice Practice duration <u>Client cancellations</u> Notice?

Evaluation questions	SECONDARY DATA					
	FACS		TBS			
	Bond matching and bond measures	Other	Resilience Outcomes Tool	Initial Contact	Re-Analysis Tool and FSP	RF Service & other data
						Reason <u>Practice details</u> Date Outcome Practice <u>Close case</u> Date of case closure Reason for closure Number of services involved at closure <u>Case re-opened</u> <u>Re-engagement</u>
How well are participants being linked into relevant services and making broader social and community connections?			Relevant increasing safety measures		As above	<u>External services</u> Type of service Name of service
Is the program sufficiently well-resourced and supported, including staff skills and professional support and development, clear guidelines etc?						Staff qualifications Training and support
How do the processes for joint working between TBS and FACS differ from business as usual, including regular data provision, and to what effect?						<u>Referral process dates</u> Referral received Allocation received Initial contact meeting
What differences can be observed across sites and what are the implications of any differences for	As above	As above	As above	As above	As above	As above

Evaluation questions	SECONDARY DATA					
	FACS		TBS			
	Bond matching and bond measures	Other	Resilience Outcomes Tool	Initial Contact	Re-Analysis Tool and FSP	RF Service & other data
clients and program outcomes?						
ECONOMIC						
Does the program offer value for money?						
What are the actual (versus budgeted) costs of the program?						TBS program cost data
How do these costs compare to similar programs in NSW and in other jurisdictions?		Funded program modelling and data e.g. IFS/IFP, IFBS				

Appendix 4 Evaluation timeline

Table 10. Reporting timeline aligned to data collection periods

		2014												2015												2016
		J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	Jan
Ethics approval																										
FACS Data																										
Schedule 2	Matched Pairs (profile on entry)																									
Ch 11.2	Control & index child																									
Schedule 3	Annual remediated bond data																									
TBS data																										
Client intake	Profile on entry																									
RAT	Assessment profile																									
Service provided	e.g dose/intensity																									
ROT	Resassessment and exit																									
Primary data																										
Interviews	Staff/stakeholders																									
	Primary carers (on exit)																									
Cost data																										
	TBS, FACS, other jurisdictions																									

Note: The timing of activities outline here is based on discussions held with the Working Group to date. It assumes that the formalisation of data sharing arrangements between FACS and ARTD will be completed by the end of April. This will reduce the likelihood changes in the timing and scope of evaluation activities, and it would allow adequate time for ARTD have any modifications (if required) of the ethics application approved and submitted by the 5 May 2014.