PRELIMINARY REPORT | December 2014

Evaluation of the Resilient Families Service

NSW TREASURY

ARTD CONSULTANTS
strategy & evaluation

Acknowledgments

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Abbreviations, acronyms and key terms

CSC	FACS Community Service Centre
EIP	Evidence Informed Practice
FACS	NSW Department of Family and Community Services
Index Child	Youngest child in a family receiving the RF service
Region 1	Eastern Sydney CSC areas, Central Sydney CSC areas, Burwood CSC areas and Lakemba CSC areas
Region 2	Bankstown CSC areas, Campbelltown CSC areas, Fairfield CSC areas, Liverpool CSC areas, and Ingleburn CSC areas
RF service	Resilient Families service
RF site	Resilient Families service delivery site (Rosebery, Campbelltown or Liverpool)
RPF	Resilience Practice Framework (or the Framework)
ROSH	Risk of Significant Harm report
SARA	Safety and Risk Assessment
SCFW	Senior Child and Family Worker (TBS staff)
SBB pilot	NSW Government Social Benefit Bond pilot
TBS	The Benevolent Society

Executive summary

Resilient Families

Resilient Families (RF) is an intensive support service for families where there are concerns about the safety and wellbeing of children. The service is delivered by The Benevolent Society (TBS) and funded under the NSW Government's Social Benefit Bond (SBB) pilot, in which private investment is applied to achieve social outcomes.

The RF service is based on TBS's Resilience Practice Framework (RPF) and informed by TBS's experience working with at-risk families and evidence-based programs, including Homebuilders.[1] The RF service commenced in October 2013 in three TBS sites across greater Sydney—Rosebery, Liverpool and Campbelltown—which cover two regions defined by the NSW Department of Family and Community Services (FACS).

The evaluation

The purpose of the evaluation is to assess the implementation, effectiveness and cost-effectiveness of the RF service. It will also look at how the child protection outcomes used for bond payment purposes align with TBS's more comprehensive assessment of resilience outcomes. The evaluation runs until January 2016 and covers the RF service provided to consenting families across the three TBS sites. This Preliminary Report covers the period from commencement to mid-2014 and focuses on processes and early implementation. It reports achievements and learnings to date and identifies opportunities to improve service delivery and data collection.

Key findings

The RF service is operational at all three sites and TBS and FACS are on track to meet the year one operational targets for requesting and referring families (based on 34 weeks of operation from 8 October 2013 to end June 2014). A total of 41 families started the RF service during this period.[2] There is reasonable evidence that a strengths-based, broadly holistic and evidence-informed service is being delivered to families.

There are gaps and inconsistencies within the early data that make it difficult to reach conclusions about some aspects of the service: in particular, there is a question around its intensity. TBS staff are focusing on promoting safety with families—consistent with the baseline assessment showing that the resilience outcomes where families are most often low functioning are Increasing Safety (93%) and Increasing Coping/ Self-regulation (71%).

As can be expected, there have been some challenging aspects to installing and delivering a new service. Within TBS these relate to the integration of the new service and ensuring that staff understand and can use the new Resilience Practice Framework (RPF). There have also been learnings within FACS, most particularly related to how the referral process and information sharing requirements operate.

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

The new referral process is largely effective

Identifying and referring clients to the RF service represents a practice shift from FACS' usual business model, and it is proving largely effective. To end June 2014, TBS exceeded its target for requesting referrals and FACS was close to meeting its target for responding to these requests (see Section 2.1.2). Most requests for referral (80%) were fulfilled within defined time periods and the majority of families invited to participate in the service (84%) agreed to do so.

There appears to be wide variation in the levels of need among participating families. Carers are generally characterised by low levels of educational attainment and labour force participation, but we do not yet have data about their previous experience in the child protection system, an important part of the service targeting. All Index Children (the youngest child in the family and subject for outcomes measurement) are within the target age (under six years old at referral), with an average age of 2.1 years.

[1] Institute for Family Development, *Homebuilders standards*, Washington, 2013

[2] Source: TBS data. Of these 41 families, 30 consented to participate in the service and the evaluation.

To what extent is the service being delivered as intended?

Timeframes are challenging

There are defined timeframes for TBS to recruit families into the RF service and develop a family case plan with them. These reflect the program theory that families at a point of crisis may be most open to making change, but they are proving difficult to meet. Qualitative accounts from TBS staff confirm that families are taking longer than expected to fully engage in the service.

The service is showing flexibility and fidelity to an evidence-based model

TBS's Service Model and Operating Guidelines for the RF service provide a degree of flexibility in delivery that enables TBS to adapt the service according to client needs. At the same time, previous research has shown that programs that adhere closely to the Homebuilders model are most effective.[3] Many Homebuilders' service characteristics are reflected in the RF model and TBS staff indicated these were reflected in their practice. Key examples are the services' values base, family involvement in goal setting, concrete and therapeutic services and client advocacy. There are also some key differences: the timeframe to make initial contact, the approach to defining intensity and the total service duration. The early data indicate the RF service is not as intensive as might be expected and the intended pattern of intensity is not evident (see Section 3.3).

As data become available, future evaluation reports will explore the materiality of these differences for achieving outcomes. Improved and additional monitoring data could provide evidence about important service elements such as: 1) the location of service delivery, to demonstrate if the service is home-based; 2) the time of service delivery, to demonstrate if it is being delivered at critical times of the day for families, such as early mornings and evenings; and 3) case plan goals, so we can assess how well goals reflect assessed needs.

The service is well resourced and there are ongoing staff training and support plans

TBS recruited experienced staff to deliver the program and supported them with training and professional supervision. A key challenge for TBS has been meeting the different support needs of their staff, especially to implement the RF service within the Resilience Practice Framework. They have introduced learning circles and strategies such as rotating team leaders to respond to this challenge.

Average costs compare well to similar programs

The average cost per client to end June 2014 was $27,190. This is slightly over the initial funding of $25,000, but compares well with other services in NSW that provide support to families, including Brighter Futures, Intensive Family Based Service, Intensive Family Support, and Intensive Family Preservation.

Conclusion

The establishment of the RF service has been largely successful. There is a high level of commitment among partner agencies to the service and its goals. TBS is responding to early implementation issues related to bedding down the new service.

At this stage it is difficult to reach conclusions about practice in areas such as intensity, referrals to external services and support of social and community connections, due to gaps in the monitoring data. These are important aspects of service delivery that need to be further examined and addressed where needed. As the RF service continues to progress from the early implementation stage, and recommendations are taken up, the service monitoring data can be expected to improve, which should allow a sound assessment of these practice issues.

Other questions that have emerged from the preliminary evaluation—such as the risk levels of referred families and which components of the service are most closely associated with client outcomes—will be explored in future reports. The recommendations below aim to support the delivery of the RF service in order to maximise outcomes for children and families.

[3] Tully, L., *Family Preservation Services: Literature Review*, Centre for Parenting & Research Service System Development, NSW Department of Community Services, 2008

Recommendations

1. TBS to review and confirm the accuracy of practice in recording of data on:
   - intensity of service
   - application of practices within the RPF, especially use of social mapping and referrals to other services.
2. TBS to explore the intensity data and determine whether any practice change or additional monitoring is required.
3. TBS to explore the implications of the data on the use of RPF practices and provide guidance to staff as needed around their use and recording.
4. TBS to build the service monitoring to collect data on service location and timing and include case plan goals within the evaluation data set.
5. FACS and TBS to continue to work on relationship building at a local level and consider structured or systematic approaches e.g. periodic meetings and shared professional development forums.
6. FACS and TBS to ensure all relevant staff are aware of the processes and requirements for information sharing and of when cases are to remain open within FACS.

1. Overview

This chapter describes the context, evidence base, service model and evaluation of the Resilient Families service.

1.1. The context for Resilient Families

1.1.1. A Social Benefit Bond pilot

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

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

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

1.1.2. A context of reform in NSW

More broadly the RF service is being delivered within a context of reform to the child protection system in NSW. In 2009, the NSW Government introduced a five-year action plan, *Keep Them Safe,* to reshape the way family and community services are delivered in NSW and to improve the safety and wellbeing of children and young people.

The plan has brought an expanded role for the non-government sector and stronger relationship between government and NGOs. It also reflects a commitment by the NSW Government to preventative and early intervention services to deliver better and more cost-effective social outcomes.

1.2. The Resilient Families model

1.2.1. Homebuilders as a theoretical basis

The RF service is based on TBS's Resilience Practice Framework (RPF) and has been informed by TBS's extensive experience in working with at-risk families as well as the international evidence-based program, Homebuilders. Homebuilders is a model of intensive, time-limited, home-based support developed in the 1970s in the United States of America. Premised on crisis as a motivator for behavioural change, the model targets families in crisis within the child protection system i.e. those at the high end of a service continuum who are at a point where out-of-home care is likely without significant change in parental behaviours and in the safety of the environment for the children concerned.

In 2008, FACS reviewed the evidence base for family preservation services and concluded that those that adhere closely to Homebuilders are most effective.[4] The literature review cites a meta-analysis by the Washington State Institute for Public Policy that examined fourteen family preservation programs, four of which adhered to key Homebuilders characteristics. It found that the four Homebuilders-based programs significantly reduced the need for children to enter care and subsequent episodes of maltreatment, while non-Homebuilders programs produced no significant effects on outcome. The review suggested there is some evidence that longer program durations might be more effective.[5]

[4] Tully, L., *Family Preservation Services: Literature Review*, Centre for Parenting & Research Service System Development, NSW Department of Community Services, 2008

[5] Ibid

Other studies have shown no statistical difference in the outcomes of preservation services, including those modelled on Homebuilders, or no difference between Homebuilders and other family preservation models. In 2012, Channa et al. published a meta-analysis of 20 studies of intensive family preservation programs, including those based on the Homebuilders model. Their analysis showed that intensive family preservation programs had a medium and positive effect on family functioning, but were generally not effective in preventing out-of-home placements.[6]

The FACS review found some evidence that family preservation services work best for highest risk families, reflecting the underlying premise of Homebuilders that crisis acts as a motivator for change.[7] This is consistent with the finding of Channa et al. that intensive family preservation programs were effective in preventing out-of-home placements for families with multiple problems. But both the FACS and Channa et al. reviews found evidence that family preservation services are less effective for families experiencing abuse and neglect, suggesting that out-of-home placement may be unavoidable for children in those families.

1.3. TBS Resilience Practice Framework

TBS, in partnership with the Parenting Research Centre, established a unifying approach to its service delivery through the development of a practice framework applied across a number of TBS child and family programs—including the RF service. The RPF has four main components:

1. domains of resilience (secure base, education, friendship, talents and interests, positive values and social competencies)
2. Evidence Informed Practices (EIPs)
3. the Resilience Assessment Tool
4. resilience outcomes.

1.3.1. Resilience outcomes

To develop the Framework, TBS reviewed the evidence base for 'what works' in supporting and promoting resilience in children. This was done to clearly articulate the outcomes and EIPs that are associated with resilience. There are five high-level outcomes to guide all of TBS' child and family programs:

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

1.3.2. Evidence Informed Practices

Building resilience is seen as a way of supporting children and families who have experienced adversity or who are vulnerable to poor developmental outcomes. In this context, resilience outcomes are understood in terms of a child achieving normal developmental goals and milestones under difficult conditions.[8]

The EIPs introduce a 'common elements' approach to service delivery. This approach hypothesises that it is not a program as a whole that works, but rather the common elements or practices within programs that work, when implemented in the right context to achieve identified behavioural outcomes.[9]

TBS has identified 42 practices shown empirically to positively affect behaviour, and aligned these to the five resilience outcomes within the RPF (see Appendix 1).[10] Most are quite simple, can be easily taught (e.g. giving descriptive praise, time-out and self-monitoring) and have outcomes that are immediately observable. Accordingly, they are seen as a useful way to disseminate practices that minimise behavioural and psychological problems, improve wellbeing, and achieve public health goals. Using these practices achieves these goals in a way that reduces reliance on implementing programmatic, and often costly, interventions.

[6] Channa M.W Al. et al. 'A meta-analysis of intensive family preservation programs', *Children and Youth Services Review,* 34 (8), 2012, pp.1472–1479

[7] See also IFBS Evaluation Early Findings, internal FACS report

[8] The Benevolent Society, Practice Resource Guide 2: *Infants at risk of abuse and neglect*, 2013, p.10

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

[10] As a "fundamental unit of behavioural influence," these procedures must be applied as a whole and are not effective if broken into component parts. Embry. D and Biglan. A, 'Evidence-based Kernels: Fundamental Units of Behavioural Influence', *Clinical Child Family Psychology Review*, 11, 2008, p.96

1.4. The Resilient Families service

1.4.1. Approach and aims

The RF Service Model and Operational Guidelines describe the service as:

> *a therapeutic, evidence informed program that provides long term, intensive support to families with children under 6 years of age where children are at risk of harm....to prevent children entering out-of-home-care.*

The objectives of the RF service are to:

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

Consistent with Homebuilders, RF provides families with practical and therapeutic supports. Key features of the RF service are:

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

The staff to client ratio in the RF service is consistent with Homebuilders, but intensity is not defined within the RF model.

1.4.2. Scope of service delivery

The RF service commenced working with clients in October 2013. It will be operational for five years and aims to support between 300 to 400 families in the following areas over this period. The service is delivered from three TBS sites in metropolitan Sydney. The three sites together cover nine CSCs across two administrative regions.[11]

- **Region 1** is serviced by the Rosebery site and covers Eastern Sydney CSC areas, Central Sydney CSC areas, Burwood CSC areas and Lakemba CSC areas.
- **Region 2** is serviced by the Campbelltown and Liverpool sites and covers Bankstown CSC areas, Campbelltown CSC areas, Fairfield CSC areas, Liverpool CSC areas and Ingleburn CSC areas.

1.4.3. Target group

Families are eligible for referral to RF if they have at least one child less than 6 years old who is living at home and has been assessed by FACS as at risk of significant harm but 'Safe with Plan' in the FACS Safety Assessment. This assessment indicates one or more dangers present for the child and that, without effective preventative action (like the RF service), the planned arrangement for the child will be out-of-home care. The child is able to remain in the home so long as planned safety interventions mitigate the identified danger(s).[12]

[11] These Regions are identified in the 2013 Operations Manual for the TBS SBB pilot and are not aligned with the current FACS Districts or the previous FACS regions. Also note, the local government areas of Camden and Wollondilly are excluded from Region 2.

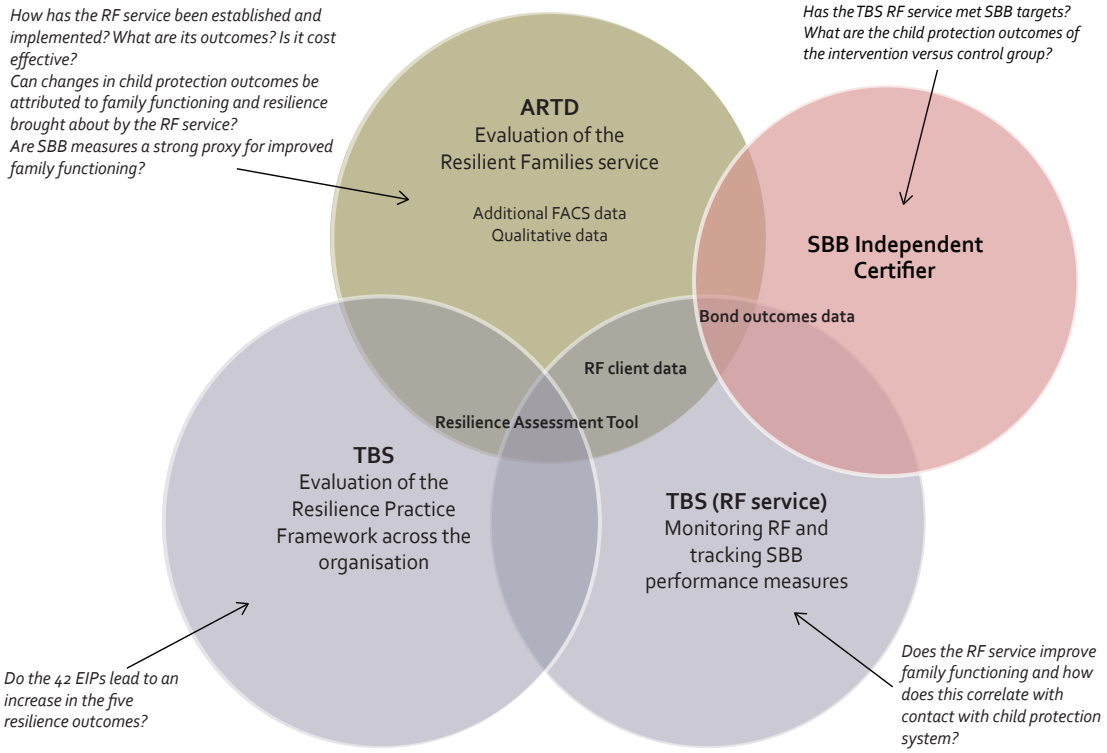
[12] FACS and Children's Research Centre, *The Structured Decision Making System Policy and Procedures Manual,* Implementation version, 2011

1.5. Multiple robust measurement of the bond pilot and service

A key feature of the model under the bond instrument is its focus on robust outcomes measurement. The Operations Manual for the TBS SBB pilot describes how changed contact with the child protection system will be measured for the intervention and control groups, and how this will be used to calculate the return on investment. An independent certifier will calculate the performance rate of the SBB based on the data provided by FACS.

At the same time, TBS are gathering a richer data set on family functioning for its internal evaluation of the RPF, looking at outcomes for clients against the five resilience outcomes. Accordingly, there are a number of simultaneous but complementary data gathering processes surrounding the pilot and the RF service (see Figure 1).

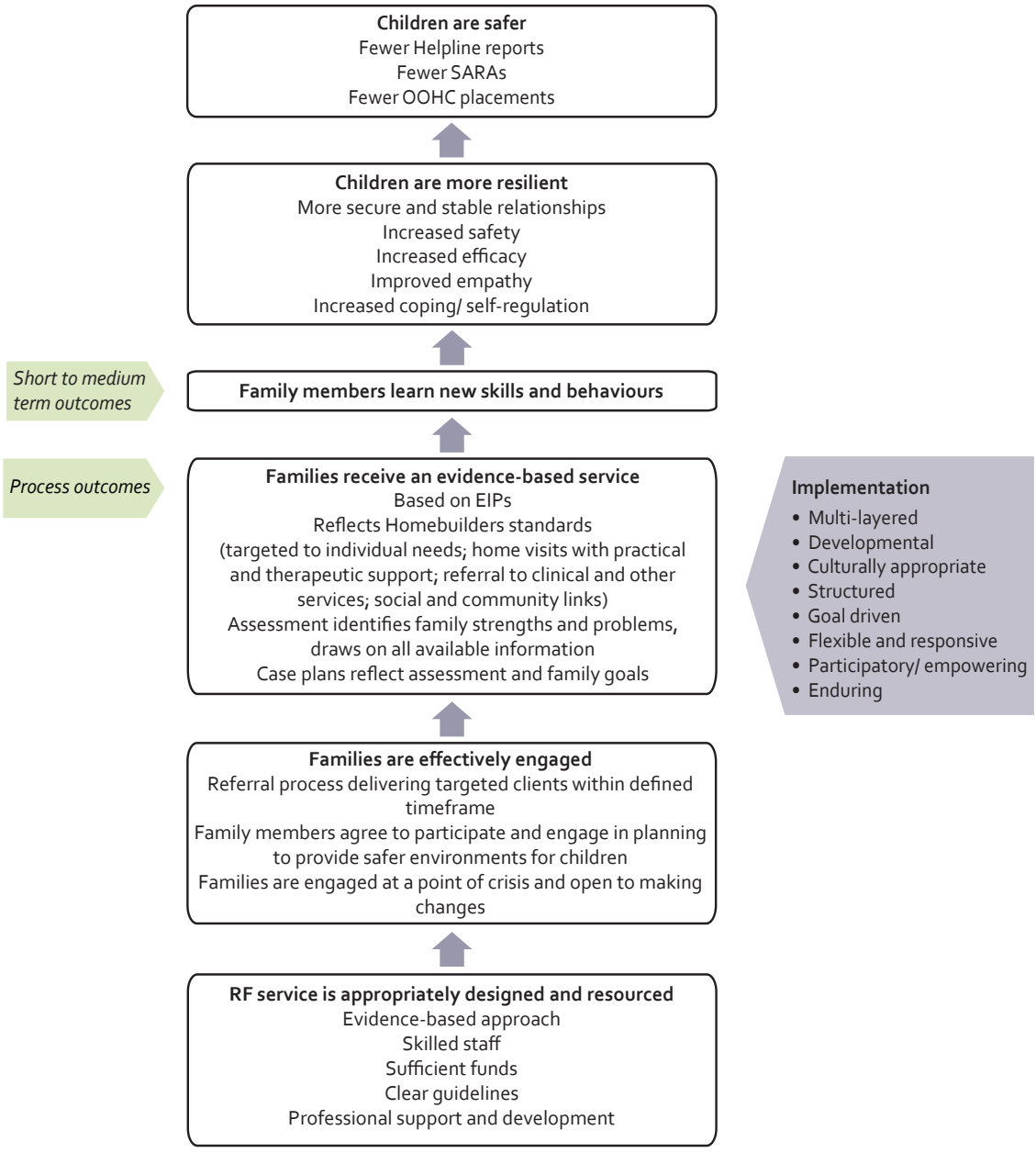
Figure 1. Scope of evaluation, monitoring and other data gathering activities for the TBS SBB pilot and RF service



1.6. Program logic

ARTD developed a program logic for the RF service based on the RF model to provide an analytical framework for the process and outcomes evaluation design. The logic shows the strategy of the RF service: a well-designed and resourced program supports effective implementation i.e. families engaging in a multi-layered, home-based service that teaches new skills and behaviours through the application of EIPs, to achieve five resilience outcomes (see Figure 2). While the strategy is relatively simple, its complexity lies in the application of the EIPs and measurement of outcomes.

Figure 2. The Resilient Families service program logic



1.7. The evaluation

The evaluation is assessing the implementation, effectiveness and cost-effectiveness of the RF service in achieving its outcomes. 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 to inform future arrangements.

1.7.1. Evaluation questions

Key evaluation questions were developed by ARTD to address both short- and longer-term outcomes in the logic hierarchy (see Figure 2). These were agreed by the Evaluation Working Group and outlined in the Evaluation Plan.[13]

Table 1. Key evaluation questions

Component	Evaluation question
Process	**How well are targeted clients being identified and referred to the RF service?** • 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? **To what extent is the RF service being delivered as intended?** • Are planned timeframes for assessment, review and service duration being met? • What is the nature and intensity of the service being delivered e.g. individually targeted, which evidence-based practices are being employed? • How well are participants being linked into relevant services and making broader social and community connections? • What affects the individualisation of plans and what are caregivers' experiences of the process? What helps and what hinders? • What is effective in helping families access and build natural supports and what are the barriers? • Is the service 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 service? 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 service outcomes?
Cost analysis	**Does the RF service appear to offer value for money?** • What are the actual (versus budgeted) costs of the service? • How do these costs compare to similar programs in NSW and in other jurisdictions?
Outcomes	**What are the outcomes of the RF service for participants?** • Do Index Children have less contact with the child protection system than the comparison group? • What changes in functioning and wellbeing are seen for Index Children and their families? What new skills and behaviours have parents/ carers learned? • Who does the service 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? **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 Practice Framework?

[13] ARTD Consultants, Evaluation Plan, 2014, http://www.dpc.nsw.gov.au/__data/assets/pdf_file/0008/168335/Evaluation_Plan_for_Resilient_Families.pdf

1.7.2. Methods

The evaluation is a mixed-method,theory-based design drawing on secondary program monitoring data and three sources of primary data collected from: TBS staff, FACS staff and RF clients. The focus and scope of data collection and analysis for the outcomes, process and economic evaluation are detailed in Appendix 2.

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

1.7.3. Three reporting stages

The overall timeframe for the evaluation of the TBS SBB pilot extends beyond the time period for the current evaluation. This evaluation covers the first three years of the RF service, from when it commenced in 2013 to 2016, and so is part of a wider evaluation approach. This phase one evaluation commenced with a planning stage and will deliver three reports:

- Preliminary (this report)
- Mid-term (April 2015)
- Final (Jan 2016).

Each report will address process, outcomes and economic components, though the emphasis will shift. Early reporting focuses on the process evaluation, while subsequent reports will have an increasing emphasis on outcomes and a more detailed analysis of costs.

1.7.4. The preliminary evaluation

In **Chapter 1**, we have presented an overview of the RF service in the context of the SBB pilot and TBS Resilience Practice Framework that is informed by the evidence-based Homebuilders model. This Preliminary Report now focuses on process evaluation questions—covering the installation and early implementation stages[14] of the RF service—and prepares the groundwork for the outcomes evaluation, which will continue into 2015.

Process evaluation components

Chapter 2 describes the targeting and referral of families to the RF service. Data on targets and timelines for referrals, the referral outcome and the demographic characteristics of referred families are presented.

Chapter 3 addresses the implementation of the RF service and assesses its fidelity in relation to the Homebuilders standards and the evidence available to demonstrate this. First, timelines for engaging families, the intensity of actual service, and the use of Evidence Informed Practices and practitioner skills are analysed. Second, resourcing and support are examined—including budgeted and actual costs, and a comparison of budgeted costs to similar programs in NSW—and discussed in view of new ways of working and innovations that the SBB approach and the RF service model bring.

These two chapters identify where processes, relationships or data could be strengthened to support intended outcomes.

The data sources for the process evaluation are:

- remediated, aggregate TBS service monitoring data covering the period 8 October 2013 to 30 June 2014
- unit record TBS service monitoring data covering the period 8 October 2013 to 6 June 2014
- interviews with TBS staff (n=10)
- interviews with FACS staff (n=8)
- TBS resilience outcome assessment baseline (n=30)
- program costs data provided by TBS and FACS
- administrative information about the RF service, supplied by TBS.

Outcomes evaluation components

Chapter 4 looks at the baseline characteristics of families according to measures from TBS resilience instruments. The first part of the chapter looks at family functioning as characterised by the standardised

[14] Fixsen, D. L. et al. *Implementation Research: A Synthesis of the Literature,* University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network, 2005

measures of survey instruments in the Resilience Outcomes Tool. The second part of the chapter uses data from these same instruments, but analyses it in terms of TBS' five resilience outcomes.

The final chapter of this report, **Chapter 5**, provides conclusions and recommends actions for TBS and FACS.

The report does not contain any FACS data about the child protection histories or experiences of participants. Remediated FACS data will be available and reported on in the next two evaluation reports.

1.7.5. Limitations

As the analysis is based on data from early implementation of a new program, there are uncertainties around its completeness and consistency across workers and sites. The Preliminary Report provides an opportunity for issues in data quality to be identified and addressed, particularly as they relate to practice by TBS staff in interpreting requirements and recording practices.

There are some gaps in the data available to describe key components of the service, and a question about the reliability of some data based on identified inconsistencies between monitoring and interview data. We have made a number of recommendations in this report aimed at addressing this limitation, and will also seek to fill data gaps in the next evaluation stage through a staff survey.

Group interviews with TBS staff aimed to capture experiences and highlight views about achievements and issues. As such, we describe the extent to which views are shared qualitatively, rather than indicating the number of people who might share a particular view.

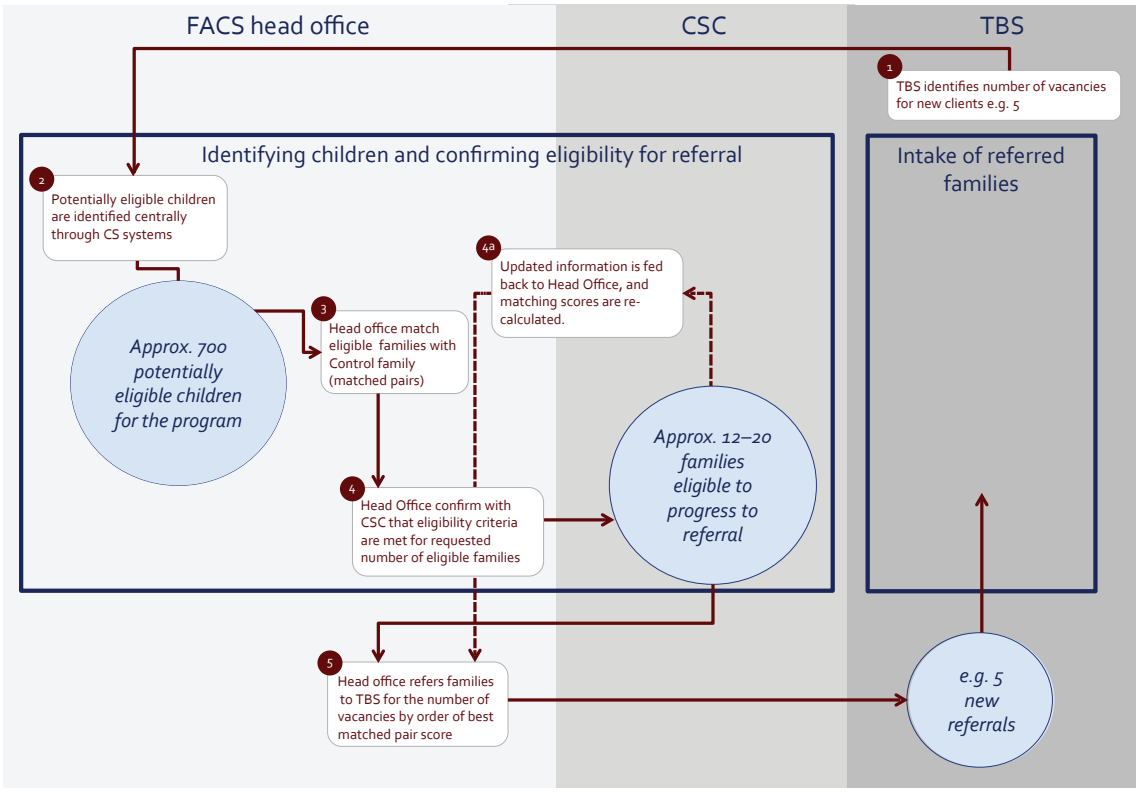
2. Targeting and referral of clients

This chapter looks at the referral process and characteristics of referred families. We draw on TBS monitoring data—both aggregate and individual records—and interviews with TBS and FACS staff.

2.1. The referral process

2.1.1. The new approach for FACS is working well

The process for identifying and referring clients to the RF service represents a practice shift from FACS' usual business model, and it is proving largely effective. Instead of cases being identified within local FACS Community Service Centres (CSCs), the referral process commences when TBS notifies FACS of vacancies in the RF service and FACS identifies families through a system-generated list of eligible children and a matched control child. The pair is ordered according to a matching score.[15] FACS then confirms the eligibility of the best matched Index Children and their families—through a process of checking records with the CSC office to get an up-to-date understanding of each family's circumstances—and then referring the families directly to TBS for intake into the RF service (see Figure 3).



2.1.2. Targets for declaring and filling vacancies are being reached

The Operations Manual for the TBS SBB pilot outlines the minimum numbers of families that TBS and FACS are aiming to meet over each year of the pilot. The evaluation data covers the period from commencement on 8 October 2013 to end June 2014. Based on this data, over the first 265 days of its operation, TBS was exceeding its target for requesting referrals (see Table 2 over the page). Sixty-one requests for referral were made during this time, exceeding the 36 requests that were expected.

[15] The Operations Manual outlines how a Highest Pair Score + Index Score are formed to reach Best Match Score, p15–17

Table 2. Planned and actual requests for referral by TBS

	Number of requests for referral		Cumulative referral targets by year			
TBS SBB pilot region	Actual requests during first 9 months	Year 1 Target adjusted to first 9 months	Year 1	Year 2	Year 3	Year 4
Region 1	20	12	17	40	68	100
Region 2	41	24	33	78	135	200
Total	61	36	50	118	203	300

Source: Remediated TBS RF data from period 8 October 2013 to 30 June 2014 (265 days)

Table 3 shows that FACS has fulfilled 49 of TBS' referral requests against an expected 65 in the first nine-month period. As these data give a snapshot, at any particular time the number of referrals requested by TBS is likely to often exceed those fulfilled because of the time involved in this process.

The data reflect 12 unfulfilled referrals, discussed in Section 2.1.3 following.

Table 3. Planned and actual referrals fulfilled by FACS

	Number of referrals fulfilled		Referral targets by year			
TBS SBB pilot region	Actual requests fulfilled during first 9 months	Year 1 Target adjusted to first 9 months	Year 1	Year 2	Year 3	Year 4
Region 1	20	22	30	37	37	30
Region 2	29	44	60	73	73	60
Total	49	65	90	110	110	90

Source: Remediated TBS RF data from period 8 October 2013 to 30 June 2014 (265 days)

2.1.3. The timeframe for referrals has mostly been met

During the current evaluation period, 80% of referral requests by TBS were met with a referral within the planned timeframe. Most of these were within 10 days (62%) and 18% within a further 10 days following an extension, as per the Operations Manual (see Table 4). It is unclear why 12 vacancies were not fulfilled. These all occurred within the first three months of implementation, suggesting it may have been due to staff becoming familiar with the new referral process. TBS and CSC staff feel that the timeframe for completing referrals is appropriate, albeit challenging.

Table 4. Vacancies declared by referral outcomes

Number of vacancies	Count	Percent
Vacancies met by referral within 10 days	38	62%
Vacancies met by referral between 10 and 20 days	11	18%
Vacancies met by referral over 20 days	0	0%
Unfulfilled vacancies	12	20%
Total vacancies declared	**61**	**100%**

Note: Each single request for referral may be for more than one vacancy.
Source: Remediated TBS RF data from period 8 October 2013 to 30 June 2014

2.2. Referral outcome

2.2.1. Families are well distributed across the three sites

By the end of June 2014, 41 families had agreed to participate in the RF service. Of these, 30 consented to participate in the evaluation. Referrals of consenting families have been fairly evenly spread across the three TBS sites: 11 in Campbelltown, 12 in Liverpool and 15 in Rosebery (see Table 5).

Table 5. Total referrals by service location

	Region 1	Region 2		Total
	Rosebery	Campbelltown	Liverpool	
Commenced service and consented to evaluation	12	9	9	30
Commenced service and did not consent to evaluation	-	-	-	11
Sub-total (commenced)				41
Declined service	3	2	3	8
Total referred				49

Source: Remediated TBS RF data from period 8 October 2013 to 30 June 2014

2.2.2. There is no strong pattern in families who accepted or declined

Around one-sixth (16%) of the referred families declined the service (see Table 5). Those who refused appear similar in characteristics to those who accepted. Within the small number involved, there were a similar proportion of Aboriginal families and families from culturally diverse backgrounds, referrals pre-birth and number of reported issues in the FACS Safety Assessment. The age of the Index Child was also similar in both groups. The main difference observed was that children in families who declined the service were more commonly reported for hazardous living conditions and substance abuse by a carer than those who accepted, but it is early in the project and the data set is small.

In the next report we will know how many times children in participating families have been reported to the FACS Helpline and for what reason, and whether there are any differences between families who accept and decline the service in this regard.

2.3. Characteristics of referred families

2.3.1. Family structure and carer characteristics suggest social and economic disadvantage

The referred families are broadly in line with the target group, although the patterns will be clearer as the size of the Intervention Group increases over time and FACS data become available.

Two-thirds of RF families have a two-carer structure. On average, primary carers are between 28 to 30 years old. Almost all primary carers are women, except in the Campbelltown site where only 56% are female. Most primary carers have education to Year 10 or below, though there is some variation across sites. Less than 20% of primary carers are employed, and their main source of income is government benefit. Employment is highest in Rosebery (see Table 18, Appendix 3). Primary carers most often speak English at home (see Table 23, Appendix 3).

Almost half of the families at two sites were living in public housing. In the third site, there were more families in either private rental or crisis accommodation. While 61% of families had not moved in the past 12 months, 39% had moved at least once and 17% had moved three times or more (Table 21 and 22, Appendix 3).

Age of Index Children

Index Children range from unborn to six years, with an average age of 2.1 years. Although they are distributed equally by gender across the RF service as a whole, they are mostly male in Campbelltown (83%) and mostly female in Rosebery (67%) (see Table 20, Appendix 3). There was one Aboriginal child at each service site. Most of the 12 children for whom we have data about educational participation attend either centre-based care or school.

Participant risk levels are not yet known

Given the research evidence that family preservation services are most effective for highest-risk families (see Section 1.2.1) it is important to understand the risk levels of RF participants. It is also important for understanding who is most likely to engage with the program and who is mostly likely to benefit, so the service can be targeted effectively and implemented efficiently.

Drawing on their professional experience, TBS staff described families as very mixed in their risk profile, from 'quite low' to 'very high' and this is confirmed by the TBS baseline assessment (see Section 4.2). A small number of FACS and TBS staff believe the referral process may be leading to systematic exclusion of families with high risk profiles whereby their unique circumstances made them difficult to match. One FACS staff member explained:

> *What is easier to match are single families, first children, parents without child protection history: these are the families we see getting matched.*

There is no data available at this stage to either substantiate or set aside this concern, but it will be explored in future reports.

3. Delivering Resilient Families

This chapter addresses the process evaluation questions about service implementation and draws on all available data sources. In this chapter, the referral data includes the 38 families who consented to the evaluation (of whom eight declined the service) and the program data includes the 30 families who consented and commenced the service.[16]

3.1. Timeframes for contact and assessment

3.1.1. Engaging with families

The timeframes for making contact with families, completing case plans and undertaking case plan reviews are built into TBS's RF Service Model and Operating Guidelines and include a target to make initial contact with families within seven business days of receiving a referral. The data show that this is occurring in some cases, but is often taking longer than planned (see Table 6).

Table 6. Business days between TBS receiving referral from FACS and TBS making initial contact with family

RF service location	Families (n)	Mean	Standard deviation	Minimum	Maximum	*Missing*
Campbelltown	10	8	6	2	19	*1*
Liverpool	10	13	5	7	25	*2*
Rosebery	13	4	3	0	11	*2*
Total	**33**	**8**	**6**	**0**	**25**	*5*

Note: Five families refused the service before the initial meeting could occur. Source: TBS RF database

It is also taking longer to complete the Resilience Assessment Tool with the families than the 30 days specified within the operating guidelines. The time taken to do this varied from 10 to 174 days, with an average of 50 days (see Table 7).

Table 7. Business days from referral to completion of Resilience Assessment Tool

RF service location	Families (n)	Mean	Standard deviation	Minimum	Maximum
Campbelltown	8	35	20.2	10	74
Liverpool	8	55.6	23.3	29	89
Rosebery	11	57.5	44	23	174
Total	**27**	**50.3**	**33.2**	**10**	**174**

Note: Three families had not completed the Resilience Assessment Tool when data was extracted. Source: TBS RF database

The data in Table 7 aligns with the comments by some TBS staff who said that many families are taking longer to engage than they expected. Across all sites, staff said they work cooperatively with families to develop their Family Support Plan (FSP), even if this takes longer than anticipated. One described the time needed to develop the right relationship for planning to be effective, and that instead at the beginning, much of their time is spent responding to immediate needs in regards to legal, housing and health issues rather than forward planning.

> *Sometimes it is not until the end of a three-month period, or even six months, that there is enough trust and stability for the family to start working on their plan. It can also take a number of months for an assessment to capture a full picture of all the issues….The first three months are spent in crisis response and most time goes to attending appointments (e.g. housing) rather than working on goals in the support plan.*
>
> [TBS staff member]

Six families had their case closed during the evaluation period, including three that relocated. TBS staff spent some months trying to secure the commitment of families that subsequently refused the service. (see Table 8 over the page). One TBS staff member felt the bond structure was impacting positively on their perseverance to keep families engaged in the service.

[16] Forty-nine clients were referred to the service from 8 October 2013 to 30 June 2014. Of these, 8 clients refused the service, and eleven declined to take part in the evaluation. Program and outcomes data were extracted 6th June 2014, at which time 30 clients had commenced the program and consented to the evaluation.

Table 8. Reasons for case closure and length of time in service

Reason for closure	Families (n)	Duration of service (months)
Family relocated	3	3.1
Family disengaged	2	2.6
Family refused service	1	1.5

Source: TBS RF database

3.2. Nature and quality of the service

3.2.1. Homebuilders provides standards for assessing the service model (program structure) and service characteristics (intervention activity)

In looking at the nature of the service delivered through RF, we draw on an assessment against standards for the Homebuilders program. While RF is not designed exclusively as a Homebuilders service, it draws on many Homebuilders characteristics. The Homebuilders standards cover two broad areas:

1. **Program structure**: concerned with program design, such as duration, intensity and quality mechanisms
2. **Intervention activity**: concerned with the dynamic service elements and qualities, such as individualised planning, provision of services and family skill development.

RF is consistent with most standards for program structure in design and practice

Design fidelity
The RF service reflects many of the Homebuilders standards for program structure in design (see Figure 7, Appendix 4), including:

- a values/ principles base
- delivery in clients' home or other natural settings
- 24-hour availability for families and back-up for staff
- a single population
- a structured approach to quality enhancement.

Key differences from the Homebuilders standards are in three areas: duration (six weeks in Homebuilders compared to 12 months in RF), immediacy of referrals (within 24 hours in Homebuilders compared to 7 or more days in RF), and the approach to defining intensity (Homebuilders explicitly defines intensity and RF does not).

Flexibility within the SBB approach means that TBS can respond to families' different needs, demands and capacity to engage. We will explore the materiality of these differences for achieving outcomes in later evaluation reports.

Practice fidelity
The data available suggests that many of the standards are being met in practice, though the service appears to be lower in intensity than prescribed in the Homebuilders model (see also Section 3.3). A more reliable assessment of fidelity could be made with additional monitoring data to indicate the time(s) of day that TBS staff work with families. An important part of the 24-hour availability standard is service delivery at challenging times for families, typically involving working in homes in the early morning and evening periods to help families develop new routines during these critical periods.

Consistency with standards for intervention activity is supported largely by qualitative data
In terms of Homebuilders standards for intervention activity, RF is highly consistent in design and, based on qualitative reports from TBS staff, also consistent in practice (see Figure 8, Appendix 4). Qualitative data provides evidence that many aspects of these standards—including goal setting and service planning, concrete and therapeutic services and collaboration and advocacy for clients—are seen in practice. In addition, program data show practice to be promoting safety and using a variety of teaching approaches, such as problem solving and using 'teachable moments' in the EIPs.

3.2.2. Referrals to other services and community connections

The Homebuilders standards emphasise the provision of concrete and therapeutic services and community connections, and working collaboratively with other services to ensure supports are in place. TBS staff described a number of services they had referred family members to (see Table 9).

Table 9. TBS staff description of services families have been referred to

Type	Services referred to
Health services	• GPs • Mental health services • Counselling services • Psychologists • Drug and alcohol services
Social support services	• Housing services • Refuge support
Parenting and family supports	• Parent support services • Daycare • Playgroups

Source: TBS RF staff focus groups

The data in Table 9 is not reflected in the TBS monitoring data, which shows only four referrals during the preliminary evaluation stage. This discrepancy suggests data recording in this area is problematic.

Community connections

Some TBS staff gave examples of how they were encouraging families to build social and other local community connections, but this is also not reflected in the current monitoring data, which show less than one hour of time recorded against the social connection mapping across the service.

3.3. Intensity of the service

3.3.1. The service is less intensive than expected

The Homebuilders standards define intensity as an average of six to eight hours per week of face-to-face time with clients (see Figure 7, Appendix 4). The average face-to-face time spent by TBS staff with RF families ranged from under one hour to eight hours per week. The average is just under two hours (1 hour and 49 minutes) per client (see Table 10).

Table 10. Number and duration of face-to-face meetings with clients per week

	Average interactions	Type of interaction	Families (n)	Mean	Standard deviation	Minimum	Maximum
Total	Number	Face-to-face	30	**1.16**	0.61	0.25	2.95
	Duration	Face-to-face	30	**1h49m**	1h31m	0h18m	8h1m

Source: TBS RF database

TBS data also show the time spent on client-related telephone calls and meetings with other professionals. Including all meetings with or about a family ('interactions'), TBS staff had an average of 3.4 meetings per week accounting for an average of 2.5 hours of client-related time per week (2 hours and 27 minutes), with variation within and across sites (see Table 11 over the page).

Table 11. Number and duration of all interactions with or about clients per week

RF service location	Average interactions*	Families (n)	Mean	Standard deviation	Minimum	Maximum
Campbelltown	Number	9	**2.9**	1.1	1.5	4.5
	Duration	9	**1h54m**	0h49m	0h46m	3h15m
Liverpool	Number	9	**3.4**	1.3	1.57	5.1
	Duration	9	**1h58m**	1h6m	0h52m	4h34m
Roseberry	Number	12	**3.9**	1.6	0.9	6.2
	Duration	12	**3h13m**	2h15m	0h42m	8h58m
Total	Number	30	**3.4**	1.4	0.9	6.2
	Duration	30	**2h27m**	1h42m	0h42m	8h58m

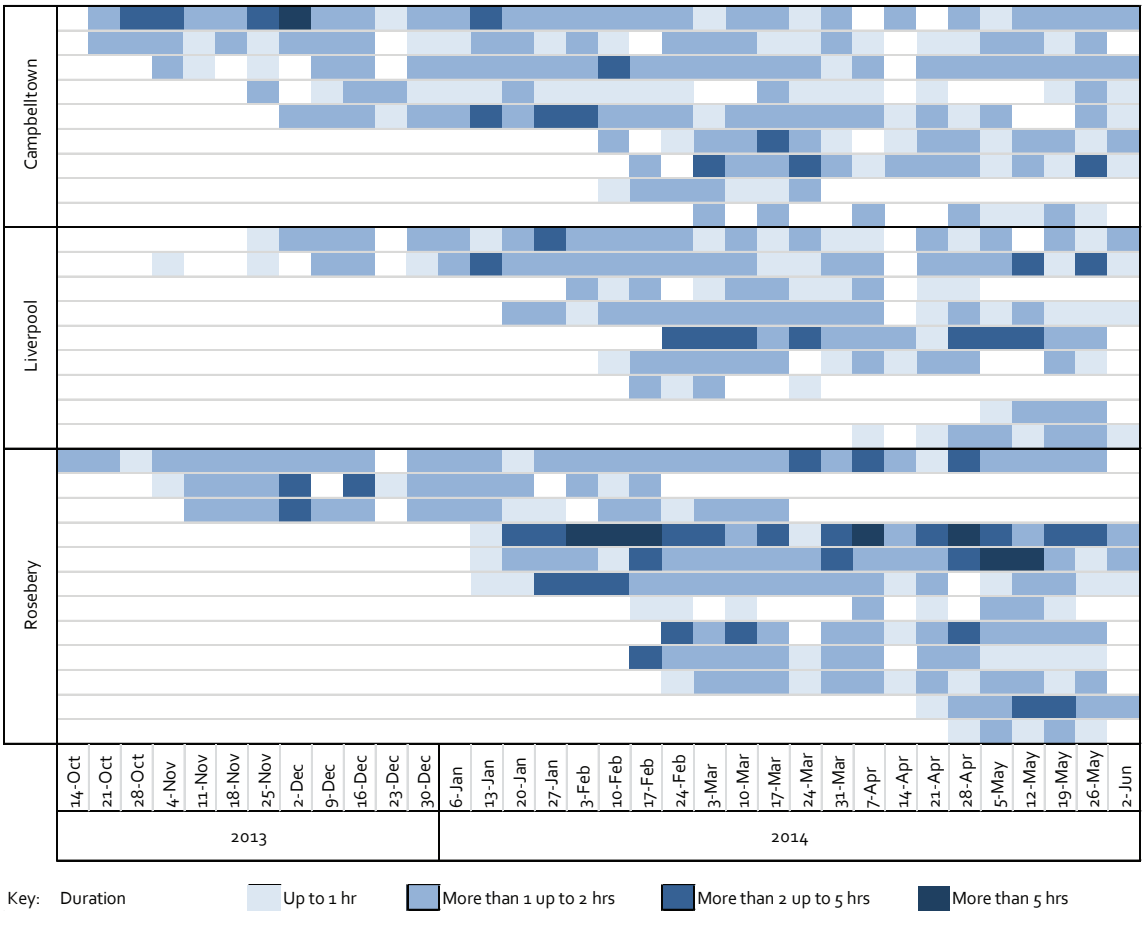
Source: TBS RF database

*Interactions includes phone calls, meetings with other professionals, and face-to-face meetings with clients

3.3.2. Service delivery does not follow the intended pattern

In Figure 4 we show the intensity of the service received by each family each week through gradations in shading. Each row represents one family. The data indicate that three families received an intensive service (more than five hours of service in a week) and 16 families received between two and five hours. The data also suggest that the planned model of an intensive 12-week period followed by a less intensive service period is not reflected in practice. The three families who received an intensive service received this at different stages in their engagement, specifically during week 7 (Campbelltown row 1); weeks 3 to 5 and weeks 12 and 15 (Rosebery row 4); and weeks 16 and 17 (Rosebery row 5).

Figure 4. Hours of service per week for each family



3.4. Use of Evidence Informed Practices

3.4.1. Safety planning is the most commonly recorded practice area that aligns with identified need

The RF service is structured by the tools and practices established in the RPF, of which the 42 EIPs are a key component. To date, TBS staff appear to have spent 15% of their time applying the EIPs, though this varies considerably across sites (see Table 12). It is not clear from the TBS documentation how consistent this is with expectations. Given the RPF and tools are new to staff, confidence and consistency in recording may also be issues (see Section 3.5.3).

Table 12. Percentage of interactions and time with clients working on EIPs

RF service location	Type of interaction*	% of interactions on EIPs	% of time on EIPs
Campbelltown	Face-to-face	71%	51%
	Total	27%	38%
Liverpool	Face-to-face	28%	8%
	Total	8%	6%
Roseberry	Face-to-face	16%	5%
	Total	7%	4%
Total	Face-to-face	35%	18%
	Total	14%	15%

Source: TBS RF database

*Interactions includes phone calls, meetings with other professionals

Of the EIP work that has been recorded at this stage, most indicates that practices are focusing on Increasing Safety (see Table 13). Increasing Safety EIPs include making safety plans, positive discipline strategies, injury prevention and child proofing, child supervision and health care, and increasing social connections.[17] This observation aligns with the baseline assessment, which show that 93% of families have needs in at least one measure under this Increasing Safety outcome (see Section 4.3.1). It also reflects interviews with TBS staff who commonly said that safety planning is, 'often the first thing that gets done and is reflected in the EIPs' (TBS staff member).

Table 13. Percentage of time spent on EIPs focused on each resilience outcome

RF service location	Increasing Safety	Increasing Self-efficacy	Secure and Stable Relationships	Increasing Coping/ Self-regulation	Improving Empathy	Total
Campbelltown	47%	22%	20%	8%	4%	100%
Liverpool	51%	10%	27%	10%	2%	100%
Rosebery	59%	14%	20%	3%	4%	100%
Total	**49%**	**20%**	**20%**	**7%**	**3%**	**100%**

Source: TBS RF database

3.4.2. Practitioner skills focused on engaging families

The RPF identifies five practitioner skills to assist TBS staff to engage with families and establish a strengths-based therapeutic alliance. In total, 48% of service delivery time involved TBS staff employing the 'engaging families' skills (see Table 14 over the page). This is consistent with earlier findings about engaging families (see Section 3.1.1).

[17] The Benevolent Society, *Practice Resource Guide 4: Increasing Safety*, 2013

Table 14. Percentage of time spent on TBS practitioner skills

RF service location	Engaging families	Parent skills training	SMART goals	Checklists and task analyses	Motivational interviewing techniques	Total
Campbelltown	52%	16%	15%	11%	7%	100%
Liverpool	39%	55%	3%	1%	3%	100%
Rosebery	27%	40%	17%	3%	13%	100%
Total	**48%**	**22%**	**14%**	**9%**	**7%**	**100%**

Source: TBS RF database

3.5. Service resourcing and support

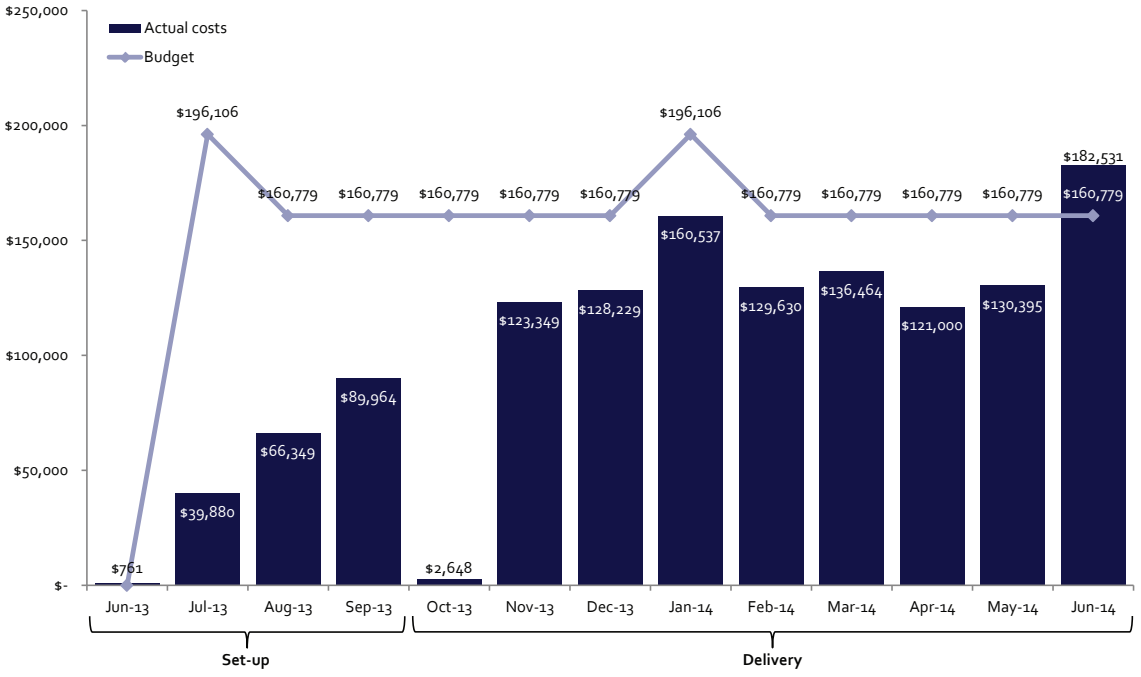
3.5.1. Service costs are tracking well against budget

The RF service has an allocated budget of $10 million over five years. To the end of June 2014, a total of 41[18] families had commenced the RF service, bringing the cost per client to an average of $27,190. This is slightly over the initial funding of $25,000 per client.

The budget was initially set in March–April 2013 with the expectation that the RF service would start operating from 1 July 2013 with funding of $2 million per annum. While TBS started incurring costs for the service from June 2013, service delivery started in October 2013 so the first few months can be considered as a set-up phase.

Figure 5 presents the actual costs of the program against the budget, by month from June 2013 to June 2014. The breakdown of actual costs shows a clear difference between the set-up and delivery phase. During the first financial year of the RF service, TBS spent $1,311,737 which represents 66% of the initial budget. When the service delivery start date was known, the funding for the 2013/14 financial year was updated to $1.5 million in the 2013/14 year. As a consequence, TBS made an adjustment to the shared services (finance, HR, IT, legal, evaluation, property services, etc.) charged against the program funding during the first months, so that the program was not overcharged before actual delivery started—this explains the very low level of actual costs in October 2013. When the first clients entered the service, costs increased rapidly to around $130k a month, with a peak in January 2014 at $160.5k and another in June 2014 at $182.5k.

Figure 5. RF service budget and actual costs, June 2013 – June 2014



Source: TBS cost data, June 2013 to June 2014

[18] Forty-nine clients were referred to the service from 8 October 2013 to 30 June 2014. Of these, eight clients refused the service.

3.5.2. Budgeted costs compare well to similar programs

This budgeted cost per family compares well other family support programs in NSW (see Table 15). The comparative analysis will be updated in future reports based on actual, rather than budgeted, costs per client (average cost per family), and looking at similar programs in other Australian jurisdictions.

Table 15. Comparison of funding for RF service with similar programs in NSW

Program	Service level	Annualised budget	Annualised target number of families	Average funding per family
Resilient Families	Intensive	$2,000,000	80	$25,000
Intensive Family Based Service	Intensive	$3,200,000	88	$36,364
Intensive Family Support	Intensive	$6,113,027	170	$35,959
Intensive Family Preservation	Intensive	$3,980,443	98	$40,617
Brighter Futures	Medium	$58,300,000	3,124	$18,662

Sources: TBS and FACS

Overall, the infrastructure and resourcing of the RF service has supported its delivery to families. The Operations Manual for the TBS SBB pilot and TBS's RF Service Model and Operating Guidelines have provided a solid basis for implementation and there are dedicated resources for managing the program within NSW Government agencies and TBS.

TBS processes for accessing brokerage at one site were identified by staff at this site as problematic. Given brokerage funding is important for supporting a flexible client-centred service,[19] TBS has changed its internal processes at this site to enable access to brokerage funding on an emergency basis, consistent with delivery of the service model.

3.5.3. Staff are skilled but have had different levels of need for training

Twelve staff were recruited into the RF service, largely from outside TBS. There is a high level of relevant experience among these staff.[20] All have experience with either, or both, statutory and non-government organisations in child and family work, and in related fields, such as drug and alcohol misuse or relationships counselling. Certain features of the RF service—especially the evidence-based approach and 12-month duration—attracted many of these applicants.

TBS staff have participated in a range of training and other professional development activities.[21] At each site, though, TBS staff felt that either the timing or amount of training they received in using the RPF were problematic. Timing issues relate largely to the fact the training for RF staff was part of a wider organisational training schedule that had to take account of multiple program needs.

Concerns about the amount of training may in part reflect the comprehensiveness of the RPF. The number of concepts and tools that make up the Framework are likely to take time to absorb and apply. TBS follows a 70:20:10 professional development model, recognising that most (70%) learning occurs through workplace experiences, 20% occurs through peers and only 10% through formal learning. Most TBS staff we spoke to recognised that the 'real learning' about the RPF was 'in the doing', and that using the Framework involved significant practice change.

Implementation of new services requires change at individual and organisational levels. This will be different for different individuals and will not occur simultaneously or evenly in all parts of a practice or an organisation.[22] As might be expected, some TBS staff found the application of the RPF a more challenging transition than others. TBS has put in place a range of strategies to address identified concerns, including regular supervision, learning circles and individual learning plans.

[19] For example, FACS' *Guidelines for the use of brokerage funds by Specialist Homelessness Services*, November 2013

[20] TBS data

[21] TBS data

[22] Fixsen, D. L., et al. *Implementation Research: A Synthesis of the Literature*., University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network, p.16, 2005

3.6. Processes for joint working

3.6.1. Joint working is supporting family engagement, but there are some areas for strengthening local relationships and processes

TBS and FACS staff have, in most cases, a positive approach to joint working, which is reflected in practice. Key joint working processes are described below.

Referring families

The centrally-driven referral process is proving mostly effective (see Chapter 2) though the large number of staff involved across multiple CSCs meant ensuring they all understood the service and their role in facilitating referrals to it was difficult. The main impact of this was around information sharing. The requirements for information sharing are clearly documented in the Operations Manual for the TBS SBB pilot. FACS and TBS staff appear to have been working together to make sure these requirements are being adhered to, but many suggested more clarity was needed. TBS indicates they are addressing this concern by clarifying roles and responsibilities with FACS.

Home visits

A key feature of referrals from FACS to TBS is a joint home visit by TBS and CSC staff or a meeting with the family, intended to support a smooth transition and reduce duplication for the family when gathering information. These visits have been occurring as intended (in 29 of 30 cases). Interviews with TBS and CSC staff indicated that the process minimises service refusals and contributes to collaborative working relationships.

FACS case closure

The Operations Manual for the TBS SBB pilot says that case management responsibility for children and families referred to RF will be transferred to TBS, 'upon completion of FACS' child protection action.' The Manual also specifies that FACS will close a case following the transfer of case management, unless there are current court orders.[23] Data about the open/ closed status of cases referred to the RF service is not available at this stage. TBS and CSC staff reported that cases are sometimes (but in less than half of all instances) kept open during the first few weeks of the RF service, especially when parties are concerned about parental drug and alcohol misuse. The TBS and FACS staff who commented on this supported CSCs keeping a case open when it involves a high-risk family. No staff referred to using the Manual when determining when to close a case.

Communication and relationship building

While FACS staff work across multiple programs and non-government organisations there are some unique aspects to the RF service. There is a tendency for communications between CSCs and TBS to rely on individual relationships rather than agreed procedures. A more systematic way of supporting these relatipnships would strengthen local processes. A few TBS staff indicated that more promotional resources would be helpful in explaining the service to FACS staff when they approach them. TBS reports they are responding to this issue, and we will report on this activity in the next evaluation report.

3.7. Culture of learning and adaptation in delivery

3.7.1. Innovation is occurring at multiple levels

The SBB approach brings with it a focus on innovation and a culture of learning, flexibility and adaptation in its delivery. The TBS SBB pilot provides an opportunity to trial new approaches to working between FACS and the non-government sector. The shift away from funding tied to defined service specifications is intended to encourage responsiveness and adaptation of the service as learnings emerge.

The RF service model brings another level of innovation. TBS's new practice framework, the RPF, focuses the service on achieving a set of child resilience outcomes through the application of a set of empirically-based behaviour change practices (see Section 1.3.2). At the same time, the model is informed by Homebuilders, the most effective family preservation service approach (see Section 1.2.1), but is not

[23] The Operations Manual for the TBS SBB pilot defines these court orders as, 'orders made by the Children's Court about the care and protection of a Child or Young Person. These include assessment orders, interim care orders, supervision orders, orders allocating parental responsibility for a Child or Young Person, orders prohibiting an act by a person with parental responsibility, contact orders, orders for the provision of support services, orders to attend therapeutic or treatment programs and variation and rescission of orders' (page7).

expressly aligned to or defined in terms of key Homebuilders standards. Flexibility within the model and its delivery are consistent with a 'no wrong door' approach.[24] However, some tension exists between fidelity of the RF service to an evidence-based model and the opportunity for flexibility and innovation in adapting the service as learnings emerge.[25] We will explore this further in future reports.

3.7.2. TBS and FACS have responded to emerging challenges

Implementation issues and challenges in the early implementation stage largely reflect what we know from the implementation literature. Notably, that wide-scale practice change will impact differently on different staff, and in different parts of an organisation. Challenges associated with staff integration and confidence in applying the RPF are being addressed by TBS, for example through team leader rotation, learning circles and additional training. TBS also reports they are responding to limited awareness of the RF service model among CSC staff through a renewed and ongoing communication strategy. Any inconsistencies in the approach to information sharing among CSC staff have been raised and TBS has met with FACS to clarify the requirements and responsibilities. TBS is keeping a log of adaptations at each site, which will tell the story of innovation in program delivery and provide important data for the evaluation in addressing the question of fidelity and innovation in relation to the final outcomes.

3.8. Differences across sites and their implications

3.8.1. Differences are observed but their implications are not known

From TBS's perspective, there have been no differences in the approach to implementation of the RF service across the sites. In practice, the data show variation across sites in a number of areas, including the timeframes from referral to first contact and for completing case planning. There also appear to be differences in the intensity of the service being delivered and the use of the EIPs.

Both the monitoring data and the qualitative data from interviews show these apparent differences. We are unable to tell at this early stage if these reflect significant differences in practice, or just different ways of recording practice. The challenges described through the qualitative data were concentrated at one site more than the other two. If there are actual differences with implementation, the evaluation is not yet at a stage to determine if these are associated with different program outcomes. TBS has been addressing and monitoring these issues, and we will explore progress in future reports. As the number of participating families grows and with improved data from monitoring, TBS will be in a better position to assess and refine implementation and, if necessary, make evidence-based innovations.

[24] Moloney, et al. *Families, life events and family service delivery: A literature review,* Australian Institute for Family Studies, 2012

[25] KPMG, *Evaluation of the Joint Development Phase of the NSW Social Benefit Bonds* Trial, p.25, 2014

4. Measuring outcomes

This chapter provides an outline of how outcomes will be measured and the data involved, and introduces reporting on TBS resilience outcomes data. In this chapter we draw on assessment data for the 30 families who consented and commenced the service and interviews with TBS staff.

4.1. Outcomes methods

The outcomes of the RF service are being measured in two ways:

1. **Using TBS data,** comparing wellbeing and functioning at entry and exit (resilience outcomes, also measured by TBS)
2. **Using FACS data,** comparing the level of contact in the child protection system for Index Children and comparing this to their matched pair control (also used to determine bond payment).

In this report we use TBS data to present the initial outcomes assessment (baseline) for the 30 participating families who have consented for their data to be used in the evaluation (though not all surveys or survey items have been completed by all families).[26] In future reports, we will examine outcomes using both data sources and explore the relationship between these to help identify the most reliable measures to be used in future bond arrangements.

4.2. Baseline characteristics for standardised measures

4.2.1. Families on average are functioning just below normative levels, but with large individual variation

The Resilience Outcomes Tool is the main assessment tool used by TBS. It includes a number of standardised measures and other questions (many taken from the Longitudinal Study of Australian Children) that are designed to measure five high-level resilience outcomes. The tool is administered to the identified primary carer of the RF Index Child about themselves and about the Index Child.

In interpreting these data, it is important to note the importance of the relationship between participants and RF Senior Child and Family Workers (SCFWs), and how this can impact on parent responses.

Most baseline characteristics show that families are at slightly lower functioning than normative populations, or just under cut-off points for problems (see Table 16 over the page). RF families also display slightly higher distress and lower subjective wellbeing than the Australian population. On individual measures, wide variation in responses indicates a wide range of functioning or wellbeing among participants at entry to the service.

[26] Forty-nine clients were referred to the service from 8 October 2013 to 30 June 2014. Of these, eight clients refused the service, and eleven declined to take part in the evaluation. Program and outcomes data were extracted 6th June 2014, at which time 30 clients had commenced the program and consented to the evaluation.

Table 16. Baseline scores for standardised measures compared with normative data

Measure	Subscale	Tool range	RF mean	Standard deviation.	*Missing data*	Normative data
Personal Wellbeing Index	–	0–100 (higher indicates greater wellbeing)	63.7	21.5	*2*	Normative mean=73.7–76.7 (Meade and Cummings, 2010)
Kessler 10	–	10–50 (higher indicates greater stress)	16.3	5.6	*0*	Normative mean = 14.5 (Slade et al., 2011)
Protective Factors Survey	Social support	0–7 (higher is better)	5.7	0.3	*0*	Comparison score=5.7 (Counts et al., 2010)
	Concrete support	0–7 (higher is better)	5.1	0.4	*0*	Comparison score=5.5 (Counts et al., 2010)
	Nurturing and attachment	0–7 (higher is better)	6.5	0.1	*1*	Comparison score=6.0 (Counts et al., 2010)
	Family functioning and resilience	0–7 (higher is better)	5.3	1.6	*0*	Comparison score=4.9 (Counts et al., 2010)
Strengths and Difficulties Questionnaire	Total difficulties	0–40 (lower indicates fewer difficulties)	14.2	5.8	*19*	Normative mean = 8.2 (Mellor, 2005)
Parenting Sense of Competence	–	16–96 (higher indicates greater confidence)	73.6	13.3	*9*	Range 60.6–60.9 (Gilmore and Cuskelly, 2009); Range 62.5–65.9 (Johnston and Mash, 1989). See Appendix 5 for detail.

Source: TBS Resilience Outcomes Tool

While normative data is not available for questions from the Longitudinal Study of Australian Children and Home and Physical Environment Inventory, baseline scores are in a similar range to other scales (see Table 28 and 29 in Appendix 5).

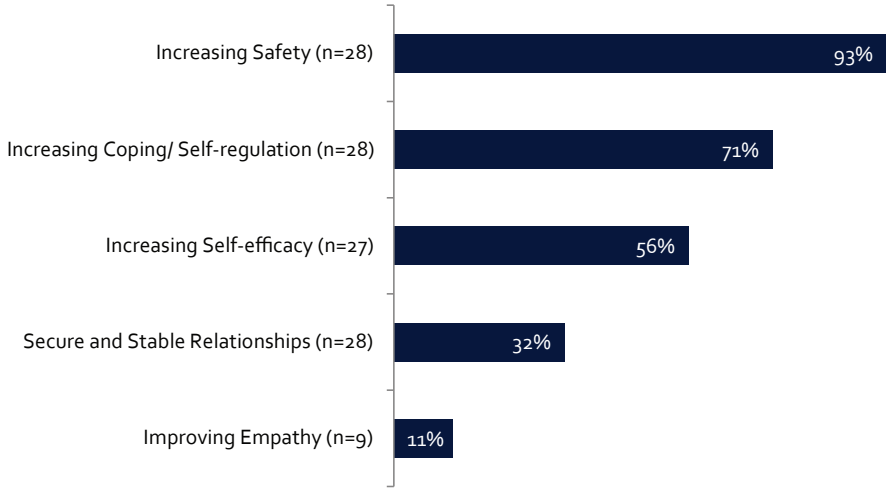
4.3. Baseline characteristics by resilience outcome

4.3.1. Safety is the most commonly assessed area of need

Figure 6 presents the baseline for the TBS resilience outcomes. Each of the five outcomes includes one or more items from the surveys reported in the previous section.

The resilience outcomes where families are low functioning most often are Increasing Safety (93%) and Increasing Coping/ Self-regulation (71%). On some items RF families perform better at baseline than normative populations: they score high overall in terms of reported parenting satisfaction and Self-efficacy.

Figure 6. Percentage of families presenting with needs on at least one item for the resilience outcomes



Note: The 'n' indicates how many families responded to items within that outcome. Where there are multiple items within an outcome, n is equal to the highest 'n' among those items. Source: TBS Resilience Outcomes Tool

Increasing Safety

The Increasing Safety outcome is made up of 14 individual items. Overall, 27 families (93%) were low functioning on at least one item. Of the individual items, poorest functioning was shown on community links (how often the child spends time with friends and family) and family resource management.

Increasing Coping/ Self-regulation

The Increasing Coping/ Self-regulation outcome is made up of six individual items relating to the emotional health/ wellbeing of both the caregiver and the child. Overall, 20 families were scored as low functioning on at least one of the items incorporated in this outcome. Poorest functioning was seen in the Strengths and Difficulties Questionnaire (SDQ) Conduct Problems subscale, and on the Kessler 10 (K10).

5. Conclusions and recommendations

5.1. Conclusions

5.1.1. A strong foundation and early implementation successes

The RF service is based on a service model with strong evidence for its effectiveness, within a comprehensive, evidence-informed practice framework. From the evidence available, the initial stages of establishment—installation and early implementation of the service—have been successful. The service has been well-resourced and the three sites are fully operational. Key service components, including the referral process and joint home visits or meetings with families, are working as intended. Many elements of the service reflect the standards for Homebuilders intensive family preservation programs, which informed the development of the RF service.

As it is early days in the implementation of a new service, within a new organisational practice framework, it can be expected that initial implementation issues will arise. Within TBS these have been largely about staff and service integration and practice support in the use of the RPF. The centralised referral process also reflects a new way of working between the government and the non-government sector and there have been some challenges ensuring FACS staff understand the service and processes for working together, particularly around the requirements for information sharing. TBS have identified and are responding to these issues.

The strong foundation has established a context in which service delivery can be refined and families' needs met.

Families and understanding complexity and risk

All families have been referred because of their assessed risk issues, but beyond this there is little data about the complexity or level of family needs. The evidence available from TBS monitoring data, baseline assessment and interviews with TBS and FACS staff suggests there is wide variation in levels of need and functioning among the families participating. While a majority (61%) were in stable housing in the 12 months prior to starting the service, 11% had moved once and 28% had moved twice or more (see Table 22, Appendix 3). The degree of case complexity is often associated with risk, which can in turn be associated with outcomes. In future reports, we will have information about participants' profile within the child protection system, including FACS' assessement of risk level at the time of referral.

5.1.2. Completeness and accuracy of the data make it difficult to reach firm conclusions about some service aspects

The completeness and accuracy of the service data are issues that make it difficult to reach conclusions at this early stage about practice in key areas, such as intensity, use of the EIPs, referral to external services and support to form social and community connections. There are also some data gaps, including the location and timing of service and case plan goals. Data in these areas would provide for greater certainty in assessing implementation in the next evaluation report and ultimately understanding the pattern of outcomes.

There is a key question around service intensity

To the extent we can rely on the available data, the service is lower intensity than that typically seen in intensive family preservation services. For each week of service, the average number and duration of meetings with or about a family varied between families and sites. Face-to-face interactions occupied the greatest percentage (73%) of total time, but many families are recorded as having less than two hours of meetings with or about them each week. Also, scattered intensity per family over time does not reflect the intended service structure: 12 weeks of intensive intervention to start.

5.1.3. Core components that may impact on outcomes are not yet known

The flexibility within the SBB approach means that TBS can respond to families' different needs and capacity to engage. On the other hand, RF is based on a tested and relatively standardised approach, where fidelity of implementation is expected to deliver the outcomes. Dosage and duration will be critical to understand how outcomes are achieved, the cost-effectiveness of service provision, and the opportunity costs for taking on further clients. Other questions that have emerged include whether the most appropriate families are being referred and the importance of timeframes for completing referrals and case plans. These will be explored in future evaluation stages.

5.2. Recommendations

On the basis of the preliminary findings we recommend the following actions for TBS. The recommendations support the delivery of the RF service to maximise outcomes for children and families.

Recommendations

1. TBS to review and confirm the accuracy of practice in recording of data on:
   - intensity of service
   - application of practices within the RPF, especially use of social mapping and referrals to other services.
2. TBS to explore the intensity data and determine whether any practice change or additional monitoring is required.
3. TBS to explore the implications of the data on the use of RPF practices and provide guidance to staff as needed around their use and recording.
4. TBS to build the service monitoring to collect data on service location and timing and include case plan goals within the evaluation data set.
5. FACS and TBS to continue to work on relationship building at a local level and consider structured or systematic approaches e.g. periodic meetings and shared professional development forums.
6. FACS and TBS to ensure all relevant staff are aware of the processes and requirements for information sharing and of when cases are to remain open within FACS.

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Appendix 1: Resilience Practice Framework

Table 17. Resilience Practice Framework: 42 EIPs aligned to the five TBS resilience outcomes

Resilience outcome	Evidence Informed Practices
Secure and Stable Relationships	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	Tangible rewards Effective requests Creating effective child and family rules Developing a safety plan Injury prevention and child proofing Basic child health caret Implementing natural and logical consequences Reducing unwanted behaviours–planned ignoring Reducing unwanted behaviours–time out Social connections maps Supervising children
Increasing Self-efficacy	Setting goals for success Praising for effort and persistence Identifying negative thinking traps Challenging negative thinking Strategies to challenge negative thinking traps
Improving Empathy	Tuning in: identifying a child's emotions Naming a child's emotions Modelling empathy Praising empathy Using emotions as a teaching opportunity Emotion coaching
Improving Coping/ Self-regulation	Promoting better sleep routines (infant) Promoting better sleep routines (toddler and young child) Promoting better sleep routines (adolescent and adults) Problem solving (child) and decreasing aggression (younger child) Problem solving (adult and family) Problem solving (child) 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: Methods

The evaluation adopts a mixed-method approach with process, outcomes and costing components. The process components are the main focus in this Preliminary Report.

1. Process evaluation

The purpose of the process evaluation is to document implementation as a basis for understanding outcomes and to identify issues that may lead to improvements in outcomes or efficiency.

Secondary sources

We used de-identified secondary data from TBS's collections that monitor administrative work, service delivery and client characteristics (Chapter 2 and 3).

These include:

- remediated, aggregate data for the total service population from commencement to end June 2014
- unit record data for consenting families covering the period from commencement to 6 June 2014

RF unit record service data items include referral dates and allocations; some Index Child and family characteristics; types and duration of client meetings; EIPs in use and practitioners skills in use; ROSH and Helpline reports made during the service period; types of external services engaged; and the date and reason for case closure.

TBS also provided RF costs data (total funding and expenditure in the service) and administrative information about the resources and types of support dedicated to the RF service and staff.

Secondary data analysis

Quantitative analysis was descriptive only and was carried out using IBM SPSS statistics v22 (SPSS) and Microsoft Excel. For service data, we looked at differences across TBS sites with a view to better understanding the context for service delivery, and 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 used items from the RF service data (plus some items from the Resilience Outcome Tool) to describe the:

- demographics of Index Children, their primary carers and other family characteristics e.g. family structure, housing
- service characteristics e.g. meeting types, frequency, duration, EIPs used, services referred to
- timeliness of processes for referral and key tasks, joint working and support for staff in delivering RF.

Primary sources

We collected primary data from face-to-face focus groups (2 hours) with RF staff and semi-structured telephone interviews (45 min to 1 hour) with RF staff and TBS SBB stakeholders.[27]

Focus groups with RF staff at each site included the RF Team Leaders and Senior Child and Family Workers (SCFWs). All 11 program staff from each of the three sites were invited to participate. We spoke to both Team Leaders and eight SCWFs (n=10). One SCFW who did not attend the focus group was interviewed separately. One SCFW was not available.

The focus groups were used to gather structured information on implementation processes and how families are engaging with the service. Interviews covered:

- 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 do not engage versus 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.

[27] The third source of primary data collection, interviews with primary carers in participating RF families will commence in the next stage of the evaluation.

Interviews with FACS client service managers and casework mangers from the RF program and five CSCs staff in CSCs (n=8).

Interviews were conducted with FACS staff with knowledge or oversight of the TBS SBB pilot and with a view to the referral and joint working processes. These interviews covered:

- 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).

Primary data analysis
Focus groups and interviews were recorded and notes were taken, which were analysed using NVivo. We developed a coding framework based on the notes and transcripts to analyse this data. All ARTD staff who did interviews or focus groups were also involved in developing the framework and in the NVivo analysis. We tested for inter-coder reliability and made adjustment to the framework accordingly. Framework nodes covered the SBB structure and governance, system interactions, RF service structure, RF service delivery practice, and overarching nodes for enablers, barriers and timeframes.

Synthesis and reporting framed by Homebuilders standards
We examined the RF service in terms of its key characteristics to evaluate both the service model and what it is delivering. The Homebuilders standards[28] provided a framework for this analysis. We assessed both the level of consistency between the RF service model and Homebuilders standards and the extent to which the services being delivered reflect the RF program characteristics and Homebuilders standards.

Using the standards helps to identify issues that need to be addressed and/or areas where the program can most improve. It provides an objective basis for comparing RF with other family preservation and reunification services, and helps set a context for interpreting findings of the results evaluation.

2. Cost analysis

The cost analysis in this report describes the value for money of the service by responding to two of the key evaluation questions: how do these costs compare to similar programs in NSW and in other jurisdictions; and what are the actual (versus budgeted) costs of the program? (see Section 3.5).

The comparative analysis included information from similar programs from the FACS portfolio in NSW. FACS programs include the Intensive Family Based Service (IFBS), Intensive Family Support (IFS), Intensive Family Preservation (IFP) and Brighter Futures. In future rounds of the evaluation, we will expand the comparative analysis to look at programs in other jurisdictions.

This cost analysis also used program costs data provided by TBS that includes a breakdown of both budgeted and actual costs by type of expenditure e.g. salaries and wages, administration, information technology, marketing and promotion, travel and transport, client expenditure, property and equipment, depreciation, shared services allocations.

3. Outcomes evaluation

We used de-identified secondary data from TBS's baseline assessment of clients' resilience (see Chapter 4). In future reports we will have FACS data to enable reporting on system outcomes.

Secondary sources
The Resilience Outcomes Tool is completed by the primary caregiver of the Index Child on entry to the RF service and then every three months as part of a progress review. The Resilience Outcomes Tool includes a number of standardised measures and other questions (many taken from the Longitudinal Study of Australian Children) designed to measure five high-level resilience outcomes.

The standardised measures included in the tool are outlined below.

[28] Institute for Family Development, *Homebuilders standards*, Washington, 2013

- **Protective Factors Survey (PFS)**:designed for caregivers receiving child maltreatment programs. It comprises of four subscales: social support, concrete support, nurturing and attachment, and family functioning.
- **Strengths and Difficulties Questionnaire (SDQ)**: designed as a brief behavioural screen questionnaire about 4–17 year olds, and can be used for a variety of purposes, including evaluation. The version used in RF is the Parent 4–10 version. The SDQ contains five subscales, and a 'Total Difficulties' score, which provides an overall measure of problems.
- **Parenting Sense of Competence (PSOC)**: a 17-item scale designed to measure parents' satisfaction with their parenting and their self-efficacy in the parenting role (Gilmore & Cuskelly, 2009).
- **Kessler 10 (K10)**: a simple measure of psychological distress, used as a brief screening tool. It contains 10 questions about emotional state.
- **Personal Wellbeing Index (PWI)**: a measure of 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.
- **Home and Physical Environment (HPE)**: a practitioner based observation of safety in the home environment.

Secondary data analysis and reporting

Quantitative analysis was descriptive only, and was carried out using IBM SPSS statistics v22 (SPSS) and Microsoft Excel. Analyses of baseline family functioning and costs were done at the level of the RF service.

We report results in two ways. Firstly, the scores for each standardised measure are reported and compared with existing normative data from Australian samples (where possible). They are then summarised to enable an overall picture of the functioning of participating parents. Secondly, we report the results according to the five TBS resilience outcomes.

For the baseline surveys, the standardised measures included in the Resilience Outcome Tool were scored according to the existing published manuals for each measure. A manual could not be located for the PSOC, so this measure was scored using the same method as used by afterdeployment.org.[29] Data had already been recoded where necessary by TBS (i.e. where individual variables had to be reversed due to the question format).

We identify the proportion of the sample that was *low functioning*. This was determined by calculating an overall index score for each outcome, using the responses to the individual items (questions) listed by TBS.

There are two ways in which index scores such as these can be calculated (Sanson & Misson 2005). Option 1 is to identify cut-off scores for each variable that 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 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 & Misson 2005) and might be the most useful approach in future reports when we are looking at change over time.

The approach taken here was to use cut-off scores to indicate problem status (Option 1) for transparency, ease of interpretability, and to easily identify people who may need assistance. 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.

[29] See After Deployment, 'Assessments' http://afterdeployment.t2.health.mil/sites/default/files/pdfs/assessment-tools/parenting-confidence-assessment.pdf

Appendix 3: Family and child characteristics

Table 18. Primary carer characteristics

Primary carer characteristics		Campbelltown	Liverpool	Rosebery	Total
Number		9	8	11	28
Age at referral	Average (mean)	28.2 years	29.8 years	30.2 years	29.6 years
	Missing data	*3*	*0*	*0*	*3*
Gender	Male	44%	0%	10%	19%
	Female	56%	100%	90%	81%
	Missing data	*0*	*0*	*1*	*1*
Employment situation	Employed full time	11%	0%	18%	11%
	Employed part time	11%	0%	0%	4%
	Employed casual	0%	0%	9%	4%
	Full time carer/ parent	67%	50%	55%	57%
	Unemployed	11%	50%	18%	25%
	Missing data	*0*	*0*	*0*	*0*
Main source of income	Wages or salary	11%	0%	18%	11%
	Child support or maintenance from ex-partner	0%	0%	9%	4%
	Government benefit, pension or allowance	89%	100%	73%	85%
	Missing data	*0*	*0*	*0*	*0*
Highest level of education achieved	Less than HSC or equivalent	78%	57%	77%	72%
	HSC or equivalent	11%	29%	11%	16%
	Post school qualification	11%	14%	11%	12%
	Missing data	*0*	*1*	*2*	*3*

Source: TBS baseline assessment

Table 19. Secondary carer characteristics

Secondary carer characteristics		Campbelltown	Liverpool	Rosebery	Total
Number		4	7	9	20
Age at referral	Average (mean)	38.7 years	32.4 years	42.8 years	38.8 years
	Missing data	*1*	*2*	*1*	*4*
Gender	Male	50%	86%	88%	79%
	Female	50%	14%	13%	21%
	Missing data	*0*	*0*	*1*	*1*
Employment situation	Employed full time	0%	25%	14%	14%
	Employed part time	0%	25%	43%	29%
	Employed casual	0%	0%	9%	4%
	Full time carer/ parent	67%	0%	14%	21%
	Unemployed	33%	50%	29%	36%
	Missing data	*1*	*3*	*2*	*6*
Main source of income	Wages or salary	25%	25%	29%	27%
	Government benefit, pension or allowance	75%	75%	71%	73%
	Missing data	*0*	*3*	*2*	*5*
Highest level of education achieved	Less than HSC or equivalent	50%	50%	0%	44%
	HSC or equivalent	0%	50%	33%	22%
	Post school qualification	50%	0%	33%	33%
	Missing data	*0*	*5*	*6*	*11*

Source: TBS baseline assessment

Table 20. Average age and gender of Index Children

Age at referral	Campbelltown	Liverpool	Rosebery	Total
Number	8	9	9	26
Average age	2.6 years	1.8 years	1.9 years	2.1 years

Gender	Campbelltown	Liverpool	Rosebery	Total
Number	6	7	9	22
Male	83%	43%	33%	50%
Female	17%	57%	67%	50%
Total	100%	100%	100%	100%
Missing	*2*	*1*	*0*	*3*

Source: TBS baseline assessment

Table 21. Type of housing

	Campbelltown	Liverpool	Rosebery	Total
Number	8	v7	11	26
Own or am paying off my house/flat/unit	13%	14%	18%	15%
Public housing	50%	43%	18%	35%
Private rental house/ flat/unit	25%	29%	36%	31%
Stay with family or friends	0%	14%	0%	14%
Caravan	0%	0%	0%	0%
Crisis/temporary housing	12%	0%	27%	15%
Homeless	0%	0%	0%	0%
Total	100%	100%	100%	100%
Missing	*1*	*1*	*0*	*2*

Source: TBS baseline assessment

Table 22. Number of times families have moved house in past 12 months

	Campbelltown	Liverpool	Rosebery	Total
Number	9	8	11	28
Not at all	67%	63%	55%	61%
Once	11%	13%	9%	11%
Twice	0%	12%	18%	11%
Three times	0%	12%	9%	6%
Four times or more	22%	0%	9%	11%
Total	100%	100%	100%	100%

Source: TBS baseline assessment

Table 23. Language spoken at home

	Campbelltown		Liverpool		Rosebery		Total	
	n	%	n	%	n	%	n	%
Bengali	0	0%	0	0%	1	8.3%	1	3.3%
Cantonese	0	0%	0	0%	1	8.3%	1	3.3%
English	9	100%	8	88.9%	9	75%	26	86.7%
Other	0	0%	1	11.1%	0	0%	1	3.3%
Turkish	0	0%	0	0%	1	8.3%	1	3.3%
Total	9	100%	9	100%	12	100%	30	100%

Source: TBS baseline assessment

Appendix 4: Homebuilders standards and RF

The Homebuilders' standards are based on research about the most effective and efficient structures (standards for program activities) and important characteristics (standards for intervention activities) for delivering the model. For each of the standards, we assess the level of consistency between each of these standards, the RF model, and how this is reflected in practice. Our practice assessment draws on the RF Service Model and Operating Guidelines, monitoring data and interviews with TBS RF staff.

1. Program structure

Figure 7. RF and Homebuilders standards for program structure

Homebuilders standards for program structure	Reflected in RF structure	Reflected in RF practice
Values based: clearly articulated set of beliefs and values guides program design and staff behaviour.	Yes, clear set of resilience principles.	Qualitative data supports this. All TBS staff demonstrated a high level of motivation and alignment with service values and principles in interviews.
Single specific target population: families whose children are at imminent risk of out-of-home care, or who are in out-of-home care and can be reunified through intensive in-home support.	Yes.	Yes, all children referred with safety assessment 'Safe with Plan' meaning without intervention the planned outcome will be out-of-home care. Anecdotally, some families at a lower risk threshold than anticipated.
Immediacy in response to referrals: referrals can be accepted 24/7; caseworker meets family within 24 hours of referrals.	7 days between referral and home visit; initial contact within business hours.	Average number of days between referral and initial contact by site is 4.4 days, 8.2 days and 12.5 days.
Service in clients' natural environment: service is provided mostly at home plus in other relevant community locations.	Yes.	73% of SCFW time spent recorded as face-to-face with clients, but no data on where this occurs.
Single therapists operate within a team: 3–5 therapists and a supervisor. Service is provided to families by a single therapist, with the team providing clinical backup.	Overall model consistent.	RF structure and arrangements are consistent.
Service intensity and caseload: therapists work typically with two families at a time, and families typically receive 40 hours or more direct face-to-face casework (over 5–6 weeks, average 6–8 hours per week).	Intensity not specified.	Intensity appears low for intensive service, average face-to-face time per week 1 hr 49min (n=30, std. dev. 1hr 31min, range ohr 18min to 8hrs 1min).
Brevity of service: intervention is time-limited and concluded when imminent risk of placement or re-placement has been averted; interventions of four to six weeks have been shown to be sufficient.	Intervention time-limited but much longer than Homebuilders 5–6 weeks (12 weeks intensive, six months less intensive, 3 months transition).	To date no family has completed service (i.e. exited with goals met).
Twenty-four hour availability: primary therapist available to family members 24/7, attends home at times family identified as problematic; supervisor available 24/7 as primary back-up, other team members available as back-up.	24/7 service but supervisor not necessarily families' primary therapist.	No data available about use of after-hours, or frequency of support at critical times of day.

Homebuilders standards for program structure	Reflected in RF structure	Reflected in RF practice
Supervision and consultation: caseworkers are able to access casework supervision 24/7; there is supervisor facilitated team consultation at least weekly.	Individual supervision fortnightly, weekly catch ups at individual sites with the manager about cases, whole of team case consultation monthly.	As described in Section 3.7 and 3.8. A small number of staff may need higher level of support.
Ongoing quality enhancement: supervisors and therapists receive initial and ongoing training, consultation and support necessary to provide quality services. Program participates in quality enhancement processes and data are used to evaluate and improve outcomes; therapist and supervisors are required to have graduate qualifications and 2–4 years of prior experience working with children and families.	Yes.	Staff received initial training though timing not optimal. High level of skills and relevant experience among staff. Systematic approach to data collection and monitoring, including assessment data being used to inform case plans and practice. Mixed levels of confidence among staff in using tools.

2. Intervention activity

Figure 8. Consistency with Homebuilders standards for intervention activity

Homebuilders standards for intervention activity	Reflected in RF structure	Reflected in RF practice
Individually tailored services: therapists tailor services and schedule sessions based on family members' needs.	Yes.	Data overall support this. TBS outcomes data show Increasing Safety is most frequent need (93% of families) and safety most common EIPs (49% of practices). SCFW interviews emphasised safety issues as common focus of practice. Case goals data needed to link service activity with individual needs.
Transition and service closure: prior to the conclusion of the service therapist and family assess goal attainment, plan for maintenance of progress and collaborate with referring agency to address ongoing service needs.	Yes.	No families are yet to complete the service.
Comprehensive assessment: therapist conducts behaviourally specific, interactive, ongoing, holistic assessment that includes information about family strengths, values, skills, needs, use of structured assessment tools.	Yes.	The Resilience Assessment Tool used at entry for all families (to be reviewed 3 monthly). Interviews with SCFWs describe their practice as strengths-, values- and skills-based. To be triangulated with data from family interviews. The next report will measure timing of case reviews.
Goal setting and service planning: therapist collaborates with family members and referring agency in developing specific, attainable intervention goals and service plans to achieve this. Goals and plans focused on factors directly related to risk of out-of-home care placement.	Yes.	Qualitative data support this. Interviews with SCFWs describe collaborative nature of goal setting with families. To be triangulated with data from family interviews. Case goals data needed to link service activity with assessed risk levels.
Provision of concrete services: therapist advocates for/ provides concrete goods and services that are directly related to achieving the family's goals, while teaching family members how to meet these on their own.	Yes.	Qualitative data supports this. Interviews with SCFWs describe their practice in these terms. To be triangulated with data from primary carer interviews. Issue with access to flexible funds at one site.
Engagement and motivation enhancement: therapist maintains positive relationship with family members and assumes responsibility for motivating family members, employing a range of motivation enhancement strategies.	Yes.	Qualitative data supports this. Interviews with SCFWs describe their practice in these terms. To be triangulated with data from family interviews.
Promoting safety: throughout the intervention the therapist assesses child, family, therapist and community safety.	Yes.	49% of time using EIPs focused on Increasing Safety. Qualitative data consistent—SCFWs report working primarily on safety concerns in many families.
Cognitive and behavioural approach: therapist applies cognitive and behavioural principles and strategies to facilitate change.	Yes.	Through EIPs.
Teaching and skill development: therapists use a variety of teaching methods to help family members acquire, maintain and generalise skills.	Yes.	Through EIPs.
Collaboration and advocacy: therapist collaborates and advocates with formal and informal community resources, while teaching family members to advocate for themselves.	Yes.	Qualitative data supports this. Interviews with SCFWs describe their practice in these terms. To be triangulated with data from family interviews.

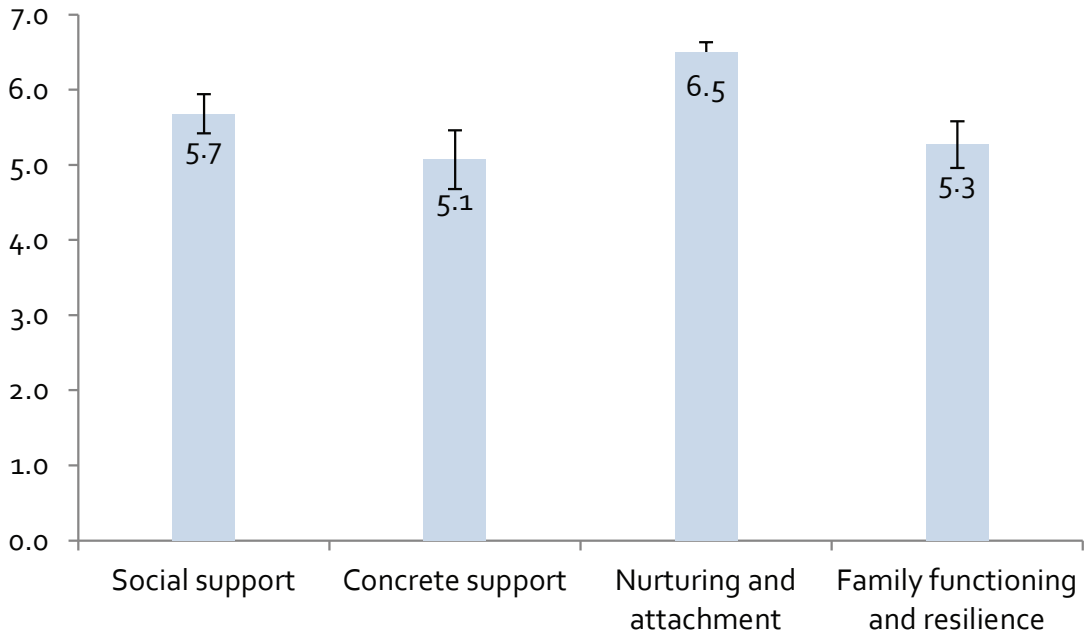
Appendix 5: TBS outcomes baseline

1. Scores for standardised measures

Protective Factors Survey

Baseline results for the Resilient Families caregiver sample are presented below. Across the four subscales of the Protective Factors Survey (PFS), the RF sample scored relatively high at baseline (higher scores indicate better outcomes). While there are no normative data for an Australian sample given the target population of the survey, we can compare these results to previous studies of similar populations. In developing the PFS, Counts et al. (2010) examined a sample of 94 US parents who were receiving services from child abuse prevention services. This sample scored 5.7, 5.5, 6.0, and 4.9 on the respective subscales (at pre-test), which is broadly comparable to results seen here.

Figure 9. PFS subscale scores



Note: Error bars represent standard error. Source: TBS Resilience Outcomes Tool

Strengths and Difficulties Questionnaire

Both the mean score of each subscale of the Strenghts and Difficulties Questionnaire (SDQ) and the percent who scored in the problematic range (Coombs, 2005), are below (see Table 24) along with normative data from an Australian sample (Mellor, 2005) . This was a randomly selected sample of 910 children and young people (aged 7 to 17 years), recruited from government schools in Victoria. Their parents and teachers completed the appropriate version of the SDQ.

Table 24. Baseline score for SDQ compared to normative data

	Resilient Families			Mellor (2005)	
	Number	Mean (standard deviation)	% at problematic level	Number	Mean (standard deviation)
Emotional Symptoms	9	2 (1.8)	11%	910	2.1 (2.0)
Conduct Problems	9	3.2 (1.6)	44%	910	1.5 (1.6)
Hyperactivity	9	6.0 (2.6)	33%	910	3.1 (2.4)
Peer Problems	9	3.0 (2.1)	44%	910	1.6 (1.9)
Prosocial Behaviour	9	6.9 (1.3)	11%	910	8.3 (1.7)
Total Difficulties	9	14.2 (5.8)	22%	910	8.2 (6.1)

Source: TBS Resilience Outcomes Tool

Of the 28 RF clients who completed this survey at baseline, nine completed the SDQ component. The percentage of the RF sample who scored at a problematic level ranged from 11% (for emotional symptoms and prosocial behaviour), to 44% (for conduct problems and peer problems).

When compared to normative data, the RF sample scored higher on Conduct Problems, Hyperactivity, Peer Problems, and Total Difficulties, indicating more problems among the RF baseline sample (no statistical analysis was undertaken). However, the sample in this instance is relatively small (n=9), preventing any firm conclusions being made.

Parenting Sense of Competence

The baseline includes 19 individuals who completed the Parenting Sense of Competence (PSOC). This measure can be reported both as a mean, or as proportions, with a cut-off score of 16–50 indicating low parental confidence. A higher score indicates greater satisfaction and self-efficacy in parenting.

The mean score on the PSOC in this sample was 73.6, which is higher than the scores found by previous studies that have used this measure. Johnston and Mash (1989) found that their sample of parents ranged between 62.5 and 65.9. In more recent research, Gilmore and Cuskelly (2009) found a range between 60.6 and 60.9.

However, these studies that have used the PSOC have differed in their approach. After analysing the factor structure of the 17 items, Gilmore and Cuskelly excluded items 8 and 17, and Johnston and Mash excluded items 1, 5 and 7. This makes any direct comparison between the RF sample and these studies difficult.

Table 25. Baseline score for Parenting Sense of Competence

	Number	Mean	Standard deviation	Min	Min
PSOC	19	73.6	13.3	44	93

Source: TBS Resilience Outcomes Tool

Kessler 10

Twenty-eight individuals completed the Kessler 10 (K10), with a mean score of 16.3. Data from a representative Australian sample resulted in a score of 14.5 (Slade, Grove and Burgess, 2011), indicating that the RF sample had a slightly higher level of distress than the Australian population.

Table 26. Baseline score for Kessler 10

	Number	Mean	Standard deviation	Min	Max
K10	28	16.3	5.6	10	31

Source: TBS Resilience Outcomes Tool

Personal Wellbeing Index

There were 27 completed responses to the Personal Wellbeing Index (PWI) at baseline. The average (mean) score was 63.7, which is around 10 points lower than the Australian average of approximately 73.7 – 76.7 (Meade and Cummins, 2010). This indicates a lower level of subjective wellbeing among this sample than the Australian population.

Table 27. Baseline score for Personal Wellbeing Index

	Number	Mean	Standard deviation	Min	Max
How satisfied are you with your life as a whole?	27	6.2	2.6	0	10
PWI (7 items)	27	63.7	21.5	20	98.6

Source: TBS Resilience Outcomes Tool

Home and Physical Environment Inventory

We were not able to locate a normative sample for the Home and Physical Assessment Inventory. The results show that no families received a negative score to indicate the home environment as a stressor, although the standard deviations are large, indicating a lot of variability within the baseline sample.

Table 28. Baseline score for Home and Physical Environment Inventory

Subscale	Number	Mean	Standard deviation	Min	Max
House	25	0.7	1.0	-1.2	2
Hazard reduction/ prevention	24	1.1	0.8	-0.7	2
Stimulation resources	24	0.5	1.0	-2	2
Child space	20	0.7	1.1	-1.7	2

Note: Positive score = strength, negative score=stressor
Source: TBS Resilience Outcomes Tool

Longitudinal Study of Australian Children

Table 29. Baseline score for Longitudinal Study of Australian Children items

Measure	Subscale	Tool range	Number	RF mean	Standard deviation	Min	Max
Longitudinal Study of Australian Children	Caregiver support	1–5 (lower indicates greater support)	28	3.4	1.0	1	5
	Caregiver connectedness	1–6 (higher indicates greater connectedness)	17	4.0	0.9	2.7	5.3
	Child connectedness	1–6 (higher indicates greater connectedness)	23	3.8	0.9	2.6	5.6
	Parenting	1–5 (higher indicates greater self-efficacy)	26	4.2	0.7	2	5
	Caregiver health and wellbeing	1–5 (higher indicates greater wellbeing)	28	3.4	0.9	1.5	5
	Family life and relationships	1–5 (higher indicates higher functioning)	28	3.9	1.0	1	5

LSAC *Caregiver and child connectedness* are averages of Q4a and Q4b items in the Retsilience Outcomes Tool. *Parenting* is average of Q12a to Q12c. *Caregiver Health and Wellbeing* is average of Q14a and Q14b
Source: TBS Resilience Outcomes Tool

2. Scores for resilience outcomes

Within each of the five resilience outcomes, we identify the proportion of the sample that was low functioning. This was determined by calculating an overall index score for each outcome, using the responses to the individual items (questions), as described in Table 30.

Table 30. Resilience outcomes, relevant survey items, and responses indicating low functioning

High-level outcome	Q	Measure	Response indicating attention needed
Secure and Stable Relationships (Range 0–6)	8	SDQ Peer Problems subscale	Score in the problematic or borderline range (>2)
	10d	PFS Knowledge of Parenting ("I praise my child when s/he behaves well")	"Never" to "About half the time"
	11	PFS Nurturing and Attachment subscale	Score of less than 4
	12b	LSAC Parenting ("Over the last six months, how often did you express affection by hugging, kissing and holding this child")	"Never/ almost never" to "sometimes"
	17	PFS Family Functioning subscale	Score of less than 4
	18	LSAC Family and Relationships ("In general, how would you rate your family's ability to get along with one another?"	"Poor" or "Fair"
Increasing Safety (Range 0–14)	1	PFS Social Support subscale	Score of less than 4
	2	PFS Concrete Support subscale	Score of less than 4
	3	LSAC Community Links ("How often do you feel that you need support but you can't get it from anyone?")	"Very often" to "Sometimes"
	4a	LSAC Community Links ("How often do you see, talk to or email the following people?")	Mean score less than 4 (6 items)
	4b	LSAC Community Links ("How often does (child) get together with, see or spend time with, the following people?")	Mean score less than 4 (5 items)
	5	Family Resource Management ("During the past year, have you been homeless or had to give up food or other necessities to pay your rent or mortgage?")	"Yes"
	6	Family Resource Management ("If an emergency struck today and you needed $500 to get you through, would you be able to manage on your current savings?")	"No"
	16	Personal Wellbeing Index	Score less than 70
	19	Home Physical Environment (4 subscales)	Any negative score
	10c	PFS Knowledge of Parenting ("My child misbehaves just to upset me")	"Strongly agree" to "Neutral"
	10e	PFS Knowledge of Parenting ("When I discipline my child, I lose control")	"Always" to "About half the time"
Increasing Self-efficacy (Range 0–5)	10a	PFS Knowledge of Parenting ("There are many times when I don't know what to do as a parent")	"Strongly agree" to "Neutral"
	10e	PFS Knowledge of Parenting ("I know how to help my child learn")	"Strongly disagree" to "Neutral"
	12a	LSAC Parenting ("How often do you feel you are good at getting this child to do what you want him/ her to do")	"Never/almost never" to "Sometimes"
	12c	LSAC Parenting ("Overall, as a parent, do you feel that you are…")	"Not very good at being a parent" to "An average parent"
	13	Parenting Sense of Competence	Score less than 51
Improving Empathy (Range 0–1)	8	SDQ Prosocial subscale	Score less than 6

High-level outcome	Q	Measure	Response indicating attention needed
Increasing Coping/ Self-regulation (Range 0–6)	14a	LSAC Health and Wellbeing ("How difficult do you feel your life is at present?")	"Very many problems or stresses" or "Many problems or stresses"
	14b	LSAC Health and Wellbeing ("How well do you think you are coping?")	"Not at all" or "A little"
	15	K10	Score of 15 or above
	8	SDQ Emotional Symptoms subscale	Score greater than 3
	8	SDQ Conduct Problems subscale	Score greater than 2
	8	SDQ Hyperactivity subscale	Score greater than 5