Brighter Futures Early Intervention Evaluation: Interim Report 3

Author:
Hilferty, F; Mullan, K; Eastman, C; Griffiths, M; Chan, S; Heese, K; Katz, I

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Telephone: +61 (2) 9385 7802 Fax: +61 (2) 9385 7838 Email: sprc@unsw.edu.au

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Social Policy Research Centre Consortium

Social Policy Research Centre, University of New South Wales
Ilan Katz (Project Director), Fiona Hilferty (Project Manager), Killian Mullan, Christine Eastman, Megan Griffiths, Sharni Chan and Karla Heese.

Centre for Health Economics Research and Evaluation, University of Technology Sydney
Marion Haas, Kees van Gool, Rebecca Reeve and Gisselle Gallego

School of Education and Early Childhood Studies, University of Western Sydney
June Wangmann, Christine Woodrow and Christine Johnston

National Institute of Social and Economic Research, London
Pam Meadows

Authors

Hilferty, F., Mullan, K., Eastman, C., Griffiths, M., Chan, S., Heese, K. and Katz, I.

Contact details

Dr Fiona Hilferty, Project Manager, or Professor Ilan Katz, Director, Social Policy Research Centre, University of New South Wales, Sydney NSW 2052, ph 02 9385 7800, fax 02 9385 7838.

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This research was commissioned by Community Services. The views reported in this paper are those of the authors and should not be attributed to the NSW Government or the Social Policy Research Centre.

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Abbreviations

ADHD	Attention Deficit Hyperactivity Disorder
AFS	Aboriginal Families Study
AMIHS	Aboriginal Maternal and Infant Health Strategy
ATSI	Aboriginal and Torres Strait Islanders
BITSEA	Brief Infant-Toddler Social and Emotional Assessment
CALD	Culturally and Linguistically Diverse
CHERE	Centre for Health Economics Research and Evaluation
CBCL	Child Behaviour Checklist
CPR	Centre for Parenting and Research
CSC	Community Services Centre
DoCS	NSW Department of Community Services
DV	Domestic violence
ECBI	Eyberg Child Behaviour Inventory
FS	Family Survey
IOS	Intensive Outcomes Study
KiDS	Key Information Directory System
LA	Lead agency
LGA	Local Government Area
LSAC	Longitudinal Study of Australian Children
LSIC	Longitudinal Study of Indigenous Children
MDS	Minimum dataset
NBRM	Negative Binomial Regression Model
NLSCY	National Longitudinal Survey of Children and Youth
NSW	New South Wales
OLS	Ordinary Least Squares
PRM	Poisson Regression Model
Program	Brighter Futures early intervention program
Report	Risk-of-harm report
UNSW	University of New South Wales

Executive Summary

Introduction

The staged roll out of Brighter Futures across NSW began in 2003, and is part of a shift in child protection policy and practice towards preventive, family-focused support and service provision. The aim of Brighter Futures is to provide targeted support to vulnerable families with young children who are at risk of being abused or neglected. The aim is to help families at an earlier stage of intervention, to stop them escalating within the child protection system. The program is being administered in partnership with 14 non-government agencies (Lead Agencies) across NSW.

The Social Policy Research Centre was commissioned in 2006 by Community Services to lead a consortium that is currently evaluating the program. The evaluation will provide a final report in September 2010. This is the final interim report which presents findings from the Results Evaluation. The aim of the Results Evaluation is to assess if the program is meeting the needs and improving the outcomes for program families. The three main outcome measures used to assess the program and present findings for this report are the Family Survey, Risk of Harm Reports, and the Intensive Outcomes Study (IOS). Details on each of these measures are provided in chapter 2, which provides comprehensive detail on evaluation design and methodology.

Who are Brighter Futures Families?

Chapter 3 of the report provides a broad overview of all the families in the program, including analysis of children's risk of harm reports prior to their families' entry to the program. Key findings are summarised below:

- A total of 5,869 families participated in the program during the evaluation period (1st July 2007 to 30th June 2009). Almost one quarter of these families (24 per cent) are Indigenous. Fifty-nine per cent of all families have been managed by Lead Agencies; and 41 per cent by Community Services. Sixty-five per cent of families entered via the Helpline and 35 per cent entered through the community pathway – which is 15 percentage points greater than capacity specifications.

- The program has been successful in engaging high proportions of Indigenous families, particularly in the Northern (29 per cent) and Western (27 per cent) regions.

- Generally, the most common vulnerabilities for families on the program are lack of social support (60 per cent), lack of parenting skills or inadequate supervision (57 per cent) and domestic violence (54 per cent). The vulnerability profile of Indigenous families is similar with lack of parenting skills or inadequate supervision (62 per cent), domestic violence (60 per cent) and lack of social support (60 per cent).

- There are differences in the vulnerability profiles of families managed by Community Services and Lead Agencies. Community Services are more likely to manage families with domestic violence and parental drug and alcohol issues; and Lead Agencies are more likely to manage families lacking social support and with child behaviour management problems.

- Indigenous families are spending less time on the program on average (50 days) shorter than non-Indigenous families.

- Community Services families are significantly more likely to be reported for carer mental health problems, domestic violence and neglect than Lead Agency families.

- Indigenous families are significantly more likely to be reported for drug and alcohol misuse and domestic violence, and significantly less likely to be reported for carer mental health problems than non-Indigenous families.

- Households in which at least one parent is employed are less likely to be reported in all types of reports except sexual abuse.

- Children from households where at least one person has a higher level of qualification (e.g. tertiary and year 12 completion as highest) are less likely to be reported for neglect; and children from households with a high income level are less likely to be reported for drug and alcohol misuse and domestic violence.

- Lead Agencies manage more children known for a longer time than Community Services. This appears to indicate that these children are receiving more reports over time as the period of exposure lengthens but do not receive an intervention until they are known for longer periods of time than Community Services children. This is in contrast to Community Services managed children, who are known for shorter periods of time and who generally have more reports per child overall after accounting for exposure time; these differences are most pronounced in reports of domestic violence and neglect. Community Services children are therefore entering an intervention much earlier than Lead Agency children after they are first reported indicating acute issues needing more immediate attention.

Family survey

The Family Survey is a longitudinal survey instrument designed to measure a family's progress on the program. Ideally, data are collected at three time points: at entry to the program (T1), six months after the first survey (T2) and on exit (T3). The results from descriptive analysis of 1,730 T1 surveys is summarised below:

- The majority of families accessing program supports and services are disadvantaged on a number of socio-economic measures (e.g. income level and source; and educational attainment level). In addition, a substantial proportion of families lack the support of family and friends, indicating high levels of social isolation (as evidenced in the prevalence of this entry vulnerability), and many families include a child displaying behavioural problems and with a medical condition, a developmental condition or a disability.

- Parents in the program generally rate their own health, the health of their child, and their ability as a parent highly. The majority of parents also score highly in measures of positive parenting, parental warmth and parental self efficacy, and low in measures of parental hostility.

- Descriptive analysis of Family Survey data indicates that there is very little difference between the families being case-managed by Community Services and those being managed by Lead Agencies. The demographic profiles of both family groups is very similar, however, Community Services' families are slightly smaller in size, with children who are slightly younger. There were no significant differences in the socio-economic characteristics of both family groups, and no significant differences in

measures of carer wellbeing (e.g. satisfaction with life, relationships, family attachment, support systems and levels of self esteem). There were also no significant differences in measures of parenting (e.g. parental warmth and hostile parenting) between families managed by CS and LA. There was a small but significant difference on one child measure of social and emotional development with children from LA families scoring slightly higher on the BITSEA (child 1-2 years) measure, indicating greater social competence. Further interpretation of these results needs to be treated with caution as they may relate to a number of factors such as the insensitivity of the measures used within the Family Survey.

The Reports Analysis

Chapter 5 presents a multivariate cross-sectional analysis of children's risk of harm reports prior to entering the Brighter Futures program. The multivariate analysis draws on variables other than risk of harm reports but some results need to be interpreted with caution due to some small sample sizes.

Key findings from this analysis are:

- Indigenous children are significantly more likely than non-Indigenous children to be reported for carer drug and alcohol abuse. Children from families with low income levels and where no parent is in paid employment are also more likely to be reported for carer drug and alcohol issues.

- Indigenous children are significantly less likely than non-Indigenous children to be reported for carer mental health issues.

- Indigenous children are significantly more likely than non-Indigenous children to be reported for domestic violence. Children living in lone-parent households are also more likely to be reported for domestic violence.

- Children in lone-mother households are significantly less likely to be reported for physical abuse and children in lone-father households are significantly more likely to be reported for all types of abuse. Older children are significantly less likely to be reported for physical and emotional abuse but more likely to be reported for sexual abuse.

- Children managed by Community Services are significantly more likely to be reported for neglect than those managed by Lead Agencies.

Analysing Change Over Time

Chapter 6 presents preliminary analysis of the change in patterns of reporting over time, and then moves to an analysis of the change over time seen in the Family Survey cohort. This analysis has highlighted several key findings:

- There is a clear downward trend over time when reports for all issues are combined and examined together. This pattern is consistent across the two observation points prior to program entry (12 and 24 months) and the two comparison points after exit (12 months and 24 months).

- Most reports for specific issues follow the pattern outlined above (i.e. a significant decrease over time); however, reports of abuse are anomalous. Reports for abuse trend

upwards however the difference in average report numbers 12 months prior and 12 months post is not significant.

- All Family Survey study children show an improvement in child behaviour scores over time.

Intensive Outcomes Study

The Intensive Outcomes Study (IOS) draws upon in-depth data collected from surveys and interviews to explore the extent to which child development; parenting practices; and family functioning have changed for a sample of program families. Only T1 data were analysed for this report. It is important to acknowledge that these are not baseline data as many families had already started receiving supports and services. Analysis suggests that the program is having a significant and positive impact on families in the short term. Some specific findings are summarised below:

- Most families indicated that the program had made a positive impact in terms of family functioning. For example, they reported improvements in family cohesiveness, and mental health of mothers and the development of routines.

- Families dealing with multiple stressors such as low income, poor housing, and social isolation were more likely to report no changes in family functioning.

- Families experiencing domestic violence were likely to show the most improvement in family functioning.

- Primary caregivers lacking in social support relied heavily on caseworkers to support them and to recognise any cognitive or developmental delays that their child may have.

- Most primary caregivers attributed improvements in child social and emotional development to participation in childcare and other groups such as playgroups.

Conclusion

The results presented throughout the report point to the effectiveness of Brighter Futures in meeting the needs and improving the outcomes for participant families. It is evident however that further analysis is needed before a more definitive interpretation can be made.

1 Introduction

Background

This is the final interim report of the longitudinal evaluation of Community Services' (formerly known as DoCS) Brighter Futures program. The evaluation of Brighter Futures is being undertaken by a consortium led by the Social Policy Research Centre (SPRC) at the University of New South Wales (UNSW). The evaluation consortium comprises: the Centre for Health Economics Research and Evaluation (CHERE), University of Technology Sydney; Gnibi College of Indigenous Australian Peoples, Southern Cross University; and the National Institute of Social and Economic Research, London.

The evaluation, which was commissioned by Community Services, began in 2006 and will continue until September, 2010. The evaluation will be concluded during a period of significant change to child protection policy and practice in New South Wales. These changes are set out in the NSW Government's report *Keep Them Safe*, which was introduced as a response to the Special Commission of Inquiry into Child Protection Services in NSW (Wood, 2008a, 2008b, 2008c, and 2008d). The Inquiry recommended the transfer of Brighter Futures to the non-government sector. *Keep Them Safe* is a five year action plan (2009-2014) by Government that aims to reshape the way family and community services are delivered in NSW so that children, young people and their families receive the services they need sooner, before problems escalate. The *Keep Them Safe* reforms include raising the threshold for reporting children at risk of harm and extending the Brighter Futures program. The Government has delayed its decision regarding Brighter Futures service delivery until the evaluation is completed. The data analysed for this report are not affected by these reforms such as raising the threshold for reporting children at risk of harm[1], however, this is the context within which the evaluation is being conducted. The context is described here as it helps to explain the importance of the evaluation for early intervention policy development, and the comparative presentation of findings in this report, based on management type (Lead Agencies and Community Services) and entry pathway (Helpline and Community Referral).

The Brighter Futures Program

In late 2002, an extra $1.2 billion was granted to Community Services to help in their child protection work. A large proportion of this money was specifically to be used in early intervention – a form of service provision that comprises a set of supports and services aimed at preventing or minimising long-term problems. This funding led to the development and implementation of Brighter Futures - an evidenced-based early intervention program. The program has been progressively rolled out across New South Wales over the past 6 years by Community Services. The program is being delivered in partnership with 14 locally-based non-government Lead Agencies with the aim of improving child and family services in NSW. A complete list of Brighter Futures funded service providers is available at: http://www.community.nsw.gov.au/docswr/_assets/main/documents/brighter_futures_agencies.pdf).

The Brighter Futures program was designed to deliver tailored and intensive services to vulnerable families, where the children are at risk of abuse or neglect. The program is

[1] The threshold for matters reported to the Community Services Helpline will be increased for mandatory reporters from 'risk of harm' to 'risk of significant harm' from January 2010. The end date of risk of harm reports analysed for this evaluation is end December 2009.

targeted to pregnant women and to families with children aged less than nine years, who are experiencing certain vulnerabilities[2] and require long-term support from a range of services. Within this group priority of access is currently given to:

1. families previously participating in the Brighter Futures program who have moved and transferred to a new area;
2. families referred through the Aboriginal Maternal and Infant Health Strategy (AMIHS), following the rollout of the AMIHS–Brighter Futures service partnership;
3. families with children under three years of age; and
4. families who have been on the eligibility list the longest.

Priority of access criteria are based on the recognition that the need for services exceeds program capacity in many areas. Further, the decision to give priority of access to families with children under three years of age is based on current research evidence indicating that the first three years of life is a critical period for brain development that lays the foundation for later cognitive and emotional development (McCain & Mustard, 2002). During early childhood, negative experiences such as a violent home environment or little cognitive stimulation have been linked to sustained, harmful effects on brain functioning and consequently on children's behaviour, cognition and emotional wellbeing (Schorr, 1997).

As an early intervention program, Brighter Futures has as an overall aim to prevent the escalation of serious family problems impacting on parents' ability to care for their children, and hence prevent any subsequent progression into the child protection system. Brighter Futures is a voluntary program, with most families being offered services following a risk-of-harm report to Community Services which has resulted in the child or children assessed as being at low to moderate risk of harm. The Brighter Futures program is a form of 'early intervention' in the sense that it specifically targets young children and families before serious and complex problems have become entrenched so that the children are in imminent danger and there is little capacity for real change within the family.

Following best practice in early intervention programs, Brighter Futures is based on a multi-component service model. This model is underpinned by a belief that the challenges faced by vulnerable, disadvantaged families require multiple, complex responses. To this end, Brighter Futures' families are offered a range of services and supports. Core services comprise placement of child/ren in a childcare facility; access to group based parenting programs; and structured home visiting programs which include parenting programs delivered one-to-one. Non-core services include brokerage and referral to non Brighter Futures funded service options such as drug and alcohol rehabilitation programs. In this way the program can be described as holistic, including interventions that aim to flexibly and responsively improve outcomes for parents and children. According to the *Service Provision Guidelines* (Community Services, 2009), families are assessed as suitable for the program if they require an intervention of approximately two years' duration and at least two core services. The length of intervention reflects Community Services' desire to effect real and sustainable change for client families.

[2] These vulnerabilities are identified in more details in the *Brighter Futures Service Provision Guidelines* (Community Services, 2009).

Brighter Futures services are designed to enhance child development, parenting capacity and family functioning. The Brighter Futures program is delivered by Community Services and non-government agencies (Lead Agencies) working in partnership. The Brighter Futures program is part of a continuum of service provision to children and families in NSW.

Structure of the Report

This report presents interim findings from the Results Evaluation of the Brighter Futures program. The Results Evaluation has been designed to assess the effectiveness of Brighter Futures in improving outcomes for client families.

Chapter 2 provides details of the evaluation design and methodology, and an overview of how the analysis was conducted for the Results Evaluation.

Chapter 3 provides an overview of families in the program. In this chapter information is provided about the characteristics of all families on entry into the program. This chapter includes an analysis of risk of harm reports prior to program entry, regional distribution, family vulnerabilities, length of time in the program, entry pathway and managing agent.

Chapters 4 and 5 provide analysis of two key outcomes measures for the Results Evaluation: the Family Survey and risk of harm reports. These measures are used to provide a comprehensive overview of the families on the program.

Chapter 6 is the core of the evaluation, analysing change over time in risk of harm reports and child behaviour.

Chapter 7 presents and discusses findings of a separate evaluation cohort – the Intensive Outcomes Study.

Finally, chapter 8 provides further interpretive and explanatory detail that highlights the main findings of the evaluation, and explores implications for existing early intervention policy and practice.

2 Evaluation Design and Methodology

2.1 Aims of the Evaluation

The independent evaluation of Brighter Futures is a longitudinal, mixed method research project that aims to determine the effectiveness of the program in achieving its stated objectives for both client families and program stakeholders. The main objectives of the evaluation are:

1. To examine the effectiveness of the Program in meeting its stated aims of:
    - reducing child abuse and neglect by reducing the likelihood of family problems escalating into crisis;
    - achieving long term benefits for children by improving intellectual development, educational outcomes and probability of employment;
    - improving parent-child relationships and the capacity of parents to build positive relationships and raise stronger, healthier children;
    - breaking inter-generational cycles of disadvantage; and
    - reducing demand for services that otherwise might be needed in the future, such as child protection, corrective or mental health services.
2. To examine the efficiency and effectiveness of the administration and implementation of the program.
3. To assess whether the program represents a good investment of public funds.

The evaluation includes three core components:

1. A *results evaluation* which will examine whether the program is meeting the needs and improving the outcomes for participant children and families;
2. A *process evaluation* which will examine implementation of the program, with a view to identifying ways of enhancing the program; and
3. An *economic evaluation* which will provide a cost-effectiveness and cost-benefit analysis of the program.

A detailed evaluation methodology which provides comprehensive information on each of the three components is available in the *Evaluation Plan: Early Intervention Program* http://www.community.nsw.gov.au/docswr/_assets/main/documents/ei_evaluationplan.pdf

2.2 Results Evaluation

This report provides interim findings of the *Results Evaluation*, a component of the Brighter Futures evaluation that draws upon multiple data sources to determine whether the program is meeting its stated aims, and is improving the outcomes for children and families who participate in program services. Selected findings from this component of the evaluation will inform the economic evaluation which will be reported on separately as part of the final evaluation report (due to be released September, 2010).

The *Results Evaluation* addresses the following research questions:

- Is Brighter Futures meeting the needs of and improving the outcomes for children and families who participate in program services?
- For which children and families is the program most effective?
- What are the factors that improve a families' likelihood of success?

2.3 Data Sources

Central to the *Results Evaluation* is the analysis of the core dataset, known as the Minimum Data Set (MDS). The MDS comprises the following data files:

- *The Family File*, containing all family-level data for families that participated in the Brighter Futures program between the 1st of July 2007 and 30th of June 2009. This includes administrative details about the managing Community Services Centre (CSC) or Lead Agency and key dates for families as they participate in the program;
- *The Reports File*, containing details of all risk-of-harm reports relating to families listed in the Family Early Intervention Data file, including subject children and their siblings aged less than nine years at entry into the program. This file contains all reports made on children between July 2002 and 24th September 2009.
- *The Services File*, which includes information on services provided to families between 1 July 2008 and 30 June 2009; and
- *The Family Survey File*, containing Family Surveys completed by participant families up to 30 June 2009.

The evaluation team received the full Services File for the first time in the MDS analysed for this report. Preliminary analysis was undertaken, however, we are not yet confident that the data accurately represent the services provided to program families. We are currently undertaking further analysis to identify accurate elements within the file and liaising with Community Services to identify the best way to report services data for the final evaluation report.

2.4 Outcome Measures

Three measures are used to evaluate the effectiveness of the program for client children and families. These are: the Family Survey; Risk of Harm Reports; and the Intensive Outcomes Study. This use of multiple measures, which comprises administrative data and data specially collected for the study, as well as qualitative and quantitative data, enables a more comprehensive assessment of program effectiveness. Each measure is discussed separately below.

Family Survey (FS)

The Family Survey is a quantitative longitudinal survey instrument, designed specifically to measure a family's progress on the program, focusing on any changes in family functioning, parenting skills, and child language and social/emotional development. The survey collects detailed information on one child (the study child) and their primary carer, as well as general demographic information about the family.

Ideally, the Family Survey is administered by caseworkers to participant families at three different time points as they progress through the Brighter Futures program – that is, within two months of entering the program (T1, baseline survey), six months after the first survey

(T2, midpoint survey), and at exit (T3, exit survey). In practice, however, there is variability in the timing of data collection. Further detail about how this variability is accounted for in the analysis of data is provided in Chapters 4 and 5.

The Family Survey is made up of multiple items, which were sourced from different instruments and scales. Four of the key measurement tools that make up the Family Survey comprise:

- *The Brief Infant Toddler Social Emotional Assessment (BITSEA).* This measure is used to assess social-emotional competence and behavioural problems in children aged 1-3 years;
- *The Eyberg Child Behaviour Inventory (ECBI).* This measure is used to assess problem behaviours in children aged 2-16 years.
- *The Longitudinal Study of Australian Children (LSAC) Parenting Scales*. Items were sourced from LSAC to measure parental warmth, hostility and self-efficacy.
- *The Rosenberg Self Esteem scale (RSE).* This is a measure of global self-esteem.

Appendix A: Summary of instruments and items utilised in the Family Survey contains a complete summary of items and instruments in the Family Survey.

Risk of Harm Reports

Risk of harm reports are notifications of suspected abuse or neglect made by members of the public or mandatory reporters[3] to the NSW Child Protection Helpline. The Helpline is a 24 hour state-wide call centre staffed by Community Services' caseworkers to receive and screen all reports of risk of harm[4] and requests for assistance from mandatory and non mandatory reporters. It is important to recognise that reports do not equal substantiations of abuse.

Throughout the evaluation we use reports as the primary measure of program effect and of escalation within the child protection system.

2.5 The Intensive Outcomes Study

The aim of the Intensive Outcomes Study (IOS) is to explore in-depth the outcomes of families engaged in the program for the purpose of informing the wider evaluation. Specifically, the IOS examines the experiences of families on the program, and the extent to which child language and social/emotional development, parenting practices and family functioning have changed.

The IOS includes survey and semi-structured interview data collected from 125 families across NSW (9 sites). This data was collected by fieldworkers from SPRC and the Centre for Parenting and Research, Community Services, at three different time points: within 10

[3] Mandatory reporters are people required by law to report to Community Services if they suspect that a child or young person is at risk of harm. Mandatory reporters include doctors, teachers, childcare workers, and others who work with children.

[4] In January 2010, the threshold for mandatory reporters will change from 'risk of harm' to 'risk of significant harm' as part of the *Keep Them Safe* reforms.

months of starting the program (T1), and then at 6 (T2) and 12 month intervals (T3).[5] T1 data was collected between June 2008 and July 2009.

The data collected from the three measures outlined above supplement each other and provide a comprehensive picture of program implementation and effect. Detailed discussion of the method of analysis for both qualitative and quantitative data is included in Appendix A: Summary of instruments and items utilised in the Family Survey and Appendix B: Qualitative analysis – Intensive Outcomes Study .

[5] This report is reporting on findings from T1. T3 data collection is still underway and will be reported on in the final evaluation report.

3 Profile of Brighter Futures Families

This chapter provides a broad overview of families in the Brighter Futures program and describes all families who have participated in the program over the course of the evaluation to date by drawing from administrative information in the Minimum Dataset (MDS) Family File and Reports File. Information is provided about the characteristics of all families on entry to the program as well as breakdowns of regional distribution, family vulnerabilities, and length of time in the program. In addition to an overall description of families, comparisons are made between managing agency (Community Services and Lead Agencies), entry pathway, and family Indigenous status.

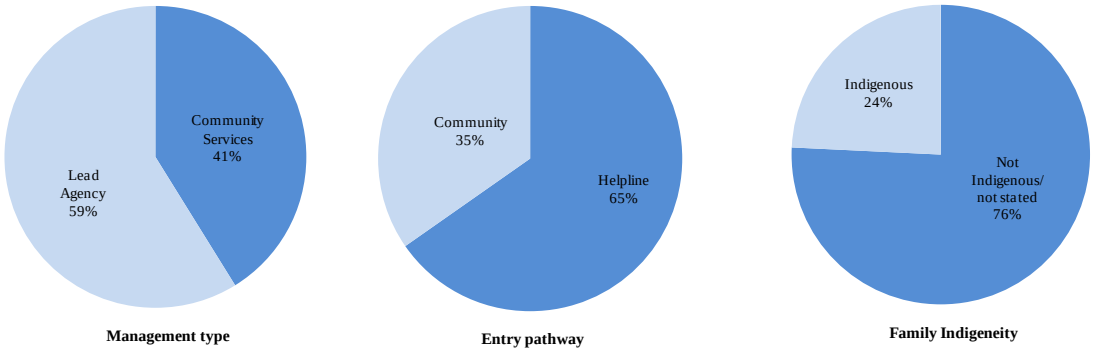
This chapter concludes with a descriptive analysis of risk of harm reports which differentiates the time that families have been known to Community Services (that is their 'exposure time').

3.1 Case management of families in Brighter Futures

All families

A total of 5,869 families participated in the Brighter Futures program during the evaluation period, from 1st July 2007 to 30th June 2009[6]. Of these, 59 per cent have been managed by Lead Agencies, 35 per cent entered through the community pathway, and 24 per cent are Indigenous (see Figure 3.1).

Figure 3.1: Characteristics of families participating in Brighter Futures



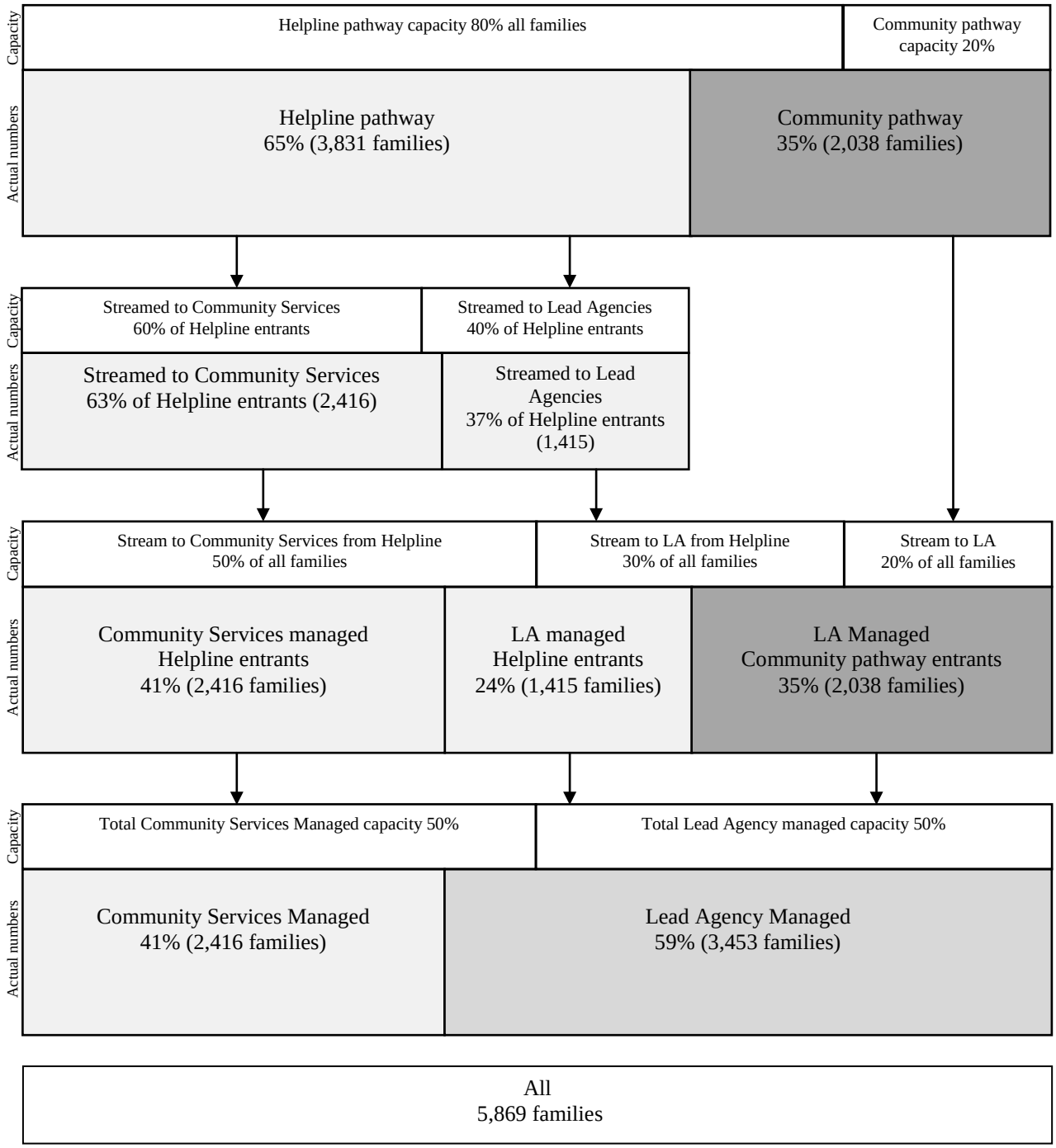
As Figure 3.2 shows, the Brighter Futures program model[7] specifies that families enter the program via one of three pathways: either as a Helpline referral; a community referral; or through the newly created Aboriginal Maternal and Infant Health Strategy (AMIHS) pathway[8]. Regardless of the entry method, all families are assessed for suitability at a Community Services Centre before being allocated to either Community Services or a Lead Agency for case management.

6 Note also that of the total number of families described in this section, 516 have at least one child that has participated in the program more than once.

7 Comprehensive information on the Brighter Futures program model is included in the program's *Service Provision Guidelines* which is accessible at: http://www.community.nsw.gov.au/DOCSWR/_assets/main/documents/EIP_service_provisions.pdf

8 For the purposes of the evaluation, AMIHS entrants are grouped with Helpline entrants.

Figure 3.2: Brighter Futures program model, with capacity specifications



Families entering the program through the community pathway have generally either been referred to the program from another service provider, or have self-referred. Brighter Futures policy has specified that these families be managed by a Lead Agency. Families entering the program via the Helpline pathway have all received at least one report that has resulted in their being identified as suitable for the Brighter Futures program. Helpline entrants can either be streamed to Community Services Early Intervention teams, or be transferred to be managed by Lead Agencies. This means that Lead Agencies manage both community entrants and those streamed from the Helpline, while Community Services teams only manage families streamed through the Helpline.

The following analysis of these components of entry needs to be considered in light of the fact that the data presented is not a snapshot of families in the program when the evaluation data was produced; rather it is a description of all families that have participated in the program over the reference period for the evaluation. This means that it shows who has participated in Brighter Futures since the evaluation began rather than who is in the program at any one point in time.

Keeping this in mind and working from the top of Figure 3.2, the program model currently specifies that 80 per cent of families should enter via the Helpline and the remaining 20 per cent through community pathway. The data show that substantially more families entering from the community pathway have participated in the program than the model specifies. Table 1 shows that over the course of the evaluation, 35 per cent of all participants have entered through the community pathway (2,038 families) and 65 per cent have been streamed via the Helpline (3,831 families).

Table 1: Entry pathway of Brighter Futures participants

	No.	Col %
Helpline entrants	3831	65
Community pathway entrants	2038	35
Total families	**5869**	**100**

The second row in Figure 3.2 describes the distribution of families streamed to Brighter Futures via the Helpline pathway. Table 2 indicates that 37 per cent of families entering from the Helpline have been managed by Lead Agencies (1,415 families) and 63 per cent of families have been managed by Community Services (2,416 families). That is, even though overall proportionally fewer families are entering the program via the Helpline, they are being streamed to the managing agents in proportions similar to the capacity specifications.

Table 2: Management type of Helpline entrants to Brighter Futures

	No.	Col %
Streamed to Community Services	2416	63
Streamed to Lead Agencies	1415	37
Total Helpline entrants	**3831**	**100**

The overall breakdown of entry pathway for all families in the program is shown in the third row of Figure 3.2, and as previously shown, the increased numbers of community entrants is contributing to a substantial change in the proportional distribution of families entering through each pathway.

Table 3 reports the breakdown of each type of entry pathway across all families, which provides additional information on how the numbers of community entrants are affecting the distribution.

Table 3: Pathway breakdown of all Brighter Futures families

	No.	Col %
Helpline entrants		
Streamed to Community Services	2416	41
Streamed to Lead Agencies	1415	24
Community entrants	2038	35
Total families	**5869**	**100**

It shows that overall the additional community entrants mean that Lead Agencies are managing fewer Helpline families than expected. Helpline entrants streamed to Lead Agencies represent 24 per cent of all families in the program which is lower than the capacity of 30 per cent. Helpline entrants streamed to Community Services represent 41 per cent of all families, a reduction of nine percentage points compared to the anticipated capacity of 50 per cent.

The final row of Figure 3.2 shows that the overall management capacity for Community Services and Lead Agencies is 50/50, however as Table 4 shows, 59 per cent of families have been managed by Lead Agencies and 41 per cent by Community Services.

Table 4: Overall management of Brighter Futures families

	No.	Col %
Managed by Community Services	2416	41
Managed by Lead Agencies	3453	59
Total families	**5869**	**100**

Overall this means that of the 5,869 families that have participated in the Brighter Futures program during the course of the evaluation, a larger proportion than specified has been managed by Lead Agencies, due to the larger numbers entering via the community pathway. A further analysis of families that are currently in the program compared to those that have exited is discussed later in this chapter.

Indigenous families

Indigenous families[9] make up almost a quarter of all families that have participated in the Brighter Futures program during the course of the evaluation (see Table 5). This is a substantial number of families, and the contributing factors to this level of participation are discussed in chapter six and the upcoming process evaluation report.

Table 5: Indigenous families in Brighter Futures

	No.	Col %
Indigenous	1422	24
Not indigenous / not stated	4447	76
Total families	**5869**	**100**

[9] Data currently available to the evaluation does not distinguish between Aboriginal, Torres Strait Islander and other Indigenous people. Due to this, the term Indigenous is used throughout this report.

3.2 Regional distribution of families in Brighter Futures

The following section shows the regional distribution of families in Brighter Futures and provides the breakdown of regional patterns of management, entry pathway and family Indigenous status.

All families

The distribution of families across Community Services' regions is shown in Table 6 below. Northern and Western regions share the highest proportion of participating families, with 19 per cent of families located in the Northern region and 17 per cent located in the Western region. The third largest proportion of families came from Metro West (14 per cent), followed by Metro Central (14 per cent) and Hunter/Central Coast with 12 per cent of families. The remaining families came from Metro South West or Southern regions, both with 11 per cent of the total number of families.

Table 6: Regional distribution of Brighter Futures families

	No.	Col %
Hunter and Central Coast	733	12
Metro Central	814	14
Metro South West	666	11
Metro West	847	14
Northern	1116	19
Southern	666	11
Western	1027	17
Total families	**5869**	**100**

Management type of families in each region

Table 7 below provides a breakdown of the distribution of families by region and management type. Community Services and Lead Agencies manage fairly similar proportions of families in each region. The largest difference in distribution is in the Metro West region, where 20 per cent of Community Services families are located, whereas only 14 per cent of Lead Agency families are in this region. Metro West is also the region with the largest proportion of CS families, whereas Hunter/Central Coast has the smallest proportion (eight per cent). Lead Agency families are fairly evenly distributed throughout the state, except for Northern region containing the largest proportion (19 per cent) of families.

Table 7: Regional distribution of managing agent for Brighter Futures families

	Community Services		Lead Agency	
	No.	Col %	No.	Col %
Hunter and Central Coast	192	8	541	16
Metro Central	371	15	443	13
Metro South West	314	13	352	10
Metro West	472	20	375	11
Northern	470	19	646	19
Southern	253	10	413	12
Western	344	14	683	20
Total families	**2416**	**100**	**3453**	**100**

Regional distribution of Brighter Futures families by entry pathway

Table 8 below provides a breakdown of the distribution of families across regions by pathway. Overall, the majority of families entered via the Helpline pathway; however, as can be seen in Table 8 the distribution varies by region. Helpline entrants outweigh Community entrants in all the Metropolitan regions of Sydney as well as Northern region. Proportionally more families entered via the Community pathway compared to the Helpline pathway in the Hunter and Central Coast region and Western region.

Table 8: Regional distribution of Brighter Futures families by entry pathway

	Helpline Entrants		Community Entrants	
	No.	Col %	No.	Col %
Hunter and Central Coast	414	11	319	16
Metro Central	566	15	248	12
Metro South West	468	12	198	10
Metro West	625	16	222	11
Northern	751	20	365	18
Southern	428	11	238	12
Western	579	15	448	22
Total	**3831**	**100**	**2038**	**100**

Distribution of Indigenous families by Community Services region

The distribution of Indigenous families across Community Services' regions is provided in

Table 9 below. Of the 1,422 Indigenous families who have participated in the program, most have come from the Northern (29 per cent) and Western (27 per cent) regions. Together these regions account for more than half of the Indigenous families in the program. Thirteen percent of Indigenous families are located in the Hunter and Central Coast regions and 12 per cent of families are located in the Southern region. The three regions that make up Metropolitan Sydney all have the lowest numbers of Indigenous families with Metro West having nine per cent, Metro South West six per cent, and Metro Central, five per cent of Indigenous families.

Table 9: Distribution of Indigenous families by Community Services region

	Indigenous		Non-indigenous	
	No.	Col %	No.	Col %
Hunter and Central Coast	178	13	555	12
Metro Central	71	5	743	17
Metro South West	79	6	587	13
Metro West	125	9	722	16
Northern	409	29	707	16
Southern	169	12	497	11
Western	391	27	636	14
Total	**1422**	**100**	**4447**	**100**

3.3 Vulnerabilities on entry to Brighter Futures

This section presents the data on recorded vulnerabilities for all families in Brighter Futures and provides analysis of vulnerabilities by management, entry pathway and the Indigenous status of families.

Families are eligible for the program if they have at least one vulnerability that, if not addressed, is likely to escalate and impact adversely on their capacity to parent adequately and/or on the wellbeing of the child/ren (Community Services, 2009).

The vulnerabilities are:

- domestic violence;
- parental drug and alcohol misuse;
- parental mental health issues;
- a lack of extended family or social supports;
- parents with significant learning difficulties or intellectual disability;
- child behaviour management problems (e.g. parent-child conflict, school problems, parenting difficulties); and
- lack of parenting skills/inadequate supervision.

The descriptive analysis of vulnerability data below provides a snapshot of families' problems on entry into the program however there are a few important points to note with respect to vulnerabilities. Vulnerability data is not collected in a systematic way but is based on limited information available to intake and caseworkers at a families' point of entry into the program. As is often the case, some problems may not emerge until a family has engaged with the program for a period of time and built a trusting relationship with their caseworker, however, updated vulnerability data is not available for analysis. As such, the vulnerability data here presents a snapshot of families upon entry to the program and should be read in conjunction with the more detailed analysis of family problems provided in chapter 4, where we examine primary reported issues.

All families

Families entering the program are likely to have multiple vulnerabilities. The following vulnerability information is based upon families with at least one vulnerability recorded. Table 10 below shows that the majority of families entering the program indicated that they lack social support (3,326 families or 60 per cent). This was followed by 3,141 families (57

per cent) indicating inadequate supervision or parenting skills and 2,982 families (54 per cent) indicating domestic violence as a vulnerability.

Table 10: Vulnerabilities of Brighter Futures families on entry to the program

	No.	% families
Domestic violence	2982	54
Parental drug and alcohol misuse	2197	40
Parental mental health issues	2852	51
Lack of social support	3326	60
Parents with learning difficulties/intellectual disability	495	9
Child behaviour management problems	2155	39
Lack of parenting skills/inadequate supervision	3141	57

Note: families can have multiple vulnerabilities; percentages are for families with at least one vulnerability recorded.

Vulnerabilities of Brighter Futures families by managing agent

Table 11 below provides the distribution of family vulnerabilities by management type. It can be seen that the profile of vulnerabilities varies between Lead Agencies and Community Services. A higher proportion of families managed by Lead Agencies are recorded as lacking in social support and as having child behaviour management problems, whereas a higher proportion of families managed by Community Services are recorded as having problems related to domestic violence and parental drug and alcohol misuse. There is a particularly large difference between Community Services and Lead Agencies for families with child behaviour management problems. Almost half of Lead Agency families (48 per cent) have indicated this as a vulnerability compared to only one quarter of Community Services families (24 per cent). Lead Agencies and Community Services have fairly equal proportions of families reported as having a lack of parenting skills/inadequate supervision and parental mental health issues.

Table 11: Vulnerabilities of Brighter Futures families by managing agent

	Lead Agency managed		Community Services managed	
	No.	% families	No.	% families
Domestic violence	1730	50	1252	60
Parental drug and alcohol misuse	1252	36	945	45
Parental mental health issues	1823	53	1029	49
Lack of social support	2311	67	1015	48
Parents with learning difficulties/intellectual disability	373	11	122	6
Child behaviour management problems	1650	48	505	24
Lack of parenting skills/inadequate supervision	1971	57	1170	56

Note: families can have multiple vulnerabilities; percentages are for families with at least one vulnerability recorded.

Vulnerabilities of Brighter Futures families by entry pathway

Table 12 shows large differences in the vulnerability composition of families entering via each pathway. Families with child behaviour management problems account for 59 per cent of community pathway entrants (1,194 families) compared to only 27 per cent of Helpline entrants (961 families). The same large difference can be seen in relation to lack of social support which is indicated as a problem for 81 per cent of community pathway entrants

(1,643 families) compared to 48 per cent of Helpline entrants (1,683 families). Conversely, domestic violence is a vulnerability in 61 per cent of the Helpline entrants (2,128 families) compared to 42 per cent of community pathway entrants (854 families). There is also a significant difference in the proportion of families with parental drug and alcohol misuse listed as a vulnerability streamed through the Helpline (1,580 families, 45 per cent) compared to community pathway entrants (617 families, 30 per cent).

Table 12: Vulnerabilities of Brighter Futures families by entry pathway

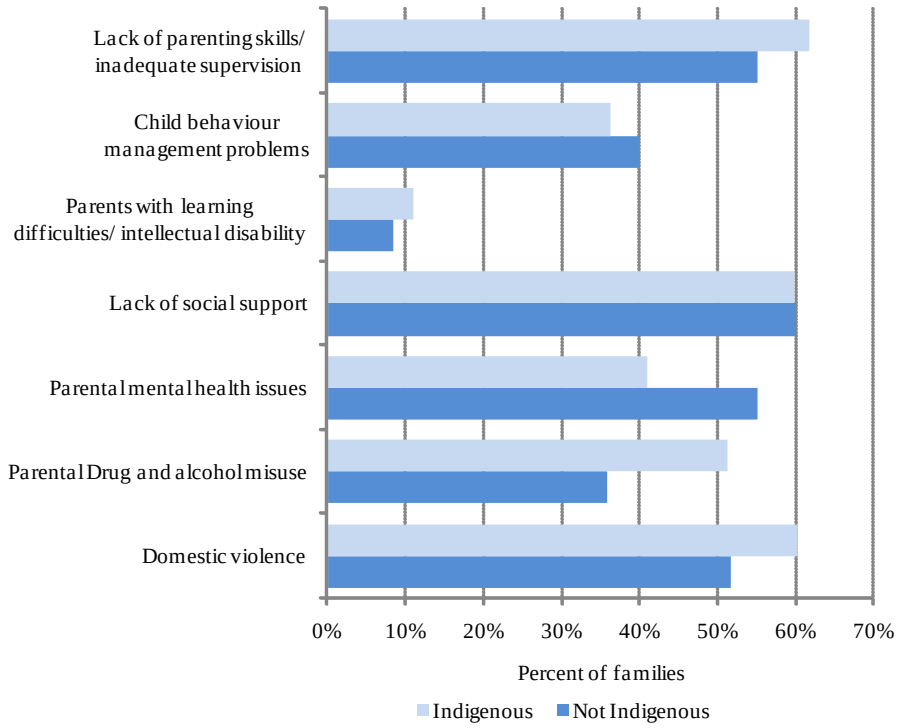
	Helpline pathway		Community Pathway	
	No.	% families	No.	% families
Domestic violence	2128	61	854	42
Parental drug and alcohol misuse	1580	45	617	30
Parental mental health issues	1698	48	1154	57
Lack of social support	1683	48	1643	81
Parents with learning difficulties/intellectual disability	216	6	279	14
Child behaviour management problems	961	27	1194	59
Lack of parenting skills/inadequate supervision	2033	58	1108	55

Note: families can have multiple vulnerabilities; percentages are for families with at least one vulnerability recorded.

Vulnerabilities of Brighter Futures families by family Indigenous status

Figure 3.3 compares the vulnerabilities of Indigenous and non-Indigenous families participating in the Brighter Futures program. The most common vulnerabilities reported for Indigenous families are inadequate supervision or parenting skills (62 per cent), domestic violence (60 per cent) and a lack of social support (60 per cent). Among non-Indigenous families the most common vulnerabilities were similar - a lack of social support (60 per cent), inadequate supervision or parenting skills (55 per cent) but instead of domestic violence, non-Indigenous families reported parental mental health (55 per cent) as a common problem. Indigenous families and non- Indigenous families were also reported as having similar concentrations of child behaviour management problems and parental learning difficulties/intellectual disabilities. The differences between these groups are more obvious in the higher proportions of Indigenous families affected by domestic violence (60 per cent Indigenous compared to 52 per cent non-Indigenous) and parental drug and alcohol misuse (51 per cent Indigenous compared to and 36 per cent non-Indigenous). Within Indigenous families there is a substantially lower concentration of families entering with parental mental health indicated as a vulnerability which is consistent with findings from the Family Survey which are discussed in chapter 4. For a breakdown of the data for each vulnerability in Indigenous families see Appendix C: Additional Brighter Futures Family Tables .

Figure 3.3: Comparison between vulnerabilities of Indigenous and non-Indigenous families on entry to Brighter Futures



3.4 Patterns of participation for Brighter Futures families

Entry into Brighter Futures is on a voluntary basis and while the recommended length of time families should spend in the program is two years, the time actually spent varies from family to family. The following section provides data on how many families are still in the program, how many families have exited the program and the average number of days spent in the program. The following tables also show the distribution of exited families by managing agent, pathway and the Indigenous status of families.

All families

Table 13 below shows that there are 2,668 families that are still in the program and 3,201 families that had exited the program prior to the 24th September 2009 (the most recent exit date in the MDS). Those families that had exited the program spent an average of 283 days in Brighter Futures. See Appendix C: Additional Brighter Futures Family Tables for breakdown by management types and entry pathway.

Table 13: Number of families in Brighter Futures

	No.	Col %
Still in program	2668	45
Exited program	3201	55
Total families	**5869**	**100**

Note: Reference date 24/09/2009

Number of families in Brighter Futures by managing agent and average time in the program

Of those families that are still in the program, more families are managed by a Lead Agency (1,605 families) than by Community Services (1,063 families). Similar proportions of families managed by Community Services and Lead Agencies have exited the program (56 per cent and 54 per cent respectively). In addition, families managed by Community Services and Lead Agencies that have exited the program spent a similar length of time in the program, 278 and 287 days respectively (see Table 14).

Table 14: Number of families in Brighter Futures by managing agent and average time spent in the program

	Community Services			Lead Agency		
	No.	Col %	Average days	No.	Col %	Average days
Still in program	1063	44		1605	46	
Exited program	1353	56	278	1848	54	287
Total families	**2416**	**100**		**3453**	**100**	

Further to this, Table 15 below shows that of the 1,848 Lead Agency families, who have exited, 70 per cent (1,287 families) were community entrants and 30 per cent (561 families) were Helpline entrants.

Table 15: Number of Lead Agency families exited from the program by pathway

	Still in program		Exited program		
	No.	Col %	No.	Col %	Average days
Helpline streamed to Lead Agency	854	53	561	30	329
Community entrants	751	47	1287	70	268
Total Lead Agency families	**1605**	**100**	**1848**	**100**	

Number of families in Brighter Futures by pathway and average time in the program on exit

When the data is presented by pathway in Table 16 below, it can be seen that a higher proportion of community entrants (63 per cent) than Helpline entrants (50 per cent) have exited the program. Further, among those who have exited, families who entered via the Helpline, stayed in the program for more days on average that those who entered via the community pathway and exited (293 days and 268 days respectively).

Table 16: Number of families in Brighter Futures by pathway and average time in the program on exit

	Helpline			Community		
	No.	Col %	Average days	No.	Col %	Average days
Still in program	1917	50		751	37	
Exited program	1914	50	293	1287	63	268
Total families	**3831**	**100**		**2038**	**100**	

Number of families participating in Brighter Futures by family Indigenous status

Table 17 below shows that there are 641 Indigenous families still in the program and 781 Indigenous families that have exited. While there is a similar proportion of Indigenous and non-Indigenous families that have exited, Indigenous families that exited the program had a substantially lower average number of days (245 days) on the program than non-Indigenous families (295 days).

Table 17: Comparison of Indigenous families versus non-Indigenous families that have exited

	Indigenous			Non-indigenous		
	No.	Col %	Average days	No.	Col %	Average days
Still in program	641	45		2027	46	
Exited program	781	55	245	2420	54	295
Total families	**1422**	**100**		**4447**	**100**	

A comparison of families that exit Brighter Futures by time spent on the program

When exited families are separated into those exiting after spending more than 90 days on the program and those exiting after less than 90 days on the program it can be seen that there are a larger proportion of community entrants compared to Helpline entrants that exit after spending less than 90 days in the program (36 per cent compared with 24 per cent) (See Table 18). Although it was shown earlier that 35 per cent of families are community entrants – a figure that is higher than the stated capacity of 20 per cent - the higher proportion of community entrants that exit before 90 days on the program may balance this figure out across the duration of the program. A comparison of families managed by Community Services and Lead Agencies shows a similar proportion exiting after less than 90 days on the program (28 per cent and 29 per cent respectively) as does a comparison of Indigenous and non-Indigenous families (28 per cent and 29 per cent respectively). The full tables are available in Appendix C: Additional Brighter Futures Family Tables.

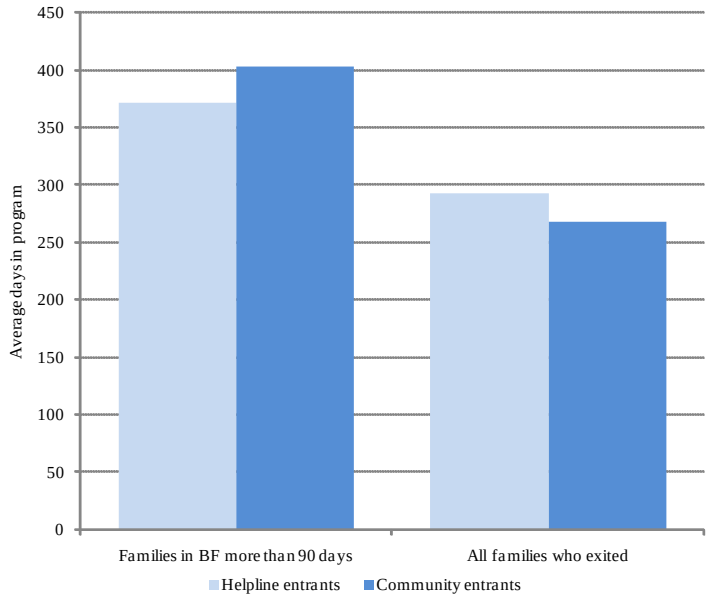
Table 18: Number of families that exit Brighter Futures after less than 90 days versus more than 90 days of intervention

	Helpline		Community	
	No.	Col %	No.	Col %
Exited after spending 90+ days on program	1454	76	828	64
Exited after <90 days on program	460	24	459	36
Total families	**1914**	**100**	**1287**	**100**

Length of time on Brighter Futures by pathway

While a higher proportion of community entrants than Helpline entrants exit after spending less than 90 days on the program, Figure 3.4 below shows that across all families, community entrants average less time on the program than Helpline entrants. However if the families that spend less than 90 days on the program are removed, community entrants are spending more time on average than the Helpline entrants. That is, community pathway families that stay on the program stay longest.

Figure 3.4: Average days in program for families who have exited Brighter Futures by pathway and time in program



3.5 Reports received prior to entry

This chapter concludes with a section that presents a descriptive analysis of children's risk of harm reports prior to entering the program. This analysis draws upon information from the Reports File, specifically risk of harm reports for 13,000 children living in families that have participated in Brighter Futures during the evaluation period. This analysis adds to the profile of families in the Brighter Futures program. The reports analysed range in date between July 2002 and September 2009[10]. Just over 80 per cent of children in the reports file (10,728) have at least one risk of harm report prior to entering the program.[11] A further 10 per cent (1,338) were not reported at all over the period, while 934 children (7.2 per cent) were reported for the first time during or after the program. In this section, we focus on the children who are participating in Brighter Futures for the first time and were reported at least once prior to entering the program[12].

Of these children as Table 19 shows, there is considerable variation in the length of time between when they were first reported and the entry of their family onto the program. On average, children are known to Community Services for about 20.4 months (SD=20) prior to entering the program, however there is a large concentration of children who are known for a very short period prior to entering the program. The time children are known to Community Services prior to entering the program is also referred to as 'exposure time' throughout this report.

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10 Reports received prior to July 2002 are not on file and therefore are not included in data available to the evaluation.

11 Note that for a small number of children (N = 15) the date of their first report was the same as the date they entered the program. These are included in the number of children with a report to the program.

12 Children who have received more than one intervention have been excluded in this part of the analysis, as were children aged over 18 years.

Table 19: Average reports and exposure time for children reported at least once prior to entering Brighter Futures

	All children (N=10728)	
Total reports	52929	
Average number of reports	4.9	(SD=5.5)
Average months of exposure to CS	20.4	(SD=20)

3.6 Types of reports received prior to entry

The following analysis differentiates between children's exposure time, and groups the primary reported issues into groups and then compares these groups with the numbers of reports children received prior to program entry.

Primary reported issue groupings[13]:

1. Carer issues
    a. Drug or alcohol abuse
    b. Carer mental health issues
    c. Other issues related to the carer
2. Domestic Violence
3. Abuse
    a. Physical abuse
    b. Emotional abuse
    c. Sexual abuse
4. Other reports

Table 20 reports the average number of reports across each of these issues for all children regardless of length of time known to Community Services prior to entry to the program. It shows that reports relating to Domestic Violence represent the largest proportion of reports received prior to entering the program, with an average of 1.43 reports per child. This is followed by the reports that make up carer issues – Drug /alcohol, mental health and other carer issues.

Table 20: Average reports for each reported issue prior to entry into Brighter Futures

Primary reported issue	Average reports	Std. Deviation	Total reports prior to entry
Drug/alcohol issues	.51	1.26	5514
Mental health issues	.69	1.29	7356
Other carer issues	.18	.56	1977
Domestic violence	1.43	2.14	15328
Physical abuse	.54	1.16	5752
Emotional/psychological abuse	.28	.74	3003
Sexual abuse	.15	.72	1561
Neglect	.78	1.64	8415
Other	.38	1.16	4023

[13] Refer to Appendix A: Summary of instruments and items utilised in the Family Survey for more detailed breakdowns of the reported issues used in these groups.

The following analysis ranks children into quintile groups based on the amount of time between their first report after July 2002 and entry into Brighter Futures. This analysis has been undertaken to provide a simple basis for further comparison of report type and population subgroup – and to control for exposure time in reports analysis. The analysis was undertaken by creating five groups, each containing 20 per cent of the cohort, approximately 2,145 children. The first quintile contains the 1 in 5 children known to Community Services for the least amount of time and the fifth quintile contains children that are known for the longest amount of time prior to entering Brighter Futures. Throughout this report, these quintiles are referred to as exposure quintiles.

As Table 21 illustrates, children in the first quintile – those known to CS the least time – are known on average for 1.2 months prior to entry. These children received 3,104 reports, an average of 1.4 reports per child. As is expected, as the exposure time lengthens, children are the subject of more reports. Children known for the longest time prior to entering the program are known for an average of 53.4 months and received a total of 21,287 reports, an average of 9.9 reports per child.

Table 21: Description of reports for each exposure quintile

Quintile Group	Number of children	Total reports	Average reports	Average months exposure to CS
1 (known for least time)	2148	3104	1.4	1.2
2	2149	5519	2.6	4.2
3	2139	9490	4.4	13.5
4	2147	13529	6.3	29.9
5 (known for longest time)	2145	21287	9.9	53.4
Total	**10728**	**52929**	**4.9**	**20.4**

When exposure time is considered, the distribution of reports shows more detail in relation to the reported issue. Although reports relating to domestic violence are overall higher in number, Table 22 illustrates that around one in three reports for children known to Community Services for the least time are for carer mental health issues (30.7% of reports in quintile 1), recall from above that these children are known to Community Services for an average of just over one month. The proportion of reports for carer mental health issues decrease as exposure time increases, mental health issues represent 20 per cent of reports for quintile 2 and drop to 10 per cent of reports for children known the longest (quintile 5).
With the exception of the first quintile as described above, domestic violence represent the largest proportion of reports in each quintile, generally representing around one in three reports in each quintile.

Reports of neglect represent the second most common reported issue in the fifth quintile (children known to CS for 53 months on average) with 16.8 per cent of reports received for these children; these represent a slight increase in proportion of reports in each quintile from 12.9 per cent of reports in quintile one.

Table 22: Number and proportion of reports by issue in each exposure quintile

Primary reported issue	1		2		3		4		5	
	N	%	N	%	N	%	N	%	N	%
Drug/alcohol issues	207	6.7	528	9.6	1087	11.5	1560	11.5	2132	10.0
Mental health issues	953	30.7	1113	20.2	1464	15.4	1698	12.6	2128	10.0
Other carer issues	154	5.0	230	4.2	395	4.2	528	3.9	670	3.1
Domestic violence	736	23.7	1643	29.8	2908	30.6	4327	32.0	5714	26.8
Physical abuse	299	9.6	555	10.1	1017	10.7	1495	11.1	2386	11.2
Emotional/ psychological abuse	164	5.3	297	5.4	597	6.3	772	5.7	1173	5.5
Sexual abuse	19	0.6	105	1.9	282	3.0	422	3.1	733	3.4
Neglect	399	12.9	846	15.3	1404	14.8	2199	16.3	3567	16.8
Other	173	5.6	202	3.7	336	3.5	528	3.9	2784	13.1
Total	**3104**	**100**	**5519**	**100**	**9490**	**100**	**13529**	**100**	**21287**	**100**

We continue by looking at reports prior to entry to Brighter Futures for Indigenous and non-Indigenous children, and then examine reports for children managed by Community Services compared with Lead Agencies.

Indigenous status of children

Approximately one in four children with at least one report prior to entry to the Brighter Futures program is Indigenous (2,514 children). As Table 23 shows, Indigenous children are known for significantly longer periods of time prior to entry compared with non-Indigenous children, (21.2 and 18.9 months respectively) and overall average significantly more reports prior to entry than non-Indigenous children (6.0 and 4.6 reports on average respectively).

Table 23: Comparison of reports and exposure for Indigenous and non-Indigenous children with at least one report prior to entering Brighter Futures

	Indigenous (N=2514)	Non-Indigenous (N=8214)	Sig.
Total reports	15117	37812	
Average number of reports	6.0	4.6	***
Average months of exposure to CS	25.5	18.9	***

Notes: *** p< .001; ** p< .01; * p< .05; NS = Not Significant

On reported issue overall[14], Indigenous children reported at least once prior to entry average significantly more reports than non-Indigenous children for reports of carer drug and alcohol issues, domestic violence and abuse and neglect. Non-Indigenous children average significantly more reports for carer mental health issues.

[14] Note that for the remainder of the report, the reported issues have been grouped into five – reports of abuse have been combined, 'other carer issues' and 'other reported issues' have been discarded.

Table 24: Comparison of reports type for Indigenous and non-Indigenous children with at least one report prior to entering Brighter Futures

	Indigenous		Non-Indigenous		Sig.
	N reports	Average reports	N reports	Average reports	
Drug & Alcohol issues	1900	0.76	3614	0.44	***
Carer mental health issues	1217	0.48	6139	0.75	***
Domestic Violence	4602	1.83	10726	1.31	***
Abuse	2584	1.03	7732	0.94	*
Neglect	2896	1.15	5519	0.67	***

Notes: *** p< .001; ** p< .01; * p< .05; NS = Not Significant, Indigenous N=2514, Non-Indigenous N=8214

When controlling for exposure time, Indigenous children are more likely than non-Indigenous children to be represented in the upper quintiles, with 28 per cent of Indigenous children reported prior to entry represented in the 5th quintile – children known the longest to Community Services, whereas the comparative figure for non-Indigenous children is 17 per cent. Indigenous children are not only more likely to be known for longer than non-Indigenous children, but also the number of reports in the top two exposure quintiles is more extreme for Indigenous children. Although this represents more reports on average than non-Indigenous children, only the fourth quintile showed a statistically significant difference between the average reports of Indigenous and non-Indigenous children.

Table 25: Description and comparison of reports by Indigenous status for each exposure quintile

Exposure quintiles	Indigenous			Non-Indigenous			Sig
	Average reports	Total reports	N children	Average reports	Total reports	N children	
1st (known for least time)	1.5	552	377	1.4	2552	1771	NS
2nd	2.6	989	387	2.6	4530	1762	NS
3rd	4.6	2195	475	4.4	7295	1664	NS
4th	7.1	4010	564	6.0	9519	1583	***
5th (known for longest time)	10.4	7371	711	9.7	13916	1434	NS
All	**6.0**	**15117**	**2514**	**4.6**	**37812**	**8214**	*******

Notes: *** p< .001; ** p< .01; * p< .05; NS = Not Significant

Analysis of reported issues after accounting for exposure time as illustrated in Table 26 shows a significant gap between Indigenous and non-Indigenous children in reports of carer drug and alcohol issues across all exposure quintiles, with the former averaging significantly more reports in this category. In contrast, non-Indigenous children average significantly more reports relating to carer mental health issues across each quintile. Average reports of abuse differ least among Indigenous and non-Indigenous. The pattern for reports of neglect shows significantly more reports on average for Indigenous children except in quintile 2. A full table is available in Appendix C: Additional Brighter Futures Family Tables.

Table 26: Average reports by reported issue across exposure quintiles by Indigenous status for children reported at least once prior to entering Brighter Futures

	Average reports, exposure quintiles				
	1	2	3	4	5
Carer drug & Alcohol issues					
Indigenous	0.2	0.5	0.7	0.9	1.2
Non-Indigenous	0.1	0.2	0.5	0.7	0.9
Carer Mental Health					
Indigenous	0.3	0.3	0.5	0.6	0.6
Non-Indigenous	0.5	0.6	0.7	0.9	1.2
Domestic Violence					
Indigenous	0.4	0.8	1.5	2.3	3.0
Non-Indigenous	0.3	0.8	1.3	1.9	2.5
Abuse					
Indigenous	0.2	0.4	0.7	1.3	1.8
Non-Indigenous	0.2	0.5	0.9	1.2	2.1
Neglect					
Indigenous	0.2	0.4	0.9	1.4	1.9
Non-Indigenous	0.2	0.4	0.6	0.9	1.5

Notes: Full table available in Appendix C: Additional Brighter Futures Family Tables.

The pattern for domestic violence is somewhat different. Children in the first three exposure quintiles do not differ significantly by Indigenous status. Indigenous children in the upper exposure quintiles do, however, average significantly more reports of domestic violence than non-Indigenous children which underscore an overall significant difference in reports of domestic violence by Indigenous status.

Family management: Community Services and Lead Agencies

Among children with at least one report prior to entering the program, 47 per cent are managed by Community Services (5,082 children) and 53 per cent are managed by Lead Agencies (5,646 children). Lead Agency children are not only known to Community Services for longer periods but also average more reports prior to entry. Lead Agency managed children are first reported on average 24 months prior to entering the program compared with 16 months for children managed by Community Services ($P < .001$).

Lead Agency children average significantly more reports overall prior to entering Brighter Futures with an average of 5.3 compared to 4.6 received by children in families managed by Community Services, as Table 27 shows.

Table 27: Comparison of reports and exposure by management type for children with at least one report prior to entering Brighter Futures

	CS Managed	LA Managed	Sig.
Total reports	23128	29801	
Average number of reports	4.6	5.3	***
Average months of exposure to CS	16.2	24.2	***

Notes: *** p< .001; ** p< .01; * p< .05; NS = Not Significant, CS Managed N=5082, LA Managed N=5646

When examining reported issues, there is no difference between management types for reports of carer mental health issues and domestic violence. Lead Agency managed children averaged more reports than Community Services' managed children for carer drug and alcohol issues, abuse and neglect. This is shown in Table 28 below.

Table 28 Comparison of report type by management type for children with at least one report prior to entering Brighter Futures

	CS Managed		LA Managed		Sig.
	N reports	Average reports	N reports	Average reports	
Drug & Alcohol issues	2400	0.5	3114	1.4	**
Carer mental health issues	3594	0.7	3762	0.9	NS
Domestic Violence	7062	1.4	8266	0.7	NS
Abuse	4370	0.9	5946	1.1	***
Neglect	3804	0.7	4611	0.8	*

Notes: *** p< .001; ** p< .01; * p< .05; NS = Not Significant

As explained above, Lead Agency managed children average significantly more reports overall, but when exposure time is equalised between groups, as shown in Table 29, Community Services managed children average more reports at each point of exposure (although not significantly different in quintiles 2 and 5). In addition, although there are more Lead Agency children overall, Community Services managed children account for 61 per cent of children in the first quintile, children known for an average of one month prior to entry. This proportion shifts after the second quintile, where Lead Agency managed children are concentrated in the upper quintiles, managing two out of three children known the longest.

Table 29: Reports across each exposure period by management type for children with at least one report prior to entering Brighter Futures

Exposure quintiles	Community Services managed			Lead Agency managed			Sig
	Average reports	Total reports	N children	Average reports	Total reports	N children	
1st (known for least time)	1.5	1959	1320	1.4	1145	828	*
2nd	2.6	2985	1148	2.5	2534	1001	NS
3rd	4.7	4413	934	4.2	5077	1205	**
4th	6.9	6653	970	5.8	6876	1177	***
5th (known for longest time)	10.0	7118	710	9.9	14169	1435	NS
All	4.6	23128	5082	5.3	29801	5646	***

Notes: *** p< .001; ** p< .01; * p< .05; NS = Not Significant

Furthermore, Table 29 shows that for Lead Agency managed children, 14,169 or almost half of all reports (48 per cent) received prior to entry were received about children known for the longest time (5^{th} quintile). Community Services managed children known for the longest time (5^{th} quintile) have a total of 7,118 reports which represents 31 per cent of all reports for Community Services managed children.

When analysed by reported issue, there is no significant difference between Community Services and Lead Agencies with respect to reports of carer drug and alcohol issues across each of the five exposure quintiles. There is a modest difference in the fifth quintile with children managed by Community Services averaging more reports of carer drug and alcohol issues than children managed by Lead Agencies, although the difference is not statistically significant. This shows that there is no difference in the average numbers of reports for carer drug and alcohol issues between managing agencies, regardless of how long children are known to Community Services prior to entry (see Appendix C: Additional Brighter Futures Family Tables for table of figures).

3.7 Discussion

This chapter has presented a broad overview of all families that have participated in Brighter Futures over the course of the evaluation. Five main findings emerged from the analysis of these data. First, although Brighter Futures has engaged community entrants at 15 percentage points above capacity, those that enter via the community pathway exited in higher proportions and when they exited, they did so after spending a lower average number of days in the program than Helpline entrants.

Second, while there are a high proportion of program families that are Indigenous, Indigenous families are exiting the program after spending 50 fewer days on average in the program than non-Indigenous families. Currently it would appear that Brighter Futures has had initial success in engaging Indigenous families, however further analysis is needed to understand why Indigenous families are spending less time on average in the program than non-Indigenous families. The Aboriginal Families Study, which will be reported on in the final evaluation report will inform further discussion of this circumstance.

Third, there are differences in the vulnerability profiles of families managed by Community Services and Lead Agencies. Overall Community Services managed a higher proportion of families with problems relating to domestic violence and parental drug and alcohol abuse and Lead Agencies managed a higher proportion of families with child behaviour management problems and a lack of social support. The analysis of reports prior to program entry adds to this finding by elaborating an additional layer of difference between families managed by Community Services and Lead Agencies.

There are two key points that emerge from the descriptive reports analysis for children managed by Community Services and those managed by Lead Agencies. Firstly, it is clear that Lead Agencies manage more children known for a longer time than Community Services. This appears to indicate that these children are receiving more reports over time as the period of exposure lengthens but do not receive an intervention until they are known for longer periods of time than Community Services children. This is in contrast to Community Services managed children, who are known for shorter periods of time and who generally have more reports per child overall after accounting for exposure time; these differences are most pronounced in reports of domestic violence and neglect. Community Services children are therefore entering an intervention much earlier than Lead Agency children after they are first reported indicating acute issues needing more immediate attention.

4 The Family Survey

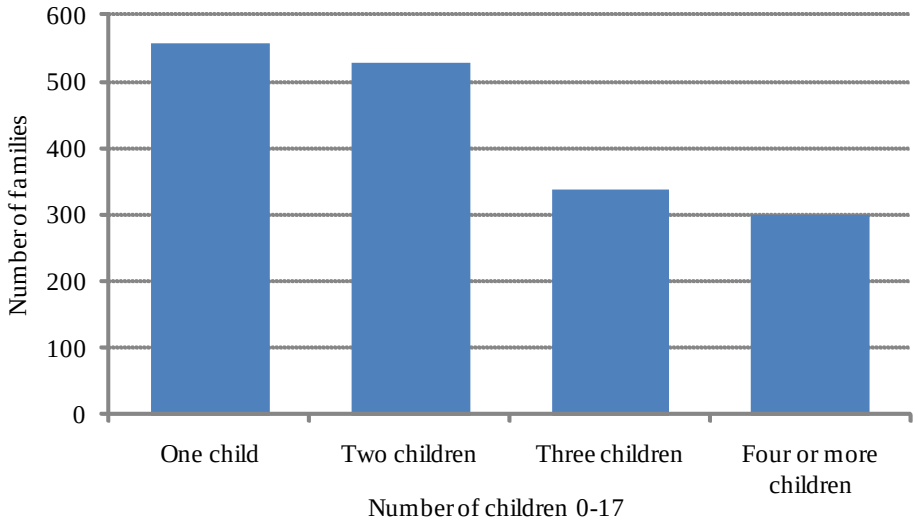
4.1 All Families

As detailed in chapter 2, the Family Survey is offered to all families at entry to the program (T1), six months after the first survey (T2) and then on exiting Brighter Futures (T3). This chapter provides a descriptive overview of Family Survey data at T1. It includes demographic information about respondent families, the primary carers of these families and information about one nominated study child in each family. An overview of all families is initially reported in this chapter, after which the survey discussion is split into three broad groups – management type, household type, and Indigenous families and findings are compared across these groups. Appendix C provides tables for all demographic information reported in this chapter.

The sample of T1 surveys for this report represents 1,730 families. Lead Agency families returned 1,083 surveys, which is just under two thirds (63 per cent) of the surveys received. Community Services families returned 647 surveys (37 per cent). Although Lead Agencies appear to be overrepresented in this sample, as overall 59 per cent of entrants to the program are managed by Lead Agencies and 41 per cent are managed by Community Services. There is no substantial difference in the distribution of management type for T1 surveys returned compared to all entrants on the program. The same can be said about pathway into Brighter Futures, with 33 per cent of T1 survey respondents entering via the community pathway compared to 35 per cent of all entrants to the program.

Looking at overall family characteristics, overwhelmingly the mother is the primary carer (1,629 or 94 per cent), with the father listed as primary carer in 76 families (4 per cent), and other types of primary carers such as grandparents are indicated for 25 families (1 per cent). The majority of the families in the cohort are lone-mother households (56 per cent), with two-parent families making up 39 per cent of the cohort, and lone-father/grandparent households comprising the remaining 4 per cent.

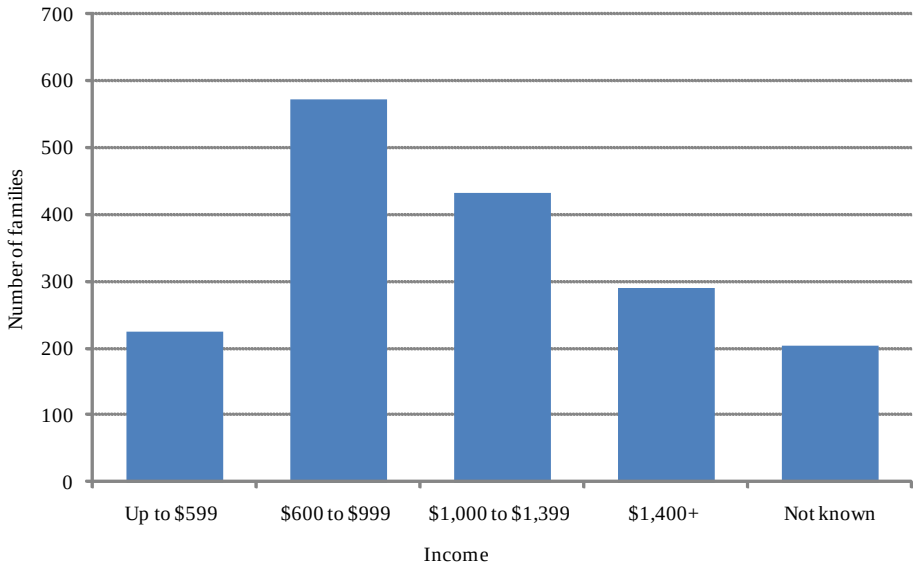
Figure 4.1: Number of children in each family for family survey respondents



As Figure 4.1 indicates, around two-thirds of the families who completed a T1 survey had either one child (32 per cent) or two children (31 per cent). These proportions closely resemble the distribution of children in the program overall.

Demographic information is collected for up to six children in each family including the nominated study child. The majority of the families (55 per cent) in the cohort had a youngest child aged less than two years, with only 17 per cent of the families having a youngest child aged more than four years. Given the young age of many program children, and the vulnerabilities of their parents, it is not surprising that 80 per cent of mothers identify themselves as either full time parents or are not employed. Consistent with this profile is the fact that in more than half of the households (52 per cent), no members have a year 12 certificate or equivalent school leaving qualification. Moreover, government benefits are the main source of income in 74 per cent of the families, with only 23 per cent receiving most of their income through paid work.

Figure 4.2: Net fortnightly income for family survey respondents



As a result, Figure 4.2 shows that most families have low income levels with 46 per cent receiving less than $1,000 per fortnight. Only 17 per cent of the cohort reported an income of more than $1,400 per fortnight.

A substantial number of children in the cohort had either a medical condition (25 per cent), a developmental condition such as autism, ADHD, or global development delay (17 per cent), or a disability (25 per cent).

In general, primary carers were positive about their own health status with 70 per cent rating themselves as being in good, very good or excellent health. Almost three quarters of the cohort (72 per cent) reported that they participate in regular exercise. Of the primary carers, 13 per cent have a disability, 60 per cent reported that they drink alcohol, and a quarter reported that they smoke cigarettes.

Of the children nominated to be the study child in each family, 56 per cent are boys (972) and 44 per cent are girls (758). Study children have an average age of 3.2 years. Parents reported positively on the health status of study children with 92 per cent rating the study child's health as either good, very good or excellent.

As described above, the Family Survey collects information relating to parenting style. These measures, which were taken from the Longitudinal Study of Australian Children (LSAC), relate to specific areas of parenting including parental warmth, parental self-efficacy, and hostile parenting. Parents in the Family Survey sample scored highly on measures of parental warmth and self-efficacy and low on the measure of parental hostility. The average raw score for parental warmth in this cohort was 9.5 where combined scores for the two items ranged between 2 and 10. Parents therefore rated themselves very highly in measures of parental warmth.

Parents also rated themselves highly on measures of self-efficacy. Possible scores for the combined three items ranged from 3 to 30, with parents averaging a score of 23.3. Finally, in a three item measure of parental hostility, parents in the cohort reported an average score of 11.2 on a scale of 3 to 30 where higher scores indicate more hostile parenting.

This positive result for cohort families using LSAC measures is repeated in an alternative five item measure of positive parenting that was taken from the National Longitudinal Study of Canadian Children (NLSCY). The average score of 20 from a total score range of 5 to 25 again shows that parents from this cohort score highly and report positive interactions with their children.

The Family Survey also includes measures of problem behaviours for children. The Brief Infant Toddler Social Emotional Assessment (BITSEA) measures problem behaviours and social competency for children aged one to three years of age. Scores for this parent-report measure of problem behaviours averaged 45.1 from a maximum score of 62. This result suggests that cohort children have somewhat high levels of social-emotional behavioural problems – a result that is supported by the qualitative data presented in chapter 7. Surprisingly, the average score for cohort children on the competency scale was also relatively high (26.7 from a maximum 33), suggesting that cohort children also display a high level of pro-social behaviours.

The final measure of child behaviour, for children over the age of two years, is the Eyberg Child Behaviour Inventory (ECBI). According to this measure, average scores of cohort children fell within the normal range, with the average score of 126.3 (from a scale with a minimum score of 36 and possible maximum of 252). In the ECBI, children with scores above 131 are considered to require clinical intervention. This measure is explored in more depth in chapter 6 by examining changes over time for ECBI scores.

In the sections below, we present further analysis of Family Survey data by providing comparative analyses based on management type (Community Services versus Lead Agency); household type (two-parent versus lone-mother families) and family Indigenous status (Indigenous versus non-Indigenous).

4.2 Community Services and Lead Agencies

Analysis of Family Survey data shows few differences between the families managed by Community Services and those managed by Lead Agencies. There was no significant difference between proportions of lone-mother and two-parent families. Lone-mother families are the dominant family type in both Community Services and Lead Agency managed families, representing 59 per cent and 55 per cent of all families respectively. Lead Agencies manage slightly more two-parent families (40 per cent versus 38 per cent Community Services) however, the difference is not significant.

There is a small but significant difference in the size of families being managed by Community Services and Lead Agencies, with Community Services handling slightly smaller families with an average of 2.2 children, in comparison to 2.4 being the average number of children within Lead Agency families. Thirty nine per cent of families managed by Lead Agencies comprise three or more children, whereas this is the case in only 34 per cent of Community Services managed families. There is also a small but significant difference in the age of children being managed by Community Services and Lead Agencies, with Community Services managed families generally younger; 58 per cent of families managed by Community Services have a youngest child aged less than 2 years, compared to 53 per cent for Lead Agency-managed families. Correspondingly, 19 per cent of Lead Agency managed families have a youngest child aged more than 4 years, compared to 14 per cent of Community Services managed families. The average age of children in Community Services managed families is 3.09 years, compared to 3.29 years in Lead Agency managed families.

There are no significant differences in the socioeconomic characteristics of families managed by Community Services and Lead Agencies. As presented in the previous section, most families have a mother who is not employed or is a full-time parent (81 per cent Community Services and 79 per cent Lead Agency), and Government benefits are the main source of income in both Community Services and Lead Agency managed families (76 per cent and 72 per cent respectively). Consistent with this finding is that the majority of Community Services and Lead Agency managed families have low income levels with more than 45 per cent of both groups earning less than $1,000 per fortnight.

The similarity between Community Services and Lead Agency managed families are also evident in the characteristics of the primary carer's health and lifestyle. Almost three quarters of the primary carers of both groups rated their health positively – as either good, very good or excellent. There was no significant difference in the smoking and alcohol consumption within both family types, nor was there any significant difference in the proportion of primary carers with a disability. This pattern is repeated in the characteristics of child health with there being no significant difference in the reported rates of disability and developmental conditions.

The similarity between Community Services and Lead Agency managed families is again evident in measures of carer wellbeing. There is no significant difference in any of the measures including scales that measured satisfaction with life, relationships, family attachment, support systems and self-esteem levels. Similarly, in all four measures of parenting (parental warmth, parental self-efficacy, hostile parenting and positive parenting), no significant difference in scores exists between Community Services and Lead Agency managed families. The average score for hostile parenting was 11.0 for Community Services and 11.3 for Lead Agency families. As discussed in the section above, these scores are relatively low, indicating that both groups report low levels of hostile parenting. The average score for parental self efficacy was relatively high for both management types, with a shared average score of 23.3. Both Community Services and Lead Agency parents again scored very highly on measures of positive parenting.

This pattern of little distinction between families based on management type is repeated in measures of child social and emotional development. There are no differences in the Eyberg and the BITSEA Problem Scale scores, with children in families managed by Community Services and Lead Agencies scoring on average within the normal range. There was a small difference in scores on the BITSEA Competence Scale (Child 1-2 years) with Community Services managed children scoring slightly more than those managed by a Lead Agency (27.4

Community Services versus 26.2 Lead Agency). This indicates that children managed by a Lead Agency show slightly more pro-social competence than children managed by Community Services.

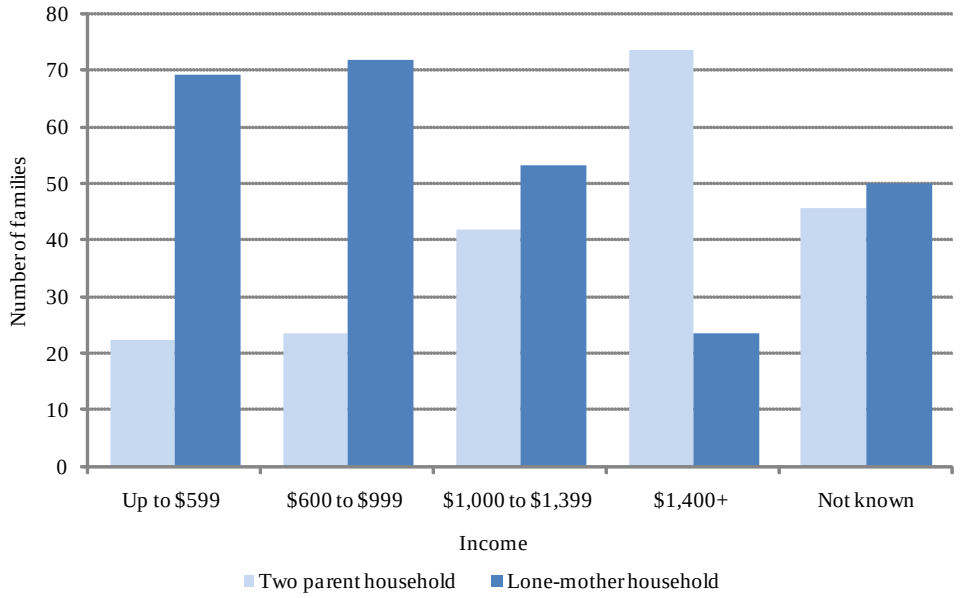
4.3 Lone-mother and two-parent families

This section provides further analysis of Family Survey data, focusing on the differences between two-parent and lone-mother households. Of the 1,730 families who completed T1 surveys, 56 per cent are lone-mother households, 39 per cent are two-parent households and the remaining 5 per cent are 'other' household types.[15] There was a significant difference between the average number of children in two-parent and lone-mother households. Two-parent families were significantly larger with an average of 2.5 children per household, in comparison with only 2.2 children in lone-mother households. Only 27 per cent of two-parent families had one child, whereas this was the case for 37 per cent of lone-mother families. As well as being larger, two-parent households were significantly more likely to include younger children, with the youngest child being less than 1 year old in 39 per cent of two-parent families compared with only 28 per cent of lone-mother families. Conversely, only 11 per cent of two-parent families had a youngest child aged 4 or more, compared to 20 per cent of lone-mother families.

Children in lone-mother households were significantly more likely to have a mother who does not work (86 per cent) than two-parent households. However, two-parent households also had a high percentage of mothers not in employment (80 per cent), as well as a large percentage of unemployed fathers (48 per cent). Given the small percentage of lone mothers in employment it is not surprising that this group also had significantly lower income levels than two-parent households. Almost 70 per cent of lone mothers earned less than $999 per fortnight and only 7 per cent of this group earned $1,400 or more per fortnight. In comparison, 32 per cent of two-parent families had income levels higher than $1,400 per fortnight, and only 42 per cent had incomes of less than $1,000 per fortnight (see Figure 4.3).

[15] Other household types mainly include lone parent fathers and children living with their grandparent(s).

Figure 4.3: Net fortnightly income by household type



There was a significant difference between the income source for two-parent and lone-mother households. Government benefits were the main income source for 90 per cent of lone-mother families. This figure is consistent with the low levels of engagement in paid employment and income in these households. Fifty-one per cent of two-parent families relied on government benefits as their main source of income. Paid work was the main source of income in 47 per cent of two-parent families, and 7 per cent of lone-mother families. There were significant differences in the highest qualification level and household types, with 41 per cent of two-parent families and 58 per cent of lone-mother households not having completed year 12.

There were some significant differences related to the health and lifestyle of carers from two-parent and lone-mother households. The primary carer in two-parent households (the mother in 97 per cent of families) was more likely to live a healthier lifestyle than carers in lone-mother households. For example, the primary carer in a two-parent household was more likely to be a non-smoker (79 per cent compared with 72 per cent for lone-mother households) and more likely to be a non-drinker (44 per cent compared with 37 per cent for lone-mother households). Based on carers' self-reported general health status and level of exercise there were, however, no significant differences between household types, with more than 60 per cent of both groups reporting good, very good or excellent health, and more than 68 per cent reporting that they exercise.

Like carers, there were no significant differences for the general health status of study children based on information given by the primary carer. Ninety-two per cent of primary carers in both household types reported that their child was in good, very good or excellent health. There was, however, a significant difference between household types and child development, with 20 per cent of two-parent families reporting that their child has a developmental problem, in comparison to only 14 per cent of lone-mother families (see Figure 4.4).

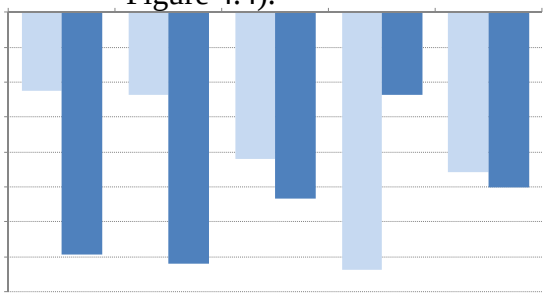
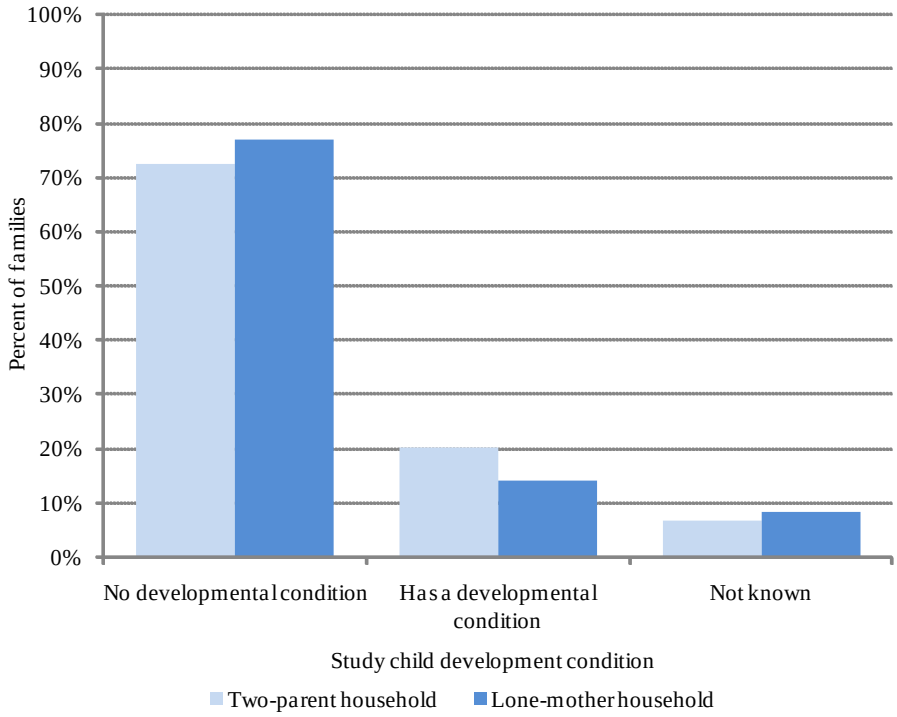


Figure 4.4 : Child development condition by household type



In measures of child social and emotional behaviour there were no significant differences between children from two-parent and lone-mother families. Both groups scored within the normal range for the Eyberg, with children from two-parent families scoring slightly higher with an average score of 128.8, in comparison to children from lone-mother families who had an average score of 125.7. Interestingly, children from two-parent families are closer to the clinical cut off score of 131 than those from lone-mother households. The BITSEA Problem Scale did not indicate any great difference on scores obtained for one or two-parent families. Both had an average score which lent towards the upper end of the scale. Two-parent families averaged 45.5 and lone-mother families had an average score of 44.9. There was no significant difference between these two scores. The BITSEA Competency Scale also showed no significant difference between scores for children in lone-mother or two-parent households. Both groups scored relatively high on the scale, showing high levels of competency behaviours.

In measures of carer wellbeing, significant differences were evident in the general satisfaction with life scale, with two-parent families reporting higher satisfaction levels than lone-mother families (6.4 and 5.9 respectively from a total score of 10). Carers in two-parent families were also more likely to report higher levels of family attachment (11.8 and 10.7 respectively from total score of 15), and were more likely to be satisfied with the support they receive from their friends. Large proportions of both groups indicated, however, that they do not feel like they get enough support in general (28 per cent two-parent households and 31 per cent lone-mother households) – a result that highlights the social isolation of many program families and confirms the high proportions of families entering with lack of social support as a vulnerability.

Finally, there were few observed differences in self-rated parenting ability between household types. In a similar pattern to that seen in the section above, 90 per cent of carers in both two-parent and lone-mother households rated themselves as an average or above average

parent. Again, there were no significant differences in scores between both household types in measures of hostile parenting (11.3 two-parent households, and 11.1 lone-mother households); parenting self-efficacy (23.3 two-parent, and 23.7 lone-mother); and parental warmth (9.4 two parent and 9.6 lone-mother). Positive parenting was the only measure which indicated a statistically significant difference between two-parent and lone-mother families. Interestingly, it was observed that lone mothers reported significantly higher scores for positive parenting behaviours (20.2) compared to two-parent households who scored 19.7.

4.4 Indigenous families[16]

From a total cohort of 1,730 families, 368 (21 per cent) contained a study child who has been identified as Indigenous. This figure is slightly lower than the overall proportion of 25 per cent Indigenous families on the program, suggesting that Indigenous families are slightly less likely to complete a Family Survey. No significant differences were seen between household types of Indigenous and non-Indigenous families. The majority of Indigenous study children were living in lone-mother households (60 per cent), as were the majority of non-Indigenous study children (55 per cent). Two parent households account for a little more than a third of Indigenous (36 per cent) and non-Indigenous families (40 per cent). The mother was the primary carer in the overwhelming majority of families (94 per cent for both Indigenous and non-Indigenous), with no significant differences in the primary carers of Indigenous and non-Indigenous children.

There were some differences, however, regarding the size of Indigenous families and the age of children, in comparison with non-Indigenous families. Indigenous families were more likely to be larger than non-Indigenous families with 2.6 the average number of children for Indigenous families, and 2.3 the average for non-Indigenous families. Almost one quarter of Indigenous families (23 per cent) had four or more children, whereas this was the case in only 16 per cent of non-Indigenous families. Indigenous families were also more likely to have younger children living within the home, with a significantly larger proportion of Indigenous families having a child aged less than 12 months (38 per cent versus 30 per cent). The average age of Indigenous children in the program was 2.8 years, whilst for non-Indigenous it was 3.3 years. The sample of Indigenous children contained more boys (55 per cent) than girls (45 per cent) – a pattern that was evident in the broader cohort.

There were also differences in the socio-economic characteristics of Indigenous and non-Indigenous families. Indigenous children were more likely to be living within a family where the mother does not work (85 per cent Indigenous versus 78 per cent non-Indigenous), and were far more likely to have a father that does not work (69 per cent Indigenous and 45 per cent non-Indigenous). This proportion of unemployed fathers is very high, especially when one considers the unemployment rate for working age men in New South Wales was 6.2 per cent in December 2009 (ABS, 2009a). Consistent with these findings, Indigenous families had a lower income level than non-Indigenous families. The income level was less than $999 per fortnight for 53 per cent of Indigenous families, but only for 44 per cent of non-Indigenous families[17]. Only 8 per cent of Indigenous families listed incomes greater than $1,400 per fortnight, whereas 19 per cent of non-Indigenous families had incomes at this

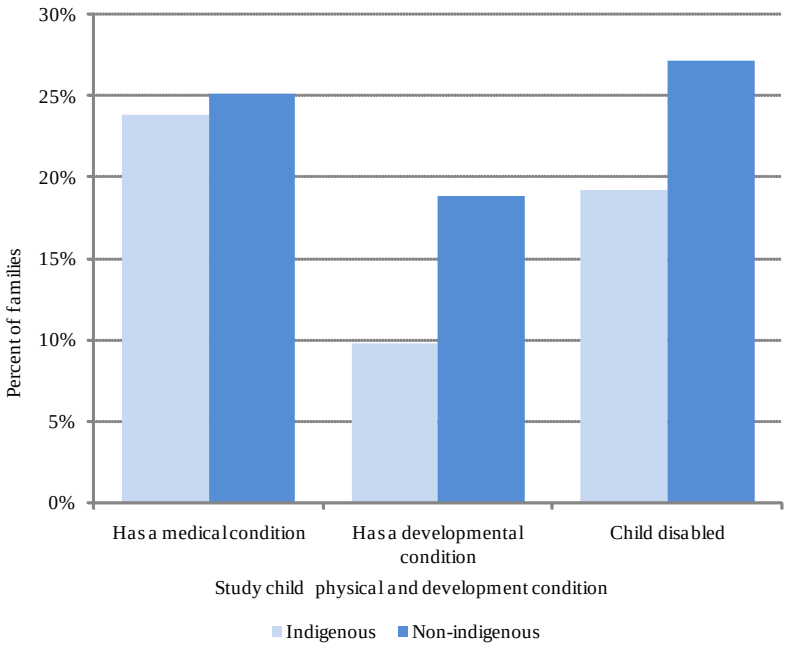
[16] Indigenous families are defined in this chapter as a family in which the study child is identified as Indigenous.

[17] Income level was not known for 16 per cent of Indigenous families and 11 per cent of non-Indigenous families.

higher level. Government benefits were the main source of income for a significantly higher proportion of Indigenous families (89 per cent Indigenous and 70 per cent for non-Indigenous families). Correspondingly, a significantly smaller proportion of Indigenous families listed paid work as the main source of their income (8 per cent Indigenous and 27 per cent non-Indigenous).

There were some significant differences regarding the health status of Indigenous and non-Indigenous parents and children. A significant proportion of both parent groups self-reported their health to be either poor or fair (25 per cent Indigenous and 30 per cent non-Indigenous), however, a significantly higher proportion of Indigenous parents than non-Indigenous parents, reported themselves to be in excellent health (14 per cent Indigenous and 7 per cent non-Indigenous). Both figures are significantly lower than the national average of around 56 per cent of individuals aged 15 years and over who stated that their health was very good to excellent (ABS, 2009c). A similar pattern of difference was reflected in the parent reports of their child's health, with more Indigenous parents reporting their child to be in excellent health (48 per cent Indigenous and 43 per cent non-Indigenous). As Figure 4.5 shows, a significantly lower proportion of Indigenous children were reported to have a developmental condition (10 per cent Indigenous and 19 per cent non-Indigenous), and a disability (19 per cent Indigenous and 27 per cent non-Indigenous).

Figure 4.5: Child health and behaviour by Indigenous status



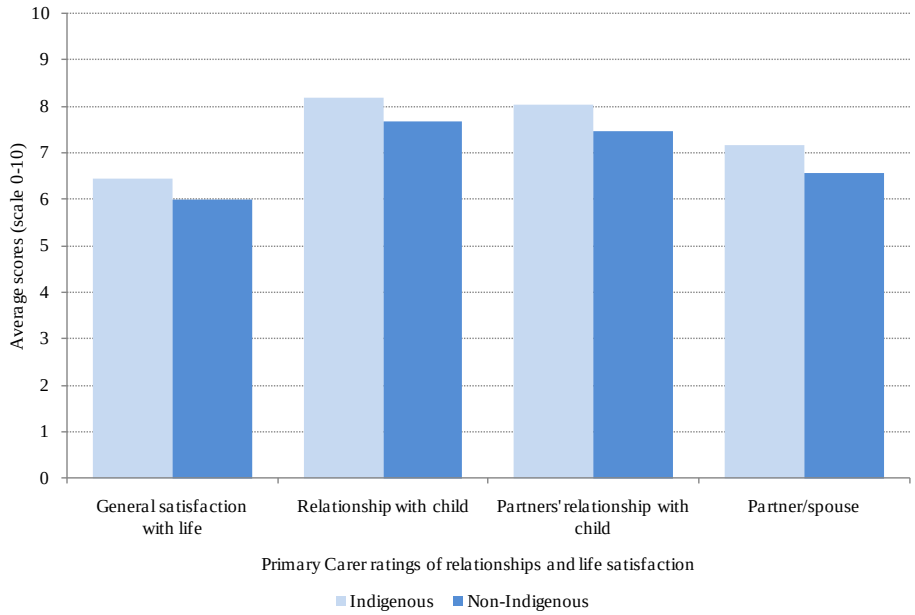
There were no significant differences between Indigenous and non-Indigenous children in two parent report measures (Eyberg and BITSEA Problem Scale) of child social and emotional behaviour and ability. Indigenous families reported an average score of 124.1 on the Eyberg scale compared to 126.9 for non-Indigenous children. Both these scores are within the normal range and no significant difference was noted between the two group's scores. There was also no significant difference found between Indigenous and non-Indigenous children on the BITSEA Problem Scale. The average score for Indigenous families was 45.8 and for non-Indigenous families it was 44.8, indicating some evidence of problem behaviours in both groups. There was a small yet significant difference between average raw scores on

the BITSEA Competency scale. Indigenous parents reported higher levels of pro-social behaviours with the average raw score of 27.5 compared to non-Indigenous families who had an average score of 26.4 ($p<.05$). Both these scores show high levels of social and emotional competence.

There were no significant differences between the disability status and the alcohol consumption of both Indigenous and non-Indigenous parents. Indigenous parents were, however, more likely to smoke cigarettes with almost one third of Indigenous parents smoking and only one quarter of non-Indigenous parents (31 per cent versus 24 per cent). There were significant differences between the exercise undertaken by Indigenous and non-Indigenous parents, with 78 per cent of Indigenous parents reporting that they engage in moderate or vigorous exercise at least once per week in comparison to only 70 per cent of non-Indigenous parents. Both of these figures are much higher than the national average of around 40 per cent of adults aged 15-54 years who engage in exercise (ABS, 2009c). Considering the low levels of employment and income amongst program families, it may be that these families do not own a car and therefore walk more often to carry out essential activities like shopping or accompanying children to school.

Some interesting distinctions are evident in measures of carer wellbeing. Indigenous parents self-reported higher average levels of satisfaction with their life in general, and with their relationship with their child and partner than non-Indigenous parents, as Figure 4.6 shows. There were significant differences in each of these measures.

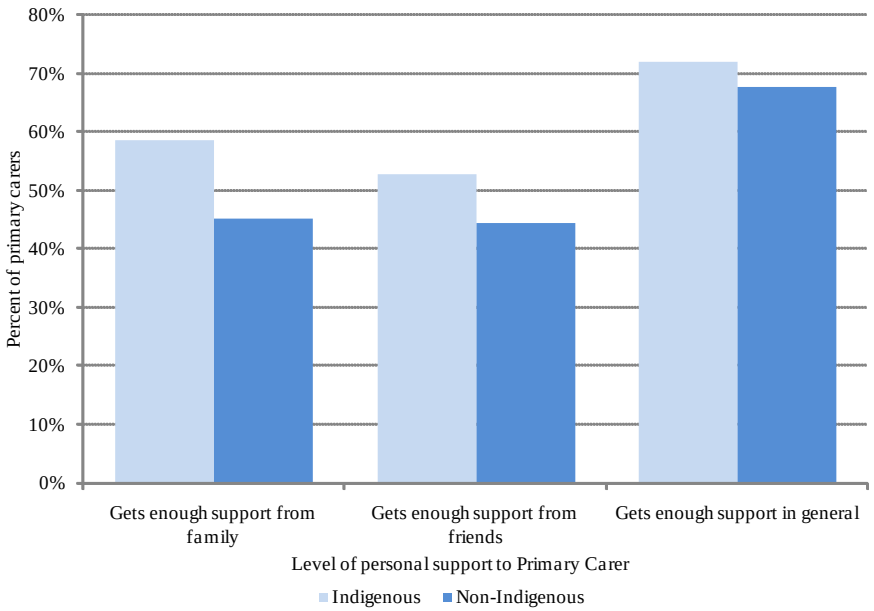
Figure 4.6: Primary carer relationship satisfaction by Indigenous status



There were also significant differences in the amount of support that Indigenous and non-Indigenous parents received from their families, with 59 per cent of Indigenous parents reporting that they receive enough support, in comparison to only 45 per cent of non-Indigenous families. Similarly, a significantly higher proportion of Indigenous parents reported that they get enough support from their friends than non-Indigenous parents (53 per cent Indigenous and 45 per cent non-Indigenous) (see Figure 4.7). Examined together, these results may suggest that Indigenous families are more socially connected within their communities. This may be consistent with a generally more positive outlook reflected in

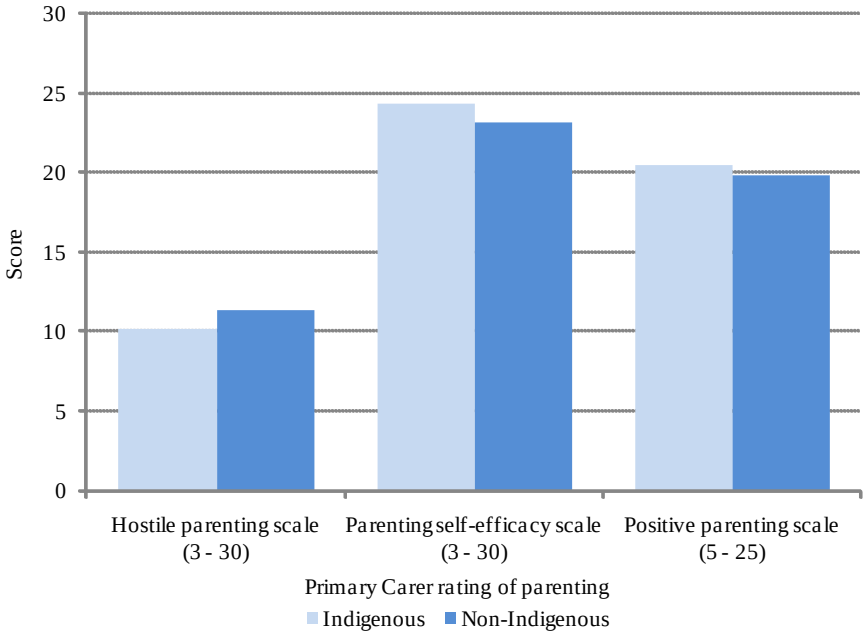
higher satisfaction with life scores, however, these results could also indicate that Indigenous families are concerned about child removal and so are misrepresenting their situation within the Family Survey. The Aboriginal Families Study, which will be reported on in the final evaluation report will inform further consideration of these issues. Finally, there was no significant difference between the self esteem scores of Indigenous and non-Indigenous parents.

Figure 4.7: Carer satisfaction with support by Indigenous status



In the self-rating measure of parenting ability, there was little difference between Indigenous and non-Indigenous parents, with both groups overwhelmingly rating themselves as either above average or average parents (88 per cent for both groups); however, there were differences in other measures. In the self-rated measure of hostile parenting, Indigenous families scored on average 10.2 which is relatively low. There is a significant difference ($p<.01$) between this score and the 11.4 averaged by non-Indigenous families. These scores indicate that Indigenous parents report less hostile parenting behaviours towards their children than non-Indigenous parents. A significant difference was also observed in the measure of parental self-efficacy. Indigenous families had an average score of 24.4 which was significantly different ($p<.001$) to that of non-Indigenous families who scored an average of 23.2. In the measure of positive parenting, Indigenous parents reported more positive parenting behaviours with an average score of 20.5 in comparison to 19.9 ($p < .01$). Although both of these scores are relatively high, Indigenous parents reported more positive behaviours towards their children (see Figure 4.8). Finally, in the measure of parental warmth there was no significant difference between Indigenous and non-Indigenous families. The Aboriginal Families Study (AFS) which is currently being undertaken in partnership between Community Services and the Social Policy Research Centre will explore these issues in more depth through interviews with families. Preliminary data from the AFS will be included in the final Brighter Futures report, which is due for release in September this year.

Figure 4.8: Parenting scales by Indigenous status



4.5 Discussion

The information presented above builds upon the picture of families in the Brighter Futures program. Analysis indicates that the families accessing program supports and services are disadvantaged on a number of measures. The majority of families are lone-mother households, with the mother either unemployed or engaged in full time parenting. Given the low level of labour force participation amongst program families, it is not surprising that the majority of families rely upon government benefits for their income and consequently have low income levels. Primary carers generally have poor educational outcomes with the majority not completing secondary school (Year 12 or equivalent). A substantial proportion of families lack the support of family and friends – indicating a high incidence of social isolation, and many families include a child displaying some behavioural problems and/or with a medical condition, developmental condition (such as autism and global developmental delay) or a disability.

Despite the presence of multiple risk factors for child abuse and neglect within families, the mixed results may also show evidence of resilience. Parents generally rate their own health and the health of their child as good or excellent, they rate their own ability as a parent highly, and they score highly in measures of positive parenting, parental warmth, and parental self-efficacy, and low in measures of parental hostility. There are a number of factors which could contribute to these results. Such factors include parental concern over the child protection context in which surveys are completed, thereby resulting in families over-estimating their parenting skills. Alternatively, some scales used within the Family Survey may not accurately measure parenting behaviour. The positive findings may also reflect the rapid improvement of families when they first enter the program – as evidenced in much of the qualitative data presented in chapter 7. As explained by caseworkers during data collection for the evaluation, it is likely that the Family Survey cohort contains an over-representation of families who have initially responded well to program supports and services, and it also appears that families still in crisis when entering the program were less likely to be interviewed at program entry. The positive results in parenting outcome measures

may therefore reflect parent's initial and rapid improvement in outlook after receiving long-needed supports and services[18] rather than any substantive improvement or change in parenting ability. These factors along with further exploration of the upward bias that may have contributed to these findings[19] will be considered when analysing the change of families over time.

Also of interest and needing to be interpreted with caution are the high average parental ratings. It is unclear whether these high ratings provide an accurate measure of parenting ability or if they reflect a relative score in relation to primary carers' own circumstances. It is interesting to note however that almost 10 per cent of the Family Survey cohort rated their parenting as below average and these families were much more likely to have reports associated with neglect.

It is worth noting that despite these possible reasons for clients' scoring positively in measures of positive parenting, parental warmth, parental self-efficacy and parental hostility, caution still needs to be taken when interpreting these results. Only a few items are used to make up each scale and more analysis will be undertaken accounting for these factors when analysing change over time.

Notwithstanding these caveats, an interesting finding regarding these initial measures is that Indigenous families - who appear most vulnerable in certain measures (e.g. income, employment, reports) rate themselves more highly than non-Indigenous families in subjective parenting measures, life satisfaction and satisfaction with support received from family and friends.

Finally, descriptive analysis of Family Survey data indicates that there is little difference between the families being case-managed by Community Services and those being managed by Lead Agencies. The demographic profile of both family groups is very similar; and there are no significant differences in their socio-economic characteristics, or in the scores for measures of carer wellbeing and parenting. There was a small but significant difference on one child measure of social and emotional development with children from Lead Agency managed families scoring slightly higher on the BITSEA (child 1-2 years) measure, indicating greater social competence. Further interpretation of these results needs to be treated with caution as they may relate to a number of factors such as the insensitivity of the measures used within the Family Survey. The following chapter builds upon the picture of program families outlined here, by presenting an analysis of the risk of harm reports of client children prior to their entry into the program.

(See Appendix C: Additional Brighter Futures Family Tables for more detailed tables on the Family Survey).

[18] Analysis of report history of children prior to entry into Brighter Futures indicates that on average families are known to DoCS for more than 20 months prior to entry into the program.

[19] Such as social desirability bias which in this case is defined as the tendency of parents being surveyed to give answers they perceive to be correct.

5 Reports Analysis: An analysis of risk of harm reports prior to entry to the Brighter Futures program

5.1 Introduction

This chapter explores various elements of risk of harm report history for children prior to entering the Brighter Futures program. The chapter incorporates administrative data and information from the Family Survey into multivariate modelling to determine the characteristics of reports prior to entry after accounting for selected parental measurement, demographic and administrative indicators. This chapter provides a foundation for the analysis of change in reporting patterns that is discussed in the following chapter.

5.2 Multivariate cross-sectional analysis of risk of harm reports prior to entry onto Brighter Futures

Changes in the number of reports before and after the program constitute a central element of the evaluation and so it is important to consider in more detail some of the factors associated with risk of harm reports. In a review of literature on child neglect, Watson et al (2005) highlighted poverty, larger families, and single parenthood as key socio-demographic characteristics of carer neglect. In addition, carers (mothers) with mental health concerns, lack of social support and drug issues are likely to be more associated with carer neglect.

Previous research exploring associations with the total number of risk of harm reports (irrespective of issue) at the level of Local Government Areas (LGAs) has shown that Indigenous status is positively associated with the number of risk of harm reports. This is also the case for lone parenthood, unemployment of both parents and the proportion of individuals in the area with no educational qualifications (NSW Department of Community Services, 2007). This echoes findings by Watson et al (2005) with respect to socioeconomic factors, but it does not shed any light on other factors associated with the carer and the child. In addition, it does not specifically consider reported issues.

The quintile analysis presented in chapter 3 above shows that the length of time that a child is known to Community Services on average increases the number of reports for that child, and at face value there are significant differences between the types of reports received by children known to Community Services and Lead Agencies for different time points, as well as differences between Indigenous and non-Indigenous children. In what follows, we extend our understanding of the factors associated with risk of harm reports using a cross-sectional multivariate analysis of reports differentiating by reported issues.

The statistical model

In this analysis, risk of harm reports are counted for each child according to report type, which means that there are a large number of zero values in the data. This means that specialised statistical models - count regression techniques - should be utilised in order to best represent the information. The method used in this analysis is the Negative Binomial

Regression Model (NBRM)[20] which is recommended in the literature for this type of analysis (see for example Cameron & Trevedi, 1998; Long, 1997).

The results below can be interpreted as the likelihood of change in an outcome, given certain factors. For this particular analysis it means that the outcomes reported reflect the likelihood of a change in the number of reports received of a certain type given certain demographic and parental characteristics that are detailed below.

The sample

Data for this analysis have been obtained from the Reports File and have been combined with indicators and measures from the Family Survey. Due to the lower numbers of survey respondents, the final sample for this analysis is 1,353 children.

In order to ensure that the sample is sufficiently representative of families in the program, an analysis of reports comparing the analysis sample to all children was conducted[21]. It showed that children in the analysis sample average a lower number of reports than the overall sample of children with a least one report prior to the program, however, the differences are not substantial. The largest difference relates to reports of neglect in the analysis sample. It would appear that families where children are reported for neglect were less likely to respond to the Family Survey. It is important to bear this in mind when considering the results for reports of neglect.

The independent variables

The primary independent variables in this analysis are Community Service management and child Indigenous status. These both take the form of 1/0 values, where 1=yes and 0=no.

Table 30 shows the factors controlled for by the model in addition to the main independent variables (see Watson et al, 2005).

[20] There are other options, but this represents a good first approach. Further analysis may explore other options. More information is included in Appendix E: Discussion of Statistical Model and Sample about the choice of model.

[21] A full description of this is included in Appendix E: Discussion of Statistical Model and Sample.

Table 30: Control factors for model

Item description	Variable included in model	Values in variable
Administrative characteristics	Managed by Community Services	1=yes, 0=no
Socio demographic characteristics		
Highest qualification of anyone in household	Year 12 certificate	1=yes, 0=no
	Tertiary	1=yes, 0=no
Net fortnightly income	Income $1,400 or more per fortnight	1=yes, 0=no
	Income not known	1=yes, 0=no
Parental employment	At least one parent employed	1=yes, 0=no
	Employment status not known	1=yes, 0=no
Household type	Lone-mother household	1=yes, 0=no
	Lone father household	1=yes, 0=no
Number of children 0 – 17 years	Two children 0 - 17 years	1=yes, 0=no
	Three or more children 0 - 17 years	1=yes, 0=no
Primary Carer characteristics		
Parenting self-rating	Average parent (relative score)	1=yes, 0=no
	Below average parent (relative score)	1=yes, 0=no
	Parental rating not known	1=yes, 0=no
Self-esteem scale	Raw self esteem score	Score 0-30
Parental hostility	Top quintile parental hostility score (relatively hostile)	1=yes, 0=no
	Parental hostility score not known	1=yes, 0=no
Child Characteristics	Indigenous	1=yes, 0=no
	Boy	1=yes, 0=no
	Child disabled	1=yes, 0=no
	Child disability not known	1=yes, 0=no
	Child age	

Appendix E: Discussion of Statistical Model and Sample includes a descriptive table outlining the proportions of each element in the sample as well as additional information about sample characteristics. It shows that characteristics of children in the analysis sample are very similar to those in the overall Family Survey sample.

Results

The output of the full regression model is reported in Appendix E: Discussion of Statistical Model and Sample. In the discussion of the results, only significant results will be presented, in addition to the two primary items of interest which are management type and family Indigenous status. Raw output from the NBRM is difficult to interpret and has been transformed to provide the percentage change in the expected count arising from a unit change in the covariates. This is reported below together with the Estimated negative binomial regression coefficients and associated level of statistical significance (*p*). Full and abridged tables for this section are available in Appendix E: Discussion of Statistical Model and Sample.

Reports of carer drug/alcohol abuse

The results for Indigenous status and case management are reported in Table 31 together with significant results for reports of carer drug and alcohol abuse. As shown, Indigenous children are significantly more likely to be reported for this issue, with a percentage change in their expected count of around 47 per cent. This confirms the descriptive analysis in chapter 3, and previous research (Smoothy & Butler, 2007). There is no significant difference between

reports of carer drug/alcohol issues between those managed by Community Services and those managed by Lead Agencies.

Reports of carer drug and alcohol abuse are negatively associated with higher levels of education and income in the family, and for children living in families where at least one parent is in paid employment. With respect to income, the expected mean count for reports in this category is predicted to decline by about 53 per cent for children living in relatively high income households. Examined together, these results show that children from lower socioeconomic groups are more likely to be the subjects of reports relating to carer drug and alcohol issues.

Table 31: Multivariate results for number of reports of carer drug/alcohol abuse prior to entry onto the Brighter Futures program[22] [23]

	Estimated negative binomial regression coefficients	% change in expected count	Sig
Indigenous	0.39	47.0	*
Managed by Community Services	0.25	27.8	NS
Other significant factors			
Tertiary	-1.01	-63.6	**
High income family	-0.75	-52.8	**
At least one parent employed	-0.62	-46.3	**
Lone-father household	1.73	464.0	***
Child's age	-0.28	-24.5	***

Notes: *** p< .001; ** p< .01; * p< .05; NS = Not Significant

Children in lone-father households are significantly more likely to be reported for carer drug and alcohol issues. This is a strong association, but the number of children in this group is small and so it is difficult to draw substantial meaning from this result. Finally, older children are less likely to be reported for carer drug and alcohol issues.

Reports of carer mental health issues

Indigenous children are significantly less likely to be reported for carer mental health issues, while those managed by Community Services are significantly more likely to be reported for carer mental health issues (see Table 32). The model predicts that the expected count for Indigenous children is 38 per cent lower than for non-Indigenous children, while for those managed by Community Services it is about 54 per cent higher than for those not managed by this agency.

Of the socio-demographic characteristics, having at least one primary caregiver in employment is significantly associated with fewer reports of carer mental health issues. There is a strong negative association between larger numbers of children in the family and reports

[22] Note that in this section the key indicators of child Indigenous status and management type are presented in all tables to indicate any changes between Indigenous and non-Indigenous children and between children managed by CS and LA's. Where results are non significant, there is no difference between these groups.

[23] Full and abridged output for this section is available in Appendix E: Discussion of Statistical Model and Sample

of carer mental health issues. Higher levels of carer self-esteem are negatively associated with reports of carer mental health issues. The self-esteem score is a continuous variable so it is possible to compute the percentage change in the expected count for a standard deviation increase in self-esteem score. The model predicts a 15 per cent decline in reports of carer mental health for a standard deviation increase in the self-esteem score. This is not surprising, as it is to be expected that the self-esteem and mental health of carers is closely related.

Table 32: Multivariate results for number of reports of carer mental health issues prior to entry onto the Brighter Futures Program

	Estimated negative binomial regression coefficients	% change in expected count	Sig
Indigenous	-0.48	-38.0	**
Managed by Community Services	0.43	54.1	***
Other significant factors			
At least one parent employed	-0.59	-44.7	***
2 children 0 - 17 years	-0.31	-26.8	**
3 or more children 0 - 17 years	-0.48	-38.4	**
Self-esteem score	-0.03	-15.3[a]	**
Lone-father household	1.10	199.5	***
Child age	-0.37	-30.9	***

Notes: *** p< .001; ** p< .01; * p< .05; NS = Not Significant,
[a] Percentage change for a standard deviation increase in the self-esteem score.

As with reports of carer drug and alcohol issues, reports of carer mental health issues are positively associated with lone-father households, and negatively associated with a child's age.

Reports of domestic violence

The descriptive analysis presented in chapter 2 showed that Indigenous children averaged significantly more reports of domestic violence than non-Indigenous children. Results from the multivariate analysis of reports of domestic violence (reported in Table 33) confirm this finding.

Other significant results contained in Table 33 show that children in families with a higher income are less likely to have reports of domestic violence, as are children living in a family where at least one primary caregiver is in paid employment. Children living in lone-parent households (whether headed by a mother or a father) are significantly more likely to be reported for domestic violence. This shows a clear connection between reports of domestic violence and family breakdown. In addition to this, children in larger families are significantly less likely to be reported for domestic violence suggesting that smaller (and perhaps younger) families are more likely to be reported for domestic violence. This is supported by a negative relationship between reports of domestic violence and child age. Finally, children who are disabled are significantly less likely to be reported for domestic violence.

Table 33: Multivariate results for number of reports of domestic violence prior to entry onto the Brighter Futures Program

	Estimated negative binomial regression coefficients	% change in expected count	*Sig*
Indigenous	0.23	25.3	*
Managed by Community Services	0.40	49.9	***
Other significant factors			
High income family	-0.46	-37	**
At least one parent employed	-0.25	-21.8	*
Lone-mother household	0.33	38.7	**
Lone-father household	1.03	179	***
Three or more children 0 - 17 years	-0.35	-29.5	**
Child disabled	-0.21	-19.3	*
Child age	-0.26	-23.2	***

Notes: *** p< .001; ** p< .01; * p< .05; NS = Not Significant

Reports of abuse: physical, emotional and sexual

Reports for physical, emotional and sexual abuse are presented below in Table 34,

Table 35 and Table 36 respectively. For all types of abuse, there is no significant difference between Indigenous and non-Indigenous children, and between children managed by Community Services and Lead Agencies. Children in lone-mother households are significantly less likely to be reported for physical abuse, while children in lone-father households are significantly more likely to be reported for all types of abuse. Once again, however, this is a small group of children and so caution should be exercised in interpreting this finding.

Table 34: Multivariate results for number of reports of physical abuse prior to entry onto the Brighter Futures Program

	Estimated negative binomial regression coefficients	% change in expected count	*Sig.*
Indigenous	-0.01	-0.7	NS
Managed by Community Services	0.13	14.1	NS
Other significant factors			
Lone-mother household	-0.31	-26.6	*
Lone-father household	1.63	410.5	***
At least one parent employed	-0.71	-50.8	***
High level of hostile parenting	0.32	37.2	*
Child age	-0.19	-17.4	***

Notes: *** p< .001; ** p< .01; * p< .05; NS = Not Significant

Parental employment is a significant factor predicting fewer reports of physical and emotional abuse. In the case of physical abuse, the model predicts a 50 per cent decline in reports for children in families where at least one parent is in paid employment, while the comparable figure in the model for emotional abuse is around 52 per cent. Children in households where parents score relatively highly on the hostile parenting scale are more

likely to be reported for physical abuse. The model predicts a 37 per cent increase in the expect count for children in these families.

Older children are significantly less likely to be reported for physical and emotional abuse, but more likely to be reported for sexual abuse. In addition, boys are less likely to be reported for sexual abuse.

Table 35: Multivariate results for number of reports of emotional abuse prior to entry onto the Brighter Futures Program

	Estimated negative binomial regression coefficients	% change in expected count	Sig.
Indigenous	-0.29	-25.5	NS
Managed by Community Services	0.13	13.8	NS
Other significant factors			
Lone-father household	1.51	351.4	***
At least one parent employed	-0.73	-51.9	**
Child age	-0.11	-10.1	*

Notes: *** p< .001; ** p< .01; * p< .05; NS = Not Significant

Table 36: Multivariate results for number of reports of sexual abuse prior to entry onto the Brighter Futures Program

	Estimated negative binomial regression coefficients	% change in expected count	Sig.
Indigenous	0.41	50.1	NS
Managed by Community Services	-0.04	-4.3	NS
Other significant factors			
Y12 Certificate	-0.89	-58.9	*
Lone-father household	1.96	612.5	*
Boy	-0.69	-50	*
Child age	0.19	20.6	*

Notes: *** p< .001; ** p< .01; * p< .05; NS = Not Significant

Reports of neglect

In the multivariate analysis, there is no significant difference in reports of neglect for Indigenous children compared with non-Indigenous children (see Table 37). Children managed by Community Services are significantly more likely to be reported for neglect than those managed by Lead Agencies.

There is a strong negative relationship between higher socioeconomic status and reports of neglect. This is illustrated by the results for children in households where at least one person has a tertiary qualification, higher income, and/or where at least one parent is in paid work.

Children whose parent (in most cases the mother) rate themselves as a below average parent are significantly more likely to be reported for neglect prior to entry into the program. The model predicts that the expected count for these children will be 85 per cent higher than for children with a parent who regards themselves as above average, which is the majority of

parents (see Table 37). As above, children in lone-father households are more likely to be reported for neglect, while older children are less likely to be reported for neglect.

Table 37: Multivariate NBRM results for number of reports of neglect prior to entry onto the Brighter Futures Program

	Estimated negative binomial regression coefficients	% change in expected count	Sig.
Indigenous	0.18	20.1	NS
Managed by Community Services	0.43	53.6	**
Other significant factors			
Tertiary	-0.42	-34.3	**
High income family	-0.73	-51.6	**
At least one parent employed	-0.43	-34.7	*
Below average self-rating as parent	0.62	85	**
Lone-father household	1.44	320	***
Child age	-0.29	-25.5	***

Notes: *** p< .001; ** p< .01; * p< .05; NS = Not Significant

5.3 Discussion

This chapter has provided a multivariate cross-sectional analysis of children's risk of harm reports prior to entering the Brighter Futures program. The analysis draws on multiple variables associated with risk of harm reports such as Indigenous status, socio-economic characteristics of the family, and family structure (e.g. lone-mother, lone-father or two-parent household), and differentiates by reported issues. Some results need to be interpreted with caution due to the small numbers involved.

Findings from this analysis extend understanding of factors associated with risk of harm reports. Results indicate that Indigenous children are significantly more likely than non-Indigenous children to be reported for carer drug and alcohol abuse. Similarly, children from families with low income levels and where no parent is in paid employment are also more likely to be reported for carer drug and alcohol issues. Indigenous children are also significantly more likely to be reported for domestic violence, as are children living in lone-parent households. Indeed, the analysis confirms a strong negative correlation between higher socioeconomic status and reports of neglect, drug and alcohol misuse, and domestic violence.

In relation to abuse, children in lone-mother households are significantly less likely to be reported for physical abuse and children in lone-father households are significantly more likely to be reported for all types of abuse. Older children are significantly less likely to be reported for physical and emotional abuse but more likely to be reported for sexual abuse. Finally, there is a strong negative relationship between higher socio-economic status and reports of neglect. Children managed by Community Services are significantly more likely to be reported for neglect than those managed by Lead Agencies.

6 Analysing change over time

This chapter reports both preliminary analysis of the change in patterns of reporting over time, and then moves to an analysis of the change over time seen in the Family Survey cohort. It shows positive trends for all children including significant reductions in reports in the first year after exiting, as well as a positive early trend in child behaviour scores for study children from the Family Survey.

The following section details the change over time in reporting patterns for children that have left the program. As the method and sample section outline, a number of factors add complexity to the analysis and these have been accounted for when considering the changes in reports. Even after considering these factors, on the whole there is a general positive trend towards fewer reports for children after exiting Brighter Futures.

6.1 Analysing change over time in risk of harm reports

This section contains an analysis of risk of harm reports for children before and after their participation in the Brighter Futures program. There are a number of important points to consider prior to conducting such an analysis and these will be discussed first.

Method

As described in chapter 3, children varied greatly in the time they were known to Community Services prior to entering the program. In order to determine the change in numbers of reports after families have exited the program, the following analysis provides comparisons of reports one year after exiting the program with reports prior to entering Brighter Futures.

There are two steps taken in order to group the children and reports for this analysis: determining the observation period prior to entry, and determining the length of time since children exited the program. The start date of the observation period is generally a child's date of birth or the earliest available report observed in the MDS, 1st July 2002, whichever is later. This means that all children will either have an observation period of their date of birth until program start, or 1st July 2002 until program start. The following diagram illustrates the point:

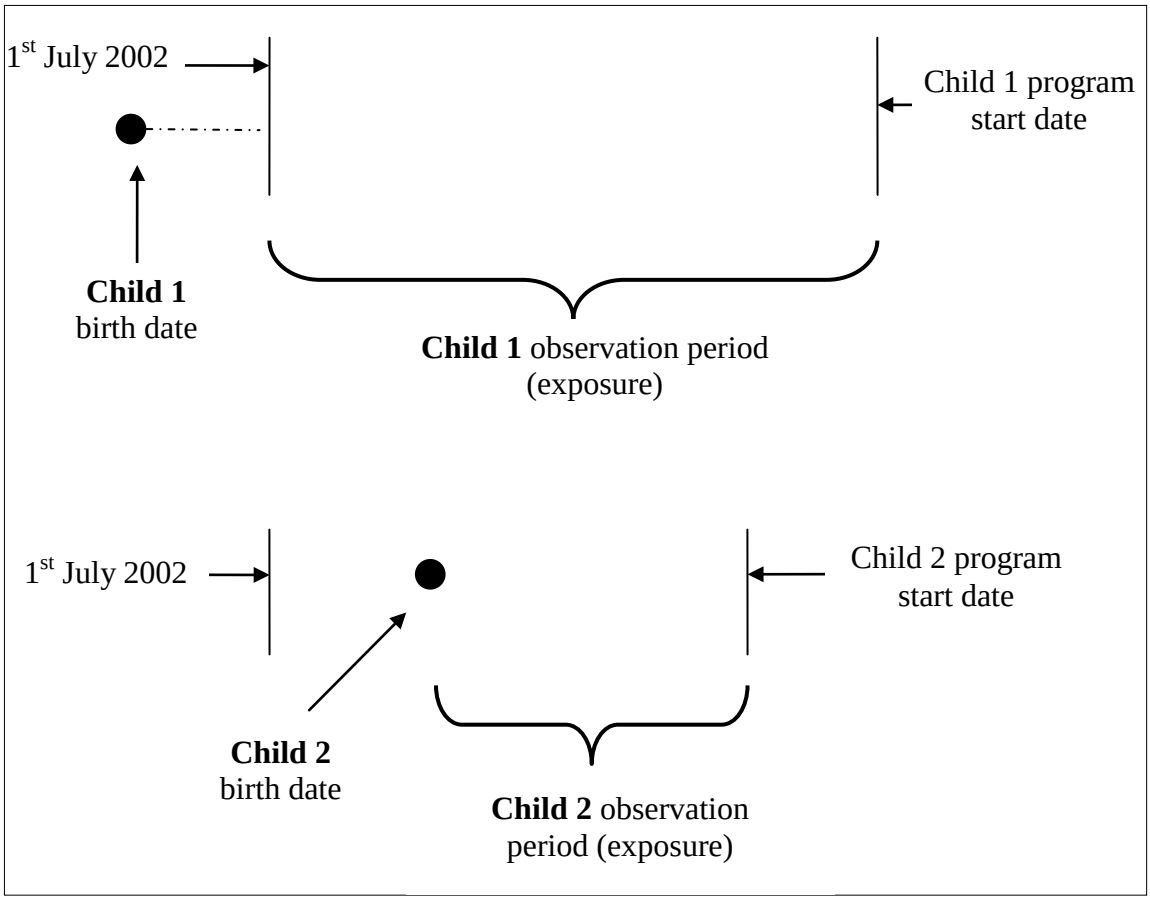


Figure 13 Defining the period of observation (exposure) prior to entry onto the Brighter Futures program

In most instances, we can only observe reports prior to entry onto the program for those children born before their family started the program. An important exception to this relates to children who have been the subject of a pre natal report. These reports will be included in the following analysis providing the child was born before their family started the program. Children who were born after their family started the program, and children who have never been the subject of a report are excluded from this preliminary analysis. We will reconsider these children in future analyses.

An important further point to consider relates to children born before their family entered the program, but who are aged less than one year when their family started the program. For these children, the observation period prior to the program is less than one year and so calculating average reports per year based on this small observation period is likely to lead to some extreme values for certain children, particularly those who are only a few months old (or younger) but who have been the subject of a relatively large number of reports (with perhaps a number of pre-natal reports). It is known that there is a spike in reports for very young children and therefore, with a view to limiting the impact of this on results, the total number of reports for these children is used in the period prior to the program. In other words, we take the total number of reports for children less than one year as a measure of the average per year for these children.

After conducting sensitivity analysis with these children excluded and included, it was shown that while the results are different, the substantive conclusions are unchanged so these children are included in the sample.

Once the observation period has been defined for each child, the next step is to compare reports before and after the program using the same units. This analysis will primarily focus on reports received in the first year after children exited the program. Given the design of this analysis, the sample for the comparison 12 months after the program must be restricted to children whose families have left the program at least 12 months – the sample for this group is 2,221 children. As the sample of children who exited the program more than two years ago is very low (N=224), this analysis will focus on the children who have exited the program for more than one year and future analysis will include the latter group as their numbers will have increased.

The approach adopted therefore is to average reports per child across a 12 month period prior to entry onto the program. We should stress that this design represents an initial step in considering the extent to which risk of harm reports are affected by engagement in the Brighter Futures program. A control group is necessary to properly assess whether the program is effective in reducing risk of harm reports. However, it is also important to recognise that the available data can be exploited in more nuanced ways that will be developed in future analyses.

Comparing total reports before the program with reports in the first 12 months after the program

We begin by looking at all reports in total. Table 38 below compares average reports in the first 12 months after the program with average reports in the 12 months prior to entering the program. The first thing to note is that there is a significant decrease when reports prior are compared with reports in the 12 months after the program.

Table 38: Comparison of reports prior to and 12 months post intervention

	Average reports over 12 months prior	Average reports 12 months after program
All children in sample	2.34	1.58***

Notes: *** P < .001; ** P < .01; * P < .05; NS = Not Significant, N=2221

This pattern of a significant reduction in average reports holds true in a comparison of Indigenous and non-Indigenous children. Table 39 replicates Table 38 for Indigenous and non-Indigenous children separately. The results indicate both Indigenous and non-Indigenous children experience an increase in reports in the year prior to program entry and that average report numbers significantly reduce in the year after exit.

Table 39: Comparison of average reports before and 12 months after Brighter Futures for Indigenous and non-Indigenous children

	Average reports over 12 months prior	Average reports 12 months after program
Indigenous	2.80	2.07***
Non-Indigenous	2.23	1.46***

Notes: *** P < .001; ** P < .01; * P < .05; NS = Not Significant
Indigenous N=458, non-Indigenous N=1763

Table 40: Comparison of average reports before and 12 months after Brighter Futures by management type of child

	Average reports over 12 months prior	Average reports 12 months after program
Lead Agency managed	1.91	1.46***
Community Services managed	2.80	1.71***

Notes: *** P < .001; ** P < .01; * P < .05; NS = Not Significant
Lead Agency managed N=1139, Community Services managed N=1082

In the 12 month period before starting the program, children managed by Lead Agencies averaged around 1.9 reports compared with 2.8 reports for children managed by Community Services. As reported in section 3.5 above, children managed by Community Services averaged more reports and were more likely to be known to Community Services for a shorter period of time. This circumstance is clearly reflected here, and results in a marked decrease between reports before and after the program. In the 12 month period after exiting the program, children managed by Lead Agencies averaged 1.46 reports and children managed by Community Services averaged 1.71 reports (see Table 40). The decrease in reports for children managed by Lead Agencies is not as large.

Comparing reports before the program with reports in the first 12 months after the program: specific reported issues

In this section we examine changes in reports for different primary reported issues. As above, we examine reports in the categories of carer drug and alcohol issues, carer mental health issues, domestic violence, abuse and neglect. A breakdown of categories within each reported issue is available in Appendix C: Additional Brighter Futures Family Tables.

In a repeat of the pattern evident above, there is a decrease in average report numbers when reports 12 months prior to program entry and compared with reports 12 months following program exit. This pattern is consistent across most reported issues as illustrated in Table 4 below. Reports of abuse present an exception to this pattern.

Table 41: Comparison of average reports before and 12 months after Brighter Futures by reported issue

	Average reports over 12 months prior	Average reports 12 months after program
Drug and alcohol	0.25	0.17***
Mental health	0.37	0.18***
Domestic violence	0.68	0.32***
Abuse	0.42	0.46 NS
Neglect	0.41	0.29***

Notes: *** P < .001; ** P < .01; * P < .05; NS = Not Significant

Reports related to drug and alcohol misuse, mental health issues, domestic violence and neglect show a significant decrease when average report numbers accumulated in the first 12 months following program exit are compared with reports 12 months prior to program entry. Reports related to domestic violence are highest overall prior to program entry, and so the decline is sharper here than all other reported issues. This result suggests that the program is particularly successful with families who were reported for domestic violence. The main anomaly within Table 41 is the result for reports of abuse. As shown, reports for abuse trend upwards, however, the increase is not significant.

6.2 Child behaviour change over time

This section presents preliminary findings of the Family Survey data analysed over time. As outlined previously, the survey method required caseworkers to offer a survey upon entering the program (defined as within two months of allocating a case management start date), then six months following the first survey, and finally upon exiting the program. In practice, the surveys returned have wide variability in the timing points that the surveys were collected, also as Chapter 4 detailed, some surveys were completed on different study children so were unable to be utilised in a comparison of child outcomes over time. An additional complication has been lower than expected rates of return for T2 and T3 surveys. Given these factors, the primary analysis has been based on the most reliable scale within the survey – that is, the scale with the largest number of respondents for either a T2 (mid-term) or T3 (exit) survey. For this report, it is the Eyberg Child Behaviour Inventory (ECBI).

The ECBI is designed as a behavioural rating scale of externalising or conduct-disordered problems in children aged 2 to 16 years. As Appendix A: Summary of instruments and items utilised in the Family Survey describes, each of the 36 questions is scaled between 1 and 7 where higher scores indicate greater intensity of problem behaviours (Eyberg and Pincus, 1999)[24] so the overall ECBI raw scores range between 36 and 252. The cut off score for problematic behaviour in this scale is the equivalent of a raw score of 131, although for this analysis we are simply comparing general change over time and not whether each individual child is above or below the clinically significant range. There will be opportunity to explore other methods in further analysis.

[24] Eyberg, S., and Pincus, D. (1999). Eyberg Child Behavior Inventory & Sutter-Eyberg Student Behavior Inventory - Revised. Psychological Assessment Resources, Odessa, FL: Psychological Assessment Resources.

Method

The preliminary model chosen for this analysis is a random intercepts longitudinal regression which allows the observations to vary within the individual and the intercepts to vary between individuals. In this analysis, a score is derived by entering available ECBI scores to determine the intercept and slope for each observation.

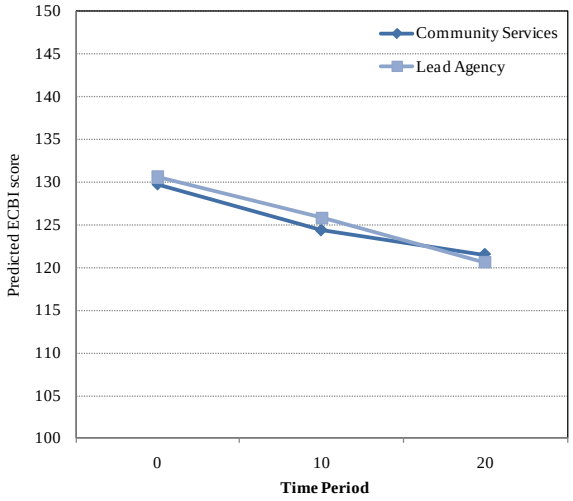
As the time that surveys were returned varied between individuals, the observations were grouped into categories of 0 (T1), then two further groups (10, 20) based on the number of months between the first survey and the subsequent or last survey. This means that the first survey returned was categorised as 0, then a second survey was categorised in the 10 or 20 group depending on how many months elapsed since the first survey was returned. If a subsequent survey was returned, the same method was employed taking the gap between surveys two and three into consideration.

For this descriptive analysis, a comparison between selected primary carer and study child characteristics and a general indication of the direction of the score trend is shown. The sample numbers for T2 and T3 are very low, so these descriptions are an introduction to the observed patterns and need to be repeated on a larger cohort in order for inference to be made.

Results

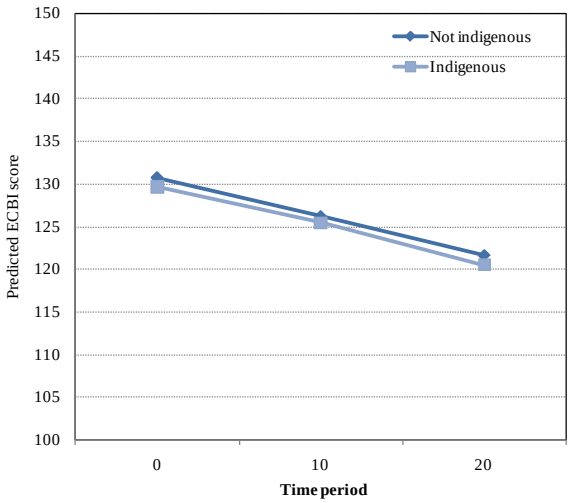
The initial findings below indicate that there is a downward change over time across all groups included in the analysis. As Figure 6.2 shows, Community Services and Lead Agency study children both show a reduction in problematic child behaviour scores, although Community Services children appear to have slightly less of a decline in scores between the mid and final points than Lead Agency children.

Figure 6.2: Change in scores of problematic child behaviours over time for Community Services and Lead Agency study children



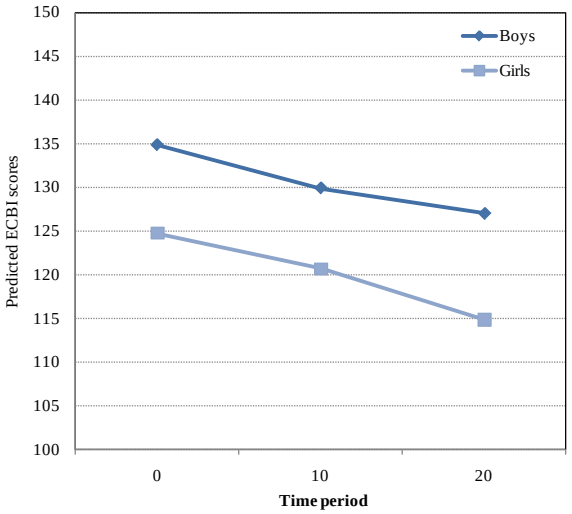
The same can be said of Indigenous and non-Indigenous children, both on average starting below the clinical cut-off score and reducing problematic child behaviours over time. As Figure 6.3 shows, both Indigenous and non-Indigenous children start at very similar points and follow a similar trajectory over time, so it appears that there are no differences between problematic child behaviours of Indigenous and non-Indigenous children.

Figure 6.3: Change in scores of problematic child behaviours over time for Indigenous and non-Indigenous children



Looking to study child gender, there is a clear difference in the amount of problematic behaviours between boys and girls at the first time point, as Figure 6.4 shows. Over time, both groups decrease – that is, problematic behaviour scores are improving – although boys appear to have a slower rate of decline between the midpoint and last scores.

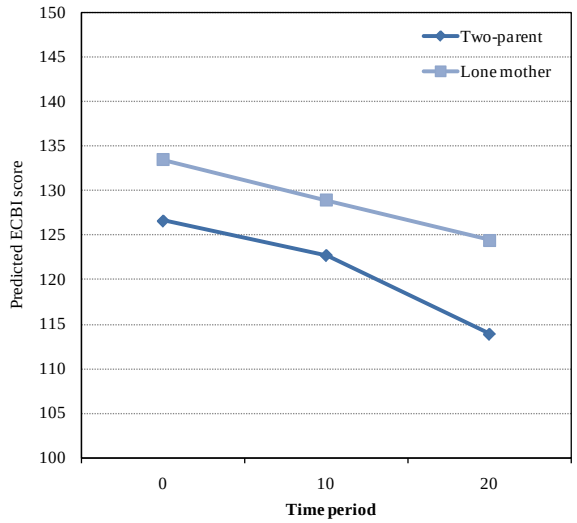
Figure 6.4: Change in scores of problematic child behaviours over time between gender of study child



The household type that study children reside in also shows differing scores. Children residing in lone-mother households are starting with more problematic behaviours than children in two parent households. Children in both household types are experiencing an improvement in behaviour scores over time. Children from lone-mother households are starting with scores just above the clinical cut-off rate and are showing a steady improvement in scores over time.

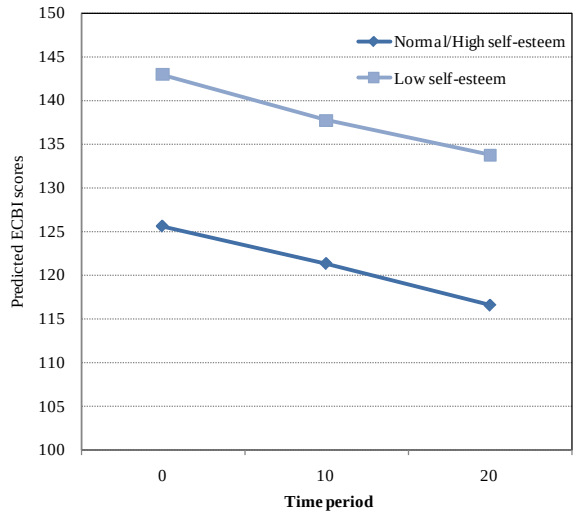
As Figure 6.5 shows, children from two-parent households appear to have a sharper improvement in problematic behaviour scores between the mid and end points than children from lone mother households.

Figure 6.5: Change in scores of problematic child behaviours over time between study children in lone mother and two parent households



Finally, scores from the Rosenberg Self Esteem scale were incorporated into the modelling. Figure 6.6 shows that children of parents with relatively low self esteem started at a point substantially above the clinical cut off score of 131, however these children improved over time. Improvement can also be seen in the children whose parents were in the normal or high self esteem ranges, however by the end point, there is still a large gap in problem behaviours between these groups.

Figure 6.6: Change in scores of problematic child behaviours over time between study children of parents with normal or high self esteem and low self esteem



6.3 Discussion

The comparative analysis of risk of harm reports for children before and after their participation in the Brighter Futures program highlights several key findings. Interpretation around these findings has been limited as further analysis is required – and will be provided in the final evaluation report, due for release in September 2010.

The first result is that there is a clear downward trend when reports for all issues are combined and examined together. This pattern is consistent across both comparison points (12 months prior and 12 months post; and 24 months prior and 24 months post). The difference in reports prior with reports in the first year after program exit is significant.

Reports for most specific issues follow this downward pattern - there is a significant decrease when comparing reports at 12 months prior to the program with average report numbers 12 months after exit. The decline in average report numbers pre and post the program is greatest for reports of domestic violence, suggesting that the program is most successfully addressing the needs of these families.

The clearest anomalous finding presented above relates to reports of abuse which trend upwards. There is a small but not significant increase in reports of abuse comparing 12 months prior to 12 months post. These findings need to be analysed further to determine contributing characteristics and to gain a deeper understanding of the pattern of reporting, however, the preliminary analysis is encouraging.

This chapter also provided an overview of the change in child behaviour scores. The analysis shows positive changes over time, but analysis is still preliminary. The analysis has shown that all children have improved in child behaviour scores, most with a steady decline in raw scores over time. The exceptions to this are children from Community Services' families and children from two parent households who appear to have marginally slower rates of improvement over time.

Additional findings include the large differences between problematic behaviour scores of boys and girls, with boys averaging considerably higher scores than girls. Large differences can also be observed between children living in two-parent and lone-mother households, as well as children whose parents have low self esteem compared to parents with higher self esteem.

Finally, it is worth reiterating that the sample numbers for these scores are very low and more analysis needs to be carried out with a larger cohort in order to further explore the observed differences. Further analysis will be provided in the final evaluation report to confirm these findings and to provide an analysis of change within the full context of the Brighter Futures program and the report histories of participant children.

7 The Intensive Outcomes Study

The aim of the Intensive Outcomes Study (IOS) is to explore in-depth the outcomes of a small sample of families involved in the Brighter Futures program. Specifically, it examines the extent to which the child's language, social/emotional and cognitive development; parenting practices; and family functioning have changed whilst on the program. This chapter provides a summary of IOS families' outcomes as described through the IOS survey and interview schedule. This report analyses T1 data collected from families within their first 10 months of engaging in Brighter Futures. While this is the first point of data collection for the IOS cohort, it is not baseline data – that is, at the time of interview many families had already started receiving services. As would be expected some early changes in outcome domains are already evident and therefore data is described in this context. Analysis of the quantitative data indicates that after being engaged in Brighter Futures, IOS families are generally doing well on average. While change over time can only be established by comparison with T2 and T3 data (presented in the final report due for release in September 2010), a story of early change is emerging through the triangulation of quantitative data with interview data.

7.1 Profiling IOS families with Family Survey data

The first round of data collection (T1) was undertaken with a sample of 125 families. In this chapter, we profile this group of families. This preliminary descriptive analysis helps to inform consideration of the representativeness of this subset of program families. Unfortunately, this consideration is hampered by the fact that demographic information on this sample is limited to a smaller subset of 63 families and only about half of the IOS families (i.e. 63) had completed a Family Survey[25], which provides demographic information. This introductory profiling chapter is therefore based on a subset of 63 families that had completed a Family Survey and an IOS survey and interview.

Single parents accounted for around half of the families – a proportion that is consistent with the 56 per cent of lone-mother households in the Family Survey sample, and the majority of these primary caregivers were not in paid employment but rather full-time parents (70 per cent). This figure is lower than the 80 per cent of mothers who identified as either full time parents or unemployed in the Family Survey sample. Only a small proportion of primary carers in the IOS sample were employed in part-time (5 per cent) or casual employment (3 per cent). Consistent with these findings, government benefits was the main source of income for the overwhelming majority of families (75 per cent) – a figure that is almost replicated in the Family Survey sample (74 per cent). Just over half of the IOS families had not completed Year 12, with the majority (54 per cent) having a highest education level of Year 9, 10 or 11. Again, these proportions are similar to those in the Family Survey sample.

Looking more closely at the primary carers themselves, 64 per cent were aged 30 years or less. However, on the whole the IOS sample is not characterised by young motherhood with a primary carer mean age of 29 years. Nearly all of the primary caregivers were female (97 per cent) and just under 15 per cent identified as Indigenous. This proportion is lower than the 21 per cent of families who identified as Indigenous in the Family Survey sample. Some primary

[25] Completion of a Family Survey was one of the requirements for recruitment into the IOS sample; however, caseworkers may have allowed some families who had not completed a Family Survey to be recruited into the study, with the aim of surveying their family at a later date. Therefore, the number of IOS families that have completed a Family Survey may change for T2 and T3.

caregivers identified as having a disability (11 per cent) and of those with a disability, 67 per cent reported having a psychiatric condition either on its own or in combination with other disabilities. The majority of the primary carers in the sample were born in Australia (84 per cent).

A little more than 80 per of the sample entered Brighter Futures through the Helpline pathway. The remaining 19 per cent entered through the community referral pathway. These entry pathway ratios are different to the ratios presented in chapter 4 above which shows that 65 per cent of Brighter Futures families have entered via the Helpline and 35 per cent through the community referral pathway.

Even though this report presents the first round of data, at the time of the descriptive analysis 26.6 per cent of the IOS sub-sample had exited from the program. Those that had exited the program had spent between 70 and 619 days (almost 2 years) in the program. Those currently in the program ranged from 5 months to 35 months (almost 3 years) in the program. The mean time spent on the program was 15.5 months[26].

7.2 Outcomes for Client Families

This section presents a descriptive analysis of the early outcomes for IOS T1 families within three domains: family, parent, and child. The section concludes with a discussion what this early profile might mean for the long term sustainability of outcomes. The descriptive analysis will involve two phases and draw on the IOS survey and interview data:

1. General descriptive analysis of the data; and

2. Descriptive analysis of the data according to attributes. For example, Indigenous status, income, education and vulnerabilities.

Family Functioning

Until recently, many early intervention programs emphasised child-focused interventions and outcomes. More recently, however, programs have become family-centred and researchers have been able to draw attention to a broader range of outcomes such as family functioning. This is particularly true for Brighter Futures which asserts a 'family focus' as a core principle. This means that the program seeks to meet the needs and interests of families through being flexible and responsive. This focus on the family is also reflected in the range of program services, with two of the three core services directed towards the parent, rather than the child (i.e. home visiting and parenting programs).

Like much of the data presented above, reported outcomes of family functioning are largely based on discussions with mothers, and so it needs to be remembered that other family members may view changes to family functioning differently. For IOS T1 interviews, data was coded to the 'family functioning' node in 71 source documents (with 90 references).

During interviews, many mothers described a number of stressors that negatively impacted on family functioning. Examples given included parental and/or child physical health problems or disabilities, parental mental health problems (especially maternal depression and anxiety), as well as difficulties associated with low income levels, poor quality housing,

[26] See Appendix G: Intensive Outcomes Study for a more detailed table.

being socially isolated, and being a single parent. As indicated in chapter five above, many client families interviewed deal with multiple stressors. During interviews, the majority of families indicated that the program had had a positive impact on family functioning, although eight families specifically commented that the program had made no impact on family functioning and a few more felt that it was too early to comment given their very recent engagement in the program. This latter statement reminds us that the data analysed for this report is from the first round of interviews only.

Below we discuss increased family cohesiveness, improved mental health of mothers, the development of routines, and improved communication as indicators of improved family functioning. These indicators were identified from the interview data as those of most importance to client families.

Some mothers commented on improved relationships within the family as a result of being more emotionally connected to their children:

> Before we were sort of like - we weren't really like a family. We were just caring for these kids you know and it's like you have to do things but now it's like we enjoy doing things together and we have – we have that close bond that most families should have but just don't because of conflict.

An improvement in cohesion is significant as the literature indicates that family cohesiveness is an important predictor of child outcomes. The improvement in family cohesion was attributed to a number of different reasons. One mother stated that she now participated in activities with her son and that a change in habits had helped her build a stronger relationship with him:

> I used to drop him at preschool and go and do stupid shit and just literally piss the day up the way but now I'm actually going out and doing things that I need to get done... On the days that he is with me we're going out and doing things together like a little – like a family should be doing whether its sitting here watching a movie together or going for a ride on his bike, we're out doing things.

Many families also reported that their caseworker helped them to cope with their emotional problems and that this lowered the stress level in the house, thereby improving family functioning:

> Definitely I am a happier person. My eldest daughter was going to see a psychologist because she was diagnosed with stress. It helped the stress because the mortgage increased and finance is always a stress. It gave me time out which I didn't have before the baby.

Some mothers commented that their improved mental wellbeing had a positive effect on the whole family:

> Like I said it has helped me to get back on my feet and to get confidence back and so I can put that into [my children], so then everything is running a lot smoother and happier and I have noticed with the girls they are a lot happier.

Another mother felt that the program had initially had a positive impact on communication between family members, but that problems were still a long way from being resolved – no doubt reflecting the reality for many program families dealing with multiple and entrenched issues:

> It did [help] in the beginning but the communication [problem] is still ongoing. I'm still seeing [my caseworker] and we're still going to have more issues about talking – with the communication because [my husband] screams a bit too you know, and that's with his job, he works in the gaol and I have to block my ears all the time cause it's as though I'm a criminal the way he screams.

Another set of data suggests that the establishment of family routines had strengthened family functioning:

> We went from a very dysfunctional family that wouldn't even sit at the dinner table and eat dinner together to now we sit at the dinner table, we eat dinner together. Friday night we play games together. We're spending more quality family time together than what we were before.

> I've given the kids like routines and structure, because before it was more like I just lived my life and they tagged along behind me like I didn't live my life for them. They were living for me but now it's sort of changed.

The second phase of analysis enabled the descriptive analysis of specific groups within the broader cohort using the IOS interview data.[27] This analysis revealed that single mothers were more tentative about reporting improvements in the way their family functioned as a whole. Whilst some indicated clear improvements in family functioning it was more common for this group to indicate that things were 'starting to improve'.

This descriptive analysis also highlighted the importance of efforts to improve family functioning for those families with domestic violence as their specified vulnerability. Data suggests that for women in domestic violence situations it could be a challenge to engage their partners in the program:

> It has changed how I work and how my kids work but not really my husband. He is more of a person that does whatever he wants. Like he doesn't believe in reading all these books and magazines and the papers and that - he just does whatever is in his head.

And yet, in other cases, there is evidence of families benefitting from a caseworker engaging the father directly and providing ongoing support through domestic violence episodes, alcohol abuse, and/or relationship breakdown:

> [My caseworker] has just been in touch with my partner, she's just met him – and I've been dealing with [my caseworker] for a couple of months now so it's been really good that she gets to meet [my partner] and [he] really

[27] This descriptive analysis involved the allocation of demographic and other variables using Nvivo. Examples of attributes include Indigenous and/or CALD status, income, education and vulnerabilities.

> believes that – because we've had another incident since I've been with Brighter Futures. With the police, we were involved again and [my caseworker] is helping us, like sort out our relationship problems and you know she's not really helping us sort them but she's helping point us in the right direction, where to go to seek help.

Generally, families with a history of domestic violence reported improvements in family functioning:

> Interviewer: Has Brighter Futures changed the way the whole family works?
>
> Participant: In some ways yes, in the way [my husband] and I share parenting roles and interact with the children I say it has changed and helped.

The comments presented in this section help us to better understand the impact of the program on families in the initial stages of intervention – especially caseworker support and the engagement of fathers in parenting – on family functioning. The first round of IOS interview data indicates that Brighter Futures has supported or enhanced the connectedness of family members. Improvements in maternal wellbeing, family cohesion and communication between family members, as well as the establishment of family routines have helped to strengthen family functioning. The final project report will investigate whether these initial positive changes have been sustained over time.

Parenting Practices

Research has shown that children are at greater risk of abuse when parents lack necessary parenting skills and knowledge. Through the inclusion of parenting education programs such as *Parents as Teachers* and *1-2-3 Magic* and the provision of parenting support, the Brighter Futures program aims to increase parents' knowledge of child development, and enhance parenting skills and confidence. This section provides a descriptive analysis of the parenting practices of families recently engaged in Brighter Futures. The findings presented come from measures sourced from the LSAC study which were included in the IOS survey instrument. The Parental Warmth scale was administered to all Brighter Futures parents or primary caregivers; further scales were administered dependant on the child's age. For those with children under 12 months, the Hostile Parenting scale was also administered. Children over the age of 12 months were measured on Consistent Parenting, Angry Parenting, Inductive Reasoning and Parental Monitoring scales. As above, the qualitative findings are based on the first round of IOS interviews (T1) – from textual data coded within 91 source documents (with 121 references).

The data scores indicate that parents rated themselves highly in the parental warmth domain. Six items from the parental warmth scales were used to assess affectionate behaviours, such as hugging and kissing their child. Each statement was scored between 1 and 5, with 1 = 'never/almost never' and 5 ='always/almost always'. Scores were summed together and divided by 6. The higher the score the more parental warmth is shown towards the child. In this sample (N = 125) the mean score was 4.3 (SD = 0.595). Parents reported that they often showed much affection towards their child.

The Hostile Parenting scale was administered to 21 of the 22 women in the cohort with children under 12 months One caregiver did not complete the scales as she was pregnant and

had no other children) This scale rates behaviour on a 10 point scale and includes statements like 'You have been angry with the child' and asks parents to indicate how often these events occur with 1 = 'not at all' to 10= 'all the time'. Scores were summed to obtain a score between 3 and 30, with a higher the score indicating a higher level of hostile parenting. The hostile parenting mean score for this cohort was 1.800 (SD = 0.869) with parents generally reporting low instances of hostile behaviour towards their child.

Measures of Consistent Parenting, Angry Parenting, Inductive Reasoning, and Parental Monitoring were administered to parents with children aged over 12 months of age. Five items from LSAC addressed the frequency with which parents set and enforced clear expectations and limits for their child's behaviour. For example, "When you discipline this child, how often does he/she ignore the punishment?" Items were rated from 1= 'never/almost never to 5= 'All the time'. Scores were calculated in order to obtain a mean score of between 1 and 5, with a higher score indicating more consistent parenting and the mean score for the Brighter Futures sample was 3.3.

Five questions from the survey were used to examine the frequency with which parental interactions with the child entailed behaviours such as disapproval, lack of praise, and anger. A sample item is "How often are you angry when you punish this child?" Responses were rated on 5-point Likert-type scales which ranged from 1 ="never/almost never" to 5 ="all the time". The higher the score the more the more angry parenting behaviours they exhibit. The IOS sample had a mean score of 2.61.

Parents were also asked two questions regarding inductive reasoning which involves giving explanations and reasons for actions. The two questions asked were 'How often do you explain to this child why he/she is being corrected' and 'How often do you talk it over and reason with this child when he/she misbehaves?'. Responses were rated on 5-point Likert-type scales and ranged from 1 ="never/almost never" to 5 ="all the time". The higher the score the more inductive reasoning behaviour they display. The IOS sample had a mean score of 3.9.

In general, T1 interview data suggests that in this early stage of the program there have been some rapid changes in parenting practices. This finding is consistent with much of the literature on program evaluations which generally report a moderate effect on parental practices, especially in the short term. During interviews, mothers spoke of implementing more effective behaviour management strategies, of changing their expectations, and of learning about age appropriate child behaviour and requirements. Some data provides quite startling indications of how little some mothers knew about parenting before engaging with the program and their caseworker:

> I don't really have [my daughter] in a routine. I pretty much just cater to her whenever she wants it. Whenever she wants a feed, she'll get a feed and stuff like that. I don't really know about much... [My parenting has changed] a little bit in that she's sleeping a lot more than what she used to because I didn't realise that babies needed to sleep during the day... And when [my caseworker] told me you know babies have to have two naps during the day as well, it made me realise oh gosh maybe what I've been doing lately isn't so good, so I started putting her to bed during the day and it's worked really well.

Interviews also revealed some clear examples of families engaging in dysfunctional or inappropriate parenting practices, thereby highlighting their need for education and support:

> [My caseworker] is due to come out sometime about sleeping patterns for [my son] in his own bed at night, but I am just going to say I'd rather wait because I like him [with me] as a security blanket.

This mother is suffering from an anxiety disorder after being sexually assaulted within her home and explains how she doesn't want to change the sleeping habits of her young son, as she feels safer with him sleeping every night in her bed. However, most comments indicated that parents had positively changed their parenting behaviour as a result of the program:

> I used to spoil my kids a lot – really bad, but since I have met [my caseworker] I have learnt to be more consistent and I have learnt to say no. I have learnt that if you say no, that's it. Because I used to give in, like I used to tell my son no, and then he will go in the room and cry, slam the door or something and then I would give in to him and say come on then. [My caseworker] taught me not to do that because that was the main thing I would give in to him, and she taught me if [my son] does do head banging and that, don't give him eye contact, just put him in a soft spot and leave him. And someone else from the playgroup told me the same thing. Before I used to yell a lot at my nine year old and [my caseworker] told me no, just ignore him, you say no, no is no and that is it, ignore him. So I do that now.

The above quote by one mother shows how through the program, parents are learning new strategies that enable them to more effectively respond to and manage their children's behaviour.

It was also clear from interviews that some parents' increased their knowledge about age appropriate behaviour and their own children and that this had resulted in changes to their parenting:

> Before I can't control [my daughter] and now I think she is young and I control her step by step and slow, slowly.

> The parenting course has helped me understand [my son] because he is four and still not talking properly so there are a lot of anger issues. He is quite a difficult little boy.

Some parents also spoke of how the provision of social support had made them feel better, thereby facilitating less reactive and more relaxed parenting:

> Not the way that we parent but the fact of the relationships of how you get on with [our children] because – not that we are more relaxed now but we're more at ease like in your mind because you've got support from another thing that you can access. So therefore it takes a bit of a load off your mind which just changes you. Knowing that there's help out there and whatever you're not as uptight and stressed and so therefore you parent differently because often if you've got things bottled up and whatever else you can have a short temper.

Second phase analysis indicated that there were some differences in the data when families were grouped according to specified attributes. One clear finding is that as household education levels increase, so to do the proportion of individuals reporting positive changes in parenting practices. For those households where the highest level of educational attainment was a university or other tertiary degree the likelihood of changes in parental practices was highest (9 out of 9 sources indicated an improvement in parenting practices).

In particular, this highly educated group talked about engaging their children more and about changes in their attitudes towards parenting:

> I think we look at the children in a positive way now, whereas before they were just a pain. You know whereas now they're our children, you know. They're, yep, they're beautiful kids.

> I notice it more in my children, the way I speak to my children. I notice that my kids just don't chuck tantrums as they used to. My husband and I talk things over instead of yelling things over. Yeah we sort of can take time out if we need time out which I think is a good thing. Yeah but basically my kids have just completely changed. They're so - they're just different now. I can handle them. Like four kids is a lot to handle but yeah, it just feels like I'm in control now.

Amongst lone mother families, there was a somewhat even distribution between those reporting positive changes as well as those reporting no change at all.

In general, families with a history of domestic violence reported positive changes, with a higher proportion of these families commenting that they feel less stressed, calmer, and less nervous. This may be because they were initially reported during a very stressful episode and that through the support of Brighter Futures and their caseworker, there has been a great improvement in their wellbeing. However, whilst these families report positive changes in their wellbeing, some report no changes in their parenting behaviour. This may be interpreted in the context of domestic violence where women experience a lack of wellbeing and have difficulties parenting during violent episodes but are able to return to a normal level of parenting fairly rapidly after intervention. For some women who have been experiencing domestic violence, it might not be a lack of parenting skills that is their problem but the domestic violence itself, and so when there is support after an episode or changes are made to the violent relationship this group may be able to quickly return to their normal parenting practice – and so don't report any improvement in parenting practices.

The evidence presented above highlights the need of many families for ongoing support and assistance with their parenting, as well as parents' belief that they and their children had made positive changes to their behaviour through the program.

Parental Wellbeing

The IOS survey included a Global Parental Efficacy Scale which was sourced from LSAC. This was administered to all parents[28] and the results are shown in Table 42 below.

Table 42: Global parental efficacy

	No.	%
A person who has some trouble being a parent	19	15.4
An average parent	49	39.8
A better than average parent	27	22.0
A Very Good Parent	28	22.8
Total	123	100

As shown above, nearly 40 per cent of parents in the IOS sample rated themselves as an average parent, and nearly half of the cohort stated that they were either a better than average parent, or a very good parent. Just over 15 per cent of parents admitted that they had some trouble being a parent and no parents felt that they were not a good parent.

The qualitative data analysed for this section comprised text coded from 62 source documents (with 92 references). IOS T1 interviews were conducted mostly with mothers and so this discussion is largely one of 'maternal wellbeing'. The descriptive data indicates that the supports and services that families have received on Brighter Futures have made an immediate impact on the wellbeing of most interviewees. More than a quarter of the IOS T1 cohort reported that they were feeling better – less stressed, more confident in their parenting, and better able to handle day-to-day problems. Positive improvements in parental wellbeing provide a good basis for achieving better child outcomes. As Dunst argues, support which is responsive to the needs of parents better enables them to engage in child rearing activities and routines necessary for achieving positive child outcomes (cited in Mahoney & Bella, 1998:84).

Two domains of parental wellbeing emerged from the data, with mothers generally talking about how increased social support and enhanced confidence in parenting had improved family functioning and increased their feelings of wellbeing:

> It's helped me with having someone to talk to and then when she comes back next week and it's all on paper – exactly what I said and that makes me nearly come to tears because I am finally being heard by someone.

> I feel less depressed. Even though I only see her once a fortnight it is a good hour to tell her how I am feeling and just talking about things – it does a lot of good to get it off my chest.

The frequency of such comments identifies social isolation as one of the most common problems identified during program eligibility assessment. These comments also highlight the

[28] Two pregnant clients did not complete scales as this was not appropriate

family focused nature of the program that aims to enhance the wellbeing of children by increasing the capacity of parents to care for and nurture them.

Many comments indicated that the home visits by caseworkers were viewed very positively and provided the opportunity for mothers to build close relationships with their caseworker. This is reflected in other studies such as Goskel et al (1998) which studied 35 parents who had been referred by child protection services to the Canadian program *Project Parent.* They found that improved parental well-being came primarily from the relational aspects of the intervention. 'In contrast to a focus on intervention components, parents related the helpful interventions they received to the effectiveness of intervention processes— namely, to the quality of the relationships they had with their individual family preservation workers and with service teams at the programs they attended. Parents identified that workers in effective programs used specific relational skills to recreate a nurturing family environment that fostered parent engagement and change throughout the process of intervention' (1998:91).

Mothers spoke strongly of the emotional support they received from their caseworker. Comments suggest that mothers were treated in non-stigmatizing and compassionate ways, often with caseworkers helping clients connect to the broader service system:

> I was a bit nervous, I didn't know how to approach [my caseworker]. And I was really upset with the way everything was going on. And as soon as [my caseworker] came in, like now I am happier – really more confident... I used to be really nervous and upset easy. But now if [my son] crosses the line it doesn't upset me as much.
>
> I'm a lot less stressed with my child because now I know that there are people at organisations out there that can help. My caseworker's got me in contact with people so I'm a lot less stressed. We're a lot happier.

The positive impact of increased social support was also evident on a specific group of mothers – those who identified as feeling depressed. Data suggests that there is a high level of maternal depression within participant families. During the interview, mothers were not specifically asked whether they suffered from depression or anxiety, yet 24 families volunteered this information, asserting that either they or their partner had depression or anxiety. This group reported that the program had already made a positive impact on their overall wellbeing:

> I've noticed the difference within myself, like I was a lot happier cause I've been diagnosed with postnatal depression and just being able to talk to somebody and you know – it's made things a lot easier.
>
> It's changed my life like before I couldn't even look at my kids because I would be so depressed, but now we enjoy each other's company. We spend a lot more time together. Yes, it's changed my life.

As evident in the last quote, some mothers spoke of their depression as having a negative impact on both their parenting ability and capacity. The majority of mothers indicated that they were aware of the relationship between their feelings of wellbeing and the behaviour of their children. Many felt that the reduction in their stress - as a result of increased social and emotional support, and the 'breathing space' afforded by the placement of their children in childcare services were having positive effects on their interactions with their children:

> It has helped me and I do feel more secure in having that support that I can call on. That has helped [my son's] security because if I am secure and know people are there then he is not going to feel the fear if I am upset and anxious – because he feels it too. It helps us both.

> The two days of daycare has enabled me to – it's almost like I can catch my breath... Before [daycare] it was always stress, constant stress. That's probably the biggest change is I was always stressed and I think that's probably why I feel a lot happier because I don't have that stress that I had before cause I would stress about food shopping, I would stress about the kids' homework, I would stress about all the things that I wasn't getting done, all the things that they needed that were constantly on my mind... Now I have so much hope because there's ways to get to all these problems.

During interviews, many mothers commented that they felt less stressed as a result of being on the program, and had developed greater confidence in their parenting ability:

> We'll for me they've given me a confidence boost and if you're a person like me and not very confident and you're not sure of everything you're doing. They're very good at doing that for you, helping you out and giving you a lot of strength.

> It's helped with my self esteem. It's empowered me to move forward with my life. It's helped me with my children – I guess with the 1-2-3 Magic and talking to other mothers in similar situations, how they're coping which has also helped me to have the confidence with my parenting.

This was particularly apparent in the experiences of single mothers. Overwhelmingly, the researchers noted the absence of men in households and as single parenthood compounds problems of social isolation it was not surprising that mothers showed positive changes in their sense of empowerment and efficacy:

> I definitely feel more empowered… I felt alone and they've helped out with childcare which is really – 'cause I have no family – I didn't have access to anybody just to say "look, … I need to sleep" or "I need help with this"… It's helped with my self-esteem. It's empowered me to move on with my life…it's also helped me to have confidence with parenting.

For some single mothers, their improved confidence and increased opportunities available to them through Brighter Futures was being translated into new and valuable skills:

> Well, all the things like they showed me, you know that I can do, that I am capable of doing those things, that I thought no, I could never to that. I can't do that that is too hard, I am not clever enough for that! And they would sit here and tell me, yes you can, who told you you can't…?

On the whole, Indigenous parents rarely discussed improvements in wellbeing. In one case this improvement was reported by an Indigenous participant in a single parent household:

> Yes definitely, they really helped. I told them I needed this transfer and I was suffering anxiety attacks because this neighbour spoke to me nastily. I

> had to go up 5 milligrams with my medication which I never had to necessarily do because I was coping fine. But they got the transfer after two months of being with the transfer on [street name] for a month and a half now which has really improved my condition my life.

Brighter Futures has been particularly important for culturally and linguistically diverse (CALD) families in breaking down some of the specific barriers they face in accessing services. For example, the mother below talks about accessing a group for young mums:

> It's really helped me get out, out there like when [caseworker] introduced me to the young mum's group – 'cause I was actually supposed to go before I got introduced to Brighter Futures but it's always been that first step of actually going there and which has been really difficult for me like introducing myself to people and stuff like that and getting involved in groups. It's quite hard and with [caseworker] there, it actually made it a lot easier and yeah, she really helped me feel more comfortable with going there and then I started going there by myself ...

And again there is a link between improved parental wellbeing for CALD women and improvements in the wellbeing of their children:

> Participant: In a big way, I am just doing more things, getting out more. Much happier, my son is much happier.
>
> Interviewer: And how do you think that you know, that he is happier, is that through…..?
>
> Participant: Just referring to, referring me to programmes and the playgroups and childcare for my son.

Parents in the lowest income band ($400-$599 a fortnight, net income from all sources) had only 3 reports of improvements to wellbeing out of a potential 11 families that fell within that category. Apart from infrequent reports of improvements in the lowest band, income had an unpredictable relationship with parental wellbeing. Around half to three quarters of families within the remaining brackets reported improvements in parental well being. The exception was one of the middle brackets ($1,000 - $1,999) where there was only one reference to improved parental wellbeing out of a potential 10. Education revealed a more predictable indicator of parental wellbeing - those with a university or other tertiary qualifications all reported positive improvements in wellbeing.

As evident above, the IOS T1 interviews have provided valuable data about the needs of mothers of young children – especially those mothers raising children under challenging conditions. For many mothers, high levels of isolation, depression and parenting stress typified their existence prior to engaging with the program. Whilst only T1 data has been analysed for this report, the descriptive analysis indicates that the program has had a rapid and positive effect on parental wellbeing, with mothers reporting that they feel less parenting stress, more confident in their ability to parent well, and part of an increased network from which they receive emotional and social support. Future analysis will report on whether these initial changes are sustained over the life of the intervention.

Attitudes to Community Services

All but one of the references to parent's attitudes to Community Services indicate a positively changed attitude (42 of 43 references). The single mother that indicated that her attitude had not changed stated that the stigma of receiving services from Community Services was so great that she was thinking of withdrawing from the program completely.

One quarter of families interviewed for the IOS (i.e. 33 from 125) commented on the stigma associated with Community Services as a provider of child protection services, able to intervene in the daily life of families at a statutory level. Most of these families said that initially they held the stereotyped view of Community Services as an agency only concerned with statutory intervention and the removal of children. Consequently families were often fearful during their initial contact with their caseworker and early period on the program:

> The first thing I thought was its DoCS! I don't want them to take my kids.
>
> I thought it was going to be very intrusive, because you think DoCS and then you just hear the bad stories about DoCS. And when they turned up on my doorstep I thought they were here to take away my children, like most fear, but it's been good.

Interview data indicates, however, that many of the families who were initially fearful now made a distinction between the child protection work of Community Services, and the provision of family support through Brighter Futures. These two functions of Community Services were viewed as separate from one another, rather than part of a continuum of services for vulnerable families. Despite the positive change in attitude of many families, some still commented on their fear that neighbours, friends or family would find out about their use of Community Service services. This was described as a potential source of shame and embarrassment:

> At first I was a bit worried just because 'Brighter Futures' were DoCS workers and not that I have any reason to be worried – but I sort of thought they might turn up in a car with DoCS on the side. What if people thought I was being visited by DoCS!
>
> Of course I thought – Oh people are going to think that DoCS are watching me.

As indicated above, some interviewees were concerned that friends and neighbours didn't find out that they were receiving support services from Community Services, fearing that such knowledge would lead to them being stigmatised within their community. Such stigma is problematic as it may reinforce the social isolation that many of these families are already experiencing. However, an unintended outcome of the program is that it challenges this stigma by educating clients and others about the broader role of Community Services in promoting the safety and wellbeing of children, and helping to build stronger families and communities. Indeed, it seems evident that by working with families in a voluntary capacity, Community Services workers are challenging the stereotyped view of their organisation held by many families. This highlights the role of Brighter Futures in changing peoples' view of Community Services.

Not one of the families who spoke about their initial fear of having their children removed, commented that they felt pressured to join the program. Rather, the majority commented on their positively changed attitude towards Community Services:

> I have changed a lot of people's views on DoCS. I said these guys have been great.
>
> It is a program that exposes DoCS in a different way. They are not out there to get you but there to support you and help you become a better parent.
>
> Some Aboriginals want intervention from DoCS with Brighter Futures... it is a matter of breaking down that wall with communication and let people understand they are not taking their children. They can change it slowly and have been[29].

A few clients connected this change in opinion to the development of a good relationship with their caseworker:

> [My caseworker] has been brilliant. He's really fits into my family well... I've felt comfortable talking to him about my situation, telling him about things that I haven't been proud of, what I've been struggling with. And I haven't felt like I've been judged – at first, because of where he comes from, from DoCS, that was very, very uncomfortable and it took me just a little while to sort of feel okay having him in my house.

Child Language Development

A significant proportion of families involved in IOS T1 interviews identified that their child has speech problems or language delays. Nineteen parents from total cohort of 125 mentioned that this was the case. One mother said, for example:

> I spoke to [my caseworker] because she organised to put her in a speech delay and put her on an urgent waiting list [for publicly funded speech therapy]. What worried me was my friend who is a teacher said 'I don't understand what she is saying'. It was starting to get noticeable in school. So we took her into a private centre and assessed her. Language, comprehensive, expression are the three areas that she is delayed in.

This high level of language delay amongst IOS children is further supported by findings from the Vineland Adaptive Behaviour Scale[30] which focused on children's communication skills (receptive, expressive and written). These three areas of communication have then been converted into adaptive levels.[31] The mean for the standard score was 102 (see Table 43).

[29] The impact of the program on Aboriginal families' attitudes to Community Services will be explored in greater depth through the Aboriginal Families Study. Preliminary findings from this study will be reported on in the final evaluation report, due for release in September 2010.

[30] More information about the Vineland Adaptive Behaviour Scale is included in chapter 3, evaluation methodology and design.

[31] Adaptive levels consist of either a High Adaptive level (standard score 130 and above), moderately high (115 – 129), adequate (86 – 114), moderately low (71 – 85) and low (below 70).

Table 43: Mean v-scores and ranges of scores for Brighter Futures children

Sub Scale V-Scores	No.	Mean	Range
Receptive	73	15.2	3 - 24
Expressive	73	14.7	5 - 24
Written	34	13.1	2 - 22
Standard Score	**52**	**102**	**74 - 159**

Broken down further, 67.3 per cent of children only had adequate levels of communication and a further 17.3 per cent had moderately low levels of communication. Low levels of communication supports the suggestion that many of the children involved in the Brighter Futures program have speech or language delays and therefore are not able to communicate at high or moderately high levels of communication.

It was clear from some statements that it had frequently been the family's caseworker who had initially identified delayed language development and had recommended an assessment:

> I never would've picked up [my daughter's] speech problem. Like my other kids just chinwag and they never seem to shut up but she has always been the quiet one. I thought she's just you know taking her time to speak and until our caseworker said 'look I think we need to look at [my daughter's] speech, she never would've progressed at all.

> [My caseworker] got a speech pathology assessment done for [my son]. They came to the school to do it. [My caseworker] has organised funding to pay for speech pathology ongoing. [The speech therapy] has been a bit erratic because I haven't been to a couple of appointments or his dad didn't take him to one appointment, and I forgot one, and he was sick too.... From Friday [my caseworker] is going to pick up [my son] from school early and take him.... That is weekly for the next 4 weeks.

Most of the parents that acknowledged that their child had a delay in speech development said that their child's ability in this area had improved as a result of being on the program. Parents attributed much of this improvement to their child's regular attendance at a childcare centre. In particular, improvements in language were talked about in terms of 'more talking' by the child and an increased vocabulary, through socialising with other children and participating in various activities encouraging speech:

> I saw an improvement in [my child] so I was very happy about that and he increased in his vocabulary.

> He has kids his age he can actually play with and get along with… He is really happy that he has his own room and goes to school. His speech has improved.

In addition to childcare, parents also attributed improvements in their child's language competence to accessing speech therapy services through the program. Some families interviewed were on waiting lists for publically funded therapy, however, families with

higher incomes were more likely to pay for private speech therapy, given the long waiting times for public services:

> She is on the waiting list with the public system, but it is a two year wait – and she starts school in 14 months. We get some funding through the carer's allowance which is $140 a fortnight which will cover her speech therapy.

Most families reported improved language development as a result of their child participating in childcare or speech therapy services regardless of family type and this was a consistent finding. There were some smaller differences across family vulnerabilities. Families with domestic violence, lack of social support, and inadequate supervision/parenting skills recorded as vulnerabilities on program entry were the most likely to report positive language outcomes particularly, those with children in childcare. Childcare was warmly received because it provided children with supervision, a stimulating environment (encouraging speech development) and social interaction with other children. Families with drug and alcohol issues were more likely to say that there had been no change in their child's language development.

One of the attributes examined closely was the level of education of parents to see if children with parents who had completed or were completing a university degree or other tertiary qualification showed any improvement in language development. Interestingly, all of these families reported positive outcomes in terms of language as a result of participating in the program. This suggests that improvements in child language development are not reliant on the education level of parents. Similar to other families, improvement was attributed to their child's engagement in childcare.

Cognitive Development

As mentioned in the previous section, the Vineland Adaptive Behavioural Scale showed that more than 80 per cent of children in the IOS have low or adequate levels of communication (receptive, expressive and written). Levels of communication may be linked with cognitive development. Children with low levels of communication may be delayed in cognitive development because they are not able to express themselves and communicate with others.

Of the mothers who discussed their children's cognitive development during interviews (44 from 125), the majority reported that they had noticed improvements in their child's cognitive development since starting the program. Much like the development of language, childcare was the main service that was attributed to improvements in cognitive development. Parents saw childcare as a stimulating environment which encouraged learning:

> It increases everything down there like therefore he's learning more because he's there more. He's you know increased his social because he's got more time with his peers. It's increased the way he is at home because he's not always he just laying, lying looking at the roof. So when he comes home he'll interact with more things because he's been stimulated.

Parents suggested that the social interaction provided by childcare was important for cognitive development:

> Well it's definitely opened up learning for [my daughter], because now she's at day care and she has all these other children around her, she's

> interacting and she's learnt so much since she's been there, her speech, she's so switched on. She just loves going there.

There were no differences between the different vulnerabilities in terms of single parents, families from Indigenous and CALD backgrounds, income level and education level. Parents with alcohol and drug issues provided many mixed responses regarding improvements in cognitive development. Many of the responses for this vulnerability were around behavioural changes rather than cognitive development. Some families that had experienced domestic violence reported improvements in their child's learning because the program was addressing some of the issues as a result of the child living in a household with domestic violence:

> Participant: They've dealt with their emotional and their grief that they had which has now allowed them to go back to school and to help with their learning and because I mean last year I was being called up to the school office every day for something the children had done and it had become you know a regular part of my day... So just to see that whole outcome and to see them turn what was happening in their life you know it was very negative into a positive, it wouldn't have happened without Brighter Futures.

Parents lacking in social support relied heavily on their caseworker and other workers involved in their children's lives to support them to find out about their child's cognitive development and the level at which their child should be. Nearly all were involved in some kind of childcare or school preparation program and mentioned positive outcomes.

While most families in the IOS attributed improvements in child cognitive development to attendance at childcare, it is important to recognise that this is problematic for a number of reasons. Existing knowledge about the impact of childcare on the cognitive functioning of disadvantaged children has come primarily from studies of intensive, high quality, centre-based programs, designed specifically to foster cognitive development (see for example Brooks-Gunn, 2003; Watson & Tully, 2008). Childcare provision through Brighter Futures does not meet these conditions for a number of reasons. Firstly, most children involved in the program attend an average of 2 days of childcare per week. Moreover, the centres of choice for many parents are those based locally, rather than those which provide the highest quality care. The impact of participation in childcare that is not specifically designed as an intervention is not well documented. Improved cognitive development for low and middle income children participating in 'average' Swedish daycare during the first several years of life has been reported (Andersson, 1989, 1992). The relevance of these findings to a typical childcare setting in NSW, however, is unknown.

Whilst the impact of attendance at an 'average' childcare centre for 2 days per week still needs to be determined, it is evident from interviews that many children would not be attending at all, if it were not for the recommendation and support of caseworkers – as well as the fact that the service was either wholly or largely paid for through the program:

> If it wasn't for [my caseworker] she probably wouldn't be in day care because I was very wary.... because she wasn't really talking when she got into day care and I didn't want anything to happen if she wasn't treated right. She couldn't speak to tell them what's wrong. Now she is great. She can count, knows her ABC's.

Given that the majority of parents say that they have seen an improvement in their child's cognitive development it would seem that this childcare is better than no childcare at all. Fieldwork also highlighted a number of other ways in children's readiness and capacity to learn were boosted. Examples included caseworkers regularly bringing books to families during home visits so that they could read to children (and sometimes illiterate parents); implementing the Parents as Teachers program, and buying developmental and age appropriate toys for children.

Child Social and Emotional Development

Healthy social and emotional development refers to a child's developing capacity to:

- experience, manage and express both positive and negative emotions;
- develop warm, satisfying relationships with other children and adults; and
- actively explore their environment and learn.

Social and emotional skills develop within the relationships children form with the people around them. Parents and families therefore play an enormous role in shaping a child's social and emotional development. Decades of early childhood research support the critical importance of early experiences in healthy social and emotional development. Parental hostility and distance, chaotic households, and those which are emotionally stressful because of factors such as poverty and family violence are known to be associated with an increased risk of poor developmental outcomes for children.

As many of these risk factors are evident in Brighter Futures families, many children are at risk of poor social and emotional developmental outcomes. Indeed, it was apparent from comments made by mothers during IOS T1 interviews that many children were already displaying signs of behavioural problems. Of the parents that commented on their child's social and emotional development during interviews, most reported that they had observed positive changes in their child's behaviour and social interactions with others. The three main areas discussed by parents were changes in peer relations; behaviour; and emotional regulation. The data was looked at across various attributes to see if there were any differences.

As part of the IOS survey, the Child Behaviour Checklist (CBCL)[32] was administered to the primary carer in each household to provide a measure of social and emotional development. Primary carers were asked a list of 99 items for 1 ½ to 5 years year olds and 112 items for 6 to 18 year olds. Parents were asked to identify whether each item describes their child's behaviour.[33] According to this measure, nearly half (49.4 per cent) of the children were classed as clinical – requiring referral to specific services (See Table 44).

[32] More information about the Child Behaviour Checklist (CBCL) is included in chapter 3, evaluation design and methodology.

[33] The parent/carer is required to indicate how well each item describes their child's behaviour within the past 2 months, using a three-point scale (0 = not true, 1 = somewhat or sometimes true, 2 = very true or often true).

Table 44: Child Behaviour checklist scores – social and emotional development

	No.	*Non-clinical %*	*Borderline %*	***Clinical %***	Mean CBCL t-Score
Internalising scale	88	51.1	15.9	33.0	58.1
Externalising Scale	88	44.3	12.5	43.2	61.2
Total problem score	**88**	**42.7**	**7.9**	**49.4**	**61.2**

Generally, improvements in social and emotional development were attributed by most parents to participation of their child in childcare or other similar groups such as playgroup. These services were valued because they offered children the opportunity to interact with other children but also adults other than a parent (particularly caseworkers and childcare personnel):

> [Brighter Futures] helped me get my son into daycare… Because his father is extremely violent, so he is used to clinging to me and they thought it would be a good idea for him to go so that he can start opening up - and he is opening up now.

> At [my son's] old preschool he was a loner. I'd drop him off and he'd go and sit and play with the Tonka truck and during the day he'd obviously do what the rest of the kids did but when I'd go to pick him up in the afternoon, he'd be sitting back in the same corner playing with the one Tonka truck. And at [his new] preschool he's always with someone. He's always got a little friend or someone with him and it's just so good to see. I didn't actually think he would do it. I just thought he was going to be one of those little closed people, but he's actually opened up and that was just really good.

During an interview with one mother who was agoraphobic and reported being sexually assaulted by a stranger within her home, it became apparent that her young son's attendance at a local childcare centre had opened up the world for him:

> I kept him with me for about 1 year of his life – he didn't know the world existed. He was like my security blanket. When I had him I had postnatal depression and agoraphobia. He is more sociable and outgoing now. I do struggle to get him to childcare but I know it is more separation anxiety on his part, not mine. I'm fine. I'll let him go cause I want my break. He speaks more – is still quite shy but nowhere near how he was.

For this mother, travelling the short walking distance to her son's childcare centre was a challenge, yet she felt that it was important that her son be offered opportunities to interact with peers and other adults.

Most single parents reported no improvement in their child's peer relations. This was mainly due to parents feeling that it was too early in the program to observe any changes. However, most had high hopes that they would see changes given more time on the program. This was the same for parents regardless of their education level.

The most obvious improvement was for CALD families. All 7 CALD families said that the social wellbeing of their child had improved. As previously mentioned, this was largely attributed to the participation of their children in childcare and playgroups, where they were given the opportunity to mix with others of similar age and also the opportunity to learn to trust and socialise with adults other than their parents:

> Yeah and at first she scared of seeing stranger like when she see you a bit and I'm talking like this she will cry the whole time but now she's much better.

> Especially when we were going to that young mum's group because she didn't know any other children, she you know thought that she was the only little baby in the world and going there really helped her like 'cause we'd go to the playgroup after the young mum's class and we'd there together and she'd be with all the other babies and stuff and she'd loved it.

For some families, changes in child behaviour were also attributed to parenting programs that they had completed as part of the program. It is likely that positive changes to child behaviour could be partly attributed to improved behaviour management strategies implemented by parents who were learning new skills and had a clearer understanding of age appropriate behaviour. For example, mothers talked about being more consistent in their discipline and using different techniques such as timeout rather than shouting at their children.

There were no significant differences for families based on income. A couple of parents with university or other tertiary qualifications did notice some changes in their child's behaviour as result of childcare:

> Basically my kids have just completely changed. They're, they're so, they're just like different now. I can handle them. Like four kids is a lot to handle but yeah, it just feels like I'm in control now yeah, so yeah.

Improvements in child behaviour are encouraging as there is much evidence of continuity between early behaviour problems (such as bullying peers) and later behaviour problems (e.g. Moffitt et al, 1996).

Finally, mothers spoke of their children being more in control of their emotions, and calmer and more settled. Again, mothers attributed these changes to the program:

> My son has changed a lot. He is still a rebel at some times but he is a lot more quiet and settled.

> [My children] are coming out of their shell a lot more where they're talking about their feelings a lot more. They're not doing what I did and holding it in all the time.

The quotes above suggest an improvement in some children's emotional regulation – their capacity to control their own impulses. This is important as the ability to regulate one's own behaviour, like other social and emotional skills facilitates children's readiness to learn at school.

Child Safety

Interview data provide specific examples of support provided by caseworkers that have improved child safety outcomes for client families. This may involve improving the physical safety of children within their home environment. Interviewed families gave examples of receiving financial assistance from their caseworker for the purchase of a cot, safety gate, child car restraint and/or other child safety equipment:

> They provided financial support they purchased a car seat for the baby so he is safe in the car and they helped me get some groceries because I was really low in income.

In addition, there were examples of families receiving financial assistance to buy a new heater, a new mattress for a child with a bed-wetting problem, and a "Vicks machine" (warm mist humidifier) for a young child with chronic asthma.

> It is not too much but it is more the cough happens. They also bought me a Vicks machine and I have noticed that helps a lot and I use that on her and she has that asthma puffer and all that.

In one interview the mother described how her caseworker had successfully advocated to Ageing, Disability and Home Care for funding to enable alterations to her home to make the home environment safer for her wheelchair bound daughter.

During the interviews a few client families described experiences where their caseworker had called the police to intervene in a violent incident at the home, thereby protecting the safety of client children:

> One day there was no money for the rent and I called [my caseworker] because I was stressed out. So I was talking to [my caseworker] in the corner of the room and [my partner] started to abuse me and [my caseworker] phoned the police. I stayed at a friend's house and [my partner] found me so I called [my caseworker] to find me a place that was safe. That is when I went to the refuge.

Sustainability of Outcomes

Sustainability is a key issue in early intervention research and the IOS T1 interviews provide only early indicators as to the likely sustainability of outcomes. Specifically, we explored factors that help to sustain or weaken the positive effects of the program. During interviews parents were asked what they would do if they required help after exiting the program. Of the 54 families that answered this question, 30 said that they would contact their caseworker, Community Services or their agency again. Whilst this could be viewed as a disappointing result – indicating the dependency forming nature of the services provided, or the dependence of the families on their caseworkers – it needs to be remembered that the first round of interviews were conducted with families who had been on the program less than 10 months. As the program is targeted to vulnerable families who are likely to need an intervention of approximately two years duration, it is not surprising that families are relying upon their caseworker for help at such an early stage of intervention. Planning for transitioning a family from the program occurs only when a family indicates that they are no longer dependent upon caseworker support.

> [My caseworker's] helped me so much and we haven't even really – I haven't done much counselling or anything yet but she's helped me a lot in the short space of time and as she said in six months time I'm going to be thinking even more differently. So I don't see myself having to need them after two years but yeah if I found myself in a situation I'd probably ring her straight up.

A much smaller number of parents interviewed at T1 indicated that they would use a resource sheet given to them by their caseworker to make contact with local agencies and service providers:

> I have a list of numbers she has given me of other people. So I would ring them – whoever specialised in the problem I was having.
>
> They put you into contact with these services where you can make that contact and keep that contact going. I still use the counselling services. I think it's fantastic and they are lovely.

This type of help seeking behaviour can be seen as a factor that will assist in sustaining the positive effects of the program. Another factor that contributes to sustainability of outcomes is the establishment of routines (e.g. set times for going to bed and eating dinner, and regular attendance at a childcare centre), and changes to parenting practices that prevent a family from slipping back into chaotic living and poor parenting practices. Outcomes can be viewed as sustainable if positive changes to parenting and family functioning become part of everyday family life. Data from T1 interviews indicates that many families are developing routine patterns but no conclusions can yet be drawn from this data. The final evaluation report, due for release in September 2010 will provide further commentary on this issue.

7.3 Discussion

The descriptive findings presented above are limited because the analysis incorporated only T1 data. However, despite the short time frame within which families have been in Brighter Futures, some preliminary conclusions can still be made from the data. The majority of families interviewed in the study are already reporting improvements in the key outcome domains of family functioning, parenting practices, parental wellbeing, and child development as a result of program supports and services. Given that most families interviewed for the IOS had been on the program less than 10 months, it seems clear that the program makes a significant impact in the short term.

Whilst most families interviewed indicated that there had been some positive improvements in family functioning, families experiencing domestic violence were likely to report the most improvement in this early stage of the intervention. In contrast, families dealing with multiple stressors such as low income, poor housing and social isolation were least likely to report positive changes in family functioning.

More analysis of the suitability of the program for different types of families is anticipated in the final report when data from T1 can be compared with T2 and T3. However, from T1 some initial patterns of interest are identified for further analysis. The program appears to be particularly helpful for integrating CALD families into the service network and in breaking down some of the social barriers they face in the community. While it is clear from the T1 data that this is having an impact on parental wellbeing, further analysis over time is needed

to determine if this will result in improved parenting practices and better child outcomes. While the program appears to be particularly well suited to the needs of CALD families the story is less clear for Indigenous families who rarely discussed improvements in caregiver wellbeing. More analysis is needed to investigate how this is played out over time and across the different cohorts.

8 Conclusion

This report has presented preliminary findings for the Results Evaluation of Brighter Futures. This component of the evaluation focuses on whether the program is meeting the needs and improving the outcomes of program families. The findings presented were drawn from three key outcome measures: the Family Survey; risk of harm reports; and the Intensive Outcomes Study. Examined together the findings presented offer an encouraging picture of program effect. The key messages from this report are highlighted below:

The targeted population is being effectively engaged in program supports and services. The Brighter Futures program is a secondary form of intervention that targets families who exhibit risk factors for child abuse and neglect. The descriptive analysis contained in chapters 3-5 of this report indicates that the families participating in Brighter Futures appear to fit the profile of the target population. The descriptive analysis details the vulnerability of Brighter Futures families, the large majority of whom are lone-mother families, with a history of being known to Community Services and have multiple vulnerabilities. In a significant proportion of households, the primary carer is either a fulltime mother or is not participating in employment and has poor educational outcomes. Most households rely upon government benefits as the sole source of income and consequently have low income levels. A substantial proportion of program children have a disability, a medical condition, a developmental problem, or exhibit problem behaviours. The profile of Brighter Futures families presented in this report confirms the need for a multi-component and flexible program that can meet the many and varied needs of families who are already manifesting problems or who are in crisis.

A larger proportion of community referral families than those specified in program model capacity ratios have participated in the program. These findings will be explored in more depth in the Process Evaluation, however this report showed that along with the higher numbers of community entrants participating in the program, they are also exiting in larger numbers than Helpline entrants. Adding to this picture is the finding that community entrant families who stay for more than three months, remain in the program longer on average than Helpline entrants.

Examined together the analysis indicates subtle differences between the families being case-managed by Community Services and those being managed by Lead Agencies. Family Survey data indicates that the families case-managed by different agencies are socio-economically a rather homogeneous group that self-report similarly on measures of parenting, wellbeing, and child behaviour. However, analyses of reports data indicates that children of families case-managed by Community Services average more reports and are more likely to be known to Community Services for a shorter period of time prior to program entry. Vulnerability data adds to this picture by showing that all families have vulnerabilities that place their children at risk of abuse, but that a higher proportion of families managed by Community Services are recorded as having problems related to domestic violence and parental drug and alcohol, whilst a high proportion of Lead Agency managed families are recorded as lacking in social support and as having child behaviour management problems. This suggests that a higher proportion of families managed by Community Services are dealing with more acute issues that require a more immediate intervention, whilst families managed by Lead Agencies are dealing with less acute but more entrenched issues.

Program staff have successfully engaged a significant number of Indigenous families. Almost a quarter of the families who have participated in the program during the evaluation period are Indigenous (24% of total or 1,422 families), suggesting that word of mouth about the benefits of program participation has spread in Indigenous communities. The findings presented herein show that the story of Indigenous families' experiences with the program is complex and not yet fully clear. Family Survey data indicates that Indigenous families are generally larger, younger, and more disadvantaged than non-Indigenous families (characterised by lower income levels, more likely to be unemployed, more likely to rely upon government benefits). Yet despite these difficulties, Indigenous parents rate themselves more highly than non-Indigenous parents in parenting measures, and in measures of satisfaction with life and social support. These incongruent results could be attributed to a number of factors such as a generally more positive outlook amongst Indigenous families, however, they could also relate to the efficiency of the survey scales used; and a bias inherent in self reported information provided by vulnerable families receiving early intervention in a child protection context. The reports analysis adds to this complex picture by showing that Indigenous children are known to Community Services longer than non-Indigenous children prior to entry into the program. Indigenous children also average significantly more reports relating to drug and alcohol issues; domestic violence (for children known the longest only); and neglect (again, only for children known the longest); and significantly less reports related to parental mental health problems. Finally, the change in all reports over time analysis indicates that Indigenous children have higher average numbers of reports prior to beginning the program than non-Indigenous children, but that the decline in reports post intervention is less sharp than the decline for non-Indigenous children. Still, there is a significant decline in average reports 12 months prior to program entry and average reports 12 months after program exit.

There is a clear and consistent picture of reports decreasing following families' engagement with the program. This is true for both non-Indigenous and Indigenous families and for those case-managed by Community Services and Lead Agencies. This downward trend holds true even though the reports analysis indicates that there is stark variation in the reporting profiles of client families – with some having received multiple reports over a number of years, and others having received their first report during the month before they entered the program. Our analysis of exposure quintiles accounts for this variation, and is a preliminary step in classifying families based on different patterns of reporting. In the final report we intend to progress analysis based on reporting profiles by undertaking cluster analysis.

The reports picture changes slightly when analysing specific issue reports. For most reported issues (carer drug and alcohol misuse; parental mental health; domestic violence and neglect) there is a clear downward trend – with the sharpest decline evident in reports of domestic violence, suggesting that the program is particularly successful in helping these families. Reports for abuse, however, trend upwards, although the increase is not significant.

Study children are showing an improvement in behaviour over time. The clear downward trend in ECBI scores of problem behaviours is significant, and supports what many mothers reported during interviews – that their child had settled down since beginning childcare.

Interviews with program families, many of whom had already started receiving services, suggests that the program makes a significant and positive impact on families

in the short term. The overwhelming majority of families interviewed reported improvements in the key domain areas of family functioning, parenting practices, parental wellbeing and child development. Families attributed these changes to the supports and services they received on the program.

The findings presented herein raise a number of key points requiring further analysis. In particular, these include more detailed analysis of the trend upward for reports of abuse, and further analysis of the sharp decline in reports of domestic violence. Further analysis is also required for the apparent contradiction between the vulnerabilities and report profile of Indigenous families with their positive reported levels of self esteem, mental health, and satisfaction with life and personal support which are all significantly higher than non-Indigenous families. It is worth restating however, that the results presented in this interim report need to be interpreted with caution. Further interpretation of the results presented here is difficult because a large number of confounding variables undoubtedly impact on report numbers and the measurement of program effect. Factors such as child maturation, family relocation, relationship breakdown, and even the placement of a child in out of home care could significantly impact on the number and/or type of reports received, and the impact of the program on individual families. Our analysis and interpretation of results will be enhanced with the inclusion of a comparison group in the final receipt of data which will be included in the final evaluation report.

Together, these findings point to the effectiveness of Brighter Futures in meeting the needs and improving the outcomes for program families. The picture described in this report is encouraging but caution around further interpretation is required. More analysis needs to be undertaken on risk of harm reports and on Family Survey data – and greater survey numbers collected at T2 and T3 is required to add weight to findings for change over time. Moreover, further contextual information from the Process Evaluation needs to be incorporated into any consideration of program effectiveness. These additional features will be included in the final evaluation report which is due for release in September, 2010.

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Appendix A: Summary of instruments and items utilised in the Family Survey

(See Chapter 2)

Table A.1: Summary of instruments and items utilised in the Family Survey

Instrument Name	Description
Brief Infant Toddler Social Emotional Assessment (BITSEA)	The BITSEA is a standardised and normative 42-item screener for 1- to 3-year-old children. It contains a 31-item BITSEA problem scale which assesses social-emotional/behavioural problems such as aggression, defiance, anxiety, and withdrawal and an 11-item BITSEA competence scale which assesses social-emotional abilities such as prosocial behaviours, and compliance. Items were rated on a 3 point Likert-type scale where 1=’not true/rarely’ and 3= ‘very true/often. The total problem score (3-65) and the total competency (3-25) are then calculated for the child.
Eyberg Child Behaviour Inventory (ECBI)	This is a 36-item inventory designed to assess problem behaviours occurring in children from age 2-16 years. An example of problem behaviour would be: *Has temper tantrums*. Each behaviour is rated on a 7 point Likert-type scale and measures how often the behaviour is perceived to occur, ranging from 1= ‘*Never*’ to 7 = ‘*Always*’. For the Intensity scale, responses are summed together to give the raw score (minimum score = 36, maximum = 252). Both scales of the ECBI are continuous therefore higher scores on the scale indicate a greater level of conduct-disordered behaviour and greater impact on the parent. If a child scores over 131 (the clinical cut off score), on this scale they are considered to require clinical intervention for their behaviour difficulties.
Longitudinal Study of Australian Children (LSAC)	*Parental Self-Efficacy* Four individual items were been taken from LSAC to measure parent quality and parental self efficacy. One item measures overall parental self efficacy which was ‘overall as a parent, do you feel you are …’. with five response categories: 1=‘a very good parent’, 2=‘a better than average parent’, 3=‘an average parent’, 4=‘a person who has some trouble at being a parent’, and 5=‘not a good parent’. Three of the items measure specific parental efficacy, i.e. parent’s attitudes and beliefs about their competency as a parent. Measure range from 1 ‘Not at all how I feel’ and 10 ‘Exactly how I feel’. *Parental Warmth* Two items from the parental warmth scales were used to assess affectionate behaviours, such as hugging and kissing their child with children aged 24 months and above. Each statement was scored between 1 and 5, 1 = ‘never/almost never’ and 5 =‘always/almost always’. *Hostile Parenting* Three items were used from LSAC to measure parental hostility. Statements included for example ‘You have been angry with the child’ and were rated on a 10-point Likert-type scale of how often these events happened, 1 = ‘not at all’ to 10= ‘all the time’, Scores were summed to obtain a score between 3 and 30, the higher the score the more hostie the parenting. *Support* This was measured through administration of a single item taken from LSAC to assess ‘how often the caregiver felt they needed support or help but could not get it (excluding caseworker)’. The scale ranged from 4= ‘very often’ to -1= ‘I don’t need support’. *Attachment to family* Caregivers were asked a range of questions drawn from the LSAC to determine the relationship that the spouse/partner had with the primary carer, the relationship with their child and their spouse/partners relationship with their children. Satisfaction/dissatisfaction with these relationships was measured on a scale of 0

	='completely dissatisfied' to 10 ='completely satisfied'. Scores obtained range from 3-15.
National Longitudinal Survey of Canadian Youth (NLSCY)	Five items also measuring positive parenting were taken from the NLSCY relating to positive parent-child interaction. These items are used for children from birth – 9 years, and scores range from 1= 'never' to 5= 'many times each day' the higher overall score, the more positive parent-child interaction.
Personal Wellbeing Index (PWI)	The Personal Wellbeing Index measures subjective wellbeing, i.e. a long-lasting sense of contentment. In this instance, the satisfaction with life as a whole scale was used. The scores range from 0= 'completely dissatisfied' to 10= 'completely satisfied'.
Rosenberg Self Esteem scale (RSE)	The RSE is a measure of global self esteem; it is a 10 item Likert-type scale with statements related to overall feelings of self worth and self acceptance. Items are answered on a 4 point scale ranging from 'strongly agree' to 'strongly disagree'. A score is obtained by summing the ratings assigned to all the items after reverse scoring the positively awarded items. Scores range from 10 – 40, the higher the score the higher the self esteem. Normal range tends to be between 15 and 25.

Appendix B: Qualitative analysis – Intensive Outcomes Study

(See Chapter 2)

Qualitative data analysis is the process of making sense of your data (Merriam, 1998). It incorporates the actions of consolidating, reducing and interpreting what participants have said and done in an effort to make meaning. Understandably, this is a complex process for which there is no exact method. To this end, we have detailed the method undertaking for analysis of IOS data.

All researchers involved in the interview analysis were qualitative experts trained in the use of NVivo data analysis software. In addition, all those involved in analysing the transcripts had also participated in data collection. Initially, the research team adopted a deductive approach by translating the research questions and theoretical framework into a list of themes to establish a coding framework (Crabtree & Miller, 1998). These themes were organised around five broad codes (outcomes; program model; services; staff; family & community).

The two researchers involved in coding all transcripts then independently coded a sample of five transcripts by hand to test the suitability of the framework for working with the raw data. Alongside this process, the researchers used a more data-driven inductive approach (Boyatzis, 1998) of pattern recognition so that emerging themes were drawn out to become additional codes for analysis. The researchers then met to compare coding, review the coding framework and assess the validity of new codes emerging from the data. The coding framework was revised to better reflect the interview data, new codes were added and more detailed descriptions were added to create the code book.

Table: example from the code book

Parent code - Outcomes

Code label – Parenting practices

Code description - All data relating to changes in parenting behaviour and practices such as child behaviour management, expectations/understanding of child development and parenting style, evidence of help seeking behaviour.

All the interviews were transcribed verbatim by a professional transcription company and uploaded into NVivo version 8 as sources. The code book itself was then translated into NVivo as tree and free nodes, thereby serving as a framework for managing such a large amount of interview data.

The NVivo nodes were used to organise sections of transcripts that were related to themes laid out in the code book together in more manageable portions for systematic interpretation and analysis (Crabtree & Miller, 1999). When all the transcripts had been coded we then had access to the data relating to each theme collected in the same place so that rather than analysing each interview individually, coding the transcripts in Nvivo allowed us to analyse the data by theme. Researchers double coded sections of transcript if they related to multiple codes which allowed a series of patterns and relationships to emerge from the data, for example a very high correlation between the node for ‘satisfaction’ and the node for ‘caseworker relationship’. Nodes were divided up amongst the researchers who then wrote summaries of the patterns and themes emerging from the nodes. The research team then met

to check these summaries against one another, and against their interview notes. This again helped to establish patterns and in an iterative approach, allowed the researchers to go back into the data for coding using word searches and frequency tools.

Analysing the data as an entire set provided a picture of the overall group and revealed general patterns. However to interrogate the data further researchers needed to be able to analyse it by a range of different variables. The deeper layer of analysis was conducted by importing quantitative data from the Family Survey into Nvivo. Attributes from the quantitative data where then assigned to cases (made up of the individual transcripts). Cases were grouped into sets according to variables such as income, education, Indigenous status and vulnerability. Researchers could then run queries in Nvivo by searching the various outcome domains which had been coded into Nvivo nodes (family functioning, parental wellbeing, parenting practices, child language and cognitive development, child social and emotional development) by attribute (single parent status, Indigenous status, vulnerability, CALD status, length of time on the program, income and education). The results of these queries where then systematically analysed to identify differences in outcome across the various different sets.

Analysing the interview data using NVivo also created an audit trail so that coding could be checked and recoded for consistency and interpretations could be checked against the data to avoid researchers inadvertently basing analysis on mere impressions of the data.

Appendix C: Additional Brighter Futures Family Tables

(See Chapter 3)

Table C.2: Vulnerabilities of Indigenous and non-Indigenous families in Brighter Futures

	Indigenous families		Non-indigenous /not stated	
	No.	% Indigenous families	No.	% Non-Indigenous families
Domestic violence	827	60	2155	52
Parental drug and alcohol misuse	701	51	1496	36
Parental mental health issues	560	41	2292	55
Lack of social support	821	60	2505	60
Parents with learning difficulties/intellectual disability	150	11	345	8
Child behaviour management problems	497	36	1658	40
Lack of parenting skills/inadequate supervision	847	62	2294	55

Note: families can have multiple vulnerabilities, percentages are for families that have at least one vulnerability recorded.

Table C.3: Average length of time for families still in Brighter Futures and those who have exited

	Still in program at 24/09/2009	Exited program
Management type		
Community Services	287	278
Lead Agency	335	287
Entry Pathway		
Helpline	302	293
Community	352	268
Indigenous status of families		
Indigenous	308	245
Non-indigenous/not stated	318	295
Detailed Lead Agency breakdown		
Streamed from Helpline	320	329
Community Entrants	352	268
All families	**316**	**283**

Table C.4: Number of families that exited after less than 90 days on the program by management

	Community Services		Lead Agency	
	No.	Col %	No.	Col %
Exited after spending 90+ days on program	972	72	1310	71
Exited after <90 days on program	381	28	538	29
Total families	**1353**	**100**	**1848**	**100**

Table C.5: Number of families that exited after less than 90 days on the program by Indigenous status of families

	Indigenous		Non-Indigenous	
	N	Col %	N	Col %
Exited after spending 90+ days on program	561	72	1721	71
Exited after <90 days on program	220	28	699	29
Total families	**781**	**100**	**2420**	**100**

Table C.6: Comparison of average days in the program for all families with those who stayed longer than 90 days

	Families in BF more than 90 days	All families who exited
Management type		
Community Services	370	278
Lead Agency	393	287
Entry Pathway		
Helpline	372	293
Community	403	268
Indigenous status of families		
Indigenous	401	295
Non-indigenous/not stated	329	245
Lead Agency pathway breakdown		
Streamed from Helpline	375	329
Community entrants	403	268
All families	**383**	**283**

Table C.7 Average reports by reported issue across exposure quintiles by Indigenous status for children reported at least once prior to entering Brighter Futures

		Not Indigenous/not stated				Indigenous				Sig.
Quintile	Reported Issue	Average reports	Standard Deviation	Number of children	Total Reports	Average reports	Standard Deviation	Number of children	Total Reports	
1	Drug & Alcohol	.1	.3	1771	138	.2	.50	377	69	***
	Carer Mental Health	.5	.7	1771	855	.3	.53	377	98	***
	Domestic Violence	.3	.7	1771	598	.4	.61	377	138	NS
	Abuse	.2	.5	1771	417	.2	.45	377	65	*
	Neglect	.2	.5	1771	305	.2	.60	377	94	*
2	Drug & Alcohol	.2	.6	1762	349	.5	1.0	387	179	***
	Carer Mental Health	.6	1.0	1762	1012	.3	.60	387	101	***
	Domestic Violence	.8	1.2	1762	1341	.8	1.12	387	302	NS
	Abuse	.5	.9	1762	807	.4	.82	387	150	NS
	Neglect	.4	.8	1762	672	.4	.85	387	174	NS
3	Drug & Alcohol	.5	1.1	1664	777	.7	1.17	475	310	*
	Carer Mental Health	.7	1.3	1664	1239	.5	.98	475	225	***
	Domestic Violence	1.3	1.7	1664	2211	1.5	1.90	475	697	NS
	Abuse	.9	1.6	1664	1545	.7	1.17	475	351	*
	Neglect	.6	1.1	1664	956	.9	1.48	475	448	***
4	Drug & Alcohol	.7	1.5	1583	1055	.9	1.60	564	505	**
	Carer Mental Health	.9	1.5	1583	1352	.6	1.09	564	346	***
	Domestic Violence	1.9	2.3	1583	3015	2.3	2.49	564	1312	***
	Abuse	1.2	2.1	1583	1973	1.3	1.95	564	716	NS
	Neglect	.9	1.5	1583	1398	1.4	2.05	564	801	***
5	Drug & Alcohol	.9	1.7	1434	1295	1.2	1.91	711	837	**
	Carer Mental Health	1.2	2.1	1434	1681	.6	1.22	711	447	***
	Domestic Violence	2.5	2.8	1434	3561	3.0	3.37	711	2153	***
	Abuse	2.1	3.2	1434	2990	1.8	2.22	711	1302	NS
	Neglect	1.5	2.2	1434	2188	1.9	3.22	711	1379	**

Notes: *** p< .001; ** p< .01; * p< .05; NS = Not Significant

Table C.8 Average reports by reported issue across exposure quintiles by management type for children reported at least once prior to entering Brighter Futures

		Community Services managed				Lead Agency managed				
Quintile	Reported Issue	Average reports	Standard Deviation	Number of children	Total Reports	Average reports	Standard Deviation	Number of children	Total Reports	Sig.
1	Drug & Alcohol	.09	.34	1320	123	.10	.38	828	84	NS
	Carer Mental Health	.49	.77	1320	646	.37	.62	828	307	***
	Domestic Violence	.33	.68	1320	438	.36	.63	828	298	NS
	Abuse	.23	.49	1320	298	.22	.50	828	184	NS
	Neglect	.19	.51	1320	256	.17	.49	828	143	NS
2	Drug & Alcohol	.25	.70	1148	292	.24	.74	1001	236	NS
	Carer Mental Health	.54	.94	1148	615	.50	.87	1001	498	NS
	Domestic Violence	.86	1.25	1148	982	.66	1.08	1001	661	***
	Abuse	.41	.76	1148	467	.49	.97	1001	490	*
	Neglect	.35	.74	1148	404	.44	.89	1001	442	*
3	Drug & Alcohol	.52	1.01	934	484	.50	1.20	1205	603	NS
	Carer Mental Health	.82	1.35	934	766	.58	1.09	1205	698	***
	Domestic Violence	1.40	1.72	934	1306	1.33	1.76	1205	1602	NS
	Abuse	.96	1.52	934	896	.83	1.46	1205	1000	*
	Neglect	.66	1.19	934	619	.65	1.20	1205	785	NS
4	Drug & Alcohol	.74	1.59	970	720	.71	1.42	1177	840	NS
	Carer Mental Health	.91	1.52	970	885	.69	1.23	1177	813	***
	Domestic Violence	2.22	2.43	970	2151	1.85	2.24	1177	2176	***
	Abuse	1.28	2.29	970	1239	1.23	1.78	1177	1450	NS
	Neglect	1.14	1.92	970	1105	.93	1.47	1177	1094	**
5	Drug & Alcohol	1.10	1.80	710	781	.94	1.80	1435	1351	NS
	Carer Mental Health	.96	1.66	710	682	1.01	1.95	1435	1446	NS
	Domestic Violence	3.08	3.60	710	2185	2.46	2.69	1435	3529	***
	Abuse	2.07	3.11	710	1470	1.97	2.83	1435	2822	NS
	Neglect	2.00	3.15	710	1420	1.50	2.28	1435	2147	***

Notes: *** p< .001; ** p< .01; * p< .05; NS = Not Significant

Table C.9: Primary reported issues by type and group

Grouped Reported Issue	Ungrouped Reported Issue
Carer Issues	Alcohol abuse by carer
	Unauthorised OOHC arrangements
	Carer in prison
	Developmental disability, carer
	Drug abuse by carer
	Emotional state of carer
	Financial problems of carer
	Gambling problems of carer
	Legal guardianship issues
	Physical disability of carer
	Psychiatric disability, carer
	Suicide risk/attempt of carer
Domestic Violence	Domestic violence
	Child/n exposed to violence
	Child/n harmed intervening
Abuse	Persistent caregiver hostility
	Physical: hit, kick, strike
	Physical: other
	Physical: poisoning
	Physical: shaking baby/child
	Physical: strangle/suffocate
	Physical: throwing baby/child
	Psychological mistreatment
	Risk of physical harm/injury
	Risk of psychological harm
	Risk of sexual harm/injury
	Sexual: penetration
	Sexual: exposure pornography
	Sexual: indecent acts/molestation
	Sexual: non-physical exploitation
Neglect	Child/n left unattended in car
	Child/n or young person abandoned
	Failure to thrive, non-organic
	Inadequate clothing
	Inadequate nutrition
	Inadequate shelter or homeless
	Inadequate supervision for age
	Medical treatment not provided
Child Behaviour	Alcohol use by child or young person
	Child inappropriate sexual behaviour
	Drug use by child or young person
	Runaway child/young person
	Suicide risk for child
Other Issues	Death of child, non accident
	Death of sibling, non accident
	Hague Convention kidnapping
No Harm or Risk Issues	No harm or risk issues
No Reports	No report
Missing	Not entered

Appendix D: Additional Family Survey Tables

(See Chapter 4)

Table D. 1: Family characteristics (frequencies)

	Management		Indigenous Status		Household Type			All
	Community Services	Lead Agency	Indigenous	Non-Indigenous	Two-parent household	Lone-mother household	Other	
Total	647	1083	368	1362	678	974	78	1730
Household type								
Two-parent household	243	435	131	547	n/a	n/a	n/a	678
Lone-mother household	380	594	222	752	n/a	n/a	n/a	974
Lone-father household	16	37	8	45	n/a	n/a	n/a	53
Grandparent/other	8	17	7	18	n/a	n/a	n/a	25
Primary carer relation to child								
Mother	613	1016	347	1282	655	974	-	1629
Father	26	50	14	62	23	-	53	76
Grandparent/other	8	17	7	18	-	-	25	25
Age of youngest child in household								
less than 12 months	211	339	141	409	265	277	8	550
12 to 24 months	163	243	82	324	178	211	17	406
24 to 48 months	184	294	100	378	160	296	22	478
more than 4 years	89	207	45	251	75	190	31	296
Number of children 0 - 17 years								
One child	234	324	114	444	183	356	19	558
Two children	194	337	90	441	203	298	30	531
Three children	115	225	80	260	145	175	20	340
Four or more children	104	197	84	217	147	145	9	301
Average number of children 0 - 17 years	2.2	2.4	2.6	2.3	2.5	2.2	2.3	2.3

Table D. 2: Family characteristics (percentages)

	Management		Indigenous Status		Household Type			All
	Community Services Col %	Lead Agency Col %	Indigenous Col %	Non-Indigenous Col %	Two-parent household Col %	Lone-mother household Col %	Other Col %	Col %
Household type								
Two-parent household	59	55	36	40	n/a	n/a	n/a	39
Lone-mother household	2	3	60	55	n/a	n/a	n/a	56
Lone-father household	1	2	2	3	n/a	n/a	n/a	3
Grandparent/other	59	55	2	1	n/a	n/a	n/a	1
Primary carer relation to child								
Mother	95	94	94	94	97	100	-	94
Father	4	5	4	5	3	-	68	4
Grandparent/other	1	2	2	1	-	-	32	1
Age of youngest child in household	33	31						
less than 12 months	25	22	38	30	39	28	10	32
12 to 24 months	28	27	22	24	26	22	22	23
24 to 48 months	14	19	27	28	24	30	28	28
more than 4 years	33	31	12	18	11	20	40	17
Number of children 0 - 17 years	36	30						
One child	30	31	31	33	27	37	24	32
Two children	18	21	24	32	30	31	38	31
Three children	16	18	22	19	21	18	26	20
Four or more children	36	30	23	16	22	15	12	17

Table D. 3: Socioeconomic characteristics (frequencies)

	Management		Indigenous Status		Household Type			All
	Community Services	Lead Agency	Indigenous	Non-Indigenous	Two-parent household	Lone-mother household	Other	
Employment of Mother								
Mother does not work	525	854	312	1067	545	834	-	1379
Mother works	91	158	34	215	124	125	-	249
Not applicable	24	54	15	63	-	-	78	78
Not known	7	17	7	17	9	15	-	24
Employment of Father								
Father does not work	143	220	96	267	324	-	39	363
Father works	113	246	39	320	347	-	12	359
Not applicable	388	611	229	770	-	974	25	999
Not known	3	6	4	5	7	-	2	9
Highest qualification of anyone in household								
No Y12 Certificate	320	563	259	624	275	566	42	883
Y12 Certificate	250	402	95	557	287	337	28	652
Tertiary	71	104	12	163	107	61	7	175
Not known	6	14	2	18	9	10	1	20
Net fortnightly income								
$1,400+ per fortnight	101	191	29	263	215	69	8	292
$1,000 to $1,399 per fortnight	171	263	84	350	182	232	20	434
$600 to $999 per fortnight	204	369	138	435	136	413	24	573
Up to $599 per fortnight	97	129	57	169	51	157	18	226
Not known	74	131	60	145	94	103	8	205
Main source of income								
Paid work	135	267	31	371	319	71	12	402
Government benefits	493	783	328	948	343	876	57	1276
Other	17	27	6	38	13	23	8	44
Not known	2	6	3	5	3	4	1	8

Table D. 4: Socioeconomic characteristics (percentages)

	Management		Indigenous Status		Household Type			All
	Community Services Col %	Lead Agency Col %	Indigenous Col %	Non-Indigenous Col %	Two-parent household Col %	Lone-mother household Col %	Other Col %	Col %
Employment of Mother								
Mother does not work	81	79	85	78	80	86	80	80
Mother works	14	15	9	16	18	13	18	14
Not applicable	4	5	4	5	-	-	-	5
Not known	1	2	2	1	1	2	1	1
Employment of Father								
Father does not work	22	20	69	45	48	-	48	21
Father works	17	23	28	54	51	-	51	21
Not applicable	60	56	-	-	-	100		58
Not known	0	1	3	1	1		1	1
Highest qualification of anyone in household								
No Y12 Certificate	49	52	70	46	41	58	41	51
Y12 Certificate	39	37	26	41	42	35	42	38
Tertiary	11	10	3	12	16	6	16	10
Not known	1	1	1	1	1	1	1	1
Net fortnightly income								
$1,400+ per fortnight	16	18	8	19	32	7	32	17
$1,000 to $1,399 per fortnight	26	24	23	26	27	24	27	25
$600 to $999 per fortnight	32	34	38	32	20	42	20	33
Up to $599 per fortnight	15	12	15	12	8	16	8	13
Not known	11	12	16	11	14	11	14	12
Main source of income								
Paid work	21	25	8	27	47	7	47	23
Government benefits	76	72	89	70	51	90	51	74
Other	3	2	2	3	2	2	2	3
Not known	0	1	1	0	0	0	0	0

Table D. 5: Carer health and lifestyle (frequencies)

	Management		Indigenous Status		Household Type			All
	Community Services	Lead Agency	Indigenous	Non-Indigenous	Two-parent household	Lone-mother household	Other	
General health status								
Poor	34	77	19	92	41	62	8	111
Fair	142	249	74	317	135	239	17	391
Good	257	386	138	505	251	361	31	643
Very good	157	271	84	344	184	229	15	428
Excellent	54	92	51	95	64	76	6	146
Not known	3	8	2	9	3	7	1	11
Disability								
Not disabled	546	881	317	1110	565	801	61	1427
Disabled	72	146	35	183	94	112	12	218
Not known	29	56	16	69	19	61	5	85
Exercise								
Exercises	473	769	287	955	466	714	62	1242
No exercise	168	305	74	399	205	253	15	473
Not known	6	9	7	8	7	7	1	15
Smoking								
Does not smoke	480	801	251	1030	534	702	45	1281
Smokes	162	272	113	321	139	264	31	434
Not known	5	10	4	11	5	8	2	15
Alcohol consumption								
Does not drink alcohol	265	417	154	528	301	358	23	682
Drinks alcohol	377	658	210	825	374	607	54	1035
Not known	5	8	4	9	3	9	1	13

Table D. 6: Carer health and lifestyle (percentages)

	Management		Indigenous Status		Household Type			All
	Community Services Col %	Lead Agency Col %	Indigenous Col %	Non-Indigenous Col %	Two-parent household Col %	Lone-mother household Col %	Other Col %	Col %
General health status								
Poor	5	7	5	7	6	6	10	6
Fair	22	23	20	23	20	25	22	23
Good	40	36	38	37	37	37	40	37
Very good	24	25	23	25	27	24	19	25
Excellent	8	8	24	7	9	8	8	8
Not known	0	1	1	1	0	1	1	1
Disability								
Not disabled	84	81	86	81	83	82	78	82
Disabled	11	513	10	13	14	11	15	13
Not known	4	5	4	5	3	6	6	5
Exercise								
Exercises	73	71	78	70	69	73	79	72
No exercise	26	28	20	29	30	26	19	27
Not known	1	1	2	1	1	1	1	1
Smoking								
Does not smoke	74	74	68	76	79	72	58	74
Smokes	25	25	31	24	21	27	40	25
Not known	1	1	1	1	1	1	3	1
Alcohol consumption								
Does not drink alcohol	41	39	43	39	44	37	29	39
Drinks alcohol	58	61	57	61	55	62	69	60
Not known	1	1	1	1	0	1	1	1

Appendix E: Discussion of Statistical Model and Sample

(See Chapter 5)

The subject of the analysis is the number of risk of harm reports, which is a count variable. That is, it is a variable which can only take non-negative integer values (0, 1, 2, 3…, N). When analysing a count variable, it is appropriate to use count regression techniques rather than standard Ordinary Least Squares (OLS) regression analysis (Long, 1997). The basic count model is known as a Poisson Regression Model (PRM), but this is often problematic in practice. The main reason for this is that the PRM assumes that the mean count is equal to the variance, which is typically not the case as there are often, in practice, an excessively large number of zero values in a count variable. The result is that the variance is larger than the mean, and is usually referred to as 'overdispersed'.

One option for dealing with this is the Negative Binomial Regression Model (NBRM).[34] This model is flexible in allowing the variance to deviate from the mean, and is recommended in the literature on count regression techniques (Cameron & Trevedi, 1998; Long, 1997). This approach is adopted here and test statistics, reported along with regression output, support this choice.

Modelling count variables is similar to other limited dependent variable approaches, such as Logit, in that the quantity of interest relates to the probability of a change in a particular outcome associated with certain covariates. In this specific case, we are interested in the probability or likelihood of a change in the expected count associated with a number of covariates detailed below. The raw output from these models is unintuitive, but it is possible to compute the percentage change in the expected count associated with a unit change in the covariates that is more intuitive, and this will be reported along with other output from the analysis.

The description of risk of harm reports prior to entry onto the program highlighted that there was broad variation in the amount of time between children's first risk of harm report and their entry onto the program, and that the length of this time was positively associated with the overall number of reports prior to the program. We referred to this as exposure, which is a well acknowledged feature of count regressions analysis. We take this into account in the specification of the models by including the log of exposure (measured in days from first report to entry onto the program) and constraining the coefficient to be 1.

The data and sample

There are two sources of data for this analysis. The first is the reports file which contains information about the number of reports for subject children and subject related participants under 9 years of age at entry to the Brighter Futures program. This data is used to compute the dependent variables for the analysis. Unfortunately, information about these children is limited to a couple of key variables including, not least, Indigenous status. To make the analysis more complete, we draw on data from the family survey. As outlined above, this survey collects wide range of data on the family, the child and the carers for those in the Brighter Futures program.

[34] There are other options, but this represents a good first approach. Further analysis may explore other options.

To create the data set for the multivariate analysis, children who are the subject child in the family survey are matched children in the reports file. The main advantage of this is that we can include a number of covariates relevant to the analysis of risk of harm reports in the multivariate analysis. The cost is that children with reports who are not subject respondents in the family survey are not included in the analysis. In addition, the analysis excludes children who are not resident with their parents because some of the covariates in the model relate directly to parents and parenting (detailed below). This is a minor restriction leading to the loss of 19 cases, with a final sample of 1353 children for the multivariate analysis.

Characteristics of these children are detailed further below in the section on the independent variables included in the models. A comparison of the average number of reports for those included in the sample with all children in the reports file was conducted and the results of this are set out now in the section on the dependent variables.

The dependent variables

There are seven dependent variables relating to different types of risk of harm reports created using data in the reports file. These relate to:

1. Carer issues: drug and/or alcohol abuse
2. Carer issues: mental health
3. Domestic violence
4. Physical abuse
5. Emotional abuse
6. Sexual abuse
7. Neglect

These are the primary reported issues, and it should be noted that up to three issues can be listed on any individual risk of harm report. Therefore, a report with a primary reported issue of neglect could also involve, for example, domestic violence, or a carer mental health issue.

Table E.1 reports the mean number of reports in each of these categories for the analysis sample, and for all children in the reports file.[35] Across most reported issues, children in the analysis sample average a lower number of reports than for the overall sample of children with a least one report prior to the program. The largest difference relates to reports of neglect which are lower in the analysis sample compared with the overall sample of children. It would appear that families where children are reported for neglect was less likely to respond to the family survey. It is important to bear this in mind when considering the results for reports of neglect. Other that this, the differences are not huge. This is encouraging as it suggests that the analysis sample is broadly similar to all children in the reports file, but it important to bear in mind the differences when considering results. One final thing to note is that in all cases the variance is greater than the mean. This supports the use of the NRBM over the PRM in the analysis.

[35] Note that this number is greater than the number of children with a report prior to entry onto the program (N = 10728), but this figure includes all children as the cross-sectional multivariate includes children not reported prior to the program.

Table E.1: Average number of reports of varying types for the analysis sample, and for all children with a report prior to entry onto the Brighter Futures program

	Analysis sample (N=1353)		All children in reports file (N=13000)	
	Mean	**Variance**	**Mean**	**Variance**
Carer: drug/alcohol issues	0.42	1.46	0.43	1.35
Carer: mental health issues	0.61	1.42	0.57	1.45
Domestic violence	1.16	4.34	1.18	4.01
Physical abuse	0.41	0.95	0.44	1.15
Emotional abuse	0.19	0.41	0.23	0.46
Sexual abuse	0.09	0.38	0.12	0.43
Neglect	0.45	1.09	0.65	2.30

The independent variables

The key independent variables of interest in the multivariate analysis is a variable indicating if a child is Indigenous (yes = 1; no = 0), and a variable indicating if the child is managed by Community Services (yes = 1; no = 0). In addition the models control for a number of other factors. Following Watson (2005), key covariates of risk of harm reports can be grouped into one of three broad groups. These are socio-demographic characteristics, carer characteristics, and child characteristics. For the first group, the highest qualification of any person in the household in included. This is a categorical variable with three values: 1) no Year 12 certificate (omitted category), 2) has a Year 12 certificate, and 3) tertiary qualification. A variable indicating households with a net income of $1, 400 or more per fortnight is included (yes = 1; no = 0). A variable indicating the type of household the child is living in is included in the model. This is a categorical variable with three values. These are: 1) two-parent household (omitted category), 2) lone-mother household, and 3) lone-father household. The number of children 0 – 17 years in the family is also included in the model. This is a categorical variable with three values: 1) one child 0 – 17 (omitted category), 2) two children 0 – 17, and 3) three or more children 0 – 17 years.

A number of variables relating to the primary carer, who in the vast majority of cases is the mother, are included in the model. A categorical variable indicating how the primary carer rates themselves as a parent is included in the model. This has three values: 1) above average parent (omitted category), 2) average parent, and 3) below average parent. The model also includes a variable indicating if the child is in a household where at least one parent is in paid employment (yes = 1; no = 0). The primary carers' average raw self-esteem score as measured by the Rosenberg self-esteem scale (Rosenberg, 1986) is included in the models. This score has a range of values from 0 – 30.

A variable indicating high levels of hostile parenting is included in the model. This is measured by taking the top quintile of the distribution of scores of a three-item scale relating to hostile parenting. Higher scores indicate higher levels of hostile parenting. Scores are concentrated at the lower end of the scale, and so one approach is to rank scores and concentrate on the top quintile (Zubrick et al, 2008). It should be stressed that this is a relative measure and that those in the bottom quintile have a relatively low score in this measure.

Two further variables relating to the child are included in the model. The first is a variable indicating if the child is a boy (yes = 1; no = 0), and the second is a variable indicating if the child is disabled (yes = 1; no = 0).

Table E.2 reports descriptive information on each of the independent variables in the models and helps to provide more information on the children included in the sample. The sample is very similar to the overall sample of children in the Family Survey described in Chapter 4. Children in the analysis are slightly less likely to come from larger families. Around 26 percent of children in the analysis sample live in families with three or more children 0 – 17 years, which is lower than the overall sample proportion of 37 percent. Approximately 47 per cent of children in the analysis sample are managed by Community Services which is lower than for the Family Survey sample overall (37 per cent). This is likely related to the fact that all children managed by Community Services enter the program through the helpline (and therefore have reports), which is not always the case for families managed by lead agencies. Finally, the characteristics of children in the analysis sample are very similar to those for the overall Family Survey sample.

Table E.2: Characteristics of the sample

			N	%
Socio-demographic characteristics	Highest qual. of anyone in household	No Y12 certificate	662	48.9
		Y12 certificate	539	39.8
		Tertiary	152	11.2
	Net fortnightly income	Income less than $1,400 per fortnight	1,059	78.3
		Income $1,400 or more per fortnights	236	17.4
		Income not known	58	4.3
	Parental employment	No parent employed	890	65.8
		At least one parent employed	450	33.3
		Not known	13	1.0
	Household type	Two-parent household	537	39.7
		Lone-mother household	773	57.1
		Other	43	3.2
	Number of children 0 – 17 years	One child 0 - 17 years	497	36.7
		Two children 0 - 17 years	489	36.1
		Three or more children 0 - 17 years	367	27.1
	Family management	Managed by Lead Agency	814	60.2
		Managed by Community Services	539	39.8
Primary carer characteristics	Parenting self-rating	Above average parent	731	54.0
		Average parent	486	35.9
		Below average parent	128	9.5
		Not known	8	0.6
	Self-esteem scale	Average score	18.1	5.4
	Hostile parenting	Bottom 4 quintiles hostile score	1,110	82.0
		Top quintile hostile score	226	16.7
		Hostile score not known	17	1.3
Child characteristics	Indigenous status	Not indigenous	967	78.4
		Indigenous	266	21.6
	Gender	Girl	524	42.5
		Boy	709	57.5
	Disability	Child not disabled	891	72.3
		Child disabled	309	25.1
		Not known	33	2.7
	Age	Average age in years	2.9	2.2

Notes: N=1353

Table E. 3: Full regression output

	Carer drug/alcohol issues	Carer mental health issues	Domestic violence	Physical abuse	Emotional abuse	Sexual abuse	Neglect
Indigenous	0.39*	-0.48**	0.23*	0.07	-0.29	0.41	0.18
	(0.20)	(0.15)	(0.11)	(0.15)	(0.23)	(0.42)	(0.16)
Managed by Community Services	0.25	0.43***	0.40***	0.14	0.13	-0.04	0.43**
	(0.16)	(0.11)	(0.09)	(0.12)	(0.17)	(0.33)	(0.13)
Y12	-0.12	0.06	-0.12	-0.08	-0.06	-0.89*	-0.42**
	(0.17)	(0.12)	(0.10)	(0.13)	(0.19)	(0.38)	(0.15)
Tertiary	-1.01**	0.01	-0.28	-0.46	-0.55	0.09	-0.73**
	(0.34)	(0.19)	(0.18)	(0.24)	(0.35)	(0.57)	(0.26)
High income	-0.75**	0.14	-0.46**	0.00	0.18	-0.43	-0.18
	(0.27)	(0.16)	(0.15)	(0.18)	(0.26)	(0.53)	(0.21)
Income not known	0.31	-0.42	-0.12	-0.24	-0.30	-1.45	0.13
	(0.45)	(0.32)	(0.24)	(0.35)	(0.52)	(1.30)	(0.36)
Lone-mother	0.05	-0.17	0.33**	-0.31*	-0.07	0.43	0.01
	(0.20)	(0.13)	(0.11)	(0.15)	(0.21)	(0.44)	(0.17)
Lone-father	1.73***	1.10***	1.03***	1.63***	1.51***	1.96*	1.44***
	(0.42)	(0.30)	(0.25)	(0.29)	(0.41)	(0.79)	(0.35)
2 children 0 - 17	-0.18	-0.31*	-0.07	-0.17	0.09	0.16	-0.03
	(0.19)	(0.12)	(0.11)	(0.14)	(0.20)	(0.39)	(0.15)
3 or more children 0 - 17	-0.14	-0.48***	-0.35**	-0.32	-0.27	0.21	-0.18
	(0.21)	(0.14)	(0.12)	(0.16)	(0.23)	(0.45)	(0.18)
Average parent	0.02	-0.11	0.03	0.05	0.18	-0.47	0.19
	(0.18)	(0.12)	(0.11)	(0.14)	(0.19)	(0.38)	(0.15)
Below average parent	-0.28	0.06	-0.36	0.22	0.01	0.21	0.61**
	(0.30)	(0.19)	(0.18)	(0.21)	(0.31)	(0.54)	(0.23)
parent rating not known	-0.30	0.65	-0.39	1.63**	-0.81	-12.35	1.43
	(1.05)	(0.66)	(0.68)	(0.62)	(1.42)	(747.45)	(0.76)
At least one parent employed	-0.62**	-0.59***	-0.25*	-0.71***	-0.73**	-0.93	-0.43*
	(0.22)	(0.15)	(0.12)	(0.17)	(0.25)	(0.48)	(0.19)
Parental employment not known	-0.74	-0.00	-0.16	-0.91	0.28	-14.69	0.11
	(0.83)	(0.54)	(0.46)	(0.75)	(0.75)	(789.40)	(0.63)
Self-esteem	0.03	-0.03**	-0.00	0.02	0.02	0.03	0.00
	(0.02)	(0.01)	(0.01)	(0.01)	(0.02)	(0.03)	(0.01)
High level hostile parenting	-0.17	0.08	-0.21	0.32*	0.21	0.26	-0.12

	(0.23)	(0.14)	(0.13)	(0.16)	(0.22)	(0.44)	(0.18)
Hostile parenting not known	0.30	0.10	-0.26	0.26	1.00	-12.70	0.15
	(0.70)	(0.49)	(0.50)	(0.56)	(0.83)	(551.53)	(0.68)
Boy	-0.06	-0.03	-0.14	0.04	-0.04	-0.69*	-0.17
	(0.16)	(0.11)	(0.09)	(0.12)	(0.17)	(0.34)	(0.13)
Child disabled	-0.27	-0.02	-0.21*	0.06	-0.33	0.46	-0.16
	(0.18)	(0.12)	(0.11)	(0.14)	(0.20)	(0.36)	(0.16)
Child disability not known	-1.94*	-0.02	0.15	0.24	0.53	0.98	-0.10
	(0.88)	(0.37)	(0.32)	(0.38)	(0.49)	(0.97)	(0.45)
Child age	-0.28***	-0.37***	-0.26***	-0.19***	-0.11*	0.19*	-0.29***
	(0.04)	(0.03)	(0.02)	(0.03)	(0.04)	(0.09)	(0.03)
Intercept	-6.82***	-5.04***	-5.61***	-6.99***	-8.19***	-10.42***	-6.46***
	(0.42)	(0.29)	(0.25)	(0.33)	(0.47)	(0.90)	(0.35)
Number of obs	1353	1353	1353	1353	1353	1353	1353
LR chi2(22)	156.24	270.88	284.29	110.91	46.74	44.86	160.03
Prob > chi2	0.0000	0.0000	0.0000	0.0000	0.0016	0.0028	0.0000
Pseudo R2	0.0704	0.0846	0.0684	0.0479	0.0350	0.0712	0.0644
chibar2(01)	555.29	315.43	821.17	179.87	108.67	164.08	342.57
Prob>=chibar2	0.000	0.000	0.000	0.000	0.000	0.000	0.000

Notes: *** P < .001; ** P < .01; * P < .05; NS = Not Significant

Table E. 4: Abridged regression output

	b	*z*	*p*	% change in expected count
Drug/alcohol issues				
Indigenous	0.39	1.97	0.049	47
Managed by Community Services	0.25	1.53	0.127	27.8
Other significant factors				
Tertiary	-1.01	-2.97	0.003	-63.6
High income family	-0.75	-2.76	0.006	-52.8
Lone-father household	1.73	4.14	0.000	464
At least one parent employed	-0.62	-2.85	0.004	-46.3
Child's age	-0.28	-7.32	0.000	-24.5
Domestic Violence				
Indigenous	0.23	1.98	0.048	25.3
Managed by Community Services	0.40	4.32	0.000	49.9
Other significant factors				
Lone-mother household	0.33	2.93	0.003	38.7
Lone-father household	1.03	4.09	0.000	179
High income family	-0.46	-3.13	0.002	-37
Three or more children 0 - 17 years	-0.35	-2.83	0.005	-29.5
At least one parent employed	-0.25	-1.97	0.049	-21.8
Child disabled	-0.21	-2.00	0.046	-19.3
Child age	-0.26	-11.94	0.000	-23.2
Neglect				
Indigenous	0.18	1.13	0.257	20.1
Managed by Community Services	0.43	3.20	0.001	53.6
Other significant factors				
Tertiary	-0.42	-2.87	0.004	-34.3
High income family	-0.73	-2.79	0.005	-51.6
Lone-father household	1.44	4.16	0.000	320
Below average self-rating as parent	0.62	2.65	0.008	85
At least one parent employed	-0.43	-2.26	0.024	-34.7
Child age	-0.29	-8.71	0.000	-25.5
Carer mental health issues				
Indigenous	-0.48	-3.26	0.001	-38
Managed by Community Services	0.43	4.04	0.000	54.1
Other significant factors				
2 children 0 - 17 years	-0.31	-2.53	0.012	-26.8
3 or more children 0 - 17 years	-0.48	-3.40	0.001	-38.4
At least one parent employed	-0.59	-3.91	0.000	-44.7
Lone-father household	1.10	3.71	0.000	199.5
Self-esteem score	-0.03	-2.78	0.005	-15.3
Child age	-0.37	-13.87	0.000	-30.9
Abuse (All)				
Indigenous	-0.01	-0.05	0.958	-0.7
Managed by Community Services	0.13	1.22	0.223	14.1
Other significant factors				
Tertiary	-0.41	-2.05	0.040	-33.7
Lone-father household	1.64	6.21	0.000	416.5
3 or more children 0 - 17 years	-0.32	-2.20	0.028	-27.1
At least one parent employed	-0.76	-5.10	0.000	-53.5
High level of hostile parenting	0.31	2.19	0.028	36.3
Child age	-0.14	-5.44	0.000	-13.1
Physical abuse				
Indigenous	-0.01	-0.05	0.958	-0.7
Managed by Community Services	0.13	1.22	0.223	14.1
Other significant factors				
Lone-mother household	-0.31	-2.05	0.040	-26.6

	b	***z***	***p***	**% change in expected count**
Lone-father household	1.63	5.67	0.000	410.5
At least one parent employed	-0.71	-4.13	0.000	-50.8
High level of hostile parenting	0.32	2.00	0.046	37.2
Child age	-0.19	-6.32	0.000	-17.4
Emotional abuse				
Indigenous	-0.29	-1.30	0.195	-25.5
Managed by Community Services	0.13	0.75	0.455	13.8
Other significant factors				
Lone-father household	1.51	3.69	0.000	351.4
At least one parent employed	-0.73	-2.93	0.003	-51.9
Child age	-0.11	-2.52	0.012	-10.1
Sexual abuse				
Indigenous	0.41	0.97	0.332	50.1
Managed by Community Services	-0.04	-0.13	0.893	-4.3
Other significant factors				
Y12 Certificate	-0.89	-2.32	0.020	-58.9
Lone-father household	1.96	2.49	0.013	612.5
Boy	-0.69	-2.06	0.039	-50
Child age	0.19	2.19	0.028	20.6

Appendix F: Change over Time Analysis

(See Chapter 6)

Table F.1: Reports prior, one year after exit by reported issues

	N	Av per yr for 24 months prior	12 mths post	Sig	12 months prior	12 mths post	Sig
All Families	2221						
Drug/alcohol issues		0.19	0.17	***	0.25	0.17	N/S
Mental health issues		0.27	0.18	***	0.37	0.18	***
Domestic violence		0.53	0.32	***	0.68	0.32	***
Abuse		0.33	0.46	N/S	0.42	0.46	***
Physical		0.18	0.23	N/S	0.23	0.23	**
Emotional		0.10	0.14	N/S	0.14	0.14	**
Sexual		0.05	0.10	**	0.06	0.10	***
Neglect		0.31	0.29	***	0.41	0.29	N/S
All		1.77	1.58	***	2.34	1.58	**
Indigenous families	458						
Drug/alcohol issues		0.37	0.28	**	0.46	0.28	N/S
Mental health issues		0.21	0.27	N/S	0.27	0.27	N/S
Domestic violence		0.65	0.41	***	0.83	0.41	***
Abuse		0.37	0.44	N/S	0.47	0.44	N/S
Physical		0.19	0.22	N/S	0.19	0.22	N/S
Emotional		0.13	0.14	N/S	0.18	0.14	N/S
Sexual		0.05	0.08	N/S	0.10	0.08	N/S
Neglect		0.44	0.43	N/S	0.56	0.43	N/S
All		2.18	2.07	***	2.80	2.07	N/S
Non-Indigenous families							
Drug/alcohol issues		0.15	0.14	**	0.19	0.14	N/S
Mental health issues		0.29	0.16	***	0.39	0.16	***
Domestic violence		0.50	0.30	***	0.64	0.30	***
Abuse		0.32	0.47	N/S	0.41	0.47	***
Physical		0.18	0.23	N/S	0.24	0.23	**
Emotional		0.09	0.14	N/S	0.12	0.14	***
Sexual		0.05	0.10	***	0.04	0.10	***
Neglect		0.27	0.26	***	0.37	0.26	N/S
All		1.66	1.46	***	2.23	1.46	**
CS families	1082						
Drug/alcohol issues		0.21	0.19	***	0.30	0.19	N/S
Mental health issues		0.36	0.21	***	0.50	0.21	***
Domestic violence		0.64	0.33	***	0.89	0.33	***
Abuse		0.34	0.51	N/S	0.46	0.51	***
Physical		0.18	0.27	N/S	0.24	0.27	***

	N	Av per yr for 24 months prior	12 mths post	Sig	12 months prior	12 mths post	Sig
Emotional		0.11	0.15	N/S	0.16	0.15	*
Sexual		0.04	0.09	*	0.05	0.09	**
Neglect		0.31	0.29	***	0.44	0.29	N/S
All		2.00	1.71	***	2.80	1.71	**
LA families	1139						
Drug/alcohol issues		0.18	0.15	*	0.21	0.15	N/S
Mental health issues		0.19	0.15	***	0.24	0.15	N/S
Domestic violence		0.43	0.32	***	0.48	0.32	**
Abuse		0.32	0.42	N/S	0.38	0.42	**
Physical		0.18	0.20	N/S	0.21	0.20	N/S
Emotional		0.09	0.12	N/S	0.11	0.12	*
Sexual		0.05	0.10	*	0.06	0.10	**
Neglect		0.31	0.30	**	0.38	0.30	N/S
All		1.55	1.46	***	1.91	1.46	N/S

Notes: *** P < .001; ** P < .01; * P < .05; NS = Not Significant

Appendix G: Intensive Outcomes Study

(See Chapter 7)

Table G. 1: Characteristics of Intensive Outcomes Study Cohort

	Selected Characteristics	No.	%
Family Type	Single parent family	27	42.9
	Second caregiver (in the household)	27	42.9
	Missing	9	14.3
	Total	63	100.0
Education Level	University	3	4.8
	Trade certificate / apprenticeship	4	6.3
	Other tertiary qualification	11	17.5
	Year 12	9	14.3
	Year 9, 10 or 11	34	54.0
	Year 8 or below	1	1.6
	Missing	1	1.6
	Total	63	100.0
Income	Government benefits	47	74.6
	Paid work	15	23.8
	Missing	1	1.6
	Total	63	100.0
Employment Status	Full-time parent	42	66.7
	Unemployed	12	19.0
	Part-time employed	3	4.8
	Casual employed	2	3.2
	Student	1	1.6
	Full-time carer	1	1.6
	Missing	2	3.2
	Total	63	100.0
Indigenous status	Indigenous	17	14.3
	Non-Indigenous	102	85.7
	Total	119	100.0
Country of Birth	Australia	53	84.1
	Other English speaking country	4	6.4
	Other non-English speaking country	6	9.5
	Total	63	100.0
Managed by	Community Services	73	61.3
	Lead Agency	45	37.8
	Missing	1	0.8
	Total	119	100.0
Entry Pathway	Helpline	96	80.7
	Community pathway referral	22	18.5
	Missing	1	0.8
	Total	119	100.0