Brighter Futures Early Intervention Program, May 2009 Interim Evaluation Report

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Social Policy Research Centre Consortium
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Abbreviations

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
CPR	Centre for Parenting and Research
CSC	Community Services Centre
Department	NSW Department of Community Services
DoCS	NSW Department of Community Services
DV	Domestic violence
ICS	Indigenous communities study
IOS	Intensive Outcomes Study
LA	Lead agency
LSAC	Longitudinal Study of Australian Children
MDS	Minimum dataset
NLSCY	National Longitudinal Survey of Children and Youth
Program	Brighter Futures early intervention program
ROH	Risk-of-harm
SPRC	Social Policy Research Centre

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Executive Summary

This report presents interim findings of the longitudinal evaluation of the Brighter Futures program. Brighter Futures is a voluntary, multi-component early intervention program that provides intensive support and services to vulnerable families with young children. The aim of the program is to halt the progression of participant families through the child protection system.

The interim findings presented here are based upon analysis of a range of quantitative and qualitative data sources. These include the Minimum Data Set (MDS) - a universal data file containing details of all risk-of-harm reports for children in the program, and data from Family Surveys completed by participant families up to 30 June 2008. In addition, analysis is presented from a first round of interviews conducted with client families (n=45) and a range of key stakeholders (n=48) including caseworkers, casework managers, early-childhood facilitators, team leaders, area coordinators and some senior executive staff.

The key findings of this interim report are as follows:

Who is in the Brighter Futures program?

- A total of 2,813 families were recorded in the MDS as having participated in the Brighter Futures program between the beginning of MDS data collection (1 July 2007) and 30 June 2008.

- Participant families were located throughout the state, with the highest proportion of families (18 per cent or 511 families) located in DoCS' Northern Region (Far North Coast, Mid North Coast and New England), followed by the Western Region (16 per cent) and Metro Central (15 per cent).

- Participant families who had received at least one risk-of-harm report in the 24 months prior to entering the program had a high average number of reports prior to their entering the program (11 per family), and there was a significant difference in the number of reports for families who entered via the DoCS Helpline pathway (12 per family prior to program entry) and for those who entered via the community pathway 9 per family prior to program entry).

- The Family Survey provides detailed demographic information for a subset of Brighter Futures client families. At 30 June 2008, there were 1,024 Family Survey study children. Eighty-nine per cent of the children were aged under six years of age with strong representation in the age groups of zero to three years.

- Family Survey data indicate that the mother was the primary carer for 94 per cent of the families who completed the survey. Almost half of the primary carers indicated that they were the sole carers of their children. The average number of children per family was 2.4, ranging from one unborn child to a family with 12 children.

- Family Survey data shows that the average age of primary carers was 30 years – with an age range of 13 to 69 years. Nineteen per cent of the primary carers

had a disability (most commonly psychiatric) and over 11 per cent had multiple disabilities. For 72 per cent of the families, government benefits were the main source of household income.

Is the program being effectively implemented?

- Specified program entry ratios of 80:20 (this ratio specifies that 80 per cent of participant families are to enter through the DoCS Helpline pathway and 20 per cent through the community referral pathway) have been difficult to realise. Sixty four per cent of the client families had entered the program through the Helpline pathway, with the additional 36 per cent entering through the community pathway.

- The 50:50 specified case management ratio between DoCS and Lead Agencies has been more closely realised, with fifty-five per cent of families being case-managed by Lead Agencies, and the remaining 45 per cent case-managed by DoCS. However, the program was not fully operational in all DoCS regions during this period.

- Families interviewed were overwhelmingly satisfied with the supports and services they received through Brighter Futures.

- A number of factors that facilitate the successful provision of services were identified in interviews with program staff. These included the training provided to program staff; the satisfaction and commitment of casework staff; the comprehensive nature of program services; and firm relationships between client and caseworker.

- A number of barriers to the successful provision of services were also identified in interviews with program staff. These included: difficulties associated with partnership service delivery; human resource challenges; a division between child protection and early intervention teams; the stigma attached to DoCS; and program administrative requirements.

Indigenous families and the Brighter Futures program

- Twenty-four per cent of the families recorded in the MDS as having participated in the program identified as Indigenous.

- A higher proportion of Indigenous families were case managed by Lead Agencies (61 per cent) than families overall (55 per cent).

- Many caseworkers felt that it was impossible to engage the local Indigenous community without Indigenous caseworkers. However, some Indigenous families who were interviewed pointed out that not all Indigenous families want to engage with Indigenous workers or use Indigenous services.

- Local knowledge of the Indigenous families in certain areas was seen as critical when attempting to bring families into Brighter Futures.

- Many caseworkers felt that it took extra time to work with Indigenous families as it was often important to develop relationships with the extended family (such as maternal grandmother) and because they were often dealing with large sibling numbers.

- Ninety-one per cent of Indigenous and culturally and linguistically diverse (CALD[1]) clients who completed the Family Survey 'agreed' or 'strongly agreed' that program services took their families' cultural beliefs and values into account.

CALD families and the Brighter Futures program

- Thirteen per cent of primary carers who completed the Family Survey indicated that they were born in a non-English speaking country. Thirteen per cent of client families also spoke a language other than English (most commonly Arabic) at home.

- Caseworkers reported CALD families often had complex needs - particularly those for whom immigration issues were yet to be resolved – and required differential service provision. Language barriers prevented caseworkers from simply referring clients to parenting programs and supported playgroups.

- Ninety-three per cent of CALD families who completed the Family Survey 'agreed' or 'strongly agreed' that the services provided to them were culturally inclusive. This was often achieved through the use of bilingual caseworkers and/or interpreters, as well as referrals to multicultural community services. CALD families interviewed as part of the Process Evaluation spoke of the benefit of having a caseworker that shared their cultural background.

- Service provision for CALD families often centred around advocating on the families' behalf to the Department of Immigration.

What is the impact of the program?

- For children who were the subject of one or more risk-of-harm reports in the three and six months prior to program entry, there has been a significant reduction in the reports received in the three and six months after participating in the program.

- Parents surveyed in this study had a higher average for the parent hostility[2] scale than those in the Australian Longitudinal Survey of Australian Children.

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1 A person born overseas in a non-English speaking country, or who has at least one parent born overseas in a non-English speaking country.

2 Parental hostility is associated with a sense of rejection, failure and insecurity, and fails to provide the child with guidance in effectively managing strong feelings (Teti & Candelaria, 2002).

- Around half of the primary carers surveyed felt that they did not get enough help, or any help at all and 40 per cent felt that they got enough support from friends or family.

- Parents in the Family Survey population program were relatively satisfied with their relationships with their children. On a scale of satisfaction/dissatisfaction with this relationship (0 = completely dissatisfied; and 10 = completely satisfied), the average was 7.6 (*SD*=2.4).

- No significant differences were noted for any of the outcomes for the children or the parents, with the exception of Personal Well Being Index, which indicated improvement in the personal wellbeing of parents. The Process Evaluation data affirms this finding and this is a significant result as it provides the foundation for improved child outcomes.

1 The Brighter Futures Program

This is the second published report of a longitudinal evaluation of the NSW Department of Community Services' (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 NSW. The evaluation began in 2006 and will continue until September 2010. The evaluation consortium comprises: the Centre for Health Economics Research and Evaluation (CHERE), University of Technology Sydney; the School of Education and Early Childhood Studies, University of Western Sydney; Gnibi College of Indigenous Australian Peoples, Southern Cross University; and the National Institute of Social and Economic Research, London.

This report provides interim findings on the characteristics of, and outcomes for, participant families, as well as issues related to program implementation. Data sources for this report are: a state-wide survey of participant families; service provision data from DoCS and partner non-government agencies; risk-of-harm report information; and interviews conducted with participant families and service providers.

The Brighter Futures program is designed to deliver tailored and intensive services to families in need. The program is targeted to unborn children through to families with children aged under nine years, who are experiencing certain vulnerabilities[3] and require long-term support from a range of services. Within this group, priority of access is currently given to:

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

The decision to give priority of access to families with children under three years of age is based on current research evidence that the first three years of life is a period of crucial brain development that lays the foundation for later cognitive and emotional development (McCain & Mustard, 2002). This priority is also based on the recognition that the need for services exceeds program capacity.

As an early intervention (EI) program, Brighter Futures has as an overall aim to prevent the escalation of serious family problems affecting 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 DoCS where the children have been assessed as being at low to moderate risk-of-harm. The Brighter Futures program is a

[3] These vulnerabilities are identified in the Brighter Futures *Service Provision Guidelines* (NSW Department of Community Services, 2007b), and listed in section 4.2.

form of EI in the sense that it specifically targets young children and families before serious and complex problems have become so entrenched that the children are in significant danger and there is little capacity for real change within the family.

Following best practice in EI programs, Brighter Futures is based on a multi-component service model. This model is underpinned by indications 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 such as case management, regular home visiting from a qualified caseworker, placement of children in a childcare facility, brokerage services and access to parenting programs. According to the *Service Provision Guidelines*, families are assessed as suitable for the program if they require an intervention of approximately two years' duration. This period of service reflects DoCS' desire to effect real and sustainable change for client families.

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

Comprehensive information on the Brighter Futures program is provided in the Brighter Futures Caseworker Manual (for DoCS families) and the Brighter Futures *Service Provision Guidelines* (for Lead Agencies). The latter are available through the following link http://www.community.nsw.gov.au/DOCSWR/_assets/main/documents/EIP_service_provisions.pdf.

2 The Evaluation of Brighter Futures

The longitudinal evaluation of Brighter Futures comprises four components. These are:

- A *Results Evaluation* that examines whether the program is delivering the intended benefits to participant children and families and is improving their lives. Information comes from:
    - the Minimum Data Set (MDS) – de-identified information provided by service providers on every child and family in the program;
    - other DoCS administrative data;
    - the Family Survey – a state-wide survey of families engaged in the program;
    - an outcomes intensive cohort – a smaller sample of families in the program who will be intensively studied; and
    - an outcomes comparison group – a group of similar families who do not receive this intervention.
- A *Process Evaluation* examining the implementation and administration of the program, with information from
    - the MDS; and
    - observation site data collection (interviews, observation, participation and discussion).
- An *Economic Evaluation* that analyses the outcome and cost data from the results and process evaluation data sources described above, and models long-term outcomes that will be cost-effective.
- An *Intensive Research Study* that explores how the program can better meet the needs of Indigenous families.

A detailed plan of the evaluation and its methodology is available at http://www.community.nsw.gov.au/docswr/_assets/main/documents/ei_evaluationplan.pdf.

3 The Methodology for this Report

This report includes analysis of various datasets. The Minimum Data Set (MDS) is the largest dataset to be analysed. It comprises the following data files:

- The Family Early Intervention Data file, containing all family-level data for families in the Brighter Futures program from 1 July 2007 to 30 June 2008, and managed both by DoCS and by the Lead Agencies.
- The Reports Data File, containing details of all risk-of-harm reports relating to the children in the Brighter Futures program and their siblings aged nine years and under, for the 24 months prior to their entering the program, for the time they are in the program, and for 12 months after exit from the program. This file includes the family's and child's Unique Family Identifier (UFI), the reported issues and the response times.
- The Family Survey File, containing all the Family Surveys completed up to 30 June 2008.

The Family Survey is a questionnaire designed to measure a family's progress on the program, including changes in family functioning, in parenting skills, and in the targeted child's social and emotional development. It also provides important demographic information about client families. It is completed by participant families as they progress through the Brighter Futures program. Baseline data is collected within two months of starting the program. This is referred to as Time 1 (T1) data. Time 2 (T2) data is collected six months after T1, and Time 3 (T3) data is collected when families exit from the program. Time 4 (T4) data is collected six to twelve months after exit. This report provides some analysis on T1 and T2 data.

The program evaluation also includes two rounds of Process Evaluation interviews with client families and program staff to explore implementation issues. The second round of interviews is currently being conducted. These interviews are separate from the Family Survey data collection. This report includes analysis of the first interview round, which comprised 93 interviews with client families and with staff from DoCS and LAs throughout the data collection period from November 2007 until the end of May 2008. The interviews were held in four observation sites throughout NSW located in the DoCS' Regions of Metro West, Metro Central, Metro South West and Northern.

Semi-structured interviews were conducted with 45 client families and 48 program staff (30 from DoCS and 18 from LAs). The majority of staff interviewed were EI caseworkers, although casework managers, intake officers, early-childhood facilitators, team leaders and area coordinators were interviewed as well. Three of the staff interviewed were Indigenous. Additionally, five interviews were conducted with key Brighter Futures staff within DoCS Head Office, and there was one interview with a Regional Director. All but one of the interviews were recorded, with the consent of the participants. De-identified audio files were sent to a transcription company for conversion to text files. Audio and text files of each interview were then uploaded into NVivo7 for detailed analysis.

Finally, data was collected through observations conducted at four Community Service Centres (CSCs) and at a number of LAs in the DoCS Regions listed above, as

well as at relevant meetings and events such as LA forums and conferences. Field notes were written for these observations and these were similarly uploaded to NVivo7 for inclusion in the analysis.

4 Who is in the Brighter Futures Program?

An accurate profile of participant families is necessary to ensure that the supports and services offered through the Brighter Futures program are targeted to the client group, and thus can more effectively meet their needs. Whilst data indicate that there is a diversity of family types and characteristics, some general comments about client families can be made.

4.1 How many families are in the Program and where are they located?

A total of 2,813 families were recorded in the MDS as having participated in the Brighter Futures program between I July 2007 and 30 June 2008. Client families recorded in the MDS were located throughout the state, although the highest proportion of families (18 per cent or 511 families) were located in DoCS' Northern Region (Far North Coast, Mid North Coast and New England), followed by the Western region and Metro Central. Table 4.1 provides a breakdown of client family numbers according to geographical regions. The distribution of families across regions and between DoCS and Lead Agencies has been affected by the progressive rollout of the program within DoCS, as the program was not fully implemented in all regions during this period.

Almost a quarter of the program participants (24 per cent or 671 families) identified as Indigenous. The highest proportion of Indigenous families was located in DoCS' Northern Region (185 families out of 511 or 36 per cent).

Table 4.1: Regional distribution of families in the Brighter Futures program

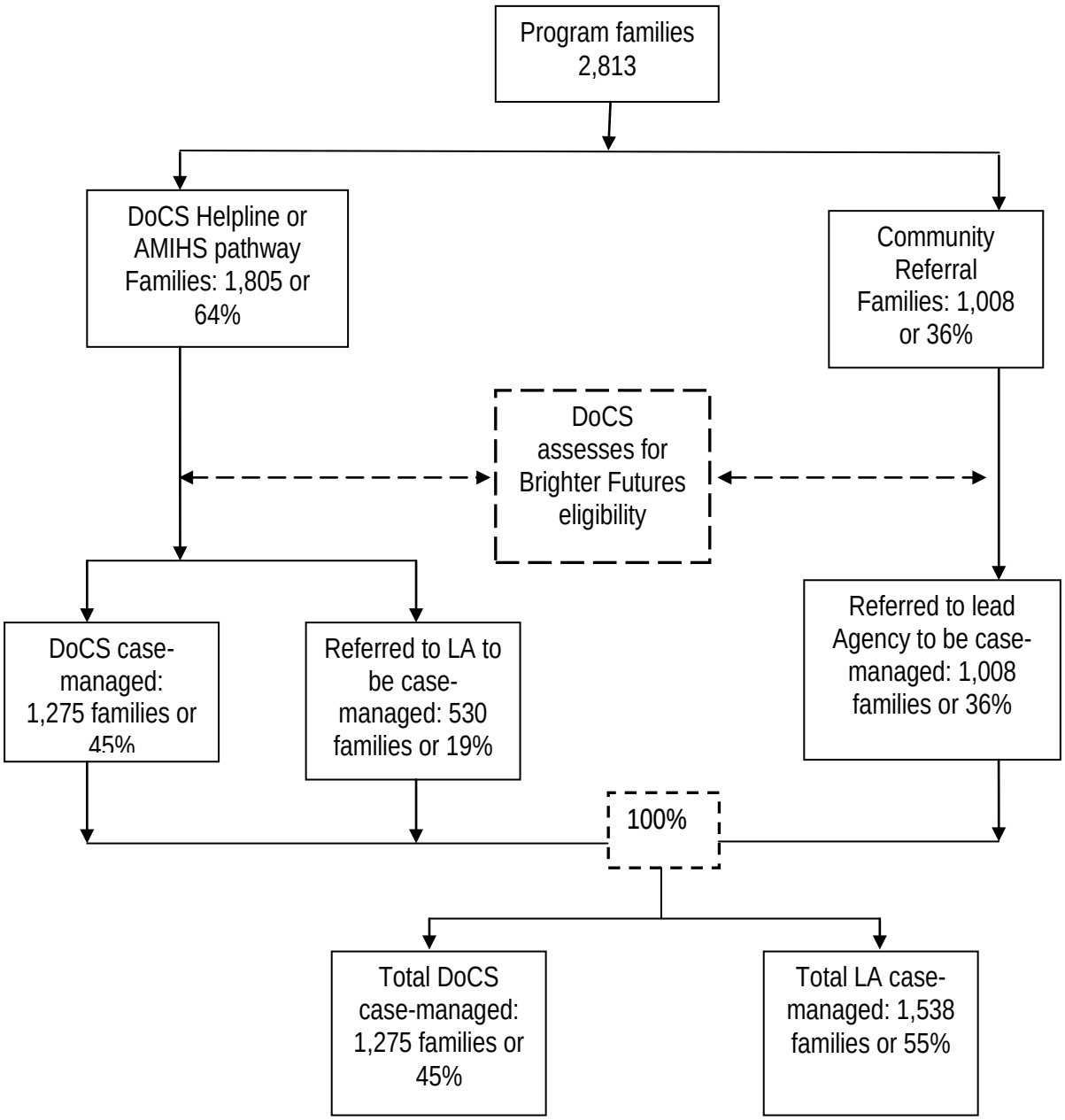
DoCS Region	Frequency	%
Hunter & Central Coast	334	12
Metro Central	413	15
Metro South West	344	12
Metro West	393	14
Northern	511	18
Southern	366	13
Western	452	16
Total	2,813	100

Source: *Family Early Intervention Data File*

Families enter the program in one of two ways: through the DoCS Helpline, or through the community pathway which involves a referral from a community source. For 1,805 families (64 per cent), entry was via the DoCS Helpline and 71 per cent of these families were case-managed by DoCS, with the rest being transferred to a local LA. There were a further 1,008 families (36 per cent) who entered the program via the community pathway and these were all case-managed by LAs (See Figure 4.1). Overall 45 per cent of families were case-managed by DoCS, and 55 per cent were case-managed by Lead Agencies.

Figure 4.1 provides a breakdown of family numbers by entry pathway and case-management.

Figure 4.1: Entry pathway and case-management of families



In three of the DoCS regions (Metro Central, Metro Southwest and Northern), the case management of families was almost evenly shared between DoCS and LAs. In the Hunter, Central Coast and Western regions, LAs case-managed a greater proportion of participant families than DoCS did (73 per cent and 66 per cent respectively). In the Metro West region, DoCS case-managed 62 per cent of the cases, with local LAs case-managing the rest.[4]

A slightly higher percentage of Indigenous families entered into the program via the community pathway (42 per cent) than did the program families overall (36 per cent). Two hundred and sixty-four Indigenous families were case-managed by DoCS (or 39 per cent). The distribution of the two types of case management for Indigenous families was roughly similar to the distribution in the overall population, with the exception of the Metro Southwest region where Indigenous families were case-managed at a greater rate by LAs than by DoCS. The fact that an Indigenous LA operated in this region may account for this distribution.

4.2 Family vulnerabilities

Families are eligible for the Brighter Futures program if they have at least one identified 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. The vulnerabilities are:

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

The client families surveyed and interviewed showed great diversity in terms of structure, resources, concerns and culture. This diversity ranged from poor families in extremely disadvantaged communities with multiple vulnerabilities and a generational history of involvement with DoCS, to more middle-class families living in privately-owned dwellings with only one or two vulnerabilities. There was a vast range of families between these two extremes.

The average number of vulnerabilities per families was 3.1, with 2,514 families (or 90 per cent) having more than one. Table 4.2 details the specific vulnerabilities. Lack of

[4] Appendix A contains a detailed table of the numbers and percentages of families by the type of case management.

social support, domestic violence and inadequate supervision or parenting skills were the three most commonly reported vulnerabilities of client families.

Table 4.2: Family vulnerabilities in the Brighter Futures program

	Non-Indigenous		Indigenous		Total	
Vulnerability*	Number	%	Number	%	Number	%
Domestic violence	1,122	52	399	59	1,521	54
Drug and alcohol misuse	760	35	354	53	1,114	40
Parental mental illness	1,172	55	282	42	1,454	52
Lack of social support	1,287	60	391	58	1,678	60
Learning/intellectual disabilities	199	9	82	12	281	10
Child behaviour management	858	40	241	36	1,099	39
Inadequate supervision or lack of parenting skills	1,179	55	405	60	1,584	56
Total Number	2,142		671		2,813*	

Source: *Family Early Intervention Data File*
Note: * Columns do not sum to 100% because families may have multiple vulnerabilities.

For Indigenous families, the average number of vulnerabilities was 3.2, with 616 families having more than one vulnerability (92 per cent)[5]. For non-Indigenous families, the average number of vulnerabilities was 3.1, with 1,898 families having more than one vulnerability (89 per cent). A higher proportion of Indigenous families had inadequate supervision or lack of parenting skills, domestic violence, and drug and alcohol misuse vulnerabilities than did the general cohort of families in the program. A lower proportion of Indigenous families were assessed with parental mental illness and child behaviour management as vulnerabilities.

Families' vulnerabilities differed by their entry pathway into the Brighter Futures program. Families entering the program via the Helpline pathway had been assessed as having higher rates of domestic violence and parental drug and alcohol misuse compared with those entering via the community pathway (60 per cent and 45 per cent compared to 43 per cent and 31 per cent respectively). In contrast, families who entered through the community pathway were more likely than those who entered through the Helpline to be needing social support (79 per cent compared with 49 per cent) and help with child behaviour management problems (57 per cent compared with 29 per cent) (Table 4.3).

[5] Missing data for 3 cases.

Table 4.3: Family vulnerabilities and pathways into Brighter Futures program

	Helpline		Community		Total	
Vulnerability	Number	%*	Number	%*	Number	%*
Domestic Violence	1,086	60	435	43	1,521	54
Drug and Alcohol misuse	804	45	310	31	1,114	40
Parental Mental Health	904	50	550	55	1,454	52
Lack of Social Support	879	49	799	79	1,678	60
Learning/Intellectual Disabilities	126	7	155	15	281	10
Child Behaviour Management	527	29	572	57	1,099	39
Parenting Skills	1,013	56	571	57	1,584	56
Total Number	1,805		1,008		2,813	

Source: *Family Early Intervention Data File*
Note: * Columns do not sum to 100% because families may have multiple vulnerabilities.

4.3 Risk-of-harm reports for families prior to entry

Of the 2,813 families recorded in the MDS as having participated in the program, 2,424 (86 per cent) had received risk-of-harm reports in the 24 months prior to starting in the program. Of the families who received at least one report in the 24 months prior to entering the program, the mean number of reports per family was 11 (median=6), and the average per child[6] was 5 (median=3). The report numbers were higher for Indigenous families. For the 586 Indigenous families recorded in the MDS as receiving at least one report in the 24 months prior to entering the program, the mean number of reports in the 24 months prior to starting in the program was 15 (median=7), and the average per child was 6 (median=4). For families reported prior to entering the program, the average number of reports prior to them entering the program via the DoCS Helpline pathway was 12 (median=6), which is higher than the average of 9 reports for the families entering via the community pathway. The mean number of reports for DoCS-managed families who received at least one report in the 24 months prior to entry was significantly higher than for those managed by LAs (14 and 9 respectively) and per child (Table 4.4).

[6] This is the average number of reports per child for families in the Brighter Futures program. This includes the Brighter Futures child and their siblings.

Table 4.4: Average number of risk-of-harm reports in the 24 months prior to entry into Brighter Futures program

		Per Family			Per Child	
	Number of families	Average	Median	Number of children	Average	Median
Overall	2,424	11	6	5,618	5	3
Indigenous	586	15	7	1,350	6	4
By Pathway						
Community	631	9	5	1,370	4	3
DoCS Helpline	1,793	12	6	4,248	5	3
By Management						
DoCS	1,265	14	6	3,086	6	4
Lead Agency	1,159	9	5	2,532	4	3
Not Reported	389					

Note: this excludes families who did not receive any risk-of-harm reports in the 24 months prior to entry
Source: *Family Report Data File*

4.4 Families exiting from program

As at 30 June 2008, 739 families had exited the program. Almost 20 per cent of these families (138 families) had exited due to having their 'plan goal achieved', while the rest of the families had left for other reasons.[7] Of the families that had exited the program with their case-plan goal achieved, 82 per cent had entered via the DoCS Helpline, 76 per cent had been case-managed by DoCS, and the average number of days they had spent in the program was 396. The 601 families who exited the program for other reasons were almost evenly split between DoCS and LA for case management and entry pathway. The length of time in the program on average was 161 days. A greater proportion of Indigenous families than families overall had exited for reasons other than plan goal achieved (Table 4.5).

[7] Other reasons include: withdrawal; unable to be located; not engaging; moving out of state.

Table 4.5: Program exit from Brighter Futures program by reason

		Plan Goal Achieved (n=138)		Other Reasons for exit (n=601)	
		#	% of 138	#	% of 601
Management	- DoCS	105	76	292	49
	- LA	33	24	309	51
Entry Path	- Community	25	18	260	43
	- Helpline	113	82	341	57
Indigenous	- Yes	11	8	167	28
	- No	127	92	434	72
Vulnerability	- Domestic Violence	61	44	310	52
	- Drug and Alcohol misuse	34	25	224	37
	- Parental Mental Health	58	42	275	46
	- Lack of Social Support	62	45	349	58
	- Learning/Intellectual Disabilities	7	5	65	11
	- Child Behaviour Management	42	30	209	35
	- Inadequate Supervision or Parenting Skills	58	42	320	53
Length of Time	- Mean (number of days)	396		161	
	- Median (number of days)	364		117	

Source: *Family Early Intervention Data File*

Summary

- A total of 2,813 families have participated in the Brighter Futures program between the beginning of MDS data collection in July 2007 and 30 June 2008.
    - 2,074 families have continued to participate in the program, while 739 have exited. 20 per cent of these families exited with their 'plan goals achieved'.
- 90 per cent of the families who entered the program had more than one vulnerability identified at initial assessment.
- 64 per cent of the families in the program entered via the Helpline pathway.
- Of the 2,813 families overall, 1,275 families were case-managed by DoCS and 1,538 families were case-managed by a LA.
- The highest proportion of client families were located in DoCS' Northern and Western regions, at 511 and 452 families respectively.

4.5 Profiling client families – Family Survey

The Family Survey provides detailed demographic information for a subset of client families and their children who completed the survey. At 30 June 2008, 1,024 baseline Family Surveys had been completed, representing 36 per cent of 2,813 families in the MDS who had participated in the Brighter Futures program since July 2007.[8] Of these families 241 (24 per cent) had completed a second survey. The extent to which the Family Survey population is comparable to the broader program population is not yet known, but this analysis will be undertaken to inform future analysis.

Among the families who responded to the Family Survey, the mother was the primary carer in 94 per cent (954) of the families, the father in five per cent, and a grandparent in one per cent. In eight families, an older sibling was another primary carer, and custody was shared. Other similar family-support program evaluations have found that mothers are predominantly the primary carers and program participants (Aldred et al, 2004).

The number of children living in each family in the Family Survey population ranged from one unborn child to 12 children, with a mean of 2.4 (Median=2, *SD*=1.4 children). Of the 2,454 children represented in the Family Survey (i.e. 'study children' and their siblings), most (2,018) were children aged under nine years of age (the Brighter Futures target age-group) and the remaining 436 were aged between 9 and 17 years. There were 459 children (19 per cent) that identified as Indigenous and 58 children (2 per cent) that were born outside of Australia.

Primary carer demographics

Primary carers' ages ranged from 13 to 69 years, with a mean age of 30 years (*SD*=8). Seventy primary carers were under the age of 20 and another 188 were aged 20 to 24 years (Table 4.6).

Table 4.6: Age of primary carer

Age of Primary Carer	Number	% (of 979)	Cumulative%
<20	70	7	7
20 – 24	188	19	26
25 – 29	242	25	51
30 – 34	213	22	73
35 – 39	165	17	90
40 – 44	70	7	97
45 – 49	18	2	99
50+	13	1	100
Total	979	100	
Missing	45		

Source: *Family Survey Data File*

[8] Family Survey was introduced in August 2007 and offered to all families who had commenced in the program since May 2007, while the MDS covers the period from July 2007.

Carers' disability and mental health

A total of 900 primary carers responded to the question on disability. Nineteen per cent (196 primary carers) said they had a disability, with the most prevalent form being psychiatric. Over 11 per cent of the primary carers reported that they had multiple disabilities (Table 4.7).

Table 4.7: Disability of primary carer

Primary Carer Disability	Number	% (of 196)
Intellectual/Learning	28	14
Psychiatric	75	38
Sensory/Speech	10	5
Physical/Diverse	24	12
Other – ADHD	28	14
Not Stated	9	5
Multiple Disability	22	11
Total with Disability	196	100
No Disability	704	
Missing	124	

Source: *Family Survey Data File*

Secondary carers

Around 47 per cent of the primary carers indicated that they were the sole carer. The vast majority of the primary carers (98 per cent) were biological parents and 2 per cent were step-parents or were caring for a relative. In 86 per cent of the 481 families with a second carer, that carer was a partner of the primary carer. The majority of these secondary carers were male (86 per cent). Secondary carers were on average 4.6 years older than primary carers. Primary and secondary carers had similar country-of-birth profiles, with the majority being born in Australia.

Eighteen per cent of the secondary carers (86 persons out of 481) reported having a disability. Once again, the main disability was psychiatric (23 persons), followed by intellectual/learning, and 10 had multiple disabilities. In 40 families, both the primary carer and the secondary carer had a disability (8 per cent).

Education

Forty-seven per cent of surveyed families stated that the highest level of education of any family member was year 9, 10 or 11, and another 4 per cent said they had only reached year 8 or below. Thirty-four per cent of the families (347 families) stated that there was a member of the household with a university or other tertiary qualification.

Source of Income

The main source of household income was government benefits for 72 per cent of the families, with paid work the main source of income for 25 per cent. Almost 60 per cent of the families who said that their main source of income was paid work had at least one household member who had tertiary qualifications, while for 61 per cent of the families whose main source of income was government benefits, year 9, 10 or 11 was the highest level of educational attainment (Table 4.8).

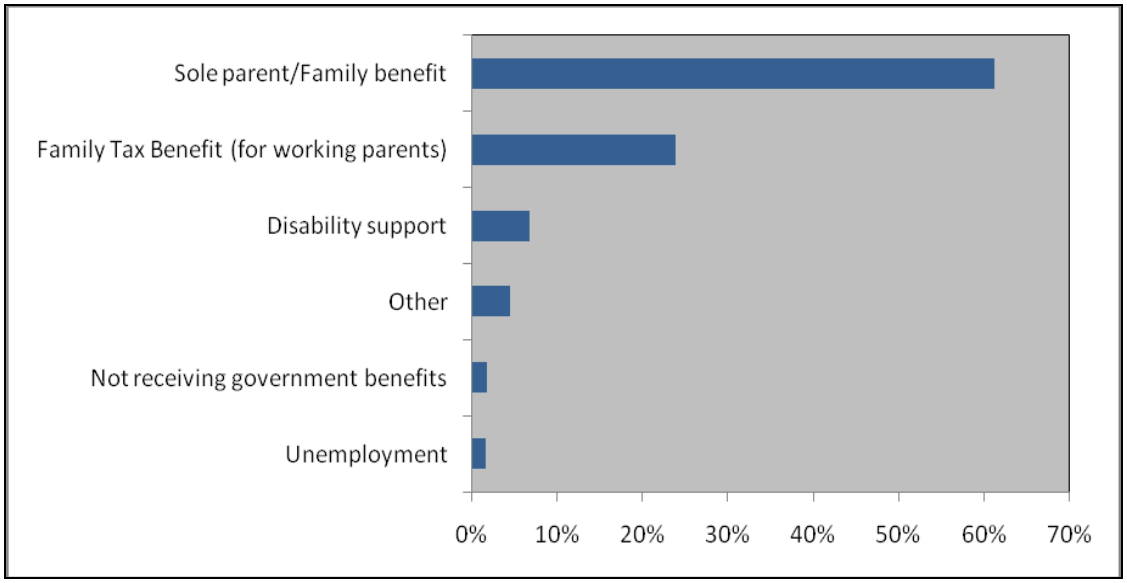
Table 4.8: Education level by source of household income

Highest level of education completed by any household member	Main source of household income: Paid work	Government Benefits	Child support or maintenance	Other	Total*	% of Total
Year 8 or below	3	37	0	2	42	4
Year 9, 10 or 11	59	407	5	6	477	47
Year 12	41	96	3	3	143	14
Trade certificate/apprenticeship	23	32	1	1	57	6
Other tertiary qualification	76	124	1	3	204	20
University	52	31	0	3	86	9
Total	254	727	10	18	1,009	100

Source: *Family Survey Data File*
Note: *15 missing cases

Sixty-two per cent of primary carers surveyed indicated that they were full-time parents and another 16 per cent were unemployed. Of those primary carers who did not have a second carer in the household, only 17 (4 per cent) were working full-time, and over 77 per cent were either unemployed or full-time parents. Sixty-one per cent of the primary carers were receiving sole parent/family benefits, 24 per cent were receiving Family Tax Benefit, and 7 per cent were receiving disability support (Figure 4.2).

Figure 4.2: Per cent of primary carers receiving government benefits by type



Source: *Family Survey Data File*
Note: 18 missing cases

Health

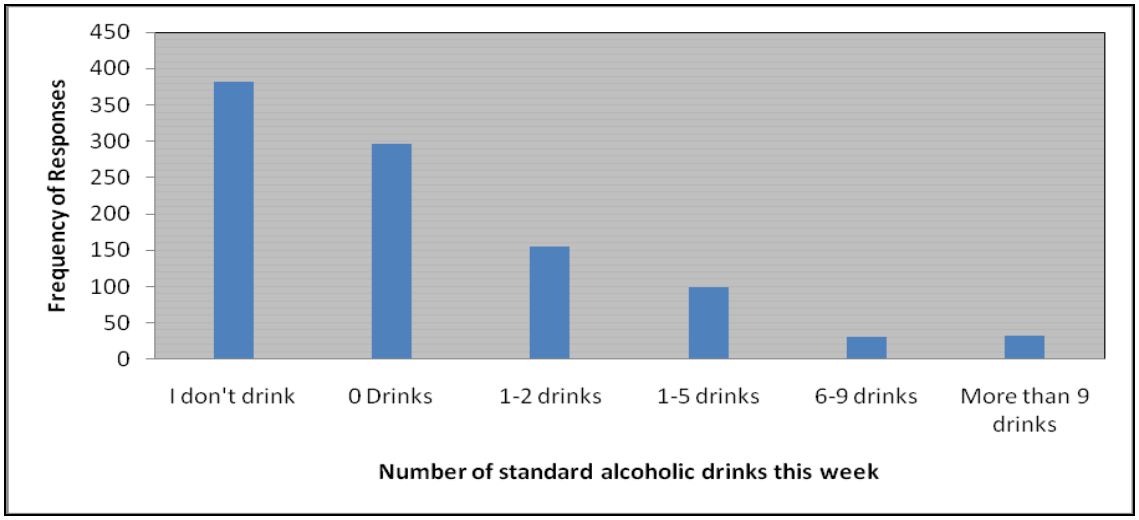
On the whole, the primary carers rated their health as good. For 37 per cent their health was 'about the same as one year ago', and another 33 per cent stated that their

health was 'somewhat or much better than a year ago'. Twenty-two per cent of primary carers (210 people) stated that their health was 'somewhat worse or much worse than a year ago'.

In response to a question about the number of days when the primary carer had done at least 30 minutes of moderate or vigorous physical activity, 28 per cent indicated that they were 'not doing any', almost 39 per cent indicated 'one to three days a week', and the remainder (around a third) indicated 'almost every day'. There was a positive association (weak but nonetheless significant) between the number of days each week the primary carer engaged in vigorous physical activity, and the reported improvement in their health (r=0.168 p<0.01). The health of the primary carer was significantly positively correlated with the health of the Family Survey study child (r=0.353 p<0.01), and significantly negatively associated with the Family Survey study child's behaviour outcome scores.[9] The primary carers' health was also associated with their own age.[10] This is supported by health surveys conducted in England and the United States that found evidence that family lifestyle choices have an important role in determining child health (Currie, Shields and Price, 2004).

When asked how many alcoholic drinks they had had in the week of the survey, 38 per cent said that they did not drink, and another 30 per cent indicated that they had consumed no alcoholic drinks (Figure 4.3). On the question of cigarettes usually smoked, 45 per cent of the primary carers indicated that they did not smoke, while around 7 per cent reported that they smoked a packet or more a day. There was a statistically significant positive relationship between reports of alcohol consumption and reports of tobacco consumption (r=0.187 p<0.01).

Figure 4.3 Number of alcoholic drinks consumed by primary carers in a week



Source: *Family Survey Data File*
Note: 12 missing cases

9 The Family Survey collects data on a nominated study child, namely the youngest reported child in the family, or where not known or not applicable, the youngest child.

10 The primary carer's health was significantly correlated to the primary carer's age (r=-0.161, ρ<0.01) and the child's behaviour (as measured by the Eyberg Child Behaviour Inventory tool and BITSEA Problem (r=-0.274, ρ<0.01 and r=-0.194, ρ<0.05 respectively)).

Summary

As at 30 June 2008, 1,024 baseline Family Surveys were completed. The Family Survey data indicated:

- That the mother was the primary carer for 94 per cent (954) of client families, the father for five per cent and a grandparent for one per cent. Less than half of the families (481) had a spouse living in the household.

- The primary carer's age ranged from 13 to 69 years with the mean age being 30 years. Out of the 900 primary carers who responded to the disability question, 196 (19 per cent) identified that they have a disability, with the most prevalent form of disability being psychiatric. Over 11 per cent of the primary carers identified as having multiple disabilities.

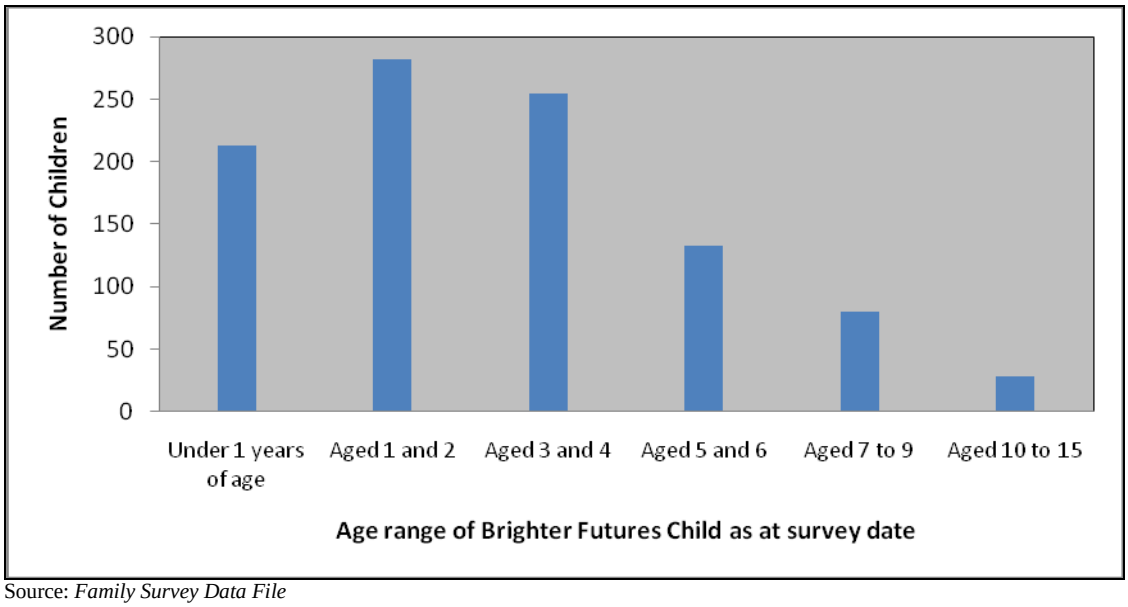
- Around 47 per cent of primary care givers indicated that they were the sole care giver, 98 per cent were biological parents and 2 per cent were step parents or were caring for a relative. Forty-seven per cent of the surveyed families stated that the highest level of education was to year 9, 10 or 11.

- The main source of household income was government benefits for 72 per cent of the families. For 25 per cent of families the main source of income was paid work. The primary carer, on average, rated their health as good. A total of 38 per cent indicated they do not drink and 45 per cent that they do not smoke. There was a statistically significant positive relationship between the primary carer's report on alcohol and tobacco consumption.

Family Survey Study Child

For each family survey that was completed, a child was nominated as the program study child (referred to as study child). This child was one that the primary carer completing the survey had nominated the youngest child in the Brighter Futures program that was the subject of a child protection report. If there was no report, or multiple children were the subject of the report, then the youngest child was chosen. The Family Survey study children were typically under the age of six (89 per cent), with a strong representation in the age groups of zero to three years (63 per cent) (Figure 4.4).

Figure 4.4: Age range of Family Survey study children



Source: *Family Survey Data File*
Note: 31 children were over 9 years of age (3 per cent). Missing data on 18 children

Boys were over-represented in the survey (56 per cent). Sixty-three per cent of all the children in the survey were aged over 24 months, and 16 per cent were aged 12 to 24 months. There were 215 children (21 per cent) aged under 12 months and three that were unborn. There were 186 (19 per cent) children in the program identified as Indigenous. Fewer than two per cent of the children were born outside Australia, but 10 per cent spoke a language other than English at home.

Table 4.9: Age and gender of Family Survey study children

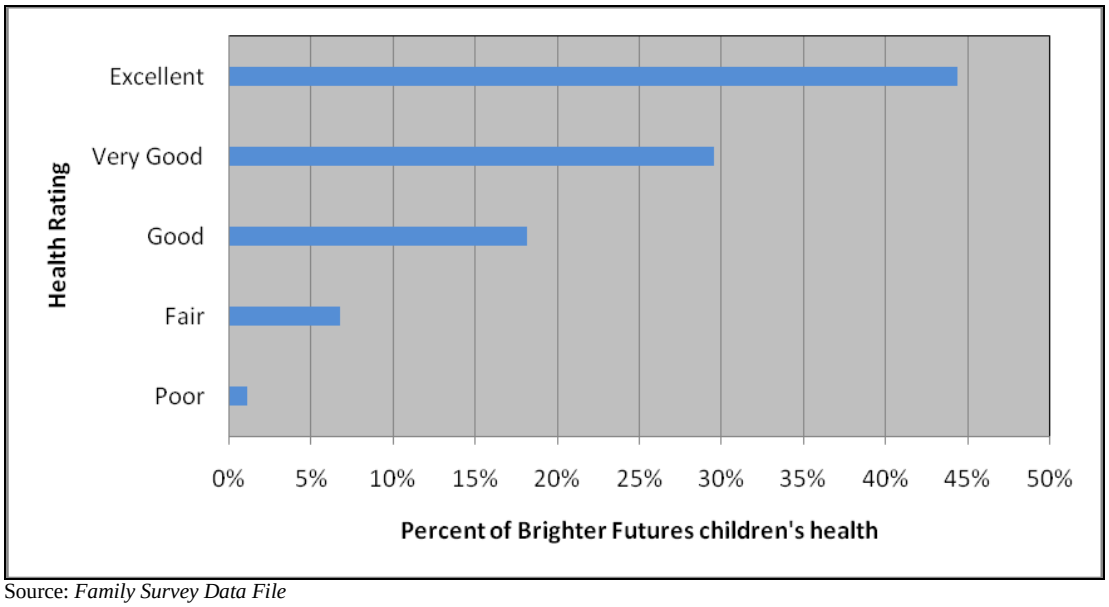
Brighter Futures Age Grouping	Female	Male	Total
Older than 24 months	259	354	613
12 to 24 months	73	89	162
Younger than 12 months	94	109	203
Total	426	552	978

Source: *Family Survey Data File*
Note: Missing data on 46 children

Health

Over 92 per cent of the children were rated by their carer to be in good, very good, or excellent health. Eleven children were rated with poor health, and 68 children (7 per cent) were reported to have fair health (Figure 4.5).

Figure 4.5 : Health of Family Survey study children, as rated by primary carer



Source: *Family Survey Data File*
Note: Missing data on 19 children

Almost 30 per cent of the children were rated by carers as having a medical condition or a developmental problem, and 10 per cent (103 children) had both medical conditions and developmental problems (Table 4.10). Boys were over-represented among those with medical and developmental problems, being 61 per cent and 65 per cent respectively of the total.

Table 4.10: Medical problems and developmental delay in Family Survey study children

Child Medical Problems	Child Developmental Delay							
	Yes		No		Total		Missing	Total
	Number	Col %	Number	Col %	Number	Col %		
Yes	103	54	115	16	218	24	54	272
No	86	46	611	84	697	76	6	703
Total	189	100	726	100	915	100	60	975
Missing	20		1		21		28	49
Total	209		727		936		88	1024

Source: *Family Survey Data File*

Developmental delays included global development delays, autism, speech delay and fine motor skills delay. The most prevalent delay described by families was speech delay (104 children). The primary carer was asked to rank the child's medical and/or developmental problem by level of severity as mild, moderate, or severe. Of the 453 conditions ranked for the Brighter Futures children, 42 per cent were ranked as moderate and 20 per cent were ranked as severe.

4.6 Profiling Indigenous families

In the Family Survey, 136 primary carers (13 per cent) identified as Indigenous. For these families, the primary carer was almost always the mother (94 per cent or 128

families), and for 60 per cent of families she was the sole carer. This was a higher rate than for non-Indigenous families (50 per cent). The number of children in Indigenous families ranged from 0 to 8, with a mean of 2.7. The age of the primary carers ranged from 15 to 57 years (two of the primary carers were grandparents). For 18 families (13 per cent) the primary carer was aged between 15 and 20 years. Indigenous families had significantly younger primary carers (mean age of 27.6) than non-Indigenous families (mean age of 30.3 years). This is consistent with national data showing that Aboriginal and Torres Strait Islander women have babies at younger ages than non-Indigenous women. Nevertheless the mean age of primary carers receiving Brighter Futures services is older than the national average age of Aboriginal and Torres Strait Islander mothers (24.8 years) (http://www.aihw.gov.au/indigenous/health/mothers_babies.cfm).

The education level, as reported by primary carers in the Family Survey, was significantly less than that for non-Indigenous carers.[11] For 91 primary carers (67 per cent) that identify as Indigenous, the highest level of education completed by any household member is year 9, 10, or 11. For 24 Indigenous primary carers (18 per cent) had the highest level of education completed as other tertiary qualifications or university.

Fourteen per cent of primary carers identifying as Indigenous had a disability, predominantly psychiatric. For non-Indigenous primary carers, 19 per cent had a disability. The higher rate of disability by non-Indigenous primary carers is consistent with the higher rate of mental illness indicated as a vulnerability for non-Indigenous families. This finding is, however, inconsistent with other research. There is a scarcity of national data that specifically measures the social and emotional wellbeing of Indigenous Australians. But what is available paints a consistent picture of much higher rates of use of mental health services by Indigenous Australians compared to other Australians (ABS & AIHW 2005; AIHW 2008).

There were 194 children identified as Indigenous in the Family Survey population, 54 per cent male and 46 per cent female. Twenty-nine per cent of children were reported by their carer as having a medical problem and 13 per cent were reported to have developmental problems. A total of 134 were aged three years or under.

[11] $t(132)=-4.303$, $p<0.001$. The variance for Indigenous and non-Indigenous was equal, the t-score presented under the assumption of equal variance not assumed. The magnitude of the difference in the means was small.

4.7 Profiling CALD families

In the Family Survey, 134 primary carers (13 per cent) were born in a non-English speaking country, and 138 (13 per cent) said they spoke a language other than English at home. The language most frequently spoken at home (other than English) was Arabic (spoken by 34 primary carers).

Summary

- As of 30 June 2008, there were 671 families (more than 20 per cent of the total) who identified as Indigenous, and 502 still remained in the program.
- Thirty-eight per cent of cases were managed by DoCS, and their main vulnerabilities were domestic violence (57 per cent), parental drug and alcohol misuse (49 per cent) and inadequate parenting skills (49 per cent). Sixty-two per cent of Indigenous families were case-managed by LAs, and their main vulnerabilities were lack of social support (66 per cent), domestic violence (59 per cent) and inadequate supervision or parenting (58 per cent).
- In the Family Survey, 136 primary carers (13 per cent) identified as Indigenous. For these families, the primary carer was almost always the mother (94 per cent or 134 families) and for 60 per cent of families she was the sole carer.

5 Is the Program Being Effectively Implemented?

5.1 How are families entering the program?

At time of data collection there were two main entry pathways into the Brighter Futures program:

1. A risk-of-harm report or a request for assistance to the DoCS Helpline (streamed to the Brighter Futures program by a DoCS Community Services Centre (CSC))
2. A community referral by an agency or an individual to a LA.

The rollout of the partnership between Brighter Futures and the Aboriginal Maternal Infant Health Strategy (AMIHS), which began in June 2008, provides a further pathway direct to a DoCS CSC.

A key feature of the Brighter Futures program is that it was designed to accommodate a program ratio of 80:20 – a model that specifies that 80 per cent of participant families are to enter through the DoCS Helpline pathway (this number also includes families that enter through the AMIHS), and 20 per cent through the community-referral pathway.[12] DoCS EI teams provide services only to families that enter the program through the DoCS Helpline, while LAs case-manage some DoCS Helpline families as well as all families who enter through a community referral. Program Service Provision Guidelines (NSW Department of Community Services, 2007b) stipulate that community referrals are to constitute 40 per cent of the capacity of LAs, and the remaining 60 per cent are to be families referred from the DoCS Helpline.

These specified program ratios have been difficult to realise. As at the end of June 2008, 1,805 families had entered the program via the DoCS Helpline pathway, and 1,008 families through the community referral pathway. This means that 64 per cent of families entered the program via the Helpline pathway and 36 per cent through the community referral pathway – different to the intended 80:20 ratio. The DoCS Helpline numbers appear also to have been boosted through referrals from LA staff. These staff reported advising clients that they could not be accepted into the program via the community referral pathway (due to exceeding the specified capacity ratios), and would have to request assistance through the DoCS Helpline. During Process Evaluation interviews some LA staff expressed frustration at the 80:20 ratio, believing that the ratios should be changed so that more families could enter via the community referral pathway. Research suggests, however, that the families most at risk for child abuse and neglect are those who are least likely to seek assistance from community-support agencies. In a discussion paper examining the participation of vulnerable families in various interventions, Watson (2005, citing Sanders & Cann) states that the risk factors that increase a family's vulnerability also increase the likelihood that they will initially refuse offers of services.

In 2006/07 there were 6,527 requests for assistance to the Helpline (Wood, 2008). Interviews with client families and LA staff indicate that some of these families have been streamed into the Brighter Futures program and were consequently receiving support through it.

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[12] DoCS Brighter Futures Service Provision Guidelines, Dec 2007.

5.2 The case-management of families by DoCS and LAs

A second key feature of the Brighter Futures program is that it was designed for 50 per cent of participant families to be managed by DoCS caseworkers and 50 per cent to be managed by LAs. This ratio is close to being met, with DoCS and LAs managing 45 per cent and 55 per cent respectively. However the ratio has been affected by the progressive rollout of the program within DoCS, as the program was not fully implemented in all regions during this period.

Caseworkers from LAs generally reported higher caseload numbers than their DoCS colleagues (as reported by Brighter Futures staff (n=48) during Round 1 interviews). Discussions with staff highlighted a number of factors that could be contributing to discrepancies in caseload numbers between DoCS and the LAs. These include:

- The more difficult and time-consuming casework required with families who enter via the Helpline pathway. DoCS caseworkers only work with Helpline families, who have not actively sought assistance (unlike many community referral families), and who are often initially resistant to offers of services.

- The differing structures of DoCS and LAs:

    - clear caseload targets are not specified in the original tender documents. Agencies are only contracted to meet a targeted number of families; and

    - many LAs have the advantage of centre-based setups which allow families to access services in-house, whereas DoCS caseworkers must travel to attend LA-run parenting programs, supported playgroups and other services.

- The differing administrative, accountability and training requirements of DoCS and LA caseworkers.

These points indicate the problematic nature of caseload comparisons. To the extent that caseloads are defined simply as the number of families handled by a Brighter Futures caseworker, they are not a true reflection of workload. As well as the points listed above, caseloads do not take account of secondary tasks performed by caseworkers, such as the facilitation or delivery of programs (e.g. delivery of the Parents As Teachers program by DoCS caseworkers), or accompanying colleagues on initial visits.

The higher number of risk-of-harm reports for Helpline families and the differing types of vulnerabilities do indicate that Helpline families have chronic and multiple problems. “We are working with families that are already living in deprived circumstances… and probably [with] more significant issues than what you would hope for.” (DoCS caseworker)

Information from the risk-of-harm reports and from the interviews suggests that the families case-managed by DoCS may be more vulnerable than those case-managed by LAs, and senior EI staff at three of the CSCs located within the four observation sites did allocate the more difficult cases to DoCS rather than to LA caseworkers. Some suggested reasons for this practice include a perception that DoCS caseworkers have

greater experience in child-protection practice. They therefore understand the thresholds for statutory intervention more clearly and are better able to assess and monitor higher-risk families. Secondly, DoCS caseworkers often have higher-level qualifications than their LA colleagues. A degree-level qualification is an essential selection criterion for all DoCS caseworkers.[13]

Interviews with program staff found much disagreement about the differences between families that entered the program via the community pathway and those that entered via the Helpline. Report and interview data do suggest some differences in the level of need, but further research is required. More definitive results will be established by further Family Survey analysis and the ongoing Intensive Outcomes Study.

In two observation sites – both high-volume CSCs – DoCS staff talked about a 'blurring distinction' between 'early intervention' and 'child protection' families:

> Those single-report families are a low priority in the scheme of things. The ones that we end up allocating are the ones that have more entrenched issues. So we are not getting those pure EI families (DoCS worker).

LA coordinators and caseworkers also spoke of working with families with a higher level of risk and need than was originally envisaged. This point was also made in some of the LA submissions to the Special Commission of Inquiry into Child Protection Services in NSW (see section 7.213 of Commission report).

Nonetheless, there is a clear difference between families that enter via the Helpline and those that enter via the community pathway, in relation to families' willingness to engage with program services. Community pathway families have usually sought help from social support services on their own initiative, and so are generally more willing to participate in Brighter Futures. Interview data suggest that Helpline families, in contrast, can be difficult to draw into the program. Caseworkers have reported that the engagement period, which often requires intensive crisis work to stabilise a family, can last for as long as six months.

5.3 What are families' views of the program?

Analysis of Family Survey data at baseline (T1 – at start of program) and at Time 2 (T2 – approximately six months into the program) indicate that participant families, both those managed by DoCS and those managed by LAs, were overwhelmingly satisfied with the quality of the program services and the amount of help they had received through Brighter Futures' services. Parents were asked to rate their overall satisfaction with the quality of the services and the amount of help they received, on a scale of 1 to 5 – with 1 being 'completely dissatisfied' and 5 being 'completely satisfied'. The results indicate that most families were either 'satisfied' or 'completely satisfied' both with the quality of the services and with the help provided through case-management, home-visiting, child care and parenting programs. The mean rating both for the quality of services received and for the amount of help provided – at both T1 and T2 – was 4.5 and above as shown in Table 5.1 below. The smaller numbers in

[13] Aboriginal caseworkers are exempted from this requirement.

the questions relating to child care and parenting programs were due to the fact that many families had not used these services at the time of data collection.

Table 5.1: Parents' ratings of satisfaction

	N T1	N T2	Mean T1	Mean T2	SD T1	SD T2
Quality of Service Received in Brighter Futures						
Case management	967	236	4.8	4.7	0.6	0.9
Home visiting	950	221	4.8	4.6	0.6	0.9
Child care	559	161	4.7	4.7	0.8	0.9
Parenting program	464	157	4.6	4.5	0.8	0.9
Amount of Service Received in Brighter Futures						
Case management	949	235	4.8	4.7	0.6	0.8
Home visiting	929	223	4.6	4.6	1.2	0.9
Child care	547	164	4.7	4.7	0.7	0.8
Parenting program	449	157	4.6	4.5	0.8	0.9

Source: *Family Survey Data File*

These findings are supported by data collected during round 1 interviews undertaken with client families (n=45), most of whom were similarly positive about the program. In total, 37 of 45 families (82 per cent) spoke of their satisfaction with the Brighter Futures program and the services offered.

Such high satisfaction levels are important, as satisfaction has been found to relate to active participation in services (medical and educational interventions in this case) (Cadman, Shurvell, Davies & Bradfield, 1984). It is reasonable to assume, then, that satisfaction with Brighter Futures may similarly be correlated with increased client participation in program services. A study by McNaughton (1994), however, provides a note of caution. In a study that specifically explored parental satisfaction with early intervention services, she found that most parents *do* report a high degree of satisfaction.

McNaughton's (1994) study suggests a relationship between client satisfaction and their expectations for services, and analysis of the Family Survey data at T1 and T2 indicate that the program did meet parental expectations to a high degree. Parents were asked to rank the extent to which program services met their expectations on a scale of 1 to 4 – with 1 being 'not at all' and 4 being 'a lot'. The mean rating was 3.6 for parenting programs and 3.7 for case management, home-visiting and child care, indicating that most parents felt that the program met their expectations either 'quite a bit' or 'a lot'. The results are shown in Table 5.2 below.

Table 5.2: Parents' expectations

	N T1	N T2	Mean T1	Mean T2	SD T1	SD T2
Extent to which this service met expectations						
Case management	918	227	3.7	3.8	0.6	0.5
Home visiting	904	216	3.7	3.8	0.6	0.6
Child care	537	162	3.7	3.8	0.7	0.5
Parenting program	439	151	3.6	3.6	0.8	0.8

Source: ***Family Survey Data File***

The topic of parental expectations was further explored in round 1 interviews, but most participants were vague in their comments. This may reflect the fact that many of the families interviewed were new to family-support services and so had no standard against which to judge. A minority of families (20 per cent) had received other types of programs in the past including: Families First; a drug rehabilitation program; a Red Cross program for refugee families; counselling for domestic violence through a local government community health centre; Anglicare counselling services; a Benevolent Society preparation-for-birth program; and an Anglicare EI program catering specifically for young mothers. The majority of families, however, had had no other program experiences which might have shaped their expectations.

Despite this many mothers expressed a clear expectation of, and need for, emotional support:

> I was happy once they explained what the program was – that someone was going to help, or offer to do things with my kids. That I wasn't going to be on my own, so it was good (DoCS client).

Comments from some families indicated that their high level of satisfaction with services may have been because they found that initial fears that their children would be removed from their care were groundless:

> I didn't pay a great deal of attention when they first came in. My biggest thing was, oh my goodness they're taking the kids. That's all that went through my head (DoCS client).

> I wouldn't change anything actually, because it is really a great program. They should advertise it and people should not be scared of DoCS. That's what I think. DoCS really scared my husband at the beginning, but we came to learn that it is not just taking kids from my family. There are other great supports (DoCS client).

As the last quote shows, some families' experiences of Brighter Futures have led to changes in their initial negative views about DoCS. Many families case-managed by DoCS spoke of how they no longer feared DoCS, and of the solid and trusting relationships they had formed with their DoCS caseworkers.

Because Brighter Futures is a new program, most families knew very little about it and were reliant upon their caseworker to give them information. During interviews,

some families expressed frustration at not knowing more about the program and about what supports and services they were entitled to:

> [My caseworker] basically asked me what I needed and then tried to get me help with whatever I needed, but I've noticed she hasn't really offered me anything that I'm entitled to, that I haven't asked for, because obviously, I don't know what I'm entitled to … So I would like her to have more initiative in that way, like to be able to come to me and say "listen you're entitled to this" or "you're entitled to that" (DoCS client).

This issue was followed up in interviews with caseworkers who spoke about the difficulty of balancing their desire to help families, with the need to ensure that families did not become dependent upon services and supports – particularly financial assistance. Analysis of round 1 interviews with families (n=45) indicates that, despite caseworkers' caution, many families were accessing financial assistance. Brokerage was used to provide assistance to half the families interviewed, most commonly for travel costs (e.g. taxi fares to supported playgroups), clothes (especially school uniforms), and rental arrears.

Brighter Futures provides families with access to a range of services. The three services most commonly used by families interviewed (n=45) were: childcare (about two-thirds of the total cohort); supported playgroups (one-third); and parenting-education programs such as Triple P and Magic 1,2,3 (one-fifth). In addition, about half of the families interviewed were referred to other services through Brighter Futures. These services included counselling (eight families), early childhood facilitators (four families) and health assessments (three families). Other less commonly used services included Learning Links (for children with learning disabilities), Baby Steps, drug rehabilitation services, speech therapy and vacation care services. Referral to other services varied widely by observation site, but was most common in the metropolitan sites. In the rural/regional site only 20 per cent of families were referred to other services, perhaps indicating a general lack of services in regional areas. As one LA manager in a regional site commented, "There is no sense in having children assessed if there is no service available."

Analysis of Family Survey data at T1 and T2 indicates that participant families felt that the program was helpful. On a self-reported measure of satisfaction, parents were asked to rate the extent to which program services had helped them deal more effectively with their concerns. The items were rated on a 4-point Likert scale ranging from 1 ('not at all') to 4 ('a lot'). The mean rating of 3.6 and above indicates that families felt that all program services (i.e. case management, home-visiting, child care and parenting programs) greatly assisted them in helping to deal with their problems. The mean rating was slightly higher for home-visiting and child care (3.7 at T2), indicating that families considered these services most helpful. Further details are provided in Table 5.3 below.

Table 5.3: Parents' ratings of helpfulness

	N T1	N T2	Mean T1	Mean T2	SD T1	SD T2
Extent to which this service helped in dealing more effectively with concerns that brought families into the program						
Case management	919	232	3.6	3.6	0.6	0.7
Home visiting	900	220	3.6	3.7	0.6	0.6
Child care	546	167	3.6	3.7	0.7	0.6
Parenting program	451	153	3.5	3.5	0.8	0.8

Source: *Family Survey Data File*

Finally, parents were asked at both points in time (T1 and T2) whether or not they would recommend Brighter Futures services to a friend, and if they would use Brighter Futures services in the future if they needed to. Parents overwhelmingly said 'yes' to both questions and for all services (99 per cent).

5.4 What are the key barriers and facilitating factors to program implementation?

A number of barriers and facilitators to effective program implementation were identified through the interviews with program staff (n=48) and through researcher observation at the four research sites. The key issues are summarised briefly below. These issues will be explored further in a second round of interviews and analysed in the context of further available data.

Barrier: Difficulties associated with partnership service delivery

The service delivery partnership between DoCS and non-government agencies is a key principle of the Brighter Futures program. The partnership model aims at broadening the scope of service provision, and enhancing the capacity to meet the needs of local children and families. The non-government agencies funded to implement the program represent a diverse range of organisations including: large, faith-based community-service providers; specialist children's services organisations; a consortium of neighbourhood centres; a local council partnering with a family-support service; and small Indigenous agencies and other regional support services. The initial evaluation findings suggest mixed results about the effectiveness of this partnership indicating both challenges and successes.

Research into partnership service delivery has consistently highlighted the considerable time and effort required for collaborative service provision (Sloper, 2002). In the first round of interviews, undertaken between November 2007 and May 2008, caseworkers from both DoCS and the LAs said they wanted to get to know their local Brighter Futures colleagues better, but the constant demands of the job prevented closer and more regular interaction. Many caseworkers commented that joint training was the perfect opportunity for forming stronger relationships and operational partnerships. Some research supports this approach, and suggests that shared learning in groups is an effective way of improving collaborative working (Sloper, 2004).

There was sometimes a lack of clarity about the roles and responsibilities of the various participants. Whilst LA coordinators and DoCS casework managers had regular meetings to ensure effective communication at a management level, communication at the caseworker level was much less regular. At times it was quite ineffective with a few DoCS caseworkers citing examples of role duplication between themselves and LA early childhood facilitators. The effectiveness of the partnership model will be explored in more detail during the next round of interviews, as some of the identified problems may in part be related to the early stage of program implementation at the time of the interviews.

Barrier: Human resource challenges

The human resource challenges in the delivery of Brighter Futures were found to be multiple and complex. Key issues were: difficulties with recruitment and retention; workforce composition; and pay disparity.

High staff turnover has consistently been found to be a problem in community services workforce studies (Briggs et al, 2007). Half of the staff interviewed for the Process Study suggest that this may be a factor in the implementation of Brighter Futures. These staff identified this as an operational problem which caused disruptions to families already receiving services, often resulting in delays to service provision. Some of the families interviewed had had multiple caseworkers and spoke about their difficulty in having to 'tell their story again' and build relationships with new caseworkers. This will be assessed in the context of available administrative data in future reporting.

Recruitment of staff was also identified as an ongoing challenge. During the time of round 1 interviews, three of the four research sites had early intervention teams that were not operating at capacity. Some sites were operating with vacant positions and others had new staff members who had yet to complete EI training.

Another workforce challenge identified during interviews was the disparity between the salaries of LA caseworkers and DoCS caseworkers. Some LA caseworkers expressed feelings of resentment that they were paid less than DoCS caseworkers to undertake what they felt was nearly identical work with children and their families. To some extent, this issue reflects the broader tension of disparities in pay between workers in government and those in non-government agencies. DoCS EI caseworkers, for instance, are employed under NSW Public Sector conditions which indicate a salary range of $53,855 - $74,408. In contrast, LA caseworkers are employed under the Social and Community Services Employees (SACS) Award which has a salary range of $29,173 - $62,123. As mentioned in section 5.2 above, however, a degree-level qualification is a requirement for all DoCS caseworkers, but not for all LA caseworkers.

Barrier: Relationship between DoCS Child Protection and EI teams

At CSCs in two of the four observation sites there was some evidence of division between EI staff and Child Protection staff. At one site, half the caseworkers interviewed commented on tension between EI and CP teams, and whilst this represents only a small number of caseworkers, it was a serious concern for those involved.

> There is conflict with Child Protection because CP struggles and they don't see that we struggle because our stuff isn't crisis response. They don't see the intensity and complexity of the work that we do ... Child Protection seems angry that there are a whole lot of resources being put into another program (DoCS worker).

There was evidence that this issue had affected the morale of EI staff at two observation sites. They felt that their role in DoCS was not understood, respected or valued by the staff involved in Child Protection. Interestingly, this issue is neither unique to Brighter Futures nor to NSW. A recent UK study of multi-agency working within an EI context (Moran et al, 2007) found that social workers operating at statutory levels appeared to place less value on EI work. The authors of the study suggested that this might be a teething issue related to staff resistance to organisational change. This issue will be examined more closely in round 2 interviews.

Barrier: Stigma attached to DoCS

Almost one-fifth of the caseworkers reported that a stigma attached to DoCS was sometimes an initial barrier to family engagement, and therefore to the successful implementation of the program. Caseworkers reported that some families, upon hearing the word 'DoCS', declined to participate in the program or were harder to engage because they thought DoCS was just for taking the kids away (DoCS family). The interview data suggest however, that this view is changing – and that Brighter Futures has the potential to change people's long-held views about DoCS.

In total, 14 families (a third of interviewees) explicitly stated that their views of DoCS had changed as a result of participating in Brighter Futures. This was particularly evident at the rural/regional site where six interviewees – most of whom were Indigenous – indicated that their beliefs about DoCS had improved:

> I've realised from this program that [DoCS] are not there to take your child. They're there to help you keep your child because the best place for your child is the mother (DoCS client).

Many families were initially unaware that DoCS provided support services believing instead that the role of DoCS was to remove children from families. Some clients also made a clear distinction between DoCS and Brighter Futures:

> I didn't even know there was a program called Brighter Futures until [my caseworker] came out and explained it all to me. I thought DoCS was just for taking the kids away, that's what I thought it was. But now I know better and it's not.

> A lot of people have been telling me "Don't go to her" because they're saying that DoCS, they're going to muck around with you and get [my daughter]. That's what some people say to me, and I'm just like, "No, they're not going to. They're just helping me with things, like the appointments and everything". I tried telling them, but they just don't want to listen, don't want to hear it (DoCS client).

Barrier: Administrative requirements

The administrative and accountability requirements associated with Brighter Futures were most commonly identified by DoCS caseworkers as concerns affecting program implementation. Half of the DoCS caseworkers interviewed felt that the administrative requirements were onerous. Moreover, caseworkers did not feel that the paperwork involved in providing services improved their case planning or service provision, but rather was a burden undertaken largely for accountability requirements. A number of caseworkers said that a single home visit required three hours of paperwork.

Many DoCS caseworkers felt that their administrative work was complicated by the computer-based case-management system, KiDS, and expressed their frustration with it. They described it as "unfriendly", "slow" and not tailored to suit the requirements of EI caseworkers. The Wood Commission report (2008) similarly detailed many features of this system that were a source of frustration and delay for DoCS staff.

Facilitator: Training and support materials

DoCS and LA caseworkers were generally happy with the training opportunities available to them. Nearly all the workers interviewed, both DoCS and LA, said that they had participated in initial EI training and/or specific training around engaging voluntary families and dealing with specific issues such as domestic violence. DoCS caseworkers were satisfied with the amount of training provided for Brighter Futures but there were some critical comments about the inconsistent quality of the training programs and the basic nature of the program content – especially from more experienced caseworkers.

Some DoCS caseworkers were also critical of the city-based location of most of the training programs, with many questioning why training could not be provided in DoCS' regions. Travelling long distances to attend training courses was difficult for part-time staff and for those with childcare responsibilities such as picking children up from schools.

LA caseworkers did not undertake as much training as their DoCS colleagues and many commented that joint training initiatives would go a long way towards building more effective partnerships in family-support service provision. Both DoCS and LA caseworkers showed a high level of interest in more shared training.

Facilitator: Satisfaction of DoCS casework staff

The overwhelming majority of DoCS EI staff interviewed showed obvious job satisfaction. Many caseworkers spoke of their immense pleasure in working with families in an intensive, supportive way directed towards keeping a family together. Staff who had worked previously in Child Protection in particular found the change in practice professionally reinvigorating, and asserted their commitment to the program and its goals:

> Involvement in the program has been fascinating and rewarding. I've seen a number of families go through significant changes, positive changes in the way they've been able to use their own personal strengths (DoCS caseworker).

> Once [staff] start to have any sort of caseload and they start working with those families, they start loving the program. It's very rewarding. But for me, I'll be honest, it wasn't really hard. It's almost saved me from leaving. I was so ready for [this type of working] (DoCS caseworker).

Expressions of job satisfaction were slightly more frequent amongst DoCS caseworkers than LA caseworkers, and levels of job satisfaction reported by caseworkers differed from one observation site to another. Interestingly, the highest level of job satisfaction was recorded in the rural/regional site where caseworkers faced a number of shortages of services.

Facilitator: Comprehensive program services

Brighter Futures is a flexible and comprehensive program that provides multiple services to vulnerable families. The program model enables caseworkers to tailor service provision to suit the individual needs of participant families in line with the resources available within local communities. During interviews with families it became apparent that mothers valued the program's responsive and intensive case management above all other services, particularly when delivered in the home. Parents did not talk about home visits as such[14]. Instead, they identified the emotional support they received from caseworkers as the main benefit of the program for them. Many mothers also spoke of the convenience and benefit of having a caseworker visit their home. Mental health problems were reported from all observation sites – maternal depression in particular was a common vulnerability. The data indicate that for this vulnerable client group, especially single mothers, casework delivered in the home is a highly appropriate component of the program model.

Of all the services available through Brighter Futures, caseworkers reported that the provision of brokerage funds and child care best facilitated program implementation, as they were an incentive for families to engage with the program. One-quarter of the caseworkers interviewed thought that their ability to provide brokerage funds to vulnerable families was an important factor in the success of Brighter Futures.

Caseworkers reported in addition that the duration of program services was a facilitator for success, as two years enabled them to build solid and trusting relationships with clients. The literature points to the importance of this relationship and to the likelihood that interventions will be more effective in a context of trust built up through understanding and shared decision-making (Fonagy et al, 2002).

Facilitator: Clients' relationships with caseworkers

Process Evaluation interviews with client families indicated that the key determinant influencing parents' evaluations of their experiences with Brighter Futures was the personality and performance of their caseworker. The majority of families were overwhelmingly positive about their caseworker:

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[14] Home-visiting services are defined in Brighter Futures as appropriate, structured, manualised and evidenced-based programs provided by well-trained and supported staff (DoCS, Service Provision Guidelines, December 2007, p. 13)

> [My caseworker] is brilliant … talking to her is like my best friend really, because I don't have many friends around me. I can't have because part of me is I'm embarrassed because of my son. He doesn't stop talking and his behavior is not appropriate, and I get too embarrassed to have friends around me. And having my caseworker there once a week – she makes me think straight and just talking to her is really good. She calms the children down so we can concentrate on the positives and just try to get things focused in a better way (Brighter Futures' client).

The majority of families interviewed had built strong relationships with their caseworkers. Indeed, it was this relationship that mothers mentioned again and again during the interviews. The relationship was often characterised as a partnership – with both mother and caseworker working together for the benefit of the child/ren.

Families appreciated caseworkers who worked beyond the procedural requirements of their job, were trustworthy in carrying out promised tasks, and were non-judgmental:

> Our caseworker – I believe she is very sympathetic and has a very kind heart. Although this job is her duty, but she could not do it so well and help us so much without a kind heart. She cared about us, not only our money problems (Brighter Futures' client).

Other attributes of caseworkers that families valued were their proactive engagement with families, and their ability to make and sustain relationships with their children.

5.5 Providing services to Indigenous families

Seven of the 44 primary carers interviewed for the Process Evaluation identified themselves, their partners, and/or at least one of their children as of Aboriginal or Torres Strait Islander background. Six of these families came from an observation site located in a rural/regional area with a large Aboriginal population. Some program staff at two other observation sites reported some difficulty in engaging Aboriginal families, although the program participation rates of Aboriginal families suggest that this is more of an isolated problem than a general difficulty.

During Process Evaluation interviews, seven DoCS caseworkers (i.e. a quarter of those interviewed) expressed the view that employing Aboriginal caseworkers was essential for engaging the local Aboriginal community and recruiting individual families. Yet at the time of round 1 data collection only two observation sites had Indigenous workers attached either to DoCS or to the LA. Caseworkers in the one site with an Indigenous caseworker expressed a desire to recruit more Indigenous caseworkers to their team in order to improve relationships with Aboriginal families and to ease the workload pressures on the existing Aboriginal caseworker. Aboriginal caseworkers were described as a valuable resource for the whole of the Brighter Futures team. As one case manager said, "We need these workers to be our link to the community and to educate our staff as well." Local knowledge of the Aboriginal families in certain areas was seen as critical when attempting to bring families into the program. One non-Indigenous caseworker also spoke of the importance of having an Aboriginal worker present when initial contact was made with an Aboriginal family.

In Process Evaluation interviews with both families and agency staff it was clear that not all Aboriginal families wanted to use Aboriginal services or to engage with

Aboriginal workers. One father, the main carer of five young children, had been recommended to attend an Aboriginal men's group. As he had had unhappy experiences attending such a group in the past (for alcohol issues), he did not want to get involved again. He was not in favour of group work and of sharing his problems. He was, however, highly supportive of the confidential one-on-one approach used by his non-Indigenous caseworker in helping him to sort through the family's issues, especially his unsatisfactory housing arrangements and his wife's gambling habits and mental health problems.

This father was not supportive of the notion that Aboriginal families "should stick to their own communities and white people should stick to their own." His experience with Brighter Futures had changed not only his perception of DoCS, but also his views about working with Brighter Futures non-Indigenous staff. As he said, "I've got more response and I've got a better feeling and attitude talking to [my caseworker] than I have talking to my own people."

Another non-Indigenous worker spoke of a similar experience, this time of privacy concerns expressed by an Aboriginal family who did not want their issues to become common knowledge in the Aboriginal community and so preferred a non-Indigenous worker. The worker argued that Aboriginal services and resources were good, but as she said, "I think it's good to have the availability of [Aboriginal services] but we shouldn't take for granted that that's what they want."

These comments fit with the perceptions of some workers interviewed who noted that some of the Aboriginal families who become involved in Brighter Futures are often trying to distance themselves from their community's entrenched problems and build better lives for their children. Workers noted that if the 'word of mouth' from Aboriginal families using Brighter Futures was positive, then other families may be more willing to participate in the program. Some workers felt that a 'softly, softly' approach worked best with Aboriginal families and that workers were more likely to gain the family's trust if the pressing external problems responsible for a family's stressful situation (for example, inadequate housing, rent arrears) were addressed before focusing on parenting concerns.

Ongoing home visits by caseworkers appeared to work well and this was a preferred option for Aboriginal families who were reluctant to become engaged in groups (e.g. playgroups, men's groups). The use of the Parents as Teachers (PAT) program by caseworkers with young Aboriginal mothers in their homes was reported by interviewed mothers and caseworkers to be beneficial, with noticeable improvements in attachment and bonding, and in children's development. Most workers interviewed were of the opinion that it took extra time to work with Aboriginal families. Managers argued that it was critical to gain an understanding of the extended family/kinship dynamics and to use understanding and sensitivity in gaining trust.

At the regional observation site, some caseworkers noted that some Aboriginal families lived in isolated settings, frequently subletting on someone else's property and living in caravans in very substandard conditions. Poor housing and no private transport, exacerbated by living in isolated suburbs or Aboriginal settlements, meant that the transporting of Aboriginal families to services was a high priority, especially picking up and dropping off Aboriginal children to attend pre-schools on a regular basis. The case manager at the rural site also stated that the few Aboriginal-based

services that do exist do not have the resources or the staff to meet the demand in larger Aboriginal communities.

Workers found that engaging with the grandparents (especially the maternal grandmothers) of the Aboriginal families in Brighter Futures was often an important aspect of maintaining the family's engagement in the program. Due to the necessity of engaging the extended family and the fact that many Aboriginal families have large numbers of children (many of them very young), some concern was expressed by case managers that there was a need to reduce the caseload of Aboriginal caseworkers.

At the regional site the numbers of Aboriginal families accessing the program were increasing, with some families requesting assistance at the local CSC or LA. Six of the seven Aboriginal families interviewed voiced their satisfaction with Brighter Futures services and with the program in general. Additionally, three of these families acknowledged that participation in the program had positively affected their perceptions of DoCS.

5.6 Providing services to CALD families[15]

Approximately 13 per cent of the Family Survey population were born in non-English-speaking countries and spoke a language other than English at home. The proportion of CALD families interviewed as part of the Process Evaluation was significantly smaller, with only two of 44 families identifying as CALD. Both of these families spoke a language other than English in the home (Chinese and Arabic), and both required translators to participate in the interview. Several other interviewees had multicultural backgrounds although they spoke English as their first language. These families did not identify as CALD. DoCS casework managers at two of the observation sites commented on the small number of CALD participants. These managers reported that the majority of their participant families were Anglo-Australian, despite the fact that the services were located in areas with large multicultural populations.

The two CALD families and most of the families with multicultural backgrounds were located in the same observation site – an area with a diverse multicultural mix. Service providers in this site were very aware of the issues for CALD and multicultural families. They had readily available translators and workers who spoke many languages (including Arabic), and there was a Multicultural Worker within the site, who was available for caseworkers to go to for advice and who would attend home visits when needed.

Several caseworkers said that service provision was often complicated by the fact that some families required help around residency issues and were legally unable to work or to access government benefits or Medicare. The two CALD families interviewed were both dealing with immigration issues and were relying on their caseworkers for support and assistance around this. Their caseworkers often provided assistance in the filling out of forms and in advocating on the families' behalf to the Department of Immigration.

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[15] The definition of CALD used by DoCS is "a person born overseas in a non-English speaking country, or who has at least one parent born overseas in a non-English speaking country."

The CALD families we spoke to reported that they were extremely satisfied with the services provided by their caseworker. This high level of satisfaction was also reflected in Family Survey data which showed that more than 91 per cent of CALD and Aboriginal clients 'agreed' or 'strongly agreed' that case-management and home-visiting services, as well as childcare and parenting programs, took into account their families' cultural beliefs and values. Parents were asked to rate, on a scale of 1 ('strongly agree') to 4 ('strongly disagree'), the extent to which they agreed with the statement that 'the service took into account my cultural beliefs and values in the way that it worked with my family'. The mean rating was 1.6 for all services. A small number of responses 'strongly disagreed' that program services acknowledged their cultural beliefs and values.

Family Survey data also showed that 93 per cent of CALD clients 'agreed' or 'strongly agreed' that the services provided to them were culturally inclusive, through the use of bilingual workers and interpreters. The mean rating of 1.9 was recorded for parenting programs by families who had been in the program approximately 9 months (T2). Further details are shown in Table 5.4 below.

Table 5.4: CALD and Aboriginal parents' rating on cultural consideration

	N T1	N T2	Mean T1	Mean T2	SD T1	SD T2
Extent to which this service took into account their cultural beliefs and values in a way that worked for their family						
Case management	275	67	1.7	1.7	0.8	0.9
Home visiting	273	61	1.7	1.7	0.8	0.9
Child care	180	57	1.6	1.7	0.8	0.9
Parenting program	156	39	1.6	1.8	0.8	0.9
For CALD clients who do not speak English well, the extent to which the service helped them overcome language barriers						
Case management	72	23	1.5	1.4	0.8	0.8
Home visiting	71	21	1.5	1.5	0.7	0.8
Child care	40	16	1.5	1.6	0.6	0.9
Parenting program	47	15	1.5	1.9	0.7	0.7

Source: *Family Survey Data File*

> Caseworkers reported that CALD families had many complex needs, particularly those for whom residency issues were yet to be resolved. CALD families often required time-consuming and differential forms of engagement and intervention, as the language barrier in particular meant that non-English-speaking clients could not simply be referred to supported playgroups and parenting programs. In providing services to these clients, caseworkers often spoke of the need to work more collaboratively with other multicultural service providers.

The two CALD families interviewed spoke of the benefit of having a caseworker who shared their cultural background. They often said their caseworker was sensitive to their particular cultural issues. As well as overcoming the language barrier for non-

English speakers, a shared cultural background strengthened the relationship between caseworker and client family. This observation aligns with other studies of family support services, particularly from the UK, where ethnic women clients felt that a caseworker of the same ethnicity was aware of their views, as well as the problems and difficulties encountered within their ethnic community (see for example Gray, 2003).

It also became clear during data collection that caseworkers with a second language were not being allocated exclusively to families who shared the same language and/or cultural background. One caseworker suggested that a narrow caseload comprising families from only one cultural group could be professionally de-skilling:

> Mostly since I started I work with Arabic families because I speak the same language and it's easier for them and it's easier for me to engage with these families ... but lately I feel I needed more, different cultures to work with (DoCS caseworker).

Caseworkers also spoke about a lack of resources and services available to families that did not speak English – in particular, multi-lingual pamphlets and brochures. Caseworkers' frustration may be due, however, to a lack of awareness of what is available as there are two pamphlets in 12 languages accessible on DoCS' website (http://www.community.nsw.gov.au/for_agencies_that_work_with_us/early_intervention_services/brighter_futures_resources.html). One pamphlet has information about the Brighter Futures Program and the other has information about parenting.

6 What is the Impact of the Program?

The four aims of the Brighter Futures program that are relevant to the program's impact are as follows:

1. To reduce child abuse and neglect by reducing the likelihood of family problems escalating into crisis and into the child protection system.

2. To reduce the demand for services that otherwise might be needed down the track, such as child protection, corrective services or mental health services.

3. To achieve long-term benefits for children by improving intellectual development, educational outcomes and employment chances.

4. To improve parent-child relationships and parents' capacity to build positive relationships and raise stronger, healthier children.

The evaluation is a longitudinal study gathering information over a two-year period. As part of this evaluation, the Family Survey is given to families three times: at intake, at six months into the program, and at exit (SPRC, 2007). Changes in outcomes for the children and for parent-child relationships are being tracked throughout their participation and after they have left the program through risk-of-harm reports.

6.1 Risk-of-harm report frequency

The Brighter Futures program aims to reduce the likelihood of family problems escalating into crisis and into the child protection system. The program's effectiveness in this regard is measured through comparing the number of risk-of-harm reports made on program families prior to entry, with the number of reports made after families exit the program.

The evaluation was provided with risk-of-harm reports on all families that are currently in the program and those that have exited. The data provided consisted of risk-of-harm reports for 24 months prior to families beginning the program, for the time they are in the program and for 12 months after they have exited the program.

For this Interim Report, the average number of risk-of-harm reports was calculated for children with at least one report in the three and six month time periods prior to program entry. This was compared to the average number of reports made for these children in the same time periods (i.e. three and six months) after exiting the program. Only children who had exited the program for at least three and six months prior to 30 June 2008 are included. Children who were not reported in the three or six months prior to entry are excluded from the analysis. These children may have received risk-of-harm reports in the three or six months after exiting the program. The methodology will be changed to include these children for the next report.

In future analysis, the number of risk-of-harm reports for families who have exited for at least 12 months will be compared to the number of reports these families received in the 12 months prior to entry. The data will also be explored in terms of the length of time in which families participate in the program.

Table 6.1 shows that, overall, the children received significantly less reports on average at three and six months post participation compared with the average number of reports received in the same time periods (i.e. three and six months) before entering the program. While there was a significant reduction in the average number of reports for Aboriginal children in the three months after exit, the reduction in reports in the six month period was not statistically significant.

Table 6.1: Average number of reports per child at 3 and 6 months prior to and post Brighter Futures program

Length of time post Brighter Futures Program	Number of children	Average number of reports prior	Average number of reports post	p-value
All Children				
3 Months	758	2.38	0.84	0.000*
6 Months	506	2.71	1.65	0.000*
Indigenous				
3 Months	164	2.87	1.35	0.000*
6 Months	95	2.74	2.49	0.467
Non-Indigenous				
3 Months	594	2.25	0.70	0.000*
6 Months	411	2.71	1.45	0.000*

Source: *Reports Data File*
*Indicates significant results

Reasons for exiting the program were grouped into two categories: plan goal achieved and other reasons, and the number of reports prior to and post program participation compared. For families that have exited for at least three months, the average number of report per child declined significantly from 2.12 to 0.39 (Table 6.2) for those who had exited due to plan goal achieved.

Table 6.2: Average number of reports per child at 3 and 6 months prior to and post Brighter Futures program by reason for exit

Length of time post Brighter Futures Program	Number of children	Average number of reports prior	Average number of reports post	p-value
Plan Goal Achieved				
3 Months	156	2.12	0.39	0.000*
6 Months	100	2.34	1.23	0.000*
Other Reasons				
3 Months	602	2.45	0.96	0.000*
6 Months	406	2.80	1.75	0.000*

Source: *Reports Data File*
*Indicates significant results

Families enter the program by community pathway or by DoCS Helpline pathway. The average number of reports was analysed prior to entry and post exit from the program at three and six months. The average number of reports per child for families that entered via the community pathway is 1.99 three months prior to entry into the

program compared to 2.47 for families that enter via the DoCS Helpline. Three months after exiting from the program, the average number of reports drops to 1.18 and 0.77 respectively (Table 6.3).

The average number of reports per child was significantly reduced three and six months post exit from the program for those who entered via both the Helpline and community pathways.

Table 6.3: Average number of reports per child at 3 and 6 months prior to and post Brighter Futures program by entry pathway

Length of time post Brighter Futures Program	Number of children	Average number of reports prior	Average number of reports post	p-value
Community				
3 Months	142	1.99	1.18	0.000*
6 Months	121	2.33	1.60	0.005*
Helpline				
3 Months	616	2.47	0.77	0.000*
6 Months	385	2.83	1.66	0.000*

Source: *Reports Data File*
*Indicates significant results

Case management is undertaken by DoCS and Lead Agencies (LAs). The average number of reports per child was less for families case-managed by Lead Agencies as compared to those case-managed by DoCS. When examining reports three and six months prior to and post the program, the average number of reports per child was significantly lower for both DoCS and Lead Agency managed families.

Table 6.4: Average number of reports per child at 3 and 6 months prior to and post Brighter Futures program by case management

Length of time post Brighter Futures Program	Number of children	Average number of reports prior	Average number of reports post	p-value
DoCS Managed				
3 Months	573	2.50	0.80	0.000*
6 Months	351	2.87	1.72	0.000*
Lead Agency Managed				
3 Months	185	2.02	0.98	0.000*
6 Months	155	2.36	1.48	0.000*

Source: *Reports Data File*
*Indicates significant results

6.2 Client families' initial outcomes

Child outcomes

The Family Survey used two instruments to measure the Brighter Futures child outcomes: the Eyberg Child Behaviour Inventory (ECBI) and the Brief Infant Toddler Social Emotional Assessment (BITSEA).

Eyberg Child Behaviour Inventory (ECBI)

The ECBI is a 36-item, multi-dimensional measure of parental perceptions of disruptive behaviour in children aged two to 16 years. It incorporates a measure of the frequency of disruptive behaviours (Intensity Scale score), rated on a 7-point scale assessing how often the behaviours currently occur (one meaning 'never', four meaning 'sometimes', and seven meaning 'always'). If children score 131 or above on this scale (the clinical cut-off score), they are considered to require clinical intervention for their behavioural difficulties. Scores are computed by summing the Intensity Scale scores.[16] In the Brighter Futures evaluation, the ECBI was completed for 640 children aged over 24 months, and produced an average score of 127 (*SD*=40), i.e. just below the clinical cut-off point.[17]

Table 6.5: Eyberg clinical cut-off scores by age range and gender

	2 to 5 years of age		6 to 9 years of age		10 years and over	
ECBI*	Girls	Boys	Girls	Boys	Girls	Boys
Eyberg Intensity is <131	128	131	26	28	10	6
Eyberg Intensity is ≥131	65	128	25	50	3	10

Source: *Family Survey Data File*
Note: *Missing data on 30 cases

This tool found that nearly half the children (46 per cent) reached the cut-off score for the clinical range, and hence were deemed to 'require intervention' for behavioural problems (Table 6.5). Sixty-nine per cent of the children who were identified as requiring intervention were two to five years of age, and 66 per cent were boys (128).

Brief Infant Toddler Social Emotional Assessment (BITSEA)

The BITSEA is a 42-item, parent-report tool for identifying children aged 12 months to 35 months who may have social-emotional and behavioural problems and/or delays. The tool was used for children aged 12 months to 24 months in the Brighter Futures evaluation. The instrument assesses both the *problem* score and the total *competency* score of the child. The BITSEA instrument was completed for 148 children in the Brighter Futures program – 70 girls and 78 boys. Ninety-seven per cent of the children's BITSEA scores suggest social-emotional and behavioural problems (mean=45, *SD*=11).

16 The ECBI has a high internal consistency for intensity (r=0.95) and has good test-retest reliability (r=0.86) (Sanders, et al., 2000).

17 Some studies use clinical cut-off scores of 127.

Parental outcomes

There is growing evidence that parenting behaviours influence child behavioural and developmental outcomes, and there are strong associations between parenting quality and child outcomes (Collins, et al., 2000, Zubrick, et al., 2006). Optimal or quality parenting varies with the age and competencies of the child, but research has identified three dimensions of parenting that have an important impact on children's subsequent health and development. These dimensions are parental warmth, hostile parenting and consistency (Zubrick, et al., 2006).

The Family Survey asked carers a number of questions on parenting, and about their relationship with the child and that of their partner with the child. Many of these questions were sourced from the Longitudinal Study of Australian Children (LSAC), the National Longitudinal Study of Canadian Youth (NLSCY), the Rosenberg Self Esteem Scale[18] (RSE) and the Personal Well Being Index (PWI)[19]. The preliminary analysis is presented below.

Parental warmth

Parental warmth refers to interactions between parent and child characterised by affectionate behaviours, a high degree of positive regard, the expression of enjoyment of the child's company and other positive expressions of approval and support (Rothbaum and Weisz, 1994). Warm and affectionate parenting has been consistently related to positive developmental outcomes for children, with good predictive power over periods of up to ten years.

The survey asked two questions to estimate parental warmth in relation to children aged 24 months and above. These were taken from the LSAC with a scale of one for 'never or almost never' to five for 'always or almost always', and the scores were summed to get a total for the parental warmth factor. The two questions were positively worded and were determined for children in two age-groupings: aged 24 months plus and aged 12 months to under 24 months. The mean result for parental warmth was 9.3 for those aged above 24 months, and 9.5 for those aged 12 to under 24 months (Table 6.6).

Table 6.6: Parental warmth at different ages

	N	Min	Max	*Mean*	*SD*
Parental Warmth Aged ≥24months	631	2	10	9.3	1.5
Parental Warmth Aged 12 to less than 24 months	154	4	10	9.5	1.0

Source: *Family Survey Data File*

[18] The Rosenberg Self Esteem Scale (RSE) is a 10 item scale that measures self esteem using self-acceptance and self worth statements.

[19] The Personal Wellbeing Index (PWI) is a scale that combines indices of living standards, personal health, life achievement, personal relationships, personal safety, community connectedness, future security, and spirituality to provide an overall estimate of personal satisfaction.

The parental warmth indicator was significantly correlated with the ECBI, and the higher the ECBI score the lower the parental warmth score (a correlation coefficient of -0.25 ($\rho<0.01$)). No significant relationship was found between the parental warmth score and the BITSEA score.

Hostile parenting

The ways in which parents manage challenging or problematic child behaviour is also important for effective parenting. The types of discipline strategies associated with poor outcomes for children have been broadly documented and when these strategies are reduced children's behaviour improves (Patterson, et al., 1989).

The scores for the questions on hostile parenting in the Family Survey were negatively skewed; i.e. the higher the score, the more often these events happened. Scores ranged from one for 'not at all' to 10 for 'all the time'. Parents in this study were found to be slightly more hostile towards their children than those in the LSAC. The Brighter Futures mean on this question was 11.5 (out of a maximum of 30 and a minimum of three) (Table 6.7), while the Australian mean, from LSAC, was 9.7.

Table 6.7: Hostile parenting

	N	*Mean*	*SD*
Parenting Hostile factor (LSAC)*	999	11.5	6.3
I have been angry with this child	998	4.1	2.3
When this child cries, he/she gets on my nerves	995	3.4	2.4
I have raised my voice with or shouted at this child	998	4.1	2.5

Source: *Family Survey Data File*
Note: *25 missing cases

Parental hostility was significantly positively correlated with the ECBI score ($r=0.575$ $p<0.01$) and the age of the child ($r=0.413$ $p<0.01$). No relationship was found between the parental hostility and age of primary carer, level of education or income level, or the BITSEA problem or competency scores.

Parental self-efficacy

Parental Self-Efficacy (PSE) refers to the extent to which parents perceived themselves to be as competent as, as good as, or better than, other parents. PSE has been found to be highly correlated with parenting behaviours (warmth, hostility and consistency), parent psycho-social wellbeing, family conflict and children's outcomes (Sanders et al., 1999). Global parental self-efficacy is assessed using a single item measuring overall self-efficacy as a parent: 'Overall, as a parent, do you feel that you are ...', with responses on a five-point Likert scale, ranging from 1 ('a very good parent') to 5 ('not very good at being a parent'). On the whole, the primary carers felt they were 'better than average' parents. Only 11 per cent of participants stated that they had 'some trouble being a parent', or felt they were 'not very good at being a parent' (Table 6.8).

However, this percentage is higher than that found among parents in the infant cohort in the LSAC Time 1 data. Fewer than two per cent of these parents said they had some trouble being a parent or were not very good at being a parent (Zubrick, et al., 2006: 94).

Table 6.8: Primary carer parental self-efficacy

	Number	Col %
A very good parent	295	30
A better than average parent	241	24
An average parent	349	35
A person who has some trouble being a parent	98	10
Not very good at being a parent	10	1
Total	993	100
Missing	31	
Total	1024	

Source: *Family Survey Data File*

Zubrick et al. (2008) found that factors such as the child's sex and age, the parent's age and employment status, and the family's income, structure and size were not significantly related to primary carer reports of their parenting self-efficacy. These researchers identified only two demographic variables associated with parenting self-efficacy: overseas birth of the mother and mother's educational level. Mothers born overseas were less likely to feel that they were not good at being a parent than Australian-born mothers (odds ratio=0.44), while mothers with low levels of education were more likely to feel they lacked parenting efficacy (Zubrick, et al., 2008).

The Family Survey also asked parents questions, sourced from LSAC, about how effective they felt in: 1) calming the child, 2) keeping the child busy while they did housework and 3) routinely caring for the child. Parents were asked to give a higher number the more the statement represented 'exactly how I feel'. The answers were summed to give a score for specific forms of parental efficacy. On average, parents felt generally effective in these areas (Table 6.9).

Table 6.9: Specific forms of parental efficacy

	N	Mean	Std. Dev
Parent specific efficacy (LSAC)*	997	23.1	5.6
I feel that I am very good at calming this child when he/she is upset	993	7.6	2.4
I feel that I am very good at keeping this child busy when I'm doing housework	994	6.9	2.6
I feel that I am very good at routine tasks of caring for this child	995	8.8	1.9

Source: *Family Survey Data File*
Note: *27 Missing Cases

The factors influencing parental self-efficacy that were found to be statistically significant were: the child's age, the ECBI score and the child's health. The older the child and the lower the ECBI, the higher the parent's self-rating ($r=0.197$ $p<0.01$ and $r=-0.258$ $p< 0.01$); the poorer the child's health, the lower the parent's rating ($r=-0.225$ $p<0.01$).

There were no statistically significant correlations between parental efficacy and BITSEA scores on children's behaviour problems and competency, the existence of a secondary carer, country of birth, number of children, education level or income.

Positive parenting

Children who experience positive interactions with a nurturing and involved parent have better school and social outcomes than those who do not (Thomas, 2006). Five items measuring positive parenting were extracted from the National Longitudinal Study of Canadian Youth (NLSCY) and summed to obtain an overall positive-parenting score. A higher score indicates more positive parent-child interaction, with scores ranging from 'never undertaking an activity' (a score of 5) to 'many times a day' (a score of 25). The positive-parenting factor mean score for the families surveyed was 19.7 (*SD*=3.8).

High levels of positive parent–child interaction were reported for more than 72 per cent of the children in the Brighter Futures program, compared with the Canadian study average of 82 per cent. Most parents in the Brighter Futures program praised their child but they were less likely to play sport or engage in hobbies together or to do something special that their child enjoyed (Table 6.10).

Table 6.10: Positive parenting

	N	Mean	Std Dev
Parenting Positive Factor (NLSCY)*	999	19.7	3.8
Do something special together that your child enjoys	993	3.8	1.0
Laugh with your child	999	4.3	0.9
Praise your child	992	4.4	0.9
Talk or play focusing attention on your child for 5 minutes or more	996	4.2	0.9
Play sports or hobbies together	977	3.1	1.4

Source: *Family Survey Data File*
Note: *25 missing cases

There was a positive correlation between the health status of the child and the degree of positive parenting by the primary carer ($r=0.244$ $p<0.01$). None of the primary carers' demographic factors such as gender, age, employment, income or education level correlated with parental behaviour, unlike the NLSCY, which did find that income was weakly related to positive parent-child interactions.

Support for primary carer

One of the vulnerabilities addressed by Brighter Futures program is the lack of extended family or social support. Social support is an important measure in itself and is an important determinant of many outcomes, for both parents and children. Parents with higher levels of social support have been found to have better psychological health outcomes and maintaining important sources for parenting support allows for more effective child-raising (Zubrick, et al., 2006: 32). In the case of the primary carers surveyed for this evaluation, only around 40 per cent felt that they got enough support from friends or family, while 50 per cent felt that they did not get enough help, or any help at all (Table 6.11).

Table 6.11: Satisfaction with the support provided by source

	Family		Friends		Other	
	Number	%	Number	%	Number	%
I don't need any help	23	2	90	9	81	9
I don't get any help at all	198	20	305	31	223	25
I don't get enough help	341	34	219	22	207	24
I get enough help	443	44	371	38	375	42
Total	1005	100	985	100	138	100
Missing	19		39		1024	

Source: *Family Survey Data File*

The survey also asked how often carers felt they needed support or help but couldn't get it from anyone (other than their caseworker). More than half (53 per cent) stated that they 'sometimes' felt they couldn't get support, while 33 per cent stated that they 'often' or 'very often' felt they couldn't (Table 6.12). These percentages are much higher than the LSAC percentages for the same question. In LSAC, only about one-quarter of primary carers reported feeling unsupported by family and friends (Zubrick, et al., 2006).

Lack of social support for the primary carers in this evaluation was associated with higher BITSEA problem scores for children aged less than 24 months ($r=0.307$ $p<0.01$), and with number of children ($r=0.152$ $p<0.01$). As was the case with the LSAC cohort of children of the same age, no relationship was found between levels of support and levels of education and income. For the primary carers of children aged 24 months and over, high ECBI scores were associated with lack of support ($r=0.193$ $p<0.01$). For comparable ages in LSAC (4 years 3 months to 5 years), variables that were significantly associated with inadequate support for carers included employment arrangements and number of children.

Table 6.12: Primary carer access to support

	Number*	%
I don't need support	10	1
Never	136	13
Sometimes	535	53
Often	200	20
Very often	127	13
Total	1008	100

Source: *Family Survey Data File*
Note: *16 Missing cases

Relationship testing

Parental wellbeing is strongly associated with relationship functioning. Parents who report low satisfaction with their relationships with their partners, and more arguments, experience higher levels of psychological distress, lower levels of coping, and more life difficulties (Zubrick, et al., 2006).

Parents in the Family Survey population were relatively satisfied with their relationships with their children. On a scale of satisfaction/dissatisfaction with this relationship (0 = completely dissatisfied and 10 = completely satisfied), the mean was 7.6 (*SD*=2.4). For primary carers who had partners, 457 carers (71 per cent) were

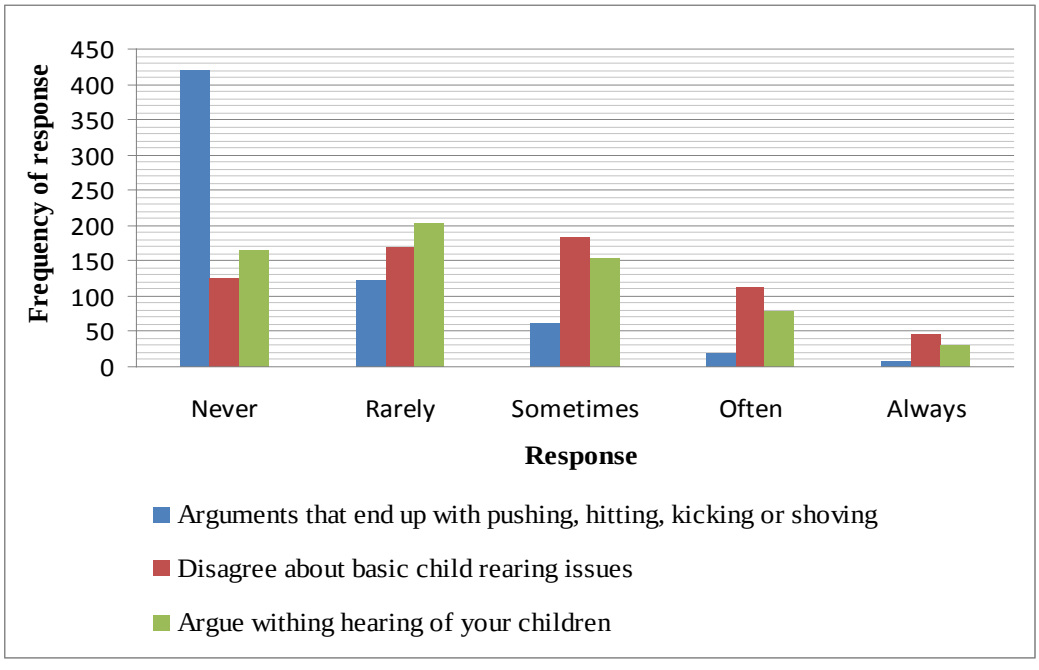
satisfied with the relationship. With a mean of 6.0 (*SD*=3.2), they were slightly less satisfied than they were with the relationships they had with their children. There was a strong positive correlation between satisfaction with relationships with children and satisfaction with relationships with partners (r=0.266 p=0.001). Moreover satisfaction with relationships with children and with partners was positively correlated with overall satisfaction with their personal circumstances.

Three items measured argumentative relationships between primary carers and partners. The responses were on a five-point Likert scale from 'never' to 'always'. These were summed to form a total argumentative relationship score ranging from 3 to 15 (high). The mean score for argumentative relationships was 6.5, indicating that arguments with partners happened rarely or occasionally. On the individual items (Table 6.13):

- The question about arguments ending up 'with people pushing, hitting, kicking or shoving' had a very low mean of 1.5.
- The question about disagreeing about basic child rearing issues had a mean of 2.7.
- The question about arguing within hearing of the children had a mean of 2.4.

Participants demonstrated feelings of attachment to their families, reporting that the family took notice of their opinions and that they were included in their own family.

Table 6.13: Frequency of response on argumentative relationship items



Source: *Family Survey Data File*

6.3 Indigenous family outcomes

The outcomes for children of Indigenous backgrounds were compared with those for children of non-Indigenous backgrounds. There were no significant differences in

scores on the BITSEA competency, the BITSEA problem or the ECBI. There were also no significant differences in the outcomes for Indigenous and non-Indigenous parents on measures of parental warmth, parental hostility, argumentative relationship or family attachment.

Significant differences have been found however between Aboriginal and non-Aboriginal parents in relation to 'positive parenting' ($t=2.435$, $p<0.05$) and 'parental efficacy' ($t=2.333$, $p<0.05$). The magnitude of the difference in the means was very small across all outcome measures.

Positive parenting describes positive, nurturing interaction between carers and their children, measured in the Brighter Futures evaluation through a self-report item in the Family Survey sourced from the Canadian National Longitudinal Survey of Children and Youth (NLSCY). Aboriginal families in the Brighter Futures Family Survey population were found to be more positive in their parenting than non-Aboriginal families.

The second measure, 'parental self-efficacy', refers to the extent to which parents perceive they are as competent, or as a good as, other parents. The Family Survey includes a question sourced from the Longitudinal Study of Australian Children (LSAC). Aboriginal parents in the survey population self-reported lower levels of confidence in their parenting than non-Aboriginal families.

Summary

- The average number of risk-of-harm reports made on children with at least one report in the three and six month time periods prior to program entry is significantly reduced three and six months after exiting the program.

- A significant reduction in risk-of-harm reports is demonstrated for Aboriginal children at three months post exit, although not at six months; and for children entering via both the Helpline and community pathways.

- The ECBI was completed for 640 children aged over 24 months in the Family Survey population. These children produced an average score of 127 *(SD*=40), i.e. just below the clinical cut-off point. Nearly half the children (46 per cent) reached the cut-off score for the clinical range, and hence were deemed to 'require intervention' for behavioural problems.

- The BITSEA instrument was completed for 148 children in the Family Survey population – 70 girls and 78 boys. A total of 97 per cent of the children's BITSEA scores suggest social-emotional and behavioural problems (mean=45, *SD*=11).

- On the whole, the primary carers in the Family Survey population felt they were 'better than average' parents. Only 11 per cent of participants stated that they had 'some trouble being a parent', or felt they were 'not very good at being a parent'.

- High levels of positive parent–child interaction were reported for more than 72 per cent of the children in the Family Survey population, compared with the Canadian study average of 82 per cent.

- Parents in the Family Survey population had a higher average for the 'parent hostility' scale than those in the Australian LSAC.

- Around half of the primary carers in the Family Survey population felt that they did not get enough help, or any help at all and 40 per cent felt that they got enough support from friends or family.

- Parents who completed the Family Survey were relatively satisfied with their relationships with their children. On a scale of satisfaction/dissatisfaction with this relationship (0 = completely dissatisfied; and 10 = completely satisfied), the mean was 7.6 (*SD*=2.4).

7 Change Over Time

The family survey instrument is designed so that families will complete it over time as they progress through the Brighter Futures program: at start of the program (within the first three months) (Time 1 (T1)), at six months after the first survey (Time 2 (T2)), at exit from the program (Time 3 (T3)), at 6 months post exit (Time 4 (T4)) and at 12 months post-exit (Fisher, et al., 2006).

Table 7.1: Demographic information on Family Survey participation over time

	T1		T2	
	N	% (of 1024)	N	% (of 241)
Primary Carer Demographics				
Primary Carer Relationship				
Mother	954	93	216	90
Father	52	5	19	8
Other	15	1	4	2
Missing	3	0	2	1
Cultural Background				
Indigenous	142	14	25	10
CALD	125	12	38	16
Disability	187	18	52	22
Secondary Carer	481	47	118	49
Geographical Location				
Major cities	455	45	119	50
Inner Regional	391	38	95	39
Outer Regional	160	16	27	11
Remote	11	1	0	0

Source: *Family Survey Data File*
Note: *Missing data for 2 cases

In time 2, there were 241 surveys that were completed by the participants. Over the six months time period, the percentage of primary carers that were fathers increased from 5 per cent to 8 per cent, with a reflective drop for mothers (Table 7.1). Marginal changes were noted in demographics of the primary carers' background, disability and geographical location. As well, very little to no change over time was noted in the number of people and the number of children in the household. In examining the paired sample statistics, marginal differences were noted between the means in T1 and that of T2 (Table 7.2).

Table 7.2: Paired Sample statistics for T1 and T2

	Paired Samples Description	N	Mean	*SD*
Pair 1	BITSEA_CompetencyT1	12	23.7	4.6
	BITSEA_CompetencyT2	12	25.3	4.0
Pair 2	BITSEA_ProblemT1	12	41.4	9.3
	BITSEA_ProblemT2	12	46.5	8.0
Pair 3	ECBI_TotalT1	147	133.0	39.2
	ECBI_TotalT2	147	127.0	41.6
Pair 4	Parental_warmth_Over24MonthT1	144	9.1	1.8
	Parental_warmth_Over24MonthT2	144	9.3	1.5
Pair 5	Parental_warmth_Under24MonthT1	12	9.1	1.8
	Parental_warmth_Under24MonthT2	12	9.3	1.1
Pair 6	Parental_efficacyT1	235	2.3	1.1
	Parental_efficacyT2	235	2.2	1.0
Pair 7	Parent_Postive1T1	238	19.1	4.0
	Parent_Postive1T2	238	19.5	3.9
Pair 8	Parent_Postive2T1	237	8.6	1.6
	Parent_Postive2T2	237	8.8	1.5
Pair 9	Relationship_argumentativeT1	134	6.5	2.5
	Relationship_argumentativeT2	134	6.2	2.1
Pair 10	Family_AttachmentT1	239	8.0	2.4
	Family_AttachmentT2	239	8.1	2.0
Pair 11	Rosenberg_Self_EsteemT1	237	23.6	2.7
	Rosenberg_Self_EsteemT2	237	23.9	2.3
Pair 12	Parent_Hostility_T1	239	12.1	6.4
	Parent_Hostility_T2	239	11.6	5.4
Pair 13	Parental_Efficacy2_T1	238	22.6	5.4
	Parental_Efficacy2_T2	238	22.7	5.6
Pair 14	Personal_Well_Being_IndexT1	236	6.0	2.0
	Personal_Well_Being_IndexT2	236	6.4	2.0

Source: Family Survey Data File

Paired t-test was conducted on the outcomes for the children and parents for the 241 participants' T1 and T2 family surveys. No significant differences were noted for any of the outcomes for the children or the parents, with the exception of Personal Well Being Index ($t(235)=-2.92$, $p<0.01$) (Table 7.3). Over time, primary carers were more satisfied with life as a whole than at the initial start of the Brighter Futures program. This is significant given that the PWI in other studies has been found to correlate significantly with well being of children[20].

[20] Personal Well Being Index is an instrument employed to measure subjective well being by the International Well-Being Group. The domains of the PWI constitute the first level deconstruction of "satisfaction with life as a whole". "Satisfaction with life as a whole is measured as an item with primary carers responding to a 0 to 10, end-defined response scale with 0 labelled "totally dissatisfied" and 10 'totally satisfied" (Olson, Ceballo and Park, 2002).

Process Evaluation data affirms these findings (i.e. findings that indicate improvement in personal wellbeing). Because the Process Evaluation involved interviews with client families much data was collected on the improved wellbeing of carers – particularly mothers. This result perhaps reflects the fact that all but one of the program interventions (i.e. childcare services) is focused on the carers. This program feature acknowledges that early intervention programs that have succeeded in achieving long term benefits have not narrowly focused on the child, but typically have a strong parental involvement component (Schonkoff & Meisels, 2000). Indeed, the literature tell us that an exclusive focus on child outcomes as a strategy is ineffective as positive child outcomes are unlikely to be sustained if parental wellbeing has not been influenced (see for example Brookes-Gunn et al, 2000). To this end, an improvement in parental wellbeing is a significant result as it provides the foundation for improved child outcomes.

Table 7.3: Paired Samples Test for T1 and T2

		Paired Differences				
		Mean	SD	t	df	Sig. (2-tailed)
Pair 1	BITSEA_Competency T1 -T2	-1.6	4.8	-1.15	11	.275
Pair 2	BITSEA_ProblemT1 - T2	-5.1	8.5	-2.07	11	.063
Pair 3	ECBI_TotalT1 - T2	6.1	34.4	2.14	146	.034
Pair 4	Parental_Warmth_Over24MonthT1 - T2	-0.2	1.9	-1.07	143	.287
Pair 5	Parental_Warmth_Under24MonthT1 - T2	-0.2	1.2	-0.48	11	.638
Pair 6	Parental_EfficacyT1 - T2	0.2	1.0	2.53	234	.012
Pair 7	Parent_Postive1T1 - T2	-0.4	3.7	-1.69	237	.092
Pair 8	Parent_Postive2T1 - T2	-0.2	1.5	-1.64	236	.102
Pair 9	Relationship_ArgumentativeT1 - T2	0.3	2.3	1.44	133	.153
Pair 10	Family_AttachmentT1 - T2	-0.1	2.8	-0.35	238	.729
Pair 11	Rosenberg_Self_EsteemT1 - T2	-0.3	2.9	-1.65	236	.101
Pair 12	Parent_Hostility_T1 - T2	0.5	5.4	1.47	238	.142
Pair 13	Parental_Efficacy2_T1 - T2	-0.1	5.6	-0.17	237	.862
Pair 14	Personal_Well_Being_IndexT1 - T2	-0.4	2.1	-2.92	235	.004

Source: *Family Survey Data File*

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