Families First Outcomes Evaluation Framework

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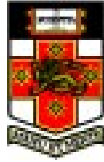

FAMILIES FIRST OUTCOMES EVALUATION FRAMEWORK

FOR THE CABINET OFFICE OF NEW SOUTH WALES

University of New South Wales Research Consortium

Social Policy Research Centre
Centre for Health Equity Training, Research and Evaluation
Centre for General Practice Integration Studies
School of Women's and Children's Health
University of New England

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Summary of the Outcomes Framework

Domain	Indicator
Child outcomes	
1. Child physical development	1.1 Antenatal and birth data
	1.2 Breastfeeding
	1.3 Immunisation
	1.4 Child injuries
	1.5 Child oral health
2. Child social and emotional development	2.1 Child social and emotional development
	2.2 Child mental health
3. Child educational development	3.1 Under school age participation
	3.2 Preparation for school
	3.3 Educational achievement
	3.4 Participation in education
Family outcomes	
4. Maternal health and wellbeing	4.1 Maternal health and wellbeing
5. Family relations	5.1 Family relations
6. Family participation outside the household	6.1 Employment, education and participation
7. Risk of harm	7.1 Child protection
	7.2 Domestic violence
Community outcomes	
8. Community networks and programs	8.1 Community cohesion
	8.2 Facilities and programs
	8.3 Participation and consultation
9. Criminal activity	9.1 Juvenile and adult crime
Supplementary community outcomes	
10. Transport	10.1 Transport access
11. Housing	11.1 Housing stability

Introduction

This document is the Final Draft of the Families First Outcomes Evaluation Framework, concerned with evaluating child, family and community outcomes. It is one of the evaluation activities for Families First. Others include process evaluation through Area Reviews of three Families First Areas in 2002-03, local Area evaluations and program evaluation of the projects funded through Families First. This outcome evaluation activity will inform the other evaluation activities.

Overall the evaluation considers whether Families First has been effective in supporting families and communities in NSW to care for children using an early intervention approach and in developing linkages between specialised health, education, community and other policies.

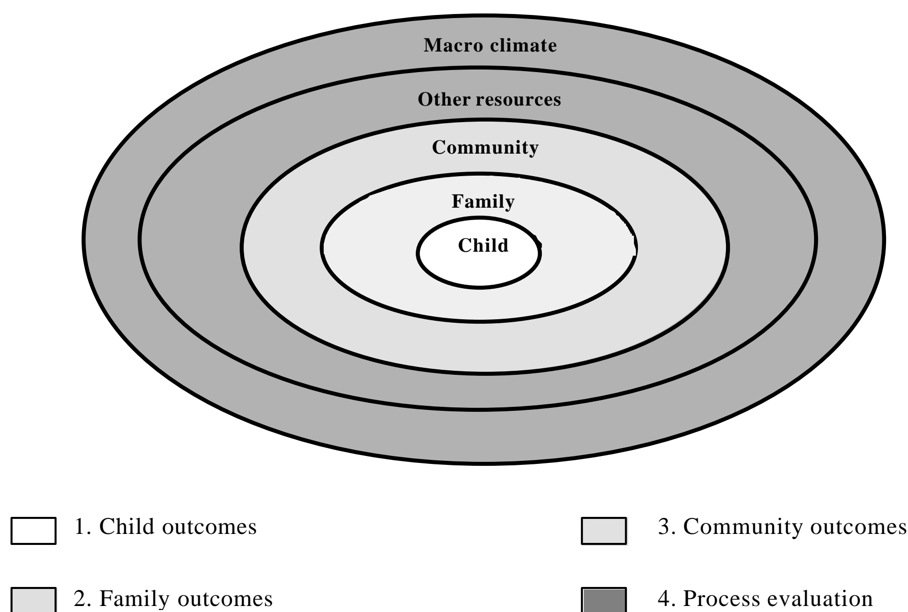
The Framework includes suggestions for minimum data collection and foundations for extending studies beyond the budget of the evaluation. A general aim in choosing the outcome indicators is to maintain compatibility with simultaneous program evaluation of similar NSW, Commonwealth and international programs.

The Cabinet Office of NSW Families First Research Unit will implement the Framework. The Research Unit will be responsible for negotiating data collection and transfer with each of the organisations that hold the recommended data sets. It will also collate the data, conduct the data analysis and present reports for information to Government and the public.

Conceptual Framework

The Outcomes framework is organised according to a human ecological theory hierarchy (Figure 1), with interaction between the layers of the model.

Figure 1: Evaluation Framework based on Bronfenbrenner's Ecological Theory



An explanation of the model is included in Appendix A. This Framework applies the Bronfenbrenner approach to defining relationships between child, family and community outcomes. Indicators in the Framework are included at the central-most position possible in the relationships. The effect of this position is that if an indicator can be defined at the child-level then it can also sit in the context of the other rings. For example, education outcomes can be defined at the child-level and has implications for family and community outcomes; compared to transport routes defined at the community-level that influences family and child outcomes.

Focus of the Framework

The overall aim of the Families First initiative is to use a coordinated network of services to support parents, carers and communities raising children to solve problems early before those problems become entrenched (OCYP, 1999). The focus of Families First is on the promotion of health and well-being, and early identification and intervention for problems. The initiative is designed to achieve the outcomes of healthier children and parents, better functioning families, and child and family friendly communities.

To achieve these outcomes, the primary objective of the Families First initiative is 'the development of a network of universal and targeted services providing support to families … because some services are more effective when universally available whilst others are known to be more effective when targeted towards particular sections of the community' (OCYP, 1999).

The Families First initiative can thus be considered to have three major foci, reflected in this Evaluation Framework:

- Outcomes[1] – for children, families and communities;
- Population focus – through the provision of universal policies; and
- Equity – through the universal availability of programs and the provision of targeted programs for 'at risk' groups.

Each of these foci are explained in more detail in Appendix A.

Structure of the Outcomes Framework

The proposed outcome indicators are presented in the remainder of this document in the categories of children, families and community. The three sections start with a summary table of proposed outcome indicators. The description of each measure includes goals, rationale, definitions, data sets and recommended subgroup analysis. Once the indicators are agreed upon possible economic returns from achieving the goals will be added. Output indicators are included only where outcome data are unlikely to be available. Throughout the framework, any definitions of terms are as defined in the particular data set referred to.

[1] The evaluation of Families First outcomes is the focus of this Evaluation Framework, rather than inputs, processes and activities and outputs.

In most of the domains, it is not suggested that there is likely to be a direct causal link between the Families First Initiative and the outcomes. Rather, the indicators represent a correlation between an outcome for children, families and communities and the intentions of the Families First Initiative. Families First operates in NSW in the context of other policies and programs with similar intentions being implemented by a range of agencies.

The Consortium recommends that the Human Services CEOs set priority goals for the Families First Initiative. These priorities would inform the directional goals for the outcome indicators in the Evaluation Framework.

Comparison between relative disadvantage of children, families and communities in different Local Government Areas (LGA) is the basis for many of the indicators. The Evaluators recommend that the Research Unit and Human Services CEOs identify priority LGAs for comparison to Statewide averages. Various measures linking to relative disadvantage to location are available in the proposed data sets. Common to many are postcode or LGA data that can be mapped to SEIFA measures as defined by the ABS.

It is also recommended that the choice of the unit of any subgroup data analysis take account of protecting confidentiality. An implication may be for example, that some subgroup data may not be reported for small localities. In other data sets when subgroup numbers are small, it might be possible to use a multiple-year moving average. Local application of the framework to supplement the data collection with other parts of the evaluation activities may also be more appropriate.

Most of the proposed indicators rely on general secondary data. The choice of data sources is explained in more detail in Appendix A, including a list of NSW Health data sets that are in the process of development. Some indicators suggest parallel collection of comparable data by the Families First Department of Community Services (DoCS) funded programs. The implications of this are discussed in Appendix A. It is expected that the indicators will be modified as other data sets are developed.

Further research

The Consortium recommends that further research be commissioned to supplement the outcomes evaluation, including:

- process and outcomes evaluation of the Families First DoCS funded activities; and
- analysis of the link between Families First activities and changes in community wellbeing.

The remainder of this document presents the proposed indicators in each of the child, family and community outcome domains. The Framework is followed by a list of references and a glossary. Appendix A describes in greater detail background to the development of the Framework. Appendix B lists contacts for each agency that holds the data sets. Appendix C and D list two of the suggested instruments, the Strengths and Difficulties Questionnaire (SDQ) and Abidin Parenting Stress Index.

A. Child Outcomes

Summary of Child Outcomes

Domain	Indicator
1. Child physical development	1.1 Antenatal and birth data
	1.2 Breastfeeding
	1.3 Immunisation
	1.4 Child injuries
	1.5 Child oral health
2. Child social and emotional development	2.1 Child social and emotional development
	2.2 Child mental health
3. Child educational development	3.1 Under school age participation
	3.2 Preparation for school
	3.3 Educational achievement
	3.4 Participation in education

The first set of indicators relates to child outcomes. At the centre of the human ecology model, these are perhaps the most crucial indicators of the success of Families First, since improving these outcomes is the explicit aim of the initiative. In the later sets of family and community outcomes, the Framework reveals how outcomes for individual children interact with the conditions or outcomes for the family and community.

1 Child Physical Development

The preventive focus of Families First endeavours to re-orient health services to provide early intervention, effective target of services and appropriate community outreach activities aimed at achieving superior child health outcomes, including fewer medical problems in adult life.

1.1 Antenatal and birth data

Goal: Increase in early attendance at antenatal care

Increase proportion of children born full-term and of adequate birth weight

Rationale: Commencement of antenatal care early in pregnancy is considered the best strategy for preventing avoidable causes of maternal and infant illness and death (WA Health, 2001). Antenatal care is an important preventative measure against low birth weight (which requires more care and places babies at greater risk of developmental problems, yet they do not tackle the range of complex factors that contribute to birth outcomes, such as socio-economic status and ethnicity (Outlook, 2001). The proportion of children with good birth outcomes will improve as families access holistic services that impact these complex factors earlier.

Definition:

a) Proportion of first antenatal visits by duration of pregnancy (timeframe: 2-5 years)

Note: Geographic isolation may affect timing of access to antenatal care.

b) Proportion of babies of adequate birth weight (2500g) (timeframe: 5-10 years)

c) Proportion of babies born full-term (timeframe: 5-10 years)

Data set: National Perinatal Statistics Unit (NPSU), AIHW (annual) (duration of pregnancy at first antenatal visit - 0-19, 20+ weeks; birth-weight; full-term; ATSI; residence; maternal country of birth; disability not available). State comparison through NPSU. Earlier data is available from the annual NSW Mothers and Babies report (NSW Midwives Data Collection (MDC), the Neonatal Intensive Care Units' (NICU) Data Collection and the NSW Birth Defects Register) for initial reporting.

Subgroups: ATSI, maternal country of birth, area of residence (socio-economic disadvantage)

1.2 Breastfeeding

Goal: Increase proportion of children exclusively breastfed until 4 and predominantly breastfed until 6 months

Rationale: "Breastfeeding is associated with improved general health, growth and development of infants and protection against a number of acute and possibly chronic diseases" (Webb et al, 2001: 2).

Definitions: Proportion of children exclusively breastfed at birth, 4 months, and predominantly breastfed until 6 months (timeframe: 5-10 years)

Data sets: Child Health Survey (annual), NSW Health (Q37 breastfed; Q2 child's age; ATSI, NESB; low income; disability not available).

Note: Recommendations have been made for a national breastfeeding data set to be developed, which would be a preferred data source (Webb et al, 2001).

Subgroups: ATSI, NESB, low income (by combining annual data)

1.3 Immunisation

Goal: Increase the rate of age appropriate immunisation

Rationale: Personal contact with health professionals, and recommendations by primary health care providers are influential in encouraging age appropriate immunisation to prevent illness (Bazeley and Kemp, 1994).

The provision of quality early childhood services will result in an increase in age appropriate immunisation rates.

Definition: Proportion of children with age appropriate immunisation at 12 months, 24 months and 6 years of age (timeframe: 2-5 years)

Data set: Immunisation Registry, Australian Centre for Immunisation Research (annual) (immunisation status; child age; residence postcode). State comparison through ACIR. Earlier data is available from Aids and Infectious Diseases Unit (AIDU), NSW Health for initial reporting.

Subgroup: low SEIFA (other demographics are not available)

1.4 Child injuries

Goal: Decrease the rate of serious intentional and unintentional childhood injuries

Rationale: Risk of injury changes with stage of development. As children grow their abilities and activities change (Injury, 2001). Children are more likely to be exposed to hazardous environments and behaviours where households do not have access to child safety protective devices and where levels of parent education do not support risk and behavioural management (IPU, 2002). Physical injury can be one of the effects of child abuse, resulting from stressful life circumstances or inappropriate power relations (Pelton, 1981; Parton and Parton, 1989).

A decrease in the rate of childhood injuries can be expected as Families First activities provide the support that fosters developmentally appropriate parenting and provides least intrusive intervention for families at risk.

Definition:

a) Hospital separation rate for intentional injury, children aged 0-5 years; and hospital separation rate for unintentional injury, children aged 0-5 years, (timeframe: 5-10 years)

b) See also 7.1 Child protection

Data sets: National Hospital Morbidity Database, National Injuries Surveillance Unit, AIHW (hospital separations, classified according to ICD-9 and 10). State comparisons. Earlier data can be obtained from NSW Inpatient Statistics Collection, NSW Health for initial reporting.

Note: Emergency department data is expected to be developed in the future, which would be a preferred data source.

Subgroups Age, gender, country of birth, ATSI, local area of residence, ARIA (Accessibility/Remoteness Index of Australia)

1.5 Child oral health

Goal: Decrease in the rate of decayed, missing and filled teeth by age

Rationale: Early intervention (preferably before the age of three) 'provides the opportunity to educate parents in proper oral hygiene, prevention of dental injuries and prevention of nursing caries by establishing proper feeding habits' (AAPD, 2001).

Therefore, early identification of dental hygiene needs and relevant education through contact with services will prevent crisis dental management at school age.

Definitions:

a) Proportion of children reported with fillings or teeth removed in the last 12 months by age (timeframe: 5-10 years)

b) Rate of decayed, missing and filled teeth (DMFT) by age (timeframe: 2-5 years)

Data sets:

a) Child Health Survey (annual), NSW Health (Q94 dental treatment; ATSI; NESB; low income)

b) Dental Statistic Research Unit, National telephone survey (biannual)

Subgroups: ATSI, NESB, low income (combined annual data); disability is not available

2 Child Social and Emotional Development

2.1 Child social and emotional development

Goal: Improve the degree of age appropriate social development

Rationale: In older childhood, 12 - 18 years, a sense of belonging and connectedness to family and school has a strong protective effect against a range of risk behaviours, emotional distress, suicidal tendencies and violence (Resnick et al, 1997). Long-term psychological, social and economic benefits accrue from strategies to improve coping and enhance resilience in children and young people (Turner-Boutle et al, 1997).

Families First early intervention support will improve child social development through enhancing opportunities for families to interact with other families and fostering good relationships among family members.

Definition: Individual measure in Families First DoCS funded programs, preferably also adopted in other NSW services (discussed in Appendix A) (timeframe: 2-5 years)

Data set: Questions to Families First DoCS funded programs (annual), preferably also other NSW services and future development of CHIME, NSW Health – early childhood information

Suggestions: Early Development Instrument (EDI): A Population-based Measure for Communities, a teacher-reported population measure developed by Mustard, Janus and Offord of Canada to test school readiness in five scales. Scales relevant to Families First include social competence and emotional maturity (Section C: Social and Emotional Development). The 58 questions would need to be selected to be applicable to under school age children. It's particularly applicable to Families First, as it assesses the outcome of the early years; the strengths and deficits of children; and the effectiveness of early interventions.

Strengths and Difficulties Questionnaire (SDQ; see Appendix C): a short, validated questionnaire that can be parent or teacher reported, suitable to be used in conjunction with the teacher-reported EDI.

Notes: Comparison to National Longitudinal Study of Children, Canada, Western Australia Child Health Survey and possibly the Longitudinal Survey of Australian Children. Analysis of the appropriateness of these instruments for ATSI and CALD groups should be undertaken.

Subgroups: ATSI, NESB, children with a disability, low SEIFA or income

2.2 Child mental health

Goals: Increase early identification of mental health care needs by age of the children

Increase access to mental health services

Increase mental health condition of children and young people

Rationale: Early identification will recognise the mental health needs of children and facilitate the implementation of intervention to enhance protective factors (coping and resilience, insight, self-reliance, enhanced social resources, problem solving and help-seeking skills, and self-esteem) and reduce risks to mental health (Dyer and McGuinness, 1996; Gardner, 1996).

Increased contact with early childhood professionals will facilitate early identification of mental health problems through increased awareness and acceptance of services and assistance (National Mental Health Strategy, 2000).

Definitions:

a) Rate of assessed mental health care needs in mental health public services by age of the children (timeframe: 2-5 years)

b) Rate of referrals for mental health-related conditions in mental health public services by age (timeframe: 2-5 years)

c) Rate of mental health condition of children and young people by age (timeframe: 5-10 years)

d) Rate of child emotional and behavioural problems by age (timeframe: 5-10 years)

e) See also 2.1 Child social and emotional development and 3.2 Preparation for School

Note: Changes in rates might reflect an improvement in identification. Rates by age will reflect changes in early identification.

Data sets: a) – d) Mental Health Outcome Assessment Tool – Children and Adolescents (MHOAT-CA) (HoNOSCA; CGAS; FIHS; SDQ; Global Family Environment Assessment Scale), Centre for Mental Health, NSW Health (annual) to be collated through CHIME

Note: Not Statewide. MHOAT-CA data are not an estimate of the prevalence of mental health, which would require population surveys or community screening eg Child and Adolescent Component of the National Survey of Mental Health and Well-being (ABS, 2000).

d) Child Health Survey (annual), NSW Health (Q158 Child emotional and behaviour problems, Q162 identification of need for professional help, Q163-4 access to services; ATSI; NESB; low income; disability not available)

Subgroups: ATSI, NESB, low income (combined annual data)

3 Child educational development

3.1 Under school age participation

Goal: Increase in the rate of attendance and the proportion of subgroups attending under school age activities

Rationale: Participation in quality early child development programs contributes to optimal child development, cognitive development and early success in school. In particular, preschool experience can reduce the gap in achievement between disadvantaged and advantaged children in the early years of school (Boocock, 1995; Ochiltree, 1994).

Attendance at under school age services (particularly for children of low-income families) has a significant positive impact on preparation for school and on school attendance in kindergarten and first grade (Gilliam & Zigler, 2000).

Definition: Rate of attendance in at least one formal children's activity (child care, preschool and other programs) before attending school (timeframe: 2-5 years)

Note: Affordability, which is likely to affect the rate, is influenced by Commonwealth assistance. Geographic isolation may affect access. This measure does not include measure of quality.

Data sets: Census of Child Care Services (annual), FaCS (children aged 0-5 attending Family Day Care, Long Day Care, Occasional Care, In-home Child Care, Multi-function Services and Aboriginal Services; does not include preschools; age, ATSI, NESB, children with disability, location of service). State comparison.

Child Health Survey (annual), NSW Health (Q293, Q297 responses 1-5, Regular use of formal child care; Q289 Attendance at preschool; Q277-8 Attendance at playgroup or other early childhood program or activity; age, ATSI, NESB, low income by combining annual data)

Subgroups: age, ATSI, NESB, children with a disability, low SEIFA or income

3.2 Preparation for school

Goals: Increase in the proportion of all children starting school at a developmentally appropriate age

Increase in levels of school preparedness for all children, including children with special needs

Increase in the number of children identified for integration and special needs programs for children entering kindergarten

Rationale: Children starting school at an older age are more likely to have school readiness skills (Crone and Whitehurst, 1999). Older children and girls are more likely to engage in positive interactive play associated with active engagement in the classroom (Coolahan et al, 2000). School preparation and age are associated with subsequent academic and behavioural outcomes (Ferguson et al, 2000).

Early identification and intervention for children who are at risk of experiencing difficulties acquiring skills in literacy and numeracy minimises the cumulative effect of failure and loss of self esteem (Stanovich, 1986; Dockett and Perry, 2001).

Increased contact with early childhood professionals and participation in formal childcare and early childhood programs will facilitate early identification of challenges to learning and the transition from prior to school to school settings.

Definitions:

a) Proportion of children starting school at an older age (timeframe: 5-10 years)
b) Levels of attendance in kindergarten, particularly for girls (absenteeism in Kindergarten is high in girls) (timeframe: 5-10 years)
c) Number of children identified for integration and special needs programs (preschool to kindergarten) as a proportion of children entering kindergarten by age by area (timeframe: 5-10 years)
d) See also 3.1 Under school age participation

Data sets:

a) School enrolment data (annual), OASIS, NSW Department of Education and Training (age of child starting school); Catholic– not available.

b) Data on school absences collected quarterly, NSW Department of Education and Training (school grade; school type; school district; gender): Catholic – not available.

c) Funding Support Program, NSW Department of Education and Training – number of children attending community-based prior to school services allocated funding for support and integration (including children with mild/global developmental delay, physical and sensory impairment); by age, location of service.

Subgroups: gender, age/grade, children with a disability, Priority Schools (proxy for disadvantage)

3.3 Educational achievement

Goal: Increase in educational achievement scores for targeted groups and Priority Schools

Rationale: Success in early intervention initiatives should be reflected in school achievement scores (Reynolds et al, 1995). In particular, exposure to prior to school experience (child care and/or playgroup) has a significant positive effect on early educational assessment outcomes over and above advantage gained by age or socio-economic status (Daniels, 1995). Further, early school, family and home environment factors are important predictors of academic achievement in late primary and high school (Jimerson et al, 1999).

Definition: Amount of improvement in scores in Years 3, 5, 7 and the degree of change in the disparity of performance between schools in higher and lower socio-economic areas and between Priority Schools and others (timeframe: 5-10 years for early childhood education, 10-15 years for later educational outcomes)

Data sets: Basic Skills Test (BST) Years 3 and 5, ELLA results year 7 (annual) NSW Department of Education and Training (results; sex; ATSI; LOTE and resident <4 years; Priority School); Catholic - not available.

Subgroups: sex, ATSI, NESB, Priority Schools (proxy for disadvantage), (disability is not available)

3.4 Participation in education

Goals: Increase in school attendance

Increase in school retention for targeted groups and Priority Schools

Rationale: Success in early intervention initiatives should be reflected in improved school attendance in all school years (absenteeism in kindergarten and year 1 is an indicator of absenteeism in year 7, Don Gordon, DET, personal communication 21.11.01) and retention.

Participation in quality early childhood programs has a positive affect on children's cognitive abilities, achievement, and social adjustment as they mature to become school children, adolescents and young adults (Entwisle, 1995). Family context (stress, attitudes to education and socialisation), children's personal resources (attitudes and behaviours) and early school experiences influence high school drop-out independently of sociodemographic factors (Alexander et al, 1997).

Definitions:

a) Rate of attendance at school by age (timeframe: 5-10 years)

b) Proportion of children who stay at school until years 9, 10, 11 and 12 in targeted groups and Priority Schools (timeframe: 10-15 years)

Data sets: School absences (quarterly), NSW Department of Education and Training (school grade; school type; school district; gender); Catholic – not available.

Mid-year Census for National Schools Collection (annual), NSW Department of Education and Training (age, grade, school type, school district, gender, retention); Catholic – not available. State comparison

Subgroups: sex, ATSI, NESB if available

B. Family Outcomes

Summary of Family Outcomes

Domain	Indicator
4. Maternal health and wellbeing	4.1 Maternal health and wellbeing
5. Family relations	5.1 Family relations
6. Family participation outside the household	6.1 Employment, education and participation
7. Risk of harm	7.1 Child protection
	7.2 Domestic violence

The second set of indicators is family outcomes. In this inner ring of the human ecology model, the Families First initiative aims to not only directly affect the outcomes for the child as described above, but to also improve the family context in which the child lives. It is through the family that children have their first contacts with other parts of their world. The nature of the family context will affect the opportunities and resilience of the child (Werner, 1997; Garmezy, 1985; Tomison & Wise, 1999).

4 Maternal Health and Wellbeing

4.1 Maternal health and wellbeing

Goals: Increase in early identification of and decrease in rate of risk factors in pregnancy

Earlier identification and improved mental and physical health of mothers

Rationale: Early access to appropriate services will improve physical, mental and emotional health of pregnant women and mothers of young children (WA Health, 2001).

Definitions:

a) Rate of risk factors during pregnancy (timeframe: 5-10 years):

i. smoking

ii. less than two years between children

iii. drug and alcohol dependence

b) Rate of identified mental health needs in mothers before birth of the child, at birth and by age of the child (timeframe: 2-5 years)

Note: Rates for a) and b) may increase reflecting an improvement in identification

c) Rate of maternal health and wellbeing (timeframe: 5-10 years)

Data sets:

a) i. NPSU (annual) (smoking in first and second half of pregnancy; ATSI, residence postcode). State comparison

ii. ABS Census (1996, 2001, 2006) (relationship in household; age of children; Indigenous status; language spoken at home; household income; residence postcode). State comparison.

Note: Expected to be included in antenatal data collated in CHIME.

iii. Drug and alcohol dependence is expected to be included in future IPC and other antenatal screening data collections

b) ABS SF-36 (see c) below). State comparison.

MHOAT in Integrated Perinatal and Infant Care (IPC), Centre for Mental Health, NSW Health, to be collated through CHIME. Not Statewide.

c) ABS SF-36 Health and Wellbeing survey 1995, 2000, future surveys. State comparison.

Child Health Survey (annual), NSW Health (Q7 In general would you say your health is excellent, very good, good, fair or poor?; ATSI; NESB; low income; family structure)

Subgroups: ATSI or NESB child, child or parent with a disability, low SEIFA (in NPSU and ABS Census data sets) or income, family structure, young mothers (under 19).

5 Family Relations

5.1 Family relations

Goal: Improve family functioning

Improve level of coping within families

Decrease degree of stress within families

Rationale: Early intervention programs that incorporate parenting skills and child development information (eg volunteer home visiting, playgroups, Family Support) may enhance parental self-efficacy and personal competence (Coleman & Harraker, 1997: 73-74), thus leading to improved family functioning and coping.

Definition: Individual family measures from Families First DoCS funded programs (timeframe: 2-5 years)

Data set: Questions to Families First DoCS funded programs, preferably also other NSW services (eg Family Support) and future development of CHIME, NSW Health – early childhood information

Suggested instruments: Selection from the Abidin Parenting Stress Index (Appendix D) and Coping skills: Follow up with the LSAC design in 2002; see also Global Family Environment Assessment Scale, John Ray, Northern Sydney Area Health Service, validated for NSW population.

Child Health Survey: Q 136: Sometimes families may have difficulty getting along with one another. They do not always agree and they may get angry. In general, how would you rate your family's ability to get along with one another? (Asked of families with older children); Q236 - 247 (from the McMaster Family Functioning Scale): Q236: Planning family activities is difficult because we misunderstand each other; Q237 In times of crisis we can turn to each other for support; Q238 We cannot talk to each other about sadness we feel; Q239 Individuals (in the family) are accepted for what they are; Q240 We avoid discussing our fears and concerns; Q241 We express feelings to each other; Q242 There are lots of bad feelings in our family; Q 243 We feel accepted for what we are; Q244 Making decisions is a problem in our family; Q245 We are able to make decisions about how to solve problems; Q246 We don't get on well together; Q247 We confide in each other.

Notes: Comparison to Child Health Survey results (annual), NSW Health (Q136, 236-247; ATSI; NESB; disability; income; family structure combined annual data). Comparison to National Longitudinal Study of Children, Canada, and the Western Australia Child Health Survey. Analysis of the appropriateness of these instruments for ATSI and CALD groups should be undertaken.

Subgroups: ATSI or NESB child, child or parent with a disability, low SEIFA or income, family structure

6 Family Participation Outside the Household

6.1 Employment, education and participation

Goal: Increase the proportion of families engaged in outside activities

Rationale: Early intervention support will assist families and children to engage in participation in outside activities through increasing their knowledge and contacts with participation opportunities.

'When children participate in sports and the arts, they quickly gain skills and enrich the quality of their lives. Joining a club or team provides an opportunity for children to learn how to interact with their peers and adults. Involvement in these activities thus protects children from having emotional and social problems' (Offord et al, 1998).

Definitions:

a) Proportion of families with children aged under 8 years with at least one adult engaged in employment (timeframe: 5-10 years)

b) Proportion of families with children aged under 8 years with at least one adult engaged in training (timeframe: 5-10 years)

c) Proportion of families with at least one adult engaged in volunteer activity (timeframe: 5-10 years)

d) Children's participation rate in leisure and cultural activities by age (timeframe: 5-10 years)

Data sets: a) and b) ABS Census (1996, 2001, 2006) (labour force status; full/part-time student status; family type; youngest child under 6 years; Indigenous status; language spoken at home; household income; SEIFA by LGA)

c) ABS Voluntary Work 4441.0 (1995, 2000, 2005) (volunteer rate; husband, wife or partner with dependent children/lone parent; born in/outside Australia; labour force status; NSW; metropolitan/other)

d) ABS Children's Participation in Cultural and Leisure Activities 4901.0 to be repeated by ACNeilsen in 2002 for the Recreation and Sport Industry Statistical Group (Rosemary Perry DSR) (participation in one or more cultural or leisure activity; age; birthplace of parents; family type; region - capital, other)

State comparisons.

Question to clients of Families First DoCS funded programs about participation

Subgroups: ATSI or NESB child, child or parent with a disability, low SEIFA or income, family structure, young mothers (under 19).

7 Risk of Harm

7.1 Child protection

Goals: Reduce the age at which children are identified as at risk of harm

Reduce the real incidence of children at risk of harm

Rationale: Early intervention (VHC, Family Support, Playgroups) will improve identification of children at risk, facilitate least intrusive intervention as a means of child protection and reduce the number of children in risk environments (Fisher et al, 2000: 9).

Definition:
a) Rate of children assessed as at risk of harm by age (0-8 years) (timeframe: 5-10 years)

Notes: Changes in rates may reflect an improvement in identification, changes to the care and protection legislation and processes.

b) See also 7.2 Domestic violence

Data set: *Child Protection Australia*, AIHW (annual), State comparison. Earlier data is available from the Client Information System (CIS) (annual), DoCS (age, sex, ATSI, NESB, disability, SEIFA) for initial reporting.

Subgroups: ATSI or NESB child, child or parent with a disability, low SEIFA or income

7.2 Domestic violence

Goal: Reduce the rate of domestic violence in households with a child

Rationale: Early identification of familial problems and support has been found to be essential in helping families utilise their own problem-solving abilities to avert the escalation of problems into pathology (Dallos & Hamilton-Brown, 2000). Families First early intervention support (eg VHV, Family Support) will reduce stress on families.

Definition: Rate of domestic violence assault incidents by LGA (timeframe: 5-10 years)

Data sets: COPS (annual, available in April for the previous year), Bureau of Crime Statistics and Research, (domestic violence flag on assault incident; age; sex; ATSI; LGA; child in the household only available from NSW Police; NESB and disability not available)

Notes: IPC, NSW Health intends to collect this data and collate through CHIME. Recorded Crime (ABS 4510.0, annual) State comparison.

Crime and Safety NSW, ABS 4509.1 (annual)

Subgroups: Characteristics of victim: age, sex, ATSI

Characteristics of area: ATSI, NESB, SEIFA, rate of children aged under 10 years, children and parents with disabilities

C. Community Outcomes

Summary of Community Outcomes

Domain	Indicator
8. Community networks and programs	8.1 Community cohesion
	8.2 Facilities and programs
	8.3 Participation and consultation
9. Criminal activity	9.1 Juvenile and adult crime

Supplementary domain	Supplementary indicator
10. Transport	10.1 Transport access
11. Housing	11.1 Housing stability

Community outcomes are in the outer set of rings of the human ecology model, potentially linking families with formal service delivery. Families First consists of three types of service orientation: universal services, targeted services and community outreach. Potentially, this latter orientation is the one most likely to create sustainable changes in child, family and community capacity. If formal services are able to effectively engage with and enhance community support networks, it is expected that the circularity of coordination between formal and informal mechanisms that support families should improve self-efficacy and outcomes at all levels.

It is recommended that community indicators be taken for all communities in NSW, comparing the relative disadvantage of targeted or priority communities for Families First. There are three reasons for recommending statewide comparisons. First, indicators can be benchmarked across communities to emphasise equity of opportunity and outcome. Second, to identify communities that are relatively disadvantaged and perhaps should be targeted. Finally, to follow the principles of Families First and health promotion, that it is a universal strategy with targeted elements, so as to improve the wellbeing status of the whole of the State and decrease the relative disadvantage of some communities.

Supplementary outcomes of transport and housing are included because of the potential, indirect impact Families First activities could have on these indicators that are important to the wellbeing of children.

Measurement unit: Identify priority LGAs – ABS Census characteristics: ATSI, NESB, SEIFA, rate of children aged under 10 years, children and parents with disabilities, rate of young mothers (under 19).

8 Community Networks and Programs

8.1 Community cohesion

Goals: Increase housing stability in disadvantaged subgroups

Increase personal social networks

Increase the representation of disadvantaged groups in award recognition

Increase local social capital

Rationale: The importance of close, confiding relationships including friends and neighbours for parents (particularly mothers) raising children has been demonstrated by a number of studies."…*informal* sources of social support tend to be more effective in enhancing personal functioning than *formal* sources" (Beckman, 1991, cited in Jack, 2000: 707).

Families First will engender trust in other people, service agencies and the local community through supporting immediate needs of families and facilitating opportunities for participation and relationships.

Definitions:

a) Proportion of families with children aged under 8 years who have remained at the same address in the last 1 and 5 years

b) Proportion of families with children aged under 8 years with local social networks they can rely on

c) Proportion of families with children aged under 8 years with someone they could borrow from in an emergency

d) Meta-analysis of social capital development as measured by location specific projects

Timeframes: 5-10 years

Data sets:

a) ABS Census (1996, 2001, 2006) (household one year and five year mobility; youngest child under 6 years; Indigenous status; language spoken at home; household income; SEIFA by LGA, young mothers)

b) Questions to Families First DoCS funded programs, preferably also other NSW services, from Child Health Survey (modified from Onyx & Bullen, 1997)

Q249: In the past three months, how often have you helped out at any local group or organisation?; Q250: In the past six months, how often have you attended a local community event such as a church or school fete, etc?; Q251: Are you an active member of a local organisation, etc? Q255: If you were caring for a child and needed to go out for a while, and could not take the child with you, would you ask someone in your neighbourhood for help?

from the National Longitudinal Survey of Children, Canada

Q202: There are people I can count on in an emergency.

Notes: Comparison to Child Health Survey results (annual), other applications of Onyx and Bullen and National Longitudinal Survey of Children, Canada. Analysis of the appropriateness of this instrument for ATSI and CALD groups should be undertaken.

c) ABS Household Expenditure Survey (1998, 2003, 2008) (sought financial help from friends/family if applicable; couple, lone parent with dependent children); person in household aged under 10 years; disability; country of birth; NSW). State comparison.

d) Meta-analysis conducted by TCO eg Wyong (baseline 2001), Paul Bullen; Inner West (baseline 2002); Bonnyrigg (baseline 2001); Kyogle (baseline 2001).

Subgroups: Characteristics of family: ATSI, NESB, child or parent with a disability, low household income, young mothers

Characteristics of area: ATSI, NESB, SEIFA, rate of children aged under 10 years, children and parents with disabilities

8.2 Facilities and programs

Goals: Increase the rate of child-oriented facilities and space

Increase the rate of child-specific programs and activities

Rationale: 'In the community domain, as would be expected, the presence of good parks, playgrounds and play spaces in the neighbourhood was strongly associated with increased rates of participation in supervised sports, and to a less extent, in unsupervised sports and the arts' (Offord et al, 1998).

Definitions:

a) Rate of child-oriented facilities and space (playgrounds, sports fields, libraries, community centres) by Local Government Area (LGA)

b) Rate of child-specific programs and activities (playgroups, story-telling at library, children's sports, children's music and art, P&Cs, support groups eg parenting, disability, special needs) by LGA

c) Rate of child and family sport and recreation facilities and programs by LGA

d) Proportion of children aged under 6 years who belong to the local library

Timeframes: 5-10 years

Data sets:

a) Local Government and Shires Association survey (1986, 1993, 1998, 2003)

b) Families First management records

c) Sport facilities and programs provider database (annual), NSW Sport and Recreation (location, access, child care facilities, available to under-represented group) comparing relative disadvantage of priority locations

Note: the quality of the database will improve after it is launched in December 2001, reflecting data collection change rather than increased availability in programs. However, it will also reflect an increase in information about programs.

d) State library information request

Subgroups: Characteristics of the LGA population: ATSI, NESB, SEIFA, rate of children aged under 10 years from ABS Census

8.3 Participation and consultation

Goal: Increase in the number of opportunities for family participation in planning and feedback mechanisms

Note: Geographic isolation may affect opportunity for participation.

Rationale: Opportunities for participation by families will improve responsiveness of agencies to community needs and enhance community cohesion (Black & Hughes, 2001).

Definitions:

a) Number of LGA consultations, programs and strategies aimed at families, children and young people by LGA

b) Number of community development programs (Schools as Community, Strengthening Communities) by LGA

c) Number of opportunities for families to engage in local community planning and programming through government and contracted Families First agency mechanisms by type of agency (government, non-government)

Timeframes: 2-5 years

Data sets: a) Local Government and Shires Association survey (1986, 1993, 1998, 2003)

b) – c) Families First Area management records as defined by FF

Subgroups: Characteristics of the LGA population: ATSI, NESB, SEIFA, rate of children aged under 10 years from ABS Census

9 Criminal activity

9.1 Juvenile and adult crime

Goal: Reduce the rate of juvenile and adult crime in disadvantaged areas

Rationale: Early intervention to enhance community cohesion and activities for young people will reduce juvenile and adult criminal activity (National Crime Authority, 1999).

'Children do not become progressively more problematic as they approach the teen years – rather than simply transforming from cute toddler to difficult adolescent, most children learn to deal better with emotions and relationships, and to control aggression, as they get older. This points to the need to intervene early to reduce youth violence' (National Longitudinal Survey of Children and Youth, 2001).

'These findings highlight the important impact that conditions of neighbourhoods, particularly neighbourhood affluence, can have on young children's competencies both directly and indirectly. Neighbourhoods must be safe and free of violence with additional benefits accruing to neighbourhoods that have shared values and expectations' (Kohen et al, 1998).

Definition: Rate of criminal incidents and persons of interest by type of offence by LGA (timeframe: 5-10 years)

Data set: COPS (annual, available in April for the previous year; from 1995), Bureau of Crime Statistics and Research (criminal incident; person of interest; type of offence; age – 8-9 years, years to 17, older than 17 (unreliable less than 8); sex; ATSI; LGA; NESB and disability not available). Recorded Crime (ABS 4510.0, annual), State victim comparison.

Subgroups: Characteristics of person of interest: age, sex, ATSI

Characteristics of area: ATSI, NESB, SEIFA, rate of children aged under 10 years, children and parents with disabilities

Supplementary Community Outcomes

10 Transport

10.1 Transport access

Goals: Increase transport access to opportunities for participation outside the home and access to services

Increase community transport funding allocation to priority LGAs relative to need to assist in transport access

Increase families' ability and desire to travel for non-essential reasons

Rationale: Adequate, affordable and equitable transport coverage to access community activity will increase community cohesion and family participation: "Transport policy plays a major role in strengthening … economic and social cohesion. […] Firstly, it helps reduce regional disparities, particularly by improving access to…peripheral regions. It also has a beneficial effect on employment, by encouraging investment in transport infrastructure and assisting workers' mobility." (Europa, 2001).

Advocacy through service integration processes from government and agencies in Families First will improve transport planning and targeting for family needs.

Definition:

a) Proportion of priority LGAs serviced by public transport at or above Minimum Service Level compared to non-priority LGAs

b) Change in community transport funding allocation by LGA

c) Proportion of family households in priority LGAs where family members travel for reasons other than going home or to work or education compared to non-priority LGAs

Timeframe: 10-15 years

Data sets:

a) Digital bus route coverage and Census data (annual), NSW Department of Transport (Minimum Service Level regime applied to metropolitan commercial bus operations, 95% of net patronage potential (population minus cars) in a contract area within 400m of a primary (7 days a week) or secondary (6 days a week) bus route; 95% within 800m of a primary bus route).

   Greater Sydney Metropolitan Region, Bus and Ferry Reform

b) Community transport funding (annual), Contracts and Compliance, Department of Transport

c) Household Transport Survey (annual), NSW Department of Transport (household trip characteristics – reason for travel; disability-related travel difficulty; personal and household characteristics – youngest child aged under 5 years, language spoken at home, employment status; location – LGA)

Note: only available for the Greater Sydney Metropolitan Region

Timeframes: 10-15 years

Subgroups: Characteristics of the LGA population: ATSI, NESB, SEIFA, rate of children aged under 10 years

11 Housing

11.1 Housing stability

Goals: Increase social housing stability

Rationale: Early intervention services (VHV, Family Support) will refer families to appropriate accommodation services to prevent crisis housing outcomes.

"It is thought that as a family relocates to a new community, a child's behaviour can become problematic due to the breakdown in the social network, such as the extended family, friends and neighbours, who have helped to regulate the child's behaviour. The total number of moves had a larger effect on childhood problems. Compared with non-movers, children who reported three or more moves were more likely to engage in problem behaviour. These results tend to support a commonly held view that moving contributes to aberrant child behaviour by intensifying problems (i.e., problem behaviour risk factors) which already exist in the family" (DeWit et al, 1998).

Definitions: Rates of public housing turnover, offer/acceptance rate, length of tenancy and rehousing applications by housing area (timeframe: 5-10 years)

See also 8.1a) Household mobility

Data sets: Community Renewal Unit Performance Reporting Data Collection (annual), Department of Housing

Subgroups: Characteristics of the housing area population: ATSI, NESB, SEIFA, rate of children aged under 10 years, children and parents with disabilities.

Appendix A: Background to the Outcomes Framework

Conceptual framework

The Framework has been developed by applying an ecological orientation to the research process in order to capture the complexities of the social context. Bronfenbrenner (1979) first developed the human ecological model in the 1970s and it has proved a valuable research tool. When Bronfenbrenner developed this approach it broke with the research traditions in human development that had been dominated by experimental laboratory approaches. The human ecological model enables groups to be located and locate themselves in the research process and places the developing child at the centre of the model, rather than people being subjected to categorisation by researchers and children viewed as pre-adults, or 'add-ons' to the adult world. It operates as a 'nested systems model' with a focus on points of connection and intersection between various aspects of the model for instance between child and family. This interest in the connecting points enables the model to accommodate 'difference and diversity ... unlike linear models which largely depend on ... overlap ... to make relationships comprehensible' (Pence, 1988:xxiii).

The strength of the ecological model is the holistic capacity for various components to build a comprehensive 'relational structure' that can adapt and adjust to this 'socio-ecological map' of the 'systemic rings'. The rings interrelate across from each level directly to all other levels or indirectly through other levels. The emphasis is on a form of unity in the prescribed areas but as Glassop (1988) suggests this may act to categorise individuals in an essentialist and universalist manner. The human ecological model appeals through its overall completeness and its context sensitive, dynamic approach with the potential to deliver comprehensive results.

The human ecological model has much to offer and is a valuable tool in this Outcomes Framework, however it also has limitations that require consideration. The idea that the complexities of child, family and community can be contained in what Pence describes as a 'nested-systems model' denies some of the realities that are exposed in the current theoretical debates. Glassop (1988) raises concerns about a universalist view of development which argues for set systems of predictable social action. These positions contain fixed views of childhood and adulthood. Such arguments have been currently critiqued by groups such as the Reconceptualising Early Childhood Education movement, which disagrees with a set notion of childhood and adulthood. There are a number of writers and researchers associated with the group such as Hatch, Tobin and Bailey who argue that there are multiple and shifting realities for children and adults. Post structural writers also argue that each context creates its own features that cannot be transposed to another setting. The application of so called scientific theories to the human circumstance is argued against. This creates a challenge to provide a research approach that can take account of the current critiques. Bronfenbrenner initiated a major reconsideration through moving away from structured research approaches that disregarded the social context. The current challenge is to continue this critique and create evaluation systems that can take account of the multiple realities of the current context.

Outcomes

An outcome is defined as the impact of the policy on the status of individuals or a group (SCRCSSP, 2000). Outcomes ‘assess the extent to which the scheme is securing its wider goals and objectives’ (Queensland Treasury 1997). The high-level outcomes articulated in the

Families First initiative do not lend themselves easily to direct assessment, and establishing a causal relationship between service outputs and broad outcomes is difficult. The impact of a policy or service cannot be determined in isolation from other external factors.

However, it is not always essential to establish direct causal links between particular outputs and outcomes, particularly where the outcomes are broad or ‘holistic’, looking at the whole person, family or community across multiple domains. Other outcomes can be defined more narrowly, focusing on a single facet of life. Such outcomes are easier to measure and more readily attributable to particular interventions. This Evaluation Framework includes both broad, ‘holistic’ outcomes and more narrow, focussed outcomes.

There are particular challenges for developing outcome-based performance indicators in the context of a family policy, including the complexity of influences on the health and well-being of individuals and the population, the difficulties associated with ‘measuring’ broad outcomes, and the time-scale associated with long-term outcomes (AIHW, 2000). Consequently, indicators are considered more appropriate than measures.

Indicators are used where direct measurement is not possible and provide a guide to performance where causal links are not obvious and where change in performance is difficult to measure directly. Whilst measures provide evidence of actual achievement of the item being measured, indicators provide evidence inferring something more general about performance indicative of broader influences.

Indicators need to be consistent with the time-scale for the achievement of both the specific, focussed outcomes and the long-term, ‘holistic’ outcomes of the Families First initiative. Evaluation of activities similar to Families First, such as health promotion, has suggested the following timeframe for outcomes:

- two to five years before a decrease in priority risk factors;
- five to ten years before an enhancement in positive and healthy development;
- ten to 15 years before a vision for a healthy community is embedded in the social contexts and institutions of a community (Griffiths et al, 2001).

Where it is reasonable to believe that a policy or program has contributed to the desired outcomes, within an appropriate time-frame, indicators of that outcome are likely to be useful for assessment and planning purposes and may assist at a program level with determining whether the range of interventions is achieving improvements (AIHW, 2000).

Focus of the framework

The Families First initiative has three major foci, reflected in the Outcomes Evaluation Framework: outcomes for children, families and communities; population focus; and equity.

Population focus

The enhancement of universal health and well-being promotion strategies such as the universal programs which form the basis of the Families First initiative, promote positive change for all groups in society, including those with disadvantage. Social learning theory (Bandura, 1986) suggests that the modification of social norms can impact on individual

behaviour by supporting healthy behaviours and providing opportunities for behavioural change. Change is facilitated through the modification of social environments and the development of personal competency. The Families First initiative, through such strategies as volunteer home visiting and inter-sectoral links, seeks community mobilisation directed towards achieving population-wide change in social norms and structures that directly benefit health and well-being and indirectly influence individual behaviours and lifestyles by changing social norms and social support (Nutbeam, 1999).

The outcomes for service models that involve cooperation between agencies, or across program areas, and particularly models seeking achievement of broad, 'holistic' outcomes, need to be conceptualised at a population, rather than individual level (AIHW, 2000). The Families First initiative promotes inter-sectoral activity to improve the health and well-being of the whole population of children and families in NSW and the early identification and intervention for those individual children and families experiencing problems before they become entrenched. Success, therefore, will be demonstrated by an improvement in the health and well-being of the population and the absence of entrenched problems. This Evaluation Framework thus focuses on the indicators of positive outcomes that are necessarily 'measured' at the population level in terms of increasing rates or proportions of children, families and communities, rather than individual gains for people or groups with problems.

The focus of this outcome evaluation is to provide a state-wide picture of the gains made through the Families First initiative, by providing indications of outcomes at a State level. Population-based outcome indicators are useful for assessment and planning purposes as they can point to the achievement of the initiative's wider goals and objectives (both short and long term), as well as providing information which local providers can use to compare and benchmark targets for individual programs and clients.

Equity

'Societies and governments have an obligation to the future to devise systems that ensure effective parenting, [and] support good early childhood development.' The expectation is that all children have equal opportunity for optimal development in the early years (McCain & Mustard, 1999: 11). To achieve equity, policies and programs need to focus on both places and people – targeting known places of disadvantage will fail to reach disadvantaged individuals living in better off areas, whilst targeting individual people will fail to address geographical and social variations in opportunity structures (Griffiths et al, 2001). Depending on which outcome, different places or people may be relatively advantaged, for example, indigenous Australians, people from non-English speaking backgrounds, rural Australians, males or females, people with disabilities or people with socio-economic disadvantage.[2]

The Families First initiative includes both universal and targeted programs, seeking both an overall improvement in the health and well-being of the population, and specific improvements for groups 'at risk'. In order to demonstrate the effectiveness of targeted programs, the outcome evaluation of the Families First initiative must be conducted both universally for benchmarking (as described in the population focus above), and with targeted

[2] Often the most disadvantaged groups have multiple disadvantage, for example, people with disabilities in rural communities also experience socio-economic disadvantage. However, opportunities for exploring the impact of multiple disadvantage are limited at the population level.

groups, variously defined. Inherent in all outcome indicators included in this Framework are thus both universal outcomes and outcomes for relevant ‘at risk’ and targeted groups, with the aim of demonstrating both overall population-level improvement and a reduction in disadvantage.

Data sources

Data definition tasks in developing the Framework included:

- identifying existing secondary data sets from Commonwealth and State agencies and other longitudinal research sources;
- identifying existing administrative data sets from Families First participants and suggesting modifications that could be made; and
- suggesting additional sample data sets to be collected by TCO, Families First participating agencies or other researchers.

The availability of existing outcome data is ranked below to prioritise where primary data collection is necessary for the evaluation. Possible data sources included:

- Population-wide data eg Census, Year 3 education tests
- Interstate comparison sample eg WA Child Health Survey
- Existing Families First Area sample data
- Data collection that could be administered by service providers
- Data collection that might be being administered by other researchers
- Data collection that must be administered by researchers for the Families First evaluation.

Some of the child and family health indicators rely on NSW Health data sets that are in the process of development. They include the following:

- Community Health Information Management Enterprise (CHIME): being developed and intended to be Statewide. It is anticipated that CHIME will be a platform for data collation across a number of sources below;
- Integrated Perinatal and Infant Care (IPC), including the Perinatal psychosocial assessment, currently funded for five Area Health Services and adopted by at least two others; to be collated through CHIME;
- Emergency Department: not yet defined or funded;
- Mental Health Outcomes and Assessment Tool (MHOAT), to be collated through CHIME; and
- Minimum Data Set for Child and Family Health: not yet defined or funded; to be collated through CHIME.

While most of the proposed indicators rely on general secondary data, four indicators suggest parallel collection of comparable data by the Families First DoCS funded programs: child social and emotional wellbeing; family relations; participation (employment, training and other public activities); and community cohesion. Participation, with some modification is

already included in the draft DoCS Minimum Data Set for the funded programs. Considerations for finalising the outcome instruments include the following:

- The instruments must be appropriate to the range of programs and sensitive to the diversity of clients. Programs in FOA4 may need to be treated differently.
- Providers are concerned about administrative burden, so the instruments, particularly if they are to be repeated, must be as concise as possible. The instruments must be relevant to the provider's program management, planning and evaluation.
- Some providers, such as Family Support Services, are already collecting outcome measures. If possible these should be adopted or modified for the purposes of Families First.
- Not all services have immediate computer access. Data collection may need to include scannable forms.
- Providers, regions and Areas are likely to want to access to their own results and comparative results. Means to analyse local results at the point of collection and to transfer comparative results may need to be designed.
- Finalising the instruments should include consultation with the providers and peak organisations.
- Full documentation and training will be needed for implementation.

These proposed outcome instruments will be designed with the expectation that other NSW service providers and agencies, such as other DoCS funded programs, NSW Health and Department of Education and Training services will consider the benefit applying these common outcomes instruments.

Appendix B: Contacts for Data Sets

Agency	Contact
Australian Centre for Immunisation Research	Margaret Burgess
Bureau of Crime Statistics and Research	Jackie Fitzgerald, Victor Korabelnikoff
Commonwealth Department of Family and Community Services, Census of Child Care Statistics	Greg Poyser, Rosemary Jardine, Maria Boyle
Local Government and Shires Associations	Noel Baum
National Perinatal Statistics Unit	Jishar Dean
NSW Department of Education and Training	Carol Carrigan, Michelle Bruniges
NSW Department of Education and Training, Schools as Community	Ruth Newman
NSW Department of Education and Training, Student Welfare	Helen Kerr-Roubicek
NSW Health, Public Health Unit	Claire Corbett
NSW Health, Aboriginal Health Branch	Paul Huntly
NSW Health, Child Health Survey	Louisa Jorm
NSW Health, Mental Health Branch	Kim Scanlon, Suzanne Pope
NSW Department of Housing	Qingsheng Zhou, Nellie Hall
NSW Department of Housing, Community Renewal	Helen Boyton
NSW Department of Sport and Recreation	Rosemary Perry
NSW Department of Transport	Helen Battellino, Tim Raimond
NSW Department of Transport, Contracts and Compliance (Community Transport)	Jennifer Aldred
NSW Department of Transport, Greater Sydney Metropolitan Region, Bus and Ferry Reform	Joanna Quilty

Appendix C: Strengths and Difficulties Questionnaire (SDQ)

	Not True	*Somewhat True*	*Certainly True*
Considerate of other people's feelings	___	___	___
Restless, overactive, cannot stay still for long	___	___	___
Often complains of headaches, stomach-aches or sickness	___	___	___
Shares readily with other children (treats, toys, pencils,	___	___	___
Often has temper tantrums or hot tempers	___	___	___
Rather solitary, tends to play alone	___	___	___
Generally obedient, usually does what adults request	___	___	___
Many worries, often seems worried	___	___	___
Helpful if someone is hurt, upset or feeling ill	___	___	___
Constantly fidgeting or squirming	___	___	___
Has at least one good friend	___	___	___
Often fights with other children or bullies them	___	___	___
Often unhappy, down-hearted or tearful	___	___	___
Generally liked by other children	___	___	___
Easily distracted, concentration wanders	___	___	___
Nervous or clingy in new situations, easily loses confidence	___	___	___
Kind to younger children	___	___	___
Often lies or cheats	___	___	___
Picked on or bullied by other children	___	___	___
Often volunteers to help others (parents, teachers, other children)	___	___	___
Thinks things out before acting	___	___	___
Steals from home, school or elsewhere	___	___	___
Gets on better with adults than with other children	___	___	___
Many fears, easily scared			
Sees tasks through to the end, good attention span			

http://homepages.tesco.net/~chanceuk/resources/Referral-Information-Form.pdf

Appendix D: Modified Abidin Parenting Stress Index

	Life Events Inventory
	"Close family member" refers only to a parent, child, grandparent or relative living in this household.
a.	A close family member was away from home a lot
b.	Our family had to move a lot
c.	A close family member had a serious medical problem (illness or accident and was in hospital)
d.	A close family member was badly hurt or very sick (but was not in hospital)
e.	A close family member was arrested or in jail
f.	Our family was known to Department for Community Services' child protection services
g.	Our child or children were upset by family arguments
h.	A close family member was robbed
i.	A favourite pet died
j.	Our child or children saw somebody get badly hurt
k.	A parent lost his/her job
l.	A parent was unemployed
m.	A close family member had an alcohol or drug problem
n.	A close family member had serious emotional problems
o.	Our family had serious financial problems
p.	A close family member has a physical handicap
q.	Our child or children have been involved in serious family arguments
r.	A parent, brother or sister died
s.	Another relative died with whom the child or children had a very close relationship
t.	Sometimes our family had too little food to eat
u.	Different people have moved in and out of our house
v.	Close family members have had serious arguments with each other
w.	Sometimes our child or children had too few clothes to wear
x.	Our child or children had to take care of others in the family
y.	Our child or children have been in a foster home
z.	Child's parents were separated and/or divorced
Aa	Our child or children have had to live with a friend or relative for a while
Bb	We have been very crowded where we live
Cc	Our neighbourhood has been unsafe
Dd	Our child's best friend moved away
Ee	Our child or children have been upset by neighbourhood violence
Ff	Our child or children have had to deal with people whose behaviour was frightening
Gg	Many times there has been no one to take care of our child or children

Glossary

Note:	Any definitions of terms used in the Framework are as defined in the particular data set referred to.
ABS	Australian Bureau of Statistics
ACER	Australian Council of Educational Research
AHS	Area Health Service
AHURI	Australian Housing and Urban Research Institute
AIFS	Australian Institute of Family Studies
AIHW	Australian Institute of Health and Welfare
ASPARD	Annual Service Plan & Reporting Document, Children's Services, Department of Community Services, NSW
ATSI	Aboriginal, Torres Strait Islander
CALD	Culturally and linguistically diverse
CHIME	Community Health Information Management Enterprise, being developed for NSW Health, ACT, Queensland, South Australia and Western Australia.
COPS	Computerised Operational Policing System
CSAHS	Central Sydney Area Health Service
DADHC	NSW Department of the Ageing, Disability and Home Care
DHAC	Commonwealth Department of Health and Aged Care
DET	NSW Department of Education and Training
DETYA	Commonwealth Department of Education, Training and Youth Affairs
DoCS	NSW Department of Community Services
FaCS	Commonwealth Department of Family and Community Services
FF	Families First
GHQ	General Health Questionnaire
HACC	Home and Community Care
IPC	Integrated Perinatal and Infant Care, Centre for Mental Health initiative. As at March 2002, funded for five Area Health Services (AHS) and replicated in two more. It is expected to be implemented in more AHS. Data is to be collated through CHIME.
ISC	Inpatient Statistics Collection, New South Wales Health
LGA	Local Government Area
LSAC	Longitudinal Survey of Australian Children, to be designed in 2002
MHOAT	Mental Health Outcome Assessment Tool

MHOAT-CA	Mental Health Outcome Assessment Tool – Children and Adolescents: Health of the National Outcome Scales for Children and Adolescents (HoNOSCA); Children's Global Assessment Scale (CGAS); ICD-10 Factors Influencing Health Status (FIHS); Strengths and Difficulties Questionnaire (SDQ)
NESB	Non English Speaking Background
NHMD	National Hospital Morbidity Database, AIHW
NHS	National Health Survey, DHAC
NPSU	National Perinatal Statistics Unit
SEIFA	Socio-Economic Indices for Areas (ABS)
SF-36	Short Form 36, Health and Wellbeing Questionnaire
Young mothers	Mothers aged under 19 years

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