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Evaluation of the Brighter Futures-SafeCare Program

*Final Process, Outcome and Economic Evaluation Report*

*V1. February 2021*

# Main Messages

SafeCare has been implemented with a high degree of program fidelity across all Brighter Futures agencies. Most aspects of the program model were adhered to with some minor variations, although, these variations supported successful program implementation and delivery in different contexts.

The successfully managed transition from dependence on the National SafeCare Training and Research Centre for training of Providers and Coaches and the coaching of Providers means the program is now self-sustaining in New South Wales at a significantly reduced cost.

The intervention (training modules in health, safety and parent-child/parent-infant interaction) led to significant increases in knowledge and skills that participants report were translated into parenting practice, as well as substantial improvements in parent’s confidence to care for their children.

After some initial resistance in staff to this very different way of working (structured behaviourally based parenting program) this trial demonstrates that SafeCare can become business-as-usual relatively quickly if implemented with strong management support and attention to culture change.

The materials and processes of SafeCare have been shown to be largely acceptable and appropriate for vulnerable population groups such as Aboriginal and Torres Strait Islander participants, participants from culturally and linguistically diverse backgrounds, and participants with intellectual and physical disabilities. However, slight adaptions to content and method of delivery have been found to improve engagement from these population groups (e.g., more visuals, additional culturally specific resources, adjusted session length).

A number of important unintended positive outcomes for families were observed (e.g., sharing learnings with social networks, interest in further study) and no negative unintended outcomes were reported.

Several recommendations for how to better support implementation based on lessons learned are made (e.g., building an understanding of how SafeCare fits within broader practice frameworks) and observations at the practice level provide good advice for operational improvements as, and if, the delivery of SafeCare continues and is scaled up to include additional Brighter Futures agencies.

The original program logic based on randomised controlled trial level evidence from the United States of America is supported in the Australian context up to the achievement of immediate (parents are better able to: identify and remove hazards from their home, care for their child’s health when they are sick or injured, interact with their child, find activities to do with their children, and manage routine activities) and intermediate outcomes (parent’s increased confidence in their parenting skills, parent’s awareness of how to create a safe home, parent’s awareness of how to care for their child’s health, parent’s awareness of how and when to access health services, increased positive interactions between parent and child). There is also evidence that the children of those who complete at least two SafeCare modules are significantly less likely to have a risk of significant harm report at the child protection helpline compared to children of families in the comparison group (i.e., those who participated in Brighter Futures only).

The timeframe for this evaluation given the significant time required to reach program maturity is not long enough to fairly expect the overall impact of SafeCare on the longer-term outcomes such as reduced ROSH reports and reduced out-of-home-care placements. Comprehensive estimates of statistical power for various effect and sample sizes are recommended to determine an appropriate time frame for future analyses.

Given the quality and availability of data in the evaluation, the conclusion is that, while it appears that children whose families complete two or more modules may have lower odds of ROSH report within 12 months of Brighter Futures acceptance, there were very small numbers with outcomes for this analysis, and analysis of all eligible children enrolled in SafeCare did not demonstrate any statistically significant benefit relative to Brighter Futures only. Further, there is insufficient evidence on secondary outcome measures to reliably estimate the effect of Brighter Futures-SafeCare on ROSH re-reports and out-of-home-care (OOHC) entries avoided compared to Brighter Futures only. Without an appropriate, reliable estimate of effect size, and duration of effect, the benefits as part of a Cost-Benefit Analysis cannot be accurately estimated and therefore are excluded from the base case Cost-Benefit Analysis. If the point estimates of effect on ROSH re-reports and OOHC entries avoided between BF-SC and BF only from the outcome evaluation are subsequently substantiated to be statistically significant and the duration of effect is demonstrated to be sustained for three years (in-line with international evidence), continuation of the program and full roll-out of BF-SC is potentially net beneficial (as determined by a benefit scenario analysis).

A number of measurement and data quality issues are identified for further attention and suggestions are made for future evaluation research effort.

The significant impact on key parenting behaviours known to support improved child safety outcomes, demonstrated by multiple randomised controlled trials elsewhere, supports the continuation and wider roll of the SafeCare program in the New South Wales context, underpinned by continued monitoring and evaluation.

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*Attachment A: Economic Evaluation Report*

*Attachment B: Desktop Review*

*Attachment C: Evaluation Plan*

*Attachment D: Individual Site Reports*

# List of Abbreviations

|  |  |
| --- | --- |
| *Abbreviation* | *Term* |
| *BCR* | Benefit Cost Ratio |
| *BF-SC* | Brighter Futures-SafeCare |
| *CALD* | Culturally and Linguistically Diverse |
| *CBA* | Cost Benefit Analysis |
| *CI* | Confidence Interval |
| *CIT* | Central Implementation Team |
| *CP* | Child Protection |
| *cPAT* | Child Planned Activities Training |
| *DCJ* | Department of Communities and Justice |
| *FACSIAR* | Family and Community Services Insights, Analysis and Research |
| *HAPI* | Home Accident Prevention Inventory |
| *iPAT* | Infant Planned Activities Training |
| *LIT* | Local Implementation Team |
| *MSC* | Most Significant Change |
| *NPV* | Net Present Value |
| *NSTRC* | National SafeCare Training and Research Centre |
| *NSW* | New South Wales |
| *OOHC* | Out of Home Care |
| *OR* | Odds Ratio |
| *PCI* | Parent Child Interaction |
| *PII* | Parent Infant Interaction |
| *PRC* | Parenting Research Centre |
| *ROSH* | Risk of Significant Harm |
| *SICC* | Sick or Injured Child Checklist |
| *USA* | United States of America |

# Executive Summary

**Terms of Reference**

Siggins Miller was engaged by the Department of Communities and Justice (DCJ; formerly known as the Department of Family and Community Services) to evaluate the Brighter Futures-SafeCare (BF-SC) program. The purpose of the evaluation was to assess the outcomes of the program that have been achieved for clients to inform future policy decisions (Outcomes Evaluation); to assess how the outcomes are achieved for clients through the interventions (Process Evaluation); and to assess the costs and benefits of the program (Economic Evaluation). The evaluation also assessed the outcomes achieved for Aboriginal and/or Torres Strait Islander families engaged in the program.

The evaluation questions were:

1. Was the trial implemented as intended?
2. Does SafeCare lead to a reduction in the risk of significant harm for families?
3. Does SafeCare improve safety in the home?
4. Does SafeCare improve parents’ capacity to attend to their child(ren)’s health needs?
5. Does SafeCare improve parents’ personal interaction with their child(ren)?
6. Does SafeCare improve parents’ confidence in their capacity to care for their child(ren)?
7. Were there any additional or unanticipated outcomes from the SafeCare implementation and have these created benefits or limitations to the delivery of SafeCare?
8. What is the incremental cost of delivering SafeCare?
9. What is the incremental value of the benefits of SafeCare from a societal perspective?
10. What is the estimated ratio of net costs to deliver SafeCare to its net benefits?

**Purpose of this report**

This report is submitted in fulfilment of the deliverable for the Final Process, Outcomes and Economic Evaluation Report. The purpose of this report is to present the findings and recommendations of the evaluation of the BF-SC program.

**Background**

An independent review of the out-of-home-care (OOHC) system in New South Wales (NSW) concluded that the child protection system is not doing enough to address the complex needs of vulnerable children and families, to break the intergenerational cycle of abuse and neglect.[[1]](#footnote-2) The review identified the need for evidence based parenting programs. SafeCare is a highly structured, evidence-based behavioural skills parenting program that was implemented as a component of the existing Brighter Futures program. Brighter Futures delivers voluntary targeted intervention services to families with at least one child under the age of nine living at home or for families expecting their first child, where concerns of risk of significant harm have been raised for those families. The SafeCare program targets a sub-set of the Brighter Futures clients: parents with children aged 0 – 5 years old.

A small trial of the SafeCare program began in 2015 at Wesley Mission (Western Sydney). Five additional Brighter Futures agencies: Mission Australia (Wagga Wagga), CareSouth (Wollongong), Samaritans (Newcastle-Lake Macquarie), Barnardos (Orana Far West) and CatholicCare (Manning-Taree) began implementation of the SafeCare program in October/November 2017. These agencies were selected through a tender process. Since this time, an additional two Brighter Futures agencies have been selected to implement the BF-SC program: SDN Children’s Services and Wandiyali Aboriginal Community and Children’s Services. These additional two agencies are not included in the current evaluation.

**Methodology**

The evaluation team used a mixed-methods approach to the BF-SC evaluation. As part of this evaluation, we used a quasi-experimental evaluation design to compare outcomes for families participating in BF-SC and a comparison group of families participating in Brighter Futures only. Both qualitative and quantitative methods of data collection were used to form the conclusions presented in this report.

The following data sources were used to inform the evaluation:

1. Parenting Research Centre (PRC) raw data sets (Nov 2017 – Dec 2020)
2. National SafeCare Training and Research Centre (NSTRC) reports (Nov 2017- Dec 2020)
3. SafeCare pre-and-post module outcomes assessments (Nov 2017 – Dec 2020)
4. Parent Satisfaction Surveys (Nov 2017 – Dec 2020)
5. Child Protection (CP) Helpline data sets (Jul 2018 – Jun 2020)
6. OOHC placement data sets (Jul 2018 – Jun 2020)
7. Brighter Futures program datasets (Jul 2018 – Jun 2020)
8. Desktop research
9. Stakeholder interviews and focus groups with SafeCare families, SafeCare Providers, Coaches, Trainers, Team Leaders, and Managers
10. Stakeholder interviews and focus groups with the NSTRC, the PRC, and DCJ
11. Family and Community Services Insights, Analysis and Research (FACSIAR) Brighter Futures Unit Costing Report
12. FACSIAR Benefits Menu June 2020
13. Review of contracts for Brighter Futures agencies, NSTRC and PRC

**Conclusions**

The following conclusions are based on a triangulation of data from all available sources.

**Was the Trial Implemented as Intended?**

Taking together data from all sources, there is evidence that the BF-SC trial was implemented as intended. This appears to be the case across the areas of staff training, program implementation, program reach, family engagement and program fidelity.

Staff training was executed successfully at the Provider, Coach and Trainer level and several Brighter Futures agencies are beginning to reach a stage of internal sustainability with the appointment of internal Coaches and Trainers. The establishment of internal Coaches and Trainers has led to a range of benefits for agencies where this is considered practical and feasible.

While some initial challenges in program implementation were evident (e.g., staff resistance to a very structured way of working), the evidence suggests that overall, the implementation of the program was largely successful. There is strong evidence that the program is operating well and reaching a stage of business as usual. In addition, there is strong evidence that the implementation approach was aligned to evidence-based models of effective program implementation.[[2]](#footnote-3) Key factors identified as supporting program implementation include ongoing support and involvement from the funder, the intermediary and the purveyor; the intention of Brighter Futures agencies to embed SafeCare as business-as-usual; strong leadership and continued communication about SafeCare within Brighter Futures agencies; and platforms to collaborate and share knowledge. The findings suggest that additional work to address issues with the data collection processes would further assist program implementation and monitoring.

The data from consultations indicates that families involved in the BF-SC program often experienced a range of complex issues (e.g., mental health, drug and alcohol, homelessness, lack of social support, domestic violence relationships, involvement in judicial proceedings, and financial hardship). Despite this, there was relatively good uptake of the program (1013 were offered the program and 563 accepted an invitation to participate in the program)[[3]](#footnote-4). Of these 268 were reported as being withdrawn from the program (31 had completed two modules, 73 had completed 1 module and 164 had not completed any modules), 120 families completed all three modules, and 175 were currently participating at the time of the evaluation. Families consistently reported their enjoyment of the modules and described how this allowed them to gain important skills to improve their parenting behaviour. The findings indicate that while SafeCare cannot address all of the complex needs of families (e.g., mental illness, domestic violence), it provides the opportunity for parents to gain skills and confidence in the areas of child safety, child health and parent child interaction (PCI) and parent infant interaction (PII).

Efforts to engage families in the SafeCare program were largely successful. All Brighter Futures agencies worked towards embedding SafeCare as business-as-usual and plan to offer the program to all eligible families. The data also indicates that the program is accessible and appropriate for different population groups such as Aboriginal and Torres Strait Islander participants, participants from culturally and linguistically diverse backgrounds, and participants with intellectual disabilities, with slight adaptions to content and method of delivery to meet the unique needs of the family (e.g., including more visuals, use of translators, adjusting session length). Almost half of the families who begin SafeCare had withdrawn from the program at the time of this evaluation, however this is comparable to other trials of SafeCare in other settings and there is evidence that families benefit from the completion of one or two modules (27% of families who exited the program early completed one module and 12% completed two modules; the remaining 61% did not complete any modules prior to exiting early).

The program is delivered in line with program requirements and in a largely consistent way across the different Brighter Futures agencies. The program materials and resources were used as intended and the intended staffing model, training and coaching model, data collection processes and eligibility criteria were adhered to. We note some slight variations from the program model in relation to how the program was delivered in practice (length of session, length of time on the program, how the program was offered to families, remote delivery of the program and staff training), but these adaptions appear to have supported implementation and program delivery in different contexts based on varying needs of the agency and the population of families they served. We also note that there may be some benefit in exploring greater flexibility in the program model to allow families to complete individual modules.

**Does SafeCare Lead to a Reduction in the Risk of Significant Harm for Families?**

A cautious and reasonable interpretation of the outcome data is that, for the relatively small number of families that have completed SafeCare to date, children of families that complete at least two SafeCare modules may have significantly lower odds of a risk of significant harm (ROSH) report within 12 months of Brighter Futures acceptance compared to children of families in the comparison group. However, due to limited sample size, a relatively short period of follow-up and only a few OOHC events observed in the data set, the estimated effect between BF-SC and BF-only, the outcomes of interest for the Cost-Benefit Analysis were not statistically significant and/or considered unreliable.

**Does SafeCare Improve Safety in the Home?**

Findings from all data sources suggest that SafeCare does improve safety in the home. Pre-and-post module outcomes assessments show that the number of hazards present in the home significantly reduced (*p* < .001; d = 1.14[[4]](#footnote-5)) after completing the Safety module. In addition, both agency staff and participating families agreed that parents were better able to identify and mitigate hazards in their home after completing the Safety module. These findings are consistent with previous trials of SafeCare in other settings.[[5]](#footnote-6),[[6]](#footnote-7),[[7]](#footnote-8) The provision of Safety equipment is an important enabler for the achievement of these outcomes, as some families did not have the means to purchase this equipment themselves (e.g., baby gates, locks).

**Does SafeCare Improve Parents’ Capacity to Attend to their Child(ren)’s Health Needs?**

The synthesis of evidence suggests that SafeCare does improve parents’ capacity to attend to their child’s health needs. Similar to the previous evaluation question, the pre-and-post module outcomes assessments demonstrate that parents are significantly better (*p* < .001; d = -1.88[[8]](#footnote-9)) at responding to health scenarios and determining the appropriate course of action after completion of the Health module. Consistent with this, agency staff reported that families were better equipped to respond to the health needs of their children and were more aware of how and when to access appropriate support. Families self-reported improved confidence responding to their child’s health needs and determining the appropriate course of action. Again, these findings are consistent with previous trials of SafeCare in other settings.[[9]](#footnote-10),7 The findings suggest that families valued the resources associated with the Health module and plan to use these beyond completion of the program.

**Does SafeCare Improve Parents’ Personal Interaction with their Child(ren)?**

The evidence demonstrates overall improvements to parents’ interactions with their children after completion of the PCI/PII modules. Agency staff witnessed notable changes, such as the presence of positive behaviours (e.g., praising, setting expectations, implementing structure and routine). Families further noted that their confidence in interacting with their child had improved and they were better able to manage routine activities. These improvements often had flow-on effects such as improved bond between parents and children, improved family dynamics and less disruptive behaviour among children. Some families even reported that this was the most beneficial module in the program. The pre-and-post module assessments were consistent with the qualitative findings, demonstrating significant improvements to parent child (*p* < .001; d = -2.438) or parent infant (*p* < .001; d = -1.828) interactions. These positive changes are consistent with trials of SafeCare in other settings.[[10]](#footnote-11),7

**Does SafeCare Improve Parents’ Confidence in their Capacity to Care for their Child(ren)?**

There is strong evidence that SafeCare improved parents’ confidence to care for their children. In most cases, families reported minimal confidence in their parenting skills prior to completing the SafeCare program. Overall, their confidence improved across all areas of health (50% increase in self-assessment of confidence post module), safety (50% increase in self-assessment of confidence post module) and PCI/PII (80% increase in self-assessment of confidence post module) after completing the program. Consultations with agency staff reinforced these findings. In addition, the most frequently reported significant impact of the program was improvements to the capacity of parents to care for their children (27% of families interviewed reported this as the most significant impact of the program). Previous research is consistent with these findings.[[11]](#footnote-12) In addition, research demonstrates the importance of improvements to parental confidence, as this can be an important mechanism for positive changes in parenting behaviour.[[12]](#footnote-13)

**Were there any Additional or Unanticipated Outcomes from the SafeCare Implementation and have these Created Benefits or Limitations to the Delivery of SafeCare?**

A synthesis of evidence from all sources demonstrates that there are a range of unintended positive outcomes as a result of the BF-SC trial for both staff and families. These benefits include, but are not limited to, improved interest in education and training among participating parents, translation of knowledge within social networks, improved family dynamics, better opportunities for career development and growth among agency staff. No unintended negative outcomes were identified. These findings demonstrate the presence of broader societal and community benefits as a result of the SafeCare program.

**What is the Incremental Cost of Delivering SafeCare?**

An assessment of the trial period, as well as two potential future scenarios were considered as part of this economic evaluation:

1. Evaluation of the BF-SC trial (onboarding and operation of 8 sites from Nov 2017 – Dec 2020);
2. Forecast scenario: Extension of the trial period (continued operation of 8 trial sites over a 10-year forecast after the trial period);
3. Forecast scenario: Full roll-out (onboarding of additional 21 sites, with operation of 29 sites over a 10-year forecast).

A total and per-family cost was found for each scenario (Table 1).[[13]](#footnote-14) Key assumptions and detailed methodologies and outputs are provided in *Attachment A: Economic Evaluation Report*.

Table 1: Total and per family cost of SafeCare.

| **Costs** | **Trial** | | **Extended trial** | | **Full roll-out** | |
| --- | --- | --- | --- | --- | --- | --- |
| *Total* | *Per family* | *Total* | *Per family* | *Total* | *Per family* |
| Total costs | $6,209,757 | $11,030 | $10,724,386 | $2,837 | $50,090,904 | $3,662 |
| DCJ | $1,791,081 | $3,181 | $927,585 | $245 | $3,210,181 | $235 |
| Brighter Futures agencies | $4,418,676 | $7,848 | $9,796,801 | $2,592 | $46,880,724 | $3,427 |

The majority of costs across all scenarios (trial, extended trial and full roll-out) are incurred to Brighter Futures agencies, primarily attributable to labour costs associated with implementation, ongoing management and SafeCare coaching. Sensitivity testing of the cost analysis determined key cost drivers as follows:

1. Discount rate (it is noted that this will also impact the benefits depending on effect sizes);
2. BF-SC uptake rate (it is noted that this will also impact the benefits depending on effect sizes);
3. Delivery of BF-SC as separate sessions, that is, the integration of BF-SC into Brighter Futures reducing additional travel and translator/interpreter time costs.

In view of the potential added costs from greater integration of BF-SC into Brighter Futures agencies’ business-as-usual approach, further consideration of the support required to achieve this is recommended. It is noted that integration may also lead to a reduction in costs (not quantified in this analysis) stemming from “replacement” of some Brighter Futures activities with BF-SC, rather than providing BF-SC activities in addition to Brighter Futures.

**What is the Incremental Value of the Benefits of SafeCare from a Societal Perspective?**

Given the quality and availability of the outcome evaluation data, and the small numbers with outcomes of interest, there is not considered to be adequately valid or reliable estimates of the association between ROSH re-reports and OOHC entries, and participation in BF-SC to be appropriately incorporated into a cost-benefit analysis (CBA). Instead, we have conducted a range of scenario analyses to demonstrate the potential benefits and subsequent potential CBAs of BF-SC.

Two key uncertainties related to benefit valuation of SafeCare have been identified: (1) primary outcome effect sizes; and (2) duration of benefits, i.e. the extent to which families continue to benefit from a reduction in the risk of ROSH re-reports or OOHC entries beyond the 12-months for which there is trial data. Both uncertainties were tested in the benefit scenario analyses. Results for the full roll-out scenario are presented in Table 2, with Scenario A representing the base-case evaluation based on the point estimates of effect from the outcome evaluation. Rationale for base case values and scenario choices are presented in *Attachment A: Economic Evaluation Report*.

As a decision criteria, an initiative is potentially worthwhile if the Net Present Value (NPV)>0 and Benefit-Cost Ratio (BCR)>117. Further details and calculation methods are provided in *Attachment A*. If the point estimates of effect on ROSH re-reports and OOHC entries avoided between BF-SC and BF only from the outcome evaluation are subsequently substantiated to be statistically significant and the duration of effect is demonstrated to be sustained for three years (in-line with international evidence), continuation of the program and full roll-out of BF-SC is potentially net beneficial.

Table 2. Benefit scenario analysis results – full roll-out.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| # | Primary outcome effect size | | Duration of benefits | Cost | Benefit | NPV | BCR |
| ROSH | OOHC |
| A | 12.23%# | 1.72%# | 3 years^ | $50,090,904 | $176,931,740 | $126,840,836 | 3.53 |
| B | 0% | 0% | 3 years | $50,090,904 | $0 | -$50,090,904 | 0.00 |
| C | 6.12% | 0.86% | 3 years | $50,090,904 | $88,960,930 | $38,870,026 | 1.78 |
| D | 24.46% | 3.44% | 3 years | $50,090,904 | $349,936,485 | $299,845,581 | 6.99 |
| E | 12.23% | 1.72% | 1 year | $50,090,904 | $63,716,668 | $13,625,764 | 1.27 |
| F | 12.23% | 1.72% | 5 years | $50,090,904 | $273,545,194 | $223,454,290 | 5.46 |

#*An approximation of risk reduction based on odds ratio point estimates determined in the outcomes analysis (controlling for correlation of outcomes within families and Brighter Futures agencies) are used as base case values (noting estimates are underpowered and unreliable). Where the outcome is frequent (as for ROSH) the OR is likely to be an overestimate of the relative risk and subsequently risk reduction.*

*^From external evidence15 and consultation, we have conservatively estimated base case as 3 years of benefits for families post-SafeCare.*

We further note that the monetarised value of ROSH re-reports and OOHC entries avoided potentially does not reflect the true societal value associated with achieving these outcomes. Specifically, the values used in this analysis represent the expected present value of avoided costs to the DCJ from providing OOHC or attending to a ROSH event. However, and in particular with respect to OOHC, the societal value of avoiding an OOHC event may be significantly larger and extend to improvements in education and productivity, reduced criminal justice and incarceration costs, reduction in drug and alcohol use, reduction in health care utilisation and improvements in health-related quality of life60.

**What is the Estimated Ratio of Net Costs to Deliver SafeCare to its Net Benefits?**

The trial of the SafeCare program represented a significant up-front investment in the establishment and implementation of BF-SC, which are likely to extend beyond the trial period as well as provide economies of scale for greater expansion. Therefore, we recommend considering the extended trial and full roll-out scenarios as better representations of future benefits and costs of BF-SC.

For the trial scenario, the BCR was only >1 when the effect size was equal to or above the suggested point estimate from the outcomes analysis (risk reduction of at least 12.23% for ROSH re-reports and 1.72% for OOHC entries as a result of SafeCare, realised over 3 years). For the forecast scenarios, whilst robust estimates of the benefits could not be appropriately incorporated into the CBA, benefit scenario analysis results indicate that if the effect sizes specified in the outcomes analysis could be achieved and these benefits continued for 3 years (noting that the outcomes analysis was underpowered, unreliable and considered outcomes for only 12 months) – the NPV and BCR returned positive results for both the extended trial and full roll-out scenarios (BCR = 4.56 and 3.53, respectively). The 12 month point estimates from the outcomes evaluation were consistent with the published outcomes from a randomised control trial of SafeCare in the United States. Specifically, Chaffin15 (2012) estimated a hazard ratio of between 0.74 and 0.83 for child protective services recidivism between SafeCare and usual care in the United States based on 2,175 families and mean follow up of 6 years. Holding effect sizes constant, the duration of benefits required to breakeven (NPV=0, BCR=1) is 1.84 years for the trial, 0.61 years for the extended trial and 0.79 years for the full roll-out. Considering international evidence [8] has shown benefits of SafeCare extending up to six years of follow up, our results imply that the continued operation and expansion of BF-SC is potentially net beneficial, dependent on the possible efficacy of the program among participants over an extended time interval. Measurement of outcomes over a longer time frame and with a greater sample size is recommended to confirm this.

**Recommendations**

We recommend that:

1. The implementation and expansion of SafeCare continue accompanied by improved monitoring and measurement of longer-term outcomes as well as costs and benefits, making maximum use of data now routinely collected through the NSTRC portal for immediate and intermediate outcomes. We suggest that analysis and reporting of these outcomes occurs on a regular basis, which should include updating of the estimates of effect size.
2. The Department continues to build on its existing efforts to strengthen the cultural capability and cultural safety of the workforce employed within Brighter Futures agencies for the delivery of culturally safe services for Aboriginal and Torres Strait Islander people.
3. The Department consider using co-design processes to work with Brighter Futures agencies, family representatives, the intermediary and the purveyor to take up the suggestions made and reflected in the body of the report about operational improvements to the systems and processes surrounding SafeCare. We recommend that focusing efforts on i) flexibility in the number of modules delivered, ii) adaptions to program content to make it more relevant for the Australian context and to better meet the needs of different population groups, iii) enhancing understanding among local Community Service Centres about the SafeCare program and what constitutes an appropriate referral may lead to the greatest improvements in program implementation and delivery and thus should be prioritised.
4. The work that is underway to streamline and improve the data collection processes for the SafeCare program continues. In particular, these discussions could seek to resolve issues with the existing data collection tools and processes such as those associated with the monthly reporting from Brighter Futures agencies.
5. The program logic for SafeCare is re-designed to document the non-program factors (i.e., varying reasons for ROSH reports, variations in how the tool for identifying how the ROSH reports is used in practice, investigation rate of ROSH reports and unforeseeable issues such as COVID-19) that impact the achievement of longer-term outcomes such as a reduction in ROSH re-reports and out-of-home care placements.
6. The Department explore the use of previously linked data across health, education and other sectors to measure other potential outcomes and impacts associated with participation in SafeCare.

# Terms of Reference

Siggins Miller was engaged by DCJ (formerly known as the Department of Family and Community Services) to conduct an evaluation of the BF-SC program.

The purpose of the evaluation was to:

* Assess how the outcomes are achieved for clients through the intervention (Process Evaluation);
* Assess the outcomes that have been achieved for clients, to inform future policy decisions (e.g., lower rate of ROSH re-reports, OOHC placements, case plan goals achieved; Outcomes Evaluation); and
* Assess the costs and benefits of the program (Economic Evaluation).

The evaluation also assessed whether (and if so, how) the SafeCare program has achieved outcomes and benefits for Aboriginal and Torres Strait Islander families, who represent about one third of families in the Brighter Futures program state-wide.

The evaluation questions were:

1. Was the trial implemented as intended?
2. Does SafeCare lead to a reduction in the risk of significant harm for families?
3. Does SafeCare improve safety in the home?
4. Does SafeCare improve parents’ capacity to attend to their child(ren)’s health needs?
5. Does SafeCare improve parents’ personal interaction with their child(ren)?
6. Does SafeCare improve parents’ confidence in their capacity to care for their child(ren)?
7. Were there any additional or unanticipated outcomes from the SafeCare implementation and have these created benefits or limitations to the delivery of SafeCare?
8. What is the incremental cost of delivering SafeCare?
9. What is the incremental value of the benefits of SafeCare from a societal perspective?
10. What is the estimated ratio of net costs to deliver SafeCare to its net benefits?

# Background

In response to the growth of the OOHC population and continuing poor outcomes for the most vulnerable children and families, the NSW Government commissioned an independent review of the OOHC system in NSW.1 The review concluded that the child protection system responds to immediate crisis but is not doing enough to address the complex needs of vulnerable children and families to break the intergenerational cycle of abuse and neglect. The review found that outcomes are particularly poor for Aboriginal children, young people and families.

To address these issues, the review recommended increased investment in evidence-based programs to reduce entries to OOHC. SafeCare is a highly structured, evidence-based behavioural skills parenting program that has been shown to reduce neglect and abuse among families with a history of, or risk factors for, abuse and neglect. There have been a number of studies examining the outcomes achieved by the SafeCare model. Findings from these studies suggested that mothers who received SafeCare were less depressed, experienced less parenting stress, and were at lower risk for future child maltreatment after services, when compared to mothers who did not receive SafeCare.[[14]](#footnote-15) The results of a large randomised state-wide control trial of almost 2,200 families from Oklahoma concluded that at six-year follow-up, SafeCare had decreased recidivism by 26% for families with children 0-5 years old.[[15]](#footnote-16) As the model was developed in the United States of America (USA), an evaluation is required to determine whether the program is successful within the NSW context and is appropriate for the needs of Aboriginal and Torres Strait Islander families.

## The Brighter-Futures SafeCare Approach

In NSW, the SafeCare model has been implemented as a component of an existing program called Brighter Futures. Consequently, the NSW program is called *Brighter Futures-SafeCare*. Brighter Futures is a longer established program[[16]](#footnote-17) that delivers voluntary targeted intervention services to families with at least one child under the age of nine living at home or to those expecting their first child, where concerns of risk of significant harm have been raised. The SafeCare program targets a subset of Brighter Futures clients: parents with children aged 0 – 5 years old. For more detail on the eligibility criteria, see *Attachment B: Desktop Review.* Brighter Futures is designed to enhance child safety, parenting capacity and family functioning. The program has two core service components which every family will receive:

* Intensive case management
* Structured home visiting program.

Within the intensive case management component there are three service sub-components available (not mandatory) dependent on the needs of individual families:

* Parenting programs
* Access to quality children’s services – childcare services, preschool
* Brokerage funded support.

As Figure 1 indicates, the SafeCare component of the BF-SC approach is part of the structured home visiting program; and provides a structured one-on-one skills-based parenting program (usually in the home, consisting of 3 modules) for parents with younger children at home.

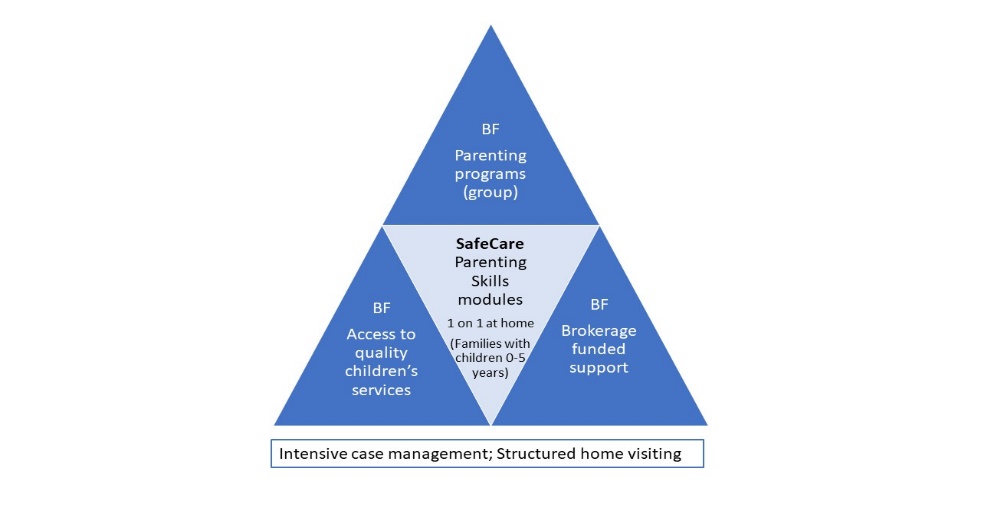


Figure 1: The SafeCare program as a sub-program of Brighter Futures (BF)

The parent training program involves one 1.5-hour home visit per week for 15-20 weeks (or longer, if needed) that targets risk factors for child neglect and physical abuse in which parents are taught skills in three module areas:

* Interacting in a positive manner with their children, to plan activities, and respond appropriately to challenging child behaviours,
* Recognising hazards in the home in order to improve the home environment, and
* Recognising and responding to symptoms of illness and injury, in addition to keeping good health records.

The goals of SafeCare are to increase positive PCI, improve how parents care for their children’s health, and enhance home safety and parent supervision, with the ultimate goal of reducing future incidents of child maltreatment. For more detail of the BF-SC approach, see *Attachment B:* *Desktop Review.*

## The Trial of the SafeCare Model in New South Wales, Australia

A small trial of the SafeCare program began in 2015 at Wesley Mission (Western Sydney). Five additional Brighter Futures agencies: Mission Australia (Wagga Wagga), CareSouth (Wollongong), Samaritans (Newcastle-Lake Macquarie), Barnardos (Orana Far West) and CatholicCare (Manning-Taree) began implementation in October/November 2017. These agencies were selected through a tender process. Since this time, an additional two Brighter Futures agencies have been selected to implement the BF-SC program, namely SDN Children’s Services and Wandiyali Aboriginal Community and Children’s Services. The additional two agencies are not included in the current evaluation however any lessons learned or recommendations that may benefit these additional Brighter Futures agencies have been documented to assist implementation and outcomes for families.

## Purpose of this Report

This report represents the Final Process, Outcomes and Economic Evaluation of the BF-SC program. The purpose of this report is to determine the effectiveness of the implementation, describe the impact of the program for families, determine whether SafeCare is contributing to successful outcomes, and determine the costs and benefits of the program overall. For the detail of the evaluation approach please see *Attachment C*: *Evaluation Plan.*

## Methodology

The following section outlines the design of the evaluation, the data sources and analyses techniques used.

### Study Design

As outlined in the proposed methodology (*Attachment C: Evaluation Plan*), the evaluation team incorporated a mixed-methods approach to the BF-SC evaluation. As part of the evaluation, we integrated qualitative methods and quantitative methods and used a quasi-experimental evaluation design to compare outcomes for families participating in BF-SC and a comparison group of families participating in Brighter Futures only. It was not possible to randomise families to receive the SafeCare program or randomise the Brighter Futures agencies selected to deliver the SafeCare program. Therefore, it was not possible to use an experimental design. An observational study was undertaken using routinely collected data.

### Data Sources

Both qualitative and quantitative methods of data collection and analysis were used to form the conclusions of this Final Process, Outcomes and Economic Evaluation Report. The following data sources were used:

1. Parenting Research Centre (PRC) data (Nov 2017 – Dec 2020)
2. National SafeCare Training and Research Centre (NSTRC) reports (Nov 2017- Dec 2020)
3. SafeCare pre-and-post module outcomes assessments (Nov 2017 – Dec 2020)
4. Parent Satisfaction Surveys (Nov 2017 – Dec 2020)
5. CP Helpline data sets (Jul 2018 – Jun 2020)
6. OOHC placement data sets (Jul 2018 – Jun 2020)
7. Brighter Futures program datasets (Jul 2018 – Jun 2020)
8. Desktop research
9. Stakeholder interviews and focus groups with SafeCare families, SafeCare Providers, Coaches, Trainers, Team Leaders, and Managers
10. Stakeholder interviews and focus groups with the NSTRC, the PRC, and DCJ
11. FACSIAR Brighter Futures Unit Costing Report
12. FACSIAR Benefits Menu June 2020
13. Review of contracts for Brighter Futures agencies, NSTRC and PRC

For a description of which data sources were used to answer each evaluation question, please see *Appendix A: Revised Data Strategy Matrix.*

#### Quantitative Data

Parenting Research Centre Implementation Data

Siggins Miller coordinated with the PRC to receive raw data sets and the associated reports made available to the central implementation team (CIT) meetings. This included data on the following factors:

* Number of families engaged in SafeCare
* Number of families who have completed SafeCare
* Number of families who dropped out of SafeCare
* Modules completed prior to drop out
* Reasons for families disengaging from SafeCare
* Reasons for families declining to participate in SafeCare
* Time taken to complete SafeCare
* Time taken to complete a SafeCare session
* Success of completed modules and whether a family achieved success or mastery

National SafeCare Training and Research Centre Reports

Siggins Miller coordinated with the NSTRC to gain access to the SafeCare portal. This portal houses site-specific reports which include data on the following factors:

* Number of active families
* Number of active Providers
* Number of inactive Providers
* Number of Providers who have left the agency
* Number of certified Coaches
* Number of Coaches working towards certification

SafeCare Pre-and-Post Module Outcomes Assessments

Siggins Miller coordinated with DCJ to receive data from the SafeCare assessment tools. DCJ coordinated with each of the Brighter Futures agencies to obtain and compile this information.

SafeCare assessment tools are used to measure the progress of families throughout the SafeCare program. The assessments are conducted prior to and after completing each SafeCare module and measure different elements of home safety, child health and PCI/PII.

For the Health module, families are assessed using the Sick or Injured Child Checklist (SICC). This assessment includes three different child health scenarios: emergency, doctor appointment and care at home. Families are scored based on their response to each health scenario.

For the Safety module, families are assessed using the Home Accident Prevention Inventory (HAPI). Families are scored on the number of hazards present in three different rooms around the home. Hazards are characterised as poison, choke, suffocation, drowning, fire/electrical, fall/activity restriction, sharp objects, weapons, crush, allergen/organic.

For the PCI module, families are assessed using the Child Planned Activities Training (cPAT) assessment form. Families are scored on the consistency and ease of specified behaviours before, during and after an activity interacting with their child. The specified behaviours include:

* Before – prepare in advance, explain activity, say what you expect and what will happen.
* During – talk about what you and your child are doing, use good physical interaction skills, give choices, praise desired behaviours, redirect misbehaviour, follow through.
* After – wrap up and transition.

For the PII module, families are assessed using the Infant Planned Activities Training (iPAT) assessment form. Families are scored on the consistency and ease of specified behaviours before, during and after an activity interacting with their infant. The specified behaviours include:

* Before – prepare in advance, explain activity and what is expected.
* During – talk about what you and your baby are doing, use good physical interaction skills, look and smile at your baby, imitate your baby, praise and use loving words, give choices, redirect baby when unsafe or doing something the parent/baby does not like.
* After – wrap up.

Parent Satisfaction Surveys

Siggins Miller coordinated with DCJ to receive data from the parent satisfaction surveys. DCJ coordinated with each of the Brighter Futures agencies to obtain and compile this information.

Parent satisfaction surveys are used to measure parent’s experience throughout the SafeCare program. The surveys are completed for each of the three SafeCare modules and for the SafeCare program overall. Parents respond to a list of statements about each module and the program overall on a scale of 1 (Strongly Agree) to 5 (Strongly Disagree).

Child Protection Helpline Data

The CP Helpline dataset includes information on all contacts made to the CP Helpline, including issues assessed and whether the child/young person was deemed to be at ROSH based on assessment at the Helpline Contact, as well as outcomes of triage and any follow-up field, safety and risk assessments. Each record in the dataset is for a specific Helpline contact, and individuals may have multiple contacts on the same day, or within a short time period, resulting in multiple observations in the dataset.

Out-of-Home-Care Placement Data

The OOHC dataset includes, for each child or young person (identified by ChildstoryID), the start date and end date for episodes of out of OOHC. An “episode” of OOHC is a defined as a continuous unbroken period of OOHC and can include multiple contiguous actual placements of differing types.

Brighter Futures Program Data

The Brighter Futures dataset includes ChildStoryID; ReferralID (which is the specific Brighter Futures identifier given to Brighter Futures referrals; date of birth; sex; Indigenous status; culturally and linguistically diverse (CALD) background; referral pathway (DCJ or community); allocation date (the date the Brighter Futures agency agreed to accept the family into the Brighter Futures program); date of first attempted contact or visit with the family by the caseworker (only available for 2019/2020 data); agreement date (the date the family agreed to participate in the Brighter Futures program); whether individuals aged 14 years or over provided written or verbal consent to participate in the program (only available for 2019/2020 data); date the Brighter Futures agency ceases management of the family; reason that case management ceased; and any additional comments / information relevant to the family.

FACSIAR Brighter Futures Unit Costing Report

The unit costing report was used to determine cost values related to BF-SC, including salary levels for caseworkers and caseworker managers, as well as standard Brighter Futures travel and session times.

FACSIAR Benefits Menu (June 2020)

The FACSIAR Benefits Menu prescribed the values for the benefits related to the primary outcomes (“a client who is the subject of a ROSH report is not re-reported at ROSH in the following year”; “reduced trauma resulting in incident of ROSH being either avoided or prevented”; “a client deemed as in need of care and protection avoids entering in OOHC”).

Review of contracts for Brighter Futures agencies, NSTRC and PRC

BF-SC trial contracts with Brighter Futures agencies, PRC and NSTRC were used to determine costs related to the implementation of BF-SC during the trial.

#### Qualitative Data

Desktop Review

Siggins Miller conducted a review of documents, peer reviewed and grey literature about the design, implementation and delivery of SafeCare nationally and internationally. The purpose of the review was two-fold. Firstly, it outlined the BF-SC implementation guidelines and provided an overview of the BF-SC program, its intended method of delivery, and the approach behind program delivery. Secondly, the desktop review outlined the evidence base of the SafeCare program and other similar parenting programs that aim to reduce the incidence of child abuse and/or neglect. The desktop review is presented in *Attachment B: Desktop Review.* The findings from the desktop review were triangulated with those of the other data sources to inform the conclusions and recommendations presented in this report.

Stakeholder Interviews and Focus Groups

As part of the evaluation, consultations were held with participating agencies, NSTRC (the purveyor), PRC (the intermediary) and DCJ (the funder) to gather insights about the progress of program implementation as well as any outcomes for families. Focus areas for these consultations included:

* Reflections on the training and certification process; program implementation and program delivery to families since its introduction.
* Barriers and enablers to engaging families and achieving program completion.
* Reflections on outcomes for families.
* Any initial unanticipated outcomes from the SafeCare implementation.
* Barriers and enablers to engaging services in implementing the program with fidelity.
* Reflections on response to external factors or events (including response to COVID-19).
* Any recommendations to strengthen implementation and delivery of the program.
* The implementation and delivery of SafeCare into the future.

In addition to the consultations held with participating agencies, the intermediary, the purveyor and the funding body, consultations were conducted with current and previous participants of the BF-SC program to understand the effectiveness of the program and individual modules, the wider impact of the program for families, and any areas for improvement.

Participant Recruitment and Sample Size

The process of stakeholder engagement and consultation to inform the evaluation of the BF-SC program was in accordance with the project evaluation framework previously submitted to the DCJ (see *Attachment C: Evaluation Plan*). Siggins Miller coordinated with the agencies currently delivering SafeCare to schedule interviews and focus groups with participating families, SafeCare Providers, Team Leaders, Coaches, Trainers and Managers. Siggins Miller subsequently coordinated with staff from NSTRC, PRC and DCJ to conduct interviews.

All BF-SC agency staff were given the opportunity to participate in interviews and focus groups. In addition, all staff associated with the project from DCJ, PRC and the NSTRC had the opportunity to participate in interviews and focus groups. Families were recruited for interviews by Brighter Futures agency staff. Families included those who were currently participating in SafeCare, had completed SafeCare, or had exited the program early. We acknowledge the potential selection bias in participating families interviewed as we did not use a random sampling technique, therefore the influence of self-selection and provider selection could be evident.

For the Outcomes Evaluation, a total of 51 interviews and focus groups were conducted with agency staff, the intermediary, the purveyor and DCJ. These consultations were conducted via teleconference. In addition, a total of 81 families who had participated in the program agreed to participate in an interview. Of these families, 12 (15%) disclosed that they identified as Aboriginal and/or Torres Strait Islander. These interviews were conducted via teleconference and face-to-face. Stakeholders were consulted across two time points, between February and May 2020 and between October and December 2020.

Participants were also given the opportunity to provide a written response based on the interview protocol, if they were unable to attend the interview or focus group. For an outline of stakeholders consulted and their role, see Table 3.

Table 3: Stakeholders consulted and their role

| **Brighter Futures agency/ Service / Department** | **Participant Role** |
| --- | --- |
| Barnardos, Orana Far West | Senior Manager |
| Middle Level Managers |
| SafeCare Coaches |
| SafeCare Providers |
| Participating families |
| CareSouth, Woollongong | Manager |
| SafeCare Trainer |
| SafeCare Coaches |
| SafeCare Providers |
| Participating families |
| CatholicCare, Taree | Agency Manager |
| Team Leader |
| SafeCare Coach |
| SafeCare Providers |
| Participating families |
| Mission Australia, Wagga Wagga | Program Manager |
| SafeCare Coaches |
| SafeCare Providers |
| Participating families |
| Samaritans, Newcastle | Manager |
| Team Leader |
| SafeCare Coaches |
| SafeCare Providers |
| Participating families |
| Wesley Mission, Western Sydney | Senior Program Manager |
| Program Managers |
| SafeCare Practice Specialist |
| Team Leaders |
| SafeCare Trainers |
| SafeCare Coaches |
| SafeCare Providers |
| Participating families |
| National SafeCare Training and Research Centre (NSCTRC) | Senior Training Specialist |
| Parenting Research Centre (PRC) | Senior Project Manager |
| Specialist |
| Department of Communities and Justice (DCJ) | Manager, Design and Stewardship |
| Senior Project Officer, Design and Stewardship |

Stakeholder Interviews for the Economic Evaluation

All Brighter Futures agencies that participated in the trial were contacted in order to determine the costs associated with BF-SC over the trial period. Brighter Futures agencies were asked to respond to a questionnaire related to time and resources spent participating in BF-SC. All but one of the agencies participated in an interview and provided the requested information (total=5). A summary of the responses to each stage of the engagement process is provided in *Attachment A: Economic Evaluation Report.*

### Data Analysis

The methods used to analyse each data source are described below.

#### Quantitative Analysis

##### Analysis of Implementation and Program Delivery Data

The implementation data provided by PRC was collated, cleaned and assessed for data quality. Raw data was analysed using descriptive statistics (*mean, standard deviation, range*) and frequencies. Figures and graphs were used to present the quantitative findings.

Based on our assessment of this data source, we note a number of specific inconsistencies that may affect the accuracy of the data for the implementation and evaluation. These include:

* Missing data in both the post-session survey completed by the caseworker and in the monthly reporting of number of families who were *offered*, who *accepted* and who *declined* an invitation to participate in SafeCare.
* Inconsistencies in the data reported for the number of families who accepted an invitation to participate in SafeCare and in the number of families recorded as completing SafeCare sessions.
* Inconsistencies in the number who agreed to participate and declined to participate, where these values do not equal the number who were offered SafeCare in some instances.

The staffing data presented in the NSTRC reports was collated and analysed using frequencies. Figures and graphs were used to present the quantitative findings.

We do note that there were some discrepancies between the NSTRC staffing reports and PRC coaching reports regarding the number of staffed trained in the delivery of SafeCare. We have based our findings on the information available through the NSTRC SafeCare portal.

##### Analysis of Immediate Outcomes

The SafeCare pre-and-post module outcomes assessment data were collated and assessed for missing data. Data for each family was included in analysis if both baseline and follow up scores were available. This data was then analysed using descriptive statistics (*mean)* and frequencies, which was presented using graphs. Paired-samples t-tests were performed to determine whether there were statistically significant differences between baseline and follow up scores. Data from the parent satisfaction surveys was collated and analysed using frequencies and presented using figures and graphs. We note that for both of these data sources, data was only available for a small number of families, and therefore may not be representative of the broader cohort of families engaged in BF-SC.

##### Analysis of Long-Term Outcomes

A contemporaneous comparison group was used to compare outcomes for families who participated in BF-SC relative to families who participated in Brighter Futures only and who met the age requirements for participation in SafeCare. Due to numerous changes over time in the child protection system in NSW, including referring and managing OOHC placements, definitions and reporting systems and in the referral and content / administration of the Brighter Futures program, the use of an historical comparison groups was not considered appropriate.

###### Sample

The sampling frame for defining individuals to be included in the evaluation is all the list of Brighter Futures Referrals, and the eligible group will be all Brighter Futures referrals aged 0-5 years who have agreed to participate in the Brighter Futures program. Those who were referred to SafeCare and met all eligibility criteria (defined below) are defined as the program or “exposed” group, those referred to Brighter Futures agencies which do not offer SafeCare and met the relevant eligibility criteria (defined below), were the comparison group.

There was no requirement that families of children in the SafeCare or comparison group have completed the Brighter Futures program, although completion of the SafeCare program was a requirement for the primary analysis. It was not possible to determine how much, if any, of the Brighter future program had been completed by either SafeCare or comparison children.

Children were eligible for inclusion in the analysis if:

* Their family was accepted by a Brighter Futures agency into the Brighter Future Program
* Their family agreed to participate in the Brighter Future Program within
  + 90 days for assessment of outcomes within 6 months of Brighter Futures agency acceptance into the program
  + 180 days for assessment of outcomes within 12 months of Brighter Futures agency acceptance into the program
* The child was aged 0-5 years on the date they were accepted into the Brighter Future program

Children were included in the comparison group if, in addition to the criteria specified above, they were not included in SafeCare, were undertaking the Brighter Futures Program with a Brighter Futures agency who did not also deliver the SafeCare program. Although SafeCare may not have been offered to families for some time following acceptance into Brighter Futures, it was necessary to use the date of Brighter Futures, rather than SafeCare, acceptance as the start date to have a consistent time fame between SafeCare and comparison children.

For the primary analysis, SafeCare children were classified according to the number of modules that they had completed (0, 1, 2 or 3), and were only included if their last report SafeCare session was within:

* 180 days of acceptance into the Brighter Futures program for assessment of outcomes within 6 months
* 365 days of acceptance into the Brighter Futures program for assessment of outcomes within 12 months

Children who’s final SafeCare session date was after the eligible time frame specified above were excluded from the primary analysis. Not appropriate to classify children according to the number of modules they have completed if they were still undertaking the program after the end of the followup / outcome assessment period. The secondary analyses included all eligible children included in the SafeCare program (as defined above), regardless of how many modules they had completed within the follow-up period, and regardless of whether or not they were still engaged in SafeCare.

###### Measures

The primary outcome is:

* ROSH report within 12 months

Secondary outcomes are:

* OOHC within 12 months
* ROSH report within six months
* OOHC within six months

It is not feasible to assess outcomes within a specified time period of completing SafeCare as there is no equivalent time point for the comparison group. The time frame needs to be consistent for SafeCare and comparison groups. The outcomes are defined as OOHC and ROSH re-report within 12 months and six months of the date that the Brighter Futures agency accepted the family into the Brighter Futures program.

There was no requirement for families to have completed Brighter Futures to be eligible as this is unlikely to be feasible, given that families can be involved in the program for up to two years. In addition, data was not available for the completion of Brighter Futures.

Although SafeCare commenced in all Brighter Futures agencies by October/November 2017, there are administrative issues with the Brighter Futures data between July 2017 and June 2018. Therefore, it is not possible to use those referred to Brighter Futures prior to 1 July 2018 as a contemporaneous comparison group. The evaluation will therefore include children of families referred to Brighter Futures between 1 July 2018 and 30 June 2019, for assessment of outcomes within 12 months of Brighter Futures referral, and children of families referred to / commencing Brighter Futures between 1 July 2018 and 31 December 2019, for assessment of outcomes within six months of Brighter Futures referral (acceptance). This then allowed for 12 month and six-month follow-up up periods to observe the outcomes (ROSH re-report and OOHC) within 12 and six-months respectively, up to 30 June 2020.

ROSH re-report

The outcome of ROSH re-report is based on assessment at the CP Helpline contact, rather than field assessment. A child / young person is defined as having a ROSH at CP Helpline if they meet the threshold for ROSH based on the categories and subcategories of harm at Helpline. This is assessed using the Screening and Response Priority Tool (SCRPT), which is a triage and assessment tool.

A Child / Young Person was defined as having a ROSH re-report within 12 months if they were classified as having a ROSH in the ROSH flag variable in the CP Helpline Contact dataset provided by FACSIAR within 365 days of their referral to Brighter Futures.

A Child / Young Person was defined as having a ROSH re-report within six months if they were classified as having a ROSH in the ROSH flag variable in the CP Helpline Contact dataset provided by FACSIAR within 180 days of their referral to Brighter Futures.

Out of Home Care

For the purposes of this evaluation, OOHC encompasses all children cared for in one of three broad types of placements: 1) statutory, 2) supported, or 3) voluntary OOHC. Statutory OOHC refers to when the Children’s Court has made an order, which requires the child or young person to live with a person who is not his or her parent in a place which is not the parental home, for more than 14 days or if the child is a protected person. It does not include care provided by a relative unless the Minister has parental responsibility. Supported OOHC refers to when the Secretary of DCJ decides the child or young person is in need of care and protection and there are no court orders in place (e.g., a family member other than the child’s parents are caring for him or her). Supported OOHC includes temporary care which is a short-term arrangement that the child or young person’s parents have agreed to where the family is supported to resolve issues concerning the child or young person’s safety, welfare and wellbeing. Voluntary OOHC is a voluntary arrangement made by a parent/s with a designated agency or agency registered with the NSW Children’s Guardian where Community Services has no involvement in the placement.

A Child / Young Person was defined as having an OOHC placement within 12 months if they had a Care Category Start Date in the OOHC dataset provided by FACSIAR within 365 days of their Referral to Brighter Futures.

A Child / Young Person was defined as having an OOHC placement within six months if they had a Care Category Start Date in the OOHC dataset provided by FACSIAR within 180 days of their Referral to Brighter Futures.

Covariates

Covariates were available from the Brighter Futures data and included sex, age at allocation date, Indigenous Status, CALD background and referral pathway. CALD background was classified as CALD background versus not CALD background. Referral Pathway was classified as community or DCJ; referrals from the Police Wellbeing Unit and Self-referral were classified as community referrals.

###### Statistical Methods

The primary analysis included children whose family had completed SafeCare within the relevant follow-up period: 365 days from the date the Brighter Futures agency agreed to accept the family into Brighter Futures (allocation date) for assessment of outcomes within 12 months, and 180 days from allocation date for assessment of outcomes within 6 months. Secondary analyses will include those who completed part of the program; either 1 or 2 of the three modules, and those who were referred to a program. Separate analyses were conducted for evaluation of each of the outcomes.

To assess comparability, sex, age at referral, Indigenous Status, CALD background, referral pathway (DCJ or Community), time between referral and agreement were compared between SafeCare and comparison individuals, using the non-parametric sign rank test for continuous variables and the Chi-Squared test for categorical variables.

The proportion of eligible children / young people who have an OOHC placement within the specified period, and the proportion of eligible children who have a subsequent CP Helpline ROSH re-report within the specified time period were compared among the SafeCare and comparison groups using the Chi-Squared test. The unadjusted number and percentage with the outcome of interest in each group, and proportions and 95% Confidence Intervals (CIs) adjusted for correlation of outcomes within families and Brighter Futures agency are reported.

Mixed effect logistic regression analyses were undertaken to compare the outcome among groups adjusted for correlation of outcomes within Brighter Futures agency and within families. In general, due to small / zero cell sizes these models had some convergence issues, and after adjusting for correlation within families, the variance of the random effects for Brighter Futures agency was generally extremely small (< 10-30), basically a zero random effect variance estimate, indicating that there was no between- Brighter Futures agency variance after adjusting for correlation of outcomes within families. The intraclass correlation coefficient for families was almost one (~0.99), unsurprisingly as we would generally expect that if one child was placed in OOHC then all family members would be placed, and that if there was a CP Helpline Report for one child in the family then all children in the family would similarly have a CP Helpline report. This means that all children in the family generally act as a unit, and there is likely to be limited statistical power in including multiple members from the same family in the analyses. Given these issues, the primary model reported is a two-level mixed model which adjusted for correlation of outcomes within families, with a variance estimate which adjusts for clustering within Brighter Futures agency. Due to the instability in the three-level model and the subsequent almost zero random effect variance for Brighter Futures agency in that model, a range of sensitivity analyses were undertaken. These include the following models:

* Mixed effects model adjusting for correlation within families
* Mixed effects model adjusting for correlation within families and Brighter Futures agency
* Mixed effects model including only one randomly selected eligible child from a family and adjusted for correlation within Brighter Futures agency
* GEE approach adjusting for correlation of outcomes within families, with exchangeable correlation structure
* GEE approach including only one randomly selected eligible child from a family and adjusted for correlation within Brighter Futures agency, with exchangeable correlation structure.

Since the groups are not randomised to referral to SafeCare, it is likely that they will differ in other characteristics other than having received the program, and ideally the analyses would be adjusted for potential confounders/ characteristics of interest. Variables available for Brighter Futures participants only included sex, age at referral, Indigenous status, CALD background and referral pathway. However, there were missing values for all of these variables except for age and referral pathway and including all covariates in regression models would have reduced the sample size even further. Therefore, the covariates were included in two additional sensitivity analyses based on the primary model specified above (mixed effects model adjusting for correlation within families with variance estimate adjusted for clustering within Brighter Futures agency):

* Including only age and referral status (which would not reduce the sample size included in the analysis)
* Including sex, age at referral, Indigenous status, CALD background and referral pathway which would reduce the sample size included in the analysis due to missing values for these covariates.

Robust variance estimates were used in analysis unless otherwise specified. Odds ratios (OR) with 95% CIs and p-values from Wald tests are presented from the regression models.

Due to the sample size, it was not possible to undertake a subgroup analysis including children of Aboriginal and Torres Strait Islander families who participated in BF-SC.

###### Limitations of the Data

Some key limitations of the available data are:

* A large proportion of Brighter Futures were excluded because they were outside of the age range. While some of these were inadvertent administrative errors, a substantial proportion of children appear to have been included in Brighter Futures who were outside of the required age range (although some of these may be siblings), compared to the smaller proportion of children who were outside the age range for SafeCare (some of these may also be siblings).
* The analysis may also be biased by the selection criteria applied to inviting Brighter Futures families to participate in SafeCare. While all eligible Brighter Futures families (i.e., those with a child aged 0-5) should be invited to participate in SafeCare, this does not appear to be the case (Table 8 shows only 257 families were referred to SafeCare). If the SafeCare participants are a small and select subgroup of Brighter Futures, then it is unclear how comparable they are to the overall Brighter Futures comparison group (in those sites where SafeCare was not offered). This may reflect issues of Brighter Futures agency or caseworker capacity, or there may be unintended preference for families perceived to be more likely to participate in, or benefit from, SafeCare .
* It is critical to highlight that the retrospective nature of the evaluation design means that are observational data that should not be used to infer cause and effect. Although they do reasonably show the association between engagement in SafeCare and ROSH reports, it is not possible to confidently rule-out that there are other differences between the SafeCare families and the comparison families that might be causally related to the rates of ROSH reports.

##### Cost-Benefit Analysis

The CBA was completed in line with the NSW Government Guide to Cost-benefit Analysis (TPP17–03), including the use of the 9-step process for completing a CBA.[[17]](#footnote-18) Per guidelines, results are presented as present values using a specified discount rate for both forecast scenarios. For the trial period, costs and benefits were not given on a per annum basis and therefore cannot be discounted appropriately, so results are presented as totals only:

* total benefits minus total costs (instead of NPV), and;
* total benefits divided by total costs (instead of BCR).

Both NPV and BCR are presented as measures for CBA analysis. NPV represents the difference between the present value of benefits and present value of costs. BCR represents the ratio of the present value of total benefits to present value of total costs. Calculation methods are included in *Attachment A: Economic Evaluation Report*. As decision criteria, an initiative is potentially worthwhile if NPV>0; BCR>1.17

The key limitations for the CBA are summarised below.

* *The evidence for effect sizes is not robust:*
  + Uncertainty of effect of BF-SC vs. BF only on ROSH re-reports and OOHC. Therefore, benefits of the BF-SC program cannot be robustly quantified in CBA.
  + Benefit scenario analysis represents only an approximation of potential effect sizes; noting the significant uncertainty in the values used.
* *Data for BF agencies’ costs was collected post-hoc:* 
  + There is potential for re-call bias in BF agencies reported cost information, that is, potential for underestimates due to completeness of memory or potential for overestimate due to bias to recall significant events and extrapolate.
  + Additionally, there is potential for BF agencies to overestimate “when in doubt” to be conservative.
* *Data for BF agencies’ costs was self-report:* 
  + Data collection was unblinded, meaning there is a potential for BF agencies to either underestimate figures due to social desirability, strategic incentive and/or to improve CBA results. Equally, there is potential to overestimate figures for potential future contract negotiation.
* *Missing BF agency data:*
  + Data missing from BF agencies has had to be estimated, leaving room for error.
* *Heterogeneity in approaches to integration of BFSC into business-as-usual:*
  + From interviews with BF agencies, we note that some sites incorporated BFSC much more heavily into the broader organisational framework than others, resulting in increased implementation and restructuring costs.

#### Qualitative Analyses

##### Thematic Analysis

Thematic analysis was conducted on the output from the consultations with agency staff, the intermediary, the purveyor, the funder and SafeCare families to identify common themes and ideas and to provide an in-depth understanding of the experience and context of participants; the nuances of program outcomes; and to inform the evaluation findings and conclusions.

We do note that the population of participating families engaged in consultations was not randomised, therefore, the findings may not be representative of the broader views of the population of families who participated in the BF-SC program. For instance, selection biases may be present in both the families who were asked to participate in consultation as well as those who agreed. In addition, the data collected may be influenced by social desirability even though families were informed that their feedback was anonymous and would have no bearing on their future involvement with Brighter Futures.

##### Most Significant Change Analysis

Most Significant Change (MSC) is an evaluation approach that involves asking stakeholders to share their personal stories and anecdotes of the most significant change they experienced as a result of their participation in the program being evaluated. It can be useful when trying to determine how different stakeholder groups define the “value” of the program in terms of “what success looks like” for them. MSC was conducted to determine the impact of the program for SafeCare families. The consultation data was analysed for key impacts. To determine which impacts were most significant, we used frequency analysis to first determine the most prominent impacts for families. Key impacts were coded by two independent raters to ensure inter-rater reliability. The most common impacts were organised using a *wordcloud.* These impacts were then cross-checked with the qualitative stories shared by SafeCare families for consistency. As this analysis was conducted on the views of families interviewed, the findings may not be representative of the broader population of families engaged in BF-SC.

# Findings

## Quantitative Findings

### Implementation and Program Delivery

This section provides an overview of the quantitative data collected by the PRC and the NSTRC about the implementation and delivery of the SafeCare program. This data was collected for the period between November 2017 and December 2020.

#### Staff Training

As per the findings and information documented in the Process Evaluation Report delivered to the Department on the 30th November 2019, the training of agency staff was initially led by Trainers based within NSTRC, and more recently, PRC and Trainers internal to participating services. There has been a gradual transition to training being offered more by local Trainers as implementation has matured. The following section provides an overview of the quantitative data relevant to training, as per the data provided by NSTRC.

As of December 2020, a total of 113 certified Providers had been trained in the delivery of SafeCare. While most of these Providers remained active in their role (65, 58%), a small number were inactive (11, 10%), or had left the agency (37, 33%). There were a range of reasons why staff were classified as inactive, such as being on leave, not having a SafeCare session in the past 30 days or no longer delivering SafeCare but retaining employment with the agency. These findings indicate that there was a relatively high level of turnover for SafeCare Providers. However, findings from the Process Evaluation previously submitted to the Department indicate that this level of turnover is not a direct result of the SafeCare program.

Wesley Mission employed the largest number of certified SafeCare Providers, followed by Samaritans, Mission Australia, CareSouth, Barnardos and CatholicCare (see Figure 2).

Figure 2: SafeCare Providers as of Dec 2020

Source: NSTRC staffing data

The agency with the largest number of SafeCare active Coaches and Trainers as of December 2020 was Wesley Mission and CareSouth, followed by Samaritans, Mission Australia, Barnardos and CatholicCare (see Figure 3).

Figure 3: Number of Active Providers, Coaches and Trainers as of Dec 2020

Source: NSTRC staffing data

#### Program Delivery

Between November 2017 and December 2020, a total of 563 eligible families agreed to participate in SafeCare. Based on monthly reporting, it appears that a total number of 1013 families were offered the opportunity to participate in SafeCare. Although, this may not be a reliable estimate given the challenges with this data source.[[18]](#footnote-19) Figure 4 demonstrates the distribution of eligible families across the Brighter Futures agencies under evaluation. As illustrated by Figure 4, Wesley Mission had the largest number of SafeCare participants during the period under evaluation. We note that the larger number recorded for Wesley Mission is likely to be a function of the length of time that Wesley Mission has been implementing SafeCare, as well as the size of the organisation, and the large geographical location that the agency services.

Figure 4: Family Participation in SafeCare (Nov 2017 – Dec 2020)

Source: PRC implementation data

As can be seen in Figure 5, the trendline demonstrates that the number of families who agreed to participate in SafeCare remained relatively consistent over time.

Figure 5: Families who agreed to participate in SafeCare by month (Nov 2017 – Dec 2020)

*Source: PRC implementation data*

*\*Month of participation was not recorded for a total number of 6 families.*

A total of 193 families recorded reasons for declining to participate in the SafeCare program.18 Again, this may not be an accurate measure of the number of families who declined participation. As seen in Figure 6, the most common reason for declining was listed as ‘other’, followed by not interested, the program being perceived as too intensive or demanding, not wanting an individual parenting program or not wanting home visits.

Figure 6: Reasons families declined to participate in SafeCare (Nov 2017 - Dec 2020)

*Source: PRC implementation data*

Of the 563 eligible families, 175 were currently participating in the BF-SC program as of December 2020 (see Figure 7).[[19]](#footnote-20) The detail of family participation across the implementation timeline are presented for each Brighter Futures agency in *Attachment D*: *Individual Site Reports*.

Figure 7: Number of Families Currently Participating in SafeCare as of Dec 2020

*Source: PRC implementation data*19

#### Family Engagement

Between November 2017 and December 2020, 120 families completed the SafeCare program. After accounting for families currently participating in the program, these findings indicate a completion rate of 31%.[[20]](#footnote-21) Figure 8 demonstrates the completion rates for families who have previously participated in the program and these findings indicate that the completion percentages range from 26% to 50% across the agencies, with CareSouth demonstrating the highest percentage of successful completions during this period. For those families who completed the program successfully, the average duration of time spent on the program was approximately 35 weeks, with minimum of 31 and a maximum of 39 weeks. We note that this length of time is substantially longer than the original program intent, which was for the program to be completed in 18 weeks. Most commonly, the time spent on a single SafeCare session was 30 minutes to one hour. This also varies from the original program intent, which was for a session to take approximately 1.5 hours. The implications of these findings are discussed in Section 4.1.24.1.5.

There were a number of families who disengaged from the program prior to completion. Of those 563 families who initially agreed to participate in the SafeCare program, 175 (31%) were current participants[[21]](#footnote-22), 120 (21%) had completed the program[[22]](#footnote-23) and 268 (48%) exited from the program early[[23]](#footnote-24) as of December 2020. Figure 9 outlines the rate of early exits organised by Brighter Futures agency for the period between November 2017 and December 2020.

Figure 8: SafeCare Program Outcomes (Nov 2011 – Dec 2020)

*Source: PRC implementation data*

Figure 8 and Figure 9 suggest that overall, there is a high rate of early exits from the SafeCare program. However, the trendline represented in Figure 9 demonstrates that the rates of early exits have slightly decreased over time.

Figure 9: Rate of early exits from SafeCare by month (Nov 2017 – Dec 2020)

*Source: PRC implementation data*

As can be seen in Figure 10, most families (164, 61%) did not complete any modules prior to exiting the program early. A small proportion of families who exited early completed one (73, 27%) and two modules (31, 12%). Of the families who had withdrawn from SafeCare and completed one module, 38 (52%) had completed the Health module, 19 (26%) had completed the Safety module and 16 (22%) had completed the PCI/PII module. We note this could simply be a function of which module was offered to families first, which is explored in more detail in Section 3.2.1.3. Of the withdrawn families who completed two modules, 17 (55%) completed the Health and Safety modules, 10 (32%) completed the Health and PCI/PII modules and 4 (13%) completed Safety and PCI/PII modules.

Figure 10: Number of modules completed prior to early exit (Nov 2017 – Dec 2020)

Source: PRC implementation data

As presented in Figure 11, the most common reason for families to exit early from the BF-SC program include ‘other’ and leaving Brighter Futures. The variable ‘other’ included a range of reasons such as:

* The family did not wish to continue the program
* The family was no longer suitable for SafeCare
* The family was unable to commit to the time requirements of the program
* The family had other pressing priorities and concerns
* The family’s goals were achieved
* The family was escalated to DCJ
* The family only wished to complete one or two modules
* SafeCare Provider resigned

Figure 11: Reasons families exited the SafeCare program early (Nov 2017 – Dec 2020)

*Source: PRC implementation data*

### Program Outcomes

This section provides an overview of the outcomes for families who participated in the SafeCare trial.

#### Immediate Outcomes

This section provides an overview of the pre-and-post module assessments completed for each of the SafeCare modules. This data provides an indication of changes in families’ knowledge and skills after completing the modules. This data was collected between November 2017 and December 2020. As discussed in the limitations section, there were a relatively small number of families who completed both baseline and follow-up assessments. As such, these findings are based on a small sample size.

Health Module

As of December 2020, data was available for a total of 96 families who had scores recorded at both baseline and follow up time points for all scenarios.[[24]](#footnote-25) Overall, the findings demonstrate improvements to the capacity of families to effectively respond to child health scenarios. Across the three scenarios, families received an average score of 54% (11 out of a total score of 20)[[25]](#footnote-26) prior to completing the health module. This increased to an average score of 89% (18 out of a total score of 20) after completing the module (see Figure 12). A paired-samples t-test revealed that there was a significant improvement in these scores after completing the module, *t*(95) = 18.4, p < .001. Furthermore, Cohens effect size value (d = -1.88[[26]](#footnote-27)) suggests the program had very large influence on parents’ capacity to manage their child’s health. For most scenarios (171 out of 288), families received a final grade of *mastery*. [[27]](#footnote-28) For the remainder of the scenarios, families received a final grade of *success* (84 out of 288) or *in progress* (2 out of 288). [[28]](#footnote-29)

Figure 12: Overall progress of families in responding to health scenarios (Nov 2017 – Dec 2020)

Source: outcomes assessment data

The greatest improvements were seen in the doctor appointment scenario, with an average score of 48% prior to completing the Health module and an average score of 88% after completing the Health module. Improvements were also evident for the other two scenarios (see Figure 13). These findings indicate that parents were less able to identify the appropriate course of action when they needed to take their children to the doctors, compared to the emergency department or care at home. After completing the module, parents were equally able to determine the appropriate course of action, regardless of whether their children needed care at home, care from a doctor or to be taken to the emergency department in response to health concerns.

Figure 13: Progress of families in responding to each health scenario (Nov 2017 – Dec 2020)

Source: outcomes assessment data

Safety Module

As of December 2020, data was available for a total of 89 families who had had scores recorded at both baseline and follow up time points for corresponding rooms in the home.[[29]](#footnote-30) Overall, the findings demonstrate a reduction in the number of hazards present in the home. Prior to completing the Safety module, the average number of hazards present in each room of the home was 21. This reduced to an average of 5 hazards per room after completing the Safety module (see Figure 14). A paired-samples t-test revealed that there was a significant improvement in these scores after completing the module, *t*(88) = 10.7, p < .001. Furthermore, Cohens effect size value (d = 1.14[[30]](#footnote-31)) suggests the program had very large influence on parents’ capacity to provide a safe home for their child. Most commonly, families received a final grade of *success* (134 out of 259) or *mastery* (105 out of 259) for the different rooms in the home. For some rooms, families received a final grade of *in progress* (6 out of 259).[[31]](#footnote-32)

Figure 14: Overall progress of families in number of hazards (Nov 2017 – Dec 2020)

Source: outcomes assessment data

Reductions in the number of hazards present after completing the Safety module were evident across all hazard types (see Figure 15). Prior to completing the Safety module, poison was the most common hazard in homes, followed by choking, suffocation, sharp objects, fire/electrical, allergen/organic, fall/activity restriction, crush, and weapons. After completing the Safety module, a small number of hazards remained including those classified as suffocation, poison, choking, sharp objects, fire/electrical, allergen/organic, crush, fall/activity restriction.

Figure 15: Progress of families across hazard types (Nov 2017 – Dec 2020)

Source: outcomes assessment data

Parent Child Interaction Module

As of December 2020, data was available for a total of 53 families who had scores recorded at both baseline and follow up time points for corresponding activities.[[32]](#footnote-33) Prior to completing the PCI module, families received an average score of 33% (6 out of a total score of 20) on the cPAT assessment (see Figure 16). After completing the PCI module, families received an average score of 73% (15 out of 20). A paired-samples t-test revealed that there was a significant improvement in these scores after completing the module, *t*(52) = -17.7, p < .001. Furthermore, Cohens effect size value (d = -2.43[[33]](#footnote-34)) suggests the program had very large influence on the capacity of parents to interact with their child. Most commonly, families received a final grade of *success* (91 out of 146) across the different PCI activities chosen, while some families received a final grade of *mastery* (38 out of 146).[[34]](#footnote-35)

Figure 16: Overall progress of families in interacting with their child (Nov 2017 – Dec 2020)

Source: outcomes assessment data

Parent Infant Interaction Module

As of December 2020, data was available for a total of 35 families who had scores recorded at both baseline and follow up time points for corresponding activities.[[35]](#footnote-36) Prior to completing the PII module, families received an average score of 38% (8 out of a total score of 20) on the iPAT assessment (see Figure 17). After completing the PII module, families received an average score of 72% (14 out of 20). A paired-samples t-test revealed that there was a significant improvement in these scores after completing the module, *t*(34) = -10.8, p < .001. Furthermore, Cohens effect size value (d = -1.82[[36]](#footnote-37)) suggests the program had very large influence on the capacity of parents to interact with their infant. Families received a final grade of *mastery* (40 out of 95), *success* (35 out of 95) or *in progress* (6 out of 95) across the different PII activities chosen.[[37]](#footnote-38)

Figure 17: Overall progress of families in interacting with their infant (Nov 2017 – Dec 2020)

Source: outcomes assessment data

#### Parent Satisfaction

This section provides an overview of the parent satisfaction surveys which are completed by participating families upon conclusion of each SafeCare module as well as the program overall. This data provides an indication of families’ thoughts about their skill improvements as well as their perception of the program overall. This data was collected between November 2017 and December 2020. As discussed in the limitations section, there were a relatively small number of families who completed the parent satisfaction surveys. As such, these findings are based on a small sample size.

Overall Program Experience

Families were asked whether they planned to continue using the skills they had learned in the program and whether they felt competent to use these new skills. Most families strongly agreed (26, 68%) that they felt competent to use the new skills that they have learnt, and the others agreed (12, 32%) with that statement. When asked whether they plan to continue the skills they have learnt from the program, most families strongly agreed (28, 74%), and the remaining families either agreed (9, 24%) or responded neutrally (1, 3%) (see Figure 18).[[38]](#footnote-39) These findings indicate that in general, families thought they could and would continue using the skills they learned.

Figure 18: Thoughts about the skills learned (Nov 2017 – Dec 2020)

*Source: parent satisfaction surveys*

Overall Thoughts About the Modules

When asked about each of the three SafeCare modules, all families either strongly agreed (28, 74%) or agreed (10, 26%) that the Safety module was useful. Most families strongly agreed (26, 70%) or agreed (10, 27%) that the Health module was useful, while one family strongly disagreed (1, 3%) with this statement. Families mostly responded with strong agreement (25, 66%) that they found the PCI/PII modules useful, while other families either agreed (12, 32%) or disagreed (1, 3%) with this (see Figure 19).[[39]](#footnote-40) These findings provide an indication that families generally found the program useful.

Figure 19: Thoughts about the SafeCare modules (Nov 2017 – Dec 2020)

*Source: parent satisfaction surveys*

Health Module

Families were asked to respond to a series of statements regarding their confidence in responding to their child’s health concerns following completion of the health module. Most of the families strongly agreed (58, 68%) or agreed (22, 26%) that deciding when their child needs emergency treatment has become easier. In addition, most families strongly agreed (55, 65%), agreed (24, 28%) that deciding when to take their child to the doctor has become easier. A small number of families responded neutrally to these statements. When asked whether caring for their child’s health when they are sick or injured has become easier, families either strongly agreed (55, 65%), agreed (25, 29%) or responded neutrally (5, 6%) with this statement (see Figure 20). These findings suggest that families were better able to respond to the health needs of their children after completing the Health module.

Figure 20: Thoughts about responding to child health concerns (Nov 2017 – Dec 2020)

*Source: parent satisfaction surveys*

Further, all families either strongly agreed (73, 85%) or agreed (13, 15%) that the training would be useful to other parents which demonstrates their support for the module and their understanding of its applicability to a wider group of parents.

Safety Module

Families were also asked to respond to a series of questions regarding what they had learned from the Safety module. Most families either strongly agreed or agreed that they were better able to identify hazards in their home (61, 77% and 17, 22% respectively), they were better able to get rid of hazards in their home (55, 70% and 22, 28% respectively) and their home was safer since completing the Safety module (57, 73% and 18, 23% respectively). In addition, most families either strongly agreed (63, 80%) or agreed (15, 19%) that they would continue using the skills learned (see Figure 21). A small number of families responded neutrally to these statements. These findings provide an indication that families have made positive changes and intent to continue to make positive changes to the safety of their home upon completion of the Safety module.

Figure 21: Thoughts about responding to hazards (Nov 2017 – Dec 2020)

*Source: parent satisfaction surveys*

Similar to the Health module, all families except one either strongly agreed (64, 81%) or agreed (14, 18%) that the Safety module would be useful to other parents.

Parent Child Interaction Module

Families were asked to respond to a series of statements about their confidence to interact with their children after completion of the PCI module. Most families strongly agreed (22, 51%) and the remaining families either agreed (17, 40%) or responded neutrally (1, 2%) to the statement that routine activities had become easier since completing the module. Most families strongly agreed (23, 53%) or agreed (17, 40%) that they had more ideas about activities to do with their children. The remaining three families responded neutrally (7%). Furthermore, when asked if interacting with their child had become easier, most of the families strongly agreed (25, 58%) and agreed (17, 40%), while others responded neutrally (1, 2%; see Figure 22). These findings provide some indication of improvements to the confidence and capacity of families to interact with their children following completion of the PCI module.

Figure 22: Thoughts about interacting with their child (Nov 2017 – Dec 2020)

*Source: parent satisfaction surveys*

All families except for one agreed that the PCI module would be useful to other parents (36, 84% strongly agreed and 6, 14% agreed).

Parent Infant Interaction Module

Most families strongly agreed (23, 66%), while the other families either agreed (9, 26%) or responded neutrally (3, 9%) to that statement that interacting with their infant has become easier since completing the PII module.[[40]](#footnote-41) In relation to whether routine activities had become easier, most families strongly agreed (21, 60%), agreed (10, 29%) and some responded neutrally (4, 11%). Furthermore, most families strongly agreed (21, 60%) that they have more ideas about the activities they would like to do with their infant, the remaining families either agreed (11, 31%) or responded neutrally (3, 9%) (see Figure 23). These findings suggest overall improvements to the capacity and confidence of families to interact with their infant after completing the PII module.

Figure 23: Thoughts about interacting with their infant (Nov 2017 – Dec 2020)

*Source: parent satisfaction surveys*

When asked if the training would be useful to other parents, most families strongly agreed (31, 89%) or agreed (3, 9%). Only one family responded with *strongly disagree* (3%).[[41]](#footnote-42)These finding provides some evidence of the overall value of the PII module for families.

#### Long-Term Outcomes

This section presents an overview of the findings when comparing child protection outcomes (ROSH re-reports and OOHC placements within 6 month and within 12 months of acceptance into Brighter Futures) for the children of families who participated in BF-SC compared to the children of families who participated in Brighter Futures only. Note that the numbers in the following results relate to children not families.

##### Eligibility Criteria

There were 4,188 children (361 in SafeCare) aged 0 to 5 years whose family had been accepted into the Brighter Futures program by a relevant Brighter Futures agency between 1st July 2018 and 31st December 2019 and had agreed to participate in program within 90 days of acceptance; these children were eligible for inclusion in the analyses of outcome within 6 months of Brighter Futures program acceptance. Of these 2,907 (258 in SafeCare) had been accepted into the Brighter Futures program by a relevant Brighter Futures agency between 1st July 2018 and 30th June 2019 and had agreed to participate in program within 180 days of acceptance; these children were eligible for inclusion in the analyses of outcome within 12 months of Brighter Futures program acceptance.

Of the 4,188 observations (361 in SafeCare) eligible for inclusion in 6-month follow-up analyses, 76 (1 in SafeCare) had a date of agreement prior to date of allocation date and 45 (none in SafeCare) had a date of agreement more than 90 days following allocation date and were excluded from analysis of outcomes within 6 months: 4,067 observations remaining for six-month outcome analysis; 360 in SafeCare.

Of the 2,907 observations (258 in SafeCare) eligible for inclusion in 12-month follow-up analyses, 61 (1 in SafeCare) had a date of agreement prior to date of allocation date and 9 (none in SafeCare) had a date of agreement more than 180 days following allocation date and were excluded from analysis of outcomes within 12 months: 2,837 observations remaining for 12-month outcome analysis; 257 in SafeCare.

Of the 360 SafeCare participants eligible for inclusion in analyses of outcomes within 6 months, 55 had their last SafeCare session within 180 days of allocation (i.e., within the follow up period) and were included in analyses which considered the number of modules completed. The number of individuals potentially eligible for inclusion in analyses of six-month outcomes which considers number of modules completed is 4, 067 - (360 - 55) = 3,762.

Of the 257 SafeCare participants eligible for inclusion in analyses of outcomes within 12 months, 121 had their last SafeCare session within 365 days of allocation (i.e., within the follow up period) and were included in analyses which considered the number of modules completed. The number of individuals potentially eligible for inclusion in analyses of six-month outcomes which considers number of modules completed is 2,837 - (257 - 121) = 2,701.

There were 1,204 children potentially eligible for inclusion in the analyses of outcomes within 6 months of allocation date who undertook the Brighter Futures program (but not the SafeCare component) with a Brighter Futures agency which also delivered the SafeCare program and were ineligible for inclusion in the evaluation.

There were 862 children potentially eligible for inclusion in the analyses of outcomes within 12 months of allocation date who undertook the Brighter Futures program (but not the SafeCare component) with a Brighter Futures agency which also delivered the SafeCare program and were ineligible for inclusion in the evaluation.

The final samples for analyses therefore included:

* 2,863 children (360 in SafeCare) eligible for inclusion in the final analysis for outcome within 6 months of Brighter Futures allocation for all eligible SafeCare participants
* 2,558 children (55 in SafeCare) eligible for inclusion in the final analysis for outcome within 6 months of Brighter Futures allocation for SafeCare participants who had their final session prior to the end of follow-up (this included analysis of the number of completed modules)
* 1,975 children (257 in SafeCare) eligible for inclusion in the final analysis for outcome within 12 months of Brighter Futures allocation for all eligible SafeCare participants
* 1,839 children (121 in SafeCare) eligible for inclusion in the final analysis for outcome within 12 months of Brighter Futures allocation for SafeCare participants who had their final session prior to the end of follow-up (this included analysis of the number of completed modules)

##### Characteristics of SafeCare versus Comparison Children

The tables below show the characteristics of comparison (Brighter Futures only children) and SafeCare children, for all eligible SafeCare participants, and for those who completed or withdrew from the program prior to the end of the follow-up period for the relevant outcome. Separate tables are provided for individuals included in six month and 12-month follow-up. Similar results were found for those included in six month and 12-month follow-up samples; although they were not consistent for samples including all referrals or those who had completed the program or were reported as no longer engaged prior to the end of the follow-up period. Sex was similar for comparison and SafeCare groups, there was evidence of a lower proportion of community referrals and Aboriginal children in the SafeCare groups. A quarter of SafeCare children and almost a third of comparison children were reported as having been referred from the community, which appears to be higher than the 10% target for this referral method.

Note that for analysis of outcomes within 6 months of allocation to Brighter Futures, there are no children who competed all three SafeCare modules, and only two children who completed one module, or two modules. SafeCare referrals were generally younger than those in the comparison group, with a longer time between allocation and agreement to participate; however, there was not a clear pattern of increasing or decreasing age or time between allocation and agreement with increasing number of modules completed.

Table 4: Demographics of comparison versus SafeCare children: 12-month analysis

| **Characteristic** | **Comparison** | | **SafeCare Modules Completed** | | | | | | | | **Chi-Squared** | | **Comparison** | | **All SafeCare Referrals** | | **Chi-Squared** | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **0** | | **1** | | **2** | | **3** | |
| **n** | **%** | **n** | **%** | **n** | **%** | **n** | **%** | **n** | **%** | **Chi-Sq** | **P** | **n** | **%** | **n** | **%** | **Chi-Sq** | **P** |
| Sex | | | | | | | | | | | | | | | | | | |
| Female | 831 | 48.9 | 43 | 49.4 | 4 | 30.8 | 3 | 42.9 | 4 | 33.3 | 2.96 | .564 | 831 | 48.9 | 119 | 46.7 | .459 | .498 |
| Male | 867 | 51.1 | 44 | 50.6 | 9 | 69.2 | 4 | 57.1 | 8 | 66.7 | . | . | 867 | 51.1 | 136 | 53.3 | . | . |
| Indigenous Status | | | | | | | | | | | | | | | | | | |
| Not Aboriginal/TSI | 972 | 60.4 | 61 | 69.3 | 8 | 72.7 | 6 | 85.7 | 9 | 75 | 6.209 | .184 | 972 | 60.4 | 174 | 70.7 | 9.627 | .002 |
| Aboriginal/TSI | 637 | 39.6 | 27 | 30.7 | 3 | 27.3 | 1 | 14.3 | 3 | 25 | . | . | 637 | 39.6 | 72 | 29.3 | . | . |
| CALD background | | | | | | | | | | | | | | | | | | |
| No | 1322 | 77.1 | 75 | 89.3 | 11 | 84.6 | 3 | 50 | 12 | 100 | 13.322 | .01 | 1322 | 77.1 | 196 | 80 | 1.013 | .314 |
| Yes | 392 | 22.9 | 9 | 10.7 | 2 | 15.4 | 3 | 50 | 0 | 0 | . | . | 392 | 22.9 | 49 | 20 | . | . |
| Referral Pathway | | | | | | | | | | | | | | | | | | |
| Community | 559 | 32.5 | 18 | 20.2 | 2 | 15.4 | 1 | 14.3 | 3 | 25 | 8.797 | .066 | 559 | 32.5 | 63 | 24.5 | 6.672 | .01 |
| DCJ | 1159 | 67.5 | 71 | 79.8 | 11 | 84.6 | 6 | 85.7 | 9 | 75 | . | . | 1159 | 67.5 | 194 | 75.5 | . | . |

Table 5: Characteristics of comparison versus SafeCare children: 12-month analysis

| **Variable** | **Summary Measure** | **Comparison** | **SafeCare Modules Completed** | | | | **Chi-Squared** | | | **Comparison** | **All SafeCare Referrals** | **Z Test** | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **0** | **1** | **2** | **3** | **Chi-Sq** | **df** | **P** |  |  | **Z** | **P** |
| Age at Allocation | N | 1718 | 89 | 13 | 7 | 12 |  |  |  | 1718 | 257 |  |  |
|  | Median | 2 | 2 | 0 | 1 | .5 |  |  |  | 2 | 1 |  |  |
|  | Q1 | 0 | 0 | 0 | 0 | 0 |  |  |  | 0 | 0 |  |  |
|  | Q3 | 4 | 3 | 0 | 4 | 2 | 18.83 | 4 | 0.001 | 4 | 3 | 3.49 | <0.001 |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Time between Allocation and Agreement | N | 1718 | 89 | 13 | 7 | 12 |  |  |  | 1718 | 257 |  |  |
| Median | 14 | 25 | 15 | 20 | 19 |  |  |  | 14 | 21 |  |  |
| Q1 | 8 | 17 | 13 | 12 | 14.5 |  |  |  | 8 | 14 |  |  |
| Q3 | 24 | 32 | 32 | 21 | 22.5 | 32.10 | 4 | <0.001 | 24 | 28 | -6.53 | <0.001 |

Table 6: Demographics of comparison versus SafeCare children: 6-month analysis

| **Characteristic** | **Comparison** | | **SafeCare Modules Completed** | | | | | | | | **Chi-Squared** | | **Comparison** | | **All SafeCare Referrals** | | **Chi-Squared** | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **0** | | **1** | | **2** | | **3** | |
| **n** | **%** | **n** | **%** | **n** | **%** | **n** | **%** | **n** | **%** | **Chi-Sq** | **P** | **n** | **%** | **n** | **%** | **Chi-Sq** | **P** |
| Sex | | | | | | | | | | | | | | | | | | |
| Female | 1205 | 48.8 | 25 | 51 | 1 | 50 | 1 | 50 | . | . | .096 | .992 | 1205 | 48.8 | 168 | 47.1 | .381 | .537 |
| Male | 1264 | 51.2 | 24 | 49 | 1 | 50 | 1 | 50 | . | . | . | . | 1264 | 51.2 | 189 | 52.9 | . | . |
| Indigenous Status | | | | | | | | | | | | | | | | | | |
| Not Aboriginal/TSI | 1416 | 60.8 | 29 | 59.2 | 2 | 100 | 2 | 100 | . | . | 2.632 | .452 | 1416 | 60.8 | 241 | 69.9 | 10.457 | .001 |
| Aboriginal/TSI | 913 | 39.2 | 20 | 40.8 | 0 | 0 | 0 | 0 | . | . | . | . | 913 | 39.2 | 104 | 30.1 | . | . |
| CALD background | | | | | | | | | | | | | | | | | | |
| No | 1933 | 77.4 | 42 | 93.3 | 2 | 100 | 0 | 0 | . | . | 13.991 | .003 | 1933 | 77.4 | 273 | 79.6 | .849 | .357 |
| Yes | 565 | 22.6 | 3 | 6.7 | 0 | 0 | 2 | 100 | . | . | . | . | 565 | 22.6 | 70 | 20.4 | . | . |
| Referral Pathway | | | | | | | | | | | | | | | | | | |
| Community | 775 | 31 | 8 | 15.7 | 0 | 0 | 0 | 0 | . | . | 7.259 | .064 | 775 | 31 | 86 | 24 | 7.33 | .007 |
| DCJ | 1728 | 69 | 43 | 84.3 | 2 | 100 | 2 | 100 | . | . | . | . | 1728 | 69 | 273 | 76 | . | . |

Table 7: Characteristics of comparison versus SafeCare children: 6-month analysis

| **Variable** | **Summary Measure** | **Comparison** | **SafeCare Modules Completed** | | | | **Chi-Squared** | | | | | **Comparison** | | **All SafeCare Referrals** | **Z Test** | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **0** | **1** | **2** | **3** | **Chi-Sq** | **df** | | **P** | |  | |  | **Z** | **P** |
| Age at Allocation | N | 2503 | 51 | 2 | 2 | 0 |  |  |  | | 2503 | | 360 | |  |  |
|  | Median | 2 | 1 | 0 | 3 | 0 |  |  |  | | 2 | | 2 | |  |  |
|  | Q1 | 0 | 0 | 0 | 1 | 0 |  |  |  | | 0 | | 0 | |  |  |
|  | Q3 | 4 | 3 | 0 | 5 | 0 | 7.93 | 3 | 0.047 | | 4 | | 3 | | 3.40 | 0.001 |
|  |  |  |  |  |  |  |  |  |  | |  | |  | |  |  |
| Time between Allocation and Agreement | N | 2503 | 51 | 2 | 2 | 0 |  |  |  | | 2503 | | 360 | |  |  |
| Median | 14 | 21 | 28 | 21 | 0 |  |  |  | | 14 | | 21 | |  |  |
| Q1 | 8 | 8 | 15 | 21 | 0 |  |  |  | | 8 | | 14.5 | |  |  |
| Q3 | 24 | 32 | 41 | 21 | 0 | 6.88 | 3 | 0.076 | | 24 | | 32 | | -9.28 |  |

##### Comparison of ROSH Re-Reports and OOHC

The tables below show the number and percentage of children with each outcome for Brighter Futures and SafeCare participants overall and by the number of SafeCare modules completed, as well as the percentages and 95% CIs, with standard errors adjusted for correlation of outcomes within families. These tables show the Odds Ratios (OR) with 95% CIs and overall Wald Test for the significance of SafeCare relative to Brighter Futures only children from the mixed effects logistic regression models adjusting for correlation of outcomes within families using a random intercept term, and with variance estimates adjusted for clustering within Brighter Futures agency.

Sixty-one percent of children in the comparison group had a ROSH report within 12 months of being accepted into the Brighter Futures program compared to between 29% and 77% of those who had completed three modules or one module only (see Table 8). There was not a clear dose-response relationship between the number of SafeCare modules completed and ROSH report within 12 months. Relative to the Brighter Futures only group there were higher odds of ROSH reports for those with no or one module, and lower odds for those who completed two or three modules (OR, 95% CI: 0.13, 0.05-0.35 and 0.12, 0.06-0.23 for those completing two or three modules respectively). This association was statistically significant in unadjusted and adjusted analyses, and in most sensitivity analyses. Please see *Appendix B: Sensitivity Analyses.*

When considering all children referred to SafeCare, ROSH report within 12 months was similar for the SafeCare and Brighter Futures only groups. Fifty-nine percent of children in the SafeCare group and 61% of those in the Brighter Futures only group had a ROSH report within 12 months, and this was not statistically significantly different between the two groups in unadjusted or adjusted analyses but was significant in sensitivity analyses adjusting for correlation within family only, and marginally non-statistically significant for analyses which adjusted for all covariates.

Forty-four percent of children in SafeCare and Brighter Futures only groups had a ROSH report within 6 months of being accepted into the Brighter Futures program; this was not statistically significantly different in unadjusted analyses. The odds of a ROSH report were statistically significantly lower for SafeCare relative to Brighter Futures only children in primary analyses (OR 0.78; 95% confidence interval (CI) 0.65, 0.94; p = 0.010), and in sensitivity analyses which adjusted for correlation of outcomes within families and Brighter Futures agency, but not for other sensitivity models.

Sixty-three percent of SafeCare participants who had not completed any module had a ROSH within 6 months, both of the two eligible SafeCare children who completed one SafeCare module and none of those completing two modules had a ROSH within six months of being accepted into Brighter Futures. Therefore, small numbers of children completing one or two modules (no children eligible for inclusion in the 6-month outcome analyses had completed 3 modules) resulted in problems with model convergence and unstable coefficient and standard error estimates. Analyses of ROSH within 6 months by the number of modules completed is not considered as reliable or appropriate.

No SafeCare participants and 17 (0.7%) children in the Brighter Futures only group had an OOHC placement within 6 months of being accepted into Brighter Futures. Five SafeCare participants (2%) and 44 comparison children (2.6%) had an OOHC placement within 12 months of being accepted into Brighter Futures; no SafeCare children who completed two or three modules had an OOHC placement. Due to the small number of SafeCare children with an OOHC placement, and the number of categories with no outcomes, no regression models could be generated for OOHC within 6 months. There were problems with convergence and estimation for some regression models for OOHC within 12 months of allocation date, particularly those including the number of SafeCare modules completed. Analysis of children referral to SafeCare (regardless of completion status) provided some evidence of a reduction in OOHC within 12 months associated with SafeCare referral: OR 0.33, 95% CI 0.12-0.92, p = 0.034 for primary model adjusted for correlation of outcomes within families, with variance estimates adjusted for correlation within Brighter Futures agencies; with similar estimates (marginally non-statistically significant) only for the model which adjusted for correlation within families. However, the OR for the models which adjusted for covariates was > 1, indicating a higher, rather than lower, odds of OOHC within 12 months and this was statistically significant in the model which adjusted for all covariates (OR 1.85; 95% CI 1.03, 3.32; p = 0.038). These conflicting results indicate the instability and unreliability of the analyses, due to small or zero cell sizes. Results for analysis of OOHC are not considered reliable.

The three most common issues reported at the Child Protection Helpline for those with a ROSH within 12 months and who had their final session within the followup period were any neglect (n=71, 67% for SafeCare participants; n=886, 60% for comparison group), any carer issue (n=64, 60% for SafeCare participants; n=710, 48% for comparison group) and any emotional abuse (n=48, 45% for SafeCare participants; n=636, 43% for comparison group).

Table 8: ROSH within 12-months

| **SafeCare Program Definition** | **Group** | **Total** | **Unadjusted** | | | | **Adjusted^** | | | **Odds Ratio#** | | | **Wald Test#&** | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **n** | **%** | **Chi-Sq** | **P** | **%** | **95% CI** | | **OR** | **95% CI** | | **Chi-Sq** | **P** |
| SafeCare modules completed@ | Comparison | 1718 | 1052 | 61.2 |  |  | 61.2 | 58.0 | 64.5 |  |  |  |  |  |
|  | SC: 0 modules completed | 89 | 62 | 69.7 | 11.08 | 0.026 | 69.7 | 56.3 | 83.1 | 2.13 | 1.46 | 3.12 | 304.74 | <0.001 |
|  | SC: 1 module completed | 13 | 10 | 76.9 |  |  | 76.9 | 47.4 | 100.0 | 3.64 | 2.31 | 5.72 |  |  |
|  | SC: 2 modules completed | 7 | 2 | 28.6 |  |  | 28.6 | 0.0 | 64.0 | 0.13 | 0.05 | 0.35 |  |  |
|  | SC: 3 modules completed | 12 | 4 | 33.3 |  |  | 33.3 | 1.5 | 65.1 | 0.12 | 0.06 | 0.23 |  |  |
| Referred to SafeCare | Comparison | 1718 | 1052 | 61.2 |  |  | 61.2 | 58.0 | 64.5 |  |  |  |  |  |
|  | In SafeCare | 257 | 151 | 58.8 | 0.58 | 0.447 | 58.8 | 50.3 | 67.2 | 0.80 | 0.55 | 1.18 | 1.24 | 0.265 |
| *^Standard errors adjusted for correlation of outcome within families #Results from mixed effects logistic regression adjusting for correlation of outcomes within families; standard errors adjusted for correlation of outcome within Providers (using cluster variance option) &Wald test may be unreliable due to small numbers overall/or with the outcome; has been included for completeness but interpretation of 95% CIs for ORs may be more appropriate in this situation @Only includes those who completed SafeCare within follow-up period* | | | | | | | | | | | | | | |

Table 9: OOHC within 12-months

| **SafeCare Program Definition** | **Group** | **Total** | **Unadjusted** | | | | **Adjusted^** | | | **Odds Ratio#** | | | **Wald Test#&** | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **n** | **%** | **Chi-Sq** | **P** | **%** | **95% CI** | | **OR** | **95% CI** | | **Chi-Sq** | **P** |
| SafeCare modules completed@ | Comparison | 1718 | 44 | 2.6 |  |  | 2.6 | 1.5 | 3.6 |  |  |  |  |  |
|  | SC: 0 modules completed | 89 | 1 | 1.1 | 41.00 | <0.001 | 1.1 | 0.0 | 3.3 | 0.00 | 0.00 | 0.00 | 29.22 | <0.001 |
|  | SC: 1 module completed | 13 | 4 | 30.8 |  |  | 30.8 | 0.0 | 64.8 |  | 1.4e+29 |  |  |  |
|  | SC: 2 modules completed | 7 | 0 | 0.0 |  |  | 0.0 | 0.0 | 0.0 | 1.00 | 1.00 | 1.00 |  |  |
|  | SC: 3 modules completed | 12 | 0 | 0.0 |  |  | 0.0 | 0.0 | 0.0 | 1.00 | 1.00 | 1.00 |  |  |
| Referred to SafeCare | Comparison | 1718 | 44 | 2.6 |  |  | 2.6 | 1.5 | 3.6 |  |  |  |  |  |
|  | In SafeCare | 257 | 5 | 1.9 | 0.35 | 0.554 | 1.9 | 0.0 | 4.2 | 0.33 | 0.12 | 0.92 | 4.49 | 0.034 |
| *^Standard errors adjusted for correlation of outcome within families #Results from mixed effects logistic regression adjusting for correlation of outcomes within families; standard errors adjusted for correlation of outcome within Providers (using cluster variance option) &Wald test may be unreliable due to small numbers overall/or with the outcome; has been included for completeness but interpretation of 95% CIs for ORs may be more appropriate in this situation @Only includes those who completed SafeCare within follow-up period* | | | | | | | | | | | | | | |

## Qualitative Findings

### Overview of Agency, Purveyor, Intermediary, and Funding Body Consultations

The following section provides an overview of findings from consultation activities with SafeCare Providers, Coaches, Trainers, Team Leaders, Managers, as well as representatives from the PRC, the NSTRC, and DCJ. The data from interviews is organised under the following key focus areas:

* Implementation
* Staff Training
* Program Delivery
* Family Outcomes
* Unintended Outcomes
* Program Fidelity
* Recommendations

#### Implementation

Overall, all participating Brighter Futures agencies, the funder, the purveyor and the intermediary believed that the implementation of the BF-SC program has been successful. In particular, representatives from NSTRC believed that this implementation of SafeCare is one of the most successful implementations of the program they have seen to date.

*“The Brighter Futures-SafeCare Trial is doing an exceptional job. They're really one of the top SafeCare Providers and everything that they're doing is done with expertise, so I’m really proud of this implementation.”*

* National SafeCare Training and Research Centre Representative

During consultations, stakeholders identified several factors that they thought supported the success of the implementation, including:

Ongoing Support and Involvement from the Intermediary, the Purveyor, and the Funder

A unique feature of the BF-SC implementation is the inclusion of an intermediary support agency. The PRC have been involved in the trial from the early stages to provide support and assistance with implementation, as well as provide professional practice support in the form of coaching, training and other activities such as webinars and learning groups. The implementation approach adopted by PRC follows the National Implementation Research Network’s Active Implementation Frameworks[[42]](#footnote-43) which draws on findings of implementation science. As part of this implementation support, the PRC have produced monthly data reports which describe implementation progress and inform decision making at the central and local levels. The implementation support provided by the PRC was seen as important for assisting Brighter Futures agencies with program set-up, tracking implementation progress, identifying challenges and problem-solving solutions, as well as creating a community of practice. During consultations, staff from the Brighter Futures agencies noted the importance of this support during the initial set-up of the program but suggested the intensity of this support may not be necessary in the future as many of the common implementation challenges have been identified and solved during the trial, and Brighter Futures agencies are beginning to reach a level of sustainability with the establishment of internal Coaches and Trainers. The PRC further noted that it was always the intention of the trial that the implementation support would reduce as Brighter Futures agencies built capacity to independently implement the program. While this support has reduced throughout the trial, the PRC have remained responsive to assist with emerging challenges, such as those encountered in response to the COVID-19 pandemic.

*“[Implementation support from PRC] was very useful but I don’t think it will be necessary for others because a lot of the issues have standard response (not just this site but other pilot sites too). But I certainly think having this support is really helpful for preparing a site.”*

* Manager, Brighter Futures agency

In addition to the support received from the PRC, staff appreciated receiving ongoing support and advice from the purveyor NSTRC regarding program delivery. Staff reported the importance of this advice and support in making any adaptions to program materials and method of delivery, such as those required in response to the COVID-19 pandemic.

Both NSTRC and DCJ described the benefits of meaningful and sustained involvement of the funding body throughout the length of the trial. DCJ has been directly involved in the trial since its initial inception and the team responsible for managing the trial has remained relatively consistent. This was thought to support successful implementation as DCJ have been able to build strong relationships with the Brighter Futures agencies and build an expectation to deliver the SafeCare program. NSTRC representatives reported that this approach works well, as implementation is less successful when the delivery of SafeCare is optional. In addition, the PRC suggested that a key strength of the BF-SC implementation is the strong understanding among the funding body of the time and investment required to implement large-scale projects successfully. It was noted that in other settings and contexts, there can be pressure to implement programs rapidly which can impact the success of implementation outcomes.

*“They [DCJ] really understand how long implementation takes, there's so much literature out there about how long it takes…I think it's fantastic that they've done this so well, to invest in the time.”*

* Parenting Research Centre Team Member

Stakeholders also reported the benefit of strong relationships between DCJ, NSTRC and PRC throughout the trial. These relationships have been supported by regular meetings and a shared interest in the success of the trial. It was thought that strengthening these relationships ensured that the DCJ, NSTRC and PRC shared common goals and were able to *“develop a strong team based on genuine relationships of respect”.*

Making SafeCare Business-as-Usual

All Brighter Futures agencies agreed that incorporating SafeCare as business-as-usual is an important step in making the implementation of the program successful and sustainable. When interviewed, staff described updating policies and processes to embed SafeCare within the agency. For instance, many Brighter Futures agencies reported that SafeCare is discussed within recruitment processes and they have updated their practice frameworks to describe how SafeCare fits within the broader Brighter Futures program. These efforts were thought to assist implementation by increasing staff member’s understanding of how the program is part of their work as well as building strong expectations that the program is delivered to eligible families.

Some staff raised concerns that the initial implementation of the program requires time and investment to ensure Brighter Futures agencies have established the appropriate systems and processes to support program delivery. As such, it was recommended that caseloads are reduced during this period to allow Brighter Futures agencies the time and capacity to set up the program properly.

Leadership Support and Continued Communication about SafeCare

Staff from several Brighter Futures agencies and PRC cited the importance of leadership support for SafeCare and continued communication about the program. Staff reported that implementation requires sustained effort and when SafeCare is not continually discussed, the rate of delivery can decline. Further, staff reported that the communication needs to involve all staff and not only those involved in the delivery of SafeCare to develop a collective responsibility and shared understanding of the benefits of the program for families. One site has established a dedicated position to champion and drive the implementation of SafeCare and another site has established SafeCare specific targets and incentives to ensure SafeCare is continually discussed and to motivate staff to deliver. Both of these strategies were thought to be beneficial. The PRC reported that leaders from Brighter Futures agencies have been responsive in recognising and responding to implementation challenges and have demonstrated persistence in embedding SafeCare as business-as-usual, which has been an important enabler.

Platforms to Collaborate and Share Knowledge

Staff and agencies reported that the establishment of the CIT meetings, the Local Implementation Team (LIT) meetings, cross-agency webinars and other internal team meetings were important platforms for communicating, sharing challenges, brainstorming solutions, and accessing peer support and advice. These platforms were regarded as especially important during the initial stages of implementation when Brighter Futures agencies encountered challenges and could learn from one another.

Barriers to Implementation

While the implementation of the program was thought to be successful overall, Brighter Futures agencies experienced some challenges in the initial implementation and some that have continued. Firstly, some agencies experienced staff resistance to change in the initial implementation of the program. Staff did not initially understand how SafeCare fit within the broader Brighter Futures program and therefore they saw it as an additional component to add into their already busy schedule. In addition, some staff had reservations about working in such a structured manner as this was different to what they were accustomed to. During interviews, Managers described the work done to date to embed SafeCare as business-as-usual and build expectations for the delivery of the program which addressed some of the concerns initially experienced. In addition, once staff began to see the benefits of the program for families, their attitudes shifted and they were more motivated to deliver the program. Staff resistance is no longer an issue experienced by Brighter Futures agencies, but these challenges provide important lessons for any future roll out of the program.

*“We struggled with staff resistance in the beginning. People were talking negatively about the SafeCare program. We continued to try and change the narrative to positive talk about the program. They liked the flexibility of the Brighter-Futures program and didn’t want to work in a structured way…then we started talking about SafeCare in our recruitment processes and brought in people who had the qualities we were looking for, who could work in a purposeful and structured way – this helped with the culture and got the team talking positively about SafeCare. It also helped when the team started seeing the positive impact SafeCare could have for families – this motivated them to deliver.”*

* Manager, Brighter Futures agency

Of note, staff turnover was also seen as a barrier to implementation given the significant time and resource investment to certify staff in the delivery of SafeCare, particularly those at the Coach and Trainer levels. The PRC further noted challenges with turnover at the managerial level, as this can result in loss of knowledge about the implementation of Brighter-Futures SafeCare.

Staff also reported challenges with the data collection processes which posed barriers for implementation. Staff perceived these processes as burdensome and noted the duplication across the different platforms of data entry, such as between the SafeCare portal and the PRC implementation survey. While some work has been completed to streamline these processes, consultations with DCJ and PRC revealed that further streamlining will be a key focus of future program activities.

Lastly, there were some inconsistencies across the Brighter Futures agencies with regard to staffing structure, responsibilities and expectations of roles. Staff recommended developing clearly defined responsibilities and expectations of each role within the SafeCare team and expectations for the staffing structure, and these be consistent across the Brighter Futures agencies. For example, one certified Coach is appointed for every five SafeCare Providers. Staff suggested that these guidelines would assist in managing staff workloads without impacting the delivery of the program to families.

Future Expansion of SafeCare

Staff from Brighter Futures agencies reflected on the lessons learned during the implementation of the trial and suggested that any future implementation of the BF-SC program 1) gain buy-in from staff prior to implementation so they understand the value of the program and have a sound understanding of what it involves; and 2) be structured and hands-on at the local level (e.g., site visits to ensure Brighter Futures agencies are adhering to best practice guidelines and that they reach an adequate number of families). In addition, PRC staff suggested that there be a review process based on the evaluation findings to determine what continued implementation support and professional practice support may be necessary.

DCJ noted further considerations for the expansion of the SafeCare trial. The original Brighter Futures agencies expressed interest in being involved in the trial and were therefore supportive of the delivery of SafeCare. If the program is rolled out to additional or all Brighter Futures agencies, consideration would need to be given to whether they would be as supportive of delivering SafeCare and if not, additional work may be needed to build this enthusiasm. In addition, consideration would need to be given to the logistics and resources required for coaching and training support, particularly for services that are too small or where it is too early in their implementation journey to have an internal Coach and Trainer. While the Department has engaged in discussions to model what the program may look like and the level of resources and support required if the program is to be expanded, these discussions are ongoing. However, it is noted that the Department have taken a proactive approach to transition planning, with mechanisms in place to support continued implementation and delivery of SafeCare while decisions about any future expansion of the program are made.

#### Staff Training

According to SafeCare Providers, Coaches, Team Leaders, Managers and representatives from PRC, NSTRC and DCJ, the delivery of SafeCare training has been largely successful. Consultation data indicates that there are a number of key factors that have contributed to this success. The detailed planning and resource allocation was viewed as a key enabler during the training process.

*“I think that part has run beautifully. The training has been planned it’s been really well resourced. I think the nature of SafeCare is that there was a lot of really clear guidance around how we had to do things so there’s a high ratio of training and the training, unlike a lot of other training, isn’t the end product. We know it continues with Coaching, so I think that’s actually worked really well.”*

* Department of Communities and Justice Representative

Additionally, the inclusion of an *Expression of Interest* process for identifying suitable staff to train was considered a unique benefit of the trial, as the engagement and enthusiasm from Brighter Futures agencies was perceived to lead on to positive flow-on effects for Managers, Coaches and SafeCare Providers alike. This combined with the endorsement and encouragement from the Department meant that there was engagement at every practice level for the delivery of SafeCare.

*“…everything has been very successful, because every agency we have trained on the Provider level really wanted to be a part of SafeCare and so they were motivated, they were motivated to be trained. They were motivated to deliver SafeCare to their families and they were just motivated to implement the program. Because it pretty much came from the top-down… the Department was encouraging agencies, the agencies wanted to do it… so the Managers were encouraging the Providers, because we had that stepped down approach, it’s worked really well.”*

* National SafeCare Training and Research Centre Representative

As noted in the responses provided by interviewees, the ongoing coaching and supervision was also a key enabler to training and translation of skills into practice. All staff interviewed, reported that the ongoing support and coaching has been a particular benefit as it has supported the accountability of staff and the wider fidelity of the program. In addition, Coaches noted that the requirement to first be a certified SafeCare Provider gave them detailed insights into the delivery of SafeCare which supported the success of coaching activities. Themes from all consultations indicate the benefits of establishing internal Coaches within the Brighter Futures agencies. According to agency staff, internal Coaching was considered more effective due to the Coach’s understanding of the local context and any barriers or challenges that may be specific to that region.

A number of SafeCare Providers also highlighted that the guidance and ongoing supervision provided by NSTRC and PRC has supported staff’s understanding of the program and their confidence to deliver SafeCare to families.

*“…I feel like the training was excellent and I think the ongoing maintenance is really good for that ongoing growth and accountability as a Provider because it makes sure you’re delivering it to standard which is important as SafeCare is based on fidelity. I think that it just really makes sure that you are continuing to grow in your competency as a Provider and as a Coach, it’s also so important that you are practicing what you preach. As in, what you are training the new Providers, you are delivering it to the highest standard that you can.”*

* SafeCare Coach

In addition to these activities, Coaches and Providers described how some Brighter Futures agencies have allowed staff to shadow SafeCare Providers prior to attending SafeCare training and have had pre-training meetings to provide an overview of the program and discuss the expectations of delivery. These strategies were perceived as beneficial for building an understanding of the program and easing any pre-training anxieties among staff.

While training and coaching is generally performed face-to-face, interviewees noted that these activities transitioned to remote delivery in response to the COVID-19 pandemic. NSTRC and PRC worked with participating Brighter Futures agencies during this time to adapt the training and coaching methods. Perceptions about the effectiveness were mixed. Some staff thought that coaching and training was as effective when delivered remotely whereas others preferred face-to-face methods. Managers described benefits of remote training as this removes travel requirements and costs associated with face-to-face delivery. Although, it was recommended that if possible, two trainees are present in the room when they receive remote training so they can practice the skills and discuss the content together. If this is not possible, other Brighter Futures agencies have allowed the SafeCare Coach to be present in the room with the staff member receiving training for this same purpose. PRC suggested that ongoing, it may be beneficial to explore the practicality and feasibility of offering blended methods of training.

According to the data from interviews and feedback provided by all staff, the success of the SafeCare training has led to a translation of skills into practice for SafeCare Providers, Coaches and Trainers.

*“…We’ve seen the uptake of delivering the program right after training, which is always a really good sign that the training is effective, and I think the coaching support alongside training really helps people learn the program and really feel supported with delivering, sometimes in a very new style of working.”*

* Parenting Research Centre Team Member

During interviews and focus groups, staff provided some insight into areas where the delivery of training could be strengthened. While staff reported that the training content was comprehensive and informative, some staff indicated that the expected timeframes for working through the training content, achieving certification and commencing program delivery could be unrealistic for staff who are time-constrained or needed additional learning support.  In addition, some staff reported that four consecutive days of training can be overwhelming, as such it is beneficial to break the training into two lots, before and after the weekend.

SafeCare Providers noted that the various reporting requirements can be confusing for new staff. As such, it would be beneficial if the training included content about these requirements. In consultation with NSTRC representatives it was noted that a training webinar is available for the reporting requirements but as this is optional, some staff do not complete this component. It was further stated that when the SafeCare app is finalised, details about how to use this will be included in the training curriculum.

For Managers, it was noted that although the information provided during the half-day workshop was often sufficient to understand the SafeCare program, Managers would benefit from more guidance about integrating SafeCare into their organisation. During interviews, a number of Managers also highlighted the difficulty of staff turnover and the impact this had on the continued implementation of SafeCare. Despite there being a sufficient amount of guidance relevant to the program content, staff suggested the development of an *Organisational Handbook*, that clearly identified the expectations of the SafeCare program, any previous lessons learned and any additional resources for Managers. Often, new staff were reliant on more verbal forms of communication about the progress of the SafeCare implementation and it was recognised for the purposes of consistency and efficiency, this information would be better documented in a manual for Managers and Team Leaders across the Brighter Futures agencies.

Of note, feedback from staff indicates that the training materials could be tailored to better reflect the Australian context. Specifically, the training videos could incorporate Australian families, Providers and Coaches. The PRC reported that updating the content would help to strengthen the program overall.

##### SafeCare Provider Recruitment and Retention

Consistent with previous findings, we note that a number of Brighter Futures agencies have implemented strategies or processes to support the recruitment and retention of SafeCare Providers.

First, the introduction of an *Expression of Interest* process has had positive outcomes for the initial training and retention of staff. Managers, Team Leaders, and Coaches all perceived that the natural process of *self-selection* that accompanies an *Expression of Interest* process meant that potential SafeCare trainees already demonstrate a level of enthusiasm and engagement in the training and subsequently, the program.

In addition to the *Expression of Interest* process, some Brighter Futures agencies have implemented tasks and interview questions as part of recruitment process to better determine the suitability and potential engagement of applicants in the delivery of SafeCare. We note that these processes have only recently been developed and as such, staff were unable to comment on the effectiveness of these strategies.

In addition to the processes, some Brighter Futures agencies have incorporated additional strategies to encourage the continuous upskilling of SafeCare Providers. Consistent with previous findings, some agencies continue to hold additional skills-building days to discuss challenges in SafeCare delivery with Providers and deliver additional practical training for the SafeCare modules. In addition, PRC delivered a series of webinars discussing challenges and solutions adopted by the Brighter Futures agencies for certain elements of SafeCare delivery e.g., delivering to families who are hearing impaired. These sessions were perceived to be beneficial as they refined the skill-base of SafeCare Providers and increased Managers’ understanding of the program.

Lastly, NSTRC recommended that Brighter Futures agencies over-train staff to ensure there is a good pipeline when they experience turnover. For instance, instead of training only one Coach, it may be beneficial to train two so there is a back-up if one Coach decides to leave the service. This could help combat the loss of investment in training, particularly at the Coach and Trainer level.

##### Train-the-Trainer Model

During interviews, agency staff and Managers spoke about the recent introduction of the train-the-trainer model to some of the Brighter Futures agencies. The opportunity to train Coaches as Trainers initially surfaced as there were additional training spots that could not be filled by PRC at the time. Beyond these opportunities, some services self-funded staff to be trained as Trainers. While this model may be beneficial for some services, Department staff noted that the train-the-trainer model may not be feasible or appropriate for all services and that rather than having a predetermined model for all, it will be important to determine what works best for each individual agency.

SafeCare Managers, Trainers, Coaches, and Providers from agencies who have implemented the train-the-trainer model noted benefits to this approach. For instance, staff perceived it to be more convenient to complete training onsite and noted that they are able to adapt the training materials to be more relevant to their context (e.g., adapting the materials to be more culturally appropriate and describing how the program fits within the agency-specific practice framework). In addition, staff described feeling more comfortable asking questions and practicing during training as they had a pre-existing relationship with the Trainer. Lastly, establishing internal Trainers was reported to enhance the sustainability of the SafeCare program and decrease reliance on external support provided by intermediaries as well as provide opportunities for career advancement.

This approach was thought to have worked well, particularly because of the interagency sharing that occurred where Wesley Mission and CareSouth have also delivered training to staff from other Brighter Futures agencies. This is of particular benefit to the smaller and less established Brighter Futures agencies, where it may not be practical or feasible to establish their own internal Trainer. In addition, the PRC noted the benefits of the Trainer Learning Group which provides a platform for Trainers to discuss issues, share strategies and receive peer support from one another. In addition, it is a mechanism that promotes consistency of practice across the agencies.

*“Being well-resourced is something that has been really helpful in training. The desire as Trainers is that we can really make it fit for our program and we can add the [site] touch to what they are experiencing.”*

* SafeCare Trainer

However, challenges with the train-the-trainer model were identified. Managers recognised that it may not be feasible to establish an internal Trainer for agencies with a smaller number of Providers and Coaches and who have a lesser need for continued training. Additionally, this may have implications for the ability of Trainers to meet their certification requirements as they are required to provide support and training to a certain number of staff to maintain certification.

The train-the-trainer model also has implications for meeting contract numbers. It was recognised that for a staff member to operate as a certified Trainer, part of their capacity needs to be dedicated towards supervising and training other members of the SafeCare team. In turn, this limits their own capacity to provide services to families.

Lastly, staff turnover among Trainers has the potential to substantially impact service capacity. We note the prerequisites (prior practice as a SafeCare Provider and Coach) and monetary investment required to establish SafeCare Trainers. As such, attrition may mean a loss of investment for services and SafeCare Trainers may be difficult to replace.

#### Program Delivery

The following section provides an overview of how the SafeCare program is currently offered in the Brighter Futures agencies under evaluation according to data from interviews and focus groups.

Based on the findings from consultations, there are differences across the Brighter Futures agencies in terms of how or when SafeCare may be offered to families. It was noted that there has been a shift in the mindset of Brighter Futures agencies to integrating SafeCare as business-as-usual, however findings from consultations indicate that the conceptualisation of business-as-usual differs between agencies.

For most agencies, the SafeCare program is started at different times in a family’s journey, depending on their needs and current situation. Among staff, there is recognition that families may not be in a position to engage in SafeCare at the beginning of their journey with Brighter Futures. This is often due to families experiencing adverse events or crises at the time of referral, including periods of homelessness, alcohol and other drugs use, and periods of domestic violence. Interviewees believed that family’s initial engagement in the SafeCare program can be highly dependent on their capacity to engage in a structured program and often, families find it difficult to devote the cognitive or emotional energy to the program during adverse and stressful life events. In these instances, SafeCare Providers may introduce the families to the concept and availability of SafeCare during initial visits but will reintroduce the family to the program once the more complex needs have been addressed. One site suggested an optimal timeframe of 12-weeks into Brighter Futures, which they believed gave enough time for case managers to assist families during a period of crisis before offering SafeCare. However, this timeframe differs on an individual case by case basis.

*“It is important to deliver SafeCare when families are ready and it’s important for Providers and others to know when that point is. I can argue SafeCare for every family but getting that family ready is so important and it is a skill to introduce it at the right time.”*

- Manager, Trial Site

While family readiness may improve initial engagement in the program, SafeCare staff suggested that in some instances it can also be beneficial to offer SafeCare to families when they are experiencing crisis as it can be an opportunity to provide distance from their chaotic situation and focus on something else. Specifically, staff reported that it provides families with perspective and can offer a different outlook for their current situation.

*“I’m of the view that families going through crisis have been going through crisis for quite some time so…sometimes putting that stuff aside for an hour or two per week helps people take themselves out of that situation and it gives them a different outlook. So, despite, for example, a family being homeless, doing SafeCare can take them out of that and gives them a different perspective…we say to families, ‘Look, I know you have a lot going on, but would you like to start SafeCare?’ and they say, ‘Actually yes.’”*

- Manager, Trial Site

Providers will often work with families to identify when they are ready to engage in SafeCare. Some Brighter Futures agencies have also implemented processes in an attempt to standardise the assessment of family readiness. For example, one site has established as Allocations Team consisting of Team Leaders, Trainers and the Program Manager. The Allocations Team is responsible for determining the readiness of the family by taking into account their complex needs and motivation to participate. Similarly, other Brighter Futures agencies have implemented a form of ‘case presentation’, where the potential readiness of a family is discussed between the SafeCare Provider and senior staff.

For other Brighter Futures agencies, it was noted that the process of offering SafeCare to families had shifted from a concept of *family readiness* to a completely embedded approach. For one site, staff stated that originally, SafeCare was only suggested to families once casework was underway and some challenges had already been managed with the family. It was noted that this approach has since changed, where the intentions is for staff to begin SafeCare at the beginning of their Brighter Futures journey. Within this site, staff introduce SafeCare as a tool for addressing ROSH and meeting case goals. Staff from this site reported that the program can be used to effectively engage families early on. In all instances, staff recognised the importance of reiterating the voluntary nature of the program to families.

##### Family Accessibility and Engagement in SafeCare

Overall, staff agreed that efforts to engage families in SafeCare have been largely successful as a large proportion of the families who were offered SafeCare were engaged in the program over the life of the trial. During interviews, SafeCare Providers reported that the successful engagement of families in the program was often influenced by how the program is initially presented to families and which aspects of the program the SafeCare Provider may highlight during the initial offer. For example, some staff focus on ‘selling the fun aspects’ of the program and other staff provide a more detailed and informative overview of the SafeCare program and how it addresses the unique goals of families. Staff reported that setting realistic expectations for families’ participation in the program promoted their long-term engagement and commitment to the program.

One site reported offering incentives to families to support their engagement and participation in the SafeCare program. For instance, families can reduce their state debt by $50 for every hour they participate in the SafeCare program. This strategy was perceived to be beneficial.

It was recognised that despite efforts to engage families being relatively successful, most families do not complete the program within the intended 18-week period. SafeCare Providers, Coaches, Trainers and Team Leaders identified a number of potential reasons that lead to longer duration of the program for some families, including the presence of learning difficulties, the occurrence of adverse events, or the need to reschedule sessions.

###### Access and Engagement with Families from Different Population Groups

Overall, SafeCare Providers, Coaches, Trainers, Team Leaders and Agency Managers noted that families who identify as Aboriginal or Torres Strait Islander or those from CALD backgrounds have been successfully engaged in the BF-SC program.

For families who identify as Aboriginal and/or Torres Strait Islander, staff explained that the presence of an Aboriginal Provider in the service was an enabler to family engagement. In such instances where an Indigenous SafeCare Provider is not available to deliver the program, it was reported that SafeCare Providers worked to ensure the program was person-centred with the addition of culturally appropriate resources (for instance, culturally specific resources and fact sheets) for families. It was recognised that an ideal situation is to provide families with the opportunity to choose the most appropriate Provider based on their needs. It was recognised that at times there may be cultural protocols or potential conflicts of interest for the Indigenous family or Provider, and families may instead wish to engage with a non-Indigenous Provider throughout the duration of the SafeCare program.

For the Brighter Futures agencies with a greater number of families from CALD backgrounds, staff reported that efforts to engage families have been highly successful. Data from consultations indicates that Brighter Futures agencies use a number of strategies to support the accessibility of CALD families and their continued participation in SafeCare. In particular, Wesley Mission suggested that their strategies to encourage and maintain the participation of families from CALD backgrounds were particularly successful. For example, they routinely seek the assistance of the Community Migrant Resource Centre for the translation and interpretation of SafeCare content. Additionally, changes are often made to the structure and delivery of the program to support families’ unique challenges and needs. SafeCare Providers may deliver sessions to non-English speaking parents separately so both parents have the opportunity to actively participate in the program activities via interpreter services. Staff have also adapted the materials for families who cannot read English, such as adding visual aids. Staff highlighted the importance of building rapport and establishing a strong relationship with CALD families, that is, practicing respectful and culturally appropriate engagement in addition to delivering the program content and ensuring they work with the families to determine how they would like to communicate. During consultations with other Brighter Futures agencies, it was recognised that some sites did not have a high proportion of CALD families participating in SafeCare. Although, staff from these sites noted that this was due to receiving a lower number of referrals for this population group, as opposed to families declining participation in SafeCare or disengaging from the program.

During interviews and focus groups, SafeCare Providers and Coaches also noted the successful efforts to engage families with cognitive, intellectual or physical disability. SafeCare Providers described adapting the content and delivery of the SafeCare program to family’s capacity and learning style. For instance, Providers may adjust the length of the session to support positive engagement. Providers also reported adapting the materials to include more visual aids where appropriate. In addition, SafeCare Providers described the use of additional resources to assist with the delivery of the SafeCare content.

*“One of my first families that I became certified with had a learning disability, I think it was a cognitive learning disability. So, it took her a little bit longer to grasp the concepts. She had low self-esteem and previously had 2 other kids removed from her. Her circumstances were different this time, she had a different partner and more social supports around her. A big part of working with her was really just boosting her self-confidence and slowing it down so that she could understand it and showing her that she could do it. She had the capacity to be a good mum and the father of her child was really hands on too. I wrote a lot of things down in dot-form, like with the homework… the health manual that we use for one of the modules – Australia has developed a picture version of it, which we use for families with learning disabilities....”*

* SafeCare Provider

Staff reported successfully delivering the program to a family with individuals who were hearing impaired. However, it was noted that the program materials could be better adapted to suit this population group. For instance, information about alternative ways to contact emergency services would be useful, as people with a hearing impairment cannot contact emergency services by calling 000.

*“We have had a recent experience delivering to a family who is hearing impaired, this was really successful, but materials needed to be adapted. Calling 000 for instance, [there is a] text service as an alternative.”*

- SafeCare Provider

###### Access and Engagement with Fathers

While staff recognised that the number of single fathers referred to the program was low, efforts to engage them have been successful and no specific barriers to access and engagement were identified.

In terms of engaging fathers alongside mothers in the program, feedback about successful engagement varied. For some Brighter Futures agencies, SafeCare Providers reported high levels of participation from fathers during SafeCare sessions. Whereas SafeCare Providers in other Brighter Futures agencies consistently reported the potential barriers to directly engaging fathers during SafeCare sessions. Staff most often described situations where the father would indirectly observe sessions with the mother but would not actively participate. Staff cited potential reasons for the lack of direct engagement or participation from fathers, including:

* The father’s perception that the mother was predominantly responsible for the care of the child;
* Apprehension or a potential fear of judgement; and
* Complex family dynamics, particularly in situations where domestic violence is present.

Staff did, however, describe instances where the father may have benefitted from SafeCare despite only observing the sessions.

*“I've also delivered to a couple in SafeCare and that wasn't too bad. Dad was a bit of a joker to start off with, so he liked to throw in those curly questions… But he was there for all the sessions… Mum used to do most of the modelling and do most of the practise, but he was always there and always listening, and then towards the midway to the end I tried to get him to do some modelling as well, which he was compliant with on most things. Occasionally he didn't want to do anything, but he was always listening and always in the background, so I think he would have picked stuff up.”*

* SafeCare Provider

Overall, staff recognised that more could be done to improve the engagement and participation of fathers and demonstrate the importance and value of SafeCare for both parents.

###### Family Participation in SafeCare

Consultation data suggests that families generally participated in the SafeCare program to improve their parenting skills and address areas of need. Although views on whether families generally completed all three modules were mixed. Providers acknowledged that completion of the program generally depended on the needs of the family and their circumstances at the time of delivery.

Overall staff agreed that it is optimal for families to complete all three modules, even if they have prior knowledge and expertise in particular areas. In these cases, the SafeCare program provides an opportunity for families to gain reassurance of their parenting skills and refresh their memory. Although, some staff suggested there may be value in offering the modules individually so the program can be more tailored to the needs of families, which may improve overall engagement. In each case, staff described benefits for families even when they completed only one module. Staff from one site reported providing certificates of completion at each module (as well as at the end of the program) to help families feel a sense of accomplishment throughout the program, even if they only complete one or two modules.

*"If a family has a really unsafe home and they have a child at risk of seriously injuring themselves and they finish safety and something changes and are unable to complete the program, ongoing they still know how to handle the situation and they know now about supervision.”*

- SafeCare Provider

Staff reported the use of several strategies to support family engagement and retention in the program. These strategies include:

* Strategically choosing the first module based on the needs of the family, which module was perceived as less intrusive or more enjoyable,
* Being flexible with the timeframe required to complete modules based on each family’s unique needs,
* Building rapport with families and working to create a non-judgemental and safe space,
* Acknowledging positive progress and celebrating achievements with families.

During interviews, it was also noted that Provider enthusiasm and enjoyment of the SafeCare program positively contributed to family engagement and completion of the program.

###### Barriers to Family Engagement in SafeCare

SafeCare Providers, Coaches, Trainers and Team Leaders were asked to describe reasons a family may not want to engage in SafeCare when initially offered the program. Overall, SafeCare Providers reported that the majority of families are willing to participate in the SafeCare program. Staff believed that the initial assessment process and the process of determining family readiness often helped to ensure families were willing to participating in the program.

It was also reported that a number of families do not complete the SafeCare program. During consultations, staff suggested several potential reasons for family’s disengagement or early exit. These included:

* Families choosing to complete one or two modules due to pre-existing knowledge or a lack of interest in specific modules.
* Periods of crisis including homelessness or domestic violence.
* Changes to personal circumstances including an illness in the family or moving out of the service area.
* Involvement from local DCJ services due to increasing levels of risk or need.

*“Crisis, drug abuse, mental health – all the factors for which they are referred to Brighter Futures. It’s both the barrier and the cause...”*

* SafeCare Provider

A central implementation team (CIT) meeting conducted in September 2020 explored reasons why families disengaged from SafeCare prior to completing the program. Leading up to disengagement from SafeCare, Providers noticed certain behaviours among families such as regularly cancelling and rescheduling visits, changes in family circumstances and priorities, as well as appearance of hesitation, disengagement or discomfort with the use of voice recorders. During this time, families have provided feedback to Providers about the difficulties with the program (e.g., time commitment, structured and scripted nature of the program, discomfort with recording sessions, existence of prior knowledge about the modules or parenting more generally) or with their life in general (e.g., desire for support in other areas, shifting priorities, under stress). Providers shared a range of strategies to support family engagement such as being well prepared, flexible and persistent, addressing ROSH concerns through SafeCare, changing module order, sending reminders about sessions, discussing benefits of the program, using incentives, celebrating achievements, building rapport with families first and working with them to determine the right time for SafeCare.

##### Brokerage Support

Across the Brighter Futures agencies, the use of brokerage funds appears to be successful in supporting the delivery of the program. Staff reported purchasing safety items, first aid materials and toys to keep on site for improved access to the materials needed to deliver the SafeCare modules. Management staff suggested that access to equipment through brokerage funds improves parents’ capacity to engage with the program and create a safe environment for their children. Furthermore, provision of these resources allowed families to have ownership of the tools to use in their homes especially if they were unable to purchase these resources themselves.

*“Yes, this [the use of brokerage funds] is working well. We prioritise safety so Providers have access to that equipment easily. We want to make sure homes are safe.”*

- Manager, Trial Site

##### Staffing Structure

Across the Brighter Futures agencies, staff described mixed approaches where Providers may deliver both SafeCare and case management to some families and only deliver SafeCare to others. Overall, staff believed that both approaches worked well but there were benefits and disadvantages to both. When working with the family for both SafeCare and Brighter Futures case work, there is greater continuity for the family as they are able to link SafeCare to case management conversations. In addition, they are able to establish a relationship and build rapport with families before delivering SafeCare which can be beneficial. However, the disadvantage is that case management issues can arise during SafeCare sessions which may interrupt the delivery of the content and extend the length of time to deliver that session. When only delivering SafeCare, Providers are able to focus on the delivery of SafeCare specific content which can be more efficient, but it can be difficult to build rapport with families at the beginning of program delivery. When there are two separate staff working with a family, it was perceived as important that there is continuous communication between the workers to build a shared understanding of the family’s issues and progress.

##### Barriers and Enablers to Program Delivery

There are a number of program and non-program enablers and barriers to the delivery of the BF-SC Program.

##### Program Factors

The enablers include:

* Providers’ enthusiasm for delivering the SafeCare program
* Providers’ ability to build strong relationships with families
* Providers’ ability to prioritise and address the immediate needs of families when required
* Providers’ flexibility in program delivery so that it can accommodate the needs and circumstances of families
* Translators’ understanding of the SafeCare program
* Continued endorsement and support for the program among management
* Continued communication about SafeCare among services
* The voluntary nature of the program
* The quality and rigour of the training delivery
* Availability of internal Trainers (for agencies with the team structure to support this)
* The clear structure of the program and availability of clear program resources
* Regular fidelity checks at each staffing level
* Understanding of how SafeCare fits with Brighter Futures casework
* Continued Coaching support
* Regular monitoring of program fidelity
* Organisational targets and incentives to promote program delivery
* Appropriate systems and processes to support program implementation and delivery
* Availability of brokerage funds
* Availability of local and central implementation meetings
* Implementation support from intermediaries
* Engaging with community services such as schools, community health centres and early intervention services to increase referrals to the program

The barriers include:

* Extended time required to deliver the program to families with complex needs
* Absence of guidelines for the implementation and program management of SafeCare
* Limited role clarity for some SafeCare staff
* Limited understanding of the SafeCare program among local community service centres
* Referrals to the program for families with higher levels of risk and complex needs
* Cold referrals
* Connection between SafeCare and Brighter Futures so when families disengage from Brighter Futures, they also disengage from SafeCare
* Burdensome data collection processes
* Availability and capacity of the workforce
* Funding on outputs rather than outcomes

Of note, in more recent rounds of consultation, staff reported that issues related to inappropriate and cold referrals have reduced in recent times.

##### Non-Program factors

The enablers include:

* Availability of other Departmental strategies and programs to meet the support needs of families in areas outside of SafeCare
* Communication and knowledge translation between DCJ, PRC, NSTRC and the Brighter Futures agencies

The barriers include:

* Turnover and staff leave
* Family readiness to participate due to crisis and presence of complex issues
* Travel time required to conduct home visits, particularly for geographically dispersed locations
* Presence of a health and environmental conditions that may impact program delivery
* Events and holidays that limit the capacity of families to engage (e.g. school holidays)
* Potential re-structures within the Department that may result in a change of personnel responsible for the management of SafeCare
* Impacts of COVID-19

#### Family Outcomes

During consultations, agency staff and all SafeCare Providers, Coaches, Team Leaders and Managers unanimously reported that participation in the SafeCare program leads to positive changes in confidence, behaviour and parenting skills for families. The program teaches families new knowledge and skills in relation to caring for their children but also reinforces the knowledge and skills that families already have. In some cases, Providers had witnessed families retaining these skills long term, beyond the delivery of the module and the program as a whole. These positive changes were observed for all three SafeCare modules.

Providers also noted that the SafeCare program allows them to have difficult conversations and address issues that may not have surfaced during case management.

*“It brings to the surface issues that families may have been hiding during case management so allows us to have tough conversations. It might be awkward to bring up, but the program gives you an opportunity to discuss these things.”*

* SafeCare Provider

##### Safety

Across all Brighter Futures agencies, SafeCare Providers and Coaches reported improvements in parent’s capacity to create a safe home following completion of the SafeCare safety module. Throughout the program, Providers witnessed parents identifying and removing hazards and using the safety resources provided (for example, use of safety straps, power point covers and baby gates). Further, Providers witnessed the continuation of these behaviours beyond completion of the safety module. There were instances where parents pointed out new hazards and described how they mitigated safety risks during later modules, demonstrating the transfer of knowledge to new situations. In addition, some families continued to identify hazards as their child became older, indicating they were applying what they had learned to new settings. There were also instances where parents demonstrated an interest in additional opportunities to expand their skills in home safety, in areas such as first aid. While this may be considered an unintended outcome of the safety module, it demonstrates parent’s investment in creating a safer home for their families (see *Section 4.2.1.4: Unintended Outcomes*).

*“I have seen a lot of changes in families, especially around safety. I’ve noticed families really taking those changes on board – changing the locks on their cupboards and keeping baby gates up and noticing that all the hazards you saw at baseline are not there. I noticed big changes in parents, like telling their child to sit on the floor and eat their rice to actually sitting with the child at the table and praising them.”*

*“I had a family that had a very unsafe home with a toddler, and there were choke hazards, rotten food and mice, cockroaches everywhere, we had so many discussions on how worrying it was and how dangerous it would be, and no change or progress, we delivered the safety module and since that time, they have been able to maintain the safety of their home, it’s just dramatically changed, and it has been maintained for 6-10 months.”*

* SafeCare Provider

The provision of safety equipment was perceived as an enabler to improvements in home safety. This was reported to be a particular benefit for families as they often had limited funds to purchase safety equipment themselves. Overall, staff reported that the Safety module is practical and easy for families to engage with.

##### Health

SafeCare Providers and Coaches unanimously reported that families were better equipped to respond to the health needs of their children and were more aware of how and when to access appropriate health and support services following the completion of the health module. Prior to the health module, families often attended the emergency room in response to mild health concerns. However, after the module, families were reportedly more confident to care for their children in the home, when appropriate, and were better able to determine the level of healthcare required in response to child illness and injury.

The health manual and recording chart provided as part of the health module were perceived as valuable resources for families in responding to health concerns. SafeCare Providers witnessed families using these resources beyond the health module which demonstrates continuation of learning. Some Brighter Futures agencies also reported providing families with additional valuable resources such as lists of key health contact numbers and healthy eating resources which appear to have contributed to improved health knowledge. Providers reported that these content about health concerns specific to the Australian context was especially beneficial for families who have relocated from other countries.

*“Throughout the health module, it does become evident that clients are learning and using these resources and understanding these steps a bit more. The modules do make a difference. The information can be learned and acknowledged and used so that’s encouraging.”*

*“She ended up telling me on the next visit how proud she was and that when her little girl had fallen over and had an accident she ran and went straight to the manual and followed the steps and even had the father checking it and looking the symptoms and really going through what we had been practicing. She found it really beneficial and was excited that the father was even excited about it. She was really excited that they were able to follow it and to put it into practice.”*

* SafeCare Provider

##### Parent-Child Interaction/ Parent-Infant Interaction

Across all Brighter Futures agencies, SafeCare Providers witnessed substantial improvements in parent child and parent infant interaction following completion of the PCI or PII module. In many instances, families lacked the knowledge and confidence to play or interact with their children prior to the module. Upon completion, Providers reported noticeable improvements in the frequency and quality of PCIs and an increase in positive parenting behaviours such communication with children, setting clear expectations, setting up independent play, using appropriate discipline methods, praising positive behaviours, incidental teaching moments, and the implementation of structure and routine. Providers also noted the presence of flow-on effects from improvements in parent child interactions, such as calmer demeanour and less disruptive behaviour among children.

*“That is the biggest one I can comment on. One mum, she said that her interaction with her daughter after completion of SafeCare was so far from where she started. I talked to the initial caseworker before I started SafeCare with this client, it was like we were talking to a different mum after she had completed the program.”*

*“Another thing I noticed was the strong attachment between the child and their parents. In the past, mum and dad did not know how to play with her. Now that they know and have those skills, the parents said that it seems so natural. They have been giving more one-on-one time with their daughter and know what areas they can improve on and what are their strengths are. Seeing the cuddles and physical touch between the daughter and her parents – it is really amazing. I can see that the daughter can see that there have been improvements in her mum and dad, and she is very cooperative when I am there.”*

* SafeCare Provider

The PCI and PII modules were perceived to be beneficial for families who had prior knowledge and expertise in interacting with their children, such as those with older children. For these families, the module provided an opportunity to reassure them of their skills and teach them about the link between their natural behaviours and child development. This was perceived to positively contribute to parenting confidence.

*“I think it’s really encouraging that there has been some really noticeable, important positive change for parents and they’ve really built on their repertoire of skills for any play activity with their kids. It’s not necessarily perfect, there are a lot of skills that the parents need to change and use, but the learning is apparent.”*

* SafeCare Provider

Views about the best point in time to complete the PCI and PII modules were mixed. Providers from some services believed it is beneficial to complete the PCI or PII module towards the end of the SafeCare program as it can be more intrusive and require a stronger level of rapport between Provider and families. However, Providers from other services believed it is beneficial to complete the PCI or PII module first as it can be perceived as more enjoyable and interactive than the other modules. Overall Providers did suggest that giving families the preference of which module to complete first is beneficial.

In one case, a family completed the PCI module and then self-referred back to the program to complete the PII module when they had another child. This was seen as a positive outcome and some Providers reported that it would be beneficial for families with younger and older children to receive both the PII and PCI module.

##### Re-reports

During interviews, some staff thought that SafeCare had led to a reduction in re-reports for issues relevant to home safety, child health and PCI following completion of these modules whereas other staff were unable to comment given limited oversight of this data. However, it was acknowledged that there are a range of factors outside of the reach of the program that may impact re-reporting rates and for this reason, it may not be an accurate measure of program success. In addition, some staff noted instances where families had self-referred back to the program due to a desire to refresh their skills which was perceived to be a positive outcome.

SafeCare Providers and Coaches commented that it would be beneficial to receive additional information about re-reporting rates and whether these have changed since the introduction of SafeCare. This may provide greater oversight of the outcomes for families and motivate Providers in the delivery of the program.

##### Appropriateness of SafeCare

SafeCare Coaches, Managers, Providers and agency staff agreed that SafeCare is part of an appropriate response to the needs of families. The knowledge and skills gained through SafeCare were noted to be of particular benefit to young parents and those with limited social supports.

During interviews, agency staff were asked to consider the potential impact for families and communities across NSW, should the delivery of the BF-SC program be successful. According to staff, the potential impacts include the following:

* Babies and children are able to remain in the care of their families and receive the level of care needed to thrive.
* There is improvement to the confidence of parents with high needs.
* Attraction and retention of quality staff, particularly in remote areas.
* Quality improvement and ongoing supervision and Coaching is embedded in service delivery.
* Client feedback and transparency is integrated into practice.
* There is shift in practice to focusing on the skills of parents, subsequently reducing the stigmatisation and pathologising of parents by moving to a strengths-based approach.

Some staff from participating Brighter Futures agencies suggested that the SafeCare program may be beneficial to families who do not meet the requirements of Brighter Futures, as an early intervention service. In these cases, families who may benefit from the program may be overlooked in the current model. It was also noted that SafeCare may provide value in other contexts such as child restoration and prenatal settings as well as to children older than five years old, particularly those with a younger intellectual age. However, it is important to note that there is no current evidence of the effectiveness of the SafeCare program in these settings and any future expansion of the program would need to consider adequate implementation support.

#### Unintended Outcomes

During consultations, a number of unintended outcomes of the BF-SC program were identified and no negative unintended outcomes were evident. The positive unintended outcomes include:

* Sharing of information and learnings from SafeCare participants to friends and family
* Increased confidence among families to advocate for the safety of their children
* Increased confidence among families to participate in community activities such as play group
* Interest in further education and training among participating families
* Improved school attendance due to better family routines
* Increased sense of joy and accomplishment from completing the modules
* Improved mental health of parents
* Desire to reduce substance use behaviours among parents
* Improved relationships between parents
* Improved problem-solving skills among parents
* Improved collaboration and information sharing among services
* Greater staff engagement and enthusiasm in their work
* Improved opportunities for career growth for caseworkers

#### Program Fidelity

The findings from consultations suggest that the program is largely delivered in line with the intended program model and in a consistent manner across the Brighter Futures agencies. All staff reported using the program materials and resources to deliver the modules as intended. In addition, the findings indicate that the intended staffing model, training and coaching model, data collection processes and eligibility criteria were adhered to. There was also evidence that Brighter Futures agencies shared resources (e.g., staff recruitment materials) which enabled greater consistency of practice across the agencies.

There were some instances where the delivery of the program varied slightly from the intended program model such as:

* Length of time families took to complete the session and the program as a whole
* The way families were introduced to the SafeCare program
* Remote delivery of training and SafeCare modules

Staff explained that in some instances, the session length and time on the program varied in order to meet the unique needs of the participating families. In particular, families with CALD backgrounds and cognitive impairments often required more time to ensure adequate understanding of program content. Staff also explained that when an interpreter is present, more time may be required for them to communicate program content. In addition, it was noted that the length of time families remain on the program may be extended due to environmental factors (COVID-19, floods etc), sickness or emerging crises where they may be placed on hold until they can recommence SafeCare.

As discussed in Section 3.2.1.3, there were slight variations across the agencies in terms of when families were introduced to the SafeCare program. Some agencies worked towards a stage of family readiness whereas others introduced the program to families early on in their Brighter Futures journey, as a tool to address ROSH concerns. Staff interviewed believed that the chosen approach was appropriate for their respective agency. There was also evidence that agencies trialled different approaches and settled on a one they believed worked best for their population of families.

We also note variations to the intended format of program delivery in response to environmental factors such as COVID-19. Some Brighter Futures agencies transitioned staff training and program delivery to online methods in response to mandated social distancing requirements. Overall, staff agreed that these methods worked well and enabled continuation of program delivery through these times. There were some initial challenges in the availability of technology and internet, which were overcome as some sites received funding to purchase the necessary equipment for families.

The implications of these program variations and how they may inform future delivery of the program are discussed in Section 4.1.5.

#### Recommendations

During consultations, agency staff and representatives from PRC, NSTRC and DCJ provided the following recommendations to strengthen the BF-SC program and its delivery:

##### Expansion of the SafeCare program

* SafeCare Providers, Coaches, Team Leaders, and Managers suggested that families or parents in other population groups could be given an opportunity to benefit from the program. Other population groups may include:
  + Parents who are working towards restoration of their children.
  + Parents who may be serving periods of incarceration. Staff suggested that delivery in a prison-setting could be facilitated through visitation with children and remote delivery.
  + Grandparents or foster carers.
  + Parents involved in early intervention services or those who do not meet the requirements of Brighter Futures.
  + Parents with children older than five years old who have an intellectual age of younger than five years old.
* Should the BF-SC program be expanded to other Brighter Futures agencies within NSW, staff considered that the intensity of implementation support could be reduced for existing Brighter Futures agencies. In this instance, it was suggested that a community of practice be developed to support the more longstanding Brighter Futures agencies and implementation issues could be addressed during quarterly meetings.

##### SafeCare Provider selection and recruitment

* Staff recommended the use of selection criteria around competencies, skill and traits for future coaching and training positions within the program. Suitability to the role was highlighted as an important enabler and barrier to program and training delivery, indicating that this would assist in ensuring a greater return on investment in further training within the program.
* Staff also suggested the potential opportunity for mentoring and peer support for families who have completed the SafeCare program. SafeCare Providers suggested that parents who successfully complete the program could be offered an opportunity to train as a SafeCare Provider or family mentor. This model is currently used in other programs and it was suggested that it can provide an added benefit to the families due to the level of understanding a peer can provide to someone experiencing similar issues. It was further noted that this would provide an employment pathway for parents in the program who experience high rates of unemployment.

##### Adaptions and Additions to the Program Content

* Staff suggested the development of an introductory module for families who identify as Aboriginal and/or Torres Strait Islander. It was recognised that in the Australian context, the importance of recognising the presence of intergenerational trauma among Indigenous peoples is particularly important for the SafeCare program. As such, it was suggested that content be developed to clearly articulate the purpose of the SafeCare program, and the measures taken to ensure cultural safety for Indigenous families who choose to participate. It was suggested that this could also assist non-Indigenous Providers to engage Indigenous families in the program in a culturally appropriate way. Staff suggested that seeking feedback from Indigenous families that have previously engaged in the SafeCare program would also be valuable. It was also stated that such introductions could be broadened to other cultures.
* Staff recommended a greater use of colour and pictures in the SafeCare resources for families, stating that this would allow engagement with resources to be more appealing.
* SafeCare Providers suggested the provision of a larger variety of case scenarios in the Health module. Staff indicated that some scenarios such as dog bites and stomach aches are repeated and instead could be replaced with different scenarios like spider and snake bites.
* Staff highlighted that some of the program resources are notably Americanised, for example, the nationality and ethnicity options offered in the SafeCare portal include ‘French’ but not ‘Aboriginal or Torres Strait Islander.’ Staff suggested that the program resources and module content could be tailored to better reflect the Australian context. For instance, the safety module could cover beach safety scenarios.
* Staff recommended that the Health manual be developed into a mobile phone app to improve accessibility for families.
* Staff suggested that the inclusion of video resources summarising key points from modules could help with consolidation and retention of key learnings between modules.
* Staff suggested that the program materials could be translated into other languages to improve accessibility for families from non-English speaking backgrounds.

##### Measuring and sharing outcomes for families

* Staff recommended the use of a follow-up with families to get a greater understanding of the maintenance of their skills learned in SafeCare. It was highlighted that this would allow Providers to be clearer in their understanding of the benefits of the program long-term for families.
* To better understand the wider impact of SafeCare, staff recommended measuring additional outcomes of the program such as parents’ wellbeing, children’s safety and behaviour. Staff suggested that SafeCare’s success should be evaluated in terms of its positive impact on families and the quality of their lives, rather than only improvements in parenting skills and child protection outcomes.
* Staff suggested establishing more formal pathways to share stories of successful family outcomes and positive feedback across the entire implementation. This was viewed as beneficial for staff motivation, morale and an appreciation of the program by partner agencies.
* Staff also suggested that it may be beneficial to share testimonies from families who had previously participated in SafeCare with new families, so they are able to observe how the program has helped other families and can get a better understanding of the value and benefits of participating in the program.

##### Referrals to the Brighter Futures-SafeCare program

* Staff highlighted the importance of the referral process and initial assessments for determining families’ suitability and readiness to participate in the SafeCare program. Staff recommended ensuring that partner agencies have a clear understanding of the SafeCare program to encourage appropriate referrals. DCJ commented on this and recommended continued efforts to educate and communicate with local community service centres about the SafeCare program and which families may be suitable for SafeCare. Staff also suggested that assessing families’ level of risk and motivation before starting the program were key to promoting their successful engagement in the program.

##### SafeCare Training

* Staff suggested that Provider training could focus more on the reporting and data collection aspect of the SafeCare program delivery.
* Staff suggested that SafeCare training is delivered in smaller groups as this would promote active engagement and provide more learning support for trainees.
* It was recommended that staff have opportunities to shadow certified Providers prior to completing the SafeCare training to build an understanding of program delivery.
* Staff recommended that other non-SafeCare senior program staff would benefit from brief training about the SafeCare program to improve understanding within the agency. For example, an overview of the theoretical components of each module and how each these are delivered to families.
* Staff suggested offering additional Manager-specific training for troubleshooting, leadership and support skills. Both Managers and other SafeCare staff acknowledged that this would enable Managers to better support the SafeCare team with program concerns and challenges.
* To ensure the consistent operation and delivery of the SafeCare program, staff recommended providing additional resources for new onboarding staff. For example, an informative overview and history of the program and a clear outline of expectations and responsibilities for each specific role within the SafeCare program. In addition, a handover guideline tool would promote a smooth transition between staff delivering the program. Senior staff suggested creating a troubleshooting guide for Managers and Team Leaders which outlines common program-related issues faced, particularly in the implementation of SafeCare and how to address these as well as clearly outlining the data collection and reporting requirements.
* NSTRC recommended that Brighter Futures agencies over-train staff, to ensure there is a good pipeline when they experience turnover. For instance, instead of training only one Coach, it may be beneficial to train two so there is a back-up if one Coach decides to leave the service.
* Staff recommended that the training materials be updated to better reflect the Australian context, such as the inclusion of Australian families in training videos.

##### Program Delivery

* It was recommended that SafeCare be adjusted to allow for delivery of one or two modules alone, based on family need and preference.
* All Brighter Futures agencies advocated for the integration of SafeCare as a foundational component of the wider Brighter Futures program.
* Staff recommended developing clearly defined responsibilities and expectations of each role within the SafeCare team and expectations for the staffing structure, and these be consistent across the Brighter Futures agencies. For example, one certified Coach is appointed for every five SafeCare Providers. Staff suggested that these guidelines would assist in managing staff workloads without impacting the delivery of the program to families.

***Continued review and service design***

* DCJ recommended that future reviews focus on the accessibility and appropriateness of the program for vulnerable population groups such as Aboriginal and Torres Strait Islander families, families from culturally and linguistically diverse families and LGBTIQA+ families. It was suggested that this review inform practice developments to increase the value of the program for these groups.
* DCJ recommended increased consumer participation in service design and review. This could be encouraged by inviting consumer representatives into implementation teams, reference groups or working groups to promote the voice of families and children.

### Overview of SafeCare Family Consultations

The following section provides an overview of findings from consultation activities with SafeCare families. The data from interviews is organised under the following key focus areas:

* Family introduction and involvement in SafeCare
* Family participation in SafeCare
* Family satisfaction and engagement in the modules
* Unintended outcomes
* Family satisfaction and engagement with the wider BF-SC program
* Family’s recommendations to strengthen the program

#### Family Introduction and Involvement in SafeCare

The sample of families interviewed consisted of a mix of single and two-parent families, first-time parents, large families, young families, families who identified as Aboriginal and Torres Strait Islander, as well as families from CALD backgrounds.[[43]](#footnote-44) Families became involved in the Brighter Futures program for a variety of reasons such as facing difficulties in domestic vitolence relationships, involvement in judicial proceedings, financial hardship, homelessness, child health concerns, mental health concerns, emotional distress associated with caring for children with special needs (for example medical conditions, intellectual or physical disability, or developmental disorders), emotional distress associated with single parenting and a lack of social support.

*“My partner and I both come from mental illness backgrounds, I have bipolar, anxiety, depression, he suffers from ADHD, anxiety and depression. After the birth of our first child I ended up with postnatal depression and it was quite difficult coping and part of it… I guess was as a precaution for the birth of our second child but also how we were going to cope post-birth… How to manage with the two children, how to manage with mental health and make sure our conditions didn’t impact on the kids. It was pretty early on before we talked through what we needed assistance with… and being able to do the parenting side of it as our older child was coming into the 2-year-old age and it was something we wanted to make sure we had. With mental health conditions we wanted to make sure we were doing it for both of them...”*

* SafeCare Participant

Of the families interviewed, most were introduced to the SafeCare program via their Brighter Futures case worker, whereas a small sample of families were introduced through their involvement in other parenting programs, the Department, the hospital or other community support groups.

Families reported that during initial conversations, SafeCare Providers explained the nature of the content and described how the program could benefit the family. In some cases, families were also given informational resources such as flyers which gave an overview of the program. Families perceived SafeCare as a parenting program that offers support and helpful information about health, safety and parenting strategies. Parents cited a variety of reasons for participating in the program. For example, some parents saw the program as a way to develop their parenting skills, increase their knowledge about parenting and engage more effectively with their children. For families with previous parenting experience, they hoped the program would refresh their skills and increase their confidence to care for their children.

*“Before I got in with my SafeCare Provider, I was 16 when I was pregnant, and I was jumping from house to house because my mum gave up on me. Then my SafeCare Provider helped me understand what it was to become a mum.”*

* SafeCare Participant

Some families consulted described their initial reservations about participating in the program. These families expressed concerns related to the nature of the program and the requirement of home visits. Families reported that they were concerned that the role of a SafeCare Provider was focused on monitoring or supervision and thus that the program would be a judgemental environment. Importantly, families explicitly stated that these were only initial concerns, and any apprehensions were alleviated by the SafeCare Provider. Families believed that the SafeCare Provider encouraged an understanding, open and accepting environment where families felt supported.

*“At the start, I was a bit iffy about having a social worker come into my house. At first, because they are funded by DCJ, and because of the stigma around social workers and struggling families, I was like ‘oh okay, they are coming in here to judge me, and if they don’t like something then they will take away my kids.’… But that isn’t how it was, they just said ‘you are doing well with this’. They were reassuring that I was doing a good job.”*

* SafeCare Participant

#### Family Participation in SafeCare

Consultation with families revealed several key reasons for their positive and ongoing engagement with the program (see Figure 24).

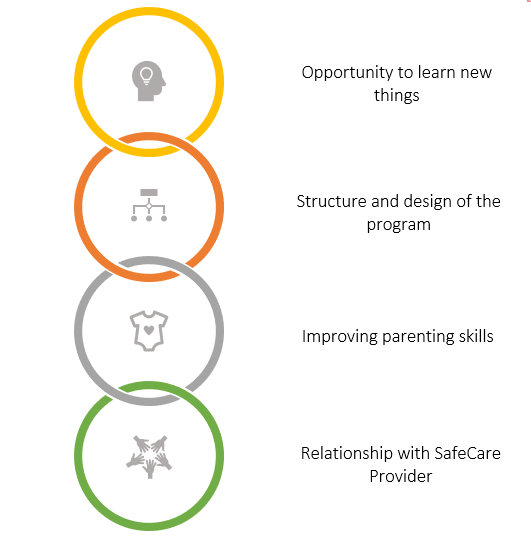
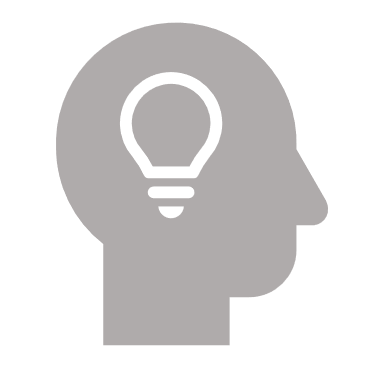
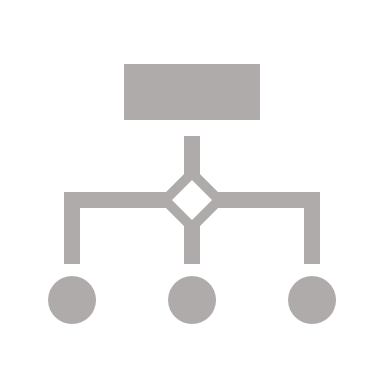


Figure 24: Key motivators for SafeCare Families and their ongoing participation

First, families expressed their satisfaction with the program content and the ***opportunity to learn new things***. For several families, they expressed a sense of gratification in mastering new skills and acquiring new knowledge, and in some instances, parents reported seeking out other opportunities for ongoing education as a result of their enjoyment of the program. For example, one parent reported their interest in completing a nursing degree and additional training in the health industry, as a result of their enjoyment of the Health module. In other instances, families reported the desire to access first aid training and emergency response training as a result of their involvement in the Safety module.



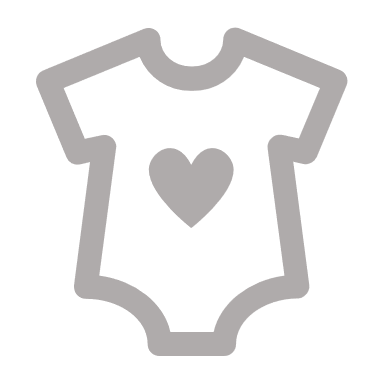
Families believed that the ***structure and design of the program*** was a key contributor to their enjoyment of SafeCare. Families reported that the program was practical and useful, and they liked participating in activities such as role-plays. Most often, families had positive reactions to SafeCare being delivered in the home. Family’s enjoyed the convenience of home visits and liked that the program could be tailored to their home context. They believed that each session had a clear framework and the SafeCare Provider clearly articulated what was expected of them during the session itself, as well as subsequent sessions. Families believed that the process of verbalising the content of the session and the plan for future sessions helped them to feel informed and involved in the decision-making. Of particular relevance, families commented on the flexibility of the program and how this facilitated their ongoing participation. For many families, they reported experiencing periods of instability or crisis during the SafeCare program and instances where they needed to reschedule due to emerging concerns e.g., sickness. In these instances, SafeCare Providers were understanding, flexible and accommodating of their needs. Families were often able to reschedule SafeCare sessions and recommence the program once their more acute needs were addressed. Parents reported that without this flexibility, it is unlikely they would have been able to continue participating in the program.



*“The program and people are flexible, understanding, and I did not feel ‘confronted’. I did not feel much pressure to do it or complete it. The program was not judgemental.”*

* SafeCare Participant

Many families reported that the opportunity to ***improve their skills and confidence to care for their children*** was the greatest contributor to their continued motivation to participate in the SafeCare program. Families also identified that the sense of accomplishment and having their achievements recognised by the SafeCare Provider was also a key contributor to their continued involvement.



Overall, all families identified that the ***relationship with the SafeCare Provider*** was a core component of their participation and engagement in the program. Families reported that the SafeCare Provider directly motivated them to continue the program by reinforcing their progress, working to ensure the sessions were enjoyable and person-centred, and delivering the program in a way that families could understand and relate to. Families also appreciated that their Provider was non-judgemental created a safe space where they could learn.



#### Family Satisfaction and Engagement in SafeCare Modules

##### Safety Module

Families consistently reported that the Safety module improved their knowledge of hazards in the home and their ability to effectively respond to these hazards. Families reported actively altering the layout of their home and the placement of hazardous items to improve home safety. For instance, families reported locking doors, removing accessible poisons, securing furniture and removing low hanging cords. There were also indications that families applied the lessons learned to other settings or environments. A number of families reported applying the skills learned to other rooms within the same house, to rooms in the homes of relatives, and areas outside of the home. In some instances, parents reported embedding these new skills and knowledge in their daily lives and sharing this information with family members and friends. One of the most notable benefits of the Safety module was the provision of resources. Parents explained that the provision of resources such as safety gates, tv straps and child locks helped them to create a safer home for their children. This was particularly important for families who did not have the funds to purchase this equipment themselves.

*“Before I had SafeCare, I was not really aware of things around the house that were dangerous for the kids, I didn’t really take much notice of that kind of thing. It has given me a different perspective of everything when it comes to the house and cleaning.”*

* SafeCare Participant

Families were asked to rate their level of confidence in caring for the safety of their children before and after completing the Safety module. They provided a rating between 1-10, with 1 indicating a complete absence of confidence and 10 indicating a state of complete confidence. Prior to completing the Safety module, on average, families rated their confidence as 6 out of 10. When providing this rating, parents commented on their lack of knowledge and awareness of the potential hazards that could impact the safety of their children. Other families commented that they had a good understanding of home safety prior to the module, but that it helped to reinforce their skills.

*“We completely went through the bathroom which was my worst area. I didn’t have locks on the cupboards or anything and had a razor that the kids could hurt themselves on. Just little things like that that I didn’t really think of.”*

*“There were a lot of hazards around that I never knew about. Because the kids are so little, we don’t see the things that they see.”*

* SafeCare Participant

Following the completion of the Safety module, parents rated their confidence as 9 out of 10. This considerable change in confidence was attributed to the practicality of the Safety module. Parents reported that the module was informative and straightforward. It was also explained that the act of identifying hazards within the family home meant that the skills and strategies were relevant to their context.

A small number of families reported challenges in the removal of hazards if they lived with friends or relatives, or if they did not own the property. In these instances, families appreciated the flexibility of Providers as they assisted families to make their home safer within the constraints of their living situation.

*“Everything that I learned was so useful”*

*“The worker helped purchase different things to make my house safer…locks for the draws, I found that useful.”*

*“I liked that I was involved in the decision-making about the hazards in the home… I didn’t feel intimidated or judged”*

* SafeCare Participant

When asked if there is anything that could improve the Safety module, families generally reported that it did not need to be improved. Although some families suggested that it could be useful to expand the content to include other areas such as backyard and car safety, and cover emergency procedures e.g., responding to fires.

##### Health Module

Overall, families appeared to benefit from the Health module and associated resources. In situations where their children experienced ill health, families reported that the health module helped them to appropriately assess situation and determine the appropriate course of action in responding to these issues. For many families, the practical resources were the most useful components of the Health module. This was particularly the case for families trained in the delivery of health services (e.g., nurse) who had prior knowledge of the module content. Families consistently reported using the health manual and health recording chart beyond completion of the module. One family even requested two copies of the health manual, one for the home and one for the car, so they could access the information wherever they went.

*“If I am not sure, I can always go back to the manual and look it up, do I really need the emergency room? Is it getting worse, or can I wait to see the doctor? Having the resources helps to double check it.”*

*“I found it [the health recording chart] really handy and I think It’s probably handy for other parents too. Because sometimes it’s hard to predict things when you get to the hospital. It’s really overwhelming, at least you would be able to jot everything down in a piece of paper before you go into the triage.”*

* SafeCare Participant

During interviews, families were asked to rate their level of confidence in caring for the health of their child, both before their involvement in the Health module, and immediately following completion. Families provided a rating between 1-10, with 1 indicating a complete absence of confidence and 10 indicating a state of complete confidence. On average, families reported their confidence to be 6 out of 10. Many families reported some level of knowledge or skills in caring for the health of their child but consistently described situations where they would experience panic and overreact to any specific health event. Families often felt that because of the initial concerns raised about their parenting, they experienced feelings of hypervigilance or panic, and would often present to the emergency department for minor conditions, such as influenza or minor cuts or grazes.

Upon completing the Health module, families rated their level of confidence in caring for the health of their child as 9 out of 10. Most often, families reported increased knowledge and awareness to be able to recognise different symptoms during periods of illness and respond appropriately. Some parents reported that the module simply confirmed the knowledge and skills they already had but agreed this was useful.

*“I absolutely loved the health module. I went through that pretty quickly. But just that kind of clarification that it is okay to wait, I don’t need to panic, I need to assess the situation first before kind of jumping in and thinking you need the emergency room now”*

*“I feel like if I didn’t do it, there’s a lot of things that I wouldn’t know now. I’ve gone over what I’ve learnt a couple of times that I’m looking back on, and it’s not just with him it’s in everyday life so it’s really helped.”*

* SafeCare Participant

As a result of their participation in the Health module, some families expressed their interest in exploring other opportunities to improve their health literacy and skills, and protective behaviours.

*“I was learning to not freak out as much and calm down a little bit and just look at the situation. From the Health Module I wanted to do a first aid course, which I haven’t done yet, but I just wanted to do one because I thought it would help me to understand things better and be able to help my child if I needed to.”*

* SafeCare Participant

When asked if anything could be improved about the Health module some families suggested that the scenarios could be more tailored to the Australian context. In particular, the scenarios could better recognise the limitations of the health service system in rural and remote contexts. For instance, in some cases it may be quicker to drive to the hospital than wait for an ambulance. One family also suggested that the module could be more hands-on, referencing first aid courses which used dolls to practice. Another family suggested that the health manual could include more information such as differential responses depending on the age of the child.

##### Parent-Child/Parent-Infant Interaction Module

Families consistently reported that the PII/PCI module helped them to:

* Communicate and interact better with their children,
* Build a stronger bond with their children,
* Implement structure and routine in their lives, and
* Manage disruptive behaviours.

After completing the module, families reported changes in their parenting approach. Specifically, in their approach to discipline, general communication, and setting appropriate boundaries.

*“Because of that module, I tend to want to sit down with my kids and pay attention to them; I don’t usually sit down with them, they usually come to me on the lounge and play with me on the lounge. Now I get down on the floor and get to their level and pay attention to them. I think it brings a bond, brings a closeness within the family. Everyone seems to get closer and bond and everyone seems to be a bit happier.”*

*“It helped eliminate some of the tantrums. I really did not know how to deal with that whatsoever. I was ashamed before I did the program. The program taught me that there are other methods to calm the kids down instead of just dropping everything and walking out of the shopping centre. I try to find a distraction. I get them to interact with the shopping to make them feel like they are a part of what I'm trying to do as an adult.”*

* SafeCare Participant

Families were asked to rate their level of confidence in interacting with their children before and after completing the PCI/PII modules. Consistent with the other modules, they provided a rating between 1-10. Prior to completing the PCI/PII modules, on average, families rated their confidence as 5 out of 10, and these average ratings were the lowest across all SafeCare modules. Parents described a number of reasons for this lack of confidence. Families often described situations where they had not had the opportunity to experience affection or supportive relationships in their own childhood, which translated in difficulties expressing this with their own children.

*“I felt like I couldn’t do it. Like I was doing it all wrong.”*

* SafeCare Participant

Following the completion of the module, parents rated their confidence as 9 out of 10. Families expressed that the module assisted them to build positive relationships with their children by providing clear and useful strategies. Most often, families described the PCI/PII modules as being of the greatest benefit for them. These modules had residual effects of improving the dynamics within the home and parent’s relationships with other family members and friends.

*“The parenting one has given us a bond with our children. It taught us how to sit down and play, how to interact, and make sure we’re on their level.”*

*“Now, I feel really okay about it all, I think the routine has made my kids feel more comfortable and made them feel more relaxed.”*

*“I would like to do that module again. It was helpful, because before it was just chaos.”*

*“Our son is an only child. We used to play with him all the time and be with him, but we didn’t know how to structure and set up independent play if we were busy but now we know that and we can communicate with him about what is happening by saying ‘we are cooking dinner now and will play with you after’.”*

* SafeCare Participant

The findings suggest that the PII/PCI module can be potentially confronting for families if completed first. Specifically, some families reported that it can be confronting to have the Provider watch how they interact with their children. Although in all instances, families reported that SafeCare Providers supported them during the initial stages and ensured that the module was delivered in a non-judgmental way.

*“I found this more helpful than I first thought. At first I thought, who is this person coming into my house telling me that I don’t know how to change a nappy. She never said that, it was just my automatic thought… A lot of it was watching how I interact with my children and they write stuff down, which did make me feel uncomfortable at first until I got used to the process and the worker. This was the first module I did… They did explain to me that I’m not doing anything wrong, its not a judgement, that it is just to get an understanding of where I am at and things that I might need to learn and that what some people already know, others don’t and vice versa.”*

* SafeCare Participant

A small number of families expressed concerns that the activities were repetitive and suggested that there could be more variety in the activities practiced.

#### Unintended Outcomes

Across interviews, families reported some unintended outcomes from the program. There was evidence that families sought out additional opportunities for education as a result of their participation in SafeCare. Other families reported instances where they translated the knowledge and skills they learned through SafeCare to their family and friends. These findings provide evidence that the SafeCare program has positive flow on effects for participating families and their social networks.

#### Family Satisfaction and Engagement with the Brighter Futures-SafeCare Program

Findings indicate that almost all families who participated in interviews reported experiencing benefits as a result of the SafeCare program. This was also the case for families who had prior knowledge or understanding of home safety, child health or parent interaction. ​Parents reported improvements to capacity to care for the health and safety of their child, as well as significant improvements to their parent-child relationships and overall family dynamics.

*“We just have more of a bond, we never had that bond before, we were just real distant and I used to…not resent them, but just, think they were so much like their father and look so much like their father and I didn't want to be near them. But now we are as close as ever, they always want to be with me. They never used to want to be with me, they always used to want to be down at my Mum's. And now they always just want to be home with me and it makes me feel better within myself that I’ve bettered myself and they're bettering themselves for me and we're bettering ourselves for each other. So, we're actually closer than what we would have been.”*

* SafeCare Participant

The majority of families stated that the PII/PCI module was their favourite part of the program. Families most consistently stated they did not have a least favourite part and that they enjoyed all aspects of the program. Families did, however, provide a number of suggestions for how the program could be strengthened (see *Section 3.2.2.6)*.

The small number of families interviewed who exited the program early shared their feedback about why they exited the program and how they could have been better supported. In one case, the family felt forced to continue with the SafeCare modules when they had more pressing crises and concerns they wanted addressed through the Brighter Futures program. This family suggested that they may have remained in the program if the Provider was more flexible in addressing these issues and if they had the opportunity to put SafeCare on hold at the time. In the other case, the family stated that their caseworker fell ill and there was not enough capacity within the agency for them to have a replacement SafeCare provider. This finding indicates the broader implications of staff leave or turnover for family participation and engagement in SafeCare.

##### Cultural Appropriateness and Safety of SafeCare

For those families interviewed who disclosed they identified as Aboriginal and/or Torres Strait Islander (n = 12), they agreed that the program was culturally appropriate, culturally safe, and the SafeCare Provider tailored the program to their cultural needs. Families who had access to an Aboriginal and Torres Strait Islander Provider reported that this was beneficial as they felt more comfortable and that the Provider was able to make the program feel more relevant to them. While they perceived the program to be culturally appropriate, a small number of families suggested that the program materials could be adapted to include cultural knowledge and provide greater representation of Aboriginal and Torres Strait Islander families.

#### Family Recommendations to Strengthen the SafeCare Program

Amongst the largely positive feedback, families offered some recommendations for how the BF-SC program could be strengthened. These included the following suggestions:

##### Module Specific

* For the PII/PCI module, families suggested offering a wider variety of activities and examples to work through, as completing the same activities repeatedly could become disengaging for both parents and children. Additionally, one family suggested that including more information on the PCI cards would support parents with practicing the activities independently.
* The inclusion of other areas to assess home safety e.g., back yard and car safety.
* The inclusion of practical evacuation strategies during an emergency (for example, fires, gas leak, flood) and practice these procedures during SafeCare sessions.
* SafeCare facilitate access to first aid training for parents to learned more advanced emergency response procedures, such as infant CPR.

##### Additional Program Content and Resources

* Consideration should be given to whether the content is relevant across metropolitan, regional and rural areas. Parents indicated that instructions may have to be updated to suit the regional context, or to reflect the advice of local health and emergency services.
* The inclusion of more visual aids in the SafeCare content could assist learners who may have difficulty with verbal content alone.
* Including a less-structured component of the program that focuses on addressing families’ unique challenges could be beneficial.
* Providing a logbook so parents can make note of any key learnings and revisit this upon completion of the program.

##### Program Delivery

* It may be beneficial to offer more flexibility with the delivery schedule of sessions depending on families’ needs and preferences. For example, having the option of two shorter sessions as opposed to one long session per week could better accommodate families’ availability and their preferred learning pace.
* Facilitating group sessions to provide families with the opportunity to connect with each other in their local community.
* Discussing what families already know prior to starting the program to avoid repetition of content and providing an option to complete one or two modules, as opposed to the entire program.
* Minimising the number of SafeCare Providers a family works with in order to build rapport and establish a strong connection between families and Providers. Families noted that turnover of SafeCare Providers influenced their participation and continuity in the program.
* Program content could be developed that accounts for children with developmental disorders, such as ADHD or intellectual disability.

##### Program Expansion

* The SafeCare program could be offered to a wider population of parents and that entry into the program is not contingent on the involvement with Brighter Futures. Other populations suggested by SafeCare participants included grandparents, other relatives, foster carers, and young mothers.

​Most Significant Change Analysis

We conducted aa MSCanalysis based on the qualitative data collected during consultations with families. We analysed the personal accounts of SafeCare participants relevant to positive changes and outcomes to identify the most significant impacts of the program. Based on the MSC analysis, we identified 12 significant impacts of the BF-SC program. As per Figure 25, we used a word cloud to illustrate the weight and relationship of these impacts.

##### Confidence to Care for My Child

**Improvements in the confidence to care for their children** was the most significant impact of the SafeCare. Families expressed that before completing the SafeCare modules, they felt that they lacked the strategies and knowledge to improve their parenting skills. Families particularly highlighted their lack of confidence in building better relationships with their children. After completing the Safety, Health and PII/PCI modules, families felt they had acquired the necessary skills and understanding to improve their parenting skills. Families reported that the modules provided them with a step-by-step approach that was practical and relevant for their daily lives. More importantly, the confidence that parents gained after completing the modules was identified as the most notable benefit. Parents expressed feeling more confident as a parent overall and they believed they were now prepared to care for their children beyond the completion of the program.

*“Because of SafeCare, I have more confidence in myself as a parent and the ability to make decisions”*

*“It made me more confident in being a mum.”*

##### Knowledge and Skills

Another key impact identified during MSC analyses was participant’s acquisition of important **knowledge and skills necessary for looking after their child**. During consultations, parents consistently identified their initial lack of knowledge, awareness or understanding in how to identify hazards in the home or build connections with their children. This often led to feelings of inadequacy and a lack of confidence. During consultations, families noted their appreciation of the practicality, applicability and simplicity of the knowledge and skills taught in the SafeCare program. For many families, the knowledge and skills they gained was the key contributor to their improved confidence and perceived capability to care for their children.

*“It made me aware of what to do and how to do it”*

##### Building a Bond with My Children

During interviews, parents often described the difficulties they experienced in interacting with their children prior to completing SafeCare. Parents described situations where they struggled to manage disruptive behaviour, build a connection with their child, and cope with the negative dynamics in the home. Several parents reported that they felt distanced from their children but were unsure of the steps that could be taken to build better, more nurturing interactions. **The ability to build a better bond and relationship with their children** was identified as a key positive impact of the program. Parents reported that the individual modules, particularly the PII/PCI module, gave them strategies, activities and the knowledge to build better relationships with their children. Families stated that these strategies could be built into their day-to-day activities and most families identified several situations where they incorporated the skills learned, such as modelling behaviours, routine, and the importance of involving children in tasks.

*“SafeCare allowed me to spend more quality time with my kids and feel comfortable with it… knowing that they are getting what they need from me”*

##### Improvements to the Dynamics in the Home

For some families, analysis indicates that the greatest impact of the SafeCare program was the **improved dynamics in the home**. During consultations, several families discussed the negative dynamics and atmosphere that existed in their home prior to their involvement in SafeCare. Parents identified that these dynamics were not selective to the parent-child relationship, but also relationships between parents, between siblings and with other family members. During interviews, families specifically discussed the residual impacts of the SafeCare program on other relationships within the home. Again, parent most often cited the PII/PCI module as being particularly important, as it assisted families to implement a routine, use positive language to reinforce good behaviour and set clear boundaries for disruptive behaviour. Overall, families believed these skills not only improved the relationship with their child but also with other family members.

*“It helped to make my family happier… we’re all happier now”*

##### Provider Support

*“The biggest positive was the support of the SafeCare Provider while learning and the positive reassurance”*

For some families the **support of the SafeCare Provider** was the most significant impacts of the program. Families consistently expressed the positive impacts of the SafeCare Provider and how their compassion, empathy and understanding helped to ensure a non-judgemental and open environment.

##### Practical Resources

The provision of **practical resources** throughout the modules had the greatest positive impact for some families. Families reported that these resources allowed them to improve the safety of their home as well as be able to better care for their children when they were ill. Families were particularly appreciative if they did not have the means to purchase this equipment themselves.

*It provided me with a lot of stuff. I got a first aid kid, shelving, locks etc…That really, really helped me.”*

##### Structure and Routine

For a number of families, improvements to structure and routine were the most significant changes for families. Parents discussed the benefits of the plans and strategies to complete day-to-day activities and how this assisted in the management of their children’s behaviour. Families highlighted the benefits for structure and routine during the sessions themselves, indicating that they felt guided through the program and the expectations were clear.

*“It has given me routine and more focus on the children”*

##### Health and Safety, Reassurance of Skills, a Sense of Achievement, Learning New Things, and Family Preservation

For remaining families, the most significant impact was identified as:

* The practicality of the **Health and Safety modules;**
* **Reassurance of skills** for families;
* The **sense of achievement** that parents experienced after completing the program;
* The opportunity to **learn new things**; and
* The prospect of **family preservation** and the ability to keep the children within parent’s care as a result of their progress in the program.

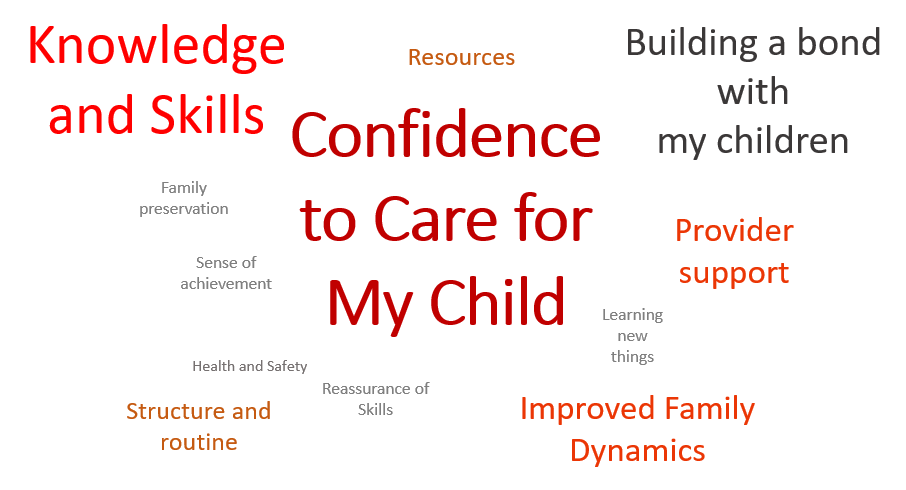


Figure 25: The Impact of the Program for Families (Most Significant Change Analysis)

## Economic Evaluation Findings

An assessment of the trial period, as well as two potential future scenarios were considered as part of this economic evaluation:

1. Evaluation of the BF-SC trial (onboarding and operation of 8 sites from Nov 2017 – Dec 2020);
2. Forecast scenario: Extension of the trial period (continued operation of 8 trial sites over a 10-year forecast after the trial period);
3. Forecast scenario: Full roll-out (onboarding of additional 21 sites, with operation of 29 sites over a 10-year forecast).

A total and per-family cost was found for each scenario (Table 10 below).[[44]](#footnote-45) Per family unit costs for each Brighter Futures agency for the trial are reported in Table 11. Key assumptions and detailed methodologies and outputs related to the Economic Evaluation are provided in *Attachment A: Economic Evaluation Report*.

Table 10: Costs of BF-SC delivery.

| Costs | **Trial** | | **Extended trial** | | **Full roll-out** | |
| --- | --- | --- | --- | --- | --- | --- |
| *Total* | *Per family* | *Total* | *Per family* | *Total* | *Per family* |
| Total costs | $6,209,757 | $11,030 | $10,724,386 | $2,837 | $50,090,904 | $3,662 |
| DCJ | $1,791,081 | $3,181 | $927,585 | $245 | $3,210,181 | $235 |
| Brighter Futures agencies | $4,418,676 | $7,848 | $9,796,801 | $2,592 | $46,880,724 | $3,427 |

*\*Costs provided for the trial were aggregated over the trial period and therefore were unable to be adjusted for timing using a discount rate.*

Table 11. Average per unit cost per family of SafeCare by Brighter Futures agency.

|  | Barnardos | CareSouth | Catholic Care | Mission Australia | Samaritans | Wesley Mission |
| --- | --- | --- | --- | --- | --- | --- |
| *Per family cost* | $5,157 | $5,695 | $4,249 | $3,869 | $13,216 | $9,201 |

In the trial scenario, there was considerable heterogeneity across organisations in the cost of providing BF-SC (see Table 11). Following consultation with the Brighter Futures agencies, it became evident that the differences in costs were primarily determined by a few key drivers:

1. *How “integrated” the BF-SC program was into the organisation*. Some Brighter Futures agencies incorporated BF-SC more heavily into the broader organisational framework than others, resulting in increased implementation and restructuring costs. Conversely, integration of BF-SC into Brighter Futures allowed some agencies to use existing home visits to deliver BF-SC, saving associated travel and labour costs.
2. *Onboarding in-house trainers versus outsourcing training to NSTRC, PRC or other providers*. Costs associated with in-house Brighter Futures agency trainers were incurred to both Wesley Mission and CareSouth, but not to the other Brighter Futures agencies.
3. *Provider size, location and eligibility of Brighter Futures participants for BF-SC*.

This analysis relied on recalled self-report information from BF agencies in most instances, which may have also contributed to the differences in the cost of BF-SC per family across agencies. As an example, Samaritans reported implementation costs of more than six times the average of other providers, making their per unit cost markedly higher than other BF agencies, though they did not have an in-house trainer. We have accounted for such outliers in BF agencies’ cost inputs in the cost sensitivity analysis.

### Cost analysis – sensitivity testing

A sensitivity analysis was conducted with key variables to:

1. determine the cost of the BF-SC program under different conditions, and
2. determine the key cost drivers of the results.

Results are presented in Table 12. Estimates of the trial results were not included in the sensitivity analyses, as costs were already incurred and were therefore not sensitive to drivers.

Table 12. Cost sensitivity analysis results.

| # | Sensitivity test | Total costs | | | |
| --- | --- | --- | --- | --- | --- |
| *Extended trial* | | *Full roll-out* | |
|  | Base case | $10,724,386 | | $50,090,904 | |
| 1 | Discount rate *(base case = 7%)* |  | |  | |
|  | 1. 0% | $15,125,383 | | $69,902,955 | |
|  | 1. 3% | $12,953,491 | | $60,124,489 | |
|  | 1. 10% | $9,421,975 | | $44,230,182 | |
| 2 | Families entering Brighter Futures annually *(base case = 0% growth)* | | | | |
|  | 1. -2% annual growth | $10,315,046 | | $48,603,520 | |
|  | 1. +2% annual growth | $11,135,440 | | $51,578,289 | |
| 3 | BF-SC uptake rate *(base case = 22.8%)* |  |  |  | |
|  | 1. 30% | $12,491,704 | | $56,506,714 | |
|  | 1. 50% | $17,407,521 | | $74,328,408 | |
|  | 1. 90% | $27,254,007 | | $109,971,797 | |
| 4 | Delivery of BF-SC as separate sessions *(base case = 0%)* | | | |
|  | 1. 25% | $11,656,498 | | $53,464,261 | |
|  | 1. 50% | $12,588,610 | | $56,837,618 | |
|  | 1. 100% | $14,452,833 | | $63,584,332 | |
| 5 | Staff turnover *(base case = 32%)* | | | |
|  | 1. 9.9% | $10,011,051 | | $47,802,480 | |
|  | 1. 27% | $10,634,724 | | $49,467,770 | |
|  | 1. 37% | $10,832,344 | | $50,458,406 | |
| 6 | Adjusting for outliers in cost inputs *(base case = no change)* | | | |
|  | 1. Adjusted for outliers | $9,020,592 | | $43,924,793 | |

### Benefit scenario analysis

While it appears that children whose families complete two or more modules may have lower odds of ROSH report within 12 months of Brighter Futures acceptance, there were very small numbers with outcomes for this analyses, and there is insufficient evidence from other outcomes analysis to reliably estimate the effect of Brighter Futures-SafeCare on ROSH re-reports and out-of-home-care entries avoided compared to Brighter Futures only. Given the quality and availability of data and the small numbers, there is not considered to be adequately valid and reliable estimates of effect size, thus the benefits as part of a CBA cannot be accurately estimated and therefore are excluded from the primary CBA analysis. While benefits could not be appropriately incorporated into the CBA, we have conducted a range of scenario analyses to demonstrate the potential benefits and subsequent potential cost-benefit outcomes of BF-SC.

There are two key uncertainties related to benefit valuation of SafeCare:

1. *Primary outcome effect sizes*, and
2. *Duration of benefits*, i.e. the extent to which families continue to benefit from a reduction in the risk of ROSH re-reports or OOHC entries beyond the 12 months for which there is trial data.

While we cannot determine robust estimates for the two uncertainties from the trial data, potential values can be inferred from external evidence [8] and based on the outcomes analysis (noting that it is underpowered, unreliable and only considers outcomes over a 12-month period). For the benefit scenario analysis, base case values for these variables have been specified in Table 12. Potential scenario parameters are described in Table 13.

Further, owing to a lack of robust specification of the statistical model to estimate the effect size, an approximation of the risk reduction based on the odds ratio was used as opposed to the predicted estimates from the regression analysis. Given that this is a scenario analysis, it represents only an approximation of the effect size measured in the outcomes evaluation. There is significant uncertainty in the effect size estimates reported in the benefit scenario analyses.

Table 12. Base case values for variables used in benefit scenario analysis.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Variable** | | **Base case value** | **Calculation method** | **Justification** |
| Primary outcome effect size | ROSH re-report | Risk reduction of 12.23% | (comparison group risk of outcome) *minus* (comparison group risk of outcome *multiplied by* odds ratio)  For example, ROSH within 12 months of allocation date:  = (61.23%)*–*(61.23%\*0.8)  = (61.23%)*–*(49%)  = 12.23% | A simplistic approximation of risk reduction based on odds ratio point estimates (controlling for correlation of outcomes within families and Brighter Futures agencies) determined in the outcomes analysis are used. We note that these estimates are underpowered, unreliable and only measure outcomes over a 12-month period. External evidence has shown significant reductions in recidivism (ROSH re-reports) as a result of SafeCare, lending support to estimated effect sizes from this outcomes analysis [8]. There is currently no international evidence for a reduction in OOHC entries as a result of SafeCare. |
| OOHC entries | Risk reduction of 1.72% |
| Duration of benefits over time | | 3 years | Previous literature [8] has demonstrated continued efficacy of SafeCare, with benefits extending up to six years of follow up, though health education programs can experience diminishing returns over time to outcomes of interest [16]. Given this, and based on consultation with DCJ, we have conservatively estimated base case as 3 years of benefits post-SafeCare. | |

In order to reflect the uncertainty and therefore potential variability in benefit values, we have chosen scenarios A-D to represent primary outcome effect sizes at 0%, 50%, 100% and 200% of base case values (rather than 95% confidence intervals, as these would be too precise). For scenarios E-F, we have increased and decreased duration of benefits by 2 years as compared to base case. We note that if additional data can be obtained and more reliable effect sizes can be established, then likely more precise and appropriate benefits scenarios can also be determined.

Results are presented in Table 13. As decision criteria, an initiative is potentially worthwhile if the NPV>0 and BCR>117. NPV provides the difference between benefits and costs, and BCR provides a ratio of benefits to costs. Further details and calculation methods are provided in *Attachment A: Economic Evaluation Report*.

Table 13. Benefit scenario analysis results.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **#** | **Primary outcome**  **effect size** | | **Duration of benefits** | ***Cost*** | ***Benefit*** | ***NPV*** | ***BCR*** |
| **ROSH** | **OOHC** |
| Trial | | | | | | | |
| **A** | 12.23% | 1.72% | 3 years | $6,209,757 | $9,744,182 | $3,534,425 | 1.57 |
| **B** | 0% | 0% | 3 years | $6,209,757 | $0 | -$6,209,757 | 0.00 |
| **C** | 6.12% | 0.86% | 3 years | $6,209,757 | $4,872,091 | -$1,337,666 | 0.78 |
| **D** | 24.46% | 3.44% | 3 years | $6,209,757 | $19,488,363 | $13,278,607 | 3.14 |
| **E** | 12.23% | 1.72% | 1 year | $6,209,757 | $3,489,257 | -$2,720,500 | 0.56 |
| **F** | 12.23% | 1.72% | 5 years | $6,209,757 | $15,145,089 | $8,935,333 | 2.44 |
| Extended trial | | | | | | | |
| **A** | 12.23% | 1.72% | 3 years | $10,724,386 | $19,702,232 | $38,164,647 | 4.56 |
| **B** | 0% | 0% | 3 years | $10,724,386 | $0 | -$10,724,386 | 0.00 |
| **C** | 6.12% | 0.86% | 3 years | $10,724,386 | $9,853,009 | $13,856,923 | 2.29 |
| **D** | 24.46% | 3.44% | 3 years | $10,724,386 | $39,389,334 | $85,968,590 | 9.02 |
| **E** | 12.23% | 1.72% | 1 year | $10,724,386 | $7,019,117 | $6,881,535 | 1.64 |
| **F** | 12.23% | 1.72% | 5 years | $10,724,386 | $30,771,264 | $64,860,470 | 7.05 |
| Full roll-out | | | | | | | |
| **A** | 12.23% | 1.72% | 3 years | $50,090,904 | $71,303,316 | $126,840,836 | 3.53 |
| **B** | 0% | 0% | 3 years | $50,090,904 | $0 | -$50,090,904 | 0.00 |
| **C** | 6.12% | 0.86% | 3 years | $50,090,904 | $35,658,510 | $38,870,026 | 1.78 |
| **D** | 24.46% | 3.44% | 3 years | $50,090,904 | $142,551,875 | $299,845,581 | 6.99 |
| **E** | 12.23% | 1.72% | 1 year | $50,090,904 | $25,402,518 | $13,625,764 | 1.27 |
| **F** | 12.23% | 1.72% | 5 years | $50,090,904 | $111,362,668 | $223,454,290 | 5.46 |

### Threshold analysis – effect sizes

A threshold analysis was completed to determine the values that the drivers of benefits are required to be in order to breakeven (NPV = 0, BCR = 1). The primary outcome effect sizes were tested by setting the other effect size to 0 and holding duration of benefits constant over 3 years. Results are presented in Table 14.

Table 14. Threshold analysis results

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Input parameter** | ***Other variables’ values*** | ***Base case*** | ***Trial*** | ***Extended trial*** | ***Full roll-out*** |
| Duration of benefits | ROSH: 12.23%  OOHC: 1.72% | 3 years | 1.84 years | 0.61 years | 0.79 years |
| ROSH re-report | Duration: 3 years  OOHC: 0% | 12.23% | 24.32% | 8.30% | 10.74% |
| OOHC entries | Duration: 3 years  ROSH: 0% | 1.72% | 1.61% | 0.55% | 0.71% |

# Conclusions

The following section presents the conclusions relative to each evaluation question. These conclusions are based on a triangulation of data from all available sources.

## Was the Trial Implemented as Intended?

Taking together data from all sources, there is evidence that the BF-SC trial was implemented and delivered as intended.

### Staff Training

As can be seen in *Section 3.1.1.1* a total of 113 certified SafeCare Providers had been trained in the delivery of SafeCare as of December 2020 and more than half of those Providers have remained active in their role. In addition, several of the Brighter Futures agencies have reached a stage of internal sustainability with the establishment of SafeCare Coaches and Trainers. At the time of reporting, all Brighter Futures agencies had at least one active Coach and two Brighter Futures agencies had active Trainers.

While it was not the original intention of the BF-SC trial to establish internal Trainers within Brighter Futures agencies, this approach has led to several benefits. Consultation data from Providers, Coaches, Trainers, PRC, NSTRC and DCJ indicates that the availability of internal Trainers has:

* Improved access to peer support and advice about training and program delivery for staff
* Improved the applicability of training for the local context
* Decreased reliance on the intermediary agency for training support
* Increased opportunities for professional development and career growth
* Allowed opportunities for interagency sharing where Trainers deliver training to other Brighter Futures agencies.

Although it is noted that establishing an internal Trainer may not be practical nor feasible for all Brighter Futures agencies and prior to establishing a Trainer, consideration should be given to the ongoing demand for training, the cost of certifying a Trainer, and the site’s capacity to meet contract numbers if a SafeCare Coach is to become a Trainer.

The evidence available suggests that there are a number of factors that contributed to training success, including:

* The training has been well-planned and well-resourced
* The use of an *Expression of Interest* process which meant that Brighter Futures agencies were enthusiastic about program delivery from the outset and this was reinforced at each staff level
* The use of strategies to build expectations and improve understanding of the program prior to training such as orientation sessions and opportunities to shadow certified Providers
* The access to continued coaching and support has resulted in the translation of skills into practice for most trainee SafeCare providers
* The establishment of local Coaches and Trainers has supported the ease of supervision in the local context and the sustainability of the program within the service.

In addition, the training successfully transitioned to remote delivery in response to COVID-19. It may be beneficial to explore the utility of remote training methods into the future as this can reduce the need for staff to travel to access training.

### Program Implementation

Overall, the implementation of the BF-SC trial appears to be largely successful. Staff from Brighter Futures agencies, the funder, the intermediary and the purveyor shared this view. There are several aspects of the implementation approach that appear to have supported this, including:

* Ongoing support and involvement of the funding body, the intermediary and the purveyor
* Strong relationships and a shared vision across the funding body, the intermediary and the purveyor
* The intention of embedding SafeCare as business-as-usual within Brighter Futures agencies
* Strong leadership and continued communication about SafeCare within Brighter Futures agencies
* The establishment of platforms to collaborate and share knowledge (i.e., CIT and LIT meetings, internal SafeCare meetings, Learning Groups, interagency webinars).

There is also strong support for the current approach to implementation in existing literature. A seminal piece of work developed by Durlak[[45]](#footnote-46) argues for the importance of effective program implementation. Aspects of implementation, including program delivery, adherence or fidelity, and planning are critical to the outcomes of a program. Often, a potentially useful program may not lead to positive outcomes due to poor implementation practices, including unrealistic timeframes, a lack of ongoing supervision and support, a lack of responsibility for implementation, and a lack of effective monitoring to inform future implementation and program design. Durlak argues that in order for program implementation to be successful, there are key eight steps that need to be considered:

1. Specify the essential ingredients of an intervention
2. Collaborate with change agents in field settings to tailor the program to the target setting
3. Obtain a clear commitment to administer the agreed-upon intervention
4. Train change agents to conduct the program effectively
5. Provide ongoing supervision and consultation once the program has begun
6. Be ready for unexpected problems
7. Do pilot work
8. Designate staff with responsibilities for implementation.

In the case of the BF-SC program, there is evidence to suggest that each of these steps has been considered (see Table 15).

Table 15: Durlak's (1998) Key Steps for Successful Program Implementation

| Durlak’s Key Steps for Successful Program Implementation | Evidence from the BF-SC Implementation |
| --- | --- |
| 1. *Specify the essential ingredients of an intervention* | * The NSTRC provided clear documentation and guidance relevant to program intentions, design, and delivery. * Supporting documentation including a program handbook were developed. |
| 1. *Collaborate with change agents in field settings to tailor the program to the target setting* | * There was a formal period of planning and collaboration prior to the roll-out of the BF-SC program. This “installation period” involved site visits by DCJ to prepare and discuss program delivery with Brighter Futures agencies; frequent CIT meetings and LIT meetings; engagement between the NSTRC, the PRC, and external evaluators. |
| 1. *Obtain a clear commitment to administer the agreed-upon intervention* | * An *Expression of Interest* was used to select potential Brighter Futures agencies with the capacity and engagement to deliver the program. |
| 1. *Train change agents to conduct the program effectively* | * Intensive training initially delivered by the NSTRC; supported by PRC. * Training was well-planned and well-resourced. * Ongoing coaching and support led to a translation of skills into practice. |
| 1. *Provide ongoing supervision and consultation once the program has begun* | * Continuous coaching, supervision and support provided to SafeCare staff. Observed to be a key factor to the translation of skills into practice. * Regular collaboration and cooperation between DCJ, PRC and NSTRC to ensure the program is delivered successfully and to troubleshoot risks or issues. * High levels of communication between DCJ and Brighter Futures agencies via CIT meetings, direct communication and support, and site visits. |
| 1. *Be ready for unexpected problems* | * The integration of an action learning approach allowed for a continuous feedback loop to address unexpected problems as they arise. * The responsiveness of the program to the COVID-19 health crisis indicates the adaptability of delivery to changing environments. |
| 1. *Do pilot work* | * The lessons learned from the initial pilot of the BF-SC program informed the current implementation. |
| 1. *Designate staff with responsibilities for implementation* | * Staff were designated at a number of different levels, both internal and external to Brighter Futures agencies including program leads, Team Leaders, Coaches, Managers, and staff from the PRC, and initially staff from the NSTRC. |

In the initial stages of implementation, Brighter Futures agencies experienced some challenges such as staff resistance to change and delivering the program and staff turnover. While these challenges have been resolved, they provide important lessons that can be used to inform any future expansion of the program. In particular, these challenges highlight the need to gain buy-in from staff at all levels prior to the roll-out of the program in additional Brighter Futures agencies. During consultations, it was suggested that this could be achieved by educating staff of the benefits of the program for families as well as building an understanding that SafeCare is a tool to address casework concerns rather than an additional, add-on feature.

One challenge that remains, is the amount of data collection involved in the trial. Throughout consultations, staff consistently expressed concerns as there is duplication of effort across the different platforms of data collection (i.e., the SafeCare portal and the implementation data collected by the intermediary agency). The Department and the intermediary recognised this issue and noted their plans to streamline the data collection processes in consultation with Brighter Futures agencies at the conclusion of the data collection period for the evaluation.

It is also important to note that the Department have taken a proactive approach to transition planning, with mechanisms in place to support continued implementation and delivery of SafeCare while decisions about any future expansion of the program are made.

### Program Reach

The data available from all sources suggests that the families involved in the BF-SC trial often experienced a range of complex issues such as mental health, drug and alcohol, homelessness, lack of social support, domestic violence relationships, involvement in judicial proceedings, and financial hardship and were frequently described to be in a stage of crisis. Based on this information, it is clear that many of the families were from vulnerable groups and had a range of different support needs.

Despite these challenging circumstances, at the time of reporting 120 families had completed the entire program (i.e., they had completed all 3 modules), 31 families completed two modules and a further 73 families completed one module. Participating families consistently described their enjoyment of the program and believed that they were able to gain important knowledge and skills to improve their parenting behaviour. In particular, as demonstrated by the MSC analysis, the program helped build their confidence in their capacity to care for their children.

The findings indicate that while SafeCare cannot address all of the complex needs of families (e.g., mental illness, domestic violence), it provides the opportunity for parents to gain skills and confidence in the areas of child safety, child health and PCI, which are key to effective parenting practices.

### Family Engagement

Efforts to engage families in the BF-SC program were largely successful. Across the trial period, a total of 563 families accepted the offer to participate in the program.[[46]](#footnote-47) The data also indicated that the rate at which families agreed to participate remained relatively stable over the life of the trial. Based on monthly reporting, it appears that a total number of 1013 families were offered the opportunity to participate in SafeCare. Although, this may not be a reliable estimate given the challenges with this data source.[[47]](#footnote-48) A relatively small number of 193 families were recorded as declining to participate in SafeCare, for reasons most often recorded as ‘other’ and thus cannot be determined. Again, this may not be an accurate measure of the number of families who declined participation.

Consistent with these findings, consultation data suggests that strategies used to engage and retain families in SafeCare were largely successful. As reported during consultations, the trial is reaching a stage of business-as-usual where the intention is that SafeCare is offered to all eligible families. This transition appears to have improved engagement over time as both staff and participating families began to perceive SafeCare as an important component of the Brighter Futures program. This finding should be considered in any future roll-out of the program where future agencies should work to embed SafeCare as business-as-usual. In addition to this, other strategies such as the use of incentives, selling the *fun* aspects of the program and allowing families to choose which module to begin with and working with the family to align SafeCare to their goals and needs appear to have improved engagement.

Participating families described their key motivators for initial and continued participation in the program such as having the opportunity to learn new things and improve their parenting skills; their positive relationship with their Provider and the support they received from them; the design of the program being practical and useful; and flexibility to reschedule when needed. Families also appreciated the convenience of home visits.

The data suggests that the program is accessible to different population groups, with some slight adaptions to program materials and delivery methods. Across the Brighter Futures agencies, Providers had successfully recruited Aboriginal and Torres Strait Islander families, families from CALD backgrounds, families with intellectual disabilities and hearing impairments within the SafeCare program. There were instances where Providers had adapted the materials such as using more visuals or including additional culturally specific resources to cater to the unique needs of families. The support from the intermediary and the purveyor to adapt these materials was an important enabler. The availability of Aboriginal and/or Torres Strait Islander Providers for Aboriginal and Torres Strait Islander families and translators for families from CALD families was perceived to improve accessibility and cultural appropriateness of program delivery. Families often reported that the program was culturally appropriate and tailored to their unique needs, and appreciated the additional resources provided (a total of 12 families who disclosed they identified as Aboriginal and/or Torres Strait Islander). In future, it may be beneficial to develop a bank of specialised and targeted resources as well as program material adaptions for use across all Brighter Futures agencies. In addition, the translation of materials in different languages may improve accessibility for some families.

While families may have engaged initially, we do note that a number of families exited the program prematurely. As per the quantitative findings presented in this report (see *Section 3.3.1*), of those eligible families who agreed to participate in the program, an average of 48% exited from the program prior to completion. While these rates were relatively consistent across the trial sites, CareSouth had the lowest rate of families who exited the program early (31%). The findings indicate that a number of both program and non-program factors contributed to families disengaging from the program. In terms of program-related factors, the length of the program and the inability for families to complete either one or two modules was viewed as a disincentive for some families who had prior knowledge and a preference to complete only specific modules. While most families who exited the program early did not complete any modules, a substantial number of families completed on or two modules. In terms of non-program factors, the findings indicate that families may disengage from the SafeCare program due to leaving the wider Brighter Futures program (either by completion or early exit) or moving out of the service area. In particular, the complexity and extremely high-risk of families often means that SafeCare families experience periods of crisis that limit their ability to continue. In one case, a family disengaged from SafeCare as they felt forced to continue, despite their shifting priorities to address more pressing concerns at the time. This finding emphasises the importance of Provider flexibility in delivery of the program to ensure the needs and priorities of the family are considered.

The current findings for the rates of premature exits are consistent with other trials of the program in other jurisdictions and countries. Based on available evidence, published early exit rates range between 33%-64%. [[48]](#footnote-49),[[49]](#footnote-50),[[50]](#footnote-51) Therefore, the retention rates appear to be a consistent challenge for the SafeCare program as a whole. Importantly, we note that early exit from the program should not, in all cases, be considered a negative outcome. The evidence suggests that several families completed one and two modules prior to premature exit from the program and were able to make positive changes from their participation in these modules.

### Program Fidelity

The evidence suggests that the program was delivered in line with program requirements and in a largely consistent way across the Brighter Futures agencies. As discussed in Section 3.2.1.6, the program materials and resources were used as intended and the intended staffing model, training and coaching model, data collection processes and eligibility criteria were adhered to. This enabled consistency across the Brighter Futures agencies and ensured the delivery of evidence-based practice, adhering to the recommendations for the broader child protection system in Australia.1

We do note, however, that there were variations from the program model and how it was implemented in practice in three key areas:

* **Program timing:** the length of SafeCare sessions and the time spent on the program was different from what was originally intended (most often, SafeCare sessions ran for 30mins to one hour as opposed to the intended 1.5 hours; the average time spent on the program was 35 weeks, which is longer than the intended 18 weeks). This was considered necessary for meeting the unique needs of families and ensuring adequate understanding of program content.
* **The way the program was offered to families:** some agencies worked towards a stage of family readiness whereas others offered the program to families when they commenced Brighter Futures. Both approaches were considered successful in their respective agencies based on the population of families they serviced.
* **Remote delivery:** some agencies transitioned staff training and SafeCare program delivery online in response to COVID-19. This was considered important for continuation of the program despite mandated social distancing requirements.

In each instance, these variations appear to have supported successful implementation and delivery of the program in different contexts, based on varying needs of the agency and the population of families that they serviced. In addition, the successful transition to online methods provides important opportunities for improved access to the program for families and improved access to training for staff that could be explored in any future roll out of the program. These findings suggest that greater flexibility in the program model regarding program timing, length, how SafeCare is offered to families and guidance for remote delivery may be beneficial.

We also note that while each Brighter Futures agency intended to deliver the SafeCare modules as a complete program rather than offering them individually, there may be some merit in increasing flexibility in the program model to allow families to complete one, two or three modules based on their unique needs. The findings from both the Outcomes Analysis (discussed in Section 4.2 below) and feedback from staff and families suggest that they may benefit from completing individual modules and this may also improve their overall engagement in the program. Although this recommendation should continue to be explored as new evidence emerges regarding the efficacy of individual modules.

## Does SafeCare Lead to a Reduction in the Risk of Significant Harm for Families?

The most reliable outcome, at this point in time, is the occurrence of ROSH reports within 12 months for the 121 families that have completed their involvement in SafeCare. The key reasons for this are:

* At this stage, ROSH reports are more appropriate than entry into OOHC as the primary outcome because OOHC is a very uncommon event, particularly when it is disaggregated across different numbers of completed SafeCare modules: only five SafeCare children entered OOHC within 12 months, and none entered OOHC from families that completed two SafeCare modules or families that completed three SafeCare modules. OOHC entries within 12 months may become an appropriate outcome when the number of completed SafeCare families is larger. For the sake of completeness, rates of entry into OOHC within 12-months are presented in Table 9.
* The key limitation of using a six-month timeframe is the small number of SafeCare families for which six-month outcomes are available to be included in analysis (n=55). A key driver of this relatively small number is that the average SafeCare completion time (approximately 30 weeks) is longer than a six-month follow-up period, which means that a six-month timeframe will continue to be too short, even in the future as more families complete SafeCare.

Table 8 shows the distribution of the 121 completed families with 12 months follow-up across the number of SafeCare modules they completed: zero (n=89); one (n=13); two (n=7); and three (n=12). Given these relatively small numbers of completed families the outcomes need to be treated cautiously. Nevertheless, the key findings to date show that:

* The odds of a ROSH report were statistically significantly lower for children of families who completed two or three SafeCare modules, relative to the comparison group (OR 0.13; 95% CI 0.05, 0.35 and OR 0.12; 95% CI 0.06, 0.23 respectively).
* The odds of a ROSH report were statistically significantly higher for children of families who completed none or one SafeCare module, relative to the comparison group (OR 2.1; 95% CI 1.5, 3.1 and OR 3.6; 95% CI 2.3, 5.7 respectively).

A cautious and reasonable interpretation of these data is that, for the relatively small number of families that have completed SafeCare to date, those that complete at least two modules have significantly lower odds of a ROSH report. However the number of SafeCare children with this outcome is very small, and not considered adequality reliable for estimates of effect size required for a Cost-Benefit Analysis, and analysis of all eligible children enrolled in SafeCare did not demonstrate any statistically significant benefit relative to Brighter Futures only

Ongoing evaluation of these outcome data, in as close to real time as possible, is strongly recommended because in addition to monitoring the impact of SafeCare, it could answer a number of inter-related questions of interest:

* What is the specific nature of the relationship between engagement in SafeCare and ROSH reports? It is too early to answer this question, but the nature of this relationship will become more apparent as more families complete SafeCare. The current result, for example, may simply reflect the small numbers of families who have completed two or more SafeCare modules (n=19), or none or one module (n=102), meaning that these statistically significant associations may not persist after more families have completed. Alternatively, the current result may be starting to highlight the nature of the dose/response relationship: it may be that the benefits of SafeCare are only achieved once a minimum of two modules are completed. This possibility is also highlighted by the analysis of those *who agreed to participate* in SafeCare, as opposed to completed (see the last row of Table 8): the odds of a ROSH report for children of all the families who agreed to participate in SafeCare, regardless of whether they completed (n=257), is not statistically significantly different to families that did not participate in SafeCare. These findings may have implications for the program model ongoing, where families could select to complete one or two modules as opposed to all three.
* What is the specific impact of Brighter Futures and SafeCare? It would be useful to more precisely separate out the impact of the level of exposure to, or completion of, the Brighter Futures program from the specific effects of SafeCare. Although engagement in Brighter Futures is a requirement for entry into SafeCare, for example, the extent of SafeCare families exposure to Brighter Futures (or whether they completed Brighter Futures) is uncertain, even though it is clear that they completed SafeCare. Similarly the degree of engagement with / completion of the Brighter Futures program for the comparison group is unknown.
* Is the impact of SafeCare mediated by covariates? As more families complete SafeCare, it may be possible to determine if the impact of SafeCare varies according to a range of variables, such as the age of the child of primary concern, Aboriginality or CALD background. This could allow more precise tailoring of SafeCare to the specific circumstances of different families. It is also important to identify if there are differences between the SafeCare and comparison families: for this report, covariate adjustment was included in the sensitivity analyses which does suggest some difference between SafeCare and comparison groups.

It is also important to note that the findings from qualitative sources that ROSH reports may not be the best measure of program success due to a variety of reasons, such as:

* ROSH reports may be received for a range of issues that are outside of the scope of what the SafeCare program can address (i.e., domestic violence, mental health, homelessness etc).
* There are variations to how the tool for identifying ROSH is used in practice by different reporters.
* Unforeseeable issues such as COVID-19 may impact income and housing, leading to a ROSH report.
* Nearly two thirds of ROSH reports are not investigated by DCJ.

It will be important that any future analysis of the effectiveness of SafeCare consider the impact of these non-program factors on the achievement reduced ROSH reports. In future, it may be beneficial to explore other broader outcome measures alongside a reduction of ROSH reports to determine the long-term impact of the SafeCare program.

## Does SafeCare Improve Safety in the Home?

Triangulating data from all sources, there is strong evidence to suggest that SafeCare improves safety in the home.

During consultations, SafeCare providers consistently reported improvements to parent’s capacity to identify and mitigate hazards in the home. SafeCare providers often witnessed parents voluntarily removing hazards and using the safety resources provided (for example, parents used safety straps, power point covers and baby gates). These findings are consistent with feedback provided by SafeCare families, who reported applying the lessons learned during the Safety module to make their home safer. Families most often reported that they were better able to identify and mitigate hazards in their home and that their home was safer upon completion of the Safety module. In addition, families commonly suggested that they would continue using the skills they had learned. Providers gave examples where this had been the case, as some families applied the lessons to other rooms in the house and appropriately adjusted the layout of their house as their child aged. There were also instances where parents demonstrated an interest in additional opportunities to expand their skills in home safety, in areas such as first aid. This finding suggests that families are internalising more protective behaviours and considering the safety of their child beyond the SafeCare module.

The Safety module was originally developed to eliminate household risks, due to the large number of household accidents among families reported to be at risk of significant harm of neglect[[51]](#footnote-52). Evidence from the current trial of SafeCare indicates that families are demonstrating the intended objectives of the Safety module. Findings from the pre- and post-module assessment using the HAPI are consistent with qualitative findings, indicating that the number of hazards present in the home significantly decreased upon completion of the Safety module. These improvements were evident across all hazard types. These findings are consistent with other trials of the SafeCare program. For instance, a study conducted by Gershater-Molko, Lutzker, and Wesch (2003)[[52]](#footnote-53) assessed the effectiveness of the SafeCare program. The Home Accident Prevention Inventory-Revised (HAPI-R; Mandel et al., 1998) was used to assess and record the number of hazards in the home. This inventory is a revised scale based on the original HAPI (Tertinger et al., 1984, 1988). The checklist divides hazards into categories such as small objects, sharp objects, ingestible objects that might cause suffocation, ﬁre and electrical hazards, ﬁrearms, falling hazards (balconies), drowning hazards, and poisonous solids and liquids. The study found a statistically significant improvement in parent’s ability to identify hazards in the home. This was also the case in other studies that examined the number of hazards pre- and post-completion of the Safety module.[[53]](#footnote-54),[[54]](#footnote-55)

The provision of Safety equipment appears to be an important enabler to improvements in home safety. Families commonly reported that these resources were useful, with some families suggesting that the provision of these resources was the greatest positive impact of the program for them. During interviews, it was explained that some families did not have access to the funds to purchase safety equipment for themselves which limited their capacity to create a safe home prior to completing the Safety module.

## Does SafeCare Improve Parents’ Capacity to Attend to Their Child(ren)’s Health Needs?

The findings from consultations, module assessments, parent satisfaction surveys and desktop document review suggest that parents are better able to attend to their children’s health needs upon completion of the SafeCare Health module.

During consultations with SafeCare Providers, Coaches and Trainers, it was consistently reported that families were better equipped to respond to the health needs of their children and were more aware of how and when to access appropriate support following completion of the Health module. These findings are consistent with reports from SafeCare families. During consultations, families reported a substantial increase in their confidence to care for the health of their child, assess situations where the child was unwell and determine the appropriate course of action. In particular, families often reported experiencing feelings of hypervigilance or panic and taking their children to the emergency department for mild health concerns prior to completing the module. After the module, families reported feeling confident to care for their children at home where appropriate and were better able to determine the level of health care required. Some families also expressed interest in gaining further health related knowledge and skills as a result of their participation in the module, which provides an indication of their enjoyment of the module.

The practical resources were considered one of the most beneficial aspects of the Health module. Families consistently reported using the Health Manual and the Health Recording Chart beyond completion of the module to identify the type of illness, determine the appropriate course of action, track symptoms and communicate with health professionals. Overall, families perceived these resources to be practical and useful.

The findings from the pre-and-post module assessments using the SICC also indicated significant improvements to the capacity of parents to attend to their children’s health needs. The average score of families in responding to a series of health-related scenarios and determining the appropriate course of action improved significantly after completing the module. This was the case for all types of scenarios (care at home, doctor’s appointment and emergency department). In addition, almost all families agreed that deciding when to take their child to the doctor; caring for their child’s health when they are sick or injured; and deciding when their child required emergency treatment had become easier upon completion of the module.

The improvements to parent’s knowledge, skills and capacity to care for the health of their children as a result of completing the Health module, are consistent with findings from existing research. A recent study examined changes in parenting behaviours pre- and post-completion of the Health module using the SICC assessment, across a range of different implementations of the SafeCare program.54 This study found significant improvements in parent’s capacity to identify the appropriate course of treatment in response to a range of different health scenarios. Another study conducted by Oppenheim‐Weller, Zeira and Mazursky (2020),[[55]](#footnote-56) assessed the effectiveness of SafeCare in an Israeli sample of mothers. In this study, mothers were presented with seven short scenarios of children not feeling well that were grouped into two dimensions. One referred to serious illness, which justifies presenting to a hospital, and the other was mild sickness, which can be treated at home. The findings indicated that mothers were significantly more likely to choose the appropriate response to a health event, following their completion of the Health module. Additionally, the study found that mother’s self-reported capacity to care for the health of their child significantly increased after completing the Health module.

## Does SafeCare Improve Parents’ Personal Interaction With Their Child(ren)?

A synthesis of findings from all sources suggests that completion of the PII/PCI module is leading to improvements in parents’ interactions with their children.

Consultations with SafeCare Providers, Coaches, and Trainers indicate that prior to completing the module, families experienced a lack of knowledge and confidence to play or interact with their children. However, upon completion, staff reported noticeable changes to the frequency and quality of interactions between SafeCare parents and their children. During SafeCare sessions, Providers observed parents exhibiting positive communication with children, setting clear expectations, setting up independent play, praising positive behaviours, using appropriate discipline methods, and implementing structure and routine in their daily activities.

These findings are consistent with data from consultations with families. Parents described an initial lack of confidence to interact with their children, which they often attributed to a lack of exposure to positive parenting during their own childhood. According to families, the SafeCare module helped to improve their interactions; communicate better and build stronger, more positive bonds with their children; implement routine and structure into their daily lives; and manage disruptive behaviours. Additionally, parents felt that the PII/PCI module led to improvements in family dynamics within the home, and their interactions with other family members. Some families reported that the PCI/PII module was of greatest benefit to them.

The findings from the pre-and-post module assessments using the cPAT and iPAT assessments demonstrate significant improvements to parents’ interactions with their children and infants. Upon completion of the module, families demonstrated more positive parenting behaviours in their interactions with their children across a series of activities including bath time, bedtime, mealtime, play, getting dressed, and nappy change. In addition, families most families agreed that routine activities and interacting with their child/infant had become easier and they had more ideas about activities they could do with their children after completing the module.

Similar to the findings for the Safety and Health module, there is evidence in existing literature to support the positive outcomes for families following completion of the PII/PCI module. A recent study examined the impact of SafeCare across a range of different settings using pre-and-post module assessments for the PII and the PCI (iPAT and cPAT, respectively).54 This study found significant improvements in the number of positive interactions between parents and children post module completion. In addition, a qualitative study explored caregivers experiences with the SafeCare program.[[56]](#footnote-57) The study included 30 caregivers participating in the SafeCare program across six separate child welfare agencies in Ontario, Canada. The qualitative findings indicated that six caregivers (20%) reported that the PII/PCI module was the most helpful of the three SafeCare modules. Caregivers described a number of key aspects that contributed to their perception of the module. Consistent with the findings of the current evaluation, caregivers in this study reported that the module gave them an appreciation for the importance of routine and structure in creating a predictable home environment and sense of safety for children. A number of parents also described their improved capacity to manage disruptive behaviours and stressful situations, while consequently improving their relationship with their children.

## Does SafeCare Improve Parents’ Confidence in Their Capacity to Care for Their Child(ren)?

Consultations with families participating in the SafeCare program, SafeCare Providers, Coaches and Trainers indicate substantial improvements in the confidence of parents to care for their children upon completion of the SafeCare program. Families engaged in the program often had a range of complex needs, limited social support and a history of involvement with child protective services, which diminished their confidence in their capacity to care for their children. After completing the SafeCare program, families consistently reported improvements to their confidence to care for the health of their children, interact with their children and create a safe home. These improvements were most notable for the skills learned in the PCI/PII module. In addition, improvements to the confidence of families to care for their children was identified as the most significant impact of the program for families interviewed. The program gave families the opportunity to learn new skills as well as provided reassurance of the skills they already had, which further contributed to their confidence.

Consistent with these findings, a recent study of parents who had participated in the SafeCare program in England found evidence that participation in SafeCare improved parent’s confidence and self-belief that they could manage the challenges of parenting more effectively.[[57]](#footnote-58) In addition, a recent study of another parenting program revealed the importance of parental confidence for behaviour change. Specifically, a study of the Home-Start parenting program demonstrated that participation in the program improved maternal sense of competence in their parenting ability, which in turn predicted changes in parenting behaviour.[[58]](#footnote-59) These findings demonstrate that improved parental confidence can lead to improved parental behaviour.

## Were there any Additional or Unanticipated Outcomes from the SafeCare Implementation and Have These Created Benefits or Limitations to the Delivery of SafeCare?

Based on the data available to the evaluation, there were several perceived unintended benefits of the SafeCare program. These benefits included:

* Sharing of information and learnings from SafeCare participants to friends and family
* Increased confidence among families to advocate for the safety of their children
* Increased confidence among families to participate in community activities such as play group
* Interest in further education and training among participating families
* Improved school attendance due to better family routines
* Increased sense of joy and accomplishment from completing the modules
* Improved self-reported parental mental health
* Desire to reduce substance use behaviours among parents
* Improved relationships between parents
* Improved problem-solving skills among parents
* Improved collaboration and information sharing among services
* Greater staff engagement and enthusiasm in their work
* Improved opportunities for career growth for caseworkers

The presence of these benefits not only indicate the impact of the SafeCare program for participating families but highlight the flow on effects for their broader social and community networks. Of note, there were no significant unintended limitations of the program.

## What is the Incremental Cost of Delivering SafeCare?

An assessment of the trial period, as well as two potential future scenarios were considered as part of this economic evaluation:

1. Evaluation of the BF-SC trial (onboarding and operation of 8 sites from Nov 2017 – Dec 2020);
2. Forecast scenario: Extension of the trial period (continued operation of 8 trial sites over a 10-year forecast after the trial period);
3. Forecast scenario: Full roll-out (onboarding of additional 21 sites, with operation of 29 sites over a 10-year forecast).

A total and per-family cost was found for each scenario (Table 16 below).[[59]](#footnote-60) Key assumptions and detailed methodologies and outputs are provided in *Attachment A: Economic Evaluation Report*.

Table 16: Total and per-family cost of BF-SC.

| Costs | **Trial** | | **Extended trial** | | **Full roll-out** | |
| --- | --- | --- | --- | --- | --- | --- |
| *Total* | *Per family* | *Total* | *Per family* | *Total* | *Per family* |
| Total costs | $6,209,757 | $11,030 | $10,724,386 | $2,837 | $50,090,904 | $3,662 |
| DCJ | $1,791,081 | $3,181 | $927,585 | $245 | $3,210,181 | $235 |
| Brighter Futures agencies | $4,418,676 | $7,848 | $9,796,801 | $2,592 | $46,880,724 | $3,427 |

The majority of costs across all scenarios (trial, extended trial and full roll-out) are incurred to Brighter Futures agencies, primarily attributable to labour costs associated with implementation, ongoing management and SafeCare coaching. Sensitivity testing of the cost analysis determined key cost drivers as follows:

1. Discount rate (it is noted that this will also impact the benefits depending on effect sizes);
2. BF-SC uptake rate (it is noted that this will also impact the benefits depending on effect sizes);
3. Delivery of BF-SC as separate sessions, that is, the integration of BF-SC into Brighter Futures reducing additional travel and translator/interpreter time costs.

Given the potential added costs from greater integration of BF-SC into Brighter Futures agencies’ business-as-usual approach, further consideration of the support required to achieve this is recommended. It is noted that integration may also lead to a reduction in costs (not quantified in this analysis) stemming from “replacement” of some Brighter Futures activities with BF-SC, rather than providing BF-SC activities in addition to Brighter Futures.

## What is the Incremental Value of the Benefits of SafeCare from a Societal Perspective?

Given the quality and availability of trial sample data, and the small numbers with outcomes of interest, there is not considered to be adequately valid or reliable estimates of an effect size of ROSH re-reports and OOHC entries as a result of BF-SC compared to BF only to be appropriately incorporated into the CBA, we have conducted a range of scenario analyses to demonstrate the potential benefits and subsequent potential CBAs of BF-SC. We identified two key uncertainties related to benefit valuation of SafeCare:

1. Primary outcome effect sizes, and
2. Duration of benefits, i.e. the extent to which families continue to benefit from a reduction in the risk of ROSH re-reports or OOHC entries beyond the 12 months for which there is trial data.

Both uncertainties were tested in the scenario analyses. The outcome of interest for the economic evaluation is the odds ratio estimated between BF-SC and BF only cohorts. Whilst not the primary outcome from the outcome evaluation, it is a better representation of the alternative policy options considered in the economic evaluation. Further, owing to a lack of robust specification of the statistical model to predict the risk difference, an approximation of the risk difference based on the odds ratio was used as opposed to the predicted estimates from the regression analysis. Where the outcome is frequent (as for ROSH) the OR is likely to be an overestimate of the relative risk and subsequently risk reduction. However, given that this is a scenario analysis, it represents only an approximation of the effect size measured in the outcomes evaluation. There is significant uncertainty in the effect size estimates reported in the benefit scenario analyses.

An approximation of risk reduction based on the odds ratio point estimates (PE) as determined in the outcomes analysis – noting that these estimates are underpowered and unreliable – are used as a base case for benefit scenario analyses. These are defined as:

* Risk reduction of 12.23% for ROSH re-reports, that is, 12.23 ROSH re-reports avoided per 100 families as a result of SafeCare;
* Risk reduction of 1.72% for OOHC entries, that is, 1.72 OOHC entries avoided per 100 families as a result of SafeCare.

In the full roll-out scenario, if effect sizes were per base case, benefits would need to be continued for at least 0.79 years to breakeven (BCR=1). If the effect size for the other primary outcome were nil and benefits to families were continued over three years, there would need to be a 0.71% (59% lower than scenario analysis base case value) and 10.74% (12% lower than scenario analysis base case value) reduction in risk of OOHC entries and ROSH re-reports, respectively, as a result of SafeCare to breakeven (BCR=1). Given that this is a scenario analysis, it represents only an approximation of the effect size measured in the outcomes evaluation; we note that there is significant uncertainty in the effect size estimates reported.

We further note that the monetarised value of ROSH and OOHC avoided potentially does not reflect the true societal value associated with achieving these outcomes. Specifically, the values used in this analysis represent the expected present value of avoided costs to the DCJ from providing OOHC or attending to a ROSH report event. However, there is evidence to suggest that reducing the number of children in OOHC, or the duration a child spends in OOHC, is associated with substantial broader societal benefits. In a longitudinal study conducted by Lima et al[[60]](#footnote-61) comparing those who experienced OOHC and a matched cohort of those at-risk, OOHC was associated with poorer education attainment, increased mental health disorder, physical ill-health, juvenile detention and incarceration and substance abuse (Table 17).

Table 17. Rates of outcomes among OOHC and matched non-OOHC cohorts.

|  |  |  |
| --- | --- | --- |
| Outcome | Incidence rate of outcome | |
| **OOHC** | **Non–OOHC** |
| Mental health disorder | 0.09 | 0.053 |
| Physical ill health | 0.38 | 0.29 |
| Juvenile detention | 0.193 | 0.076 |
| Incarceration | 0.050 | 0.036 |
| Substance abuse | 0.0277 | 0.0118 |

There is a wide range of literature linking a monetary value to the outcomes assessed by Lima et al.60 A summary is provided in Table 18 below.

Table 18. Values of outcomes.

| Cost | $(2020) value |
| --- | --- |
| Cost of incarceration (per event)[[61]](#footnote-62) | $119,007 |
| Cost of crime (per incident)[[62]](#footnote-63) | $5,485 |
| Cost of hospital admission (per separation)Error! Bookmark not defined. | $4,895 |
| Cost of mental illness (per person per annum)[[63]](#footnote-64) | $4,247 |
| Unemployment pension – Newstart/Jobseeker (per person per annum)Error! Bookmark not defined. | $14,761 |
| Government spending on unemployment services (per person per annum)Error! Bookmark not defined. | $2,470 |
| Cost of Foetal Alcohol Syndrome (per person per lifetime)[[64]](#footnote-65) | $102,995 |
| Cost of moderate alcohol use disorder (per person per episode)Error! Bookmark not defined. | $192,088 |
| Cost of moderate to severe cannabis dependence (per person per episode)Error! Bookmark not defined. | $256,629 |
| Cost of moderate to severe amphetamine dependence (per person per episode)Error! Bookmark not defined. | $312,718 |
| Cost of moderate to severe opioid dependence (per person per episode)Error! Bookmark not defined. | $278,143 |

We advise that the potential indirect impacts over the long term (and their values) may also represent a substantial benefit to society. Whilst it was outside the scope of this evaluation to include the monetised value of these potential long-term impacts, further consideration of measuring and valuing these benefits is warranted.

The AQoL-4D, a multi-attribute utility instrument used to measure health-related QoL, was employed as part of the BF-SC trial to assess QoL of participating families pre- and post-SafeCare modules. The study is presented in Appendix 5 of *Attachment A: Economic Evaluation Report*. Given the limitations with this study due to changes in the methodological approach of the overall evaluation, as outlined in the discussion, the results are not considered to be a robust measure of the impacts of BF-SC on health-related quality of life and therefore have not been relied upon in the CBA. Consideration of such benefits are therefore more appropriately captured within the qualitative studies conducted as part of the overall evaluation.

## What is the Estimated Ratio of Net Costs to Deliver SafeCare to its Net Benefits?

For the trial scenario, the BCR was only >1 when the effect size was equal to or above the suggested point estimate from the outcomes analysis (risk reduction of at least 12.23% for ROSH re-reports and 1.72% for OOHC entries as a result of SafeCare, realised over 3 years). This is likely due to the significant up-front investment costs in establishing and implementing BF-SC, which are likely to provide economies of scale for any further expansion. Therefore, we recommend considering the extended trial and full roll-out scenarios as better representations of the ongoing benefits and costs associated with BF-SC.

Whilst robust estimates of the benefits could not be appropriately incorporated into the CBA, benefit scenario analysis results indicate that if the point estimates of the effect sizes specified in the outcomes analysis could be achieved and these benefits continued for 3 years (noting that the outcomes analysis was underpowered, unreliable and considered outcomes at only 12 months) – the NPV and BCR returned positive results for both the extended trial and full roll-out scenarios (BCR = 4.56 and 3.43, respectively). Holding effect sizes constant, the duration of benefits required to breakeven (NPV=0, BCR=1) is 1.84 years for the trial, 0.61 years for the extended trial and 0.79 years for the full roll-out. Considering international evidence [8] has shown benefits of SafeCare extending up to six years of follow up, our results imply that the continued operation and expansion of BF-SC is potentially net beneficial, dependent on the possible efficacy of the program among participants over an extended time interval. Measurement of outcomes over a longer time frame and with a greater sample size is recommended to confirm this.

BF-SC (and Brighter Futures-only) are provided to a specific sub-set of the NSW population with considerable heterogeneity among the target group. As such, BF-SC is potentially at risk of inequitable distribution of benefits at a societal level and at a within-Brighter Futures level:

* *Societal:* BF-SC will provide benefits only to a subset of the population who are eligible for the program. Investment in SafeCare means an allocation of resources to benefit one group of people which could otherwise be used to benefit others.
* *Within-BF:* The Brighter Futures-only and BF-SC groups in the trial sample showed significant differences in some characteristics. This means that BF-SC may disproportionately benefit some sub-groups within Brighter Futures more than others. However, it is unclear from outcomes analysis if this is due to limitations of the data or due to potential selection bias.

Distribution of benefits should be considered when evaluating the program, especially in relation to:

1. Indigeneity status: By offering SafeCare only to children in the Brighter Futures (child protection) program, BF-SC may provide benefits to a higher proportion of Aboriginal and Torres Strait Islander children than non-Indigenous children on a societal level. Looking at the population within-Brighter Futures, there were significantly more non-Indigenous children completing BF-SC than Brighter Futures only in the trial sample, and so there may be a disproportionate provision of benefits to non-Indigenous Brighter Futures families.
2. Referral pathway: There were significantly more children from a DCJ referral pathway completing BF-SC than Brighter Futures-only in the sample, and so there may be disproportionate provision of benefits to Brighter Futures families referred by DCJ.
3. Age: Brighter Futures is available to families with children aged 0-9, while the SafeCare program is eligible to families with children aged 0-5. Therefore, there may be a disproportionate provision of benefits to families with children under 5 years of age.

## Key Concluding Message

Overall, the complex hypothesis that this trial set out to test is outlined in the program logic (see *Appendix C: Program Logic*)*.* Triangulating data from all sources we found strong evidence of the inputs, activities, outputs, immediate and intermediate outcomes documented in this program logic. Based on the current stage of program implementation and the limitations to the data available, it is difficult to draw conclusions about the impact of SafeCare on longer-term outcomes at this point. Although, we did find evidence of several non-program related factors that may impact longer term outcomes such as OOHC and ROSH reports (such as varying reasons for a ROSH report that are not related to SafeCare, variations in how the tool to determine a ROSH report is used, unforeseeable issues such as COVID-19 and proportion of ROSH concerns not investigated) which are not currently documented in the program logic. Therefore, we suggest that amendments are made to the program logic to acknowledge the complex determinants of these outcomes.

# Recommendations

We recommend that:

1. The implementation and expansion of SafeCare continue accompanied by improved monitoring and measurement of longer-term outcomes as well as costs and benefits, making maximum use of data now routinely collected through the NSTRC portal for immediate and intermediate outcomes. We suggest that analysis and reporting of these outcomes occurs on a regular basis, which should include updating of the estimates of effect size.
2. The Department continues to build on its existing efforts to strengthen the cultural capability and cultural safety of the workforce employed within Brighter Futures agencies for the delivery of culturally safe services for Aboriginal and Torres Strait Islander people.
3. The Department consider using co-design processes to work with Brighter Futures agencies, family representatives, the intermediary and the purveyor to take up the suggestions made and reflected in the body of the report about operational improvements to the systems and processes surrounding SafeCare. We recommend that focusing efforts on i) flexibility in the number of modules delivered, ii) adaptions to program content to make it more relevant for the Australian context and to better meet the needs of different population groups, iii) enhancing understanding among local Community Service Centres about the SafeCare program and what constitutes an appropriate referral may lead to the greatest improvements in program implementation and delivery and thus should be prioritised.
4. The work that is underway to streamline and improve the data collection processes for the SafeCare program continues. In particular, these discussions could seek to resolve issues with the existing data collection tools and processes such as those associated with the monthly reporting from Brighter Futures agencies.
5. The program logic for SafeCare is re-designed to document the non-program factors that impact the achievement of longer-term outcomes such as a reduction in ROSH re-reports and out-of-home care placements.
6. The Department explore the use of previously linked data across health, education and other sectors to measure other potential outcomes and impacts associated with participation in SafeCare.

# Appendix A: Revised Data Strategy Matrix

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **PROCESS EVALUATION** | | | | | |
| **PRIMARY OUTCOME** | | | | | |
| **Evaluation question** | | | **Indicator(s)** | | **Data sources** |
| ***1. Was the trial implemented as intended?*** | *a) Was the staff training program implemented as intended?* | # of staff trained as SC providers  # of staff certified as SC providers  % of staff certified as SC providers within a service  # of staff certified as coaches  % of staff certified as coaches within a service  Reasons for any variations from intended implementation of training | | * PRC data * NSTRC data * Interviews and focus groups with Brighter futures agencies * Interviews with PRC, NSTRC and DCJ staff * Document review | |
| *b) Was the SC program implemented as intended?* | Number of families receiving SC in a reporting period  Number of families who have completed their first module in a reporting period  Number of families who have completed their second module in a reporting period  Number of families who have completed their third module this reporting period  Number of families who successfully completed SafeCare (3 modules total) in reporting period  Number of SC providers not delivering SC to families in a reporting period  Reasons for any variations from intended implementation of SC delivery | | * PRC data * Interviews and focus groups with Brighter Futures agencies * Interviews with PRC, NSTRC and DCJ staff * Document review | |
| *c) Did the trial reach the targeted population?* | Demographics of family members: Age, sex, Aboriginality, location etc.  Family complexity | | * Interviews and focus groups with Brighter Futures agencies and participating families * Interviews with PRC, NSTRC and DCJ staff * DoCS Connect (KiDS-CIW)/ Child story (DCJ) | |
| *d) Were families successfully engaged in the SC program?* | Number of families who commence the SafeCare program  Number of families who complete the SafeCare program  Number of families who decline the offer of SafeCare  Reason for families declining SafeCare  Number of families who have 'dropped out' of SafeCare  Reason for families 'dropping out' of SafeCare  Reasons for delays or interruptions to delivering SafeCare program | | * PRC data * Agency data * Interviews and focus groups with Brighter Futures agencies * Interviews with PRC and FACS staff * Document review | |
| *e) Was program fidelity achieved?* | Evidence of program fidelity (adherence to the program model and consistency in program implementation and delivery across Brighter Futures agencies) | | * PRC data * Interviews and focus groups with Brighter Futures agencies * Interviews with PRC, NSTRC and DCJ staff | |
| ***2. Were there any additional or unanticipated outcomes from the SC implementation, and have these created benefits or limitations to the delivery of the SC program?*** |  | Evidence of unintended outcomes | | * PRC data * Interviews and focus groups with Brighter futures agencies * Interviews with PRC, NSTRC and DCJ staff * Document review | |
| **OUTCOMES EVALUATION** | | | | | |
| **PRIMARY OUTCOME** | | | | | |
| **Evaluation question** | | | **Indicator(s)** | | **Data sources** |
| *Does SafeCare lead to a reduction in the risk of neglect or significant harm for families?* | | | **Lower rate of re-notifications to the child protection helpline for BF-SC compared to BF alone.**  *Risk of Significant Harm* (ROSH) re-reports (6 and 12 month follow up) | | DoCS Connect (KiDS-CIW)/ Child story (DCJ) |
| **Out-of-home placements and restorations**  - frequency | | DoCS Connect (KiDS-CIW)/ Child story (DCJ) |
| **Case plan goals achieved** | | DoCS Connect (KiDS-CIW)/ Child story (DCJ) |
| **SECONDARY (INTERMEDIATE) OUTOMES** | | | | | |
| **Evaluation question** | | | **Indicator(s)** | | **Data sources** |
| *Does SafeCare improve safety in the home?* | | | Increased awareness and knowledge about safety in the home | | * ROSH re-reports – primary reported issue is safety related * Client baseline rating by SafeCare Provider * Client self-rating on completion of safety module * Caseworker rating on completion of safety module * Interviews and focus groups with Brighter Futures agencies and participating families * Desktop Review |
| *Does SafeCare improve the parent’s capacity to attend to their child’s health needs?* | | | Increased awareness and knowledge about child development and child health | | * ROSH re-reports – primary reported issue is health related * Client baseline rating by SafeCare Provider * Client self-rating on completion of health module * Caseworker rating on completion of health module * Interviews and focus groups with Brighter Futures agencies and participating families * Desktop Review |
| *Does SafeCare improve the parent’s personal interactions with their children?* | | | Increased positive personal interactions between child(ren) and parent(s) | | * ROSH re-reports – primary reported issue is parenting skills related * Client baseline rating by SafeCare Provider * Client self-rating on completion of PII/PCI module * Caseworker rating on completion of PII/PCI module * Interviews and focus groups with Brighter Futures agencies and participating families * Desktop Review |
| *Does the SafeCare program improve parents’ confidence in their capacity to care for their child(ren)?* | | | Increased confidence in parenting capacity | | * Client baseline rating by SafeCare Provider * Client self-rating on completion of SC program * Interviews and focus groups with Brighter Futures agencies and participating families * Online survey of parents * Most Significant Change analysis |
|  | | | | | |
| **Evaluation question** | | | **Indicator(s)** | | **Data sources** |
| *What is the incremental cost of delivering SC?* | | |  | | * Stakeholder interviews with SafeCare Managers from each Brighter Futures agency * FACSIAR Brighter Futures Unit Costing Report * Review of contracts for Brighter Futures agencies, NSTRC and PRC |
| *What is the incremental value of the benefits of SC from a societal perspective?* | | |  | | * Stakeholder interviews with SafeCare Managers from each Brighter Futures agency * FACSIAR Benefits Menu June 2020 |
| *What is the estimated ratio of net costs to deliver SC relative to its net benefits?* | | |  | | * Stakeholder interviews with SafeCare Managers from each Brighter Futures agency * FACSIAR Brighter Futures Unit Costing Report * Review of contracts for Brighter Futures agencies, NSTRC and PRC * FACSIAR Benefits Menu June 2020 |

# Appendix B: Sensitivity Analyses

Table 19: ROSH within 12-months - sensitivity analyses by module completed

| **Analysis** | **Group@** | **Odds Ratio^** | | | **Wald Test^#** | |
| --- | --- | --- | --- | --- | --- | --- |
| **OR** | **95% CI** | | **Chi-Sq** | **P** |
| **ME; adjusted for correlation within family** | **SC: 0 modules completed** | 2.13 | 1.55 | 2.94 | 79.27 | <0.001 |
|  | **SC: 1 module completed** | 3.64 | 1.61 | 8.21 |  |  |
|  | **SC: 2 modules completed** | 0.13 | 0.05 | 0.31 |  |  |
|  | **SC: 3 modules completed** | 0.12 | 0.06 | 0.24 |  |  |
| **ME; adjusted for correlation within Provider and family** | **SC: 0 modules completed** | 2.14 | 1.46 | 3.13 | 302.43 | <0.001 |
|  | **SC: 1 module completed** | 3.64 | 2.32 | 5.73 |  |  |
|  | **SC: 2 modules completed** | 0.13 | 0.05 | 0.35 |  |  |
|  | **SC: 3 modules completed** | 0.12 | 0.06 | 0.23 |  |  |
| **ME; adjusted for correlation within family; Provider cluster variance** | **SC: 0 modules completed** | 2.13 | 1.46 | 3.12 | 304.74 | <0.001 |
|  | **SC: 1 module completed** | 3.64 | 2.31 | 5.72 |  |  |
|  | **SC: 2 modules completed** | 0.13 | 0.05 | 0.35 |  |  |
|  | **SC: 3 modules completed** | 0.12 | 0.06 | 0.23 |  |  |
| **ME; one child per family; adjusted for correlation within Provider** | **SC: 0 modules completed** | 1.52 | 0.74 | 3.10 | 179.80 | <0.001 |
|  | **SC: 1 module completed** | 2.32 | 0.94 | 5.75 |  |  |
|  | **SC: 2 modules completed** | 0.33 | 0.05 | 2.12 |  |  |
|  | **SC: 3 modules completed** | 0.27 | 0.07 | 1.05 |  |  |
| **ME; adjusted for correlation within family, age, Referral Pathway, Provider cluster variance** | **SC: 0 modules completed** | 2.31 | 1.40 | 3.81 | 242.43 | <0.001 |
|  | **SC: 1 module completed** | 5.78 | 1.65 | 20.20 |  |  |
|  | **SC: 2 modules completed** | 0.12 | 0.04 | 0.33 |  |  |
|  | **SC: 3 modules completed** | 0.14 | 0.06 | 0.30 |  |  |
| **ME; adjusted for correlation within family, all covariates, Provider cluster variance** | **SC: 0 modules completed** | 2.88 | 1.73 | 4.80 | 57.68 | <0.001 |
|  | **SC: 1 module completed** | 3.93 | 1.12 | 13.84 |  |  |
|  | **SC: 2 modules completed** | 0.05 | 0.01 | 0.22 |  |  |
|  | **SC: 3 modules completed** | 0.17 | 0.07 | 0.41 |  |  |
| **GEE; adjusted for correlation within family** | **SC: 0 modules completed** | 1.55 | 0.85 | 2.82 | 8.33 | 0.080 |
|  | **SC: 1 module completed** | 2.24 | 0.46 | 10.87 |  |  |
|  | **SC: 2 modules completed** | 0.32 | 0.06 | 1.75 |  |  |
|  | **SC: 3 modules completed** | 0.28 | 0.07 | 1.08 |  |  |
| **GEE; one child per family; adjusted for correlation within Provider** | **SC: 0 modules completed** | 1.50 | 0.73 | 3.10 | 193.33 | <0.001 |
|  | **SC: 1 module completed** | 2.29 | 0.93 | 5.61 |  |  |
|  | **SC: 2 modules completed** | 0.33 | 0.05 | 2.11 |  |  |
|  | **SC: 3 modules completed** | 0.28 | 0.07 | 1.05 |  |  |
| *^Odds Ratios and Wald Test for all SafeCare Referrals relative to the Comparison Group #Wald test for overall significance of number of modules completed @Only includes those who completed SafeCare within follow-up period* | | | | | | |

Table 20: ROSH within 12- months - sensitivity analyses overall

| **Analysis** | **Group** | **Odds Ratio^** | | | **Wald Test^** | |
| --- | --- | --- | --- | --- | --- | --- |
| **OR** | **95% CI** | | **Chi-Sq** | **P** |
| **ME; adjusted for correlation within family** | **Referred to SafeCare** | 0.80 | 0.67 | 0.96 | 5.74 | 0.017 |
| **ME; adjusted for correlation within Provider and family** | **Referred to SafeCare** | 0.80 | 0.55 | 1.18 | 1.25 | 0.264 |
| **ME; adjusted for correlation within family; Provider cluster variance** | **Referred to SafeCare** | 0.80 | 0.55 | 1.18 | 1.24 | 0.265 |
| **ME; one child per family; adjusted for correlation within Provider** | **Referred to SafeCare** | 1.05 | 0.53 | 2.07 | 0.02 | 0.899 |
| **ME; adjusted for correlation within family, age, Referral Pathway, Provider cluster variance** | **Referred to SafeCare** | 0.85 | 0.53 | 1.36 | 0.47 | 0.492 |
| **ME; adjusted for correlation within family, all covariates, Provider cluster variance** | **Referred to SafeCare** | 0.74 | 0.54 | 1.02 | 3.34 | 0.067 |
| **GEE; adjusted for correlation within family** | **Referred to SafeCare** | 0.87 | 0.62 | 1.23 | 0.60 | 0.439 |
| **GEE; one child per family; adjusted for correlation within Provider** | **Referred to SafeCare** | 0.97 | 0.46 | 2.03 | 0.01 | 0.940 |
| *^Odds Ratios and Wald Test for all SafeCare Referrals relative to the Comparison Group* | | | | | | |

Table 21: ROSH within 6-months - sensitivity analyses by module completed

| **Analysis** | **Group@** | **Odds Ratio^** | | | **Wald Test^#** | |
| --- | --- | --- | --- | --- | --- | --- |
| **OR** | **95% CI** | | **Chi-Sq** | **P** |
| **ME; adjusted for correlation within family** | **SC: 0 modules completed** | 2.29 | 1.58 | 3.33 | 18.90 | <0.001 |
|  | **SC: 1 module completed** | 1.00 | 1.00 | 1.00 |  |  |
|  | **SC: 2 modules completed** | 1.00 | 1.00 | 1.00 |  |  |
| **ME; adjusted for correlation within Provider and family** | **SC: 0 modules completed** | 2.30 | 1.85 | 2.86 | 55.99 | <0.001 |
|  | **SC: 1 module completed** | 1.00 | 1.00 | 1.00 |  |  |
|  | **SC: 2 modules completed** | 1.00 | 1.00 | 1.00 |  |  |
| **ME; adjusted for correlation within family; Provider cluster variance** | **SC: 0 modules completed** | 2.29 | 1.84 | 2.85 | 55.30 | <0.001 |
|  | **SC: 1 module completed** | 1.00 | 1.00 | 1.00 |  |  |
|  | **SC: 2 modules completed** | 1.00 | 1.00 | 1.00 |  |  |
| **ME; one child per family; adjusted for correlation within Provider** | **SC: 0 modules completed** | 1.43 | 0.92 | 2.24 | 2.49 | 0.114 |
|  | **SC: 1 module completed** | 1.00 | 1.00 | 1.00 |  |  |
|  | **SC: 2 modules completed** | 1.00 | 1.00 | 1.00 |  |  |
| **ME; adjusted for correlation within family, age, Referral Pathway, Provider cluster variance** | **SC: 0 modules completed** | 2.51 | 1.64 | 3.83 | 18.08 | <0.001 |
|  | **SC: 1 module completed** | 1.00 | 1.00 | 1.00 |  |  |
|  | **SC: 2 modules completed** | 1.00 | 1.00 | 1.00 |  |  |
| **ME; adjusted for correlation within family, all covariates, Provider cluster variance** | **SC: 0 modules completed** | 2.68 | 1.53 | 4.69 | 11.82 | 0.001 |
|  | **SC: 1 module completed** | 1.00 | 1.00 | 1.00 |  |  |
|  | **SC: 2 modules completed** | 1.00 | 1.00 | 1.00 |  |  |
| **GEE; adjusted for correlation within family** | **SC: 0 modules completed** | 1.46 | 0.71 | 3.00 | 1.03 | 0.310 |
|  | **SC: 1 module completed** | 1.00 | 1.00 | 1.00 |  |  |
|  | **SC: 2 modules completed** | 1.00 | 1.00 | 1.00 |  |  |
| **GEE; one child per family; adjusted for correlation within Provider** | **SC: 0 modules completed** | 1.43 | 0.92 | 2.23 | 2.53 | 0.112 |
|  | **SC: 1 module completed** | 1.00 | 1.00 | 1.00 |  |  |
|  | **SC: 2 modules completed** | 1.00 | 1.00 | 1.00 |  |  |
| *^Odds Ratios and Wald Test for all SafeCare Referrals relative to the Comparison Group #Wald test for overall significance of number of modules completed @Only includes those who completed SafeCare within follow-up period* | | | | | | |

Table 22: ROSH within 6-months - sensitivity analyses overall

| **Analysis** | **Group** | **Odds Ratio^** | | | **Wald Test^** | |
| --- | --- | --- | --- | --- | --- | --- |
| **OR** | **95% CI** | | **Chi-Sq** | **P** |
| **ME; adjusted for correlation within family** | **Referred to SafeCare** | 0.78 | 0.67 | 0.91 | 10.15 | 0.001 |
| **ME; adjusted for correlation within Provider and family** | **Referred to SafeCare** | 0.78 | 0.65 | 0.94 | 6.71 | 0.010 |
| **ME; adjusted for correlation within family; Provider cluster variance** | **Referred to SafeCare** | 0.78 | 0.65 | 0.94 | 6.62 | 0.010 |
| **ME; one child per family; adjusted for correlation within Provider** | **Referred to SafeCare** | 0.86 | 0.59 | 1.23 | 0.71 | 0.401 |
| **ME; adjusted for correlation within family, age, Referral Pathway, Provider cluster variance** | **Referred to SafeCare** | 0.84 | 0.67 | 1.05 | 2.36 | 0.124 |
| **ME; adjusted for correlation within family, all covariates, Provider cluster variance** | **Referred to SafeCare** | 0.86 | 0.65 | 1.15 | 1.04 | 0.309 |
| **GEE; adjusted for correlation within family** | **Referred to SafeCare** | 0.85 | 0.64 | 1.13 | 1.22 | 0.270 |
| **GEE; one child per family; adjusted for correlation within Provider** | **Referred to SafeCare** | 0.85 | 0.59 | 1.24 | 0.70 | 0.402 |
| *^Odds Ratios and Wald Test for all SafeCare Referrals relative to the Comparison Group* | | | | | | |

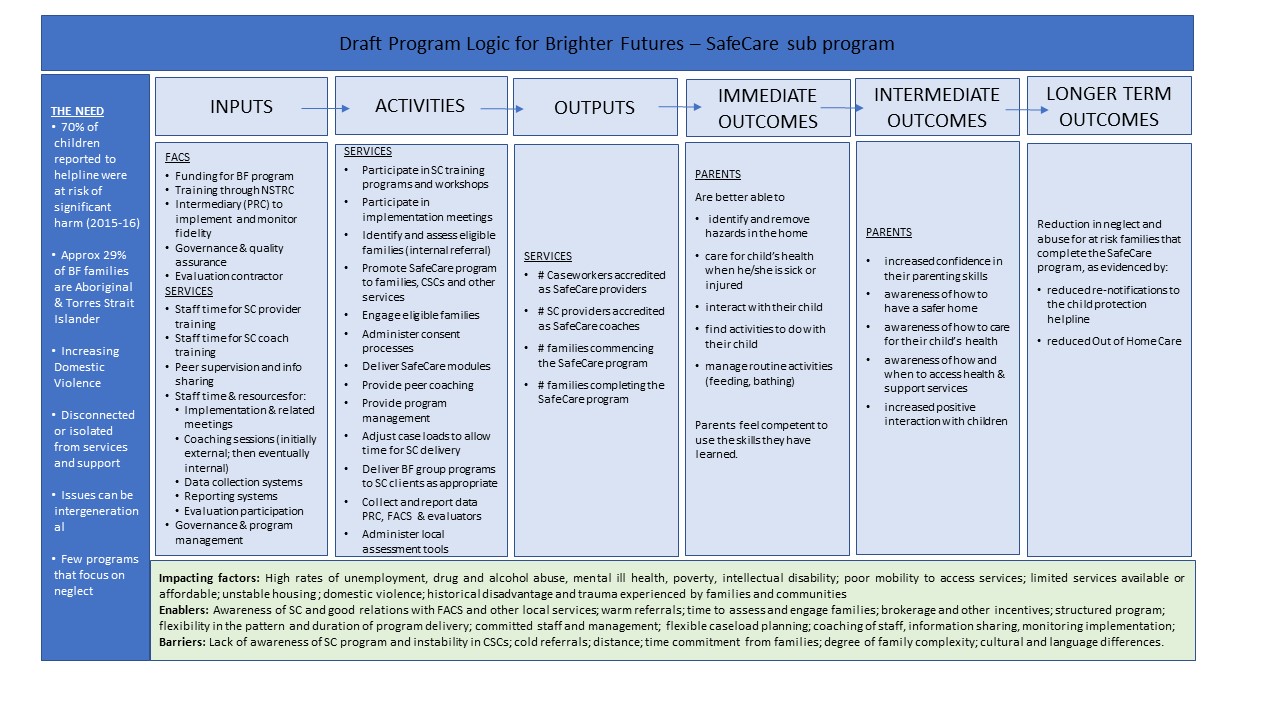
Table 23: OOHC within 12-months - sensitivity analyses by module completed

| **Analysis** | **Group@** | **Odds Ratio^** | | | **Wald Test^#** | |
| --- | --- | --- | --- | --- | --- | --- |
| **OR** | **95% CI** | | **Chi-Sq** | **P** |
| **ME; adjusted for correlation within family** | **SC: 0 modules completed** | 0.00 | 0.00 | 0.00 | 45.56 | <0.001 |
|  | **SC: 1 module completed** |  | 7.1e+32 |  |  |  |
|  | **SC: 2 modules completed** | 1.00 | 1.00 | 1.00 |  |  |
|  | **SC: 3 modules completed** | 1.00 | 1.00 | 1.00 |  |  |
| **ME; adjusted for correlation within Provider and family** | **SC: 0 modules completed** | 0.00 | 0.00 | 0.00 | 45.56 | <0.001 |
|  | **SC: 1 module completed** |  | 7.1e+32 |  |  |  |
|  | **SC: 2 modules completed** | 1.00 | 1.00 | 1.00 |  |  |
|  | **SC: 3 modules completed** | 1.00 | 1.00 | 1.00 |  |  |
| **ME; adjusted for correlation within family; Provider cluster variance** | **SC: 0 modules completed** | 0.00 | 0.00 | 0.00 | 29.22 | <0.001 |
|  | **SC: 1 module completed** |  | 1.4e+29 |  |  |  |
|  | **SC: 2 modules completed** | 1.00 | 1.00 | 1.00 |  |  |
|  | **SC: 3 modules completed** | 1.00 | 1.00 | 1.00 |  |  |
| **ME; one child per family; adjusted for correlation within Provider** | **SC: 0 modules completed** | 0.73 | 0.12 | 4.58 | 28.42 | <0.001 |
|  | **SC: 1 module completed** | 10.83 | 4.25 | 27.58 |  |  |
|  | **SC: 2 modules completed** | 1.00 | 1.00 | 1.00 |  |  |
|  | **SC: 3 modules completed** | 1.00 | 1.00 | 1.00 |  |  |
| **ME; adjusted for correlation within family, age, Referral Pathway, Provider cluster variance** | **SC: 0 modules completed** | 1.14 | 0.31 | 4.23 | 3.07 | 0.215 |
|  | **SC: 1 module completed** |  | 0.00 |  |  |  |
|  | **SC: 2 modules completed** | 1.00 | 1.00 | 1.00 |  |  |
|  | **SC: 3 modules completed** | 1.00 | 1.00 | 1.00 |  |  |
| **ME; adjusted for correlation within family, all covariates, Provider cluster variance** | **SC: 0 modules completed** | 1.14 | 0.31 | 4.23 | 3.07 | 0.215 |
|  | **SC: 1 module completed** |  | 0.00 |  |  |  |
|  | **SC: 2 modules completed** | 1.00 | 1.00 | 1.00 |  |  |
|  | **SC: 3 modules completed** | 1.00 | 1.00 | 1.00 |  |  |
| **GEE; adjusted for correlation within family** | **SC: 0 modules completed** | 0.36 | 0.05 | 2.65 | 9.82 | 0.007 |
|  | **SC: 1 module completed** | 11.13 | 2.21 | 55.97 |  |  |
|  | **SC: 2 modules completed** | 1.00 | 1.00 | 1.00 |  |  |
|  | **SC: 3 modules completed** | 1.00 | 1.00 | 1.00 |  |  |
| **GEE; one child per family; adjusted for correlation within Provider** | **SC: 0 modules completed** | 0.72 | 0.12 | 4.53 | 27.97 | <0.001 |
|  | **SC: 1 module completed** | 10.63 | 4.14 | 27.26 |  |  |
|  | **SC: 2 modules completed** | 1.00 | 1.00 | 1.00 |  |  |
|  | **SC: 3 modules completed** | 1.00 | 1.00 | 1.00 |  |  |
| *^Odds Ratios and Wald Test for all SafeCare Referrals relative to the Comparison Group #Wald test for overall significance of number of modules completed @Only includes those who completed SafeCare within follow-up period* | | | | | | |

Table 24: OOHC within 12-months - sensitivity analyses overall

| **Analysis** | **Group** | **Odds Ratio^** | | | **Wald Test^** | |
| --- | --- | --- | --- | --- | --- | --- |
| **OR** | **95% CI** | | **Chi-Sq** | **P** |
| **ME; adjusted for correlation within family** | **Referred to SafeCare** | 0.33 | 0.11 | 1.01 | 3.74 | 0.053 |
| **ME; adjusted for correlation within Provider and family** | **Referred to SafeCare** | 0.71 | 0.21 | 2.48 | 0.28 | 0.597 |
| **ME; adjusted for correlation within family; Provider cluster variance** | **Referred to SafeCare** | 0.33 | 0.12 | 0.92 | 4.49 | 0.034 |
| **ME; one child per family; adjusted for correlation within Provider** | **Referred to SafeCare** | 0.76 | 0.41 | 1.42 | 0.72 | 0.396 |
| **ME; adjusted for correlation within family, age, Referral Pathway, Provider cluster variance** | **Referred to SafeCare** | 1.73 | 0.54 | 5.53 | 0.85 | 0.356 |
| **ME; adjusted for correlation within family, all covariates, Provider cluster variance** | **Referred to SafeCare** | 1.85 | 1.03 | 3.32 | 4.31 | 0.038 |
| **GEE; adjusted for correlation within family** | **Referred to SafeCare** | 0.63 | 0.18 | 2.18 | 0.53 | 0.465 |
| **GEE; one child per family; adjusted for correlation within Provider** | **Referred to SafeCare** | 0.74 | 0.41 | 1.34 | 0.96 | 0.328 |
| *^Odds Ratios and Wald Test for all SafeCare Referrals relative to the Comparison Group* | | | | | | |

# Appendix C: Program Logic



1. Tune, D. (2018). Independent review of out of home care in New South Wales: Final report. Retrieved from <https://psa.asn.au/wp-content/uploads/2018/06/TUNE-REPORT-indep-review-out-of-home-care-in-nsw-ilovepdf-compressed1.pdf> [↑](#footnote-ref-2)
2. Durlak, J. A. (1998). Why program implementation is important. Journal of Prevention & Intervention in the Community, 17(2), 5-18. doi:10.1300/J005v17n02\_02 [↑](#footnote-ref-3)
3. Please note that the number of families offered the SafeCare program and thus the proportion of families who agreed to participate may be inaccurate due to challenges with this data. For more information about these challenges, please see Section 3.1.1 [↑](#footnote-ref-4)
4. Effect size calculated using the following formula: mean 1 – mean 2 / standard deviation pooled [↑](#footnote-ref-5)
5. Gershater-Molko, R. M., Lutzker, J. R., & Wesch, D. (2003). Project SafeCare: Improving health, safety, and parenting skills in families reported for, and at-risk for child maltreatment. Journal of family violence, 18(6), 377-386. [↑](#footnote-ref-6)
6. Rostad, W. L., McFry, E. A., Self-Brown, S.*,* Damashek, A., Whitaker, D. J. (2017). Reducing Safety Hazards in the Home through the Use of an Evidence-Based Parenting Program. *J Child Fam* Study,*25***,**2602–2609. doi: 10.1007/s10826-017-0756-y [↑](#footnote-ref-7)
7. Rogers-Brown, J. S., Self-Brown, S., Romano, E., Weeks, E., Thompson, W. W., & Whitaker, D. J. (2020). Behaviour change across implementations of the SafeCare model in real world settings*. Children and Youth Services Review, 117*. doi: 10.1016/j.childyouth.2020.105284 [↑](#footnote-ref-8)
8. Effect size calculated using the following formula: mean 1 – mean 2 / standard deviation pooled [↑](#footnote-ref-9)
9. Oppenheim‐Weller, S., Zeira, A., & Mazursky, N. (2020). Evaluating SafeCare® in Israel: Benefits for the families. Child & Family Social Work. [↑](#footnote-ref-10)
10. Gallitto, E., Romano, E., & Drolet, M. (2018). Caregivers' perspectives on the SafeCare® programme: Implementing an evidence‐based intervention for child neglect. Child & Family Social Work, 23(2), 307-315. doi:10.1111/cfs.12419 [↑](#footnote-ref-11)
11. National Society for the Prevention of Cruelty to Children. (2015). *SafeCare: Parent’s Perspectives on a home-based parenting program for neglect.* https://letterfromsanta.nspcc.org.uk/globalassets/documents/research-reports/safecare-parents-perspectives-report.pdf [↑](#footnote-ref-12)
12. Deković, M., Asscher, J. J., Hermanns, J., Reitz, E., Prinzie, P., & Van Den Akker, A. L. (2010). Tracing changes in families who participated in the home-start parenting program: parental sense of competence as mechanism of change. Prevention science, 11(3), 263-274. [↑](#footnote-ref-13)
13. Please note that due to rounding, the total costs shown in the table may not equal the sum of DCJ and Brighter Future agency costs. [↑](#footnote-ref-14)
14. Lutzker, J. R., & Bigelow, K. M. (2001). *Reducing child maltreatment: A guidebook for parent services*. Guilford Press. [↑](#footnote-ref-15)
15. Chaffin, M., Hecht, D., Bard, D., Silovsky, J. F., & Beasley, W. H. (2012). A statewide trial of the SafeCare home-based services model with parents in Child Protective Services. *Pediatrics*, *129*(3), 509-515. [↑](#footnote-ref-16)
16. Delivered since 2003. Currently, 16 NGO agencies deliver the Brighter Futures program to families across 29 agencies in NSW. [↑](#footnote-ref-17)
17. NSW Government. (2017). Guide to cost-benefit analysis. Retrieved from <https://arp.nsw.gov.au/tpp17-03-nsw-government-guide-cost-benefit-analysis> [↑](#footnote-ref-18)
18. There are challenges with the data recorded on a monthly basis which is the only source of data to determine the number of families who were offered SafeCare, the number who agreed to participate (although the number who commenced SafeCare can be determined through other sources), the number who declined to participate and the reason for this. Firstly, there are discrepancies between the number of families recorded as agreeing to participate in SafeCare and the number of families reported as commencing SafeCare (reported through Survey Monkey after a SafeCare session). Secondly, the number who agreed to participate and declined to participate does not equal the number who were offered SafeCare in some instances. Thirdly, there are months where Brighter Futures agencies failed to report this data. Therefore, this may not be a reliable source for determining these variables. [↑](#footnote-ref-19)
19. Number of families currently participating in SafeCare calculated by subtracting the number of families who have completed and exited the program early from the total number of families engaged in SafeCare. Please interpret this variable with caution as the values may be impacted by missing data. [↑](#footnote-ref-20)
20. Completion rate calculated by dividing the number of participants who completed the program by the total number of participants who either completed the program or exited the program early. [↑](#footnote-ref-21)
21. Remaining families after accounting for those who have completed or exited early. [↑](#footnote-ref-22)
22. Families who had a 6th session recorded for all three SafeCare modules. [↑](#footnote-ref-23)
23. Families who had been recorded as no longer engaged in SafeCare. [↑](#footnote-ref-24)
24. There are a total of three different scenarios in the Health module assessment that describe the different types of care required in response to health concerns: doctor’s appointment (DA), care at home (CH) and emergency department (ED). [↑](#footnote-ref-25)
25. All values and percentages are presented rounded to zero decimal places. Therefore, the score and percentage recorded may not exactly match. [↑](#footnote-ref-26)
26. Effect size calculated using the following formula: mean 1 – mean 2 / standard deviation pooled [↑](#footnote-ref-27)
27. Families are graded with *success* if they reach 85% success for the module, *mastery* if they reach 100% success for the module. For a score below 85% families are graded as *in progress.* For the health module, each family completes three scenarios. [↑](#footnote-ref-28)
28. The final grade was not recorded for 31 scenarios. [↑](#footnote-ref-29)
29. Families typically had scores recorded for three different rooms in the home. This could include any room such as kitchen, bathroom, child’s room, lounge room etc. [↑](#footnote-ref-30)
30. Effect size calculated using the following formula: mean 1 – mean 2 / standard deviation pooled [↑](#footnote-ref-31)
31. The final grade was not recorded for 14 rooms. [↑](#footnote-ref-32)
32. Families chose several different activities for the cPAT assessment including bedtime, play, mealtime, snack time, toileting, bath time and getting dressed. [↑](#footnote-ref-33)
33. Effect size calculated using the following formula: mean 1 – mean 2 / standard deviation pooled [↑](#footnote-ref-34)
34. The final grade was not recorded for 17 activities. [↑](#footnote-ref-35)
35. Families chose several different activities for the iPAT assessment including nap time, playtime, nappy change, mealtime, bath time, bouncer play, and getting dressed. [↑](#footnote-ref-36)
36. Effect size calculated using the following formula: mean 1 – mean 2 / standard deviation pooled [↑](#footnote-ref-37)
37. The final grade was not recorded for 14 activities. [↑](#footnote-ref-38)
38. Please note that due to rounding, the values do not add to 100%. [↑](#footnote-ref-39)
39. Please note that due to rounding, the values do not add to 100%. [↑](#footnote-ref-40)
40. Please note that due to rounding, the values do not add to 100%. [↑](#footnote-ref-41)
41. Please note that due to rounding, the values do not add to 100%. [↑](#footnote-ref-42)
42. National Implementation Research Network. (n.d.). Active Implementation Hub. Retrieved from [Active Implementation Hub | NIRN (unc.edu)](https://nirn.fpg.unc.edu/ai-hub) [↑](#footnote-ref-43)
43. A distribution of demographics by agency has not been provided to protect the confidentiality and privacy of the SafeCare families who participated in consultations. [↑](#footnote-ref-44)
44. Please note that due to rounding, the total costs shown in the table may not equal the sum of DCJ and Brighter Future agency costs. [↑](#footnote-ref-45)
45. Durlak, J. A. (1998). Why program implementation is important. Journal of Prevention & Intervention in the Community, 17(2), 5-18. doi:10.1300/J005v17n02\_02 [↑](#footnote-ref-46)
46. The number of families who accepted the offer to participate in the program is defined as those who commenced the program. [↑](#footnote-ref-47)
47. There are challenges with the data recorded on a monthly basis which is the only source of data to determine the number of families who were offered SafeCare, the number who agreed to participate (although the number who commenced SafeCare can be determined through other sources), the number who declined to participate and the reason for this. Firstly, there are discrepancies between the number of families recorded as agreeing to participate in SafeCare and the number of families reported as commencing SafeCare (reported through Survey Monkey after a SafeCare session). Secondly, the number who agreed to participate and declined to participate does not equal the number who were offered SafeCare in some instances. Thirdly, there are months where Brighter Futures agencies failed to report this data. Therefore, this may not be a reliable source for determining these variables. [↑](#footnote-ref-48)
48. Bolt, M. (2015). The Association of Participant Characteristics and Service Delivery with Program Completion Rates for SafeCare in Georgia. [↑](#footnote-ref-49)
49. Palmer, R. (2012). Assessing the Relationship between SafeCare Fidelity and Competence Measures. [↑](#footnote-ref-50)
50. Slemaker, A., Espeleta, H. C., Heidari, Z., Bohora, S. B., & Silovsky, J. F. (2017). Childhood injury prevention: predictors of home hazards in Latino families enrolled in SafeCare®+. Journal of pediatric psychology, 42(7), 738-747. [↑](#footnote-ref-51)
51. Barone, V. J., Greene, B. F., & Lutzker, J. R. (1986). Home safety with families being treated for child abuse and neglect. Behavior Modification, 10(1), 93-114. [↑](#footnote-ref-52)
52. Gershater-Molko, R. M., Lutzker, J. R., & Wesch, D. (2003). Project SafeCare: Improving health, safety, and parenting skills in families reported for, and at-risk for child maltreatment. Journal of family violence, 18(6), 377-386. [↑](#footnote-ref-53)
53. Rostad, W. L., McFry, E. A., Self-Brown, S.*,* Damashek, A., Whitaker, D. J. (2017). Reducing Safety Hazards in the Home through the Use of an Evidence-Based Parenting Program. *J Child Fam* Study,*25***,**2602–2609. doi: 10.1007/s10826-017-0756-y [↑](#footnote-ref-54)
54. Rogers-Brown, J. S., Self-Brown, S., Romano, E., Weeks, E., Thompson, W. W., & Whitaker, D. J. (2020). Behaviour change across implementations of the SafeCare model in real world settings*. Children and Youth Services Review, 117*. doi: 10.1016/j.childyouth.2020.105284 [↑](#footnote-ref-55)
55. Oppenheim‐Weller, S., Zeira, A., & Mazursky, N. (2020). Evaluating SafeCare® in Israel: Benefits for the families. Child & Family Social Work. [↑](#footnote-ref-56)
56. Gallitto, E., Romano, E., & Drolet, M. (2018). Caregivers' perspectives on the SafeCare® programme: Implementing an evidence‐based intervention for child neglect. Child & Family Social Work, 23(2), 307-315. doi:10.1111/cfs.12419 [↑](#footnote-ref-57)
57. National Society for the Prevention of Cruelty to Children. (2015). *SafeCare: Parent’s Perspectives on a home-based parenting program for neglect.* https://letterfromsanta.nspcc.org.uk/globalassets/documents/research-reports/safecare-parents-perspectives-report.pdf [↑](#footnote-ref-58)
58. Deković, M., Asscher, J. J., Hermanns, J., Reitz, E., Prinzie, P., & Van Den Akker, A. L. (2010). Tracing changes in families who participated in the home-start parenting program: parental sense of competence as mechanism of change. Prevention science, 11(3), 263-274. [↑](#footnote-ref-59)
59. Please note that due to rounding, the total costs don’t equal the sum of DCJ and Brighter Future agency costs. [↑](#footnote-ref-60)
60. Lima, F., Maclean, M., & O’Donnell, M. (2018). Exploring outcomes for young people who have experienced out-of-home care. International Journal of Population Data Science, 3(4). doi:10.23889/ijpds.v3i4.728 [↑](#footnote-ref-61)
61. Bushnell, A. (2017). Australia's criminal justice costs: An international comparison. Institute of Public Affairs. [↑](#footnote-ref-62)
62. Deloitte Access Economics. (2018). Extending care to 21 years in New South Wales. [↑](#footnote-ref-63)
63. Productivity Commission. (2020). Mental Health Inquiry Report Volume 2. Australian Government: Canberra. [↑](#footnote-ref-64)
64. FACSIAR Economics. (2020). Family and community services benefits menu. NSW Government. [↑](#footnote-ref-65)