Evaluation of Brighter Futures-SafeCare Program

Process Evaluation Final Report

February 2020

SIGGINS MILLER

Griffith UNIVERSITY

NDARC

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 program (BF-SC). The purpose of the evaluation is 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 will also assess the outcomes achieved for Aboriginal and/or Torres Strait Islander families engaged in the program.

Purpose of this report

This report is submitted in fulfilment of the deliverables for the Process Evaluation. The purpose of this report is to determine whether the SafeCare trial was implemented as intended and whether there were any unintended outcomes observed as a result of the SafeCare implementation (see *Attachment A: Evaluation Plan*).

Background

An independent review of the 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. The SafeCare model was identified as an appropriate response to this need. 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, 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 at risk of neglecting and/or abusing their children and parents with a history of child neglect and/or abuse with children 0 – 5 years.

A small trial of the SafeCare program began implementation in 2015, for three of the Wesley Mission sites in Western Sydney. As of October/November 2017, five additional sites (Wagga, Newcastle- Lake Macquarie, Illawarra, Orana Far West and Manning-Taree) began implementation. These eight sites were selected through a tender process and will continue to deliver the program until the end of 2020.

Methodology

The evaluation used a mixed-methods design, including:

- Desktop review,
- Analysis of existing quantitative data,
- Stakeholder interviews and focus groups and
- Stakeholder survey.

Data was triangulated from all sources to form a contribution story and answer the specified evaluation questions.

Conclusions

1. Was the trial implemented as intended?

a. Was the staff training program implemented as intended?

- There is evidence that the staff training program was implemented as intended. A total of 33 certified providers including 9 coaches were trained as of October 2019. Additionally, providers and coaches reported that the training enhanced their knowledge and skills.

- The availability of post-training support and coaching appears to have assisted SafeCare providers to translate skills learned into practice and improve delivery of the program.
- There is evidence to suggests that train-the-trainer models are an efficient and cost-effective method of delivering wide-scale training. As such, this may be an effective approach for ongoing training of SafeCare staff. This model may also support future sustainability of the SafeCare program. The outcomes of this model are not yet apparent thus, will be explored in the Outcomes Evaluation.
- The data suggest that the selection of suitable providers, with consideration for their willingness and motivation to deliver SafeCare, is important for engagement in training activities and wider delivery of the program.
- The findings suggest that the training videos were not reflective of a real-life scenario when delivering the SafeCare program. Additionally, the materials were not perceived to be representative of the Australian context.
- Additional skill building workshops were perceived to support the ongoing development of providers; however, this strategy was not adopted by all sites.
- Managers reported a lack of in-depth knowledge related to the SafeCare modules following their training.
- There is a potential shortage of certified coaches for some trial sites, which may limit their capacity to implement the train-the trainer model and reach the sustainability stage of implementation. For CatholicCare, most SafeCare providers were employed on a part-time basis which was not perceived to be suitable for the intensive nature of a SafeCare Coach position.

b. Was the SafeCare program implemented as intended?

- There is evidence suggesting that the SafeCare program has been successfully integrated into the existing Brighter Futures program in some sites, however providers continued to report challenges in incorporating SafeCare into their casework during sessions with families.
- Strategies to support the integration of SafeCare with Brighter Futures were established in one site, specifically the development of a Brighter Futures practice framework that is aligned with the SafeCare program. This was perceived to support providers to integrate SafeCare with Brighter Futures casework.
- There was a perceived lack of implementation support for the initial trial sites, which reportedly resulted in organisational change resistance and staff turnover. Since this time, intermediary agencies, the Parenting Research Centre (PRC) and the National SafeCare Training and Research Centre (NSCTRC), have been established to support implementation efforts. All agencies agreed that support provided by intermediaries, including staff training, provision of implementation resources and establishment of central and local implementation team meetings, has been beneficial.
- The implementation of SafeCare appears to have improved over time and the program is now accepted as usual practice.
- Central and local implementation team meetings were perceived to be beneficial for the implementation of the SafeCare program, however the frequency of these meetings appears to increase process burden for agencies.
- A number of challenges were experienced in relation to data collection and reporting requirements. These activities were perceived to be excessive and a number of issues were

reported with regard to receiving inaccurate data reports, the absence of data tracking mechanisms and the inability to report contextual information related to a drop out.
- There have been changes to the machinery of government since the SafeCare trial began that will need to be considered alongside evaluation findings.

c. Did the trial reach the targeted population?

- Data for family demographics and complexity was not available at the time of the Process Evaluation, however, will be explored in the Outcomes Evaluation.
- The findings suggest that there were inconsistencies between sites for when the program was offered to families, due to differing perspectives of family readiness or suitability for the program.

d. Were families successfully engaged in the program?

- There is evidence that families were successfully engaged in the SafeCare program. As of October 2019, 97 families had completed SafeCare and 92 families were currently participating in SafeCare across the sites. Overall, 27% of eligible families were engaged in the program.
- The health module had the highest completion rate (143 families completed), followed by the safety module (119 families completed) and the parent interaction module (130 families completed).
- Family engagement was supported by the flexible delivery of the program, working collaboratively with families to align SafeCare to their needs, and allowing families to choose which module to begin with.
- Preliminary outcomes such as improved confidence, safety behavior, health awareness and parent-child interaction were observed.
- The findings suggest that 45 families declined to participate in SafeCare between February and September 2018 because it was perceived to be too intensive, they did not want home visits, or they did not want to engage in a parenting program all together. The rate of declining participation in SafeCare was not reported following September 2018.
- Of the 357 families that commenced the SafeCare program, 168 families dropped out prior to program completion as of October 2019. A recent study of a SafeCare trial in the United States revealed similar rates of drop out, with 18% of the 266 families participating in some level of intervention but not completing all three modules and 35% participating in baseline data collection but not completing the intervention.[1] Research also suggests that high dropout rates are common in child maltreatment intervention and research programs.[2]
- Reasons reported for dropping out of the program include leaving the wider Brighter Futures program, leaving the area, lack of time, illness in the family or child removed from care.
- Ineligible or cold referrals from local DCJ services hindered efforts to successfully engage families in the SafeCare program.
- The findings suggest that issues such as family crises and instability in the home were common among the target population for the program. These issues often posed barriers to successful engagement as families were preoccupied or experiencing emotional distress.

[1] 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.

[2] Hansen, D. J., Warner-Rogers, J. E., & Hecht, D. B. (1998). Implementing and evaluating an individualized behavioral intervention program for maltreating families. In *Handbook of Child Abuse Research and Treatment* (pp. 133-158). Springer, Boston, MA.

e. What are the barriers and enablers to program fidelity?

- There is evidence that program fidelity was achieved throughout the implementation of SafeCare.
- The findings suggest that program fidelity was supported by the clear structure of the SafeCare materials, the regular processes built into program delivery to assess program fidelity, and the support offered by coaches and intermediary agencies to implement and deliver the program as intended.
- Consultations identified elements of the program materials that were not perceived to be appropriate in the Australian context and for all families. This resulted in the adaption of program materials and potential variation in how the program was delivered across sites.
- Non-program related factors such as long travel distances to access families, characteristics of the target population such as mental health issues and learning delays and provider willingness and motivation to deliver the SafeCare program were reported to impact the effectiveness and timeliness of SafeCare program delivery. In addition, the limited resourcing of the program was reported to have implications for ongoing delivery and sustainability of the program.

2. Were there any additional or unanticipated outcomes from the SafeCare implementation, and have these created benefits or limitations to the delivery of the SafeCare program?

- The findings suggest that positive unintended outcomes were observed as a result of the SafeCare implementation. These include an increased interest in education among participating parents and an increased sense of achievement and recognition for parents.
- Recent research studies suggest that SafeCare may lead to a number of unintended positive outcomes such as reduced parental depression and anxiety/stress, and improved parental self-esteem and relationships with partners. At this stage of the evaluation, there is not enough evidence to determine whether SafeCare in this context leads to the outcomes listed, however, this will be explored in more detail in the Outcomes Evaluation.
- Potential unintended negative outcomes were also observed as a result of the implementation of SafeCare, including organisational change resistance and turnover in initial trial sites and increased burden on staff as a result of data collection and reporting requirements. However overall, the findings suggest that new and existing staff have adapted well to the implementation of the SafeCare model.

Recommendations

To improve the implementation and delivery of the SafeCare trial moving forward, we provide the following recommendations.

Implementation of the SafeCare trial

1. Consideration could be given to documenting any effective strategies that have been implemented by sites to support their staff to deliver the SafeCare program (i.e. additional skill building workshops, practice frameworks). This information would assist other agencies in their delivery of the program; would help promote continuity between sites; and help to inform any future roll out of the program. This information could be disseminated using pre-established communication channels to reduce process burden for participating sites, such as central implementation team (CIT) meetings.
2. The Department, in consultation with NSCTRC and PRC, could consider reducing the frequency of the implementation team meetings for trial sites to reach a balance between local and central implementation team meetings.

Training

3. We recommend that managers are provided with the opportunity to gain more in-depth understanding of the SafeCare program and modules.

Program Referrals

To improve the appropriateness of referrals:

4. The Department may wish to consider the development of a resource that outlines appropriate client pathways for local DCJ services. This could be delivered alongside any planned promotion or advertisement activities for local DCJ services.

Family Engagement

5. We recommend that the Department, in consultation with NSCTRC and agency representatives, develop clearer guidelines outlining family suitability for SafeCare. This may help to ensure a consistent approach for when the program is offered to families between different sites.
6. The Department, in consultation with NSCTRC, may wish to consider exploring the evidence-base for the delivery of individual SafeCare models.

SafeCare materials

To improve the relevance and appropriateness of training and program materials for all participating families, we recommend that:

7. The training materials be adapted to better reflect the Australian context and to ensure they are applicable to the realities of delivering SafeCare in Australian homes. For example, removing the safety hazard of drowning in the toilet and including information regarding the use of sunscreen. In doing so, there should be consultation with providers to understand common challenges in delivery of SafeCare and this information should be included in a revised version of the facilitator guide.
8. The materials be adapted to include culturally responsive and safe content for Aboriginal and/or Torres Strait Islander families. This should include consultation with Aboriginal and/or Torres Strait Islander community members and community-controlled services.
9. Consideration be given to translating the materials into other languages to support program completion among families from culturally and linguistically diverse backgrounds.
10. Additional visual content be included in the SafeCare materials to support program completion among families with an intellectual disability or learning delays.

Data collection and reporting

To improve internal data collection and reporting activities conducted as part of the SafeCare trial, we recommend that:

11. The data collection activities be reviewed and streamlined to reduce process burden for participating trial sites. This should be done in consultation with representatives from agencies to gauge the depth and breadth of information they find useful in the data reports.
12. A regular review cycle of the data collection processes be implemented bi-annually, for quality improvement purposes.
13. The Department, in consultation with PRC, investigate the source for inaccuracy in the data reports and develop strategies to mitigate the issues identified.

14. There is an opportunity for staff to provide context about a family drop out in the data collection tools. This could be limited to a free text box. This information could be used to develop clearer guidelines of what constitutes a drop out and inform strategies to maintain family engagement.
15. Consideration could be given to the option for providers to report a 'good news story' to PRC. One story could then be selected for presentation in the CIT data reports to provide context of the positive outcomes achieved for families.

Sustainability

16. The Department may wish to consider the findings of this evaluation and engage in consultation with those sites who are experiencing challenges in establishing certified coaches in their agency. The aim of this consultation should be to develop strategies to further support the agency. These strategies could be informed by lessons learned from other more mature sites who have effectively overcome these barriers.

Contents

1. 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 conduct an evaluation of the Brighter Futures-SafeCare program (BF-SC).

The purpose of the evaluation is to:

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

The evaluation will also assess 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.

1.2 Purpose of this Report

This report is submitted in fulfilment of the deliverables for the Process Evaluation. The purpose of this report is to provide findings and recommendations in relation to the key Process Evaluation questions. The Process Evaluation questions are:

- Was the trial implemented as intended?
    - Was the staff training program implemented as intended?
    - Was the SafeCare program implemented as intended?
    - Did the trial reach the targeted population?
    - Were families successfully engaged in the SafeCare program?
    - Was program fidelity achieved?
- Were there any additional or unanticipated outcomes from the SafeCare implementation, and have these created benefits or limitations to the delivery of the SafeCare program?

For more detail of the data strategy matrix and the program logic, see *Attachment A: Evaluation Plan.*

2. Background

In response to the growth of the Out-of-Home-Care (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.[3]

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.

The *SafeCare* model was identified in the independent report as an appropriate response to address these issues. 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. Studies cited in the report have concluded that SafeCare has the potential to support parents to provide their children with appropriate care and to keep families together.

Additionally, 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,

[3] *Their Futures Matter: a new approach* (2015) https://www.childabuseroyalcommission.gov.au/sites/default/files/WEB.0189.001.1036.pdf

when compared to mothers who did not receive SafeCare.[4] 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.[5]

As the model was developed in the USA, an evaluation is required to ensure that it works within the NSW context and is appropriate for the needs of Aboriginal and Torres Strait Islander Families.

2.1 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 (BF-SC)*. Brighter Futures is a longer established program[6] that delivers voluntary targeted intervention services to families with at least one child under the age of nine living at home, where concerns of risk of significant harm have been raised for those families. The SafeCare program targets a sub-set of Brighter Futures clients: parents at risk of neglecting and/or abusing their children and parents with a history of child neglect and/or abuse with children 0 – 5 years. 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.

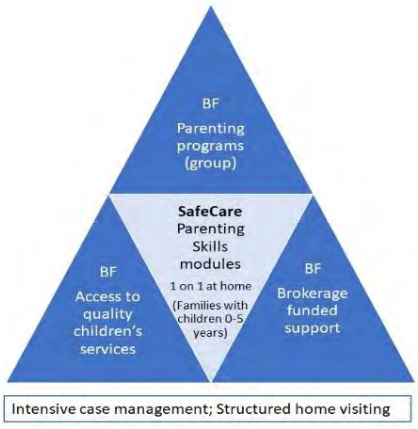

Figure 1: The SafeCare program as a sub-program of Brighter Futures (BF)

[4] Lutzker, J. R., & Bigelow, K. M. (2001). *Reducing child maltreatment: A guidebook for parent services*. Guilford Press.
[5] 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.
[6] Delivered since 2003. Currently, 16 NGO agencies deliver the Brighter Futures program to families across 29 sites in NSW.

2.2 The Trial of the SafeCare Model

A small trial of the SafeCare program began implementation in 2015 for three Wesley Mission sites in Western Sydney (Blacktown, Cumberland and Napean). Five additional sites (Wagga Wagga, Newcastle-Lake Macquarie, Illawarra, Orana Far West and Manning-Taree) began implementation in October/November 2017. The eight trial sites (managed by 6 NGO agencies) were selected through a tender process.

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 parent-child interaction, 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.

The SafeCare trial will continue until the end of 2020.

For more detail of the BF-SC approach, see *Attachment B: Desktop Review.*

3. Methodology

As outlined in the proposed methodology (*Attachment A - Evaluation Plan*), the evaluation team will use a mixed-methods, quasi-experimental evaluation design, called a Stepped Wedge Design (SWD), to evaluate the program itself and the impact of the program on family outcomes.

The Process Evaluation will make use of the mixed-method approach, while the Outcomes Evaluation will use the stepped-wedge design to determine the overall impact of the Brighter Futures-SafeCare program.

Process Evaluation Methodology

The project team used a mixed-methods approach to collect and analyse data to address the evaluation questions. Activities conducted as part of this Process Evaluation have demonstrated that the data collection strategy required further refinement, both from a conceptual and practical point of view.

The Process Evaluation questions, and the data sources required to answer them, are better conceptualised as sub-questions of a higher, overarching question. Further, based on the data collected throughout this Process Evaluation and limited access to some of the intended data sources, it was identified that a refinement of data sources was required to adequately answer each evaluation question. Please see *Attachment A: Evaluation Plan* for the detail of the evaluation questions, sub-questions and data sources required to answer them.

3.1 Data Sources

The following section provides an overview of the data sources used to answer the Process Evaluation questions and sub-questions.

The following data was used to inform the Process Evaluation:

1. Analysis of PRC raw data sets/central implementation team (CIT) reports
2. Analysis of CIT coaching reports
3. Desktop research
4. Stakeholder interviews and focus groups
5. Stakeholder survey

The purpose of including these data sources is outlined in the relevant section below.

3.1.1 Quantitative Data

PRC data sets

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

- Number of families engaged in Brighter Futures, who are eligible for SafeCare
- Proportion of Brighter Futures families engaged in SafeCare
- Total number of families who have completed SafeCare
- Total number of families who dropped out of SafeCare
- Reasons for families disengaging from SafeCare
- Reasons for families declining 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

Another source of data provided for the Process Evaluation are the CIT coaching reports. These reports provided the following information:

- Number of active providers
- Number of coaches
- Number of families being served
- Number of providers who have completed one module towards certification
- Number of providers who have completed two modules towards certification
- Number of SafeCare certified providers
- Number of inactive SafeCare providers
- Number of SafeCare providers who have left the agency

This data was used to count activities and outputs and answer specific questions of the Process Evaluation.

3.1.2 Qualitative Data

Desktop research

The evaluators examined all available documents provided by DCJ and the PRC regarding the planning and implementation of the SafeCare program in NSW (see *Attachment B: Desktop Review*). In addition, a desktop review of peer reviewed and grey literature related to the development, implementation and evaluation of the SafeCare program in other jurisdictions and countries was conducted. These data sources were used to inform evaluation questions related to the implementation and delivery of the program in the current content.

Stakeholder interviews and focus groups

As part of the Process Evaluation data collection, consultations were conducted with participating agencies, NSCTRC, PRC and DCJ to gather insights about program implementation, delivery and preliminary outcomes. A convenience sampling method was used. This is a non-probability method where people are sampled because they are convenient or reachable. This method was used to engage all possible stakeholder groups relevant to the SafeCare program and maximise the data available to the Process Evaluation. Given the small number of participating agencies, this method enabled Siggins Miller to access an adequate number of stakeholders across each agency, site and staffing role.

Siggins Miller coordinated with the agencies currently delivering SafeCare to schedule interviews and focus groups with SafeCare providers, team leaders, coaches and managers. Siggins Miller subsequently coordinated with staff from NSCTRC, PRC and DCJ to conduct interviews. 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 overview of stakeholders consulted, their role and consultation method see Table 1.

The purpose of the consultations with participating agencies was to explore:

- 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 the initial outcomes for families.
- Any initial unanticipated outcomes from the SafeCare implementation.
- Barriers and enablers to engaging services in implementing the program with fidelity.

Consultations were held between May 2019 and July 2019.

Table 1. Overview of sample for interviews and focus groups

Participating SafeCare Agencies		
Site	Staff involved in consultations	Number of consultations
Barnardos	2x Managers 4x SafeCare Providers	2x focus groups 1x individual interview
CareSouth	1x Managers 3x SafeCare Providers 1x SafeCare Coaches	2x focus groups
CatholicCare	1x Managers 4x SafeCare Providers	1x focus group 1x individual interview
Mission Australia	2x Managers 2x SafeCare Providers 1x SafeCare Coaches	1x focus group 2x individual interviews
Samaritans	2x Managers 10x SafeCare Providers	1x focus group 1x individual interview
Wesley Mission	5x Managers/ Coordinators 1x SafeCare Provider (Blacktown) 2x SafeCare Team Leaders (Blacktown) 3x SafeCare Providers (Cumberland) 3x SafeCare Team Leaders (Cumberland) 3x SafeCare Providers (Napean) 3x SafeCare Team Leaders (Napean) 4x SafeCare Coaches/ SafeCare specialist	5x focus groups
Other Stakeholder Groups		
Agency	Staff involved in consultations	Number of consultations
National SafeCare Training and Research Centre	1x staff member	1x individual interview

Parenting Research Centre	2x staff members	1x focus group
Department of Communities and Justice	1x staff member	1x individual interview

Stakeholder survey

In addition to stakeholder interviews and focus groups, Siggins Miller created and distributed a survey to managers, coordinators and team leaders at each of the SafeCare trial sites. The survey aimed to gather opinions about staff turnover and its association with the implementation of SafeCare. At the time of this evaluation report, eight staff had completed the survey from the six agencies (see Table 2).

Table 2. Overview of sample for survey

Site	Survey respondents
Barnardos	2x Managers
CareSouth	Manager
CatholicCare	Manager
Mission Australia	Manager
Samaritans	1x Coordinator
Wesley Mission	2x Manager/ Specialist

3.2 Data Analysis

3.2.1 Quantitative Data Analysis

Quantitative data was investigated at both a program and site-level. Data was analysed using descriptive statistics and is presented in frequencies and proportions.

3.2.2 Qualitative Data Analysis

Thematic analysis was conducted of the interviews, focus group and survey responses to identify common themes and patterns; and to provide an in-depth understanding about the Brighter Futures- SafeCare program operation; the nuances of program success; and to inform the evaluation findings and conclusions.

4. Limitations of Data

During the initial stages of this Process Evaluation, it was identified that access to *FACS administrative data sets* would be interrupted. Between February 2019 and August 2019, Siggins Miller were advised that there would be delays in accessing routine data collected by FACS (previously in DoCS Connect (KiDS-CIW) and from mid-2018 in the new system Child story). On the 28th August 2019, Siggins Miller received notification that we were able to continue with the application process for access to the *FACS administrative data.* Siggins Miller in collaboration with our partners in the National Drug and Alcohol Research Centre (NDARC) submitted an ICT Risk Assessment – Data Request to the Department on the 4th September 2019. Approvals for the release of data were received in the week beginning the 11th November 2019.

Due to the delays in accessing this data, analysis of *FACS administrative data sets* will only be included in the draft interim outcome evaluation report due to the Department on the 31st July 2020; and in the final evaluation report due on the 26th February 2021.

4.1 Limitations to the quantitative data provided

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

- Inconsistencies in the data reported for the number of *active families, completed families, disengaged families, and certified providers.* A prominent issue that was identified is that the number of active families reported in the CIT data reports often does not match the number of active families reported in the coaching report **for the same month**.
- For data outlining *active providers, certified providers* and *inactive providers* in coaching reports, it is difficult to determine how these variables have been calculated for each site and whether the same formula has been used for each site.

Inaccuracies between the CIT data reports, and CIT coaching reports may be due to either differences in the origins of the raw data, or inaccuracies in the way the data is populated for reports.

We also note there has already been discussion with the Department and PRC about issues in the way the data is presented in the CIT data reports. We will continue to work collaboratively to review the raw data sources and the presentation of data in reports with the aim of identifying areas for improvement.

5. Findings

This section outlines the key findings from data collection to date, including quantitative data provided in CIT raw data/monthly reports and CIT coaching reports; as well as qualitative data obtained from stakeholder consultation activities.

5.1 Staff Training

5.1.1 Delivery of training to staff

As of October 2019, a total of 33 certified providers including 9 coaches, were employed across the agencies commissioned to deliver the SafeCare program. CareSouth employed the largest number of certified SafeCare providers, followed by Wesley Mission, Samaritans, Barnardos, Mission Australia and CatholicCare (see Figure 2). The agency with the largest number of SafeCare certified coaches was Wesley Mission, followed by CareSouth, Samaritans, Mission Australia, Barnardos and CatholicCare (see Figure 2). Across the agencies, a total of 22 staff members were currently undertaking training towards SafeCare certification.

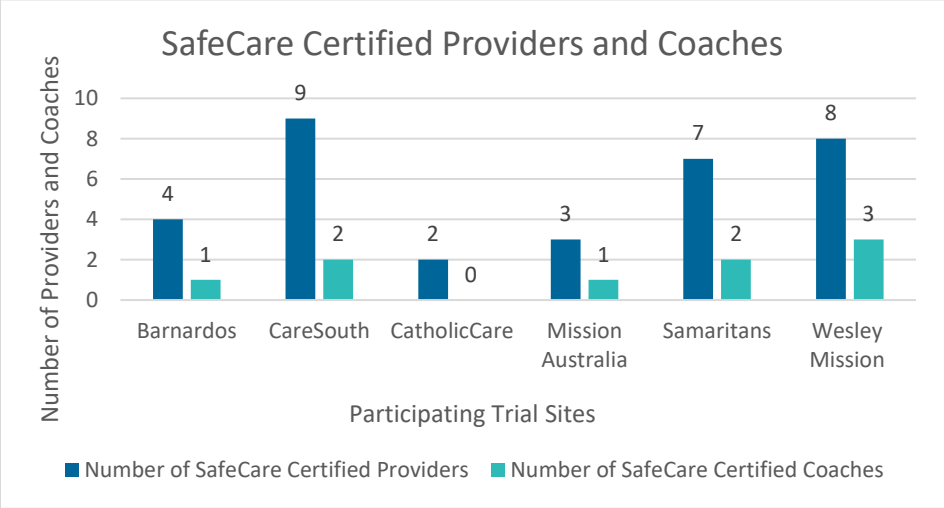

Figure 2: Number of Certified Providers and Coaches
**Data presented as of October 2019.*
**The number of certified providers includes coaches.*

5.1.2 Post training support for providers

During consultations, it was noted that providers had access to a number of avenues of support following the SafeCare training. Staff consistently reported that they received guidance and support from SafeCare coaches, who gave feedback on program delivery and assisted staff in working through challenges they experienced when delivering the SafeCare modules. It was also noted that PRC provided coaching support for approximately 12 providers from two agencies at the time of consultations, because these agencies did not have the capacity for internal SafeCare coaches.

It was also noted that the NSCTRC followed up with providers after the SafeCare training to discuss potential improvements to their program delivery. In addition, staff from NSCTRC reported offering advice to assist providers in managing their caseload and the integration of Brighter Futures with SafeCare.

The monthly coaching meetings were also perceived to assist SafeCare providers in their delivery of the program. These meetings were found to beneficial for both providers and coaches, providing a platform to share common challenges that occur during program delivery and strategies to overcome them. Providers also reported that the webinars and peer-reviewed articles offered by PRC with the support of longer standing agencies were a useful resource that assisted with translating training into practice.

5.1.3 Training materials and content

SafeCare coaches reported that they are able to adapt their training delivery to support providers in making the SafeCare materials more relevant to the Australian context. Coaches also reported assisting providers to understand the additional challenges that may be present in the delivery of the program, as the training videos often did not reflect a real-life scenario.

5.1.4 Effectiveness of training

Based on the data available to the evaluation, the training appears to be effective in preparing agency staff to deliver the SafeCare program. Data from interviews suggests that these training sessions improved the knowledge and skills of providers and coaches, enabling them to deliver the program. Furthermore, coaches reported that the training enhanced their ability to facilitate provider training and support providers.

Although managers and coordinators reported that the training was effective in providing them with an overview of the program, some managers indicated that they would benefit from additional training to understand the specifics of the SafeCare modules and their intended delivery. Managers suggested that this additional information would allow them to better support providers, identify appropriate referrals, manage resource allocation and undertake workforce planning. While this was identified as a potential limitation of the training, it was mitigated by attending one-on-one meetings with the SafeCare specialists or the SafeCare team meetings.

In addition, one agency reported incorporating additional strategies to encourage continuous upskilling of SafeCare providers. According to consultation data, Wesley Mission coaches held additional skills-building days to discuss challenges in SafeCare delivery with providers and deliver additional practical training for the SafeCare modules. These sessions were perceived to be beneficial as they refined the skill-base of SafeCare providers and increased managers' understanding of the program. Further, coaches reported that SafeCare providers enjoyed these sessions and as a result, there had been an increase in positive conversations about the SafeCare program.

It is also evident from interviews with the NSCTRC that training delivery has improved over time by identifying lessons learned from previous training implementation. For example, introducing the *Expression of Interest* process was perceived to improve training delivery, as staff appeared to be more enthusiastic and engaged in training. DCJ also commented that it is important to consider an individual's willingness and motivation to deliver SafeCare when selecting SafeCare providers.

5.2 Implementation

Interviews with all stakeholders revealed that the implementation of the BF-SC program has been largely successful.

Following the challenges that were experienced at the initial trial sites (i.e. Wesley Mission), the PRC and NSCTRC were established as intermediaries to support the implementation of SafeCare. In line with good practice and implementation science, the Department has supported the implementation of this program and the maintenance of its' fidelity, through providing resources and support at the provider level, the organisational level and the system level. All agencies reported that PRC and NSCTRC have been active in supporting ongoing staff training, local and central implementation meetings, webinars, and change frameworks. All agencies interviewed, including representatives from DCJ, agreed that the support from the PRC and the NSCTRC has been beneficial and effective. In addition, providers described the value of coaching meetings provided by NSCTRC during the implementation process of SafeCare.

5.2.1 Data collection and reporting requirements

Based on the information available to the evaluation team, it appears that the current data collection, reporting and monitoring process acted as barriers for implementation of the program. Interviews with

PRC revealed that the purpose of data collection and monitoring processes is to inform decision-making throughout implementation. While PRC viewed this data as important for the local and central implementation teams, the amount of data collected is viewed as excessive by providers. In addition, agency staff noted instances where errors were reflected in the data reports received, which increased workload for them to retrieve the accurate information. Interviews also revealed that there is no tracking mechanism for the data submitted. As such, it can be difficult for agencies to access their data for the purposes of data cleaning or checking.

In addition, challenges were noted with the IT platforms used to upload the data. A provider from Mission Australia explained that a portal was initially developed to upload audio files. However, this was then changed to using Dropbox, followed by the use of another data system that was then removed, all of which did not allow providers to upload the required information. Managers reported that no clear data collection strategy was organised during the initial implementation of the trial, however that data collection methods have improved.

Finally, agency staff reported that specific data fields included in the spreadsheets provided to the PRC, do not allow enough context. Specifically, the 'Drop-out' field does not allow for further information regarding the reasons a family has exited the program. Importantly, SafeCare provider from CareSouth reported that a 'drop-out' does not necessarily constitute a negative outcome for families and further clarification is sometimes needed to provide contextual information. Information provided in an implementation team meeting also suggested that the fields for a drop out, for example 'left the Brighter Futures program' and 'moved out of the area' were not always mutually exclusive which has implications for the accuracy and consistency of what is reported. Furthermore, staff suggested that it would be beneficial to highlight the success of when a family completes one module in the data reports, as this is still a positive outcome.

> *"A family dropped out because of removal of children… but this was a success as the children were still being looked after. It was relinquishment, as the mother realised, she wasn't capable or able to look after her children and she needed help. It's considered a drop out in our stats, but we still feel it was a success for us. We are still getting the outcome that benefits the children."*
>
> - SafeCare Provider, CareSouth

5.2.2 Cooperation between the funding body and participating agencies

NSCTRC identified that the level of dedication and cooperation between the funding body and the agencies has been an important factor contributing to the successful implementation of SafeCare.

> *"I'm going to say that this implementation of Brighter Futures-SafeCare is one of our most successful implementations, it's been done very well, and I really attribute it to fact that the funders are heavily involved. I think a lot of times, there's a disconnect between the people who are funding the programs and the actual program implementation and so I feel like because [DCJ] are so involved and because they're so dedicated to the program, that's why it's been run and been so successful. There are places where I can definitely see it can be more successful, especially with the number of families served, I'd like to see that number go up. But I would say it's a very successful implementation..."*
>
> - NSCTRC

Data from interviews suggests that both local and central implementation team meetings were beneficial in the implementation of SafeCare. These meetings allowed frequent and continued conversation of the SafeCare program as well as discussion of implementation issues. These meetings also allowed NSCTRC to

provide implementation guidance when necessary. However, as some agencies have matured in their capacity to provide SafeCare, they note that for them, the frequency of these meetings could be reduced as they are beginning to be seen as an unnecessary level of process burden. The Department could consider requiring intense involvement early in the implementation and then reducing the level of involvement as agencies report confidence and maturity in their processes. Importantly, an opportunity exists for those mature agencies to assist in the mentoring of less-experienced agencies to provide guidance during initial stages of implementation. Therefore, the Department could consider transitioning mature, more experienced agencies to a mentoring role whereby they assist and support other agencies in the implementation of the SafeCare, if SafeCare is to be scaled.

5.3 Program Delivery

The data provided to the evaluation indicates that as of October 2019, the average number of Brighter Futures families eligible for SafeCare ranged from 31 to 229, depending on the agency. The agency with the largest number of eligible families was Wesley Mission, followed by Mission Australia, CareSouth, Barnardos, Samaritans and CatholicCare (see Figure 3).

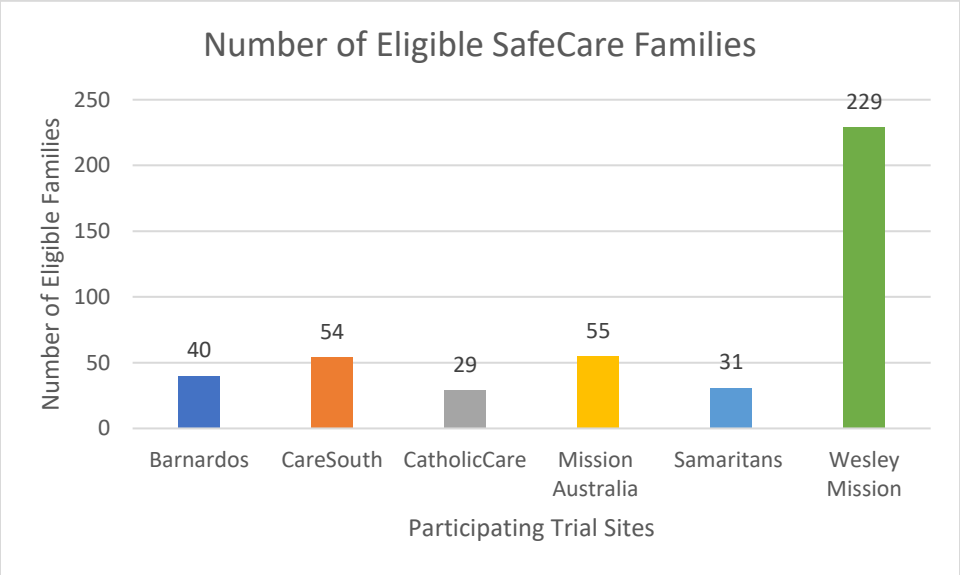

Figure 3: Number of eligible SafeCare families.
**Data presented as of October 2019.*
**Data was not available for CatholicCare in the October CIT report, therefore the data presented for CatholicCare is as of September 2019.*

Across these agencies, on average between 15% and 58% of eligible families were engaged in the program, see Figure 4. The agency with the highest percentage of families engaged was Samaritans, followed by CareSouth, CatholicCare, Barnardos, Mission Australian and Wesley Mission. Data was not available for CatholicCare in the October monthly CIT report. As per advice from the DCJ, the optimal target for the delivery of SafeCare to eligible families is 50%. However, it was acknowledged that at this stage of implementation, agencies are unlikely to have the current capacity to reach this target. In response, train-the-trainer sessions and workshops have begun to be implemented, to support the workforce capacity of services and increase the number of families engaged in the program.

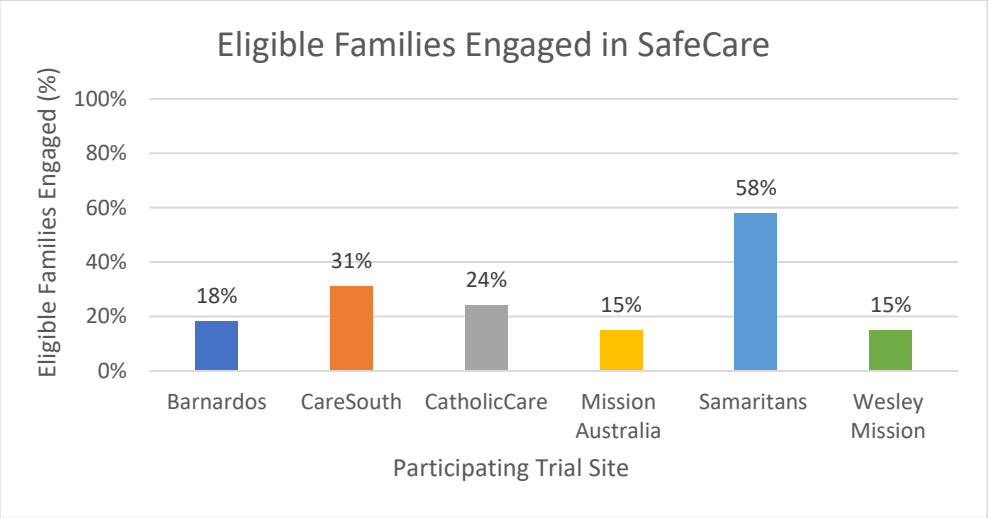

Figure 4 Current proportion of Brighter Futures families engaged in SafeCare.
**Data presented as of October 2019.*
**Data was not available for CatholicCare in the October CIT report, therefore the data presented for CatholicCare is as of September 2019.*

The average caseload for agency providers was determined by the ratio of active families to active providers, which gives some insight into the capacity of the workforce to deliver SafeCare to a higher number of families. Although it is noted that this estimate does not consider the employment type of providers (i.e. whether providers are employed in a full time or part time position). During the period under evaluation, the average SafeCare caseload for providers was reported to be between 1.8:1 and 2.7:1, see Figure 4. However, findings from consultations highlighted that SafeCare providers may also provide case management to families outside of the SafeCare program. Data outlining the overall caseload for SafeCare providers was not included as a primary source of information during the initial planning phase for the evaluation (see the data strategy matrix in *Attachment A*: *Evaluation Plan)* therefore this data was not available to the evaluation. However, the findings suggest that this data will be important to understanding the impact of caseload on the capacity of agencies to increase the number of families engaged in SafeCare. We propose a discussion with the Department to determine the level of access to this information for future evaluation activities to inform the Outcomes Evaluation.

As outlined in the SafeCare Site Guide from the NSCTRC, the recommended caseload for 0.5 Full-time equivalent (FTE) is six to eight families and for 1 FTE is 12 to 15 families. Although, determining the optimal caseload for SafeCare providers in this context would need consider the Australian context, particularly for regional and remote settings. Consultation data suggests that for some sites, travel time between appointments can exceed up to two hours which may limit the number of families that can be serviced by each provider.

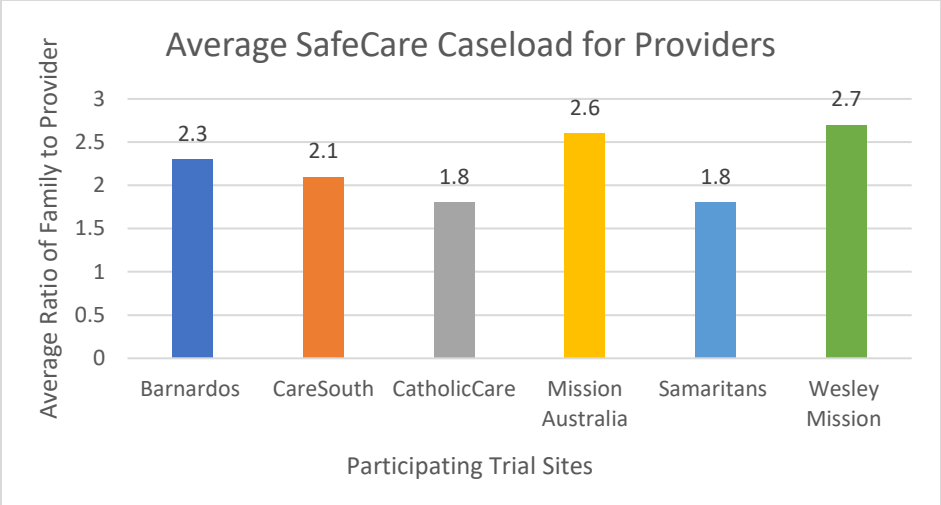

Figure 5: Average Caseload Expressed as a Ratio of SafeCare Families to SafeCare Provider
**Data presented as of October 2019.*

Data from consultations further suggested several factors that were important for program delivery and that may have limited capacity to increase the number of families receiving SafeCare. These are:

- The number of certified SafeCare providers,
- Staff workload, and
- Provider suitability.

5.3.1 Number of certified providers

Based on the data available to the evaluation, it appears that the limited number of providers trained in SafeCare was a barrier for agencies to meet the required contact numbers for SafeCare. As of October 2019, between two and nine staff were certified SafeCare providers across the agencies. Furthermore, eight staff members in total were inactive providers of SafeCare (seven of these staff members were currently taking leave and one staff member did not have any active SafeCare families at the time). In addition, staff reported that there was a limited number of spaces available at each stage of training. Agency staff believed that this limited their ability to train more providers, which ultimately impacted the delivery of the SafeCare program. During the period of consultation, we note that training opportunities for coaches have increased and it is the intention of DCJ that additional providers will be trained in the immediate future. Therefore, these efforts will be explored in future evaluation activities.

> *"As I said, even I would say for me, with my accredited providers I would love to offer it to some of our other families in our program we just don't have the capacity."*
>
> - Manager, Barnardos

5.3.2 Staff workload

Interviews consistently highlighted the challenges for providers integrating SafeCare with case management. Additionally, NSCTRC and the participating agencies reported that SafeCare increased provider case management loads and stated that more time and preparation is required to deliver SafeCare compared to other programs. One provider from CareSouth suggested that when delivering SafeCare the case load should be counted as 1.5 families. Interview data further outlined that these factors ultimately impact a providers' ability to deliver SafeCare. A Manager from Samaritans also commented that the additional workload has not been factored in by DCJ when determining the

contracted number of SafeCare families, which may lead to staff burnout and a reduction in the quality of casework.

When reflecting on these issues, NSCTRC reported offering support to agencies on a management level to assist with the integration of SafeCare and case management, but that the solution is often reducing case load. They further suggested that reducing case load may enhance providers' motivation to deliver the program. While interview data suggests that resourcing is currently a consideration for DCJ, no immediate solutions had been identified as further resourcing would depend on the evidence of SafeCare outcomes. This information suggests that more consideration may need to be given to managing caseload for the SafeCare program.

> *"I have to say with the current model that we're asked to deliver and also with the expectation of meeting the number of families that we actually hold in our program… seeing a team here with full caseloads and then delivering SafeCare on top… I have noticed the difference in the last couple of years, probably in staff stress around time, they're really pushed for time in delivering the two under this current model."*
>
> - SafeCare Provider, Samaritans

Despite these issues, interview data suggests that the integration of SafeCare and case management has led to positive outcomes. A manager from Mission stated that they had observed problems when the SafeCare provider and case worker were two different staff members, including a lack of communication and handover between the staff. Additionally, providers at Barnardos and CareSouth who have provided SafeCare separately to casework and as an integrated service reported that they found the integration of SafeCare and case work more effective. This is because the integrated approach increased rapport and allowed a greater understanding of the family's needs.

5.3.3 Provider suitability

Interviews consistently highlighted that provider suitability is an important consideration for the effective delivery of the SafeCare program. Specifically, provider enthusiasm, engagement and motivation to deliver SafeCare were identified as important factors for successful program delivery. Agency managers further commented that the structure of the program may not be suited to all providers. Therefore, agency managers used strategies to select suitable SafeCare providers, such as expression of interest processes and initial conversations with providers to discern their level of enthusiasm about SafeCare.

5.4 Family Engagement in the SafeCare Program

Based on the findings from consultations, there are differing views regarding family engagement and participation in the SafeCare program. The success of efforts to engage families in the program appears to be determined by complex factors that are both program-related and non-program related. The SafeCare program is a voluntary program which means agencies need to be creative in how to engage and retain families. The strategies utilised by agencies appear to be improving over time.

As of October 2019, between 7 and 34 families were currently participating in SafeCare across the agencies. The agency with the largest number of participating families was Wesley Mission, followed by Samaritans, CareSouth, Mission Australia, Barnardos and CatholicCare (see Figure 6). At this time, between 6 and 35 families had completed SafeCare across the agencies. The agency with the highest reported completions was Wesley Mission, followed by CareSouth, Samaritans, CatholicCare, Barnardos and Mission Australia (see Figure 6).

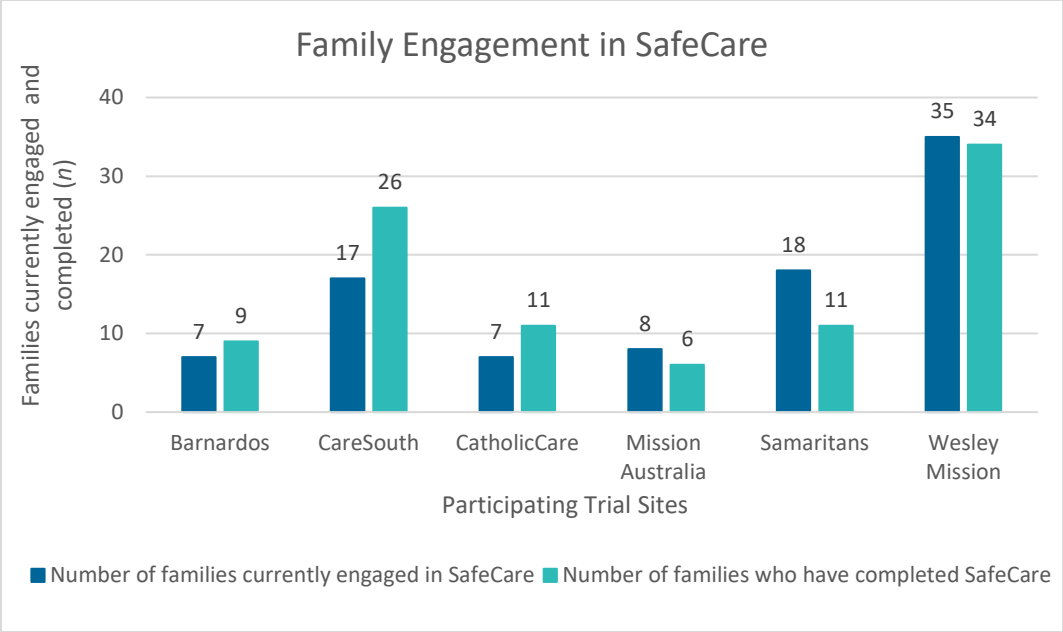

Figure 6 Number of families currently engaged in SafeCare and number of families completed SafeCare.
**Data presented as of October 2019.*

The number of families who had disengaged from SafeCare as of October 2019 ranged between 11 and 82, depending on the agency. The agency with the highest number of disengaged families was Wesley Mission, followed by Samaritans, Mission Australia, CareSouth, Barnardos, and CatholicCare (see Figure 7). According to the data, the most common reason for disengaging from SafeCare was leaving Brighter Futures, followed by other, moving out of the area, illness in the family and child removed from care.

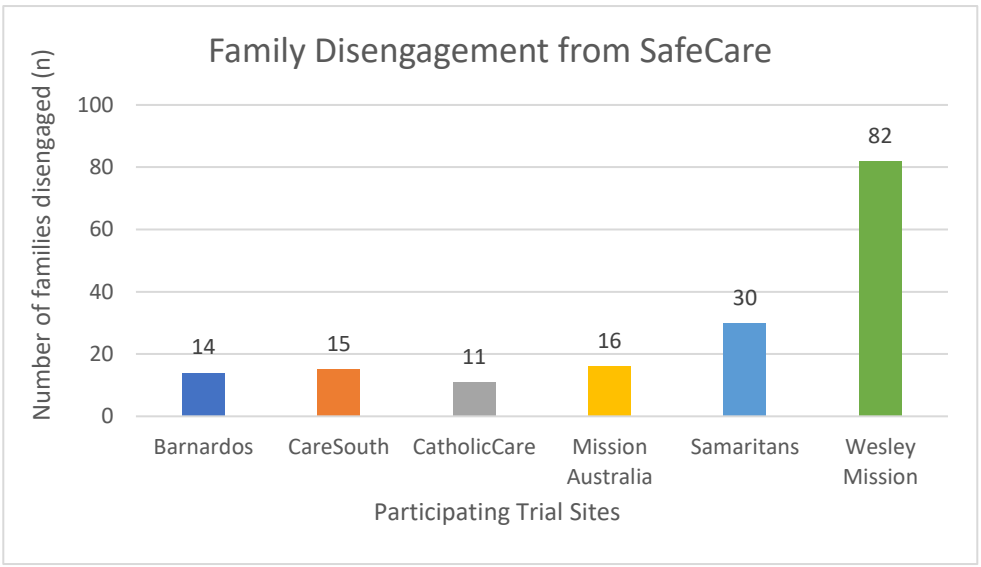

Figure 7 Number of families disengaged from SafeCare.
**Data presented as of October 2019.*

Relative to the overall number of families who had participated in SafeCare as of October 2019, the proportion of families who had disengaged ranged from 26% to 54% depending on the site. CareSouth

had the lowest proportion of families disengage from the program, followed by CatholicCare, Barnardos, Samaritans, Mission Australia and Wesley Mission (see Figure 8).

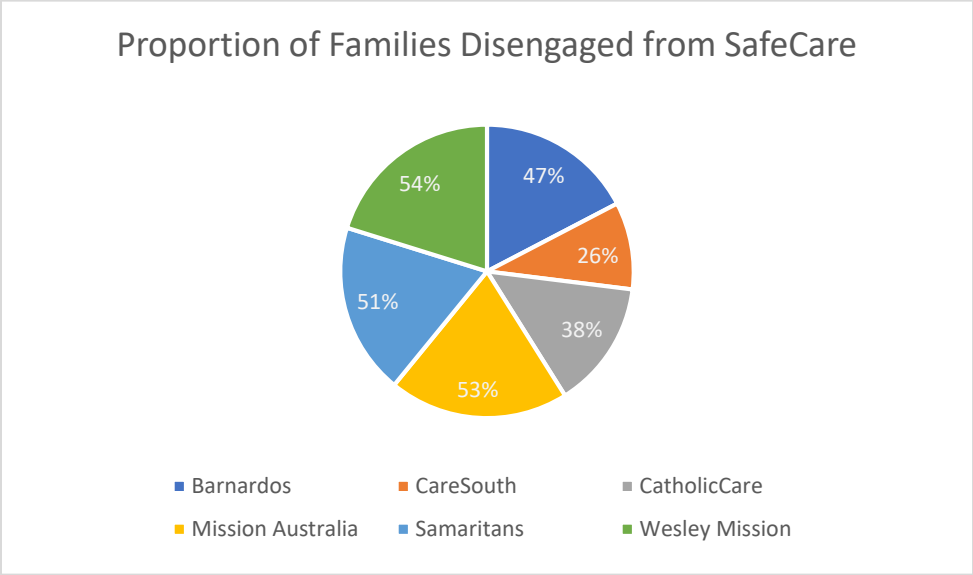

Figure 8 Proportion of families disengaged from SafeCare.
**Data presented as of October 2019.*

Between February and September 2018, a total of 45 families were recorded as having declined invitation to participate in SafeCare. The most common reason given was other (29), program too demanding (7), not wanting a parenting program (4), not interested (3), or not wanting home visits (2; see Figure 9).

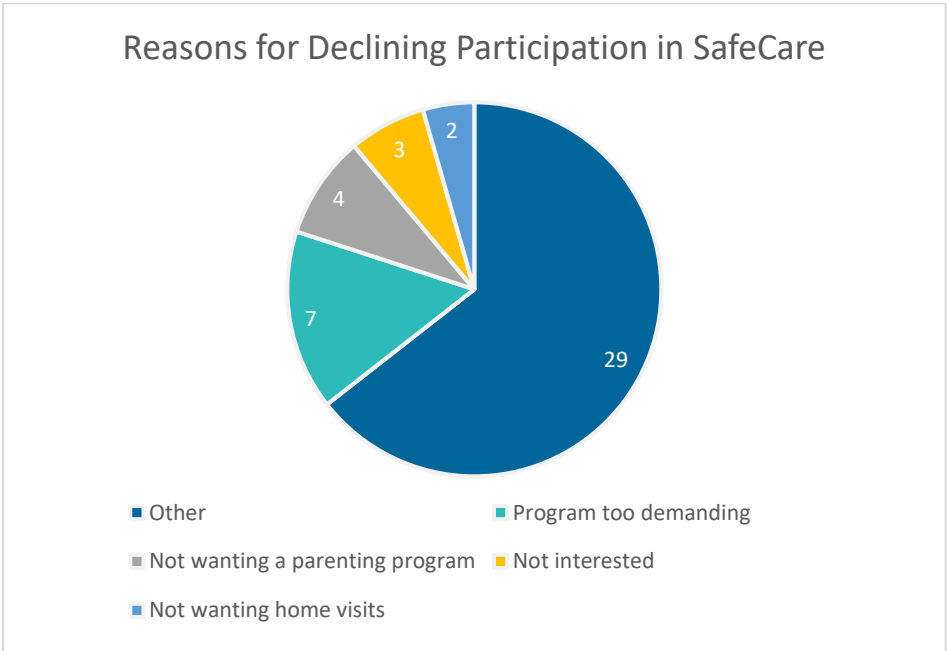

Figure 9 Reasons for declining participation in SafeCare
**Data presented for February to September 2018. Rates of declining participation in SafeCare were not recorded past September 2018.*

Based on the data available to the evaluation, participation in the SafeCare program appears to vary substantially by site. The variation appears to be due to factors such as organisational capacity, workforce capacity and time involved in SafeCare.

5.4.1 Appropriateness of referrals

Consultation data highlighted that the style of referral (*warm* or *cold*) and appropriateness of referral to the SafeCare program can impact efforts to engage families. In this context, cold referrals were described as referrals to SafeCare without initial contact with the family. Warm referrals were described as when the family is aware of the referral to SafeCare and information may already be known about the family. Warm referrals were described by Samaritans staff to be instrumental in fostering rapport with the family and their readiness to be in the SafeCare program. Samaritans staff also stated they had been receiving more cold referrals recently, which lead to a perceived higher turnover of families as referrals had been made but the families were unable to be engaged by SafeCare providers. Managers from Wesley Mission also highlighted that cold referrals may negatively impact family engagement, as providers do not understand the family's situation, cannot assess a family's readiness and may struggle to adapt the SafeCare program to the family as needed.

> *"The challenge that we, and other agencies offering Brighter Futures face is that the majority of referrals that come to us are a cold referral. A family doesn't even know that we are going to knock at their door, so to then integrate something like SafeCare can be challenging for these highly complex families. Are they engaged? Are they not? For the referrals that we are getting for Brighter Futures, are they suitable for Brighter Futures to start with? And, if there is doubt there, there is going to be serious doubt about SafeCare."*

Cold referrals were noted as a particular issue for Wesley Mission by managers and DCJ. Managers from Wesley Mission reported that a large majority of their referrals are cold referrals. They believe that this presents a challenge whereby the suitability of the family for Brighter Futures and consequently their suitability for SafeCare, is unclear. When discussing the issues of cold vs. warm referrals, DCJ staff acknowledged that cold referrals have been a factor contributing to the occurrence of issues for an agency. DCJ staff also echoed that Wesley Mission have been receiving cold referrals and complex families which are barriers to SafeCare effectiveness and family participation. Cold referrals were perceived to be a system issue and noted as a problem that requires DCJ's attention, yet resourcing was considered a barrier to addressing this problem.

Agencies also reported that local DCJ staff are often not aware of the eligibility requirements when referring to the SafeCare program, meaning a number of families referred to program have been ineligible. Specifically, referrals sent from DCJ were ineligible due to open child protection plans, or if the family was escalating in their level of risk and case complexity, and therefore were not ready for the SafeCare intervention. Agency staff suggested that value could be added to the delivery of the program if local staff at DCJ were given a richer understanding of the program and its capabilities for the purpose of referral. DCJ staff clarified that more education was needed internally to improve understanding of the SafeCare program and the eligibility criteria. In addition, it was noted in an implementation meeting that programs are often rolled out in silos, and that mapping of available services may assist with directing future program referrals.

5.4.2 Family readiness

SafeCare providers, team leaders and managers indicated that overall, the efforts to engage families in the program have been successful. However, reports emerged in consultations that family readiness is a key determinant of whether a family successfully engages with the program. Readiness is impacted by a

number of different factors, which include ensuring that the safety and needs of the family are a priority before attempting to engage them with SafeCare. A manager from CatholicCare reported that for families to engage with the program in a meaningful way, it is important to address their complex needs during case management first. Agencies reported that offering SafeCare to families prematurely can result in a failure to engage families due to a lack of family readiness, and that this does not mean that families are not engaged with SafeCare at all, but that the timing of engagement is a key consideration.

Additionally, Mission Australia staff indicated it is important to recognise if a family is suitable and ready for the SafeCare program before introducing it to them, to ensure initial engagement and continued participation. Staff suggested that caseworkers were improving in their ability to identify when a family was ready for SafeCare.

Respondents from CatholicCare stated that when the right families were chosen to participate in the SafeCare program, their efforts to engage them had been more successful, estimating approximately 70% success rates. Although, it was identified that having complex, high-risk families can cause more difficulty in engaging them in the program initially. SafeCare providers reported that engaging a family before they are ready can further initiate feelings of low self-esteem and low self-worth should the parent's performance be affected by their availability or capacity to engage in the modules.

Crisis Factors

Various other agencies also highlighted that crisis factors can be a barrier to family readiness to be in the SafeCare program. Samaritans staff identified that being new to casework often meant the family might not yet be ready for a parenting program and issues such as criminal matters, homelessness and mental health were barriers to readiness for the program. This considered, providers reported doing their best to overcome barriers.

> *"I had one family who was homeless and didn't have any accommodation and we actually delivered [SafeCare] in McDonalds. It doesn't necessarily need to be in the home it just needs to be somewhere that's mutually agreeable."*
>
> - Provider, Samaritans

Timing and Rapport

Differing views exist about the appropriate time to offer SafeCare to families. Barnardos staff indicated that family readiness and timing was an important factor to enable engagement in the SafeCare program. It was noted, that offering the program to families towards the end of their participation in Brighter Futures has resulted in unintended outcomes. In some circumstances, SafeCare had been offered to families who were nearing their completion of the wider Brighter Futures program which meant that their time in case management was extended. According to interviews, this meant that agencies were not able to offer a place to an additional family due to limited workforce capacity and concerns were raised about the contractual implications of this approach.

Conversely, some agencies reported beginning conversations with families directly after receiving an initial referral. They reported that as providers, they were encouraged to offer the program to families early in the process. If crises exist, some SafeCare providers reported that they continue to strongly encourage families to engage with SafeCare alongside case management. These agencies recognised that issues such as risk of homelessness, violence, substance misuse, or poor mental health can make it difficult to deliver the program, but that the focus should be on the benefit of the program to the safety of the children in families.

Rapport was also a key factor in family engagement. Staff stated they would attempt to build trust, rapport and interest in the SafeCare program with the family before they considered introducing it. It was reported that this was important as it helped overcome barriers, such as some elements of the program being perceived as formal or intimidating, for example coming into the home, using a recorder and having a clip board.

Other barriers to engagement in SafeCare

A SafeCare provider from Barnardos identified that many of the families referred to the program by local DCJ services experience high-risk drug and alcohol use or have current matters with child protective services. System-level non-program factors relating to family engagement will be discussed in a later sub-section, though some factors affecting engagement unrelated to the program itself that have been reported by families to agencies include:

- Competing priorities
- Leaving the area for an extended period due to hospital admission
- A lack of time to be in the program.

Family Suitability

Related to the effects of timing and family readiness on family engagement is decisions on the eligibility of a family to start the SafeCare program. Wesley Mission Cumberland providers reported that in the initial implementation of SafeCare, there was a push to provide SafeCare to every family. However, they now follow a more collaborative approach which involves having a conversation with the family to determine if they want to complete the program and to consider whether it aligns with their goals. Wesley Mission Cumberland providers also reported that their service has criteria for family suitability and that they hold weekly allocation meetings to assess which families are eligible for SafeCare. It was noted that eligibility depends on crisis or other issues occurring in the home and whether it is the right time to offer the SafeCare program.

> *"If the family wants to do it, they are going to do it. If they see value in it then they are going to attend but if we are pushing it on them then they are not really going to finish it and they are not going to be engaged in it."*
>
> \- SafeCare Provider, Wesley Mission (Cumberland)

During interviews with agencies, the establishment of a preliminary assessment period within the SafeCare program was suggested. In their view, this could serve as an initial triage point to determine the readiness and willingness of the family to engage. A SafeCare provider from Barnardos added that this timeframe could also provide an opportunity to build rapport with the family and establish their goals for the program should they wish to engage. According to initial suggestions provided during interviews, a time period of 3-6 weeks would be sufficient to conduct initial assessments and potentially address the acute needs of families.

As per the eligibility criteria for the Brighter Futures Service Provision Guidelines,[7] families are not eligible for a Brighter Futures service or program, if there is:

- Significant risk of harm to the child's safety;
- There are indications of long-standing, deliberate physical or psychological abuse or ongoing risk of child sexual abuse or harm;

[7] Brighter Futures Service Provision Guidelines. (2017). Department of Family and Community Services.

- A household member or carer has become the subject of criminal proceedings;
- A current care order exists for the child or Guardianship orders are in place;
- The safety of staff is compromised; or
- Families that have Key Information Directory System (KiDS) Case Plans.

Based on these criteria, it is appropriate to consider the readiness of families to engage in the SafeCare program during times of crisis and periods of intensive case management may be required. However, opportunities to engage families in the intervention early in the process should remain the focus of case management, as even the process of engagement is therapeutic.

Agency staff's practices of gauging eligibility before engaging families in the SafeCare program contrasts views expressed by DCJ and the NSTRC. During consultations, respondents from DCJ and NSTRC believed that the SafeCare program should be progressing away from a voluntary opt-in program to mandatory participation by families involved in Brighter Futures. The contrast in opinions on how families should participate in SafeCare suggests clear guidelines may need to be established in the future to ensure consistency among participating agencies. Further, the effect of increasing participation would need to be assessed against family engagement, outcomes and agency resources.

5.4.3 Program structure and delivery

Program Structure

SafeCare providers and coaches commonly highlighted the structure and consistency of the SafeCare program as a strong enabler to family engagement and participation. According to interviews, the SafeCare program provides a clear plan for the family, ensures the objectives of the program are communicated and that each session is goal oriented. Additionally, SafeCare providers reported that parents experience an increase in confidence when reaching these goals, which further encourages their participation in the program. Having measurable goals also assisted the delivery of SafeCare by helping providers track progress with families. For example, one Barnardos provider noted that a parent had separated with their partner due to domestic violence and the SafeCare program was instrumental in assisting the mother to have structure and goals and build her confidence through small "wins". Wesley Mission Coaches explained that the structure and goal directed objectives of the program allow families to receive positive and corrective feedback which gives them confidence and empowers them to improve their skills. Further, modelling the behaviours for families provides them with opportunities to practice and receive feedback, which has promoted conversations and enhanced engagement.

Agency staff noted that the SafeCare program is consistent and predictable for families and the small achievements involved in progressing through the modules creates additional buy-in. The benefit of these small wins can inform recommendations for how providers may be able to adapt their delivery to increase family engagement and participation. For example, creating smaller wins within the sections of modules for families who progress at a slower rate (e.g. due to developmental delays or intellectual disorders), in order to keep families engaged with the SafeCare program.

Program Length

Consultation data highlighted that families may be reluctant to commit to an extensive 18-week program, which may negatively impact the initial uptake and continued participation in SafeCare. Consultations with agencies highlighted that the ability to offer the modules independently may help to overcome barriers associated with the time commitment and improve initial engagement. NSCTRC also suggested it may be easier to engage a family by offering a single module and then once it is completed, offer additional modules.

"[The time commitment] is often a barrier I find. It's three modules and you are signing them up for another program, [as] Brighter Futures is a program in itself. You're asking them to take part in another program as well. And in that program, we are looking at a good 16 weeks at best, I think it's a lot longer, if you account for sickness or other things that occur during that time… it can be a bit drawn out."

Data outlining the completion rates of different modules was not available to the evaluation, although will be analysed as part of future evaluation activities. Anecdotally, CatholicCare providers indicated that they prefer to start with the health module as a "softer entry," because they perceived this module to be less intrusive, more conversational and it provides the opportunity to build rapport with the family.

SafeCare Materials

Overall, agency respondents reported that the materials are effective learning aids which assist families to meet the outcomes of the SafeCare program. However, staff at all levels stated that materials could be improved to reflect the Australian context, diverse cultural backgrounds and intellectual capabilities of families. Staff suggested that it may be beneficial to make the materials less generic and include representations from diverse cultural backgrounds or elements of Indigenous art. One provider noted that they attempt to provide additional culturally relevant resources where applicable. During consultations it was also suggested that translated versions of the training materials could assist progression through the training modules for families that speak a language other than English.

Additionally, a coach from Wesley Mission suggested that coaching materials could be improved by including examples that reflect Australian Brighter Futures families. In line with this, a provider from CareSouth reported that they included additional content into the health module such as the need for sunscreen, Aloe Vera and insect repellent as specific needs for Australian families. A manager from Barnardos also described how they have learned that families with intellectual difficulties need more visual material to progress efficiently through the SafeCare program. Therefore, it was suggested that the materials could be improved to accommodate these needs.

Despite these suggestions, interview data from NSCTRC highlighted that the materials were developed to be culturally neutral and that it is the job of the provider to adapt their words, expression and tone to make the materials more relevant for the family.

Provider Suitability and Flexible Delivery

Based on the information gathered from agency staff, DCJ and the NSTRC, family participation in the SafeCare program appears to be supported by adapting the SafeCare program to meet the needs of families, provider suitability, provider experience and capability (e.g. ability to build rapport).

The findings from consultations suggest that SafeCare providers, under the supervision of team leaders and coaches, attempt to tailor the SafeCare program to the needs of individual families by altering the order of modules delivered while still maintaining program fidelity. For example, SafeCare providers from Samaritans often involved families in decision-making for which SafeCare module they would like to complete first. They believe that this promoted the enthusiasm of families to participate in the program and that if the families recognise the benefits of completing the first module, they may be more likely to complete the rest of the program. CareSouth respondents also commented that one of the reasons why they considered SafeCare had been successful was because it could be adapted to fit the unique needs of families, while being both structured and measurable.

With such factors in mind, it may be valuable to promote the uptake of flexibility in module order and delivery with respect to a family's needs. Consideration could also be given to mapping the capabilities and competencies of high performing SafeCare staff to aid decision making around provider suitability. DCJ noted that to improve provider suitability they allow agencies to decide who will be trained. Although some agencies do not have the ability to choose due to the limited number of providers, those that do may benefit from a structured competency and capability framework for SafeCare providers.

While the flexibility of the program does allow providers to adapt and tailor the program to suit the needs of families, issues with fidelity still need to be considered. For example, providers and agencies have considered creative and innovative solutions to population factors affecting engagement, such as delivering SafeCare in McDonalds or in the agency office for consumers who are experiencing homelessness. While this allows the case manager to deliver aspects of SafeCare to the family despite the existing restraint of homelessness, the effectiveness of the delivery of SafeCare might be compromised. For example, as part of the safety module, families are required to identify for hazards in the home, and this might not be possible to do in McDonalds practically, and instead might need to be spoken about through conversation. Further consideration should be given to solutions for systemic problems affecting engagement. The nature of delivering Brighter Futures and SafeCare together means that flexibility is often required. However, staff highlighted that it is important to be able to remain on track with the SafeCare program during sessions, rather than being continually distracted by case management issues. It was reported that it can be difficult for providers to set these boundaries within their SafeCare sessions, but that this is important for family engagement in the program.

5.4.4 Characteristics of participating families

During consultations all respondents noted that key reasons for families disengaging from the SafeCare appear to be population based. According to interviews, examples of complex issues that affect a family's capacity to engage in the SafeCare program include:

- Mental health crises
- Involvement with child protective services
- Alcohol and substance use
- Homelessness
- Domestic violence
- Involvement in the criminal justice system

In instances where non-program related issues arise, providers attempted to workshop these issues with the families and instead, place the family 'on hold' so they may return to the program after the crisis has been addressed. Based on the findings from consultations, the reasons for families being placed 'on hold' during the program, are consistent with the reasons identified for families not wanting to continue with the program. According to data from interviews, issues that contribute to a family being placed 'on hold' include:

- Domestic violence
- Alcohol or substance use
- Pregnancy
- Involvement with the criminal justice system
- Homelessness
- Health issues

Population based factors were found to be consistent barriers to the continued participation of families in the program. A barrier to the triangulation of the data at present is that there no ability to specify why

a family disengaged when providers input this into the survey monkey responses. This is discussed in more detail in *Section 5.2.1: Data collection and reporting requirements.*

5.5 Family Outcomes

5.5.1 Program outcomes

Based on the preliminary findings, participation in the SafeCare program appears to lead to positive changes for families. However, the degree of success or mastery achieved by families varies across the participating sites.

According to information provided by NSCTRC, a family receives a grade of '*Success'* if the parent has positively demonstrated the majority of activities or behaviours under assessment. In this case, the parent may still need to improve in some areas. A family receives a grade of '*Mastery'* if they positively demonstrate ***all*** activities or behaviours under assessment for that module. For more information about the assessment rubric, see *Attachment B*: *Desktop Review.* The following section presents the findings for the number of success and mastery module completions as well as the average rates of success and mastery for SafeCare module completions during the period under evaluation. Based on data provided by the PRC between August 2018 and October 2019, the number and average rates of success or mastery for a module, varies considerably across individual modules and across participating sites.

For the SafeCare Safety module, CareSouth reported the largest number of mastery module completions for families, followed by Wesley Mission, CatholicCare, Samaritans, Barnardos and Mission Australia (see Figure 10).

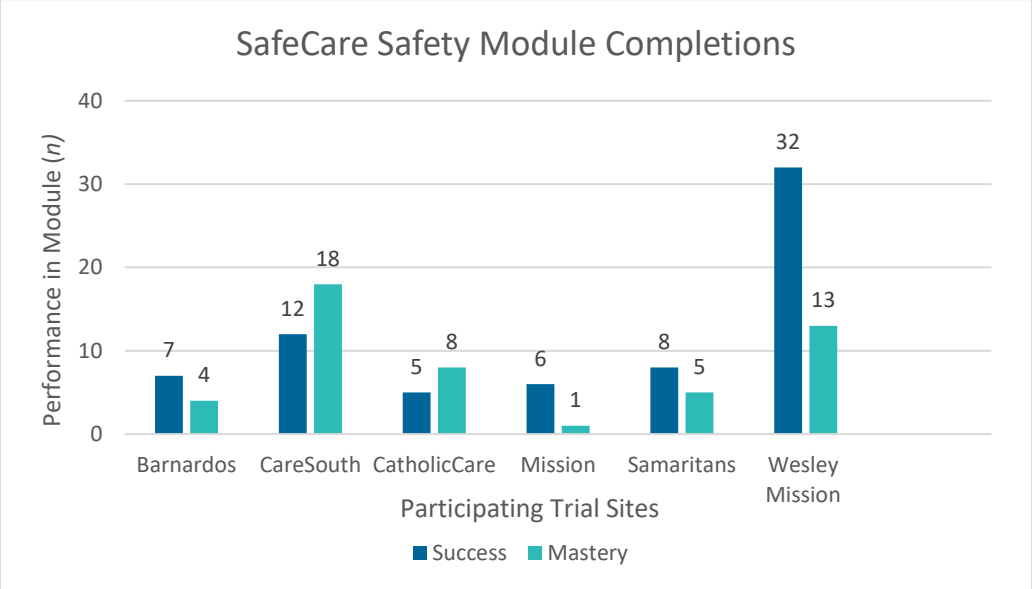

Figure 10: SafeCare Safety Module Performance
**Data presented as of October 2019.*

On average, CatholicCare and CareSouth reported the highest rates of mastery for families, followed by Samaritans, Barnardos and Wesley Mission and Mission Australia (see Figure 11).

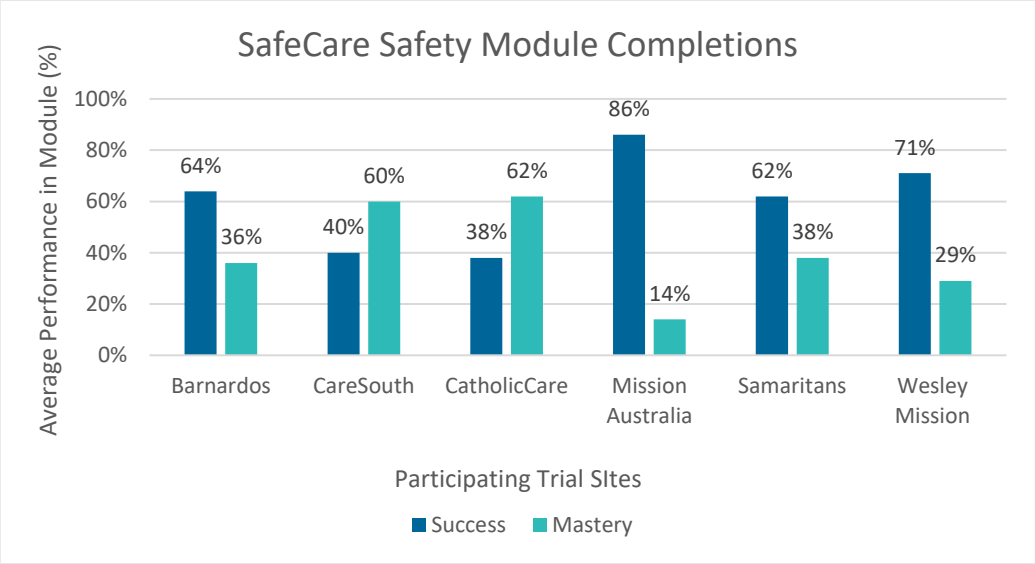

Figure 11: SafeCare Safety Module Performance
**Data presented for the average performance of families for the period between August 2018 and October 2019.*

For the SafeCare Health module, Wesley Mission reported the largest number of mastery module completions for families, followed by Samaritans, CareSouth, CatholicCare, Barnardos and Mission Australia (see Figure 12).

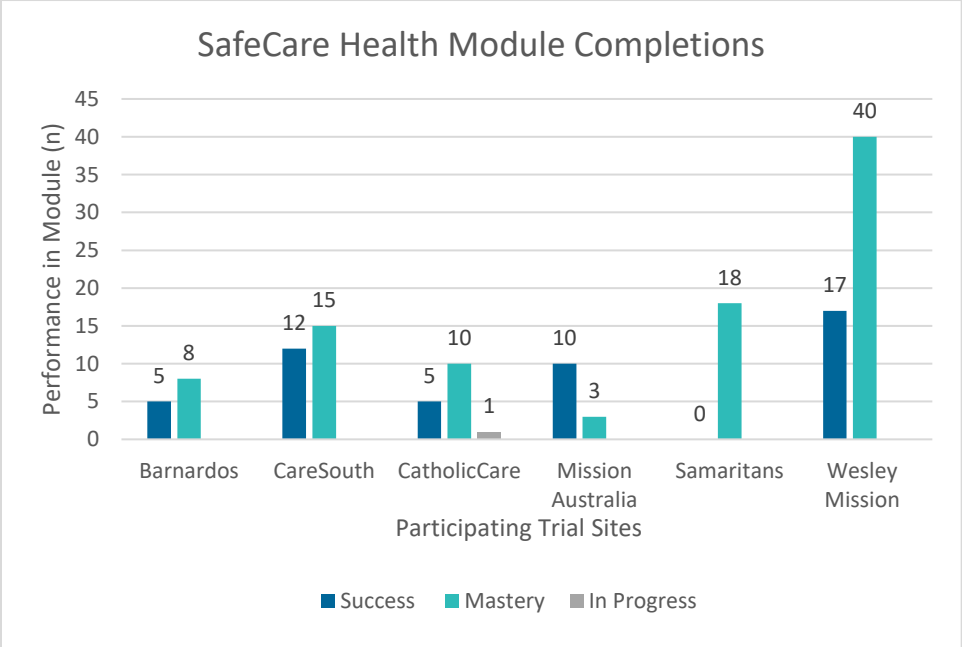

Figure 12: SafeCare Health Module Performance
**Data presented for the total number of families in October 2019.*

Samaritans on average, reported the highest rates of mastery for families, followed by Wesley Mission, CatholicCare, Barnardos, CareSouth and Mission Australia (see Figure 13).

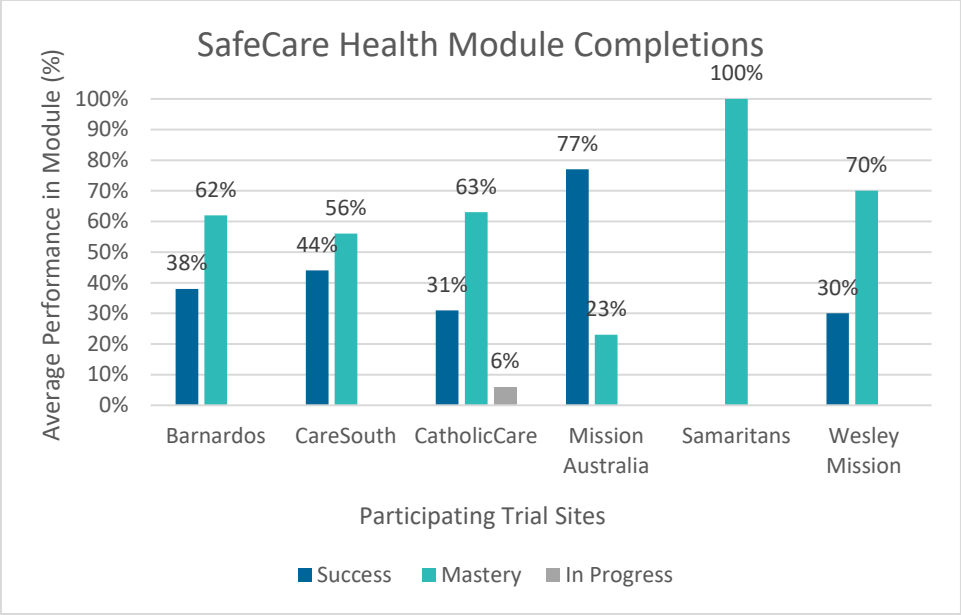

Figure 13: SafeCare Health Module Performance
**Data presented for the average performance of families for the period between August 2018 and October 2019.*

For the SafeCare Parent Child Interaction/Parent Infant Interaction modules, Wesley Mission reported the largest number of mastery module completions for families, followed by CareSouth, Samaritans, Barnardos, CatholicCare and Mission Australia (see Figure 14).

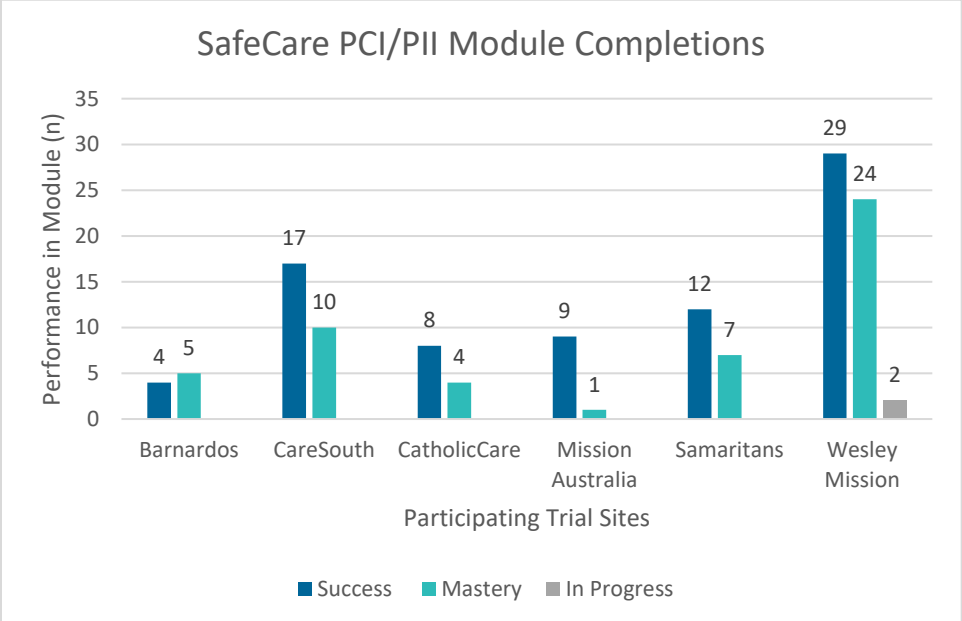

Figure 14: SafeCare PII/PCI Module Performance
**Data presented for the total number of families in October 2019.*

Barnardos reported the highest rates of Mastery for the PCI/PCII module during the period under evaluation. This was followed by Wesley Mission, CareSouth, Samaritans, CatholicCare and Mission Australia (see Figure 15).

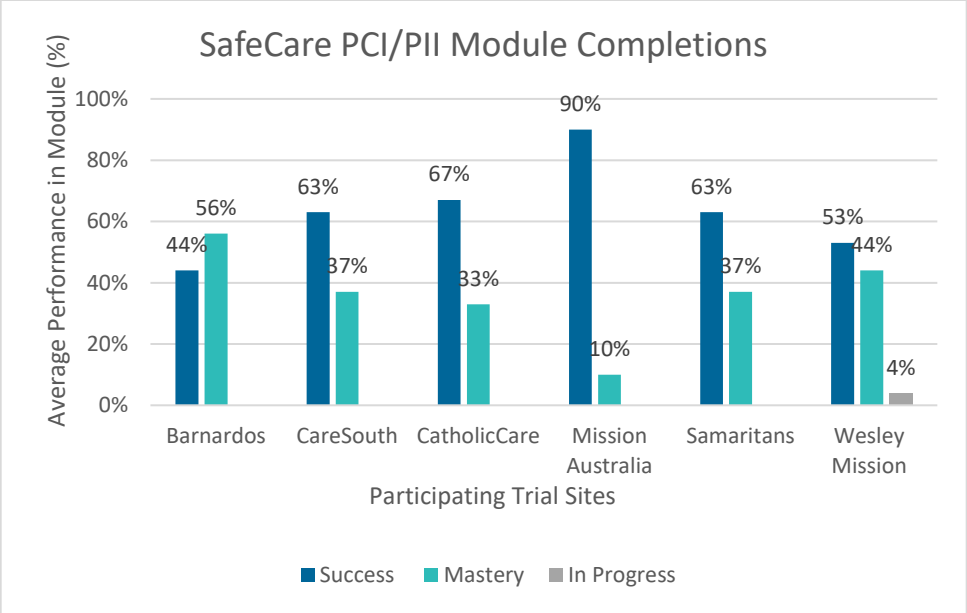

Figure 15: SafeCare PII/PCI Module Performance
**Data presented for the average performance of families for the period between August 2018 and October 2019.*

A review of the current literature revealed little evidence of success and mastery rates for SafeCare module completions in other jurisdictions. Although, a study by Taban and Lutzker investigated parent self-reported outcomes after completion of the SafeCare program using a 5-point Likert scale ranging from (1) strongly agree to (5) strongly disagree.[8] For the safety, health and parent interaction module, parents on average agreed to strongly agreed (mean = 1.38, 1.50, 1.98 respectively) that the module improved their parenting skills.

During consultations, all SafeCare providers, coaches, team leaders and managers unanimously reported that participation in the SafeCare program leads to positive changes in behaviour and parenting skills for families. These positive changes were observed for all four SafeCare modules.

For the safety module, all SafeCare providers reported that parents became more aware of the safety in their home as a result of completing the Safety module. According to data from interviews, this module provided a practical approach to identifying risks and hazards in the home. Another reported benefit of the module was that it appears to provide an opportunity for more difficult discussions about risks and safety within the home, particularly in regard to risks raised in Risk of Significant Harm (RoSH) reports.

> *"It's just about reducing risk, it complements the Brighter Futures program in that way quite well, in that, we have difficult conversations and raise RoSH reports in Brighter Futures. I had a family that had very poor supervision in their home of their 3-year-old and SafeCare gave me the opportunity to talk to that family and I wasn't the case worker for the family but I was aware of the issues in the home. So, it really allowed me to have quite an involved conversation around the supervision of that child.*
>
> \- SafeCare Provider, CareSouth

[8] Taban, N., Lutzker, J. R. (2001). Consumer Evaluation of an Ecobehavioural Program for Prevention and Intervention of Child Maltreatment. *Journal of Family Violence, 16*(3), 323-330.

SafeCare providers from Barnardos and Mission Australia reported that families also demonstrated improved awareness about health resources and services after completion of the health module. Respondents reported that the health module provides the family with the necessary resources and information should a medical emergency arise. According to a SafeCare provider from Samaritans, it can be difficult to determine how well the health module impacts on children's health directly but there has been a noticeable change in the knowledge and awareness of parents in accessing health information and services.

For the PII and PCI modules, SafeCare providers from all agencies consistently reported increases in the confidence of parents when interacting with their children. When asked about how the SafeCare program appears to support the confidence of parents, interviewees reported that the supportive, positive feedback incorporated into the program is an important contributor. According to data from consultations, the program appears to avoid a disciplinary approach and instead takes a strengths-based approach with families.

> *"[The program works] because it focuses on the positives and builds the confidence of families… and I think it does it in a way that doesn't insight shame, it does it in a way where the parent feels like you're walking alongside them. So, it does address things that they can improve on, but it's so subtle that it's things parents wouldn't even pick up on. The approach, the training and from what I've seen from our workers… it's what really makes it a really good program. It really gives them the opportunity to reflect on their parenting skills and what they want to work on rather than us telling them this is what you need to work on. It gives workers a structured approach to work with and present… and you can always fall back on that. You know families don't feel judged because it's in the program, it's not us saying it."*
>
> - SafeCare Provider, Wesley Mission (Cumberland)

SafeCare providers also reported observing changes in the way parents managed the behaviour of their children, and how they engaged with their children during routine tasks such as bathing or planning and organising resources for their children, which was seen as a positive outcome.

> *"[There are benefits] also for the children. I have seen another family of late, where there was no interaction with the child and Mum was starting to say I'm a bit worried about speech and after we did the PCI module, he is very interactive with Mum. His speech is just bubbling over now, he'll come up to you, he will look you in the eyes, he'll engage with you, he'll bring you toys and he's very engageable…so even from the point of view of child connection, their ability to go to their parents has been a huge shift, and that builds on the parents confidence, 'they are coming to me, there is that connection'…".*
>
> - SafeCare Provider, Wesley Mission (Cumberland)

5.5.2 Unintended outcomes

Based on the preliminary findings, the implementation of the Brighter Futures-SafeCare program has contributed to a number of unintended outcomes.

Initial observations during consultations suggest that the program may have important positive flow-on effects for families. It was reported by CareSouth SafeCare providers that participation in the SafeCare program by young parents had facilitated interest in studying and further education. In one example, a

young mother who had left high school due to pregnancy, wanted to study at TAFE to become a nurse as because of her enjoyment of the SafeCare health module. Another example offered by a SafeCare provider described the benefits for a young father who had previously disengaged from education. It was reported that the father deeply appreciated receiving a certificate that recognised his achievement following the successful completion of each SafeCare module. It was reported that the father valued this recognition, as he had not previously finished any program or education that he had attempted.

Despite the positive unintended outcomes observed, the findings also suggest that the SafeCare implementation may be contributing to a number of negative unintended outcomes for staff. This was highlighted during consultations with DCJ staff, where it was recognised that the implementation of SafeCare requires significant effort and time and that appropriate support is needed to assist SafeCare providers to adapt to the changes in work. DCJ staff acknowledged that the SafeCare program requires an increase in monitoring, data collection and reporting activities, but that these activities help the Department to understand the implementation of the program and make improvements where possible. As per findings from consultations, SafeCare providers, coaches and managers recognise the value of the data collection and reporting requirements, however these activities are perceived to be excessive and a key contributor to an increase in workload. The implications of the monitoring, data collection and reporting requirements are outlined in *Section 5.2.1: Data collection and reporting requirements*.

5.5.3 Renotification rates

Based on the findings from consultations, overall rates of RoSH reports or renotifications were not perceived to be an effective tool for measuring the success of the program. All SafeCare providers and agency managers reported that it is difficult to determine whether the SafeCare program contributes to a reduction in renotifications. They reported that despite a family being involved in SafeCare, renotifications may still occur. In many situations, SafeCare providers and agency managers reported that renotifications occur for other reasons unrelated to the initial SafeCare referral. For example, a family referred to Brighter Futures may have received a RoSH report for safety in the home, but a renotification may have been raised for domestic violence, a content area that is not addressed through SafeCare. According to the providers, there are many non-program related factors that also contribute to renotifications, such as drug and alcohol misuse, domestic violence, or relationships. Therefore, it is difficult to draw links between the SafeCare program delivery itself and the overall renotification rates.

Based on this evidence, identifying RoSH reports that are relevant to the content areas of SafeCare, such as parent-child interaction, health, and safety and supervision, would be a more reliable indication of potential change for families. This would also provide a more reliable indication of the success of the program as it aligns with the intended outcomes.

However, it is important to note that previous research determining the effectiveness of the SafeCare program commonly uses renotification rates are used as an outcome indicator, with reports that SafeCare decreased recidivism by 26% for families with children between 0-5 years of age[9]. This outcome measure was used within these studies to assess the overall outcome for community family neglect and abuse incidence reduction. Although, based on the findings from consultations, it will be important to gain further information on the factors associated with re-notification to assess whether the impacts are due to the program delivery or whether it is due to non-program related factors.

SafeCare providers also reported that they do not currently have access to RoSH reports for their respective families. According to interviews, agency managers are able to access this information, however this information is not consistently relayed to SafeCare providers. SafeCare providers and team

[9] Chaffin, M., Hecht, D., Bard, D., Silovsky, J., & Beasley, W. (2012). A statewide trial of the SafeCare home-based services model with parents in Child Protective Services. Pediatrics, 129(3), 509-515.

leaders reported that access to this information would be a useful tool in measuring the progress of SafeCare families. In their view, if a family were to receive a renotification related to safety during their participation in the program, it would indicate to SafeCare providers that the family may benefit from further education or a specific module may need to be revisited.

The Department and agency managers could also consider the development of pathway to inform SafeCare providers of renotifications for families participating in SafeCare to inform service provision.

5.6 Program Fidelity

Given the role of the intermediary is to support the implementation of the program with fidelity, the consultation activities did not collect data related to program fidelity, in an attempt to reduce duplication of effort. Instead, consultation activities assessed the enablers and barriers to program delivery that impact program fidelity. Information provided by stakeholders consulted identified a number of program and non-program related factors that appear to either enable or hinder the successful delivery of the program. These factors are discussed in detail below.

5.6.1 Program factors

Program factors observed to support successful implementation and delivery of the program include:

- Having a clear structure of the SafeCare program
- Ability of SafeCare providers to determine the suitability and readiness of families
- The level of support provided during training
- The level of support provided by intermediaries

Several factors were also identified that may act as barriers to the successful delivery of the program. These include:

- The limited cultural responsiveness of SafeCare content
- The limited visual materials to cater to families with intellectual disabilities
- Perceived increased in the workload for SafeCare providers and coaches

5.6.2 Non-program factors

Based on the findings from data collection activities conducted to date, there are a number of non-program related factors that were observed to either support or hinder the successful implementation of the program. These are discussed below.

Travel

During interviews, travel was identified as a non-program related factor specific to rural and remote services that may help or hinder program delivery. Managers and providers servicing rural and remote areas consistently reported a need to travel in excess of 2 hours for in home visits. This travel time became a particular challenge when families needed to reschedule. In addition, interviews also highlighted safety concerns for providers if they are required to travel outside of business hours.

Population factors

The findings suggest that there are a number of population related factors that impact a family's ability to successfully engage with and complete the SafeCare program, for example mental health issues. These factors are discussed in *Section 5.4.4: Characteristics of participating families.* Additional factors that were perceived to be barriers to the successful delivery of the program include learning delays and having a first language other than English. As the program targets complex families with a number of high risks or social and economic disadvantages, these issues are to be expected but nonetheless hinder the success of the program.

Provider motivation

Based on the information gathered from consultations, provider motivation to deliver SafeCare appears to be a key factor that acts as both an enabler and barrier to the program effectiveness. Specifically, when providers were motivated and enthusiastic to deliver SafeCare, benefits were reported in terms of enhanced training effectiveness and enhanced delivery of the program. In contrast, when providers were not motivated to deliver SafeCare it was reported to act as a barrier to the successful implementation and delivery of the program. Expression of interest processes were seen as an effective way to select suitable providers by both agencies and NSCTRC. For more detail on provider motivation, see *Section 5.3.3: Provider suitability*.

DCJ education and referral appropriateness

Based on the information available to the evaluation, the limited awareness and understanding of SafeCare amongst DCJ staff appears to be a barrier to program effectiveness. This issue was consistently reported by agency managers. Data available suggests that this lack of understanding hinders the success of the program by resulting in cold referrals and ineligible referrals (for more detail, *see Section 5.4.1: Appropriateness of Referrals*). DCJ acknowledged this issue and recommended that more education and training is required for DCJ staff to enhance program effectiveness.

Resourcing

Based on information gathered during consultations, concerns were reported that the current resourcing model would not allow the sustainability of the SafeCare program. Data from agency interviews suggested that there were some instances where funds were being reallocated from the Brighter Futures funding to support the SafeCare program. Further discussions with DCJ highlighted that program resourcing was a consideration for DCJ, however no certain solution had been identified. A DCJ respondent noted that evidence was needed for the effectiveness of SafeCare before consideration could be given to solutions.

Furthermore, the number of staff available to deliver SafeCare was identified as an issue impacting program delivery. While this has already been highlighted in terms of requiring more training for potential providers, it also appears to be a resourcing issue for some agencies wherein they do not have the number of staff available to deliver SafeCare to the number of families they would like to.

5.7 Recommendations from consultations

Information gathered from consultations, identified 13 key areas for improvement of the SafeCare program.

5.7.1 Developing and Adapting Materials

Recommendations from SafeCare providers for developing and adapting materials included an increase in visual materials to support families with learning disabilities; the addition of culturally targeted material for Aboriginal and Torres Strait Islander participants; the addition of translated materials that reflect the diverse Australian population; adjusting the safety module to reflect risks which are more prevalent in the Australian context, which would include removing US based hazards such as drowning in the toilet and gun safety and adjusting the health module by including sunscreen and insect repellent to address Australian family needs.

5.7.2 Measuring Long-Term Retention of Parenting Skills

Providers stated that the use of a 6-month check-up post SafeCare completion with families could aid the long-term retention of the parenting skills acquired in the program. Providers noted that additional monitoring could serve to encourage parents to continue developing their parenting skills.

5.7.3 Improvements to Data Collection

Providers suggested that including a free text box for explaining dropouts would enhance the interpretation of data used to improve delivery and implementation. Providers noted that the families they work with are often complex and at times dropouts can reflect a positive outcome for the family yet a negative outcome for the program. Further, coaches noted that including an option for further comment when measuring parent outcomes could be beneficial when interpreting the data for SafeCare. They further explained that the current data collection options do not allow for relative improvement to be shown. For example, if a family moves from 0 to 3 ticks, they are still showing marked improvement even if they are not achieving mastery. In addition, managers noted that they often receive data reports with missing data and errors. Managers suggested being able to see a summary of the data before it is sent to PRC along with receiving receipts when data is sent as potential improvements. This would allow managers to identify errors earlier, ensure correct data is being logged and limit the time required to fix errors.

5.7.4 Flexibility in Delivery

Providers stated the ability to separate and adapt modules to meet the requirements of the families could lead to improvements in family engagement and an increase in positive outcomes. Aligned with this, managers noted that being able to separate modules and deliver them individually could improve family engagement. In contrast, staff from the NSCTRC recommended that the message should be to complete all 3 modules. While they noted that completing one module is better than none, there is no data available to determine the effectiveness of providing single modules to families.

5.7.5 Additional Skills-Building Days

Coaches at one agency described the benefit of skills-building days, which could be expanded throughout the other trial sites. The skill building days involved problem solving and technical skill building to assist providers in the delivery of the program. Furthermore, providers were able to request particular areas of difficulty to be addressed in these sessions.

5.7.6 Increasing education and awareness of SafeCare for Department Staff

In response to the issue of ineligible or cold referrals from DCJ, managers recommended a structured training process or set of guidelines to aid DCJ staff in their understanding of the SafeCare program. Staff from DCJ stated that initially local DCJ staff were educated on the SafeCare program, however, continual structured training may need to be provided to ensure the referral process operates effectively.

5.7.7 Expansion of SafeCare

Managers expressed that they saw value in SafeCare being delivered to families seeking restoration and families who are expecting children (prenatal). Managers outlined that parents can often have a child restored without having the parenting skills that SafeCare promotes. In addition, SafeCare could be an early intervention strategy for parent's expecting children. However, it is important to note that there is no current evidence of the effectiveness of the SafeCare program in these settings. During consultations PRC and DCJ staff noted that future expansion to additional agencies and sites would require significant implementation support.

5.7.8 Communication/Handovers for SafeCare Providers and Caseworkers

In situations where there are separate case workers and SafeCare providers servicing a family, managers recommended that structured handovers after every visit be included in the program delivery guidelines. This would ensure that both case worker and SafeCare provider understand the family's needs at any given time.

5.7.9 Increased Training

To improve the workforce capacity and agencies internal capability to deliver SafeCare, managers suggested increasing the number of training sessions for providers and coaches each year. In addition, managers suggested increasing the number of staff that can participate at each training session. Respondents from PRC noted there is a need to increase the number of internal coaches at a number of agencies so that they can be self-sufficient in delivering SafeCare.

5.7.10 Implementation Benchmarking

Staff from PRC suggested using high performing organisations as benchmarks to understand the key competencies required for efficient implementation. These competencies could then be used to inform future implementation.

5.7.11 Business as Usual Model

Staff from the NSTRC stated that from their perspective the delivery of SafeCare could be enhanced by transitioning SafeCare from a voluntary opt-in program to a business as usual model that is delivered to every family. Respondents from the NSTRC did note that they were unsure of the feasibility of this recommendation and stated that this would need to be discussed with DCJ. Similar to recommendations provided by the NSTRC, respondents from DCJ suggested that delivery of SafeCare should move from voluntary to business as usual with all eligible families receiving SafeCare.

5.7.12 Reducing Caseload

During consultations with the NSTRC, staff suggested that reducing caseloads for providers may increase the motivation of staff delivering SafeCare. Respondents from NSTRC noted that the SafeCare program does involve increased preparation and reporting and this should be taken into consideration.

5.8 Staff Turnover

This section outlines findings from a survey distributed to Managers, Coordinators, and Team Leaders at each of the SafeCare trial sites. The survey explored the issue of staff turnover and its relationship to the implementation of SafeCare.

All staff surveyed reported experiencing staff turnover within their service during the implementation of Brighter Futures- SafeCare Program. However, this level of turnover was mostly perceived to be consistent with previous years and not an impact of the SafeCare program. Furthermore, staff turnover included a combination of SafeCare providers and other staff that did not deliver the SafeCare program.

Staff turnover was reported to have varied impacts across the different sites. For some, staff reported minimal impact as a result of staff turnover because they were still able to achieve results throughout the SafeCare trial. For others, staff turnover was perceived to negatively impact both the service and the families engaged in SafeCare. Firstly, staff turnover was reported to result in a loss of skill and knowledge about SafeCare, as well as a loss of 'mentors' for new SafeCare providers within the service. Secondly, staff turnover meant that a new provider had to be assigned to the families engaged in SafeCare and in some cases, these families were placed on a waitlist until another provider had the capacity to deliver the program to them. This was perceived to result in higher rates of drop out. Additionally, it was noted that time and resources are required to recruit and train new staff which has implications for staff workload and maintaining client numbers.

Despite these negative impacts, some staff also reported positive impacts of staff turnover. Staff explained that turnover results in the recruitment of new providers that are introduced to BF-SC model in the beginning of their employment. This was reported to improve engagement in, and endorsement of SafeCare. This is in contrast to existing staff that may be reluctant to change the way their practice.

Consistent with this, other staff reported that a substantial amount of work was required to manage staff anxiety associated with the initial implementation of the program and to motivate them to deliver SafeCare.

Overall, staff reported that turnover was not a result of the SafeCare program, but rather a result of non-program related factors. For example, one staff member reported that staff had left the service because of caring responsibilities and others had left to secure a higher salary. However, there were some particular elements of the SafeCare program that were perceived to contribute to staff turnover. These were: the perception of increased workload, change in role, initial objection to the model, difficulties experienced during implementation and career progression potential. At a systems level, staff also reported that limited funding may have impacted turnover; and that changes to government may have impacted DCJ's ability to make appropriate referrals into SafeCare, which in turn may have impacted staff turnover.

When asked about newly trained staff, survey respondents noted that over time and with adequate training and support, staff adapted well to the delivery of SafeCare. However, it was noted that it took time and effort for SafeCare to be delivered as 'business as usual'. When asked about existing staff, views about their ability to adapt to the implementation of SafeCare were mixed. Staff reported that some existing staff have adapted very well to the implementation of SafeCare and that some found it difficult or were reluctant to deliver the new model.

Staff reported that the main challenges for providers to transition to the delivery of SafeCare were unwillingness and/or difficulty in changing the way of working, lack of confidence to deliver SafeCare, difficulty balancing SafeCare with responding to family crises, poor time management and organisation, the perception of increased workload, and IT challenges associated with the SafeCare portal.

Of note, one survey respondent reported that the introduction of SafeCare resulted in increased job satisfaction and an enhanced sense of achievement among providers because the program was perceived to be purposeful and had achieved positive outcomes for families.

6. Conclusions and Recommendations

Question 1: Was the trial implemented as intended?

Based on the findings of evaluation activities conducted to date, there is evidence suggesting that the trial is being implemented as intended. The elements that appear to support successful implementation of the program include the training model, the post-training support for providers, the implementation support from intermediary agencies, regular implementation team meetings, and the clear structure of the program. However, there are a number of barriers that may be limiting the full effectiveness of the SafeCare trial, such as the data collection and reporting requirements, the appropriateness of materials used for training and program delivery, the appropriateness of referrals, and family readiness for SafeCare.

The following section outlines the evidence for this overall evaluation question, with reference to the following:

- The implementation of the training program
- The implementation of the SafeCare program itself
- Whether the program reached the target population
- Whether families were successfully engaged in the program
- Whether program fidelity was achieved

Question 1a: Was the staff training program implemented as intended?

The following section provides evidence relevant to the implementation of the ***staff training program***.

A triangulation of data from all sources suggests that the training program was implemented as intended. There is evidence that the planned process for SafeCare certification was followed and that the training delivered improved the knowledge and skills of providers, coaches and managers.

As outlined in the desktop review (see *Attachment B: Desktop Review)*, to reach SafeCare certification providers are required to attend a four-day training workshop. Following this workshop, providers receive coaching on a monthly basis to monitor program fidelity is achieved. To reach certification, providers are required to demonstrate strong fidelity in three sessions of each of the three modules. After certification, program fidelity is continually monitored through monthly fidelity checks, that reduce to 3-monthly fidelity checks when providers have been active in their role for over two years. To be eligible to become a SafeCare coach, staff must be considered experts in the delivery of SafeCare as a provider. Training to become a coach involves a 1-2-day workshop. Field certification is gained after conducting two supervised sessions across the three modules. SafeCare coaches receive ongoing support from a SafeCare trainer for a period of 6-months.

Data available through consultations, quantitative data and program documents suggests that the process to reach and maintain SafeCare certification as both a provider and coach has been implemented as intended. Providers and coaches both reported attending the training workshops and adhering to the post-workshop monitoring activities. The quantitative data highlights that 33 providers, including 9 coaches had been certified in SafeCare as of October 2019. Managers also reported attending a half day workshop to gain an understanding of the program.

Data from consultations suggest that post-training support and coaching was available to providers. Aligned with this, recent research suggests that coaching is important to support the transfer of training into practice.[10] In addition, coaches reviewed the practice of providers and gave feedback to strengthen the delivery of the SafeCare program. Existing evidence highlights the potential benefits of this approach. An in-depth review of training transfer reported that opportunities to practice skills and receive feedback enhance the long-term retention of skills.[11] Taken together, the training program not only appears to have been implemented as intended, but these practices also appear to have ongoing benefits for the learning, retention and upskilling of staff.

It is noted that the implementation of the SafeCare program also includes a train-the-trainer model. Based on the findings of the evaluation to date, the implementation of the train-the-trainer model is in its early stages. Internal coaches have been established in the majority of agencies and one coach has completed the train-the-trainer course, with the intention of facilitating SafeCare training for other upcoming coaches. As can be inferred from the findings, the train-the-trainer component of the SafeCare implementation is yet to be established in all sites and the impact of this model is not yet apparent at this point in the evaluation. It should be noted however, that research suggests that train-the-trainer models are efficient, cost-effective and support the translation of skills into practice[12] and these potential outcomes will be explored in the Outcomes Evaluation to be delivered to the department in 26th February 2021.

In addition to the preliminary outcomes outlined in this section, the findings also suggest that the implementation of the training has improved over time. As per the findings from consultations, issues such as staff resistance to change and staff turnover were experienced during the initial stages of implementation. However, these issues appear to have lessened over the course of implementation. In some instances, sites have adopted strategies to improve staff recruitment and retention, including the use of *expression of interest* selection processes for SafeCare training, and having conversations with staff to gauge their willingness and enthusiasm to deliver the program. According to the findings, these strategies were perceived to improve engagement in the training and the retention of certified providers.

Although the training content and materials were found to be effective in supporting learning, some potential improvements were suggested. The findings suggest that the training videos could be adapted to better reflect a real-life scenario or common challenges experienced in the delivery of the program. Additionally, staff reported that the materials could be tailored to better suit the Australian context. For example, the hazard of drowning in the toilet was not perceived to be relevant to Australian homes. In some instances, coaches reported providing additional advice during training delivery to address the limitations of the training materials. However, this approach may lead to inconsistencies in the way the training is being delivered across the agencies. As such, a review of the training materials could be considered with an emphasis on improving the relatability of the materials for providers and families.

In addition, it is noted that one agency held additional skill building workshops to support the ongoing development of SafeCare providers. Although these workshops were perceived to be effective, it is difficult to determine the true effectiveness of the training implementation as this additional strategy was not implemented across all agencies involved in the SafeCare trial. As such, consideration could be given to documenting the strategies found to be effective in the implementation of the training program and disseminating this as a resource to all trial sites. To reduce additional process burden, these strategies and

[10] Wang, L. & Wentling, T. L. (2001, March). The relationship between distance coaching and transfer of training. In *Proceedings from the Academy of Human Resource Development Conference. Tulsa, Oklahoma.*

[11] Burke, L. A. & Hutchins, H. M. (2007). Training transfer: An integrative literature review. *Human Resource Development Review, 6*(3), 263-296.

[12] Suhrheinrich, J. (2011). Examining the effectiveness of a train-the-trainer model: training teachers to use pivotal response training. *Society for Research on Educational Effectiveness.* Retrieved from https://eric.ed.gov/?id=ED518863

resources could be shared using previously established modes of communication, such as webinars or local implementation team (LIT) meetings.

It is also noted that there were some instances where managers reported they would have benefitted from additional training or resources during the implementation of the SafeCare program. Specifically, more in-depth information about the training modules was requested to assist them to support providers, identify appropriate referrals, allocate resources and effectively engage in workforce planning.

Finally, a triangulation of data from all sources suggests that the consistent training of coaches will be important for implementation and the future sustainability of the SafeCare program. As noted in the desktop review (see *Attachment B*: *Desktop Review*), the sustainability stage of implementation involves implementing the train-the-trainer model and establishing trainers to deliver the SafeCare training to SafeCare coaches and providers. If this objective is met, this will mean that agencies will become more self-sufficient, subsequently reducing the strain on resources required to deliver widescale training programs across social and support services.[13,14] However, to become a trainer, a staff member must first be a certified coach. During consultation, a potential shortage of coaches was noted for some sites. CatholicCare reported they did not have any internal staff certified as SafeCare coaches. It was further noted that most of the current CatholicCare SafeCare providers were employed on a part-time basis which was not perceived to be suitable for taking on additional duties of a coaching position. Furthermore, PRC reported providing coaching support to two agencies as they had limited capacity to do so internally.

Moving forward, it will be important to first ensure that all agencies have access to an internal coach, to then reach the next stage of establishing trainers. This is an important first step to reaching the sustainability stage of implementation. Consideration should be given to consultation with CatholicCare to understand any barriers experienced by the agency in establishing certified coaches. This information could be used to inform strategies to support the agency.

Conclusions

- There is evidence that the staff training program was implemented as intended. A total of 33 certified providers including 9 coaches were trained as of October 2019. Additionally, providers and coaches reported that the training enhanced their knowledge and skills.
- The availability of post-training support and coaching appears to have assisted SafeCare providers to translate skills learned into practice and improve delivery of the program.
- There is evidence to suggests that train-the-trainer models are an efficient and cost-effective method of delivering wide-scale training. As such, this may be an effective approach for ongoing training of SafeCare staff. This model may also support future sustainability of the SafeCare program. The outcomes of this model are not yet apparent thus, will be explored in the Outcomes Evaluation.
- The data suggest that the selection of suitable providers, with consideration for their willingness and motivation to deliver SafeCare, is important for engagement in training activities and wider delivery of the program.
- The findings suggest that the training videos were not reflective of a real-life scenario when delivering the SafeCare program. Additionally, the materials were not perceived to be representative of the Australian context.

[13] Suhrheinrich, J. (2011). Examining the Effectiveness of a Train-the-Trainer Model: Training Teachers to Use Pivotal Response Training. Society for Research on Educational Effectiveness.

[14] Lai, A. Y., Stewart, S. M., Mui, M. W., Wan, A., Yew, C., Lam, T. H., & Chan, S. S. (2017). An evaluation of a train-the-trainer workshop for social service workers to develop community-based family interventions. Frontiers in public health, 5, 141.

- Additional skill building workshops were perceived to support the ongoing development of providers; however, this strategy was not adopted by all sites.
- Managers reported a lack of in-depth knowledge related to the SafeCare modules following their training.
- There is a potential shortage of certified coaches for some trial sites, which may limit their capacity to implement the train-the trainer model and reach the sustainability stage of implementation. For CatholicCare, most SafeCare providers were employed on a part-time basis which was not perceived to be suitable for the intensive nature of a SafeCare Coach position.

Question 1b: Was the SafeCare program implemented as intended?

The following section provides evidence relevant to the implementation of the ***SafeCare program.***

A triangulation of data from all sources suggests that the SafeCare program was implemented as intended. A number of components of the implementation methodology effectively supported the ongoing delivery of the program. The following information provides an overview of the program guidelines, the implementation of the program at the trial sites and recent changes to the machinery of government that may impact future implementation and delivery of the program.

Program guidelines

As noted in the desktop review (*Attachment B*: *Desktop Review*), SafeCare was intended to:

- Be integrated into the existing Brighter Futures program for participating agencies across New South Wales (NSW); and
- Target a sub-set of Brighter Futures clients that included parents at risk, or with a history of neglecting and/or abusing their children, with children aged between 0 and 5 years old.

There is some evidence to suggest the SafeCare program has been integrated into existing practice, however this was not found to be consistent across all sites.

To support the integration of the programs, Wesley Mission developed a new Brighter Futures practice framework that was based on the learnings of the SafeCare program. This new framework was reported to have a strong connection to the language and principles used in SafeCare, which was perceived to support providers to integrate the delivery of SafeCare with their casework under the Brighter Futures program.

Based on the findings, this appears to be an important strategy that supported successful implementation of the SafeCare program. However, it is not clear whether this strategy was used by other trial sites. It is also noted that providers continued to report challenges integrating SafeCare and casework in their sessions. As noted in other sections of this report (see *Question 1b: Was the SafeCare Program Implemented as Intended?*), consideration could be given to documenting strategies that were found to be effective in the implementation of SafeCare and disseminating this as a resource to support the implementation of the program across all trial sites. Additionally, as some sites have been established for longer than others and are further along in the stages of implementation, consideration could also be given to documenting the lessons learned and using this to inform implementation in newer trial sites, or any future roll out of the program.

There is also limited evidence to suggest that the SafeCare program has successfully targeted the appropriate sub-set of Brighter Futures clients, however more detail is provided in *Question 1c – Did the trial reach the target population?*

Implementation at the trial sites

The implementation of BF-SC was intended to follow four stages. The stages are:

1. Pre-implementation preparation
2. Initial implementation
3. Ongoing implementation
4. Sustainability

The data available to the evaluation suggests that the capacity for the initial trial site (i.e. Wesley Mission) to enact the pre-implementation preparation stage was reduced due to the perceived lack of implementation support. It is also noted that this site experienced high levels of organisational change resistance and turnover of staff, which was perceived to be a result of the implementation of SafeCare.

Following the implementation at the initial trial site, the PRC and NSCTRC were established as intermediaries to support all stages of the implementation. Since the establishment of intermediary support, implementation methods have improved and SafeCare is accepted as usual practice among staff. Additionally, all stakeholders agreed that the support provided by the intermediaries for staff training, local and central implementation meetings, as well as the provision of implementation resources has been beneficial in guiding the implementation of the program in line with guidelines. Supporting this approach, a recent research paper identified lessons learned for the implementation of SafeCare and recognised the importance of preliminary and adequate readiness processes, as well as regular use of supporting agencies, such as the NSCTRC and other personnel relevant to implementation of SafeCare.[15]

The findings suggest that the local and central implementation team meetings are effective in supporting the implementation of SafeCare. These meetings give staff an opportunity to troubleshoot and problem-solve issues relating to implementation, allowing frequent and continued conversation about SafeCare. Additionally, these meetings allow regular communication between intermediary agencies and participating trial sites, which research suggests is also important for implementation.[15] While these meetings were perceived to be beneficial, it is noted that they were viewed as excessive by some staff. The evidence does suggest that these meetings are beneficial for the agencies involved in this trial, therefore consideration could be given to balancing the frequency of LIT and CIT meetings to reduce process burden on staff.

When asked about any factors that impact the delivery of the SafeCare program, staff highlighted the challenges associated with the data collection and reporting requirements. As outlined in other sections of this report (see *Section 5.7.3: Improvements to Data Collection)*, the data collection and reporting activities were perceived to be excessive and burdensome. In addition, agencies reported issues with receiving inaccurate data reports and highlighted the difficulties with not having access to their agencies' raw data for quality improvement and tracking purposes. Staff also reported the importance of providing more context to the data. During consultations, staff consistently suggested the benefit of providing more information for those families who have 'dropped out' of the program. According to staff, a 'drop-out' is not always considered as a negative outcome for families, however the current data collection tool does not provide the opportunity to adequately address the reasons for a family disengaging from the program. Finally, it is noted that the current data collection systems do not allow for the reporting of relative improvements for parents if they do not achieve success or mastery.

Overall, consideration should be given to streamlining data collection and reporting activities and addressing these current issues. This could be done in consultation with the agencies to ensure the data reports reflect the information that is considered to be important for implementation by the department and agencies. It should be noted that there have been recent discussions between Siggins Miller, the PRC

[15] Shanley, J., Graham, M., Lutzker, J., Edwards-Gaura, A., Whitaker, D., & Self-Brown, S. (2013). Lessons learned from national and international implementations of SafeCare®. *International Public Health Journal, 5*(1), 31-38.

and DCJ regarding improvements to data collection and reporting requirements and strategies for quality improvement are currently underway. The outcome of these improvements will be explored in future evaluation activities.

What has changed since initial implementation?

In the same timeframe as the implementation of the SafeCare program, there were significant changes in the New South Wales (NSW) machinery of government. From 1st July 2019, the NSW public sector streamlined ten existing clusters into eight new clusters to deliver the work of the government. The new clusters are:

- Premier and Cabinet
- Treasury
- Customer Service
- Planning Industry and Environment
- Transport
- Health
- Education
- Stronger Communities

The formerly known Department of Family and Community Services (the funding body for SafeCare) merged with the Department of Justice to form a new principle department, the Department of Communities and Justice. This new department sits within the Stronger Communities cluster. The objective of merging the existing Family and Communities, and Justice clusters was to provide more opportunity to focus on prevention and early intervention in the social welfare system within the entire law and order system. According to information outlined by the NSW Government Premier and Cabinet, this arrangement is expected to encourage greater collaboration across the more traditional and separate family, communities, and justice functions of government. The implications of this merger for the NSW SafeCare trial are not yet clear, however, the outcome of this change will need to be considered alongside the current evaluation.

Conclusions

- There is evidence suggesting that the SafeCare program has been successfully integrated into the existing Brighter Futures program in some sites, however providers continued to report challenges in incorporating SafeCare into their casework during sessions with families.
- Strategies to support the integration of SafeCare with Brighter Futures were established in one site, specifically the development of a Brighter Futures practice framework that is aligned with the SafeCare program. This was perceived to support providers to integrate SafeCare with Brighter Futures casework.
- There was a perceived lack of implementation support for the initial trial sites, which reportedly resulted in organisational change resistance and staff turnover. Since this time, intermediary agencies, the Parenting Research Centre (PRC) and the National SafeCare Training and Research Centre (NSCTRC), have been established to support implementation efforts. All agencies agreed that support provided by intermediaries, including staff training, provision of implementation resources and establishment of central and local implementation team meetings, has been beneficial.
- The implementation of SafeCare appears to have improved over time and the program is now accepted as usual practice.

- Central and local implementation team meetings were perceived to be beneficial for the implementation of the SafeCare program, however the frequency of these meetings appears to increase process burden for agencies.
- A number of challenges were experienced in relation to data collection and reporting requirements. These activities were perceived to be excessive and a number of issues were reported with regard to receiving inaccurate data reports, the absence of data tracking mechanisms and the inability to report contextual information related to a drop out.
- There have been changes to the machinery of government since the SafeCare trial began that will need to be considered alongside evaluation findings.

Question 1c: Did the trial reach the targeted population?

At the time of the evaluation, access to Child Story data was limited. Approval to access this data source was obtained at the delayed date of 20th November 2019. Therefore, the detail of family members' demographics and family complexity will be explored in the Outcomes Evaluation (see the data strategy matrix in *Attachment A: Evaluation Plan*).

Of note, a consistent theme that emerged from the data was the concept of family readiness for the SafeCare program and this was impacted by family complexity. The findings suggest that there were differences of opinion regarding the ability to engage a family in the SafeCare program if they were experiencing crises (e.g., homelessness, domestic violence). There appears to be substantial differences in the perceived appropriateness of families for the program, based on their level of risk or complexity. As such, some providers offered the SafeCare program to families upon initial engagement and other providers delayed offering the SafeCare program until it was perceived to be an appropriate time and stability in the home had been achieved.

Due to this inconsistency within and between sites, it is difficult to determine the true reach of the trial. It is recommended that clearer guidelines be established for the engagement of families in the SafeCare program to promote consistent practice and enhance accessibility for eligible families.

Conclusions

- Data for family demographics and complexity was not available at the time of the Process Evaluation, however, will be explored in the Outcomes Evaluation.
- The findings suggest that there were inconsistencies between sites for when the program was offered to families, due to differing perspectives of family readiness or suitability for the program.

Question 1d: Were families successfully engaged in the SafeCare program?

Taking together findings from all sources, there is some evidence that families have successfully engaged in the SafeCare program. However, the findings suggest that there are a number of program and non-program factors that may impact a family's capacity to participate in the program. The following section outlines family's participation in the program, followed by a discussion of the program and non-program related factors observed to impact family engagement.

As outlined in the figure below, a total of 97 families had completed SafeCare and a further 92 families were currently engaged in SafeCare as of October 2019 (see figure 6). Overall, 27% of eligible families were engaged in the program. These findings suggest that a sufficient number of families had successfully engaged with the SafeCare program.

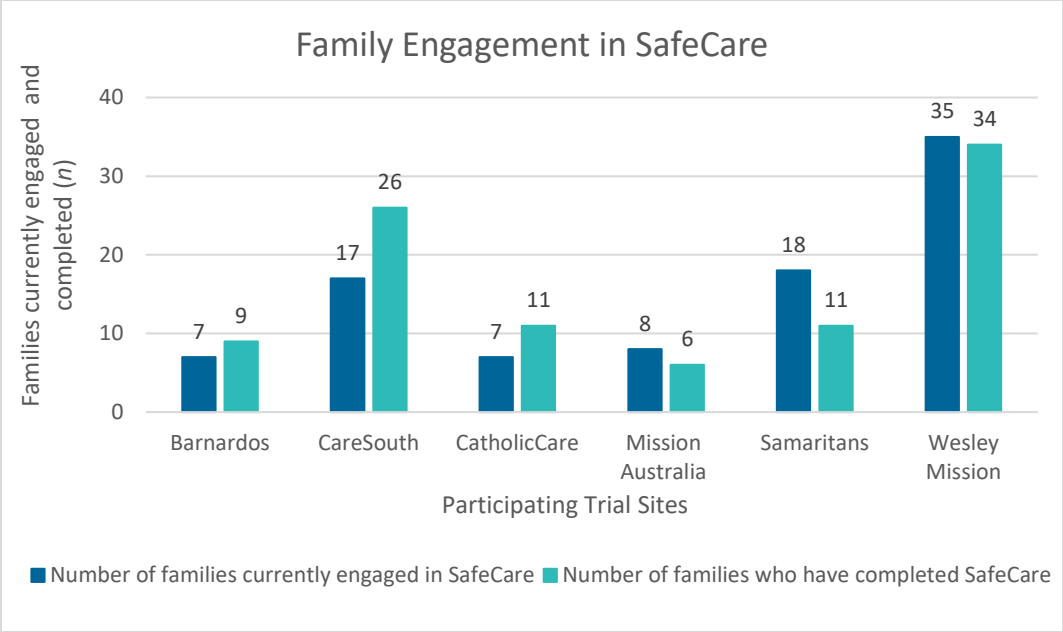

Figure 6 (as presented in Section 5.3: Family Engagement in the SafeCare Program). Number of families currently engaged in SafeCare and number of families completed SafeCare.
**Data presented as of October 2019.*

In addition, the findings demonstrate that families successfully engaged with all three SafeCare modules. The health module had the highest completion rate (143 families completed), followed by the safety module (119 families completed) and the parent interaction module (130 families completed).

Overall, the findings suggest that the engagement of families was largely supported by the efforts of providers and coaches. Specifically, the following practices were found to effectively support family engagement in the program:

- Provider's flexibility in their delivery of the program while still maintaining fidelity;
- Provider's ability to work collaboratively with families to align the SafeCare program to their needs; and
- Providing families with an opportunity to be involved in decision-making, allowing them to choose which module to begin with.

When families were engaged in the SafeCare program, the impact on improved confidence, safety behavior, health awareness and parent-child interaction was noteworthy. The findings suggest that a large proportion of families achieved either success or mastery across all three of the SafeCare modules. This is also supported by consultation findings, as providers witnessed improvements in confidence and parenting behavior as a result of engagement with the program. These findings provide initial insights into the preliminary outcomes achieved as a result of engagement with the SafeCare program.

In addition, there were a number of unintended benefits observed as a result of engagement with the program. For example, the program was observed to enhance the sense of achievement for parents and increase interest in further education. For more detail on unintended outcomes see *Question 2: Were there any additional or unanticipated outcomes from the SafeCare implementation and have these created benefits or limitations to the delivery of the SafeCare program?*

However, it should be noted that a number of barriers exist in firstly engaging and then maintaining the participation of families across the entire SafeCare program. The findings suggest that the engagement of eligible families is still below the suggested target and a high proportion of families tend to disengage from the program after the first module. Reasons for this appear to be based on both program and non-program related factors. As such, the following section outlines the program and non-program factors that appear to impact a family's capacity to either engage or remain engaged in the SafeCare program.

Program and non-program factors impacting family engagement

Program-related factors

Based on the findings from the evaluation activities conducted to date, evidence suggests that there are a number of program and non-program related factors that impact a family's capacity to engage in the SafeCare program. In relation to program factors, 45 families declined to participate in SafeCare between February and September 2018 because the program was perceived to be too intensive, parents did not want a program with home visits, or they did not want to engage in a parenting program all together. Updated figures were not available to the evaluation as the rate of declining to participate in SafeCare was not reported beyond September 2018.

Issues were also experienced engaging families due to ineligible or *cold* referrals. As noted in *Section 5.4.1: Appropriateness of referrals,* these issues impacted family suitability for the program, and efforts to develop rapport with families. These referral challenges were perceived to be a result of limited education and awareness of SafeCare among local DCJ services. The findings highlight the importance of continued education and conversation about the SafeCare program among referring bodies. As noted during consultations, this issue is known to DCJ and any progress in regard to additional education for local DCJ services will be explored in future evaluation activities. Therefore, in addition to any promotion or advertisement activities that are planned for local DCJ offices, the development of a document that outlines appropriate client pathways and programs could be considered. The document could first outline a suite of available programs in the area and the eligibility criteria for each. This document could provide important information for local DCJ services about the most appropriate programs for families, subsequently improving the appropriateness of referrals not only for SafeCare but for other parenting programs under the supervision of DCJ.

It is also noted that current workload and workforce constraints have implications for the number of families that can be engaged with the SafeCare program at any given time. While the optimal target of engaging eligible families in the program is 50%, agencies expressed concerns with reaching this target given their current capacity. In some cases, eligible families were placed on a waitlist before they could access the SafeCare program. As noted in other sections of this report, it may be beneficial to increase the frequency of SafeCare training sessions and the number of staff that can be trained in each session to support the enhancement of workforce capacity.

Non-program-related factors

It is also noted that a number of non-program related factors limited family engagement in the program. Of the 357 families that commenced the SafeCare program, 168 families dropped out prior to program completion as of October 2019. The reasons for this included leaving the wider Brighter Futures program, leaving the area, lack of time, illness in the family or the child was removed from care. While this may be considered a negative outcome, research suggests that dropout rates for the SafeCare program in other jurisdictions are also high. A recent study in the United states revealed that 18% of the 266 families participating in the trial engaged in some level of intervention but did not complete all three modules and 35% of the 266 families participated in baseline data collection but did not engage in the intervention.[1] In addition, research suggests that a high level of attrition is common in child maltreatment intervention and research programs.[2]

The long-term impacts of families dropping out of the SafeCare program were not explored in the Process Evaluation however will be explored in the Outcomes Evaluation. Although, given the number of studies examining the effectiveness of the SafeCare program and the outcomes achieved as a result of each module (see *Attachment B*: *Desktop Review*) it is anticipated that some intervention, as opposed to no intervention at all, would improve outcomes for families. Therefore, strategies that improve initial engagement in the program should be explored. During consultations, a potential evidence-base for delivering individual modules was discussed with representatives from NSCTRC, PRC and DCJ. However, decisions about whether or not this is feasible and whether or not an evidence-base does exist, will be explored in future evaluation activities.

Additionally, issues were experienced due to characteristics of the target population. Specifically, families often experienced multiple vulnerabilities and crises (e.g. homelessness, domestic violence, alcohol and other drug issues). As noted in *Question 1c,* family crises and instability in the home often acted as barriers to successful engagement in the program and led to the perception that the family was not ready nor suitable for SafeCare. This occurred because families were often preoccupied with the crises or experienced emotional distress as a result of their situation. While these issues are not a result of the program itself, they have important implications for the success of the program.

Conclusions

- There is evidence that families were successfully engaged in the SafeCare program. As of October 2019, 97 families had completed SafeCare and 92 families were currently participating in SafeCare across the sites. Overall, 27% of eligible families were engaged in the program.
- The health module had the highest completion rate (143 families completed), followed by the safety module (119 families completed) and the parent interaction module (130 families completed).
- Family engagement was supported by the flexible delivery of the program, working collaboratively with families to align SafeCare to their needs, and allowing families to choose which module to begin with.
- Preliminary outcomes such as improved confidence, safety behavior, health awareness and parent-child interaction were observed.
- The findings suggest that 45 families declined to participate in SafeCare between February and September 2018 because it was perceived to be too intensive, they did not want home visits, or they did not want to engage in a parenting program all together. The rate of declining participation in SafeCare was not reported following September 2018.
- Of the 357 families that commenced the SafeCare program, 168 families dropped out prior to program completion as of October 2019. A recent study of a SafeCare trial in the United States revealed similar rates of drop out, with 18% of the 266 families participating in some level of intervention but not completing all three modules and 35% participating in baseline data collection but not completing the intervention.[1] Research also suggests that high dropout rates are common in child maltreatment intervention and research programs.[2]
- Reasons reported for dropping out of the program include leaving the wider Brighter Futures program, leaving the area, lack of time, illness in the family or child removed from care.
- Ineligible or cold referrals from local DCJ services hindered efforts to successfully engage families in the SafeCare program.

- The findings suggest that issues such as family crises and instability in the home were common among the target population for the program. These issues often posed barriers to successful engagement as families were preoccupied or experiencing emotional distress.

Question 1e: What are the barriers and enablers to program fidelity?

A triangulation of data from all sources suggests that, to date, program fidelity has been achieved throughout the implementation of SafeCare. As noted in previous questions of this report, the training program and the wider SafeCare program were implemented as intended. However, the findings suggest that there are a number of barriers and enablers to program delivery that have implications for achieving program fidelity.

In relation to program factors, data suggests that the clear structure of SafeCare program and the support provided by coaches and intermediaries enabled the achievement of program fidelity. This was also supported by clear processes to assess program fidelity during all stages of program delivery. However, as noted in *Question 1d,* ineligible or cold referrals from local DCJ were consistently reported to be a barrier to program delivery.

Additionally, the findings suggest that the program materials for families could be adapted to better reflect the Australian context and cater to vulnerable groups engaged in SafeCare. Specifically, the materials could be improved by enhancing cultural appropriateness for Aboriginal and/or Torres Strait Islander families, translating the materials into other languages and adapting the materials to better cater to families with an intellectual disability. This may assist in promoting a consistent approach to program delivery that is tailored to the context and needs of Australian families.

It should also be noted that there were a number of non-program related factors that impacted the successful delivery of the program. These include:

- Travel: when providers are required to travel long distances to deliver the program, it limits the amount of families that can be serviced.
- Characteristics of participating families: characteristics such as mental health problems, learning delays and culturally and linguistically diverse background may increase the time and support required for families to progress through the modules.
- Provider motivation: providers who are willing and motivated to deliver the SafeCare program may be more engaged in and satisfied with their work which may also lead to enhanced program delivery.
- Resourcing: the current resourcing model for the SafeCare program may not be adequate for the ongoing delivery and sustainability of the program.

While these factors are not a result of the SafeCare program, they have implications for its continued implementation and delivery and should be considered alongside this evaluation.

Conclusions

- There is evidence that program fidelity was achieved throughout the implementation of SafeCare.
- The findings suggest that program fidelity was supported by the clear structure of the SafeCare materials, the regular processes built into program delivery to assess program fidelity, and the support offered by coaches and intermediary agencies to implement and deliver the program as intended.
- Consultations identified elements of the program materials that were not perceived to be appropriate in the Australian context and for all families. This resulted in the adaption of program materials and potential variation in how the program was delivered across sites.

- Non-program related factors such as long travel distances to access families, characteristics of the target population such as mental health issues and learning delays and provider willingness and motivation to deliver the SafeCare program were reported to impact the effectiveness and timeliness of SafeCare program delivery. In addition, the limited resourcing of the program was reported to have implications for ongoing delivery and sustainability of the program.

Question 2: Were there any additional or unanticipated outcomes from the SafeCare implementation, and have these created benefits or limitations to the delivery of the SafeCare program?

In addition to the findings and preliminary outcomes already discussed in this report, the findings of evaluation activities conducted to date also suggest that the SafeCare program contributed to a number of unintended preliminary outcomes, both potentially positive and negative.

As noted in *Section 5.5.2: Unintended Outcomes,* the positive unintended outcomes observed as a result of the SafeCare implementation included an increased interest in education among participating parents, as well as an increased sense of achievement and recognition for parents. Consistent with these observations, a review of research suggests that the SafeCare program leads to a number of positive unintended outcomes, including improvements in family resources, social support and parental depression (see *Attachment B*: *Desktop Review*). Additionally, a review of similar intervention-based parenting programs revealed positive unintended outcomes such as a reduction in parental depression, parental anxiety/stress, and improvements in parental self-esteem and relationships with partners.[16] Therefore, it is anticipated that positive unintended outcomes may continue to be observed as a result of engagement with SafeCare and will be explored further in the Outcomes Evaluation.

Also noted in *Section 5.5.2: Unintended Outcomes*, a potentially negative unintended outcome observed as a result of the SafeCare implementation was a level of change resistance and staff turnover in the initial pilot sites (i.e. Wesley Mission). However, findings suggest that staff attitudes towards SafeCare have improved since the initial implementation. Additionally, for agencies that implemented SafeCare following the initial trial site, the rate of staff turnover was not perceived to be a result of the program but rather a result of non-program factors, such as seeking a higher salary or career progression elsewhere; or leaving the agency due to personal or family reasons. Overall, the data suggests that new and existing staff have adapted well to the implementation of the SafeCare model (see *Section 5.8: Staff Turnover*).

Finally, the data collection and reporting requirements appear to be impacting staff workload and satisfaction. Although initially intended to support implementation, a number of issues have been identified that have the potential to impact the program moving forward, as outlined in other sections of this report.

Conclusions

- The findings suggest that positive unintended outcomes were observed as a result of the SafeCare implementation. These include an increased interest in education among participating parents and an increased sense of achievement and recognition for parents.
- Recent research studies suggest that SafeCare may lead to a number of unintended positive outcomes such as reduced parental depression and anxiety/stress, and improved parental self-esteem and relationships with partners. At this stage of the evaluation, there is not enough

[16] Barlow, J., Coren, E., & Stewart-Brown. (2002). Meta-analysis of the effectiveness of parenting programmes in improving maternal psychosocial health. *Pub Med, 52*(476), 223-233.

evidence to determine whether SafeCare in this context leads to the outcomes listed, however, this will be explored in more detail in the Outcomes Evaluation.

- Potential unintended negative outcomes were also observed as a result of the implementation of SafeCare, including organisational change resistance and turnover in initial trial sites and increased burden on staff as a result of data collection and reporting requirements. However overall, the findings suggest that new and existing staff have adapted well to the implementation of the SafeCare model.

Recommendations

To improve the implementation and delivery of the SafeCare trial moving forward, we provide the following recommendations.

Implementation of the SafeCare trial

1. Consideration could be given to documenting any effective strategies that have been implemented by sites to support their staff to deliver the SafeCare program (i.e. additional skill building workshops, practice frameworks). This information would assist other agencies in their delivery of the program; would help promote continuity between sites; and help to inform any future roll out of the program. This information could be disseminated using pre-established communication channels to reduce process burden for participating sites, such as central implementation team (CIT) meetings.
2. The Department, in consultation with NSCTRC and PRC, could consider reducing the frequency of the implementation team meetings for trial sites to reach a balance between local and central implementation team meetings.

Training

3. We recommend that managers are provided with the opportunity to gain more in-depth understanding of the SafeCare program and modules.

Program Referrals

To improve the appropriateness of referrals:

4. The Department may wish to consider the development of a resource that outlines appropriate client pathways for local DCJ services. This could be delivered alongside any planned promotion or advertisement activities for local DCJ services.

Family Engagement

5. We recommend that the Department, in consultation with NSCTRC and agency representatives, develop clearer guidelines outlining family suitability for SafeCare. This may help to ensure a consistent approach for when the program is offered to families between different sites.
6. The Department, in consultation with NSCTRC, may wish to consider exploring the evidence-base for the delivery of individual SafeCare models.

SafeCare materials

To improve the relevance and appropriateness of training and program materials for all participating families, we recommend that:

7. The training materials be adapted to better reflect the Australian context and to ensure they are applicable to the realities of delivering SafeCare in Australian homes. For example, removing the safety hazard of drowning in the toilet and including information regarding the use of sunscreen.

In doing so, there should be consultation with providers to understand common challenges in delivery of SafeCare and this information should be included in a revised version of the facilitator guide.

8. The materials be adapted to include culturally responsive and safe content for Aboriginal and/or Torres Strait Islander families. This should include consultation with Aboriginal and/or Torres Strait Islander community members and community-controlled services.
9. Consideration be given to translating the materials into other languages to support program completion among families from culturally and linguistically diverse backgrounds.
10. Additional visual content be included in the SafeCare materials to support program completion among families with an intellectual disability or learning delays.

Data collection and reporting

To improve internal data collection and reporting activities conducted as part of the SafeCare trial, we recommend that:

11. The data collection activities be reviewed and streamlined to reduce process burden for participating trial sites. This should be done in consultation with representatives from agencies to gauge the depth and breadth of information they find useful in the data reports.
12. A regular review cycle of the data collection processes be implemented bi-annually, for quality improvement purposes.
13. The Department, in consultation with PRC, investigate the source for inaccuracy in the data reports and develop strategies to mitigate the issues identified.
14. There is an opportunity for staff to provide context about a family drop out in the data collection tools. This could be limited to a free text box. This information could be used to develop clearer guidelines of what constitutes a drop out and inform strategies to maintain family engagement.
15. Consideration could be given to the option for providers to report a 'good news story' to PRC. One story could then be selected for presentation in the CIT data reports to provide context of the positive outcomes achieved for families.

Sustainability

16. The Department may wish to consider the findings of this evaluation and engage in consultation with those sites who are experiencing challenges in establishing certified coaches in their agency. The aim of this consultation should be to develop strategies to further support the agency. These strategies could be informed by lessons learned from other more mature sites who have effectively overcome these barriers.

Implications for SafeCare moving forward

As outlined elsewhere in this report, the design and implementation of BF-SC appears to be aligned to best practice standards and has been implemented as intended. The evaluation is also aware of a number of studies that have demonstrated the effectiveness of SafeCare in improving parenting skills, child health care skills and safety in the home.[17] Additionally, research has found that SafeCare reduced recidivism/re-reporting and that these effects were observed for a period of up to six years.[18] Therefore, should the

[17] 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,* 377- 386.

[18] Chaffin, M., Hecht, D., Bard, D., Silovsky, J., & Beasley, W. (2012). A statewide trial of the SafeCare home-based services model with parents in Child Protective Services. *Pediatrics, 129*(3), 509-515.

implementation of SafeCare continue, and should program fidelity be maintained, it is expected that the benefits of the program will be ongoing. The detail of the outcomes achieved for families will be included in the Outcomes Evaluation due to the Department on the 26th February 2021.

The Outcomes Evaluation will employ a stepped-wedge design to assess the outcomes that have been achieved for clients, to inform future policy decisions. The Outcomes Evaluation will also include an Economic Evaluation to assess the costs and benefits of the program. For detail on the questions answered by the Outcomes and Economic Evaluations, see the data strategy matrix in *Attachment A*: *Evaluation Plan.*