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Brighter Futures Early Intervention Program

Interim Report 1

For the NSW Department of Community Services

Social Policy Research Centre Consortium

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Centre for Health Economics Research and Evaluation
School of Education and Early Childhood Studies
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Abbreviations

ATSI	Aboriginal and Torres Strait Islanders
CALD	Culturally and linguistically diverse
CHERE	Centre for Health Economics Research and Evaluation
CPR	Centre for Parenting and Research
CSC	Community Services Centre
Department	NSW Department of Community Services
DoCS	NSW Department of Community Services
ICS	Indigenous communities study
IOS	Intensive Outcomes Study
LA	Lead agency
MDS	Minimum dataset
Program	Brighter Futures early intervention program
SPRC	Social Policy Research Centre

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Brighter Futures is a voluntary program that provides targeted support tailored to meet the needs of vulnerable families with children aged under nine years or who are expecting a child. Brighter Futures provides families with the necessary services and resources to help prevent an escalation of emerging child protection issues. It aims to strengthen parenting and other skills to promote the necessary conditions for healthy child development and wellbeing. The Brighter Futures program is delivered by DoCS and non-government agencies working in partnership to support children and families. This report provides a baseline of activity in the Program up to September 2007.

As at September 2007, 975 families had participated in the program, with 39 per cent managed by DoCS and 61 per cent by lead agencies. A total of 6976 reports of risk of harm or requests for assistance were made to the DoCS Helpline with respect to these families for the period of 24 months prior to entering the program, with almost 90 per cent having a level of urgency of low to medium. The main vulnerability of the families in the Program was lack of social support followed by parental mental health issues and domestic violence. Seventy-four percent of families had more than one identified vulnerability.

The Family Survey is a questionnaire which is offered to each family in the Brighter Futures program. It has been developed to measure outcomes for the child and family as they progress through the program. The Survey has been offered to all families who entered the program since 1 May 2007. As of September 2007 there were 168 family surveys completed. For almost all the participants, the mother was the primary carer, with 61 per cent of single mothers providing care for one to two children. For the primary carer, almost one third had a disability, over a half had year 9, 10 or 11 as the highest level of education, and for 65 per cent, their main source of income as government benefits with 18 per cent being employed on a part-time or casual basis.

The Brighter Futures children are typically under the age of six with a strong representation in the age group of two to four years. More than a third of the children had a medical condition and half of the children had a development delay. Nearly half of the children were identified to require intervention for behavior problems. Most of the children also had socio-emotional problems.

Warmth, hostile parenting and consistency were three dimensions of parenting that had been identified in previous research as having an important impact on children's subsequent health and development. Parental warmth was identified to significantly correlate with children's behavior score. On average, the Brighter Futures parents scored slightly higher on the 'hostile parenting' measure than the Australian population as a whole as represented by the Longitudinal Study of Australian Children (LSAC).

On average, the primary carers assessed themselves as a 'better than average parent'. However 13 per cent of participants stated that they had some trouble or were not very good at being a parent, compared to less than two per cent of the LSAC participants. More than half of the primary carers stated that they sometimes felt that they needed support but could not get it from anyone and 37 per cent stated that they often or very often felt that way.

Primary carers demonstrated high levels of satisfaction with the services and the amount of service they received from the Brighter Futures program.

1 Introduction

This is the first interim report of an evaluation of the NSW Department of Community Services' (DoCS) Brighter Futures program by a consortium led by the Social Policy Research Centre (SPRC) at the University of NSW. The evaluation design began in 2006 and the evaluation will continue until 2010. The consortium comprises the Centre for Health Economics Research and Evaluation (CHERE), University of Technology Sydney; the School of Education and Early Childhood Studies, University of Western Sydney; Gnibi College of Indigenous Australian Peoples, Southern Cross University; and the National Institute of Social and Economic Research, London.

2 Program Overview

Brighter Futures is a voluntary program that provides targeted support tailored to meet the needs of vulnerable families with children aged under nine years or who are expecting a child. Brighter Futures provides families with the necessary services and resources to help prevent an escalation of emerging child protection issues. It aims to strengthen parenting and other skills to promote the necessary conditions for healthy child development and wellbeing. The Brighter Futures program is delivered by DoCS and non-government agencies working in partnership to support children and families.

2.1 Aims

The Brighter Futures program's aims are to:

- reduce child abuse and neglect by reducing the likelihood of family problems escalating into crisis within the child protection system
- achieve long term benefits for children by improving intellectual development, educational outcomes and employment chances
- improve parent-child relationships and the capacity of parents to build positive relationships and raise stronger, healthier children
- break intergenerational cycles of disadvantage
- reduce demand for services that otherwise might be needed down the track such as child protection, corrective services or mental health services.

2.2 Target group

Brighter Futures is designed for families who have children aged under nine years or who are expecting a child. Priority of access is given to:

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

Priority of access for families with children under three years of age is based on current research evidence that the first three years of life is a period of crucial brain development and lays the foundation for later cognitive and emotional development.

2.3 Partnership delivery (DoCS and Lead Agency)

Currently there are two entry pathways to the Brighter Futures program:

- a report of risk of harm or a request for assistance to the DoCS Helpline that is streamed to the Brighter Futures program by the Community Services Centre (CSC), or
- a referral to a Lead Agency by a community agency or individual.

In 2008 the rollout of the Aboriginal Maternal Infant Health Strategy (AMIHS) and Brighter Futures partnership will provide a further pathway direct to a DoCS Community Services Centre.

Regardless of the pathway into the Brighter Futures program, the eligibility decision is always made at the local DoCS Community Services Centre. Lead Agencies can only begin working with families once confirmation is received from DoCS that the family is eligible.

The total capacity in the Brighter Futures program state-wide is:

- 80 per cent: families referred from the DoCS Helpline (and eligible families referred directly to DoCS from AMIHS once the partnership arrangements are operating) and streamed to the Brighter Futures program
- 20 per cent: families referred to a Lead Agency from the community referral pathway.

All community referrals assessed as eligible are to be case managed by Lead Agencies and will constitute 40 per cent of their capacity. The remaining 60 per cent of families case managed by Lead Agencies are to be referrals from DoCS comprised of reports received via the Helpline or, once rolled out, AMIHS referrals that are received directly by the DoCS Community Services Centre.

The Lead Agency's agreed proportion of Helpline and community referred families (or capacity) is specified in the Lead Agency's contract with DoCS. The Lead Agency can only refuse a DoCS referred family if it does not have capacity to provide case management.

AMIHS workers can continue to use the community referral pathway following the rollout of the AMIHS – Brighter Futures service partnership.

2.4 Core services

Families participating in the program are assessed as likely to need an intervention of approximately two years duration and require case management and at least two of the following Brighter Futures funded service options:

- Quality children's services – includes any of the services, that are licensed under the NSW Children's Services Regulation 2004, such as long-day care, preschools, family day care.
- Parenting programs designed to assist parents to enhance their parenting competencies by increasing their knowledge of child development and parenting practices.

- Home visiting intended to provide support and skill development to parents in the home environment.

These services are designed to enhance child development, parenting capacity and family functioning. Some of these services are offered by DoCS, but they will mainly be provided by Brighter Futures funded agencies.

Services delivered by Brighter Futures program funded agencies are only available to families participating in the Brighter Futures program. Families may also be referred to universal and specialist services available within the local service system. This will depend on their assessed strengths and needs, including any risk of harm; e.g. parental drug and alcohol misuse and mental health issues. (DoCS, 2007c)[1].

[1] NSW Department of Community Services (2007), *DoCS Brighter Futures Caseworker Manual – 3rd Edition*, December 2007.

3 The Evaluation of Brighter Futures

The evaluation comprises 4 components:

- A *results evaluation* that examines whether the program is meeting the needs and improving the longer term outcomes for children and families who participate. The information collected for this evaluation includes the minimum data set – information provided by service providers on every child and family in the program; other DoCS administrative data; the Family Survey - a state-wide survey of families engaged in the program; an outcomes intensive cohort – a smaller sample of families in the program who will be intensively studied and the outcomes comparison group – a group of similar families who do not receive this intervention.

- A *process evaluation* that will examine implementation and administration of the program. Data sources are the minimum dataset and observation site evaluation data collection (interviews, observation, participation and discussion)

- An *economic evaluation* that will analyse the outcome and cost data from the results and process evaluation data sources described above and model long term outcomes that will produce a cost-benefit and cost-effectiveness analysis; and

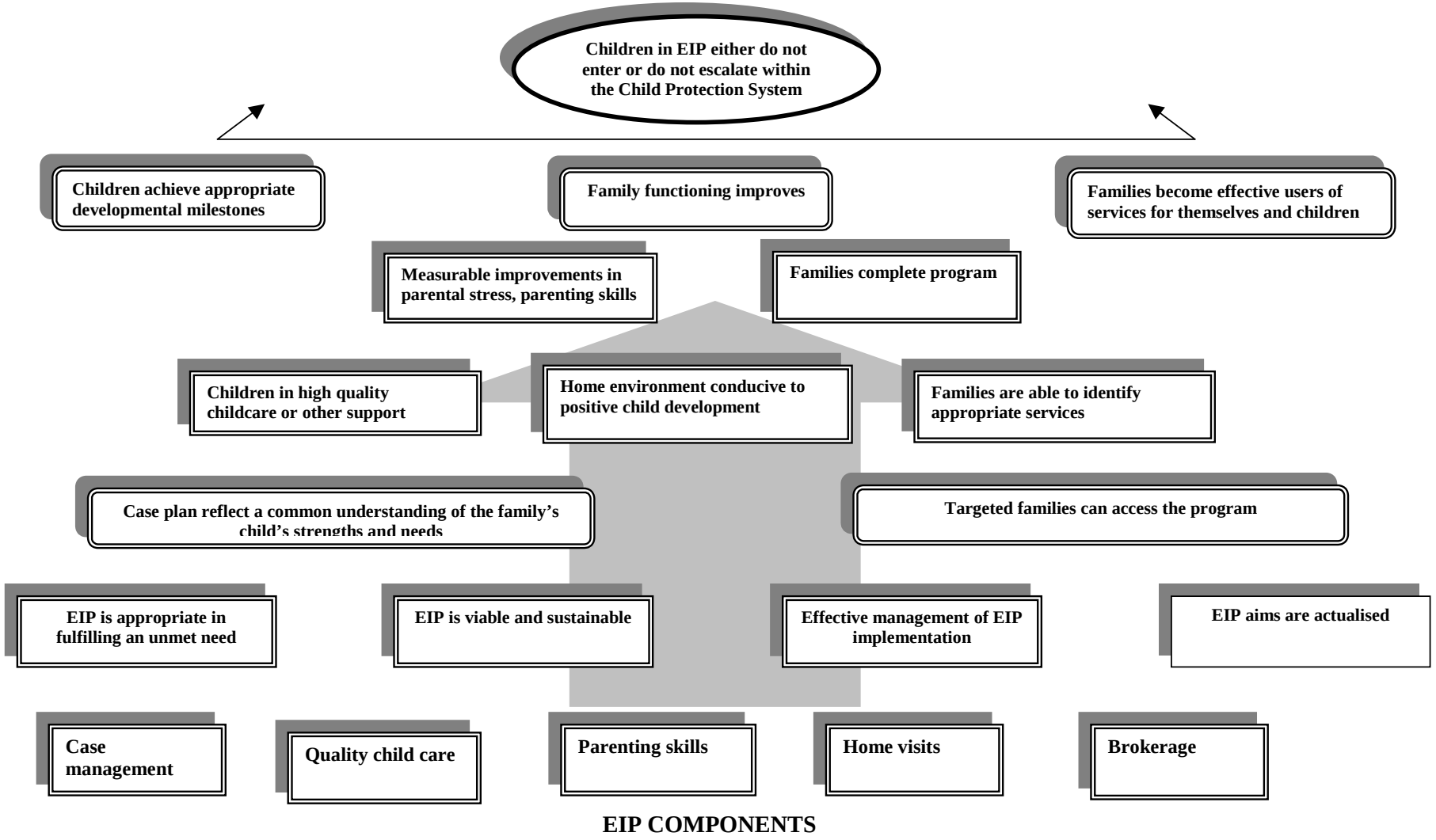
- An *intensive research* study that will explore how the program can better meet the needs of Indigenous families.

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

3.1 Program logic and performance measures

The Program Logic in Figure 3.1 describes the links between the inputs, processes and activities of the program and the impact they will have on the community (results) through a series of logical steps. The program logic and performance measures have been developed in consideration of the early, intermediate and longer-term results expected from the program and the research literature on appropriate performance measures for these stages.

Figure 1: Early Intervention Program Logic



4 Preliminary Analysis on the Brighter Futures referral outcomes and family characteristics

The first wave of data on families in the Brighter Futures program is based on families entering the program up to the end of September 2007. These data will be part of the baseline against which to measure the program's results, and to identify whether the program is being effectively implemented (DoCS, 2007d: 6).

Most of the contracts with the non-government sector for this program were finalised across the state in March 2007 with the majority of the agencies becoming operational during 2007. Similarly, the Brighter Futures teams were developed progressively, with many becoming operational during 2007. Consequently the data provide an overview of the early stages of program implementation.

Preliminary analysis is presented below on the implementation of the program date in terms of the outcome of the referral process and the number and characteristics of families entering the program. The data provided contained elements that have been collated and de-identified to protect the identity of individuals and families. Only a *Unique Family Identifier* and *Unique Person Identifier* for all Brighter Futures Families and their members had been included.

4.1 Number of Families in the Brighter Futures Program and their Management

DoCS Early Intervention (EI) Teams provide case management for families who enter the program via the DoCS Helpline referral pathway. Lead agencies case manage all those that enter via community referrals, and they also manage some Helpline referred families[2].

The baseline data indicated that as at September 2007, 975 families had participated in the Brighter Futures program, with 882 families still in the program, and 93 having exited. Of the 975 families, 39 per cent were managed by DoCS and 61per cent were managed by lead agencies.

Forty one per cent of families entered into the program through the community referral pathway. These were all managed by a lead agency. Lead agencies were also case managing 34 per cent of the families that came into the program from DoCS reports (Table 4-1).

Table 4-1: DoCS or Lead Agency-Managed * First Contact Path Crosstabulation

		First contact path					
		DoCS	%	Community	%	Total	%
DoCS or LA-Managed	DoCS	381		0		381	
	LA	193		401		594	
Total		574	59%	401	41%	975	100%

[2] NSW Department of Community Services (2007), *DoCS Brighter Futures Service Provision Guidelines*, December 2007, page 7.

A key feature of the Brighter Futures program model is the expectation that, overall, 80 per cent of families will be referred from DoCS Helpline reports and requests for assistance, and 20 per cent will be families referred to Lead Agencies by the community[3]. These planned proportions were not reflected in this early phase of program roll-out.

4.2 Geographical distribution of the families in Brighter Futures Program

About a quarter of families in the program (26 per cent) were located within the Metro Central region, with 62 per cent managed by the lead agency in that region. The lowest proportional representation is in the Southern and Northern region, with seven and eight per cent respectively (Table 4-2).

Table 4-2: DoCS or Lead Agency-Managed by DoCS Region

		DoCS or LA-Managed (Row %)				
		DoCS	%	LA	%	Total
REGION	Hunter & Central Coast	36	27%	97	73%	133
	Metro Central	96	38%	155	62%	251
	Metro South West	56	34%	108	66%	164
	Metro West	69	44%	88	56%	157
	Northern	56	68%	26	32%	82
	Southern	36	50%	36	50%	72
	Western	32	28%	84	72%	116
Total		381	39%	594	61%	975

In the regions of Hunter and Central Coast, Metro South West, Metro Central and Western a high proportion of families entered the program via the community pathway. For the Southern region 94 per cent of the families in the program entered via the DoCS referral pathway (Table 4-3). This may be due to the progressive roll out of the Brighter Futures program across the State (NSW DoCS, 2006)[4].

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

[4] NSW Department of Community Services (2006), *About the Brighter Futures Early Intervention Program*, December 2006.

Table 4-3: DoCS and Lead Agency managed families by area

		Reported Status(no.)			Reported Status (%)	
		Not Reported	Reported	Total	Not Reported	Reported
REGION	Hunter & Central Coast	32	101	133	24.1	75.9
	Metro Central	56	195	251	22.3	77.7
	Metro South West	40	124	164	24.4	75.6
	Metro West	17	140	157	10.8	89.2
	Northern	8	74	82	9.8	90.2
	Southern	4	68	72	5.6	94.4
	Western	27	89	116	23.3	76.7
Total		184	791	975	18.9	81.1

4.3 Reports to DoCS Helpline of Brighter Futures families

The DoCS Helpline operates 24 hours a day, 7 days a week. The Helpline records information received either as a report of risk of harm or as a request for assistance and completes the Initial Assessment Record. The family's eligibility for the Brighter Futures program is determined at the CSC. Families are initially assessed as eligible if the level of risk is "low" or "medium" and the required response time is '<72 hours' or '<10 days' or '>10 days' (NSW DoCS, 2007c: 37).

Of the 975 families in the Brighter Futures program, 780 families (involving 1711 children) had been reported to the DoCS Helpline[5]. For these families in the Brighter Futures Program, there were a total of 6976 reports received by the Helpline for the period of 24 months prior to entering the program. Eleven percent of families were reported only once to the Helpline. When analysing the reports by child, the mean number of reports per child was 4.1 per child and the median was 3. For almost seven per cent of children in the Brighter Futures program there were more than 10 reports.

These findings suggest that there was a great deal of variation in the amount of reporting for families in the Brighter Futures program with some families receiving no reports other than the report which resulted in their participation in the Program, whereas others were subject to multiple reports. In particular some families were subject to reports on different children.

When the Helpline receives a report, a caseworker at the Helpline makes an initial assessment to determine what action needs to be taken. As part of this process, the caseworker obtains the information about the safety, welfare and wellbeing of the child. Consideration is given to any information held by DoCS about the child and/or family such as previous reports or recent contact with the family as part of the process. The caseworker then decides what action needs to be taken. For the 6976 reports received by the DoCS Helpline regarding the families in the Brighter Futures program, 0.1 per cent had no required response time assigned, 10.0 per cent were assigned a required response of less than 24 hours, and 42.2 per cent a response of less than 72 hours (Table 4-4). This means that almost 90 per cent of the reports on the families have a level of urgency of low to medium. For those 10 per cent of the

[5] This figure may include some families who were reported to Brighter Futures via the community referral route as they may have been subject to separate reports not associated with their referral into the Program.

reports which had a response time of '<24 hours', additional information or review of information may have indicated that the urgency level is medium or low and the required response time is reclassified at the CSC (NSW DoCS, 2007c).

Table 4-4: Number of Required Response Time of Helpline Calls within 24 months of commencing Brighter Futures[6]

Required Response Time	Number	%
No Response Required	5	0.1
Less than 24 hours	498	10.0
Less than 72 hours	2095	42.2
Less than 10 days	2343	47.2
10 days or more	19	0.4
Total valid response levels	4960	100
Missing data[7]	2016	
Total calls	6976	

As stated above, a report is made to the DoCS Helpline where a reporter suspects that a child or young person is at risk of harm. Risk of harm means that there is concern about the safety, welfare or wellbeing of a child or young person for any of the following reasons: neglect; physical or sexual abuse and assault; emotional abuse; or domestic or family violence. For families in the Brighter Futures program, the most frequent primary reported issues were domestic violence (30 per cent), disability of carer (15 per cent), and risk of physical, psychological or sexual harm/injury (13 per cent). Inadequate clothing, nutrition, shelter or supervision made up 12 per cent of the reported issues, with 311 of the 834 calls specifically related to inadequate shelter or homelessness.

4.4 Family vulnerabilities in the Brighter Futures program

Families eligible for the Brighter Futures program must have at least one vulnerability that, if not addressed, is likely to escalate and impact adversely on their capacity to parent adequately and/or on the wellbeing of the child/ren. The vulnerabilities are:

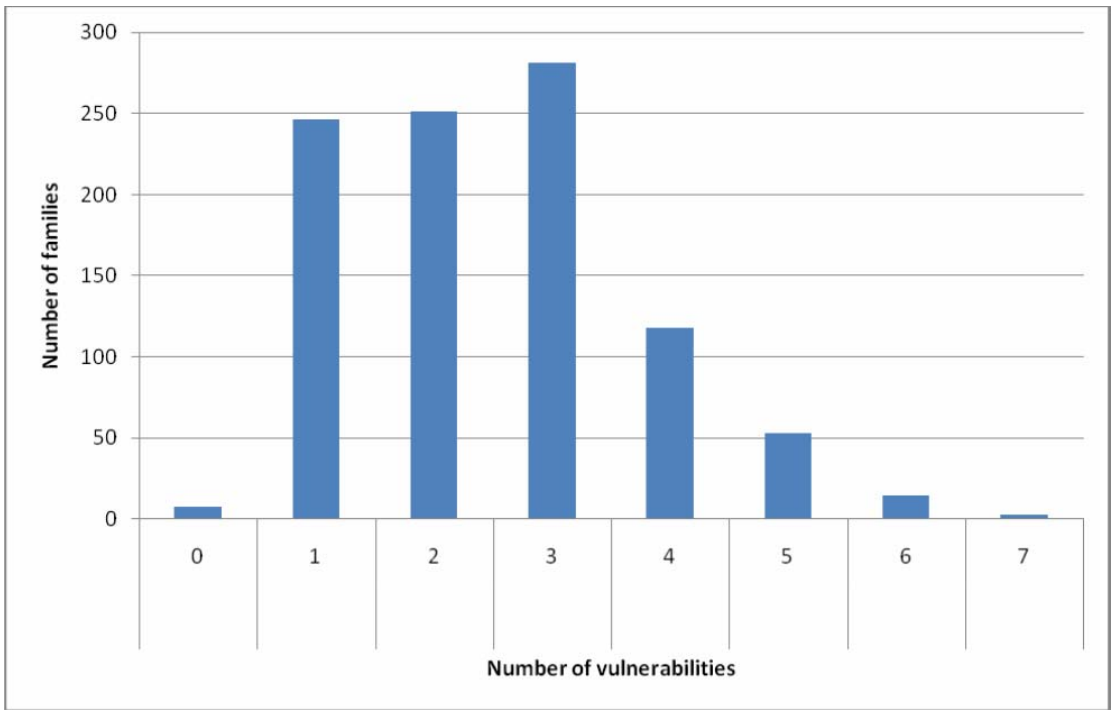
- domestic violence
- parental drug and alcohol misuse
- parental mental health issues
- lack of extended family or social supports
- parent(s) with significant learning difficulties and/or intellectual disability
- child behaviour management problems
- inadequate parenting skills/supervision.

[6] Reports data contains both reports referred to a CSC/Joint Investigative Response Team for secondary assessment and those referred for information only. Required Response Time is only required to be completed on the former; hence a high number of missing values are recorded for this indicator.

[7] The reports examined include those referred to a CSC/JIRT 'for secondary assessment' and those 'for information'. For the latter category required response time is not a mandatory field hence a high number of missing values are reported.

Seventy four percent of families had more than one identified vulnerability and only eight of the 975 families had no identified vulnerability (Figure 2).

Figure 2 Number of vulnerabilities by number of families



The main vulnerability assessed for 51 per cent of families was lack of social support followed by parental mental health issues (47 per cent) and domestic violence (46 per cent) (Table 4-5).

Table 4-5: Number of families with identified vulnerability by type

Type of vulnerability	Identified as Vulnerability	
	No.	% total families
Domestic Violence	452	46%
Drug and Alcohol misuse	258	26%
Parental Mental Health	454	47%
Lack of Social Support	496	51%
Learning /Intellectual Disabilities	67	7%
Child Behaviour Management	360	37%
Parenting Skills	352	36%
Total Number of Families	**975**	

Of those entering via the DoCS Helpline pathway, a greater proportion entered with domestic violence as a vulnerability than those entering via the community pathway (51 per cent compared to 27 per cent). More of the DoCS-referred families entered with parental drug and alcohol misuse (29 per cent compared to 17 per cent) and inadequate supervision or parenting skills (37 per cent compared to 30 per cent) as vulnerabilities. More families with parental mental health issues enter through the community pathway than through the DoCS Helpline referral (56 per cent compared to 44 per cent) (Table 4-6).

Table 4-6: Pathways into Brighter Futures Program and Family Vulnerabilities

	Helpline		Community	
Vulnerability	Number	%	Number.	%
Domestic Violence	402	50.8	50	27.2
Drug and Alcohol misuse	227	28.7	31	16.8
Parental Mental Health	351	44.4	103	56.0
Lack of Social Support	399	50.4	97	52.7
Learning/Intellectual Disabilities	54	6.8	13	7.1
Child Behaviour Management	285	36.0	75	40.8
Parenting Skills	296	37.4	56	30.4

For DoCS managed families, the most prevalent vulnerabilities were domestic violence, parental mental health and lack of social support, in order of importance. While for lead agency managed cases, the vulnerabilities that were prevalent were lack of social support, parental mental health and child behaviour management (Table 4-7).

Table 4-7: DoCS and Lead Agency managed families by Family Vulnerabilities

	DoCS		**Lead Agency**	
Vulnerability	Number	% of Total	Number.	% of Total
Domestic Violence	168	23.7%	284	16.4%
Drug and Alcohol misuse	97	13.7%	161	9.3%
Parental Mental Health	136	19.2%	318	18.4%
Lack of Social Support	114	16.1%	382	22.1%
Learning/Intellectual Disabilities	9	1.3%	58	3.4%
Child Behaviour Management	74	10.4%	286	16.5%
Parenting Skills	111	15.7%	241	13.9%
Total:	709		1730	

5 Family Survey Data Analysis

A key component of the evaluation of the Brighter Futures program is the Family Survey. The Family Survey is a questionnaire designed to measure families' progress during the program including changes in family functioning, parenting skills, and the targeted child's language and social/emotional development, as well as to provide important demographic information about client families.

The questions in the Family Survey are from research tools and scales frequently used both in Australia and internationally to assess the impact of early intervention programs[8]. It uses scales that can be completed by either the case worker or the carer.

The Family Survey was introduced in August 2007 and offered to all families who had entered the program since 1 May 2007. The survey is designed to be conducted at three intervals: within two months of program entry, six months after completion of the first survey and at program exit. For this baseline analysis there were 168 Family Surveys completed, representing 17 per cent of all families who had entered since the program commenced.

Almost all (165) were still in the program, two had left the program and one had missing data on entry. Three families indicated that they had been attending the program for one year or longer, and of these families one had recently stopped using the program. The families who had completed the Family Survey by the cut off date of September 2007 had been in the program an average of 3.3 months. From this group, only two families had exited the program, having been engaged for four and five months respectively.

5.1 Family demographics

The mother was the primary carer for 91 per cent of the participants, the father for 6.5 per cent and a grandparent for 1.2 per cent. For one child, the eldest sibling was the primary carer. With regard to the question about the primary carer, there were 30 missing variables for the participants. The data received is on 147 participants.

With regards to the number of people that usually live in the household other than the primary carer, 67 of the mothers that are providing care are living without a spouse or partner and 65 are partnered. For the ten fathers that are the primary carers, four indicated that they are providing care without a spouse or partner.

The number of children in the household ranged from 1 to 8, with a mean of 2.7 children and a median of two children. For 61 per cent of single mothers providing care, they had either one or two children. There were two families with single mothers who were each caring for more than five children.

There were 437 children aged under 18 years in the program, 77 per cent are aged between 0 to 8. There was a slightly greater representation of male children in the study at 54 per cent, however gender information was only provided on 420 children.

[8] DoCS Brighter Futures Caseworker Manual, Abridged Version, December 2007, www.community.nsw.gov.au/DOCSWR/_assets/main/documents/early_intervention/EIP_CASEWORKER_MANUAL.doc.

Of the 410 children that had country of birth details provided, 97 per cent were Australian. The other countries of birth listed are Sudan (1 per cent), Iraq (1 per cent), Argentina (0.2 per cent), Egypt (0.5 per cent) and New Zealand (0.7 per cent). Approximately 22 per cent of the children were identified as being Indigenous Australian - Aboriginal or Torres Strait Islander.

For the participants who answered the question on languages spoken at home other than English, 5.7 per cent spoke Arabic, 2.5 per cent spoke Vietnamese, and 2.0 per cent spoke Greek (Table 5-1).

Table 5-1: Languages spoken other than English at home (otherwise N/A).

Languages spoken other than English at home	Number of Children	%
Arabic	23	5.7
Vietnamese	10	2.5
Greek	8	2.0
Hindi	7	1.7
Others(a)	24	6.0
N/A (English Only)	331	82.1
Total	403	

Notes: (a) Others include all other languages.

There were three or more children in the household for 43 per cent of families in this cohort. Two families had children that were unborn (Table 5-2).

Table 5-2: Total number of children in the household

Number of children in household	Frequency	%	Cumulative%
unborn	2	1.4	1.4
1	31	21.4	22.8
2	50	34.5	57.2
3	21	14.5	71.7
4	20	13.8	85.5
5	13	9.0	94.5
6	5	3.4	97.9
7	2	1.4	99.3
8	1	0.7	100.0
Total	145	100	
Missing	23		
Total	168		

5.2 Primary Carer Demographics

Almost three quarters of primary carers were Australian, and a third came from a non-English speaking country (Table 5-3).

Table 5-3: Origin of primary carer

Origin of Primary Carer	%
Australian	73.2
Other English speaking countries	6
Non-English speaking countries	32
Missing	4.2 (7 cases)

For the primary carers living in the household, 154 were female and 10 were male. Of these carers, 22 identified themselves as Indigenous Australian (Aboriginal or Torres Strait Islander). From Table 5-4, it can be observed that around 11 per cent of the primary carers were aged 20 or less. Indigenous people have a similar age profile to the aggregate.

Table 5-4: Age of primary carer

Age of Primary Carer	Number	% (of 161)	Cumulative%
<20	18	11.2	11.2
20 – 29	56	34.8	46.0
30- 39	62	38.5	84.5
40 – 49	23	14.3	98.8
50+	2	1.2	100
Missing	7		

Forty eight percent of the primary caregivers indicated that they were the sole caregiver. Of the 52 per cent of households with a second caregiver, 92 per cent were partners of the primary carer. The majority (68 of 88) of these participants were male and 13 were female. Secondary carers had very similar age and country of birth profiles to those of the primary carers as shown in the above tables.

The primary and secondary carers are mainly from the same country of origin (Table 5-5).

Table 5-5: Primary and secondary carer origins

		Secondary carer origin			Total
		Australian	Other English Speaking Countries	Other non-English Speaking Countries	
Primary Carer origin	Australian	56	2	2	60
	Other English Speaking Countries	4	0	0	4
	Other non-English Speaking Countries	4	1	9	14
Total		64	3	11	78

Sixty four percent of the participants who do not have a second caregiver in the household stated that they also do not have a significant second caregiver living elsewhere. The vast majority of the primary caregivers (97 per cent) were biological parents and two per cent were step-parents.

Disability – 22 per cent of the primary carers (30 persons) had a disability[9]. Of this group, seven had intellectual or learning disability; 14 had a psychiatric disability;

[9] For the 168 respondents, there were 21 missing variable and 12 declined or not stated.

five had a physical/diverse disability and four had stated that they had other disabilities (two with ADD/ADHD; one depression/anxiety; and one hearing)[10].

Education - 55 per cent of participants stated that the highest level of education of any member of the household was year 9, 10 or 11.

Source of income – the main source of household income is government benefits, representing 65 per cent (Table 5-6).

Table 5-6: Education of primary carer by source of household income

Main source of household income		Paid work	Government Benefits	Child support or maintenance	Other	Total
Highest level of Education	Year 8 or below	1	10	0	1	12
	Year 9, 10 or 11	15	64	2	0	81
	Year 12	10	14	1	0	25
	Trade certificate/apprenticeship	3	3	0	0	6
	Other tertiary qualification	17	14	0	1	32
	University	7	5	0	0	12
Total		53	110	3	2	168

Almost half the primary carers were receiving Sole Parent/Family Benefit payment, 30 per cent received family tax benefit and 11 per cent received disability support (Table 5-7).

Table 5-7: Primary Carer Government Benefits

Type of benefit	Number	%
Missing	1	0.6
Sole parent/Family benefit	83	49.4
Family Tax Benefit (for working families)	50	29.8
Disability Support	19	11.3
Unemployment	5	3.0
Other	7	4.2
Not receiving a government benefit	3	1.8
Total	168	100.0

[10] Of this group of primary carers with disability, there were four that had more than one disability, two with combination of psychiatric and physical disability.

Primary Carer's Health

The primary carer's health is significantly correlated with the child's overall health, the primary carer's age and the child's behaviour.[11] None of the other variables demonstrated a statistically significant correlation with the primary carer's reporting on their lifestyle choices.

On average primary carers did something they considered to be enjoyable at least two to three times a week, regardless of their age, country grouping, the number of children, or the child's overall health. Most of the carers (81 per cent) stated that they took time to do something for themselves more than once a week.

About a third of primary carers (35 per cent) reported being of poor or fair health, with eight per cent stating that their health was much worse now than a year ago and another 20 per cent stating that their health was somewhat worse now than a year ago. Around a third of the primary carers stated that they had done no moderate or vigorous physical activity (at least 30 minutes). Only 10 per cent stated that they do some moderate or vigorous physical activity one day a week.

Given that self-esteem may act as a mediator in the relationship between parenting programs and parent self-efficacy, the survey used a tool to measure global self esteem (Rosenberg, 1965)[12]. The primary carer's self esteem results (RSE) were found to be statistically correlated with their life satisfaction[13] but there was no statistically significant correlation between the primary carer's self esteem[14] and the child's behaviour[15].

5.3 Secondary Care Demographics

Households with a second carer were more likely to have paid work as a source of income as compared to the 81 participants who did not have a second carer, 72 were reliant on government benefits as their main source of income (Table 5-8).

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[11] The primary carer's health was significantly correlated with the child's overall health (r=0.276, ρ<0.01), the primary carer's age (r=-0.173, ρ<0.01) and the child's behaviour (as measured by the Eyberg Child Behaviour Inventory tool) (r=-0.202, ρ<0.0).

[12] Rosenberg, M. (1965). *Society and the adolescent self-image*. Princeton, NJ: Princeton University Press. The Rosenberg Self Esteem tool is a 10-item scale in which respondents specify their agreement with a statement. Items were answered on a four-point scale from strongly agree to strongly disagree. The RSE score was calculated by summing the participants' responses across all 10 RSE questions, a technique that has been used by other researchers, such as Kaplan and Pokormy 1969; McCarthy and Hose 1982; Shahani et al 1990; Hagborg 1993 http://www.mhsip.org/reportcard/rosenberg.PDF (downloaded 27 November, 2007).

[13] Carer's self-esteem correlation with their life satisfaction (r=0.367, ρ<0.01).

[14] As measured by the Rosenberg Self-Esteem Scale.

[15] As measured by the Eyberg Child Behaviour Inventory and the Brief Infant Toddler Social Emotional Assessment (BITSEA) tools.

Table 5-8: Secondary carer in household by main source of income

		Main source of household income				Total
		Paid work	Government Benefits	Child support or maintenance from ex-partner	Other	
Second Carer in Household	Yes	48	35	0	1	84
	No	5	72	3	1	81
		0	3	0	0	3
Total		53	110	3	2	168

In terms of employment, 18 per cent of the primary carers were employed, primarily in part-time or casual jobs. Around 71 per cent of the secondary carers stated that they were full-time parents or were unemployed, although 67 per cent of secondary carers living in the household were working, with most working full time (Table 5-9).

Table 5-9: Employment status by carer (households including secondary carer)

	Primary Carer		**Secondary Carer**	
	Number	%	Number	%
Missing	2	1.2	92	54.8
Full-time	7	4.2	38	22.6
Part-time	12	7.1	7	4.2
Casual	9	5.4	6	3.6
Unemployed, looking for PT work	9	5.4	2	1.2
Unemployed, looking for FT work	1	0.6	4	2.4
Unemployed, other	13	7.7	5	3.0
Full-time parent	106	63.1	12	7.1
Other	9	5.4	2	1.2
Total	168	100	168	100

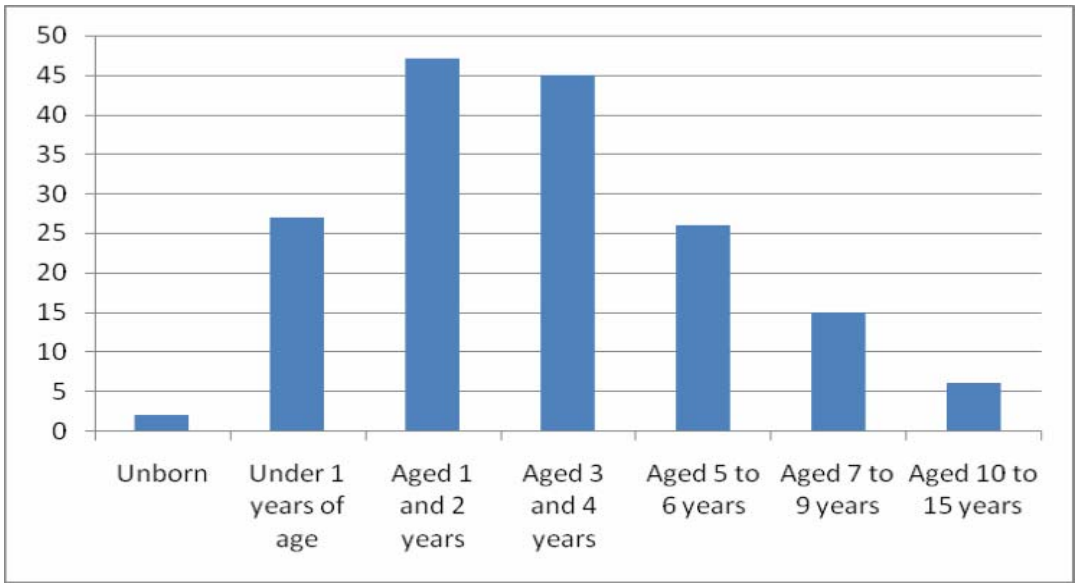
Analysis is not presented on secondary carer benefits given the very small number of participant responses.

Only 16 of the 168 participants answered the question about net household income. The average for that group was $52,000 or more per year.

5.4 Brighter Futures Children Demographics

The Brighter Futures program is designed for children under nine years of age with a priority given to children aged under three years of age. Children in the Brighter Futures program are typically under the age of six (84 per cent), with a strong representation in the age groups of two to four years (Figure 3).

Figure 3 Age range of children in Brighter Futures*



**There were six children identified as Brighter Futures children that were aged above 9 years of age.*

In general, the children in the Brighter Futures program were rated to be of good, very good, or excellent health by their carer. No child was rated as having poor health, and nine per cent of children were reported to have fair health (Table 5-10).

Table 5-10: Health of Brighter Futures children

	Number	%	Valid %	Cumulative %
missing	2	1.2	1.2	1.2
Fair	15	8.9	8.9	10.1
Good	38	22.6	22.6	32.7
Very Good	49	29.2	29.2	61.9
Excellent	64	38.1	38.1	100.0
Total	168	100.0	100.0	

More than a third of the children in the program (36 per cent) had a medical condition, and half of these children also had a development delay (Table 5-11).

Table 5-11: Medical problems and developmental delay in BF children

		Developmental delay			Total
		missing	No	Yes	
Medical problem	No	1	86	14	101
	Yes	9	24	27	60
		4	0	3	7
Total		14	110	44	168

6 Program outcome measures

Two of the five aims of the Brighter Futures program are as follows:

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

- improve parent-child relationships and the capacity of parents to build positive relationships and raise stronger, healthier children.

In this section, the measures that will be used to measure the above outcomes will be detailed together with the results for the first wave of data on the children and families in the Brighter Futures program.

The evaluation of the Brighter Futures program is a longitudinal study whereby information is gathered over a two-year period to see how the program is working over time. As part of this, the Family Survey is given to families three times over a two year period (SPRC, 2007): at intake into the program, at six months into the program and at the exit of the program. Changes in the outcomes for the children and parent-child relationships will be tracked throughout and post their participation in the Brighter Futures program.

6.1 Children's outcomes

Two instruments are used to measure the Brighter Futures child outcomes, the Eyberg Child Behaviour Inventory (ECBI) and the Brief Infant Toddler Social Emotional Assessment (BITSEA). The ECBI is tool designed to measure behavioural problems in children and adolescents aged between two and 16 years, as reported by their carers. It measures the number of difficult behaviour problems and the frequency with which they occur. The BITSEA screens social-emotional/behavioural problems and delays in competence in children aged between 12 months and 24 months. The scores predict cognitive development as well as behavioural problems in children.

Eyberg Child Behaviour Inventory

The ECBI was used to rate behavioural problems on a 7-point Intensity Scale, assessing how often the behaviours currently occur (one meaning 'never', four meaning 'sometimes', and seven meaning 'always'). If children score 131 or more on this scale (the clinical cut off score), they are considered to require clinical intervention for their behaviour difficulties).[16] Scores are computed by summing the Intensity Scale scores. The ECBI was completed on 108 children aged 24 months and produced an average score of 125.

[16] Some studies use clinical cut-off scores of 127.

Table 6-1: Eyberg clinical cut off

	Number	%
Eyberg Intensity is <131	58	53.7
Eyberg Intensity is ≥131	50	46.3
Total	108	100.0

This tool found nearly half the number of children (46 per cent) would 'require intervention' for behaviour problems (Table 6-1). The two factors found to be most associated with behaviour problems were the health of the child and a lack of parental warmth. That is, the better the health of the child and the higher the score for parental warmth (the interaction between the parent and the child) the lower the Eyberg score, meaning children did not require clinical intervention for behaviour difficulties.

Correlation tests were conducted on a range of factors that may relate to behavioural difficulties measured by the Eyberg Intensity Score, including education levels of parents, and income and employment as presented in the table below. None were found to statistically correlate with the Eyberg Intensity Score.

Brief Infant Toddler Social Emotional Assessment (BITSEA)

Behavioural problems among young children in the Better Futures program were also indicated by the BITSEA tool which was completed for 26 children aged between 12 months and 24 months. BITSEA is a 42-item parent-report measure for identifying social-emotional/behavioural problems and delays in competence.

The instrument assesses the total **problem** score and the total **competency** score of the child. For those assessed, the mean **problem** score was 45.1 and the mean for **competency** was 21 (**Table 6-2**). These were above the clinical cut off scores defined for gender and age (see Table 6-3), suggesting socio-emotional problems and competence are of concern for the average child of this age group in the program.

Table 6-2: BITSEA descriptive statistics

Bitsea	Number	Range	Minimum	Maximum	Mean	SD
Problem	26	68	1	69	45.25	13.75
Competency	26	25	3	28	21.5	5.98

Table 6-3: BITSEA cut off scores

BITSEA socio-emotional problems/competence are of concern if >=

		Cut scores	
	Age band	Girls	Boys
Problem total	12-17 months	13	15
	18-23 months	15	15
	24-29 months	13	14
	30-35 months	14	14
Competence total	12-17 months	11	11
	18-23 months	15	13
	24-29 months	15	14
	30-35 months	15	14

6.2 Parent Practices Outcomes

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

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

Parental Self-Efficacy

The study found parents' attitudes and beliefs about their competency as a parent were closely related to parenting quality.[17] On average, the primary carers felt they were a 'better than average parent' – the median result was 'a better than average parent', with the mean slightly worse. Thirteen per cent of participants stated that they had some trouble being a parent or were not very good at being a parent (Table 6-4).

This compares to the Longitudinal Study of Australian Children (LSAC) Wave 1 data, in which less than two per cent of parents in the infant and child cohort rated themselves as having some trouble being a parent or were not very good at being a parent (Zubrick, et al., 2006: 94).

Table 6-4: Primary Carer Self Rating as a Parent

		Number	Valid %	Cumulative %
Valid	A very good parent	49	30.1	30.1
	A better than average parent	33	20.2	50.3
	An average parent	60	36.8	87.1
	A person who has some trouble being a parent	18	11.0	98.2
	Not very good at being a parent	3	1.8	
	Total	163		
Missing	System	5		
Total		168	100.0	100.0

On questions of specific parental efficacy, using questions from LSAC, the mean score was at 22.45 out of a possible 30, with the higher the number, the more 'exactly how I feel' (Table 6-5).

[17] This was assessed using a single item developed for use with parents in the Early Childhood Longitudinal Study – Birth Cohort for parents of children from nine months and older. National Center for Education Statistics, 2004; LSAC, 2008.

Table 6-5: Descriptive Statistics for Parent efficacy

	N	Mean	Std. Dev	Variance
Parent specific efficacy (LSAC)	**165**	**22.449**	**5.582**	**31.163**
I feel that I am very good at calming this child when he/she is upset	163	7.42	2.413	5.825
I feel that I am very good at keeping this child busy when I'm doing housework	163	6.71	2.603	6.774
I feel that I am very good at routine tasks of caring for this child	164	8.54	2.189	4.790
Valid	161			

The study asked parents questions from the LSAC about how effective they felt in 1) calming the child 2) keeping the child busy while the parent did housework and 3) routinely caring for the child. Parents were asked to give a higher number, the more the statement represented 'exactly how I feel'. On average, parents felt generally effective in these areas. The mean score was 22 out of a possible 30 (Table 6-5).

In correlation testing of the primary carer self rating the only two factors that were significantly correlated were the Eyberg Intensity score and the child's overall health rating[18] .

There was no statistically significant correlation between parent efficacy and behaviour measured by the BITSEA scores on behaviour problems and competency; the existence of secondary carer, country of birth, number of children, education level or income.

Positive Parenting

Children who experience positive interactions with a nurturing, involved parent have better school and social outcomes than those who do not (Thomas, 2006). Four items measuring positive parenting were extracted from the National Longitudinal Study of Canadian Youth (NLSCY). For this scale, a higher score indicates more positive parent-child interaction with scores ranging from 'never undertaking an activity' (a score of 5) to 'many times a day' (a score of 25). A parenting positive factor mean score of 19.4 was calculated for all families.

High levels of positive parent–child interaction were reported for more than 77 per cent of the children in the Brighter Futures program compared to the Canadian study average of 82 per cent of children. Most parents in the Brighter Futures praised their child but fewer played sports or hobbies together.

[18] Eyberg Intensity (r=0.204 p< 0.037; and the child's overall health (r=-0.161 p< 0.040).

Table 6-6: Descriptive Statistics on Positive Parenting

	N	Mean	Std Dev	Variance
Parenting Positive Factor (NLSCY)	166	19.434	3.987	15.896
Do something special together that your child enjoys	164	3.80	1.038	1.078
Laugh with your child	166	4.31	.970	.941
Praise your child	163	4.41	.837	.700
Talk or play focusing attention on your child for 5 minutes or more	165	4.24	.987	.974
Play sports or hobbies together	162	2.90	1.408	1.983
Valid N (listwise)	159			

Tests for correlation were conducted on positive parenting, hostile parenting and specific parental efficacy. The Brighter Futures child's overall health was identified as the only variable that was significantly correlated[19] with positive parenting. None of the primary carer's demographic factors such as gender, age, employment, income or education level were correlated with parental outcomes. This contrasts with the Canadian study that identified that income was weakly related to the positive parent-child interaction.

Parental Warmth

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

Two questions were asked to estimate parental warmth in relation to children aged 24 months and above. These were taken from the LSAC with a scale of one for 'never or almost never' to five for 'always or almost always'.

The scores ranged from 2 to 10 (the possible results are 0 to 10), with a high mean of 9.3 and standard deviation of 1.6. The parental warmth indicator was tested against the Eyberg Intensity Indicator and they were found to be highly correlated (Table 6-7).

Table 6-7: Correlations - Eyberg with parent warmth

		Eyberg Intensity	Parent Warmth
Eyberg Intensity Score	Pearsons Correlation	1	-.203*
	Sig. (2-tailed)		.042
	N	108	101
Parent Warmth	Pearsons Correlation	-.203*	1
	Sig. (2-tailed)	.042	
	N	101	101

Note: * Correlation is significant at the 0.05 level (2-tailed)

[19] ($\rho<0.05$)

Hostile Parenting

The ways in which parents manage challenging or problematic child behavior is also important for effective parenting. The types of discipline strategies associated with poor outcomes for children have been broadly documented and when these strategies are limited, children's behaviour improves (Patterson, et al., 1989). The scores on hostile parenting are negatively skewed. The higher the score, the more often these events happen from one signifying 'not at all' to 10 'all the time'. On average, parents in the study were slightly more hostile to their children than those in the LSAC. The Brighter Futures mean on this question was 11.76 out of a maximum of 30 and a minimum of three (Table 6-88). The Australian mean in relation to this question for primary carers was 9.7.

Table 6-8: Descriptive Statistics on Hostile Parenting

	N	Mean	Std. Dev	Variance
Parenting Hostile factor (LSAC)	**166**	**11.759**	**6.209**	**38.55**
I have been angry with this child	166	4.23	2.306	5.32
When this child cries, he/she gets on my nerves	165	3.45	2.448	5.99
I have raised my voice with or shouted at this child	165	4.13	2.586	6.69
Valid	165			

Support for Primary Carer

One of the Brighter Futures program vulnerabilities is lack of extended family or social supports. Social support is an important measure in itself and is also an important determinant of many outcomes, for both parents and children. Parents with higher levels of social support have been found to have better psychological health outcomes, and have important sources for parenting support allowing for more effective child-raising (Zubrick, et al., 2006: 32). The survey asked how often the carers feel that they need support or help but can't get it from anyone (other than their caseworker). More than half (52 per cent) stated sometimes and 37 per cent stated that they often or very often feel that way (Table 6-9).

These findings were much higher than those obtained from the LSAC with almost a quarter of primary carers from both infants and children reported feeling a lack of support from family and friends living elsewhere (Zubrick, et al., 2006). The Brighter Futures program participants' response was found to be correlated with the age of the primary carer[20] but there was no statistically significant relationship with the number of children, whether the primary carer was the mother or father, the country grouping, or the child's overall health.

[20] (r=0.250, ρ<0.01)

Table 6-9: Primary Carer Need for Support but can't get it

		Number	%
Valid	I don't need support	2	1.2
	Never	19	11.3
	Sometimes	85	50.6
	Often	41	24.4
	Very often	21	12.5
	Total	168	100.0

Relationship Testing

Parental well-being is strongly associated with relationship functioning. Parents who report low satisfaction with their relationship with their partner and more arguments also experience higher levels of psychological distress, lower levels of coping, and more life difficulties (Zubrick, et al., 2006).[21].

Most parents in the Brighter Futures program were relatively satisfied with their relationship with their child. On a scale of satisfaction/dissatisfaction with this relationship where zero is completely dissatisfied and 10 is completely satisfied, the mean was 7.73. They were slightly less satisfied with their own life and personal circumstances. On average the respondents scored 6.08 on a scale in which zero is completely dissatisfied and 10 is completely satisfied

Of the primary carers, 103 had had a partner or spouse in the past six months. These parents were asked a range of questions drawn from the LSAC to determine the relationship that the spouse or partner had with the primary carer and with the children. The answers range from zero for completely dissatisfied to 10 for completely satisfied. Primary carers were less satisfied with their relationship with their partner than they were with their partner's relationship with their children. Satisfaction over these relationships was correlated with the primary carer's age, parent's hostility, and the child's overall health.

Primary carers indicated that arguments with their partner happen rarely or occasionally. Participants demonstrate feelings of attachment to their family, reporting the family takes notice of their opinions and that they tend to be included in their own family.

This may be because the primary difficulties in these families relate to the children themselves, or it may be a factor of response bias i.e. that parents were either consciously or unconsciously reporting findings about themselves which they expected the researchers would approve of. This phenomenon is expected in a study such as this, and we will have to wait until the six month follow up to see whether these scores change.

[21] From LSAC and other academic literature, across both infant and child cohorts.

6.3 Brighter Futures Program Satisfaction

Participants were generally satisfied with the services and the amount of services received from the Brighter Futures Program (Table 6-10). In summary:

- Nearly all (92 per cent) stated that they were satisfied or completely satisfied with case management.[22]
- Nearly all (97 per cent) stated that they were satisfied or completely satisfied with home visits[23].
- More than half (59 per cent) stated that they were satisfied with the child care service, and, 35 per cent stated that it was not applicable.
- Nearly half (48 per cent) of families stated that they were satisfied with parenting programs and 46 per cent stated that it was not applicable.

Table 6-10: Satisfaction with child care by age of child

		BF Age Range						
		Under 1 years of aged	Aged 2-3 years	Aged 3-4 years of age	Aged 5-6 years of age	Aged 6-10 years of age	Aged 10-16 years of age	Total
Service_Quality _Childcare	Not applicable	14	11	14	6	11	1	57
	Completely dissatisfied	1	1	0	0	0	0	2
	Dissatisfied	0	0	0	0	0	0	1
	Neither satisfied of dissatisfied	1	2	2	0	1	2	8
	Satisfied	1	3	4	1	0	1	10
	Completely satisfied	10	27	21	10	8	2	78
Total		27	45	41	17	20	6	156

[22] Of the 168 participants, six had missing data and two stated that it was not applicable suggesting that they may not be receiving this service.

[23] Of the 168 participants, seven had missing data and one stated that it was not applicable suggesting that they may not be receiving this service.

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