LONGITUDINAL IMPACT EVALUATION OF **RAPID RESPONSE**

Anglicare Victoria

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Acronyms and Abbreviations

CFECFW	Centre for Excellence in Child and Family Welfare
CRIS	Client Relationship Information System
DHHS	Department of Health and Human Services
EBM	Evidence-Based Model
ECMS	Electronic Case Management System
NCFAS	North Carolina Family Assessment Scale
OoHC	Out-of-Home Care
SOS	Signs of Safety

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Executive Summary

The Rapid Response program is operated by Anglicare Victoria and funded by the Victorian Department of Health and Human Services* (DHHS). Rapid Response aims to reduce out of home care (OoHC) placements by addressing the specific risk factors that resulted in Child Protection involvement. It also aims to strengthen family functioning through a range of therapeutic approaches.

Anglicare Victoria engaged Monash University to evaluate the Rapid Response program. The evaluation was multifaceted, containing implementation, process, delivery, and outcome components. The evaluation used a mixed methods approach and drew on multiple data sources to develop findings and conclusions, including a literature review, quantitative analysis, and qualitative data collection and analysis.

The evaluation collected and analysed these data to respond to 2 key lines of enquiry outlined below:

What is the impact of Rapid Response on children and their families?

For those that completed Rapid Response, at program closure and 3 and 6 months post Rapid Response, 97.0%, 88.1% and 80.2% of children and young people remained in parental care respectively. For the comparison group, 50% remained in parental care after an unsuccessful referral to the program.
After completing Rapid Response, the majority of families had met all or most of their Child Protection goals, while safety, environment, parental capabilities, family interactions and child well-being were all found to significantly improve.

What are the associations between implementation quality and program outcomes?

- The governance approach of Rapid Response is a critical component of its implementation
- The extent to which the referral process functions effectively defines the success of the model
- Factors to consider for program scale-up including staffing, the Child-Protection-Rapid Response relationship, training and dose.

* In 2021 DHHS was split into two departments - the Department of Families, Fairness and Housing and the Department of Health.

Rapid Response is delivered by highly skilled teams driven to demonstrate that providing the right of type support at times of crisis can prevent placements in OoHC.

Anglicare Victoria continually assesses the Rapid Response model and has adapted the original model to improve system suitability. From its origins in the Homebuilders model (Kinney, Booth & Haapla, 1991) to a stand-alone intervention, the phases of Rapid Response are pragmatic and logical (described in detail in the main section of the report), while keeping stakeholder interests at the forefront of all decision making.

Direct replication of the current Rapid Response model, however, may not be enough to ensure that the intended outcomes of the model are achieved by future iterations of Rapid Response. In particular, further consideration of learning and development strategies, the Child Protection–Rapid Response relationship, a single agency implementation model, variations across catchments and incomplete cases are required.

Designed and delivered by Anglicare Victoria, an Australian, non-government organisation that provides support to disadvantaged children, young people and families, Rapid Response targets the increasing rates of OoHC placements in Australia (AIHW, 2018).

Rapid Response's placement prevention model acts as a direct alternative to Child Protection intervention, as the final option before the removal of a child. Critical to the model is a 'rapid response' (within 24 hours) and singular intervention focus by the Practitioner to support the family where a Protection Application is about to be issued. Specifically, Rapid Response works with families to address the specific risk factors that resulted in Child Protection involvement and focuses on strengthening family functioning thereby removing — or at the very least reducing — the need for further Child Protection involvement.

Rapid Response Senior Practitioners have a flexible working week (business days only), allowing them to conduct visits in the home at key times, based on the family's needs and the goals identified by Child Protection.

Ultimately, the primary goal of Rapid Response is to stabilise the crisis, providing families with durable and longstanding supports that will enable the child to remain safely at home.

Note: Child Protection are the sole referrers to the program. While all referrals require that both the Child Protection Practitioner and Team Manager agree that a child is at imminent risk of a Protection Application by Emergency Care and OoHC placement, Child Protection act as the gate keeper to ensure the child meets this threshold.

Where is Rapid Response being delivered?

At the time of reporting, Rapid Response was being delivered in the following 4 Victorian catchments: South (Bayside Peninsula), West (Western Melbourne and Brimbank Milton), Outer East and North (Hume Moreland and North East). During the evaluation period, Rapid Response was also being delivered in Bendigo (Loddon Mallee and Greater Bendigo), however operations ceased in November 2019 (see Implementation and Delivery section for further details).

Program Staffing and Governance

At each catchment, the Rapid Response team includes three Senior Practitioners and one Team Leader (all FTE). All teams are overseen by the Rapid Response Practice Lead (FTE), a position implemented by Anglicare Victoria to drive practice development, develop the Rapid Response in-house training and improve program standardisation. For quality assurances, ongoing corrective action (i.e. to resolve problems and facilitate successful program implementation) and to ensure organisational policy, standards and procedures are upheld, additional program oversight is provided by Anglicare Victoria Program Managers and the General Manager of Business Development and Evidence-Based Models.

Senior Practitioners: Key responsibilities include providing the intervention face-to-face in the family home (at flexible times), conducting assessments on family functioning and supporting the family to achieve the goals outlined by Child Protection to improve safety in the home. Senior Practitioners report directly to the Team Leader.

Team Leaders: Instrumental in coordinating the day-to-day delivery of Rapid Response, Team Leaders plan and implement responses in relation to sector and service developments and provide ongoing support, supervision, and performance management of team members. Team Leader responsibilities also include developing and maintaining partnerships with key agencies including the Victorian Government DHHS and Child Protection while ensuring Rapid Response receives appropriate referrals.

Practice Lead: Responsible for overseeing and ensuring model fidelity, program training and practice consistency across all of the Rapid Response teams. The Practice Lead provides expert practice leadership and consultation, addressing any systemic barriers to program success in addition to holding key leadership roles in the Anglicare Victoria Rapid Response Governance Group and Communities of Practice forums.

Governance: Essential to the advancement and sustainment of Rapid Response is an effective partnership with local Child Protection teams. This partnership is fostered by regular contact between Team Leaders and Child Protection Team Managers (to build and maintain effective referral pathways) and quarterly governance meetings that consist of senior representatives from both Anglicare Victoria and DHHS. These governance meetings provide a context from which high-level decision making on key issues (e.g. referrals, outcomes, projections and operational issues) and accountability occur.

Evaluation Approach

Study Design

While many intervention evaluations focus on determining how an intervention has produced changes in individual outcomes, emerging evidence suggests that in order to establish long-term improvements in the health of communities and sustain interventions at scale, it is also beneficial to evaluate the effect of implementation at organisational and system levels (Mendel et al., 2008). This study, therefore, was conceptualised as a longitudinal impact evaluation based on the general premise of Hybrid Type 2 designs (i.e. the simultaneous assessment of implementation and intervention outcomes [Curran, Bauer, Mittman, Pyne, & Stetler, 2012]). This design is especially pertinent for evaluating interventions in the OoHC system because such a design can be used to evaluate the implementation of Rapid Response while also permitting the evaluation of program effectiveness in 'real world' settings.

The report had two overarching aims:

AIM 1	To evaluate the impact of Rapid Response on Children and their families
AIM 2	To explore associations between implementation quality and program outcomes.

To assess the effectiveness of Rapid Response, de-identified administrative client data provided by DHHS and Anglicare Victoria was used to compare differences in OoHC outcomes. These data are collected as part of both organisations' administrative processes when offering support services to the community. Effectively, two sets of data were provided; one set of data for clients that participated in Rapid Response and another set of data for clients who were referred to the program, but because the program was at capacity they engaged with the Child Protection system 'as usual'. This latter group of participants form a naturally occurring usual care comparison group as randomisation is not possible (Child Protection agencies control Rapid Response referrals) nor ethical (we cannot lay claim to the principle of equipoise in light of previous evaluations of Rapid Response). Given no direct recruitment of young people or their families occurred in this study, the design posed little risk, using existing administrative client data without modifying or withholding access to important services.

The implementation of Rapid Response was assessed through a combination of semi-structured interviews and focus groups with internal stakeholders (i.e. Rapid Response Practitioners, Team Leaders and Practice Managers), program audits (based on Anglicare Victoria's electronic case management system [ECMS]) and researcher observations.

Ethics

Ethics approval was obtained from the Monash University Human Research Ethics Committee (Project ID: 18177). External research and ethics approvals were also obtained from DHHS and Anglicare Victoria.

Participants Staff

A total of 23 Anglicare Victoria staff (denoted as 'Rapid Response Practitioner' or 'Rapid Response Leadership' when quotations is cited) participated in this research, spread across all catchments. Of this, 14 Rapid Response Practitioners (2 from the West, 2 from the East, 3 from the North, 4 from Bendigo and 3 from the South) participated in one of 5 small focus groups, while Team Leaders (5), the Practice Lead (1) and Program Managers (3) participated in individual face-to-face interviews. At the time of the interviews, staff had been in their role for an average of 10.8 months (ranging from 6 to 24 months) while their average age was 29.25.

Client data

The 251* families that were included in this evaluation participated in the Rapid Response program between June 2018 and September 2019. Data for this intervention group were only available for the evaluation if case details had been entered into Anglicare Victoria's ECMS. Because the migration of Rapid Response reporting into the ECMS was staggered across catchments, this evaluation does not include all cases that participated during this time frame. For the comparison group, 42 cases were recorded from February 2019 – January 2020.

*This sample size is adequate to detect small to medium effects (d = .15 - .45 for matched pairs and independent sample mean difference models) at 80% power (calculated using G*Power 3.1 [Faul, Erdfelder, Buchner, & Lang, 2009] and based on previous studies that reported positive placement prevention effects [see Al et al., 2012]).

Intervention Group

A total of 251 cases participated in this research, spread across each of the five catchments. Participants had an average age of 8.53 years (SD = 4,92; Range .02 - 16.72 years) with 140 males (55.8%) and 111 females (44.2%). Twenty-eight (11.2%) children and young people identified as Aboriginal and Torres Strait Islander while 66 (26.3%) were from the Outer East, 64 (25.5%) from the West, 9 (3.6%) from Bendigo, 26 (10.4%) from the North, and 86 (34.3%) from the South.

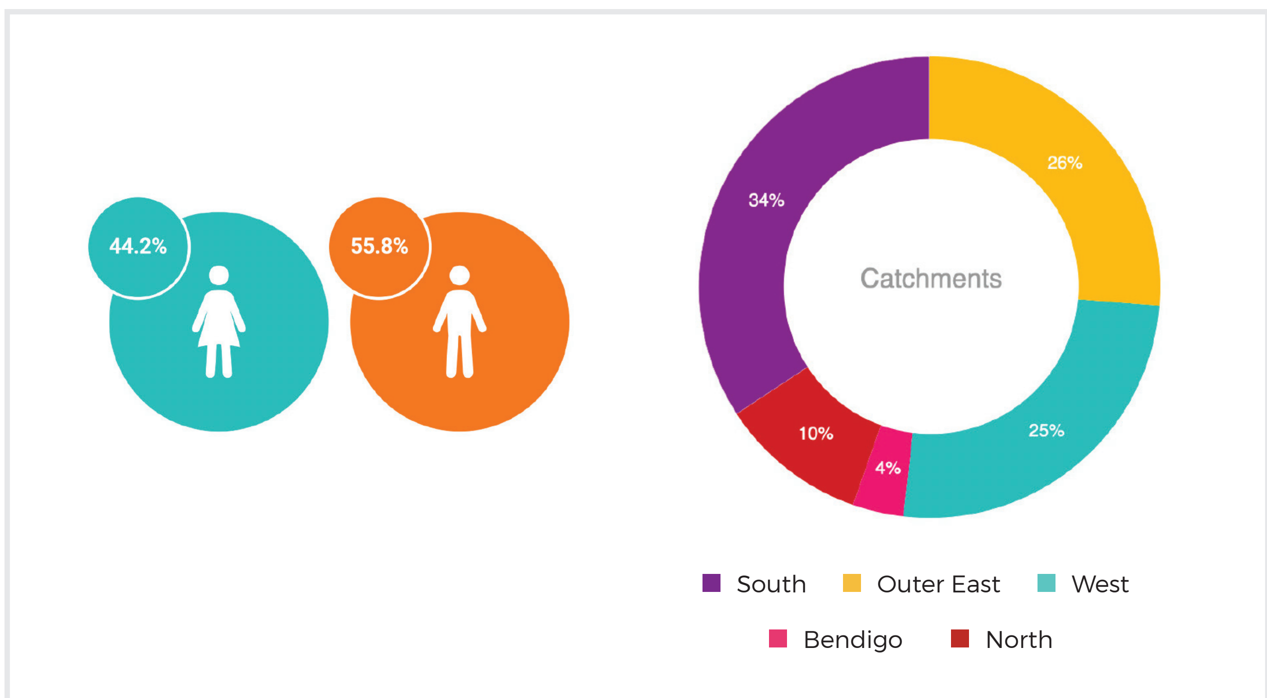


Figure 1. Intervention group demographic data

The most frequently cited reasons for referral (and Child Protection involvement) included domestic and family violence (157 participants, 62.5%), emotional, psychical and/or sexual abuse (82, 32.7%), mental health concerns (124, 49.4.7%), problematic alcohol and/or drug use (66, 26.3%), parenting difficulties (194, 77.3%) and housing issues (34, 13.5%). Cases may have multiple reasons for referral.

System 'as usual' comparison group

A total of 42 cases participated in this research across three of the five catchments. Participants had an average age of 7.02 years (SD = 5.29; Range .41 - 16.38 years) with 25 females (59.5.%) and 17 males (40.5.%). No information pertaining to Aboriginal and Torres Strait Islander heritage was available. One (2.4%) case was from the Outer East, 9 (21.4%) from the West, 0 from Bendigo, 0 from the North, and 32 (76.2%) from the South.

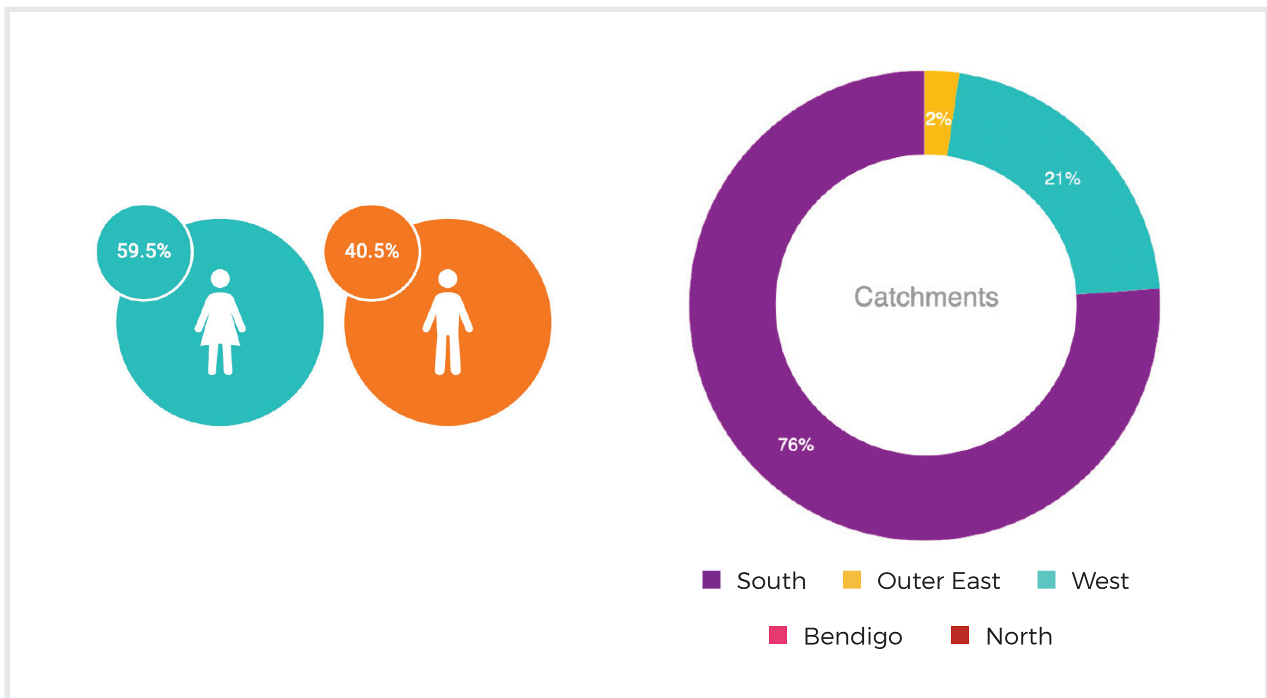


Figure 2. Comparison group demographic data

Materials and Data Collection Goals. During the Start-up meeting, Child Protection are asked to advise their minimum standards in regard to what is required for them to be satisfied with the level of safety within the home and for the closure of the case. It is here that the specific goals of the intervention are established and agreed upon. At closure of the program, Rapid Response Practitioners record the specifics of each goal and whether or not each goal was met.

Safety. Safety was measured at Start-up, Mid (week 2) and Closure meetings (week 4) by Child Protection. Specifically, Child Protection use the integrated safety framework Signs of Safety (SOS, Turnell & Edwards, 2017) to map the harm, danger, complicating factors, strengths and existing and required safety to make a safety judgment of children participating in Rapid Response. SOS is a child intervention framework that uses a strengths-based, safety-organised approach ranked on a Likert scale from 0 (it is certain that the child will be [re]abused) to 10 (there is enough safety for child protection authorities to close the case). Data for this variable is only available for families that participated in Rapid Response.

Family functioning. At Start-up and Closure interviews (week 4), Rapid Response practitioners use the North Carolina Family Assessment Scale to measure improvements in parenting and family functioning (NCFAS, Kirk et al., 2005). The NCFAS provides a 6-point assessment ranging from -3 (Serious Problem), -2 (Moderate Problem), -1 (Mild Problem), 0 (Baseline/Adequate), 1 (Mild Strength), and 2 (Clear Strength) in relation to the following domains: environment, parental capabilities, family interactions, family safety, and child well-being. Data for this variable is only available for families that participated in Rapid Response.

OoHC involvement. For young people that participated in Rapid Response and those that were referred to the program when it was at capacity, OoHC placement data (provided by DHHS) were collected up to 6 months post program closure (for the intervention group) or time of rejected referral (for the comparison group). These data include the number of times (if any) a child was placed in OoHC, the duration of each stay, and placement type (i.e. foster, kinship or residential care). For the intervention group, 6 months post closure of Rapid Response and the date of the placement report had occurred for 225 cases (89.6%), with the remaining cases (26, 10.4%) having more than 3 but less than 6 months elapsed. For the comparison group, it had been 6 months post the referral for 9 cases (21.4%), greater than 3 but less than 6 months for 13 cases (31.0%), and less than 3 months for 20 cases (47.6%) from the date the placement report was run.

Implementation and delivery. Implementation and program delivery were assessed through a combination of semi-structured interviews and focus groups with internal stakeholders (Anglicare Victoria staff). The interviews assessed a broad range of factors including program characteristics, impact, compatibility, priority, roles and responsibilities and process that impede or facilitate delivery. Based on previous community health implementation research (Borrelli, 2011; Schmidt, Watt, McDermott & Mills, 2017), information was collected about the service context and Rapid Response model components to calculate fidelity. Fidelity calculations were based on program length, amount of contact and adherence to responding within 24 hours of referral. In addition to monitoring intervention delivery, assessment administration was also measured to assess consistency of measurement and maintenance of active intervention components (i.e. regular assessment of safety and measurable, specific goals).

Data- and calculation-related considerations

For this evaluation, we have focused solely on the children and young people identified as being 'in scope' for the Rapid Response intervention as opposed to grouping families and all of their children together (which includes those not in scope, such as the sibling of a young person participating in Rapid Response but not in scope themselves). To ensure all cases included in the evaluation were in scope for Rapid Response and thus received the intervention, each Client Relationship Information System (CRIS) ID was cross-checked against the case notes recorded in the ECMS. In addition, all cases from the intervention group included in this evaluation were checked by each of the Rapid Response Team Leaders to ensure not only that each case was in scope, but that start and end dates were correct and to provide further information on any case irregularities (e.g. such as program length being longer than 30 days).

During the data cleaning phase and Team Leader checks, a number of apparent duplicate cases were identified. These duplicate cases fell into two categories: 1) two cases with the same CRIS ID and same Person ID (Person IDs are automatically generated by the ECMS as a case identifier) and 2) two cases with the same CRIS ID but different Person IDs. For the current evaluation, both forms of duplication were removed.

The first category of duplication was removed as these represented a small number of cases that received a double dosage of the program and were entered into the ECMS twice. The second category of duplication was also removed as these cases represented a situation in which two or more siblings had been assigned the same CRIS ID. If these cases were also in scope, then the missing CRIS IDs would not have been assessed for OoHC placements, potentially over- or under-representing the program's effect on reducing placements in care.

In terms of calculating placements in care, we have not included the following:

- Permanent care: not included as an "entry to care" as the Rapid Response intervention is there to support permanent care placements.
- Respite care: not included as an "entry to care" as this is aimed at supporting the family and is usually voluntary.
- Secure welfare: when secure welfare is the only form of care (i.e. component) a young person has for a given placement episode it has not been included as an "entry to care". Secure welfare admissions are generally to keep the young person safe from harm to the self or from high-risk behaviours putting others at risk (and thus not the focus of Rapid Response). However, if the secure welfare placement falls within a residential, kinship or foster care stay, this has been counted as one placement with the days in secure welfare included as part of the total number of days in care.

Consecutive placement components were treated as single placement episodes. That is, if the child or young person was in residential care from 10/3/18 to 12/3/18 and then in kinship care from 13/3/18 to 14/6/18, this is counted as one placement of 97 days. All placement calculations include the end date.

At 6 months post Rapid Response, to account for the cases with less than 6 months in the program at the time of the study, placement calculations were conducted using the pairwise delete for missing data points.

Program Impact

Of the 251 cases, 202 (80.5%) completed the program (mean program length = 29.5 days [SD = 9.4]; mode program length = 29 days]), while 49 (19.5%) started but did not complete the program (mean program length = 16.6 days [SD = 8.5]; mode program length = 14 days). Reasons for non-completion for the 49 incomplete cases included family withdrawals (9, 18.4%), Anglicare Victoria withdrawals due to safety concerns (related to either the children and young people or Rapid Response staff) or no family engagement (26, 53.1%) and Child Protection withdrawals due to safety concerns (14, 28.5%).

Goals, Safety and Family Functioning*

The following analyses were conducted on the 202 cases that completed Rapid Response. Please see Table 1 (end of main report) and Appendices A – E for the results of these analyses split by catchment. At program closure, 109 (54.0%) had all goals met, 55 (27.2%) had most goals met, 37 (18.4%) had some goals met and 1 (.5%) had no goals met. Thus, 81.2% of participants had met most or all of the goals of the intervention (established and agreed upon with Child Protection at the Start-up meeting).

In regard to safety, Child Protection ratings in SOS scores demonstrated an increase from Start-up to Mid and Closure meetings (see Table 2). A series of paired sample t-tests was conducted in which safety was found to significantly increase from each time point (Start-up to Mid Review [t(167) = 20.1, p<.001, d = 1.6], Mid Review to Closure [t(165) = 15.5, p<.001, d = 1.2] and Start-up to Closure [t(177) = 29.2, p<.001, d = 4.9].

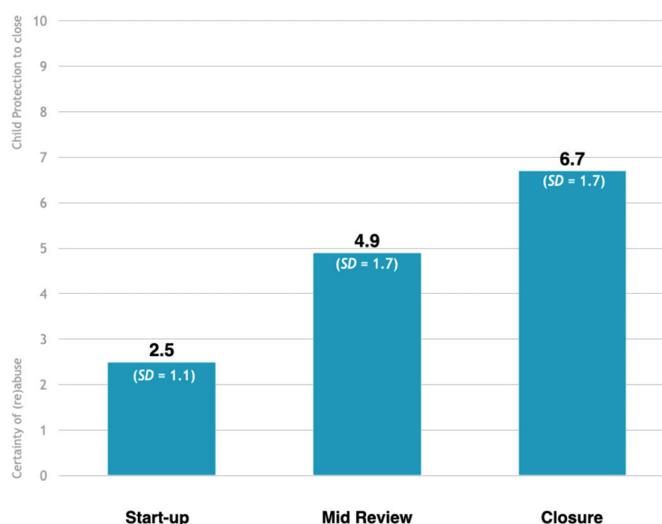


Table 1. Increases in safety from Start-up, to Mid and Closure

*Preliminary analyses revealed that the dependent variable satisfied the assumption of univariate normality (i.e. Kurtosis and Skew). Analyses were run using pairwise deletion.

Effect sizes for these significant differences were all large (Cohen, 1988). The positive changes in safety from Start-up to Mid and Closure meetings suggest an overall decrease in harm, danger, and complicating factors and an increase in protective factors for those that completed the program. As evinced by the large effect sizes for safety, on average, completed cases demonstrated a substantial shift from the strong possibility of abuse to enough safety for child protection authorities to consider closing the case.

In regard to family functioning, substantial increases were reported from program Start-up to Closure for each domain (see Table 3) of the NCFAS.

Specifically, paired sample t-tests revealed significant improvements for environment (t[199] = 7.9, p<.001, d = 0.6), parental capabilities (t[199]=20.6, p<.001, d = 1.5), family interactions (t[199]=17.0, p<.001, d = 1.2), family safety (t[199]=16.8, p<.001, d = 1.2), and child well-being (t[199]=16.4, p<.001, d = 1.2). Effect sizes for these significant differences ranged from moderate to large (Cohen, 1988). The positive changes across all family functioning domains from Start-up to Closure meetings suggest an overall increase in parental capacity, familial interactions and the home environment for those that completed the program. As evinced by the moderate to large effect sizes, on average, completed cases demonstrated a substantial shift in each domain, with most domains moving from being rated as moderate problems to mild problems and closer towards being baseline or adequate.

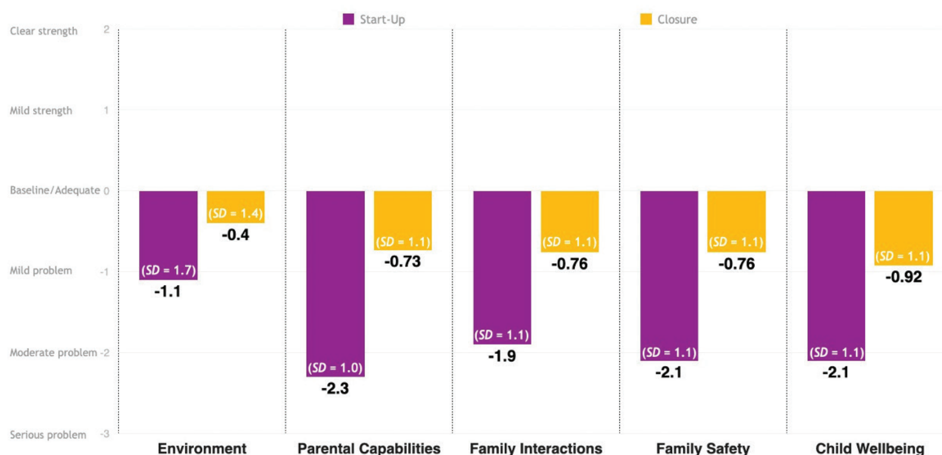


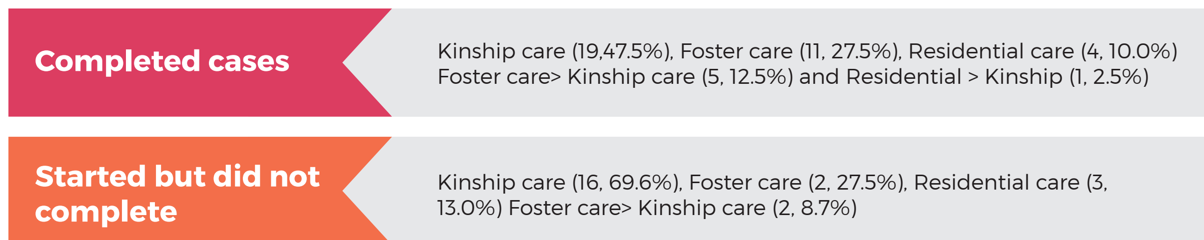
Table 2. Improvements in family functioning from Start-up to Closure meetings

OoHC Placements

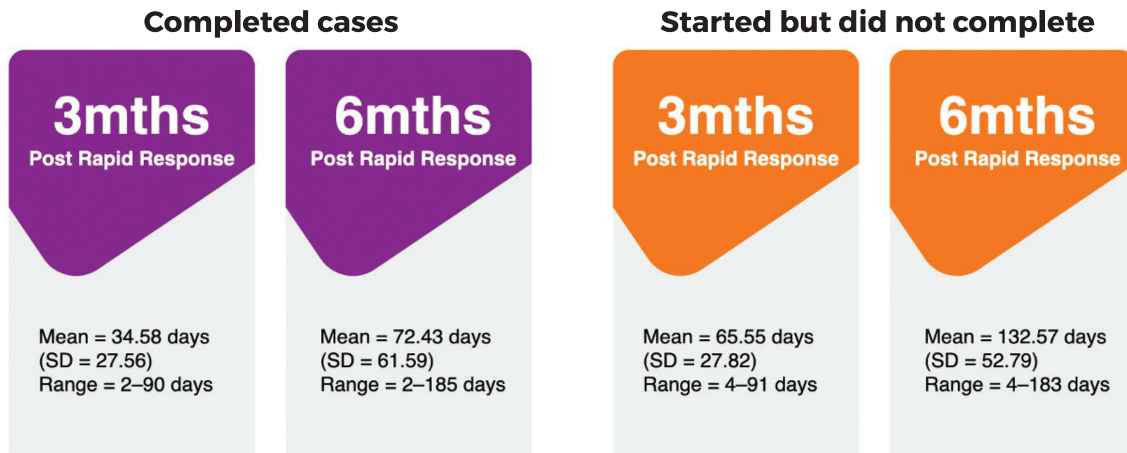
Please see Table 4 (end of main report) and Appendices A – E for the results of these analyses split by catchment.

Intervention group

Placement types:



Placement types:



At program closure, for the 202 children and young people that completed Rapid Response, **196 (97.0%) remained in parental care,** while 6 (3.0%) were placed in OoHC. For the 49 children and young people that started but did not complete Rapid Response, 19 (38.8%) remained in parental care, 19 (38.8%) were placed in OoHC and 11 (22.4%) cases were unknown. Of the whole sample at this time point (N = 251), a total of 215 (85.7%) children remained in parent care, 25 (10.0%) were placed in OoHC and 11 (4.4%) were unknown.

At 3 months post the program, for the 202 children and young people that completed Rapid Response, **178 (88.1%) remained in parental care,** while 24 (11.9%) had a placement in OoHC (18 additional cases from program closure). Of these 24 cases, 22 had no more than one placement while 2 cases had 2 placements in care. For the 49 children and young people that started but did not complete Rapid Response, 29 (59.2%) remained in parental care and 20 (40.8%) were placed in OoHC. Of these 20 cases, 18 had no more than one placement while 2 cases had 2 placements in care.

Of the whole sample at this time point (N = 251), a total of 207 (82.5%) children remained in parental care, while 44 (17.5%) were placed in OoHC.

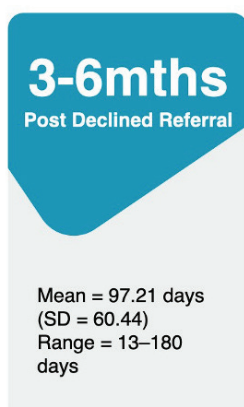
At 6 months post the program, there were 177 children and young people that completed Rapid Response for which 6 months of data were available. Of these 177 cases, **142 (80.2%) remained in parental care,** while 35 (19.8%) had a placement in OoHC (11 additional cases from 3 months post Rapid Response). Of these 35 cases, 31 had no more than one placement while 4 cases had 2 placements in care. At 6 months post the program, there were 48 children and young people that started but did not complete Rapid Response, for which 6 months of data were available. Of these 48 cases, 28 (58.3%) remained in parental care and 20 (41.7%) were placed in OoHC. Of these 20 cases, 18 had no more than one placement while 2 cases had 2 placements in care. Of the whole sample at this time point (N = 225), a total of 170 (75.6%) children remained in parental care, while 55 (24.4%) were placed in OoHC.

Comparison group

Placement types:

Comparison group	Kinship care (85.7%), Residential care (9.5%) and Residential care > Kinship care (4.8%)

Placement Length:



Of the 42 cases referred to Rapid Response when it was at capacity (i.e. the comparison group), **21 (50%) entered care.** Of these 21 cases, 19 had no more than one placement while 2 cases had 2 placements in care. The average number of days that elapsed between the referral and this placement in care was 11. Of the 21 cases that entered care, **15 (71.4%) cases entered OoHC within 4 days or less of the referral.** The remaining 6 cases were placed in care within 60 days of the referral. No information was available in terms of outcomes for the 21 children and young people who did not enter care, however, the presumption is that they remained with parents/primary caregiver.

As can be seen above, at program closure, a substantial difference of **47% was reported** between the number of cases that were placed in care between the group of completed cases and comparison group. This difference is reduced but remains noteworthy when comparing placement data for completed cases 6 months post Rapid Response with the comparison group (30.2% difference between the number of children and young people placed in care).

Differences in the number of children and young people placed in care between those that completed the program and those that started but did not finish (i.e. the intervention group) were also noted. For example, at 6 months post the program 88.1% of completed cases remained in parental care compared to 58.3% of cases that started but did not complete Rapid Response. These findings suggest that in light of families experiencing a crisis and having a child at high risk of being placed in OoHC, many of the families that complete Rapid Response appear to receive adequate support to avoid increased child protection measures. Importantly, the differences between those that completed the program and those that started but did not finish highlight the need for further investigation into the outcomes and trajectories of families that start but do not complete Rapid Response is required.

For example, although Rapid Response is positioned as a final option prior to the removal of a child or young person from their family and subsequent placement in care, not all cases from the comparison group (referred to the program but it was at capacity) or that started but did not complete Rapid Response enter care. For the comparison group, 50% of cases are presumed to have remained in parental care, while 58.3% of incomplete cases remained in parental care at 6 months post.

The results from these analyses should also be interpreted in light of several other study limitations. Firstly, the majority of cases in the comparison group (76.2%) were recruited from the South catchment. This was due largely to data access issues in other catchments. The South catchment was already collecting data as a means of demonstrating demand in that region. Secondly, the comparison group data only spans a 6-month period for 9 (21.4%) cases, suggesting the number of cases with a placement in care may increase. Finally, the intervention group includes an uneven distribution of cases from each of the catchments (Outer East [n = 66, 26.3%], West [n= 64, 25.5%], Bendigo [n = 9, 3.6%], North [n = 26, 10.4%] and South [n = 86, 34.3%]). While no meaningful differences were found between the catchments for safety or family functioning (see Appendices A – E), differences were noted for the number of placements in care that were recorded. These deviations are likely the result of small sample sizes and missing data (the Bendigo team had referral issues resulting in the program ceasing operations in this catchment and the North was the last catchment to merge its recording of case information into the ECMS). Consequently, the sample findings may not be reflective of each catchment's impact and should be interpreted with care.

Implementation and Delivery

The study revealed the following key points regarding the implementation and delivery of the program:

The Rapid Response model has now evolved significantly beyond the original Homebuilders framework and now delivers in-house training. Since its induction, the focus of Rapid Response has shifted considerably from the US-based Homebuilders model of placement prevention (Kinney et al., 1991), evolving into its own model that is sensitive and appropriate to the Australian social welfare system. The catalyst for this change was manifold and organic. Firstly, Homebuilders does not have defined criteria for 'at risk'. As the implementation of Rapid Response unfolded, Anglicare Victoria increasingly saw the need to define this at the point of imminent entry to care, permitting clear parameters for referral pathways. Secondly, the Homebuilders model is relatively and purposively vague, in which manualised approaches are not prescribed. In contrast, Anglicare Victoria sought to define not only the relationship with Child Protection and the referral pathways, but manualise the program to improve fidelity with which the model is delivered. Thirdly, an increasing number of Anglicare Victoria staff have expressed ambivalence with respect to the Homebuilders training. In particular, the Americanised content and additional focus on reunification were not seen as relevant to Rapid Response staff. Fourthly, an internal evaluation conducted by Anglicare Victoria demonstrated that having a more limited and bespoke approach to being on call with flexible hours achieved the same supports and outcomes that being on call 24/7 did (but at a substantially reduced cost). Finally, Rapid Response relies heavily on the SOS Child Protection framework (as opposed to only the safety assessment available in the NCFAS that is used in the Homebuilders model) as it is seen as more applicable and accurate to the program's ethos and primary aims. While it is too early to determine the impact of the in-house training, Anglicare Victoria's decision to adapt the original model was appropriate.

"I found the Homebuilders [training] helpful, but then, you're sitting there knowing what the Rapid Response program is about going, okay, that's not relevant to us. We were like, do we just stop listening when they are talking about the stuff that's not relevant to us like the weekend work and the 24/7 on-call elements of the program?" - Rapid Response Practitioner

"For me, I really liked the Homebuilders training and think it is foundational to social work, tapping into important core elements. However, a lot of the training refers back to things happening in America, which makes it difficult to follow or apply." - Rapid Response Leadership

“Staff were attending the Homebuilders training and being a bit unclear and confused as much of we what do became more different over time. We therefore have been trialling our own Rapid Response in-house training and have been getting some early positive results and feedback.” - Rapid Response Leadership

Rapid Response is delivered with fidelity. Both competence and adherence are two key aspects, or dimensions, of implementation fidelity (Breitenstein et al., 2010). For this evaluation, measurements of adherence focused on the presence of prescribed behaviours as defined in the Rapid Response Manual. These included program length (most frequently reported program length was 29 days in line with the 4 week structure of the program), frequency of contact (staff reported a range of 10-15 service hours per week per case, with approximately 8 hours of this being direct contact) and the proportion of cases in which the Start-up meeting occurred with 24 hours of referral acceptance (75.3% of cases within 24 hours, 24.7% within 2-3 business days). Competence in delivering an intervention includes qualities related to communication and technical abilities (Breitenstein et al., 2010). For families that completed the program, the evaluation observed moderate to high levels of assessment administration (missing data for all NCFAS assessments ranged from .5 – 2% and 5.9 – 12.4% for SOS [while Rapid Response teams are not responsible for conducting the SOS assessment, insurances should be put in place to ensure this data is consistently uploaded into the ECMS]). Rapid Response, therefore, is mostly delivered as intended and is done so competently and according to the practice framework (i.e. with good adherence).

Additionally, both the staffing and governance structures of Rapid Response represent strong, high-level strategic commitments from Anglicare Victoria and DHHS in the sustainment and delivery of Rapid Response. Such standards and feedback loops are critical components of effective implementation, allowing service providers, program developers and government staff regular opportunities to share and act on information to improve the model and deliver it with fidelity (Pew-MacArthur, 2014).

Promisingly, these feedback loops also have the potential to work in two directions: Anglicare Victoria collects data and assesses program progress and then shares the information with DHHS and Child Protection agencies, which in turn use the data to make necessary adjustments in policy and administrative practices to better support Anglicare Victoria with service delivery. Such practices could be an important factor in helping to bridge the long recognised gap between evidence and policy makers (Oliver, 2014).

The focus on safety and transparency assists the families to get through the point of crisis. All Anglicare Victoria staff interviewed for the evaluation described the importance of focusing on safety while maintaining open, direct and transparent channels of communication with the families.

This solution-focused partnership approach goes beyond just helping families cope with adversity to leveraging their strengths and resources. Substantial effort is invested by Rapid Response Practitioners to create an environment that is trusting and open enough to address the safety concerns identified by Child Protection.

Staff described that within a few days of participating in the program, most families come to understand that Rapid Response is genuinely committed to helping them maintain their family composition. It is at this crucial point in time that families truly engage with the program and begin their therapeutic journey, learning the parenting skills to help avoid their child being placed in care.

"We need to be able to challenge families and doing that in a way that is respectful and always keeping Child Protection's protective concerns at the forefront of our work. And so being really open and honest with families about that gives a really good... I mean it probably sounds daunting when I'm saying it out loud but it actually... Families actually respond really well to it, to us being really clear and transparent about what the concerns are." - Rapid Response Practitioner

"I feel like part of our role is actually getting the parents through the initial crisis stage that is actually there or they're experiencing when Child Protection are coming... they're in quite a heightened state. So, I actually feel over the four weeks that we have them that we're helping them to get through the initial work that they have to do including addressing their own responses to the Child Protection intervention." - Rapid Response Practitioner

Rapid Response has a strong focus on program delivery and integrity. Management is committed to achieving consistency in both family preservation accomplishments and program delivery across all participating catchments. This is seen as vital to supporting any potential future scaling up of Rapid Response. Early on, in the initial implementation phases of the program (as new Rapid Response teams were incrementally added to each catchment), there was a period of time in which each program was running relatively independent of the other; each team was focused on developing referral pathways and ensuring Practitioners were appropriately trained and well-versed in the model. After allowing time for each of the teams to mature, Anglicare Victoria embarked on a process of refinement.

In particular, Rapid Response management spent considerable time visiting the teams, liaising with Child Protection and discussing the model with staff in order to prioritise areas of improvement. Below we outline the practices and professional developments implemented:

Team Leader meetings: Team Leaders meet monthly for 2 hours to discuss Rapid Response practices, share concerns and solve problems. These meetings also offer the more established teams an opportunity to share what has and has not worked in their teams with the newer, more recently established teams.

Emphasis on identifying and updating program content and processes: Rapid Response's Practice Framework and written guidelines are regularly revised to ensure clarity for staff. The pragmatism evident in Rapid Response's program manual has directly supported the program's success. A commitment to collecting and using program data for ongoing monitoring was solidified by Anglicare Victoria's introduction of its electronic case management system (ECMS). For Rapid Response, all assessments, client detail and case notes are now logged in the ECMS. This process has also facilitated significant improvements in Anglicare Victoria's collection and use of program data. Organisational culture and practices have also grown from solely case management foci, to effective performance management that allows management to track and report key program indicators with relative ease. This broadening appreciation of program data also provides staff with useful performance information to help direct resources to areas needing improvement while improving accountability by offering DHHS and Child Protection up-to-date information on referrals and program effectiveness.

Introduction of the Practice Lead role: another enhancement that has markedly increased model integrity is the introduction of the Practice Lead in late 2018. The Practice Lead works across all catchments and teams, providing consultancy and leadership across a broad range of areas that relate to Rapid Response (e.g. issues surrounding incorrect referrals, how to work with disengaged families, case management using the ECMS and conducting assessments). Upon assuming the role, the Practice Lead has driven a focus on program delivery and integrity, instilling a balanced level of standardisation while permitting enough flexibility for adaptation to support localised implementation and needs (an example of why this is necessary is that the staffing and administrative processes of Child Protection are not identical across each catchment).

"Across the board [all catchments] we have really tightened up on all of our reporting and assessments. As Team Leaders, there is so much to learn from one another." - Rapid Response Leadership

"We have spent a lot of time updating and embedding the Rapid Response Practice Framework and Manual and improving data collection and reporting via our newly installed electronic system." - Rapid Response Leadership

"We want to be confident that not only are the staff delivering the model as it has been defined [in the manual], but that the program data we collect is accurate and used to inform future decisions about the program." - Rapid Response Leadership

The extent to which the referral process functions effectively defines the success of the model. Rapid Response depends on a strong, trusting working relationship with Child Protection to ensure a reliable stream of referrals. The evaluation observed that significant time, effort and resources are required to develop and maintain this relationship between the service provider and Child Protection as the sole referrer. All Rapid Response Team Leaders identified building and maintaining this relationship as a primary role of their position. Referencing their attendance to weekly triage meetings, governance meetings and regular communications with Child Protection regarding referrals as important factors in building rapport and receiving the correct type of cases. Based on staff interviews, it is clear that it takes time to ensure that Rapid Response receives the right referrals, with variability in demand within and between catchments driven largely by the quality of the relationship between the Rapid Response and Child Protection teams. Furthermore, while some programs employ waiting lists in which families may have to wait weeks before they engage with a service, Rapid Response receives cases directly from Child Protection.

This process ensures families get a response at the very point they are experiencing a crisis. With no waiting list and parametrised referral pathways, the Rapid Response team is able to accurately indicate when they can next support a family in need.

"I see my role first of all, to try to build this relationship with Child Protection from the ground, and we have spent quite a bit of time thinking about how best to do this." - Rapid Response Leadership

"Early on, it was really about... You were almost a salesperson, really trying to pitch it [Rapid Response] and build that relationship." - Rapid Response Leadership

“We want to be confident that not only are the staff delivering the model as it has been defined [in the manual], but that the program data we collect is accurate and used to inform future decisions about the program.”

- Rapid Response Leadership

"There is a heavy emphasis on building and maintaining that relationship [with Child Protection], and a part of it is about how do we create awareness about what makes an appropriate referral, and a lot of that is either in-person work or on the phone." Rapid Response Leadership

Currently, for all existing programs, the relationship with Child Protection is strong, supporting open communication and appropriate referrals to the program. During the course of this evaluation, however, Anglicare Victoria (in collaboration with DHHS and Child Protection) decided that Rapid Response Bendigo would cease operations due to consistently low referrals (end of 2019). The closure of this Rapid Response team highlights not only the importance of the Child Protection–Rapid Response relationship but also emphasises other implementation learnings. Although Child Protection were open and willing to trying to improve referrals to the Rapid Response Bendigo team (with multiple local strategies attempted) other factors also played a significant role.

For example, in the Bendigo catchment, there are several other Anglicare Victoria family service programs currently being delivered. It is possible that too many family services from the one organisation across a relatively small population made Rapid Response more challenging to sustain in Bendigo. In addition, because Rapid Response was first implemented in Bendigo and based on the Homebuilders model (Kinney et al., 1991), elements of the program had to be retrofitted to align with how Rapid Response had evolved over time with the addition of new teams. The evolution of the program suggests that in the social welfare context, models with high levels of fidelity and firm referral criteria may require higher levels of consideration when thinking about sustainability. While more generic and unstructured programs may in theory deliver to a wide variety of cohorts and clients (as fidelity restrictions and referral parameters are more flexible or relaxed), structured programs with defined case criteria such as Rapid Response rely on a single channel or referral pathway.

While the impact of this retrofitting is not fully understood, it was cited by Anglicare staff as a potential factor that may have affected the full adoption of Rapid Response in Bendigo.

"There are multiple services involved, we seem to struggle with that... plus CP [Child Protection] not knowing or not referring when they should be, probably because of how strict the criteria is. That's what they have mentioned, that is why they are not referring as much." - Rapid Response Bendigo staff (interviewed 8 months prior to program closure)

"I think there's potentially a mismatch between at what point Child Protection might want an intensive service and at what point we're saying it is suitable for us. I think they would like to have that intensity probably earlier before they're looking to remove, whereas our criteria is really clear that it's at the point of removal." - Rapid Response Bendigo staff (interviewed 8 months prior to program closure)

Conclusion

Rapid Response has a wide range of embedded sustainability factors necessary for program continuity in the community (Ceptureanu et al., 2018). These include staff involvement and integration, preliminary program effectiveness, coordinator competence, organisational stability, program integration within the organisation, program theory, leadership, partnering, program evaluation and transparency.

However, in light of these factors, a number of considerations remain to take into account for program scale-up:

Staffing: Senior Practitioners, Team Leaders and the Practice Lead cover a wide range of concerns, presenting issues and complex environments within their roles in the Rapid Response program. With a depth of experience and expertise that is crucial to the success of the program, only well-trained, high calibre staff with strong risk management skills appear suitable for the Rapid Response program. If this model was to be scaled up, a strong learning and development strategy would be required to ensure the addition of new staff and sites did not weaken the program's ability to provide high-intensity and pragmatic support. Leading education providers use built-in supports to ensure the qualities of high-performing educators are spread and scaled within their practice frameworks. In doing so, the focus and reliance shifts from high performing individuals to sharing and enforcing the qualities of those individuals within their educational practices. Such a process permits steady program scale-up by using a model that is not dependent upon a person or persons, but the key qualities required for the model to be delivered with fidelity. A robust scale-up strategy for Rapid Response will safeguard against relying too heavily on staff or program champions, embedding the necessary qualities required for each role within the program into its learning and development approach.

"All of the staff are senior practitioner level, and it's not that easy to replace people at that level, especially in a regional place." - Rapid Response Leadership

The Child Protection–Rapid Response relationship: Anglicare Victoria and Child Protection have worked together to provide and fine tune current referral pathways. As this evaluation has noted, however, both processes take considerable time and effort to achieve and the resources required to do so should not be overlooked in the context of scaling up Rapid Response. While Rapid Response has demonstrated feasibility, new sites will need to be prepared for relatively slow growth during the initial implementation stage. The challenges faced in Bendigo highlighted the importance of this relationship to the success or failure of a program.

It also demonstrated the necessity for pre-implementation demand mapping for any new area or region considering implementing Rapid Response. Learning from the difficulties experienced in Bendigo – and building on the success of the four Rapid Response teams currently running – will be paramount if further replication and scale-up is to be successful.

Training and practice support: Also essential to the scale-up of Rapid Response is the Practice Lead role. This role will need to be reproduced relative to the current number of the active teams. Currently, the sole Practice Lead provides oversight for 4 catchments. For this role to be maintained and performed successfully, the team-to-Practice Lead ratio should be maintained.

Single agency model: Rapid Response is delivered by a single agency, with multiple benefits to this approach that need to be retained in future implementations of the Rapid Response model that may occur within, or outside of, Anglicare Victoria. In particular, the current single agency model permits a holistic approach to improvement and recovery, lowering the chance that critical issues are missed (a single point of contact such as the Practice Lead means issues are less likely to get lost through communication failure). Scrutinising how and if the processes and benefits of a single agency model can be maintained should Rapid Response be implemented by a different organisation would be key if such a need arises.

Where to Next?

David Poynter, General Manager Evidence Based Models, Anglicare Victoria
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To read more on our approach to this evaluation and research in this sector more generally, please click here and here for a case study and sector insights – both conducted by the CFECFW.

Many of the problems we face in the social welfare sector require research-based knowledge acted upon by social welfare providers and practitioners together with government agencies. However, a number of interacting factors and competing agendas (i.e. academia vs practice goals) widen the gap between research and practice in this space (including, but not limited to: restricted timing and resources of practitioners, insufficient funding, lack of timely feedback for EBMs, inadequate infrastructure and system organisation to support translation, and a belief such processes are simply linear). Therefore, to conduct this evaluation as a genuine partnership – working together across every phase of the research with teams integrated as opposed to working in silos – we entered into an agreement to achieve the following:

1. Research alignment with both organisation and industry priorities
2. All learning will be shared and accessible
3. Processes underpinned by a Knowledge to Action Framework
4. Researcher to be embedded in Anglicare Victoria, becoming a "staff member" to understand the organisation and infuse capacity building and knowledge across the organisation for sustainability.

Our intention during this evaluation was to shift from the narrow approach of thinking simply about whether the program works, to focusing our lines of enquiry on what the impact of Rapid Response is on children and their families and what the associations between implementation quality and program outcomes are. This re-focus also represents a shift in thinking from being program-centric to thinking and evaluating systemically in which a strong and thorough understanding of how the context and implementation of the program influences both its performance (i.e. number of accepted referrals) and impact. That is, the effects on the whole system, rather than just the isolated program, should be considered when assessing outcomes of an intervention.

During this evaluation, we learned a number of important lessons. These include the importance of continually monitoring data collection for integrity and validation, frequently testing hypotheses based on what the data was telling us (i.e. rapid-cycle testing) and the value in sharing findings regularly with staff, management, leadership and external partners. Not only does the latter help shift the culture around research at the organisation level and empower staff, but it allows multiple perspectives in analysis and thinking that can be overlooked.

The findings of this evaluation, especially when considered in light of two previous evaluations of Rapid Response that reported promising results (one internally conducted, the other by the Centre for Evaluation, Research and Evidence, DHHS), demonstrate Rapid Response to not only be a feasible option for children and young people at imminent risk of harm but also the importance of thinking systematically when developing a program. For example, as opposed to either keeping a child in a potentially unsafe environment or removing the child, Rapid Response provides another alternative in which the young person can remain at home while the family is supported to improve safety. In this way, Rapid Response acts as a necessary third option for the social welfare system in Victoria.

However, there is still work to be done. Questions remain regarding dosage (i.e. intensity) and program length. In particular, does the high dosage in a short period of time have a larger impact than lower dosages provided over a longer time period?

That is, what is the best return for effects on outcomes and how much of Rapid Response's success is dependent upon program length when intensity is taken into account? A deeper understanding of this relationship may provide future opportunities to modify the Rapid Response model so that some families receive an abridged intervention (e.g. 2 weeks of intensive support) while for others, the program is extended, giving families the best chance to improve safety and meet Child Protection goals (e.g. 6 weeks of intensive support that gradually declines in the last 2 weeks). Within this additional inquiry it would also be pertinent to include an exploration into the remaining features of the Rapid Response model that are based on Homebuilders – such as aiming to respond with 24 hours of referral acceptance – and if such factors are key to program success or can be refined. Additionally, a better understanding of the association between presenting family factors and positive outcomes would also help to shed light on the program's impact and assist in refining referral parameters.

In an attempt to answer these questions and continue developing our approach to evaluating Rapid Response and other child and family service programs, we have begun a new phase of data collection which will first capture all OoHC data for young people in which it had not been 6 months post program completion (i.e. intervention group or referral comparison group). In addition, we have also begun investigating the impact of Rapid Response from late 2019 and through 2020, where COVID restrictions meant large program adaptations were required. Finally, and continuing our ongoing collaboration with DHHS (now the Department of Families, Fairness and Housing), we are working with the Human Services Modelling & Forecasting team to develop matched archival comparison group datasets. Importantly, these data will assist in both our understanding of, and confidence in, Rapid Response's effect on reducing the number of young people entering care.

In the very least, we hope the results of the current evaluation help to support the notion that intensive placement prevention programs are viable options for children and young people at imminent risk of harm.

“I really love Rapid Response, I can tell you that, because I feel that it enables me to do what I believe we should be doing. You see the start-up of it and then you see the ending of it, on some level, there is always some improvement.”

- Rapid Response Practitioner

Appendix A:

Quantitative Analyses for the Outer East

Total cases = 66 (26.3% of total sample)

Mean age = 7.80 years (SD = 4.72), Range .03 – 16.64 years

Aboriginal or Torres Strait Islander Children: 8 Yes (12.1%), 58 No (87.9%)

35 males (53.0%) and 31 females (47.0%)

Completed: 51

Started but did not complete: 15

Goals, safety and family functioning

At program closure, 29 (56.9%) had all goals met, 12 (23.5%) had most goals met and 10 (19.6%) had some goals met. Thus, 80.4% of participants had most or all of the goals of the intervention met (established and agreed upon with Child Protection at the Start-up meeting).

In regard to safety, Child Protection ratings in SOS scores demonstrated an increase from Start-up, to Mid and Closure meetings (Start-up $\dot{X}$ = 2.23, Mid Review $\dot{X}$ = 4.36, Closure $\dot{X}$ = 6.62). A series of paired sample t-tests were conducted in which safety was found to significantly increase from each time point (Start-up to Mid Review [t(43) = 8.4, p<.001, d = 1.3], Mid Review to Closure [t(43) = 9.9, p<.001, d = 1.5] and Start-up to Closure [t(49) = 18.0, p<.001, d = 2.4]. Effect sizes for these significant differences were all large (Cohen, 1988).

In regard to family functioning, substantial increases were reported from program Start-up to Closure for each domain of the NCFAS. Specifically, paired sample t-tests revealed significant improvements for environment (Start-up $\dot{X}$ = -1.73, Closure $\dot{X}$ = .96, t[50] = 5.1, p<.001, d = 0.6), parental capabilities (Start-up $\dot{X}$ = -2.27, Closure $\dot{X}$ = -1.14, t[50]=11.7, p<.001, d = 1.6), family interactions (Start-up $\dot{X}$ = -1.92, Closure $\dot{X}$ = -.1.24, t[50]=7.3, p<.001, d = 1.0), family safety (Start-up $\dot{X}$ = -1.90, Closure $\dot{X}$ = -1.16, t[50]=4.6, p<.001, d = .6), and child well-being (Start-up $\dot{X}$ = -1.96, Closure $\dot{X}$ = -1.02, t[50]=6.9, p<.001, d = .9). Effect sizes for these significant differences ranged from moderate to large (Cohen, 1988).

($\dot{X}$ = mean score)

At program closure, for the 51 children and young people that completed Rapid Response in the Outer East, 51 (100.0%) remained in parental care. For the 15 children and young people that started but did not complete Rapid Response in the Outer East, 11 (73.3%) remained in parental care, 3 (20.0%) were placed in OoHC and 1 (6.7%) cases were unknown. Of the whole sample at this time point (N = 66), a total of 62 (93.9%) children remained in parental care, 3 (4.5%) were placed in OOHC and 1 (1.5%) was unknown.

At 3 months post the program, for the 51 children and young people that completed Rapid Response in the Outer East, 41 (80.4%) remained in parental care, while 10 (19.6%) had a placement in OoHC (10 additional cases from program closure). Of these 10 cases no case had more than one placement. For the 15 children and young people that started but did not complete Rapid Response in the Outer East, 9 (60.0%) remained in parental care and 6 (40.0%) were placed in OoHC. Of these 6 cases, 5 had no more than one placement while 1 case had 2 placements in care. Of the whole sample at this time point (N = 66), a total of 50 (75.8%) children remained in parental care while 16 (24.2%) were placed in OOHC.

At 6 months post the program, there were 43 children and young people that completed Rapid Response for which 6 months of data were available. Of these 43 cases that completed Rapid Response in the Outer East, 32 (74.4%) remained in parental care, while 11 (25.6%) had a placement in OoHC (1 additional case from 3 months post Rapid Response). Of these 11 cases, none had more than one placement. At 6 months post the program, there were 14 children and young people that started but did not completed Rapid Response for which 6 months of data were available. Of these 14 cases that started but did not complete Rapid Response in the Outer East, 9 (64.3%) remained in parental care and 5 (35.7%) were placed in OoHC (no additional cases). Of these 5 cases, 4 had no more than one placement while 1 case had 2 placements in care. Of the whole sample at this time point (N = 57), a total of 41 (71.9%) children remained in parental care while 16 (24.2%) were placed in OOHC.

Appendix B:

Quantitative Analyses for the West

Total cases = 64 (25.5%)

Mean age = 8.71 years (SD = 5.42), Range .15 – 16.61 years

Aboriginal or Torres Strait Islander Children: 8 Yes (12.5%), 56 No (87.5%)

37 males (57.8%) and 27 females (42.2%)

Completed: 50

Started but did not complete: 14

Goals, safety and family functioning

At program closure, 24 (48.0%) had all goals met, 17 (34.0%) had most goals met, 8 (16.0%) had some goals met and 1 (2.0%) had no goals met. Thus, 82% of participants had most or all of the goals of the intervention met (established and agreed upon with Child Protection at the Start-up meeting).

In regard to safety, Child Protection ratings in SOS scores demonstrated an increase from Start-up, to Mid and Closure meetings (Start-up $\dot{X} = 2.26$, Mid Review $\dot{X} = 4.36$, Closure $\dot{X} = 6.62$). A series of paired sample t-tests were conducted in which safety was found to significantly increase from each time point (Start-up to Mid Review [$t(34) = 12.9$, $p<.001$, $d = 2.2$], Mid Review to Closure [$t(31) = 4.0$, $p<.001$, $d = 0.7$] and Start- up to Closure [$t(37) = 14.9$, $p<.001$, $d = 2.5$]. Effect sizes for these significant differences ranged from moderate to large (Cohen, 1988).

In regard to family functioning, substantial increases were reported from program Start-up to Closure for each domain of the NCFAS. Specifically, paired sample t-tests revealed significant improvements for environment (Start-up $\dot{X} = -.68$, Closure $\dot{X} = -.04$, $t[49] = 4.6$, $p<.001$, $d = 0.7$), parental capabilities (Start-up $\dot{X} = -1.74$, Closure $\dot{X} = -.48$, $t[49]= 11.1$, $p<.001$, $d = 1.6$), family interactions (Start-up $\dot{X} = -1.48$, Closure $\dot{X} = -.70$ $t[49]= 6.1$, $p<.001$, $d = 0.9$), family safety (Start-up $\dot{X} = -1.58$, Closure $\dot{X} = -.64$, $t[49]= 9.0$, $p<.001$, $d = 1.3$), and child well-being (Start-up $\dot{X} = -1.82$, Closure $\dot{X} = -1.12$, $t[49]=7.7$, $p<.001$, $d = 1.1$). Effect sizes for these significant differences ranged from moderate to large (Cohen, 1988).

($\dot{X}$ = mean score)

At program closure, for the 50 children and young people that completed Rapid Response in the West, 48 (96.0%) remained in parental care, while 2 (4.0%) were placed in OoHC. For the 14 children and young people that started but did not complete Rapid Response in the West, 1 (7.1%) remained in parental care, 9 (64.3%) were placed in OoHC and 4 (28.6%) cases were unknown. Of the whole sample at this time point (N = 64), a total of 49 (76.6%) children remained in parental care, 11 (17.2%) were placed in OOHC and the status of 4 (6.3%) was unknown.

At 3 months post the program, for the 50 children and young people that completed Rapid Response in the West, 44 (88.0%) remained in parental care, while 6 (12.0%) had a placement in OoHC (4 additional cases from program closure). Of these 6 cases, 5 had no more than one placement, while 1 case had 2 placements in care. For the 14 children and young people that started but did not complete Rapid Response in the West, 6 (42.9%) remained in parental care and 8 (57.1%) were placed in OoHC. Of these 8 cases, 7 had no more than one placement while 1 case had 2 placements in care. Of the whole sample at this time point (N = 64), a total of 50 (78.1%) children remained in parental care while 14 (21.9%) were placed in OOHC.

At 6 months post the program, the 44 children and young people that completed Rapid Response for which 6 months of data were available. Of these 44 cases that completed Rapid Response in the West, 35 (79.5%) remained in parental care, while 9 (20.5%) had a placement in OoHC (3 additional cases from 3 months post Rapid Response). Of these 9 cases, 7 had no more than one placement, while 2 cases had 2 placements. At 6 months post the program, there were 14 children and young people that started but did not complete Rapid Response for which 6 months of data were available. Of these cases that started but did not complete Rapid Response in the West, 6 (42.9%) remained in parental care and 8 (57.1%) were placed in OoHC (no additional cases). Of these 8 cases, 7 had no more than one placement while 1 case had 2 placements in care. Of the whole sample at this time point (N = 58), a total of 41 (70.7%) children remained in parental care while 17 (29.3%) were placed in OoHC.

Appendix C:

Quantitative Analyses for Bendigo

Total cases = 9 (3.6% of total sample)

Mean age = 7.31 years (SD = 5.59), Range .08 – 15.95 years

Aboriginal or Torres Strait Islander Children: 1 Yes (11.1%), 8 No (88.9%)

7 males (77.8%) and 2 females (22.2%)

Completed: 7

Started but did not complete: 2

Goals, safety and family functioning

At program closure, 2 (28.6%) had all goals met, 4 (57.1%) had most goals met, and 1 (14.3%) had some goals met. Thus, 85.7% of participants had most or all of the goals of the intervention met (established and agreed upon with Child Protection at the Start-up meeting).

In regard to safety, Child Protection ratings in SOS scores demonstrated an increase from Start-up to Closure meetings (Start-up X = 1.80, Closure Ẋ = 5,75). A series of paired sample t-tests were conducted in which safety was found to significantly increase from each time point (Start-up to Closure [t(3) = 19.0, p<.001]). No data were available to compute SOS Mid Review mean. No effect size provided as a bivariate correlation could not be calculated because at least one of the variables are constant (i.e. no variance, the values for at least one of the variables are the same for every case).

In regard to family functioning, substantial increases were reported from program Start-up to Closure for each domain of the NCFAS. Specifically, paired sample t-tests revealed significant improvements for environment (Start-up Ẋ = -.71, Closure Ẋ = .14, t[6] = 6.0, p<.001, d = 2.3), parental capabilities (Start-up Ẋ = -1.86, Closure Ẋ = .14, t[6] = 5.3, p<.001, d = 2.0), family interactions (Start-up Ẋ = -1.71, Closure Ẋ = .14, t[6] = 4.6, p<.001, d = 1.7), family safety (Start-up Ẋ = -1.71, Closure Ẋ = -.57, t[6] = 2.8, p<.001, d = 1.1), and child well-being (Start-up Ẋ = -1.00, Closure Ẋ = -.43, t[6] = 2.8, p<.001, d = 0.9). Effect sizes for these significant differences were large (Cohen, 1988).

(Ẋ = mean score)

At program closure, for the 7 children and young people that completed Rapid Response in Bendigo, all remained in parental care. For the 2 children and young people that started but did not complete Rapid Response, both were placed in OoHC. Of the whole sample at this time point (N = 9), a total of 7 (77.8%) children remained in parental care while 2 (22.2%) were placed in OoHC.

At 3 months post the program, for the 7 children and young people that completed Rapid Response in Bendigo, all remained in parental care. For the 2 children and young people that started but did not complete Rapid Response in the Bendigo, both remained in parental care. Of the whole sample at this time point (N = 9), all children and young people (100.0%) remained in parental care.

At 6 months post the program, there were 4 children and young people that completed Rapid Response for which 6 months of data were available. Of these 4 cases that completed Rapid Response in Bendigo, 3 (75.5%) remained in parental care, while 1 (25.0%) had a placement in OoHC (1 additional case from 3 months post Rapid Response). This one case had only one placement in care. At 6 months post the program, there were 2 children and young people that started but did not completed Rapid Response for which 6 months of data were available. Of these 2 cases that started but did not complete Rapid Response in Bendigo, both remained in parental care (no additional placements). Of the whole sample at this time point (N = 6), a total of 5 (83.3%) children remained in parental care, while 1 was placed in OoHC (16.7%).

Appendix D:

Quantitative Analyses for the North

Total cases = 26 (10.4% of total sample)

Mean age = 10.13 years (SD = 4.84), Range .90 – 16.72 years

Aboriginal or Torres Strait Islander Children: 1 Yes (3.8%), 25 No (96.2%)

13 males (50.0%) and 13 females (50.0%)

Completed: 25

Started but did not complete: 1

Goals, safety and family functioning

At program closure, 20 (80.0%) had all goals met and 5 (20.0%) had most goals met. Thus, 100% of participants had most or all of the goals of the intervention met (established and agreed upon with Child Protection at the Start-up meeting).

In regard to safety, Child Protection ratings in SOS scores demonstrated an increase from Start-up, to Mid and Closure meetings (Start-up $\dot{X}$ = 1.61, Mid Review $\dot{X}$ = 5.60, Closure $\dot{X}$ = 7.60). A series of paired sample t-tests were conducted in which safety was found to significantly increase from each time point (Start-up to Mid Review [$t(22) = 15.6$, $p<.001$, $d = 3.2$], Mid Review to Closure [$t(24) = 5.4$, $p<.001$, $d = 1.1$] and Start-up to Closure [$t(22) = 14.6$, $p<.001$, $d = 3.0$]. Effect sizes for these significant differences ranged from moderate to large (Cohen, 1988).

In regard to family functioning, substantial increases were reported from program Start-up to Closure for each domain of the NCFAS. Specifically, paired sample t-tests revealed significant improvements for environment (Start-up $\dot{X}$ = -1.32, Closure $\dot{X}$ = .40, $t[24] = 2.82$, $p<.001$, $d = 0.6$), parental capabilities (Start-up $\dot{X}$ = -2.88, Closure $\dot{X}$ = -.24, $t[24] = 11.1$, $p<.001$, $d = 2.2$), family interactions (Start-up $\dot{X}$ = -1.28, Closure $\dot{X}$ = -.12, $t[24] = 15.5$, $p<.001$, $d = 3.1$), family safety (Start-up $\dot{X}$ = -2.44, Closure $\dot{X}$ = -.44, $t[24] = 9.6$, $p<.001$, $d = 1.9$), and child well-being (Start-up $\dot{X}$ = -2.20, Closure $\dot{X}$ = -.64, $t[24] = 9.0$, $p<.001$, $d = 1.8$). Effect sizes for these significant differences ranged from moderate to large (Cohen, 1988).

($\dot{X}$ = mean score)

At program closure, for the 25 children and young people that completed Rapid Response in the North, all remained in parental care. The 1 child or young person that started but did not complete Rapid Response was placed in care. Of the whole sample at program closure (N = 26), a total of 25 (96.2%) children remained in parental care while 1 (3.8%) were placed in OoHC.

At 3 months post the program, for the 25 children and young people that completed Rapid Response in the North, all remained in parental care. For the 1 child or young person that started but did not complete Rapid Response, this case remained in care. Of the whole sample at program closure (N = 26), a total of 25 (96.2%) children remained in parental care while 1 (3.8%) were placed in OoHC.

At 6 months post the program, there were 22 children and young people that completed Rapid Response in the North for which 6 months of data were available. Of these 22 cases, all remained in parental care. At 6 months post the program, there was 1 child or young person that started but did not complete Rapid Response for which 6 months of data were available. For the 1 child or young person that started but did not complete Rapid Response, this case remained in care. Of the whole sample at this time point (N = 23), a total of 22 (95.7%) children remained in parental care while 1 (4.3%) was placed in OoHC.

Appendix E:

Quantitative Analyses for the South

Total cases = 85 (34.3% of total sample)

Mean age = 8.54 years ($SD = 4.64$), Range .90 – 16.72 years

Aboriginal or Torres Strait Islander Children: 10 Yes (11.6%), 76 No (88.4%)

49 males (57.0%) and 37 females (43.0%)

Completed: 69

Started but did not complete: 17

Goals, safety and family functioning

At program closure, 34 (49.3%) had all goals met, 22 (31.9%) had most goals met, and 13 (18.8%) had some goals met. Thus, 81.2% of participants had most or all of the goals of the intervention met (established and agreed upon with Child Protection at the Start-up meeting).

In regard to safety, Child Protection ratings in SOS scores demonstrated an increase from Start-up to Mid and Closure meetings (Start-up $\dot{X} = 2.61$, Mid Review $\dot{X} = 4.71$, Closure $\dot{X} = 6.50$). A series of paired sample t-tests were conducted in which safety was found to significantly increase from each time point (Start-up to Mid Review [$t(64) = 11.5$, $p<.001$, $d = 1.4$], Mid Review to Closure [$t(64) = 11.8$, $p<.001$, $d = 1.5$] and Start- up to Closure [$t(62) = 15.5$, $p<.001$, $d = 2.0$]. Effect sizes for these significant differences ranged from moderate to large (Cohen, 1988).

In regard to family functioning, substantial increases were reported from program Start-up to Closure for each domain of the NCFAS. Specifically, paired sample t-tests revealed significant improvements for environment (Start-up $\dot{X} = -.85$, Closure $\dot{X} = -.24$, $t[66] = 3.46$, $p<.001$, $d = 0.4$), parental capabilities (Start-up $\dot{X} = -2.42$, Closure $\dot{X} = -.88$, $t[66] = 11.6$, $p<.001$, $d = 1.4$), family interactions (Start-up $X = -2.40$, Closure $\dot{X} = -.78$, $t[66] = 13.6$, $p<.001$, $d = 1.7$), family safety (Start-up $\dot{X} = -2.58$, Closure $\dot{X} = -.69$, $t[66] = 14.8$, $p<.001$, $d = 1.8$), and child well-being (Start-up $\dot{X} = -2.42$, Closure $\dot{X} = -.87$, $t[66] = 11.6$, $p<.001$, $d = 1.4$). Effect sizes for these significant differences ranged from moderate to large (Cohen, 1988).

($\dot{X}$ = mean score)

At program closure, for the 69 children and young people that completed Rapid Response in the South, 65 (94.2%) remained in parental care, while 4 (5.8%) were placed in care. For the 17 children and young people that started but did not complete Rapid Response in the South, 7 (41.2%) remained in parental care, 4 (23.5%) were placed in OoHC and 6 (35.3%) cases were unknown. Of the whole sample at this time point (N = 86), a total of 72 (83.7%) children remained in parental care, 8 (9.3%) were placed in OoHC and 6 (7.0%) were unknown.

At 3 months post the program, for the 69 children and young people that completed Rapid Response in the South, 61 (88.4%) remained in parental care, while 8 (11.6%) had a placement in OoHC (4 additional cases from program closure). Of these 8 cases, 7 had more than one placement, while 1 case had 2 placements. For the 17 children and young people that started but did not complete Rapid Response in the South, 12 (70.6%) remained in parental care and 5 (29.4%) were placed in OoHC (1 additional case from Program Closure). Of these 5 cases, none had more than one placement in care. Of the whole sample at this time point (N = 86), a total of 73 (84.9%) children remained in parental care while 13 (15.1%) were placed in OoHC.

At 6 months post the program, there were 64 children and young people that completed Rapid Response for which 6 months of data were available. Of these 64 cases that completed Rapid Response in the South, 50 (78.1%) remained in parental care, while 14 (21.9%) had a placement in OoHC (6 additional case from 3 months post Rapid Response). Of these 14 cases, 12 had more than one placement, while 2 cases had 2 placements. At 6 months post the program, there were 17 children and young people that started but did not complete Rapid Response for which 6 months of data were available. Of these 17 cases that started but did not complete Rapid Response in the South, 11 (64.7%) remained in parental care and 6 (35.3%) were placed in OoHC (1 additional case from 3 months post). Of these 6 cases, none had more than one placement in care. Of the whole sample at this time point (N = 81), a total of 61 (75.3%) children remained in parental care, while 20 (24.7%) were placed in OoHC.

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