

# LINKS Trauma Healing Service Evaluation (Report 1)

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## Executive Summary

The LINKS Trauma Healing Service (LINKS) involves multi-disciplinary teams delivering evidence-based treatment programs to children and young people (CYP) in out-of-home care (OOHC).

Currently delivered in two locations in NSW, LINKS aims to:

- increase stability of OOHC placements;
- respond to trauma and other underlying causes of child abuse and neglect; and
- decrease trauma symptoms and improve psychological wellbeing of CYP and carers.

A mix of primary and secondary data was used to assess early findings regarding client outcomes and experiences of LINKS, and to examine aspects of the implementation of the service. Data sources for this first report of the LINKS evaluation included existing administrative data from FACS and the LINKS service provider, fourteen interviews with LINKS staff, managers and agency leads, and ten interviews with carers of CYP clients, one of whom was an Aboriginal carer of an Aboriginal CYP and two were non-Aboriginal carers of Aboriginal CYP.

Data collection completeness and quality is adequate for analysis with some areas for improvement in future waves of evaluation. For instance, 40% of outcome measures for the five CYP who have completed and exited LINKS could not be reported, due to missing data for some items making up an outcome measure. Also, four records in the placement dataset were not up-to-date and seven dates for placement start and end were implausible. In general, data appeared to meet expectations regarding accuracy, recency, non-obsolescence and being up-to-date.

### Key findings

Overall, LINKS has met initial implementation and fidelity expectations, although current performance measures require more time to adequately inform TFM about the value of the service.

A total of 142 referrals have been made to LINKS for 139 unique CYP. Of these unique CYP, 113 were accepted. Almost one in five referrals (18%) either was not accepted as they did not meet referral criteria (e.g., CYP not in placement) or they declined a service. In keeping with TFM's expectations about the type of clients LINKS would serve, almost half (47%) of referrals were for Aboriginal CYP, and around half showed evidence of placement instability leading up to referral.

Early implementation of LINKS is on track, and the four programs are well received by staff and families:

- Staff and carers reported high satisfaction with LINKS.
- Multidisciplinary teams and supportive leadership were a reported strength identified by staff.
- LINKS exceeds carers' expectations and is perceived as much more effective than other previously accessed supports.

Collaborative relationships with services are emerging:

- The LINKS service provider has established good networks with other services and with the Aboriginal community, however ongoing attention is needed to sustain these networks.

Accessibility of LINKS is adequate but barriers to access do exist:

- Carers noted a barrier to LINKS acceptability and accessibility was co-location with FACS.
- A further barrier can be carers' lack of involvement and understanding of LINKS and insufficient information for families at the point of referral.

Adaptation of the programs is common:

- Staff reported they often need to make adjustments to the evidence-based programs offered within LINKS, including adaptations for cultural appropriateness with Aboriginal families and adaptations to include carers more in program work. The exact nature and extent of adaptation is unclear, and therefore its effect on treatment outcomes is hard to quantify.

Of the 81 CYP who had been allocated to a LINKS program or programs in the 11 months up to August 2018, most were allocated to Trauma-Focused Cognitive Behavioural Therapy (TF-CBT; 64% of cases). Tuning into Kids (TIK) and TIK-Teens (TIK(T)) were used in 40% of cases, often in combination with TF-CBT and Eye Movement Desensitisation and Reprocessing (EMDR). Parent-Child Interaction Therapy (PCIT; 16%) and EMDR (8%) were less common.

Over a third (36%) of CYP allocated to a program exited prior to program completion.

Five CYP had completed a program and exited LINKS by August 2018. While the number of clients who have completed a program are small, and there are moderate rates of early discontinuation, there is a positive indication of treatment effects for the five who have completed a program:

- LINKS is demonstrating positive outcomes in the following areas: improved psychological wellbeing, improved behavioural and emotional functioning, improved placement stability, educational stability and decrease in child/young person's contact with the criminal justice system.
- Placement either remains stable ( $n=1$  stayed in 'emergency care') or improved to permanency ( $n=4$ ).
- Four treatment completers did not have any ROSH reports made during the period of treatment.

Every CYP who has experienced a LINKS program, including those who did not complete a program as planned, was reported to have made gains in wellbeing. However, entry to mid-point decreases were observed for some domains (health, learning, getting on with others and future outlook). Also, for the 81 CYPs allocated to a program (treatment completers and others) there is some evidence of mid-treatment increases in trauma symptoms which will need to be closely monitored as more CYP complete a program.

## Recommendations

**Referrals:** Given that over a third of clients allocated to a program exited the service before completing a program, and that 18% of those referred did not meet inclusion criteria or declined the service, referral processes and information sharing procedures require refinement. In particular clarity around the need for placements to be stable upon entry into LINKS should be reviewed as many carers and staff noted instability to be a challenge to initiation of a program, despite the purpose of LINKS being to support CYPs who have experienced recent placement instability.

**Enhancing carers' capacity:** Carer involvement in CYP's treatment is essential for long term maintenance of treatment effects. Qualitative evidence indicates that greater engagement of carers and their involvement in programs is needed.

**Coaching in the program models:** Adopting an objective measure of treatment fidelity which could be used to drive practice improvement would help to ensure adherence to the programs as intended. Routine use of fidelity data should guide practice coaching to support the achievement of positive outcomes for families.

**Improvements to data collection:** Continuing appraisal of entry, mid and exit data for the increasing number of clients accessing LINKS is required to build confidence in preliminary findings. Potential bias in self-selection (staff and carer) into interviews will be addressed in future evaluation reports, when greater volumes of quantitative data are available to support or counter qualitative claims about implementation and outcomes. Some improvements to current data collection procedures have been recommended by the evaluators, to facilitate more robust understanding of the factors associated with early discontinuation and successful treatment. These data improvements will significantly enhance the capacity of the evaluation to address questions relating to the impact of the programs on CYP and family outcomes, and to understanding the costs and benefits of LINKS.



# 1. Introduction

## 1.1. Overview of the LINKS Trauma Healing Service

The LINKS Trauma Healing Service (hereby referred to as 'LINKS') is one of the evidence-based initiatives launched under the Their Futures Matter (TFM) reform. The reform aims to improve life outcomes for vulnerable children and families in NSW by applying an investment approach to direct and prioritise funding and resources. As part of this approach, a number of evidence-based programs were commissioned to improve outcomes for children and young people (CYP) currently in out-of-home care (OOHC). Their Futures Matter (TFM) internally commissioned *FACS Psychological Services* to deliver LINKS at two sites, with the service agreement being signed in September 2017.

### Intervention sites

There are two intervention sites:

- The greater Newcastle region in Hunter New England District, which commenced working with clients in October 2017.
- The eastern side of Nepean Blue Mountains District centred on Penrith and St Marys, which commenced working with clients in February 2018.

### Programs offered

Within LINKS, multi-disciplinary teams deliver trauma treatment to a targeted group of children and young people (CYP) in out-of-home care (OOHC), according to client need. TFM commissioned Psychological Services to deliver four evidence-based programs (more information about each program is provided in Appendix A):

- Trauma-Focused Cognitive Behavioural Therapy (TF-CBT)
- Eye Movement Desensitisation and Reprocessing (EMDR)
- Parent-Child Interaction Therapy (PCIT)
- Tuning into Kids/Tuning into Teens (TIK/TIK(T)).

The LINKS service is being implemented to:

1. increase stability of OOHC placements; and
2. respond to the trauma and other underlying causes of child abuse and neglect.

LINKS seeks to decrease trauma symptoms and improve psychological wellbeing for targeted cohorts of children in OOHC<sup>1</sup>, which in turn are expected to positively impact other areas of life.

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<sup>1</sup>Out-of-home care (OOHC) refers to the care of CYP who are unable to live with their own families and can involve placement of the CYP with alternate caregivers until they are able to safely return home (time in care can vary). Subtypes of OOHC include immediate or crisis care (emergency placements due to concerns about immediate safety), respite care (short periods of time - e.g., school holidays, weekends), short to medium-term care (placements up to 6 months with a strong focus on reunification - called 'restoration'), long-term care (placements for longer than 6 months, usually when CYP is not expected to return to their family), and relative or kinship care (CYP lives with a relative or someone they already know). Source: <https://www.facs.nsw.gov.au/families/out-of-home-care/about-out-of-home-care/care-types>.

The target cohort for LINKS is CYP who are under 15 years of age who are in statutory foster/relative/kinship care where these placements are unstable and children are at high risk of entering residential care. Placement instability indicators include:

- where the child has had two or more placements in the last six months; or
- where respite care use has increased in the past 12 months.

## 1.2. Evaluation of the LINKS Trauma Healing Service

### Objectives

The purpose of the evaluation is to develop high quality evidence on effectiveness (improved client outcomes) and efficiency (cost-benefits of the system) of the LINKS Trauma Healing Service. The evaluation will investigate how LINKS is being implemented in two locations in NSW and assess the effectiveness of LINKS particularly relating to trauma symptoms, psychological wellbeing, behavioural and emotional functioning and placement stability. It will also provide an assessment of the cost-effectiveness of the service which will help to determine efficiency.

### Key evaluation questions

This evaluation is underpinned by the overarching question: *Did the LINKS Trauma Healing Service work?* Specific primary and secondary evaluation questions that are guiding the evaluation are listed in Table 1.

### Broad description of methodology

The evaluation is being conducted by the Parenting Research Centre (PRC), in collaboration with the Cultural and Indigenous Research Centre of Australia (CIRCA) and Deakin Health Economics (DHE), Deakin University. See Appendix B for detail about project governance.

To achieve the abovementioned objectives this evaluation comprises three components - process, outcome and economic evaluations, using a hybrid effectiveness-implementation design (Bernet et al., 2013) incorporating a mixed-model repeated-measures quasi-experimental design for the outcomes evaluation component and a cost-benefit analysis. A quasi-experimental research design has been adopted to quantitatively measure client outcomes in response to treatment in comparison to a matched sample no-treatment (or 'business as usual' treatment) comparison group.<sup>2</sup>

The various methods employed for these three overlapping evaluation components are summarised in Table 1. The hybrid approach will integrate data collection and analysis for the three components of the evaluation.

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<sup>2</sup> Note, however, that this current report (the first of three from the evaluation) does not include comparison of treatment and non-treatment groups, nor does it include any cost-benefit analyses at this time.

**Table 1. Overview of methods used to address evaluation questions**

Evaluation Questions	Outcomes/indicators	Analysis of FACS administrative data	Semi-structured interviews with LINKS staff, managers and agency leads	In depth family interviews	Service provider administrative data	12-month follow-up interviews with treatment group families
<b>Primary questions</b>						
<ul style="list-style-type: none"> <li>Is LINKS effective in increasing stability of OOHC placements (fewer non-respite placement moves)?</li> <li>Does LINKS provide value for money for achieving placement stability</li> </ul>	<ul style="list-style-type: none"> <li>Increased stability of OOHC placements (fewer non-respite placement moves)</li> </ul>	✓		✓	✓	✓
<b>Secondary questions</b>						
<p><b>Outcomes for families</b></p> <ul style="list-style-type: none"> <li>Is LINKS effective at reducing trauma-related symptoms for CYP receiving treatment?</li> <li>Is LINKS effective at improving the wellbeing (physical and psychological) of CYP receiving treatment?</li> <li>Is LINKS effective at improving secondary outcomes for CYP and caregivers involved in treatment, such as behavioural and emotional functioning, improved education and justice outcomes, and caregiver wellbeing?</li> </ul>	<ul style="list-style-type: none"> <li>Reduction in trauma symptoms</li> <li>Improved psychological wellbeing of CYP</li> <li>Improved behavioural and emotional functioning of CYP</li> <li>Improved carer capacity and wellbeing</li> </ul>	✓		✓	✓	✓
<p><b>Implementation outcomes</b></p> <ul style="list-style-type: none"> <li>What was the reach and appropriateness (including cultural appropriateness) of the service to the target cohort?</li> </ul>	<ul style="list-style-type: none"> <li>Acceptability: evidence base and relevance</li> <li>Adoption: uptake of programs</li> <li>Appropriateness: suitable for cohort and setting</li> <li>Feasibility: ease of implementation; barriers/ facilitators to implementation</li> <li>Fidelity: programs delivered as intended</li> </ul>		✓	✓	✓	

Evaluation Questions	Outcomes/indicators	Analysis of FACS administrative data	Semi-structured interviews with LINKS staff, managers and agency leads	In depth family interviews	Service provider administrative data	12-month follow-up interviews with treatment group families
	<ul style="list-style-type: none"> <li>• Penetration: reaching intended cohort; proportion of eligible children serviced</li> <li>• Sustainability: implementable over the long term</li> <li>• Organisational readiness               <ul style="list-style-type: none"> <li>- Evidence-based programs</li> <li>- Resources available</li> <li>- Skilled staff</li> <li>- Organisational processes in place (e.g., referral processes, training &amp; support, decision making regarding program allocation)</li> </ul> </li> </ul>					
<p><b>Cost-efficiency</b></p> <ul style="list-style-type: none"> <li>• What are the costs of LINKS?</li> <li>• What are the benefits of LINKS in terms of reduction of costs to FACS? In terms of reduction of costs to other government agencies?</li> <li>• Do the economic benefits of the program outweigh the costs?</li> <li>• What is the efficient cost of delivering LINKS?</li> <li>• How do current costs compare to the efficient cost?</li> </ul>	<ul style="list-style-type: none"> <li>• Economic costs associated with delivery of LINKS</li> <li>• Economic benefits of LINKS</li> </ul>	✓	✓	✓	✓	

### **1.3. Specific focus of this first evaluation report: Process evaluation data collected to date and initial examination of service outcomes (where possible)**

At this stage of the implementation and evaluation of LINKS, the current report focuses on early indicators of the success of implementation of the four programs (see Appendix A) and areas for implementation improvement to guide course correction; plus an examination of available data about outcomes for families who have participated in LINKS up to the end of August 2018. Thus at this early stage of the evaluation, no data from the matched-sample comparison group is reported; only treatment group data is reported herein.

Below we report on data collected from families and LINKS staff related to the implementation of LINKS. This includes exploration of the readiness of sites and staff to adopt the programs, the degree to which systems and organisational processes (e.g. referral systems) and resources (e.g. trained staff) are in place to successfully deliver the programs with fidelity, client satisfaction with LINKS, and facilitators and barriers to ongoing successful implementation of LINKS.

We also report on client outcome data collected by FACS and by the LINKS service provider, for CYP and carers who have been referred for treatment. This includes administrative data about child placements and reports of risk of significant harm made to child protective services, and service usage data.

It also includes examination of data from standardised measures of trauma symptoms (Trauma Symptoms Checklist), children's behavioural and emotional functioning (the Strengths and Difficulties Questionnaire), children's psychological wellbeing (Personal Wellbeing Index and HoNOSCA), and carer capacity and wellbeing (Personal Wellbeing Index, Parental Stress Scale).

## 2. Methodology

### 2.1. Adaptation of the Consolidated Framework for Implementation Research (CFIR)

We adapted the Consolidated Framework for Implementation Research (CFIR; Damschroder et al., 2009) as a guide to evaluate the initial stages of LINKS implementation. The CFIR is a conceptual framework that was developed to guide systematic assessment of multilevel implementation contexts to identify factors that might influence program implementation and effectiveness.

The CFIR is composed of five major domains:

1. Intervention characteristics: features of an intervention that might influence implementation (e.g., stakeholders' perceptions about the relative advantage of implementing the intervention, complexity).
2. Inner setting: features of the implementing organisation that might influence implementation (e.g., implementation climate, leadership engagement).
3. Outer setting: features of the external context or environment that might influence implementation (e.g., participants' needs and resources).
4. Characteristics of individuals involved in implementation that might influence implementation (e.g., knowledge and attitudes about the intervention).
5. Implementation process: strategies or tactics that might influence implementation (e.g., engaging appropriate individuals in the implementation and use of the intervention, reflecting, and evaluating).

As the CFIR is intended to be flexible in application, it was suitable to guide the evaluation of the implementation of LINKS, particularly because it provided a comprehensive framework to identify factors that may emerge in various contexts to influence implementation (Damschroder & Lowery, 2013).

The CFIR was used to guide development of interview questions to ask of two groups of evaluation informants: families and provider staff. We examined each CFIR domain and respective (sub-) constructs thought to be necessary and helpful for the assessment of the implementation process and considered their relevance for the evaluation of LINKS at this time point. This list of questions provided the basis for semi-structured interview guides and reflective questions, which were asked of our two groups of evaluation informants during face-to-face and phone interviews in September 2018 (see Appendices D and E for interview schedules). We began interviews by asking open-ended questions, eliciting descriptions of respondents' roles and how LINKS has been implemented at each site. We probed aspects of informants' narratives to understand how LINKS had been implemented retrospectively. We focused our questions on interviewees' perceptions of LINKS and the specific programs, aspects of the inner and outer setting, and perceptions about the process of implementation.

The CFIR was also used to guide development of the data coding and analysis of interview data. Specifically, the CFIR was used as a template for content analysis. Taking a menu-of-constructs approach from CFIR allowed us to flexibly include only constructs that apply to the evaluation at hand, which in turn permitted us to limit the duration of our interviews to a reasonable time period.

### 2.2. Overview of methodology framework

This report focuses on quantitative data collected about clients of LINKS, as well as qualitative data collected from client families and staff about implementation of the service.

The specific methods used for this stage of the evaluation are outlined in Table 1 above, which also stipulates how each data collection methodology was and will be used to inform evaluation questions and intended outcomes within the evaluation.

A mix of primary and secondary data is being used to assess client outcomes and experience, and to measure program implementation:

- *Existing administrative data from FACS and the LINKS service provider.* Indicators of client experience obtained from administrative data sources include: engagement and retention data (e.g., number of program sessions, rates of completion of service plans, length of engagement), outcomes on standardised and non-standardised measures of relevant client and family constructs (e.g., trauma symptoms, child emotional/behavioural functioning, wellbeing) and client satisfaction measures. Indicators of implementation captured from administrative data sources include: referral and engagement data, data about fidelity to the program models, and organisational readiness information.
- *Staff interviews* at both LINKS sites to assess contextual and program factors affecting implementation. Questions cover topics related to: staff and family retention, staff training and supervision exposure (including their satisfaction with these if available), staff experience with the programs, perceptions about the acceptability, feasibility, effectiveness and cultural appropriateness of the programs, organisational readiness, and program adaptations.
- *Consultations with agency leads and managers* capture management-level views about the client experience such as referral processes and engagement, as well as information on program implementation - organisational readiness, training, supervision, resources, reach, fidelity, and sustainability.
- *In-depth client interviews* to elicit client perspectives on the acceptability of the programs, and to capture families' views on implementation (satisfaction, needs met, cultural appropriateness). Families who are in scope for these interviews are those who have completed (or are nearing completion of treatment with LINKS). This does not include families who were referred but did not engage or those who left the service early. We acknowledge that TFM is interested in understanding the perspectives of families who do not – for various reasons – complete a program, but this is not achievable within the resources made available to the evaluators. Additional time and different recruitment methods would be required to facilitate inclusion of early terminators in the interviews. Nevertheless, we will be able to draw upon the quantitative data from FACS and from the service provider to identify characteristics of those who do and don't engage and those who leave LINKS prior to treatment completion.

Agreements were established between FACS and the service provider outlining the scope of the evaluation and articulating roles and responsibilities, data sharing and collection protocols, and participant recruitment approaches. Resources were provided to sites to support the evaluation (e.g., recruitment information fliers for case managers, scripts to engage families in carer/family interviews, regular phone and email contact with the evaluators to guide recruitment).

### 2.3. Examination of completeness and quality of data collection

We reviewed a combination of structured and unstructured data. For the purpose of this report, unstructured data types included free-entry text, while structured data types included coded data (such as CYP identification codes and outcome measures data) or data entered into fields requiring specific alphanumeric formats. Drawing from the literature we focused on three different dimensions of data quality: completeness, correctness and timeliness.

- **Completeness:** Completeness is the level at which a data field has been answered in its entirety. Bovee et al., (2001) describes completeness as 'information having all required parts

of an entity's description'. Measuring completeness can ensure CYP profiles are accurately answered in whole and that an entire picture of the client situation emerges. We assessed the following variables to see if data values were missing or unusable for the evaluation: CYP who started and completed LINKS treatment, service use data and outcomes measures. We examined the overall completeness of data at various stages of treatment (on entry, mid and exit) and assessed whether the data was collected and reported appropriately in relation to documentation provided to the evaluators about LINKS.

- **Correctness (accuracy):** The data were considered correct when the information they contained appear to be free from significant errors. The definition of correctness suggested by Hogan and Wagner (1997) states that data correctness is the proportion of data elements present that are correct, or that variables recording different information have values that make sense when considered together (e.g., age is recorded as 8, and education level is recorded as primary). We examined whether the data contained any mathematical errors. We also reviewed data entry logs for data duplication, including assessing repetition of the same individuals under different program streams, different placement status or different exit reasons.
- **Timeliness:** Timeliness refers to data recency or currency. Data are timely if they contain information describing their timeliness. Redman (1996) argues that timeliness is the degree to which a datum is up-to-date. A datum value is up-to-date if it is correct despite possible discrepancies caused by time related changes to the correct value. For example, timeliness could be measured by what period is covered by the data held in a dataset, how often the data are updated, and when the last update was. Data were considered current if they were recorded in the dataset within a reasonable period of time following a valid referral, start of program or, alternatively, if they were representative of the CYP state (e.g., placement) at a desired time of interest (Redman, 1996). We reviewed data entry logs and assessed whether data were entered into the dataset within an acceptable time limit and whether the data can be considered obsolete.

## 2.4. Analysis and review of FACS administrative data

For the current report we explored data available in FACS administrative data records on outcomes of interest to the broader evaluation, specifically on risk of significant harm (ROSH) reports received during treatment or since exit, and placement status on entry and on exit. We report change over time on these outcomes by examining on entry, mid- and exit data for each child who had participated in LINKS up to end August 2018.

## 2.5. Analysis and review of service provider records

Routinely collected administrative data collated by the LINKS service provider were analysed to understand outcomes associated with treatment programs. As summarised in Table 2, entry, mid- and exit data on the following standardised measures of relevant CYP and carer outcomes were analysed (see Appendix C for more information about each measure): the Trauma Symptom Checklist for Children or for Young Children (TSCC or TSCYC), the Personal Wellbeing Index School Children version (PWI-SC) and Adult version (PWI-A), the Strengths and Difficulties Questionnaire (SDQ), the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA), and the Parental Stress Scale.

In addition we examined carer-report data collated about CYP presentations to emergency, school attendance (total absences, school days missed due to suspensions and employment/training information), and data about the CYP's contact with the justice system (warnings received, time in custody and number of court appearances).



For the process evaluation the following routinely collected administrative data (individual client level data) from the service provider were analysed: CYP and carer demographic information (e.g., age, gender, Aboriginality), treatment details (e.g., program received, sessions attended, completion data), satisfaction ratings, and referral information. For clinicians, we analysed data provided about treatment fidelity using a series of program-specific checklists (i.e., the TF-CBT Brief Practice Checklist - self-assessed, the PCIT Treatment Integrity Checklist - self-assessed, the EMDR Recent Traumatic Episode Protocol - assessed by another practitioner based on session tapes, and the TIK/TIK(T) Fidelity checklist – self assessed).

**Table 2. Measures used to report against client outcomes from service provider administrative data**

Client Outcomes	Measures	Completed by?	When collected?	
Decreased CYP trauma symptoms	Trauma Symptom Checklist for Young Children (3-12 years); OR	Carer report	On entry; after 6-10 sessions (mid-point); on exit; and 6 & 12 months after exit	
	Trauma Symptom Checklist for Children (8-16 years)	Carer report		
Improved CYP psychological wellbeing	Personal Wellbeing Index – School Children (12 years and older); OR	CYP report		
	Strengths and Difficulties Questionnaire (2-11 years)	Carer report		
Improved CYP behavioural and emotional functioning	Health of the Nation Outcome Scales for Children and Adolescents (5-18 years)	Clinician report		
	Strengths and Difficulties Questionnaire (SDQ) (2-17 years)	Carer report		
Strengthened caregiver capacity	Parental Stress Scale	Carer report		
	Personal Wellbeing Index – Adult OR Intellectual Disability (for carers)	Carer report		
Improved CYP physical wellbeing	Presentations to Emergency	Carer report		On entry; on exit; and 6 & 12 months after exit
	Principal emergency department diagnosis	Carer report		
Increased CYP engagement in education	School attendance (total absences)	Carer report		
	School suspensions	Carer report		
	School days missed	Carer report		
	Employed or Enrolled in further study or training course (if over 17 and no longer engaged in school)	Carer report		
Decrease in CYP's contact with the justice system (or stability where already low)	Warning/cautions	Carer report		
	Court appearances	Carer report		
	Time in custody	Carer report		

## 2.6. Interviews with LINKS staff

An iterative process was followed to engage LINKS staff in the evaluation, designed to maximise the likelihood that all LINKS staff would participate in interviews, and thereby reduce the risk of participation bias. TFM introduced the evaluators to agency leads/managers at LINKS via email in August 2018. The message included a letter of endorsement for the evaluation from TFM (including a reminder to managers that supporting an evaluation is part of their service agreement with FACS). Subsequent emails addressed to each site manager included a one-page introduction to the evaluation, covering a description of all the activities that the evaluation team were undertaking and a general statement on the requirements for each service site. Within one week of sending this email to site managers, the PRC followed up with telephone calls to site managers to introduce the evaluation and outline the specific planned activities for the site. Detailed planning for the staff and family interviews and agency lead/manager consultation commenced with site managers during this and subsequent telephone calls.

Following these initial contacts, PRC sent an email to all managers and agency leads inviting them to participate in a consultation for the evaluation, with a detailed evaluation information sheet and consent form attached to the email. A further email invited LINKS managers to pass a written information sheet and consent form onto staff in their service. Staff were asked to get in contact with the PRC to indicate their willingness to participate in an interview and to arrange a suitable time for this.

Following receipt of signed consent forms, staff, managers and the agency lead participated in interviews either via phone or in person.

The purpose of interviews with managers and the agency lead was to gather detailed information from management perspectives to understand how implementation support elements (e.g., resources, training and leadership), had contributed to the delivery of LINKS and its four treatment programs with fidelity, and to understand the degree to which these factors may have impacted client outcomes.

The purpose of interviews with service delivery and administrative staff was to gather detailed information from a range of informants to understand: how implementation support elements (e.g., training and supervision) had contributed to the delivery of a program with fidelity; the degree to which these factors may have impacted client outcomes; and the extent to which the programs are viewed as useful, acceptable and appropriate. Within these overarching questions, a range of sub-questions adapted from the Consolidated Framework of Implementation Research (CFIR) were considered to gain understanding of the staff experience (satisfaction, engagement, retention, cultural appropriateness). The questions also explored the effectiveness of implementation elements - adoption, reach and penetration, feasibility, organisational readiness, stage of implementation, training, supervision, referral processes, implementation fidelity and sustainability.

The interviews were conducted with two managers and one agency lead (Director) and with 11 mental health clinicians, psychiatrists, speech therapists, and administrative support staff. The majority of these interviews were conducted in person with four occurring via telephone. All 18 staff at each site were invited to participate, with 12 consenting to be interviewed and 11 actually available for interviews within the timelines of this report.

Qualitative data capture methods (e.g., interviews) always carry an element of potential bias associated with participants' desire to give socially acceptable answers. To ameliorate this risk, the participant information sheets, consent forms, and statements made by interviewers prior to interviews always made clear the independence of the evaluators and the confidential nature of their discussions. Another potential bias is that the types of participants who agree to interviews could be those who feel more positive about discussing their experiences. However, bias

in one direction is often counterbalanced by the likelihood that participants who have had negative experiences will also take the opportunity to give feedback.

A single interviewer conducted all interviews. Written summaries of each interview were created by the interviewer in situ during the interviews to capture key emerging themes and concepts. In addition, interviews were audio-taped to enable the confirmation of information collected and to provide examples of participants' comments in the reporting of findings.

Data were analysed thematically by an evaluator who was not the interviewer, to identify common themes in relation to implementation of LINKS. We adopted a two stage approach to thematic analysis using deductive reasoning based on CFIR constructs to reduce and organise the data to support the analysis. An initial categorisation of staff's data was completed using themes from the evaluation questions (for instance, themes about LINKS acceptability, appropriateness and fidelity). The initial themes and coding were reviewed by the evaluation team and the Project Board to confirm relevance of generated themes and to generate further themes (for instance "initial acceptance of LINKS" or "barriers to acceptance of LINKS").

Note that for this report the qualitative data collected from staff and from the agency lead and managers were combined in thematic analysis and are reported as a collective in the Results section below. In the future it will be possible to extract findings and report results for both informant types separately, however for this report, given the scope of topic covered, it was deemed appropriate to combine the two informant groups.

## **2.7. Interviews with families**

CIRCA conducted ten in-depth interviews with carers who were participating in and/or had children in their care who were accessing and engaging with the LINKS Trauma Healing Service. There was a mix of foster and relative/kinship carers. The purpose of the interviews was to explore the experiences of carers and families in relation to LINKS, focusing on their views about the fidelity, appropriateness, outcomes and feasibility of the program. All interviews were guided by an agreed upon interview schedule. Interviews captured the experiences of carers/families across the two LINKS sites: the greater Newcastle region in Hunter New England District ( $n=4$ ); and Penrith/St Marys of the Nepean region ( $n=6$ ). The length of time carers interviewed had been engaging with LINKS varied from 2 to 12 months.

Recruitment of carers and families occurred over two stages. Purposeful sampling was employed in preference to another approach to sampling interview participants (e.g., probabilistic or random sampling). Purposeful sampling allows for capture of rich information from participants who could provide detailed insights about LINKS given the duration of their engagement (Palinkas et al., 2015). These were families who we determined to be especially knowledgeable about and experienced with LINKS. First, the service provider informed carers about the research and gained in-principle consent to be contacted by CIRCA for interview. Next, CIRCA consultants made contact with each carer, explained the voluntary and confidential nature of the research, and gained formal consent to proceed with each interview.

Interviews with non-Aboriginal families ( $n=7$ ) were conducted over the phone. Aboriginal families ( $n=3$ ) were interviewed by local Aboriginal research consultants either over the phone or in person, depending on the preference of the family. Of the three Aboriginal family interviewees, one interviewee was an Aboriginal carer of an Aboriginal child and two interviewees were non-Aboriginal carers of Aboriginal identified children. Acknowledging there is potential for bias related to the cultural appropriateness of programs when the carer of an Aboriginal child is not Aboriginal themselves, future stages of this evaluation will endeavour to recruit a larger number of Aboriginal carers in order to further investigate questions of the cultural appropriateness of LINKS from Aboriginal perspectives.

All carer interviews were audio recorded. Interviewees received a \$50 grocery voucher for participating in the evaluation.

Deductive thematic analysis of the data was informed by the overarching topics in the discussion guide and the research questions. We used CFIR constructs to reduce and organise the data to support the analysis and to provide a broader context to explain the main findings.

## 3. Results

### 3.1. Completeness and quality of data collection

This section discusses the completeness of the service provider administrative dataset and FACS administrative datasets (including placement and risk of significant harm (ROSH) reports).

#### Completeness (Table 3)

**Service provider's records.** The data comprehensiveness, coverage of evaluation needs and completeness of service provider's administrative data ranged between 60% to 100%. The non-missing record was 100%, meaning that all CYP were accounted for across relevant datasets.

There were 142 referrals recorded between October 2017 and August 2018. Of these, there were 17 cases (12%) of incomplete data, which accounted for 88% of completeness record. Of these 17 cases, three records did not report a start date of acceptance/non-acceptance of referral; 13 did not report an allocation to a program/s and one did not report consent. For the three records that did not report a start date of acceptance/non-acceptance of referral, these were CYP who did not start a program at initial referral and were later re-referred into LINKS. Thus while there are 142 referrals recorded, only 139 are unique referrals.

There were five recorded cases of CYP who had exited the program due to completion of treatment. Of these, three CYP had sufficient and complete records of on-entry, mid-term and exit assessment measures, contributing to 60% of the data completeness (from program start to exit from program).

We also assessed staff knowledge about required data-collection procedures, failure to follow procedures and whether the type of data collected were in accordance with TFM specifications. The extent to which data are collected using consistent procedures and definitions across staff collectors and across two sites were considered by comparing information captured during staff interviews with written data collection procedures provided by TFM. We were satisfied that enough data was collected and recorded appropriately and as specified by TFM documentation.

**FACS (placement) data.** Placement records dating back to February 2006 were provided for all 34 of the CYP who have exited LINKS either due to treatment completion or early discontinuation.

Across all 34 records, the data comprehensiveness, coverage of evaluation needs and completeness of placement data ranged between 85% to 100%. Of the 34 placement records, there were five cases of incomplete placement purpose recorded which means 85% of this data was complete. The data provided by FACS regarding placements was recorded appropriately in relation to TFM requirements.

**FACS (ROSH) report.** All five records of the CYP who had started and completed LINKS were reported in FACS ROSH report records. These five CYP have sufficient and complete records of date referred, date ended, exit reason and assessment issue, signaling 100% data comprehensiveness. The data regarding ROSH reports was recorded appropriately in relation to TFM requirements. The non-missing record was 100%.

**Table 3. Data completeness**

Completeness	Indicator	Percentage Service provider administrative dataset	Percentage FACS (placement) administrative dataset*	Percentage FACS (ROSH) administrative dataset*
Data is comprehensive	Non-missing records (CYP records were accounted for)	100%	100%	100%
Data is complete	Completion of data from referral date to start of program	88%	NA	100%
	Completion of data from start of program to exit from LINKS*	60%**	NA	NA
	Number of cases with at least one incomplete placement purpose for open cases/open placement matching records	NA	85%	NA
Data covers evaluation needs	Data collected and recorded appropriately	100%	NA	NA
	Data collected and recorded as specified by TFM documentation	100%	100%	100%

\* Only cases where treatment was completed were used for this report.

\*\* If one item in the questionnaire is not answered, the percentage is marked down immediately.

### Timeliness (Table 4)

Both FACS and service provider’s administrative datasets recorded between 79% to 100% for data recency, non-obsolescence and being up-to-date. Overall, we were satisfied that data collection protocols were implemented within an acceptable period post referral acceptance. There were no obvious ‘red flags’ in the reported data such as large completion rates reported early in the program year or completions out of proportion to the number of CYP, or substantial variation in actuals from one site to another.

**Service provider’s records.** The data recency, obsolescence and updated-ness of service provider’s administrative data were 100%. Of the 139 unique CYP referrals recorded between October 2017 and August 2018, all have a referral acceptance or declined date recorded (100% rating for data recency).

The data’s non-obsolescence (indicated by examining records about the number of days from date of acceptance of a referral to the first day of program commencement) and updated-ness (indicated by examining records about the number of days from exit to completion of carer’s PWI at exit) were 100%.

**FACS (placement) data.** Of the 34 CYP for whom placement data was made available to the evaluators (those who have exited LINKS), there were four records of dates that were not up to date<sup>3</sup> (indicating 88% data recency). There were seven (21%) CYP with placement data for whom

<sup>3</sup> Data were considered current (timeliness) if they were recorded in the dataset within a reasonable period of time following a valid start date or, alternatively, if they were representative of the CYP placement state at a desired time of interest.

start to end dates of placement were deemed unreasonable (such as end date remained opened when it should be closed); this suggests 79% of the data met recency criteria.

**FACS (ROSH) report.** Overall, ROSH data timeliness (including data recency, non-obsolescence and recency) was strong with 100% of the data entered in a timely way.

**Table 4. Data timeliness**

Timeliness	Indicator	Percentage Service provider administrative dataset	Percentage FACS (placement) administrative dataset	Percentage FACS (ROSH) administrative dataset*
Dates are recent	Reasonable <sup>1</sup> number of days from date of referral to date of acceptance	100%	NA	NA
	Dates are up to August 2018	100%	88%	100%
Data are not obsolete	Reasonable <sup>1</sup> number of days from date of acceptance to the first day of program commencement*	100%	NA	100%
Data are up-to-date	Reasonable <sup>2</sup> number of days from date of exit to the date of completion of carer's PWI at exit*	100%	NA	NA
	Reasonable <sup>3</sup> number of days from placement start date to placement end date (excluding dates with mathematical errors)	NA	79%	NA
	Reasonable number of days from start of treatment date to end of treatment date*	100%	NA	100%

<sup>1</sup> Based on staff interviews - the usual turnaround time is one week

<sup>2</sup> Based on staff interviews – the usual turnaround time is less than one week

<sup>3</sup> When a placement date remained open when another placement for a later date has been closed

\* Only cases who completed treatment were used for this report.

### Accuracy (Table 5)

To assess accuracy, we looked for the presence of multiple representations of the same data objects within a given dataset. We also traced the lineage of the data, looking specifically for elements of important relationship linkages such as self-reports provided by CYP and measures reported by CYP's carers. To further assess accuracy, we compared the data collection tools with data collection protocols.

**Service provider's records.** The overall correctness and accuracy<sup>4</sup> of service provider's administrative data was 100%. There was one record of typing error in the measurement

<sup>4</sup> Data accuracy can be difficult to assess as it depends on the CYP/carer providing correct data and the intake clinician's ability to document and enter the data accurately. Accuracy is best determined by comparing records in the respective datasets to paper records, or the records of another reliable provider. For example, a referral in question can be compared to a paper case file from CAU.

assessment; we were satisfied that this was due to a typing error and did not record this against the data's correctness and accuracy. All data were deemed 100% accurate in relation to case identification codes matching other dataset codes.

**FACS (placement) data.** Of the 34 CYP who have exited LINKS placement records between February 2006 and August 2018 include four records of date-related mathematical errors (12%), and eight cases (24%) of multiple reports of the same individuals under different open placement status (includes open placement matching without completed dates). All data were deemed 100% accurate in relation to case identification codes matching other dataset codes. The overall correctness and accuracy of placement data ranges between 76% to 100% across different indicators of accuracy.

**FACS (ROSH) report.** For the five CYP who had started and completed LINKS treatment between October 2017 and August 2018, all data were deemed 100% accurate in relation to case identification codes matching other dataset codes and consistent recording of reasons for exit for each CYP.

**Table 5. Data correctness/accuracy**

Correctness or accuracy	Indicator	Percentage Service provider administrative dataset	Percentage FACS (placement) administrative dataset	Percentage FACS (ROSH) administrative dataset*
Data are correct	No mathematical errors	100%	NA	NA
	No date related mathematical error	NA	88%	NA
	Relationship linkages (TFM linkage IDs)	100%	100%	100%
Data contains very few errors	No report of the same individuals under different program streams	100%	NA	NA
	No report of the same individuals under different open placement status	NA	76%	NA
	No report of the same individuals under different exit reason/s	100%	NA	100%

\* Only cases who completed treatment were used for this report.

### 3.2. Process evaluation - focus on service implementation

#### Functioning of referral system including client groups missed/excluded from service

LINKS guidelines state that all referrals to LINKS have to be made by case managers/caseworkers. As specified in the manual the referral process includes the following steps:



- All referrals are initially sent to the Central Assessment Unit (CAU) mailbox where they are registered by the caseworker in the CAU database and then sent to the LINKS mailbox.
- The LINKS Client Service Officer then directs a referral to the relevant LINKS Manager.
- The LINKS Manager assesses suitability and informs the referring caseworker of an outcome.
- An eligible referral is then allocated to a lead clinician.

### Staff interviews

Overall, all 11 staff consider LINKS had an important place in addressing the need for providing evidence-based programs to CYP affected by trauma. A perceived gap existed that LINKS was filling – specifically a gap in trauma treatment for children in OOHC.

All staff taking part in the interviews confirmed that the above referral steps were used in the daily operations of the service. Eligible referrals are reviewed and discussed in a weekly meeting. LINKS Managers allocate referrals to lead clinicians, and inform the referrer of lead clinician details. In cases when a referral is not eligible, the Service Manager provides a letter to the referring caseworker outlining the reasons for ineligibility.

One limitation identified by staff ( $n=4$ ) in regard to the referral process was not having enough information provided by caseworkers, in relation to CYP history, allied health treatment reports, family background and access to information held in ChildStory.

### Service provider records

Administrative data indicated that by end August 2018 LINKS had received 142 referrals about 139 CYP. All referrals (100%) were made by caseworkers. Most referrals were received internally through FACS ( $n=102$ ; 72%). There was a similar ratio of referrals for male and female CYP ( $n=72$ , 51% and  $n=70$ , 49% respectively). Forty-seven percent ( $n=67$ ) of referrals were for Aboriginal families. The greatest proportion of referred CYP (66%,  $n=93$ ) were attending primary school, 25% ( $n=35$ ) were in high school, and 7% ( $n=11$ ) were attending childcare or preschool. Of the remaining clients (2%,  $n=3$ ), one child did not regularly attend school, one was not enrolled in school, and information about education was not provided for one child.

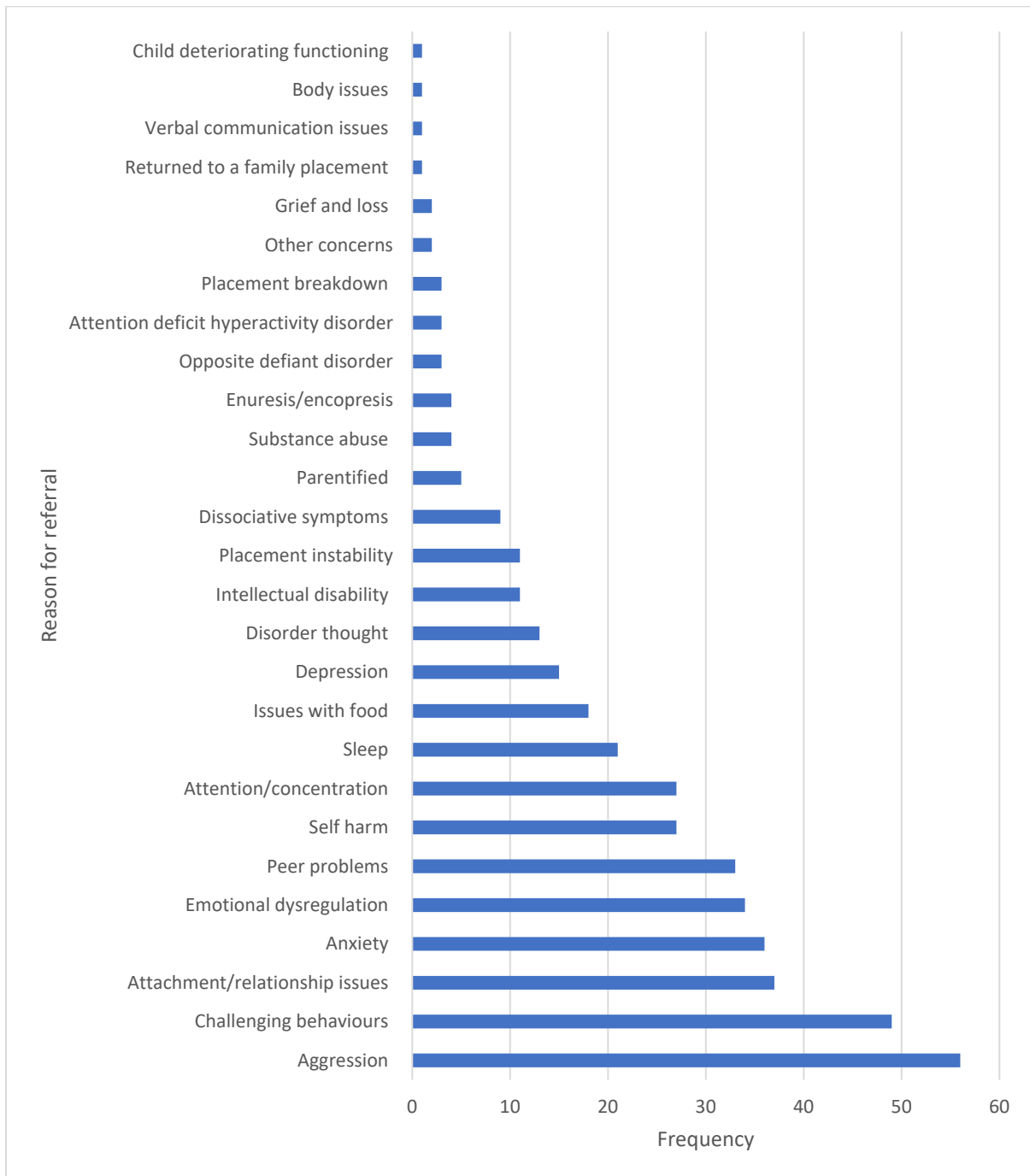
All of the referrals were for children aged 15 years or younger. For children who have exited LINKS ( $n=34$ ), half ( $n=17$ ) met referral criteria for placement instability (i.e., had two or more placements in the last six months or had increased use of respite in past 12 months).

Various reasons for referring CYP were recorded, with multiple referral reasons possible (and given) per client. The most common referral concerns included aggression, challenging behaviours, attachment/relationship issues, anxiety and self-regulation (see Figure 1).

Most of the 142 referrals to LINKS were accepted to the service ( $n=116$ , 82%) while 18% ( $n=26$ ) of referrals did not meet inclusion criteria or declined the service. Some reasons for families not being offered or taking up a program included:

- CYP not in a placement or is in temporary accommodation
- CYP is in residential care
- CYP is engaged with another service
- Specific support required that is not provided by the service (e.g., an Autism Spectrum Disorder-specific intervention)
- Distance
- CYP is likely to move out of the district within two months.

Figure 1. Reasons for referral (n=142), as indicated by service provider



## Family interviews

Carers reported the CYP in their care was referred to LINKS by their FACS or OOHC service provider caseworkers. Referrals tended to come at a time that carers described as being characterised by 'chaos' and 'instability'. Carers reported feeling out of their depth and unable to manage the unique demands of the children in their care who had experienced trauma and were exhibiting behavioural and psychological symptoms associated with their experiences.

There were two ways by which the referral process commenced. One involved carers making requests to their caseworkers for individualised support that met the specific needs of their children during a period of instability and 'desperation'. In these instances, carers stated that they were provided with little information about LINKS from their FACS caseworkers during the referral process but that LINKS staff provided greater detail about the service once the referral had been accepted and prior to commencement with the service.

For other carers, referrals to LINKS resulted from suggestions by caseworkers who were attuned to the trauma-related behavioural and psychological issues the CYP were experiencing and the impact this was having at home. Carers, in particular those who reported having a good working relationship with their caseworkers, explained that they trusted the recommendation of their caseworkers despite not receiving much information about LINKS from their caseworkers.

Overall, most carers indicated they did not experience difficulty in accessing the service once the referral had been accepted. Carers reported that once they started working with LINKS, accessing the service was easy, flexible and consistent. The main concern that carers voiced in relation to accessing LINKS was a fear of only having short term access to the service. Carers were worried about losing the support they were receiving from LINKS staff, stressing that continuity and stability in the relationships built between their families and LINKS staff was vital to long term improvements and stability.

Some carers expressed that they had some difficulty accessing LINKS due to its location. One carer explained that it was difficult to juggle other family demands alongside travelling a long distance to LINKS appointments, while another carer stated that treatment with LINKS had to stop, following the family's relocation to a region where LINKS was not offered.

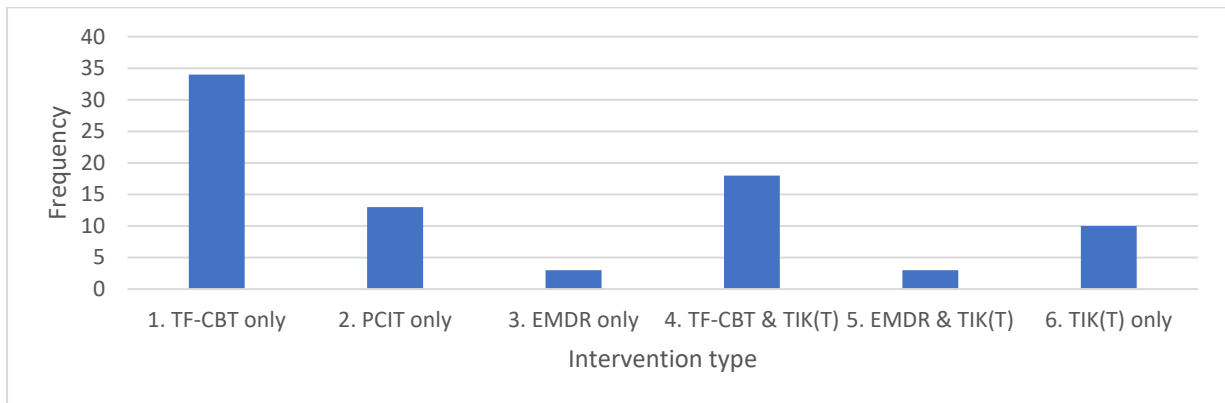
## Differences in treatment type (e.g., PCIT, TIK/TIK(T), TF-CBT, EMDR) implementation

### Service provider records

Of 116 of referrals accepted, three were for non-unique CYP. Thus of the 113 unique referrals 81 (72%) were allocated to one or multiple LINKS programs (see Figure 2; Appendix A contains details about each program, including recommended frequency and duration). Most of these clients were allocated to only TF-CBT ( $n=34$ , 42%). Twenty-two percent ( $n=18$ ) were assigned to a combination of TF-CBT and TIK(T), followed by 16% ( $n=13$ ) allocated to only PCIT and 12% ( $n=10$ ) to TIK(T) only. Those receiving only EMDR or EMDR plus TIK(T) received three referrals each (4% each).

There were 32 CYP whose referrals were accepted, but who were not (yet) allocated to a program. It is not always clear from service provider data why referrals had not been allocated, although given commentary drawn from family and staff interview, it is likely that placement instability or other family or CYP issues play a role in decisions to delay treatment commencement.

**Figure 2. Number of referrals allocated to each program**



### Staff interviews

In general, all 11 staff participating in the interviews expressed positive views about all four LINKS programs.

TF-CBT was perceived to be flexible since CYP do not have to go through every stage of the program and carers can also be included in sessions depending on CYP needs. Further, the narrative component of the program was viewed as suitable for different cultures, including Aboriginal families. Another positive aspect of TF-CBT was that it could be completed off-site.

All 11 staff reported that TIK/TIK(T) was also adaptable, so it could be delivered in a culturally appropriate way. The group format was believed to assist families to see that there are many others who share similar challenges, which contributed to group members supporting each other. It was acknowledged though that not all carers are willing to take part in a group program. TIK/TIK(T) was perceived as feasible when having sufficient numbers of families participating.

It was suggested that it would be helpful for PCIT to include more trauma information and additional time to spend with carers. It was also perceived to be expensive as it required a particular setting and equipment.

Two staff indicated that to take part in EMDR, CYP needed to fit a particular set of criteria. In cases where CYP presented with significant dissociative symptoms or aggressive behaviour, more time was needed to build rapport prior to commencement of the program. It was suggested that EMDR could be more inclusive of carers. Staff suggested that EMDR was particularly helpful for older adolescents.

### Implementation with Aboriginal families

#### Staff interviews

LINKS aims to provide culturally appropriate service to a range of family types, including Aboriginal CYP and their carers. To achieve this aim with Aboriginal families, staff indicated spending a great amount of time building networks and connections within the community, including engaging with Elders and families to build trust and relationships. Emphasis was placed on getting to know families and their cultural values, which was perceived as a crucial step to delivering programs without compromising fidelity.

Two staff also reported participating in a cultural awareness training and NAIDOC celebrations so that LINKS was introduced to the Indigenous community.

Staff found it very helpful having an Aboriginal psychologist on the team with whom they were able to consult when needed.

Most staff ( $n=10$ ) identified challenges regarding engaging Aboriginal families in the service. These concerns related to the place where sessions were typically conducted as LINKS shared their offices with FACS. For this reason, some sessions needed to be organised outside the FACS office where families felt more comfortable. This was seen as essential for building trust - particularly for families experiencing intergenerational trauma.

Two staff emphasised that the worker often had to be known in the community, so families knew who to speak to when they were referred to the service. Emphasising that they are part of LINKS and not FACS was helpful in engaging families.

Another issue was raised in relation to the time allowed to work with families. Five staff emphasised that Aboriginal families needed more time to build trust and rapport before engaging in a program.

Further, some program materials (such as TIK(T) narratives) needed to be modified to better fit the cultural needs of Aboriginal families. However, staff indicated that these modifications were performed with attention to retaining treatment fidelity.

### Treatment fidelity

Treatment fidelity indicates to what extent a program is delivered as intended. It is suggested that treatment fidelity is essential to effective translation of evidence-based programs into practice (Breitenstein et al., 2010). Notwithstanding the need to attend to fidelity, adaptation of programs is sometimes necessary – researchers cite the frequent commentary of service providers that programs developed overseas require adjustments to ensure they are relevant to the particular context or specific cultural group – for instance Aboriginal Australians - with which they are to be implemented (see Botvin, 2004 and Devieux et al., 2005).

### Service provider records

Treatment fidelity ratings indicated that all LINKS staff achieved a score of 100% on checklist items for three of the four programs (when rated either by others or by themselves) and a mean score of 92.5% (when rated by themselves) on TF-CBT. While this indicates a high fidelity rating overall, there is room for improvement in both fidelity to the TF-CBT model but also in the approach to fidelity assessment as self-assessment has potential to yield positively biased ratings.

One form of treatment fidelity relates to the client's experience of the program. However, because only two families have reported data on this (out of a possible five who have completed a program), we are unable to show individual scores. Overall, the two families for whom data is available reported high levels of satisfaction with LINKS.

### Staff interviews

#### Evidence base of the programs

Staff were asked about types of information or evidence they had which suggested that the implementation of LINKS would lead to positive outcomes for CYP and their families. The main sources of evidence reported by all staff included published articles, information from conferences, training and meetings, and discussions with colleagues. Slightly less than half ( $n=5$ ) indicated that their views about the effectiveness of programs were shaped by their clinical experience. Staff overall reflected positive views about the evidence base of the programs offered through LINKS.

### **Training and supervision**

All staff reported they had been trained in the programs they were delivering.

In relation to training and resources needed for implementing the programs, all staff believed the service was well resourced. They reported having access to toys, assessment materials, treatment manuals, internal communications and discussions with colleagues. They also reported attending relevant conferences, workshops and getting regular supervision to further extend their knowledge and improve their skills. The majority of staff reported feeling supported and satisfied with supervision received. However, one staff member suggested that a process of deciding who gets to attend a particular training could be improved. This person perceived that these decisions were made without discussion with staff members to check interests and preferences. Another concern was related to the supervision process whereby it was suggested that clinical supervision should be provided separately to management supervision.

### **Adaptation**

Staff perceived LINKS to be a flexible service and believed that this flexibility was needed to effectively work with CYP and carers. However, they also indicated that some adaptations of programs were needed at times. For example, engaging carers in the service was perceived to be an important factor in successful implementation of the programs to achieve best outcomes for CYP. As such, many staff indicated that having additional time and freedom to work with carers would enhance the program implementation and outcomes.

Staff also suggested that some modifications to materials were needed to match the child's cognitive development so they could understand program concepts. Staff would sometimes change the format of materials presentation to address cultural needs (visual vs. written) or introduce a psychoeducation component on trauma for carers.

In addition, some staff ( $n=4$ ) viewed that difficulties with CYP self-regulation - which was identified as a common concern for those referred to LINKS - were not adequately addressed by every program that LINKS offered. Hence, in some instances, staff provided additional attention to this concern by adapting a program to include sessions on self-regulation of emotions.

Nevertheless, all staff reported that any amendments to programs were made in consultation with the manager and the program developer so that fidelity can be maintained.

### **Ease of use**

Most staff ( $n=9$ ) reported that the programs offered through LINKS were not complicated and had a clear framework for delivery. Staff perceived that complexity arose from other factors related, for example, to the child's environment (e.g., unstable placement) or when the family needed a range of services. One staff member added that the programs required many hours of planning in order to be implemented effectively, clearly and simply to families.

### **Other implementation facilitators**

Most staff perceived having a multidisciplinary team as a great asset. Staff believed they worked well together, were focused on achieving similar goals and were drawing from each other's experiences and background. Leadership was also appraised as being supportive. While the overall working environment was perceived positively, one staff member disagreed with these views and believed that the LINKS work environment was not positive, with people being stressed about data or the number of reports they needed to do as part of LINKS delivery.

## Implementation barriers with CYP and family/carer

In relation to the CYP's and families' needs and resources, staff identified several barriers to effective implementation of the programs. These included:

- *Carer's own instability, history of trauma and chaotic living environment*  
Staff indicated that the carer's mental health, traumatic experiences and crisis made it difficult for them to provide support for their children or to put the CYP's needs first.
- *Carer motivation level*  
Some carers were perceived as not being willing to engage at a level required to achieve positive outcomes.
- *Carers not being aware of the referral to LINKS*  
Staff reported that at times caseworkers did not advise the carer that a referral had been made to LINKS.
- *Placement breakdown*  
Staff reported that stability of placement often needed to be a priority and addressed (sometimes by staff themselves) prior to the program taking place.
- *Distance from service/transportation difficulties*  
Some families were living up to 1.5 hours away from the service making it difficult to attend treatment sessions. This was further complicated if carers were not able to drive so they had to rely on public transport - which was often not reliable - or rely on caseworkers to transport them to their appointments. These difficulties sometimes contributed to clients missing their appointments.
- *Carer's other commitments including looking after their other children or working full time*  
These factors also contributed to many missed appointments since carers did not have alternatives for babysitting other children, or their working hours preventing them to attend sessions.
- *Using FACS offices to deliver programs*  
This was perceived as a significant barrier particularly for Aboriginal families with previous history with FACS.
- *Time needed to engage families*  
Staff believed that longer time was often needed to build rapport with families and get their trust to be able to effectively engage them in the programs.

## Family interviews

Experiences of treatment fidelity can also be understood from the perspectives of family members.

Regarding the individual programs offered within LINKS, some carers had accessed TIK/TIK(T) and reported that the program involved weekly two hour group workshops over six to eight weeks. Carers described how, as part of this program, they were provided with information about how to communicate more effectively with children who have experienced trauma and how to support their emotional needs.

Across programs, the majority of carers reported that they were accessing support services for their children from a LINKS psychologist and/or occupational therapist. Children typically had weekly, one-hour sessions with a LINKS therapist. Carers were generally aware of the kinds of activities their children were participating in when in sessions, for example, play therapy and talking through feelings and experiences. This was particularly the case for carers who were present during sessions and were actively participating in a treatment alongside their children, for example in PCIT. Carers who were not participating in sessions alongside their children were less likely to know the specific

details of the treatments or the name of the program being accessed. Family involvement in programs was once again identified as an important element of program success.

### **Meeting expectations**

Carers overwhelmingly expressed that LINKS delivered what they had hoped. Carers felt that the information about the service they had received from LINKS staff upon commencement was in line with the services that were delivered to them.

Some carers discussed how they were initially sceptical about whether LINKS could decrease severe trauma symptoms, and were wary of the techniques and treatments utilised to achieve this. In these instances, carers were pleasantly surprised and felt that their expectations of LINKS were exceeded because they were able to see significant improvements in the behaviour of the child in their care.

### **Meeting the needs of children and families**

LINKS was viewed as fitting well with the needs of the CYP it was servicing. Carers believed that the CYP in their care needed specialised, trauma-informed assistance and believed that LINKS psychologists were meeting this need. Carers stressed the importance of children having access to support outside of the home so that they could work through their experiences of trauma with someone who has the right level of expertise.

LINKS was deemed appropriate and suitable by carers in that it fitted well with the routines of their families. Carers found the service to be flexible to the demands of their schedules and the needs of their children, and appreciated the consistent and scheduled nature of their weekly appointments.

In terms of meeting the cultural needs of Aboriginal and Torres Strait Islander CYP and families, it was noted that carers were unaware of whether any Aboriginal workers were involved in delivering LINKS. Nevertheless, one non-Aboriginal carer of an Aboriginal child did comment that she believed her LINKS worker was attuned to the child's cultural needs.

### **Comparison with other services**

Carers often compared their experiences with LINKS to their experiences with their current or previous FACS caseworkers. While many carers reported having positive relationships with their caseworkers, some carers felt that they received more frequent and personalised support from LINKS staff when compared to their caseworkers. Some carers appreciated that this was due to a lack of resources and/or a lack of awareness about trauma symptoms among caseworkers. Other carers noted that it was due to the specialised nature of LINKS and its delivery of tailored trauma-informed supports for children and families.

Moreover, many carers had accessed support services to address the trauma-based needs of the children in their care in the past. When comparing LINKS to other previously engaged support services, carers overwhelmingly suggested that LINKS was better able to meet the specific needs of their families. An important aspect of LINKS identified by carers was that they felt they were being heard and having greater input in relation to their involvement with LINKS when compared to other services. Carers emphasised that their input was taken on board by LINKS staff and resulted in better outcomes for their children and families. Other reasons why carers believed LINKS was superior to other services included that they formed better relationships with LINKS staff, were given better strategies to use in the home and found the environment to be more relaxed.

### **Relationship between children and LINKS staff**

Carers commended the capacity of LINKS staff to form strong and positive relationships with the children in their care. Carers believed that a sense of connectedness and trust had been established and that LINKS staff were invested in improving the wellbeing of their children. Carers reported that their children looked forward to meeting with their LINKS therapist. Carers felt that the trust and understanding that had been built between their children and LINKS staff meant that their children



were happy and comfortable during sessions and were more likely to have honest and open discussions with their LINKS therapist. Carers stressed that this was a crucial aspect of the success they were seeing.

### **Relationship between carers/families and LINKS staff**

Carers emphasised that they had developed strong and positive relationships with LINKS staff and that this in turn strengthened their capacity to cope with the trauma symptoms exhibited by the children in their care. Carers viewed LINKS staff as a fundamental part of their support system, taking comfort in knowing that LINKS staff were there to assist and listen to them whenever they were experiencing difficulties in the home. Carers reported that LINKS staff were available to them not just during sessions, but over the phone, and praised LINKS staff for their responsiveness. LINKS staff were also praised for keeping carers informed about the treatments their children were engaged in and seeking their input.

In addition, carers valued the non-judgemental nature of LINKS staff. Carers explained that LINKS staff understood the unique demands of caring for children who have experienced trauma and that this was lacking in their regular support systems or other generalist support services. This meant that carers were able to speak openly about their challenging experiences because they felt free from judgement. As such, LINKS staff were viewed as better positioned to provide support that was relevant to their experiences.

### **Connecting with other carers**

Carers who had participated in the TIK/TIK(T) programs reported that they appreciated the opportunity to connect with other carers who were also caring for children with trauma symptoms. Carers valued being able to learn and hear stories from other carers, discussing how this in turn strengthened their insight into how to manage and cope with their children and how it made them feel less isolated.

### **Overall satisfaction**

Carers expressed high levels of satisfaction with LINKS. High levels of satisfaction were attributed to the way in which LINKS treatments and LINKS staff were attuned to the specific needs of the children and families it services and how this subsequently led to significant improvements to the behaviour of children and increased stability in placements.

### **Improving LINKS**

When prompted about what could be improved about LINKS, a number of suggestions were proposed. The most common ways carers believed LINKS could be improved was through increasing the awareness of LINKS among carers, providing LINKS services to more families, and ensuring that access to the service is offered and facilitated as early on in placements as possible.

Other recommendations included improving communication between FACS caseworkers and LINKS staff to aid information sharing, and providing treatments to children in less formal and sterile environments.

One carer suggested providing ongoing support groups for carers because they had found the opportunity to connect with carers to be a rich and beneficial experience. This also inspired the carer to suggest a similar support program where teenagers could connect with peers who have had similar trauma related experiences.

### **Recommending LINKS**

Carers were asked whether they would recommend LINKS to other families and overwhelmingly responded in the affirmative. Carers believed that other families could benefit greatly from having the same level of support from LINKS staff that they had been afforded, including their responsiveness and capacity to provide trauma informed psychological support that produced

tangible changes in the behaviours and overall wellbeing of their children. Carers also believed that other carers could benefit from learning about how trauma impacts on children and strategies to manage trauma symptoms in the home.

### 3.3. Initial examination of service outcomes

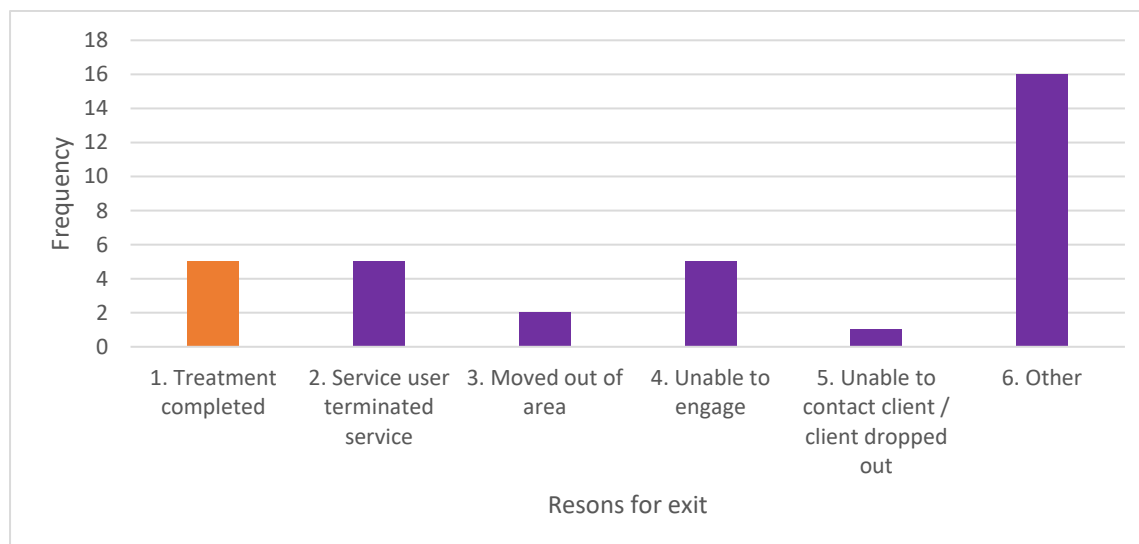
#### Service provider records

Figure 3 indicates reasons for exits from LINKS. Overall, 34 of the 81 CYP (42%) who have been allocated to a LINKS program have exited the service as at end August 2018. Of those who exited, five (15%) completed a program. Of these five, two achieved their treatment goals, two progressed towards achieving treatment goals and for one family no reason was provided.

Beyond treatment completion, other reasons for exit from a program included:

- families terminated service (5)
- families moved out of area (2)
- unable to engage families and terminated service (5)
- unable to contact/client dropped out (1)
- other (e.g., placement breakdown, carer working full time, the child is seeing therapist elsewhere, family declined service) (16).

Figure 3. Reasons for exit from LINKS



The following tables and charts in this section summarise outcomes data collected using standardised measures for clients and family members at three time points: entry, mid-program and on exit from LINKS. Due to the limited data available at this stage, statistical analysis has not been performed, and notwithstanding the need to consider properties associated with the data obtained (e.g., skewness and heterogeneity of variance), we provide below a summary of frequencies, means and standard deviations of available data. For each measure we have provided two tables – one for clients who are either still continuing (have not yet exited) or who exited prior to treatment completion, and one for the five clients who have exited after completion of a treatment program as at August 2018.

## Child psychological wellbeing and behavioural and emotional functioning

Data on the carer-completed SDQ show trends over time in the desired direction. For the small number of children who have completed a program there are improvements in all subscales and in the total scale score (Table 6). Scores at exit for the emotional symptoms subscale was on par with Australian norms for this measure (Mean = 2.1, SD = 2.0; Mellor, 2005). The differences between treatment completers and other LINKS clients on this subscale is illustrated in Figure 4.

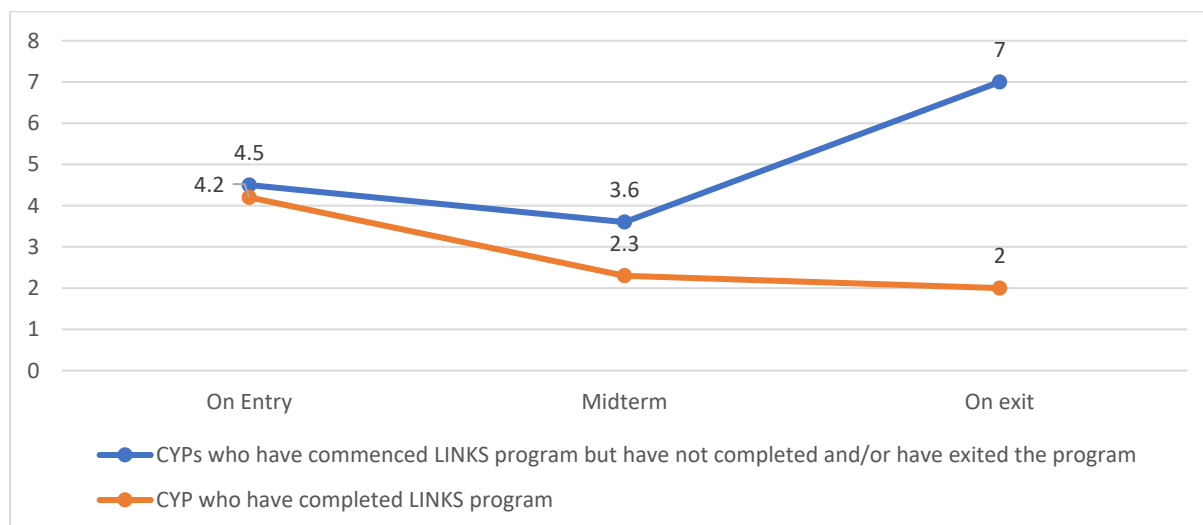
The observation that mean scores on entry (for both treatment completers and others) were high (e.g., an SDQ Total Score over 20 indicates clinically significant challenges) suggests LINKS is reaching the intended target group of children experiencing behavioural, emotional and psychological difficulties.

**Table 6. Subscale and total scores for the Strengths and Difficulties Questionnaire<sup>1</sup>**

Clients who have commenced LINKS but not yet exited plus those who have exited without completion						
SUBSCALE	On Entry (n=76)		Mid-Point (n=26)		On Exit (n=2)	
	Mean	SD	Mean	SD	Mean	SD
Emotional symptoms score	4.5	2.5	3.6	2.4	7.0	0
Conduct problems score	4.9	2.7	4.0 (n=25)	2.7	7.0	0
Hyperactivity/inattention score	6.6	2.6	5.9 (n=25)	2.7	9.5	0.7
Peer relationships problem score	3.7 (n=74)	2.1	3.1 (n=25)	2.0	3.5	3.5
Prosocial behaviour score	6.0 (n=75)	2.3	6.3 (n=24)	1.7	8.0	0
<b>Total Difficulties score (sum of subscale scores)</b>	<b>25.5</b>	<b>2.8</b>	<b>21.9</b>	<b>6.5</b>	<b>35</b>	<b>2.4</b>
Clients who have completed treatment in LINKS						
SUBSCALE	On Entry (n=5)		Mid-Point (n=3)		On Exit (n=5)	
	Mean	SD	Mean	SD	Mean	SD
Emotional symptoms score	4.2	2.9	2.3	2.1	2.0	2.3
Conduct problems score	6.4	2.5	4.0	1.7	4.2	2.2
Hyperactivity/inattention score	8.4	1.8	6.0	2.6	6.4	3.1
Peer relationships problem score	5.3 (n=3)	1.5	3.3	0.6	2.8	1.3
Prosocial behaviour score	4.8	3.0	4.3	1.1	7.2	2.6
<b>Total Difficulties score (sum of subscale scores)</b>	<b>27</b>	<b>6.6</b>	<b>20</b>	<b>3</b>	<b>22.6</b>	<b>5.9</b>

<sup>1</sup> Relevant only for children 2-17 years of age.

**Figure 4. Change over time in Emotional Symptoms subscale of the SDQ**



Data for the clinician-completed HoNOSCA showed consistently downward trends in ratings of problems across items, in the desired direction for all items except for physical illness or disability, which is perhaps affected by challenges associated with the child’s developmental status or health conditions that are not directly targeted by a LINKS program (see Table 7). This trend towards improvements was observable for the LINKS completer group and the ongoing treatment/exited early group.

Again, these data suggest LINKS is reaching the intended target cohort of children experiencing behavioural, emotional and psychological difficulties. HoNOSCA item scores of 2 or more and total scores over 20 indicate clinically significant concerns. Given mean scores on many items on entry are over 2, LINKS seems to be meeting expectations in reaching CYP in need of support.

**Table 7. Subscale and total scores for the HoNOSCA**

Clients who have commenced LINKS but not yet exited plus those who have exited without completion						
SUBSCALE	On Entry (n=71)		Mid-Point (n=25)		On Exit (n=2)	
	Mean	SD	Mean	SD	Mean	SD
Problems with disruptive, antisocial or aggressive behaviour	2.1	1.3	1.5	1.2	1.0	0
Problems with over-activity, attention or concentration	2.0	1.2	1.5	0.8	2.0	0
Non-accidental self-injury	0.5 (n=68)	0.8	0.1	0.3	0	0
Problems with alcohol, substance or solvent misuse	0.1 (n=69)	0.5	0	0	0	0
Problems with scholastic or language skills	1.8 (n=69)	1.3	1.0	0.9	1.0	0
Physical illness or disability problems	0.4 (n=69)	0.9	0.1	0.4	0	0
Problems associated with hallucinations, delusions or abnormal perceptions	0.1 (n=69)	0.5	0	0	0	0
Problems with non-organic somatic symptoms	0.9 (n=69)	1.2	0.4	0.6	0	0
Problems with emotional and related symptoms	2.4 (n=71)	1.2	1.6	1.0	2.0	0
Problems with peer relationships	2.1 (n=71)	1.2	1.4	1.1	0.5	0.7

Problems with self-care and independence	1.0 (n=65)	1.1	0.7	0.9	1.0	0
Problems with family life and relationships	2.1 (n=71)	1.2	1.6	1.2	1.5	0.7
Poor school attendance	0.9 (n=71)	1.4	0.4	0.9	2.0	1.4
<b>TOTAL SCORE</b>	<b>16.2 (n=63)</b>	<b>6.5</b>	<b>10.5</b>	<b>4.1</b>	<b>11.0</b>	<b>1.4</b>
Problems with knowledge or understanding about the nature of the child or adolescent's difficulties (in the previous two weeks)	1.3 (n=70)	1.4	1.0	1.3	0	0
Problems with lack of information about services or management of the child or adolescent's difficulties	1.0 (n=70)	1.2	0.6	1.0	1.0	0
<b>Clients who have completed treatment in LINKS</b>						
	<b>On Entry (n=5)</b>		<b>Mid-Point (n=3)</b>		<b>On Exit (n=5)</b>	
<b>SUBSCALE</b>	<b>Mean</b>	<b>SD</b>	<b>Mean</b>	<b>SD</b>	<b>Mean</b>	<b>SD</b>
Problems with disruptive, antisocial or aggressive behaviour	2.8	0.8	1.3	0.6	1.4	0.5
Problems with over-activity, attention or concentration	3.0	1.0	1.3	0.6	1.6	0.5
Non-accidental self-injury	0.4	0.5	0	0	0	0
Problems with alcohol, substance or solvent misuse.	0	0	0	0	0	0
Problems with scholastic or language skills.	2.0	2.0	1.3	2.3	1.6	1.5
Physical illness or disability problems	0.8	1.3	0.3	0.6	1.0	1.0
Problems associated with hallucinations, delusions or abnormal perceptions	0.2	0.4	0	0	0	0
Problems with non-organic somatic symptoms	1.4	1.9	0.7	0.6	0	0
Problems with emotional and related symptoms	1.8	1.6	1.7	1.5	1.0	0.7
Problems with peer relationships	2.6	0.9	1.7	0.6	1.6	0.9
Problems with self-care and independence	1.0	1.2	0	0	0	0
Problems with family life and relationships	3.8	0.4	2.0	1.0	1.6	0.9
Poor school attendance	1.4	1.9	0.7	1.2	0.8	1.1
<b>TOTAL SCORE</b>	<b>24.7</b>	<b>11.7</b>	<b>11.0</b>	<b>7.5</b>	<b>10.6</b>	<b>4.7</b>
Problems with knowledge or understanding about the nature of the child or adolescent's difficulties (in the previous two weeks)	3.0	0	0.3	0.6	0.7	0.6
Problems with lack of information about services or management of the child or adolescent's difficulties	2.4	0.5	0.7	1.2	0	0

<sup>1</sup>Relevant only for CYP 5-18 years of age.

Data about personal wellbeing (Table 8) indicates that for CYP who have successfully completed a LINKS program, improvements were observed across all items of the PWI-SC. For those who have not completed a treatment or who exited early, trends are generally positive, however, entry to mid-point decreases were observed for some items (health, learning, getting on with others and future outlook).

According to the scale developers, PWI scores (CYP and adult) between 73.4 and 76.4 represent the average range of wellbeing within an Australian context and scores below 73.4 suggests poorer wellbeing and an increase risk of depression (Mead & Cummins, 2010). Given that entry scores for all items across both treatment completers and others is below this cut-off for all by one item (safety), the CYP receiving LINKS do seem to be experiencing concerning levels of distress upon referral.

**Table 8. Subscale and total scores for the PWI-SC<sup>1,2</sup>**

Clients who have commenced LINKS but not yet exited plus those who have exited without completion						
Item	On Entry (n=70)		Mid-Point (n=23)		On Exit (n=2)	
	Mean	SD	Mean	SD	Mean	SD
How happy do you feel about your life as a whole?	66	19	69	19	70	0
How happy do you feel about the things you have? Like the money you have and the things you own?	70	16	79	13	-	-
How happy do you feel about how healthy you are?	66	17	64	16	70	0
How happy do you feel about the things you make or the things you learn?	72	16	68	18	70	0
How happy do you feel about getting on with the people you know ?	71	19	69	19	-	-
How happy do you feel about how safe you feel?	75	21	81	13	-	-
How happy do you feel about doing things away from where you are currently living?	65	23	69	15	-	-
How happy do you feel about how things will be later on in your life?	73	17	70	17	70	0
Clients who have completed treatment in LINKS						
Item	On Entry (n=3)		Mid-Point (n=3)		On Exit (n=2)	
	Mean	SD	Mean	SD	Mean	SD
How happy do you feel about your life as a whole ?	50	14	63	12	70	0
How happy do you feel about the things you have? Like the money you have and the things you own?	58	28	67	23	65	21
How happy do you feel about how healthy you are?	60	30	63	29	60	14
How happy do you feel about the things you make or the things you learn?	53	25	67	6	65	7
How happy do you feel about getting on with the people you know ?	53	32	67	6	75	7
How happy do you feel about how safe you feel?	60	30	60	42	75	7
How happy do you feel about doing things away from where you are currently living?	63	25	77	6	85	7
How happy do you feel about how things will be later on in your life ?	57	31	63	21	70	14

<sup>1</sup>Relevant only for CYP 12+ years of age.

- indicates missing data

## Trauma Symptoms

TSCC and TSCYC raw scores have been transformed into age- and sex-appropriate T scores, which are summarised at an aggregated level in Table 10. Very few mean T scores for subscales on entry are in the clinically concerning range. Only anger/aggression for 3-12 year olds at entry is in the clinically elevated range, as are all posttraumatic stress subscale mean T scores for the younger cohort of children. For older CYP as a group, no entry subscales T scores are in the clinically elevated range.

Despite potential that trauma symptoms are not overly high at entry into LINKS, some subscales of the carer-completed TSCC and TSCYC show trends in the desired direction for those who have completed a program, although this is not consistent across subscales.

Given the small number of clients in each age group at exit ( $n=1$  for each sub-group), it is more appropriate at this point to examine entry to mid-point changes. Many subscale trends are in the desired direction, however, across many subscales mean mid-point scores looked worse for CYP in domains of depression, anxiety, anger/aggression, post-traumatic stress, dissociation, sexual preoccupation and fantasy ratings for 8-16 year olds and overt dissociation for 3-12 year olds (very small increases in mean scores at mid-point for the continuing treatment/exit group, larger increases at mid-point for the treatment completed group). It is possible that this increase in concerns at mid-point reflects the tendency for trauma symptoms to increase somewhat during trauma treatment. This common phenomenon will be examined in greater detail in Report 2, when more data is available about a larger number of treatment completers at exit.

**Table 9. Subscale and total scores for the TSCC and TSCYC**

Clients who have commenced LINKS but not yet exited plus those who have exited without completion												
	3-12 years						8-16 years					
	Trauma Symptom Checklist for Young Children (TSCYC)						Trauma Symptom Checklist for Children (TSCC)					
	On Entry ( $n=53$ )		Mid-Point ( $n=19$ )		On Exit ( $n=1$ )		On Entry ( $n=23$ )		Mid-Point ( $n=8$ )		On Exit ( $n=1$ )	
SUBSCALE	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Anxiety	59.4	14.5	54.2	13.1	51	NA	51.2	13.5	50.1	10.8	46	NA
Depression	58.6	14.0	54.6	14.1	49	NA	51	10.5	51.6	16.4	47	NA
Anger/Aggression	70.0	21.2	64.5	22.3	65	NA	50.13	9.4	51.3	13.0	48	NA
Posttraumatic Stress/ Intrusion	59.8	17.4	57.9	16.2	43	NA	50.7	12.0	50.3	10.4	39	NA
Posttraumatic Stress - Avoidance (TSCYC only)	65.0	21.9	59.7	21.8	45	NA						
Posttraumatic Stress - Arousal (TSCYC only)	65.8	17.5	60.1	14.4	63	NA						
Posttraumatic Stress – Total (TSCYC only)	66.6	17.7	61.5	17.8	52	NA						
Dissociation	62.2	18.6	53.6	15.3	62	NA	49.9	9.5	48.5	13.1	40	NA
Overt Dissociation (TSCC only)							50.2	9.4	48.8	11.4	41	NA



Sexual Concerns	58.4	19.1	58.7	20.4	46	NA	46.4	10.0	44.83	6.1	36	NA
Sexual Preoccupation (TSCC only)							48.0	10.9	46.5	8.5	37	NA
Sexual Distress (TSCC only)							46.26	6.4	44.8	4.2	41	NA
Fantasy (TSCC only)							46.53	12.1	48.4	12.3	40	NA
<b>Clients who have completed treatment in LINKS</b>												
	<b>3-12 years</b>						<b>8-16 years</b>					
	Trauma Symptom Checklist for Young Children						Trauma Symptom Checklist for Children					
	<b>On Entry (n=1)</b>		<b>Mid-Point (n=1)</b>		<b>On Exit (n=1)</b>		<b>On Entry (n=4)</b>		<b>Mid-Point (n=3)</b>		<b>On Exit (n=1)</b>	
<b>SUBSCALE</b>	<b>Mean</b>	<b>SD</b>	<b>Mean</b>	<b>SD</b>	<b>Mean</b>	<b>SD</b>	<b>Mean</b>	<b>SD</b>	<b>Mean</b>	<b>SD</b>	<b>Mean</b>	<b>SD</b>
Anxiety	51	NA	40	NA	40	NA	58.3	11.1	64.5	2.1	60	NA
Depression	49	NA	45	NA	49	NA	53.0	15.6	65.0	2.8	63	NA
Anger/Aggression	109	NA	-	-	79	NA	45.5	7.4	60.0	7.1	63	NA
Posttraumatic Stress/ Intrusion	43	NA	43	NA	43	NA	59	16.2	66.0	1.4	58	NA
Posttraumatic Stress - Avoidance (TSCYC only)	50	NA	56	NA	45	NA						
Posttraumatic Stress - Arousal (TSCYC only)	55	NA	59	NA	55	NA						
Posttraumatic Stress – Total (TSCYC only)	50	NA	54	NA	49	NA						
Dissociation	43	NA	43	NA	43	NA	50.0	13.0	55.5	6.4	58	NA
Overt Dissociation (TSCC only)							48.0	9.4	49.5	5.0	51	NA
Sexual Concerns	77	NA	46	NA	46	NA	56.5	15.7	47.6	9.1	48	NA
Sexual Preoccupation (TSCC only)							52.5	9.0	71	12.8	45	NA
Sexual Distress (TSCC only)							55.8	15.6	53.0	1.4	50	NA
Fantasy (TSCC only)							49.7	11.7	53.5	9.2	41	NA

### Carer functioning

A small number (two for PWI and up to five for PSS) of carers of treatment completers provided data on these measures of carer wellbeing. While carers' self-reported wellbeing does improve with time, parent stress levels appeared neither to improve nor deteriorate with treatment.

## Placement stability

Only one of the five exiting clients had a ROSH report during the program. None of the five had a ROSH report in the 90 day period since the program had ended.

Table 10 shows placement status for the five treatment completers at entry and exit from LINKS. In summary:

- Placement changed from ‘emergency’ to ‘permanent care’ for one CYP
- One CYP remained in emergency care at exit
- Placement changed from ‘respite care’ to ‘permanent care’ for one CYP
- Placement changed from ‘transition to permanent care’ to ‘permanent care’ for two CYP.

**Table 10. Placement status on entry and exit for those who have completed a treatment program**

	On Entry (n=5)	On Exit (n=5)
Placement status	2 (Emergency care) 1 (respite care) 2 (transition to permanent care)	1 in emergency care remained 1 in emergency went into permanent care 1 in respite care went into permanent care 2 in transition to permanent care went into permanent care

## Self-reported Emergency Department use, school attendance and justice outcomes

At this stage little can be concluded from the small amount of data available for clients on measures of emergency department presentations, school attendance and contact with the justice system. For the five clients who have completed and exited LINKS there were no reported visits to emergency or appearances in court during the period of treatment, all were still attending school, and one had been suspended from school for a period of 2 days.

## Interviews with families

Although for the broader evaluation conclusions about outcomes associated with the LINKS programs will be drawn largely from administrative data sources, we also asked questions about perceived outcomes for CYP and others in the family when we interviewed the ten carers who were nearing treatment completion. Notwithstanding the potential for participant bias due to self-selection into the interviews, information from this qualitative data source is summarised below.

### Carers’ reported outcomes for CYP

#### Improved behaviour and wellbeing

All interviewed carers reported seeing a marked reduction in the trauma symptoms exhibited by their children, including improved behaviours and psychological wellbeing, following the delivery of treatments from LINKS therapists. Carers reported that many of the difficult or concerning behaviours of the CYP in their care were occurring far less frequently. Carers described the CYP in their care as being more settled and relaxed, happier and better behaved in comparison to before they started treatment.

#### Improved capacity to communicate

Carers reported that LINKS allowed CYP in their care to overcome barriers to communicating that they were experiencing as a result of their trauma. Carers saw the capacity of their children to communicate improve dramatically after working with a LINKS therapist. Carers highlighted that this

resulted in improved communication with their children and noticed that they were more willing to open up to them or their therapist about their trauma and feelings as a result.

### **Improved capacity to manage and cope with trauma**

Carers stressed that LINKS had assisted their children to better deal with their trauma. In addressing their traumatic experiences in sessions with LINKS staff, carers believed that their children were able to gain a better understanding of their own trauma which in turn reduced the symptoms associated with it.

Moreover, LINKS staff were credited with equipping CYP with strategies to manage and regulate their feelings and by doing so, their behaviours and wellbeing were positively impacted and their capacity to cope with the trauma they have experienced increased.

### **Making CYP feel safe**

The behavioural improvements carers were witnessing were further attributed to the way in which LINKS staff had formed trusting relationships with the CYP they were treating and had fostered greater trust between carers and the CYP in their care. Carers believed that this had the effect of making CYP feel safer in their placements.

### **Referrals to medical treatments and support**

Another significant outcome of LINKS was that CYP and families gained facilitated and supported access to psychiatrists and speech therapists for often undiagnosed or untreated psychological or cognitive conditions and disorders. Carers saw or were hoping to see improvements to the wellbeing of their children following supported psychiatric treatment. Carers were impressed with the assistance of LINKS staff in ensuring their children were able to gain access to the ongoing support they needed in order to improve their long term wellbeing and many had already seen significant improvements.

## **Carers' reported outcomes for carers and families**

### **Improved capacity to manage and understand trauma affected CYP**

While we do not always know to what extent each carer was actually involved in the treatment program offered to their CYP, carers reporting they had learned many important skills and strategies that assisted them to support and care for their trauma affected children. Carers reported having a deeper understanding of how trauma impacts on CYP and manifests itself in certain behaviours after engaging with LINKS. In gaining a deeper understanding of trauma related issues, carers felt that their ability to understand their children improved. Carers believed that learning about trauma and being equipped with strategies to manage trauma symptoms had flow on effects for the overall wellbeing of their children.

### **Increased stability in placements**

Carers indicated that participating in LINKS increased stability in their homes and placements and gave them more hope in the future of their family. Carers expressed this in three different ways. Firstly, and importantly, some carers asserted that their current placements would have likely fallen apart had they not received the support they did from LINKS.

Secondly, some carers suggested that without the support they have received from LINKS, their family and home lives would be a lot more challenging and unstable. Carers believed that without LINKS, it would have been harder to continue as a carer for their children, and while they wouldn't have given up, they would have been less hopeful about the future of their family.

Thirdly, carers reflected about their previous failed placements and considered whether LINKS could have altered or made a difference to that outcome. Some carers indicated that if they had received support from LINKS, they might have been better placed to continue as carers of CYP from their previous failed placements.

### **Goal setting and achieving**

Carers were asked a series of questions about goal setting and goal achievement. For each question, carers were asked to give a rating on a scale from 0-5. In relation to how much input carers and CYP had in goal setting, 0 indicated 'no control' and 5 indicated 'complete control'. In relation to achieving goals, 0 indicated 'did not achieve my goals at all' and 5 indicated 'completely achieved my goals'.

Overall, carers reported high levels of input into goal setting and high levels of goal achievement. The average and most common rating given in response to how much input carers had in setting goals was 4. The average rating given in response to how much input CYP had in setting goals was 3.5 and the most common rating was 4 (question did not apply to those who were caring for very young children). The average and most common rating given in response to the extent that carers believed they and their children had achieved their goals was 4.

Some carers discussed the level of input they had towards goal setting in more depth. One carer did not have knowledge of what the specific goals were but understood why they were undergoing LINKS treatments and that they trusted the LINKS team. Carers commonly reported high levels of success in achieving program goals and gave specific examples. Some carers commented that long term results were not necessarily measurable as yet because of the short length of time they had been engaged in the service but they nonetheless believed they would see positive results in the long-term based on what they have experienced in the short-term.

## 4. Conclusions

This first report from the evaluation of the LINKS Trauma Healing Service comes early in its implementation. LINKS has been in operation for less than a year, and any conclusions about outcomes can be considered preliminary at best. The value of reporting on processes and early indications of service outcomes at this stage is to identify facilitators and barriers to the implementation of LINKS, and to identify opportunities for improvements to support the delivery of the programs with fidelity and good effect.

### 4.1. Completeness and quality of data collection

#### Completeness

Data completeness ratings ranged from 60% to 100%. The completion of data for CYP who had completed and exited LINKS was 60% due to missed reporting of some items for outcome measures. Also, information about placement purpose was missing for five CYP who have exited from the service.

#### Timeliness

Ratings of data recency, non-obsolateness and being up-to-date ranged from 79% to 100% indicating adequate data collection protocols were implemented within an acceptable period.

#### Accuracy

Both ROSH and service provider administrative datasets had accuracy ratings of 100%. FACS placement data scored 100% for relationship linkages, 76% for placement status and 88% for date-related errors.

### 4.2. Process evaluation – focus on service implementation

#### Functioning of referral system

Staff generally felt that referrals were being made, assessed and managed as intended. Nevertheless, the low rates of completion of the program (only five so far out of the 81 who were allocated to a program), and the high rates of early exit (36% of those allocated to a program) may indicate issues with the appropriateness of referrals made into LINKS. Referral criteria may need to be reviewed, or more efforts taken to clarify and promote eligible criteria to potential referrers. Supporting this, 18% of those referred did not meet inclusion criteria or declined the service, and for many CYP – especially those over 12 years of age – trauma symptoms on entry into LINKS were not in the clinically elevated range, so this issue is worth additional consideration.

Alternatively, it may be that treatment acceptance rates and early termination from service is related to family factors. Referrals tended to come at a time that carers described as chaotic and unstable. Staff also noted that complexity arose when a CYP's placement was unstable, and this impacted on the time required to deliver a program and the ease of use of a program. This raises the question about the timing of referrals, and whether other types of family support are required prior to starting a trauma healing program, to position the family in a less chaotic and more stable frame before trauma-focused program work begins.

Most (72%) referrals are from FACS. In the database, all other referrals were described as 'external' with no additional information available about the source of other referrals. Given this constitutes almost a third of referrals to LINKS it would be valuable to know more about these referrals. For example, it might provide useful information to help us understand whether there are any links between referrer type and program uptake or early termination.

Carers noted that their caseworker was often unable to provide them with much information about LINKS – families would benefit from understanding more about the service prior to entry (e.g., likely duration of treatment, expectations about carer involvement). Providing more information to carers at referral may positively influence rates of appropriate referrals and reduce the number of families declining a service post referral. It is likely to also increase carer engagement with service delivery. Carer engagement was raised as an issue by carers and staff alike. Greater involvement of carers in treatment work will result in improvement maintenance of treatment effects.

### Differences in treatment type

Staff reported high levels of satisfaction with the suite of programs offered through LINKS, noting that the service and programs:

- are filling a gap in service for CYP in OOHC exposed to trauma
- are valued by carers
- can often be delivered in culturally appropriate ways (although some challenges exist due to some negative views about the co-location of LINKS with FACS)
- TIK/TIK(T) fostered opportunities for peer-to-peer carer support.

Acknowledging that the small number of carers ( $n=10$ ) interviewed for this report may be those who have more favourable views about LINKS, carers also cited high levels of satisfaction with LINKS, noting that it:

- meets and, in most cases, exceeds expectations
- meets the unique and specific needs of trauma affected CYP and their families
- is perceived by carers as much more effective than other previously accessed support services
- develops and maintains strong and positive relationships between LINKS staff and CYP and their families.

TF-CBT was the most commonly used program (64% of cases). TIK and TIK(T) were commonly used (40% of cases), often in combination with TF-CBT and EMDR. EMDR was not widely used (8% of clients, mainly adolescents). This may be related to restrictions on eligibility for this program - clients need to fit a rigid set of criteria. Staff also noted that CYP for whom EMDR was indicated often needed more rapport building time as many presented with dissociative symptoms and aggression, which could impact on initial acceptance of the treatment.

PCIT was used in 16% of cases. However, some staff reflected that PCIT does not include enough focus on trauma and that due to the resources and delivery setting required could be expensive to deliver. Clinicians often reported that they wanted to (and in some cases did) adapt PCIT using their clinical judgement as a guide.

### Implementation with Aboriginal families

Almost half (47%) of CYP referred to LINKS were Aboriginal, in line with expectations for the service.

Staff were building relationships with local services and community representatives (e.g., Aboriginal Elders) to enhance the acceptability and cultural suitability of LINKS. Presence of Aboriginal staff in the LINKS team was viewed as a strength of the service.

Staff discussed the need to modify delivery of LINKS programs for Aboriginal families. Broadly these modifications were about allowing more time to foster the client-therapist relationship, and making adjustments to some treatment materials to better fit the cultural needs of Aboriginal CYP and families. However, in the absence of more precise information about the nature and extent of program adaptations it is difficult to understand how these may be influencing program effectiveness.

For some Aboriginal families the co-location of LINKS services with FACS was problematic because of prior interactions the family may have had with FACS.

## Treatment fidelity

Fidelity ratings reflecting staff adherence to program models were high – 100% for three programs, and an average of 92.5% for TF-CBT. It is important to note, however, that as most of these ratings are based on self-report by staff they are a subjective measure of treatment fidelity.

Staff coaching involves use of a specific set of teaching, prompting and feedback skills to support use of a program with fidelity. It is unclear to what extent coaching is being used in LINKS as a driver of treatment fidelity, if at all. Staff mentioned supervision, but this may not focus sufficiently on staff skill development and performance improvement in applying the core elements of the LINKS programs.

It is also unclear whether staff are using any post-training implementation supports to monitor and improve adherence to the treatment models of the four programs. This was not specifically asked during staff interviews, but will be followed up in future reports for this evaluation. There was mention of observing tapes of sessions for EMDR, but the frequency and coverage of this is not clear. Other activities that check fidelity to the program models and that works to improve fidelity should be adopted to promote the likelihood that clients are receiving the programs as intended.

### Fidelity versus adaption

Staff reported that some modification to the programs were applied to improve CYP engagement with the service, provide necessary psychoeducation and to adjust materials to better fit a client's developmental level or their cultural needs. While these modifications were made based on clinical judgements, they were typically conducted in consultations with the manager and the developer of the program.

Adaptations were described for Aboriginal families, including more time to build rapport and trust and some treatment materials needed to be modified to better fit cultural needs.

Many staff noted that they felt modifications to program models were required to engage and involve carers more in the programs. Staff indicated that having more time and freedom to work with carers would enhance program implementation and outcomes. However, most of the programs - if not all, require carer involvement, so it is unclear to what extent clinicians are feeling this does not occur, and for what reasons it may not occur (i.e., is it a challenge to get carers to engage, do they see it as their role or the caseworker's role).

Arguably, treatment effects for the CYP will be best sustained if carers are equipped at exit with the skills they might require to support the CYP effectively. Supporting this, staff noted that carers' involvement and learning was not adequately addressed by every LINKS program, so clinicians sometimes added a component to their treatment plan addressing carer learning and skill development. It will be important in future stages of the evaluation to monitor trends associated with the impact of variations in carer engagement and program involvement using exit and 12 month follow-up data, but also in carer and staff interviews.

Carer needs (mental health, own history of trauma) and other demands on carers' time (e.g., work, travel time, other children) were identified by staff as barriers to implementation of programs. Staff reported that stability of placement needed to be a priority and addressed prior to the program taking place. This adds to the argument that carer engagement is an essential aspect of the service that requires further consideration by LINKS.

In relation to the ease of use and implementation of LINKS and of the individual treatment programs, staff reported:

- Multidisciplinary teams were an asset to LINKS
- Leadership associated with LINKS was supportive
- Additional engagement and trust-building work was often needed to use the programs with Aboriginal families

- Client complexity and carers' own mental health and motivation sometimes impacted on staff reports about how easy the programs were to use.

Some suggestions for the future were made by carers. For instance, carers felt that it was important to ensure LINKS is offered early in a new placement. This would need to be balanced with placement stability, which was noted as critical by staff interviewees. Carers also noted that:

- LINKS should be available on a more widespread basis
- Location of the service was sometimes an issue (e.g., distance to travel, co-location with FACS), suggesting increased home-visiting may be required
- They would strongly recommend LINKS to other families
- They often did not want to exit the program because of the value they saw in participating.

### 4.3. Initial examination of service outcomes

#### Service provider records

Acknowledging that LINKS has been in operation for less than a year, it is important to be cautious in interpreting service outcomes data at this stage of the evaluation. Nevertheless, the data summarised in this report is vital to identify facilitators and barriers to the implementation of LINKS with fidelity, and as an opportunity for continuous refinement before more rigorous outcomes assessment is undertaken.

Further, at this stage of the evaluation there is no counterfactual to report on. For the next report we will be including examination of data from a matched sample who did not attend LINKS, which will enable us to make firmer conclusions about attribution of any findings regarding client outcomes to the LINKS trauma programs.

Although early in implementation, and with treatment completion data available for only five clients, treatment outcomes appear to be in the intended direction and there is no evidence of harm or negative outcomes to CYP from participating in LINKS.

In summary:

- Data on the carer-completed SDQ show trends in the desired direction. There are improvements with treatment, although only one scale showed exit scores for CYP who have completed LINKS that are close to norms for Australian children. While gains appear to have been made with treatment, particularly for emotional symptoms, there is still evidence that CYP exiting LINKS after completing a program continue to experience externalising problems and challenges in interactions with peers.
- Data for the clinician-completed HoNOSCA consistently shows trends in the desired direction. That is there are decreases in problems for CYP who have completed a program, and for those still engaged in a program.
- CYP who have successfully completed a LINKS program experienced improvements across all items of the PWI-SC. For those who have not completed a treatment or who exited early, trends are generally positive, however, on entry to mid-point decreases were observed for some items (health, learning, getting on with others and future outlook). It will be important to monitor this, and - with more data into the future - to examine differences between early treatment completers and early terminators.
- Some subscales of the carer-completed TSCC and TSCYC show trends in the desired direction for those who have completed a program, although this is not consistent across subscales. Considering all CYP allocated to a program (whether completed, early termination or continuing) trends in entry to mid-point scores suggest some movement in a negative direction. This was the case particularly for the small number (5) of CYP who ended up



exiting having completed a program. These CYP tended to show the greatest movement (in the wrong direction) across subscales measuring depression, anger, post-traumatic stress, dissociation and preoccupation with sex. It will be important to continue monitoring trends in mid to exit scores for these CYP, and to contrast this with age-based norms for the measures, as the available data is insufficient at this stage to know if mid-point increases are in line with expectations following trauma treatment introduction (i.e., a temporary iatrogenic treatment effect), or if scores at exit will be a significant improvement on mid-point challenges or if the changes (e.g., in preoccupation with sex) would be expected given the developmental stage of CYP.

- For the small number of families with CYP who successfully completed a program, carers' sense of personal wellbeing improves with time but parent stress levels do not appear to improve with treatment.
- At this stage little can be concluded from the small amount of data available for clients on measures of school attendance and contact with the justice system; only one CYP who had completed a program had been suspended from school (2 days), and there were no justice system concerns or hospitalisations.
- For the small number of clients successfully completing a program placement either remains stable ( $n=1$  stayed in 'emergency care') or improved to permanency ( $n=4$ ). One of these clients had a ROSH report made during the period of treatment.

### Interviews with families

Carers reported a number of noteworthy outcomes from participating in LINKS including:

- improved overall wellbeing of CYP and family wellbeing
- improved capacity for CYP and families to communicate with each other
- improved capacity for CYP and families to cope with and understand trauma
- increased stability in placements.

Families in scope for interviews are those who have completed (or are nearing completion) of a treatment with LINKS. This does not include families who were referred but did not engage or those who left the service early. We acknowledge that TFM are interested in understanding the perspectives of families who do not complete a program. This could be examined as part of the scope of the evaluation if more resources were made available to the evaluators. Additional time and different recruitment methods would be required to facilitate inclusion of early terminators in the family interviews.

#### 4.4. Successes and strengths of LINKS

In general, LINKS staff appear to have been 'ready to implement' the programs. Staff reported that they were equipped to implement each program through understanding of the evidence base for each, and by receiving training and supervision. Thus, the programs selected for inclusion in LINKS are built on a good evidence base and are acceptable to most stakeholders, including carers. Some programs were more utilised than others (e.g., TF-CBT and TIK/TIK(T) were the most common), perhaps indicating higher levels of staff confidence in using these programs, or greater confidence that they were a good fit for referred clients.

It was widely acknowledged by staff that a strength of the service is the use of multidisciplinary teams, including Aboriginal clinicians.

There is flexibility in the process of adoption of programs, with allowances for adaptations to suit context, including cultural considerations.

A further strength emerging from the findings of this evaluation is that there are generally promising outcomes for families indicated at this early stage of the implementation of LINKS.

## 4.5. Recommendations

This report outlines findings from the early stages of implementation of LINKS, which has led to the identification of a number of opportunities for refinements to the service and its implementation.

### Referral appropriateness

- Increase FACS caseworker awareness and understanding of LINKS to promote referral of suitable families.
- Improve documentation requesting referral information about the family.
- Provide more information to carers from caseworkers at the point of referral.
- Increase awareness of the existence of LINKS among eligible carers.
- Referrals to LINKS to occur early in a new placement if possible, with clear guidelines about the requirements for placement stability.
- Collect data about who is making referrals (greater specification for the 'external' category).
- Include additional categories in the database for 'reason for exit' to assist future data analysis as at present the 'other reason' variable accounts for around 40% of exits.

### Carer engagement

- Improve carer engagement and involvement in the programs, including for the child-focused programs, to promote maintenance of treatment effects.
- Consider carer booster training at exit.

### Cultural appropriateness

- Collect and examine data about specific adjustments being made by clinicians to the programs to better understand core elements that are predictors of program success for different groups of clients.

### Adaptation

- Provide clarification to clinicians about core components of each program, and areas where adaptation by clinicians is permitted
- Adopt a system whereby clinicians keep an accessible, documented record of adaptations made to programs and of the ways such adaptations have been communicated with LINKS team members
- Adopt an objective measure of treatment fidelity (along the lines of observing videotapes, as per EMDR)
- Treatment fidelity to be assessed regularly and used routinely to drive practice improvement
- Consider staff coaching as a specific skill-development practice enhancement approach, in addition to peer and/or clinical supervision, if not already offered.

### Improve data collection

- Add additional response options for the 'reasons for exit' question to reduce the number of responses allocated to the 'other' category.
- Add additional response options for 'external referral' to better understand who the external source of referral was made by.
- Ensure completion of all items in standardised outcome measurement tools.

#### **4.6. Next steps for the evaluation**

From January 2019, 12-month follow-up interviews with families who have exited LINKS will commence. Throughout 2019, additional family interviews will take place with carers who are nearing the end of their involvement with LINKS. Another round of administrative (FACS and service provider) data will be transferred to the PRC for analysis in October 2019.

The second report from this evaluation will be prepared and submitted in December 2019, and will report on three aspects of the evaluation - process, outcomes and economic.

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## Appendix A: Descriptions of each program<sup>5</sup>

### Trauma-Focused Cognitive Behaviour Therapy (TF-CBT)

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a conjoint parent-child treatment that uses cognitive-behavioural principles and exposure techniques to prevent and treat post-traumatic stress, depression, and behavioural problems.

TF-CBT uses trauma sensitive interventions and gradual exposure to the CYP's traumatic experience to help the CYP develop coping skills. Key elements of the program include psychoeducation (e.g., common reactions to trauma exposure), coping skills (e.g., relaxation, feelings identification, cognitive coping), gradual exposure (e.g., imaginal, in-vivo), cognitive processing of trauma-related thoughts and beliefs, and caregiver involvement (e.g., parent training, conjoint child-parent sessions).

The approach is designed to be developmentally appropriate for the needs of CYP and their caregivers. To accommodate a variety of traumatic experiences, TF-CBT includes general psychoeducational materials with recommendations for tailoring treatment for individuals who have experienced physical abuse, sexual abuse, or interpersonal violence.

TF-CBT is delivered to CYP aged 3-18 years in weekly 45 minute sessions over 12-18 weeks.

*Pre-requisite qualifications:* According to program developers, professionals require a Master's Degree or above in a mental health discipline and must have received training in the program. TF-CBT usually involves parallel sessions with CYP and their non-offending caregivers plus some joint caregiver- CYP sessions in the later stages of the program.

#### *Evidence:*

TF-CBT is rated as well-supported by the Californian Evidence-Based Clearinghouse. To receive a rating of well-supported the program must have at least two rigorous randomised controlled trials (RCT) with one showing a sustained effect of at least one year.

A review of meta-analyses, reviews, and individual studies by Ramirez de Arellano et al. (2014) identified 10 RCTs and reported a high level of evidence for TF-CBT for many types of trauma and for reducing symptoms of posttraumatic stress disorder.

In a meta-analysis of TF-CBT for treating post-traumatic stress disorder (PTSD) and co-occurring depression among CYP, Lenz and Hollenbaugh (2017) identified 21 studies representing 1860 CYP. The authors reported that TF-CBT was exceptionally superior to no treatment or wait-list comparisons and moderately superior to alternative treatments.

A review by The Australian Centre for Posttraumatic Mental Health and Parenting Research Centre (2013) identified seven evaluations of TF-CBT which included four RCTs. Two of the RCTs had follow-up at 12 months post-intervention and reported significant reductions in posttraumatic stress disorder, child abuse-related shame and child dissociation.

The extensive research evidence available about TF-CBT supports its use with CYP 3-18 years who have experienced trauma as a result of sexual or physical abuse, family violence and other traumatic events. There is evidence of effectiveness in improving CYP outcomes associated with child mental health (depression, anxiety, PTSD) and behavioural functioning. Evidence also supports this as a

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<sup>5</sup> Information about each program has been compiled by the evaluators from a number of sources, including the Californian Evidence-Based Clearinghouse, the Blueprints for Healthy Youth Development website, and the Substance Abuse and Mental Health Services Administration (SAMHSA) website. We acknowledge that this information is largely based on US sources, but provide it here as a guide to the intentions of the developers of the programs

program leading to improvements in caregivers' emotional distress and parenting. TF-CBT uses cognitive behavioural techniques and exposure treatment strategies and has strong evidence of effectiveness for CYP in foster care (Dorsey et al., 2011; Weiner et al., 2009).

While it is unclear if TF-CBT has been evaluated for effectiveness with Aboriginal and Torres Strait Islander CYP, it has been used with effect with diverse cultural populations including Latin American and African American CYP with evidence of effectiveness (e.g., Deblinger et al., 1996, 1999, 2006; Cohen et al., 1996, 1997, 2005) and CYP in Africa (O'Callaghan et al., 2013). TF-CBT has been adapted to suit different cultural groups including Native American CYP, with early evidence suggesting it is a suitable and acceptable program.

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### Parent Child Interaction Therapy (PCIT)

PCIT is an evidence-based behavioural parent training treatment for young children with emotional and behavioural disorders that aims to improve the quality of the parent/carer-child relationship and changing parent/carer-child interaction patterns.

PCIT uses in vivo coaching of parental behaviours. Skills are taught via didactic presentations to parents, and direct coaching of parents while they are interacting with their children. In didactic sessions (usually two sessions), the focus is on teaching the parent specific skills related to each phase of the therapy and these sessions are conducted prior to the direct coaching sessions. The remainder of PCIT (usually about 10–12 sessions) involves direct coaching sessions. These sessions are conducted with the parent and child in a play therapy room with the therapist in another room behind a one-way mirror. The therapist and the parent communicate through an earpiece. The therapist provides direct coaching of parental communication and behaviour management skills and provides immediate feedback and reinforcement.

PCIT is a mastery-based program, that is, families remain in treatment until parents have demonstrated mastery of the treatment skills and rate their child's behaviour as within normal limits on a standardised measure of child behaviour. Therefore treatment length varies but averages around one hour weekly sessions for 14 weeks.

### *Evidence:*

PCIT is rated as well-supported by the California Evidence-Based Clearinghouse. To receive a rating of well-supported the program must have at least two rigorous RCTs with one showing a sustained effect of at least one year.

In a meta-analysis of PCIT for children with clinically significant externalising behaviour problems (Ward et al., 2016), analysis of a combined sample size of 254 treated and 118 control group children showed a large positive effect on improving externalising behaviour problems.

Rae and Zimmer-Gembeck (2007) conducted a meta-analysis of 13 studies and found a large positive effect for child behavioural outcomes.

The program has undergone three RCTs in the United States. The most recent RCT (Thomas & Zimmer-Gembeck, 2011) found improvements in child behaviour, parental behaviour and statistically significant improvements in parent report of child problems and parental stress.

### *References:*

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Ward, M.A., Theule, J., & Cheung, K. (2016). Parent–Child Interaction Therapy for Child Disruptive Behaviour Disorders: A Meta-analysis. *Child Youth Care Forum*, 45(5), 675-690.

A full list of PCIT research is available here:

<http://www.pcit.org/literature.html>

## **Tuning in to Kids / Tuning in to Teens**

The Tuning in to Kids (TIK) parenting programme aims to promote the development of emotional competence and prevent behaviour problems in young children by improving parents' own emotional competence as well as teaching them emotion coaching skills.

The program teaches parents simple emotion coaching skills - that is how to recognise, understand, and manage their own and their children's emotions. When their children are emotional, parents: notice the emotion, name it, show empathy and then wait for the emotion to subside (often by comforting the child) before trying to talk about the situation leading to the emotional experience and or what to do about it. The program aims to prevent problems developing in children, promote emotional competence in parents and children, and when present, reduce and treat problems with children's emotional and behavioural functioning.

Tuning in to Teens (TIK\*T) is a modification of the Tuning in to Kids program for parents of adolescents.

It is delivered to groups of 8-12 parents in 6 X 2-hour weekly sessions. The program can be adapted to a 10 X 2 hour weekly sessions program for clinical/high need participants.

*Pre-requisite qualifications:* Professionals require a Bachelor's level or Master's level degree in a discipline such as psychology, social work, occupational therapy, psychiatry, nursing, speech-language therapy, teaching, or medicine.

### *Evidence:*

Tuning in to kids has undergone several studies and evaluations (including an RCT) for various treatment groups and is rated as supported by California Evidence-Based Clearinghouse. To receive a rating of supported a program must have at least one rigorous RCT with a sustained effect of at least 6 months.

An RCT was undertaken to evaluate the effectiveness of Tuning in to Teens (Kehoe, Havighurst & Harley, 2014). The outcomes of the evaluation showed:

- Parents reported significant reductions in the young person's anxiety, depressive symptoms, somatic complaints and behaviour problems.
- Parents reported significant reductions in their own anxiety/depressive symptoms and improved emotional competence when compared to control families who reported no changes.
- Parents and their children reported improvements in parenting and reductions in family conflict.

Research on TIK supports its use with CYP aged 3–15 years, including those with significant behavioural and emotional disturbance, and those who have experienced trauma as a result of child abuse or neglect. Although not yet published in the peer-reviewed literature, the developers of TIK have described the findings from a pilot study of the 'Trauma-focused Tuning in to Kids' program that was delivered in a clinical setting with 77 parents/caregivers of CYP (3–15 years) who had experienced complex trauma. The study employed a single-group pre- and post-intervention design and found significant improvements in CYP's emotion socialisation, the parent-child relationship, parent mental health and CYP's emotional and behavioural functioning.

While TIK is being used with Aboriginal and Torres Strait Islander families, there have been no studies published on this to date. The program was developed in Australia, and is available in a range of languages relevant to the Australian community (Arabic, Cantonese, Somali, Vietnamese).

#### *References:*

Kehoe, C. E., Havighurst, S. S. & Harley, A. E. (2014). Tuning in to Teens: Improving parent emotion socialization to reduce youth internalizing difficulties. *Social Development, 23*(2), 413-431.

A full list and summary of the research is available here:

<http://www.tuningintokids.org.au/professionals/research/>

### **Eye Movement Desensitization and Reprocessing (EMDR) for child trauma**

EMDR is a psychotherapy in which the person being treated recalls a traumatic memory while generating one of several types of bilateral sensory input such as side-to-side eye movements or hand tapping. The traumatic memory is desensitized by short imaginal exposure with bilateral stimuli and the process is repeated until the accompanying level of disturbance has disappeared and the dysfunctional cognitions about the trauma have become functional.

EMDR treatment starts with history taking and treatment planning. The therapist then asks the client to focus on the traumatic memory by means of directive questioning. The client is asked to give a negative, dysfunctional cognition related to the traumatic memory, and in addition, to create a positive, functional cognition. Then, attention is given to the emotion that is connected to the memory and dysfunctional cognition, and the client is asked to find places in the body where the physical phenomena are felt. After that, the client focuses on the traumatic memory and its associated dysfunctional cognition, emotion and the physical sensations in combination with the bilateral stimulation. Each new connected association with the traumatic memory is followed by a



new series of stimuli. The level of disturbance is repeatedly measured on a ten-point Likert-scale until substantially decreased to zero (desensitisation).

It is delivered to clients in weekly 50-90 minute sessions. The length of treatment is variable depending on the severity of the trauma but generally ranges from 3-12 sessions.

*Pre-requisite qualifications:* program providers must be allied health professionals with specialist training in mental health (Psychiatry, Psychology, Mental Health Social Workers, Psychological Medicine, etc) who have full registration with the Australian Health Practitioner Regulation Agency or NSW Registration Board. Social Workers must also be eligible for membership to AASW.

*Evidence:*

EMDR is rated as well-supported by the California Evidence-Based Clearinghouse. To receive a rating of well-supported the program must have at least two rigorous RCTs with one showing a sustained effect of at least one year.

The efficacy of EMDR for PTSD in CYP has been established in several meta-analyses.

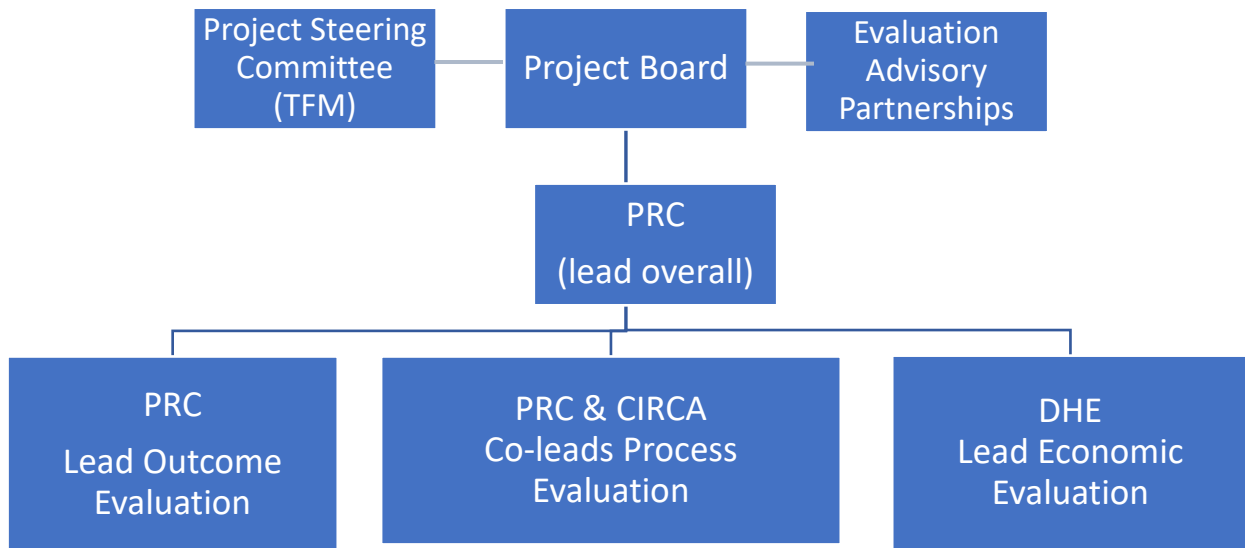
EMDR has also been used with CYP in OOHC settings. For example, Soberman and colleagues (2002) found that EMDR resulted in significant reductions in behaviour problems in boys with conduct problems in residential care. In the absence of evidence regarding its effective use with Australian Aboriginal CYP we note that EMDR has been used in studies that include with Native American CYP. For example, Scheck and colleagues (1998) found that EDMDR resulted in significant improvements in depression, anxiety, PTSD, intrusive thoughts and avoidance.

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## Appendix B: Governance arrangements

Figure A5: LINKS Evaluation Governance Structure



The evaluation is managed according to an agreed structure. PRC have broad oversight of the evaluation including project management and reporting responsibilities. The three components will be led by PRC (Outcomes Evaluation), CIRCA and PRC (Process Evaluation) and DHE (Economic Evaluation). A Project Board has been appointed to provide guidance to the evaluators, consisting of senior members of the three evaluation partners (Associate Professor Jan Matthews, Dr Naomi Hackworth, Ms Annette Michaux and Dr Catherine Wade from the PRC; Andrew Anderson from CIRCA; and Professor Lisa Gold from DHE), plus Professor Sandra Eades from University of Melbourne, who brings extensive research and health sector expertise particularly in relation to Indigenous populations.

## Appendix C: Child/young person and family outcomes measures used in the evaluation

The **Trauma Symptom Checklists for Children (TSCC)** and for **Young Children (TSCYC)** are standardised and normed trauma measures for CYP who have been exposed to traumatic events such as child abuse, peer assault, and community violence.

The **TSCC** is a 54-item self-report measure for CYP between 8 to 16 years of age who have experienced or witnessed traumatic events. All items are presented as thoughts, feelings, and behaviours, and are responded to on a 4-point Likert scale, from 0 ('never') to 3 ('almost all of the time'). These items tap into the follow six clinical scales:

- Anxiety (ANX)
- Depression (DEP)
- Anger (ANG)
- Posttraumatic stress (PTS)
- Dissociation (DIS)
- Sexual concerns (SC)

Raw scores are converted into T scores for comparison with normative populations, with higher scores indicating greater posttraumatic symptomology (Briere, 1996). With the exception of the sexual concerns scale, T scores of 65 or above are considered clinically significant. T scores between 60 to 65 indicate difficulty or subclinical symptomology. For the sexual concerns scale, T scores of 70 or above are considered clinically significant.

Based on the TSCC, the **TSCYC** is a 90-item caretaker-report measure for carers of CYP between 3 and 12 years of age who have experienced or witnessed traumatic events. All items are presented as symptoms in relation to how often they have occurred in the past month, and are rated to on a 4-point Likert scale from 1 ('not at all') to 4 ('very often') (Briere et al., 2001). Eight clinical scales and a summary scale provide information about acute and chronic symptomatology that are common for many traumatised CYP. The subscales are:

- Anxiety (ANX)
- Depression (DEP)
- Anger/Aggression (ANG)
- Posttraumatic Stress-Intrusion (PTS-I)
- Posttraumatic Stress-Avoidance (PST-AV)
- Posttraumatic Stress-Arousal (PTS – AR)
- Dissociation (DIS)
- Sexual Concerns (SC)

All raw scores are converted to T scores for norm comparison, with high scores indicative of greater symptomology. T scores between 65 and 70 are suggestive of subclinical symptomology and considered to be problematic, while scores 70 and above indicate clinically elevated symptomology.

The TSCC and TSCYC have separate norms for males and females in each age group: 3-12 years and 8-16 years. The measures contain scales to ascertain the validity of carer reports (Response Level and Atypical Response).

*Psychometric information:* With the exception of the sexual concerns scale, TSCC scales have high internal consistency in the normative sample, with alphas ranging from .82 to .89 (Briere, 1996). The sexual concerns scale was considered moderately reliable (alpha = .77). Reliability analysis of the TSCYC indicated high internal consistency for all scales, with alphas ranging from .81 for sexual

concerns to .91 for both the anger and dissociation scales (average of .87 across all scales; Briere et al., 2001). Although the response level validity scale was moderately reliable (alpha = .73), atypical response had low reliability (alpha = .36) (Briere et al., 2001).

In relation to content validity, 75 items of the TSCC were initially created to tap into six domains: anxiety, depression, anger, posttraumatic stress, dissociation, and sexual concerns or preoccupation. After consultation with clinicians specialising in the treatment of traumatised CYP, 21 items were discarded as redundant or less meaningful indicators of the domains of interest. The 54 items of the measure were then included in several studies of child abuse impacts (Elliot & Briere, 1994; Friedrich, 1991), where reliability and validity analyses suggested no further need for scale refinement (Briere, 1996).

Regarding convergent and discriminant validity, TSCC scales correlated with scales of similar content (concurrent validity) and showed less correlation with scales of less similar content (discriminant validity). Briere and Lanktree (1995) found significant intercorrelations between the TSCC and the Youth and Parent Report versions of the Child Behaviour Checklist (CBCL), and the Children's Depression Inventory (CDI).

In relation to construct validity, Singer and colleagues (1995) and Evans, Briere, Boggiano, and Barrett (1994) found that TSCC respondents' experience of stressful life events were associated with and predicted by significant amounts of variance in all TSCC scales. TSCC scales were more powerful predictors of life stressors than were the CDI or the RCMAS. Elliot and Briere (1994) found that sexually abused CYP scored higher on each of the TSCC scales than non-abused CYP, and in CYP with sexual abuse histories, disclosure of abuse status was predicted by TSCC scores. Elliot and Briere (1995) found that childhood sexual abuse was uniquely related to all TSCC scales except Anger. Physical abuse was uniquely associated with all scales except Sexual Concerns and neglect was specifically related to Depression and Dissociation. Lanktree and Briere (1995) reported change in TSCC scores with therapy.

Briere and colleagues (2001) found the TSCYC had adequate construct validity as indicated by associations between different childhood abuses and three scales of the TSCYC (Posttraumatic Stress, Sexual Concerns, and Dissociation). Other studies have confirmed these findings (e.g., Elliot & Briere, 1994).

In relation to criterion (or predictive) validity, evidence that the TSCC taps posttraumatic distress is demonstrated in studies where TSCC scores are highest after more severe trauma and specific scales differentiate trauma type (Smith, Swenson, Hanson & Saunders, 1994; Briere & Lanktree, 1995). Diaz, (1994) examined the relative ability of several measures and variables to discriminate 81 sexually abused girls from 151 controls and found that the Posttraumatic Stress, Depression and Anxiety scales of the TSCC were significant discriminators over other measures, including the CBCL, the Rosenberg Self-Esteem Scale and a measure of suicidality and substance abuse history.

**The Personal Wellbeing Index (PWI)** is a self-report measure of quality of life across domains related to health, safety and social functioning (International Wellbeing Group, 2013).

The PWI can be used with any section of the population. The adult version of the PWI (PWI-A) contains seven items, each one corresponding to a quality of life domain: standard of living, health, life achievement, personal relationships, personal safety, community-connectedness, future security and spirituality-religion. The PWI-A also has optional items - the one that taps into general life satisfaction was used in the LINKS evaluation. All items for the PWI-A are responded to on a 11-point scale from 0 ('no satisfaction at all') to 10 ('completely satisfied') (International Wellbeing Group, 2013).

Parallel versions of the adult PWI have been developed:

- PWI-School Children (PWI-SC) is for use with CYP attending primary or secondary school. This instrument comprises seven items addressing satisfaction with the following life domains: standard of living, health, life achievements, personal relationships, personal safety, community connectedness, and future security. The PWI-SC has an optional item tapping into happiness with life as a whole (Cummins & Lau, 2005). Items on the PWI-SC are responded to on an 11-point scale from 0 ('very sad') to 10 ('very happy') (Cummins & Lau, 2005).
- PWI-Intellectual Disability (PWI-ID) is designed as an alternative to the PWI-A for adults who have an intellectual disability or other form of cognitive disability.

Raw scores can be converted into standard scores ranging from 0 to 100, with higher scores indicating greater satisfaction or happiness (International Wellbeing Group, 2013). At a group level, standardised scores between 73.4 and 76.4 represent the average range of wellbeing within an Australian context (Mead & Cummins, 2010). At an individual level, average wellbeing scores range from 50 to 90 points. According to Mead and Cummins (2010), scores that fall below these ranges are suggestive of poorer wellbeing and an increased risk of depression. Increasingly lower scores translate to progressively higher risk of depression. These data range interpretations are the same for the adult (International Wellbeing Group, 2013) and child (Cummins & Lau, 2005) versions of the PWI.

The PWI-SC is being used in the LINKS evaluation to monitor CYP-reported changes in psychological wellbeing (only for young people aged 12+ years). The PWI-A or PWI-ID is being used to monitor changes in carer capacity for the adult carer of CYP and where relevant for another carer of CYP.

*Psychometric information:* Australian and International data indicates the PWI has moderate to good internal consistency, with Cronbach's alphas ranging from .70 to .85 (International Wellbeing Group, 2013). Inter-domain correlations are reported between .30 to .55, indicating moderately strong correlations. The PWI has good test-retest reliability, with an intra-class correlation coefficient of .84 over a 1 to 2 week interval (International Wellbeing Group, 2013).

According to the International Wellbeing Group (2013), the unique and shared variance of all seven domains explains between 40 to 60% of variance in 'satisfaction with life as a whole'. This, in addition to the seven domains consistently establishing a single factor that accounts for approximately 50 percent of variance in Australian samples, supports the construct validity of the PWI as a measure of quality of life (International Wellbeing Group, 2013).

A moderately strong correlation ( $r = .78$ ) between the PWI and the Satisfaction with Life scale (a 5-item scale measuring life satisfaction; Diener, Emmons, Larsen, & Griffin, 1985), suggesting good convergent validity (International Wellbeing Group, 2013).

**The Strengths and Difficulties Questionnaire (SDQ)** is a behavioural screening questionnaire for CYP aged 2 to 17 years, developed by United Kingdom child psychiatrist Robert Goodman. There are multiple version of the SDQ, including teacher report and CYP report versions, however, for the LINKS evaluation only the carer report version has been used. There are versions of the SDQ in different lengths: a short form (25 items), a longer form with impact supplement, and a follow-up form designed for use after a behavioural intervention. The 25 item version was used for LINKS, comprising 5 subscales of 5 items each. The subscales are:

- 1) Emotional symptoms subscale
- 2) Conduct problems subscale
- 3) Hyperactivity/inattention subscale

- 4) Peer relationships problem subscale
- 5) Prosocial behaviour subscale.

This questionnaire takes 3–10 minutes to complete. Items are rated on a 3-point scale, with potential responses including ‘not true’, ‘somewhat true’, or ‘certainly true’. Scores on each of the five subscales range from 0 to 10, and the total ‘difficulties’ score ranges from 0 to 40 (note that the total score does not include prosocial behaviour subscale ratings). With the exception of the prosocial behaviour subscale, high scores are indicative of greater behavioural or emotional concern. For total scores with parents as informants, scores ranging from 0 to 13 indicate the normal range, scores ranging from 14 to 16 indicate the borderline range, while scores ranging from 17 to 40 are considered to be in the abnormal range. ‘Normal’, ‘borderline’, and ‘abnormal’ cut-offs do differ slightly between informants (i.e., parent, teacher, or self). For further information about cut-off ranges and scoring instructions for different informants and subscales, see <http://www.sdqinfo.com/>.

*Psychometric information:* Internal consistency of each subscales and the total score have Cronbach’s alphas between .57 to .85, and an overall mean of .73 suggesting satisfactory reliability (Goodman, 2001). The mean interrater correlation has been reported to be .34, indicating acceptable agreement between different raters (i.e., parents, teachers, and CYP). Findings from Goodman’s (2001) research also indicated that those who rated in the top tenth percentile (representing the high-risk group according to SDQ cut-off criteria) had an increased probability of experiencing psychiatric risks and disorders. This suggests the SDQ is a valid measure of behavioural and emotional dysfunction, with the potential to detect psychiatric symptoms in accordance with diagnostic criteria.

**The Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA)** is a clinician-rated instrument for use in child and adolescent mental health services measuring general health and social functioning.

The measure is made up of two sections. The first section consists of 13 items relating to different types of problems regarding behaviour, impairments, symptoms, and social wellbeing.

The second section consists of two items relating to carer’s knowledge of the nature of the young person’s difficulties and their understanding about services available. Ratings on these two items are not a part of the total score calculated for items 1–13.

The HoNOSCA is completed by a qualified mental health professional (clinician) using information obtained from a comprehensive mental health assessment and from routine clinical work. Clinicians are advised to draw upon information from all available sources when completing ratings, including information provided by the service user and as well as clinical notes.

Each item is rated on a 5-point scale from 0 (‘no problems’) to 4 (‘severe to very severe problems’). Scores from items 1 to 13 are summed to form a total HoNOSCA score, which can range from 0 to 52. The total HoNOSCA score represents the overall severity of an individual’s psychiatric symptoms, with higher scores indicating more severe symptoms (Gowers et al., 1998).

According to the HoNOS Guide for New Zealand Clinicians (Te Pou o te Whakaaro Nui, 2016), items rated 2 (‘mild problem’) or above can be considered clinically significant, and it is advised that follow-up procedures be undertaken (i.e., ongoing monitoring, active treatment or management plan) in relation to those specific items.

*Psychometric information:* Several studies have explored the test-retest reliability of the HoNOSCA with correlations between .69 and .80 in total HoNOSCA scores (e.g., Pirkis et al., 2005) suggesting the HoNOSCA is a stable measure over time and that it has adequate test-retest reliability.

Growers and colleagues (1999) reported intraclass correlations from .67 to .98, indicating moderate to strong interrater reliability.

To explore this scale's concurrent validity, Pirkis et al (2005) reviewed studies that examined the relationship between the HoNOSCA and other similar scales. Results indicated that the HoNOSCA correlated well with scales such as the Paddington Complexity Scale, the Global Assessment of Psychosocial Disability, and the Children's Global Assessment Scale ( $r > .60$ ).

Pirkis and colleagues (2005) also noted that the HoNOSCA could be used to discriminate between those who would later receive intensive outreach treatment and those who would obtain other forms of community-based care. Thus the HoNOSCA has adequate predictive validity.

**The Parental Stress Scale (PSS)** is a carer-report measure of the levels of stress experienced by parents, that was developed by Berry and Jones (1995) as an alternative to the 101-item Parenting Stress Index (Abidin, 1995). The PSS contains 18 items that consider both positive and negative aspects of parenting.

The PSS has two components: pleasure or positive themes of parenthood (emotional benefits, self-enrichment, personal development) and negative components (demands on resources, opportunity costs and restrictions). Respondents are asked to agree or disagree with items in terms of their typical relationship with their CYP and to rate each item on a five-point scale: strongly disagree (1), disagree (2), undecided (3), agree (4), and strongly agree (5). The eight positive items are reverse scored so that possible scores on the scale can range between 18-90. Higher scores indicate greater stress.

The PSS is suitable for use with mothers and fathers and for parents of CYP with and without clinical problems. It can be used to assess changes in parental stress levels for parents/carers who have accessed targeted support, such as family support, parenting courses and one to one parenting support.

*Psychometric information:* The PSS has adequate reliability, with a Cronbach's alpha coefficient of .83, a mean inter-item correlation of .23, item-whole correlations between .27 and .59 (mean of .43), and a test-retest correlation of .81 across a 6-week period (Berry & Jones, 1995).

To explore the concurrent validity of the PSS, scores were compared to the Perceived Stress Scale. Correlation coefficients ranged from .46 (mothers' scores) to .53 (fathers' scores), suggesting a moderate relationship between stress scores on these different scales (Berry & Jones, 1995). Berry and Jones (1995) also noted that mothers of children with developmental disability (e.g., cerebral palsy) scored significantly higher on the PSS compared to non-clinical controls. Such findings are consistent with those of Beckman (1991) when using the Parenting Stress Index, which highlights the capacity of the PSS to differentiate stress levels between clinical and non-clinical parent populations, and that the PSS performs as well as the Parenting Stress Index in assessing parent-related stress.

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## Appendix D: Staff Interview Schedule

Program Characteristics
<b>Evidence Strength and Quality</b>
<ul style="list-style-type: none"> <li>What kind of information or evidence are you aware of that shows whether the intervention (programs individually and/or the service as a whole) will work in your setting?</li> </ul>
<b>Adaptability</b>
<ul style="list-style-type: none"> <li>What kinds of changes or alterations do you think you will need to make/have made already to the intervention (any of the 4 programs or service as a whole), so it will work effectively in your setting? Can you expand further?</li> </ul>
<b>Complexity</b>
<ul style="list-style-type: none"> <li>How complicated is the intervention (programs individually and/or the service as a whole) to deliver to families?</li> </ul>
<b>Design Quality and Packaging</b>
<ul style="list-style-type: none"> <li>What supports, such as online resources, training, supervision, coaching, program guidelines, fidelity score feedback, marketing materials, or a toolkit, are available to help you implement and use the intervention?</li> </ul>
Outer Setting
<b>Patient needs and resources</b>
<ul style="list-style-type: none"> <li>What barriers do the individuals served by your organisation face to participating in the intervention?</li> </ul>
<b>Peer Pressure</b>
<ul style="list-style-type: none"> <li>Can you tell me what you know about any other organisations that have implemented the four programs or other similar programs?</li> </ul>
Inner Setting
<b>Structural Characteristics</b>
<ul style="list-style-type: none"> <li>How will the infrastructure of your organisation (social architecture, age, maturity, size, or physical layout) affect the implementation of the intervention (programs individually and/or the service as a whole)?</li> </ul>
<b>Acceptability</b>
<ul style="list-style-type: none"> <li>What are the barriers to successful implementation of the LINKS service?</li> </ul>
<b>Networks and Communication</b>
<ul style="list-style-type: none"> <li>How do you typically find out about new information such as new initiatives, accomplishments, issues, new staff, staff departures?</li> </ul>
<b>Culture</b>
<ul style="list-style-type: none"> <li>How do you think your organisation's culture (general beliefs, values, assumptions that people embrace) will affect the implementation of the intervention?</li> </ul>
<b>Implementation Climate</b>
<ul style="list-style-type: none"> <li>What is the general level of receptivity in your organisation to implementing the intervention?</li> </ul>
<b>Tension for change</b>
<ul style="list-style-type: none"> <li>How essential is this intervention (programs individually and/or the service as a whole) to meet the needs of the individuals served by your organisation or other organisational goals and objectives?</li> </ul>
<b>Compatibility</b>
<ul style="list-style-type: none"> <li>Was the program (programs individually and/or the service as a whole) a good fit for the families/children in your service? In what ways did it fit/not fit? (consider the things the family values, and the routines they have – was the program a good fit with those?)</li> </ul>
<b>Organisational Incentives and Rewards</b>
<ul style="list-style-type: none"> <li>What kinds of incentives or special recognition/events are there to help ensure that the implementation of the programs is successful?</li> </ul>
<b>Goals, governance and Feedback</b>
<ul style="list-style-type: none"> <li>Have you/your unit/your organisation set goals related to the implementation of the intervention? To what extent are organisational goals monitored for progress?</li> <li>How does the governance of LINKS operate? What's working well and what are the challenges in relation to governance?</li> <li>Do you get any feedback about your work? in what form? Reports? Informal?</li> </ul>
<b>Readiness for Implementation</b>
<i>Organisational readiness/evidence-based interventions</i>
<ul style="list-style-type: none"> <li>Which of the four programs did you find the most appropriate for the presenting family needs?</li> </ul>
<i>Feasibility</i>
<ul style="list-style-type: none"> <li>Was it feasible to implement the LINKS service (or specific programs) based on the resources available?</li> <li>What were the barriers?</li> <li>Facilitators?</li> </ul>

<b>Leadership and engagement</b>
What level of involvement has leadership at your organisation had so far with the implementation of LINKS?
<b>Available Resources</b>
<i>Organisational processes in place</i>
<ul style="list-style-type: none"> <li>• Could you tell us more about the LINKS referral processes?</li> <li>• Could you tell us more about the training and support that has been provided for the LINKS staff?</li> <li>• Could you tell us more about the processes related to decisions around program allocation?</li> </ul>
<b>Staff</b>
<i>Skilled staff</i>
<ul style="list-style-type: none"> <li>• What staff and type of skills are needed to provide supports to families participating in the LINKS service?</li> <li>• Do you expect to have sufficient resources to implement and administer the program?</li> </ul>
<b>Access to Knowledge and Information</b>
<ul style="list-style-type: none"> <li>• What kind of training have you already received? What kind of training is planned for you? For colleagues?</li> </ul>
<b>Characteristic of Individuals</b>
<b>Knowledge and Beliefs about the Intervention</b>
<ul style="list-style-type: none"> <li>• Do you think the intervention will be effective in your setting? Why? Why not?</li> </ul>
<b>Self-efficacy</b>
<ul style="list-style-type: none"> <li>• How confident are you that you will be able to successfully implement the intervention (programs individually and/or the service as a whole)?</li> </ul>
<b>Process</b>
<b>Planning</b>
<ul style="list-style-type: none"> <li>• What have you done to implement the intervention (programs individually and/or the service as a whole)?</li> </ul>
<b>Formally Appointed Internal Implementation Leaders</b>
<ul style="list-style-type: none"> <li>• Who leads the implementation of the intervention? Who else is involved with leading the implementation?</li> </ul>
<b>Intervention Participants</b>
<ul style="list-style-type: none"> <li>• How do you or your colleagues communicate to the individuals that are served by your organisation about the intervention (programs individually and/or the service as a whole)?</li> </ul>
<b>Executing</b>
<ul style="list-style-type: none"> <li>• Has LINKS been implemented according to the implementation plan?</li> </ul>
<b>Reflecting and Evaluating</b>
<i>Evaluation framework &amp; data collection processes</i>
<ul style="list-style-type: none"> <li>• Could you tell us more about the LINKS data collection process processes? (could be survey, electronic, yarning, data-sharing with allied health workers).</li> <li>• To what extent do you think LINKS is meeting families' and children's needs?</li> <li>• What parts of the program do you think were most helpful/had most impact for families and children</li> <li>• What have been the least helpful things about the LINKS for the families and children who have been involved with the program? What could have been improved? What changes are needed to make it better for families and children?</li> <li>• Do you receive feedback about the implementation or the intervention itself? How do you receive this feedback? Reports? Etc...</li> </ul>
<i>Appropriateness</i>
<ul style="list-style-type: none"> <li>• What activities covered in the programs (programs individually and/or the service as a whole) are the most/least helpful for the families?</li> </ul>
<i>Cultural appropriateness [Applies for Aboriginal parents/carers/families]</i>
<ul style="list-style-type: none"> <li>• To what extent do the programs take account of families' and children's cultural needs?</li> <li>• Do you think the program is culturally appropriate?</li> <li>• What more could be done to take account of families' and children's cultural needs?</li> </ul>
<b>How will you assess progress towards implementation or intervention goals?</b>
<i>Sustainability</i>
1. Overall, do you find this program sustainable in the long run? What can be improved?

## Appendix E: Carer Interview Schedule

General background questions
<ul style="list-style-type: none"> <li>• How long have you and your family been receiving support through LINKS?</li> </ul>
<ul style="list-style-type: none"> <li>• How did you find out about LINKS and what were you hoping to get out of it for you and your family?</li> </ul>
<ul style="list-style-type: none"> <li>• How much input did you have regarding your involvement in LINKS?</li> </ul>
<ul style="list-style-type: none"> <li>• What did you think about the information you received about the program before you started? (was it enough? Is the program what you expected from the information you were given?)</li> </ul>
Fidelity
<ul style="list-style-type: none"> <li>• What support/help did you and your child get from LINKS? What did LINKS workers do with or for you and your child? How did they work with you (in home, showing you new skills, talking to you, etc)</li> </ul>
<ul style="list-style-type: none"> <li>• How often did you/your child meet with LINKS staff? How many times per week/month? For how long?</li> </ul>
<ul style="list-style-type: none"> <li>• What types of activities did you/your child do with LINKS staff during sessions?</li> </ul>
Acceptability & Appropriateness
<ul style="list-style-type: none"> <li>• Was the program a good fit for you and your family? In what ways did it fit/not fit? (consider the things the family values, and the routines they have – was the program a good fit with those?)</li> </ul>
<ul style="list-style-type: none"> <li>• Is this program different to other support (if any) you have received in the past for your child?</li> </ul>
<ul style="list-style-type: none"> <li>• If yes, what was different?</li> </ul>
<ul style="list-style-type: none"> <li>• To what extent did the LINKS program meet your and your child's needs?</li> </ul>
<ul style="list-style-type: none"> <li>• What parts of the program do you think were most helpful/had most impact for you and your child?</li> </ul>
<ul style="list-style-type: none"> <li>• What were the least helpful things for you when you were involved with the program? What could have been improved? What changes are needed to make it better for you/your child?</li> </ul>
<ul style="list-style-type: none"> <li>• [For Aboriginal parents/carers] To what extent did the program take account of your/your child's cultural needs? (prompt for – did you receive support through Aboriginal staff, do you think the program is culturally appropriate) What more could have been done to take account of your/your child's cultural needs?</li> </ul>
<ul style="list-style-type: none"> <li>• What did you think of the program staff? What about the relationships between the therapist and your child?</li> </ul>
Outcomes
<ul style="list-style-type: none"> <li>• In what ways did the LINKS program help you and/or your child? What has changed as a result of the program?</li> </ul>
<ul style="list-style-type: none"> <li>• As a result of your participation in the LINKS program, what was the most important (significant) change that occurred in your family (for you and/or your child)?</li> </ul>
<ul style="list-style-type: none"> <li>• Why is this change important to you/or people involved?</li> </ul>
<ul style="list-style-type: none"> <li>• What difference has this change made or will make in the future?</li> </ul>
<ul style="list-style-type: none"> <li>• How much say did you and your child have in setting your goals? (On a scale from 0 to 5)</li> </ul>
<ul style="list-style-type: none"> <li>• How much input do you think <u>you</u> had over what was worked on? (5 meaning complete control; 0 meaning no control at all)</li> </ul>
<ul style="list-style-type: none"> <li>• And how much input do you think <u>your child</u> had over what to work on? (5 meaning complete control; 0 meaning no control at all)</li> </ul>
<ul style="list-style-type: none"> <li>• To what extent did you/your child achieve your/their goals?</li> </ul>
Feasibility
<ul style="list-style-type: none"> <li>• Do you have any suggestions for improvement in LINKS?</li> </ul>
<ul style="list-style-type: none"> <li>• Would you recommend this program to other families? Why/why not?</li> </ul>
<ul style="list-style-type: none"> <li>• Did you experience any difficulties accessing the service, or consider stopping treatment early? If so, what were the issues and how could we improve the service?</li> </ul>

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