



Never Stand Still

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Social Policy Research Centre

Alternatives to Income Management

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Glossary

APY	Anangu Pitjantjatjara Yankunytjatjara
CCT	Conditional Cash Transfer
CIM	Compulsory Income Management (Conditional Income Management in the CYWRT)
CPIM	Child Protection Income Management
CYWRT	Cape York Welfare Reform Trial
FRC	Family Responsibilities Commission
HIPPY	Home Instruction for Parents of Preschool Youngsters
IM	Income Management
KTS	Keep Them Safe
MST	Multisystemic Therapy
NIM	New Income Management (in the NT)
NPY	Ngaanyatjarra Pitjantjatjara Yankunytjatjara
NTER	Northern Territory Emergency Response
PBIM	Place Based Income Management
PRC	Parenting Research Centre
SPRC	Social Policy Research Centre
UCT	Unconditional Cash Transfer
VIM	Voluntary Income Management

Executive Summary

Income management (IM) has been part of social policy in Australia since 2007 when it was first introduced as part of the Northern Territory Emergency Response. Since then, income management schemes have been attempted in various places in Australia with a variation of governance arrangements, welfare recipients and take-up requirements. These different schemes have, nonetheless, similar objectives. By limiting the amount of the benefit in cash and prohibiting the use of the remaining amount on proscribed goods, IM aims to limit access to alcohol, drugs, pornography and tobacco. It also aims to change behaviour by reducing substance misuse, gambling and financial harassment and by improving parenting and financial management practices.

Most of the policy debates have been ideological and political in nature rather than focusing on the empirical evidence for the effectiveness of income management in achieving its stated objectives. With this in mind, the New South Wales (NSW) Aboriginal Affairs commissioned The Social Policy Research Centre (SPRC) and the Parenting Research Centre (PRC) to compile this report to gather available evidence on income management approaches with the aim of informing policies targeted at improving the wellbeing of Aboriginal children and communities.

The report addresses the following questions:

- What empirical evidence exists about the success and challenges of income management approaches and, in particular, of elements of implementation, governance, service provision and community factors?
- What are the characteristics of individuals or communities who are positively or negatively affected?
- Are there unintended consequences of income management approaches? If so, how do they manifest?
- Can the aims of income management be achieved through other approaches?

The key findings of this report are:

- Implementation
 - Although it is not possible to directly link the implementation of IM to its outcomes, evaluations indicate that Aboriginal communities are more accepting of IM when it is introduced following genuine consultation. This is also true of alternatives to IM; all programs in Aboriginal communities which are aimed at improving the wellbeing

of community members and changing behaviour should be implemented in consultation and collaboration with the community.

- Evidence favours institutional arrangements that promote tailored packages to support individuals subject to IM rather than IM being imposed as a blanket measure which is triggered by people's benefit status.
- IM is strongly associated with the Northern Territory Emergency Response and therefore many communities are resistant to its implementation because it is seen as heavy handed government intervention in the lives of Aboriginal peoples.
- No specific individual or community characteristic were found to be associated with a positive outcome of IM. Individuals who are positively affected by IM tend to be those who volunteer or whose financial management is out of control. Others who also benefit are those whose communities had local institutions (like the Family Responsibilities Commission) and whose community services and opportunities were placed as a comprehensive package to support individuals rather than IM as a stand-alone measure. Conversely, IM was found to be detrimental to those who already manage their finances well or who require flexibility in their life styles. Many of those subject to IM perceive it as being discriminatory and humiliating.
- There are unintended consequences of IM manifested through the difficulties in making ends meet when income is quarantined or in using the BasicsCard in informal transactions, when travelling and in different outlets. Another unintended consequence relates to the potential increase in financial harassment and the misuse of the BasicsCard to gamble, pool funds and buy excluded items, such as tobacco, alcohol, gambling services and products, and pornographic material. IM has also created feelings of shame and discrimination and increased mistrust of government interventions by Aboriginal communities. This is mainly related to the point above about the way it has been imposed, rather than the content of the policy per se.
- The key long-term aim of IM is to produce behavioural change. This is not an easily achievable outcome. No evaluation has found that compulsory forms of income management have resulted in medium- or long-term behavioural change at the individual or community level. There is some evidence that voluntary forms of IM have some impact on financial harassment and possibly on financial management although they can also result in higher levels of dependency on the welfare system for those who become habituated to IM. In addition, there is evidence of some unintended negative consequences of IM, particularly compulsory forms of IM.

- The review identified a number of alternative approaches to IM although no program is guaranteed to produce behavioural change. Conditional Cash Transfers and Unconditional Cash Transfers have not been used in Australia and their applicability to Aboriginal communities is limited. However, there are parenting programs in Australia that have been evaluated with Aboriginal families. The report considers them suitable alternatives to IM as long as they are implemented in consultation with communities and that communities have control over their implementation.

In sum, no study has demonstrated that income management has resulted in improved parenting practices and child wellbeing for the mainstream population or specifically for Aboriginal communities. Conversely, evidence indicates that income management can result in a number of unintended negative consequences for some families and communities. The research indicates that managing a family's income through IM or the use of strict and punitive conditionalities tying cash to a specific behaviour, as is the case of some Conditional Cash Transfer programs, may not be the most suitable policy to improve the wellbeing of Aboriginal children and their communities. For improvement to occur, complementary policies and multi-component approaches are required over a period of time. This report recommends caution on the use of income management for Aboriginal children and their communities and supports alternative programs that have an established evidence base, such as Nurse Family Partnership, The Incredible Years, Multisystemic Therapy, SafeCare and Triple-P.

Overview

This is a report for NSW Aboriginal Affairs which assesses the evidence base for the effectiveness of income management (IM) and also alternatives to IM, including Conditional and Unconditional Cash Transfers as well as parenting programs and other programs which have focused on improving the wellbeing of Aboriginal children and communities.

Income Management (IM)

In 2007, the Australian Government introduced a new approach to the payment of income support to specific groups of people who are in receipt of various welfare payments. 'Income Management' limits the amount of benefit provided directly to an individual to a proportion of the overall payment, and restricts the rest of the payment so that it cannot be spent on alcohol, tobacco, gambling and pornographic material. Income Management involves Centrelink either making payments to specific merchants, services or landlords, or making funds available through a BasicsCard. The BasicsCard is a type of debit card which can only be used at approved merchants for the purchase of non-excluded items. It cannot be used at an ATM to withdraw cash.

Different programs of IM have been progressively implemented across Australia since the measure was originally implemented in the Northern Territory as part of the Northern Territory Emergency Response (NTER), referred to as 'The Intervention'. Although different IM programs have slightly different aims, they are all fairly similar. For example the Australian Government's Policy Statement (2009 cited in Katz *et al.* 2010, p. 13) identifies the aims of New Income Management (NIM) being to:

"...provide for the welfare of individuals and families, and particularly children..." by ensuring that people meet their immediate priority needs and those of their children and other dependents. Income management can reduce the amount of welfare funds available to be spent on alcohol, gambling, tobacco products and pornography and can reduce the likelihood that a person will be at risk of harassment or financial abuse in relation to their welfare payments."

"Governments have a responsibility – particularly in relation to vulnerable and at risk citizens – to ensure income support payments are allocated in beneficial ways. The Government believes that the first call on welfare payments should be life essentials and the interests of children."

"In the Government's view, the substantial benefits that can be achieved for these individuals through income management include: putting food on the table; stabilising housing; ensuring key bills are paid; helping minimise harassment; and helping people save money. In this way, income management lays the foundations for pathways to economic and social

participation through helping to stabilise household budgeting that assists people to meet the basic needs of life. We recognise that these are benefits which are relevant to Indigenous people and non-Indigenous people in similar situations.”

In summary the aims of IM are to:

- improve parenting practices and therefore the wellbeing of children;
- improve financial management
- reduce alcohol and drug misuse
- reduce problem gambling and use of pornography
- reduce financial harassment of vulnerable people.

To date there are income management programs in the following locations:

- Western Australia: Metropolitan Perth, the Kimberley region, the Ngaanyatjarra Lands, Laverton and Kiwirrkurra community
- Queensland: Rockhampton, Logan (Place Based Income Management - PBIM), and the four communities (Aurukun, Hope Vale, Mossman Gorge and Coen) participating in Cape York Welfare Reform Trial
- South Australia: The Anangu Pitjantjatjara Yankunytjatjara Lands (APY), Playford, Greater Adelaide and the Ceduna region (PBIM)
- New South Wales: Bankstown (PBIM)
- Victoria: Greater Shepparton (PBIM)
- The Northern Territory (NIM).

The DSS website¹ provides information on the following measures within IM:

Voluntary measure (VIM)

“People who volunteer to go onto income management have 50 per cent of their income support payments income managed.”

¹ <https://www.dss.gov.au/node/33895> (Accessed 26 May 2016).

Vulnerable Income Management (Vulnerable IM)

Assessed

“A social worker may recommend IM to a person who needs help to manage their money and/or look after themselves; including people who are homeless, or who are at risk of homelessness. These people have 50 per cent of their income support payments income managed.”

Automatic Trigger

“Young people who receive the Unreasonable To Live At Home allowance, Special Benefit, or Crisis Payment (prison release) have 50 per cent of their income support payments income managed”. This measure has not been evaluated.

Child Protection measure (CPIM)

“Income management is a tool for child protection authorities to help protect children who are experiencing abuse or neglect. Under this measure 70 per cent of income support payments are income managed.

Long Term Welfare Payment Recipients and Disengaged Youth measures (also known as the Parenting/Participation measure) (Northern Territory only)

People in the Northern Territory who have been out of work for some time, go onto this measure and have 50 per cent of their income support payments income managed.”

Supporting People at Risk measure (Northern Territory only)

“People needing help with alcohol and/or drug issues who are referred by the Alcohol Mandatory Treatment Tribunal go onto this measure and have 70 per cent of their income support payments income managed.”

Note that this measure has not been evaluated.

Cape York Welfare Reform² (Cape York only) (CYWRT)

“People referred by the Family Responsibilities Commission (FRC) have 60, 75 or 90 per cent of their income support payments income managed.

Under all measures of income management, lump sums and advance payments are 100 per cent income managed.”

² See <https://www.dss.gov.au/our-responsibilities/families-and-children/publications-articles/cape-york-welfare-reform-fact-sheets-2012> for further information about the CYWRT which involves 14 different initiatives.

The Healthy Welfare/Cashless Debit Card

The Healthy Welfare Card or Cashless Debit Card is not strictly speaking a form of income management in that individuals do not have to discuss with Centrelink how they will spend their welfare payment. However, it is similar in many ways. Like IM, the 'Healthy Welfare Card' is aimed specifically at reducing alcohol misuse in Indigenous communities. It will be trialled in a small number of communities, starting in early 2016 in the Ceduna region in South Australia, followed by Kununurra and Wyndham in Western Australia.

Under the trial, all recipients of working age income support payments who live in a trial location will receive a cashless debit card. According to the publicly available material, the card will look and operate like any other mainstream debit card, and can be used in any store which uses the EFTPOS system with the exception that it will not work at alcohol or gambling outlets, and cash cannot be withdrawn using the card. Eighty per cent of the customer's welfare payment will be paid onto the cashless debit card.

As the Cashless Debit Card has not yet been implemented, it has not been evaluated.

Evaluations of IM

To date, there have been a small number of evaluations of IM (Bray *et al.* 2014; Brimblecombe *et al.* 2010; Deloitte Access Economics 2015; Department of Social Services 2014; Equality Rights Alliance 2011; FaHCSIA 2012; Katz & Bates 2014; ORIMA Research 2010), some of which have been funded by the DSS and some independently. The most robust evaluations are those of Bray and colleagues in the NT and Deloitte Access Economics for Place Based Income Management (PBIM). Both of these were well funded comprehensive evaluations which included longitudinal cohorts of people who were income managed and compared them to similar individuals who were not subject to IM. Both were funded by the Department of Social Services and its predecessors.

The Cape York Welfare Reform Trial (CYWRT) - commissioned by the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) and carried out by independent consultants, academics and research centres - was also comprehensive in its range of evaluation activities. However, the broad scope of the evaluation did not allow for a particular focus on IM. IM was only one component of the Family Responsibility Commission (FRC), which in turn was only one of the initiatives in the CYWRT, although it was the central reform of the Trial. All the other studies were of smaller scale involving convenience samples of particular measures.

Overall, as several authors have highlighted (Bray *et al.* 2012; Mendes *et al.* 2014), there are methodological problems present in the evaluations of IM that need to be kept in mind. The absence of baseline data in the NT evaluation places reliance on

recollection of events previous to The Intervention instead of hard data. The limited use of comparison groups due to the difficulties in benchmarking against other communities (small numbers and specific characteristics within a community) makes it harder to disaggregate the impacts of IM. The multitude of other policies that were implemented or in place when IM started adds another layer of difficulty.

Research aims

The aims of the project are to inform policy making for the NSW Government and in particular Aboriginal Affairs, by providing an analysis of the evidence to date on the impacts of IM.

The research addresses the following four questions:

1. What empirical evidence exists about the success or otherwise of income management approaches or particular elements of income management?
 - a. What is concluded generally in terms of the effects of income management
 - b. What is concluded in particular about the effects of the implementation processes, the development and governance of the approach, the provision of services, and environmental or community factors?
2. What are the characteristics of individuals or communities who receive some benefit, no benefit or are negatively impacted?
3. Are there unintended consequences of income management approaches?
 - a. How do they manifest?
4. Can the aims of income management be achieved through other approaches?

Human rights issues

This report is focused primarily on the empirical evidence for whether and how IM has been demonstrated to achieve its stated aims. It should be noted that IM has been a very controversial policy ever since its introduction almost a decade ago. Many of the debates around IM have focused on human rights issues, particularly in relation to the fact that IM disproportionately applies to Aboriginal communities. The disquiet about IM was expressed by the (Parliamentary Joint Committee on Human Rights 2013, p. 75) which concluded:

“...the committee has recognised that Indigenous people and many others have significant concerns about the human rights compatibility of a number

of the measures central to the *Stronger Futures* measures. The committee notes that the issue of whether some of the measures have had the beneficial effects that were hoped for, is contested and that there is much work to be done in terms of evaluation of the ongoing impact of the measures.”

The Committee also noted the significant limitations on human rights that a number of the *Stronger Futures* measures represent, in particular the income management measures and the school attendance measures which

“...involve extending regulation a long way into the private and family lives of the persons affected by these schemes....the onus is on government to clearly demonstrate that these measures involve not just the pursuit of an important social objective, but that there is a rational connection between the measures and the achievement of the goal, and that the measures adopted are reasonable and proportionate to the achievement of that goal”(p. 76).

While this report focuses on the empirical evidence for IM and its alternatives, it must be noted that the empirical evidence is only one of the factors to be taken into account when implementing policies for Aboriginal peoples. The policy context in which income management is most contested and debated revolves around the concerns about human rights and the extent to which income management is discriminatory against Aboriginal peoples. Income management is also strongly associated by those subject to the Northern Territory Emergency Response (‘The Intervention’) measure and with heavy handed top down government interventions in the lives of Aboriginal families. Therefore, human rights issues must to be taken into account even when examining empirical evidence and most importantly when considering policy options.

Report structure

The report is subdivided in two parts. Part I answers questions one, two and three, posed previously under Research Aims. It examines IM itself and describes the various IM programs which have been implemented in Australia since IM was first introduced in 2007. It then subsequently examines the evidence base for IM, including the implementation, outcomes and intended and unintended consequences.

Part II of the report deals with question four under Research Aims, answered in two different ways. First, there is a brief summary of international research on Conditional Cash Transfers (CCTs) and Unconditional Cash Transfers (UCTs). Both types of transfers provide cash to low-income families to support change in their behaviours and improve the wellbeing of children. CCTs are explicit in the specific set of behaviours desired to achieve, the so-called ‘conditions’. In CCTs, cash transfers are only provided if beneficiaries meet the conditionalities requirements. The report then presents a review of the evidence for interventions in Australia and internationally aimed at the outcomes intended by IM, in particular parenting practices. Although there is no research which compares IM with

parenting programs, the purpose of this part of the report is to provide evidence of alternative ways of achieving the kinds of behaviour changes which IM is expected to achieve.

Part I: Review of evidence of income management programs in Australia

Chapter I. Successes and challenges of income management approaches in Australia

This section aims to answer the following question: “What empirical evidence exists about the success or otherwise of income management approaches or particular elements of income management?”

1.1 Effect of implementation

The mode of implementation of IM has differed considerably across different locations and for different models:

- The Northern Territory Emergency Response (NTER) ('The Intervention') was implemented without consultation with communities. In particular, IM was introduced without taking into account the views or perspectives of the 73 prescribed Indigenous communities.
- The Cape York Welfare Reform Trial (CYWRT) was implemented after two years of consultations with communities, although it is not clear whether consultations in Conditional Income Management (CIM) were included and how they would be used within the trial.
- In the Northern Territory, the 'new model' of IM was implemented with little consultation following the Rudd government's decision to re-introduce the Racial Discrimination Act and apply IM to the whole of the Northern Territory rather than only Aboriginal communities. This followed the Yu review's (Yu *et al.* 2008) recommendation to cease compulsory measures and only include Voluntary Income Management (VIM).
- The Place Based Income Management (PBIM) programs were implemented with minimal consultation with communities.
- Anangu Pitjantjatjara Yankunytjatjara (APY), Ngaanyatjarra Pitjantjatjara Yankunytjatjara (NPY) and to a lesser extent the Western Australian models were requested by the communities and only include VIM and Child Protection Income Management (CPIM).
- Implementation of the Healthy Welfare Card is contingent on community leaders formally agreeing to its implementation in their communities. To date only two communities have consented, neither of them in NSW.

It is not possible to empirically link the implementation of IM to outcomes. However, the various evaluations indicate that communities are much more accepting of IM where there has been genuine consultation. Various reports have indicated that implementation by government without consultation has created resentment and long-term challenges for IM, even in cases where individuals feel that they have benefited from it. Many participants have reported to be treated unfairly when placed on CIM, and many describe the program as being discriminatory (Bray *et al.* 2014). IM is strongly associated with the NTER and therefore with the imposition by government of restrictions and loss of human rights for Aboriginal peoples and communities without any consultation.

Another aspect of implementation has been the practical difficulties with the BasicsCard. In the first report of the evaluation of New Income Management (NIM) in the Northern Territory, this was identified as a major cause of concern for many participants. Subsequent reports (Bray *et al.* 2014; Deloitte Access Economics 2015) indicated that practical issues included:

- inability to contact Centrelink and/or frustration at being 'micro-managed' by Centrelink staff
- imposition of surcharges on the use of BasicsCard
- not being able to use the BasicsCard at markets, garage sales and many retail outlets, even for the purchase of beneficial goods. Thus, welfare recipients are being forced to shop at larger supermarkets or expensive community stores
- difficulty for private renters whose landlords wanted cash or who did not accept the BasicsCard
- difficulty in using the BasicsCard while travelling or in remote locations.

The ways in which merchants are approved to accept the BasicsCard limits the type and size of shops eligible to apply. In order to gain approval, the merchant needs to make undertakings not to sell excluded items on the BasicsCard, maintain records that could be audited and have half of their turnover in priority goods (Bray *et al.* 2015). These requirements make it difficult for small or specialised shops to be approved.

Although many of these issues have been resolved more recently, there are still significant practical difficulties for some people. Even in the APY lands and PBIM, where all the participants were voluntary, these practical issues affected many IM clients.

1.2 Governance approaches

Governance per se has not been a focus of many of the evaluations. The consultations prior to the introduction of IM were a key component of the CYWRT, which required formal agreement by mayors of the communities in Cape York. There were no consultations prior to the NTER, nor to the introduction of New Income Management in the NT. The APY lands scheme had a different governance approach. Residents of the APY lands requested to introduce IM in their communities as a measure to protect against financial harassment, substance misuse and gambling. However, they were only supportive of voluntary measures, not programs akin to 'The Intervention' (Katz & Bates 2014).

Once IM has been introduced in a particular location it has become part of the overall Centrelink program and is managed by the Centrelink hierarchy. In theory, all the IM programs are trials, but they have all been continued since inception and there is no record of communities being consulted about whether IM should continue or how it could or should be changed.

The only program which has been discontinued is the Northern Territory Emergency Response (NTER) IM, and this was in response to the government's decision to reinstitute the Racial Discrimination Act in the Northern Territory, rather than as a response to community concerns.

Evidence based on the CPIM in Western Australia and CIM are in favour of institutional arrangements that promote governance approaches based on tailored packages to support individuals (Bray *et al.* 2015). Referrals by the Northern Territory Department of Children and Families (DCF) due to child neglect and by the Northern Territory Alcohol Mandatory Treatment Tribunal to CIM were found to help stabilise some individuals as an on-going case management strategy. The collaboration between the Department of Human Services and the Department for Child Protection and Family Support in Western Australia were found to be productive and useful in helping families and meeting the needs of children. However, in some of the PBIM sites, the child protection services were not willing to cooperate with Centrelink on CPIM, leading to very low numbers of referrals.

The CYWRT has an innovative and unique form of governance involving a tripartite partnership between the Queensland and Australian governments and the Cape York Institute.³ The governance arrangements were set up to represent the welfare reform philosophy of moving beyond passive, government-defined service delivery and instead empowering Indigenous involvement in leadership of policy and

³ Cape York Institute's responsibilities as trial partner include oversight and coordination of the work of the Cape York regional organisations charged with delivering trial elements (2008 Project Board Agreement, pp. 10–11).

program design and delivery. None of the other programs have attempted to facilitate Indigenous governance as an objective.

In relation to Child Protection Income Management and Vulnerable Income Management, Centrelink is dependent on referrals from State statutory services such as child protection and housing departments. These relationships have reportedly worked well in some cases but not in others. In some jurisdictions particular (including NSW), child protection workers have been reluctant to refer clients to Centrelink because they are opposed to IM and/or they do not think it is appropriate for their clients. In other jurisdictions, particularly in WA, there has been more cooperation between state agencies and Centrelink around IM.

1.3 Interaction with other services and programs

As originally conceived, most IM programs have been part of a range of interventions. The NTER involved over 120 separate interventions, many of which continued for NIM in the Northern Territory (see Part II, section 5.5.15 *Northern Territory Emergency Response*). The CYWRT involved 15 different initiatives in the four target communities in Cape York. These projects fall under four welfare reform streams: social responsibility, education, housing and economic opportunity. PBIM was part of the Building Australia's Future Workforce initiative which involved a range of initiatives in education and employment.

The provision of a whole range of services has made it very difficult for the evaluations to disaggregate the effects of IM from those of other programs in the communities, and the question remains open as to whether the outcomes measured (both positive and negative) would have been achieved without the imposition of IM. Researchers were not able to control for the interaction of IM with other services and programs, rather it is acknowledged that such interaction may result in positive bias in IM outcomes (Bray *et al.* 2015). This leaves the possibility that these services would have produced the same outcomes irrespective of the implementation of IM.

There was some evidence that the most important interventions in the CYWRT communities were the Alcohol Management Plans and the closing down of the taverns in some of the communities, rather than the Welfare Reform trials themselves. Reductions in alcohol use and community violence followed the introduction of the Alcohol Management Plans and slightly preceded the introduction of the CYWRT. Furthermore, other comparative Indigenous communities show similar trends of improvement.

With regards to PBIM, many of the targeted communities already had substantial Commonwealth and state government programs in place, including initiatives such as Communities for Children, which is also a place based initiative run by the Commonwealth government (see Part II, section 5.5.18. *Stronger Families and Communities Strategy*).

In some cases, services had specifically been introduced to complement IM. These included Money Management in the NIM and Intensive Family Support Services, which was linked to CPIM in the Northern Territory and APY lands. The evaluations found that Money Management had a very low take-up rate by customers on IM, and the courses provided were seen by most customers as not relevant to them. Intensive Family Support Services was a successful intervention, but poorly targeted at CPIM clients, and it was eventually resolved to drop the requirement that clients should be on CPIM in order to receive Intensive Family Support Services.

1.4 Areas for improvement

None of the evaluations makes direct recommendations, but it is clear from some of the findings and the conclusions that there are a number of improvements that could be made to IM.

Impact of implementation:

As indicated above, the way IM was implemented in communities appears to have a significant impact on its acceptance and ultimately its effectiveness. Ideally, IM should be implemented at the request of the community itself as in the case of the APY and NPY lands. If the community has not requested IM, it is important that the community is fully consulted and that the community (or its representatives) is fully informed of the implications of implementing IM.

A second issue relates to service provision. IM should always be implemented in the context of a broader range of services in order to support the needs of people subjected to IM.

The technical and practical challenges created by the BasicsCard to those on IM should be minimised so that people are not prevented from spending their money appropriately, and are not overburdened with technical glitches.

Lastly, in order to measure impact, baseline studies should be carried out before the implementation of IM programs. The absence of baseline studies made it difficult to obtain reliable and unbiased quantitative data to measure the impact of the intervention.

Governance approaches:

In accordance with the discussion on implementation, the evaluations show that it is important that the community maintains control of IM and has the right to continue, amend or cease to implement IM if they are not satisfied that it is achieving the desired impact. While there have been consultations in all the programs outside the Northern Territory, most of the evaluations show that community members have been dissatisfied with the level of consultation prior to the introduction of IM. It is, however, not clear that this is a particular issue for IM, as other evaluations and

reviews, particularly of initiatives in Aboriginal communities, have commented on the challenges of consultation with communities.

If it is culturally and logistically appropriate in an individual community, then IM should be implemented in the context of a body such as the Family Responsibilities Commission (FRC). However, this can be very resource intensive. It requires changes to legislation, extensive consultation and high levels of training and support for Commissioners. This approach, therefore, requires careful planning and resourcing.

It is important that IM is evaluated as rigorously as possible, and that findings are shared with community leaders and other stakeholders. Data collection, analysis and reporting should form a core component of the governance of IM.

Service provision:

The various evaluations of IM have indicated that IM works best when it is part of a range of services which are provided to community members to support them in achieving IM goals. This is particularly true in terms of improvements in parenting, financial management, substance misuse and avoiding financial harassment. Ideally, the individual should be assigned a case manager who will support them to use IM in the most appropriate way and to access and coordinate the relevant services. This was the original plan for CYWRT, and although people in those communities had a high level of service, it was not coordinated adequately.

Community factors:

Given that there is no possibility of measuring the impact of IM as a single intervention, the impacts of IM in the community are based on perceptions of those interviewed. The evaluations show that there are mixed perceptions of the impacts of IM in communities.

On the one hand, there was a reported degree of frustration that little has changed in the community life after the NTER. The problems of financial exploitation, alcohol and drugs are still predominant in these communities. People work around the restrictions imposed by income management. Similar findings were reported for APY communities.

On the other hand, community members of CYWRT perceived improvements in their community life. Children seemed to be more active, healthier and happier than prior to the trial. The social change survey indicated that the FRC was endorsed by community members and there was a strong emphasis on individual and family responsibility. Community wellbeing, home living, engagement and health support are also aligned with their aspirations.

The perceptions of APY community members seem to demonstrate both views. Financial harassment ('humberging'), gambling, alcohol and cannabis ('gunja') continued to be problems in these communities even after the introduction of IM. However, some people had the overall perception that there was a positive impact due to the reduced amount of cash available.

It is possible that IM has a short-term impact on communities when it is first introduced, but that over time, community members become habituated to it, finding ways of obtaining prohibited goods and thus limiting its effects. This can also ultimately lead to unintended consequences such as increased financial harassment of community members who are employed or who have cash from other sources such as mining royalties. Ultimately, this is likely to be because IM does not address the causes of social problems in Aboriginal communities, and while these causes continue, IM (or any other specific intervention) is bound to have limited, if any, positive impact on community life in the long term.

Chapter 2. Characteristics of individuals or communities

This section aims to answer the following question: “What are the characteristics of individuals or communities who receive some benefit, no benefit or are negatively impacted?” The evidence gathered for this section overlaps with that for section Chapter 3 as some IM programs are targeted at specific groups and may have unintended consequences, or negative impacts.

Different modes of IM are targeted at different groups and in various geographical areas (Bray *et al.* 2014,2015). In December 2013, the Northern Territory New Income Management (NIM) had 18,300 people subject to income management, of whom 16,514 were Indigenous Australians. 76.8% were on Compulsory Income Management (CIM) (3,981 in Disengaged Youth and 10,071 in Long-term Welfare Recipient) and 20.1% on Voluntary IM (Bray *et al.* 2014, p. 298). As of January 2016, 87% of the total 20,940 people on IM were Indigenous Australians. Out of the total, 4,172 were in Disengaged Youth, 12,544 were on Long-term Welfare Recipient and 3,303 were on Voluntary IM⁴.

In 2013, 34% of Indigenous Australians above 15 years old were subjected to income management as a result of high rates of Income Support receipt. Close to 60% were women; 39.8% were single, 28.9% were members of couples with dependent children, 17.8% were single parents and 13.5% were couples with no children. The proportion of older VIM recipients was higher as a result of being on Disability Support Pension (65.7%) or an Age Pension (20.8%). Of those on VIM, 86.5% were part of the previous Northern Territory Emergency Response (NTER) IM. The number of people on Child Protection Income Management (CPIM) was small. The number of Vulnerable Income Management (Vulnerable IM) increased from 150 in 2013 to 242 in 2014 as a result of the automatic Vulnerable IM. The number of Vulnerable IM assessed measure remained stable at around 150 people.

The Place Based Income Management (PBIM) evaluation (Deloitte Access Economics 2014) highlights that the type of income support payment is more important in determining the likelihood of an individual receiving IM, rather than Indigenous status, gender or family status. People who receive PBIM and who are likely to receive VIM are over 30 years of age and have moved address at least once in the past two years, are in government housing and are receiving income

⁴ For more information, please refer to “Income Management Summary – 1 January 2016. See <http://data.gov.au/dataset/income-management-summary-data/resource/35b9b9d7-dd01-46a0-8934-81649ef502c2> (Accessed 26 May 2016).

support payment (Disability support pension or age pension). Those who have a higher likelihood of receiving Vulnerable IM (assessed) are in either one of these three subgroups: (i) aged between 29-33 years, not in government housing and with less than two children under five; (ii) aged 30 years or younger, in government housing and not on Youth Allowance or Special Benefits payments; (iii) in government housing but have not moved address in the past 2 years and with income support payments for more than 17.8 years.

Although the majority of people on the Northern Territory NIM are Indigenous, Bray et al (2014) report that the proportion of Indigenous people on income support was higher in remote communities in the Northern Territory, whereas the proportion of non-Indigenous in income support was higher in the areas of Greater Darwin and Alice Springs.

In addition, it is important to highlight that in these communities, Indigenous people have both low rates of applying for exemption of IM and high rates of rejection. 36.3% of non-Indigenous people are granted an exemption as opposed to 4.9% of Indigenous (Bray *et al.* 2014, p. 98). Exemption rates also vary according to gender, the exemption rates for males being significantly lower than for females. Although some people found the exemption process easy (p. 111), there was a sense of humiliation and shame to be subjected to it. The Commonwealth Ombudsman (2012), using a sample of 40 out of 171 people who applied for and were refused exemption between August 2010 and March 2011, suggested improvements to the exemption process. They found that inappropriate decisions were made that did not meet the mandatory requirements. The review resulted in changes of business practices, such as the implementation of quality standards, checklist and the involvement of senior staff in the revision process of those decisions.

The PBIM evaluation highlighted that PBIM participants generally live in more disadvantaged locations than those not on PBIM. Across the different PBIM initiatives, those that receive the Vulnerable IM (assessed) live in the most socially and economically disadvantaged areas and those that receive the Vulnerable IM (automatic trigger) live in the least disadvantaged areas.

Although the evidence is only based on one program (the Cape York Welfare Reform Trial - CYWRT) that attempted to involve community leaders in the implementation of IM, there is a general perception that in communities that have the involvement of local institutions like the Family Responsibilities Commission (FRC) and a multitude of services (Wellbeing Centre, Student Case Management, Parenting and Family violence courses) and opportunities (MPOWER, Student Education Trusts and Pride of Place), individuals and families are better supported and better able to address some of their vulnerabilities. Although the report (FaHCSIA 2012) acknowledges the lack of causality between the multiple interventions and the positive perceptions of community change and prosocial behaviour, the results reinforce previous research on distributive and procedural justice that demonstrates that when individuals are treated with respect and

fairness, they are willing to abide by administrative decisions such as those of the FRC. The positive perception is also a result of the ongoing definition and re-definition of the community's shared aspirations and goals, promoting a sustainable change of individual attitudes and behaviour. However, the extent to which this positive perception is the result of the FRC or the combination of several services and opportunities is uncertain.

Overall, the evaluations did not find any particular groups of people or particular characteristics of communities that are likely to benefit from IM. In other words, no specific individual or community demographic characteristics were found to be associated with a positive outcome of the IM program. As indicated in section 3.1 below, IM appears to benefit those individuals whose financial management is out of control and who require a clear structure to ensure that they have cash available for essential items. It also seems to have some effect on some people who are being financially harassed. However, in both cases, it appears to be most effective as part of a comprehensive support package rather than a stand-alone measure. Conversely, IM is detrimental to those who already manage their finances and who require flexibility in their financial arrangements so that they can, for example, travel and seek employment. For many individuals, IM has had little overall effect as they were not spending 50% of their income on prohibited items prior to the Intervention and therefore other than the irritations of the BasicsCard, these individuals continued with their previous lifestyles. Generally, IM has been more successful for people who volunteer to be placed on the measure or who are assessed as requiring IM, than those who have been subject to IM merely because of their circumstances or benefit status.

Chapter 3. Consequences of income management

This section aims to answer the following question: “Are there unintended consequences of income management approaches? How do they manifest?”

3.1 Intended consequences

Outcomes

Overall the measure appears to be successful for many (but not all) people who are:

- motivated to change their behaviour or lifestyle and who see their money management as a major part of this change
- victims of financial harassment and who find it difficult to protect themselves in other ways
- in a financial crisis or whose ability to manage their finances is severely compromised and who need an externally imposed framework so that they can stabilize their situation
- having their income managed as a result of an intervention by the Family Responsibilities Commission (FRC), as a last resort, after conference meetings, counselling and referral to support services.

In general, evaluations have found that Voluntary Income Management (VIM) is more effective in these areas than any other form of compulsory income management⁵. The exception appears to be some Child Protection Income Management (CPIM) clients in Western Australia and some clients of the FRC in the Cape York Welfare Reform Trial (CYWRT). The common factor with these two groups is that they have been placed on IM through a careful assessment process and their progress is closely monitored and managed. They are not subject to a blanket measure, and IM for them is time limited with clear objectives. According to the CYWRT report:

...income management is effective for some people whose lives have been dislocated and who need some form of authority exerted in order to provide a framework in which they can take responsibility for addressing their issues. The social change survey also confirmed that, for some people, income

⁵ Some people on VIM may not have been fully aware of the voluntary aspect of VIM (Bray *et al.* 2014). This happened when VIM was first introduced to those who were already at the NTER IM. However, for those who were not on the NTER IM, they were asked whether they would like their income to be managed.

management had contributed to children being healthier. The data indicate that some community members had become habituated to income management or had found ways around it (FaHCSIA 2012).

As indicated by Deloitte Access Economics:

PBIM [Place Based Income Management] has been an effective program for the purpose of improving the financial stability, management and confidence of some DHS customers. These customers are often those who are self-motivated to be placed on the program (and therefore, volunteer). It is suggested that over time, the Department gives consideration to re-orienting the focus of measures to reflect the characteristics of the voluntary measure. That is, that over time, there is a lower reliance on compulsory mechanisms to engage consumers in the program unless there are exceptional circumstances at play. One way in which this could be achieved is to remove the automatic trigger for enrolment in the VULN-AT [Vulnerable Income Management, automatic trigger] measure (Deloitte Access Economics 2015, p. iv).

However, these intended positive outcomes of VIM are limited. As the Northern Territory New Income Management (NIM) evaluation outlines (Bray *et al.* 2014), although people on VIM tend to have a positive perception of IM making their lives easier and helping them to manage their income, even for this group, IM had only a small and even uncertain impact on short-term outcomes. It is also less likely to help people moving off income support as those on VIM are largely on Disability Support Payment and Age Pension. Also, those that wish to stay in IM report that they would like to because it is easy to stay on IM and they are used to it. The data does not provide an overall trend of improvement but rather mixed perceptions. On the one hand, those on VIM perceive a reduction in alcohol, improvement in being able to pay bills on time and not running out of money; on the other hand, there was an increase in gambling and in asking others for money to buy essentials.

Child Protection Income Management (CPIM)

CPIM is perhaps the most difficult measure to analyse because there have been multiple reports which appear to conflict with each other. In particular, the various Western Australia reports were mostly positive; the Northern Territory NIM report found only limited impact, and the Place Based reports found little impact. Overall, it appears that:

The effectiveness of income management when used in child protection cases was largely dependent upon the circumstances in which it was used.

CPIM was generally seen as being most effective in those cases where families were willing to engage with services and with a process of change... (but)...limited where families were unwilling make such a commitment, and that in these circumstances families were able to use a number of strategies to circumvent the restrictions of CPIM.

It was seen as a more useful tool for working with families where neglect was linked to the management of money, or alcohol or substance misuse, or problem gambling, with less support for its application in cases where the neglect arose from other causes, although some felt it did not do any harm in these situations (Hand *et al.* 2016, p. 29).

It should be noted that none of the evaluations were able to measure the actual impact of CPIM on the wellbeing of children - its ultimate aim. The evaluations relied mostly on the perceptions of caseworkers and to a lesser extent parents' views.

Children's wellbeing

Another objective of IM is to improve the wellbeing of children through better parenting practices. The evaluations conducted so far show that there are mixed findings on whether IM helps to achieve that objective.

The evaluation of CYWRT demonstrated an increase in school attendance although this increase was not across all the years of education. The review of CPIM in Western Australia showed an improvement in the perception of children's wellbeing due to the effect of IM in stabilising housing arrangements. The NIM evaluation reported a potential reduction in alcohol problems in the family for those on VIM, and also positively affecting children's wellbeing. However, for those on VIM in the NT and APY lands, where there was reported smaller improvements in parenting, there is the need to supplement these positive outcomes with additional interventions.

Other reports show more caution against these perceptions of improvement in children's wellbeing. The Equality Rights Alliance report how little or no effect IM had on the daily lives of women in the Northern Territory. The PBIM evaluation states that there is not enough evidence to determine if IM had an impact or not on children's wellbeing.

In sum, the lack of baseline studies and the inability to conduct randomised controlled trials (or quasi-experiments) does not allow a quantitative analysis of the overall impact of the program on children's wellbeing. There is currently no clear evidence that children's wellbeing has improved as a result of IM.

3.2 Unintended consequences

The research on IM indicates that it can create a number of unintended consequences for some people. Some of these unintended consequences are described above under implementation, referring to the difficulties people experience managing their finances when they are quarantined and also the practicalities of using the BasicsCard, which is not accepted in many outlets or for more informal transactions. BasicsCard users have reported difficulty while travelling, mainly those living in rural areas travelling to urban areas.

It should be noted that there were a few unintended positive consequences of IM. Firstly, the introduction of IM forced customers to have a much higher level of contact with Centrelink than was previously the case. Although this caused difficulties for many people, it had the effect of ensuring that customers were receiving the correct benefits and provided them with an opportunity to discuss their situation with Centrelink. In the case of Vulnerable IM, a Centrelink social worker was often the only service provider in contact with the individual (although in many cases they did not see the social worker face-to-face). Another positive consequence was that the BasicsCard provided a free banking service for people living in remote areas, where ATM costs could be very high, often eating into their income.

In terms of the intended impact of IM on behaviour, there were a number of unintended consequences, all of which were negative. Perhaps the most important of these was that a proportion of people subject to IM become habituated to it. Rather than acting as an incentive for people to take more responsibility for their finances, some customers became used to Centrelink workers controlling the way they spent their money, and could therefore become **more** rather than **less** dependent on the welfare system. This was especially true for those on VIM, (which in addition provided cash incentives for people to remain on IM) but was also reported in other schemes such as CYWRT.

Other unintended consequences of IM included that it could, under certain circumstances, increase rather than combat financial harassment. In these cases, people were reportedly harassed for their BasicsCard or for their discretionary payments, resulting in their having even less cash available. Similarly, the NIM evaluation showed that IM could act as a disincentive for people to go off welfare and into work. This was because they knew that they would be harassed for the cash they would earn. These outcomes are a consequence of the fact that IM does not address the issue of financial harassment itself. People who are determined to get money can find ways of subverting IM and possibly make life even more difficult for those subject to the measure.

The NIM evaluation also reported that some people used the BasicsCard to gamble, shared their BasicsCard PIN and that families would club together to buy excluded items (e.g. alcohol, tobacco, gambling services and products, and pornographic material), again subverting the impact of IM. The extent of these activities is, however, not known.

Some of the specific measures which were implemented to complement IM were found to be ineffective, in particular Money Management and the Matched Savings programs. These measures have had a very low uptake and no measurable impact on customers.

Summary

Singling out the impact of IM in general, and specifically in improving parenting practices and child wellbeing in Aboriginal communities, is a methodological challenge due to several difficulties, such as a lack of baseline studies, limited use of comparison groups and the multitude of simultaneous interventions. Although several evaluations of IM were carried out (refer to Appendix A), there were limitations in terms of methods and broader applicability of the evaluation findings.

That being said, there are some recurrent themes from these evaluations. Income management programs are mostly successful when they are implemented after community consultation, when the community is engaged through their own social mechanisms (Family Responsibilities Commission) or when the individual voluntarily take-up the program. Although only a few cases of Child Protection Income Management were examined, this type of IM seems to have a positive effect in helping parents who neglect their children because they are unable budget appropriately, but not for the majority of child neglect cases where family issues other than budgeting appear to be more pressing.

In addition to governance approaches that favour community participation and a level of individual buy-in, the interaction of IM with other services is an important prerequisite for improving the odds of the success of IM programs. In order to help individuals and their families, the literature emphasises the role of support services that may address some of the causes of anti-social behaviour, housing and/or financial instability.

There is no clear evidence that IM helped to improve the wellbeing of children. Some studies reported an increase in school attendance (Cape York Welfare Reform Trial); others reported a potential reduction of alcohol problems in the family (New Income Management in the Northern Territory), but no evaluation could demonstrate how much the IM intervention led to or caused an improvement in children's wellbeing due to a lack of baseline studies and an inability to conduct Randomised Controlled Trials or Quasi-experiments.

Qualitative evaluations carried out in Aboriginal communities, however, demonstrated both spectrums of children's wellbeing. For some groups, IM (preferably Voluntary Income Management) led to improvement in parenting, reduction of alcohol problems in the family and improvement in the wellbeing of children through financial and housing stability. For others, IM made it more difficult for them to manage their scarce resources by limiting their cash in hand, the stores they can use their BasicsCard to purchase items in and created difficulty in paying their rent. Again, those that requested to be put on Voluntary Income Management showed a more positive perception of their own situation, of the program and the societal changes due to the program.

Overall, income management seems to have a tangential effect on changing people's behaviour. Its success depends, among other things, on the type of governance arrangements (i.e. voluntary take-ups in addition to supportive community arrangements and public services). On the one hand, it can benefit those who are being financially harassed or who may need help with financial management. On the other hand, there are reports of how IM was seen as an unfair measure as they managed their finances well prior to intervention. These made the people in question feel embarrassed and discriminated against. Although it is possible that IM had an impact on changing people's behaviour, attitudes towards the consumption of proscribed items does not seem to have changed as evaluations found that individuals find ways of obtaining prohibited goods, continuing their humbugging, therefore limiting the effects of the intervention.

Part 2: Interventions that may be suitable alternatives to income management

Part 2 aims to answer the following question: “Can the aims of income management be achieved through other approaches?”

Part 2 focuses on evaluations of programs which are aimed at producing similar outcomes to IM. The first section (prepared by the Social Policy Research Centre - SPRC) is a brief analysis of the international literature addressing Conditional Cash Transfers and Unconditional Cash Transfers. These have not been used in Australia but are increasingly promoted in disadvantaged communities in developing countries.

The second section (prepared by the Parenting Research Centre - PRC) is an update of recent work undertaken by the PRC which focuses on the effectiveness of parenting programs and also looks at other programs aimed specifically at Indigenous populations.

It is important to note that all the interventions discussed here are programs targeted at individuals and families who demonstrate particular difficulties or problems. There are a range of community-based interventions which take a completely different approach and which attempt to address disadvantage, child wellbeing and substance dependency at the community level by mobilising communities to take more control and responsibility for the issues within those communities. This is the approach taken by NSW Aboriginal Affairs in the OCHRE program. This type of intervention is not reviewed in this document, but it may well facilitate better outcomes than any of the individually targeted programs.

Chapter 4. Review of conditional and unconditional cash transfers

Conditional cash transfers (CCTs) are programs which provide cash to participants on condition that they engage in socially beneficial behaviours. The vast majority of these programs have been implemented in developing countries in deprived communities or poor households, and they focus on behaviours such as sending children to school or ensuring that they are vaccinated. The theory behind CCTs is that incentives in the forms of conditional cash would increase human capital of beneficiaries by ensuring that the rights to education and health are fulfilled in the short and long term. This would, in turn, modify socially undesirable behaviour, such as not attending school, and reinforce the 'obligations' present in the social contract. According to this view, assistance should be given to those who abide by the rules, ensured by the state through the use of conditionalities. In this social contract, both the state and the individual have 'co-responsibilities' or 'mutual obligations'. The benefit is not a hand-out or an entitlement (Fiszbein & Schady 2009).

Different fields of knowledge emphasise or justify the use and the long-term effects of CCTs. Economists outline that a healthier and more educated workforce (or an increase in human capital) would result in economic growth and poverty reduction, breaking the inter-generational cycle of poverty (*idem*). International development specialists acknowledge the growth of CCTs as an international social protection intervention able to deliver international aid, reduce poverty and operationally easy to monitor (i.e. attendance rates) (Hall 2015). Political scientists highlight the political feasibility of CCTs once tax payers are more prone to accept interventions that have the recipient's commitment to modify behaviour (Britto 2008; Fiszbein & Schady 2009; Sawhill 1989). However, social policy academics (Titmuss 1987; Townsend 2004,2009) and rights-based groups tend to favour the use of universal transfers or Unconditional Cash Transfers (UCT) for the reasons outlined below.

The theory behind the use of UCT links poverty with reasons that go beyond individual behaviour. Structural inequalities influence individuals' choices, future expectations and the probability of continuing living in deprivation. CCTs create a dual society in which second-class citizens have a different set of rights and responsibilities, with the potential (if conditionalities are too strict) to reinforce poverty, segregation and inequality. For the particular case of Indigenous communities, Altman (2005), analysing the specific case of customary, state and market sectors in Indigenous Australia, shows that cultural goods present in societies that are of importance for an individual in a broader cultural role in their community. Conditionalities may disregard the roles of the customary sector in Indigenous communities. Lastly, proponents of UCT advocate that the evidence in favour of the use of CCTs is not conclusive (as demonstrated in the next sub-sections).

While the CCTs – UCT debate happens mostly in developing countries and in the international development or social protection fields, in developed countries (and more recently in developing countries too) there is an important discussion on conditional welfare and basic income. Basic income, as defined by the Basic Income Earth Network (BIEN), is “an income paid by a political community to all its members on an individual basis, without means test or work requirements”(van Parijs 2000, p. 3). On one end of the spectrum, there is a growing political trend of enforcing the use of conditionalities in welfare states based on neoliberal and fiscal austerity principles. On the other end, discussions on Basic Income are increasingly moving from the academic and political debates to the policy environment.

There are several differences between Basic Income and UCTs, as analysed in this report. Basic Income is given to all members of a political community (citizens or not, rich or poor) whereas UCTs are generally part of means-tested minimum income guarantee programs, aimed at assisting households in need. While UCT programs were designed with a specific objective in mind (improving school enrolment, food nutrition and others), Basic Income has no restrictions as to the nature and objective of the use of the transfer received.

Considering these differences, a logical comparison to IM is CCT. Both programs aim to change behaviour. While IM does not allow the use of funds for proscribed goods, CCTs provide the transfer on the condition that recipients act in accordance to program conditions. In addition, CCTs/UCTs have been carefully evaluated using different methods and in different countries for more than a decade. Thus, although there has been discussions on the use of Basic Income as a potential policy for Aboriginal communities in remote Australia (Altman 2016), the focus of the subsequent sections of the report is on the evaluation of CCTs/UCTs.

Research on CCTs generally compares CCTs to cash transfers without conditionality and sometimes to no intervention at all. There is no research which compares CCTs to IM or equivalent programs because IM is only used in Australia and CCTs are not. In addition, conditionalities are generally imposed to a very specific set of behaviours, e.g. attending pre-natal care, as opposed to the broad IM objectives of changing overall behaviour or altering community norms around alcohol or gambling. Nonetheless, research into CCT can shed light on how interventions can, or not, change a specific behaviour and, in the long term, potentially change community outcomes.

In order to carry out a systematic analysis of the literature, the authors devised a protocol search (refer to Appendix B). Eligible studies were meta-analyses, systematic reviews and comprehensive reviews of CCTs and UCTs, mainly published between 2007 to 2015. The literature reviewed can be grouped in three broad topics. The report first outlines the evidence on the cost-effectiveness of CCTs as opposed to UCTs, followed by a review of the literature in terms of outcomes (health and education, financial inclusion, and drug and alcohol) and the

status-of-knowledge on the importance of cash as opposed to condition. The section ends with a summary table of the main CCT and UCT evaluations.

4.1 Cost effectiveness

There is limited evidence on the cost effectiveness of results-based finance⁶ (Oxman & Fretheim 2009) which focusses specifically on CCTs and UCTs (Glassman *et al.* 2013; Murray *et al.* 2014; Slavin 2010). Garcia and Moore (2012) carried out a desk review of cash transfers in Sub-Saharan Africa which indicate that CCTs seem to be more cost-efficient than UCTs, as small transfers of CCTs had a comparable impact to large UCT transfers. However, there is limited evidence on the impact of conditions overall, and no conclusive evidence that conditions are effective in changing behaviour in the long term (Oxman & Fretheim 2009). Cash alone (i.e. without any conditions attached) may be sufficient. This is important as conditionalities create additional costs for both governments and recipients (Arnold *et al.* 2011; Gaarder *et al.* 2010) in addition to fostering potential unintended consequences, such as distortions (tasks that are not rewarded with incentives), motivating unintended behaviour, gaming and dependency (Bray *et al.* 2014; Oxman & Fretheim 2009).

According to Lagarde *et al.* (2007), impact evaluations and changes in behaviour (school attendance, for example) are calculated using CCT in general. It is not possible to isolate the effect of which component of the CCT is more important – the cash or the conditionality. CCTs may be more palatable politically than cash alone, though these programs are more costly economically than handing over cash to impoverished individuals and communities. One review of CCT concludes: “There are many other reasons (not related to impact) for and against the use of conditions and their appropriateness is likely to be very context specific.” (Manley *et al.* 2012).

In addition, a cost-effectiveness analysis between CCTs and supply-side programs has not yet been conducted (Lagarde *et al.* 2007; Murray *et al.* 2014). In particular, there is a lack of evidence to test the assumption that the failure of some disadvantaged families to access resources such as schools or health services is due to demand-driven factors (i.e. unwillingness on behalf of the families) rather than supply side factors (appropriateness, accessibility or quality of the school or health service). There has also been little analysis to test the proposition that inequalities in health/nutrition are due to demand-side factors (relative to supply-side factors). Even if both are important, it is not clear which is the most cost-effective approach for governments to maximise the benefits of the programs, and indeed, enforcing conditionalities through the use of services when the pertinence

⁶ Results-based finance or pay for performance refers to the transfer of money or goods conditional on achieving a pre-defined target.

(quality/access) is unknown may not produce the expected effects (Gaarder *et al.* 2010).

This is a similar issue for IM, especially in Aboriginal communities, where the availability of services and resources such as employment are severely restricted and often of poor quality. In these circumstances, it may be more appropriate and effective to improve service delivery than impose conditions on the local population.

4.2 Outcomes

Education and health outcomes

Findings on the impact of CCTs in school outcomes (enrolment, attendance) are more consolidated than health outcomes (immunisation, health checks). In general, there is a positive association between UCT, CCTs and school outcomes (Baird *et al.* 2013; Fiszbein & Schady 2009; Kabeer *et al.* 2012; Saavedra & Garcia 2012). In a meta-regression analysis, Baird *et al.* (2013) found no significant difference when comparing CCTs to UCTs in their effect on school outcomes (enrolment and attendance). However, if CCT programs are grouped by the monitoring, enforcement and the penalisation of conditionalities, then CCTs have substantively larger effects on school outcomes.

The evidence is not as conclusive in terms of final school outcomes (Arnold *et al.* 2011; Baird *et al.* 2013; Fiszbein & Schady 2009; Reimers *et al.* 2006). A number of evaluations have indicated that greater service use and improvements in school attendance have not resulted in better performance in achievement tests (Arnold *et al.* 2011; Fiszbein & Schady 2009) or that their improvements are small at best (Baird *et al.* 2013). Reimers *et al.* (2006) state that there is not enough evidence whether students learn more with CCTs. They also consider CCTs as “educationally inefficient” by prioritising families based on poverty levels and not students based on educational need. Garcia (2012) found that CCTs improved learning outcomes (test scores) but these improvements come with a cost. In a Malawi RCT (Baird *et al.* 2011), it was found that while CCTs increased school attendance, UCT was able to significantly decrease the probability that girls would become pregnant or get married. Thus, CCTs “can also undermine the social protection dimension of cash transfer programs” (Baird *et al.* 2011, p. 42).

In terms of nutritional and anthropometric outcomes, there is mixed evidence about the difference between CCTs and UCTs on, for example, height for age, weight for age, and nutritional status. Some authors report no significant (Manley *et al.* 2012) while others report an improvement and a successful increase in the use of services (Lagarde *et al.* 2007), or an improvement for some groups (pre-school nutritional status)(Hoddinott & Bassett 2009). Even if there is a positive nutritional and anthropometric outcome, the overall effect on health status is not so clear, which can be attributed to the varied quality and supply of services (Fiszbein & Schady

2009; Gaarder *et al.* 2010; Lagarde *et al.* 2007; Manley *et al.* 2012). Hence, the replicability of interventions like these is unclear as it depends on the underlying structure of primary health care services as well as payment systems (Lagarde *et al.* 2009). Other authors criticise the use of CCTs to address nutritional status, suggesting that CCTs are not the most suited policy, suggesting that interventions should focus on supply of services.

Thus, there is little evidence that conditioning cash transfer to recipients of welfare (or conditioning the use of cash transfers to certain items as in the case of IM) is an effective policy option that alters behaviour in order to ensure that long-term outcomes are reached. There is instead a concern that conditioning welfare may harm recipients if conditions are too strict. This may penalise beneficiaries as well as undermine the very nature of social protection inbuilt in the instrument of cash transfers by restricting recipients' options when un-tied cash is no longer an alternative.

Financial inclusion

Conditional cash transfers are also being used to promote financial inclusion. There is some limited evidence that payment mechanisms provide access to other financial services (e.g. savings and insurance), which are still used after they stop receiving transfers (Arnold *et al.* 2011). This is not the case for the BasicsCard as it is not linked to a bank and does not provide access to other financial services within the banking system. In addition, as stated above, Centrelink customers do not use the IM money management services.

Drug and alcohol use

As part of the rationale for conditioning the use of cash transfers to predetermined, socially-desirable behaviour is the concern that households would misuse cash received by purchasing for example drugs and alcohol. It is often cited that CCTs should be given to mothers as they would put the interest of their children first, as opposed to fathers, who would potentially spend the funds on alcohol and substance abuse. This discourse holds similarity with IM in Australia as cash is not given to families but allocated to the BasicsCard to purchase items or services other than those proscribed by the program. Drugs, alcohol and gambling products are prohibited items which cannot be purchased using the BasicsCard. IM has, since its inception, been aimed at addressing the growing concern about the use of alcohol and misuse of substances in Aboriginal communities.

Analysing experimental and quasi-experimental CCT and UCT studies from 1997 to 2004, Evans & Popova (2014) found that across 44 estimates from 19 studies, there was no significant impact or significant negative impact of CCTs/UCTs on the

consumption of alcohol and tobacco⁷. This means that giving cash to families does not result in an increase in consumption of those goods. This result is independent of the use or not of conditionalities when giving families their benefit. Thus, it is not the conditionality requirement that makes families not consume alcohol or tobacco. As the authors suggest, "these results provide strong evidence that concerns that transfers will be used on alcohol and tobacco are unfounded" (p. 14).

This same study reviews qualitative evidence on the use of transfers to purchase alcohol and tobacco. Interestingly, qualitative reports suggest a substantive number of participants have a perception that cash transfers are used to purchase these goods. The authors restate the quantitative findings as the qualitative evidence is not based on household expenditure but on perceptions of how others use their money, which can be inaccurate and biased ("saliency bias"⁸). Also, the fact that on average, there is no significant impact does not mean that transfers are never used for purchasing alcohol or tobacco. It may be that individuals who use the transfers in this way come to the attention of the research participants.

These findings are significant for IM. One of the basic assumptions underpinning IM is that welfare payments in themselves have a negative effect on recipients and encourage alcohol and substance misuse as the payment is 'sit down' money not dependent on the recipient working or contributing to society (Cape York Institute 2007). This evaluation shows that in the cases analysed, the fear that welfare transfers would be used to purchase alcohol and tobacco is 'unfounded'.

4.3 Is it the cash or the condition?

Research evidence collected so far has not succeeded in differentiating whether the impacts result from CCT as a general program or from components of CCT. This means that the effect of conditionality cannot be disaggregated from the cash effect or other factors. For example, health status is likely to be influenced by the increase of cash, better diets, higher degree of information, nutritional sessions and other programs that are run simultaneously to CCTs and, finally, conditionalities (Lagarde *et al.* 2007). Identifying the impacts of conditionalities to improvement in long-term outcomes is therefore an arduous exercise. The results are currently still country- and context- specific and a body of consolidated evidence is still to be constructed.

Randomised controlled trials (RCTs) involving CCTs and UCTs have only recently been implemented with an aim to evaluate the impact of conditionalities on specific outcomes. The Malawi RCT (Baird *et al.* 2011) shows that although CCT was efficient in increasing school attendance, UCT was efficient in reducing teenage

⁷ There were only two non-experimental studies that suggest a positive significant impact, however the magnitude of this effect is small. No review of CCT and UCT on substance misuse was found up to date.

⁸ Interviewees or focus group participants can give more weight to evidence that is more noticeable or to dramatic events in their communities (e.g. village drunkard).

pregnancy and early marriage. This preliminary result points to the need to look at policy trade-offs and the overall social protection system.

To date, there is limited evidence singling out the impact of conditions. Cash alone (UCT) may be sufficient and it can also be more efficient considering that CCTs require additional monitoring costs. Perhaps the widespread use of CCTs has more to do with political feasibility than economic costs or social impacts (Britto 2008; Manley *et al.* 2012). It may be easier to elicit the support of the taxpayer (and consequently of the government) if cash transfers are seen to be provided on the basis that recipients behave in the manner required by the state. This, however, raises several concerns in regards to citizenship rights, individual liberty and degrees of state intervention.

A recurrent element in the literature is the emphasis placed on availability of quality services. Some CCTs, like Chile Solidario (MIDEPLAN 2004), condition transfers to a personalised approach in which individuals are exposed to different public services which are agreed upon between the individuals and the social worker. Proponents of CCTs (Fiszbein & Schady 2009, pp. 24-26) acknowledge that "the cash-condition package offered by CCT programs may not be enough, and a comprehensive program that relies on more active participation by social workers and others may be needed". In some ways, CCTs and IM are similar as they both act as mechanisms that prompt individuals, families or communities to engage with public services. It is likely that in many cases, neither the condition nor the income management is what makes a difference but the service apparatus available to individuals, families and communities, including its quality, its acceptance by communities and its capacity to address personalised needs. There may also be a range of reasons other than service quality which hinder access to services including cultural barriers, practical difficulties and opportunity costs.

4.4 Considerations in assessing alternatives to IM

The literature review on CCTs and UCTs demonstrates that there are still several questions to be addressed before favouring the use of conditional cash transfers over IM. Little is known about the cost-effectiveness of investing in the supply-side versus the demand-side (Gaarder *et al.* 2010), of imposing conditional cash transfers versus unconditional transfers, of which aspect is more important in CCT (cash or condition) and of the desirability of restricting welfare (through conditionalities) in low-income settings and with limited supply of services (Lagarde *et al.* 2007). These questions raise key points on the need to implement IM as a policy that imposes restrictions on welfare recipients.

In addition, there are limitations of those studies when considering the specific Australian case. As Slavin (2010, p. 78) states:

It cannot be assumed that the findings of studies in developing countries apply directly to high-poverty schools in developed countries. Limited research on financial incentives in developed countries shows some potential, but the picture is mixed.

The majority of the rigorous evaluations were conducted in developing countries of Latin America and Africa, which are different contexts to Australia. As Glassman *et al.* (2013) caution, the effects of CCTs are not comparable in different settings as there is a variety of supply in services and poverty definitions. The aggregate findings from meta-analyses or systematic reviews may not be significant to Indigenous communities in Australia.

The CCT literature review does, however, place special emphasis on the effective quality services, a topic of importance also raised in the IM literature review. In places with limited services and supply-side bottlenecks, like those found in rural remote areas, it is unlikely that CCTs would have the desired policy outcome. IM or CCTs put individuals in contact with services, but it is the service and not the IM that can make a potential contribution to attitudes and behavioural change. Even then, unless there is some attempt to deal with the underlying issues which cause parental neglect, community violence and substance abuse, there is not a strong likelihood that services themselves will result in long-term behaviour change at a community level.

There is an academic debate about the possibility of advancing Basic Income in Australia and New Zealand (Mays *et al.* 2016). While some of the proponents of Basic Income in Australia highlight the benefits and applicability of Basic Income for specific groups (e.g. people with disabilities, remote Australians), making their call for “Basic Income” more likely to be a minimum income guarantee or a UCT, the proposal for a universal basic income to all Australians (conditional on permanent residence) continues to be advocated by Basic Income Guarantee Australia (BIGA). However, as Tomlinson (2016, p. 66) states “We are going to have to wait for the

emergence of a government that is socially progressive, one capable of seeing through the neoliberal fog.” This is because to propose Basic Income would require a substantial change in the current political thinking as well as a very substantial reconfiguring of the structure of the welfare regime in Australia. So, for the purposes of this report, the next chapter analyses several suitable programs that are already in place in Australia. It also assesses their evidence base against outcomes such as improved parenting, school attendance, child health and wellbeing, financial harassment and management, and alcohol and drug misuse. It is important to note that no single programme, being CCT, UCT or Basic Income, is likely to address the multitude of issues IM was designed to achieve.

Overall, the conclusion of this part of the review strongly indicates that the behaviours which IM is aimed at changing are complex, long standing and arising from a range of different personal, family and community factors as well as a history of policy failure. CCTs and UCTs are promising programs which could be rigorously tested in Australia. Unlike IM and depending on the design of the conditions⁹, CCTs and UCTs do not affect the human rights of participants or others impacted by the program. Therefore, even if their effects are limited, the unintended negative consequences are likely to be far fewer than those created by IM.

⁹ Conditionalities could be designed within a human-rights framework and in a non-punitive way. Conversely, conditionalities could also be designed in a neoliberal framework of the ‘deserving poor’, being punitive and strictly enforced. The former approaches CCTs to UCTs making the conditionality aspect more of a ‘reminder’ of the program objective.

Chapter 5. Review of parenting programs in Australia

5.1 Effectiveness of parenting programs

This review of the evidence sought to identify interventions that may be suitable alternatives to income management. Findings were derived from two sources:

1. An update of a previous international Rapid Evidence Assessment undertaken by the Parenting Research Centre (PRC) in early 2015 (Parenting Research Centre 2015).
2. A search for interventions specifically evaluated with Aboriginal and Torres Strait Islander families via the following sources:
 - a. two Australian evidence-based clearinghouses
 - b. a scoping review of parenting interventions for Indigenous parents (Macvean *et al.* 2015)
 - c. the outcomes evaluation of Keep Them Safe (Cassells *et al.* 2014).

These sources and procedures are described below.

An update of a previous review undertaken by the Parenting Research Centre

In May of 2015, the PRC undertook a rapid evidence assessment (REA) of interventions for vulnerable families, parents and children (Parenting Research Centre 2015)¹⁰. The methodology in this REA involved an extensive search of four established, highly used and credible international web-based clearinghouses for interventions of relevance to families, parents, children and young people experiencing a wide range of concerns, such as substance misuse, child maltreatment, mental health problems, and domestic and family violence, that may make them vulnerable for poor outcomes. Additional relevant interventions that had been previously identified in other recent REAs by the PRC were also added to this review. Refer to box 1 for details.

Box 1: International clearinghouses and PRC rapid evidence assessments used to identify interventions

International clearinghouses

California Evidence-Based Clearinghouse (CEBC) (<http://www.cebc4cw.org/>)

¹⁰ The initial REA that was updated for the purpose of the current report was funded by the New South Wales Department of Family and Community Services.

National Center for Community-Based Child Abuse Prevention
(<http://friendsnrc.org/cbcap-priority-areas/evidence-base-practice-in-cbcap/evidence-based-program-directory>)

Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Evidence-Based Programs and Practices
(<http://www.samhsa.gov/nrepp>)

Blueprints for Violence Prevention
(<http://www.blueprintsprograms.com/allPrograms.php>)

PRC rapid evidence assessments (available here <http://www.parentingrc.org.au>)

1. (Australian Centre for Posttraumatic Mental Health and Parenting Research Centre 2013)
2. (Macvean *et al.* 2015)
3. (Shlonsky *et al.* 2013)

The evidence arising from the four clearinghouses and the past PRC REAs were combined and a single rigorous rating scheme developed by the PRC (refer to Figure 1) was applied across all interventions. This enabled the identification of interventions that could be more confidently considered effective for improving parent and child outcomes. An outcome domain framework was also used in this REA (adapted from our previous work, see Box 2) and this framework is included in the current review on alternatives to income management.

The review by PRC (Parenting Research Centre 2015) rated 45 interventions as emerging or higher. These interventions were considered to be the most effective out of all the relevant interventions identified on the clearinghouses, because they showed significant benefit in at least one randomised controlled trial (RCT) and this benefit was still present at least six months after the conclusion of the intervention. Interventions with ratings below the level of emerging were not considered in the previous review because the funder was seeking evidence for effective interventions.

In the current review on alternatives to income management, these 45 interventions were assessed for relevance and suitability, based on the following criteria:

Inclusion criteria:

- Interventions for parents and families
- Interventions either available in Australia or dissemination ready (see below for explanation of dissemination readiness).

Exclusion criteria:

- Interventions only delivered to children and young people (out of scope according to Aboriginal Affairs)
- Interventions specifically targeting children exposed to sexual abuse (out of scope according to Aboriginal Affairs)
- Interventions that do not appear to be available in Australia and do not appear to be dissemination ready (deemed to be unsuitable to recommend for use in Australia at the moment).

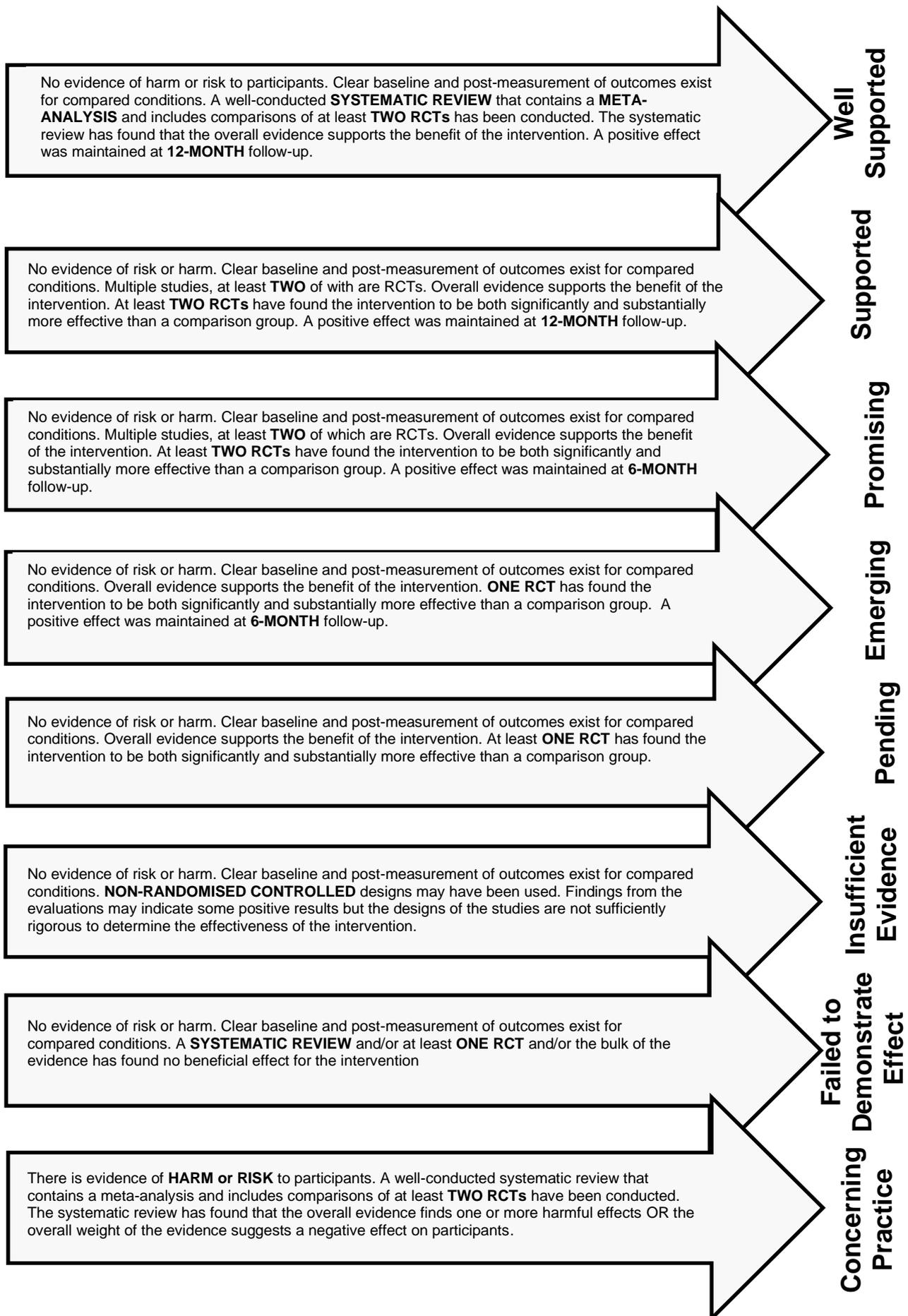
In order to determine if these interventions would be suitable options for use as alternatives to income management in the Australian context, we sought information regarding use in Australia and dissemination readiness from clearinghouses, intervention developer websites and from colleagues working in the NSW context.

Dissemination readiness refers to whether the intervention has sufficient materials and supports available so that it could be packaged and implemented in Australia. Clearinghouses such as California Evidence-Based Clearinghouse (CEBC), Blueprints and Substance Abuse and Mental Health Services Administration (SAMHSA) have useful information about dissemination or implementation readiness. The types of factors they consider when reporting dissemination readiness include: if there is a manual, if there is implementation support available, and if there are fidelity measures available to ensure the intervention is implemented as intended. Interventions identified in PRC (Parenting Research Centre 2015) that were ***not available in Australia and did not appear to be dissemination ready, were not included in the current review.***

If interventions identified in PRC (2015) met the above criteria, the clearinghouses were checked to determine if any of the interventions had been re-evaluated since the earlier search. If needed, the interventions were then rerated using the scale in Figure 1.

Further to this, clearinghouses, developer websites and colleagues were consulted to determine if the interventions had been used with any Indigenous populations, in particular Aboriginal and Torres Strait Islander families. **Although not clear from all of these sources, it is probable that more of the interventions reported here have been used and evaluated with Indigenous families.**

Figure 1: Rating scale used to categorise the effectiveness of the interventions



Box 2: Outcomes framework used in PRC (2015) to identify outcome domains targeted by interventions (adapted from (Macvean *et al.* 2013) and (Wade *et al.* 2012)

Child development: normative standards for growth and development; antenatal and infant development (e.g. antenatal and parental smoking and mother's alcohol/drug use, foetal and early childhood exposure to trauma or abuse, birth weight, breastfeeding, immunisation); covers prenatal through to 6 years; overall health; temperament; language and cognitive development (e.g. early childhood brain development, pre-academic skills, approaches to learning, successful in reading, writing, literacy and numeracy, problem-solving and decision-making skills, completion of secondary education, academic achievement, school engagement, attachment and retention, truancy, absenteeism); child adaptive behaviour (e.g. self-care skills, motor skills); parent promotion of child health and development; parent knowledge of child development.

Child behaviour: includes both internalising and externalising behaviour difficulties; problem behaviour; consistent parenting; child behaviour management; positive child behaviour and pro-social behaviour; social and emotional development (e.g. mental health, identity, social competence, self-control, self-esteem, self-efficacy, emotional management and expression, trauma symptoms, coping, emotional intelligence); law-abiding behaviour and underage convictions (particularly for adolescents); risk avoidance and risky behaviour (e.g. youth pregnancy, youth suicide, youth smoking, substance use).

Safety and physical wellbeing: includes optimal physical health and healthy lifestyle (e.g. adequate nutrition, free from preventable disease, sun protection, healthy teeth and gums, healthy weight, free from asthma, adequate exercise and physical activity, healthy adult/parent lifestyle); safety (e.g. safe from injury and harm); stability, material wellbeing and economic security (e.g. ability to pay for essentials, adequate family housing, family income and family social capital); effects of long-term exposure to persistent poverty; basic child care, for example, bathing, putting baby to bed, clothing, food and nutrition, child self-care, avoidance of neglect

Child maltreatment prevention: includes prevention of all forms of abuse as well as neglect, reduction of maltreatment, prevention of re-occurrence of maltreatment.

Family functioning: includes parent-child interactions (e.g. positive interactions between parents and children, emotional warmth and responsiveness, absence of hostility); consistency and reliability (e.g. children able to rely on supportive adults, providing guidance, providing adequate boundaries); attachment; stimulating learning and development; the parental relationship and relationships between other family members (e.g. child free from exposure to conflict or family violence, positive family functioning, stability in relationships, connection to primary caregiver, connection to family); good parental mental health.

Support networks: includes social relationships and social support (e.g. connection to school and friends, connection to community, connection to culture), family's community participation; community resources.

Systems outcomes: notification and re-notification to agencies, maltreatment investigations and re-investigation, verified maltreatment investigations and re-investigations, referrals to agencies, presentation to emergency department, help-seeking behaviour, out-of-home care, length of stay, placement stability, maltreatment in care, placement with family, placement in community, placement with siblings, frequency, duration, and quality of parent visitation, level of restrictiveness of care, family reunification/restoration, adoption, re-entry to care, service utilisation, foster parent recruitment and retention, utilisation of kinship care.

A search for interventions evaluated with Aboriginal and Torres Strait Islander families

Several sources were searched for relevant interventions that had been evaluated with Aboriginal and Torres Strait Islander families, as described below. For consistency, any relevant interventions identified via these sources were rated using the same scale as Figure 1. Studies identified via these sources were included if they were evaluations of parenting or family support and community interventions. We sought interventions that targeted ways for parents and families to support the health, wellbeing and educational involvement of their children. Studies reporting the impact of the intervention on at least one of the following outcomes were included:

- Improved parenting
- School attendance
- Child health and wellbeing
- Financial harassment
- Financial management
- Alcohol and drug misuse

Interventions in schools were in scope as long as there was parental involvement. We also included domestic and family violence interventions if child outcomes were reported. Papers reporting only descriptions of interventions, case studies, only satisfaction or cultural acceptability findings were excluded. Evaluations of income management as a sole intervention were not considered.

Two Australian evidence-based clearinghouses

Two Australian evidence-based clearinghouses were investigated to identify relevant interventions that have specifically been evaluated with Aboriginal and Torres Strait Islander families. These databases do not rate or assess studies or have any rigorous inclusion criteria, as used in the clearinghouses that were sourced in PRC (Parenting Research Centre 2015).

1. Australian Institute of Family Studies, Child Family Community Australia (CFCA) publications <https://aifs.gov.au/cfca/publications>

CFCA publications were searched under the headings 'Evaluations' and Indigenous families'

2. Australian Institute of Health and Welfare, Closing the Gap Clearinghouse publications <http://www.aihw.gov.au/closingthegap/publications/>

Closing the Gap publications were searched by selecting the option 'assessed collection' so that only evaluations were identified.

For both of the Australian clearinghouses, titles and abstracts were screened to determine if they related to evaluations of interventions with Aboriginal families. The full text of potentially relevant studies were read to confirm inclusion in this review.

A scoping review of parenting interventions for Indigenous parents

A scoping review conducted by Macvean *et al.* (2015), which used a systematic methodology to identify parenting interventions for Indigenous parents, was checked for additional relevant programs that have been evaluated in Australia.

The Keep Them Safe (KTS) outcomes evaluation

The Keep Them Safe (KTS) initiative was introduced in 2009 in response to recommendations arising from the *Special Commission of Inquiry into Child Protection in NSW*. In 2014, this initiative was evaluated for the NSW Department of Premier and Cabinet (Cassells *et al.* 2014). Several of the interventions under KTS involved Aboriginal and Torres Strait Islander families. This review utilised the KTS outcomes evaluation to identify relevant interventions that have been evaluated with Aboriginal families. We drew on information from the synthesis of evaluations (http://www.keepthemsafe.nsw.gov.au/_data/assets/pdf_file/0003/166287/KTS_Anex_F_Synthesis_of_Evaluations_Final_Report.pdf) and used the same selection criteria to determine which interventions would be included here. **It is highly likely that additional interventions involved Aboriginal families; however, we have only included ones that reported involvement of Aboriginal families.**

5.2 Results

The search for suitable alternative interventions for families on income management identified 46 possible options. Twenty-eight of these interventions were identified through our previous REAs, and 18 via the searches of Closing the Gap and Australian Institute of Family Studies, Child Family Community Australia (CFCA), the examination of the scoping review by Macvean *et al.* (2015) and the KTS outcomes evaluation.

The following section provides descriptions of all 48 interventions. Interventions identified via PRC (2015) are described first, starting with the 13 that have been used in Australia. These are followed by 15 interventions that do not appear to have been implemented in Australia but are dissemination ready. Next are the 18 interventions which have been evaluated with Aboriginal and Torres Strait Islander families. All of these interventions are summarised in tables in Appendix D, Table 4, Table 5 and Table 6, respectively.

5.3 Interventions identified in previous reviews - in use in Australia

Interventions that have been evaluated rigorously and have been found to be effective for improving child, parent or family outcomes are described below. All of these interventions are in use in Australia.

Nurse Family Partnership

Rating – Well Supported

Nurse Family Partnership is a home visiting intervention for low-income or adolescent first time mothers. The intervention commences during the second trimester and continues until the child is two years old. The intervention targets all of the outcomes in the outcomes framework (refer to Box 2) and is delivered by trained and qualified nurses.

In addition to providing education to parents regarding health behaviour, caring for children and family planning, the home-visiting nurses link parents to services and housing, income and nutritional assistance, and help them to access vocational training and child care. Individualised service plans are developed in collaboration with the parents, and parents are provided with problem solving skills and praise. Sessions are structured and last for approximately one to 1.5 hours, with a total of 20 – 30 sessions over the course of the intervention, which goes for approximately 2.5 years.

A study conducted by the Nurse Family Partnership developer (Olds *et al.* 2002) compared the effectiveness of Nurse Family Partnership delivered by

paraprofessionals to the usual nurse-delivered method, and also to a control group. Findings up to two years after the completion of the intervention suggest that the families in the nurse-delivered group had significantly better outcomes than in the other two groups. These results indicate that delivery of NFP by a nurse is preferable to paraprofessional delivery.

Nurse Family Partnership is currently in use in Australia and also specifically used with Aboriginal and Torres Strait Islander families. This intervention has an Aboriginal community worker available to support families.

Attachment and Biobehavioral Catch-up

Rating - Supported

Attachment and Biobehavioral Catch-up is an attachment-based intervention that helps caregivers provide nurturing care to children aged 6 months to 2 years old who have experienced adversity due to maltreatment or disruptions in care. The intervention targets child behaviour, child maltreatment prevention and family functioning.

Attachment and Biobehavioral Catch-up is a manualised intervention, with ten weekly sessions of one hour, delivered by coaches in the home. Coaches are screened, trained over 2-3 days, and supervised for a year. The following are involved in Attachment and Biobehavioral Catch-up: (1) caregiver is coached to provide a nurturing response to child behaviour which pushes them away, overriding tendencies to respond in kind; (2) caregiver is coached to provide an environment which assists the child's self-regulatory capacity; and (3) caregiver is assisted to decrease any of their own behaviour which may frighten or overwhelm the child.

Attachment and Biobehavioral Catch-up is available in Australia and has in America Alaska been used with Native American and Alaska Native families.

The Incredible Years

Rating - Supported

Incredible Years is designed to prevent, reduce and treat emotional and behavioural problems in children aged 4 to 8 years. The intervention targets youth offending and delinquency and is delivered by Master's level (or equivalent) clinicians in a variety of different settings, including birth family home, community daily living settings, community agency, foster/kinship care, outpatient clinic, hospital, paediatric primary care setting, religious organisation, school or the workplace. The intervention targets child development, child behaviour, family functioning and support networks. The intervention includes parent, teacher and child programs that can be used separately or together. The parent and child programs consist of one two-hour session per week; the classroom program consists of 60 sessions offered 2-3 times

a week, and the teacher program is offered in 5-6 full day workshops or 18-21 two hour sessions.

Incredible Years includes three programs, namely the BASIC Parent Training Program, the ADVANCE Parent Training Program and the Child Training Program. The BASIC program is for parents of high-risk children and parents of children with behaviour problems. The program targets the following skills: building strong relationships with children, providing praise and incentives, building social and academic competency, setting limits and establishing household rules as well as handling misbehaviour. The ADVANCE program targets interpersonal skills such as communicating effectively with children and others; handling stress, anger and depression; problem solving between adults; helping children to problem solve, and providing and receiving support. The child training program aims to improve social competency and decrease conduct related problems. For this program, training occurs in emotion management, social skills, problem solving and classroom behaviour.

Incredible Years is available in Australia and has been used with Aboriginal and Torres Strait Islander families and in New Zealand with Maori and Pacific Islander families. In NSW, Incredible Years has been used within the Wesley Mission and Burnside Uniting Care Brighter Futures program with Aboriginal families.

Multisystemic Therapy (MST)

Rating - Supported

Multisystemic Therapy (MST) is for delinquent and antisocial youth aged 12 to 17 years who are at imminent risk of out-of-home placement due to serious offenses, who are physically and verbally aggressive and/or have substance misuse issues. The intervention is delivered in community and home based settings with the aim of reducing youth criminal behaviour and out-of-home placements. MST targets child behaviour, family functioning, support networks and systems outcomes.

MST sessions are delivered by therapists with a Master's degree and typically occur from three times a week to daily with the intensity of services depending on the needs of the family. The recommended duration of the intervention is 3 to 5 months with session length varying from 50 minutes to 2 hours. Contents of the intervention include: incorporation of treatment approaches to address a range of peer, family, school and community risk factors, empowering caregivers and promoting youth behaviour change in addition to the inclusion of quality assurance protocols to ensure treatment fidelity and positive intervention outcomes.

MST is available in Australia and has been evaluated with Aboriginal and Torres Strait Islander families, Native American and Alaska Native, and Maori and Pacific Islander families. In NSW, MST is currently in use in Juvenile Justice (Sydney and Newcastle). There is an evaluation in progress with the NSW Bureau of Crime

Statistics and Research, and a qualitative evaluation is also being undertaken with the **University of Western Sydney**. Both of these NSW sites are also running a variation of MST, MST-SA (substance abuse). Here, MST is mostly in use with Aboriginal and Culturally and Linguistically Diverse families.

Parent-Child Interaction Therapy

Rating - Supported

Parent-Child Interaction Therapy is an intervention for children aged between 2 and 7 years, where there are parent-child relationship problems (including maltreating behaviours or risk of maltreating behaviours) and child behaviour problems. The target outcomes of this intervention are child behaviour and development, and family functioning.

Parent-Child Interaction Therapy teaches parents skills that they can use as social reinforcers of positive child behaviour, and behaviour management skills to decrease negative behaviour. Parents work with therapist coaches to master the two aspects of Parent-Child Interaction Therapy: (1) child directed interaction, where the parent learns to give positive attention to the child following positive/non-negative behaviour while ignoring negative behaviour; (2) parent directed interaction, where the parent learns to lead the child's behaviour effectively.

Parents are observed via a one-way mirror and coached via wireless communications by a therapist at each treatment session, which is typically held in a community agency or outpatient clinic. Parents have one or two 1-hour sessions with the therapist each week, for 10-20 sessions. Sessions continue until each element is mastered and the child's behaviour has improved to criterion. Parents complete homework between sessions to consolidate skills learned at sessions. Therapists are required to have completed graduate clinical training to master's level, and be licensed as a mental health care provider.

Parent-Child Interaction Therapy is available in Australia. It has been used with Native American and Alaska Native families.

SafeCare

Rating - Supported

SafeCare is an intervention that targets parents of children aged 0 to 5 years who are at-risk of or who have a history of child abuse or neglect. The outcomes targeted by this intervention are family functioning, child behaviour and development, child safety and physical wellbeing, and maltreatment prevention.

SafeCare is a home visiting intervention, with weekly sessions of 1.5 hours' duration running for 18-20 weeks. Sessions are conducted by trained staff, preferably with

TAFE education as minimum. Parents are taught to interact positively with their children (planning activities and responding appropriately to challenging behaviour), to recognise and prevent hazards in the home, and to recognise and respond appropriately to symptoms of illness or injury in the child.

SafeCare involves: (1) planned activities, assessment and training (covering time management, explaining rules to children, rewarding behaviour, incidental teaching, discussing outcomes and expectations with child); (2) home safety assessment and training (identifying and removing hazards); and (3) infant and child health care assessment and training (including problem solving training where needed). Training uses modelling, role rehearsal, and set performance criteria, with booster training if performance falls below criteria. Staff are monitored for fidelity to the intervention model.

SafeCare is available in Australia and is in use with Aboriginal and Torres Strait Islander families. There is good evidence with Native American and Alaska Native families.

Triple P

Rating – varying levels of evidence depending on variation of the program. In general, the intervention is considered Supported.

Triple P - Positive Parenting Program - is a multi-tiered, 5-level system of parenting education and support for parents of children aged from 0 to 16 years. The evidence for the different levels of Triple P ranges from Emerging to Supported. In general, Triple P targets child behaviour and family functioning.

"Developed for use with families from many cultural groups, Triple P is designed to prevent social, emotional, behavioural, and developmental problems in children by enhancing their parents' knowledge, skills, and confidence. The program, which can also be used for early intervention and treatment, is founded on social learning theory and draws on cognitive, developmental, and public health theories. Triple P has five intervention levels of increasing intensity to meet each family's specific needs. Each level includes and builds upon strategies used at previous levels:

- Level 1 (Universal Triple P) is a media-based information strategy designed to increase community awareness of parenting resources, encourage parents to participate in programs, and communicate solutions to common behavioral and developmental concerns.
- Level 2 (Selected Triple P) provides specific advice on how to solve common child developmental issues (e.g., toilet training) and minor child behavior problems (e.g., bedtime problems). Included are parenting tip sheets and videotapes that demonstrate specific parenting strategies. Level 2 is

delivered mainly through one or two brief face-to-face 20-minute consultations.

- Level 3 (Primary Care Triple P) targets children with mild to moderate behavior difficulties (e.g., tantrums, fighting with siblings) and includes active skills training that combines advice with rehearsal and self-evaluation to teach parents how to manage these behaviors. Level 3 is delivered through brief and flexible consultation, typically in the form of four 20-minute sessions.
- Level 4 (Standard Triple P and Group Triple P), an intensive strategy for parents of children with more severe behavior difficulties (e.g., aggressive or oppositional behavior), is designed to teach positive parenting skills and their application to a range of target behaviors, settings, and children. Level 4 is delivered in 10 individual or 8 group sessions totaling about 10 hours.
- Level 5 (Enhanced Triple P) is an enhanced behavioral family strategy for families in which parenting difficulties are complicated by other sources of family distress (e.g., relationship conflict, parental depression or high levels of stress). Program modules include practice sessions to enhance parenting skills, mood management strategies, stress coping skills, and partner support skills. Enhanced Triple P extends Standard Triple P by adding three to five sessions tailored to the needs of the family.

Variations of some Triple P levels are available for parents of young children with developmental disabilities (Stepping Stones Triple P) and for parents who have abused (Pathways Triple P).” (SAMHSA, http://nrepp.samhsa.gov/01_landing.aspx). Two relevant variations of Triple P are described below.

Group Triple P for Indigenous families (Turner *et al.* 2007)– sourced from Closing the Gap Clearinghouse)

Rating – Emerging

Indigenous Triple P is a culturally sensitive adaptation of the Triple P Positive Parenting Program. Through workshop style group sessions, the intervention teaches 17 positive child management strategies to help parents promote child development and manage child behaviour. Groups have 10 to 12 parents and the program runs for 8 sessions: one introduction session, four parent training sessions, two home consultations and one closing session. This intervention targets child development, child behaviour and family functioning.

In the Indigenous adaptation of the program, modifications are made to the content, structure, delivery and language of the program to appropriately reflect the socio-political context and to incorporate more traditional ways of learning and group sharing. The program was evaluated with Aboriginal families in four community

health centres in Queensland, using a randomised, repeated measures design with a group comparison (wait list control group). Participants were tested at baseline, post intervention and at a 6-month follow up.

Parents attending Indigenous Group Triple P reported significantly lower rates of child behaviour in comparison to the wait list control group. In the intervention group, child behaviour ratings significantly dropped from the clinical to the non-clinical range. Parents in the intervention group also reported a significant decrease in the use of dysfunctional parenting strategies. All intervention gains were maintained at the 6-month follow up period.

Triple P Standard and Enhanced Group Behavioural Family Interventions

Rating - Emerging

One of PRC's past REAs identified studies in which two versions of Triple P had been tested with families and these may be of interest in this review. Evidence for these is presented here.

The Triple P Positive Parenting Programs—Standard and Enhanced Group Behavioural Family Interventions (Triple P)- target children in families where there is a history of maltreatment. Two interventions are reported here, targeting two populations: (1) children with a mean age of 4 years; (2) children with a mean age of 3 years AND parents with mental illness and concerns about child behaviour. There are standard and enhanced interventions for both of these populations. Triple P target outcomes for these populations are: prevention of maltreatment (future maltreatment if this has already occurred), family functioning, child development and behaviour.

Components for and session details for the target population (1) are:

- Standard: Strategies for promoting the child's competence and for managing misbehaviour, planning for situations at high risk for difficult child behaviour and planned activities training. Four weekly group sessions in the community and four individual telephone calls.
- Enhanced: As above, plus cognitive reframing for parents' negative attributions to child behaviour and anger management strategies. Sessions as above, plus four additional group sessions.

Components and session details for target population (2) are:

- Standard: Strategies for promoting the child's competence and for managing misbehaviour, planning for situations at high risk for difficult child behaviour and planned activities training. Ten weekly individual sessions, half at home and half delivered in a clinic.

- Enhanced: As above, plus partner support for couples, coping skills for couples, and social support for single parents. Twelve individual sessions, half at home and half delivered in a clinic.

The intervention is delivered in the community for population (1) and divided between clinic and home for population (2). The intervention may be delivered by any relevant qualified professional.

Triple P is widely available in Australia. It has been used with various Indigenous populations, including Aboriginal and Torres Strait Islander families.

Child FIRST

Rating - Emerging

The Child FIRST intervention targets children aged between 6 months and 3 years with emotional and behavioural problems where parent psychosocial factors/mental illness put the child at risk of maltreatment. The outcomes targeted by Child FIRST are: child development and behaviour, safety and physical wellbeing, prevention of maltreatment, family functioning and systems outcomes. The intervention is delivered in the home, in 24 weekly sessions.

Child FIRST intervention components are: assessment of child and family; individualised plan; linkage to other services; consideration of family priorities, culture, strengths, and needs; collaboration with family; home visits as guided by parental needs; observation of child's cognitive, emotional, and physical development and of parent-child interactions; psychoeducation; reflective process to understand child's feelings and meaning of the child's challenging behaviours; psychodynamic understanding of maternal history, feelings, and experience of child; alternative perspectives on child behaviour; development of new parental responses; and positive reinforcement of parent and child strengths.

Child FIRST is an Australian initiative and is in use with Aboriginal and Torres Strait Islander families.

Clinician-Based Cognitive Psychoeducational Intervention for Families (Family Talk)

Rating - Emerging

Clinician-Based Cognitive Psychoeducational Intervention for Families (Family Talk) is an intervention for families where a parent has a significant mood disorder and children are aged between 6 and 17 years. The outcomes targeted in Family Talk are: child behaviour, support networks and family functioning.

Family Talk involves: (1) family member assessments, (2) education about risks and resilience in children and affective disorders, (3) linking information to the family experience, (4) reducing children's feelings of blame and guilt, and (5) helping children develop relationships within the family and outside the family.

The intervention takes place in the home and in outpatient and community settings. Sessions for 6-11 modules are held with parents alone and with the whole family. Refresher meetings and telephone contacts continue at 6- to 9-month intervals.

Family Talk is delivered by trained psychologists, social workers, and nurses, following an implementation manual.

Family Talk has been used in Australia but it does not appear to have been used with any Indigenous populations.

Home Instruction for Parents of Preschool Youngsters (HIPPY)

Rating - Emerging

Home Instruction for Parents of Preschool Youngsters is a home-based intervention for parents with children aged up to five years in families with little resources or education, or for teenage parents. The target outcomes are child development and child behaviour. The intervention is delivered by staff with training but no particular qualifications. The minimum duration of the home visits is 30 weeks, and up to 3 years, with each session lasting about one hour. The primary purpose is to ensure school readiness, and resources are provided to assist with the child's education needs, but also their socio-emotional and physical needs. HIPPY uses a curriculum to engage parents and encourage parent and child interaction in educational activities.

HIPPY is widely available in Australia and currently in use within several Aboriginal and Torres Strait Islander communities.

Homebuilders

Rating - Emerging

Homebuilders is an intensive family preservation service that is delivered in various settings, such as the home and community, to children at risk of out-of-home placement into foster care, juvenile justice facilities, group care or psychiatric hospitals. The service is for children and young people from birth to 18 years and it targets child behaviour, child development, family functioning, child maltreatment prevention, support networks and systems outcomes.

This service is delivered by qualified, experienced and trained psychologists, social workers and counsellors. Recommended intervention is three to five 2-hour face-to-face sessions per week, plus telephone contact. This intervention lasts for four to six

weeks, with booster sessions available in the following six months. Homebuilders works to engage and motivate families, uses assessment and goal setting and cognitive and behavioural practices designed to change behaviour. Parents and children are provided with skill development opportunities, as well as concrete services as required. Homebuilders provides 24/7 crisis assistance and is flexible and individually tailored.

Homebuilders is in use in Australia, including with Aboriginal and Torres Strait Islander families. In NSW, Homebuilders is in use in South West Sydney and on the Mid North Coast (Taree, Port Macquarie, Kempsey, Coffs Harbour) within Burnside Uniting Care.

Multisystemic Therapy for Child Abuse and Neglect MST-CAN)

Rating - Emerging

Multisystemic Therapy for Child Abuse and Neglect targets children aged 6 to 17 years who have been exposed to or who are at risk of maltreatment. It is delivered to all family members, in the home and community, and targets child development, safety and physical wellbeing, child behaviour, maltreatment prevention, family functioning and systems outcomes.

MST-CAN is delivered by teams, including counsellors or social workers, a psychiatrist, a crisis caseworker and a supervisor qualified in counselling or social work. The objective is to prevent re-abuse and out-of-home placement. Problem solving, family communication, anger management, Post-Traumatic Stress Disorder and issues of abuse and neglect are the focus of the therapy. Intensive services are provided at least three times a week, but where needed also on a daily basis. Services are available around the clock. Sessions last between 50 minutes to two hours, with a total service duration of 6 – 9 months.

MST-CAN is dissemination ready. It has been used in Australia, but reportedly only in one trial to date. It does not appear to have been used with Aboriginal and Torres Strait Islander families or Indigenous populations in other countries.

Parents Under Pressure

Rating - Emerging

Parents Under Pressure is for families of children aged 2 to 8 years in which there is a parent with substance misuse problems. It targets child behaviour, safety and physical wellbeing, maltreatment prevention, family functioning and support networks. Parents Under Pressure is delivered in the home by a trained Parents Under Pressure therapist in 10 weekly sessions.

Parents Under Pressure commences with an assessment and plan development. Content focuses on strengthening parenting skills that are positive and non-punitive; life skills including budgeting, health care and exercise; and family relationships. Management of substance abuse relapse is also covered in the intervention.

Parents Under Pressure is an Australian program and has been used with Aboriginal and Torres Strait Islander families.

Key points

This section has identified interventions of high relevance to families who may be eligible for income management in Australia. Some of the concerns that may make families eligible for participation in the interventions described above include:

- families having little resources or education
- being a new or adolescent parent
- children experiencing maltreatment or parents at risk of maltreating behaviour or neglecting their children
- families experiencing issues of mental illness or substance misuse
- families experiencing difficult child behaviour or conduct, or young people being involved with juvenile justice
- parents and children having problems in their relationship.

The interventions in this section have covered a range of child ages, from antenatal through to adolescents. All have been used in Australia and all have demonstrated some benefits for families, children or young people through rigorous research. Several of these interventions have been used with Aboriginal and Torres Strait Islander families or other Indigenous populations.

5.4 Interventions identified in previous review - dissemination ready

The following interventions have been evaluated in rigorous studies and have been found to have some benefit on child, parent or family outcomes. They do not appear to be available in Australia at present; however, they are dissemination ready.

Trauma-Focused Cognitive Behavioural Therapy

Rating - Well Supported

Trauma-Focused Cognitive Behavioural Therapy is an intervention for children aged between 3 and 18 years and their parents, where the child has been exposed to some form of trauma, including maltreatment or trauma associated with domestic violence. Children participating in Trauma-Focused Cognitive Behavioural Therapy have been identified as experiencing significant Post-Traumatic Stress Disorder (PTSD) or symptoms of PTSD arising from the trauma. They may also be experiencing depression, anxiety and shame as a result of the trauma. Trauma-Focused Cognitive Behavioural Therapy targets child behaviour, family functioning, child development, safety and physical wellbeing, and support networks.

The intervention is typically delivered by trained psychologists or social workers in a clinical setting, although other settings including the home have also been utilised. The intervention is delivered in eight to 16 sessions lasting 30 – 45 minutes each. Content of the intervention includes: psychoeducation and parenting skills, relaxation, affective expression, coping, trauma narrative and processing, in vivo exposure, and personal safety and future growth.

Trauma-Focused Cognitive Behavioural Therapy is a widely researched intervention suitable for families with children who are experiencing serious psychological symptoms. While much of the research has been with children exposed to sexual abuse or to various traumatic events such as war, natural disaster or community violence, the key to the intervention is the presence of psychological **sequela (such as PSTD)** rather than the source of the trauma.

Trauma-Focused Cognitive Behavioural Therapy is dissemination ready and has been used with Native American and Alaska Native families.

Coping Power

Rating - Supported

Coping Power is an intervention for children aged 5 to 11 at risk of substance abuse and their parents. Its target outcomes are child development and behaviour, family functioning and support networks.

The intervention has a version for parents and at-risk children, a universal version for parents and children aimed at middle school transitions, and a stand-alone universal version for children only. The version for at-risk families covers: (1) for children: problem-solving and conflict management techniques, coping mechanisms, social skill development and positive social support; and (2) for parents: stress management, disruptive behaviour identification, effective discipline and communication structures, and management of child behaviour outside the home. The universal version cover home-school involvement, concerns about transition to middle school, and predictors of substance use, adapted for parents and children as appropriate.

Coping Power is a 16-month intervention delivered in schools. Children attend 22 group sessions in 5th grade and 12 group sessions in 6th grade. Groups are of 5-8 children meeting for 40-50 minutes. Children receive a half-hour individual session once every two months. Groups of 12 parents attend 16 sessions in their child's 5th grade year and 5 sessions during 6th grade.

Coping Power is delivered by a school-family program specialist and a guidance counsellor using workbooks and other materials.

Coping Power is dissemination ready and has been used with Native American and Alaska Native families.

DARE To Be You

Rating - Supported

DARE To Be You is an intervention that targets families where children aged 2 to 5 years are at high risk of future substance abuse (due to, for example, parent substance abuse or parent mental illness). DARE To Be You is designed to improve the aspects of parenting associated with children's resilience, and lower children's risk of potential future substance abuse and other high-risk activities.

The target outcomes of DARE To Be You are: child development and behaviour, family functioning and support networks. DARE To Be You workshops focus on: developing parental sense of competence and satisfaction with their role as parents, increasing parents' internal locus of control, enhancing decision-making skills, mastering effective child-rearing strategies, learning stress management and developmental norms (to reduce frustrations with child behaviour and increase empathy), and strengthening of peer support.

Workshop sessions of 2.5 hours run over 10-12 weeks. Each session includes a 10-30-minute joint practice session for parents and children. Annual reinforcement workshops (four 2-hour sessions) are available to consolidate skills and foster supportive networks. DARE To Be You workshops are delivered by multiagency community teams.

DARE To Be You is dissemination ready and has been used with Native American and Alaska Native families.

Early Risers "Skills for Success"

Rating - Supported

Early Risers "Skills for Success" is for children aged 6 to 12 years who are at risk of conduct problems, such as substance misuse. The intervention targets child behaviour, family functioning, support networks and systems outcomes. It is delivered to children in the school setting and in camps, and to parents in the school

or at a community location. Information about number and duration of sessions is not indicated.

Early Risers is delivered by personnel with qualifications and experience in child or family education. Children are provided with training in social-emotional skills development, reading, motivation, problem solving and peer relationships. Academic skills are also supported and home-school communication is facilitated. Parents receive parenting education and support to address their individual concerns. Individual plans are development and goal setting. Referral to services is provided as needed.

Early Risers is dissemination ready. It does not appear to have been used with any Indigenous families.

Functional Family Therapy

Rating - Supported

Functional Family Therapy targets youth aged 11 to 18 years with serious problem behaviours, including conduct disorder, violent acting-out, youth offending and delinquency as well as substance misuse. Delivered by therapists in a range of settings (i.e. birth family home, adoptive home, community agency, foster/kinship care and school) the intervention targets child behaviour, family functioning, support networks and systems outcomes.

Functional Family Therapy consists of four phases each targeting unique goals, assessment focus and therapist skills and risk and protective factors. The four phases are: 1) Engagement, which aims to increase the families' initial expectation of position change; 2) Motivation, which aims to produce a motivational context for long-term care; 3) Behaviour Change, which has the goal of facilitating individual and interactive/relational change; and 4) Generalisation, which aims to maintain change at individual and family levels as well as facilitate change in multiple systems. Functional Family Therapy is delivered over 8 to 12 one hour sessions for mild cases, and up to 30 sessions for more severe cases. Sessions typically occur weekly over 3-4 months, but frequency can be increased if needed.

Functional Family Therapy is dissemination ready. It has been used with Native American and Alaska Native families and also ***in New Zealand with Maori and Pacific Islander families.***

Multidimensional Family Therapy

Rating - Supported

Multidimensional Family Therapy targets adolescents aged 11 to 18 years with substance misuse, delinquency, and related behavioural and emotional problems.

Multidimensional Family Therapy consists of four domains: the adolescent domain, the parent domain, the family domain and the community domain. The intervention aims to improve parenting practices, family problem solving skills, parent teamwork, parent and adolescent functioning, as well as adolescent communication, emotional regulation and coping skills. Multidimensional Family Therapy targets child development, child behaviour, family functioning, support networks and systems outcomes.

Multidimensional Family Therapy is delivered by therapists with a Master's level degree in counselling, family therapy, mental health, social work or another related field. It is delivered in home and community settings over 3-4 months for at risk and early intervention families, and 5-6 months for youth with more serious problems. With regards to the intensity of the intervention, at risk youth and early intervention youth typically receive 1-2 sessions a week while youth with more severe problems receive 1-3 sessions a week. Sessions last between 45-90 minutes for all cases and frequency of sessions slowly decline during the last 4-6 weeks of treatment. Contents of Multidimensional Family Therapy include: a mix of youth, family and parent sessions, face-to-face sessions, telephone calls and community sessions with the school or child welfare.

Multidimensional Family Therapy is dissemination ready. It does not appear to have been used with any Indigenous families.

Multisystemic Therapy for Youth with Problem Sexual Behaviours (MST-PSB)

Rating - Supported

Multisystemic Therapy for Youth with Problem Sexual Behaviours (MST-PSB) is an intervention for adolescents aged 13 to 17 years who have committed sexual offenses and demonstrated other problem behaviours. The aim of the intervention is to reduce problem sexual behaviour, other antisocial behaviour and decrease the risk of out-of-home placements. MST-PSB is delivered by Master's level therapists trained in the human services field. The intervention targets child behaviour, family functioning, support networks and systems outcomes. It uses an ecological model of care by incorporating resources based in the community such as case workers, school professionals and probation/parole officers.

The intervention is delivered in home, school and community settings over five to seven months. Families typically require 2 to 4 sessions per week during the most intensive parts of treatment, with high need families requiring more sessions. Contents of the intervention depend on the individual characteristics and needs of the family, but typically focus on deficits in family relations, peer relations and school performance and the youth's cognitive processes. In addition to this, parents attend family therapy sessions, increase their skills in the provision of youth guidance and development of social support networks.

MST-PSB is dissemination ready. It does not appear to have been used with any Indigenous **families**.

Oregon Model Parent Management Training

Rating - Supported

The Oregon Model Parent Management Training is for parents of children with disruptive behaviours who are 2 to 18 years of age. Versions of this intervention have also been adapted for children with conduct disorder, substance abuse and delinquency, and for child neglect and abuse. The intervention targets child behaviour, maltreatment prevention, family functioning, support networks and systems outcomes.

The Oregon Model can be delivered in the home or in the community by personnel with Master's qualifications in a relevant field plus 5 years of clinical experience. Parents participate in 14 weekly group sessions of 1.5 to 2 hours, and 20-25 one-hour individual family sessions. The total duration of the intervention is approximately 5 to 6 months.

The content of the intervention focuses on behaviour management, such as fostering positive behaviour and preventing and dealing appropriately with undesirable behaviour. Parenting skills, problem solving abilities and communication skills are also focused on. Goals are developed with the parents and delivery is experiential and includes role-play and modelling.

The Oregon Model is dissemination ready. It has been used with Native American and Alaska Native families.

ParentCORPS

Rating - Supported

ParentCORPS is targeted at children aged 3 to 6 years in families living in low-income communities. The intervention aims to promote healthy development and school achievement for this population by improving children's social, emotional, and self-regulatory development, as well as collaborating with early childhood educators to promote children's functioning in behavioural, academic, mental health and physical domains. ParentCORPS targets child development, child behaviour and family functioning.

The intervention consists of both parent and child groups which are delivered in schools and other community settings (i.e. early childhood education or child care centres). Parent groups are facilitated by trained mental health professionals and child groups by trained classroom teachers. The intervention consists of 14 weekly group sessions lasting 2 hours each (approximately 15 participants in a group). The

contents of parent groups include: creating a structure and routine for children, generating opportunities for positive parent-child interactions, adopting strategies that are meaningful and relevant to the families' culture, and using positive reinforcement for good behaviour and ignoring mild misbehaviour. Parents are introduced to these strategies through group discussions, role plays, video series and a photography based book of family stories and homework. Contents of the child groups include: interactive lessons, experiential activities and play to promote social, emotional and self-regulatory skills.

ParentCORPS is dissemination ready. It does not appear to have been used with any Indigenous **families**.

Adolescent-Focused Family Behavior Therapy (Adolescent FBT)

Rating - Promising

Adolescent-Focused Family Behavior Therapy (Adolescent FBT) targets youth aged 11 to 17 years with substance misuse, mental illness and offending or delinquent behaviours. The aim of Adolescent FBT is to improve outcomes in several areas including substance misuse, mental health problems, conduct problems, family issues and school/work attendance. The intervention targets child development, child behaviour, safety and physical wellbeing, family functioning and support networks.

The intervention is delivered in an outpatient clinic by state-licensed mental health professionals who have experience working with the population and an interest in the therapy. The duration and intensity of Adolescent FBT varies depending on multiple factors that are unique to the client, the client's family and the treatment provider; however, typically, the intervention lasts between 6 months to 1 year. Content of the intervention includes: treatment planning, behavioural goal setting , contingency management skills training, emergency management, communication skills, self-control, home safety tours, tele-therapy, job-getting skills training and stimulus control.

Adolescent-FBT is dissemination ready. It has had some use with Native American and Alaska Native families.

Adult-Focused Family Behavior Therapy (Adult-Focused FBT)

Rating - Promising

Adult-Focused Family Behavior Therapy (Adult-Focused FBT) is a suite of interventions targeting adults with substance misuse and co-existing issues such as mental illness, trauma, and family dysfunction, and where there is child maltreatment. Adult-Focused FBT covers substance misuse management, family

and child wellbeing, and instrumental interventions such as providing basic necessities and practical assistance.

The target outcomes of Adult-Focused FBT are: safety and physical wellbeing, family functioning, support networks, child behaviour, and child maltreatment prevention.

Treatment for the parents involves: program orientation, behavioural goal and reward setting, treatment planning, communication skills training, job-getting skills training, child management skills training, management of finances, self-control, assurance of basic necessities, home safety, and environmental control.

Adult-focused FBT is delivered by licensed mental health professionals in the home, outpatient clinic, community agency, or residential care facility. Sessions of 1-2 hours are conducted once or twice in the first week, decreasing in frequency and continuing for 6 months to one year depending on client and family needs. Training for therapists and supervisors takes place in an initial 3-day workshop, a 2.5-day top-up workshop 4 months later, and ongoing telephone training meetings.

Adult-FBT is dissemination ready. It has had some use with Native American and Alaska Native families.

Parenting with Love and Limits

Rating - Promising

Parenting with Love and Limits is for youth aged 10 to 18 years with severe emotional and behavioural problems and co-occurring problems such as depression, substance misuse, truancy, domestic violence, or suicidal ideation. It targets child behaviour, safety and physical wellbeing, and family functioning.

The intervention is delivered by trained Master's level counselling clinicians in 2-hour weekly group sessions for six weeks to parents and children. Family sessions are also conducted weekly for 1-2 hours over four to 20 sessions. Delivery can occur in the home and clinical settings.

Parenting with Love and Limits is dissemination ready. It has been used with Native American and Alaska Native families, as well as Maori families.

Safe Environment for Every Kid Model

Rating - Promising

Safe Environment for Every Kid Model is an intervention to prevent child maltreatment in at-risk families. It targets children aged 0 to 5 years in families with risk factors for maltreatment such as parental mental illness or substance abuse.

The target outcomes for Safe Environment for Every Kid Model are: maltreatment prevention, support networks, safety and physical wellbeing, and child development.

Safe Environment for Every Kid Model involves: (1) health professional training, (2) motivational interviewing, (3) standardised assessment using a tailored questionnaire, (4) plain-language parent resources, (5) collaboration between medical and mental health professionals.

Safe Environment for Every Kid Model is delivered in paediatric primary settings by licensed medical professionals (paediatricians, family medicine physicians, nurse practitioners, and physician assistants) and licensed, Master's level mental health professionals. Screening questionnaires are administered at regular check-ups in the child's first 5 years; intervention intensity depends on the specific situation and continues until the child is 5 years of age.

Safe Environment for Every Kid Model is dissemination ready. It does not appear to have been used with any **Indigenous families**.

AVANCE Parent-Child Education Program

Rating - Emerging

AVANCE Parent-Child Education Program is an intervention for vulnerable pregnant women or women with children aged up to three years. Vulnerabilities include teenage parenting or low education levels. Delivery is based in the home and in community settings. The intervention targets child development.

Parenting education covers topics such as the child's physical, social, emotional, and cognitive development. Parents learn how to make toys and how to support their child's learning through play. Parent's personal growth and education are also supported. Education enrichment is also offered to the child participants in order to prepare them for school.

Staff are trained and the parent educator requires a degree in education, psychology or a similar field. Parents participate in 3-hour group sessions once a week and the child education program is run at the same time as these sessions. Home visits with parents and children occur monthly for 30 – 45 minutes. The total intervention duration is nine months.

AVANCE Parent-Child Education Program is dissemination ready. It has been used with Native American families.

Community Advocacy Project

Rating - Emerging

The Community Advocacy Project is an advocacy intervention for survivors of domestic abuse and their children. It was designed for survivors who have used shelters, but may also be suitable for survivors who have not used shelters.

The Community Advocacy Project's target outcomes are: increasing children's self-confidence; decreasing women's depression; increasing women's access to resources, social support and quality of life; and increasing women's and children's safety. It therefore targets family functioning, support networks and systems outcomes.

The Community Advocacy Project is delivered in the home, for 4-6 hours per week over ten weeks. Advocates are trained in domestic abuse dynamics, safety planning, strengths-based philosophy and community resources. Ongoing training and supervision is seen as essential to model fidelity. Supervisors have at least two years' experience providing domestic abuse services in community settings, and are trained in empathy, active listening, safety planning, and strengths-based services.

The Community Advocacy Project is dissemination ready. It has been used with Native American and Alaska Native families.

Key points

Although not currently available in Australia, the interventions identified above may be suitable for use in the Australian context as alternatives to income management. Some of the concerns that may make families eligible for participation in the interventions described above include:

- families with children and young people experiencing, for example, conduct problems, substance misuse, offending behaviours, mental illness
- children and young people who have been exposed to trauma
- families at risk of maltreating behaviours
- families where there has been domestic and family violence
- families with adult substance misuse and mental illness.

The interventions in this section have covered a range of child ages, from antenatal through to adolescents. Several of them have been used with Indigenous families from other countries. All have shown some benefits to families, children or young people through rigorous research, and all are dissemination ready to potential adoption and implementation in the Australian context.

5.5 Interventions evaluated with Aboriginal and Torres Strait Islander families

The interventions in the following section have largely been identified through unpublished literature. They represent less well-researched interventions, all of which have been evaluated in Australia with Aboriginal families.

Rating - All of the interventions in this section have been rated Insufficient Evidence. Their evaluation methodologies do not allow for adequate assessment of their effectiveness for improving outcomes.

Aboriginal Family and Community Healing Program

The Aboriginal Family and Community Healing Program (Kowanko *et al.* 2009) is an umbrella program that hosts a variety of holistic, culturally appropriate activities for men, women, youth, and communities to address social and emotional wellbeing, family violence and substance misuse throughout the community. The services offered aim to develop community and agency capacity to support families and to help individuals develop skills for effective communication and conflict resolution. The program hosts more than 30 services, for example family wellbeing groups, peer support initiatives, wellness camps and leadership courses.

The Aboriginal Family and Community Healing Program targets child development, safety and physical wellbeing, child maltreatment prevention, family functioning and support networks. The program sits within the Central Northern Adelaide Health Service, and was qualitatively evaluated.

Responses from qualitative interviews showed an overall improvement in community capacity to support families. A total of 22 interviews and focus groups with 27 workers (some participated more than once) and 19 clients of the Aboriginal Family and Community Healing Program Program were conducted. Clients also reported gains in communication and conflict resolution skills, some of which helped them address situations of family violence.

Aboriginal Student Liaison Officers

Aboriginal Student Liaison Officers, included in the Keep Them Safe (KTS) evaluation (Cassells *et al.* 2014) work with students and their communities to improve school attendance. Working individually with Aboriginal children and young people with school engagement and attendance problems, the Aboriginal Student Liaison Officers also involve Aboriginal community members to support school attendance. Aboriginal Student Liaison Officers target child development and support networks outcome domains.

Under the KTS initiative (Cassells *et al.* 2014), Aboriginal Student Liaison Officers positions increased in NSW from 10 to 25 workers. Survey feedback showed stakeholders believed the additional Aboriginal Student Liaison Officers contributed to greater school enrolment, engagement and attendance, and fewer children leaving school early (KPMG 2013). **Data on school engagement in school to support this was not available** (Cassells *et al.* 2014).

Alcohol Restriction

This program targets safety and physical wellbeing, and child maltreatment prevention. It restricts the sale of packaged liquor, so that any liquor exceeding 2.7% alcohol content is prohibited within the community (The Drug and Alcohol Office 2010). The consumption of alcohol was permitted within two licensed premises in the community.

The program was implemented in Fitzroy Crossing, and was evaluated in a non-controlled trial, using mixed methods. Altogether, 184 respondents were surveyed about the use of alcohol by individuals residing in the community, 154 of whom were from the Fitzroy Crossing and Fitzroy Valley communities.

On the whole, the findings for this intervention are mixed. Police records show an increase in the number of reported incidents of domestic violence, both alcohol and non-alcohol related, although survey respondents reported a decrease in the first year. Respondents noted that post restriction, fathers were more proactive in caring for their children's health and generally offered better care for their children. There was an increase in school attendance and overall, children in the community seemed healthier, a difference that was hypothesized to be linked to more money being spent on clothing and food. However, there was a simultaneous increase in the number of children being left in the care of family members while parents travelled to nearby communities to access alcohol. Finally, the perception of increase in breaking and entering by youth was not supported by police record data.

There was an increase in violence within the two licensed venues, as well as an increase in the amount of alcohol being brought in from neighbouring communities. Residents also noted an increase in the number of community members relocating to communities without alcohol restrictions.

Boomerangs Parenting Program

The Boomerangs Parenting Program (Lee, Griffiths, Glossop, & Eapen, 2010 in Macvean *et al.* 2015) focuses on secure attachment between mother and child through the improvement of parenting skills and parent sensitivity. Families participate in parent and child play sessions and parent groups. The intervention is divided into 20 sessions, two of which are 3 day camps. The intervention targets child development, child behaviour and family functioning.

The program was implemented in semi-rural and rural areas of the Sydney South West area, and was evaluated using a single group design with 3 parents.

Overall, the intervention was reported to be successful. One parent increased the frequency of time spent reading with their child, whereas another family saw an increase in the number of requests for books by the children. In one family, the use of praise increased. In two of the three families, there was a positive change in parents following the lead of their child as well as the frequency of mutual gaze with the child.

Bridging the Gap

The Bridging the Gap project (Freeman 2008) is a home shared-book reading program for kindergarten students. Aboriginal Education Assistants visit families fortnightly to distribute books, activity plans, audio tapes and journals to parents and children. The program runs for 20 weeks and it targets child development.

The program was implemented in New South Wales and was evaluated in a pre- and post intervention design, with a contrast group (children in the year above, some of which were siblings of the intervention group children). A total of 22 children and their families were involved in the program in Terms 2 and 3 of the school year.

Results on standardized test show that a majority of children had age appropriate reading comprehension skills after the intervention, despite some remaining at risk of illiteracy. There was only a slight reduction in receptive language skills, and many children remained below age appropriate levels after the intervention. General improvements were also noted in letter identification and listening comprehension, of which the latter was most improved in children from disadvantaged homes (homes with fewer books).

Child Growth Project: Improving Growth Assessment and Action in Aboriginal Communities

The Growth Assessment and Action program (Smith 2002) is an initiative to improve the growth and health of children in rural and remote areas of the Northern Territory by standardizing health care practices. The Child Growth Project builds on the Growth Assessment and Action, by adding the additional component of community and family involvement in the monitoring and promotion of child growth. The project targets child development, physical wellbeing, family functioning and support networks.

The project was undertaken by the Gapuwiyak community of the Northern Territory as a participatory action research project. The entire population of about 800 Yolŋu and Balanda formed the overall community sample. A representative sampling strategy was used to recruit 43 Yolŋu to the "community" group for individual and group interviews. There were a total of 13 health service providers at the Gapuwiyak

clinic recruited to the "clinic" group. After evaluation and identification of existing gaps in knowledge on child growth in the community, it was communally determined that the best response would be the establishment of a Family Centre. However, funding was limited, thus reducing the program to supported play groups. Evaluation of the play groups included quantitative and qualitative data.

While the project did foster significant community action, there was no significant decrease in the number of children in the community who were underweight over the course of the project.

Family Home Visiting Program

The Family Home Visiting Program (Sivak, Arney, & Lewig, 2008 in Macvean *et al.* 2015) enables parents to provide optimal parental support for their children. Professionals visit families during the first two years of their children's life on a weekly basis in the first 6 months, fortnightly in the following 6 months, and monthly in the second year. The intervention offers general parenting support. The content of the intervention varies, including ensuring timely child health checks, helping parents toilet train their children and encouraging book reading. It targets child development, child behaviour, safety and physical wellbeing, family functioning and support networks.

The program was evaluated using a single group design. A total of five focus groups and 23 interviews were conducted and participants were invited to partake in a 1:1 interview. There were a total of 47 focus group attendees and 25 individual interviewees.

Parents in this program reported receiving useful assistance in their parenting and feeling more supported.

Family Referral Services

The establishment of Family Referral Services was a key element of the Keep Them Safe (Cassells *et al.* 2014) action plan. The Mid North Coast, New England North West and Western New South Wales regions have a strong Aboriginal focus.

Family Referral Services provides information links to local support services for vulnerable children, young people and their families, and offers time-limited services to families who are not referred to an appropriate service straight away. The service is particularly focused on families that do not meet the statutory threshold for child protection intervention. Family Referral Services also endeavours to improve the knowledge of service providers in local support services, and to strengthen coordination and collaboration.

The service targets child development, safety and physical wellbeing, and child maltreatment prevention outcome domains.

In the Family Referral Services Casework Pilot evaluation, a Community Services caseworker was co-located in 5 FRS sites. Initial findings from this pilot suggest the Family Referral Services referral model is a viable alternate pathway for low priority Risk of Significant Harm (ROSH) families who may miss out on services through the statutory child protection system (KPMG 2014).

Hey Dad! Program for Indigenous Dads, Uncles and Pops

The Indigenous version of Hey Dad! (Beatty & Doran 2007) is a manualised group intervention for Aboriginal male caregivers. The content is adapted to reflect the Aboriginal historical and socio-economic context. The workshops are divided into five topics: being a dad today, understanding kids, yarning, keeping kids safe, and coaching kids. It is delivered by trained facilitators. Hey Dad! targets child behaviour, safety and physical wellbeing, family functioning and support networks.

The program was piloted in three communities in New South Wales, in a single group, cross sectional design. Thirty-one enrolment forms were received from Aboriginal men attending the Hey, Dad! Sessions.

All participants stated the intervention improved their ability to communicate within a family context, it enhanced their parenting knowledge and conflict resolution skills, and widened their support networks within their family and community.

Intensive Family Based Services

Intensive Family Based Services (Cassells *et al.* 2014) was developed as part of the KTS initiative (Cassells *et al.* 2014). Intensive Family Based Services provides intensive level casework and a spectrum of practical and therapeutic support services to families whose children are at high risk of removal, for a period of up to 12 months. The model includes post-service support for up to six months after the intensive crisis service, with less intensive case management.

Intensive Family Based Services targets child development, safety and physical wellbeing and child maltreatment prevention outcome domains.

The 'early results' from the Intensive Family Based Services evaluation reported in the KTS evaluation suggest families who participated in Intensive Family Based Services received significantly fewer risk of significant harm reports after the intervention than families in the non-randomised comparison group (ARTD Consultants 2013b). These findings may prove stronger in the final report.

Koori Fathering Program

The Koori Fathering Program (Newell *et al.* 2006) is a course developed by and for Aboriginal men with the aim of developing positive family relationships by strengthening their communication skills, learning to appropriately display affection,

learning positive discipline and understanding their children's development and needs. The group runs for 15 weeks, each 3-hour session addressing a different topic. Group leaders are fathers from the community who are trained to facilitate the group but are also encouraged to act as participants. The program targets child development, child behaviour, family functioning and support networks.

The project was piloted in the Northern Rivers Areas and its two first rounds were evaluated in a repeated measures, single group design. Three men participated in both rounds of the program.

Qualitative data indicate a change in knowledge and attitudes about parenting, increased understanding of child development and positive ways of disciplining. The group allowed men to build a support network of fathers within their community. Self-reported quantitative data show an increase in overall parenting as well as a slight positive change in relationship with their partners and children.

Let's Start: Indigenous adaptation of the Exploring Together Pre-school Program

The Exploring Together Pre-school Program is a manualised group intervention for children aged 3 to 6 years and their parents. It focuses on improving parenting, developing children's social skills, reducing behaviour problems in children, and developing positive interactions between parents and child. The 10-week program comprises groups of approximately 6 children. Weekly sessions are led by trained facilitators and divide time between parent-child interactive groups and parent-only and child-only groups. Home visits, teacher meetings and referral to other services are also included. The intervention targets child development, child behaviour, family functioning and support networks.

Let's Start is a culturally adapted version of the Exploring Together Pre-school Program that is delivered by Aboriginal facilitators. The content was modified to be relevant to the Aboriginal context (Robinson & Tyler 2006; Robinson *et al.* 2009). Let's Start was trialled in communities across the Northern Territory (Tiwi Islands, Darwin and Palmerston). The evaluation followed a single group, repeated measures design including assessment at the 6-month follow-up. By December 2008, 234 referrals had been received from teachers in over 25 schools, with 110 children attending the program (excluding pilot families).

Results from the evaluation demonstrate that Let's Start contributed to a significant reduction in child problem behaviours at home and at school, an effect that was enhanced at follow up. The improvement was mediated by attendance where those who attended 5 sessions or more showed a significantly greater decrease in child problem behaviours. There was also a significant improvement in parent wellbeing during the intervention as well as at follow-up.

Ngapartji Ngapartji

The Ngapartji Ngapartji project (Palmer 2010) hosts arts based community workshops in which children create artwork (e.g. digital storytelling and theatre) and tour neighbouring communities. The aim is twofold: to preserve Aboriginal culture and language as well as to contribute to positive community outcomes (increased literacy, crime reduction). It targets child development and support networks

It was implemented in Alice Springs, and evaluated using qualitative methodology. No sample size was reported.

The evaluation found that children who were involved in the program avoided contact with the criminal justice system. The content also promoted crime reduction, which was positively received by the community. The evaluation reports that the program has improved children's involvement in school as well as developed their literacy skills. The project also contributed to strengthening community networks for youth, adults and Elders alike by promoting intergenerational and cultural exchanges.

Norseman Agreement

The Norseman Agreement (Schineanu *et al.* 2010) limits the sale of alcohol within the community, an initiative was self-imposed by community members. It targets safety and physical wellbeing

It was implemented in Norseman, West Australia, and evaluated using mixed methods. Qualitative data was collected in face-to-face interviews or focus groups on three different occasions between November 2008 and June 2009. Responses from the first occasion (November 2008) were collected from 12 people, the second occasion (May 2009) from 25 people (11 actively participated in the group discussions), and the third occasion (June 2009) from responses from a mail out to the Norseman community.

Results show a significant reduction in alcohol consumption, police tasks, assaults, and alcohol related hospital admission. Following the agreement, community members became more involved in their family. It was noted that community members improved in healthy behaviours, most notably in nutrition. Parents began to make arrangements for their children to have access to healthier lunches at school.

Northern Territory Emergency Response (NTER)

The Northern Territory Emergency Response (NTER) (Australian Indigenous Doctors' Association and Centre for Health Equity Training 2010) involved a range of community wide interventions to improve living conditions in Aboriginal communities across the state, with particular emphasis on protecting children from

family violence and sexual abuse. It should be noted that IM was a major component of the NTER and therefore it should not be seen as an alternative to IM. However, IM was only one component and overall the NTER implemented over 120 initiatives, including external leadership and governance, alcohol restrictions, prohibited materials, housing, education and mandatory child health checks. The education intervention included working with parents to increase their level of involvement in their child's education, as well as overall community involvement in education. It targets safety and physical wellbeing, child maltreatment prevention, family functioning and support networks. Twenty-one key stakeholder interviews were conducted.

The NTER was evaluated using the health impact assessment framework. Qualitative methods were used to collect information in order to identify major health impacts. While compulsory child health checks increase access to health services, they seemed to be detrimental to psychological health, causing anxiety, depression and stress. The evaluation also raised serious concerns regarding the negative impact the checks may have on the removal of children. Alcohol restrictions did not contribute to decreasing the number of cases of alcohol related child maltreatment, violence or sexual abuse; in fact, the opposite effect was noticed, namely an increase in exposure to violence.

In 2011, an independent evaluation of the NTER, prepared by independent authors, found that despite some improvements, outcomes for health, education, employment, housing and safety were still considerably below those for non-Indigenous people. In addition, the sense of urgency in the NTER implementation resulted in poor consultation and abrupt imposition of measures. Some of those measures were welcomed by communities, such as the increased numbers of teachers, police officers and night patrols. Other measures, such as IM, resulted in broken trust and a sense of unfairness and stigma. However, the authors emphasise the difficulty of singling out the impacts of the policy on particular outcomes due to the number of elements that constitute the NTER, other policies that were implemented concomitantly and the short duration of the NTER.

The report recommends that in order to be sustainable, policies should work on agreed timetables with the communities, work on community strengths, work on their capacity to build on government services ("indigenous governance"), and focus on long-term commitments and improvements.

Orana Supported Playgroups

Orana Supported Playgroups (Johnston 2004) is a mobile intervention that encourages and supports parents to plan and organize play groups in their communities. An early childhood educator and an Aboriginal co-facilitator travel to communities with toys and equipment where they recruit groups of parents that are coached on creating weekly or fortnightly playgroups. Parents receive continuous support in the hopes that they can eventually reach full autonomy. It targets child

development, child behaviour, safety and physical wellbeing, child maltreatment prevention, family functioning and support networks.

The program was implemented and evaluated in Queensland. At the time of the report, nine play groups had been established with the evaluation using qualitative methodology. Five of seven play group co-facilitators were interviewed by telephone and the remaining two during site visits; twelve key service providers were interviewed (ten by telephone and two during a site visit); and fourteen of the eighteen Advisory Group members were interviewed using semi-structured interview questions via telephone or face-to-face settings.

For children in the play groups, there was less exposure to abuse and neglect. Parents learnt different, more positive ways to interact with their children. Through the play groups, mothers developed positive connections with each other and with the children in the group. Overall, there was an improvement in mother-child relationships and parenting skills, thus improving the environment for the children. Parents gained knowledge on child protection systems and their obligations towards contributing to their child's safety. Service providers also noted that mothers from the group exhibited better hygiene as they progressed through the group.

Protecting Aboriginal Children Together

Using a consultation-based model, Protecting Aboriginal Children Together (Cassells *et al.* 2014) provides cultural advice to families at important decision-making times about the care and protection of Aboriginal children and young people. Protecting Aboriginal Children Together includes services and consultations such as pre-assessment, home visits and 12-month care plans and was part of the KTS evaluation.

Protecting Aboriginal Children Together focusses on child development, safety and physical wellbeing, and child maltreatment prevention outcome domains.

Since 2011 the model has been piloted in two NSW sites, Shellharbour and Moree.

The evaluation indicated that there were fewer reports and re-reports about children and young people and fewer children in care. Family function was reportedly improved as was the capacity of the community to care for and protect children and young people. Evaluation of Protecting Aboriginal Children Together shows the program is generally performing as planned; however, data availability is a major concern. The evaluation report does not discuss the efficacy of this program in meeting child outcomes (ARTD Consultants 2013a).

Stronger Families and Communities Strategy

The Stronger Families and Communities Strategy 2005-2009 (Edwards *et al.* 2009; Flaxman *et al.* 2009) was composed of three programs. Communities for Children is

a program delivery model that engages entire communities in child development to ensure that services are tailored to the unique needs of the area. It also aims to facilitate coordination and collaboration between services. The funding for this initiative allowed for the creation of new services such as parenting groups. Invest to Grow funded early childhood programs and the development of various tools to help families support young children in their development. Finally, Local Answers funded short term projects to build capacity within the community. The strategy targeted child development, family functioning and support networks.

The strategy was evaluated using mixed methods (case studies, interviews, and quantitative data). Case studies were undertaken in 20 Communities for Children sites comprising of four components: 25 telephone interviews (CfC n=23; LA n=2), two focus groups with facilitating and community partners working in remote CfC communities in the Northern Territory and Queensland, Communities for Children (CfC) fieldwork in 5 CfC sites and five comparison communities sites, and document analysis of 23 Invest to Grow project reports.

Overall, over the course of implementation, parental health and mental health improved in the Communities for Children sites compared to the comparison sites. Nevertheless, parents in intervention and comparison sites reported a significant decrease in parenting skills, with the gap between Indigenous and non-Indigenous parents widening. Parents also reported significant declines in home learning environments, support in child rearing (from partners and other community members). Despite these results, parents felt the neighbourhood had become a better place to raise their children. A later follow-up of the longitudinal comparison between CfC and comparison sites found that by age 7, there were no significant differences between CfC and comparison sites in any of the outcome domains (Edwards *et al.* 2014).

Key points

The interventions detailed in this section are all highly relevant to the Australian context, and in particular to Aboriginal and Torres Strait Islander families. Most of the interventions have been found to have some initially positive findings. A few were found to have a mixture of positive and negative findings. While the low rigour of study designs does not allow for conclusions about effectiveness, or lack of effectiveness, to be drawn at this stage, the information presented here provides an indication of what types of interventions have been evaluated with Aboriginal families. The range of concerns addressed by these family and community interventions include:

- school attendance and engagement
- child health, literacy, development and wellbeing
- alcohol use

- issues of child protection and care
- risk of removal into out-of-home care
- community and family violence and crime
- parenting in general, as well as two interventions specifically for fathers.

5.6 Discussion points

This review has identified several initiatives aimed at improving parenting and child outcomes, which are core objectives of income management. These initiatives could provide suitable alternatives to income management, and include initiatives that have good levels of evidence to suggest that they are effective, initiatives that are currently available in Australia, and initiatives that have been evaluated with Aboriginal and other Indigenous families.

Supporting families with multiple problems such as child neglect, financial and housing difficulties, substance misuse and mental illness requires a multi-initiative and multi-component approach. Initiatives for such families usually comprise of multiple components which can address several outcomes for more than one family member. Further, due to the interrelated nature of families, initiatives that impact one family member can benefit other family members and similarly initiatives that impact one outcome, can impact other outcomes.

Some of the initiatives reported here have been widely implemented and researched. An initiative such as Triple P has been funded for ongoing evaluation, often by the developer. Less established initiatives and ones that have received less funding and research attention may still be effective. A lack of evidence does not necessarily mean that an initiative is ineffective; it simply means that we do not know yet. Initiatives that have not been sufficiently evaluated may be effective, or they may be found to be ineffective or even result in harm.

Examining the initiatives presented here, the better options in terms of the evidence are the ones that were rated **Well Supported and Supported**. Breaking that down further for the **Australian context** and taking into account their use with **Aboriginal and Torres Strait Islander families**, the most suitable options, should they *fit the needs of the services and families*, appear to be:

- Nurse Family Partnership
- The Incredible Years
- Multisystemic Therapy
- SafeCare
- Triple-P.

5.7 Implementation in Aboriginal Communities

There is convincing evidence, in Australia and internationally, that successful implementation of policies and programs in Aboriginal communities requires careful consultation with the community prior to implementation, consent prior to the implementation of the program by the community and that the community should be able to control whether the program continues (Robinson *et al.* 2016). Imposing any program on communities without their consent and ongoing consultation is likely to lead to implementation failure and lack of engagement, irrespective of the evidence base for the program. This includes those which have been evaluated in Aboriginal settings.

5.8 Limitations

While the two Australian clearinghouses were searched systematically, it is possible that additional published and unpublished studies exist on other organisation websites or are available via academic databases. However, the search for interventions identified in the previous REA was comprehensive and recent evidence was sought regarding these interventions.

While every effort was made to determine the availability of interventions within Australia, and with Aboriginal and other Indigenous families, these details were not always evident. It is possible that further interventions and studies have been introduced in Australia and have involved Indigenous families.

Chapter 6. Conclusion and implications for income management

Overall, there is limited robust research on the long-term behavioural effects of IM. Nevertheless, the evidence base regarding IM is developing and despite the fact that there are stark differences in the conclusions from different studies, the evidence provides a clear picture of what IM is and is not able to achieve. There have been no economic evaluations of IM, and therefore it is not known whether this is a cost effective measure in any context.

In general, there is strong evidence that compulsory IM does not in itself produce the kinds of behaviour changes which it was designed to achieve. In particular, no study has provided clear evidence that any of the compulsory measures have resulted in demonstrably improved parenting practices, school attendance, child health, reductions in alcohol and substance misuse or gambling. There are also no measurable community level effects, such as reductions in violence, alcohol consumption or crime, attributable to IM.

Some positive effects were, however, found in Voluntary Income Management and Child Protection Income Management. Voluntary Income Management is seen by some of those subject to the measure as being beneficial, primarily by reducing financial harassment and in some cases, stabilizing the person's lifestyle when this is perceived to be out of control. Child Protection Income Management is somewhat effective for families who neglect their children and where the neglect is directly related to their inability to manage their finances. However, there is a danger of individuals becoming habituated to IM (particularly Voluntary Income Management) and not developing the skills to manage their incomes or deal with financial harassment without IM. Furthermore, the evidence from a number of studies indicates that there are a range of unintended negative consequences resulting from IM, including the practicalities of managing the BasicsCard; the stigma and humiliation felt by Aboriginal peoples and members of the mainstream population who are subject to IM, which is associated with the NT Intervention; and the withdrawal of human rights.

Aside from individuals voluntarily taking up IM ("buy-in"), other factors that seem to contribute to the success of the implementation of the program are genuine community consultation and the implementation of IM with the agreement and active participation of community governance mechanisms, such as the Family Responsibilities Commission. Although some can perceive IM as beneficial, mainly for those being financially harassed or who may need help with financial management; others perceive IM as an unfair and discriminatory measure. Some Aboriginal communities have implemented similar schemes to IM in their communities, but these are community controlled and have a very different

connotation to IM within those communities. None of these schemes have been evaluated and therefore cannot be included in this review.

IM also appears to be most successful when it is accompanied by case management, or at least coordination, and the provision of a range of supports and services to individuals who recognize that their parenting is not adequate or that their lifestyle is unhealthy or damaging to their wellbeing or that of their children. There are also some indications that it is more effective as a short term measure where the individual has clear goals for its imposition and a shared understanding with the case manager (or equivalent) about what it is intended to achieve within those timescales (as in Child Protection Income Management and Cape York Welfare Reform Trial IM). Nevertheless, it is important to note that IM has not been compared to other programs which are aimed at addressing these issues, and in particular that any attribution of improvements to IM is difficult to establish. This review has also concluded that there are a number of alternatives to IM.

Conditional Cash Transfers (CCTs) and Unconditional Cash Transfers (UCTs) have not been used in the Australian context and their applicability to Australia may therefore be limited. The literature presents divided views; with behavioural economists favouring the use of CCTs; and social policy specialists or rights-based groups favouring the use of UCT, further advocating Basic Income. Research shows that the contexts in which these CCTs and UCTs are implemented, the specific design of the program and how it is targeted are key to success. Carefully designed Conditional and/or Unconditional Cash Transfer schemes could be implemented in Aboriginal communities in Australia and evaluated. If successful, these would provide an alternative to income management which could potentially be more effective and, if unconditional and rights-based, would not carry the stigma of income management.

With regards to parenting programs, the review identified several suitable alternatives to income management, including programs that are currently available in Australia with good levels of evidence to suggest that they are effective, and programs that have been evaluated with Aboriginal and other Indigenous families. There is more evidence to support programs that were rated “**Well Supported**” and “**Supported**”. Breaking that down further for the **Australian context** and taking into account the programs’ use with **Aboriginal families**, the most suitable options, should they *fit the needs of the services and families*, appear to be: Nurse Family Partnership, The Incredible Years, Multisystemic Therapy, SafeCare and Triple-P. Overall, the evidence indicates that no single program, as a one-size-fits-all approach, is likely to address the range of issues which income management is aimed to improve, and that multiple programs working together will be required. Substance misuse, gambling, parenting difficulties, school attendance and use of pornography in Aboriginal communities all arise out of a long history of colonisation and disadvantage, and no single intervention is likely to be able to address these issues. Indeed there are indications that factors such as cultural continuity and

connection to country play as significant a role in the wellbeing of Aboriginal communities as interventions (Chandler & Lalonde 1998,2008; Holland *et al.* 2013).

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Appendix A Summary table of key evaluations of Income Management in Australia

Error! Reference source not found. presents a detailed account of main income management evaluations conducted in Australia. The first column provides a ranking based on the types of research design, rigour and appropriateness of the findings with respects to internal validity or causal assessment (Trochim 2006). Internal validity is relevant in program evaluations that identify if the intervention made a difference in the expected outcome, establishing causality.

The overall ranking, in terms of internal validity, follows the 'hierarchy of evidence' from the natural science. This hierarchy favours Randomised Controlled Trials (RCT), followed by quasi-experiments, non-experiments and expert opinions. RCT are generally based on large and representative sample size, controlling for experiments, participant bias and external variables. Following RCT there are quasi-experiments, in which there is no randomised assignment (not random selection) of groups but there are either multiple control groups or multiple waves of measurement (cohort studies). The design could include the use of difference-in-difference, regression discontinuity, time-series design, instrumental variables, propensity score matching, panel analysis and others. Non-experimental methods, such as case studies, observational data, case-controlled studies, are the weakest in terms of internal validity due to the inability to control for confounding variables, having a greater potential to introduce bias (Abeysinghe & Parkhurst 2013).

Hierarchy of evidence (adapted from (Abeysinghe & Parkhurst 2013):

- Randomised Controlled Trials
 - Systematic reviews and meta-analysis of Randomised Controlled Trials (RCTs)
 - RCTs with definitive results (large and well-conducted studies)
 - RCTs with non-definitive results (including smaller RCTs)
- Quasi-experiments, such as cohort studies, multiple case control studies
- Non-experiments, e.g. case studies
- Expert opinion

It is important to state that amongst all evaluations of IM in Australia none involved an RCT or even a true quasi experimental design. Within each type of design (quasi-experiment and non-experiment), there is a variety of methods that could be

used, e.g. cohort studies, case studies. There is no attempt to prioritise among the different methods within each type of design, as each study could be assessed as more or less rigorous depending on sample size, representativeness, selection mechanism and other specificities of each design. There is, however, a prioritisation in terms of sample sizes and scope of the study. In theory, if the quality and methodological rigour were the same, the larger the sample size and, consequently, the research scope, the more potential for drawing inferences and generalisations.

Second, various evaluations of income management use mixed-methods. Although the table ranks the evaluation as overall, it is important to keep in mind that findings within each study would have different weight according to the internal validity.

Finally, although the hierarchy of evidence provides a practical measurement, the use of internal validity to rank evaluation is not consensus in social sciences. This method has the assumption that causal factors are constant in place and time and that taking the research problem out of social, political and cultural context is the best way of understanding it (Abeyasinghe & Parkhurst 2013). Nutley *et al.* (2013) also raise questions about the appropriateness of the use of the hierarchy of study design in social policy. The appropriateness of the research design depends on the research question. For example, if the question aims to address whether stakeholders are satisfied with the service, qualitative research may be more favourable than RCTs. Conversely, if the aim is to understand if the intervention would do more good than harm, RCT weights more favourably than other methods. For the specific case of this report, which aims to understand the overall potential outcomes of IM interventions, quantitative studies of large cohorts, whenever available, were prioritised above small in-depth qualitative analyses.

Table 1: Summary of key studies on Income Management in Australia

Rank	Reference	Methods	Demographics	Successful overall?	Successful income not spent in proscribed items	Successful in reducing financial harassment	Successful in building financial capabilities	Successful implementation of BasicsCard	Successful in changing people' s behaviour? Food, alcohol, better save/usage of money etc.	Successful in improving children' s wellbeing?	Views: IM made things better for them	Views: IM is unfair, discriminatory, inconvenient or embarrassing
1	<i>Evaluating New Income Management in the Northern Territory: Final Evaluation Report.</i> (Bray et al. 2014,2015)-	<i>Mixed-methods</i>	<i>Most participants in CIM, majority are Indigenous on extended periods of time</i>	<i>X</i> <i>Participants likely to remain dependent of IM</i>	<i>✓</i>	<i>X no evidence</i>	<i>X no evidence</i>	<i>X but valued as free-fee service</i>	<i>X but small reported improvements for VIM</i>	<i>X only those on VIM reported reduction of alcohol problems in their family</i>	<i>40%</i>	<i>Substantial</i>
2	<i>Place-based income management Access</i> (Deloitte	<i>Mixed-methods</i>	<i>Indigenous status, CALD status and gender not significant predictors but age and type of</i>	<i>✓ for those who voluntarily take-up IM</i>	<i>X no significant impact on self-</i>	<i>✓ based on self-report and staff</i>	<i>✓ for VIM</i>	<i>X for Vulnerable IM, limiting living/payment</i>	<i>✓ for VIM</i> <i>X for Vulnerable IM</i>	<i>? Uncertain, not enough evidence for CPIM</i> <i>? Possibly, VIM/Vulnerable IM</i>	<i>Mostly for those on VIM. Case workers hold positive</i>	<i>For mostly placed on compulsory</i>

Rank	Reference	Methods	Demographics	Successful overall?	Successful income not spent in proscribed items	Successful in reducing financial harassment	Successful in building financial capabilities	Successful implementation of BasicsCard	Successful in changing people' s behaviour? Food, alcohol, better save/usage of money etc.	Successful in improving children' s wellbeing?	Views: IM made things better for them	Views: IM is unfair, discriminatory, inconvenient or embarrassing
	<i>Economics 2015)</i>		<i>income support the individual receives.</i>		<i>reports</i>	<i>reports</i>	<i>X for Vulnerable IM</i>	<i>arrange ments</i>		<i>(social worker assessed) with potential improvement on financial stability/housing</i>	<i>views of the program</i>	
3	<i>Cape York Welfare Reform Trial (FaHCSIA 2012)</i>	<i>Mixed-methods</i>	<i>Cape York Indigenous Communities</i>	<i>✓ IM in conjunction with FRC</i>	<i>N/A</i>	<i>✓</i>	<i>✓</i>	<i>✓</i>	<i>✓</i>	<i>✓ incl. school attendance, although increase in high school in Aurukun</i>	<i>67% better services and support</i>	<i>Some dissent on BasicsCard paternalism</i>

Rank	Reference	Methods	Demographics	Successful overall?	Successful income not spent in proscribed items	Successful in reducing financial harassment	Successful in building financial capabilities	Successful implementation of BasicsCard	Successful in changing people' s behaviour? Food, alcohol, better save/usage of money etc.	Successful in improving children' s wellbeing?	Views: IM made things better for them	Views: IM is unfair, discriminatory, inconvenient or embarrassing
										not clear if due to trial		
4	Voluntary Income Management (Katz & Bates 2014)	Mixed-methods	Anangu Pitjantjatjara Yankunytjatjara (APY) Communities . Mostly without dependent children, receiving Disability Support Pension and Newstart Allowance	✓IM with consultation, requested by communities and mostly VIM	✓but smaller impacts on substance misuse	? Mixed views, for some improved, others not.	✓ managing money by using the Kitty account	✓but reported difficulty in using BasicsCard: not widely accepted	✓but need to have additional interventions	✓but limited with smaller improvements in parenting	Some found useful	Number of respondents did not want to try IM or tried and decided to discontinue

Rank	Reference	Methods	Demographics	Successful overall?	Successful income not spent in proscribed items	Successful in reducing financial harassment	Successful in building financial capabilities	Successful implementation of BasicsCard	Successful in changing people's behaviour? Food, alcohol, better save/usage of money etc.	Successful in improving children's wellbeing?	Views: IM made things better for them	Views: IM is unfair, discriminatory, inconvenient or embarrassing
5	Child Protection Scheme of IM and VIM (Orima 2010)	Mixed-methods	Kimberley region and Perth. Most people with Disability Support Pension, Parenting Payment Single and Newstart Allowance	✓ effective in helping people meeting their needs and their children's but risks long-term dependency	? risk of misuse the Basics Card to purchase drugs/alcohol	N/A	? not conclusive evidence	✓ but needs more merchants	✓ measured by ability to pay for essential items	✓	Mostly agreed life was better with IM	19% of Child Protection Income Management and 9% VIM thought IM made their life worse
6	A review of child protection income	Mixed-methods	People on child protection income	✓	✓ perceived as	✓	? not clear evidence	? Some degree of misuse;	✓ reported more money for food, clothing and	✓ perceived as improving lives of children by	Child protection staff found	IM resulted in shame for some recipients

<i>Rank Reference</i>	<i>Methods</i>	<i>Demographics</i>	<i>Successful overall?</i>	<i>Successful income not spent in proscribed items</i>	<i>Successful in reducing financial harassment</i>	<i>Successful in building financial capabilities</i>	<i>Successful implementation of BasicsCard</i>	<i>Successful in changing people' s behaviour? Food, alcohol, better save/usage of money etc.</i>	<i>Successful in improving children' s wellbeing?</i>	<i>Views: IM made things better for them</i>	<i>Views: IM is unfair, discriminatory, inconvenient or embarrassing</i>
<i>management in WA (DSS 2014)</i>		<i>management, small sample size</i>		<i>successful</i>			<i>restricted places to shop; restricted use</i>	<i>restricted use of cigarettes and alcohol but families need support mechanisms</i>	<i>stabilising housing, utilities</i>	<i>useful to meet needs, stabilise housing and paying utilities</i>	<i>1/3 recipients want nothing to do with IM</i>
										<i>2/3 recipients wanted to stay or to return</i>	

Rank	Reference	Methods	Demographics	Successful overall?	Successful income not spent in proscribed items	Successful in reducing financial harassment	Successful in building financial capabilities	Successful implementation of BasicsCard	Successful in changing people's behaviour? Food, alcohol, better save/usage of money etc.	Successful in improving children's wellbeing?	Views: IM made things better for them	Views: IM is unfair, discriminatory, inconvenient or embarrassing
7	Impact of IM on store sales in the Northern Territory (Brimblecombe et al 2010)	Quantitative	People living in 10 communities in Arnhem Land	X IM not associated with healthier food/drink purchases or reduction of tobacco sales	X IM no effect sales of tobacco products	N/A	N/A	N/A	X	N/A	N/A	N/A
8	Women's experience of IM in the Northern Territory (Equality Rights Alliance 2011)	Qualitative	Study carried out with women in selected urban groups	N/A	N/A	X IM does not make them feel safer.	N/A	X card created difficultly and costs of paying for goods	X little or no effect in what they bought	X Most women reported that BasicsCard did not make it easy for them to look after family,		Many reported discomfort, loss of sense of respect, dignity

<i>Rank</i>	<i>Reference</i>	<i>Methods</i>	<i>Demographics</i>	<i>Successful overall?</i>	<i>Successful income not spent in proscribed items</i>	<i>Successful in reducing financial harassment</i>	<i>Successful in building financial capabilities</i>	<i>Successful implementation of BasicsCard</i>	<i>Successful in changing people' s behaviour? Food, alcohol, better save/usage of money etc.</i>	<i>Successful in improving children' s wellbeing?</i>	<i>Views: IM made things better for them</i>	<i>Views: IM is unfair, discriminatory, inconvenient or embarrassing</i>
					<i>n</i>	<i>reported lack of trust with Centrelink to report problems</i>		<i>and services</i>		<i>additional burden</i>		

Appendix B Search Protocol for Conditional Cash Transfers and Unconditional Cash Transfers evaluations

Criteria for including studies in the review

Types of studies

Eligible studies include meta-analysis, systematic reviews and other comprehensive reviews on conditional cash transfers (CCT) and unconditional cash transfers (UCT). The proposed hierarchy of evidence will be used in ranking these different reviews and studies, based on internal validity (experimental, quasi-experimental and non-experimental designs).

The search is limited to published and unpublished studies, including academic journals, working papers, reports, technical reports. Commentaries, op-eds, media and policy briefings will not be included. Preference will be given to published recent studies (2007-2015).

Types of outcome measures

The selection criteria for inclusion of studies are based on the evidence of impacts of alternative approaches to Income Management (IM) to outcomes of specific interest for this review of evidence. They are:

- Improved parenting
- School attendance
- Child health and wellbeing
- Financial harassment
- Alcohol and drug misuse

The above outcomes are of particular relevance if the reviews investigate programs aimed to address challenges in rural or remote areas or targeted to Indigenous communities.

Search strategies for identification of studies

Electronic searches

Error! Reference source not found. below shows which databases and search terms will be used. Items will be searched in title, or title, abstract and keywords, depending on the search engine's capacity. Searches were conducted on 24/08/15 and from 12/03/16 to 15/03/16.

Table 2: Databases and search terms

<p>The Cochrane Library, The Campbell Collaboration, EBSCO, Eldis, Google Scholar, International Bibliography of the Social Sciences (IBSS), ScienceDirect, Scopus, Social Science Research Network (SSRN), Web of Science.</p>	<p>One of:</p> <ul style="list-style-type: none">• “Conditional cash”• “Unconditional cash” <p>AND one of:</p> <ul style="list-style-type: none">• Parent*• Educ* OR school* -*• “Child* health”• Financial AND (harass*OR manag*)• Alcohol* OR drug* OR gamb*• Indigenous•
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Data collection and analysis

Selection of studies

Data collection will be based on the previous knowledge of research associates on meta-analysis or systematic reviews of CCTs and UCTs plus the search strategy previously described. The selection of studies will follow these steps:

1. Research associates will conduct the search based on the criteria outlined above. Studies that meet the criteria will be downloaded to reference management software. Duplicates will be deleted. Date of the search and number of hits will be recorded.
2. Research associates will read abstracts and further refine the search. Total size of the sample to be recorded.

Any discrepancies would be discussed with and resolved by the principal investigators.

Appendix C Summary table – Evaluations of Conditional Cash Transfers and Unconditional Cash Transfers

Table 3: Review of evidence on CCT and UCT

Source	Eligibility	Outcomes	Do cash and conditionality make a difference?	OBS
Baird <i>et al.</i> 2013	Campbell meta-analysis of CCT and UCT impacts on schooling outcomes	Enrolment	Yes	Both UCT and CCT have a significant effect on enrolment. Higher effects for programmes with stricter monitoring of conditionalities.
		Attendance	Yes	Both UCT and CCT increase the likelihood of attending school increases, but likelihood of attending school increases with the intensity of the conditionalities
		Test scores	Perhaps	Small effects at best
Saavedra & Garcia (2012)	Meta-analysis of CCT impacts on schooling outcomes	Enrolment	Yes	More generous transfer amounts positively and significantly associated to larger effects; supply-side interventions have larger effects on primary enrolment
		Attendance	Yes	
		Dropout	Yes	
		Grade promotion	Perhaps	Positively associated with larger secondary enrolments and attendance effects
Manley <i>et al.</i> (2012)	Meta-analysis of CCT and UCTs impacts on children's anthropometric outcomes	Height for age	No	CCTs have smaller effects than UCTs but difference is not significant
		Nutritional status	No	Both CCT and UCT increased food consumption but no effect on nutritional status. Conditions related to working and savings show strong negative and significant impacts on nutritional status.

Source	Eligibility	Outcomes	Do cash and conditionality make a difference?	OBS
Kabeer <i>et al.</i> (2012)	Meta-analysis of CCTs' economic impacts on child education, child labour, consumption and savings	Enrolment	Yes	Larger impacts for older boys (in working-age), for girls in general, for rural locations and among ethnic minorities
		Child labour	Yes	Statistically significant reduction of the incidence of child labour, higher impacts on girls
		Consumption	Yes	
		Savings	Probably	Increased the likelihood of the use of land to produce foods of higher market and nutritional value.
Gaarder <i>et al.</i> (2010)	Literature review of most rigorous impact evaluations of CCTs on nutrition and health outcomes	Health outcomes	Uncertain	Mixed effects, most results based on the Mexican case. Encouraging the utilisation of health services when services are unknown or of poor quality may not produce the expected results.
		Nutritional status	Uncertain	No evidence on the conditionalities effect.
Lagarde <i>et al.</i> (2007)	Systematic review on the effectiveness of CCTs in improving access to and use of health services and health outcomes	Access and use of health services	Probably	Suggest to focus on the supply of adequate and effective services for a more reliable effect
		Nutritional and anthropometric outcomes	Probably	Positive results limited to some groups such as newborns and infants.
		Health outcomes	Uncertain	Gaps in knowledge: importance of different CCT components and supply-side interventions

Source	Eligibility	Outcomes	Do cash and conditionality make a difference?	OBS
Hoddinot & Bassett 2009	Review of four CCT programs on children's nutritional status	Preschool nutritional status	Probably	Positive and sizeable effect in some countries, no effects in others. However, CCTs may not be the best intervention to address nutritional status. The authors suggest alternatives such as counselling sessions, provision of nutritional supplements for young children and pregnant women, and focus on supply-side services
Evans & Popova 2014	Systematic review of CCT and UCT and effects on alcohol and tobacco	Use of alcohol and tobacco	No	No significant impact or significant negative impact of transfers on expenditures on alcohol and tobacco. On two studies there was a positive significant effect, but of small magnitude.
Arnold <i>et al.</i> 2010	Review of CCT and UCT on several objectives, including human development, program design, cost-effectiveness	<p>Outputs: Enrolment, vaccination and antenatal checkups</p> <p>Outcomes: Nutrition, mortality, morbidity, literacy and numeracy</p> <p>Child labour</p> <p>Investments and financial inclusion</p>	<p>Probably</p> <p>Uncertain</p> <p>Yes</p> <p>Probably</p>	<p>Strong evidence in both CCT and UCT</p> <p>mixed results</p> <p>robust evidence but difficult to dissociate the impact of cash from that of condition</p> <p>Limited evidence that what is not spent on consumption is invested in assets. Limited evidence that payments provide access to other financial services that are used after transfers stopped.</p>

Source	Eligibility	Outcomes	Do cash and conditionality make a difference?	OBS
Fiszbein & Schady 2009	Review of CCT Impact Evaluations on poverty, education, health, and nutrition outcomes	Exiting poverty	Unlikely	Transfers unlikely to help to exit poverty without complementary support
		Consumption	Yes	Larger impacts with more generous transfers
		Child labour	Yes	
		Enrolment	Yes	Increased specially among the groups with lower enrolment rates to start with
		School outcomes	No	Higher enrolment rate has not translated in better performance in tests
		Use of health services	Probably	Evidence is not as clear-cut as school outputs
Garcia & Moore 2012	Desk review of CCT and UCT in Sub-Saharan Africa	Health outcomes	Possibly	Some evaluations found that CCTs contributed to improvements in child height
		Food consumption	Yes	
		Enrolment and attendance	Yes	Both UCT and CCT improved enrolment, but higher in CCT
		Learning outcomes	Yes	UCT did not improve scores, but UCT was able to significantly decrease the probability that girls who dropped out of school to become pregnant or get married.
		Nutritional status	Uncertain	Positive results obtained from UCT transfers

Source	Eligibility	Outcomes	Do cash and conditionality make a difference?	OBS
Pega et al 2015	Systematic review on the use of conditional cash transfers for assistance in humanitarian disasters: effect on use of health services and health outcomes	Health outcomes (height for age, days spent sick in bed, home environment Quality of parenting behaviour UCS or food voucher? Any effect on child death or acute malnutrition dep. on intervention?	Uncertain Uncertain no	Review very specific for humanitarian disasters. Only three studies, all relating to drought. No single health outcome was reported by more than one study. UCT either had no effect or a positive effect on outcome, but more studies needed.
Lagarde <i>et al.</i> (2009)	Systematic review on the impact of conditional cash transfers on health outcomes and use of health services in low and middle income countries.	Health outcomes: nutritional status, anthropometric measures, self-reported episodes of illness. Use of health services	Uncertain Uncertain	Positive effects but unable to attribute it solely to cash or to the condition.

Source	Eligibility	Outcomes	Do cash and conditionality make a difference?	OBS
Reimers <i>et al.</i> 2006	Systematic review on how the "Education" in Conditional Cash to help Transfers in Education	Education (long-term outcome)	no	Little evidence on whether students learn more; modest effects on school participation, progression and attainment.
Murray <i>et al.</i> 2014	Systematic review on the effects of demand-side financing on utilisation, experiences and outcomes of maternity care in low- and middle-income countries	Maternal or infant mortality/morbidity	Uncertain	Attention must be paid to the supply of services, implementation and sustainability. Research on cost-effectiveness is needed.
Bassani <i>et al.</i> 2013	Systematic review and meta-analysis on financial incentives and coverage of child health interventions	Immunisation coverage	no	Small increase in immunisation coverage but non-significant

Source	Eligibility	Outcomes	Do cash and conditionality make a difference?	OBS
Witter et al 2012	Systematic review of paying for performance to improve the delivery of health interventions in low- and middle-income countries (Review)	Changes in the delivery or utilisation of health services; changes in resources used	Uncertain	Current evidence is too weak to draw conclusions, however it is safe to state that the effects of this intervention depends on several variables (design of intervention, context, additional funding etc)
Oxman and Fretheim 2009	Systematic review Its help to achieve the Millennium Development Goals? Overview of the effectiveness of results-based financing	Behavioural change in health care (e.g. health care use, compliance with medication).	limited	CCTs make a difference in the short-run for simple and well-defined behavioural goals but sustained behavioural changes were not found in the long term. However, it has several unintended consequences: motivating unintended behaviours, distortions (ignoring important tasks that are not rewarded), gaming etc.
Owusu-Addo and Cross 2014	Systematic review to assess effectiveness of CCTs in the delivery of 2015	access to health services, nutrition, immunisation and morbidity	limited	CCTs are effective on improving children's wealth, but CCTs require a functioning health care.

Source	Eligibility	Outcomes	Do cash and conditionality make a difference?	OBS
Glassman et al 2014	Systematic review on maternal and newborn health outcomes	Health outcomes: antenatal visits, delivery at health facility, low birthweight.	yes	CCTs increased the uptake of services (antenatal visits, skilled attendance at birth, delivery at health facility) and reduced incidence of low birth weight.
Vitora et al. 2012	Systematic review of maternal nutrition programs to improve birth outcomes	Maternal nutrition interventions	limited	Limited evidence - only from Latin American countries.
Slavin 2010	Systematic review of CCT on education outcomes	School attendance graduation and enrolment in post-secondary education learning and workforce participation	Yes yes, but less well documented Uncertain	The authors caution against the use of CCTs, very costly and other interventions more related to education are preferable, such as improving schools themselves, professional preparation of teachers. Instead of bypassing educators and going directly to the family, strengthening schools and educators could have broader and longer lasting effects.

Appendix D Alternative interventions for families on Income Management identified by the Parenting Research Centre (PRC):

Table 4: Interventions in use in Australia that were identified in previous review – populations and outcomes targeted

<i>Intervention</i>	<i>Population</i>	<i>Child development outcomes</i>	<i>Child behaviour outcomes</i>	<i>Safety and physical wellbeing outcomes</i>	<i>Maltreatment prevention outcomes</i>	<i>Family functioning outcomes</i>	<i>Support networks outcomes</i>	<i>Systems outcomes</i>
Well Supported								
Nurse-Family Partnerships	First-time, low-income or adolescent mothers. Commences prenatally and continues until the child is two years old	✓✓✓✓✓	✓	✓	✓	✓	✓	✓
Supported								
Attachment and Biobehavioral Catch-up	Caregivers of infants 6 months – 2 years who have experienced early adversity, such as due to maltreatment or disruptions in care		✓		✓	✓		
The Incredible Years	Families with children aged 4 – 8 years with behavioural or conduct problems. Also used with children at high-risk	✓	✓			✓	✓	

<i>Intervention</i>	<i>Population</i>	<i>Child development outcomes</i>	<i>Child behaviour outcomes</i>	<i>Safety and physical wellbeing outcomes</i>	<i>Maltreatment prevention outcomes</i>	<i>Family functioning outcomes</i>	<i>Support networks outcomes</i>	<i>Systems outcomes</i>
Multisystemic Therapy (MST)	Youth aged 12 to 17 years old who are serious juvenile offenders with possible substance abuse issues who are at risk of out-of-home placement due to antisocial or delinquent behaviours and/or youth involved with the juvenile justice system		✓			✓	✓	✓
Parent-Child Interaction Therapy	Children aged 2 – 7 years with behaviour and parent-child relationship problems. Maybe be conducted with parents or other carers.	✓	✓			✓		
SafeCare	Parents of children aged 0 – 5 years at-risk for child neglect and/or abuse and/or parents with a history of child maltreatment.	✓	✓	✓	✓	✓		
Triple P	Parents of children aged up to 16 year. Primarily targets children with behavioural problems. Variation available for Indigenous families.		✓			✓		
Emerging								
Child FIRST	Children aged between 6 months and 3 years with emotional and behaviour problems where the parents are at	✓	✓	✓	✓	✓		✓

<i>Intervention</i>	<i>Population</i>	<i>Child development outcomes</i>	<i>Child behaviour outcomes</i>	<i>Safety and physical wellbeing outcomes</i>	<i>Maltreatment prevention outcomes</i>	<i>Family functioning outcomes</i>	<i>Support networks outcomes</i>	<i>Systems outcomes</i>
	psychosocial risk due to maltreatment or parental mental illness.							
Clinician-Based Cognitive Psychoeducational Intervention for Families (Family Talk)	Parents with significant mood disorders, with children aged 6 years and older.		✓			✓	✓	
Home Instruction for Parents of Preschool Youngsters (HIPPY)	Parents with children aged up to 5 years, who have little resources or education or who are adolescent parents.	✓	✓					
Homebuilders	Families with children aged up to 18 years at imminent risk of placement into, or needing intensive services to return from, residential or group treatment, foster care, or juvenile justice facilities or psychiatric hospitals.	✓	✓		✓	✓	✓	✓

<i>Intervention</i>	<i>Population</i>	<i>Child development outcomes</i>	<i>Child behaviour outcomes</i>	<i>Safety and physical wellbeing outcomes</i>	<i>Maltreatment prevention outcomes</i>	<i>Family functioning outcomes</i>	<i>Support networks outcomes</i>	<i>Systems outcomes</i>
Multisystemic Therapy for Child Abuse and Neglect (MST-CAN)	Children aged between 6 and 17 who have been maltreated or who are at risk of maltreatment.	✓	✓	✓	✓	✓		✓
Parents Under Pressure	Families of children aged 2–8 years who are at risk of child maltreatment due to problems such as parental substance misuse, mental illness, severe financial stress and family conflict.		✓	✓	✓	✓	✓	

Table 5: Interventions identified in previous review that are dissemination ready – populations and outcomes targeted

<i>Intervention</i>	<i>Population</i>	<i>Child development outcomes</i>	<i>Child behaviour outcomes</i>	<i>Safety and physical wellbeing outcomes</i>	<i>Maltreatment prevention outcomes</i>	<i>Family functioning outcomes</i>	<i>Support networks outcomes</i>	<i>Systems outcomes</i>
Well Supported								
Trauma-Focused Cognitive Behavioural Therapy	Children, and their parents, who are experiencing significant emotional and behavioural problems related to trauma, including maltreatment or vulnerable family circumstances.	✓	✓	✓		✓	✓	
Supported								
Coping Power	Children aged 5 – 11 at risk of substance misuse.	✓	✓			✓	✓	
DARE to be You	Children aged 2—5 years at risk of future substance misuse.	✓	✓			✓	✓	
Early Risers “Skills for Success”	Children aged 6 to 12-years who are at high risk of conduct problems, including substance use.		✓			✓	✓	✓
Functional Family Therapy	Youth aged 11- 18 years with problems such as violent acting-out, conduct disorder, and substance abuse.		✓			✓	✓	✓

<i>Intervention</i>	<i>Population</i>	<i>Child development outcomes</i>	<i>Child behaviour outcomes</i>	<i>Safety and physical wellbeing outcomes</i>	<i>Maltreatment prevention outcomes</i>	<i>Family functioning outcomes</i>	<i>Support networks outcomes</i>	<i>Systems outcomes</i>
Multidimensional Family Therapy	Adolescents aged 11 to 18 years with substance use, delinquency, and related behavioural and emotional problems.	✓	✓			✓	✓	✓
Multisystemic Therapy for Youth With Problem Sexual Behaviors (MST-PSB)	Youths aged 13 – 17 years who have committed sexual offenses and demonstrated other problem behaviours.		✓			✓	✓	
Oregon Model Parent Management Training	Parents of children 2 - 18 years with disruptive behaviours. Versions adapted for children with substance abuse, delinquency, conduct disorder, and child neglect and abuse.		✓		✓	✓	✓	✓
ParentCORPS	Children aged 3 – 6 years in families living in low-income communities.	✓	✓			✓		
Promising								

<i>Intervention</i>	<i>Population</i>	<i>Child development outcomes</i>	<i>Child behaviour outcomes</i>	<i>Safety and physical wellbeing outcomes</i>	<i>Maltreatment prevention outcomes</i>	<i>Family functioning outcomes</i>	<i>Support networks outcomes</i>	<i>Systems outcomes</i>
Adolescent-Focused Family Behavior Therapy (Adolescent FBT)	Youth aged 11 – 17 years with drug abuse, and co-existing problems such as conduct problems and depression.	✓	✓	✓		✓	✓	
Adult-Focused Family Behavior Therapy (Adult-Focused FBT)	Adults with drug abuse and dependence, and other problems including family dysfunction, depression, child maltreatment and trauma.		✓	✓	✓	✓	✓	
Parenting With Love and Limits	Youth aged 10 – 18 years with severe emotional and behavioral problems and co-occurring problems including domestic violence, alcohol or drug use, depression, suicidal ideation, destruction of property, or chronic truancy.		✓	✓		✓		
Safe Environment for Every Kid Model	Families with children aged 0-5 years who are at risk of maltreating behaviours due to parental substance abuse or depression.	✓		✓	✓		✓	
Emerging								

<i>Intervention</i>	<i>Population</i>	<i>Child development outcomes</i>	<i>Child behaviour outcomes</i>	<i>Safety and physical wellbeing outcomes</i>	<i>Maltreatment prevention outcomes</i>	<i>Family functioning outcomes</i>	<i>Support networks outcomes</i>	<i>Systems outcomes</i>
AVANCE Parent-Child Education Program	Parents with children from 0 – 3 years or pregnant women. Vulnerable due to issues such as teenage parenting or low education levels.	✓						
Community Advocacy Project	Survivors of domestic violence and their children.					✓	✓	✓

Table 6: Interventions evaluated with Aboriginal and Torres Strait Islander families – populations and outcomes targeted

<i>Intervention</i>	<i>Population – all involve Aboriginal children, young people, families or communities</i>	<i>Child development outcomes</i>	<i>Child behaviour outcomes</i>	<i>Safety and physical wellbeing outcomes</i>	<i>Maltreatment prevention outcomes</i>	<i>Family functioning outcomes</i>	<i>Support networks outcomes</i>	<i>Systems outcomes</i>
Insufficient Evidence								
Aboriginal Family and Community Healing Program	Men, women and youth within agencies and also communities	✓		✓	✓	✓	✓	
Aboriginal Student Liaison Officers	Students of compulsory school age who are not registered for home schooling	✓					✓	
Alcohol Restriction	Communities			✓	✓			
Boomerangs Parenting Program	New mothers and their children	✓	✓			✓		
Bridging the Gap	Kindergarten students and their parents	✓						
Child Growth Project: Improving Growth Assessment and	Communities in rural and remote areas	✓		✓		✓	✓	

<i>Intervention</i>	<i>Population – all involve Aboriginal children, young people, families or communities</i>	<i>Child development outcomes</i>	<i>Child behaviour outcomes</i>	<i>Safety and physical wellbeing outcomes</i>	<i>Maltreatment prevention outcomes</i>	<i>Family functioning outcomes</i>	<i>Support networks outcomes</i>	<i>Systems outcomes</i>
Action in Aboriginal Communities								
Family Home Visiting Program	Families with children under two years of age	✓	✓	✓		✓	✓	
Family Referral Service	Vulnerable children, young people and families	✓		✓	✓			
Hey Dad! Program for Indigenous dads, uncles and pops	Male caregivers		✓	✓		✓	✓	
Intensive Family Based Services	Families of children at high risk of placement into out-of-home care	✓		✓	✓			
Koori Fathering Program	Fathers	✓	✓			✓	✓	

<i>Intervention</i>	<i>Population – all involve Aboriginal children, young people, families or communities</i>	<i>Child development outcomes</i>	<i>Child behaviour outcomes</i>	<i>Safety and physical wellbeing outcomes</i>	<i>Maltreatment prevention outcomes</i>	<i>Family functioning outcomes</i>	<i>Support networks outcomes</i>	<i>Systems outcomes</i>
Let's Start: Indigenous adaptation of the Exploring Together Preschool Program	Children aged 3 to 6 years and their parents	✓	✓			✓	✓	
Ngapartji Ngapartji	Adolescents	✓					✓	
Norseman Agreement	Communities			✓				
Northern Territory Emergency Response	Communities, with a particular focus where there is risk of family violence and sexual abuse			✓	✓	✓	✓	
Orana Supported Playgroups	Parents with young children		✓	✓	✓	✓	✓	
Protecting Aboriginal Children Together	Children and Families involved with statutory child protection interventions	✓		✓	✓			

<i>Intervention</i>	<i>Population – all involve Aboriginal children, young people, families or communities</i>	<i>Child development outcomes</i>	<i>Child behaviour outcomes</i>	<i>Safety and physical wellbeing outcomes</i>	<i>Maltreatment prevention outcomes</i>	<i>Family functioning outcomes</i>	<i>Support networks outcomes</i>	<i>Systems outcomes</i>
Stronger Families and Communities Strategy	Communities	✓				✓	✓	