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Evaluation of the Homeless Youth Assistance Program

Final Report

For the NSW Department of Communities and Justice

Centre for Evidence and Implementation

MONASH University

THE BEHAVIOURAL INSIGHTS TEAM

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About CEI

The Centre for Evidence and Implementation (CEI) is a global, not-for-profit evidence intermediary dedicated to using the best evidence in practice and policy to improve the lives of children, families, and communities facing adversity. Established in Australia in late 2015, CEI is a multi-disciplinary team across four offices in Singapore, Melbourne, Sydney and London. We work with our clients, including policymakers, governments, practitioners, program providers, organization leaders, philanthropists and funders in three key areas of work:

- Understand the evidence base
- Develop methods and processes to put the evidence into practice
- Trial, test and evaluate policies and programs to drive more effective decisions and deliver better outcomes

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Background

Unaccompanied children and young people (CYP) experiencing homelessness are an extremely vulnerable group who have traditionally had few service options for support in NSW. The Homeless Youth Assistance Program (HYAP), a response to this service gap, is a $54 million, six-year initiative from the Department of Communities and Justice (DCJ) that arose out of the *Going Home Staying Home* reforms. Through HYAP, DCJ funds non-government organisations (NGOs) to provide a package of services to young people aged over 12 and under 16 who are homeless or at risk of homelessness. This package aims to provide integrated support and accommodation options to:

- reunify CYP with their families and broader support networks; or
- enable CYP to transition to longer-term supported accommodation.

In 2017, DCJ engaged the Centre for Evidence and Implementation (CEI) and its partners, the Behavioural Insights Team (BIT) and the University of Melbourne (now Monash University, Department of Social Work), to undertake an implementation, outcome and economic evaluation of HYAP from 2017-2020.

This report presents the methodology and results of the HYAP evaluation and recommendations for further improvement of the program.

About this evaluation

Our evaluation of HYAP was informed by an approach that:

- *Leveraged Implementation Science* — to generate actionable insights into where HYAP is performing well and where it can be improved
- *Used an implementation-outcome hybrid design* — to assess client outcomes and implementation indicators from regularly collected administrative data that linked homelessness and child protection datasets and the cost of delivering the service[1]
- *Used mixed methods for incorporating feedback from both service providers and DCJ* — to guide the analysis of implementation barriers and enablers at the system and local levels
- *Incorporated the lived experiences of services users* — to include a client voice perspective which is too often ignored
- *Placed ethical research principles at the forefront* — to ensure this highly vulnerable group of CYP were not placed at risk from the conduct of the evaluation.

The evaluation questions that framed our approach were:

- What are the client profiles targeted by provider agencies?
- What is the level of client satisfaction with the HYAP services received?
- Are HYAP services being implemented as planned?
- What are the barriers and facilitators to the delivery of HYAP services?
- Are clients living in safe, secure accommodation?
- Have clients reconnected with family members and/or friends?
- Have clients achieved their case management goals associated with seven key outcome domains (i.e. social and community, home, education and skills, health, empowerment, economic, and safety)?
- What is the unit cost of providing a unit of HYAP services to children and young people?
- What are the elements that determine the makeup of the unit cost?

[1] Considerable time was spent by The Evaluation Team in working closely with DCJ throughout 2019 to build a restructured CIMS data file that enabled HYAP data to be analysed longitudinally (i.e. the CIMS data file is available from DCJ only as a monthly point in time data extract). To our knowledge, this is the first time CIMS data has been restructured in this way. This work was critical to the delivery of the outcome evaluation and to our understanding of whether HYAP has been effective in achieving the desired outcomes.

Key results

The key results presented here in summary form are drawn from the following chapters that examine data in relation to each evaluation question in-depth.

What are the client profiles targeted by provider agencies?

HYAP service providers were more responsive to needs that are proactive in targeting groups

Female and Aboriginal CYP were overrepresented in HYAP relative to their proportion of the NSW population. Prior work by the Evaluation Team with HYAP providers suggested they might be targeting different CYP groups to work with. However, findings from this analysis suggest that HYAP providers are not so much targeting particular client profiles as they are responding to the needs of CYP who present at their service. This is evidenced by the large proportion of CYP who showed up for services but did not meet the eligibility criteria for HYAP at entry as well as provider observations that their HYAP cohort had more complex needs than could be dealt with by their service.

Among CYP presenting at HYAP, more than half were known to the community services sector through prior involvement with the child protection system. Furthermore, the most frequent classification of service need identified was counselling and relationship needs, which would include family breakdown and domestic violence services. All of which point to the fact that the HYAP cohort is very vulnerable.

What is the level of client satisfaction with the HYAP services received?

Generally, satisfaction was high

CYP currently or previously engaged with HYAP services were, in general, very positive about the support they received from service providers across the categories for which they sought assistance. This result should be interpreted with caution as it is based on a small sample of CYP who were highly engaged with their provider and consented to participate in an interview, where many of their peers did not.

Not all CYP had their needs met through HYAP. For example, the majority of CYP who sought help with accommodation did not receive this assistance either from their provider or from a service to which they were referred. The positive client responses observed could therefore be an indicator of the experience CYP have with providers when HYAP works well and their needs are met. Alternatively, it may be CYP are grateful for any kind of assistance in navigating their complex lives whether HYAP meets all their needs or not.

Are HYAP services being implemented as planned?

No, but these deviations are driven by the diverse set of CYPs that come to HYAP

It was difficult to determine if HYAP was implemented as intended due to the variation in the way in which it was scoped and delivered. The Evaluation Team's analysis suggests HYAP is not currently being implemented as planned. Almost a third (30.6 per cent) of the CYP receiving HYAP services do not meet the eligibility criteria — they are either outside the age range or not part of a group who are all under 16. This means a considerable proportion of the funding directed toward assistance for unaccompanied CYP aged over 12 and under 16 is being spent elsewhere.

This is not to suggest HYAP providers are ignoring the CYP that they should be helping. Instead, the findings suggest that HYAP providers are proactively adapting their practice, procedures and even service approach to — as best they can — meet the needs of CYP who present at their service, irrespective of eligibility. Providers' implementation of HYAP, in this sense, is being driven by who turns up to HYAP and what services are available locally to meet CYP need.

What are the barriers and facilitators to the delivery of HYAP services?

The unavailability of appropriate services was the key barrier to the delivery of HYAP services

The limited availability of appropriate services to meet CYP needs, including challenges accessing support from child protection services, is the most serious systemic barrier to the delivery of HYAP. The availability of local services at the time of commissioning influenced the original design of HYAP services in each district more so than any other factor. Local model design can be a strength because providers can tailor service delivery to local context and use resources efficiently – notably, providers considered the presence of effective district HYAP protocols as a key facilitator of HYAP service delivery. However, it can also mask service inequities or the absence of high-quality services to address the needs of this vulnerable cohort of CYP. This was observed in the administrative data — a large proportion of CYP who presented at HYAP with complex needs, including a child protection history, were not able to have these needs met by the HYAP service model and local referral infrastructure.

Are clients living in safe, secure accommodation?

Yes, but not for the most vulnerable CYPs and many older CYPs later appeared in Specialist Homelessness Services

Several indicators suggested CYP who were able to access accommodation services through HYAP ended up in safe and stable accommodation. First, CYP provided with or referred to medium or longer-term housing were less likely to have a new risk of significant harm report, potentially indicating that greater housing stability decreased reported child maltreatment concerns. Second, CYP did not tend to return to HYAP once they left; and if they did exit HYAP services and return,[2] the presenting need was rarely accommodation. Third, there was a small positive improvement in CYP's own ratings of their accommodation outcomes while receiving HYAP services.

However, these gains may be short-lived for segments of this population. While not part of the original analysis plan, the Evaluation Team identified a concerning trend among CYP aged 16 years and older who were no longer eligible for HYAP. Almost one third (30 per cent) of those who had exited HYAP presented to SHS with needs related to housing and family breakdown.

Moreover, these outcomes, either measured through administrative data or self-reported, did not hold for vulnerable CYP who had a child protection history. CYP with a history were more likely to come back. Though somewhat less convincing due to the quality of the data,

[2] Even if CYP did return to HYAP it is not possible to say why this occurred. It does not necessarily mean, for example, the quality of services CYP received was poor or that the assistance their support worker provided did not meet their needs. It could be that vulnerable CYP returned to seek support from a trusted provider when there were few alternative options for help.

younger CYP — aged 12 to 14 years old — were less likely than older CYP to be assessed as having improved accommodation concerns through HYAP.

Have clients reconnected with family members and/or friends?

Yes, but only older CYPs

Data from the HYAP client outcomes tool suggests that older CYP accessing HYAP showed a small improvement in their connections to family. CYP with a child protection history, or those who were younger, did not fare as well with family connections. Vulnerable CYP had a large number of risk of significant harm reports after HYAP began, indicating continued tension within families and significant household disruption.[3] However, reconnection with family is a high bar. Even though counselling and relationship services were often delivered to CYP through HYAP, it would be extremely difficult for HYAP providers to have any impact on family reconnections for vulnerable CYP with a child protection history (the majority of the HYAP cohort). The Evaluation Team is unable to comment on CYP's potential reconnection with friends while they were receiving HYAP services due to a lack of available data.

Have clients achieved their case management goals associated with seven key outcome domains?

Potentially, but only 10 per cent of CYPs completed the assessment

Minor improvements were observed in CYP ratings of their achievement of all case management goals — except mental health[4] — while they were receiving HYAP. However, these gains were only seen by a certain cohort. Younger CYP, CYP with prior risk of significant harm reports, and CYP with prior out-of-home care experience either showed no improvement or showed worse ratings over time.

The Evaluation Team has significant concerns about the ability of the HYAP Client Outcomes Tool to validly and reliably measure vulnerable CYP's outcomes. Additionally, only 11 per cent of CYP who received HYAP services also completed two outcome assessments, which suggests the tool had implementation issues. As a result, these results should be interpreted with caution.

What is the unit cost of providing a unit of HYAP services to children and young people?

There was a worryingly high variation in the unit cost of HYAP services

A high variation in unit cost estimates driven by variation in HYAP service models across provider was observed. The cost per unit or 'spell'[5] of HYAP ranged from a low of $1,215 to a high of $34,169. This means an average unit cost is a poor measure of actual HYAP cost. Instead, the Evaluation Team recommends DCJ examine the specific services offered by a sample of HYAP providers and use those costs to make funding decisions.

[3] It was observed that older CYP who were closer to 'ageing out' of the system did not get the same attention from child protection services as their younger peers - in that they received fewer face to face assessments.

[4] Employment was not included because all HYAP CYP were under the age of 16.

[5] A spell refers to a continuous period of services at one or more HYAP providers. This is analogous to an episode, as used by DCJ in OOHC to reflect a continuous period of time in care that may have more than one placement within it.

What are the elements that determine the makeup of the unit cost?

This also varied greatly

How staff spend their time varies greatly across HYAP providers and is likely driven by the particular service model they implement. In aggregate, HYAP staff spent most time on case management, however this varied between providers. The amount of time spent on providing accommodation was the other main source of provider variance. HYAP providers spend the vast majority of their time on activities directly related to service delivery, with the remainder spent on administration.

Concluding comments

The people who benefited most from HYAP were the CYPs who it was designed for.

Much of the discussion in this report focusses on the needs, service use characteristics and outcomes of vulnerable CYP aged over 12 and under 16 years who have a child protection history. This was appropriate given these CYP make up the majority of the HYAP cohort. However, many CYP who present to HYAP do not have this background. As a whole, these CYP achieved better outcomes, particularly in terms of their self-reported achievement of case management outcome goals (although the Evaluation Team has reservations about the validity of the HYAP Client Outcomes Tool).

It is also reasonable to suggest that, once the cycle of housing and relationship issues gets to a certain point, some CYP will transition from HYAP prevention-type services to the adult SHS system. Designing a better identification process and response is needed, with prevention services aimed at mitigating family tensions provided to less vulnerable CYP. Furthermore, more structured, intensive responsive services should be provided to children who face serious, long-standing child protection concerns.

Data limitations

There were several limitations to this evaluation. The most significant data limitations related to CIMS. The first was large-scale missing data for the HYAP Client Outcomes Tool, which had a significant impact on the sample size available for analysis to answer different evaluation questions. The second was the inability to generate a valid historical counterfactual of CYP who did not receive HYAP due to the relative age of the CIMS database and its use for this population. Thirdly, it was not easy to look at services provided to those in the same family. There may be merit in exploring the possibility of using these data to follow both individuals and families, but it is well beyond the scope of this evaluation.

This does not invalidate our findings — the Evaluation Team have been careful to state limitations where they occurred — but the absence of high-quality data decreases the confidence with which our findings can be stated.

1. Recommendations

HYAP was developed to address a gap in services for a highly vulnerable group of CYP. DCJ undertook extensive consultation with the sector and involved DCJ district offices in the development, procurement and implementation of service models it hoped would be able to adapt to local needs and provide appropriate solutions in their communities.

The reality on the ground is that HYAP operates in a difficult space where housing services intersect with the child protection system. Providers need to develop “work arounds” to address implementation issues which are often external to their service models, such as developing a relationship with a local DCJ office to avoid getting a case closed at the child protection helpline.

The Evaluation Team has developed the following recommendations in response to this context. Applying our expertise in Implementation and Behavioural Sciences to the evaluation findings, a series of recommendations for improving outcomes for unaccompanied CYP aged over 12 and under 16 years old experiencing, or at-risk of, homelessness have been proposed. Recommendations are either internal to the HYAP model and could be used to strengthen the model within its existing framework, or directly address the needs of this cohort or are external to HYAP and reflect wider systemic issues. Each recommendation is related to key evaluation findings.

1.1. Redesign HYAP to meet the needs of the target cohort

HYAP was designed as an early intervention service to prevent homelessness for unaccompanied CYP aged over 12 and under 16. However, the cohort who most sought help from HYAP were highly vulnerable CYP who already had contact with the child protection system. The help they received was driven more by the provider they were connected with than the problem for which they had sought help. This suggests the HYAP

program model, focused on both an early intervention approach and a provider-driven response to the service delivery model, needs to be rethought. A redesign of HYAP that focuses on the actual cohort that received HYAP services will lead to the development of a more targeted and better designed service response.

1.2. Strengthen the HYAP service offering through access to evidence-informed practice

HYAP providers do not currently have the tools or evidence they need to appropriately and effectively respond to CYP presenting with complex needs. The Evidence Review undertaken by the Evaluation Team in 2017-18 identified practice elements that could potentially benefit CYP at-risk of homelessness (Centre for Evidence and Implementation, 2018b). There are a number of ways in which evidence-informed practices could be integrated into a model like HYAP. One approach — used by the Department of Health and Human Services in Victoria — is to trial offering a 'menu' of evidence-informed practice elements for which providers can select those most appropriate to their local context. While the criteria for inclusion on this list would need to be well considered, at the very least those services which are currently provided but have limited evidence of impact could be removed.

1.3. Develop minimum standards and service requirements for HYAP, including specifications for when providers need support from child protection services

NSW is a large state with a diverse population that has numerous localised needs and differences in available services. The Evaluation Team understands the need for any program or model to adapt to local contexts. Even so, it is important to have a series of minimum standards and service requirements for HYAP. Following the NSW Ombudsman's (2018) report, minimum standards and service requirements should be applied to the scope of the district protocol and the responsibilities of the point of contact in each DCJ district office. Given the numbers of vulnerable CYP who accessed HYAP who had already been the subject of a risk of significant harm report, there is a clear need to develop standards and requirements for HYAP that articulate how and when providers can access support from child protection services.

1.4. Support high-quality implementation of district HYAP protocols

Improving the content and quality of district protocols for HYAP is one thing, ensuring they are implemented effectively so that service delivery to vulnerable CYP is enhanced rather than impeded is another. The current quality of implementation of HYAP district protocols across the program needs work. While some HYAP providers appear to be benefitting from district protocols with strong local service buy-in, other providers are unsure of their utility or even that they exist at all. A planned and structured implementation process, led by DCJ and using tried and tested approaches, such as that described in the Active Implementation Framework, will strengthen the effectiveness of the district protocols in facilitating HYAP services.

1.5. Improve service integration across homelessness and child protection systems

Poor integration across the homelessness and child protection systems is a critical barrier to the ongoing viability of HYAP. The model of HYAP service delivery was driven in large part by the presentation of vulnerable CYP with child protection histories to HYAP services. Outcomes for vulnerable CYP seem to have more to do with whether there has been a child protection response before, indicating that CYP and potentially the child protection system itself are in a cycle of escalating issues that culminate in a pattern of homelessness that continues to young adulthood. All the hallmarks of CYP aging out of the child protection system into homelessness are being observed at an earlier stage — particularly the finding that CYP who are closer to 'ageing out' of the child protection system are more likely to seek assistance from a SHS post HYAP. Our findings suggest a need for better integration across DCJ portfolios. It is particularly important to bridge the gaps of services offered between early childhood and early adolescence.

1.6. Improve the quality of homelessness data

The CIMS data used to inform this evaluation has significant limitations. CIMS is extracted in the form of a monthly point in time extract. Even though the Evaluation Team was able to convert this to a longitudinal by-person unit record format, there were still limitations in terms of understanding what services HYAP clients actually received and for what purpose. The largest limitation was the amount of missing data in the CIMS file which reduced the sample for some analyses by almost 90 per cent of the total sample of CYP who first presented at and accessed HYAP. Incentivising providers to ensure that data is complete and accurate will benefit future evaluations of homelessness programs.

2. Background & Context

2.1. Unaccompanied children and young people are a vulnerable population

Children and young people (CYP) experiencing homelessness – and in particular those that are unaccompanied[6] – are an extremely vulnerable group. At a time when CYP should be building the skills for a transition to adulthood – gaining an education, playing with friends, exploring identity, and spending time with those that love them - this group is forced to focus on finding a safe place to sleep and dealing with the issues that placed them in this situation.

CYP who experience homelessness are more likely than adults experiencing homelessness to report leaving home due to family dysfunction or conflict within the household. This includes:

- childhood trauma;
- domestic and family violence;
- being 'kicked-out' of the family home;
- physical, verbal or sexual abuse;
- neglect due to mental health issues; or

[6] In this context 'unaccompanied CYP' is used as an umbrella term for a range of minors and young people who are outside of a family or institutional setting and who are not accompanied by a parent or legal guardian. They form a highly vulnerable client group at risk of becoming, or are already disconnected from, their families and wider support networks (NSW Department of Family and Community Services, 2016).

- neglect due to parental substance use (Barker, Thomson, Humphries, & McArthur, 2011; Embleton, Lee, Gunn, Ayuku, & Braitstein, 2016; Hyde, 2005; Mallett, Rosenthal, & Keys, 2005; Martijn & Sharpe, 2006).

CYP who become homeless are often disconnected from family, community and social networks and are at an increased risk of substance abuse, sexually risky and criminal behaviour, mental health problems, educational disruption, food insecurity and health issues (Chamberlain & Johnson, 2013; Crawford et al., 2015; Embleton et al., 2016; Hyde, 2005)

Those CYP who are at-risk/are homeless as a result of issues arising from family dysfunction can end up in circumstances which reinforce their further risk of homelessness, including:

- separating themselves from environments they perceive to be unsupportive;
- a desire for, or attainment of, financial independence;
- untreated mental health issues;
- substance use; and
- contact with the criminal justice system (Wang et al., 2019).

Many chronically homeless adults had their first experience of homelessness before the age of 18, highlighting the importance of early intervention (Chamberlain & Johnson, 2013; Flatau et al., 2013; Mallett et al., 2005). However, there is a significant lack of robust evidence supporting the effectiveness of youth homelessness interventions (Altena, Brilleslijper-Kater, & Wolf, 2010; Pergamit, Gelatt, Stratford, Beckwith, & Martin, 2016). This is particularly the case for Aboriginal CYP experiencing homelessness even though this group is over-represented among CYP experiencing homelessness (Conroy & Williams, 2017).

2.1.1. Intersections between homelessness and the child protection system

Despite the central role family violence plays in the experience of homelessness for CYP (Australian Institute of Health and Welfare, 2016; Embleton et al., 2016), little is known about this highly vulnerable cohort's intersection with the child protection system. The limited data that does exist in Australia – albeit not including NSW – suggest these CYP have significant health and safety needs, over and above that of CYP who present to Specialist Homelessness Services (SHS) without a child protection history (Australian Institute of Health and Welfare, 2016). For example, CYP under 16 years of age who accessed SHS and received child protection services were (compared with a matched group who did not have a child protection history) more likely to:

- report having a mental health issue;
- report having a drug and/or alcohol issue;
- be experiencing domestic and family violence; and
- experience more than 1 episode of homelessness over a 4-year period (Australian Institute of Health and Welfare, 2016).

While this group was more likely to have requests for accommodation services met and more intensive levels of support (e.g. more days, support periods and nights of accommodation), perhaps given their increased vulnerability, they were also as likely as the group with a child protection history to be homeless following SHS support.

The Evaluation Team is aware of the close relationship between the homelessness and child protection systems even if the data is hard to come by. For example, there is a legislated requirement for SHS in NSW to use the Mandatory Reporter Guide and make a subsequent report to the Child Protection Hotline when an unaccompanied CYP aged over 12 and under 16 presents at their service (NSW Department of Family and Community Services, 2015). The most consistently reported risk factor for homelessness among young people leaving out-of-home care (OOHC) is placement instability (Conroy & Williams, 2017). A history of running away and earlier episodes of sleeping rough is also common among this group (Conroy & Williams, 2017; Flatau, Thielking, MacKenzie, & Steen, 2015).

2.2. What is a successful outcome for this population?

The best outcome for unaccompanied CYP aged over 12 and under 16 years who are at-risk of homelessness is reconnection with their families, provided this enables them to live in a safe and stable home environment. CYP of this age group have specific developmental needs related to friendship, learning and cognitive maturity. These needs differ substantially from young people aged 16 years and older at-risk of homelessness, who have needs in terms of finding safe accommodation, stable income, and transitioning to independence.

Yfoundations, in partnership with Homelessness NSW and DV NSW, have identified five outcome domains considered fundamental for the healthy growth and development of all CYP in their guidelines for SHS working with unaccompanied CYP aged over 12 and under 16 year olds (Yfoundations, n.d.). These are:

- Health and Wellness
- Safety and Stability
- Home and Place
- Connections
- Education and Employment.

As such, a successful outcome for this cohort is dependent, not just on positive family reconnections and safety, but the presence of a comprehensive service support system that provides an integrated response to CYP need.

2.3. What is HYAP and how does it try to solve this issue?

HYAP is a $54 million, six-year initiative that arose out of the *Going Home Staying Home* reforms. It is a service funded and managed by DCJ that funds non-government organisations (NGOs) to provide a package of services to young people aged over 12 and under 16 who are homeless or at risk of homelessness.

The package of services provided under the HYAP aims to provide integrated support and accommodation options to:

- reunify children and young people with their families and broader support networks; or
- enable children and young people to transition to longer-term supported accommodation — see Box.

NGOs were invited to tender to provide services which met the seven service components — as per the HYAP Service Delivery Framework — that are included in Table 2.1.

Objectives of the Homeless Youth Assistance Program

- Rebuilding family, kin and cultural connections and working towards family reconnection, where appropriate
- Engaging the child/young person with education or training
- Providing access to mainstream health, mental health and wellbeing services
- Engaging the child/young person with the broader community to build knowledge, a sense of belonging which will support their development of age appropriate living skills
- Facilitating transitions to longer term supported accommodation when family reconnection is not achievable

Table 2.1 Homeless Youth Assistance Program: Service Requirements

 Ensure the safety and wellbeing of children and young people	Deliver service responses that meet duty of care and minimise and manage risks to children and young people. HYAP services' duty of care will be underpinned by the values of respect, responsibility, collaboration, client focus and professional integrity. This may include delivering or facilitating access to accommodation-based service responses, which will be fully supervised (e.g. 24 hours per day, 7 days per week) by appropriately qualified staff and/or carers.
 Deliver Client Centered Services	Place people at the centre of service delivery and be responsive to individual differences, cultural diversity and client preferences. Client-centered responses are guided by dialogue and an understanding of client needs and strengths in order to promote and facilitate greater client responsibility and build empowerment and self-esteem. Client-centered services individually tailor the intensity, type and duration of support and the accommodation setting in which support will be delivered.

Deliver strengths-based case management approaches	Respect the individual and promote and facilitate collaborative approaches that work towards meeting the client's needs and building and sustaining their capacity. Interventions are based on client self-determination and aim to assist individuals to identify and achieve their own goals. Effective strengths-based case management approaches pay attention to individual resilience, abilities, knowledge, interests and capacity. The development of a structured case plan that addresses the individual's immediate needs while building capacity and identifying goals and objectives is a central tool in breaking the cycle of homelessness.
Deliver trauma-informed services	Support traumatised children and young people to recovery. This service will recognise homelessness as both a consequence of trauma and as a form of trauma in itself. Trauma-informed services recognise that clients that have experienced homelessness often have histories characterised by loss of family, community, identity, social networks, stability and safety. A trauma-informed approach influences every aspect of an organisation, including: how staff and clients interact, how clients are supported to interact with one another, the physical environment, daily routines and the relationship between the service and the wider community.
Deliver wraparound services	Identify and target the social, emotional, educational, cultural and physical needs of children and young people. Wraparound services are characterised by coordinated community-based service delivery that addresses the individual needs of a child as identified through an assessment and case planning process. The provision of wraparound services are based upon a comprehensive assessment of a client's strengths, needs and experiences and seek to engage the right specialist support services at the right time in a child's development.

Source: NSW Department of Family and Community Services (2016)

2.3.1. Who is providing HYAP?

HYAP services are provided by non-government service providers who were engaged through a competitive tendering process. Seventeen providers were contracted to provide services across nineteen catchment areas (as defined by DCJ) in NSW — see Appendix A for more information about providers and their catchment areas.

2.4. In what context was HYAP implemented?

Across the nation, funding for the provision of services to support people who are homeless or are at-risk of homelessness is provided by both the Commonwealth and State Governments in the form of Specialist Homelessness Services (SHS).

In NSW, the SHS program is administered by the Department of Communities and Justice (DCJ). In this role, DCJ is responsible for:

- directing the program and governing policy;
- funding and contracting service providers; and
- performance management and continuous quality improvement (CQI).

SHS are delivered by non-government organisations (NGOs) whose service portfolios range from a general response, to individuals facing a housing crisis, to those that are targeted to specific groups such as women escaping domestic and family violence.

Reform in Commonwealth-State funding arrangements sparked by the National Affordable Housing Agreement (NAHA) and the National Partnership Agreement on Homelessness (NPAH) led to a shift in the focus of the SHS sector (NSW Government, 2009, 2012). New policy arrangements sought to shift resources toward:

- prevention and early intervention to stop people becoming homeless and/or lessen the impact of homelessness;
- implementing services that 'break the cycle' of homelessness by helping people deal with crises, find stable accommodation and obtain employment; and
- creating a connected system that seeks to link clients to joined-up services in order to reduce the number of people who are homeless.

It was in this context the Going Home Staying Home reforms were implemented — the rationale for which is summarised and included in Appendix A. The reforms sought to: better design services; make it easier for clients to access services; improve planning and resource allocation; develop the homelessness sector and workforce; and develop better ways of contracting to deliver quality and continuous improvement.

2.4.1. The Ombudsman's Report

After this evaluation was commissioned and had commenced, the NSW Ombudsman produced a report *More than Shelter* in 2018 that investigated legislative, policy and service delivery issues related to services provided to the population eligible for HYAP (NSW Ombudsman, 2018).

The Evaluation Team has considered the recommendations of the Ombudsman's report — which are included in Appendix A — and has endeavoured to include them where relevant in our discussion.

2.4.2. Premier's Priorities

The NSW Premier's Priorities are a set of focus areas for improvement across policy portfolios and NSW agencies. Each Priority, which may change over time, is marked by a target. Progress is tracked yearly using agency data and publicly reported. Each NSW government agency has responsibility for a Priority and is expected to develop programs and policy that work toward achieving the target. There are two current Priorities that are the responsibility of DCJ and overlap with HYAP in terms of the targeted cohort:

- *Protecting our most vulnerable children* — Decrease the proportion of children and young people re-reported at risk of significant harm by 20 per cent by 2023.
- *Reducing homelessness* — Reduce street homelessness across NSW by 50 per cent by 2025.

3. This Evaluation

3.1. About the approach

This evaluation is informed by an approach that:

- *Is informed by Implementation Science* — to generate actionable insights into where HYAP is performing well and where it can be improved
- *Used an implementation-outcome hybrid design* — to assess client outcomes and implementation indicators from regularly collected administrative data and the cost of delivering the service
- *Used mixed methods to incorporate feedback from service providers and DCJ* — to guide the analysis of implementation barriers and enablers at the system and local level
- *Utilises the lived experiences of services users*— to incorporate a client voice perspective which is too often ignored
- *Places ethical research principles at the forefront* — to ensure this highly vulnerable group of CYP were not placed at risk from the conduct of the evaluation.

3.1.1. Informed by Implementation Science

Implementation Science is the study of methods and strategies to promote the uptake of evidence-informed programs and practices into 'business as usual', with the aim of improving service quality (Eccles & Mittman, 2006) — see Box below.

The notion that good implementation outcomes are a precursor to positive intervention effects is captured by Proctor et al.'s conceptual model of implementation research (Proctor et al., 2009, 2011).

This model distinguishes implementation outcomes from service system and client outcomes. The basic assumption reflected in this model is that, in order to achieve positive outcomes for children and families, services need to be delivered with high quality for them to be accessible, timely and effective. Such service quality will only be achieved if considerable effort is put into their implementation — a process that can be measured in different ways and with a focus on different aspects.

What is Implementation Science?

Evidence-informed programs and practices are incorporated into 'business as usual' at very different speeds and there is often a gap between what works and what is being done in practice. There are many reasons for this including:

- research can be difficult to access and translate into a real-world environment;
- the evidence-informed program or practice is not a good fit for the local context;
- service providers or staff are not interested in making changes to how they work; and
- barriers relating to the broader operating context, such as funding models or geographical location and resource availability.

The field of Implementation Science aims to close this gap between research and practice. Further information on how to apply Implementation Science to the child and family service sector is contained in Implementation in action: a guide to implementing evidence-informed programs and practices (Hateley-Browne, Hodge, Polimeni, & Mildon, 2019).

3.1.2. Implementation-outcome hybrid design

A hybrid implementation-outcome design was used to assess the effectiveness of HYAP. Hybrid designs represent a new innovative approach to evaluation that can speed up the dissemination and adoption of programs by addressing the effect of the program on client outcomes and the processes required to deliver, embed and sustain the intervention in human services systems (Landes, McBain, & Curran, 2019). In simple terms, this design enabled us to examine both whether HYAP was achieving the desired outcomes for CYP (i.e. outcomes) and what it takes to achieve them (i.e. implementation, including costs).

Evaluations should be as rigorous as possible with respect to evaluating whether a service was 'effective' or not, but every evaluation in real-world settings cannot, and sometimes should not, involve a randomised controlled trial. There are other ways to test whether interventions are effective and, while they have a lesser degree of certainty, they can be highly informative in decision-making. It is also important to establish what works for whom among those receiving the intervention. To achieve this, a *within group* — those

who receive the 'treatment' — approach is used to establish whether specific services, mixes of services, or the service providers themselves are linked with better outcomes.

In the case of HYAP, establishing a valid counterfactual is challenging for four reasons:

- It is not possible to accurately ascertain which CYP received HYAP and which did not. HYAP providers receive a contract for providing individual services but the specific funds and services are not exclusive to HYAP CYP.
- The wide and unspecified variability in the types of services provided and the population served by HYAP providers means there is no singular HYAP model to evaluate.
- The state-wide availability of HYAP and, indeed, existing policy that encourages HYAP eligible CYP to receive services from HYAP providers, means that there is an uncontrollable selection effect in operation. This effectively disallows the Evaluation Team from simply comparing those who received HYAP from those who did not using a contemporaneous cohort.
- The CIMS data, the primary source of information for services provided to this population, has only been in operation for roughly the same amount of time as HYAP has been in operation. This means that it is not possible to use CIMS to select a comparable historical cohort of eligible CYP.

Given these challenges, an evaluation plan was designed that:

- Profiles CYP who utilise services to establish that the intervention is reaching the target population;
- Explores service utilisation patterns and implementation information from interviews with CYP and surveys of service providers in order to establish whether the services provided match the intended goals of the program and to establish estimates of program cost;
- Investigates whether providing HYAP funding to individual providers results in improvements in outcomes for all eligible CYP receiving services from each provider; and
- Examines whether differences in service mix explain differences in outcome.

This approach requires longitudinal information about the type, frequency, duration and timing of services that each CYP receives, including periods where they may have left and returned to a provider, in order to establish whether the type and dose of services is associated with outcomes of interest. To better establish whether the services are responsible for the observed outcomes, demographics, historical services received, and type and level of need are controlled for statistically[7].

3.1.3. Mixed methods to incorporate implementation outcomes

An assessment of implementation quality requires an understanding of what has been implemented and how well the program has been implemented in the context of an organisation and service system. This focus is important because evidence in child welfare shows that effective programs are dependent on effective implementation (Albers,

[7] For example, higher need CYP may have greater service utilisation and poorer outcomes compared with lower need clients, which can be measured and accounted for in the analysis.

Mildon, Lyon, & Shlonsky, 2017). A mixed-method approach to 'triangulate' qualitative data from both DCJ and HYAP providers was used to gain a more in-depth understanding of barriers and enablers to HYAP implementation at the system and local levels was employed. This was achieved through data convergence and connection – a process where both sets of data are compared to determine if they meet the same conclusion and/or build upon one another to expand, transform or elaborate the depth of findings (Palinkas et al., 2011).

3.1.4. Client voice

The perspective of clients on the service they are receiving is an integral component of the assessment of program implementation, yet too often the inclusion of client voice is considered difficult, time-consuming or even unethical. Proxy measures of client satisfaction made by those who work with them are a poor substitute for the experience of clients, even when this client is a vulnerable CYP. The acceptability and appropriateness of a program, as judged by the client, are key measures of implementation outcomes (Proctor et al, 2011). Clients who find a program to be unacceptable or inappropriate to their needs are less likely to engage with services and fail to return for future visits when needed. This places the CYP at further risk of poor outcomes.

3.1.5. Ethical approval and processes

Ethical approval for this evaluation was secured through the Monash University Human Research Ethics Committee (MUHREC) — Ethics identification number: 18079.

Feedback from the MUHREC during the review process influenced decisions in providing sufficient information about the project to participants, securing their informed consent, detailing the information sought from participants and detailing the mode in which it was secured and stored. The conditions of this approval required the Evaluation team to:

- *Provide participants with an explanatory statement* — that details the information sought by the Evaluation Team, how it will be collected and what will be done with it.
- *Obtain informed consent from participants prior to their participation* — either through use of a consent form or a recorded verbal consent process.
- *Protect the confidentiality of research participants* — by deidentifying any information collected and reporting it in aggregate so that individuals or organisations cannot be identified.
- *Look after the interests of participants who are minors* — by ensuring that participants are at least 15 years of age and are renumerated for their time.
- *Respect the time and interests of professional participants* — by limiting the time commitment required for service provider and DCJ participation.

3.2. Evaluation aims and scope

The aim of this evaluation is to investigate whether unaccompanied children and young people, aged over 12 and under 16, transitioned out of homelessness following the receipt of HYAP services.

Of particular interest will be whether different approaches to delivering HYAP services were associated with differential outcomes for clients. Therefore, the evaluation will focus on:

- the implementation of HYAP;
- the outcomes achieved for clients under different service provision models; and
- the cost of providing different HYAP models.

The evaluation questions for each element of the evaluation are detailed in Table 3.1 below.

Table 3.1 How the evaluation questions were approached

Evaluation question	Topic	Source
What are the client profiles targeted by provider agencies?	Patterns of HYAP service delivery	Quantitative analysis of linked administrative data (CIMS and ChildStory)
What is the level of client satisfaction with the HYAP services received?	Client perspectives of HYAP services	Interviews with a sample of CYP receiving HYAP services
Are HYAP services being implemented as planned?	HYAP Practice model variation	Quantitative analysis of linked administrative data (CIMS and ChildStory)
What are the barriers and facilitators to the delivery of HYAP services?	Barriers and enablers affecting the implementation of HYAP from the perspective of providers	Focus groups with representatives of HYAP providers
Are clients living in safe, secure accommodation?	Analysis of select outcomes, within those young people receiving HYAP	Quantitative analysis of linked administrative data (CIMS and ChildStory)
Have clients reconnected with family members and/or friends?	Analysis of select outcomes, within those young people receiving HYAP	Quantitative analysis of linked administrative data (CIMS and ChildStory)
Have clients achieved their case management goals associated with seven key outcome domains (i.e. social and community, home, education and skills, health, empowerment, economic, and safety)?	Analysis of select outcomes, within those young people receiving HYAP	Quantitative analysis of administrative data (CIMS)
What is the unit cost of providing a unit of HYAP services to children and young people?	Analysis of the cost of providing HYAP services in each site	Online costing survey developed by the Evaluation Team
What are the elements that determine the makeup of the unit cost?	Analysis of the cost of providing HYAP services in each site	Online costing survey developed by the Evaluation Team

3.3. Information sources

3.3.1. Regularly collected administrative data

This evaluation is the first to link Client Information Management System (CIMS), one of the main administrative data systems used by providers of homelessness services, and ChildStory data, the main administrative data system containing child protection and out of home care metadata. One possible reason these data have not been linked before is that the CIMS data are arranged and stored as a complex series of monthly data slices that are not particularly well-suited for individual-level data linkage or analytics.

The Evaluation Team worked closely with DCJ throughout 2019 to build a restructured file that enables HYAP data to be analysed longitudinally. This work was critical to the delivery of the outcome evaluation and to our understanding of whether HYAP has been effective in achieving the desired outcomes. To our knowledge, this is the first time that CIMS data has been restructured in this way.

While informative, the key limitation of both the monthly service and transformed by person dataset is that it is not easy to look at services provided to those in the same family. There may be merit in exploring the possibility of using these data to follow both individuals and families, but it is well beyond the scope of this project to do so and would require considerable time to do well. For this evaluation, this prevents the analysis from observing how HYAP providers may be working with individual CYPs and their families. As it stands the data can only be used to examine categories of services and cannot readily and reliably tell, specifically, what was done with whom and for what purpose.

3.3.2. Focus groups and interviews

Qualitative information to inform the assessment of HYAP implementation was collected using focus groups. The Evaluation Team has expertise in the collection of data with vulnerable groups, and this approach was used successfully in incorporating the voice of clients in an understanding of how well HYAP was implemented.

The Evaluation Team had planned to undertake two focus groups with DCJ earlier this year — one with the DCJ Youth Homelessness Team who were responsible for the development of HYAP and oversee the implementation of the program as a whole and one with representatives of DCJ homelessness operations staff located across DCJ districts. However, this process had to be altered, at the request of DCJ, in light of COVID-19 pandemic.

To capture their input, the Evaluation Team prepared a series of questions for the Youth Homelessness Team that focused on understanding components of the program and implementation that had arisen in focus groups with service providers. While not as dynamic as a focus group, it was still possible to access useful information which was triangulated with other data to gain a more comprehensive view of HYAP implementation. Unfortunately, the COVID-19 restrictions meant that it was not possible to include the perspectives of DCJ homelessness operations staff in this evaluation.

3.3.3. Costing survey

The Evaluation Team collected data from providers to inform an estimate of the unit cost of providing a spell[8] of HYAP services through the use of an online survey. Information on the resources used to deliver HYAP services and how staff used their time was collected from service providers through an online survey.

3.4. This report

3.4.1. Evaluation context

In 2017, DCJ engaged the Centre for Evidence and Implementation (CEI) and its partners, the Behavioural Insights Team (BIT) and the University of Melbourne (now Monash University, Department of Social Work) to undertake an implementation, outcome and economic evaluation of the HYAP from 2017-2020. Over the course of the evaluation, the following products have been produced:

- An Evidence Review — this review sought to identify evidence-based interventions that enhance family reunification and/or family functioning in a cohort defined as over 12 and under 16 years of age who are at risk of homelessness and/or out-of-home care placements. The evidence review did not identify any programs or interventions that specifically target the population and the outcomes of interest to HYAP. Moreover, no studies were found that reported on homelessness outcomes. However, four interventions were identified that are designed for young people in OOHC and pursue target populations and/or outcomes that are similar to those of HYAP. These promising studies were clustered into two areas: placement prevention/family preservation and transition supports (Centre for Evidence and Implementation, 2018b).
- Program logics for service providers — this analysis, published in the report Development of program logics to inform the evaluation of the Homeless Youth Assistance Program, revealed that HYAP is loosely defined and the services delivered under its auspices vary widely between service providers (Centre for Evidence and Implementation, 2018a).
- Interim Evaluation Report — the Interim Report identified issues in the implementation of HYAP from the perspective of providers and provided an overview of the demographics, characteristics and needs of CYP who present at HYAP for their first appearance.

3.4.2. Report structure

The remainder of this report is structured around the evaluation questions with a chapter addressing each question. Each chapter includes a brief description of the context, methods used and key insights generated by the Evaluation Team. Additional information is included in appendices. It is structured as:

- Chapter 4 — What are the client profiles targeted by provider agencies?
- Chapter 5 — What is the level of client satisfaction with the HYAP services received?
- Chapter 6 — Are HYAP services being implemented as planned?
- Chapter 7 — What are the barriers and facilitators to the delivery of HYAP services?

[8] A spell refers to a continuous period of services at one or more HYAP providers. This is analogous to an episode, as used by DCJ in OOHC to reflect a continuous period of time in care that may have more than one placement within it.

- Chapter 8 — Are clients living in safe, secure accommodation?
- Chapter 9 — Have clients reconnected with family members and/or friends?
- Chapter 10 — Have clients achieved their case management goals associated with seven key outcome domains (i.e. social and community, home, education and skills, health, empowerment, economic, and safety)?
- Chapter 11 — What is the unit cost of providing a unit of HYAP services to children and young people?
- Chapter 12 — What are the elements that determine the makeup of the unit cost?

4. What are the client profiles targeted by provider agencies?

Key takeaways

- The pattern of prior ROSH and non-ROSH reports suggests that CYP accessing HYAP are not simply turning up at HYAP as at-risk individuals of homelessness but as very vulnerable individuals with extensive involvement with child protection services
  - When they first presented at HYAP, more than half (55.9 per cent) of the CYP were known to the community services sector through prior involvement with the child protection system
  - Families of CYP receiving HYAP have a substantial history of documented concerns including psychological, cognitive or mental health issues for at least one carer or child in the family, as well as family violence and substance abuse
  - Roughly 4 per cent of CYP were in OOHC when they presented at HYAP for the first time

- The most frequent reason CYP presented at HYAP for was for Relationship/Family Breakdown, followed by domestic and family violence and financial difficulties

- Female and Aboriginal CYP are overrepresented amongst CYP who present at HYAP relative to their proportion of the NSW population

- Overall, older CYP (aged >15) are more likely to present to HYAP, however the number of younger CYP (aged <15) increased over time and the number of older CYP has slightly decreased

4.1. Introduction

Children and young people who are experiencing, or who are at-risk of, homelessness present at HYAP services for a range of reasons. This chapter explores who they are, what kind of problems they face and how HYAP providers work with them. To understand this, the Evaluation Team examined the following characteristics of CYP who received HYAP services:

- Demographic characteristics
- Age at first presentation
- Prior involvement with the child protection system
- Previously reported as being at Risk of Significant Harm
- Frequency of ROSH & non-ROSH reports
- Prior receipt of a safety or risk assessment
- In OOHC on presentation

4.2. Methodology

Routinely collected administrative data can provide insights into the characteristics of clients and the types of services they receive. Linking multiple sources of data together can provide deeper insights. This analysis uses data extracted from two sources which aggregate regularly collect administrative data, they are:

- *Client Information Management System (CIMS)* — which includes information on type, length and frequency of housing and homelessness services accessed by CYP; and
- *ChildStory* — which includes details on any current or previous child protection concerns or time spent in in the OOHC system.

Together these two data sources allowed the Evaluation Team to report descriptive statistics on the demographic characteristics, child protection service history, and some of the underlying needs of CYP who turned up at HYAP.[9]

[9] Data were linked by the data custodian (DCJ) using a multi-factor statistical linkage key (SLK). A more complex probabilistic match was beyond the scope of this project, as is generating estimates of the sensitivity and specificity of the match. The quality assurance process was guided by content expertise and experience in each of the two datasets, resulting in a number of adjustments that increased the number of matched cases substantially. That said, results from both linked and non-linked data should be treated as estimates of actual demographic profiles, past and present case characteristics and service utilisation patterns due to known and unknown inconsistencies and gaps in the underlying data from both sources.

4.3. Insights

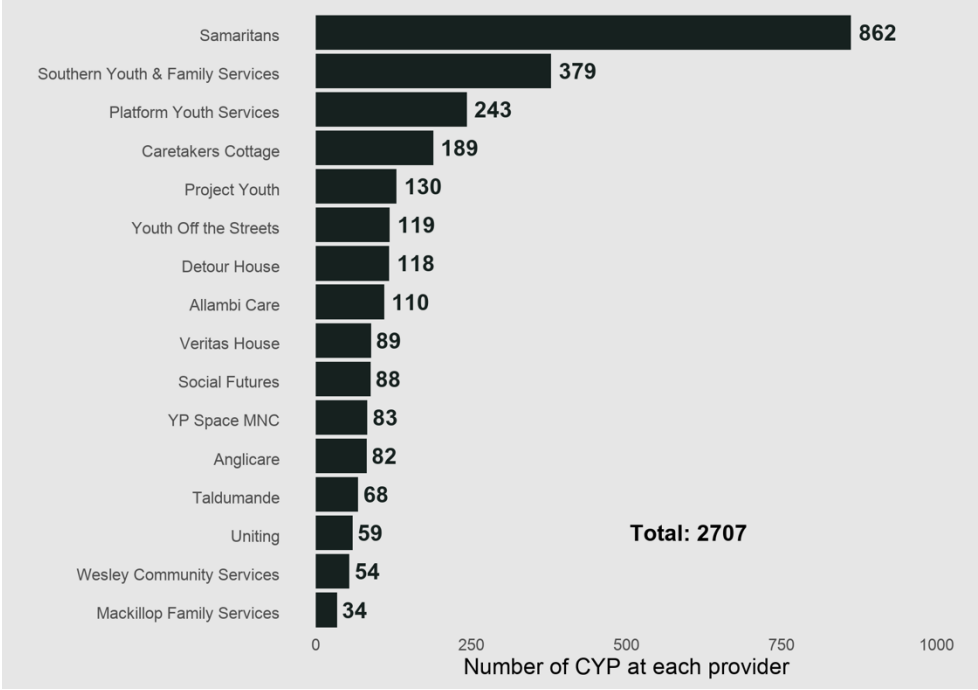
This section presents key insights organised into the following sections:

- Overall numbers of CYP receiving HYAP services
- Characteristics of CYP who present at HYAP — including: age, gender and Indigenous status
- Child protection history of CYP who present at HYAP — including: prior non-ROSH history, prior ROSH history and prior OOHC history
- Profiles of prior risk and need among the families of CYP who present at HYAP

4.3.1. Number of CYP receiving HYAP services

During the period between FY2016-17 & FY2018-19, over 2700 (n=2707) CYP received HYAP services. A breakdown of this count is shown in Figure 4.1 below.

Figure 4.1 Count of CYP receiving HYAP services by provider



4.3.2. Characteristics of CYP who present at HYAP for the first time[10]

Demographic characteristics

Amongst CYP aged between 10-19 in NSW, 6.2 per cent are Aboriginal and 48.6 per cent are female.

[10] CYP can present numerous times for discrete services to HYAP and may already have been receiving services from a HYAP provider when the program commenced. 'For the first time', in this context, means the beginning of the first recorded service period received by a CYP. If the CYP was already in a service period prior to being eligible for HYAP, the start date was defined as the first day they became eligible within that service period.

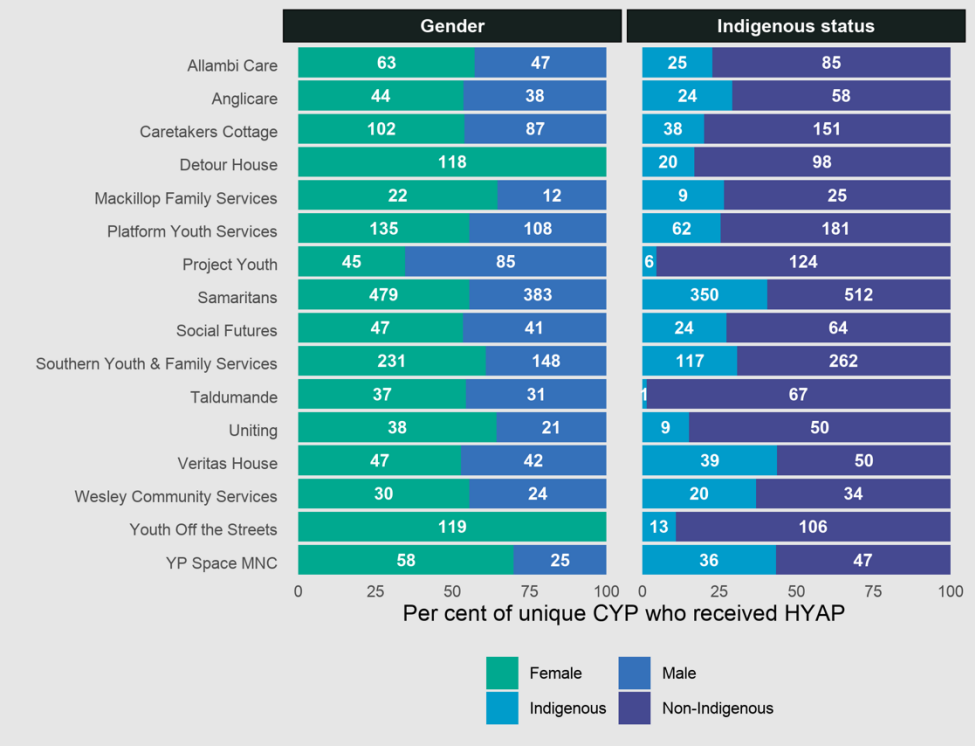
Based on these figures from the ABS (2018), both Female and Aboriginal CYP are overrepresented amongst the CYP who present for the first time at HYAP services relative to their proportion of the state population. As shown in Table 4.1 below, approximately 60 per cent of CYP are female and almost 30 per cent are of known Aboriginal or Torres Strait Islander heritage.

Table 4.1 Breakdown of CYP presenting at HYAP by Gender and Indigenous status (FY2016-FY2019)

	Male	Female	Aboriginal	Non-Aboriginal	Total
#	1092	1615	793	1914	2707
%	40.4 per cent	59.6 per cent	29.3 per cent	70.7 per cent	

That said, there was a fair degree of variability amongst providers. Two providers only provided services to females and the ratio of Indigenous to non-Indigenous status varied from a low of 1.5 per cent to a high of 78 per cent — see Figure 4.2.

Figure 4.2 Breakdown of CYP presenting at HYAP by Gender and Indigenous status (FY2016-FY2019)

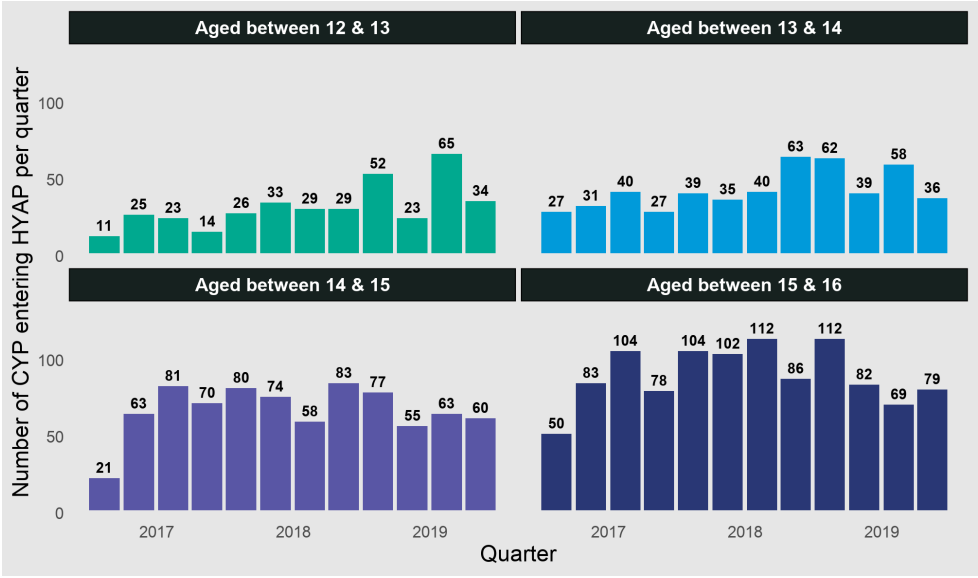


Age at first presentation

CYP are eligible for HYAP services while they are aged between 12 and 16. In aggregate, over the three period for which data are available, there is a clear picture that older CYP (aged 15 and 16) are more likely to present at HYAP than those aged between 12 and 14.

A more nuanced picture emerges when looking at age of first presentation by quarter (Figure 4.3). While older CYP are more likely to present to HYAP, the number of younger CYP (aged 12-13 and aged 13-14) has increased over time while potentially decreasing for older CYP over the same period. This may have implications for how services are provided should this trend hold.

Figure 4.3 Age of CYP at the commencement of their first HYAP spell (FY2016-FY2019)



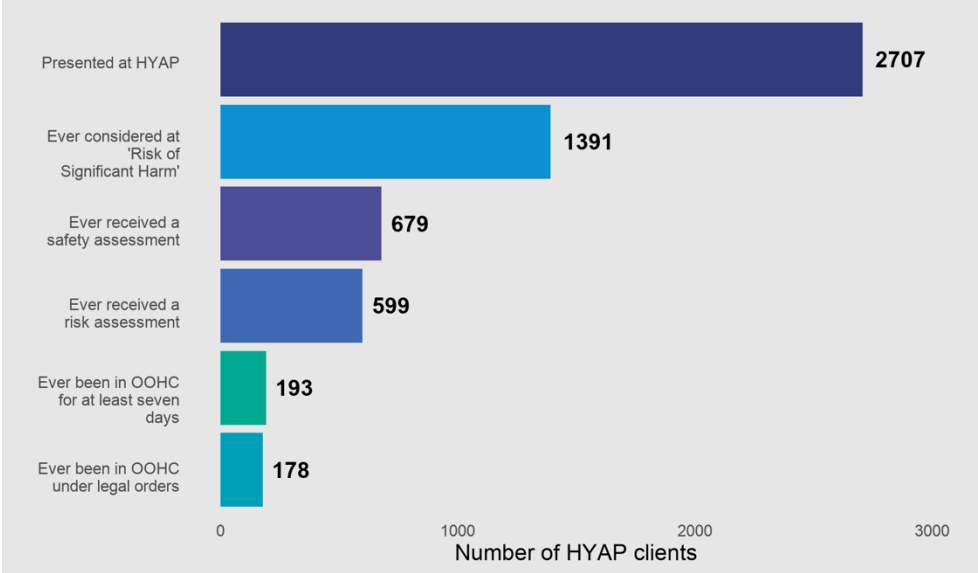
4.3.3. Prior involvement with the child protection system

Most CYP who present at HYAP do not appear 'out of the blue'. They and their families are often known to community service providers and the Department through previous service interactions and reports to the child protection helpline. When they first presented at HYAP, more than half (55.9 per cent) of the CYP had prior involvement with the child protection system.[11] The way in which they had prior involvement is summarised in Figure 4.4 below.[12]

Over half (51.4 per cent) of CYP had at least one prior ROSH report, one quarter had a face to face assessment where an Structured Decision Making (SDM™) safety assessment (25.1 per cent) and risk assessment (22.1 per cent) were completed, and 7.1 per cent had been in OOHC on at least one occasion.[13,14,15]

[11] Note: Calculation not reflected in Figure
[12] Note: Categories are not mutually exclusive, CYP can be in more than one category
[13] Safety and Risk Assessments are completed as part of a face to face assessment
[14] Note: Almost all risk assessments have an accompanying safety assessment, but a larger number of safety assessments do not have an accompanying risk assessment.
[15] An episode in OOHC consists of a continuous 8-day period of time in which a CYP is placed in care by DCJ

Figure 4.4 How CYP who present at HYAP are known to the child protection system



Previously reported as being at Risk of Significant Harm

More than half of the CYP who received HYAP services had been the subject of the report to the child protection helpline. More CYP had been considered to be ROSH (n = 1391) than non-ROSH (n = 1293)[16] — see Table 4.2.

The last report prior to presentation at HYAP reflects the last known reported child protection concerns for CYP before they turned up at HYAP. Key insights include:

- CYP at risk due to own behaviour was the primary concern for 27.5 per cent of the last ROSH reports and 17.2 per cent of the last Non-ROSH reports, strongly indicating that CYP had substantial individual safety issues prior to HYAP entry.
- Almost two out of three ROSH (64 per cent) and over four out of 5 Non-ROSH (82.2 per cent) had primary concerns related to one or more caregivers.[17] This reflects that:
    - these CYP are not simply turning up at HYAP as individuals with risky behaviour
    - these CYP come from families that are already known to child protection. The implication is that a great deal of social services have been offered or provided, and a great deal more will need to be provided in order to improve outcomes.

[16] Note: this may be a data artefact related to changes in criteria defining these terms that went into effect in FY2010-11.

[17] Caregiver issues consist of all primary concerns except CYP at risk due to own behaviour, no information provided, other issues, and prenatal report.

Table 4.2 Recorded reason for last ROSH or non-ROSH prior to first presentation at HYAP services

Primary reason for ROSH or non-ROSH	# of ROSH reports	% of total ROSH reports	# of non-ROSH reports	% of total non-ROSH reports
CYP at risk due to own behaviour	355	27.5	239	17.2
Neglect	313	24.2	399	28.7
Physical abuse	155	12.0	292	21.0
Sexual abuse	129	10.0	229	16.5
Emotional abuse	93	7.2	87	6.3
No harm or risk issues	52	4.0	1	0.1
Domestic Violence	48	3.7	65	4.7
(No information provided)	47	3.6	5	0.4
Drug/alcohol use by carer	44	3.4	45	3.2
Carer: mental health issues	26	2.0	19	1.4
Carer: other issues	19	1.5	5	0.4
Other issues	9	0.7	0	0.0
Prenatal Report	3	0.2	5	0.4
Total	1391	100	1293	100

Frequency of ROSH & non-ROSH reports

Prior to their involvement in HYAP more than half (51.4 per cent) of CYP were the subject of at least one ROSH report, and 44.7 per cent of them were the subject of one afterward. However, this doesn't tell the whole story.

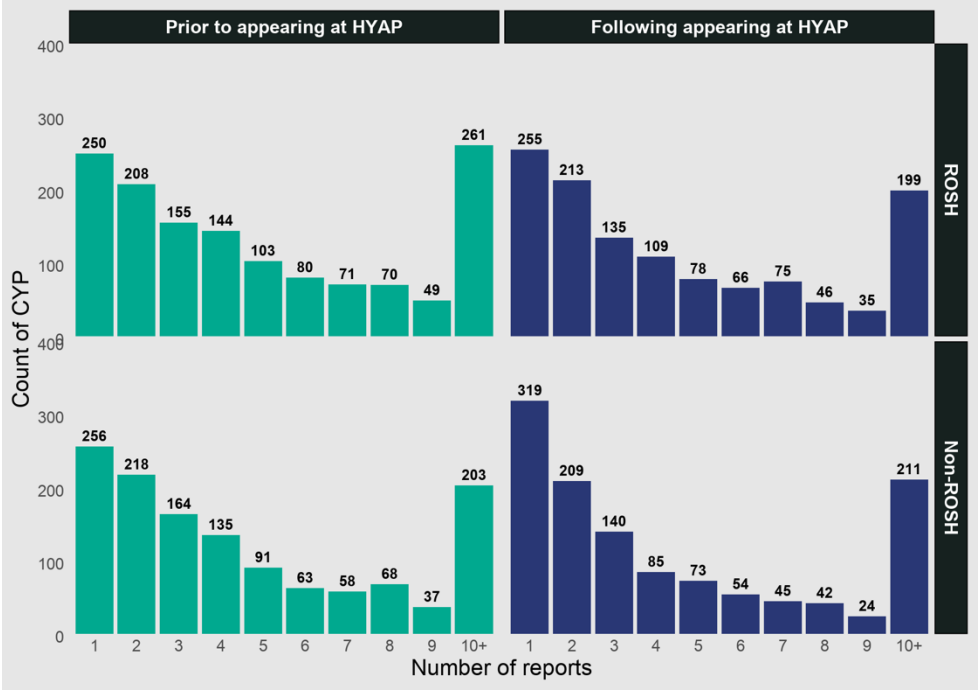
A large number of CYP were the subject of more than one ROSH and/or Non-ROSH report, and a large number of these had multiple prior ROSH and Non-ROSH reports. Moreover, these CYP continued to be reported as ROSH or Non-ROSH following an interaction with HYAP services.

Figure 4.5 below details the ROSH and Non-ROSH reports for CYP both before and after their first HYAP spell commenced. Because a HYAP service may be triggered by or trigger a

report to the child protection helpline, reports occurring three days before (n=166), on the day (n=29), and three days after (n=7) the start of the first HYAP presentation are excluded. Key findings include:

- The patterns of prior and subsequent ROSH and Non-ROSH reports suggest that, for a large segment of CYP receiving HYAP, the introduction of HYAP occurs after a cycle of involvement has already begun, and this pattern is likely to continue despite the provision of services.
- 9.6 per cent of all CYP were the subject of 10 or more ROSH reports prior to their first HYAP spell, with 7.5 per cent subject to the same amount of non-ROSH.
- 7.4 per cent of all CYP were the subject of 10 or more ROSH reports following their first HYAP spell, with 7.8 per cent subject to the non-ROSH equivalent.

Figure 4.5 Frequency of ROSH & non-ROSH reports prior to HYAP, at the commencement of HYAP services, and following the completion of their spell[18]



Prior receipt of a safety and risk assessment

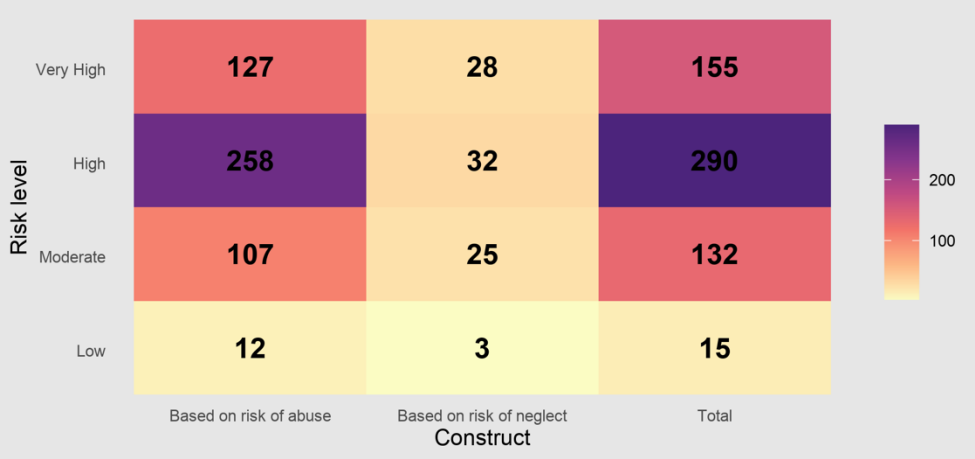
More than a quarter (22.1 per cent) of CYP who received HYAP received at least one face-to-face assessment that included both a safety and risk assessment as part of the SDM system deployed by DCJ.[19]

In the last risk assessment rating prior to HYAP, 75 per cent of family risk assessments were rated as high or very high — see Figure 4.6. This fairly reliable and valid prognostic tool suggests that these families are extremely likely to return to the attention of child protection, most often for abuse (e.g., physical abuse, sexual abuse, emotional abuse).

[18] Figures for both ROSH and Non-ROSH exclude a three-day window, either side of first HYAP presentation date, to conservatively account for reports triggered by the HYAP service itself (e.g., a HYAP provider filing a report with DCJ).

[19] The SDM Risk Assessment tool is a statistically driven, family-level tool used during the assessment process to predict the likelihood that a new, substantiated ROSH report will occur in the future.

Figure 4.6 Outcome of risk assessment



4.3.4. Profiles of CYP and their families

Extending the use of SDM tools further, a profile of the child protection-involved CYPs families indicates a range of caregiver issues that have implications for the extent of issues CYPs and HYAP providers will likely contend with when a CYP turns up to HYAP for the first time.

The Evaluation Team constructed a profile of CYP families using all prior safety and risk assessment measures (not just the last measure). The profile considered if there were one or more endorsements involving family caregiver or child concern falling in the health, mental health, domestic and family violence, substance abuse, parental history of child maltreatment, or housing areas[20] — see Table 4.3. This profile suggests that:

- there is a substantial recorded history of family concerns including psychological, cognitive or mental health issues for at least one carer (38.6 per cent) or one child in the family (27.2 per cent), family violence (36.8 per cent), or carer substance abuse (35.1 per cent); and
- the primary carer may also have their own history of child protection (20.6 per cent) and the family may be experiencing unsafe housing or homelessness themselves (11.5 per cent).

Table 4.3 Count of CYP presenting with care or protection orders at the start of their first HYAP spell

Safety and Risk variables	#	%
Does the parent/ carer have any psychological, cognitive, or mental health issues?	262	38.6
Is there any family violence in the household? (Domestic violence in past year / Any prior DV ROSH?)	250	36.8
Does the carer have a history of substance abuse? (drug and/or alcohol)	238	35.1

[20] Note: These findings are likely an undercount. Risk and safety items are only counted if they are known and recorded on the form.

Does the child have any diagnosed psychological, behavioural, emotional, or medical problems?	185	27.2
Did the parent / carer have a history of child protection?	140	20.6
Does the child have any developmental, intellectual, learning, or physical disabilities?	119	17.5
Is housing unsafe or are they homeless?	78	11.5

In OOHC on presentation

Of the 2707 CYP who received HYAP, seven per cent (n=193) had been placed in OOHC and four per cent (n=110) were on a current care and protection order at the time they first presented.

According to the information in CIMS, about six per cent of CYP (n=149) had current care or protection orders, with 22 of these in the category "Friends or Family Not Reimbursed" (see Table B.1 in Appendix B). Small differences in data sources aside, a small but substantial number of CYP had gotten to the point where they had been removed from their families and placed in care. Some turned up, either as runaways or to receive services, while they were simultaneously receiving OOHC services from child protection.

Summary

These findings from the historical data mean that not only are a majority of HYAP CYP known to child protection, many are well known and are likely to continue to be well-known regardless of their HYAP experience. Many of the next chapters will further detail the types of services provided and whether CYP have better outcomes. But one of the main findings will always come back to this:

A substantial proportion of CYP beginning a HYAP service, and by extension their families, are already well into the child protection pathway. The expectation that the HYAP service will prevent future child protection services may be well-intended but, for this particular group of CYP, the primary prevention option has passed.

5. Are HYAP services being implemented as intended?

Key takeaways

- Although HYAP is designed to prevent homelessness, the service funds a wide range of services in addition to housing and financial assistance

- The range of services offered varies by provider, and the types and duration of services CYP end up receiving may have more to do with which provider they received services from, rather than the documented problem for which they presented with

- More than one-third (35 per cent) of the CYP receiving services from a HYAP provider do not meet the program's eligibility criteria

5.1. Introduction

Understanding how HYAP has been interpreted and implemented by HYAP providers and the context in which it has been implemented will provide DCJ with insights into how HYAP was actually delivered, including potential inefficiencies and areas for improvement.

In reading this chapter, the reader should be aware that HYAP was not implemented in a vacuum. The context in which HYAP was developed and implemented was both dynamic and highly influenced by external factors. This is especially true of the interplay between HYAP the child protection system. Given the substantial differences in the service models delivered by each provider, the Evaluation Team was unable to use a standardised assessment of fidelity to a model for this evaluation. Instead, the Evaluation Team defined HYAP as being implemented as planned if it met the needs of CYP. This was broken into four sub-questions, which are described in Table 5.1.

Table 5.1 Questions to assess if HYAP was implemented as intended

Implementation domain	Question	Implementation outcome
Fidelity	Who are services provided to?	Are services provided being provided to the intended cohort?
Appropriateness	What types of services did they receive from providers?	Do the types of services being provided match the problem the intervention is intended to address?
Engagement	Did CYP use HYAP services? How long did CYP engage with HYAP for?	How many CYP used services? How many different types of services did they receive? Does the length of service align with the type of service provided?
Client needs	How did the services they receive vary by client type?	Did providers adapt services to client needs?

5.2. Methodology

The analysis presented in this chapter is informed by an analysis of routinely collected administrative data that have been linked using a statistical linkage key, they are:

- *Client Information Management System (CIMS)* — which includes information on type, length and frequency of housing and homelessness services accessed by CYP; and
- *ChildStory* — which includes details on any current or previous child protection concerns or time spent in in the OOHC system.

5.2.1. Analysis methods

Three analytic approaches were used to investigate different elements of this question — see Table 5.2 below.

- *Descriptive statistics* — were used to summarise and explain key themes and trends
- *Time to event analysis* — was used in the estimation of time-related constructs
- *Content synthesis* — was used to synthesise these findings with insights from focus groups with providers

Table 5.2 Methods used to inform this analysis

	Who are services bring provided to?	How long were they engaged with services for?	What types of services did they receive?	How did they vary by client type?	Is it being delivered as intended?
Descriptive statistics					
Time to event analysis					
Content synthesis					

5.3. Insights

This section presents key findings grouped into the following constructs:

- *Fidelity* — Who services are provided to
- *Appropriateness* — The types of services being provided
- *Extent and Length of Engagement* — Number of services and length of time they are provided
- *Engagement* — Variation in services by client characteristics
- Implications for implementation

5.3.1. Fidelity — Who services are provided to

To investigate if HYAP services are being provided to the intended cohort the Evaluation Team examined data sourced from the Client Information Management System to establish:

- How many CYP received HYAP services between FY2016-17 and FY2018-19; and

- What proportion of CYP who received HYAP services met the eligibility criteria for the program — see Box below.

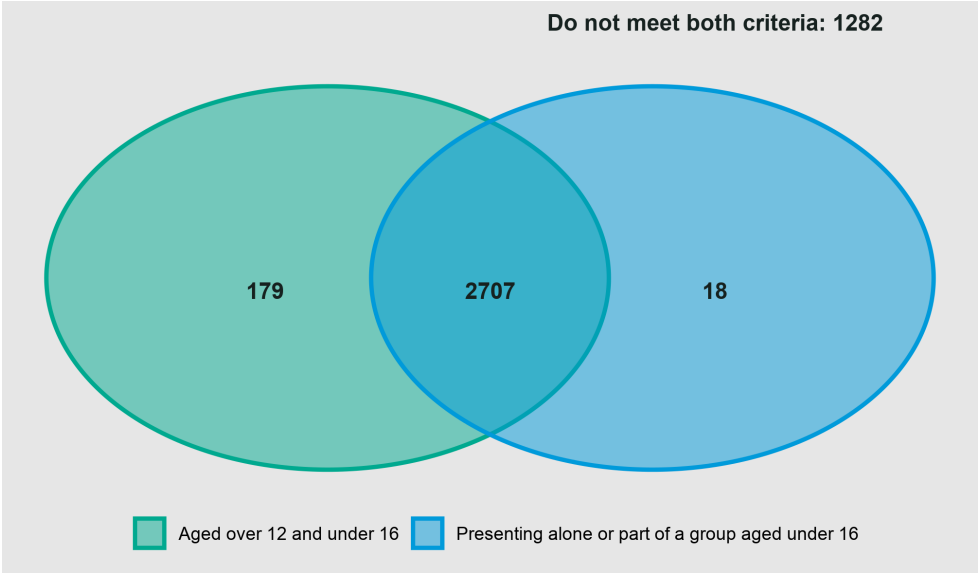
The analysis established that between FY2016-17 and FY 2018-19 there were 4186 CYP who received a spell of services from a HYAP provider. Of that total number who received HYAP services, 2707 individuals (64.7 per cent) met the eligibility criteria.[21] As shown in see Figure 5.1:

- 179 individuals (4.2 per cent) met the age criteria, but did not present alone (i.e. they presented in a group where at least one other individual was older than 16)
- 18 individuals (less than 1 per cent) presented alone — or as part of a group who were all aged under 16 — but did not meet the age criteria (i.e. they were under 12 years old)
- 1282 individuals (30.6 per cent) did not meet both criteria, with 1479 not meeting either criteria.[22]

Who meets the criteria for HYAP

To identify who meets the criteria for receiving HYAP services, the Evaluation Team examined an extract from the Client Information Management System to determine if: a) they are aged between over 12 and under 16 years old, b) they present alone, or as part of a group who are all under the age of 16 and c) they received services from a provider funded to deliver HYAP service on or after 1 July 2016

Figure 5.1 CYP who received services from HYAP providers by eligibility reason



No wrong door

The Evaluation Team is aware that, through the 'no wrong door' policy, providers are required to complete an and assessment and referral for all presenting clients regardless of eligibility for their particular service. If ineligible clients came to the provider and were

[21] The original HYAP policy, as written, funded providers to work with this specific eligibility group. While providers may have worked with other youth, only those who were eligible could be included as part of the HYAP evaluation.

[22] A breakdown of this by provider is included in Table C.1 in Appendix C

immediately referred, these would result in a higher proportion of spells of 1 day in duration for ineligible clients compared with eligible clients. To test whether this was occurring, the length of the spell — greater than versus equal to or less than one day — that ineligible clients received services was examined and tested to see whether significant and substantial differences existed between the age groups. The takeaways from this analysis — presented in Table 5.3 — are:

- The vast majority of ineligible CYP (87.4 per cent) received more than one day of support suggesting that they received more than the basic 'no wrong door' levels of support from HYAP on their first visit.
- The proportion of CYP who were ineligible for HYAP and only received one day of support significantly differed according to age, with individuals older than 16 significantly more likely to be referred elsewhere after one day or less (13.9 per cent) compared to those who were age-eligible (aged over 12 and under 16) but did not present alone (19 per cent) and those less than 12 years old (6.7 per cent).

Table 5.3 Length of time ineligible CYP received HYAP services for

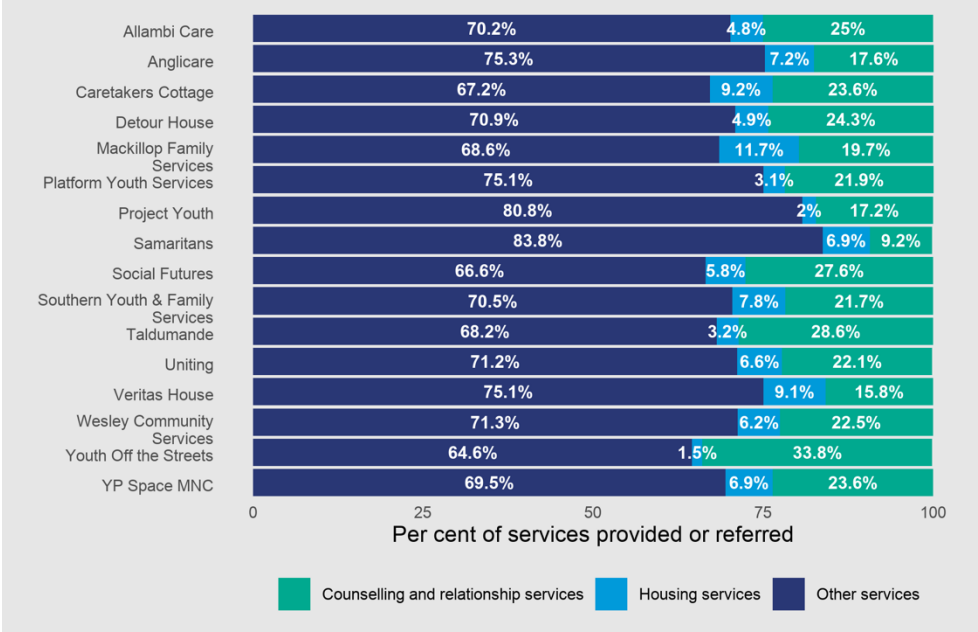
Age of CYP at first visit	Count of ineligible CYP that received services	% of CYP that received services for 1 day	% of CYP that received services for > 1 day
Less than 12	30	6.7 per cent	93.3 per cent
12-13	30	0 per cent	100 per cent
13-14	39	7.7 per cent	92.3 per cent
14-15	50	8 per cent	92 per cent
15-16	60	3.3 per cent	96.7 per cent
Greater than 16	1270	13.9 per cent	86.1 per cent
Overall	1479	12.6 per cent	87.4 per cent

5.3.2. Appropriateness — The types of the services provided

Broadly speaking, the most relevant categories of services[23] provided to CYP in the HYAP cohort are *housing services* and *counselling & mental health and relationship services.*[24] The extent to which these categories of services are provided to the HYAP cohort was explored by examining how service utilisation in these two main areas varied by provider. The results of this analysis — presented in Figure 5.2 — show that the provision of housing services and counselling, mental health and relationship services is dwarfed by the provision of other services, which mostly entails advice/information and other basic assistance'.[25] This is consistent across all providers.

[23] As they are recorded in CIMS
[24] Many of the other categories are mostly relevant for adults receiving housing services from SHS. See Table C.2 in Appendix C for how these are categorised.
[25] See Figure C.1 in Appendix C for a breakdown of *other services*

Figure 5.2 Service types referred or delivered by each provider for a CYP's first presentation at HYAP



5.3.3. Extent and Length of Engagement — Number of services and length of time they are provided

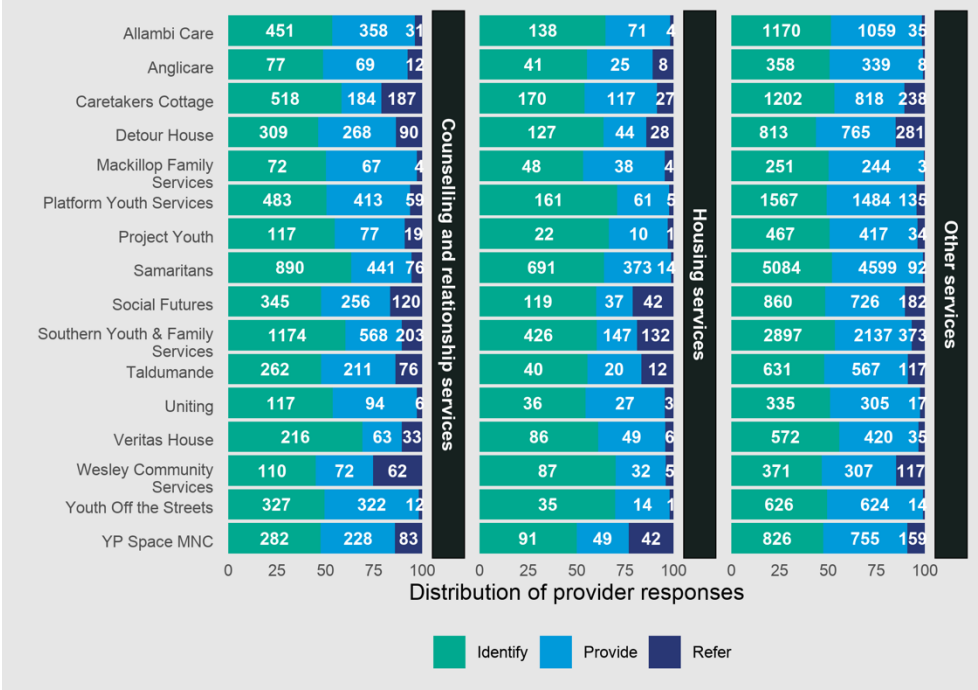
The extent to which CYP are provided with or referred to one or more services indicates whether they engage with a provider, at least initially. The length of engagement can also indicate that the service being provided is sufficiently engaging to stick with. In addition, differences between the types of services provided and their duration can shed light on whether the type of service varies by identified service need. This would be expected given need necessarily translates to different types of services provided and corresponding differences in duration of delivery.

Number of services provided

There are no direct measures of engagement or reach in the CIMS dataset. However, the number and range of services provided indicate whether a service is being utilised in different ways by different providers (which might reflect local variation). Overall, a lot of services are both identified and provided, or referred, which suggests that most CYP engaged with the HYAP at least once for multiple reasons — see Figure 5.3. There is variation in both the count of needs identified, provided and referred between providers and how these were distributed between providers. While some identify or provide more than others, this likely reflects the size of the providers catchment and/or the variation in their approach. Key messages included:

- the count of counselling and relationship services provided ranged from a high of 568 cases (Southern Youth and Family Services) to a low of 63 cases (Veritas House)
- a wide range was observed in both the provision and referral of housing services — services provided ranged from a high of 373 cases (Samaritans) to a low of 10 cases (Project Youth) while those referred ranged from 132 (Southern Youth and Family Services) to 1 (Youth off the Streets and Project Youth)
- the highest number of services provided was for other services — the highest count of provided services was from Samaritans (n = 4599) with the highest referral from Detour House (n=281)

Figure 5.3 Proportion and count of service types delivered by each provider for a CYP's first presentation at HYAP



Spell length by main presenting reason

The absence of guidelines for the optimal or required spell length providers should be delivering prevents the Evaluation Team from benchmarking providers. Recognising that CYP engage with HYAP services for a range of reasons, the Evaluation Team explored the extent to which a CYP's main presenting reason influenced how long they engaged with HYAP services. Different service types generally have differences in duration — for example, short-term housing versus longer term counselling for trauma. If HYAP engaged clients equally across service types, substantial variation in duration by the type of service would be expected to be observed. This involved undertaking two time to event analyses:

- *A Kaplan-Meier Estimator* — examined the extent to which the length of time a CYP receives services varies between all presentation reasons, as well as between pairs of similar presentation types.[26]
- *Cox Proportional-Hazards* — considered whether a CYPs characteristics — age, gender, Indigenous status, prior involvement with the child protection system (prior ROSH, non-ROSH, CP assessment), prior OOHC placement and the provider they received services from — affected the length of time they engaged with HYAP services.

Key insights from the modelling suggest that:

- Unadjusted estimates from the Kaplan-Meier Estimator, suggest that the length of time a CYP is engaged in HYAP varies by the type of service they received or were referred to — see Figure 5.4.
- The model identified significant differences[27] between those:

[26] These pairs were selected based on the Evaluation Team's content expertise.

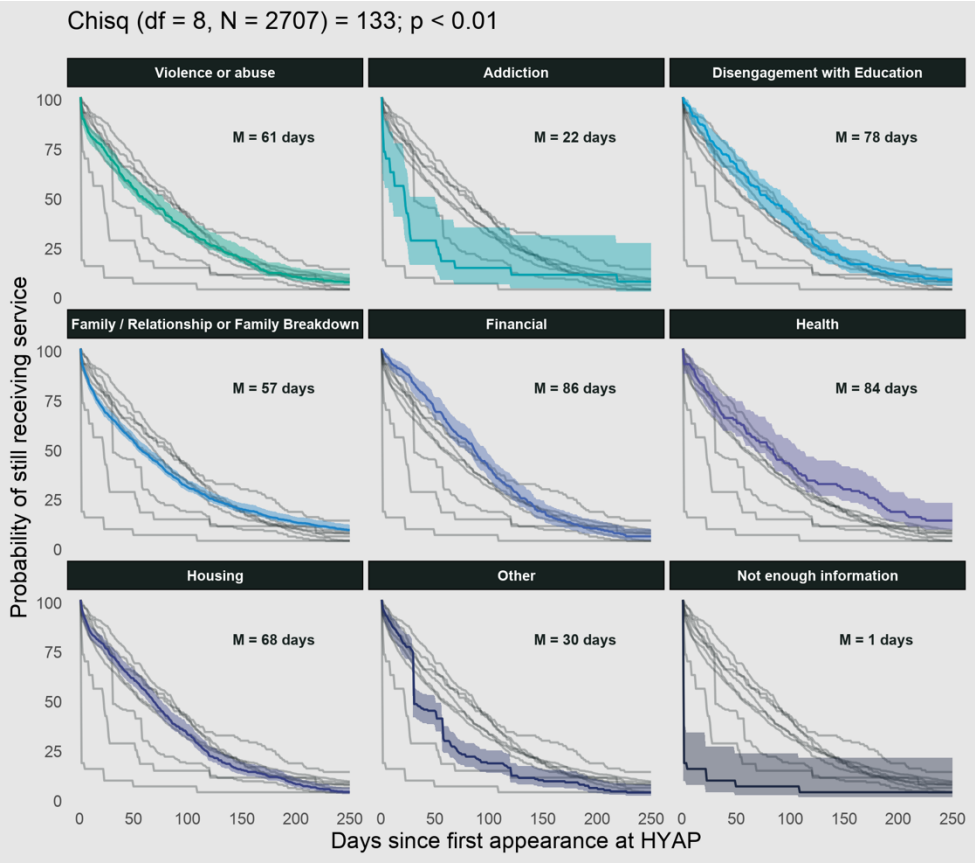
[27] There is no significant variation between those who present for violence or abuse (M=61 days) and family / relationship or family breakdown (M=57 days).

- who present for addiction (M=22 days)[28] and health & mental health (M=84 days) reasons; and

- who present for housing (M=68 days) and financial (M=86 days) reasons.

- However, results from the Cox Proportional Hazards modelling suggested that once other factors are taken into account[29], the primary reason for presentation is not a predictor of how long a CYP will receive services for during their first spell.[30]

Figure 5.4 Time to event curves by main reason for presenting (FY2016-FY2019)



Spell length by type of service provided

The Evaluation Team examined how provision of other of the two main categories of services of interest to this cohort — *housing services* and *counselling & mental health and relationship services* — affected the length time until a CYP is engaged in HYAP for by fitting a Kaplan-Meier Estimator. Key insights from this analysis include:

[28] The median (M) presented on each panel shows at which point half of the CYP who presented for that reason had completed their first spell of HYAP. The median is used because it is less influenced by extreme values. The steepness of the curve expresses how quickly the initial HYAP spell will end, with steeper drops indicating quicker transition to the end of the service.

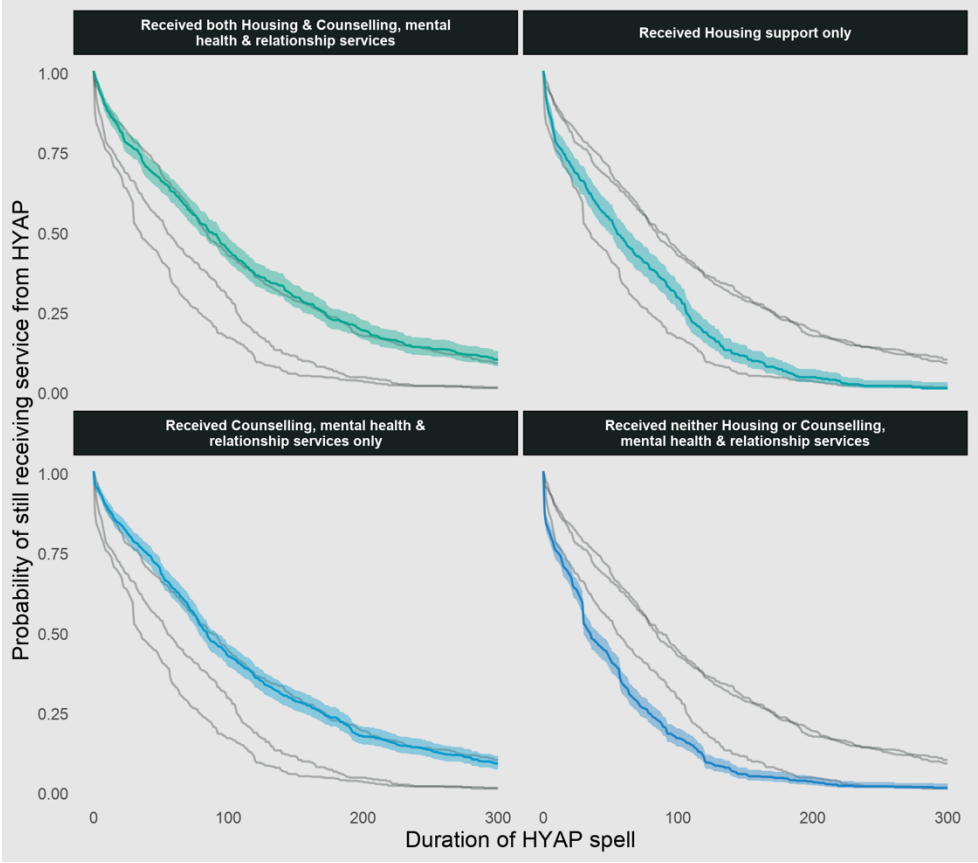
[29] Age, gender, Indigenous status, prior involvement with the child protection system (prior ROSH, non-ROSH, CP assessment), prior OOHC placement and the provider they received services from

[30] Age, gender, Indigenous status, prior involvement with the child protection system (prior ROSH, non-ROSH, CP assessment), prior OOHC placement and the provider they received services from

- the unadjusted results suggest that the length of time a CYP is engaged in HYAP varies by the type of service they received or were referred to[31]
- Kaplan-Meier curves indicate a fairly clear distinction between those who received both housing and counselling (M=85 days) or counselling only (M=84 days) and those who received housing only (M=55 days) or other services (M=34 days)

A caveat for this analysis is that, unlike the Kaplan-Meier curves presented in Figure 5.2, CYP who presented at HYAP for the first time could have had more than one service which could have been delivered by the provider or the CYP could have been referred elsewhere.

Figure 5.5 Time to event curves by type of service provided (FY2016-FY2019)



5.3.4. Engagement — Variation in services by client characteristics

The extent to which services provided meet client needs was explored by examining how the length of a HYAP spell varied by client characteristics. The Evaluation Team used a Cox Proportional Hazards model to examine the extent to which the length of service duration was influenced by a range of individual characteristics, including:

- Demographics — age, gender, Indigenous status,

[31] Note: the Kaplan-Meier estimator results are unadjusted and do not control for any other factors that might influence the length of services CYP will receive in their first spell (continuous period of service receipt),

- Prior involvement in the child protection system — prior ROSH, non-ROSH and CP assessment,
- Prior-OOHC placement,
- The provider they received services from.

The sample size allowed the Evaluation Team to explore in greater detail the individual association of housing and counselling support factors. The results suggest a complex picture of length of spell with key insights including:

- When delivered or referred out, each of the services listed in the Box were independently associated with shorter stays in HYAP i.e. CYP receiving these services were all more likely to have shorter stays in HYAP when compared with other individual or clustered sets of services.
- Previous use of short-term accommodation had a small association with increased time in a HYAP spell.[32]
- The greatest association with duration of HYAP services was the provider, possibly indicating that those who could provide the service in-house or who maintained the CYP in their service when referring out had longer HYAP spells.
- CYP with a prior ROSH or non-ROSH history were somewhat more likely to have shorter stays, but this was balanced out — CYP with a history of OOHC were more likely to have longer stays.

Services associated with shorter stays in HYAP

Long or medium term housing // Sustaining tenancy or preventing foreclosures // Assistance for sexual assault // Assistance for domestic violence // Relationship assistance // Assistance for trauma // Assistance for behaviour problems // Mental health services

5.3.5. Implications for implementation

Although HYAP is designed to prevent homelessness, the service provides a wide range of services in addition to housing and financial assistance. The range of services offered varies by provider, and the types and duration of services CYP end up receiving may have more to do with which provider they received services from, rather than the documented problem for which they presented with. The type of services that CYPs were given or referred also determined the length of time that CYPs received HYAP services. However, the length of time was more determined by the service provider than service type. This suggests that:

- the main presenting problem does not predict length of stay
- type of service or services provided or referred predicts length of stay – most housing and counselling services tend to be associated with decreased length of stay
- the strongest predictor of length of stay is the individual provider.

These findings are consistent with some of the issues and themes raised by providers in the implementation focus groups. In particular, the 'local responses' HYAP models appear to be guided by *what services were available locally*, as opposed to *what are the most appropriate services* required to work with a population with complex needs. For example, more intensive service models focused on child protection issues, such as Functional

[32] Defined as if a CYP was provided or referred to 'short term or emergency housing' at any time during their first HYAP spell.

Family Therapy-Child Welfare (FFT-CW), which may have been appropriate for some presenting CYP, had limited availability because they were available only in specific regions and had capped numbers for entry. These more appropriate services do not form part of the HYAP response, leaving HYAP providers to address the needs of CYP as best they could with the resources and service infrastructure available.

6. What are the barriers and facilitators to the delivery of HYAP services?

Key takeaways

- The availability of local services at the time of commissioning influenced the design of HYAP services in each district more so than any other factor
- The availability of appropriate services for CYP prior to, and during, HYAP varies across the state and can affect whether or not CYP in different locations have access to the same response
- There is a disconnect between DCJ and HYAP providers in terms of what constitutes an appropriate response for this cohort
- Well implemented district protocols can support providers and DCJ act in the best interests of CYP in HYAP

6.1. Introduction

The success or failure of a new policy or program can be affected by factors which both hinder and help its implementation, and ultimately its ability to achieve its intended outcomes. Factors which support the implementation of a policy or program are *facilitators,* while those that stymie it are *barriers.* In practice, barriers to implementation can relate to the availability of resources, while facilitators may include, for example, employing skilled staff (Bach-Mortensen, Lange & Montgomery, 2018).

Ideally, barriers and facilitators should be explored prior to program implementation so they can be addressed during the implementation process. However, identifying those factors that hinder and/or enable the implementation of a program during an evaluation can help inform future service provision and improve implementation by providing:

- visibility of what's working and not working; and
- insights into which implementation processes require more focus.

6.1.1. How do you assess barriers and facilitators?

Benefits of a conceptual framework

The use of a conceptual framework can provide guidance in the interpretation of findings and how to apply them to practice. The Consolidated Framework for Implementation Research (CFIR) is a meta-theoretical framework that synthesises information and evidence about constructs and domains that affect implementation processes — see Box below (Damschroder et al., 2009). The CFIR can assist in an evaluation context by guiding evaluators to assess to what extent:

- the program or intervention was acceptable to providers and funders;
- local adaptations were required, permitted and applied;
- the program or intervention was implemented as intended (i.e. with fidelity to the original model); and
- what barriers and facilitators supported or hindered the implementation of the program or intervention.

The Consolidated Framework for Implementation Research

The CFIR describes five implementation domains that potentially impact the implementation of evidence-informed practices:

→ **The practice or intervention itself**
Because its different attributes will influence how easy it can be taken up by individuals and organisations

→ **The individuals involved in the implementation**
Because their skills, expertise, attitudes and values can influence how they engage in the implementation process

→ **The inner setting, or organisation/system, into which the implementation is embedded**

Because factors such as hierarchical structures, climate and culture will influence how quickly and easily a new intervention can be taken up and used by an organisation

→ **The outer setting surrounding the implementation**

Because funding structures, legislation, policy agendas and similar factors in the environment of the implementation can change or totally stop an implementation

→ **The implementation process itself**

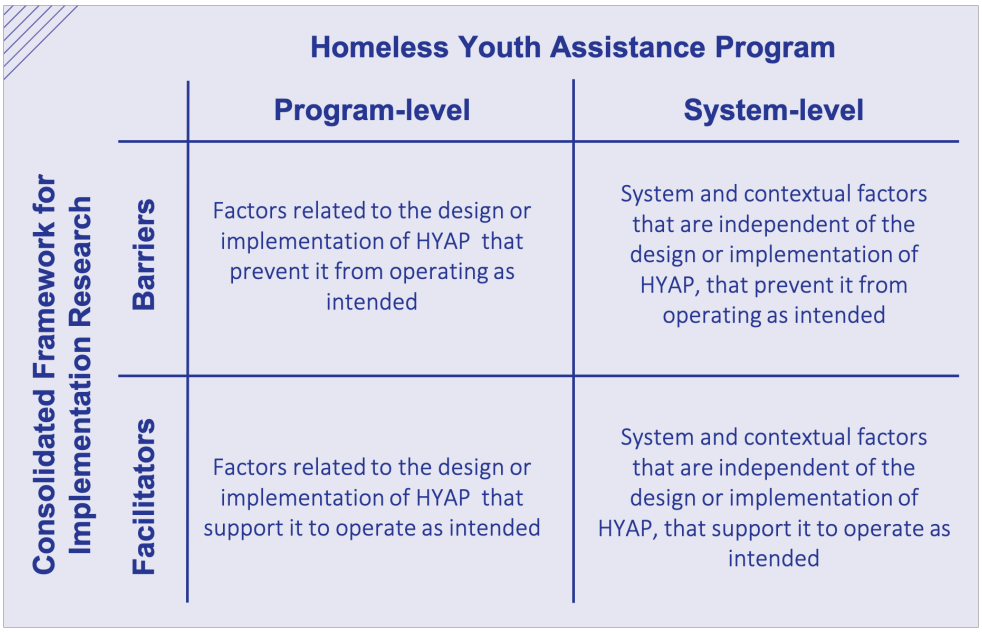
Because the attention paid, resources invested and commitment made to an implementation process will enhance – or diminish – the likelihood of its success.

Applying a conceptual framework to this evaluation

To provide DCJ with the most actionable and useful insights into the HYAP model, its implementation, and how it might be strengthened in future iterations, it is necessary to adapt the CFIR to this evaluation.

This is because the CFIR was developed to better understand factors influencing the implementation of evidence informed practices (EIP), which are often highly structured and well-defined manualised programs. HYAP is not a highly structured and well-defined model. There are radical differences in the way in which HYAP has been defined, funded and implemented in each of the locations in which it is provided. Moreover, some of those decisions have been influenced by the funder and others by the provider. For that reason, it makes sense to focus on a single element of it — the barriers and facilitators to program implementation — and apply this across internal and external elements of HYAP. This is illustrated in Figure 6.1.

Figure 6.1 Our modified CFIR-informed framework for assessing the implementation of HYAP



6.2. Methodology

The Evaluation Team undertook primary research with HYAP service providers and representatives from DCJ to inform the analysis of barriers and facilitators. This occurred in two rounds.

- *Round 1 (September-October 2019)* — with representatives from each HYAP provider; and
- *Round 2 (February-March 2020)* — with representatives from DCJ.

6.2.1. Understanding barriers and facilitators from the perspective of providers

The Evaluation Team conducted focus groups with representatives of each HYAP provider to understand what was done to adjust HYAP to their local context and what challenges to service implementation they had faced over time. The purpose of these focus groups was to understand:

- how each provider interpreted and implemented HYAP;
- barriers and facilitators to HYAP implementation at each stage or component of the model; and
- how HYAP could be improved to better meet the needs of clients.

Focus groups were held with each provider separately via teleconference. The process used to recruit participants is outlined in Table 6.1 below. Seventeen out of eighteen providers participated, with details provided in Appendix D.

Table 6.1 Invitation, Recruitment & Consent Process for focus groups with HYAP service providers

Invitation	The Evaluation Team contacted providers by email in August and September 2019 to provide information about the focus groups and their scope. Additional contact was made with provider contacts to answer questions and clarify the content and scope of the focus groups. Providers who did not respond were contacted via multiple mediums until a response was obtained.
Recruitment	Providers were emailed a copy of the Explanatory Statement and Discussion Guide approved by the Monash University Human Research Ethics Committee and asked to review it and identify the individuals within their organisation who were best placed to provide input. The Evaluation Team liaised with providers to find a mutually beneficial date and time to hold the focus group.
Consent	The focus groups were held via teleconferencing platform (Zoom). Participants affirmed understanding of the Explanatory Statement and provided Verbal Consent at the start of the recording.

6.2.2. Understanding barriers and facilitators from DCJ's perspective

The Evaluation Team sought to obtain DCJ's perspective on barriers and facilitators through three focus groups — one with representatives from DCJ's Youth Homelessness Team and two separate ones with representatives from DCJ district offices.

The availability of DCJ personnel for these focus groups was affected by the COVID-19 pandemic, with the Minister for Community Services directing DCJ personnel to prioritise operational work. As a workaround, the Youth Homelessness team offered to provide written responses to questions from the Evaluation Team. The adapted discussion guide is included in Appendix D.

6.2.3. Analysis methods

Qualitative data from both sources was subject to a modified framework thematic analysis which provides a systematic way to analyse large amounts of qualitative data according to an existing framework (in this case, the CFIR). This approach enabled the rapid identification of barriers and facilitators to HYAP implementation, grouped by whether they are program-related or system-related. The analytic process involved:

1. reviewing the focus group data (HYAP provider recordings and field notes) and written response from DCJ using a direct analysis approach to ensure familiarity with the data (Greenwood, Kendrick, Davies, & Gill, 2017);
2. applying codes to the data using a mix of a priori codes generated from the conceptual framework and open coding (i.e. codes emergent from the data);
3. categorising codes into the emergent themes that describe implementation barriers and implementation facilitators; and
4. synthesising results in order to present a comprehensive analysis of HYAP implementation.

The analysis also focused on the identification of what Massey (2011) termed 'attributional data'. This data, important to the interpretation of qualitative data when used in the context of evaluation, relates to theories or hypotheses about the topic of interest generated from the discussion that can be tested in the outcome evaluation.

6.3. Insights

This section outlines barriers and facilitators identified by providers and DCJ, grouped by whether they are at the system level or program level.

6.3.1. System-level barriers to implementation

Based on input from providers, a number of external or system-level factors that acted as barriers to the delivery of HYAP services were identified — namely:

- referral pathways channel complex or inappropriate clients to HYAP services;
- clients are presenting with child protection concerns, which is not the focus of HYAP;
- few, if any, early intervention services have been available for this cohort;
- few services are available to meet the current needs of the cohort;
- CYP in this cohort are ineligible for many potentially beneficial services;
- there are insufficient safe accommodation options; and

- there are few appropriate 'post-HYAP' options.

Each of these factors is detailed below.

Referral pathways channel complex or inappropriate clients to HYAP services

The manner in which CYP are referred to HYAP services varies markedly. DCJ notes this is decided at the district level and reflects the content of the District Protocols. In practice, some providers operated on an open referral basis and worked with CYP referred to them from a wide range of other sources, whereas other providers worked solely with CYP who were referred by their local DCJ district.

Providers felt that the source of referrals affected the type of clients who presented, and their suitability for a HYAP response. For example:

- Referrals from DCJ — Providers felt that many of the referrals from DCJ warranted a response from the statutory system (i.e. an OOHC placement). However, since there was no such response, HYAP providers had to work with clients for whom restoration was not a safe or preferred option; and

- Direct referrals from juvenile detention facilities — CYP referred through this channel might have had an Apprehended Violence Order (AVO) placed against them by police after attending a violent incident in the home. In situations like these, providers noted that even if restoration was the goal, the AVO and/or bail conditions meant that *"we can't do anything if the Police have put an AVO on them, even if the family wants them back"*.

Clients are presenting with child protection concerns, which is not the focus of HYAP

There was a strong theme from almost all respondents that many CYP referred to HYAP had outstanding child protection concerns. It is important to note that responses to this varied by location. Some providers noted that they could refer CYP to a DCJ district office for an appropriate response, whereas others said that *"once CYP were in HYAP, DCJ felt that they were safe and did not want to hear anymore from them"*.

Many providers felt that these CYP with complex needs and overlapping child protection concerns had little hope of family restoration and would be better served with a statutory response. These issues presented a number of challenges for both provider and CYP:

- Nature of the challenges facing this cohort — many providers felt that CYP with child protection concerns had issues and underlying problems that HYAP would be unable to solve with the time and resources available to them;

- Service provision reduces immediate risk of significant harm — providers expressed frustration that any ROSH report they made to the Child Protection Helpline would be 'assessed as safe' and closed as the CYP was accessing services through HYAP; and

- Victims becoming perpetrators — some providers noted that some of the CYP presenting with 'behavioural difficulties' had been reported at ROSH many times, and over an extended period of time. As they became older and stronger the system began to see them as perpetrators rather than victims.

DCJ appears to be aware of this issue and in a written response noted "*the services delivered to unaccompanied children aged 12 to 15 years are not intended either to fill a gap in the child protection response or provide a parallel equivalent… [M]echanisms are in place to ensure that homelessness services delivered to this cohort are appropriate and link*

to DCJ's child protection response where appropriate." In DCJ's view, mechanisms to support providers include:

- specific practice requirements outlined in service contracts and in the SHS Practice Guidelines;
- a specific policy outlining how homelessness services should be delivered to the cohort; and
- local protocols which outline how the state-wide policy is to be implemented locally.

However, there appears to be a disconnect between what providers expect a reasonable response to be and what DCJ are mandated and/or able to provide.

Few, if any, early intervention services have been available for this cohort

HYAP is viewed by DCJ as part of an early intervention strategy to prevent homelessness and prevent entry or escalation into the statutory child protection system.

In focus groups with providers a strong thread of feedback about the absence of appropriate early intervention services to serve the needs of this cohort was provided. Some providers felt that early intervention or family preservation at a younger age would prevent some of the issues that clients presented with from escalating at an older age and requiring a HYAP-level response.

Alongside this, some providers objected to the idea that HYAP was considered an 'early intervention' service on the grounds that intervening when a CYP is 12 years old for family preservation issues *"is too late for early intervention"*. Others noted it was 'curious' that HYAP was considered early intervention as many of the CYP presenting had intergenerational issues. As one provider put it, *"we know their older siblings"*.

This points to a disconnect between departmental aspirations of HYAP as part of an early intervention strategy and implementation of the program on the ground by HYAP providers. Not only is HYAP deemed to be *"too late"* for many CYP, providers state that there is no early intervention system infrastructure in which to refer, and meet the needs, of this group.

Few services are available to meet the current needs of the cohort

The availability of appropriate services for this cohort was highlighted as an issue by almost every provider. In particular, providers commented:

- Referrals to external services are difficult — there are limited options for HYAP providers to refer CYP or their families to services that meet their needs. Issues raised that relate to this include:
    - there are no appropriate mental health services for this cohort — it was repeatedly highlighted that Headspace does not work with either complex cases or under 16-year-olds;
    - accessing a qualified mental health professional (either a psychologist or psychiatrist) in a timely fashion is not possible across the state, and even in Sydney;
    - family mediation services are full or hard to access — which given the cohort and its needs is a significant barrier; and
    - access to education is almost impossible in some locations if a CYP has been suspended or expelled from the local school.

- There are few or no other services available for this cohort — which results in the HYAP provider becoming a 'catch-all' for all young people experiencing a crisis within their region. In some cases, DCJ and others referred CYP who were not at-risk of homelessness, but had mental health issues. Providers accepted these referrals because "there was nowhere else they could go". In other cases, CYP are referred to HYAP services when they are discharged from hospital and are unable to return home.

DCJ is aware relevant services are in general targeted toward younger or older children with different needs, and that "*this is not just true in the homelessness sector but in the surrounding health, youth and family sectors too, leaving a gap in services for the HYAP client group"*.

It is evident that work is required to map existing and/or appropriate services for this cohort, including what options are available as the level of case complexity increases. For example, program documentation refers to Headspace as a potential mental health services delivery partner, yet provider feedback suggests that CYP in HYAP are ineligible for Headspace services.

CYP in this cohort are ineligible for many potentially beneficial services

Providers were acutely aware of the services to which DCJ can facilitate access if a CYP has an active case plan or is the Parental Responsibility of the Minister (PRM). Many HYAP providers felt that there was more that DCJ could do to provide an appropriate response for those 'complex cases' who do not respond to general HYAP services.

In particular, multiple providers mentioned their need to access DCJ-brokered services like Functional Family Therapy Child Welfare (FFT–CW®) and Multi-Systemic Therapy Child Abuse and Neglect (MST–CAN®) that they believe clients and families would benefit from. However, they have not be able to access these services due to either closed referral pathways, strict eligibility criteria or an absence of such services in their location.

The Evaluation Team notes that DCJ also proposed the same intensive restoration programs as "*providing similar services for the same age group"* for CYP with complex needs who do not respond to HYAP services. They also cited *Family Group Conferencing* and *Youth Hope*, which providers noted have limited geographic availability.

There is a disconnect between DCJ and providers regarding what services are available. Rather than let CYP fall through the cracks, HYAP providers see themselves as doing what they can, but they also perceive that this is not enough, especially in complex cases.

There are insufficient safe accommodation options

Among the other issues noted regarding the availability of services, providers were frustrated by circumstances when they are unable to find safe accommodation options for CYP in HYAP and, as a result, the CYP will end up in a situation where they are not safely accommodated.

Many providers described this as trying to find the 'least-worst' option. Sometimes this might mean a CYP ended up staying in HYAP accommodation for an extended period of time. At other times this might mean they 'self-place' and couch surf with friends. As one provider put it: *"If we are full, [DCJ] will not pick them up, which means we end up working with children who are couch-surfing or rough sleeping".*

DCJ noted *"if there are no safe accommodation options available, SHS/HYAP providers should make a report to child protection as per the MRG [mandatory reporter guide] tool direction".*

In practice this is difficult, however. Multiple providers were exasperated about cases where they 'run out of options' and report to the Child Protection Helpline, yet there is no response from DCJ. They stressed that *"DCJ see that they are in HYAP and that takes them out of the 'immediate safety concerns' box and they get closed without a response"*. An almost universal refrain from providers was that *"if they [the CYP] cannot be restored or safely accommodated then they should be eligible for a statutory response."*

There appears to be a disconnect between the way in which DCJ's Child Protection Helpline assesses safety and risk for these very vulnerable CYP and how HYAP providers view the reality of their situation.

There are few appropriate 'post-HYAP' options

For CYP who 'age out' of HYAP without achieving family reunification there are limited options. At 16, these CYP are considered adults by the SHS system and can end up staying with friends, in adult SHS shelters or alternating between the two. Providers stressed that:

- due to the transient nature and crisis facing individuals in adult SHS shelters, this is not an ideal outcome for a 16-year old;
- there is no support to help these CYP after they leave HYAP to 'transition to independence'. This contrasts with aftercare support available to young people leaving the OOHC system at 18.

These CYP aging-out of HYAP are arguably more vulnerable than CYP leaving OOHC — who are widely recognised to be at-risk of poor housing, employment, health and social engagement outcomes — due to their younger age and inability to access transitional supports.

6.3.2. Program-level barriers to implementation

A number of barriers were identified at the program-level. These barriers relate to the HYAP model itself or the ability of providers to deliver it. Identified issues included:

- state-wide inconsistencies related to the process used to design the service model;
- a poor fit between the population and the model;
- limits in the length of time accommodation can, or should, be provided;
- consent and legal barriers;
- absence of transitional support; and
- funding issues.

State-wide inconsistencies related to the process used to design the service model

The way in which HYAP varies radically across the state is a direct result of the way in which it was designed and implemented. This may be an inadvertent outcome of how consultation was used in forming the policy. As DCJ indicated, the design of services for 'HYAP Stage Two' was informed by *"substantial consultation with government and non-government stakeholders"*. This was operationalised at the DCJ District level with *"districts… required to identify the most appropriate service delivery approach, or a combination of these approaches, based on an analysis of local client need, the characteristics of the local service system, and the outcomes of local collaborative service planning processes."*

In practice, this means providers are delivering a service packages that bear little similarity with each other. For example:

- some providers have limits on the length of time they will provide accommodation support, others do not;
- some providers are told to exclude OOHC cases where the CYP is PRM, others are not;
- some providers have multiple referral pathways, others do not and only get referrals from DCJ;
- some providers prioritise engaging with families, others prioritise the CYP; and
- some providers exclude CYP from an accommodated response if they have unmanaged mental health or AOD issues, others do not.

Consequently, target populations, referral pathways and available services all vary, and every provider is doing something different.

A potentially poor fit between the population and the model

Providers were clear that there was often a poor fit between the complex needs of CYP and the HYAP model. This was despite the fact that services commissioned under HYAP were those that were locally available. Some of the specific issues they raised were:

- Limited by the time available — depending on their service model, providers had a relatively small window of time to work with clients and they felt they could often only achieve a 'band aid' solution in that period.
- Crisis is too late — those providers whose service packages focused on prevention noted that *"when families are in crisis there isn't a lot we can do".*
- CYP are not at risk of homelessness — some providers noted that the referrals they received from the DCJ were not appropriate i.e. there is nothing in the home that suggests they are at risk of homelessness "they just want us to do something".

As one provider observed, *"the way this program is defined, any kid is at risk of homelessness, but realistically, it could only help about 10 per cent of them. The rest require a more intense response"*.

The implicit policy logic underpinning HYAP is that giving funding to local services will ensure that the needs of CYP are met. This is because those local to the CYP will have a better understanding of their needs. As such, the assumption is that this will allow providers to commission the services that CYP need locally. However, the HYAP experience is not one in which the needs of the CYP drive the availability of the local services, but rather that the availability of the local services drives the services provided to the CYP.

Accommodation provision

The length of time CYP can be, want to be, and should be accommodated was an issue on which providers felt strongly about. Issues raised included:

- The length of time support is provided for was contentious — while DCJ recommended providing up to three months of accommodation, for some CYP there were no options available after this period. Additionally, it was noted that CYP spending extended periods of time in these housing situations is not ideal.
- Providers with accommodation need to consider the 'house dynamic' when considering when to accommodate a CYP — for that reason, some providers exclude

CYP presenting with 'unmanaged' mental health issues and alcohol and drug (AOD) issues, which further limits options for these vulnerable CYP.

- The program is voluntary and CYP can only take living in these conditions for so long — it was stressed to us that the 'house rules' caused friction for some CYP after an extended period of time, and that some CYP would rather self-place in a potentially unsafe environment than stay in HYAP accommodation.

Consent and legal barriers

DCJ noted that issues regarding consent and decision making on behalf of a CYP or by a CYP can be complicated and depend on the individual circumstances.

Providers do not have the ability to make decisions or provide consent on behalf of a CYP — they need to obtain consent of a parent or person with parental responsibility. Providers stressed that their ability to provide services to CYP was bound by parental consent, and withholding of this consent could have a negative impact on the CYP. Providers cited a range of reasons why a parent might not provide consent, from: *"being absent"* through to *"concern that it would affect their ability to access family tax benefits"*. Additionally, if consent was provided initially, the prospect that consent could later be withdrawn could affect the viability of a placement.

Whilst both providers and DCJ recognise this is an issue, both parties are reluctant to advocate for legislative change. DCJ conducted a scoping exercise in 2019 that concluded that provisions in the *Act* should not be changed.

A related issue was the absence of identifying documentation (e.g. birth certificates and Medicare cards) that parents were asked to provide for CYP. Even if consent had been provided, the absence of these documents influenced the ability of CYP to access medical and educational services.

Absence of transitional support

Providers stressed that there are CYP receiving HYAP who:

- cannot be restored to their families;
- cannot stay with friends or relatives; and/or
- have not received a statutory response from DCJ.

The provision of support for CYP who are unable or unwilling to return to their family home is a complex issue. On one hand, the HYAP Service Delivery Framework state that *"HYAP aims to … facilitate transitions to more appropriate long-term supported accommodation, when family reconnection is not possible"* (NSW Department of Family and Community Services, 2016). On the other hand, it is unclear what this 'appropriate long-term supported accommodation' looks like. Providers note that the only option for these CYP is to stay in HYAP, in non-consecutive support periods, and potentially with different providers, until they are 16 and enter the adult SHS system.

DCJ recognises there are some CYP in this situation and notes that *"it might seem appropriate to consider an approach which provides a little more stability and allows support to be tailored to be delivered over a longer period however any consideration of transitional accommodation as an approach is limited by the fact that services do not have and cannot obtain parental responsibility".*

However, it is unclear what this approach might look like in practice. In response to a question about what form appropriate transitional accommodation might take, DCJ noted that *"transitional accommodation is not considered appropriate for unaccompanied*

children aged 12 to 15 years as children in this age group need a permanent and stable home". DCJ goes on to state that *"DCJ remains of the view that transitional accommodation is not an appropriate service for this cohort".*

Taken as a whole, it would appear that DCJ is asking HYAP providers to come up with an 'appropriate response' for these CYP and providers are countering that 'an appropriate response is a statutory one'. This is a significant implementation issue and some work needs to be done to decide what an appropriate response for these CYP is and how it could be implemented consistently state-wide.

Funding issues

DCJ noted that the funding allocation for each district was directly related to the DCJ district offices' perception of the needs of CYP in the district and the services available for the HYAP cohort.

It is unclear by which means DCJ districts determined the needs of CYP in their district, however as shown in Chapter 11, there is a substantial variation in the amount of money allocated per CYP across the state. It makes sense that this is one of the reasons why HYAP varies so substantially by site.

This aligns with statements from DCJ that: *"since each district approach (what they thought their district service system needed) and provider proposal (including co-contribution) is different, there is variation in the total funding allocated to each District and provider".*

The Fair Work Commission's Social and Community Services Equal Renumeration Order (ERO) means that most HYAP providers are subject to increasing wage costs as this is phased in until 2020. Some providers emphasised that, over time, their wage bill will take up a larger proportion of HYAP funding and leave fewer financial resources available for flexible items such as brokerage.

6.3.3. System-level implementation facilitators

A number of system level facilitators were identified by providers and DCJ. These included:

- having an operational district protocol with DCJ; and
- localised links with DCJ and other services.

Well implemented district protocols support collaboration

Each district is expected to have a document outlining *protocols for responding to unaccompanied children and young people 12-15 years of age who are at risk of homelessness*. The template was developed and circulated to districts to develop appropriate responses for their context. DCJ's vision was that the document would provide key information in relation to duty of care, referral pathways, case management and escalation pathways in order to guide the development of district-level responses.

The protocols are meant to be developed in consultation between providers, DCJ and partner agencies (health, education, justice etc) and outline who is responsible for providing a service response in different circumstances. The protocol is supposed to be agreed and endorsed by all parties and serve as a template for reference. According to DCJ, local protocols have been established in each district. Their purpose is to outline how the state level policy will be implemented locally and the responsibilities of each key stakeholder including arrangements with local DCJ Community Services teams and escalation processes.

Providers reported mixed progress in the completion of this process with responses varying from:

- "I've never heard of it"
- "Ours is in draft form and is awaiting approval"
- "Yes, we have one and it's great"

Providers who considered they had an 'operational' or 'active' district protocol stressed that it is a useful document when the processes are followed. However, some noted *"that just because we have a protocol, it doesn't mean we always get to use it"*.

DCJ similarly stated that this process has not always been smooth, noting that some districts developed protocols, but were not able to operationalise them. Barriers preventing this were due to either outstanding local issues — which were addressed in part or fully with 'work-arounds' — while others were more complex state-wide systemic barriers being addressed by the DCJ central office. DCJ notes *"these issues do not prevent the operation of a protocol but do create a barrier to implementing an 'ideal' protocol"*.

Strong links between providers, DCJ and other services

Feedback from providers suggests that strong linkages between providers, DCJ and other service providers can facilitate the provision of an appropriate response to their clients. Ways in which agencies can be supported to work together include:

- Having an effective dedicated contact in each DCJ district office for providers to work with — this is something the NSW Ombudsman highlighted in their 2018 report and that DCJ sought to address through introduction of DCJ contacts in mid-2019. Some providers stressed they had a strong and effective relationship with their district office through a dedicated contact which allowed them to engage DCJ services without going through the Helpline. Others were either unaware of a contact or thought that the contact did not materially change anything as "there's no change in resourcing so they can't really 'do anything'". For their part, DCJ note that they are actively monitoring — through regular surveys — how each district is implementing the dedicated contact point for HYAP providers and ensuring the role is transferred when personnel change.
- Playing to provider strengths — provider feedback on this varied, with some saying that *"it really helps that we aren't a statutory authority in building rapport with families"*, while others directly contrasted this by saying "DCJ can support us with the threat of the 'statutory stick' if recalcitrant families are reluctant to engage with providers".
- Localised child protection helpline — a localised helpline exists in one DCJ district, and the provider stressed that this helpline facilitated a strong relationship with DCJ. They noted that together they had developed a district protocol with a differential response based on the age of the CYP referred to HYAP.
- Memorandum of understanding (MOU) with other providers — some providers had MOUs with providers of other services — for example other HYAP providers or 'early intervention and placement prevention' services — which assisted them to refer clients in both directions.
- Other family support services — some providers noted that, for brief periods of time, they had been able to access some intensive services being trialled by DCJ (e.g. FFT-CW). This was perceived to have a strong complementarity to HYAP services.

6.3.4. Program-level implementation facilitators

This section outlines some of the program level facilitators identified by DCJ and providers. These include:

- fit between the client and service;
- flexible approach to service delivery;
- setting achievable goals for clients; and
- supportive organisational setting.

Fit between the client and service

Overwhelmingly, providers considered a facilitator of the HYAP program to be a high degree of fit between client need and the actual service able to be provided. The fit between client and HYAP service was most pertinent when CYP presented with issues requiring responses in either primary or tertiary prevention. For example, some providers differed on their implementation of either:

- a preventative accommodation model — which focused on services and intervention in order to keep the CYP in the home; or
- an accommodate and follow up model — which focused on outreach services to support restoration.

Flexible approach to service delivery

Providers were flexible in their approach to service delivery and proactive in designing and providing services that met local need. For example, some providers used HYAP in order to:

- provide services such as parenting programs for parents of teenagers;
- do preventative work through community building and volunteer mentoring for at-risk young people;
- trial novel accommodation models involving OOHC-like carers for children and young people or supervised housing models;
- undertake outreach in schools, which was particularly important for those providers with open referrals; and/or
- help CYP and families navigate bureaucracy in order to access the funding, support and programs they needed.

Setting achievable client goals

Providers stressed the importance of setting achievable goals in partnership with CYP and talking through these goals clearly with the CYP and, if appropriate, parents. This might take the form of:

- Clarifying the intention of service responses — e.g. clarifying that accommodation for the CYP is temporary and is intended to provide respite while issues are addressed rather than be a long-term solution
- Client-led goal setting — e.g. talking with CYP about restoration and what CYP want to get out of it

- Having an exit plan prior to intake — an exit plan can mean the HYAP is seen as a bridge between other arrangements such as returning to family members after the weekend.

Supportive organisational setting

A commonly reported facilitator to the implementation of HYAP was a supportive organisation and staff. Providers noted that they had:

- engaged staff who were committed to HYAP and the provision of services to this vulnerable cohort of CYP. They explained that staff loved their jobs, and this aligned with our general observations during interviews.
- strong institutional support from senior management to advocate for their clients and implement the model that made the best use of their resources.

Some organisations were also able to take advantage of internal referral pathways and additional resources to meet client need, although this tended to be a feature of larger established organisations who had more options.

7. What is the level of client satisfaction with the HYAP services received?

Key takeaways

- The findings from the client interviews suggest that CYP who were currently or previously engaged with HYAP services were generally positive about the support they received from service providers.
- Clients did not have strong opinions about the services received and how they could be improved
- Clients did however feel that the way in which information was communicated between support workers and clients could be improved in the future by having more effective communication.

7.1. Introduction

CYP engaging with HYAP services are vulnerable due to both their age and the experiences which lead them to seek assistance. Despite their status as a core user type, perspectives of service users are frequently ignored, not captured or narrowly focused (Sanders & Kirby, 2014).

In human services, most service user feedback has been captured through satisfaction surveys, which is problematic as satisfaction measures are prone to bias if the user has no

comparable experience to base their feedback on. This is particularly an issue for service users who are socially disadvantaged, marginalised and dependent on needed services. Furthermore, service user needs extend to other domains including accessibility, cultural relevance and perceived flexibility (Becker, Spirito, & Vanmali, 2015).

Consideration of this — and feedback from members of the HYAP-AC — led the Evaluation Team to examine client satisfaction through the lens of 'client voice'.

7.1.1. What is client voice?

The Australian Institute of Family Studies describe the importance of child, youth and family services in enhancing opportunities for families to be heard, premised on the concept of a strengths-based approach to empowering children and families. By considering the stories, perspectives, concerns and strengths – respecting, acknowledging and creating space for *client voice* – child and family services strengthen their capacity to understand client needs and develop tailored, appropriate strategies for overcoming obstacles (McDonald, 2011).

Client voice can refer to the expression of views, needs, opinions, outcomes and experiences of the users of a community service (Victorian Department of Health and Human Services, 2019a). Although it is often an umbrella term for input from clients on their views on services, it is also the output of the activities in these services and is therefore very relevant at all stages of the child, youth and family's involvement with the community service system, across the individual, organisation, and system levels.

Adopting a client voice framework allows services to develop and maintain effective, safe, and person-centred practices for every client every time, while serving a secondary purpose of reinforcing the responsibilities and expectations of service providers in the system to constantly seek opportunities to listen and respond to the views and experiences of the child, youth and family (Victorian Department of Health and Human Services, 2019a).

By privileging the voices of children, youth and families, service providers can keep their practices centred around the client as in individual as well as within the broader context of the family. Research on person-centred services and care has demonstrated a significant impact on quality and efficiency of planning, developing and monitoring care, including a subsequent increase in the person's engagement in their own care, motivation and empowerment in making changes to their own lives (Victorian Department of Health and Human Services, 2019b).

7.2. Methodology

The Evaluation Team obtained client voice feedback through semi-structured interviews with current and former HYAP clients. Interviews were facilitated by staff with experience engaging with vulnerable young people. A convenience sampling approach was selected in order to maximise the potential pool of respondents.

Understanding that the population receiving HYAP services is 'hard to reach', the Evaluation Team — with advice from the HYAP-AC — developed an approach that sought to prioritise client welfare while also balancing the need to protect the rapport that exists between client and service provider. Key features of this approach — detailed in Table 7.1 below — included:

- *Informed consent allowed participants to opt out at any time* —which maximised choice for clients and allowed them to change their minds;
- *Invitations came from a trusted source* — providers approached clients to invite them to participate, which allowed them to identify who might be willing to participate based upon knowledge of their circumstances;
- *Interviews were held on the client's terms* —interviews were conducted at a time of the client's choosing via a teleconferencing platform which meant that clients could chat with the Evaluation Team in a location of their choice;
- *Privacy was paramount* — recognising the vulnerability of this population, the Evaluation Team took particular care to protect the privacy and confidentiality of participants by using providers as an intermediary; which was reinforced by
- *Non-repercussive nature of participation* – the Evaluation Team took careful effort to reiterate that there were no consequences to providing feedback on HYAP services, regardless of their positive or negative nature, i.e. explicit reminders that feedback provided would not impact on services that clients were currently receiving, or would receive in the future; and this was supplemented by
- *Checking in with clients' comfort at the start of the interview* – the Evaluation Team ensured that clients were comfortable to have their support workers with them during the interview for support, or waiting outside the interview room, to provide them with privacy where requested; and
- *An age limit was set* — clients needed to be fifteen years or older to participate in an interview.

All providers responded to the Evaluation Team's request to approach and invite CYP to participate, however not all of them were able to identify CYP who were interested in doing so.[33]

Table 7.1 Invitation, Recruitment & Consent Process for interviews with current and former HYAP clients

Invitation	The Evaluation Team contacted providers by email in November 2019 and January 2020 and requested their assistance to identify and approach CYP who might be willing to participate in an interview Additional contact was made with provider contacts to answer questions and clarify the content and scope of the interviews Providers who did not respond were contacted via multiple mediums until a response was obtained.
Recruitment	Providers used the Explanatory Statement approved by the Monash University Human Research Ethics Committee to inform CYP about the purpose and nature of the interview Providers approached current and former clients and invited them to participate The Evaluation Team liaised with providers to find a mutually beneficial date and time to interview CYP interested in participating in the evaluation.

[33] See Appendix E for additional information

Interviews	Interviews were held at a convenient location for clients and providers Interviews were held via teleconferencing platform (Zoom) which allowed for verbal consent procedures to be recorded.
Consent	CYP were read the Explanatory Statement and Verbal Consent Script prior to the interview Following the interview, the interviewer emailed a gift voucher for the value of $25 to the provider to provide to the participant.

7.2.1. Analysis methods

Client responses to questions were entered anonymously into a spreadsheet by the interviewer.

An analyst who was not involved in the interviewing process undertook qualitative content analysis of the open-ended questions by highlighting key ideas or themes in each domain.

Descriptive analyses were undertaken on questions that asked clients to rate their level of satisfaction for each relevant domain.

7.2.2. Data collection

Between January and March 2020, the Evaluation Team interviewed twenty-three CYP aged over 15 who were currently or previously engaged with HYAP services[34] — in the sample of participants:

- 70 per cent of providers were represented
- 74 per cent of respondents identified as female and 26 per cent as male
- 52 per cent of respondents lived in regional areas.

Key themes from these interviews are highlighted below against each of the seven domains — accommodation, social networks, skills, goals, services and crisis — explored during the interview.

7.3. Insights

7.3.1. Accommodation

Eighty-five per cent of the CYP who participated in an interview needed help from their HYAP provider to find accommodation. Those who received accommodation services stayed with a HYAP provider from between 3 months up to 1.5 years. As shown in Figure 7.1, most of the clients had positive sentiments regarding the accommodation services that were provided. Key issues raised included:

[34] A condition of our ethical approval was that CYP must be at least 15 years old at the time of the interview.

Accommodation availability

- One client who needed accommodation support, noted that a service provider could not help them find a place to stay as there no spots available in the refuge.

Satisfaction with accommodation service

- Most clients felt safe at the accommodation provided by HYAP providers, one client noted *'[they felt] a lot safer than [they] felt at home'*.

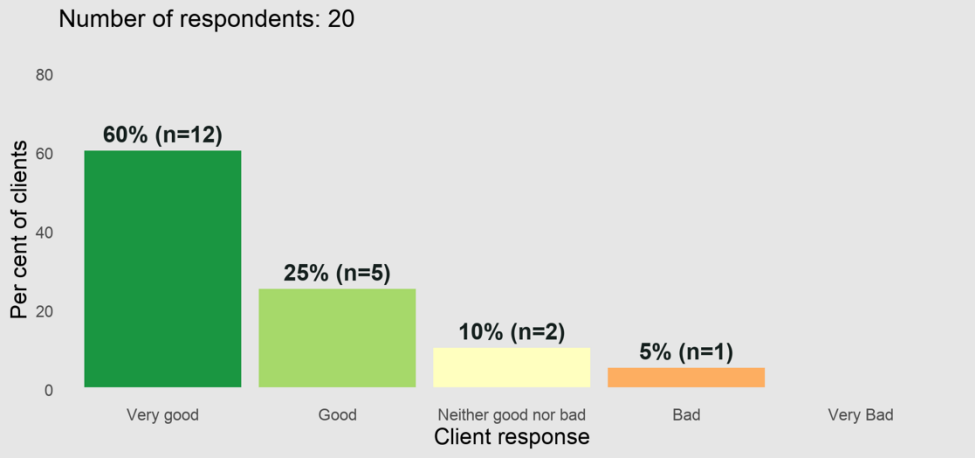
- One client was satisfied with the emotional support provided by HYAP providers, and the way in which their support worker engaged them in decision-making about their care, stating *'they always ask, and they are always encouraging me to do what's good for me, and not for everyone else around me'*.

- Some suggestions for improving HYAP accommodation services included:

    - a client who felt that the communication could have been managed with more professionalism and kindness, '[*the service provider] decided not to put me into that transitional property, because I didn't feel safe there, but it was more just how that conversation was handled, which I thought wasn't very professional… and that upset me'*

    - another client felt that more *frequent* communication with the residents at the refuge would have been more beneficial at reducing isolation.

Figure 7.1 Client perceptions on provided accommodation services



7.3.2. Social networks

Sixteen clients sought assistance with growing or maintaining their support networks. The support they received included being connected to family members and friends, planning family meetings, having the support worker serve as a mediator between them and their family or teach them how to be more open and form a closer bond with their family. As shown in Figure 7.2, most clients were satisfied with this support. Key findings from the interviews included:

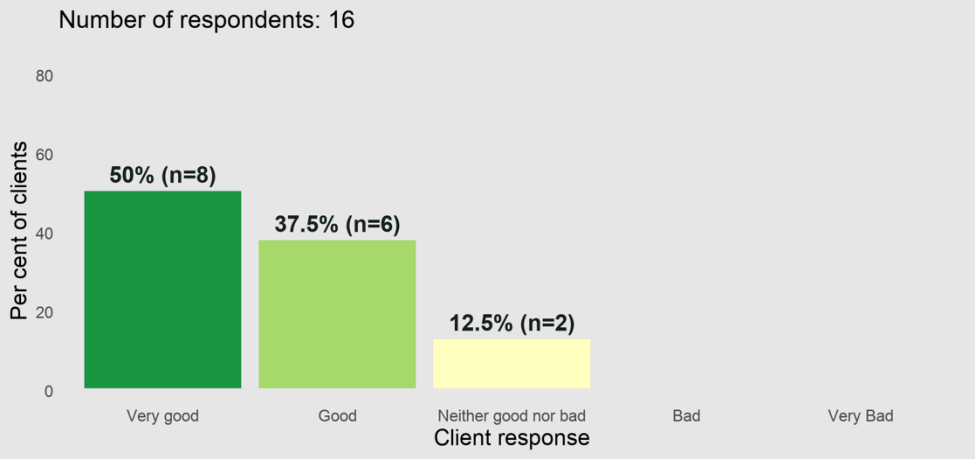
Connecting with family members and friends

- Most clients felt that this support strengthened familial bonds, with one client stating how '[the service provider] connected me with my sister, and they tried to help me make more friends at the refuge, so I have more people with me'.

Prioritised clients' needs

- Support providers made the clients' needs a priority, as one client stated 'they [the service provider] didn't keep me here [refuge] when I wanted to move back to my parents'.

Figure 7.2 Client perceptions on support provided to engage with or develop social networks



7.3.3. Skills

Almost all of the clients that were interviewed sought assistance to develop additional skills, including building living and independence skills (e.g. doing chores, cooking and looking for a job), managing emotions (e.g. anxiety and anger) and engaging in school or TAFE (e.g. returning to school, obtaining educational supplies, study for exams and participate in extracurricular activities). As shown in Figure 7.3, the vast majority of clients were satisfied with the provision of support given to develop their skills. Findings from the client interviews show:

Encouragement of healthy school habits

- Nearly all clients reported positive outcomes from the skill support provided by HYAP providers, most of which were related to meeting their needs at school (e.g. encourage healthy lunches, get in touch with teachers, continue staying in school and even help finish school).

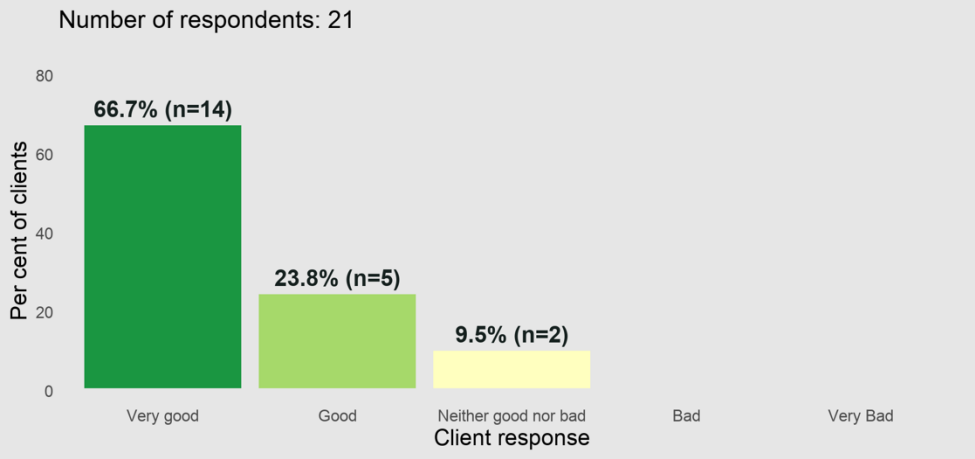
Satisfaction with skills provision

- Some suggestions for improving HYAP in terms of the skill development provided to clients included:

Two clients reported that that the support workers needed to be more organised and communicate more frequently and effectively with the residents: '*They* [support workers] *treat some of the* [young people] *more fairly than others, and they're very strict about going to school every day. They force things on some of the* [young people] *here, and I don't think that's right'*

One client reported that their support worker did not follow through with the practical assistance they had discussed — *'there was all this talk about helping, but none of that actually happened'*.

Figure 7.3 Client perceptions on support provided to develop skills



7.3.4. Goals

All clients worked with providers to achieve some goals. Specific goals varied by a client circumstances, however they included personal goals (i.e. move back in with a parent, quit smoking, get a driver's license, manage mental health issues), academic goals (i.e. get back into/or stay in school) or financial and employment goals (i.e. get a tax file number, look for a job, ask for assistance from Centrelink, develop a resume, obtain bank cards and learn how to save money). As is shown in Figure 7.4, most clients were satisfied with the support received to achieve their goals. Key findings from the interviews included:

Service providers' skills

- One client expressed how their success in achieving a goal depended on who their support worker was and their level of diligence.
- Some clients appreciated the level of detail and effort that went into planning their goals, such as developing both short- and long-term goals

Satisfaction with support workers

- Clients appreciated support that was encouraging, direct, and respectful of their privacy.
- One client felt that reviewing goals on a more frequent basis would have been more beneficial: 'Making a plan on how I could achieve those goals, ticking them off regularly because it's so satisfying, reviewing them with them on a weekly or fortnightly basis, instead of six months'.

Figure 7.4 Client perceptions on support provided to achieve goals

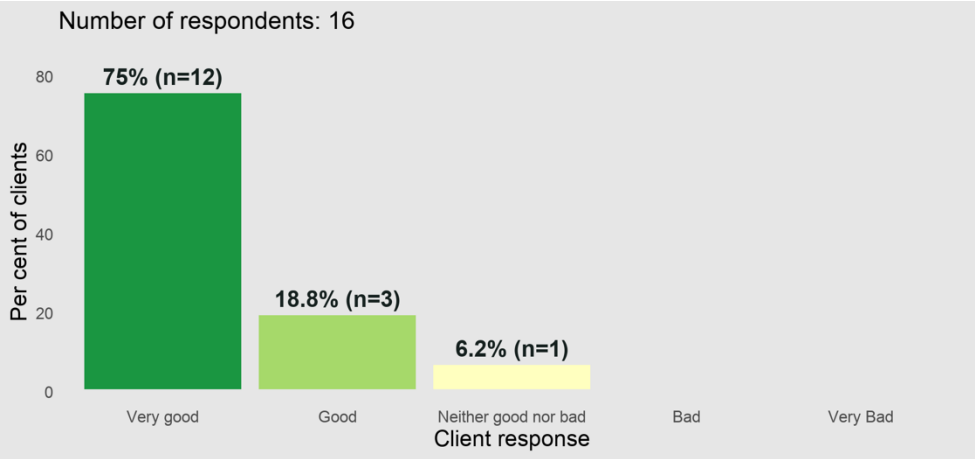
7.3.5. Services

Sixteen of the clients that were interviewed sought assistance through engaging with other services. These services included Centrelink, headspace, transport services, healthcare clinics, drug and alcohol counselling, sexual assault support services, assistance to build family relationships and services to improve academic skills. As shown in Figure in 7.5, a high portion of clients were satisfied with the assistance they received to access services. Key findings from the interviews included:

Service providers were understanding of their clients' needs and provided stability

- Clients felt that their service providers referred them to services based on their needs and not what the service providers thought they needed
- All clients felt that the referrals received yielded positive outcomes, for example, they were able to achieve stability and consistency after being referred to local counsellors by their support workers.

Figure 7.5 Client perceptions on referred services



7.3.6. Crisis

Of those clients who were interviewed, seven sought assistance from a HYAP provider in a 'crisis or emergency situation'. Clients that required it were provided with support in a

range of ways including 'picking them up and taking them back to their homes or refuge', 'talking through their problems' and 'taking them for a meal'. As shown in Figure 7.6, clients were satisfied with the crisis or emergency support received when required. Key findings from the interviews included:

Accessibility to phones and support workers

- Clients were aware of who they could contact in order to get support during a crisis and felt at ease when they received this support, however, one client stated that at times it was difficult to get in touch with their support worker because they did not have access to a phone.

- In one instance, one client reported that a support worker tried to return their call but called the wrong refuge.

Figure 7.6 Client perceptions on support provided during crisis periods

7.3.7. Strengths and limitations

These findings have a strong caveat in that they reflect the views of twenty-three current or former HYAP clients identified through a convenience sampling approach. These clients may not be representative of the 'average' HYAP client, nor are there enough of them to generalise findings to a wider population.

CYP who are currently or formerly receiving HYAP services are a vulnerable group that is often characterised as 'hard-to-reach'. The use of the term 'hard-to-reach' is widely used to describe young people. However, some research suggests that it is not that young people are hard to reach from the services' point of view, but rather that the services are hard to reach from the young people's point of view (Black & Gronda, 2011).

To maximise the chance of reaching this population, the Evaluation Team engaged with clients through their service providers. Whilst providers were unfailingly helpful in seeking to identify clients who might be willing to participate in an interview, feedback from them suggested that many clients had immediate pressing problems and did not have the time, willingness or mental space to engage with another 'new person'.

Whilst these findings are limited by the number of clients whom the Evaluation Team was able to engage with, the fact that client voice was able to be incorporated into this evaluation is a positive.

8. Are clients living in safe, secure accommodation?

Key takeaways

- CYP provided with or referred to medium or longer-term housing were less likely to have a new ROSH report, potentially indicating that greater housing stability can decrease reported child maltreatment concerns

- The biggest predictor of having a ROSH report following a spell in HYAP was having history of prior-ROSH reports

- Once considerable momentum with child protection involvement has been established, receipt of HYAP services does not appear to stop that momentum

- CYP do not tend to return to HYAP once they leave

- If CYP do exit HYAP services and return, housing is both the main presenting reason and the new presenting reason only about 7 per cent of the time

8.1. Introduction

One of the major focuses of HYAP is the provision or referral of CYP with safe, secure accommodation. Access to information about the specific type and quality of accommodation offered were unavailable in the CIMS and ChildStory databases. The Evaluation Team can only assume accommodation provided met standards when they were formal, paid resources. The accommodation information available in the administrative data is the classification of housing (i.e., emergency, short-term, medium-term, long-term) and the use of financial assistance schemes designed to acquire or maintain an accommodation (e.g., rental support).

The Evaluation Team also have information about how long a service period lasted, whether a CYP returned to HYAP for the same or similar service, and whether a provider documented that their housing situation improved. In addition, information from ChildStory can be used to analyse whether CYP experienced one or more ROSH reports or placements in OOHC during or after HYAP services began, indicating they were unsafe and not securely accommodated.

8.2. Methodology

The analysis presented in this chapter is informed by an analysis of routinely collected administrative data that have been linked using a statistical linkage key, they are:

- *Client Information Management System (CIMS)* — which includes information on type, length and frequency of housing and homelessness services accessed by CYP; and
- *ChildStory* — which includes details on any current or previous child protection concerns or time spent in the OOHC system.

8.2.1. Analysis methods

The Evaluation Team developed a series of sub-questions and two analytic approaches to investigate different elements of this question:

- *Descriptive statistics* — were used to summarise and explain key themes and trends
- *Time to event analysis* — was used in the estimation of time-related constructs

An explanation of how they were applied is detailed in Table 8.1 below.

Table 8.1 Methods used to inform this analysis

	How many CYP presented at HYAP with housing needs?	What types of services did they receive?	Were their housing needs met?	Were CYP safe after their first HYAP spell?
Descriptive statistics				
Time to event analysis				

8.3. Insights

Key findings of this analysis are presented in the following order:

- How many CYP presented at HYAP with housing needs?
- What types of services did they receive?
- Were their housing needs met?
- Were CYP safe after their first HYAP spell?
    - Did CYP have a ROSH report following the receipt of housing services?
    - Did CYP have a face-to-face CP assessment after the start of HYAP services?
    - Did CYP enter OOHC after the start of HYAP services?

8.3.1. How many CYP presenting at HYAP with housing needs?

Individuals were not in safe, secure accommodation when they first qualified for HYAP services. This is evidenced by:

- Housing instability in the month prior to presentation — given their age, an alarming proportion of CYP self-reported at being in short term accommodation (15.8 per cent) or sleeping rough (13.7 per cent); and
- Housing instability when they commence a spell at HYAP — where the proportion of CYP in short-term accommodation increased to (22.5 per cent) and somewhat fewer reported sleeping rough (10.2 per cent).

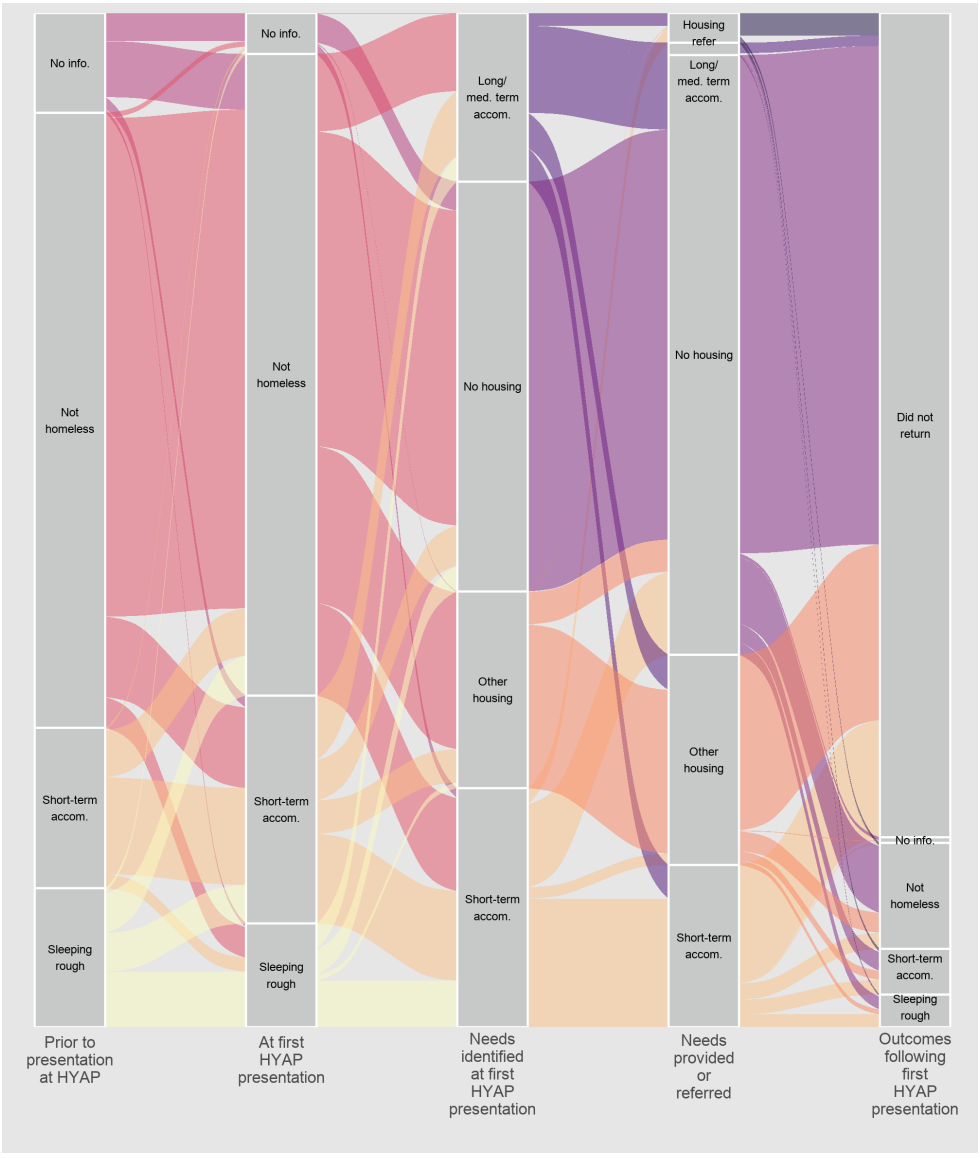
CYP presented with a range of housing needs, some of which were primary, some secondary or which became apparent later in their first spell of services. CYP took a number of pathways with respect to self-reported housing status and their housing needs during HYAP. These pathways are visualised in Figure 8.1 below. Key points include:

- if their housing needs identified at first HYAP presentation — 59.6 per cent of CYP had housing needs identified during their first spell,
- whether those needs were provided for or they were referred for that service elsewhere — 16 per cent of CYP were provided with short term accommodation at

their first presentation, 1.2 per cent were provided with medium- or long-term housing and 2.9 per cent had housing needs referred to other providers,

- their self-reported housing status in the month prior to their second HYAP appearance (if they returned) — 4.5 per cent of those that returned were in short-term accommodation and 3.2 per cent were sleeping rough.

Figure 8.1 Alluvial plot showing flow of CYP though HYAP housing services



8.3.2. What types of services did they receive?

Most CYP with self-reported or identified housing needs were provided with or referred to a housing service. There were, however, exceptions, including:

- for reasons that are unclear, 24.9 per cent of CYP who self-reported sleeping rough at the commencement of their HYAP spell (n=241) did not have a corresponding housing need identified; and

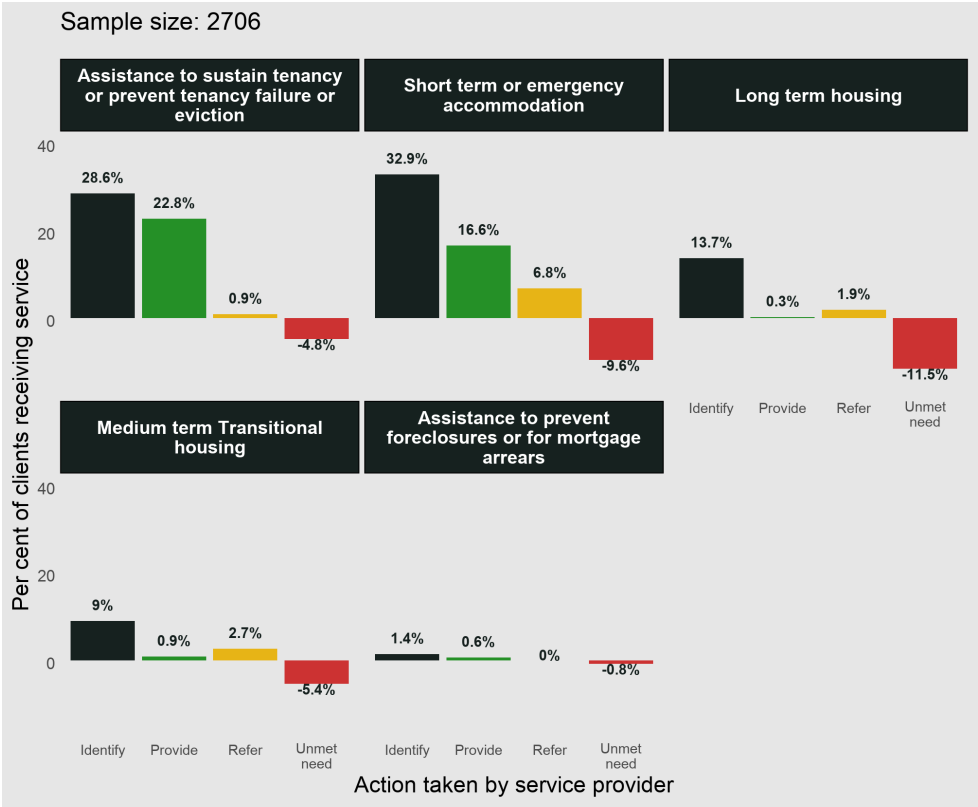
- 50.5 per cent of those same CYP self-reporting as sleeping rough did not receive a housing service.

Within their first spell of HYAP, the vast majority (82.3 per cent) of CYP with an identified need to sustain or maintain tenancy were provided assistance (79.2 per cent) or were referred elsewhere (3.1 per cent).[35] Similarly, among those with a short-term or emergency accommodation need, 50.5 per cent were provided and 20.7 per cent were referred for that service.

Longer term and medium-term housing were far less often provided or referred, as was assistance for foreclosure, which may be related to the ages of the CYP. However, about one in ten CYP who had short-term (9.6 per cent) or medium-term (11.5 per cent) housing needs identified were not provided with or referred to those specific housing services.

In some cases, there is an 'unmet need' that arises when a CYP presents with an issue that cannot be met by a service provider or their referral network. The measure 'unmet need' is likely to be an undercount as CYP can be referred to, and provided, a service simultaneously. Also, a service referred to is not necessarily a service received. CIMS data do not include whether the referral resulted in a service actually being provided. The largest 'unmet need' for housing services is for CYP who require 'long term housing' (11.5 per cent) — see Figure 8.2 for summary.

Figure 8.2 Housing services identified, provided or referred to CYP in HYAP during their first spell



[35] More than one service need can be identified in a continuous spell of HYAP, and service needs within that spell can be identified at any time.

8.3.3. Were their housing needs met?

Housing needs can change over time, with some CYP becoming more or less secure depending on myriad circumstances beyond the control of HYAP providers. That said, one way of measuring success is to measure whether individuals returned to services for the same need they first arrived with.

Examining the main reasons that CYP first presented to HYAP, whether they returned, and whether they returned for the same reason provide insight into whether the original set of needs were addressed. There are limitations to this approach. CYP could have returned because the service was beneficial and they found themselves in need at a later time. CYP could also have had expectations of the service, and these were not met so they did not return for that service. An indication of whether this is the case is if they returned for a different service (i.e., the first service was good enough that they returned a second time for a different issue).

CYP who had a main identifying reason of housing-related service represented 19 per cent of all main reasons and fell into seven broad categories — see Table 8.2.

Most CYP (82 per cent) did not return to HYAP, but it is unclear whether they would have returned if they needed something or whether they received everything they needed the first time. Of the 18 per cent that did return, they only came back for the same problem about 7 per cent of the time.

The most frequent reasons for return were *housing crisis* (6 per cent of total returns) and *housing affordability stress* (5 per cent of total returns). The main presenting reason with the highest proportion of returns was *transition from other custodial relationship (29 per cent)* followed by *housing crisis* (16 per cent) and *housing affordability stress* (15 per cent). Thus returns, when they come, are often for different reasons indicating a level of housing security among a large segment of the HYAP population and a level of continuing instability for a smaller subset of the population.

Table 8.2 Main reason for presentation at HYAP — housing categories

Main reason for presentation	# identified with this reason during their first spell	# of CYP that return to HYAP for the same reason for a second spell	Proportion that return to HYAP for any reason	Proportion that return to HYAP for the same reason
Housing Crisis	168	37	22 per cent	16 per cent
Inadequate Or Inappropriate Dwelling Conditions	125	19	15 per cent	5 per cent
Housing Affordability Stress	90	13	14 per cent	15 per cent
Previous Accommodation Ended	42	9	21 per cent	0 per cent
Unable To Return Home Due To Environmental Reasons	30	5	17 per cent	0 per cent

Transition From Other Care Arrangements	25	2	8 per cent	0 per cent
Transition From Custodial Arrangements	22	7	32 per cent	29 per cent
Itinerant	7	1	14 per cent	0 per cent
Transition From Foster Care And Child Safety Residential Placements	6	1	17 per cent	0 per cent
Total	515	94		
Overall average			18 per cent	7 per cent

8.3.4. Were CYP safe after the first time they showed up?

Safety was measured in terms of whether CYP experienced a child protection report that crossed the threshold of risk of significant harm (ROSH), whether they had a face to face assessment, and whether they were placed in out of home care (OOHC). Each analysis focuses on the primary clusters of *housing services* and *counselling & mental health and relationship services.*[36] Where the sample sized allowed, the Evaluation Team used a Cox Proportional Hazards model to examine the extent to which the length of service duration was influenced by a range of individual characteristics, including:

- Demographics — age, gender, Indigenous status,
- Prior involvement in the child protection system — prior ROSH, non-ROSH and CP assessment,
- Prior-OOHC placement,
- The provider they received services from.

The sample size allowed the Evaluation Team to explore in greater detail the individual association of housing and counselling support factors. The results suggest that the strongest predictors in these models are involvement in child protection history. That is, the provision of housing had only a minimal association with child protection and out of home care receipt after HYAP began.

Did CYP have a ROSH report following the receipt of housing services?

Overall, CYP who presented at HYAP received or were referred to housing services about 41 per cent of the time in their first spell in HYAP and received some form of counselling service almost half (45 per cent) of the time. After their time in HYAP commenced, a large proportion of CYP (n=1027; 38 per cent) had at least one subsequent ROSH report.[37]

When adjusting for the standard set of covariates using Cox Proportional Hazards Regression (not shown):

- CYP who received or were referred to short-term housing were slightly more likely to experience a subsequent ROSH report, and

[36] See Table C.2 in Appendix C for how these are categorised

[37] Only CYP without an active investigation within three days from the start of HYAP were included. An investigation was considered closed if it was marked as closed in the data or 60 days had elapsed from the date of the report, whichever came first.

- those receiving or being referred to long or medium-term housing were less likely to experience a subsequent ROSH report.

However, while these are important findings, the most important predictor, by far, was whether a CYP had a prior ROSH or non-ROSH report. This indicates that HYAP providers are, at least for some CYP, contending with a cycle of child protection involvement that is well under way and is likely to continue despite considerable intervention efforts.

Did CYP have a face-to-face CP assessment after the start of HYAP services?

CYP who have a ROSH report in NSW are followed up with a face to face assessment if they are screened in for one following a triage process. Generally, these are CYP assessed as having more urgent and serious risk or safety concerns. After HYAP began, about 14 per cent of CYP had at least one face to face assessment that included a safety assessment.[38]

Similar to the ROSH analysis above, short term housing was minimally associated with a slight increase in the likelihood of a face-to-face assessment but medium- or long-term housing was not. Again, by far, the strongest association was having had a prior history of ROSH or non-ROSH reports prior to the start of HYAP. Of interest, there was a trend in the data suggesting that older CYP were less likely to have a face-to-face assessment with every year increase in age and were more likely to be assessed in later years. That is, younger CYP ages 12-14 had an increased likelihood of having a face to face assessment but all CYP were more likely to be assessed in the period between from 2017-2019. The upshot is that, similar to ROSH reports, the broader contexts in the lives of CYP likely have more to do with whether child protection becomes highly involved by responding to maltreatment reports with a face to face assessment. In addition, the prioritisation of younger children for face to face assessment may reflect a child protection system slowly transition CYP to housing services as they begin to age out of child protection services.

Did CYP enter OOHC after the start of HYAP services?

There are only a small number of stronger indicators of child safety being compromised than a risk of significant harm report considered serious enough to warrant a face-to-face assessment. One of these indicators would be placement in OOHC. There were 116 CYP who, using ChildStory data, were in OOHC for 8 days or more when they had their first presentation at HYAP and almost half of these (43 per cent) had a prior OOHC episode. HYAP is likely being used as a resource by CYP in the child protection system when they are struggling with their placement. After receiving HYAP services, 106 CYP had at least one more episode of OOHC lasting 8 or more days, and about one-quarter (n=26) of these entries to care occurred within a HYAP service episode.

While these numbers are seemingly small, they are far greater than what would be expected in the general population. Simple estimates from AIHW figures for NSW in 2018-19 indicate that roughly 1 per 1000 CYP between the ages of 10-17 were admitted to at least one episode of OOHC in 2018-19 (Australian Institute of Health and Welfare, 2020).[39] HYAP entries spanned four years, with most CYP having a far longer follow-up period than one year (i.e., they presented at HYAP in 2016-2017) and some far less (i.e., presented in 2018-2019). Nevertheless, it is clear that CYP presenting at HYAP are being admitted to

[38] Only CYP who had a face to face assessment with an associated safety assessment and no active investigation within three days from the start of HYAP were included. An investigation was considered closed if it was marked as closed in the data or 60 days had elapsed from the date of the report, whichever came first.

[39] New AIHW counting rules make it difficult and probably inadvisable to make comparisons across years.

OOHC at a far higher rate than the state average (overall, 106 out of 2707 or more than 40/1000 had at least one OOHC episode start after presenting at HYAP).

9. Have clients reconnected with family members and/or friends?

Key takeaways

- CYP had a large number of ROSH reports after HYAP began, indicating continued tension within families
- The provision of counselling and relationship services was a major proportion of the services provided, representing more than half of all identified service needs, and these were largely provided rather than referred out.
- The provision or referral of Counselling and relationship services did not influence the frequency or timing of subsequent ROSH reports or face to face assessments – the overriding predictor was prior history of ROSH and non-ROSH reports
- Specific providers were not associated with increases or decreases in the likelihood of CYP having a ROSH or face to face assessment subsequent to HYAP start
- Once CYP turn sixteen and are no longer eligible for HYAP services almost one third of them (30 per cent) access SHS services, mostly for housing and family / relationship services

9.1. Introduction

As seen in chapter 4, the majority of CYP who present for the first time at HYAP have a child protection history of previous non-ROSH and ROSH reports, face to face assessments, and/or placement in OOHC. Moreover, for those who had a safety and risk assessment, findings from chapter 4 indicate presence of family issues that extend well beyond the report period (e.g., caregiver issues that tend to be long-term such as substance abuse and mental health issues serious enough to have interfered with parenting).

Despite coming from potentially challenging backgrounds, CYP are at an age that they cannot care for themselves independently and ultimately require not only safe, stable housing, but a caregiving environment that contributes to their development and well-being.

Reconnecting with family members or friends is difficult to measure well as it requires detailed information, purposely gathered and largely relies on self-reported sources. Unfortunately, this information is not captured in the data sources at the Evaluation Team's disposal, requiring us to use proxy measures to a greater extent than usual and to focus most closely on family connections.

To explore this, the Evaluation Team examined the patterns of services received by CYP during a HYAP spell. This involved examining:

- *Estimating the proportion of CYP for whom reconnection with family members and/or friends is a goal* — by counting the number of CYP who presented for reasons which fall under the umbrella of counselling and relationships
- *Determining if their needs were met* — by examining if they presented at HYAP for a second time for the same reason
- *Estimating the extent to which family issues were a continuing issue once HYAP services began* — by examining whether CYP had a new ROSH, Face to Face Assessment, or placement in OOHC and its association with the receipt of services for counselling and relationships.

Measures of family connection are also explored as part of the analysis of outcome domains in chapter 10. That analysis establishes that there was some improvement in family connection, however it did not apply for all CYP in HYAP - CYP who had a child protection history did not fare as well as CYP without a child protection history.

9.2. Methodology

Routinely collected administrative data can provide insights into the characteristics of clients and the types of services they receive. Linking multiple sources of data together can provide deeper insights. This analysis uses data extracted from two sources which aggregate regularly collect administrative data, they are:

- *Client Information Management System (CIMS)* — which includes information on type, length and frequency of housing and homelessness services accessed by CYP; and
- *ChildStory* — which includes details on any current or previous child protection concerns or time spent in the OOHC system.

Together these two data sources allow the Evaluation Team to report descriptive statistics on who received services for family and relationship issues, if their needs were met and if they returned to HYAP for the same reason.

9.2.1. Analysis methods

The Evaluation Team used two analytic approaches to investigate different elements of this question:

- *Descriptive statistics* — were used to summarise and explain key themes and trends
- *Time to event analysis* — was used in the estimation of time-related constructs

An explanation of how they were applied is detailed in Table 9.1 below.

Table 9.1 Methods used to inform this analysis

	How do providers meet the needs of CYP with counselling and relationship needs?	Did CYP return to HYAP for the same reason?	Did CYP have a ROSH report following the receipt of counselling services?	Did CYP have a face to face assessment following the receipt of counselling services?	Did CYP access housing services from SHS after they were no longer HYAP eligible?
Descriptive statistics					
Time to event analysis					

9.3. Insights

Key findings from this analysis are organised around the following questions:

- How do providers meet the needs of CYP with counselling and relationship needs?
- Did CYP return to HYAP for the same reason?
- Did CYP have a ROSH report following the receipt of counselling services?
- Did CYP have a face to face assessment following the receipt of counselling services?
- Did CYP access housing services from SHS after they were no longer HYAP eligible?

9.3.1. How do providers meet the needs of CYP with counselling and relationship needs?

Providers work with CYP receiving HYAP to identify their needs and either provide the support they require or refer them to other service providers for assistance. CYP can present with multiple needs concurrently.

In Figure 9.1 below, the Evaluation Team has outlined:

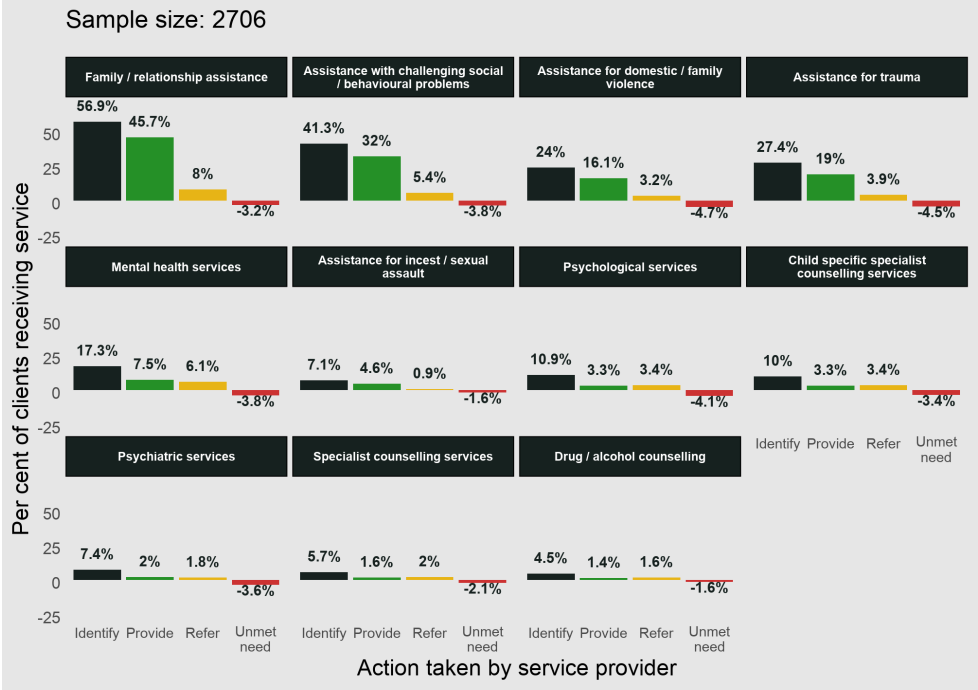
- the proportion for CYP who had an identified need for services that fall into the category of 'counselling and relationship needs';
- the percentage of CYP who were either provided or referred to services to meet their needs; and
- the proportion of CYP with 'unmet needs', which represents that gap between services that were identified and either provided or referred.

The key insights from this analysis are that:

- More than half of the CYP who received HYAP services had an 'identified need' for family/relationship assistance at some point during their first HYAP spell.
- Almost a quarter of CYP had an identified need for domestic and family violence services.
- Most CYP with identified family and relationship service needs identified (83%) were either provided (64 per cent) or referred (19 per cent) to a service for that need, indicating that HYAP providers were sensitive to these types of issues during their interactions with CYP and they often made the decision to provide that service in-house.
- Very rarely did a need remain unmet[40] if it was identified (17 per cent), and these tended to be for higher end services that would often not be available in house and can be difficult to obtain (e.g., psychological and psychiatric services for CYP).

[40] In some cases, there is an 'unmet need' that arises when a CYP presents with an issue that cannot be met by a service provider or their referral network. The measure 'unmet need' is likely to be an undercount as CYP can be referred to, and provided, a service simultaneously.

Figure 9.1 Counselling and relationship services identified, provided and referred to CYP during their first spell in HYAP (FY2016-FY2019)



9.3.2. Did CYP return to HYAP for the same reason?

Examining the main reasons that CYP first presented to HYAP, whether they returned, and whether they returned for the same reason provide insight into whether the original set of needs were addressed. There are limitations to this approach. CYP could have returned because the service was beneficial and they found themselves in need at a later time. CYP could also have had expectations of the service, and these were not met so they did not return for that service. An indication of whether this is the case is if they returned for a different service (i.e., the first service was good enough that they returned a second time for a different issue).

Key findings from this analysis — summarised in Table 9.2 — suggest that:

- CYP who had a main identifying reason for service of family relationships represented 39 per cent of all main reasons and fell into three broad categories:
    - Relationship/Family Breakdown (29 per cent),
    - Time out from family/other situation (7.2 per cent), and
    - Lack of family and/or community support (3 per cent).
- Most CYP (81 per cent) did not return to HYAP so it is unknown whether they would have returned if they needed something or whether they received everything they needed the first time.
- If they did return, they only came back for the same main reason about one-quarter (23 per cent) of the time overall. The most frequent reason for the same return was relationship/family breakdown (44 per cent), indicating ongoing problems were fairly likely if CYP returned to HYAP.

Table 9.2 Main reasons for presentation at HYAP — counselling and relationship services

Main reason for presentation	# identified with this reason during their first spell	# of CYP that return to HYAP for the same reason for a second spell	Proportion that return to HYAP for any reason	Proportion that return to HYAP for the same reason
Relationship / Family Breakdown	780	158	20 per cent	44 per cent
Time Out From Family / Other Situation	195	38	19 per cent	18 per cent
Lack Of Family And / Or Community Support	82	13	16 per cent	8 per cent
Total	1,057	209		
Overall average			19 per cent	23 per cent

9.3.3. Did CYP have a ROSH report following the receipt of counselling services?

Chapter 8 explored time to next ROSH report using Cox Proportional Hazards Regression. The same analysis applies here, and the answers are largely the same but will focus on counselling, mental health and relationship services rather than housing support.

Safety was measured in terms of whether CYP experienced a child protection report that crossed the threshold of risk of significant harm (ROSH), and whether they had a face to face assessment.[41] However, included is an overall look at the number of CYP who made use of SHS housing services after they were no longer age-eligible for HYAP. Each of the first two analyses focus on the primary cluster *counselling & mental health and relationship services.*[42] Where the sample sized allowed, an analysis was conducted focusing on whether the outcome still held when adjusted for:

- Demographics — age, gender, Indigenous status,
- Prior involvement in the child protection system — prior ROSH, non-ROSH and CP assessment,
- Prior-OOHC placement,
- The provider they received services from

Overall, CYP who presented at HYAP received or were referred to Counselling services about 54 per cent of the time in their first spell in HYAP (Table 9.3).

[41] See OOHC analysis in section 8.2
[42] See Table C.2 in Appendix C for how these are categorised

Table 9.3 New ROSH after commencement of HYAP services, by type of service received

Type of Service Provided	Count	Per cent
Both housing and counselling	669	24.7 per cent
Housing only	432	16 per cent
Neither Housing or Counselling	797	29.4 per cent
Counselling only	809	29.9 per cent
Total	2707	100 per cent

After HYAP began, a large proportion of CYP (n=1027; 38 per cent) had at least one ROSH report.[43] However, when adjusting for the standard set of covariates listed above using Cox Proportional Hazards Regression (not shown), being provided with or referred to counselling was no longer associated a higher or lower likelihood of experiencing ROSH. The most important predictor, by far, was whether a CYP had a prior ROSH or non-ROSH report. The key takeaways here are that:

- HYAP providers are, at least for some CYP, contending with a cycle of child protection involvement that is well under way and is likely to continue despite considerable intervention efforts.
- The provider was not an influential predictor of whether or not a CYP had a ROSH report following the start of a HYAP spell — that is, none of the providers were associated with CYP having a significantly lower probability of a subsequent ROSH report

9.3.4. Did CYP have a face to face assessment following the receipt of counselling services?

CYP who have a ROSH report in NSW are followed up with a face to face assessment if they are screened in for one following a triage process. Generally, these are CYP assessed as having more urgent and serious risk or safety concerns. After HYAP began, about 14 per cent of CYP had at least one face to face assessment that also included a safety assessment.[44]

Similar to the ROSH analysis above, none of the counselling services that were provided or referred were significantly associated with having a safety assessment, nor was there much association between which provider delivered the service. The overriding factor was child protection history – if there was a history, the likelihood of a new assessment was far

[43] Only CYP without an active investigation within three days from the start of HYAP were included. An investigation was considered closed if it was marked as closed in the data or 60 days had elapsed from the date of the report, whichever came first.

[44] Only CYP who had a face to face assessment with an associated safety assessment and no active investigation within three days from the start of HYAP were included. An investigation was considered closed if it was marked as closed in the data or 60 days had elapsed from the date of the report, whichever came first.

higher. Again, older CYP were less likely to have a face to face assessment, possibly meaning that these a number of these CYP are in a slow transition to the adult homelessness system. Similar to ROSH post HYAP start, the provider was not a predictor of face to face assessment.

9.3.5. Did CYP access housing services from SHS after they were no longer HYAP eligible?

Although not part of the original analysis plans, the emerging finding that older youth were potentially transitioning from HYAP to the larger SHS housing system prompted the Evaluation Team to conduct a simple analysis of whether CYP began a new service episode for SHS housing services from either HYAP or non-HYAP providers after they turned 16 and were no longer age-eligible for HYAP. If CYP turn up in substantial numbers, it would reflect continued family and other relationship issues which are inevitably linked with housing insecurity.

To this end, the Evaluation Team drew an exit cohort of all HYAP CYP in CIMS who turned age 16 before 30 June 2019 (n=1352). Key findings this analysis include:

- 30 per cent (n=407) returned to SHS, overwhelmingly (87 per cent, n=354) to non-HYAP providers.
- In their first visit to SHS services after turning 16 (n=407), the largest reason for return was Housing (37 per cent), closely followed by Family/Relationship or Family Breakdown (33 per cent).
- Housing services were provided or referred more often than the main presenting reason would suggest, with 47 per cent of the 407 CYP receiving or being referred to one or more housing services in their first visit to SHS post HYAP.

Table 9.4 CYP previously in HYAP receiving SHS services after age 16

Main presenting reason	%
Addiction	2.2
Disengagement with education	2.9
Family / Relationship or Family Breakdown	33.4
Financial	6.9
Health	2.2
Housing	37.1
Not enough information	0.2
Other	3.4
Violence or abuse	11.5

10. Have clients achieved their case management goals associated with seven key outcome domains?

Key takeaways

- The Evaluation Team has significant concerns about the ability of the HYAP Client Outcomes Tool to validly and reliably measure vulnerable CYP's outcomes

- Only 11 per cent of CYP who received HYAP services also completed two outcome assessments, which suggests the tool had implementation issues

- Minor improvements were observed across some outcome domains, however these were generally moderated by client characteristics, with younger CYP, those with prior ROSH and prior OOHC experience either showing no improvement, or getting worse over time

- Younger CYP did not see improvements in family connection or accommodation, two key areas for HYAP that are tightly bound with future child protection outcomes.

- Only 10 per cent of CYP who received HYAP services also had two completed outcome assessments suggesting the tool had implementation issues

10.1. Introduction

An outcomes-focused approach can provide greater transparency about what works and why. The HYAP *Client Outcomes Tool* (HYAP-COT) was designed to capture reflective discussions between caseworkers or service managers and clients about what the service is achieving or not achieving for young people.

The Client Outcomes Tool assesses outcomes across seven wellbeing outcome domains: safety, home, economic, health, education and skills, social and community, and empowerment. These outcomes reflect each of the domains of the Department's *Human Services Outcome Framework* (HSOF) — see Table 10.1.

Through integration of the HSOF, the aim of using the HYAP-COT is to provide a deeper understanding of CYP circumstances over time and whether case plans were achieved relevant to these domains.

Table 10.1 The NSW Human Services Outcome Framework

Social & Community	All people in NSW are able to participate and feel culturally and socially connected
Home	All people in NSW are able to have a safe and affordable place to live
Education & Skills	All people in NSW are able to learn, contribute and achieve
Health	All people in NSW are able to live a healthy life
Empowerment	All people in NSW are able to contribute to decision making that affects them and live fulfilling lives
Economic	All people in NSW are able to contribute to, and benefit from our economy

	Safety	All people in NSW are able to be safe

Source: NSW Department of Finance, Services and Innovation (2020)

10.2. Methodology

10.2.1. Client Outcomes Tool

The HYAP-COT is an eight-item tool designed to measure client outcomes in the following domains:

- family connections,
- accommodation,
- education,
- employment,
- physical health,
- mental and emotional wellbeing,
- health and safety risk behaviours, and
- living skills

Each of these domains is rated on a 1-5 scale, where 1 represents poor outcomes, and 5 represents positive outcomes, with intermediate response ratings between these two points. The Evaluation Team has strong reservations about the ability of the HYAP-COT to validly and reliably measure outcomes (see summary of concerns previously provided to DCJ in Appendix F).

The HYAP-COT is administered by providers for CYP receiving HYAP with the results entered into the Client Information Management System (CIMS).

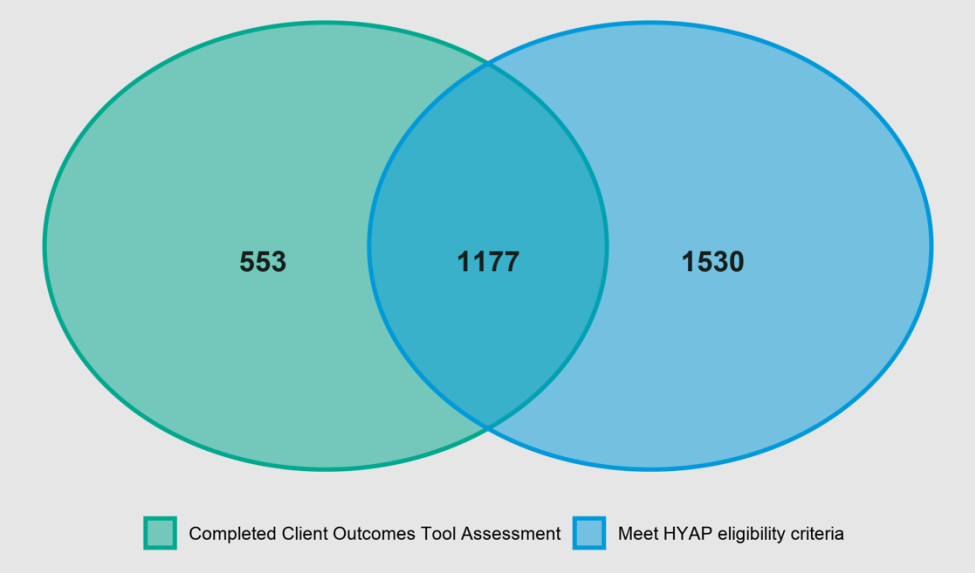
Documentation surrounding the development of the HYAP-COT indicates that the original intention of DCJ was to have providers administer the tool with all CYP receiving HYAP services, using it as both a case management tool and as a source of data to inform the evaluation.

10.2.2. Sample

In practice the HYAP-COT was only used with a subset of all CYP who received HYAP and even within this group there is a substantial amount of missing information. In the CIMS database, there are records for 1730 CYP with at least a partially completed assessment. Of those, only 1177 (43 per cent) met the eligibility criteria and received services from a HYAP provider — see Figure 10.1 below. Of those individuals:

- 959 individuals at least partially completed an initial baseline assessment
- 666 of which completed the entire initial baseline assessment
- 298 individuals at least partially completed one or more subsequent assessments

Figure 10.1 CYP who met HYAP eligibility criteria who completed an assessment



The sample size of CYP who are eligible for this analysis is further decreased by the need to have valid assessments for at least two timepoints (i.e., beginning and end) for all seven of the eight subscales (employment was dropped in consideration of the younger age of CYP participating in HYAP).[45]

Therefore, the sample of CYP who received a baseline assessment and at least one subsequent assessment totalled 298. Table 10.2 below shows the distribution of clients with completed HYAP-COT assessments from different providers.

[45] An initial 'baseline' assessment was the closest record to the start date that was within 60 days of the start of the spell and no later than the end of the spell. A 'final' assessment was identified as the closest record to the end date that was within 30 days of the end of the spell and no earlier than the start of the spell.

Table 10.2 Count of CYP with baseline and at least one subsequent assessment, by provider

Provider	# of eligible CYP with completed baseline COT	# of eligible CYP with completed baseline COT and subsequent COT	# of eligible CYP who received services	% of clients with completed baseline COT	% of clients with completed baseline COT and subsequent COT
Allambi Care	50	8	110	45.5 per cent	7.3 per cent
Anglicare	0	0	82	0.0 per cent	0.0 per cent
Caretakers Cottage	100	36	189	52.9 per cent	19.0 per cent
Detour House	9	1	118	7.6 per cent	0.8 per cent
Mackillop Family Services	26	20	34	76.5 per cent	58.8 per cent
Platform Youth Services	7	6	243	2.9 per cent	2.5 per cent
Project Youth	18	2	130	13.8 per cent	1.5 per cent
Samaritans	196	39	862	22.7 per cent	4.5 per cent
Social Futures	62	52	88	70.5 per cent	59.1 per cent
Southern Youth & Family Services	7	1	379	1.8 per cent	0.3 per cent
Taldumande	36	32	68	52.9 per cent	47.1 per cent
Uniting	30	10	59	50.8 per cent	16.9 per cent
Veritas House	56	43	89	62.9 per cent	48.3 per cent
Wesley Community Services	6	3	54	11.1 per cent	5.6 per cent
Youth Off the Streets	1	0	119	0.8 per cent	0.0 per cent
YP Space MNC	62	45	83	74.7 per cent	54.2 per cent
Total	666	298	2707	24.6 per cent	11.0 per cent

10.2.3. Analysis methods

The Evaluation Team estimated a series of generalised linear models to assess the relative contribution of client characteristics — age, gender, Indigenous status, OOHC history and ROSH history — to the change in COT scores across the seven outcome domains at follow-up. Duration between services start and service end was included as a fixed factor.

The Evaluation Team fitted two models, which varied principally by the population being investigated.

- Model 1 — included those CYP who received at least one assessment (n = 666) — this model can be thought of as the intent-to-treat analysis[46], and
- Model 2 — included only those CYP with a valid baseline assessment and at least partially completed[47] final assessment near the documented end of service or the closest assessment date prior to the date of data extract (n = 298) — this can be thought of as the per protocol analysis.[48]

The populations in each of these models was broadly similar — see Table 10.3 below. The aim of these two models was to establish if:

- if client characteristics predict outcome scores after controlling for other factors such as baseline score, service provider and follow-up interval; and
- estimate the relative contribution of each characteristic to the outcome score, after controlling for preceding predictors.

All models were assessed for meeting statistical assumptions and, where needed, transformations were done to meet these assumptions.

[46] The rationale for this model is to minimise any potential bias produced by reporting exclusively on clients who were followed up for subsequent assessment. Missing values were imputed using 'last observation carried forward' — which is commonly used in longitudinal studies. If a person drops out of a study before it ends, their last observed score on the dependent variable is used for subsequent observation points. This includes the last observation also being the first observation if no other observations are present. There is a risk of bias from this approach that can arise when individuals get better, but this is not measured, then the results suggest they did not improve when they actually did. Likewise, the reverse is possible when individuals get worse, but this is not measured, then the results suggest that they did better than they actually did.

[47] If the last record was incomplete, any missing values were carried forward from the most recent assessment (which may have been from either another assessment within the spell or from the first complete record)

[48] Per protocol, also commonly known as treatment of the treated, is typically used to argue that those who complete an intervention would have these results. It is not a conservative approach and results can be biased if the reason data is missing has anything to do with outcomes.

Table 10.3 Breakdown of the demographic characteristics of CYP included in each model

Model	Age		Gender		Indigenous		ROSH history		OOHC history		Total
	12 or 13	14 or 15	Male	Female	Yes	No	Yes	No	Yes	No	
Model 1	28.7 per cent (n= 191)	71.3 per cent (n=475)	42.5 per cent (n=283)	57.5 per cent (n=383)	31.7 per cent (n=211)	68.3 per cent (n=216)	59.3 per cent (n=395)	40.7 per cent (n=271)	8.9 per cent (n=59)	91.1 per cent (n=607)	n=666
Model 2	22.1 per cent (n=66)	77.9 per cent (n=1846)	44.3 per cent (n=132)	55.7 per cent (n=383)	27.5 per cent (n=82)	72.5 per cent (n=216)	66.1 per cent (n=197)	33.9 per cent (n=101)	8.7 per cent (n=26)	91.2 per cent (n=272)	n=298
HYAP eligible	31.8 per cent (n=861)	68.2 per cent (n=1846)	40.3 per cent (n=1092)	59.6 per cent (n=1615)	29.7 per cent (n=804)	70.3 per cent (n=1903)	51.4 per cent (n=1391)	48.6 per cent (n=1316)	7.1 per cent (n=193)	92.3 per cent (n=2514)	n=2707

10.3. Insights

Although HYAP-COT has some limitations both structurally (reliability and validity) and in its implementation (missing data), it is the only available tool reflecting CYP progress across these domains. The Evaluation Team has attempted to decrease some of the bias associated with using it to measure outcomes by taking a conservative approach alongside a more traditional but potentially more biased treatment completer approach.

Improvements seen in both models were minimal when controlling for known factors that can influence these outcomes. Most notably, these included age, child protection history, and OOHC. Age was interesting in that, even when older CYP seemed to report some gains, these did not materialise for the youngest CYP in the sample for family connection, accommodation and risk-taking behaviour.

If this finding holds for the general population of HYAP service users (i.e., those missing from the HYAP-COT analysis), there is great reason for concern since this younger cohort are possibly the most vulnerable. As seen in virtually every other analysis in this report, child protection (ROSH) and OOHC history mediated a number of gains experienced by those without the history. Given family connections are the preferred pathway to maintaining or establishing permanence, this finding does not bode well.

10.3.1. Model results

The modelling produced statistically significant results across four of the domains — see Table 10.4. These results are stratified by model and domain and presented below. For those domains where no predictor produced a significant result, the Evaluation Team presented a mean adjusted for interval across all of the predictors.

Table 10.4 Summary of results, by model and predictor

	Is < 14 years old?		Is female?		Is Indigenous?		Has ROSH history?		Has OOHC history?		Overall	
Model	#1	#2	#1	#2	#1	#2	#1	#2	#1	#2	#1	#2
Family connections	⌄	⌄	›	›	›	›	›	›	⌄	⌄	NA	NA
Accommodation	⌄	⌄	›	›	›	›	›	›	›	›	NA	NA
Education & Training	›	›	›	›	›	›	›	›	›	›	⌃	⌃
Physical health	›	›	›	›	›	›	›	›	›	›	⌃	⌃
Mental health & emotional wellbeing	›	›	›	›	›	›	›	›	›	›	⌃	⌃
Risk-taking behaviours	⌄	⌄	›	›	›	›	›	›	›	›	NA	NA
Age-appropriate living skills	›	›	›	›	›	›	›	›	›	›	NA	NA

Legend: ⌄ No change, result not significant; › No change, result significant; ⌄ negative change, result not significant; ⌄ negative change, result significant; ⌃ positive change, result not significant; ⌃ positive change, result significant

10.3.2. Family connections

Small improvements were observed in scores across the family connections domain for both models — see Figure 10.2 — with the exception of:

- CYP with a history in OOHC — whose scores decreased;
- CYP aged 12-13 — whose scores remained the same; and
- CYP aged 13-14 — whose scores got worse.

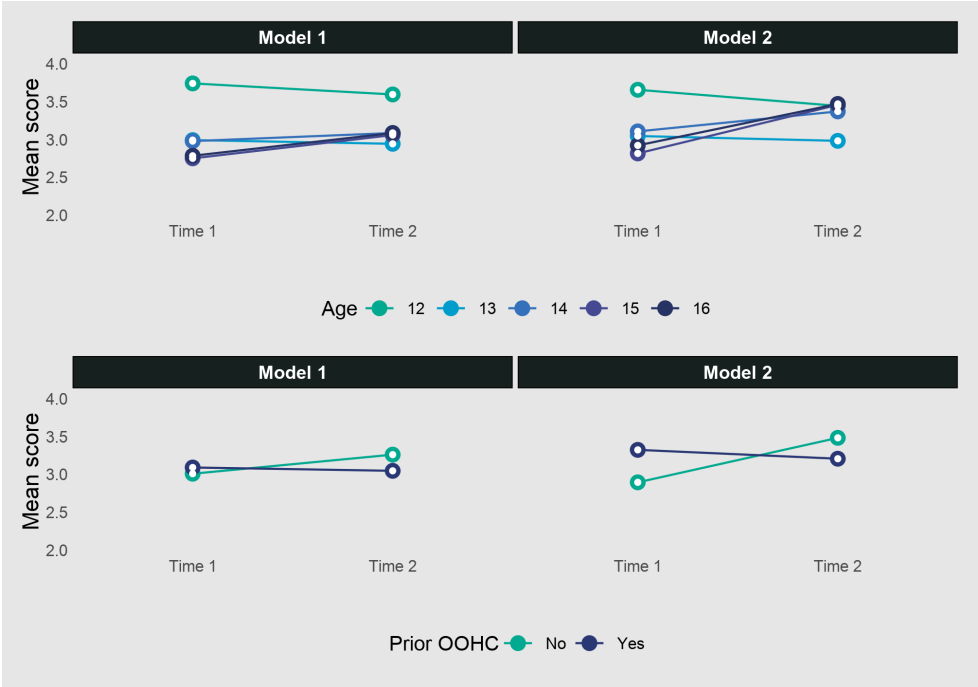
Figure 10.2 Change in mean score for family connections domain

10.3.3. Accommodation

Small improvements were observed in scores across the accommodation domain for both models — see Figure 10.3 — with the exception of:

- CYP with a history in OOHC — whose scores remained the same; and
- CYP aged 12-14 — whose scores got worse.

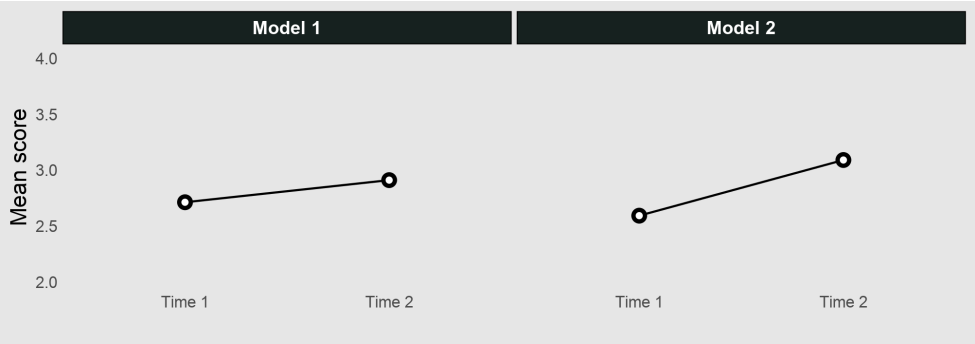
Figure 10.3 Change in mean score for accommodation domain



10.3.4. Education and training

Small improvements over time were observed in both models — see Figure 10.4.

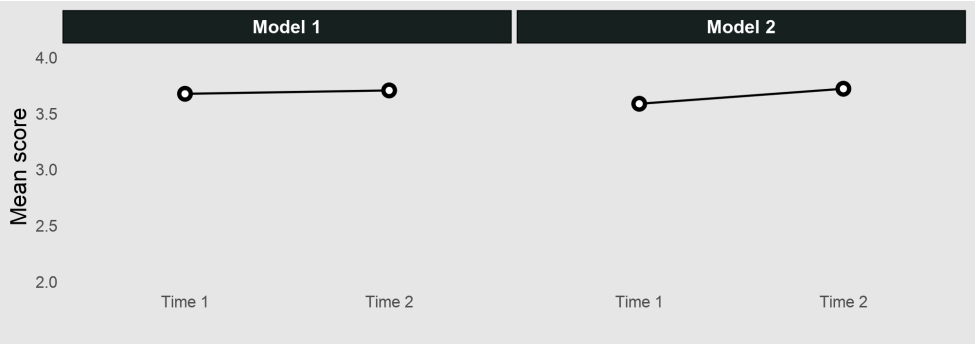
Figure 10.4 Change in mean score for education domain



10.3.5. Physical Health

Minor improvements were observed in physical health scores in both models over time — see Figure 10.5.

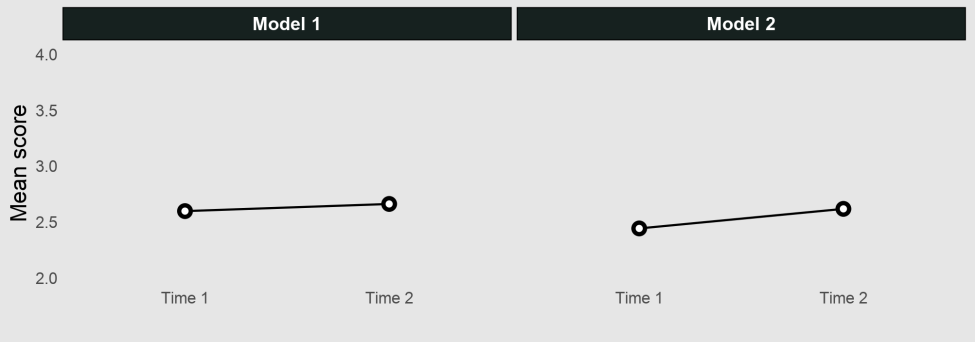
Figure 10.5 Change in mean score for physical health domain



10.3.6. Mental and emotional wellbeing

A negligible improvement was observed to the adjusted mean scores for the mental health and wellbeing domain for Model 2, however this effect washes out in Model 1 (with the larger ITT sample) — see Figure 10.6.

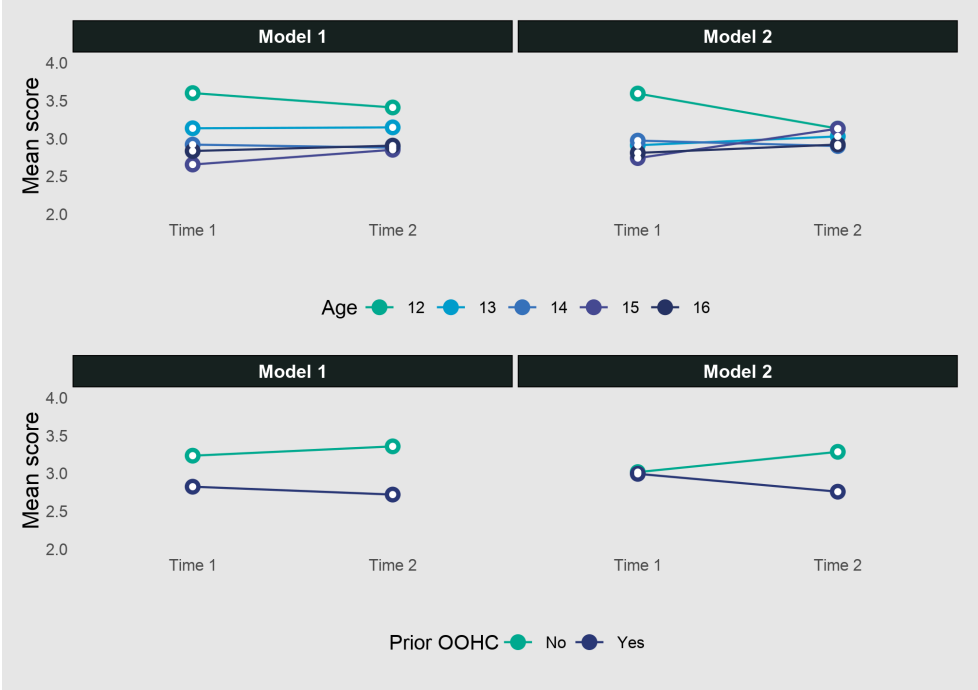
Figure 10.6 Change in mean score for mental health and wellbeing domain



10.3.7. Risk taking

Small improvements were observed across both models for the risk-taking domain, with the exception of CYP aged between 12 and 13. These CYP started out with higher scores than their older counterparts, but got worse between Time 1 and Time 2 — see Figure 10.7. In addition, CYP with a history in OOHC got worse.

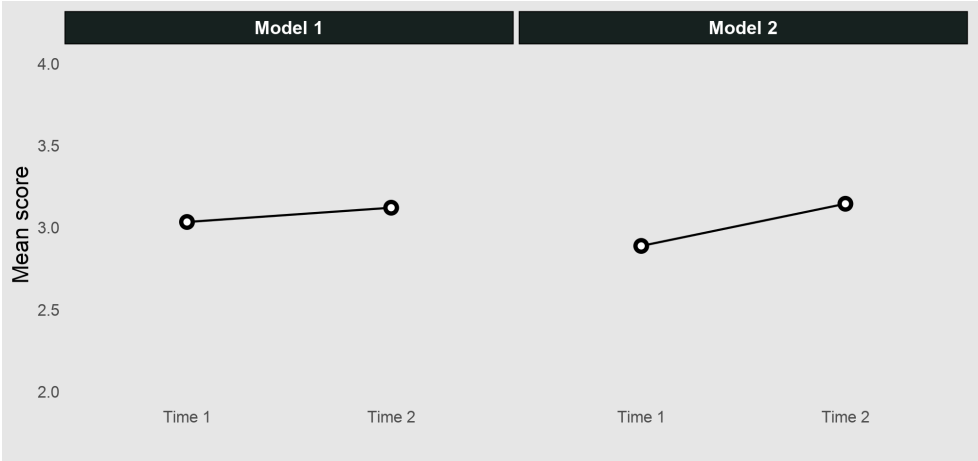
Figure 10.7 Change in mean score for risk taking domain



10.3.8. Living skills

Small improvements were observed in the living skills domain between Time 1 and Time 2 in both models, however for CYP with a prior ROSH report this effect is moderated — see Figure 10.8.

Figure 10.8 Change in mean score for living skills domain



11. What is the unit cost of providing a unit of HYAP services to children and young people?

Key takeaways

- Estimates of the cost per spell of HYAP range from a low of $1,215 to a high of $34,169.
- The high variation in cost estimates is driven by the high variation in HYAP service models used.
- This means that an average unit cost is likely to give DCJ unwarranted certainty in any cost analyses. Instead, if DCJ want to understand the cost of implementing a model of HYAP, they should look at the specific services offered by a specific HYAP provider and use those costs to make a funding decision.

11.1. Introduction

Obtaining credible estimates of the cost of delivering a service are important for both funders and service providers in deciding whether to expand service coverage or replicate different approaches elsewhere. With evidence of effectiveness, estimates of the cost of providing a service can allow providers to determine how a program's costs compare with its benefits, and help DCJ allocate resources effectively. This analysis — which underpins the results of the next two chapters — focuses on the cost side of the equation and examines how much it costs to deliver a 'spell' of HYAP services and what resources are used in implementing them. This estimate of the cost of delivering a service will provide DCJ with an understanding of the funding required to deliver a model in a new location.

11.1.1. What is in a cost?

When the term 'cost' is used in this report, it refers to opportunity costs.[49] The cost of a program is the value of all of the resources or 'ingredients' used in the delivery of the program had they been assigned to their most valuable alternative use. For example, if a clinical psychologist is hired and is used to deliver psychotherapy, then their salary and on-costs are their costs. If they are end up spending most of their time as a counsellor and project manager, then they are still costed at the same rate as if they were providing clinical psychotherapy.

Opportunity costs are further broken down by the type of cost:

- the total cost of delivering the program is the cost of delivering the services to all participants
- the average or unit cost is the cost per individual participant
- the marginal cost is the cost per additional participant.

In this analysis, the cost of delivering HYAP was viewed from the perspective of the service provider. This perspective provides an indication of the resources required to replicate this approach in a comparable context and at similar scale, which is of most relevance from a commissioning perspective. This perspective excludes costs to participants and government.[50]

In order to accurately capture the cost of delivering HYAP, the Evaluation Team incorporated costs that are not generally captured in program budgets, for example:

- The value of paid and unpaid overtime for staff delivering services (that is not reflected in salaries or fringe benefits)
- The value of any donated goods and services including any volunteer time.

[49] It is worth noting that expenditure and cost are not one in the same. An expenditure generally refers to dollar outlays by a specific group — for example, DCJ payments to HYAP service providers — whereas the cost of providing a service might be higher due to co-financing arrangements, use of volunteer labour or financial or in-kind donations.

[50] Cost to participants could include any out-of-pocket expenses incurred by CYP to participate in the program (e.g. cost of a phone call) or the opportunity cost of any time CYP spent on HYAP activities. Costs to the government could include the cost of any increased use in services arising from participating in HYAP e.g. Headspace, Medicare or DCJ.

11.2. Methodology

To arrive at an estimate of the unit cost of delivering HYAP, the Evaluation Team investigated three sub-questions:

- What are the total costs of providing HYAP during a typical 12-month period, by provider?
- What is the average length of a spell of HYAP services, by provider?
- What does it cost to provide HYAP to a typical client per spell, by provider?

Information to answer these questions was collected through the use of an online survey of providers and administrative data — see Table 11.1.

Table 11.1 Data sources

Estimate	Source	Description
Resources used to deliver HYAP in a 12-month period	Survey of HYAP providers	Online survey that asked for retrospective estimates of costs during the reporting period
HYAP case load during a 12-month period	Administrative data extracted from CIMS	Subset of data for the reporting period for those providers that participated in the survey

11.2.1. Resources costed in this analysis

This analysis employed the 'ingredient' method to determine the cost of service delivery. This 'bottom up' approach involves obtaining information on the type of resources used by each provider, assigning values to each and aggregating them to estimate the total cost of the program (Levin, McEwan, Belfield, Bowden, & Shand, 2018). A breakdown of the resources investigated in this analysis is shown in Table 11.2 below.

Table 11.2 Types of resources considered in this cost analysis

Salary expenses	Inclusive of all wage and salary expenses, employer superannuation contributions
Fringe benefits	Any non-financial benefit that supplements an employee's wage or salary e.g. a company car
Supplies and materials	Office supplies, computer software, postage, education materials, mobile phone expenses

Durable equipment	Computers, cars, office furniture and accommodation furnishings
Contracted services	Cleaning, repair, maintenance or property management services
Rent	For office space or accommodation
Brokerage	Payments for items for HYAP clients, services not provided by your organisation etc.
Overhead costs	Shared functions such as accounting, human resources or marketing expenses
Donated supplies	Monetary value of any donated goods
Volunteer time	Estimate of the value donated volunteer time

11.2.2. Data collection

Information on the resources used to deliver HYAP services was collected from service providers through an online survey, hosted on the Qualtrics platform. The survey elicited responses from service providers between February and May 2020.

Invitations were sent to the nominated contacts at each of the seventeen HYAP service providers. Responses were received from nine providers during the time the survey was open.[51] One response was excluded due to incompleteness. See Appendix G for details of respondents.

11.2.3. How the unit costs were calculated

The method used to estimate the unit cost is summarised in Table 11.3 below.[52]

[51] Note: the cost survey was open during the time of the COVID-19 pandemic and this may have affected the number of providers who were able to participate in the survey.

[52] Key additional elements include:

- All estimates use 2018/19 dollars — no discounting was applied since all costs incurred in the same time period
- The value of volunteer time — was estimated using a shadow price sourced from *Social and community services employee award*[52] (Fair Work Ombudsman, 2019)
- The value of donated durable equipment — was assigned over multiple years if it had greater than 1 year of useful life

Table 11.3 Method used to calculate the unit cost

Step 1		Calculate the total cost of delivering HYAP services at each provider in 2018/19
Step 2		Estimate the average length of a HYAP spell at each provider in 2018/19
Step 3		Sum all of individual HYAP spells to estimate the total days of HYAP delivered at each provider in 2018/19
Step 4		Estimate the average cost per day by dividing the total annual cost (from Step 1) by total 'HYAP days' in 2018/19 (from Step 3)
Step 5		Estimate the unit cost per spell by multiplying the average cost per day (from Step 4) with the average spell length (from Step 2) at each provider

11.3. Insights

Results are presented in a disaggregated fashion because of the variation in the design and implementation of HYAP between sites, as well as the clients they serve. As service providers participated on the condition of anonymity, names of organisations have been removed from any results.

11.3.1. The total cost of providing HYAP services

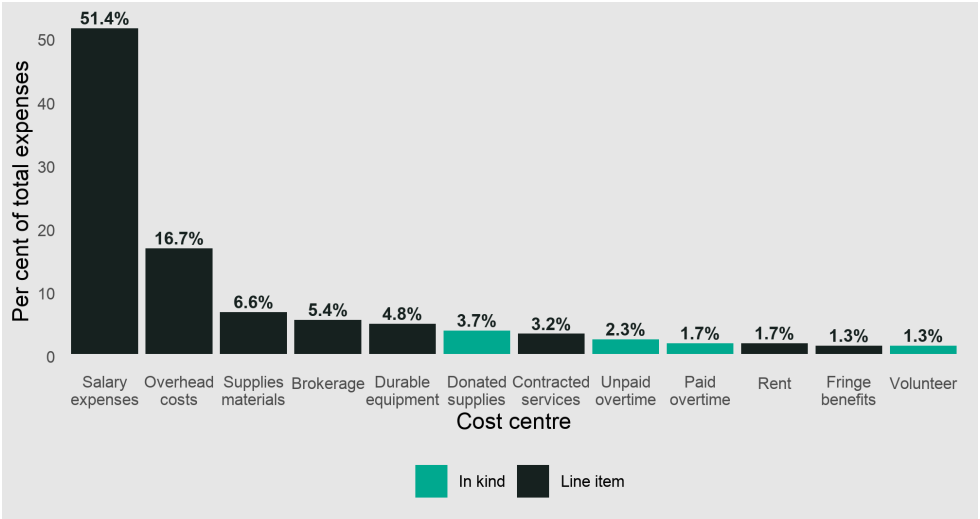
Understanding the total annual cost of providing HYAP services is integral to the rest of the cost analysis, as it directly affects all subsequent estimates. This estimate of the total cost includes the market value of purchased resources (e.g. salary expenses) and shadow price estimates of donated goods and services (e.g. volunteer time). As shown in Table 11.4, there was wide variation in the total annual cost of providing HYAP services, with estimates ranging from $245,000 to $1,147,901.

Table 11.4 Breakdown of expenditure by resource category, for all sites

Provider #	Salary expenses	Overhead costs	Supplies materials	Brokerage	Durable equipment	Donated supplies	Contracted services	Unpaid overtime	Rent	Paid overtime	Fringe benefits	Volunteer	Total
1	$129,000	$119,200	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$248,200
2	$621,000	$53,169	$8861	$22,153	$4430	$17,600	$22,153	$8171	$0	$32,684	$0	$23,816	$814,040
3	$387,500	$251,732	$50,346	$25,173	$0	$0	$25,173	$0	$0	$0	$0	$0	$739,926
4	$90,650	$52,789	$65,987	$13,197	$65,987	$0	$19,796	$17,039	$26,394	$47,710	$13,197	$40,595	$453,345
5	$389,500	$245,967	$147,580	$122,983	$122,983	$0	$49,193	$10,250	$49,193	$10,250	$0	$0	$1,147,901
6	$480,800	$42,804	$6114	$18,344	$6114	$151,600	$12,229	$23,723	$0	$0	$0	$3247	$744,979
7	$590,000	$98,796	$65,864	$24,699	$49,398	$0	$41,165	$62,105	$0	$0	$24,699	$0	$956,727
8	$60,000	$31,200	$6240	$62,400	$9360	$29,000	$0	$0	$15,600	$0	$31,200	$0	$245,000

In aggregate, the largest resource category across all providers was for salaries, which made up more than half (51.4 per cent) of the estimate. Of note is that 8 per cent of costs were from in-kind support, see Figure 11.1.

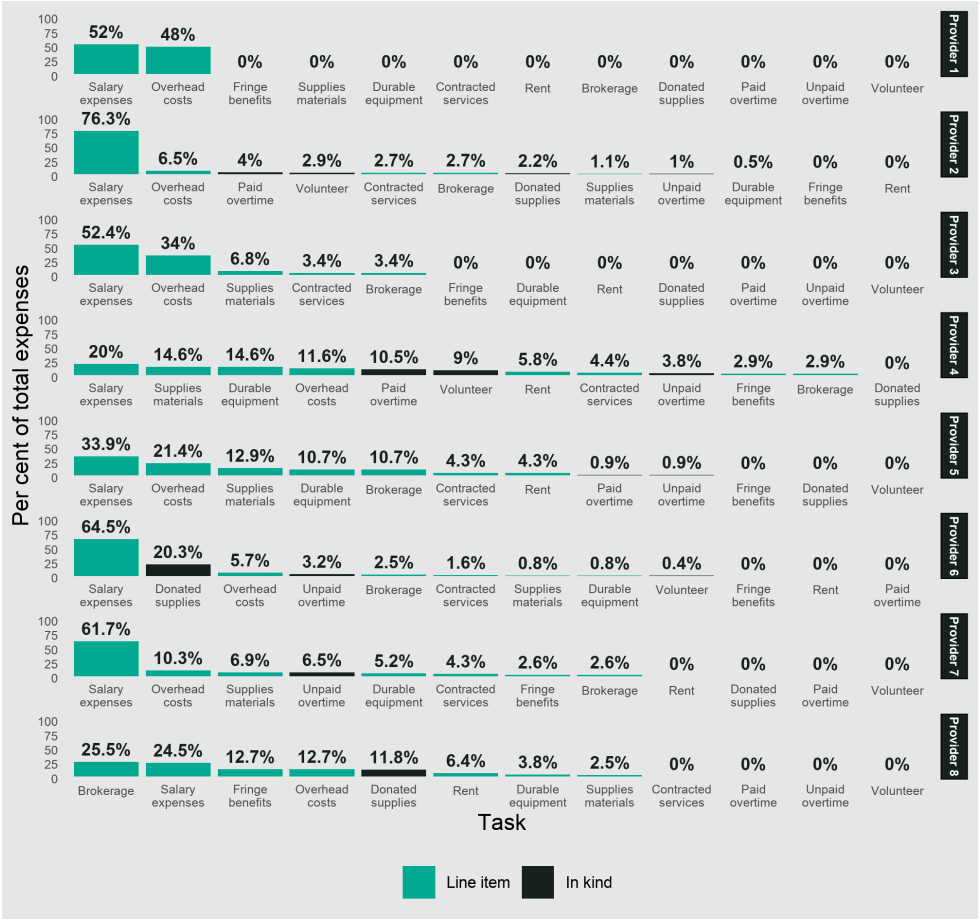
Figure 11.1 Distribution of HYAP expenditure by resource category, for all sites



When the costs are broken down by provider and expense type, it can be seen how the make-up of costs vary hugely by provider. This is shown in Figure 11.2 below, where the expense types are ordered by their proportion of the total. Key points include:

- Salary expenses represent the largest component of total costs across all providers, with the exception of one which spent a larger amount on brokerage
- Overhead costs constitute the second highest component, followed by supplies and materials and durable equipment
- Additional hours, both paid and unpaid, represent notable components for some providers, but not for others
- Likewise, some providers make active use of donated supplies and volunteer time, while others do not.

Figure 11.2 Distribution of HYAP expenditure by resources type, by sites

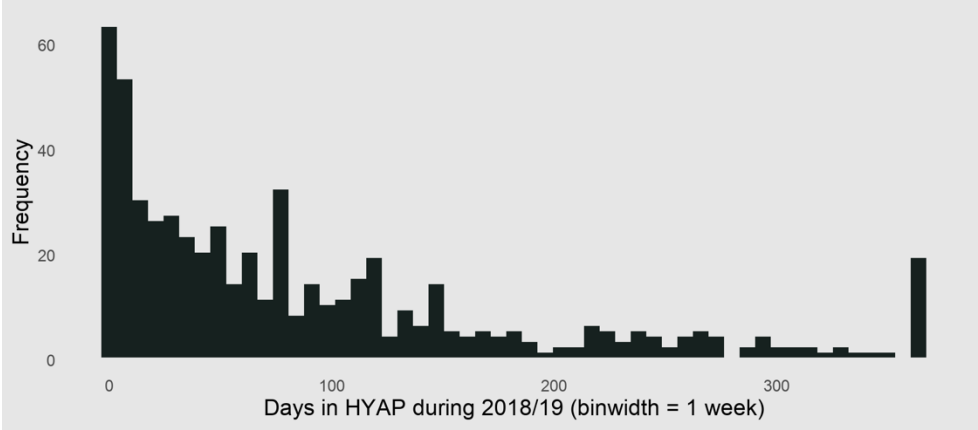


11.3.2. Variation in HYAP spell lengths

Understanding the length of time (i.e. 'spell') a CYP is involved in HYAP is essential for estimating the cost per day of services and the cost per spell. The time component of interest is the total days spent in HYAP during 2018/19, as opposed to the length of an individual spell, as this takes into account CYP who return more than once. Figure 11.3 depicts a histogram showing the distribution of the length of spells for all providers participating in this cost analysis. At this aggregate level:

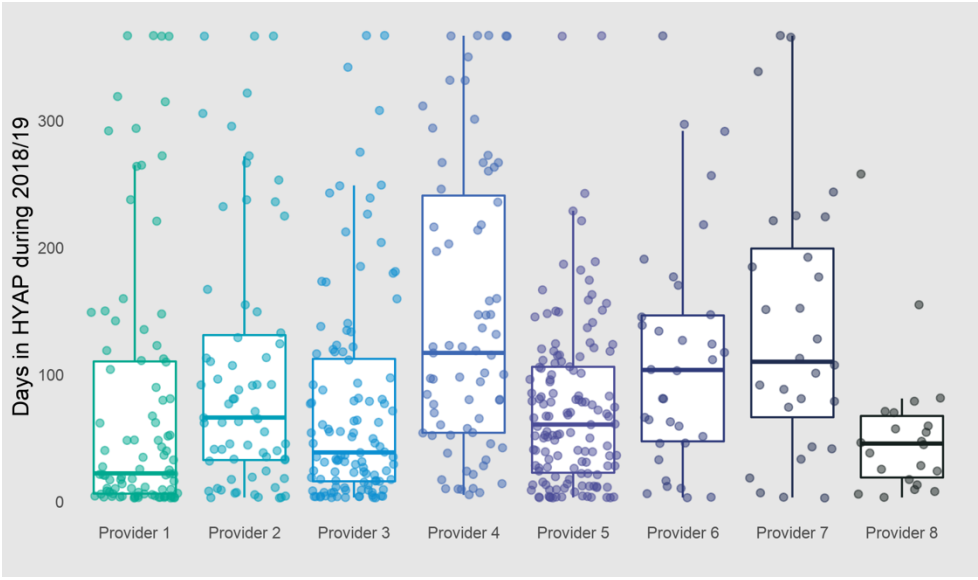
- sixty-four per cent of CYP in this sample received HYAP services for 90 days or less in 2018/19
- there is a 'long tail' however and eighteen CYP (3.2 per cent) spent the entire year receiving HYAP services.

Figure 11.3 Distribution of the length of HYAP spells, all service providers in this sample



When disaggregated by provider, there is distinct variation in the length of time that CYP receive HYAP services for — see Figure 11.4 below. Some providers have a cluster of spells that are less than a week, others are more evenly spread. Only one, Provider 8, has a tight range with all but two falling within a three-month length.

Figure 11.4 Distribution of the length of HYAP spells by service provider for 2018/19



11.3.3. Cost per spell of service delivery

The cost per spell of HYAP service varies significantly between HYAP providers. The results of this analysis, which are detailed in Table 11.5 below, produce estimates that range from $1,215 per service episode, up to $34,169.

Table 11.5 Total cost of delivering HYAP

Provider #	Average spell length (days)	Average cost per (day)	Cost per spell
Provider 1	77.7	$35	$2697
Provider 2	105.9	$115	$1215
Provider 3	73.1	$90	$6606
Provider 4	144.4	$44	$6385
Provider 5	72.5	$118	$8566
Provider 6	111.6	$196	$21,911
Provider 7	135.6	$252	$34,169
Provider 8	52.2	$213	$11,136

11.4. Strengths and limitations

This analysis has a couple of limitations that should be considered when interpreting findings. Including:

- it assumes that 2018/19 was a typical year of 'steady state' operations for HYAP providers and reflects typical operating standards and procedures
- nine out of eighteen providers participated in the survey and one response was excluded due to incompleteness, as a result these results might not be an accurate reflection of the experiences of all HYAP providers
- estimates of program costs and staff time use were sourced from self-reported estimates by providers and the analysis may be biased by this.

12. What are the elements that determine the makeup of the unit cost?

Key takeaways

- How staff spend their time varies greatly across HYAP providers and is likely driven by the particular service model they implement
- In aggregate, HYAP staff spent the most amount of time on case management however this varies between providers
- A wide range of accommodation was also seen, it was the most prominent activity for one provider, while another reported spending no time on it
- In aggregate, service providers spend approximately 75 per cent of their time on activities directly related to service delivery, with the remainder spent on administration.

12.1. Introduction

Across HYAP providers, staff costs constitute the majority of the total annual cost of service delivery. Therefore, the Evaluation Team examined how these costs breakdown and explored what staff are doing with their time. Knowing this will help DCJ support the implementation and delivery of these programs in the future.

12.2. Methodology

When investigating the components of the unit cost, the Evaluation Team focused on three sub-questions:

- What are the core program components that providers deliver?
- How are staff resources allocated among these program activities?
- What is the distribution of staff time between service delivery and administration?

Information to answer these questions was collected through the use of an online survey of providers and administrative data — see Table 12.1.

Table 12.1 Data sources

Estimate	Source	Description
Resources used to deliver HYAP in a 12-month period	Survey of HYAP providers	Online survey that asked for retrospective estimates of costs during the reporting period
HYAP case load during a 12-month period	Administrative data extracted from CIMS	Subset of data for the reporting period for those providers that participated in the survey

12.2.1. Data collection

Information on staff time use to deliver HYAP services was collected from service providers through an online survey, hosted on the Qualtrics platform. The survey elicited responses from service providers between February and May 2020.

Invitations were sent to the nominated contacts at each of the seventeen HYAP service providers. Responses were received from nine providers during the time the survey was open. One response was excluded due to incompleteness. See Appendix G for details of respondents.

12.2.2. Analysis methods

The method used to allocate the staff time use is summarised in Table 12.2 below.

Table 12.2 Method used to assess staff time use across program components

Step 1		For each staff member at a provider, an estimate of a) the proportion of their total time spent on program components and b) their FTE hours worked was obtained
Step 2		Use the proportions from (Step 1) to estimate the proportion of an FTE spent on each program component for each staff member
Step 3		Sum the total FTE's at each provider and use the results of (Step 2) to obtain the breakdown of activities by provider

12.3. Insights

The variation in the design and implementation of HYAP between sites, as well as the clients they serve led the Evaluation Team to present these results in a disaggregated fashion. As service providers participated on the condition of anonymity, names of organisations have been removed from any results.

12.3.1. Core program components delivered by each provider

In 2018, the Evaluation Team worked with service providers to document the core components of their HYAP service offering. The results are summarised in a report and series of program logics (Centre for Evidence and Implementation, 2018a). The Evaluation Team used the findings from that report as well as their knowledge of human services to develop a series of program components to use in the costing survey. These components are detailed in Table 12.3 below.

An additional category has been added to the table to denote whether the component in question is directly related to service delivery or is related to program or provider administration.

Table 12.3 Program components

Name	Description	Category
Administration	General management & administration of HYAP services — including liaising with DCJ regarding contract management, district protocols etc.	Administration
Accommodation	Accommodation support & supervision — including supervision of clients receiving accommodated services	Service delivery

Assessment	Initial screening and assessment of HYAP clients — including obtaining consent from the client's parent or legal guardian	Service delivery
Case Management	Case management and service linkage — including any case work undertaken directly with clients and their families, linkage to externally provided services and the organisation of brokered services	Service delivery
Collaboration	Planning & collaboration with government agency partners — including attending interagency meetings with DCJ, Police, Juvenile Justice etc.	Administration
External Communication	External communication & building awareness of HYAP — including outreach visits to schools, community events etc.	Administration
Fundraising	Fundraising activities to supplement HYAP funding — including the development of tender responses and grant applications	Administration
Human Resources	Human Resources — inclusive of all HR activities relating to paid and volunteer staff, including recruitment	Administration
Referrals	Onboarding referrals and eligibility determination — including liaising with DCJ regarding clients presenting at ROSH	Service delivery
Supervision	Supervision for staff working with clients — including attendance at or facilitating of sessions for staff and volunteers	Service delivery
Training	Providing or attending any job or skills-related training for HYAP provider staff — including volunteers	Service delivery
Travel	Travel & transportation — including travel to and from appointments with clients and their families and the transportation of clients to activities	Service delivery

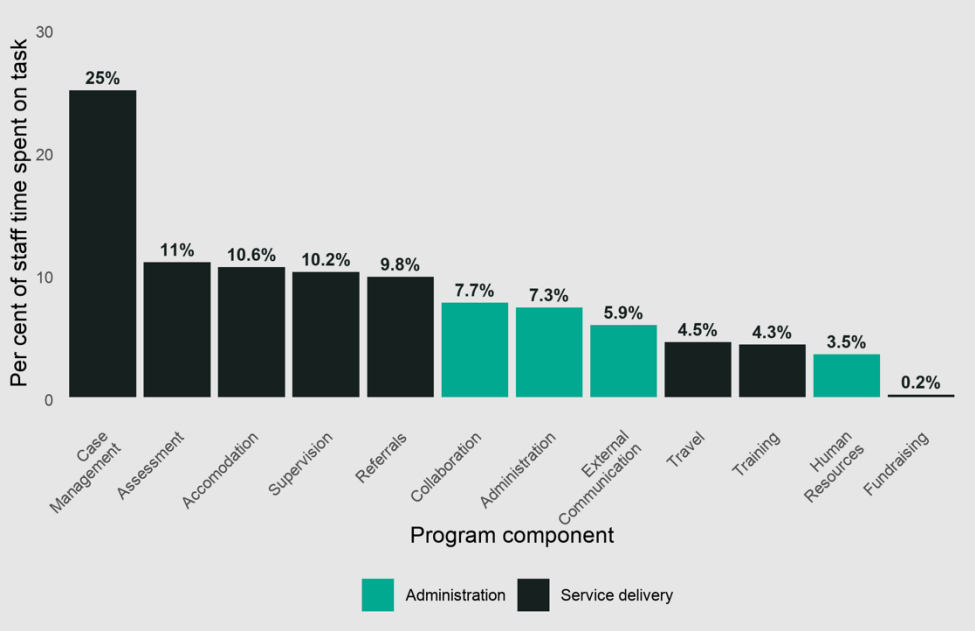
12.3.2. Allocation of staff resources across program components

At an aggregate level, the largest component of staff time was allocated to *case management,* which is unsurprising given it is one of the core components that all HYAP providers share. Other key insights support findings from the implementation focus groups with providers, including:

- the relatively high proportion of time spent onboarding clients (~10 per cent) — which could reflect overly complex referral pathways; and

- time spent completing consent and assessment activities (11 per cent) — which could reflect the difficulty of obtaining consent from parents/guardians and reporting CYP at ROSH to the child protection helpline.

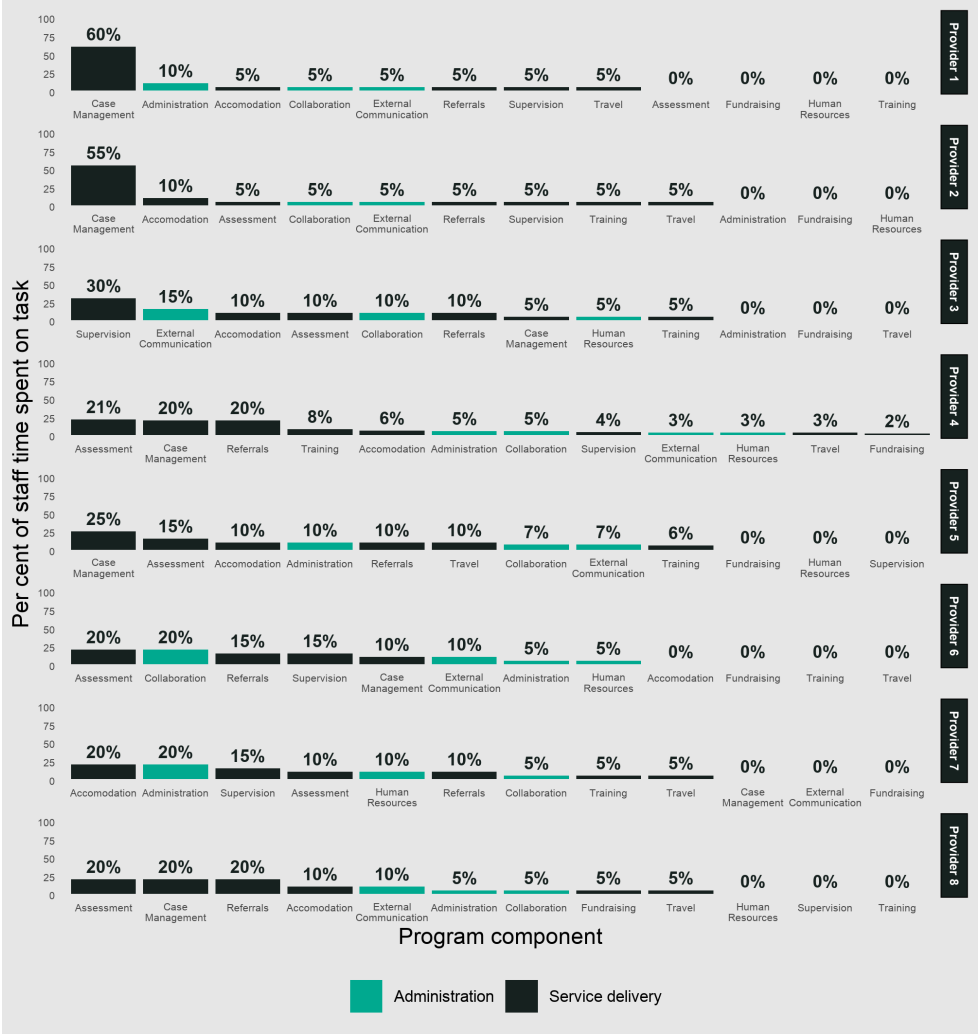
Figure 12.1 Percentage allocation of staff resources across program components, in aggregate



When these figures are broken down by provider, it can be seen that:

- Case management features highly for five of the eight providers, but for two it barely registers highlighting the variation in service offerings between providers
- Surprisingly accommodation activities take up less time than was expected, a wide range was observed with one provider noting it was where they spent the most time while another reported spending no time on it
- Collaborating with government agency partners is present for all providers, however the time it takes varies, ranging from 5 – 20 per cent
- Time spent travelling varies, which is to be expected given the geographical distribution of providers
- Fundraising represented a minor time component, but it did feature for two of the eight providers suggesting that provider concerns about the amount of funding available to deliver services are legitimate.

Figure 12.2 Percentage allocation of staff resources across program components, by site

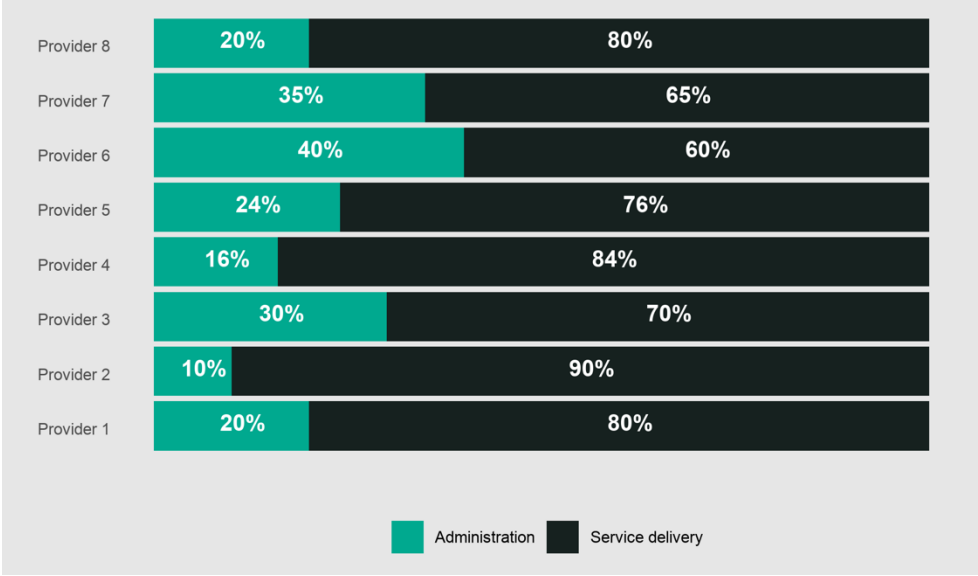


12.3.3. Distribution of staff time between service delivery and administration

Program activities were categorised into two groups ‘service delivery’ and ‘administration’ and time spent on both was aggregated to assess if there was any notable variation between providers. At an aggregate level, approximately three-quarters (75.5 per cent) of staff time was dedicated to primary service delivery activities with the remainder spent on administration (24.5 per cent).

When disaggregated by provider, some variation is observed. The proportion of staff time spent on administration ranged from 10 per cent through to 40 per cent. When these figures were cross checked with the providers service offering, it was observed that those providers who primarily delivered accommodated services spent less time on administration than those who also delivered non-accommodated services.

Figure 12.3 Distribution of staff time between administrative and service delivery activities, by provider



12.4. Strengths and limitations

The analysis has a couple of limitations that should be considered when interpreting findings. Including:

- it assumes that 2018/19 was a typical year of 'steady state' operations for HYAP providers and reflects typical operating standards and procedures
- nine out of eighteen providers participated in the survey and one response was excluded due to incompleteness, as a result these results might not be an accurate reflection of the experiences of all HYAP providers estimates of program costs and staff time use were sourced from self-reported estimates by providers and the analysis may be biased by this.

References

Albers, B., Mildon, R., Lyon, A. R., & Shlonsky, A. (2017). Implementation frameworks in child, youth and family services – Results from a scoping review. *Children and Youth Services Review*, *81*(February), 101–116. https://doi.org/10.1016/j.childyouth.2017.07.003

Altena, A. M., Brilleslijper-Kater, S. N., & Wolf, J. L. M. (2010). Effective Interventions for Homeless Youth. A Systematic Review. *American Journal of Preventive Medicine*, *38*(6), 637–645. https://doi.org/10.1016/j.amepre.2010.02.017

Australian Bureau of Statistics. (2018). *Estimates of Aboriginal and Torres Strait Islander Australians, June 2016*. Canberra: Australian Government. Retrieved from https://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/3238.0.55.001Main+Features1June 2016?OpenDocument

Australian Institute of Health and Welfare. (2016). *Vulnerable young people: interactions across homelessness, youth justice and child protection — 1 July 2011 to 30 June 2015*. Canberra. https://doi.org/Cat. no. HOU 279

Australian Institute of Health and Welfare. (2020). *Child protection Australia 2018–19*. Canberra: Australian Government. Retrieved from https://www.aihw.gov.au/reports/child-protection/child-protection-australia-2018-19/data

Bach-Mortensen, A. M., Lange, B. C. L., & Montgomery, P. (2018). Barriers and facilitators to implementing evidence-based interventions among third sector organisations: A systematic review. *Implementation Science*, *13*(1), 1–19. https://doi.org/10.1186/s13012-018-0789-7

Barker, J., Thomson, L., Humphries, P., & McArthur, M. (2011). *Literature Review: Effective interventions for working with young people who are homeless or at risk of homelessness*. Canberra. Retrieved from https://www.dss.gov.au/sites/default/files/documents/06_2012/literature_review.pdf

Becker, S. J., Spirito, A., & Vanmali, R. (2015). Perceptions of "Evidence-Based Practice" among the consumers of adolescent substance use treatment. *Health Education Journal*, *75*(3), 358–369. https://doi.org/10.1177/0017896915581061

Black, C., & Gronda, H. (2011). *Evidence for improving access to homelessness services*. Melbourne. Retrieved from https://www.ahuri.edu.au/__data/assets/pdf_file/0025/7279/SYN059_Evidence_for_improving_access_to_homelessness_services.pdf

Centre for Evidence and Implementation. (2018a). *Development of program logics to inform the evaluation of the Homeless Youth Assistance Program Prepared for the NSW Department of Family and Community Services*. Sydney.

Centre for Evidence and Implementation. (2018b). *Evaluation of the Homeless Youth Assistance Program: Evidence Review*. Sydney.

Chamberlain, C., & Johnson, G. (2013). Pathways into adult homelessness. *Journal of Sociology*, *49*(1), 60–77. https://doi.org/10.1177/1440783311422458

Conroy, E., & Williams, M. (2017). *Homelessness at Transition: Evidence Check*. Sydney. Retrieved from https://www.saxinstitute.org.au/wp-content/uploads/Homeless-at-transition.pdf

Crawford, B., Yamazaki, R., Franke, E., Amanatidis, S., Ravulo, J., & Torvaldsen, S. (2015). Is something better than nothing? Food insecurity and eating patterns of young people experiencing homelessness. *Australian and New Zealand Journal of Public Health*, *39*(4), 350–354. https://doi.org/10.1111/1753-6405.12371

Damschroder, L. J., Aron, D. C., Keith, R. E., Kirsh, S. R., Alexander, J. A., & Lowery, J. C. (2009). Fostering implementation of health services research findings into practice: A consolidated framework for advancing implementation science. *Implementation Science*, *4*(50). https://doi.org/10.1186/1748-5908-4-50

Eccles, M. P., & Mittman, B. S. (2006). Welcome to implementation science. *Implementation Science*, *1*(1), 1–3. https://doi.org/10.1186/1748-5908-1-1

Embleton, L., Lee, H., Gunn, J., Ayuku, D., & Braitstein, P. (2016). Causes of Child and Youth Homelessness in Developed and Developing Countries: A Systematic Review and Meta-analysis. *JAMA Pediatrics*, *170*(5), 435–444. https://doi.org/10.1001/jamapediatrics.2016.0156

Fair Work Ombudsman. (2019). *Pay Guide: Social, Community, Home Care and Disability Services Industry Award 2010 [MA000100] and Social and Community Services Employees (State) Award [AN120505] (NSW)*. Canberra.

Flatau, P., Conroy, E., Spooner, C., Edwards, R., Eardley, T., Forbes, C., … Monash University Research Centre. (2013). *Lifetime and intergenerational experiences of homelessness in Australia*. *AHURI Final Report*. Melbourne: Australian Housing and Urban Research Institute.

Flatau, P., Thielking, M., MacKenzie, D., & Steen, A. (2015). *The cost of youth homelessness in Australia Study: Snapshot Report 1*. Melbourne.

Greenwood, M., Kendrick, T., Davies, H., & Gill, F. J. (2017). Hearing voices: Comparing two methods for analysis of focus group data. *Applied Nursing Research*, *35*, 90–93. https://doi.org/10.1016/j.apnr.2017.02.024

Hateley-Browne, J., Hodge, L., Polimeni, M., & Mildon, R. (2019). *Implementation in action*. Melbourne. Retrieved from https://aifs.gov.au/cfca/publications/guidelines/implementation-action

Hyde, J. (2005). From home to street: Understanding young people's transitions into homelessness. *Journal of Adolescence*, *28*, 171–183. https://doi.org/10.1016/j.adolescence.2005.02.001

KPMG. (2015). *Going Home Staying Home Post Implementation Review*. Sydney. Retrieved from https://www.housing.nsw.gov.au/__data/assets/pdf_file/0008/340559/GHSHPostImplementationReviewKPMG.pdf

Landes, S. J., McBain, S. A., & Curran, G. M. (2019). An Introduction to Effectiveness-Implementation Hybrid Designs. *Psychiatry Research*, 112513. https://doi.org/10.1016/j.psychres.2019.112513

Levin, H. M., McEwan, P. J., Belfield, C., Bowden, A. B., & Shand, R. (2018). *Economic Evaluation in Education: Cost-Effectiveness and Benefit-Cost Analysis* (Third Edit). Thousand Oaks, CA: SAGE Publications.

Mallett, S., Rosenthal, D., & Keys, D. (2005). Young people, drug use and family conflict: Pathways into homelessness. *Journal of Adolescence*, *28*, 185–199. https://doi.org/10.1016/j.adolescence.2005.02.002

Martijn, C., & Sharpe, L. (2006). Pathways to youth homelessness. *Social Science and Medicine*, *62*(1), 1–12. https://doi.org/10.1016/j.socscimed.2005.05.007

Massey, O. T. (2011). A proposed model for the analysis and interpretation of focus groups in evaluation research. *Evaluation and Program Planning*, *34*(1), 21–28. https://doi.org/10.1016/j.evalprogplan.2010.06.003

McDonald, M. (2011). *What role can child and family services play in enhancing opportunities for parents and families? Exploring the concepts of social exclusion and social inclusion*. Melbourne. Retrieved from http://www.aifs.gov.au/cfca/

NSW Department of Family and Community Services. (2015). *Unaccompanied Children and Young People 12-15 Years Accessing Specialist Homelessness Services Policy*. Sydney.

NSW Department of Family and Community Services. (2016). *Homeless Youth Assistance Program (HYAP) — Service Delivery Framework*. Sydney.

NSW Department of Finance, Services and Innovation. (2020). The Human Services Outcomes Framework. Retrieved from https://www.finance.nsw.gov.au/node/7846

NSW Government. (2009). *A Way Home: Reducing Homelessness in NSW NSW Homelessness Action Plan 2009 – 2014*. Sydney.

NSW Government. (2012). *National Partnership Agreement on Homelessness — NSW Implementation Plan 2009-2013*. Sydney. Retrieved from http://www.federalfinancialrelations.gov.au/content/npa/housing/national-partnership/past/homelessness_NSW_superseded.PDF

NSW Ombudsman. (2018). *More than shelter — addressing legal and policy gaps in supporting homeless children: A special report to Parliament under section 31 of the Ombudsman Act 1974*. Sydney. Retrieved from www.ombo.nsw.gov.au

Palinkas, L. A., Aarons, G. A., Horwitz, S., Chamberlain, P., Hurlburt, M., & Landsverk, J. (2011). Mixed method designs in implementation research. *Administration and Policy in Mental Health and Mental Health Services Research*, *38*(1), 44–53. https://doi.org/10.1007/s10488-010-0314-z

Pergamit, M., Gelatt, J., Stratford, B., Beckwith, S., & Martin, M. C. (2016). *Family Interventions for Youth Experiencing or at Risk of Homelessness*. Washington DC: Urban Institute and Child Trends. Retrieved from https://aspe.hhs.gov/system/files/pdf/205401/FamilyInterventions.pdf

Proctor, E. K., Landsverk, J., Aarons, G. A., Chambers, D., Glisson, C., & Mittman, B. (2009). Implementation Research in Mental Health Services: an Emerging Science with Conceptual, Methodological, and Training challenges. *Administration and Policy in Mental Health and Mental Health Services Research*, *36*(1). https://doi.org/10.1007/s10488-008-0197-4

Proctor, E. K., Silmere, H., Raghavan, R., Hovmand, P., Aarons, G., Bunger, A., … Hensley, M. (2011). Outcomes for implementation research: Conceptual distinctions, measurement

challenges, and research agenda. *Administration and Policy in Mental Health and Mental Health Services Research*, *38*(2), 65–76. https://doi.org/10.1007/s10488-010-0319-7

Sanders, M. R., & Kirby, J. N. (2014). Surviving or thriving: Quality assurance mechanisms to promote innovation in the development of evidence-based parenting interventions. *Prevention Science*, 1–11. https://doi.org/10.1007/s11121-014-0475-1

Victorian Department of Health and Human Services. (2019a). *Client voice framework for community services*. Melbourne. Retrieved from https://www.dhhs.vic.gov.au/client-voice

Victorian Department of Health and Human Services. (2019b). *Department of Health and Human Services Strategic Plan*. Melbourne. Retrieved from https://www.dhhs.vic.gov.au/our-strategy

Wang, J. Z., Mott, S., Magwood, O., Mathew, C., Mclellan, A., Kpade, V., … Andermann, A. (2019). The impact of interventions for youth experiencing homelessness on housing, mental health, substance use, and family cohesion: a systematic review. *BMC Public Health*, *19*(1), 1528. https://doi.org/10.1186/s12889-019-7856-0

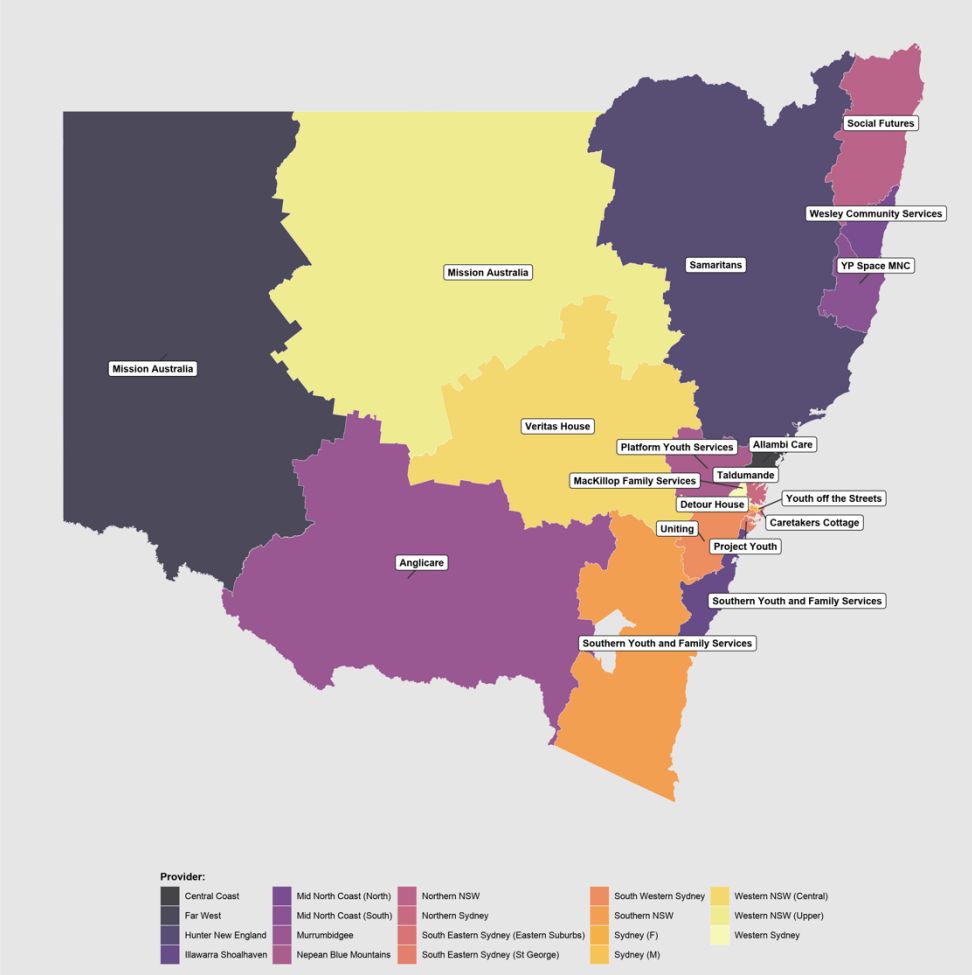
Yfoundations. (n.d.). *Good Practice Guidelines for working with Unaccompanied Children 12 – 15 years accessing Specialist Homelessness Services (SHS)*. Sydney. Retrieved from https://www.homelessnessnsw.org.au/sites/homelessnessnsw/files/2017-08/Good Practice Guidelines for working with Unaccompanied Children 12 – 15 years accessing Specialist Homelessness Services %28SHS%29JUNEv2.pdf

Appendix A Contextual Information

This appendix includes additional contextual information relevant to the Homeless Youth Assistance Program including:

- Providers and their catchment areas — see Figure A.1
- The Rationale for the Going Home Staying Home Reforms — see Box A.1
- Summary of recommendations from NSW Ombudsman's report *More than Shelter* — see Box A.2

Figure A.1 HYAP providers and their catchment areas



Box A.2 Rationale for Going Home Staying Home Reforms

According to an analysis by KPMG, the rationale for reform of the SHS sector was to address some of the following 'known issues' affecting service delivery:

→ **Growing and potentially mismatched need**
Historical allocations and incremental decision making resulted in services being provided in the same places and ways they have always been, rather than providing them where users live and needs are emerging.

→ **Lack of cross-sector collaboration**
People with multiple needs (e.g. homeless and mental health issues) can find it difficult to have their needs met within the previous system, which was focused on funding programs and outputs, rather than finding whole-of-person solutions.

→ **Barriers to service innovation**
Rigidity in funding and output based program requirements made it challenging for providers to tailor services to achieve the best outcomes for individual service users, or to expand good models beyond individual agencies.

→ **Limited accountability for outcomes**
Funding arrangements, data collection and reporting were not linked to service outcomes, and financial and program related data was not comprehensive nor consistent across the service system.

→ **Limited focus on prevention**
Funding prioritised crisis interventions at the expense of devoting some resources to prevention, and the potential to reduce subsequent demand if effective.

Source: KPMG (2015)

Box A.3 Summary of recommendations from NSW Ombudsman's report *More than Shelter*

1. The Department of Family and Community Services (FACS) should provide advice to the NSW Government about a proposed framework to address the lack of decision-making authority relating to children staying in homelessness services - outlined in section 2 of the report.

2. FACS should work with youth homelessness services and other key partner agencies (e.g. Health, Education, Justice) to promptly finalise the remaining district-level Protocols for responding to unaccompanied children and young people 12-15 years of age who are

homeless or at risk of being homeless and, where necessary, revise the existing district-level protocols to reflect the amended policy.

3. FACS should promptly revise the Unaccompanied Children and Young People 12–15 Years Accessing Specialist Homelessness Services policy to:

    a. Include much greater clarity about, and a stronger commitment relating to, its role in supporting youth homelessness services.

    b. Commit to providing a single nominated FACS contact point for youth homelessness services in each district or community services centre, and outline their specific roles and responsibilities.

4. FACS should promptly revise the Unaccompanied Children and Young People 12–15 Years Accessing Specialist Homelessness Services policy to specify a mandated case review process for children who 'over-stay' in youth homelessness services.

5. FACS should promptly start a review of the use of homelessness services by children in out-of-home care to enable a better understanding of the circumstances in which children are leaving their placements and how to respond to their needs.

6. FACS should work with the youth homelessness sector and the Children's Guardian to ensure there is a robust process in place which guarantees the accuracy of data relating to children in statutory OOHC who are staying in homelessness services, as well as the timely reporting of these children to both FACS and the Children's Guardian when they enter homelessness services.

7. After consultation with the Children's Guardian, the Advocate for Children and Young People and the youth homelessness sector, FACS should promptly provide advice to the NSW Government about establishing regulatory standards to govern the quality of care provided by youth specialist homelessness services.

8. In light of the observations in the report, and as part of finalising the Specialist Homelessness Services continuous improvement plan and the HYAP Evaluation Plan, FACS should:

    a. Promptly settle the performance measures required to adequately monitor and report on service and client outcomes for children who access homelessness services, including identifying children in statutory OOHC as a specific cohort.

    b. Capture data to allow FACS to measure its capacity to respond to risk of significant harm reports made by homelessness services, and the re-reporting of children who have accessed homelessness services.

9. The Department of Family and Community Services should regularly report publicly on the client and service outcomes referred to in recommendation 8.

Source: NSW Ombudsman (2018)

Appendix B Client profiles — supplementary information

This appendix contains supplementary information for *Chapter 4 — What are client profiles targeted by provider agencies.*

Table B.1 Count of CYP presenting with care or protection orders at the start of their first HYAP spell

Type of care and protection order present	Count
Not Stated / Inadequately Described	2558
Foster Care	30
Relatives / Friends Reimbursed	30
Parents	29
Relatives / Friends Not Reimbursed	22
Residential Care	22
Other Living Arrangements	12
Other Home Care Reimbursed	3
Independent Living	1

Appendix C Implemented as planned — supplementary information

This appendix contains supplementary information for Chapter 5 — *Are HYAP services being implemented as planned?*

Table C.1 Count of CYP served by each provider and eligibility reason

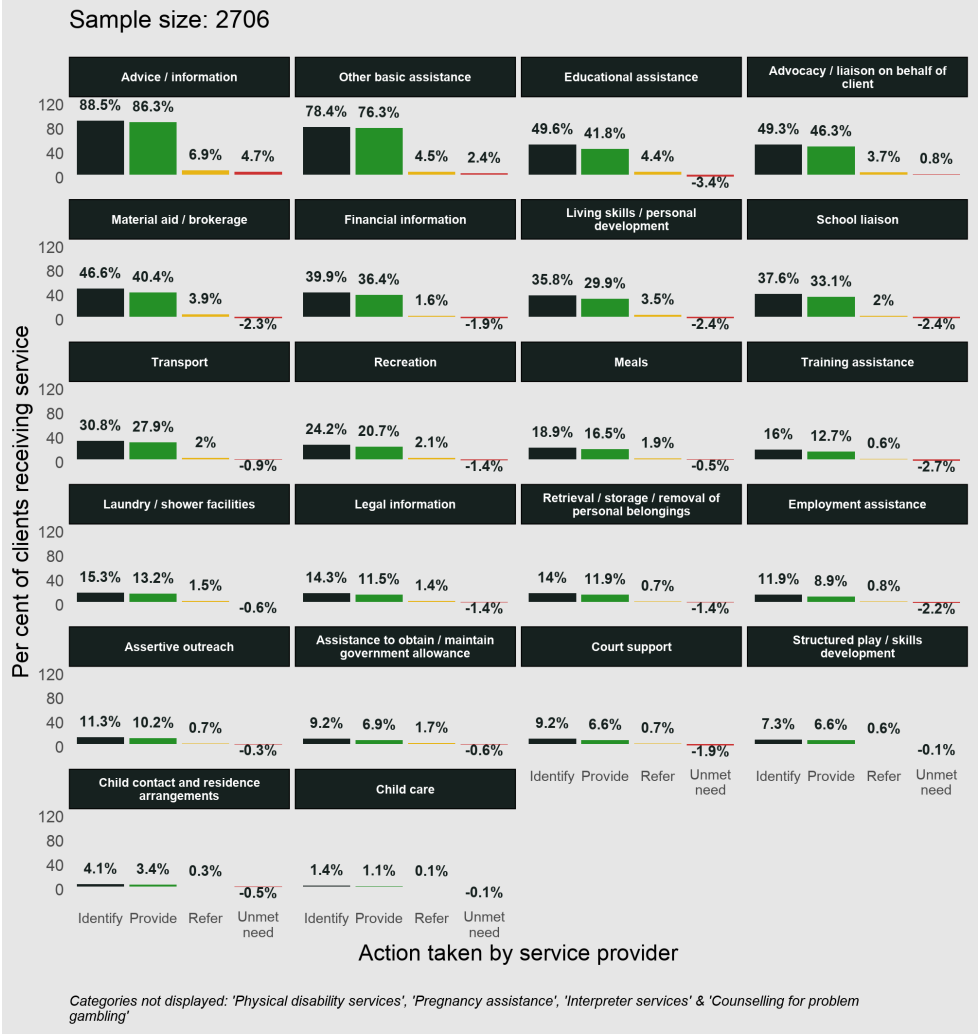
Provider name	Count of CYP served by provider	Aged over 12 and under 16	Presenting alone	Meet both criteria	Proportion that meet both criteria
Allambi Care	133	126	123	123	92.5 per cent
Anglicare	82	82	82	82	100.0 per cent
Caretakers Cottage	502	228	228	228	45.4 per cent
Detour House	354	172	172	172	48.6 per cent
Mackillop Family Services	53	53	53	53	100.0 per cent
Platform Youth Services	297	280	281	280	94.3 per cent
Project Youth	173	137	138	137	79.2 per cent
Samaritans	912	878	882	873	95.7 per cent
Social Futures	88	88	88	88	100.0 per cent
Southern Youth & Family Services	698	511	397	394	56.4 per cent
Taldumande	98	85	77	77	78.6 per cent
Uniting	75	75	75	75	100.0 per cent
Veritas House	97	94	94	94	96.9 per cent
Wesley Community Services	187	112	58	58	31.0 per cent

Youth Off the Streets	229	144	147	144	62.9 per cent
YP Space MNC	575	85	85	84	14.6 per cent

Table C.2 Cluster of services delivered using in analysis by the Evaluation Team

Service Grouping	CIMS variables
Housing services	Assistance to prevent foreclosures or for mortgage arrears; Assistance to sustain tenancy or prevent tenancy failure or eviction; Long term housing; Medium term Transitional housing; Short term or emergency accommodation
Counselling and relationship services	Assistance for domestic/family violence; Assistance for incest/sexual assault; Assistance for trauma; Assistance with challenging social/behavioural problems; Child specific specialist counselling services; Drug/alcohol counselling; Family/relationship assistance; Mental health services; Psychiatric services; Psychological services; Specialist counselling services
Other	Advice/information; Advocacy/liaison on behalf of client; Assertive outreach; Assistance to connect culturally; Assistance to obtain/maintain government allowance; Assistance with immigration services; Child care; Child contact and residence arrangements; Child protection services; Counselling for problem gambling; Court support; Culturally specific services; Educational assistance; Employment assistance; Family planning support: Financial advice and counselling; Financial information; Health/medical services; Intellectual disability services; Interpreter services; Laundry/shower facilities; Legal information; Living skills/personal development: Material aid/brokerage; Meals; Other basic assistance; Other specialised service; Parenting skills education; Physical disability services; Pregnancy assistance; Professional legal services; Recreation; Retrieval/storage/removal of personal belongings; School liaison; Structured play/skills development; Training assistance; Transport

Figure C.1 “Other services” identified, provided or referred to CYP in HYAP at their first presentation



Categories not displayed: 'Physical disability services', 'Pregnancy assistance', 'Interpreter services' & 'Counselling for problem gambling'

Appendix D Barriers & Facilitators — supplementary information

This appendix includes additional detail about the focus groups conducted with service providers including:

- How the focus groups were conducted
- Details of each of the focus groups
- The discussion guide using during the focus groups
- The modified discussion guide sent to DCJ

D.1 How the focus groups were conducted

The focus groups with HYAP providers were conducted via teleconference. The sessions were facilitated by one or multiple experienced qualitative researchers from CEI who shared roles as moderator and scribe. The following process was followed for each focus group:

- A list of primary contacts for each HYAP provider was sourced from DCJ
- Each HYAP provider was contacted by email and informed about the purpose of the focus group, the email contained a copy of the Explanatory Statement and Discussion Guide which outlined the purpose of the focus group and content to be covered
- Providers were asked to identify the individuals in their organisation best placed to provide input and to nominate a preferred time for a focus group
- At the commencement of the focus group the facilitator sought permission to record the focus group
- The facilitator verbally went through the Explanatory Statement and verbal consent procedures prior to commencement
- Respondent feedback was recorded by facilitators anonymously to protect the confidentiality of respondents.

Sixteen focus groups were held in total, covering 18 locations — see Table D.1.

Table D.1 Details of focus groups with service providers

Provider	District coverage	Focus group held	Number of participants
Allambi Care Limited	Central Coast	Yes	1
Anglicare (NSW South, NSW West and ACT)	Murrumbidgee	Yes	2
Caretakers Cottage Inc	South Eastern Sydney	Yes	3
Detour House Inc	Sydney	Yes	3
MacKillop Family Services Ltd	Western Sydney	Yes	3
Mission Australia	Western NSW & Far Western NSW	Yes	4
Social Futures	Northern NSW	Yes	2
Platform Youth Services Ltd	Nepean Blue Mountains	Yes	4
Project Youth Inc	South Eastern Sydney	Yes	2
Samaritans Foundation Diocese of Newcastle	Hunter New England	Yes	3
Southern Youth and Family Services Limited	Illawarra Shoalhaven & Southern NSW	Yes	4
Taldumande Youth Services Inc	Northern Sydney	Yes	4
Uniting (NSW/ACT)	South Western Sydney	Yes	3
Veritas House Inc	Western NSW	Yes	5
Wesley Community Services Limited	Mid North Coast	Yes	3
Youth Off The Streets Ltd	Sydney	No	—
YP Space MNC Inc	Mid North Coast	Yes	3

D.2 Discussion guide used in focus group with service providers

This discussion guide is based upon the domains of the Consolidated Framework for Implementation Research (CFIR). The CFIR is a meta-theoretical framework that synthesises information and evidence about constructs and domains that affect implementation processes.

Implementation enablers and barriers can be related to five different areas: the types of services offered; the individuals involved in implementing the service; the organisational setting in which the service is implemented; the organisations outer context; and the quality of the implementation process itself. In the focus group, we will briefly discuss the five areas that impact implementation and then ask for your input about which areas you think are key challenges or enablers for HYAP service providers.

Note: This discussion guide is indicative and may not be reflective of the exact content of each focus group.

D.2.1. Purpose and consent

Evaluation Team to provide brief overview of the purpose of the focus group and how it will be used to inform the evaluation

Verbal consent will be obtained in order to record the teleconference and use the information provided to inform our evaluation findings.

D.2.2. Introductions

Please introduce yourself to the group and tell us how long you have been involved with the Homeless Youth Assistance Program (HYAP).

What is your current role (program manager, executive manager, administrator) in relation to HYAP?

D.2.3. The types of services offered

What is it?

The types of services offered are important because the different attributes (complexity, adaptability, cost, evidence strength and quality and design quality) of the services will influence how easy it can be taken up by individuals and service provider agencies.

Indicative talking points:

- What are some troubles that your clients face?
- What do you do to help clients?
- Is there anything you can't do?

D.2.4. The Individuals involved

What is it?

The individuals involved in implementing the service are important because their skills, expertise, attitudes, behaviours and values influence how they engage in the implementation process and how the organisation setting operates.

Indicative talking points:

- How were the HYAP guidelines interpreted by your team?
- What are the three things that they do always?
- How do they work together?

D.2.5. The external context

What is it?

The organisation's outer context is important because funding structures, legislation, policy agendas and similar factors in the environment of the implementation can change or totally stop an implementation.

Indicative talking points:

- What challenges did you experience outside of your workplace (i.e. outside your control) that have made it difficult to implement HYAP?
- Are you able to get the things they need in a timely fashion?
- Are there things that they need that you can't get?

D.2.6. The organisational context

What is it?

The organisation setting in which the service is implemented is important because factors such as hierarchical structures, culture, communication and access to training and resources will influence how quickly and easily a new program can be taken up and utilised by an organisation.

Indicative talking points:

- In what ways were service providers well-prepared to deliver HYAP?
- How do you know what your clients need?

D.2.7. The quality of the implementation process

What is it?

The quality of the implementation process itself is important because the attention paid, resources invested, and commitment made to an implementation process will enhance, or diminish, the likelihood of its success.

Indicative talking points:

- How did the process of implementing HYAP work?
- What are you doing that works to improve outcomes for your clients?

D.2.8. Overall

Do you have any other feedback on how HYAP could be strengthened to better meet the needs of the young people it seeks to support? Please explain.

D.3 Modified discussion guide sent to DCJ

The Centre for Evidence and Implementation (CEI), along with its partners Monash University and the Behavioural Insights Team (BIT) have been engaged by the Department of Communities and Justice (DCJ), formerly known as the Department Family and

Community Services (FACS) to undertake an independent evaluation of the Homeless Youth Assistance Program (HYAP)

We are interested in obtaining some information from you in order to understand the implementation of HYAP from the perspective of DCJ.

We have compiled a series of questions based upon the domains of the Consolidated Framework for Implementation Research (CFIR).[53] The CFIR is a meta-theoretical framework that synthesises information and evidence about constructs and domains that affect implementation processes.

Implementation enablers and barriers can be related to five different areas: the types of services offered; the individuals involved in implementing the service; the organisational setting in which the service is implemented; the organisations outer context; and the quality of the implementation process itself. We are interested in obtaining your input about which areas you think are key challenges or enablers in the implementation of HYAP.

D.3.1. The types of services offered

What is it?

The types of services offered are important because the different attributes (complexity, adaptability, cost, evidence strength and quality and design quality) of the services will influence how easy it can be taken up by individuals and service provider agencies.

Specific questions:

- In what context was HYAP developed?
    - How was this population served before HYAP?
    - How did it fit into the broader policy/reform context (i.e. Going home, Staying home)?
    - Was it looking to solve an emerging problem or existing problem?
    - What does 'early intervention' mean in the context of HYAP? What is HYAP trying to provide 'early intervention' to prevent?
- What decisions led to the current approach being pursued?
    - Why does HYAP look so different in each of its catchment areas?
    - Was this a deliberate decision or something that emerged from the procurement process?
    - What considerations were used in allocation of funding between locations? (We have heard about the use of a resource allocation model developed by an external consultant)
    - Is there a reason ERO was not considered in contracts with providers?
- How were the program's goals decided?

[53] Damschroder, L. J., Aron, D. C., Keith, R. E., Kirsh, S. R., Alexander, J. A., & Lowery, J. C. (2009). Fostering implementation of health services research findings into practice: A consolidated framework for advancing implementation science. Implementation Science, 4(1). https://doi.org/10.1186/1748-5908-4-50

- What does a successful 'transition to independence' look like for CYP who are unable to return to their family home? What goals/thresholds were envisioned for this group knowing what we know about the vulnerability of (older) young people leaving care?

- During the programs' design phase, to what extent were the following items considered:
    - the existence of appropriate early intervention services for this cohort?
    - the availability of appropriate services for this cohort?

D.3.2. The Individuals involved

What is it?

The individuals involved in implementing the service are important because their skills, expertise, attitudes, behaviours and values influence how they engage in the implementation process and how the organisation setting operates.

Specific questions:

- The process of establishing district protocols that detail how DCJ will respond to 'unaccompanied children and young people 12-15 years of age who are homeless or at risk of being homeless' varied between districts. What are some of the issues that affected this? e.g. resourcing, competing priorities, district decision-making.

- The process of DCJ districts establishing a nominated point of contact in each district office to liaise with HYAP providers also varied between districts. What are some of the issues that affected this? e.g. resourcing, competing priorities, district decision-making.

D.3.3. The external context

What is it?

The organisation's outer context is important because funding structures, legislation, policy agendas and similar factors in the environment of the implementation can change or totally stop an implementation.

Specific questions:

- Are there any external factors (e.g. legislation) that prevent providers/DCJ from responding to the needs of HYAP clients?

- To what extent is DCJ provided with adequate funding to implement HYAP?

D.3.4. The organisational context

What is it?

The organisation setting in which the service is implemented is important because factors such as hierarchical structures, culture, communication and access to training and resources will influence how quickly and easily a new program can be taken up and utilised by an organisation.

Specific questions:

- How does DCJ ensure that HYAP clients with identified child protection concerns receive an appropriate response?

- What other options exist for complex clients who do not respond to HYAP services?

- What does DCJ do to support HYAP clients/providers where there are no safe accommodation options available?
- What does DCJ consider to be appropriate transitional accommodation for a CYP who cannot return to their family?

D.3.5. The quality of the implementation process

What is it?

The quality of the implementation process itself is important because the attention paid, resources invested, and commitment made to an implementation process will enhance, or diminish, the likelihood of its success.

Specific questions:

- Are there any issues that you have observed with the delivery of HYAP?
- What implementation support was provided by DCJ to HYAP providers, including at the district level?

D.3.6. Overall

Do you have any thoughts on how HYAP could be strengthened to better meet the needs of the young people it seeks to support? Please explain.

Appendix E Client voice — supplementary information

This appendix includes addition detail about the client interviews including:

- A breakdown of the client interviews by site — see Table E.1
- The discussion guide using during the interview — see section E.1.

Table E.1 Client interviews by site

Catchment area	Provider	# clients interviewed	Comment
Sydney	Detour House	2	
Sydney	Youth Off The Streets	2	
Central Coast	Allambi Care	0	No clients interested in participating
Hunter New England	Samaritans	1	
Mid North Coast I	Wesley Community Services	0	No clients interested in participating
Mid North Coast II	YP Space MNC	2	
Murrumbidgee	Anglicare	0	No clients interested in participating
Nepean Blue Mountains	Platform Youth Services	1	
Northern NSW	Social Futures	0	No clients interested in participating
Northern Sydney	Taldumande Youth Services	2	
South Eastern Sydney I	Caretakers Cottage	3	
South Eastern Sydney II	Project Youth	0	No clients interested in participating
South Western Sydney	Uniting	1	
Illawarra Shoalhaven & Southern NSW	Southern Youth and Family Services Limited	3	

Western NSW I	Veritas House	5	
Western NSW II & Far Western NSW	Mission Australia	1	
Western Sydney	MacKillop Family Services	0	No clients interested in participating

E.1 Discussion guide used in interviews with CYP

E.1.1. Introduction

- How long have you received services through the Homelessness Youth Assistance Program or HYAP, through [insert provider name]?
- Is there one person at [insert provider name] you can contact if you need to?
- Has this always been the case?

E.1.2. Accommodation

- Did you need help with finding somewhere to stay? [If yes - continue, if no - skip to next section]
- Did [insert service provider name] help you by finding somewhere to stay?
- What did they do?
- Did they ask you what you wanted?
- Did you feel safe?
- Did it work out? For how long?
- Is there anything they could have done differently?
- On a scale of 1 to 5 - 1 being very good, 2 being good, 3 being neither good nor bad, 4 being bad, and 5 being very bad - how would you rate the support you received in finding safe accommodation?

E.1.3. Social networks

- Do you think that you needed help to connect with family, relatives and friends who could provide you with support? [If yes - continue, if no - skip to next section]
- Did the connections [insert service provider name] helped you with have anything to do with finding somewhere to stay?
- What did they do?
- Did they ask you what you wanted?
- How did it work out?
- Is there anything they could have done differently?
- On a scale of 1 to 5 - 1 being very good, 2 being good, 3 being neither good nor bad, 4 being bad, and 5 being very bad - how would you rate the support you received in helping you connect with a support network?

E.1.4. Skills

- Did [insert service provider name] ask you if you wanted any help with school or to learn new skills?
- Did the [insert service provider name] then help you with school or with learning new skills?
- What did they do?
- Did they ask you what you wanted?
- How did it work out?
- Is there anything they could have done differently?
- On a scale of 1 to 5 - 1 being very good, 2 being good, 3 being neither good nor bad, 4 being bad, and 5 being very bad - how would you rate the support you received in helping you with school or developing new skills?

E.1.5. Goals

- Did [insert service provider name] work with you to set some goals?
- What did they do?
- Did they ask you what goals you wanted to achieve?
- How did it work out? Do you think you achieved your goals?
- Is there anything they could have done differently?
- On a scale of 1 to 5 - 1 being very good, 2 being good, 3 being neither good nor bad, 4 being bad, and 5 being very bad - how would you rate the support you received in helping you set and achieve these goals?

E.1.6. Services

- Did [insert service provider name] put you in contact with any other people or services to provide help?
- What did they do?
- Did they ask you what you wanted?
- How did it work out?
- Do you think it helped?
- Is there anything they could have done differently?
- On a scale of 1 to 5 - 1 being very good, 2 being good, 3 being neither good nor bad, 4 being bad, and 5 being very bad - how would you rate the support you received in in getting in contact with other people or services?

E.1.7. Crisis

- Have you ever had a moment where you really needed emergency help from someone at [insert service provider name]?
- Did you know who to contact?

- Were you able to get hold of them or someone else who could help you?
- If yes, what did they do?
- Did they ask you want you wanted?
- How did it work out?
- Is there anything they could have done differently?
- On a scale of 1 to 5 - 1 being very good, 2 being good, 3 being neither good nor bad, 4 being bad, and 5 being very bad - how would you rate the emergency support you received?

E.1.8. General feedback

- Were you able to get help when you needed it?
- Would you like to add anything about stuff that's been challenging for you that HYAP was not able to help you with?
- Do you have any suggestions for improving HYAP?
- Are there things about HYAP that were really good?
- Do you have any other feedback?

Appendix F Outcome domains — supplementary information

This appendix contains supplementary information for *Chapter 10 — Have clients achieved their case management goals associated with seven key outcome domains.*

The Client Outcomes Tool was developed to help case managers explore the issues and challenges experienced by young people and how they change over time. The Evaluation Team has substantial concerns about the validity and reliability of the tool that affect its ability to measure outcomes over time:

- Validity of the tool — validity refers to the ability of a measurement tool to capture what it is intended to measure.
- Reliability of the tool — reliability refers to the capacity of a measurement tool to measure the same thing in a consistent manner e.g. between two assessors, over-time or between items on a tool.

F.1.1. Validity

Concerns about the tool's capacity to consistently capture information include:

- Some questions have too many constructs being described (i.e. it is difficult to interpret which construct is improving and not improving).
- Responses within constructs cannot be objectively assessed (i.e. a difference between a score of '2' and '3' as opposed to '4' and '5' equals '1' but may not equal '1' in reality). This affects the ability to compare changes within individuals and across individuals.
- Responses are subjected to interpretation which is a concern especially when they differ by a single word e.g. the interpretation of "little awareness" to "some awareness" is subjective and two clients with identical behaviour may be classified differently due to the assessor's interpretation of the questions and responses.

F.1.2. Reliability

Concerns about the tool's capacity to accurately measure each of the constructs include:

- There is no clearly defined reference period for any of the items, which increases the chance of response bias due to differences in interpretation e.g. in the clients' engagement in employment or education category, one client may refer to his/her attendance as "regular" since the last quarterly month, while another might report "regular" attendance by referring within the last month, but attendance was "infrequent" prior to that.
- Differences in interpretation can arise because clients or practitioners interpret responses differently, this is because the question wordings create ambiguity making differentiation between clients in the two response categories difficult and potentially subjective.

- The use of double-barrelled (combining two or more constructs into one scale) questions can affect the evaluation of client responses e.g. the domains employment and education ask about frequency of attendance and level of engagement simultaneously. While each response option is a different combination of engagement and attendance, the response set is not complete. This may result in increased reporting error due to differences in the true response and the available options.

Appendix G Unit cost — supplementary information

This appendix includes additional detail about the costing survey:

- A breakdown of the responses by site — see Table G.1

Table G.1 Details of costing survey responses

Provider	District coverage	Response received
Allambi Care Limited	Central Coast	No
Anglicare (NSW South, NSW West and ACT)	Murrumbidgee	No
Caretakers Cottage Inc	South Eastern Sydney	Yes
Detour House Inc	Sydney	Yes
MacKillop Family Services Ltd	Western Sydney	No
Mission Australia	Far Western NSW & Western NSW	No
Social Futures	Northern NSW	No
Platform Youth Services Ltd	Nepean Blue Mountains	Yes
Project Youth Inc	South Eastern Sydney	Yes
Samaritans Foundation Diocese of Newcastle	Hunter New England	Yes
Southern Youth and Family Services Limited	Illawarra Shoalhaven & Southern NSW	Yes
Taldumande Youth Services Inc	Northern Sydney	Yes
Uniting (NSW/ACT)	South Western Sydney	Yes
Veritas House Inc	Western NSW	No
Wesley Community Services Limited	Mid North Coast	Yes
Youth Off The Streets Ltd	Sydney	No
YP Space MNC Inc	Mid North Coast	Yes

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