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Evaluation of the Permanency Support Program

Final Report

For the NSW Department of Communities and Justice

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The following work undertaken by the Evaluation Consortium is independent and impartial.

Acknowledgement of Country

We acknowledge the Traditional Custodians of the lands on which this evaluation was undertaken and pay our respects to Elders past and present.

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In an evaluation of a child protection reform, it is only right that we also recognise the past and continuing injustices perpetrated against Aboriginal children, families and communities and acknowledge the stolen generations and ongoing experience of intergenerational trauma. We thank the three Aboriginal communities who kindly participated in our case studies of PSP delivery and the Aboriginal Community Controlled Organisations who participated in focus groups and case reviews.

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List of abbreviations

ACCO	Aboriginal Community-Controlled Organisation
CALD	Culturally and Linguistically Diverse
CAT	Child Assessment Tool
CFDU	Child and Family District Unit
DCJ	Department of Communities and Justice
OOHC	Out-of-Home Care
PRC	Parent Responsibility Contract
PSP	Permanency Support Program
ROSH	Risk of Significant Harm

Definitions

Aboriginal	The term 'Aboriginal' in this report refers to both Aboriginal and Torres Strait Islander peoples. It is used to refer to the numerous nations, language groups and clans in NSW. 'Indigenous' is retained when it is part of the title of a program, report or quotation, or when the context requires it.
Aboriginal Community-Controlled Organisation	An independent, not -for- profit organisation that is incorporated as an Aboriginal organisation, is controlled and operated by Aboriginal people, is based in the local Aboriginal community and delivers services to Aboriginal communities.
Aboriginal and Torres Strait Islander Child Placement Principles	The Aboriginal Child Placement Principle, or Aboriginal and Torres Strait Islander Child Placement Principle, is a broad principle provided in Section 13 of the *Children and Young Persons (Care and Protection) Act 1998.* The principle applies to the involvement of Aboriginal children and families in the child protection system and is made up of the following five elements: (i) prevention; (ii) partnership; (iii) placement; (iv) participation; and (v) connection.
Service Activity Compliance Abatement	The reduction or removal of a payment or other non-financial measures applicable where a performance failure has occurred according to contracted Key Performance Indicators.
Child	The terms 'child' or 'children' are used in this report to refer to all children under the age of 18. This accords with the definition incorporated into the United Nations Convention on the Rights of the Child. When discussing older

	children (generally accepted to be those aged 14 to 17) the terms 'young person' or 'young people' may also be used.
Child Assessment Tool (CAT)	The CAT assesses and provides a recommendation with regards to the level of care a child needs. The tool focuses on the safety and wellbeing of the child, including developmental milestones, health, behavioural needs and social skill attainment.
Child Needs Package	Packages that fund the services required to address the specific needs of the child or young person. The Child Assessment Tool is used to identify the level of support required.
Case planning	A participatory process that identifies required goals, objectives and tasks to protect and support children and their families.
Case Plan Goal Packages	The packages that support the permanency goal for each child or young person. The package includes costs based on services required to achieve the case plan goal.
ChildStory	Child protection IT system, developed by DCJ, that places the child at the centre of the story and builds a network of family, carers, caseworkers and service providers around them. ChildStory includes a partner Community that allows service providers to view information and interact with DCJ in real time about the children and families they are working with.
Cultural plan	A plan developed for an Aboriginal or Culturally Linguistic and Diverse (CALD) child or young person. It is a standalone document that details how the child's cultural needs and interests will be met, and how their cultural, spiritual identity and sense of belonging will be maintained and preserved.
Guardianship	Where a guardian takes on full parental responsibility of the child or young person, making all decisions about their care until they reach 18 years of age. A child or young person under a guardianship order is not considered to be in OOHC but in the independent care of their guardian.
Guardianship order	A type of final order that allocates to a guardian all aspects of parental responsibility for a child who has been in OOHC and whom the court has found to be in need of care and protection, until the child reaches the age of 18 years.
Family Action Plan for Change	A plan developed by the family to address the worries and dangers to support a restoration case plan goal.
Foster care	Refers to services delivered by DCJ or Service Providers for children in statutory out-of-home care, which are provided by Authorised Carers, prospective guardians and prospective adoptive parents generally in the carer's own home, or rarely in a home owned or rented by the Service Provider.
High needs Children	Children with a CAT outcome of High.
Kinship	Kinship extends beyond biological relationships and relates to cultural social connections of families.

Kinship care	Refers to services delivered by DCJ or Service Providers for children in statutory out-of-home care, which are provided by a family member including extended family member.
Leaving care planning	The process of developing a plan with a young person (from the age of 15 years) to identify supports that need to be put in place and actions that need to occur to assist the young person transition into independence until the age of 25 years.
Long term care	An OOHC placement with an order allocating parental responsibility to the Minister until the child reaches the age of 18 and a long-term care permanency goal.
Low needs children	Children with CAT outcome of Low.
Medium needs children	Children with CAT outcome of Medium.
Non-Risk of Significant Harm (ROSH) report	A child protection report that does meet the Risk of Significant Harm (ROSH) threshold.
Out-of-Home Care (OOHC)	The control of care and accommodation arrangements of a child by a person other than the child's parents or legal guardian following an order made by the Children's Court (i.e., statutory OOHC) or with the agreement of the child's parents or legal guardian (i.e., temporary care arrangements).
Parent responsibility contract	Parent responsibility contract is a written contact registered with the court between DCJ and at least one of the child's primary care givers which specifies provisions to be met by the primary care giver and care order to be filed if the contract is breached. The provisions aim to improve the parenting skills of the primary caregiver and set strict minimum expectations to be met in order to retain care.
Permanency Coordinators	Permanency Coordinators are employed by DCJ to provide support to the DCJ and PSP service provider teams involved in casework, with regards to permanency planning and support. They were tasked with embedding a culture that values and prioritises relational, physical, cultural and legal permanency for children.
Permanent Support Program (PSP)	A large DCJ funded program which provides services to vulnerable families and children to supports safety, wellbeing and positive life outcomes for children and young people in the child protection and OOHC systems in NSW. The services are delivered across family preservation, foster care and kinship care cases.
Preservation	Package provided to support families and children living at home with their parent/s a relative or kin where a child is at imminent risk of entering OOHC.
PSP service providers	The OOHC accredited not-for-profit agencies, including Aboriginal Community Controlled Organisations, who are funded to deliver services as part of PSP and under PSP contracting arrangements and service agreements.

Residential Care	Care provided in a property owned or rented by a service provider, staffed by direct care workers and with access to multidisciplinary specialist services. The recommissioning of this type of care has seen a significant shift in approach. Services provided are now referred to as Intensive Therapeutic Transitional Care (ITTC), Therapeutic Supported Independent Living (TSIL), Therapeutic Sibling Option Placement (TSOP), Therapeutic Homed Based Care (THBC) and Intensive Therapeutic Care Homes (ITC Homes).
Restoration	When a child or young person returns to live with their parent or parents for the long term with approval from NSW Children's Court.
Risk of Significant Harm (ROSH)	A child or young person is assessed at ROSH if the circumstances that are causing concern for the safety, welfare or wellbeing of the child or young person are present to a significant extent. This means it is sufficiently serious to warrant a response by a statutory authority, irrespective of a family's consent.
Service providers	All agencies delivering services across NSW's child protection and OOHC system including PSP funded service providers and other service providers.

Executive Summary

This report presents findings from a three-year evaluation of the Permanency Support Program (PSP).[1] PSP is a service reform developed by the Department of Communities and Justice (DCJ) designed to give every child and young person a loving home for life, whether that be with parents, extended family, or kin, or through guardianship or open adoption for non-Aboriginal children.[2] Implementation of PSP began in October 2017.

The Evaluation Team recognises there are numerous structural challenges to reforming the NSW child protection system, many of these common to other jurisdictions. These include the fact that service system resourcing – practiced within a context of significant latent and unmet demand – is weighted toward acute, intensive, and expensive services. There is limited resourcing to effectively intervene early, and ideally at a child's first presentation to a service, and this has significant unintended consequences for children and families. These consequences loom large for Aboriginal children and families in the context of the structural inequalities they experience, their over-representation in the system, and Australian state and federal governments' role in the stolen generations. We are cognisant of these challenges, and of the independent reviews of the child protection system undertaken over the past decade in NSW. They inform key evaluation findings and practical recommendations for DCJ to improve design and delivery of permanency support.

In this report, the Evaluation Team — the Centre for Evidence and Implementation, the Cultural and Indigenous Research Centre Australia, the Melbourne Institute, and Monash University — present and describe the evidence suggesting that, while there has been a service shift toward permanency and some limited improvement in outcomes, PSP experienced significant implementation challenges and failed to demonstrate the larger positive impact on children that DCJ intended through this reform effort. This overall finding of limited impact must be interpreted within the scope of this evaluation – a

[1] ChildStory data used in the evaluation covers a period of 2.75 years.
[2] More information on PSP can be found in the following link: https://www.facs.nsw.gov.au/families/permanency-support-program (last accessed 28 October 2022)

relatively short-term evaluation undertaken between 2019 and 2022 focused on the effectiveness of PSP packages delivered by non-government providers of PSP primarily geared toward improving children's safety and permanency. We were unable to assess children's health and some wellbeing outcomes, for example, including those related to cultural and spiritual identity and social functioning.

This is a large report – appropriate for an evaluation of a significant whole-of-system reform with over 50 discrete evaluation questions. Rather than list findings question by question, we present findings by report section, integrated across all methods used in the evaluation (i.e., quasi-experimental design, cost-benefit analysis, case reviews, focus groups and interviews with DCJ and PSP providers, PSP provider surveys and participants in three Aboriginal case study sites). Given Aboriginal children and families' over-representation in the child protection and out-of-home care (OOHC) system, we also include a separate section summarising how Aboriginal children, families and communities experienced PSP and the impact of PSP on Aboriginal children's safety, permanency, and wellbeing outcomes.

Following is a summary of PSP, our evaluation methods, key findings and overarching recommendations emerging from this work.

The Permanency Support Program

PSP is the one of the most significant child protection and out-of-home care (OOHC) service reforms implemented by the NSW government for decades. Starting in October 2017,[3] PSP was designed to embed the permanent placement principles into practice to improve safety and wellbeing outcomes for children. PSP was designed to achieve three core objectives:

- Fewer entries into care: by keeping children and families together at home.
- Shorter time in care: by increasing the number of children returning home to their families or finding other permanent homes for them, including guardianship arrangements or adoptions.
- Better care experience: by investing in higher quality services and providing more targeted and evidence-informed support to address children's individual needs.

An additional objective of PSP, which was added later, was to address the over-representation of Aboriginal children in the care system.

In this program, caseworkers employed by funded, non-government PSP service providers work with those who love and care for a child (including parents, extended families, guardians and carers) to identify the best permanency goal for a child and achieve this goal within two-years. The importance of permanency for child development is well-established, and is based on theories of attachment, child development and the formation of cultural identity. There are four dimensions of permanency, however, which is important in understanding the PSP reform and its potential impact:

- Relational permanency: a child has the experience of having positive, loving, trusting and nurturing relationships with significant others, including parents, siblings, friends, family and carers.

[3] PSP packages, the major focus of this evaluation, were not initiated until July 1st 2018.

- Physical permanency: a child has stable living arrangements (i.e., placement stability) and is connected to their community.
- Cultural permanency: a child maintains a meaningful connection to culture through taking part in cultural practices, connecting with family and community, and valuing connection to Country.
- Legal permanency: a child lives with at least one parent or primary caregiver who has legal responsibility for them.[4] [5]

In practice, PSP represents a complex reform program comprised of numerous adjustments to the delivery of OOHC functions and services including changes to roles and responsibilities of system stakeholders, changes to legislation, changes to case management policy and most significantly, changes to the service provider funding model. PSP introduced a shift from placement-based funding (i.e., bed per night payments) to a service-based funding model for children in OOHC. This innovation saw PSP service providers receive funding based on the services provided to children in OOHC, and further, have the flexibility to pool funds to pay for services and other supports where it is most needed.

This is the crux of PSP – it is a package-based funding system tailored to individual children, designed to enable the delivery of services that foster permanency by two-years and improve safety and wellbeing outcomes for children.

Evaluation design

We used a 'Type I' effectiveness-implementation hybrid design with an integrated, dual focus on assessing the effectiveness of PSP (including cost benefit analysis) and better understanding the context for implementation, including factors that may have helped or hindered change.[6] This approach, developed to facilitate the transfer of evidence from evaluation into policy, yields essential insights for DCJ in future decision-making about permanency support for vulnerable children. The primary emphasis of the evaluation was on the effectiveness, cost-benefit profile and sustainability of PSP. Assessment of implementation (e.g., services delivered through PSP and barriers and enablers to this delivery) and reach (e.g., characteristics of children who received PSP packages) was critical to understanding PSP service context and operation.

The evaluation includes a specific focus on the experiences and perceptions of Aboriginal families, workers and communities and the impact of PSP service delivery on outcomes for this group. We engaged with peak bodies (e.g., AbSec), reference groups (e.g., the Aboriginal Reference Group), and Aboriginal Community-Controlled Organisations (ACCOs) at different points throughout the evaluation. ACCOs are reflected in PSP service provider focus groups, surveys, and case reviews - and we worked with ACCOs to refine the design of the methodology for data collection and the discussion guides at each case study site. Aboriginal Research Consultants conducted all but two interviews in case study sites with Aboriginal parents and carers, non-Aboriginal carers, case workers/managers and community stakeholders. We paired appropriate Aboriginal researchers with research participants to ensure cultural safety.

[4] In NSW, legal permanency can be achieved through preserving a family with at least one parent, restoring a child or young person to at least one of their parents, placing a child with kin, relative or a carer under a guardianship order or adoption.
[5] Adoption is not an acceptable outcome for Aboriginal children and should only be considered where long-term care is not possible.
[6] A Type I design involves testing effects of a 'clinical' intervention on relevant outcomes while observing and gathering information on implementation. See Curran et al. (2012).

We adopted a pragmatic approach to the evaluation of PSP by balancing the available budget, resources, and program information with a rigorous methodology. There are some important limitations to our approach, which should be kept in mind while reading the findings of our evaluation. These include limitations related to data quality and availability, which sometimes required us to rely more heavily on insights from qualitative data. Thus, some findings should be viewed as exploratory (clearly marked throughout the report). We would have liked more follow-up time to test a broader set of wellbeing outcomes and whether some positive outcomes related to PSP may have been achieved later in time - particularly during children's key developmental transitions. However, this was not possible within the timing of this engagement. These limitations, we hope, will be the focus of a longer-term evaluation commissioned by DCJ.

Key findings

PSP implementation

Our evaluation of PSP implementation was concerned with understanding what children received through PSP, and what enablers and barriers helped or hindered PSP service delivery. The three key findings for PSP implementation are informed by the perspective of PSP providers, DCJ and Aboriginal people who have engaged with the NSW child protection and OOHC system, ChildStory administrative data and explored across a sample of children's case notes with different characteristics.

PSP led to changes in casework practice, but this did not lead to permanency goals being achieved within two years

PSP successfully embedded permanency planning and practice across the OOHC system. This was evidenced both in changes to caseworker's 'mindset' and a range of operational changes made by PSP service providers to deliver PSP, including recruiting specialist PSP staff, developing site-specific case management templates and forms which embedded permanency planning principles, and establishing local PSP implementation teams. These changes were enabled by a supportive environment and culture within PSP service providers and DCJ Permanency Coordinators who acted as 'change managers', supporting PSP service providers to address early implementation challenges and adapt to new ways of working.

These changes, coupled with increased funding, did not however result in an increase in the proportion of children achieving permanency goals within two years, irrespective of the type of permanency goal. The delivery of services and casework to achieve permanency was influenced by several factors. These factors included child and family characteristics and complexity, the degree of autonomy displayed by parents and carers, the amount of preliminary permanency planning to be completed, challenges with accessing appropriate genealogy information, bottlenecks with Child and Family District Units (CFDU), and administration for legal work and court delays. We note some factors are beyond the control of PSP service providers. Court processes in particular influenced goal attainment. This is most pronounced in a permanency goal of restoration for children entering care, where from the Court's perspective, permanency casework begins when a Final Order is made – which can be between 9-months to 18-months into a child's care experience in PSP. We observed in the case notes that restoration goals required significant casework and family support from PSP service providers.

Children who achieved permanency within two-years tended to have 'cases' that did not require a lot of preliminary permanency planning and casework, had legal requirements that could be completed quickly, and had a high level of support from PSP service providers who had sufficient access to the right expertise and resources to meet the needs of the children, family members and carers. We noted many PSP service providers, and

particularly those that were larger with more capacity, began planning before the permanency goal was assigned and engaged in parallel planning – that is, planning for more than one case plan goal in the event the original goal was unsuccessful. This suggests that even in those cases where a permanency goal for a child was recorded as achieved within the two-year timeframe, this may not reflect the real cumulative time.

PSP enabled flexibility in service provision to address needs and context, although tensions exist with service accessibility and standardised care

The PSP funding model provides flexibility for PSP service providers to determine what practices and services will best meet the needs of the children, families, and carers. This is 'best-practice' design - services delivered to meet individual need and context are equitable by definition (if they are received, effective and culturally acceptable). The case review gave us insights into what services were organised and delivered to children, families, and carers through PSP, including health care, dental care, disability care, educational support, training, legal, housing, drug and alcohol, parenting support, domestic and family violence support, childcare, respite care, and any other social and community services. PSP service providers can choose to source and implement evidence-based programs and evidence-informed practices, although this is not prescribed by DCJ and we found little evidence of their use.

We observed difficulties with child, family, and carer access to external services, especially among PSP service providers who did not deliver health, behavioural or parenting services themselves (these were often smaller providers with minimal in-house service infrastructure). The services which appeared least able to meet demand, due to availability, were those targeting complex needs and behaviours and specialising in trauma. These specialist psychological interventions included play therapy, specialised trauma informed therapies (e.g., Eye Movement Desensitisation and Reprocessing)[7], interventions addressing inappropriate sexual behaviours and interventions for victims of sexual violence. While caseworkers were diligent in working to overcome accessibility challenges, this resulted in negative experiences for children and families through longer service wait times, issues with geographical accessibility, and referral to 'proxy' services that did not align to level of need or the severity of safety risks. This was especially the case when PSP service providers were seeking services to address inappropriate sexual behaviours and serious criminal and violent behaviours. Limitations to service availability and accessibility, matched to need, result in inequitable outcomes for children and families, particularly when these interventions are critical in addressing violence, sexual abuse, and trauma.

Flexibility was also applied to the way DCJ Districts implemented PSP. Districts developed individualised PSP implementation plans matched to their local context, and this led to different models and approaches to PSP (such as maintaining a pool of carers to be able to provide emergency placements more quickly and effectively), which in turn, influenced the way Permanency Coordinators worked and where they sat in the system. Across districts, Permanency Coordinators sat under operational managers, manager of client services, within the commissioning team, or under the supervision of Community Services Directors. This also meant there was little consistency in PSP across NSW, and a child and family living in one District could receive very different care in another, for example. Effective implementation adapts services to context but, in the absence of outcome monitoring, or consistency over the practice areas in focus, it can also inadvertently lead to different standards of PSP service delivery across Districts. In the case of poor service accessibility, it can embed existing inequities into permanency outcomes because poor service accessibility is not evenly distributed across the State (e.g., urban versus rural/remote).

[7] Eye Movement Desensitisation and Reprocessing, often referred to as EMDR, is a structured psychotherapy technique to address trauma.

This suggests there needs to be a better balance between designing PSP for flexibility – allowing Districts and service providers to draw on their unique strengths – and ensuring effective, accessible, standardised services are available for the children and families that need them.

Implementation support for PSP has been variable, and this has influenced service provider's capacity to deliver PSP services

Quality implementation of novel services takes dedicated time and resourcing. DCJ invested early in several implementation strategies, including implementation planning for PSP both centrally and in Districts, the formation of District-level implementation teams and dedicated resourcing through funds to Districts and the establishment of the PC role to support PSP service providers in achieving children's permanency goals. Despite this planning, PSP service providers experienced significant implementation challenges on initial roll-out of the reform. To put this in context, all innovations experience implementation challenges and that is why implementation teams are a critical mechanism for implementation – they monitor implementation and design strategies to address barriers to service delivery. PSP faced three significant challenges to implementation that interacted to create tensions initially between PSP service providers and DCJ:

a) Delays in the formalisation and communication of the PSP service model and PC role to both DCJ Districts and PSP service providers

b) Problems with DCJ systems not connected to PSP but necessary for PSP success, notably ChildStory, which PSP service providers struggled to access for client case management and payment, and

c) Overestimation of the capacity and capability of PSP service providers to deliver PSP and undertake the casework required to achieve permanency goals.

This last challenge could have been avoided by undertaking implementation readiness assessments with PSP service providers prior to initiating service delivery and using this data to tailor specialised implementation support. Instead, it sparked tension within DCJ about how much to intervene to support PSP service providers who were funded for delivery but still developing capabilities – a tension that was also experienced at the PC level.

DCJ introduced the PSP Learning Hub, and the underpinning PSP Sector Workforce Development and Training Strategy, in response to PSP service provider capability training needs. Within Districts, this enabling practice infrastructure, combined with PSP program maturity and consolidation of PC roles, was seen to characterise a period where real progress in PSP implementation was being made. This progress has been threatened with the removal of dedicated implementation support funding and consequent disbandment of implementation teams. Implementation is not a one-off event but an ongoing process, and even well-defined, evidenced, highly prescriptive programs can take between two to four years before achieving sustainability and business-as-usual operation. PSP might be expected to take even more time given the complexity of the program, and it is not clear within Districts how PCs will be able to take forward implementation support without access to the supportive infrastructure that existed previously. This is particularly important given that PSP is in the phase of implementation requiring ongoing monitoring of implementation and the adjustment of implementation strategies to support PSP service providers to deliver and maintain high quality PSP casework and services.

PSP reach

Our evaluation of PSP Reach focused on which children and families received PSP packages compared to those who did not, and the extent to which specialist packages were used among those who were likely to be eligible. The key finding for PSP Reach is informed by analysis of ChildStory administrative data, supplemented with insights from the qualitative case reviews and focus groups with PSP service providers.

PSP packages were overwhelmingly directed toward the 'back-end' of the system (i.e. OOHC), at least in part because 'front end' packages (i.e. family preservation) were limited

Packages for family preservation appeared to reach the right population of households (i.e., high risk following face-to-face assessments for Risk of Significant Harm), but only a tiny proportion of the eligible population received a PSP Family Preservation package. This appears due to the limited number of packages available – 380 packages in total – and potentially issues related to low-uptake or poor visibility of these packages (provided at the discretion of DCJ) compared with the other demand-driven PSP packages. Most PSP packages initiated over the evaluation period were provided to children in ongoing care who had generally been in care for long periods of time. Although over ninety-five percent of children who were entering OOHC and received PSP packages initially received restoration case plan packages, few in that cohort eventually received restoration support packages during the evaluation period, and the number receiving restoration case plan packages clearly decreased over time. Together, these findings likely reflect the low restoration rate observed and a shift in permanency goals towards long term care. Overall, the reach of PSP packages indicate that the focus of the PSP program has, to date, been on the 'back end' of the child protection and OOHC system, as it has focused on supporting children already in the system (some of whom had been in the system for many years) rather than at the 'front end' (or middle in the case of restoration), to help children remain at home and prevent them from entering the system in the first place.

PSP effectiveness

There is little evidence that receipt of a PSP package substantially improved children's safety, permanency, stability, and wellbeing

We measured the effectiveness of PSP by examining predictors of positive and negative outcomes related to children's safety, permanency, stability, and wellbeing[8] associated with different PSP packages while children were in different stages of the child protection / out-of-home care system. We achieved this using three different cohorts with statistically matched comparison groups using administrative data contained in ChildStory, extracts from housing / homelessness, youth justice and education, as well as PSP-related data collected by agencies and compiled by DCJ:

- Family Preservation cohort - households who received a family preservation package matched to a comparison group of households who were eligible for the package but did not receive it.
- Entry/Re-entry cohort - children who entered a new episode[9] of foster or kinship care matched to a historical comparison group with similar characteristics, and
- Ongoing Care cohort - children who were already in foster or kinship care[10] and held a PSP package matched to a historical comparison group with similar characteristics.

In summary, most results (presented in Figure ES.1) were not statistically significant - meaning outcomes were no different for children who received PSP packages compared

[8] Wellbeing outcomes were limited to those where data was available and complete.
[9] Between 1st October 2018 and 31st December 2020
[10] On 1st October 2018

with their matched controls. The exceptions (i.e., where outcomes had improved or declined for PSP package recipients compared to their matched controls) tended to have small effects sizes. These included:

- Children in the Entry/Re-entry cohort who received a PSP package initially had greater placement stability than the matched historical comparison group. However, this difference only lasted four months at which point the PSP package group did no better than the historical comparison group.
- Children in the Ongoing Care cohort who received a PSP package had slightly less placement stability than the matched historical comparison group (i.e., the PSP group had a higher probability of changing caregiver than the historical comparison group).
- Children in the Ongoing Care cohort were rarely returned home to live with their parent(s), but those receiving a PSP package had a slightly higher likelihood of returning home.
- Open adoption occurs very infrequently, and those receiving PSP packages were more likely to be adopted.
- Children in the Ongoing Care cohort receiving a PSP package were less likely to be charged with a criminal offence, however this finding is extremely tentative as it is also reflective of broader state and national trends toward decreases in youth criminal offences and we were unable to account for this in our analysis.[11]

[11] Australian Institute of Health and Welfare 2021. Youth detention population in Australia 2020. Cat. no. JUV 135. Canberra: AIHW (https://www.youthjustice.dcj.nsw.gov.au/Pages/youth-justice/about/statistics_custody.aspx)

Figure ES.1 Forest plot comparing those that received PSP packages relative to a comparison group that did not.

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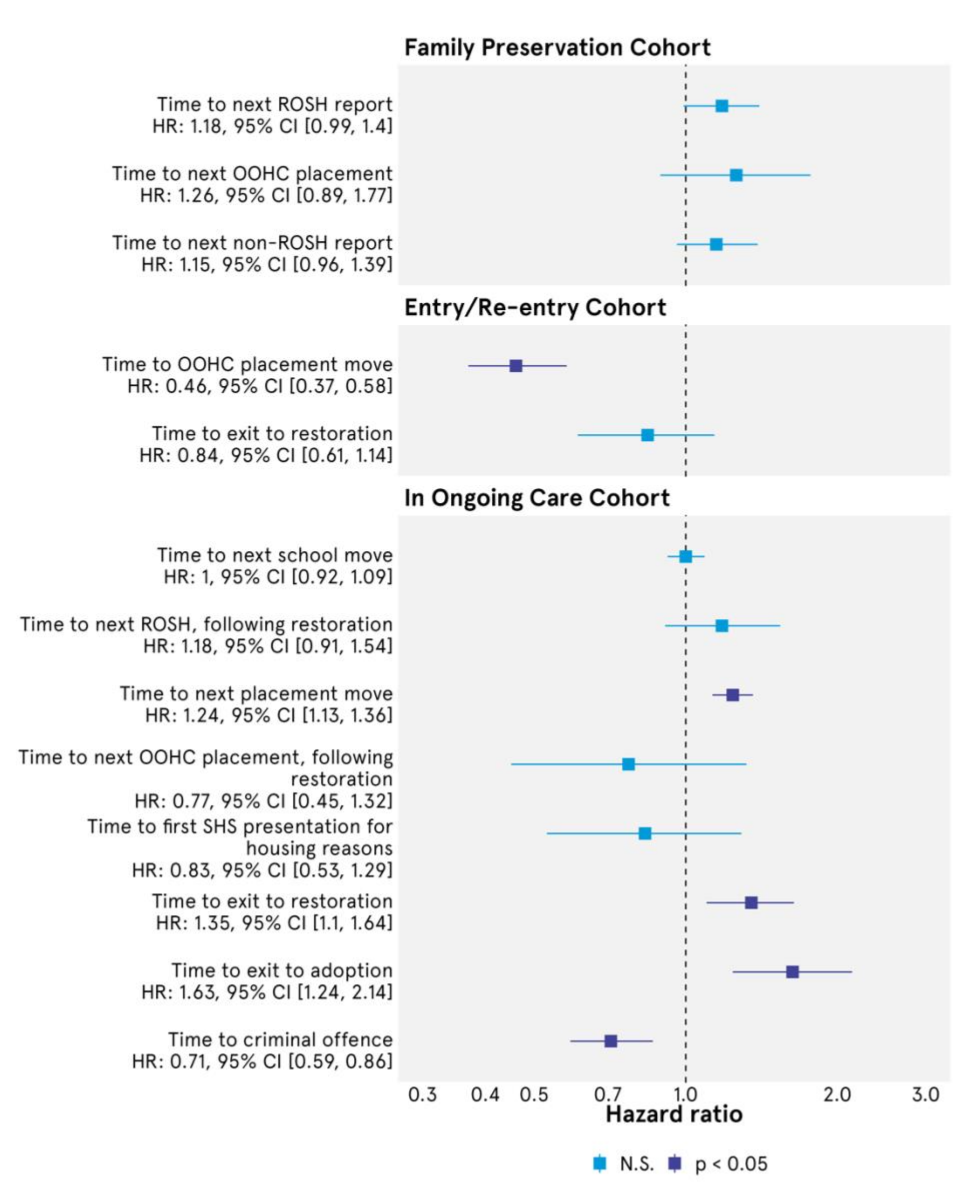


Reading the PSP summary of results forest plot

A forest plot is a way of visualizing statistical data. The above forest plot presents the results of all the comparative outcomes analysed using cox regression models in the three cohorts of this evaluation. The outcome measured (each in their own statistical model) is listed down the left-hand side. The depiction on the right-hand side shows the difference between those

families/children that received PSP packages compared to their matched control group for that particular outcome.[12]

The results provided in this figure are the hazard ratio (HR) and confidence intervals (CI) generated by each model.[13] The vertical dashed line in the figure represents an HR of 1.0 and if the confidence interval includes 1.0 (i.e., the horizontal blue line crosses the vertical dashed one), then there is no statistically significant difference between those receiving PSP packages and their statistically matched control.

Significant findings to the left of the vertical line mean that the PSP package group is less likely to experience that particular outcome than the comparison group over the course of the evaluation. Significant findings to the right of the vertical line mean that the PSP package group is more likely to experience that particular outcome than the comparison group. The further away the centre of the blue horizontal line is from the dashed vertical line, the stronger the effect as long as no part of the blue line crosses the dashed vertical line in the middle.

Children's background and history of interaction with the child protection system mattered more to outcomes than PSP

The receipt of PSP packages did not appear to play as strong a role in determining children's safety, permanency, stability or wellbeing as immutable characteristics, such as the demographic background of the child and their history of interaction with the child protection system. These were far better predictors of outcomes than was receipt of PSP. Demographic and historical factors can strongly influence the trajectory of children through the various stages of the OOHC system, particularly the proportion of time children spent in their current episode of care. The challenge for DCJ through PSP is that, in most cases, the length of time PSP services were provided was only a small part of children's overall time in care, making it difficult to affect the types of meaningful change the reform was designed to deliver. It was unlikely that PSP packages could overcome both the serious issues facing children who have been maltreated and the potentially negative effects of spending long periods of time in OOHC, especially given the relatively short length of time PSP had been in operation and the observed implementation challenges PSP faced.

PSP economic analysis

The economic evaluation consists of a cost-benefit analysis comparing the value of benefits and costs associated with the implementation of PSP measured over the 2.75 years of the evaluation observation period. The potential benefits include both benefits to the government in the form of cost savings and (social) benefits to children, families and communities (e.g., improved health outcomes and quality of life). The cost savings to government are estimated based on the PSP effectiveness results so far. The value of the social benefits associated with PSP were largely excluded due to the limited outcome data

[12] All comparison models used in this evaluation control for a range of demographic, historical and service factors that are detailed in the body of the report and the appendices.
[13] For a detailed description on hazard ratios and confidence intervals, see the chapter on Effectiveness later in this report.

available across wellbeing, health, education, safety and non-legal permanency outcomes. Improvements in these latter outcomes may lead to further benefits to the government.

The following two key findings are informed by the CBA and supplementary data from focus groups with PSP service providers and DCJ.

The costs of PSP are much larger than the benefits calculated so far

Using the estimated costs and benefits calculated for the evaluation, we found that the costs of PSP are much larger than the benefits of PSP so far, given its relatively modest impacts for just a few selected outcomes. This leads to benefits-costs ratios (BCRs) that are all well under one (the breakeven point), ranging between 0.065 and 0.139. With no significant benefits estimated for Family Preservation, its Benefit to Cost Ratio (BCR) is 0. This indicates that the average costs far outweigh the average benefits for all cohorts evaluated in this report. The difference in average costs between pre- and post PSP services is $50,548 per child for the observation window of 2.75 years in the Ongoing Care cohort, and $15,153 per child for the observation window of 2.75 years in the Entry / Re-entry cohort.

However, these BCR values need to be interpreted with caution given the period of observation was relatively short and several potentially important outcomes on health, wellbeing and education could not be included in the benefits calculated in this report. For instance, the limited information we had on education was affected by the COVID pandemic which meant the NAPLAN testing did not go ahead in the years that were crucial to this evaluation. Furthermore, available education outcomes on high school completion may have been negatively affected by the pandemic, and any negative impacts are likely to have been the largest for the most disadvantaged groups in society including children in OOHC.

Education, health and wellbeing outcomes are relevant in their own right, but in addition they are also likely to feed into future outcomes. For example, a child that is healthy and happy is more likely to do well at school, complete Year 12 and continue in further education. Improved education outcomes are known to lead to better life outcomes well into the future. The estimated benefits associated with improvements in education can lead to substantial benefits over a lifetime. Achieving such improvements for a large proportion of children could lead to substantial savings to the NSW Government, and much better future life outcomes for children leaving OOHC.

The short amount of time since PSP was introduced may mean that concrete improvements in education, Youth Justice outcomes and physical health are forthcoming, however these have not yet materialised or could not yet be assessed with the available data.

There is a lack of detailed data on how PSP funding is spent or what services are delivered

There is a lack of detailed data on how PSP funding was used to support children's permanency across all permanency goals or what services were delivered to achieve these goals – including whether any of these services were evidence-informed and therefore likely to have a positive impact on children or families. This lack of available data, and mechanisms for collection, means DCJ and PSP providers are unable to systematically track services and supports delivered, how much specific services cost, and determine which services matter most for children's safety, permanency and wellbeing.

Further implementation considerations

Achieving sustainability in complex systems requires an ongoing process of monitoring, adaptation and improvement to find an optimal fit between PSP, PSP service providers, DCJ and the wider system. The two key findings for PSP sustainability are informed by all components of the evaluation including the findings and recommendations from earlier reviews and reforms of NSW's child protection and OOHC system, the objectives and mechanisms which underpin PSP's design and implementation, and all evaluation findings.

PSP design, implementation, capacity and system constraints inhibit the achievement of permanency outcomes

PSP is a complex reform implemented within a complex system. In such an environment, it is unsurprising that implementation has proven challenging and elements of the design of PSP have been found wanting. These challenges – some of which were unintended impacts of PSP delivery - played a role in the reform's inability to substantially improve children's safety, permanency, and wellbeing outcomes, and were manifest in the design and implementation of PSP packages, capacity constraints and casework to achieve permanency including coordination with DCJ.

We observed, in the case reviews, considerable variability in permanency planning, casework and support work required according to the complexity of the case, resulting from, for example, the completeness of family history, the completion of legal processes and court documents, and differences in opinion on the most appropriate permanency goal across stakeholders. There were incompatibilities between PSP package structures and the casework required to achieve permanency, such as the more extensive casework required for:

- Family finding and consultation for Aboriginal children in permanency planning (Case plan goal packages), Kinship care (Baseline packages), and cultural planning (Specialist packages), and
- Facilitating relational permanency for siblings (4+Sibling package), a practice critical to positive outcomes.

Further, we observed the Child Needs Assessment (CAT) score poorly discriminated level of need, resulting in insufficient funding flexibility for PSP service providers to undertake the casework and deliver the services required to address a child's needs level.[14] While PSP enabled casework and service delivery to be supported by 'pooled PSP package funds', we did not find clear evidence from PSP service providers that 'pooling' of funds occurred.

There were differences across PSP service providers which may have contributed to permanency outcomes not being achieved, such as in organisational:

- Capacity and capability relating to organisational size and the ability to provide health and behavioural services 'in-house'
- Expertise with elements of permanency planning and outcomes such as guardianship and adoption, or intensive care approaches (i.e., for children and families with complex needs), and

[14] This observation is based on Child Needs Package level, case information and the case notes stored by PSP service providers for the cases reviewed in the case review, not a discrete assessment of the CAT tool.

- Expertise in cultural safety and partnership with Aboriginal children and families (i.e., provided by ACCOs).

We observed differences in the prioritisation of legal permanency as a goal across children, in the main because children had a case plan goal of long-term care (including as a temporary goal before further planning) and caseworkers focused on other permanency elements not as readily observable in the 'PSP reporting system' (i.e., relational, physical, and cultural permanency). Even in cases that were progressing towards permanency, we observed frequent and significant delays resulting from DCJ capacity constraints (e.g., lack of case management oversight and permanency support), poor clarity over roles and responsibilities between DCJ and PSP service providers, and inconsistent coordination and decision-making from DCJ. This included inconsistency in the allocation of packages across children with similar characteristics compounded by poor practices in recording and updating package allocation information in ChildStory.

The payment structure within Program Level agreements do not effectively incentivise the achievement of positive outcomes

We considered the evidence collected across all components of the evaluation to assess whether PSP service providers appeared to be responding to the incentives set out in the Program Level Agreements, if positive outcomes were sufficiently rewarded (or penalised) by the fee schedule, and whether the incentives in place appeared sufficient to incentivise early intervention, family preservation, or supporting exits from the system through family restoration, guardianship and adoption.

We found PSP service providers did not appear to be operating in line with Program Level Agreements in the following ways:

- PSP service providers did not accept referrals or provide the placement vacancies they were funded and contracted to provide - creating inefficiencies in the system and resulting in additional children in alternative non-foster care arrangements - and DCJ did not operationalise contract abatements for not providing placements in line with contracted service agreements.
- There is an insufficient pool of carers across the state and DCJ districts have reported finding it harder to match carers to children.

There is no direct financial reward for achieving positive outcomes under the current PSP package payment system:

- The fact that packages are paid for two years neither rewards or penalises the achievement of permanency outcomes.
- The two-year timeframe had mixed impacts on outcomes depending on case complexity and alignment with permanency.
- Successful guardianship arrangements result in PSP service providers no longer receiving funding for the placement, and
- Although priced to reflect differing effort, PSP package-based funding does not adequately address the substantial and observable differences in the resources and effort required to achieve permanency, wellbeing, and safety outcomes across different cases.

We also note that the fee schedule was not designed to incentivise activities toward the achievement of any other positive outcomes, such as improved education or health outcomes.

Our findings suggest that PSP was unable to focus resources and efforts toward early intervention and exits from OOHC:

- There was a low number of PSP Family Preservation packages allocated, compared with the number of families who were eligible, potentially resulting from limited package numbers, low uptake, and limited visibility.
- PSP Family Preservation packages were allocated on a discretionary basis by DCJ while other PSP packages are demand driven, and
- Exits from OOHC were not designed to 'translate' into cost savings that can be allocated toward front-end investments in prevention in systems while there was still significant unmet need at the back-end.

We note incentive structures can also be influenced by, for example, operational changes and implementation challenges (e.g., increases in administrative processes and learning new processes and practices).

Impact of PSP on Aboriginal children, families, and communities

While the impact of PSP on Aboriginal children, families and communities is considered across all sections in the report, we present the key findings here separately so they may be easily examined for future action. The four key findings focused on Aboriginal children, families and communities are informed by all components of the evaluation including the findings and recommendations from earlier reviews and reforms of NSW's child protection and OOHC system, the objectives and mechanisms which underpin PSP's design and implementation, and all evaluation findings.

Aboriginal children, parent, carers, and community stakeholders had a limited understanding of PSP

Most of the Aboriginal children, parents, carers, and some community stakeholders who were interviewed across the three case study sites were unaware of or had a limited understanding of PSP and its differences from previous programs or reforms introduced for Aboriginal people. This suggests a need for better communication of the reform to, for example, promote the program as seeking to address the historical legacy of child removal policies, promote the value of PSP caseworkers as a support worker who can assist families and children with family preservation or restoration, and to attract more Aboriginal carers. It also raises the possibility that some case study participants related their experiences with the child protection and OOHC system in general, and perhaps historically, rather than their experiences with PSP specifically.

While Aboriginal children, parent, carers, and community stakeholders were largely positive about services received, deficiencies still exist

Across the three Aboriginal case study sites, most parents, carers and community members were positive about the services they received from their PSP service provider and gave examples of how caseworkers met their needs. Parents and carers at all three sites expressed greater satisfaction with services received when contact with case workers was consistent (in person and by phone and email), when they felt listened to and supported, and where parents had good communication with workers when their child is

in OOHC. The satisfaction of children, parents and carers was reduced when they perceived that casework staff were providing a standardised rather than tailored response to their needs.

Most children, parents, carers and community members interviewed in the three Aboriginal case study sites indicated that PSP services supported their cultural safety to some degree. This included activities such as: learning Aboriginal cultural history and language; participating in cultural events; accessing an Aboriginal mentor; attending a cultural camp; and developing a cultural plan. All of the 39 cases reviewed involving Aboriginal children had a cultural plan in place, although several of the cultural plans reviewed would not be considered current because they were older than 12 months. Many activities appeared not to be updated regularly. A small number of the cases with cultural plans did not receive the Cultural Plan (Aboriginal) packages. The information and activities included in the cultural plan and across casework practice were observed to vary substantially across the cases reviewed. We noted that the ACCOs participating in the case review embedded cultural support practices across most of their interactions with children, family members and carers, and had notable expertise in delivering culturally safe casework and services and fostering trusted relationships with Aboriginal children and family members.

Data from the three Aboriginal case study sites found that participants interviewed considered the Aboriginal placement principles and reform components of PSP to be acceptable, appropriate and effective - when they were in place. Children, parents and carers reported that practices still exist, either current or in the recent past, that do not align with the Aboriginal Child Principles. These included: children not being placed with family members who could be carers; placements changing without informing children beforehand; non-Aboriginal OOHC services receiving government funds to make care arrangements for Aboriginal children; and insufficient numbers of Aboriginal Case Workers to guide Aboriginal families and support them through the OOHC system.

Overall, PSP did not affect Aboriginal children differently than non-Aboriginal children

Across most of our statistical models, Aboriginal children were no more or less likely to experience safety, permanency or wellbeing outcomes than non-Aboriginal children. That is, once we controlled for a host of demographic, historical and service level characteristics, the likelihood that Aboriginal children would experience more adverse outcomes than non-Aboriginal children was no longer present. This does not mean that Aboriginal children do not experience worse outcomes than non-Aboriginal children – it just means that the structural factors driving service level differences in the child protection response (i.e., poverty, poor housing, substance misuse, domestic violence) are likely being accounted for in our models. Moreover, this finding of no difference extended to PSP. After controlling for numerous demographic, case-level and service level characteristics, we found that Aboriginal children achieved similar outcomes through PSP as non-Aboriginal children. In other words, PSP packages did not make much of a difference for anybody. On the positive side, it did not appear to result in worse outcomes for Aboriginal children.

PSP has increased the funding directed towards Aboriginal children

The costs of PSP currently outweigh the benefits so far for Aboriginal children. The difference in average costs between pre- and post PSP services increases to $52,818 and $25,717 for the Ongoing Care and Entry / Re-entry cohort respectively. The larger increase for the Aboriginal Entry / Re-entry cohort appears mostly due to the relatively low expenditure for this cohort before PSP was introduced.

Introduction of Cultural Plan (Aboriginal) and Aboriginal Foster Care baseline packages has increased the funding directed towards Aboriginal children.

2. Recommendations

While there has been a service shift toward permanency, and some improvement in outcomes through PSP, we conclude **PSP has not resulted in the positive, transformative change envisaged for children at the beginning of the reform effort**. We acknowledge the efforts of PSP service providers, and their DCJ district partners, in building capacity for permanency support but the significant implementation challenges experienced, failure to demonstrate a sizeable positive impact on children, and the substantial costs of the funding and operational model suggest that **the design of PSP should be substantially overhauled and specific components of the reform discontinued**. The opportunity cost of continuing to implement PSP in its current form is likely to prevent NSW from investing in more effective reform.

We have made five overarching recommendations to improve DCJ's provision of permanency support to children in improving children's wellbeing, permanency and safety outcomes, as well as specific recommendations that address issues of service design and system support including incentives. These recommendations are closely related to the hypothesised mechanisms of change, and underlying assumptions, which guided the design of PSP.

Implementing new reforms and practices in the child protection and OOHC system, such as PSP, requires multiple changes in individual and collective behaviour within service providers, DCJ and supporting services. This is much broader than financial mechanisms, and requires an understanding of, and action on, the 'sources of behaviour' – that is, capability (i.e., do PSP service providers have sufficient knowledge and skill to deliver PSP services?), opportunity (i.e., are PSP service providers able to use this capacity to deliver PSP services in practice?), and motivation (i.e., are PSP service providers being properly incentivised to achieve the positive outcomes being targeted?). In short, PSP service providers, Permanency Coordinators and DCJ Districts cannot undertake high quality permanency casework, and deliver effective services, if they consistently experience challenges to implementation that impede behaviour change. Most importantly, children

and families cannot benefit from what they do not receive. It is with this frame of reference that we propose the recommendations below.

Principles for service system re-design

A fundamental principle for the implementation of these recommendations is that DCJ and the NSW Government reduce resource waste by, where possible, implementing the recommendations of reviews into the NSW child protection and OOHC care system relevant to PSP, and drawing on promising tools and processes piloted within DCJ, Their Futures Matter and the sector that have not yet been widely adopted. The following principles apply to all permanency service design and system support recommendations. That is, design and support to implement should:

- Be grounded in effective practice that specifically address what children and families need
- Be informed by the preferences and values of children and families
- Occur in collaboration between DCJ, PSP service providers, and key sector organisations
- Be integrated within a continuum of care for children, young people, and families
- Be rigorously pilot tested, and further adapted, before scaling up, and
- Deliver culturally appropriate services, which is particularly important for Aboriginal families and children if we are to restore their faith in the system and its decision-making.

How to read and interpret recommendations

We have organised the recommendations below into two sections. The first section presents overarching recommendations arising from the evaluation findings and what we know to be necessary conditions for system change, including a statement capturing what success looks like if this recommendation is implemented well. These recommendations focus on good system design and functioning that, if implemented well, will make a difference to children's outcomes over time.

The second section presents targeted recommendations, related to the above, but organised according to sphere of influence within the child protection system. We understand recommendations are not always taken up by departments because implementation is challenging, especially if it requires the integration of external systems. This is related, at least in part, to poor clarity about what needs to happen at which point in the system. We organise recommendations into three categories using an ecological framework for implementation within complex, dynamic systems adapted from international colleagues in implementation science[15]:

- recommended changes to the PSP model (i.e., model components, casework practice staff, outcomes)
- recommended changes to the context in which PSP is delivered (i.e., the practice setting, workforce development, information systems), and

[15] Chambers, D.A., Glasgow, R.E. & Stange, K.C. (2013). The dynamic sustainability framework: addressing the paradox of sustainment amid ongoing change. *Implementation Science*, 8: 117.

- recommended changes to the broader ecological system within which PSP service providers exist and operate (i.e., other practice settings, policy, market forces).

Effective service reform is achieved through a process of continuous 'fit' between these three elements. For example, PSP may introduce a new package to address a gap in sibling relational permanency; targeted providers are supported to specialise in this area, implement the change and deliver relational permanency services to siblings based on best practice evidence; and DCJ provides governance and resourcing for implementation of the sibling relational permanency policy including performance monitoring and improvement. A change to one element of the system (e.g., a Premier's Priority sets a focus in one area of the system or on a specific practice) will require adaptations elsewhere in the system to support effective practice and optimal outcomes for children. This is a simple example, representing only a single action within the PSP reform, but it provides an example of the different actions required by different actors at different levels of the system.

Before making any changes to PSP based on the recommendations we strongly suggest these are carefully planned and carried out by DCJ using sound implementation principles and quality infrastructure. Service and system reform failures are socially and economically costly. Further, implementing these recommendations will lead to changes (large and small) that affect DCJ Districts, PSP service providers, and children and families in the way they deliver and receive services – and this needs to be managed carefully. These types of changes, and the impacts they can have, often receive little attention. Given the scale of these recommendations, we acknowledge that action will likely be broken into smaller parts and/or phased across the system (e.g., a focus on new design in family preservation or a trial of performance monitoring and improvement with as a small number of providers). Therefore, it is critical to invest time and expertise in understanding both how these smaller changes and their implementation effect the larger system so that actions work toward system change rather than remaining isolated initiatives that, at best, make marginal improvements when far more is needed.

Overarching recommendations

We have made five overarching recommendations.

Recommendation 1: Shift PSP from a focus on administrative processes to a focus on practice and child wellbeing, safety, and permanency outcomes

What success looks like: Routine wellbeing assessments inform needs, drive evidence-informed, high-quality practice that improve the most important outcomes in the lives of children and young people.

PSP packages and administrative processes are only as good as their ability to create an enabling environment for effective practice and service intervention to occur. At present, the packages are the focus of activity rather than a means to an end. For example, case plan goal reviews are an opportunity not only to review permanency goals, but to proactively conduct wellbeing assessments, and put into place services to meet children's needs. An enabling environment can be achieved by more clearly articulating what the desired outcomes would look like for children and families, working backward to identify practices and services that have a high likelihood of reaching those outcomes, and then creating administrative processes and incentives that support their implementation. This shift is, in many ways, underway at DCJ - but it needs to focus more clearly on accurately measuring actual outcomes and not on compliance with administrative processes. This requires building on, and learning from, existing DCJ work such as the Quality Assurance Framework for Out-Of-Home Care, the in-development PSP Data Roadmap, the PSP

Learning Hub, and the Targeted Earlier Intervention measurement platform which evaluates meaningful outcomes for individual children and families as well as provider performance in achieving them.

Recommendation 2: Facilitate the performance of PSP service providers to achieve children's wellbeing, safety, and permanency outcomes

What success looks like: Specialist practice and implementation support enables consistent delivery of evidence-informed practice tailored to children's needs.

We observed substantial variations in the capacity of PSP providers and districts to deliver high quality services and associated outcomes during the initial implementation of PSP. This raises equity concerns that children, families and carers may receive a different quality of PSP service delivery depending on which provider they are engaged with and where they live. We do not see this as being largely driven by poor performance of PSP providers. Rather, we see this as performance differences resulting from capacity and opportunity constraints (or implementation challenges that impede PSP delivery). Major impediments to quality PSP delivery include service gaps, access to evidence on what practices and services work and how to implement them in their service context, and process and system challenges.

It is one thing to know what works and how to implement it, and quite another to develop a workforce that can do it. The success of this recommendation is dependent on not only a new wave of effective services and core components to improve children's outcomes but a workforce that can quickly adopt and adapt these well.

Recommendation 3: Review the full incentive structure which emerges from the PSP funding model, PSP operating model and external system factors to incentivise the achievement of wellbeing, safety, and permanency outcomes

What success looks like: Incentives and strategies designed to facilitate continuous service improvement are embedded in the system.

A substantial gap in PSP's design is that incentives were only considered from the perspective of funding.[16] This evaluation demonstrated that incentives were highly influenced by, for example, organisational and operational structures and external factors that often arose as implementation challenges. Incentives cannot be developed independently of systems, or they risk – as we saw in this evaluation – misalignment with the behaviours they are intended to influence (e.g., the misalignment between the work required to complete family finding and the package remuneration). Instead, incentives best emerge from models and processes in operation, which are then tested locally and at higher levels of the system. The targeted recommendations below must also be considered in concert with the other recommendations that support PSP service provider capacity building and the removal of implementation barriers to effective PSP service delivery.

[16] We note these incentives were not fully operationalised. Abatements, for example, were not implemented, which in effect enabled PSP service providers to continue to be remunerated for outcomes they did not achieve.

Recommendation 4: Grow and embed system mechanisms to reduce waste

What success looks like: Services are data-driven, evidence-informed and well-implemented; services without these features are de-implemented.

Continuing to invest in services that do not deliver is not only detrimental to children and families, it wastes limited resources and takes funds away from more effective programs and implementation efforts. Further, failure to effectively address impediments to service implementation results in an inefficient system with poor role clarity and potential inequalities in delivery – and these undermine incentive-based reform efforts. PSP service providers, and the Permanency Coordinators and Districts that support them, will be unable to effectively respond to incentives if implementation barriers at the operations and system level continue to impede the work of achieving children's permanency. Implementation efforts are well worth the investment. Evidence suggests a novel service implemented well can be more effective in improving outcomes than an 'evidence-based' program implemented poorly.[17] Effective infrastructure to support implementation is critical to the success of the PSP reform and can be achieved through building on DCJ initiatives such as the PSP Learning Hub, PSP Data Roadmap, District implementation teams and permanency coordinators, and accessible data systems.

There has historically been little focus on the de-implementation of services that do not work. Like implementation, de-implementation is a considered and structured process – involving removing, replacing, reducing, or restricting the delivery of an inappropriate (i.e., not the most effective or cost-effective to provide or no longer necessary) or ineffective intervention.[18] Rarely practiced, de-implementation minimises harm, prevents waste, builds public trust, and ultimately improves outcomes.[19] If the NSW Government decides to change the PSP funding and operational model and alter delivery based on the findings and recommendations in this report, we strongly suggest de-implementation practices and processes are put into place to ease the transition.

Recommendation 5: Shift investment toward the 'front end' of the system and across the care continuum

What success looks like: The *right* services are delivered at the *right* time to the *right* children and families in the *right* way.

Despite regular calls to shift the balance of investment from the back end of the child and family services system (i.e., acute intervention and care) to the front end (early intervention), little meaningful change has been achieved in practice. This is not for a lack of political will within and across governments and responsible departments. Rather, the level of investment required to 'rebalance' the system – in the face of known challenges such as high demand for child protection services (including unmet demand) - requires significant and sustained strategic investment. A successful child and family services system delivers the right services (i.e., evidence-informed, and effective services to address need) at the right time (i.e., in response to a problem as it first emerges) to the right people (i.e., those in the most need who can benefit most) in the right way (i.e.,

[17] Lipsey, M.W. (2009). The primary factors that characterize effective interventions with juvenile offenders: a meta-analytic overview. *Victims and Offenders, 4*: 124-147.
[18] McKay, V, R., Morshed, A. B., Brownson, R.C., Proctor, E.K. & Prusaczyk, B. (2018). Letting go: conceptualizing intervention de-implementation in public health and social science settings. *American Journal of Community Psychology, 62*: 189-202.
[19] Norton, W.E. & Chambers, D.A. (2020). Unpacking the complexities of de-implementing inappropriate health interventions. *Implementation Science, 15*(2).

tailored to people's needs, preferences and values). This means not just a focus on the ends of the system but on the entire continuum of care.

Targeted recommendations

Recommended changes to the PSP model

We have made six recommendations related to influencing the PSP model, including targeted funding packages to address identified gaps in permanency care, implementing an evidence-informed practice framework that can be applied flexibly to meet need, a framework to measure child and family outcomes at the practice-level, and developing a new model for family preservation. We recommend DCJ:

- Review and address the misalignment between the amount of casework required to achieve permanency and the funding provided by PSP packages (see for example, the discrepancies identified in the funding available, and casework practised for Family Finding and use of the 4+ Siblings package). This will require a recalculation of the range of time required to perform this casework and a reconsideration of the amount compliance-driven administrative reporting.
- Override the default low needs package for entries into care if a child has a previous and recent Child Assessment Tool (CAT) score in the system. Children entering care were initially given a lower Child's Needs package than their most recent CAT score suggested. Over time, children were generally moved to higher child's needs packages. The same pattern held for children already in care. This suggests that allocating children a needs package based on the CAT score in the system will be a more accurate and will better facilitate the casework and services required to improve children's outcomes.
- Create new packages which incentivise casework and permanency planning in areas of best evidence for children's wellbeing, such as keeping siblings together to foster relational permanency. This could be achieved through a 'complex family package' that increases in value according to the number of siblings in a family (even if not living together) and appropriately resources service providers to work with the entire family across providers. Given many siblings are already dispersed across providers, there would need to be a mechanism to transfer children to the one provider (and the work that has occurred in achieving permanency) and potentially compensate other providers for their time. Alternatively, trialling shared packages between providers for the sibling services delivery could also be considered.
- Implement a PSP practice framework that is evidence-informed, client-centred, flexible, and tailored to context. DCJ is currently developing a PSP Practice Framework and we recommend this framework integrate research and evidence for effective practice, practice theory, experiential knowledge, and ethical principles into a guide that enables caseworkers to flexibly apply effective practices[20] in their everyday work. Workforce development and implementation support will be required to ensure the framework and practices are implemented to a high-quality. Implementation is not a point in time activity; ongoing infrastructure and support will be critical to success.

[20] Effective practices are practice elements found within a broad range of programs and interventions that are effective in enabling change and can be applied flexibly to meet need (e.g., building family communication skills). They are common building blocks of programs that have been shown to work to bring about better outcomes. For more information, please see this video: https://www.ceiglobal.org/work-and-insights/animation-how-can-practice-elements-help-you-build-better-evidence-informed

- Implement a 'practice-level' PSP outcomes framework that describes reliable and valid ways to holistically measure child safety, permanency, and wellbeing at the individual and family levels. Current NSW state outcomes frameworks, while well-intended, are too high-level to assess individual need and to monitor progress to outcomes that are tailored to those needs. This more detailed framework would describe specific, meaningful outcomes for individual children and their families, and how to measure them. For instance, a framework should go beyond measuring whether a child was reunified and identify specific tools that assess concerning parenting practices and reliably and validly assess their improvement over time.
- Develop and test an evidence-informed model for family preservation and restoration (given the current model is ineffective). Model design should be based on current best evidence for effective practice, families' preferences and values and sector expertise. Aboriginal families must be involved in the design and testing of a model for use by ACCOs and NGOs, as many Aboriginal children continue to receive permanency support services from NGOs. If this recommendation is implemented, a companion process of de-implementation of the current family preservation model (including DCJ components such as the broadcasting system) must be undertaken to ensure the workforce is clear on role in service delivery.

Recommended changes to the context in which PSP is delivered

We have made three recommendations related to influencing the context in which PSP is delivered focused on undertaking sector-wide workforce development, monitoring outcomes that contribute to practice improvement and supporting PSP provider access to practice elements and effective practices and programs. We recommend DCJ:

- Undertake sector-wide workforce development with implementation support (e.g., training plus coaching using data on performance) to enable PSP service providers to understand, select and effectively implement practice elements tailored to NSW's unique contexts. This includes the development of tailored, culturally appropriate practices with Aboriginal Community Controlled Organisations. Based on the Victorian Government's experience, we expect this recommendation, if implemented well, to foster gains in outcomes, particularly in the areas of family preservation and restoration.
- Enable quality by monitoring outcomes that contribute to practice improvement. Specifically, implementation (including whether the right population is being reached, what service is being delivered, and the quality of the service) and child wellbeing, safety and permanency outcomes. This should be done across the sector (including PSP service providers and districts) so performance can be improved through high quality audit and feedback. Audit and Feedback is a specific implementation strategy, similar to Continuous Quality Improvement (CQI), that facilitates the effectiveness of services, and children's outcomes, through a data-driven feedback cycle.[21] – but the data have to include the right population and information for it to be effective.
- Make available and incentivise the use of high-quality evidence advisory systems (e.g., locally adapted What Works systems or through investment in an expanded PSP Learning Hub) and the effective practices contained within them to improve children's outcomes. Without motivation, support, and a universally accessible system, these are likely to be underutilised, so substantial investment and incentives are crucial.

[21] This process – of monitoring outcomes, reporting outcomes back to service providers and caseworkers, identifying areas for improvement, and enacting plans – could be facilitated by local implementation teams working in partnership with PSP service providers, Permanency Coordinators and districts.

Recommended changes to the broader ecological system within which PSP service providers exist and operate

We have made five recommendations related to influencing the broader system in which PSP is delivered focused on resourcing and embedding implementation infrastructure across the permanency support system, implementing a system to monitor provider and system performance, addressing system gaps, investing in system-wide data to drive improvement and investing in system change. We recommend DCJ:

- Embed implementation infrastructure by maintaining discrete funding for PSP implementation teams at the district level and establishing an implementation team at the DCJ PSP central office level. It is critical staff at both team levels possess specialist implementation support skills,[22] to ensure teams can plan, implement, monitor and address local and systemic barriers to effective service delivery. As a first step, using the implementation challenges identified in this report (i.e., clarity of DCJ and PSP service provider roles, legal reporting and court issues, DCJ delays in authorisation of case plan goals) implementation teams could map delivery, operation and system challenges (including those that are related to foundational casework as well as permanency support) and devise, implement and monitor strategies to address them. Effective implementation teams make good use of constrained resourcing and can be used to plan new services and components of services, and to oversee the de-implementation of ineffective services or components of services.

- Implement a performance monitoring system that uses children's wellbeing outcomes (as described above), as well as more standard systems outcomes (e.g., new ROSH reports, OOHC placements, permanency outcomes), to routinely report on the range of outcomes as a whole and by District. Strong consideration should be given to a transparent reporting system that goes well beyond the yearly AIHW report such as the California Child Welfare Indicators Project (https://ccwip.berkeley.edu/). This system could then be used to benchmark current performance and develop easily understood and meaningful metrics; create incentives to reward improved performance; initiate mandatory program improvement plans to guide needed changes among low performing providers; and develop detailed, tested plans for avoiding perverse incentives that maintain children in long-term care.

- Work with NSW central government and line agencies such as the Ministry of Health/NSW Health to address PSP service gaps across NSW identified in this evaluation related to the availability of specialist psychological services for sexual abuse, violence and trauma. Other service gaps should also be addressed, in partnership with NSW Health, the Department of Education, and functions within DCJ (e.g., housing) to facilitate children's outcomes in the areas of health (e.g., mental health services, alcohol and other drug (AOD) treatment), housing (e.g., including for victims of domestic violence who have children), and education (e.g., high quality educational enrichment programs).

- Invest in, and facilitate the collection and integration of, high-quality data at the PSP service provider and system levels using ChildStory and the Human Services Data Set to enable monitoring and evaluation of specific services provided and outcomes achieved at the child level. A Minimum Dataset (MDS) at the service-level should be established for PSP which systematically collects data on child wellbeing and the type, timing, duration, and frequency of services referred to and whether these were provided and by whom. Combined with reliable and valid assessment measures that are either standard (or can be standardised across providers), this asset will enable DCJ to properly evaluate, and invest in, what works for whom and at what time rather

[22] Albers, B. et al. (2020). Implementation support skills: findings from a systematic integrative review. *Research on Social Work Practice, 31*, https://doi.org/10.1177/1049731520967419

than relying solely on non-specific, low-quality administrative data that is unsuited to delivering a reform of this complexity.

- Establish an appropriate governance mechanism responsible for systemic change in permanency support presented through these recommendations and oversees planning, implementation and monitoring, including phasing of action, to ensure action is aligned and drives outcomes. For example, the practice framework implementation strategy must be linked to workforce development and the outcomes framework to ensure permanency support functions as an effective system grounded in continuous quality improvement.
- Scope big-picture system reform by drawing on local and international experts in the field of child protection and permanency support and learning from other jurisdictions across Australia and globally. Three examples of this kind of action include investigating the:
  - Models, funding and infrastructure involved in shifting focus from legal permanency to relational permanency and cultural permanency to improve children's outcomes.
  - applicability of policy mechanisms such as the Victorian Government's Early Intervention Investment Framework, which funds projects that prevent entry into the system, to the NSW child and family services context.
  - the development of a child and family services 'continuum of care' policy framework, akin to a 'stepped care' model in mental health, comprising a hierarchy of interventions, from the least to the most intensive, which can be matched to the needs of children's and families.

Part one

Background, Introduction to PSP and PSP Implementation overview

3. Background & Context

In the last decade, significant reforms and reviews of NSW's child protection and out-of-home care (OOHC) system were conducted to address the growing number of children in OOHC and the over-representation of Aboriginal children and families[23] within the child protection and OOHC systems. This section presents an overview of the key reforms and reviews of NSW's OOHC system to explain the context within which PSP was designed and implemented. This is important in understanding both the policy landscape for PSP and the program and service context, across NSW government, in which PSP was designed to improve outcomes for children and families.

3.1. Background

3.1.1. Independent reviews of OOHC in NSW

The David Tune Report

In 2015, David Tune AO PSM was commissioned by the NSW Government to undertake an Independent Review of OOHC care focused on evaluating the current state of OOHC in NSW in response to a sustained increase in the OOHC population and continuing poor outcomes for NSW's most vulnerable children and families (Tune, 2016). The objective of the review was to develop a long-term strategy and vision for systemic reform of OOHC in NSW by identifying the causes behind the poor outcomes and proposing a system-wide solution in the form of actionable recommendations (presented in the box below). The review identified four core systemic issues preventing the NSW OOHC system from being effective and sustainable (Tune, 2016):

- The system was not client-centered, as it was designed around programs and service models instead of the needs of vulnerable families.

[23] We adhere to DCJ's practice of referring to Aboriginal children and families (rather than Aboriginal and Torres Strait Islander), in recognition that Aboriginal people are the original inhabitants of NSW.

- The cross-government agency approach to shared responsibilities was not able to improve outcomes for children and families with complex needs, whose needs cross the boundaries of government agencies.
- DCJ (previously FACS) held primary accountability for very vulnerable families but had little influence over the drivers or levers for change.
- Expenditure was crisis driven, not well aligned to the evidence, and not effectively targeting vulnerable children and families.

The David Tune Report (2016) – Recommendations

Personalised, targeted support

Introduce personalised support packages, based on needs assessments, to fund the services and support required to improve health, education, employment, parenting skills, housing, permanency and stability for children, and empowerment outcomes for vulnerable children and families. A set of sub-recommendations, listed below, were identified as key components to delivering personalised, targeted support:

- Introduce a **common risk and needs assessment** tool informed by data analytics
- Establish **a new role to coordinate the delivery of the personalised support packages** and provide **sustained local support** to achieve the required outcomes
- **Build up the capacity and readiness** of the OOHC service sector to deliver the personalised support packages
- **Establish protocols for practice** to embed consistent planning and pathways

An investment and commissioning approach

Introduce an investment and commissioning model based on an outcomes framework, for vulnerable children and families, across government agencies and anchored in a cost model aligned to the purpose of the investment approach. This recommendation relied on the following sub-recommendations:

- Establish a **cross-agency outcome framework** aligned to a set of quantifiable indicators to **provide greater focus on outcomes** and a single view of desired measurable client outcomes.
- Set up a cross-agency vulnerable children and family dataset underpinned by the cross-agency outcome framework.
- Build evidence-base of effective interventions and services to ensure investments are guided by evidence.
- Align investment in interventions and services to a service continuum for vulnerable children and families.
- Establish a new commission with statutory authority and access to cross-agency funds to design and implement the investment and commissioning model.

- Build local planning and decision-making capacity through the establishment of local cross-agency teams in each district to provide advice on the local performance, local needs and the implementation of the investment and commissioning model.
- Increase funding for investments within the investment and commissioning model.

The Family Is Culture report

In 2016, Professor Megan Davis was commissioned by the NSW Government to undertake an Independent Review of Aboriginal children in OOHC with the objective of examining the circumstances of Aboriginal children in the OOHC system. In response, the Family Is Culture report, published in November 2019, detailed the systemic causes behind the disproportionate number of Aboriginal children in care in NSW. These are presented below (Davis, 2019):

- **Culture gap and culturally inappropriate casework practice:** the review reported a systemic lack of understanding of Aboriginal culture across the child protection service system created by a cultural gap from decoupling of NSW's Child Protection and OOHC system from the history of Aboriginal people. This means DCJ and service provider staff did not have a sufficient understanding of the history of Aboriginal people, their local Aboriginal population and the ways Aboriginal people remain affected by historical and contemporary policies and laws. The culture gap prevents service providers from understanding the historical continuity of the current system - that is, the context of dispossession, the stolen generations and intergenerational trauma - and understanding the meaning and importance of Aboriginal cultural practices and self-determination.
- **Limited Aboriginal evidence-based policies and service interventions:** a systemic lack of understanding of Aboriginal culture across the child protection system is coupled with insufficient involvement of family and community members in decision making and casework and limited access to culturally safe services.
- **Insufficient self-determination:** the review found the NSW government has not recognised that enforcing the right to self-determination within the system is about more than setting up partnership and is 'about finding agreed ways that Aboriginal people and their communities can have control over their own lives and have a collective say in the future well-being of their children' (Davis, 2019).

The Family is Culture identified 135 wide ranging recommendations and a small sub-set of these recommendations deemed most relevant to the implementation of PSP are presented in the box below.

The Family is Culture Recommendations

The Family is Culture recommendations identified as most relevant to the design and implementation of PSP:

- Conduct regular case studies and develop recommendations from the bottom up.

- Review the risk and safety assessment process.
- Develop and embed cultural frameworks.
- Change legislation to align it to Aboriginal family and cultural norms.
- Provide training to build practical skills for casework on the ground.
- Increase investment in and knowledge from the social care sector.
- Increase resources and preventative work prior to entry into care.
- Ensure social work practice is of high quality through continued research, monitoring and knowledge translation.
- Increase scrutiny and accountability of decision-making within the sector by increasing transparency and improving record keeping and appropriate application of risk assessment tools.
- Embed a deeper understanding of Aboriginal history and culture and knowledge of historical context into social work practice.

Realign focus to ensure children remain connected to family, community, culture and country and recognise community as a strength for children.

3.1.2. Recent reforms of OOHC in NSW

Safe Home for Life reform program

The Safe Home for Life OOHC system program of reforms was announced in October 2014 and implemented from 2014 to 2018 to deliver 'more services and better outcomes for more children at risk and in care' (FACS, 2014). The program was guided by the proposed reforms included in the Child Protection: Legislative Reform Proposals discussion paper released by the NSW Department of Family and Community Services (now known as DCJ) (FACS, 2012) and the findings from its consultation process conducted to gather extensive stakeholder feedback (Department of Family Services, 2013).

The Safe Home for Life reforms were designed to intervene across the entire OOHC system from pre-intake early intervention to after care services. The core elements of the reform included:

- The introduction of 'permanency and stability' as a system-wide goal underpinned by the introduction of Permanency Placement Principles and a renewed focus on supporting open adoptions for non-Aboriginal children.
- Extensive legislative reform, including the introduction of guardianship orders.
- A redesign of local services led by districts and co-designed with local communities.
- A replacement and consolidation of the OOHC information technology systems used by NSW government to increase access to accurate and timely data reporting. This led to the implementation of the information technology system ChildStory, which began in late 2017.

3.1.3. Shaping a Better Child Protection System discussion paper

In 2017, the NSW Government released a discussion paper, Shaping a Better Child Protection System (NSW Government, 2017). The discussion paper outlined proposed amendments to the Care Act and the *Adoption Act 2000* (NSW) which were designed to embed the PSP program of reforms into the NSW legislation focused on two main areas of reform: (i) earlier family preservation and restoration; and (ii) streamlining court processes and orders. The NSW Department of Family and Community Services conducted community consultations on the discussion paper and released a report summarising the outcomes of the consultation (Department of Family and Community Services, 2018). The discussion paper and the outcomes of the consultation informed a set of amendments to the Care Act and the Adoption Act 2000 completed in 2018 including the introduction of mandatory alternative dispute resolution (ADR) before seeking care orders and numerous reforms to court processes and orders. An overview of all the amendments is provided in the PSP implementation overview Section 2.3.

Their Futures Matter

The NSW Government set up the NSW Stronger Communities Investment Unit in 2015 to oversee the delivery of the Their Futures Matter cross-government department reform in response to the David Tune Report (2016). In line with the review recommendations, the NSW Stronger Communities Investment Unit introduced a plan to transition NSW's child protection and OOHC system from a placement-based system to a system based on delivering tailored support packages to children and their families. As part of this plan, the Stronger Communities Investment Unit identified the pre-requisites, presented below, considered as essential to successfully implementing personalised tailored support packages guided by an investment approach (NSW Government, 2016):

- Base the commissioning of services on:
  - The ability of services to achieve measurable and meaningful outcomes.
  - A data driven understanding of the life trajectories of vulnerable children and families, and
  - A common risk and needs assessment tool designed in alignment with the new delivery model.
- Invest in and shift investment to evidence-based services and interventions, and
- Introduce a single outcomes framework across agencies anchored in a common definition of wellbeing outcomes and associated wellbeing indicators.

Their Futures Matter audit

In 2020, the Auditor-General of NSW released a report examining the extent to which Their Futures Matter was able to deliver on its objectives (Auditor-General of New South Wales, 2020). The audit findings, directly linked to the pre-requisites detailed above, are summarised below:

- The Their Futures Matter reform started building an evidence base and laid important foundations to build upon.
- The Their Futures Matter evidence base is insufficient to shift more resources from crisis to early intervention.
- The Their Futures Matter bodies were not given sufficient powers to establish an investment approach for supporting vulnerable children and families.

The objectives considered in the audit align closely to the Tune report (2016) sub recommendations made under the overarching recommendation of setting up an investment and commissioning approach. The findings suggest that some progress was made toward achieving elements of the Tune report objectives. However overall, the audit findings suggest that TFM was not able to implement a cross-agency investment and commissioning approach as intended. Some of the sub-recommendations were also addressed outside of the TFMs reform, for example the development of a cross-agency outcome framework, which is covered in more detail in PSP outcome framework section below.

3.1.4. Key Concepts

Permanency

The permanent placement principles which underpin PSP are based on four concepts of permanency — relational, physical, cultural and legal. The importance of permanency for child development is well-established, and is based on theories of attachment, child development and formation of cultural identity (Tilbury and Osmond, 2006). The four dimensions of permanency are:

- Relational permanency: a child has the experience of having positive loving, trusting and nurturing relationships with significant others, including parents, siblings, friends, family and carers.
- Physical permanency: a child has stable living arrangements (i.e., placement stability) and is connected to their community.
- Cultural permanency: a child maintains a meaningful connection to culture through taking part in cultural practices, connecting with family and community, and valuing connection to Country (Curijo, 2022).
- Legal permanency: a child lives with at least one parent or primary caregiver who has legal responsibility for them. In NSW, legal permanency can be achieved through preserving a family with at least one parent, restoring a child or young person to at least one of their parents, placing a child with kin, relative or a carer under a guardianship order or adoption24.

The different forms of permanency are seen as essential to a young person's wellbeing. It is critical that relational, physical and cultural permanency are established before legal permanency is sought. It is also recognised that definitions and goals of permanency may differ by age (Salazar et al., 2018).

Permanency planning

The concept of 'permanency planning' in child protection and OOHC systems emerged in the United States and the United Kingdom in the 1970s (Cripps and Laurens, 2016). Permanency planning can be generally defined as 'a systematic, goal-directed and timely approach to case planning for children subject to child protection intervention aimed at promoting stability and continuity' (Tilbury and Osmond, 2006). There is limited research on the effectiveness of permanency planning within child protection systems, and on the elements of best practice (Cripps and Laurens, 2016; Tilbury and Osmond, 2006). The primary focus areas and noteworthy research findings within the permanency planning literature are summarised below.

[24] Adoption is not an acceptable outcome for Aboriginal and Torres Strait children and should only be considered where long-term care is not possible

Cultural considerations

Specific concerns have been raised about the potential effect of permanency planning on cultural identity and community control in Australian Indigenous law publications (Cripps & Laurens, 2016; Libesman, 2017) and the Family Is Culture independent review (Davis, 2019). Cripps and Laurens (2016) suggest the use of legislative requirements for permanent placement of children within a prescribed timeframe to hasten the process for moving children out of statutory OOHC and into stable environments will adversely impact the cultural identity of Aboriginal children in Australia. Moreover, Libesman (2017) asserts that the early permanent placement of children in OOHC conflicts with the concepts of self-determination and community control for Aboriginal people, organisations and communities at the heart of the recommendations of the Bringing Them Home Report (Human Rights and Equal Opportunity Commission, 1997) and in legislation. Libesman (2017) argues that imposing prescribed timeframes to establish permanent placement of children limits the capacity of Aboriginal organisations to do the support work necessary to restore children to their birth parents. This pressures Aboriginal organisations to prioritise permanent placement over other values that are used to determine the safety and wellbeing of Aboriginal children, such as self-determination and participation in decision-making. These concerns were echoed in the Family is Culture report (Davis, 2019) which reported Aboriginal stakeholders believe the concept of 'permanency and stability' did not recognise cultural differences and specifically the fact that 'Aboriginal children could enjoy permanency and stability when being cared for by a number of relatives and kin at different times.'

Permanency planning adjusted to developmental phases

A large-scale study in the United States on the risk factors related to re-entry to care from kin guardian homes found that, if guardianship arrangements are going to fail, they are most likely to fail when children become adolescents (Parolini et al., 2018). This study suggests that scrutiny and review of children's and families' needs at vital points in children's developmental pathways can prevent placement and guardianship breakdown (see also Lee et al., 2012; Rolock & White, 2016; Testa et al., 2015). As a precaution against the risk of placement and guardianship breakdown associated with this developmental phase, services should provide ongoing, developmentally sensitive, age-appropriate services for children.

Sibling co-placement and relationships

Sibling co-placement and preservation of sibling relationships in child welfare settings has been linked to increased chances of reunification and placement stability (Shlonsky et al. 2005; Webster et al., 2005). Children entering care at the same time are more likely to be placed in the same foster home, and some findings suggest that these children are also more likely to return home (Webster et al., 2005). McBeath et al.'s (2014) literature review states that although positive sibling relationships may lead to beneficial outcomes for at-risk youth, sibling bonds may also be characterised by maladaptive behaviours and conflicts. Awareness of the effect of sibling separation on permanency may encourage greater efforts at the frontline and administrative levels to seek out and maintain intact sibling placements (Shlonsky et al., 2003; Shlonsky et al., 2005; Webster et al., 2005).

Differential response

Permanency planning through employing a differential response approach constitutes tailoring the responses used across the child protection and OOHC system to each family's needs and circumstances. This approach was developed to prevent the use of overly coercive child protection services by helping families provide acceptable levels of care to their children while maintaining them in the home. Only when this is not possible should agencies consider a more intrusive intervention, such as out-of-home placement (Hughes et al., 2013). It was developed with the intention of incorporating family-centred, strengths-based practices into child protective services by diverting lower risk families into

an assessment track rather than requiring the traditional investigative processes (Hughes et al., 2013). A differential response approach to permanency planning identifies family preservation as the preferred permanency goal, followed by restoration, and prioritises providing adequate and targeted support and services to children and families matched to their level of need and as early as possible.

Continuum of Care

A continuum of care represents the span of services and interventions available to vulnerable children and families across the entire child protection and OOHC system from targeted early intervention to post-care support. Vulnerable children and families are best supported through an evidence-informed continuum of care that provides timely, tailored, appropriate, integrated services and interventions designed around a robust understanding of vulnerable children and families' pathways through the system (Tune, 2016).

'The continuum creates a system backbone that allows services to connect, join up and support a child and family.' Tune, 2016

Tune (2016) found that an effective service continuum, which ensures that safety issues and needs are addressed as early as possible, is reliant on the existence of effective and consistent risk and need identification, effective casework coordination guided by protocols of practice and the alignment of investment in evidence-based services to the continuum. Allowing caseworkers to base their case plans on risk and need assessment outcomes, practice guidelines and the service continuum guidelines will inform the procurement and delivery of health, education and community services and interventions to achieve case plan goals.

The 'continuum of care' defined by DCJ to underpin service delivery across the child protection and OOHC system has four primary segments: (1) preservation; (2) assessment and case plan goals; (3) placement transition and step-down; and (4) exit and post-care support. The span of the DCJ 'continuum of care' differs from the recommended service continuum proposed by Tune (2016). The service continuum recommended in the Tune report (2016) - developed with cross-government consultation facilitated by the Australian Research Alliance for Children and Youth - also incorporates services intended to be delivered prior to the preservation segment. These front-end services include the delivery of community strengthening services and services targeted to children and families with risk factors who are not considered at imminent risk of removal within the core service continuum. This observation does not suggest that there are no programs and services delivered at the front end of the care continuum in NSW[25], only that the services and care continuum for vulnerable children and families in NSW is not well integrated. The continuum presented in the Aboriginal Case Management Policy (NSW Government, 2018) to guide case management delivery practice does incorporate early intervention services. It includes the following three interconnected segments: Aboriginal community response

[25] For example, the DCJ funded Targeted Earlier Intervention program delivers early intervention services including community strengthening

(lowest risk level), Aboriginal family strengthening (medium risk level) and Aboriginal child safety (high level of risk).

The limited integration of NSW's continuum of care prevents government agencies and other service providers from effectively working and making referrals across the continuum. The continuum of care defined by DCJ and the provision of services along the continuum are not in scope for this evaluation. However, we believe it is likely that the limited integration across NSW's continuum of care contributes to some of the challenges faced by government agencies and services providers in delivering services. The following common service delivery barriers are associated with the service continuum - limited services in rural and regional areas, long waiting times for services and high service costs - and can be expected to impact government agencies and service providers' ability to efficiently make referrals across the continuum.

3.2. What is the Permanency Support Program?

PSP is the largest child protection and OOHC service reform implemented by DCJ. It was designed to build on the Safe Home for Life reforms to embed the permanent placement principles into practice. PSP also included the recommissioning of OOHC services, including residential placements and intensive therapeutic care services, planned as part of Their Future Matters' whole-of-system reform agenda. Specially, PSP addresses the recommendation to introduce 'personalised, targeted support' for children and families, with a particular focus on three of the sub-recommendations presented as integral to introducing personalised and targeted support: establishing a new role to coordinate the delivery of the personalised support packages and provide sustained local support; building up the capacity and readiness of the OOHC service sector to deliver the personalised support packages; and establishing protocols for practice. The only other sub-recommendation, related risk and needs assessments, is out of scope for PSP.

3.2.1. PSP objectives

PSP was designed to achieve three core objectives:

- Fewer entries into care: by keeping children at home, and minimising entries and re-entries into care.
- Shorter time in care: by increasing the number of children either being restored to their families or finding other permanent homes, including guardianship arrangements or adoptions.
- Better care experience: by investing in higher quality services and providing more targeted and evidence-informed support to address individual needs.

An additional objective of PSP was to address the over-representation of Aboriginal children in the care system was added later.

3.2.2. PSP practice components

To achieve these objectives, PSP coupled the recommissioning of OOHC services with the introduction of new service delivery practices across the four areas listed below, as presented on DCJ's *About the Permanency Support Program* site (DCJ, 2020):

- 'Permanency and early intervention principles built into casework'
- 'Working intensively with birth parents and families to support change'

- ‘Recruitment, development and support of carers, guardians and adoptive parents’
- ‘Intensive Therapeutic Care system reform (replacing residential care) [26]’

3.2.3. PSP operational components

The new PSP commissioning model and practices were associated with the introduction of substantial changes to the following components of NSW’s child protection and OOHC system:

- Service delivery model.
- Approach to contracting, introduced through a new funding deed and program level agreements, including the introduction of payments tied to performance.
- Operational guidelines including service requirements for service providers.
- Performance and management framework including mandatory reporting requirements.
- Assessment and monitoring tools and processes.

The changes initiated by PSP only applied to the services delivered as part of PSP. The distinction between PSP and non-PSP services is detailed in the rest of this chapter.

3.2.4. Mechanisms of change and assumptions underpin the design of PSP

This section presents the hypothesised mechanisms of change and their underlying assumptions which guided the design of PSP. These mechanisms represent how PSP was expected to impact the permanency and wellbeing outcomes for children in NSW’s child protection and OOHC system.

- *Mechanism 1 – M.1*: Shift funding from the back-end of care pathways to the front-end to increase investment in prevention and early intervention:
  - M.1.1: At the individual case level: by encouraging PSP service providers to spend more in the earlier stages of the care pathway for the cases they manage
  - M.1.2: At the fund level: by reinvesting savings created by increasing the number of children exiting the system via permanency into preventative care

  Underlying assumptions of Mechanism 1:
  - A.1.1: The PSP funding model, payment structure and contractual agreements incentivise earlier investments by PSP services providers
  - A.1.2: Additional funding would be made available over time to increase the number of family preservation packages
  - A.1.3: PSP service providers can use funding to provide evidence-based services aligned to the needs of the children and family in a timely manner
  - A.1.4: There is no unmet need at the back-end of the system and entries to OOHC will decrease (i.e., any freed-up capacity will be allocated to the front end of the

[26] Out of scope for the evaluation

system rather than meeting continued demand for intensive child protection services).

- *Mechanism 2 – M.2:* Flexibility around how PSP service providers use funding, adjusted according to case goals, needs level and circumstances, to let service providers determine which evidence-based services are most suitable in each case.

  Underlying assumptions of Mechanism 2:

  - A.2.1: Service provision by PSP service providers is guided by evidence-informed practice frameworks aligned to case characteristics including culture, permanency goals and level of need Evidence informed practice framework are available to PSP service providers
  - A.2.2: PSP service providers are able to facilitate access to evidence-based services they identify as align to the needs of the children and families
  - A.2.3: Funding is aligned for the level of needs and circumstances of cases
  - A.2.4: A single outcome framework aligned to all the positive outcomes targeted by PSP is used to evaluate services and frameworks for different pathways

- *Mechanism 3 – M.3:* Shift responsibilities from the government to PSP services providers, where appropriate, to improve case coordination and create efficiencies by combining case management, placement provision, placement support and service provision responsibilities under the same agency earlier and more frequently.

  Underlying assumptions of Mechanism 3:

  - A.3.1: The roles and responsibilities of the system stakeholders are aligned to the system functions and processes, clearly articulated and well understood
  - A.3.2: The PSP services providers have the capability and capacity to take on the additional responsibilities

3.2.5. PSP outcomes framework

The overarching objective of PSP is to achieve improvements in safety, permanency and wellbeing outcomes of children who are at risk of significant harm or in OOHC. The Tune report (2016) recommended the introduction of an outcome framework covering all the desired measurable child and family outcomes to provide a single and holistic focus on improving children's outcomes.

The NSW Quality Assurance Framework (QAF), commissioned by FACS (now DCJ), is an example of an outcomes framework to measure wellbeing outcomes for children in the OOHC system. The QAF provides a common data collection process across the child protection and OOHC system to introduce a common outcomes framework and develop PSP providers' capacity to make data driven decisions about the best way to meet the needs of children (Mildon, Shlonsky, Parolini, & Michaux, 2015). The QAF also represents an approach for building a system-wide dataset of child level holistic life quality outcome measures. The QAF was constructed to include all the information needed for practitioners to address a child's needs and track their progress against all the targeted outcomes. The QAF domains are aligned with PSP's focus on (i) safety, (ii) permanency and (iii) wellbeing. The wellbeing domain is broken down in the following sub-domains: health and development, cultural and spiritual identity, emotional and psychological wellbeing, education potential and social functioning.

The QAF includes data from a range of sources including children, carers, DCJ, Department of Education and NSW Health to enable all agencies involved with a case to access

complete and reliable information. The QAF has been trialled with four PSP service providers providing OOHC services in NSW and will soon be trialled in ITC.

3.2.6. What did PSP change across NSW's Child Protection and OOHC system

In practice, PSP represents a reform program comprised of numerous adjustments to the delivery of OOHC functions and services, guided by the PSP objectives, PSP practice components and mechanisms of change, to transform the NSW's child protection and OOHC service system based on recommendations and findings from system-wide reviews.

The PSP reform is considered below as part of the complete child protection and OOHC case management, services, support and practice continuum to highlight the inherent interconnectedness of the continuum and convey the level of complexity which characterises the reform program. The PSP reform overview details both the system components changed directly as part of the planned changes (e.g., transfer of primary case management responsibilities) and the indirect changes which emerged as a consequence of the planned changes (e.g., PSP service providers required to be more involved with legal processes). It is not possible to disentangle the effects of the different PSP reform components from the rest of the child protection and OOHC system, as the system can only be implemented as a whole. For further information on the PSP design refer tothe PSP Program Description document (DCJ, 2017), which provides a complete overview of PSP, its design principles and the changes being introduced to achieve greater permanency, safety and wellbeing for children.

This section presents an overview of the NSW child protection and OOHC system within which PSP was implemented, identifies functions and services reformed as part of the PSP reform program and describes how PSP reformed these functions and services. This information is complemented by PSP implementation overview at the end of this chapter, which describes the main adaptions and continuous improvement activities, which occurred during the implementation period.

Child Protection and OOHC system

The child protection and OOHC system is a complex system based on a combination of legislation, policies, and practice frameworks that set out the overarching rules, objectives and roles within the system. The legislation, policies and practice frameworks are operationalised through the development and implementation of operational policies, procedures, business rules, practice guidelines and service requirements that govern the complex landscape of child protection and OOHC functions, processes, and decisions. The child protection and OOHC functions, processes and decisions are also supported by structured decision-making tools, assessment tools and forms. Ultimately, the child protection and OOHC functions, processes and decisions that directly impact outcomes for children and families are conducted by the individuals who occupy the roles and panels in the organisations which make up the child protection and OOHC system.

What changed with PSP: child protection and OOHC system

The PSP reform program was operationalised through the redesign of the family preservation, foster care, kinship care system and intensive therapeutic care systems and associated roles and responsibilities, funding model, practice frameworks and guidelines, and processes and procedures. These guide how the organisations and individuals who deliver PSP are intended to use and interact with PSP's core elements to achieve its objectives. It is important to note, not all the functions and services across the OOHC system were reformed as part of PSP and the intensive therapeutic care system PSP reform component is out of scope for this evaluation. The degree of change introduced by

PSP varies largely across the different systems and functions reformed by PSP is detailed in the rest of this chapter.

PSP Roles and responsibilities

The description and allocation of PSP roles and responsibilities set out how the government and other organisations involved in delivering elements of PSP are expected to work together. Table 2.1 provides an overview of the roles performed by the organisations and partnerships involved with delivering element of the system.

Table 3.1 Description of role of organisations and partnerships involved in PSP

Organisations and partnerships	Description of role
Department of Communities and Justice (DCJ)	DCJ oversees the design, implementation, commissioning, contract management and evaluation of PSP.
DCJ Child and Family District Units (CFDUs)	CFDUs are responsible for referrals and legal aspects of PSP cases. CFDUs also provide primary or secondary case management, case allocation, offer expertise of permanency principles.
DCJ Community Service Centres	DCJ Community Service Centres provide operational support across all NSW districts to ensure the safety and wellbeing of children and build stronger families and communities. CSCs also provide primary case management, oversee monitoring safety and risk assessments and lead court work during interim orders following a child's entry to care and hold primary case management for family preservation matters.
PSP Service Providers	PSP Service Providers include non-government organisations (NGOs) with OOHC accreditation who deliver social care, supports and services including case management under PSP contracts.
Service Providers	All programs, service and support providers delivering services to children, families and carers across the care continuum.
Aboriginal Community-Controlled Organisation (ACCO)	An independent, not-for-profit organisation that is incorporated as an Aboriginal organisation, is controlled and operated by Aboriginal people, is based in the local Aboriginal community and delivers services to Aboriginal communities.
NSW Department of Health	NSW Department of Health has partnered with DCJ to deliver NSW Health OOHC Health Pathway Program.
Joint Child Protection Response Program (JCPRP)	JCPRP is a tri-agency program delivered by the NSW Department of Communities and Justice (DCJ), the NSW Police Force (NSWPF) and NSW Health. The program

Organisations and partnerships	Description of role
	operates statewide and provides a comprehensive and coordinated safety, criminal justice and health response to children alleged to have experienced sexual abuse, serious physical abuse and serious neglect.

What changed with PSP: Roles and responsibilities

PSP brought on a restructure of the roles performed by DCJ and its partners across the system. The role and responsibilities of service providers across the system increased through changes to the way primary and secondary case responsibilities are allocated. The Permanency Case Management Policy, and associated Rules and Practice Guidance (DCJ, 2020) document provides an overview of the roles and responsibilities of PSP stakeholders.

NSW Legislation, practice framework and case management policies

Legislation

The Children's Court of NSW has jurisdiction to transfer parental responsibility from the child's birth parents to the Minister or another suitable person when it determines that a child or young person cannot remain in the care of their birth parents due to child protection concerns. The Supreme Court is responsible for granting adoptions orders.

The *Children and Young Persons (Care and Protection) Act 1998* is the main Act guiding child protection and OOHC decisions and casework made by the Children's Court. The Act sets out a set of principles to be followed by DCJ and any service providers delivering work on DCJ's behalf. The Children's Court requires DCJ to demonstrate that it has considered and followed all the principles in relevant Acts.

The *Children and Young Persons (Care and Protection) Act 1998* contains:

- Permanent Placement Principles: these guide how children should be provided with a safe, stable home including setting out a hierarchy of preferred permanency goals.
- Aboriginal and Torres Strait Islander Child and Young Person Placement Principles: these provide an order of preferences over who an Aboriginal child should be placed with if needed, which is to be followed when arranging a placement or pursuing a guardianship order for an Aboriginal or Torres Strait Islander child or young person.
- Principles for Administration of Act: these identify a set of principles to be applied in the administration of the Act including 'in any action or decision concerning a particular child or young person, the safety, welfare and well-being of the child or young person are paramount' and a child or young person 'be given an opportunity to express those views freely'.
- OOHC record keeping requirements for service providers.
- A requirement that the Charter of Rights for Children and Young People in Out-of-Home Care are supported by carers and caseworkers.

The *Adoption Act 2000* details the adoption principles, role of the Secretary (i.e., DCJ), procures (e.g., adoption plans) and requirements, including consent and service provider accreditations.

What changed with PSP: Legislation

A number of legislative changes to the *Children and Young Persons (Care and Protection) Act 1998* and *Adoption Act 2000* were designed and introduced to adapt the legislation to better support the process of achieving permanency for children. The amendments included the introduction of:

- Children's Court's decision over whether a restoration is possible can be made over 24 months from the hearing instead of on the date of the hearing.
- Alternative dispute resolution must be offered to families before seeking care orders instead of the Children's Court deciding on its appropriateness.
- Shorter-term care orders introduced for cases where the Children's Court has approved a permanency plan with a restoration, guardianship and adoption goal. In these cases, short-term care orders replace long term court orders to progress more quickly to restoration, adoption and guardianship.
- Introduction of guardianship order by consent in cases where parents are able to decide who can best care for their child(ren) to reduce the length of the court process.
- Changes to the adoption approval process by the Supreme Court to allow authorisation by legal guardians.

Practice frameworks and standards

The development of practice frameworks and standards across the child protection and OOHC system is overseen by the Office of the Children's Guardian and DCJ.

In 2015, the Office of the Children's Guardian published the NSW Child Safe Standards for Permanent Care based on the statutory responsibilities of OOHC and adoption service providers set out in the *Children and Young Persons (Care and Protection) Act 1998*, the *Adoption Act 2000*, and relevant regulations (Office of the Children's Guardian, 2015). The Office of the Children's Guardian oversees the OOHC and adoption service providers accreditation process, for which the NSW Child Safe Standards establish the minimum requirements. All PSP service providers must hold the OOHC accreditation, while the adoption accreditation is only required for PSP service providers delivering adoption services.

DCJ developed internal NSW Practice Framework in 2017 (Department of Family and Community Services, 2017) followed by Practice Framework Standards in 2020 (DCJ, 2020) to guide how child protection and OOHC practitioners in NSW work with children and families by establishing practice principles, values and standards.

DCJ does not currently recommend the use of any specific practice frameworks to guide PSP service providers' approach to working with children and families. Instead DCJ suggests that PSP service providers strengthen their ability to achieve permanency and wellbeing outcomes by selecting their own evidence-based practice frameworks.

What changed with PSP: Practice framework and standards

PSP has not yet introduced changes to practice frameworks and standards governing the delivery of OOHC services by PSP service providers - as practice frameworks and standards from the Office of the Children's Guardian and DCJ were in place before the introduction of PSP. DCJ has commissioned the NSW Parenting Research Centre to co-design a PSP Permanency Practice Framework with PSP service providers. The PSP Permanency Practice Framework is being developed to support the work PSP service providers perform on cases

with restoration, guardianship and adoption permanency goals. Refer to the PSP implementation overview presented at the end of this chapter for further details.

Case Management Policies

The Permanency Case Management Policy and associated Practice Rules and Guidance was developed by DCJ to shape case management practice across NSW's child protection and OOHC system. It is supplemented by the Aboriginal Case Management Policy, a distinct and complementary case management policy, developed collaboratively by Aboriginal communities, AbSec and DCJ, to be applied alongside the Permanency Case Management Policy (DCJ, 2020).

The Permanency Case Management Policy is designed to:

- Explain DCJ's approach to achieving safety, permanency and wellbeing for vulnerable children.
- Clarify the roles and responsibilities of DCJ and service providers through the child protection and OOHC system.
- Provide a set of rules and practice guidelines to translate the roles and responsibilities into a set of minimum requirements DCJ and service providers are expected to meet in working collaboratively to ensure the functions, processes, and decisions that make up the child protection and OOHC system are implemented effectively.

The Aboriginal Case Management Policy sets out an operational framework for Aboriginal-led and culturally embedded case management practice to safeguard the best interests of Aboriginal children that focuses on 'delivering services aligned to family need, applying "downward pressure" with respect to identified risks, diverting families from more intensive or intrusive interventions and strengthening supports to reduce risk of harm and promote healthy development' (NSW government, 2018). The policy provides a set of rules and practice guidance outlining expectations, roles and responsibilities of practitioners across the operating functions contained within the continuum of support across 'three interconnected segments: Aboriginal community response (lowest risk), Aboriginal family strengthening, Aboriginal child safety (high level of risk)' and incorporates the delivery of universal services, family preservation, restoration, out-of-home care (OOHC) and after care services.

What changed with PSP: Case Management Policies

The Permanency Case Management Policy was developed as part of PSP to provide a guide for embedding permanency placement principles across the system. The Aboriginal Case Management Policy was developed independently in parallel to PSP to provide guidelines on how to adapt the Permanency Case Management Policy to meet the needs of Aboriginal children, families, and communities. Refer to the PSP implementation timeline presented at the end of Section 2 for further details.

Funding model

Under the PSP funding model, DCJ funds PSP service providers to deliver contracted services and placement capacity obligations specified in the program requirements set out in the PSP contract. The PSP funded service providers are paid in line with the PSP payment structure based on the number and characteristics of the cases they manage.

Program requirements and documentation

The services funded under the PSP contract are referred to as PSP funded services. All the PSP funded services are governed by the program requirements, set out in the PSP contract, which specify the set of conditions, service requirements and capacity requirements to be met by PSP providers and the contractual implications of not delivering accordingly. The program requirements are set up as contractual requirements specified in a funding deed, Program Level Agreements (PLAs) and the relevant legislation, and DCJ policies and guidelines.

Payment structure

Services

Funding for delivering services under the PSP model is determined at the case level and according to a case's permanency goal, placement type, child needs and some pre-specified case characteristics. The funding per case is allocated across four service payment package categories. Each case is assigned one package from the three core package categories which are the case plan goal packages (permanency goal), baseline packages (placement type) and child needs packages (based on assessed level of need). The case plan goal packages deliver additional funding over a two-year period to cases with restoration, guardianship and adoption permanency goals. The final category, Other Specialist Packages, covers all additional payments which are allocated according to eligibility criteria. These packages cover funding for cultural planning and support, leaving care planning and support, establishing large sibling group placements, and additional care support and complex needs. The service package structure is illustrated in Figure 2.1 below.

Temporary care arrangements are the only services provided by PSP providers under PSP policy and guidelines, which are not covered under the PSP funding model. This service is instead provided under a fee for service payment structure (refer to the Voluntary OOHC: Temporary Care Arrangements overview).

Pooling of funds

PSP service providers are expected to pool funds from different cases together to reallocate unused funding from cases to cover the funding gaps that occur in other cases. Pooling of funds provides flexibility to account for the changes in a case's resource requirements and complexity which are likely to occur over time.

Placement capacity payments and referral refusal abatements

The PSP funding model includes payments to PSP service providers to fund their provision of placement capacity, through recruiting and maintaining a pool of carers. Placement capacity payments are paid to PSP service providers as a fee per vacant placement. The number of empty placements is calculated as the difference between the number of actual placements and each provider's contacted placement capacity. The PSP contracts stipulate that PSP providers should retain a minimum of a three per cent buffer between their actual and contracted placement volumes and, if vacancies are higher than three per cent, the agency is compensated for the actual number of vacancies. The placement capacity payments are bundled with abatements designed to be issued when agencies do not meet their contractual requirements of accepting referrals for an immediate placement within a four-hour deadline where they have funded placement vacancies.

Figure 3.1 Overview of PSP packages

Case Plan Goal Packages	+	Baseline Packages	+	Child Needs Packages	+	Other Specialist Packages
*Family Preservation**		Foster Care		Low Needs		Cultural Plan (Aboriginal)
*Relative/Kinship (Preservation)**		Aboriginal Foster Care		Medium Needs		CALD
Restoration/Guardianship/ Adoption		Supported Independent Living		High Needs		15+ Years Old Reconnect
Long Term Care		Therapeutic Sibling Option Placement				Leaving care
		Intensive Therapeutic Care Home				4+ Sibling Placement Option
		Therapeutic Supported Independent Living				Complex needs
		Therapeutic Home Based Care				Legal adoption
		Intensive Therapeutic Care Significant Disability**				
		*Case Coordination (Preservation)**				
		Case Coordination (Not in placement)				
		Case Coordination (Post Permanency Support)				
		Intensive Therapeutic Transitional Care				

** Intensive Therapeutic Care Homes (ITCH) and Intensive Therapeutic Care Significant Disability (ITC-SD) are separate to this funding model*
***A standalone package available on a case-by-case basis for up to six months*
****These packages come into effect from 1 July 2023*

Payment rates

DCJ sets the payment rates annually and introduces new payment types to address funding gaps identified and publishes detailed up to date information on their Funding and financial support web page. Refer to the Business Rules: Eligibility criteria for PSP services Packages document (DCJ, 2020) for a complete overview of the package structure.

PSP changes: Funding model

PSP introduced a shift from placement-based funding (i.e., bed per night payments) to a service-based funding model for children in OOHC – that is, PSP providers receive funding based on the services provided to children in OOHC.

The new funding model set new service delivery expectations for the sector and re-assigned responsibility over the delivery of certain functions. The new functions assigned

to PSP service providers included responsibility for achievement of permanency outcomes, working with parents, earlier case management and, collaborating more closely with DCJ and other services to meet children and families' needs. The introduction on individualised packages allocated according to eligibility criteria changed the roles of DCJ contract management and Child and Family District Units (CFDUs) and added administrative effort from reviewing and approving application forms.

The PSP placement capacity payments represent a new payment structure but not a new payment type. Prior to PSP, vacancy payments were paid to providers who had 95 per cent of their funded capacity filled and providers were compensated by being paid for 100 per cent of their contract volume.

Functions, processes and decisions overview

This section presents an overview the PSP functions and services as part of the NSW child protection and OOHC system to highlight which components of the overall system PSP represents and how PSP is connected to the other system components. The changes introduced by PSP are explained for each of the functions, which are described in terms of decisions, actions, roles, guidelines, resources and potential outcomes. These are described further below.

Reporting and assessing child protection concerns

The function which oversees the entry point into the system, reporting and assessing the child protection concerns, presented in Table 2.2, is not part of PSP. The decisions and outcomes of this function determine which families will be involved with PSP funded services and represents the initial stages of involvement with the child protection and OOHC system for families.

Table 3.2 Overview of the reporting and assessing child protection concerns function

Description	Roles	Guidelines and resources	Possible outcomes ***This includes outcomes linked to decisions made and actions taken***
Reporting and prioritising child protection concerns (ROSH report) stage			
Child protection concerns are raised as Risk of Significant Harm (ROSH) reports. They are usually triggered by a report or notification made to the Child Protection Helpline	DCJ Child Protection Helpline, Mandatory Reporters	**Structured Decision-Making (SDM) tools** Mandatory Reporter Guide (MRG) an interactive tool is available to Mandatory reporters to determine whether to report, Screening and Response Priority Tool (SCRPT) **Guidelines and business rules** Maximum response time set according to Screening and Response Priority Tool	A decision on whether child is at ROSH A referral to Family Preservation program or other services can be made if child(ren) is not found to be at ROSH ROSH report transferred to a Community Service Centre (CSC) or Joint Child Protection Response Program via the Joint Referral Unit[27]
Triage allocation of the ROSH report stage			

[27] If the report evidence of sexual abuse, extreme neglect or serious physical injuries

Description	Roles	Guidelines and resources	Possible outcomes ***This includes outcomes linked to decisions made and actions taken***
CSC assess the report and gather additional information as required	Community Service Centre, DCJ caseworker	Guidelines and business rules According to relevant internal DCJ guidelines	A decision on whether to investigate further by allocating the case to a field officer A referral to Family Preservation program or other services can be made if the case is not allocated to field officer
Safety assessment stage			
DCJ caseworker to conduct internal pre-assessment consultation and a safety assessment during a home visit	DCJ caseworker, Family members	Assessment tools Safety Assessment, Risk Assessment and Risk Re-assessment tools (SARA SDM)	Next steps based on safety assessment outcome: • if 'safe' complete a risk assessment looking at risk of future harm, • if 'safe with a plan' develop a safety plan, • if 'unsafe' remove the child from the home
Develop safety plan stage			
DCJ caseworker and family develop a safety plan together which addresses safety concerns in the initial assessment with adequate and immediate safety interventions	DCJ caseworker, Family members	Guidelines and business rules Plan to be reviewed in line with review guidelines. Assessment tools SARA SDM	Safety plan in place detailing clear actions to be taken to ensure safety requirements are met
Initial risk assessment phase			
DCJ caseworker to conduct a risk assessment which examines the likelihood that the child will be abused or neglected in the next 12–18 months and a review of the safety assessment to assess whether it is safe for the child to stay at home	DCJ caseworker, Family Members	Guidelines and business rules Risk assessment must be conducted within 30 days of the initial safety assessment. Assessment tools SARA SDM	Choose next steps based on risk assessment outcome: If risk level is less than 'high' the case can be referred to a non-PSP funded family preservation program (e.g., Brighter Futures, Targeted Early Intervention Program) and not considered 'in need of care and protection'. If risk level is 'high' or 'very high' the child is considered 'in need of care and protection' and a case plan called a family action plan based on their risk assessment is required

Description	Roles	Guidelines and resources	Possible outcomes ***This includes outcomes linked to decisions made and actions taken***
			• if the child remains at home the case plan goal is set to 'Family Preservation, • if the child is removed the case plan goal is set to 'Restoration'

The initial risk assessment phase is followed by risk reassessment, described below.

Risk reassessment

Risk reassessments, presented in Table 2.3, are conducted as part of standard business rules across different functions including the reporting and accessing child protection, the family preservation, restoration functions, or as a response to a change of circumstances including newly received ROSH report.

Table 3.3 Overview of the risk reassessment function

Risk reassessments			
Conduct risk reassessment to determine whether the case should be kept open and a safety assessment to determine whether the child is safe at home	DCJ caseworker, PSP provider caseworker	**Guidelines and business rules** PSP Family Preservation Framework (if PSP funded placement) **Tools** SARA SDM **Rules** 90 days after the completion of the family action plan and every 90 days after that or soon if circumstance change	Choose next steps based on risk assessment outcome: • if the risk level is low or moderate and safety assessment outcome is 'safe' the case can be closed, • if the risk level is high or very high the case remains open • if the risk level if high or very high over two reassessments the caseworker should consider a higher level of intervention such as Parent Responsibility Contract, Registered Care Plan Or Application for a Care Order

Family Preservation

The Family Preservation function (see Table 2.4) represents the first level of intervention from DCJ to support families with making sustained changes to address the child protection risks identified. It oversees the delivery of family preservation services and the ongoing reassessment of child protection concerns. This function follows the assessment of child protection concerns where risk was assessed as 'high' or 'very high' risk and the safety in the home was assessed as 'safe' or 'safe with a plan'.

Table 3.4 Overview of the family preservation function

Description	Roles	Guidelines and resources	Outcomes *This includes outcomes linked to decisions made and actions taken*
Case Management including developing a Family Action Plan			
DCJ start casework with family and develops the family action plan, DCJ or PSP provider manage the case	DCJ caseworker, PSP provider caseworker	**Guidelines and business rules** PSP Family Preservation Framework, PSP Family Preservation business rules including minimum review requirements **Practice tools** Family Group Conference, Family Finding	A decision over allocating a case to PSP provider as part of PSP Family Preservation Program Family Action Plan setting out all actions required to achieve the family preservation and to deliver tailored services and support
Delivering family preservation services			
Oversee the provision of services and deliver services in line with the Family Action Plan. This includes family support and family group consultations	DCJ caseworker, PSP providers, other funded providers	**Guidelines and business rules** PSP Family Preservation Framework **Resources** Non-PSP funded family preservation programs, external programs and services	Referrals to suitable services and programs Child and family members engagement with new services and programs to support their family preservation efforts Assessments, progress updates and recommendations from the professionals delivering services and support
Making recommendations and decisions over Family preservation outcomes			
The case management of cases involves making recommendations concerning family preservation outcomes in line with the child's best interest	DCJ case worker, PSP service provider	**Structured Decision-making** SARA SDM, Family Action Plan monitoring **Tools** Parent responsibility contract[28]	Recommendation and justification to be shared with the Children's Court and family members

What changed with PSP: Family Preservation

The PSP Preservation program is the PSP component which targets the family preservation segment of the system. It introduced the option for DCJ to transfer primary case responsibilities from DCJ and PSP service providers in family preservation cases. The PSP Preservation program represents the only family preservation services delivered by service

providers with OOHC Accreditation by the Office of the Children' Guardian. When PSP service providers deliver family preservation case management and services, they are expected to demonstrate fidelity to the PSP Family Preservation program by delivering on the core components identified in its program logic (DCJ, 2019).

The family preservation services delivered by DCJ funded programs outside of PSP[29] were not replaced by PSP and their objectives and remained the same pre-PSP and post-PSP. An overview of the non-PSP funded family preservation services are presented in Appendix A.1. The cases referred to PSP Family Preservation packages should constitute cases with higher risk of entering care than the cases eligible for non-PSP funded family preservation programs or cases for which these programs are considered unsuitable (e.g., cases concerning Aboriginal and CALD children). This allows PSP service providers to increase system wide family preservation service capacity and allows PSP providers to continue working with the family via PSP restoration packages if a preservation is unsuccessful.

PSP Family Preservation program overview

The goals of the PSP Family Preservation program are defined in the PSP Family Preservation framework in terms of a primary goal: "more children remain safe at home with their families, are healthy and thriving, and have improved long-term outcomes" and a set of secondary goals understood to collectively contribute to progress toward the primary goal (DCJ, 2019). The secondary goals focus on the provision of culturally safe and responsive services, effective and tailored interventions and support for parents, sufficient support for children to address their wellbeing and educational needs and fostering an environment which empowers children and parents. The PSP Family Preservation program, as described in PSP Family Preservation framework, recognises the value of Aboriginal culture as a protective factor and was designed to be largely guided by the Aboriginal Child Placement Principles (DCJ, 2019).

The PSP Family Preservation framework explains that there is a lack of clarity on what works and how to deliver the factors associated with success in family preservation services, especially for CALD and Aboriginal families. It guides the delivery of family preservation practices by encouraging uptake for evidence-based services, summarising factors contributing to positive outcomes published in relevant reviews and evaluations and by referencing other DCJ documents including the PSP Family Preservation logic model and NSW practice framework. Consequently, the PSP Family Preservation framework does not provide an operational framework for PSP providers to follow. The recommendations in the framework are vague (e.g., 'intensity has been found to increase health outcomes') and do not translate into actionable guidelines which inform how PSP service providers should focus their time and efforts. The framework's reliance on PSP service providers adopting evidence-based practices and developing their own approach within a context where the evidence base is very sparse, makes the PSP Family Preservation program less evidence-based than the non-PSP funded Family Preservation programs.

Voluntary OOHC: Temporary Care Arrangements

Temporary care arrangements (Table 2.5) represent the least intrusive OOHC care arrangement option used by DCJ to support families with making sustained changes.

The decision to enter temporary care arrangements is a voluntary decision made by parents. It is considered suitable only when DCJ does not hold significant concerns over a

[29] The non-PSP funded family preservation programs include Brighter Futures, Youth Hope, Newpin, Intensive Family Preservation (IFP), Intensive Family Based Services (IFBS), Resilient Families, Multisystemic Therapy – Child Abuse and Neglect (MST-CAN®) and Functional Family Therapy – Child Welfare (FFT-CW®)

child's safety. Temporary care arrangements are always paired with restoration as a case plan goal, can only be arranged for an initial period of three months with the possibility of a three-month extension and must be entered voluntarily by all parties.

Table 3.5 Over of the temporary care arrangements function

Description	Roles	Guidelines and resources	Outcomes ***This includes outcomes linked to decisions made and actions taken***
Case Management: pursuing restoration as case plan goal			
Preparation of case plan, case planning, case plan review, risk and safety reassessments	DCJ caseworker	**Guidelines and business rules** Temporary Care Arrangement Quick Guides for PSP providers **Tools** Restoration assessment	Search for suitable kin placements Assessment of potential kin placements Arrange foster care placement if required A decision to restore, extend or apply for a court order (i.e., transfer to statutory OOHC)
Providing and supporting placements			
DCJ finds a PSP provider to provide a foster carer on a 'fee-for-service' basis, if kinship placement could not be arranged. DCJ or service provider who set up the placement, then delivers ongoing support to child and carers	DCJ caseworker, PSP service providers, non-PSP service provider	**Guidelines and business rules** Temporary Care Arrangement Quick Guides for PSP providers **Funding** Funded on a 'fee-for-service' basis and not as part of PSP contracted volumes. The day rate is equivalent to PSP package payments	Find foster care placement if required Deliver services and support to child Deliver services and support to kinship carers and foster carers

What changed with PSP: Temporary Care Arrangements

Prior to PSP, service providers delivered temporary care arrangement placements as part of their contracted volumes. Under PSP, Temporary care arrangement services are not included in the PSP service model and not funded under PSP contracts (i.e., excluded from PSP service providers' contracted volume). Instead, temporary care arrangements are funded under a fee for service payment structure which includes service requirements and associated payments for PSP service providers delivering services.

Statutory OOHC overview

A child's entry into statutory OOHC is marked by DCJ lodging a care order or an emergency care and protection order application with the Children's Court requesting it make a finding that the child is in need of care and protection and subsequently grant parental responsibility to the Minister. This section presents the function and processes which make up the statutory OOHC system. These functions and processes can run alongside each other (e.g., legal and permanency planning), be completed multiple times as circumstances change (e.g., placement set-up) or be required continuously if a case is open (e.g., case planning and service delivery). The PSP program description, PSP contracts

and Permanency Case Management policies outline the roles and responsibilities, guidelines, service requirements and business rules governing this function.

Placement set-up in statutory OOHC

The placement set-up process is triggered when a child enters care or when a placement breaks down. It includes the following core activities:

- Search for suitable relative or kin carers.
- Determine whether a foster carer is required.
- Make referral to transfer the case to a PSP service provider.
- PSP service provider to accept or decline the referral request.
- Search for suitable foster carer from the pool of available approved foster carers (for foster care arrangements only).
- Conduct carer assessment and approval (for kinship care arrangements only).
- Primary case management responsibility allocation.
- Placement transition.

Roles: Placement set-up in statutory OOHC

- DCJ Child and Family District Units (CFDU) are responsible for placement set-up unless the primary case management responsibilities have already been transferred and it was agreed that the PSP service provider would complete the activities.
- DCJ CFDUs oversee the process of allocating cases and transferring cases to PSP providers, the allocation includes new entries and re-entries into care and transfers from one PSP provider to another and are governed by PSP contract requirements. DCJ CFDUs consider PSP service provider's capacity and aim to maximise the suitability of the match between the case and the PSP providers when allocating a case. Some of the guidelines and considerations governing the allocation process include allocating Aboriginal children to ACCOs, placing siblings with the same PSP providers and PSP service providers' capacity to take on a case within the required timeframe and provide a suitable carer.
- DCJ CFDUs pass on all the relevant information including court documents, assessments, and case plans when a case is transferred.
- DCJ CFDUs transfer all foster care cases to PSP service providers as DCJ no longer delivers or recruits their own foster carers.
- DCJ CFDUs (in collaboration with CSCs) transfer a portion of the kinship care cases to ACCOs, as DCJ retained responsibility over finding kin carers. DCJ CFDUs determine which case to transfer according to the case's history, the complexity of the case, the legal requirements of the case and the way a particular DCJ CFDU operates.

The changes introduced by PSP: Placement set-up in statutory OOHC

- PSP changed the rules and guidance DCJ CFDUs follow to allocate primary case responsibilities. The responsibility for setting up placements remains with DCJ unless a PSP service provider already holds primary case responsibilities.
- Earlier transfer of primary case management responsibilities to PSP service providers. Under PSP, transfers take place on commencement of a placement with a PSP Provider. Prior to PSP, transfers only happened after a final order was issued by the Children's Court.

- A higher proportion of primary case management responsibilities to be transferred to PSP service providers with regards to foster care placement and kinship care placements.

Permanency planning, case management and casework in statutory OOHC

This function includes all the aspects of casework aimed at achieving permanency for children. The core activities include:

- Permanency planning: selecting a permanency goal in line with the legislated placement principles, developing a case plan to pursue the permanency goal selected, reviewing the suitability of the permanency goal.
- Permanency casework: family finding, family group consultation, family and case history gathering, gathering advice and assessments from educational, health and social care professionals, restoration, guardianship and open adoption assessments.
- Decision making, consultation and monitoring: mandatory collaborative DCJ and PSP service provider case reviews, structured decisions making processes and forms.
- Supporting legal processes:
  - Documenting case work, conducting assessment, working with parents and other family members to gather information and opinions, developing case plans with inputs from children, parents, carers and family members and educational, health and social care professionals.
  - Supporting children, families and carers through the legal process.

In addition, DCJ and the PSP service providers accredited by the NSW Children's Guardian to provide adoption services provide a range of specialised services aimed at facilitating open adoptions, these include:

- Local adoption programs.
- Open adoption hotline to provide information and guidance over the adoption process to carers and others.
- Adoption support to children and family members.
- Specialist understanding of the legal process through the Supreme court.

Roles: Permanency planning, case management and casework in statutory OOHC

- PSP service providers with primary case management responsibility oversee the delivery of these activities.
- DCJ collaborate with and provide support to PSP service providers.
- DCJ CFDU approve the initial selection and changes of case plan goal.
- Open Adoption and Permanency Services unit, a specialist unit within DCJ, oversee the intercountry and local adoption programs and a function that supports the progression of OOHC adoption matters.

The changes introduced by PSP: Permanency planning, case management and casework in statutory OOHC

PSP represents a full-scale operationalisation of Permanent Placement Principles and permanency planning across the system. It set out to embed and prioritise permanency planning and casework from the time a child enters care. The casework required to achieve permanency is different in nature to the work required to maintain a stable placement, to account for this PSP introduced the following new role and practices:

- Permanency Coordinators: the role of Permanency Coordinators was introduced to facilitate and coordinate the new PSP packaged care service model and help embed the reform.
- Permanency case plan goal: a new requirement to assign a formal permanency case plan goal to each statutory OOHC case. This requirement attempts to ensure early and explicit identification of the most appropriate permanency goal for all cases and that case plans are developed in alignment with the permanency goal assigned. As part of PSP, DCJ enforces an expectation that permanency outcomes are achieved within a two-year timeframe (see PSP funding model description above). The permanency case plan goal, in line with the permanent placement principles, is set to restoration as a default for new entrants to OOHC, until a Case plan is completed to support the work required by the Court to assess restoration and determine if it is realistic or not.
- Permanency case plan goal reviews: a new requirement for DCJ and PSP service providers to conduct collaborative permanency case plan goal reviews in line with minimum requirements over frequency. The minimum requirements are set according to the permanency goal being pursued; 3 monthly for preservation; 6 monthly for restoration, guardianship, adoption; and 12 monthly for long term care. The permanency case plan goal reviews involve a meeting between DCJ permanency coordinators, case workers from the PSP provider, as well as additional DCJ and PSP provider staff who are involved in the case if required. The aim of the reviews is the consider the appropriateness of the case plan goal assigned to a case, the progress toward the permanency goal and the challenges impacting the case to come up with clear recommendations for the PSP provider to follow.

Placement support in statutory OOHC

Placement support refers to the case management and casework delivered with the aim of ensuring safety and stability of existing placements and the delivery of adequate support to the children and carers in the placement. It includes the following activities:

- Developing and maintaining OOHC case plans, cultural plans, behaviour support plans, health plans, education plans and NDIS plans, in line with mandatory requirements and case characteristics
- Carer assessments
- Home visits assessments including assessing safety in placement
- Securing funding
- Crisis management
- Supporting carers, mentoring, coaching and emotional support
- Supporting the child(ren) in placement
- Life story work
- Referrals to services
- Respite and emergency care provision
- Casework to prevent placement breakdowns or to manage placement breakdowns when they occur
- Carer reviews and reportable conduct reviews

Roles: Placement support in statutory OOHC

Placement support responsibilities are taken on by the PSP service provider or the DCJ CSC who holds primary case management responsibility.

The changes introduced by PSP: Placement support in statutory OOHC

PSP did not substantially change the way this function is delivered. Some changes to placement support services were brought on by the introduction of a new funding model, new processes, focus on permanency and the release of new policies, business rules, guidelines and service requirements across the system.

Cultural planning and support in statutory OOHC

The function is tasked with planning and delivering services and casework to support the connection to family, kin, community and culture for all Aboriginal children in care. The activities covered include:

- Cultural planning including the development and review of cultural care plans and cultural support plans
- Gathering information on family history
- Embedding culturally informed practice throughout case management
- Genealogy work
- Delivery of cultural activities
- Participation in cultural trips and program including visiting Country, family members and culturally significant places.

Roles: Cultural planning and support in statutory OOHC

The cultural planning and support activities are taken on by the PSP service provider or the DCJ CSC who holds primary case management responsibility.

The changes introduced by PSP: Cultural planning and support in statutory OOHC

PSP introduced specialist packages to fund the delivery of additional cultural planning and support for Aboriginal children and to fund the targeted recruitment, training and support of CALD carers. It is unclear to what extent this is different to the level of funding received by service providers for the provision of cultural planning and support before PSP. It is important to consider the development of the Aboriginal Case Management Policy and any associated ACCO sector capacity building work delivered in parallel to PSP when examining the way this function as changed since PSP was introduced.

Service delivery in statutory OOHC

This function captures the delivery of all services, supports and programs delivered by DCJ, PSP service providers and external education services, health care and social care providers used to meet the needs of children and families involved with NSW's child protection and OOHC system. These services make up the system's service care continuum.

Roles: Service delivery in statutory OOHC

The management and coordination of service delivery is handled by the organisation who holds primary case management responsibilities, as described in the placement support overview. The PSP service provider decide to arrange the delivery of services through their own services, DCJ funded programs or services and other suitable services available.

The changes introduced by PSP: Service delivery in statutory OOHC

PSP introduced package-based funding for PSP service providers which sets service requirements according to case characteristics including cultural characteristics, level of needs of the child and family members and age of the child. Additional PSP brought on changes to the responsibilities and guidelines governing the approach to case managing

service delivery (i.e., sourcing evidence-based interventions). The service delivery function itself appears to have remained largely unchanged, as DCJ does not provide guidelines or advice on the evidence-based programs and services to be delivered as part of PSP funded service delivery.

Carer recruitment and training for statutory OOHC

This function is responsible for creating and maintaining a pool of trained carers to support restorations, be potential guardians or adoptive parents, permanency carers and provide emergency, short-term and long-term foster care and respite placements. Further, accredited adoption service providers maintain a pool of carers with the intention to adopt across NSW.

Roles: Carer recruitment and training for statutory OOHC

The responsibility of recruiting and training carers sits with PSP service providers, who are required to provision placements and carers in line with their PSP contract arrangements.

The changes introduced by PSP: Carer recruitment and training for statutory OOHC

As part of PSP, DCJ allocated the full responsibility for recruiting and training carers to PSP service providers, when in the past both service providers and DCJ maintained pools of carers. Consequently, and in line with PSP guidelines, most DCJ districts stopped maintaining their own pool of emergency, respite and foster care carers. This differs across districts and some districts, in response to local demand, have trialled keeping a small pool of emergency carers.

Prior to PSP, the agency Connecting Carers was contracted by DCJ to deliver carer support and advocacy services across the state but did not provide carer recruitment services.

As part of PSP, DCJ contracted My Family Forever (MFF) to deliver state-wide carer recruitment services to support PSP Providers own recruitment strategies. This occurred in the form of the MFF carer program established to support recruitment of emergency carers, respite carers, short/medium/long term foster carers, relative/kin carers, restoration carers, guardians, and adoptive parents. The MFF carer program runs carer information sessions, receives and reviews enquiries from potential carers, provides follow-up information, conducts initial screening of carers and allocates them to PSP providers for further assessment, training, and authorisation.

The MMF carer program started providing additional services subsidised by DCJ during Covid, including online training sessions for new and prospective foster carers and relative kinship carers. MFF also provides carer support groups, 1:1 carer coaching, a carer portal and a range of in person and online trainings (including understanding trauma, parenting traumatised children, emotional regulation, challenging conversations and coping when a placement has ended).

Legal process

The legal system and Children's Court are an important part of the child protection and OOHC system and the legal process detailed in Table 2.6 below drives a significant portion of the practices and casework requirements.

Table 3.6 Over of the legal process function

Description	Roles	Guidelines and resources	Outcomes ***This includes outcomes linked to decisions made and actions taken***
Care order application			
Apply for a care order, appear in front of the court to request interim order, prepare court documentation	DCJ caseworker, Children's Court	Guidelines and business rules Legislation (i.e., all relevant Acts and principles) Tools SARA SDM	Report explaining the reasons for the application, evidence of the support provided to prevent the removal and ensure wellbeing and safety of the child A decision over whether to grant interim care order or not If an interim order is granted, the court generally requests a Summary of the Proposed Plan for the Child from DCJ and evidence in reply to the application from birth parents
Establishing the case			
Court to determine whether the child is in need of care and protection. Family members to contest this decision if they are in opposition	Children's Court Magistrate, DCJ caseworker, Family members	Guidelines and business rules Legislation (i.e., all relevant Acts and principles) Practice tools Dispute resolution conference	Summary of the Proposed Plan for the Child from DCJ Evidence in reply to the application from birth parents A decision from Children's Court over whether a child is in need of care or not
Making decisions over placement arrangement			
Placement hearings are conducted, where Children's Court reviews and considers family member evidence, DCJ's recommendations, case plans and other court documentation provided by DCJ. PSP providers support DCJ with the preparation of the case plan and supporting documents	Children's Court Magistrate, DCJ caseworker, Family Members, PSP providers	Guidelines and business rules Legislation (i.e., all relevant Acts and principles) Practice tools Dispute resolution conference, Court may refer the parties to an external alternative dispute resolution (ADR), Restoration assessment	Final care plan, permanency plan, cultural care plan, family information, completed restoration/guardianship assessment Court request for additional information and case management, A decision over whether to grant the court order being sought (i.e., any relevant interim or final orders) A decision to grant final order if the Children's Court finds that principles set out in relevant legislation were addressed adequately
Monitoring, reviewing and appealing court orders			

Description	Roles	Guidelines and resources	Outcomes ***This includes outcomes linked to decisions made and actions taken***
DCJ monitors and manages the implementation of courts orders. Children's Court to monitor implementation of orders and oversee appeals and reviews of court orders	Children's Court Magistrate, DCJ caseworker	Guidelines and business rules Legislation (i.e., all relevant Acts and principles) Practice tools Dispute resolution conference, Court may refer the parties to an external alternative dispute resolution (ADR)	Report detailing progress with regards to the implementation of court orders A decision to issue variation or rescission of care order Identification of court order breaches

What changed with PSP: Legal process
The legislation and consequently the legal process was reformed over time as part of older NSW child protection and OOHC reforms and in preparation for PSP through separate amendments to the legislation delivered (refer the section legislation overview above).

DCJ cannot delegate certain statutory powers and responsibility to PSP providers including complying with the statutory case planning timeframes and demonstrating to the court that it has managed the case according to permanency and Aboriginal placement principles. This is true for all cases including cases where primary case management responsibility sits with a PSP service provider.

Primary case management responsibility is transferred to services providers earlier under PSP which increased PSP service providers' level of involvement of across the legal process. The period before a final order is granted is particularly impacted, as prior to PSP, primary case management was not transferred to a service provider until a final order was made by the Children's Court. The type of casework DCJ completes following a child's entry to care and before a final order is granted has changed. DCJ now focusses on court work, while PSP service providers focus on the casework with children, parents and carers. However, DCJ and the Children's Court retain a high level of input in case management decisions, even when primary case responsibility sits with a PSP service provider.

3.2.7. Activities linked to PSP

This section provides high level overviews of activities taking place alongside the implementation of PSP, with the aim of establishing a context within which PSP could be implemented successfully to provide insights on how external reforms are linked to PSP. The activities themselves are not in scope for this evaluation and thus only minimal information is included in this report. Please note, the suitability, timelines and implementation outcomes of the activities described in this section could have affected PSP's ability to achieve its objectives.

Building capacity in the Aboriginal controlled service providers

PSP seeks to increase the delivery of cultural support and culturally safe practices to tackle the overrepresentation of Aboriginal children in OOHC. The allocation or shift of primary case management responsibility of cases involving Aboriginal children to Aboriginal Community Controlled Organisations is recognised as key to this effort.

Additional projects and resources are being delivered alongside PSP to build up Aboriginal Community Controlled Organisations' (ACCOs) capacity to deliver effective child protection and statutory OOHC services. This work includes the development and on the ground implementation of the Aboriginal Case Management Policy and is supported by other actions such as DCJ's response to Family is Culture Report, and progress toward Closing the Gap targets and achievement of Premiers Priorities.

OOHC Accreditation

Agencies that are accredited by the NSW Children's Guardian to provide statutory out-of-home care services are known as designated agencies. Only designated agencies accredited by the NSW Children's Guardian can provide out-of-home care in NSW.

Panel of Independent Assessors

DCJ set up a panel of Independent Assessors to be engaged by DCJ and PSP service providers to support permanency planning and deliver restoration, guardianship and open adoption assessments when needed.

ChildStory

The implementation of ChildStory is the outcome of a major system redesign undertaken as part of the Safe Home for Life reform. ChildStory was designed to be the only source of information on children and families in the child protection and OOHC system held by DCJ. The information captured in ChildStory includes case and family characteristics, safety and risk assessments, child's needs assessments, PSP packages information, decision outcomes and rationale, family history, family relationships and copies of certain documents including case plans and case review forms. ChildStory also provides placement broadcast system to send placement requests to PSP service providers and contract management functionality.

DCJ implemented ChildStory at the same time as PSP. Challenges in the implementation of this major new IT system across DCJ had corresponding impacts on PSP information quality. ChildStory does not integrate with PSP service provider's information management systems, which means that PSP services providers are required to complete both the ChildStory data requirements and their internal data processes.

3.2.8. Other contextual factors

COVID-19 pandemic

Beginning in March 2020, the COVID-19 pandemic led to the introduction of state-wide social distancing, isolation and lockdown orders, thus impacting the child welfare sector and the delivery of PSP. These restrictions negatively impacted the amount of time caseworkers and assessors were able to spend time with children and families. Such impacts were ongoing at the conclusion of the study period in 2021. This means that there is considerable overlap of PSP service provision in the evaluation (1st October 2018 and 31st December 2020) with COVID restrictions (March 2020 to 31st December 2020), which would not have been present for historical comparison groups used in the evaluation. That said, throughout this time, caseworkers continued to provide services to vulnerable children and, where necessary, provided these services virtually.

3.3. PSP implementation overview

PSP is a complex reform program which was implemented across all districts and local areas in NSW. As expected in a large and complex system reform compromising of changes affecting every aspect of the child protection and OOHC system, the implementation phase was prolonged, adaptive, and iterative. In practice, the implementation process involved initiating reform changes or adaptations with planned implementation support, monitoring implementation process, identifying barriers and enablers that emerged and adapting PSP's operational structure, resources, and policies to address the barriers.

This evaluation makes a distinction between how PSP was designed, as reported in the section above, and how PSP was implementation and adapted, presented in this section. This section sets out to document what was implemented and when, as well as how and why PSP was adapted during the implementation.

The implementation period included a nine-month transition phase (October 2017 – June 2018) before full implementation of PSP commenced (July 2018). A timeline detailing the implementation of PSP, including the launch of delayed PSP components and the roll out of adaption in conjunction with the data collection timeline is presented at the end of this chapter.

The information detailed in this section was collected as part of PSP document reviews, interviews conducted with DCJ staff involved in the implementation of PSP and through informal discussions with the PSP implementation team.

3.3.1. Implementation planning

Implementation planning for PSP consisted of the development of a state-wide implementation strategy. This was complemented by detailed implementation plans developed by each individual DCJ District, and PSP providers. These plans detailed the actions planned to meet a set of milestones during both the PSP transition period and full implementation period.

The state-wide implementation strategy set out the implementation requirements across all system functions, the implementation interdependencies and the implementation approaches and strategies to be employed across the implementation stages. While the district level implementation plans summarised and tracked the objectives, key activities and the roles responsible for each activity.

The development of implementation plans by PSP providers was a contracted requirement which was coupled with the requirement to submit quarterly implementation plan reports summarising achievements and delays with regards to the transition milestones set out. The contracting requirement did not include guidelines on the way the plan should be structured and completed.

3.3.2. Implementation strategies

DCJ intended to use a set of strategies and resources, described below, to support the implementation of PSP and address the implementation barriers they faced. We are unable to assess whether these implementation strategies were put into place as intended by DCJ, although we can assess at some level the outcomes of these strategies (i.e., what challenges were experienced and continue to be experienced, what services were delivered).

Transition payments to PSP providers

DCJ made transition payments to each PSP service provider to fund the implementation and capacity building activities identified in their implementation planning work. This included adapting their operating structures, systems, frameworks and building up the knowledge base required to be ready to delivery PSP. A Case Plan Goal Supplement Payment was also provided a 'top up' payment during the nine month transition period to fund additional casework aimed at progressing permanency outcomes for the children identified as being able to achieve permanency.

Feedback and improvements

DCJ set out to work collaboratively with stakeholders during the transition phase to identify and address barriers and gaps as they emerged. DCJ further discussed delivery challenges and solutions with PSP service providers to adapt operational business rules and processes iteratively.

Change Management and communication

DCJ developed a change management strategy to support implementation. This strategy focused on identifying changes associated with PSP operation, assessing anticipated impacts of these changes and formulating targeted change strategies to support PSP stakeholders through implementation and business-as-usual delivery. The change management strategy informed the development of a Communications and Engagement Plan, which aligned the communication and stakeholder engagement activities with the change strategies identified.

As part of the communication and engagement activities, DCJ developed and distributed a set of core PSP documentation, including policies, practice frameworks, guidelines, procedures, and forms, to explain and guide the implementation of the PSP core components. These resources defined the different aspects of the system with varying levels of detail and served as instructions to PSP stakeholders. In addition to the core PSP documentation, DCJ distributed a set of posters and videos to introduce and explain PSP's goals and approach to a wider audience across all NSW.

Training, capacity building and support

Permanency coordinators and DCJ district implementation teams were a key source of implementation support for PSP service providers. Permanency coordinators acted as a bridge between the DCJ and the PSP service providers and adapted their role to provide support tailored to each PSP service provider.

DCJ delivered and continues to deliver a range of training materials and resources including Q&A Webinars, factsheets, how to guides and training videos to help PSP practitioners build knowledge and skills to operate effectively and to achieve better outcomes for children and families. Practice support is provided through the PSP Workforce Training and Development Strategy, which DCJ contracted and is delivered by an external provider via the PSP Learning Hub (see PSP Learning Hub overview below).

Additional training was provided through the training resources developed by DCJ partners on case management and practice elements delivered as part of PSP. This included training on restoration practice and the Structured Decision Making (SDM) tool and Aboriginal Case Management Policy based training.

3.3.3. Implementation delivery

This section provides an overview of the core implementation activities and monitoring.

Implementation monitoring and reporting

DCJ Districts reported centrally each quarter on their implementation plans, which was monitored by the DCJ central PSP team, including oversight by the PSP Program Board.

DCJ contract managers formally monitored PSP service provider's progress against their implementation plans as part of monthly contract meetings. In addition, CFDUs monitored the quality of the PSP services delivery during the implementation as part of their assigned responsibilities in the PSP delivery model. These responsibilities include delivering secondary case management and legal services, as well as overseeing the service delivery of case allocation, case reviews, permanency goal reviews, PSP package applications processes.

DCJ does not however record nor have access to information on service delivery outcomes or quality unless it is provided directly by PSP service providers. DCJ's ability to monitor implementation and service outputs was limited by the data requirements set out by DCJ being largely contractual and transactional in nature and by challenges experienced with some of the ChildStory based data generation processes (e.g., inability to track the number of placement requests sent to each PSP service provider).

Outside of the regular data collection and monitoring activities, DCJ completed an internal evaluation of the Permanency Coordinator role, released in June 2020.

Actioning implementation plans

While monitoring processes were in place for implementation plans, it is unclear to the evaluation team to what extent the actions detailed in the implementation plans developed by CFDUs and PSP service providers were completed.

DCJ representatives interviewed stated that the capacity of PSP service providers to deliver the program as intended was unclear initially. During early implementation and through discussions with PSP service providers, it became clear that the capacity building required to deliver PSP as intended was extensive, often difficult to anticipate and complex for many of the PSP service providers. The complexity was driven by the simultaneous introduction of a larger set of changes impacting every aspect of service delivery coupled with a lack of clarity over the implications of the changes for their operational structures, processes and practices.

3.3.4. Adaptions

Since PSP was launched, DCJ and PSP providers have worked together to assess and improve the acceptability, appropriateness and sustainability of PSP as a system. A significant number of PSP policies, processes, funding model features and resources have been adapted to address gaps and challenges that emerged throughout the implementation.

'…over the course of the last three and a half years I think we've plugged many of the gaps.' – DCJ Representative

The key adaptions which took place during the evaluation period are summarised in this section. Please note that DCJ and PSP providers continue to collaborate to improve various PSP components including decision making tools, practice frameworks, training offering, resources and processes.

Funding and contracting

The NSW Government announced additional funding of $12 million in the 2021-22 NSW Budget to establish of a new Permanency Taskforce to support permanency planning and increase the number of adoptions and guardianships throughout the system (NSW Government, 2021).

Referral refusal abatements

According to DCJ representatives, DCJ has not been able to implement the abatements to be issued to PSP providers as a consequence for not accepting placement referrals within the terms of their contractual arrangements. This was reportedly due to not being able to track the number of referrals sent and accepted on ChildStory, as was originally intended.

New Care Model and PSP packages

DCJ has released new PSP packages after the launch of PSP. These packages were created to address funding gaps identified in the original set of packages. The following packages were added:

- Case Coordination - Restoration Support baseline package designed to fund the provision of case support to children who have been placed with their parent/s in accordance with an approved plan but remain under the care of the Minister.
- Additional Carer Support specialist package designed to increase support to children with a range of diagnosed needs and behaviours that require additional carer capacity and case responsiveness. Eligibility criteria is set out in the business rules.
- Case Coordination - Not in Placement baseline package designed to support service providers to continue supporting a child who is not in placement and to work towards returning the child to an authorised placement for up to 6 months.

Additionally, DCJ launched a new Interim Care Model to establish and govern the process of setting up and case managing short-term placement under PSP. As part of the ICM, a new package was released to fund the provision of short-term placement set-up and support.

PSP Learning Hub

DCJ commissioned an external provider to deliver a PSP Learning Hub to address a ‘knowledge gap’ observed in the sector and aims to help the sector build skills and knowledge to support permanency. The Learning Hub comprises of a website with PSP information and resources, online training, face to face training, coaching, mentoring and communities of practice.

The content is being created and delivered over time and covers the following themes legislation and standards, guiding principles of PSP, case planning, cultural planning, understanding and supporting child development and the delivery of casework tailored to achieve restoration and other forms of permanency.

Case management policies

The Permanency case management policies were reviewed and adapted throughout the implementation process and continue to be reviewed, as part of continuous improvement activities informed by consultations with varied PSP stakeholders. The main changes to case management policies include:

- Alternative care arrangement policy was developed and launched to address the lack of PSP policies governing alternative care arrangements.

- Away from Placement policy was developed to provide a framework of care for children away from their placement temporarily or not in placement for a longer period.

The Aboriginal Case Management Policy and PSP Family Preservation framework were updated in line with some of the recommendations from the Family Is Culture review (Family is Culture, 2019).

Processes

In a similar way to the case management policies, processes and business rules are reviewed and updated across time. The main process related changes identified include:

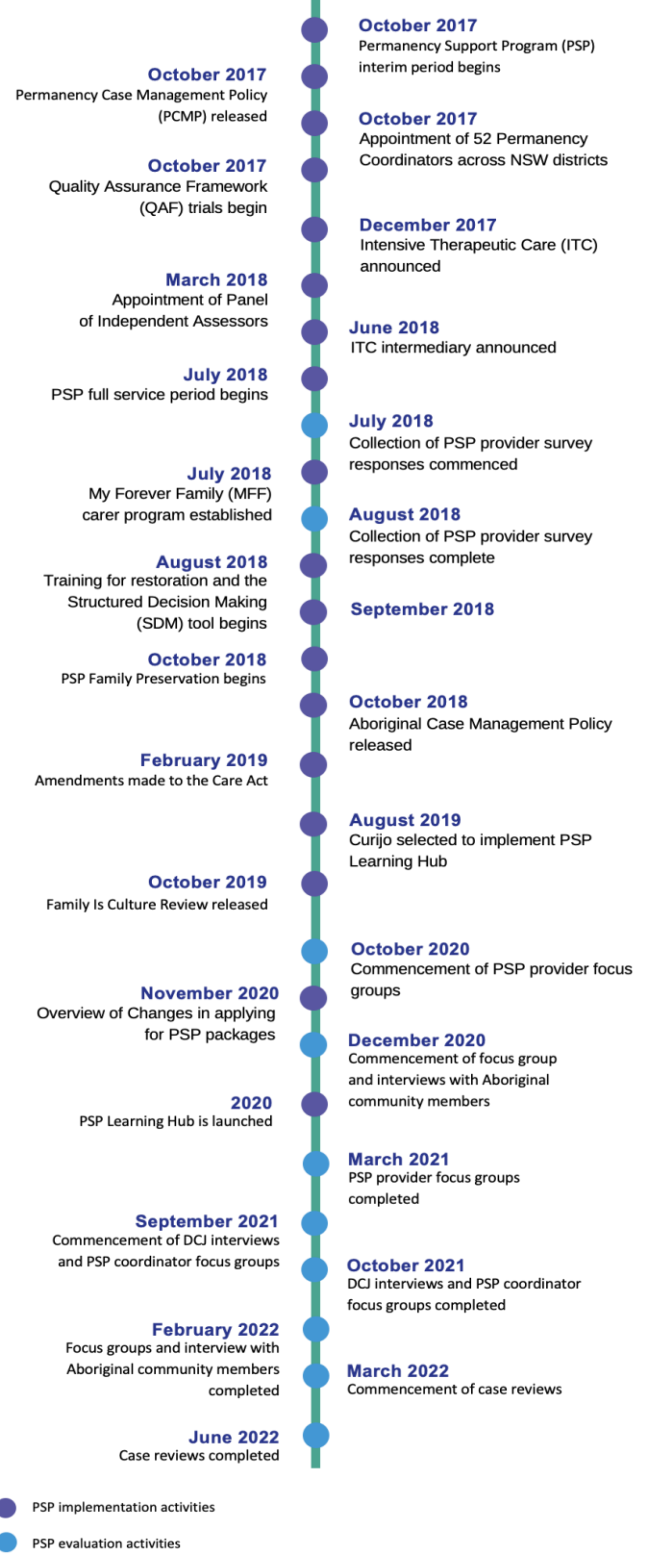
- The NSW QAF has been trialed but has not been rolled out to PSP service providers across PSP. A new trial of the framework with PSP service providers delivering Intensive Therapeutic Care is planned to commence in late 2022.
- A redesign of the PSP Package application process aiming to streamline the administrative process was introduced in November 2020 and has been ongoing since.
- The Complex Needs Payment Specialist Package was introduced in June 2018 as part of the original PSP model to cover exceptional circumstances where additional funding for specific time limited supports may be required to meet a child or young person's individual needs. Further redesign occurred in 2020 to clarify the business rules around its use, amend the application form, clarify roles and responsibilities in reviewing the applications for DCJ staff and introduce an in-principle approval pathway for urgent requests.
- The Alternative Care Arrangements process and policy guidance was introduced in July/August 2018 to clarify how hotel/motel/service apartments (i.e., Alternative Care Arrangements) were funded where a child or young person is being case managed by a service provider following the introduction of PSP. Further work to adjust the Alternative Care Arrangement process was completed in March 2020.

Practice frameworks and resources

DCJ is funding a number of new projects to review evidence, develop practice frameworks and pilot them to strengthen the practice components of PSP. This includes the new Permanency Practice Framework being co-designed by the Parenting Research Centre and three PSP providers. It is being trialled from June 2022 to March 2023 and evaluated in June 2023.

Overview of the PSP implementation and evaluation timelines

Figure 3.3 Timeline of PSP Implementation



Part two

Evaluation overview

4. This evaluation

4.1. Evaluation scope

The aim of this evaluation is to develop high-quality evidence on the reach, effectiveness and economic benefit of PSP and consider how the reform is being implemented and maintained. The evaluation includes a specific focus on the experiences and perceptions of Aboriginal families and communities and the impact of PSP on outcomes for this group. In line with the scope commissioned by and discussed in detail with DCJ, the evaluation focuses on:

- The cases where PSP service providers hold primary case management responsibility rather than DCJ.

The following PSP components are out of scope:

- The delivery of Intensive Therapeutic Care funded through PSP packages.
- The reach, effectiveness and economic evaluation of services classified as PSP but not PSP funded (i.e., not funded as part of PSP service provider contracts). This includes Temporary Care Arrangements and Alternative Care Arrangements.

4.1.1. Data collection timeline

Quantitative data (i.e., administrative and cost data) were collected over a 32 month observation period extending both pre and post-PSP. The pre-PSP observation period spans from the October 2014 to June 2017 and the post-PSP observation period from October 2018 to June 2021.

The survey and qualitative data were collected over an extended period, from July 2020 to June 2022, as detailed below and illustrated on the PSP implementation timeline – see Figure 2.3.

- PSP service provider survey responses were collected from July to August 2020.
- PSP service provider focus groups were conducted between October 2020 and March 2021.
- Focus groups and interviews with Aboriginal community members were conducted from December 2020 to February 2022.
- DCJ interviews and permanency coordinator focus groups were conducted during September to October 2021.
- The case reviews were completed from March 2022 to June 2022.

4.2. Evaluation approach

4.2.1. Hybrid design approach

To evaluate PSP, the Evaluation Team used a 'Type I' effectiveness-implementation hybrid design (Curran et al, 2012), with an integrated, dual focus on assessing the effectiveness of PSP (including cost benefit) and better understanding the context for implementation, including factors that may have helped or hindered change.[30] This approach can provide substantial benefits over traditional, independent process and outcome evaluations by facilitating rapid translational gains and real-time adoption of more effective implementation strategies, as well as generating more actionable insights for policy makers.

The primary emphasis of the evaluation was on the effectiveness and cost-benefit of PSP. Assessment of implementation (e.g., services delivered through PSP and barriers and enablers to this delivery) and reach (e.g., characteristics of children who received PSP packages) was critical to understanding PSP service context and operation.

4.2.2. Implementation science

Implementation science focuses on 'how' a program or practice can fit with and improve a service, including what helps and hinders effective service delivery. Implementation evaluation focuses on understanding what has been implemented and how well the program or service has been implemented in the context of an organisation and system. This is not simply of interest in itself - good implementation outcomes are a precursor to positive intervention effects (Proctor et al., 2009, 2011). 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.

Complex programs and system reforms such as PSP can be challenging to implement. Changes at the systems or policy level, as well as factors within organisations themselves,

[30] Curran et al. (2012) have identified three types by hybrid design:
Type I — testing effects of a clinical intervention on relevant outcomes while observing and gathering information on implementation
Type II — dual testing of clinical and implementation interventions/strategies
Type III — testing of an implementation strategy while observing and gathering information on the clinical intervention's impact on relevant outcomes

can help or hinder outcomes of the program. Our evaluation will consider these factors when assessing the effectiveness of PSP.

4.2.3. Culturally safe and appropriate evaluation

The Evaluation Team is skilled in using culturally safe approaches for evaluation and data collection with Aboriginal children, families and communities. Aboriginal Community-Controlled Organisations (ACCOs) providing PSP services participated in survey, focus groups and case file reviews administered by CEI as part of understanding PSP implementation across PSP service providers. Deep dive case studies of PSP implementation in Aboriginal communities were undertaken by CIRCA, who have expertise in culturally safe evaluation and data collection. For this evaluation, CIRCA conducted qualitative interviews and focus groups in three case study sites to gather information about the implementation and impact of PSP for Aboriginal children, their parents and carers. We gathered this information from Aboriginal parents and carers, non-Aboriginal carers, case workers/managers and community stakeholders.

CIRCA's approach to research with Aboriginal and Torres Strait Islander peoples considers culture and ensures cultural appropriateness and safety at all stages of the research process: design, participant recruitment, data collection, and analysis. For this evaluation CIRCA worked with Aboriginal Community-Controlled Organisations (ACCOs) to refine the design of the methodology for data collection and the discussion guides at each site. In two of the case study sites the PSP-funded ACCOs provided this input and in the case study site with the non-ACCO PSP-funded organisation, CIRCA engaged with a local ACCO to get this input. In addition, for this evaluation CIRCA's Aboriginal Research Consultants conducted all but two interviews (which were conducted by one of CIRCA's non-Aboriginal Research Consultants), and non-Aboriginal researchers were not present in any of the interviews or groups facilitated by Aboriginal researchers. We carefully paired appropriate Aboriginal researchers with research participants – although we aimed for local pairings, because this subject matter was sensitive, in one community there were concerns that our local Research Consultant was 'too close' to the topic. At this site, we paired community member research participants with another Aboriginal Research Consultant who was not from the local area.

This in-culture pairing approach allows our researchers and research participants the ability to converse with one another easily and freely. This approach guarantees the highest level of cultural safety to research participants, because it ensures that people will not feel their cultural background or experience is being questioned or doubted. Finally, in the analysis phase of this evaluation, CIRCA's Aboriginal Research Consultants have provided input to the interpretation of data and findings.

4.2.4. PSP Evaluation Independent Advisory Group

The PSP evaluation Independent Advisory Group (PSPE-IAG) was set up to ensure sector input into the evaluation of PSP. The group does not form part of any other governance or reporting structures (either departmental or sector) for PSP. The PSPE-IAG collaborated with the Evaluation Team to:

- Provide input and feedback about the PSP Evaluation process and how the Evaluation Team could interact with providers through the course of the evaluation.
- Identify and/or refine issues relevant to the development and dissemination of data collection tools used for the Implementation component of the evaluation.
- Provide feedback on selected key documents that were produced over the course of the evaluation.

4.3. Evaluation questions

We used methods appropriate for each evaluation question, based on available information sources.

Evaluation question by domain	Information source	Method for analysis
Implementation		
What services are PSP providers delivering to meet the permanency case plan goals? • What services were delivered to a child or young person and families (in the context of restoration and preservation) or carers (adoption and guardianship or to support a restoration)? • How much of those services did they receive? • Are these services, where indicated, evidence-informed? • What services are being provided in relation to the specialist services to support permanency?	• Interviews with DCJ • Focus groups with PSP service providers • Case review data	• Thematic analysis • Case study • Process evaluation
To what extent does service delivery differ: • Depending on the type of permanency case plan goal or level of need? • Depending on the length of time that children have been in out-of-home care? • Depending on the type of care arrangement (foster care, kindship care and self-placements were considered)?	• Interviews with DCJ • Focus groups with PSP service providers • Survey data • Case review data • Administrative data	• Descriptive analysis • Thematic analysis • Functional analysis • Data modelling • Case study • Process evaluation
What are the enablers to quality delivery of PSP services?	• Interviews with DCJ • Focus groups with PSP service providers • Survey data • Case review data	• Descriptive analysis • Thematic analysis • Functional analysis • Case study • Triangulation
What are the barriers to quality delivery of PSP services	• Interviews with DCJ • Focus groups with PSP service providers • Survey data • Case review data	• Descriptive analysis • Thematic analysis • Functional analysis • Case study • Triangulation
What casework is being carried out by PSP service providers to review the permanency case plan goals to determine if it is the appropriate goal for that child and to meet the permanency case plan goal selected? • How many children had a case plan reviewed in the OOHC data within a year?	• Interviews with DCJ • Focus groups with PSP service providers • Case review data	• Thematic analysis • Functional analysis • Case study • Process evaluation • Triangulation

Evaluation question by domain	Information source	Method for analysis
• How many and how often have children had their permanency case plan goals changed following a permanency case plan goal review? • What are the barriers and enablers to quality review of permanency case plan goals? • To what extent does casework differ depending on the type of permanency case plan goal or level of need? • To what extent does casework differ depending on the length of time that children have been in out-of-home care? • To what extent does casework differ depending on the type of care arrangement (foster care, kindship care and self-placements were considered)?		
Have PSP service providers increased their capacity to deliver PSP?	• Interviews and focus groups with DCJ • Focus groups with PSP service providers • Case review data	
Were permanency outcomes achieved for children within the allocated two-year timeframe? • What is the impact of the two-year timeframe on case management practice?	• Administrative data • Interviews with DCJ • Focus groups with PSP service providers	• Descriptive analysis • Data modelling • Thematic analysis
Case studies of Aboriginal children, families and communities experience of PSP • How has PSP been communicated with Aboriginal children, families and communities? • Is PSP delivery meeting the needs of Aboriginal children and families? • Have the Aboriginal Child Placement Principles been applied consistently and appropriately?	Interview and focus group data from parents, carers, children and caseworkers	Thematic analysis
Has PSP been implemented in a culturally safe, inclusive and respectful way? • Have the principles of Aboriginal self-determination (s11), participation in decision making (s12) and Aboriginal child placement (s13) outlined in the Care and Protection Act 1998 (NSW) been practiced within PSP? • Have adaptations been made to better meet the needs of Aboriginal children and families? • Do children, families, and communities feel that the PSP services that they have received or observed are culturally safe and offered in a way that support feelings of cultural safety?	Interview and focus group data from parents, carers, children and caseworkers	Thematic analysis

Evaluation question by domain	Information source	Method for analysis
What is the level of engagement and satisfaction with the services received?	Interview and focus group data from parents, carers, children and caseworkers	Thematic analysis
Is PSP acceptable for/to Aboriginal children, families and communities? Which elements are deemed most/least acceptable?	Interview and focus group data from parents, carers, children and caseworkers	Thematic analysis
Were Aboriginal-specific reform components (e.g., Aboriginal foster care and cultural planning, Aboriginal coordinator positions) acceptable, appropriate and effective?	Interview and focus group data from parents, carers, children and caseworkers	Thematic analysis
How have clients experienced the PSP services received, and what is their level of satisfaction with the services?	Interview and focus group data from parents, carers and children	Thematic analysis
Are the experiences for Aboriginal children and families in line with intended outcomes of improving the safety, permanency and wellbeing of Aboriginal children?	Interview and focus group data from parents, carers, children and caseworkers	Thematic analysis
How are these experiences and outcomes perceived by Aboriginal children, families and communities when compared to experiences and outcomes for DCJ's former service delivery model (where Aboriginal children, families and communities have previous experiences with former service delivery models)?	Interview and focus group data from parents, carers, children and caseworkers	Thematic analysis
What factors have influenced outcomes for Aboriginal children and families receiving PSP (e.g., Aboriginal family led decision making, Aboriginal controlled mechanisms being involved in decision making)?	Interview and focus group data from parents, carers, children and caseworkers	Thematic analysis
Reach		
What are the characteristics of children who received PSP packages as opposed to those who did not receive PSP packages?	Administrative data – ChildStory data	Descriptive analysis

Evaluation question by domain	Information source	Method for analysis
What is the mix of packages allocated? • How many children were transitioned to long-term care versus other case plan goals? • Are children with high needs being allocated an appropriate level of needs packages? • Has there been uptake of the 4+ sibling package? • How many children aged 15+ have leaving care packages and 15+ reconnect packages? What is the allocation rate for family preservation packages? What is the allocation rate for case coordination restoration support packages?	Administrative data – PSP package and ChildStory data	Descriptive analysis
Do children who are flagged in the DCJ system as Aboriginal or CALD have cultural plans?	Administrative data – PSP package and ChildStory data	Descriptive analysis
To what extent is funding from packages reaching the intended child? Or to what extent do PSP service providers 'pool' the funding from the packages or allocate it to the child who has received that package?	• Interviews with DCJ • Focus groups with PSP service providers • Case review data	• Thematic analysis • Case study
Effectiveness		
What happened following receipt of PSP packages in terms of children's safety? • Has PSP contributed to fewer reported maltreatment incidents or entries into care for those receiving Family Preservation packages? • Has PSP contributed to fewer reported maltreatment incidents or re-entries into care following restoration?	Administrative data – PSP package and ChildStory data	Time-to-event analysis
What happened following receipt of PSP packages in terms of children's permanency? • Has receiving one or more PSP packages resulted in increased exits from care into a permanent, safe home through restoration to their family? • Has PSP resulted in increased exists from care into guardianship or adoption? • Are some service providers delivering better outcomes (i.e., are service providers with particular attributes delivering better outcomes)? What has contributed to this?	Administrative data – PSP package and ChildStory data	Time-to-event analysis
What happened following receipt of PSP packages in terms of placement stability? • Has PSP resulted in a reduction in placement changes?	Administrative data – PSP package and ChildStory data	• Time-to-event analysis • Descriptive analysis

Evaluation question by domain	Information source	Method for analysis
What happened following receipt of PSP packages in terms of children's wellbeing? • Has PSP resulted in improved child mental and physical health outcomes? • Has PSP resulted in improved child educational outcomes?	Administrative data – PSP package and ChildStory data	• Time-to-event analysis • Data modelling
How do PSP safety, permanency and wellbeing outcomes for Aboriginal children and families compare with outcomes for non-Aboriginal children and families?	Administrative data – PSP package and ChildStory data	• Time-to-event analysis • Descriptive analysis
To what extent do any of the outcomes differ by type of PSP package received or length of time in OOHC: • Do the outcomes differ depending on the PSP case plan goal package or other package? • Do the outcomes differ depending on the length of time that children have been in OOHC?	Administrative data – PSP package and ChildStory data	• Time-to-event analysis • Descriptive analysis
Economic		
What is the cost of providing Family Preservation services?	• Administrative data • Cost data	• Descriptive analysis
What is the average cost of OOHC services provided by service providers before and after PSP was introduced?	• Administrative data • Cost data	• Descriptive analysis
Is PSP a more cost-effective way of administering the child protection system in NSW than the pre-PSP usual service provision?	• Administrative data • Cost data	• Descriptive analysis • Cost-benefit analysis
Further implementation considerations		
If permanency outcomes are not being achieved, is it due to: the design of the PSP funding model, or a broader issue either within DCJ or PSP service providers or both? • Are the necessary supports provided to PSP service providers adequate? • Are the packages fit for purpose? • Are some PSP service providers performing better than others in achieving outcomes and what has contributed to this?	• Interviews with DCJ • Focus groups with PSP service providers • Survey data • Case review data Interviews and focus groups with caseworkers	• Thematic analysis • Functional analysis Triangulation of data sources
What are the unintended impacts (if any) in delivery of PSP?	• Interviews with DCJ • Focus groups with PSP service providers • Survey data	• Thematic analysis • Functional analysis •

Evaluation question by domain	Information source	Method for analysis
	• Case review data • Interviews and focus groups with caseworkers	
Does the new payment structure within the Program Level Agreements provide an incentive to achieve positive outcomes? • Does the fee schedule provide incentives to achieve positive outcomes in theory?	• Interviews with DCJ • Focus groups with PSP service providers • Case review data	• Thematic analysis • Case study • Process evaluation
How sustainable is the funding model? • Are there funding gaps?	Triangulation of all data sources	Triangulation of all data sources

4.4. Information sources

4.4.1. Administrative data

Data on children receiving PSP packages were linked with ChildStory, the NSW case management system for child protection and OOHC. ChildStory data for all cohorts were then linked with NSW Specialist Homelessness Services data (SHS), Department of Education (DoE) and NSW Education Standards Authority (NESA) school data (NAPLAN and HSC data), and BOCSAR Re-Offending Data (ROD) to measure youth justice outcomes. For more detail, please see Appendix C: Quantitative Methods for more detail on data sources and definitions.

4.4.2. Cost data

To inform the cost-benefit analysis in the economic evaluation various administrative data sources that provide information at the child-level are used, complemented with some aggregate information provided by DCJ regarding fixed costs, such as the cost of Permanency Coordinators, and regarding pre-PSP vacancy costs and Placement Capacity Payments (post-PSP vacancy costs).

The child-level information was provided in a secure environment under strict access rules. For the period after PSP was introduced, this included:

- OOHC file with information on placement start and end dates,
- The PSP payment files with information on start and end dates of PSP packages provided to PSP service providers for children in their care,
- Allowances data and Adoption and Guardianship Allowances data,
- One-off payments recorded in the Complex Needs and Exception Supports file.

For the pre-PSP period, this included:

- OOHC file with information on placement start and end dates,
- CAT score data with information on the type and level of care required (and thus daily fees paid) for children receiving NGO services,

- Monthly payment data from December 2014 to June 2017, which includes DCJ Allowances and one-off payments for children in NGO or DCJ care.

DCJ has also provided information on the number of Permanency Coordinators appointed (n=52) and the cost of these positions. In addition, aggregate information on Placement Capacity Payments and on pre-PSP vacancy payments to PSP service providers for providers of non-residential care has been provided by financial year with information on the total number of children receiving non-residential care services from PSP service providers in the respective financial years.

4.4.3. Focus groups with PSP service providers

Semi-structured focus groups were held with 58 staff across 14 PSP service providers to explore the barriers and enablers of PSP delivery and to provide insights related to implementation. PSP Service providers were identified through a random sample of all providers and stratified according to PSP service type, organisation size, location, and whether they were ACCOs. Randomly selected PSP service providers were then asked to nominate staff closely involved in the delivery of PSP services.

Focus groups were conducted via telephone between October 2020 and March 2021 and lasted between 45 to 90 minutes. These discussions were guided by a series of questions developed based on the Consolidated Framework for Implementation Research (CFIR), an instrument consisting of a menu of constructs that have been associated with effective implementation at various levels (i.e., implementation factors related to the characteristics of PSP, the outer setting or service context, the characteristics of clients and implementing staff, and implementation process) (Damschroder et al., 2009). Questions were further refined in consultation with the PSP Evaluation Independent Advisory Group regarding the constructs that may be most relevant. Focus group participants represented a mix of roles and levels of experience including PSP managers, team leaders, case managers, caseworkers, practitioners and coordinators working across a range of functions; family preservation, restoration, OOHC, adoption, therapeutic care, carer support and community services.

4.4.4. Interviews with DCJ staff

Semi-structured interviews were conducted virtually with five staff across DCJ's central and district offices from September to October 2021, and one semi-structured focus group, lasting 60 minutes, was held with 4 staff from DCJ's local offices in October 2021. The interview participants included two staff from DCJ central and three from district offices, who occupy a mix of executive, implementation and performance, partnership and commissioning, and district service delivery roles involved with the design, commissioning, implementation, and on-going delivery of PSP. While the focus group focused on the role of PSP permanency coordinators and included two Practice and Permanency managers and two Permanency coordinators.

The interview and focus group discussions were guided by a series of questions designed by the evaluation team to glean insights regarding barriers and enablers to the implementation of PSP, any adaptations made to the implementation plan, and changes to DCJ's practice. Guiding questions were adapted based on the individual's role. For example, individuals in strategic positions were asked questions regarding the motivation behind the design and implementation of PSP components while local staff were asked about permanency case plan goals and reviews.

4.4.5. PSP service provider case reviews

The case review data collection involved developing case selection guidelines and a case nomination template to facilitate the sampling selection. PSP service provider members of the PSP Evaluation Independent Advisory Group were invited to participate in the case review, and other service providers were approached through a snowballing strategy. Five PSP service providers participated in the case review, agreeing to collectively select a sample of cases with a wide range of case pathways and characteristics. We developed a data extraction template to collect key information across all functions performed by PSP service providers in line with the PSP package-based service agreements and refined this template in consultation with DCJ and PSP service providers.

As case reviews can be very time intensive, the data extraction process did not involve extracting all the relevant case information available. Instead, the evaluators focused on reviewing case information contained in case plans, cultural plans, case review, structured decision tools, communications between agencies and other documents containing insights on the nature and intensity of case work and services delivered to support the case goals and plans. We spent between two and five hours reviewing and extracting data on each case, although more time was spent reviewing complex or unusual cases.

The case reviews were conducted by two CEI researchers from March 2022 to June 2022. The review covered the case information recorded between the launch of PSP (June 2018) and when the case was reviewed (March/June 2022). Some case information recorded before June 2018 was reviewed where it provided relevant explanations and context. No identifying information, either of children, families or staff members involved in case management was recorded.

The participating PSP service providers included two Aboriginal Controlled Community Organisations (ACCOs): Wandiyali and South Coast Medical Service Aboriginal Corporation, two state-wide service providers: Barnardos Australia and Uniting NSW/ACT and a service provider specialising in more complex cases: Allambi Care. All participating organisations reviewed the reporting of case review data for their relevant organisation sections to ensure full anonymity of all cases included. They also gave permission for their organisations to be named in this evaluation report.

We reviewed 74 PSP funded cases using the PSP providers' case management systems and documents and extracted information using the data extraction template. Over one-third of cases managed by ACCOs (n=27; 36%).

An overview of the case review sample characteristics is presented in Table 3.1 below. Please note, PSP Family Preservation cases were not included in the case review, as the evaluation team and the participating PSP service providers were not able to arrange their inclusion within our timelines. We suggest conducting a similar exercise focusing exclusively on PSP Family Preservation cases.

Table 4.1 Characteristics of cases included in case reviews (n = 74)

Case characteristics	Number (n)	Percentage (%)
Aboriginal children	39	51

Case characteristics		
	Number (n)	Percentage (%)
Rural	8	11
Moved district	3	4
Achieved permanency goal	12	16
Permanency goal (at the time the case was reviewed)		
	Number (n=)	*Percentage (%)*
Adoption	7	9
Guardianship	14	19
Restoration	14	19
Long-term care	39	53
Age of the child		
	Number (n=)	*Percentage (%)*
Age 0-5	15	20
Age 6-11	27	36
Age 12-15	16	22
Above 15	16	22

4.4.6. PSP service provider survey

A 19-item version of the CFIR Inner Settings Measure was adapted to fit the PSP service context and administered by the evaluation team to ensure a minimum set of data on implementation enablers and barriers was collected across all PSP service providers. This tool measures organisational capacity for implementation across a number of constructs within the Inner Settings domain, including Culture, Learning Climate, Leadership Engagement and Available Resources (Walker et al., 2019). The tool has demonstrated adequate structural validity, reliability and discriminant validity in a research context. Two questions were added to explore respondent opinions on the impacts of COVID-19 pandemic on their ability to provide high-quality services. A list of the survey questions is presented in Appendix B.1.

The survey was distributed to all PSP service providers for completion by caseworkers and other PSP provider staff who provide PSP services. Responses were collected from July – August 2020 across a 6-week period using the online survey platform, Qualtrics. A total of 181 respondents from 38 PSP service providers completed the survey, and their demographic breakdown is presented in Table 4.2 below. Notably more than half (54 per cent) of respondents were from regional locations and caseworkers made up the highest proportion of respondents (58 per cent).

Table 4.2 Demographics of 181 participants who completed the PSP provider survey (n =181)

Demographic information		Participants (%)
Location	Metropolitan area	32
	Regional area	54
	Remote or rural area	14
Occupation	Caseworker	58
	Manager	23
	Team Leader	11
	Other	8

4.4.7. Aboriginal case studies

Qualitative data were collected at three case study sites from Aboriginal parents, Aboriginal children in care, Aboriginal and non-Aboriginal carers, community stakeholders and case workers/managers delivering PSP – see Table 3.3. The purpose of this qualitative data was to provide grounded contextual information about the experience of individuals with PSP. Specifically, the case study sites provided a multi-directional view from interviews with Aboriginal children, parents and carers receiving PSP services, community members and PSP caseworkers/managers. This qualitative data is not intended to be representative of the wider population of PSP clients or workers, but rather to explore the direct experiences of individuals with the program to better understand how it impacts on their lives.

The three Aboriginal case study site locations were identified in partnership with and based on data from DCJ. These sites were also informed by feedback and advice given by the DCJ Aboriginal Reference Group and Aboriginal Outcomes Team. All three sites were in regional areas and selected due to the presence of a high proportion of Aboriginal children receiving PSP services. In two of the sites, PSP service providers were ACCOs and in the third site, the PSP service provider was a mainstream organisation.

Table 4.3 Breakdown of participants in Aboriginal case study sites

	Site A	Site B	Site C
Aboriginal parents	0	4	1
Aboriginal children	2	0	4
Aboriginal carers	1	1	2 (a couple)
Non-Aboriginal carers	2 (a couple)	1	0

	Site A	Site B	Site C
Case workers/managers	5	6	6
Community members	3	4	3
Total number of participants	**13**	**16**	**16**

Once case study sites were identified, CIRCA sought permission from Aboriginal communities via local ACCOs, to determine community support and willingness to participate in the evaluation, prior to finalising the site selection. The process of determining community support and willingness to participate for all three PSP sites took a year and a half. There was significant reluctance on the part of PSP service providers at multiple sites to participate for reasons that are unclear. It is possible that the relationship between the government and Aboriginal service providers in the context of child protection in Aboriginal communities, and delivery of PSP in particular, impacted on the willingness of PSP service providers to participate. Other potential reasons include a lack of interest or time among service providers and a lack of trust in being involved in an external evaluation.

Participant selection at finalised case study sites was made through different strategies: referrals from the participating PSP service providers and case workers/managers, local network connections of CIRCA's Aboriginal field researchers, and snowball sampling techniques. All participants were asked to give informed consent, with children being asked for assent and their parent/guardian/PSP service provider to give consent. Each parent, carer and community stakeholder participant were remunerated with a $80 cash payment.

Discussion guide questions reflected the evaluation questions and were refined with input from CIRCA's local Aboriginal Research Consultants and from Aboriginal stakeholders at case study sites. Data was gathered through 60-minute, semi-structured, one-on-one interviews or 90-minute focus groups.

4.5. Analysis methods

4.5.1. Quantitative Effectiveness Analyses

As PSP packages are not randomly allocated and the allocation may be influenced by a number of reasons that can influence outcomes (e.g., high rating on a risk assessment tool; entry to NGO-managed care), our sampling plan included a three-step process to select comparison samples that were similar to those who received PSP packages (please refer to Appendix C: Quantitative Methods for details). These were then used as counterfactuals to test the effectiveness of PSP packages across a range of outcomes. Our approach was to:

- Develop three different cohorts within the child protection and OOHC system
  - Family preservation cohort: households reported for a child maltreatment concern that were assessed as high or very high risk.
  - Entry/Re-entry cohort: children entering a new episode of care either for the first time ever or after having a previous stay in care that had ended.

- Ongoing care cohort: children in care at a single point in time[31]

- Ascertain the known characteristics of children in each of these cohorts who received at least one PSP package.
- Create a statistically matched comparison group of children who did not receive one or more PSP packages for each cohort. Depending on a number of factors, the comparison group could have been either contemporaneous (similar dates of service provision) or historical (pre-PSP). Statistical matching was conducted using propensity score matching or PSM (see explanation box below and Appendix C: Quantitative Methods).

What is Propensity Score Matching?

Propensity score matching (PSM) is a statistical technique that involves matching individuals who received a service with individuals who are similar in terms of their demographic characteristics (e.g., age, sex), assessment scores (e.g., risk rating), service history (e.g., prior ROSH reports), and other observable characteristics or features. In this way, we can 'control for' or account for the influence these factors might have on whether an individual receives one or more PSP packages. The aim of PSM is to create a comparison group that is comprised of individuals that are similar to the individuals who received the intervention (in this case, one or more PSP packages). For greater detail on the matching process, refer to Appendix A

Following matching, we analysed the relative difference in outcomes between children receiving PSP packages and their matched counterfactuals using Cox Proportional Hazards Regression models.

Where possible, we examined the impact of the COVID-19 pandemic by running separate models that limited the study period to before the beginning of the pandemic (up to March 2020 and equivalent in the comparison period) and compared these to our 'standard model' of the full evaluation period. This approach was limited to the Ongoing Care cohort as it was the only one with a large enough sample with sufficient pre-pandemic follow-up time, both of which were needed to produce viable statistical models.

For more detail on the methodology used in the Quantitative Effectiveness section, including how the cohorts were created, the matching process and why we used cox proportional hazards regression models, see Appendix C: Quantitative Methods.

4.5.2. Cost-benefit analysis

The CBA consists of a number of steps which are summarised in Table 3.4 and described in more detail below. A first step is to identify the service model options to be analysed and compared. We consider the costs and benefits of the following two options:

[31] 1st October 2018 for those with PSP packages and 1st October 2014 for those in the historical comparison

1 The current policy environment for NGOs after PSP was introduced. The focus is on NGOs only; this scenario reflects the NGO-PSP environment.

2 A base case scenario of no change in the service provision for children in NGO care: that is, the NGO-Pre-PSP environment reflecting the costs and benefits if the pre-PSP type of service provision would have continued.

The challenge in comparing these two groups of children is that we also need to control for other changes over time in service provision such as confounding effects of other DCJ services and policies (e.g., Their Futures Matter, Aboriginal Outcomes Framework, NSW Practice Framework), as well as for the potential impact of COVID. These issues are discussed in the Effectiveness analysis, so that in the economic evaluation we start from the assumption that the two groups are sufficiently comparable while we consider the direction of potentially confounding effects.

Table 4.4 CBA Steps

Step 1		**Specify the set of options to be analysed** We consider the costs and benefits of the following two options: 1. The current policy environment for NGOs after PSP was introduced. 2. A base case scenario of no change in the service provision for children in NGO care: that is, the NGO-Pre-PSP environment.
Step 2		**Decide whose costs and benefits count** We compare the costs and benefits for children placed with an NGO in NSW who were not in residential care at the start of our observation period or at the time they entered in OOHC.
Step 3		**Identify the impacts and select measurement indicators** We determine the actual (realised) costs and estimate benefits based on the results from the Effectiveness component of the evaluation.
Step 4		**Predict the impacts over the life of the proposed regulation** Per NSW Government (2017) guidelines, we use an evaluation period of at most 20 to 30 years.
Step 5		**Monetise (attach dollar values to) impacts** This step is concerned with reliably quantifying and valuing the outcomes.
Step 6		**Discount future costs and benefits to obtain present values** We use a discount rate of 7 percent in real terms.
Step 7		**Compute the Benefits-Costs Ratio (BCR), using the net present value (NPV) of the differences in benefits and in costs between the two options under step 1, dividing the NPV of benefits by the NPV of costs**

		The costs and benefits will be weighted similarly for the different groups. It should be noted that we currently do not have sufficient information to determine the full benefits arising from the PSP approach.
Step 8		**Perform sensitivity analysis** The base CBA can be varied in a few dimensions to examine the sensitivity of results to small variations in the parameters of the analysis.
Step 9		**Recommendation** We reach a conclusion, leading to a statement regarding the cost effectiveness of PSP.

In a second step, we need to decide whose costs and benefits count. We compare the costs and benefits of the NGO-Pre-PSP service provision with the NGO-Post-PSP service model to assess whether the change in service provision through PSP increased the cost effectiveness of administering the OOHC system. The exact same comparison groups are used in the CBA as in the Effectiveness analyses.[32] We focus on the costs and benefits associated with placing children with an NGO in NSW. Children who were in residential care at the start of our observation period or at the time they entered in OOHC are excluded from the cost-benefit analyses.

In a third step, the impacts of interest are identified and measurement indicators are selected to assess these impacts. Two subsections in this section entitled “Costs” and “Benefits” describe how we determine the actual (realised) costs and how we estimate benefits based on the results from the Effectiveness component of the evaluation.

The fourth step involves predicting the impacts over the life of the proposed regulation. Per NSW Government (2017) guidelines, we use an evaluation period of at most 20 to 30 years and in most cases stay well below this. The estimation of benefits far into the future is associated with large prediction errors, especially given the relatively short observation period for the evaluation in this report and the young age of those affected, as well as the limited impacts estimated in the Effectiveness analyses. The longer the period of evaluation relative to the period during which we observe outcomes, the more uncertainty is associated with predicted outcomes towards the end of the period.

The fifth step of monetising (attaching dollar values to) impacts is concerned with reliably quantifying and valuing the outcomes. For the outcome variables related to safety/wellbeing, permanency and education, we have some direct estimates of the impact arising from the PSP service model change. [33] To monetise impacts, we use the work done by FACSIAR Economics (2022) on quantifying a range of benefits.

[32] The comparison groups constructed in the Effectiveness analyses consist of children and youth in NGO services only who were not in residential care upon entering OOHC or if they already were in OOHC on 1 October 2014 or 1 October 2018 were not in residential care on that date. We follow the same approach for the CBA.

[33] Originally health and employment outcomes were also to be included but this was not feasible given what data were available.

To enable comparisons over time, a sixth step discounting future costs and benefits to obtain present values is included. Per FACSIAR Economics (2018) guidelines and as used in FACSIAR's 2022 benefits guide, we use a discount rate of 7 percent in real terms.

The seventh step consists of computing the Net Present Value (NPV) of the differences in the benefits and in the costs between the two options defined in the first step and calculating the Benefits-Costs Ratio (BCR) by dividing the NPV of the benefits by the NPV of the costs. The BCRs are computed for the full sample of analysis of families and children in the OOHC system in this report. We also compute the NPV of the costs for Aboriginal families, but as there is just one separate estimate in relation to the impact on the outcomes, the CBA analysis cannot be done separately for Aboriginal families. Per FACSIAR Economics (2018) guidelines, the costs and benefits will be weighted similarly for the different groups.

It should be noted that we currently do not have sufficient information to determine the full benefits arising from the PSP approach. For example, no information is available on health outcomes and limited information is available on education outcomes (and for a short period only). Furthermore, no information is available on children's subjective wellbeing. The BCR should therefore be interpreted with caution.

In an eighth step we perform sensitivity analysis if relevant given the results obtained so far. The base CBA can be varied in a few dimensions to examine the sensitivity of results for the full population to small variations in the parameters of the analysis. These could include for example:

- How do the CBA results differ if an evaluation period of at most 10 years is used?
- How do the CBA results differ if discount rates of 3 percent and 10 percent, respectively, are used?
- How do the CBA results differ if outcomes are 10% better (or worse) than estimated in the outcome evaluation?
- How do the CBA results differ if different assumptions are used in the monetisation of outcomes? For example, investigate the impact of a 10% higher benefit arising from an outcome than is reported in FACSIAR's benefits guide.

A ninth, and final step completes the CBA with a recommendation. We report the results including sensitivity testing and reach a conclusion, leading to a statement regarding the cost effectiveness of PSP.

Costs

We compute the costs of providing services to children who are receiving NGO-PSP packages and compare these to the costs of providing services to children who are receiving services through an NGO in the pre-PSP environment. Children who were in residential care at the start of the observation period are excluded, but if children subsequently move into residential care or ITC, the cost of this care is included. When children receive DCJ services at some point during the observation window, the cost of these services are included too (Care Allowances as well as Adoption and Guardianship Allowances). We do not include the costs of Temporary and Alternative Care Arrangements.

We have access to the actual cost of providing services to each individual child so that we can account for differences between children in terms of costs of the services allocated to them. Post-PSP, NGOs receive a certain amount of funding depending on the specific

children in their care, and this is the cost to DCJ of providing care for these children, regardless of how the NGO spends the funding exactly (on which we have no information). The current data provide individual-level information for the PSP packages where we know exactly which payments for which packages are provided for which children and over what period of time. This is important, as the Effectiveness analysis approach in this PSP evaluation aims to construct a comparison group of children receiving NGO-Pre-PSP services who are similar to the group of children receiving NGO-Post-PSP services. We compute the costs for the same groups of children included in the Effectiveness analysis so that the costs and benefits calculations are completely aligned. In addition to the cost of PSP packages, we also include one-off (or ad hoc) costs included in the 'Complex Needs' data, as well as per-child costs arising from the 52 Permanency Coordinators who were newly introduced post-PSP. However, we assume that the cost of other DCJ staff involved in casework in relation to children in NGO services does not change as a result of PSP, and therefore these costs are excluded. Placement Capacity Payments per relevant child are also calculated to allow for the cost of vacancies in the system and these are added to the overall cost.

The research team received comparably precise information for children who received services from NGOs before PSP was introduced. Using CAT score data combined with the OOHC data, we can reconstruct the level of allowances paid to NGOs for providing services to the children in their care. When CAT score data are not available, we use priority placement type information to estimate the cost of NGO services.[34] In addition, we observe 'one-off' payments and payments for DCJ services through monthly payment data which we add to the NGO allowances costs. As mentioned above, the cost of DCJ staff involved in casework in relation to children in NGO services is excluded, but we add per-child cost of vacancies using aggregate information provided by DCJ.

Cohorts and Periods used in the Calculations

Using data on the different cohorts identified in the Effectiveness analyses, we determine the costs of providing services for children receiving PSP and for children not receiving PSP over the period starting from 1 October 2018 and 1 October 2014, respectively. All costs are computed separately for children in the Entry/Re-entry cohort (who entered OOHC after 1 October 2014 and before the end of 2016 or after 1 October 2018 and before the end of 2020) and for children in the Ongoing Care cohort (who were already in OOHC on 1 October 2014 or on 1 October 2018), so that costs and benefits pre- and post-PSP can be compared separately for these two groups.

For new OOHC entries we calculate costs from the moment of entry into OOHC up to the end of June 2017 (or 2021). For the 'Ongoing Care' cohort who may have been in OOHC for a considerable amount of time, we compute the costs from the reference date of 1 October up to the end of June 2017 (or 2021). For historical cases we use 2020/21 prices to ensure costs are comparable between NGO-PSP cases and the historical matched cases. Based on the year-on-year increases in service fees before and after PSP was introduced (see Table 3.5) we calculate annual price increases and apply these to the historical prices to obtain the hypothetical 2020/21 price for services under the base case scenario that PSP had not been introduced and instead the status quo had been maintained.

[34] For children without a CAT score, we do not know the level of need (or payment type), such as whether they need General Foster Care or Intensive Foster Care. As the majority of children require the lowest level of care, we assume that all children for whom the relevant information is not observed need care at the lowest need level, and we use the fee associated with the lowest need level for that type of care.

The hypothetical fees in Table 3.5 used to calculate pre-PSP cost in 2020/2021 prices so that these can be easily compared to the post-PSP cost. Similarly, we use the 2020/2021 Package prices in all financial years post-PSP to express all prices in 2020/2021 dollars.

The costs are computed over the period from 1 October 2018 to 30 June 2021 for the children in the post-PSP environment, and from 1 October 2014 to 30 June 2017 for the children in the pre-PSP environment. To obtain an understanding of the costs for the children in our post-PSP 'treatment' group relative to all children in the post-PSP period of analysis, we compute the overall and average cost for all children receiving at least one PSP package during this period as well. This allows us to assess the percentage of children exposed to PSP who are included in the Effectiveness analysis in this report, and the percentage of PSP payments to the children included in the Effectiveness analysis, as well as the average costs per child for our 'treatment' group relative to the average costs per child when all children in PSP are included. This provides an indication of how representative the children included in the analyses are of the full population of children in NGO care experiencing PSP over this period.

Table 4.5 Observed and hypothetical annual fees for NGO-provided Services under the base care scenario of no PSP (using observed price increases)

Unit price of one bed night in	Observed price in 2013/14	Observed price in 2014/15	% price growth in 2014/15	Observed price in 2015/16	% price growth in 2015/16	Observed price in 2016/17	% price growth in 2016/17	Observed price in 2017/18	% price growth in 2017/18
General Foster Care (GFC)	$ 106.61	$ 109.16	2.40	$ 111.89	2.50	$ 114.58	2.40	$ 117.27	2.35
General Foster Care (GFC2)	$ 135.42	$ 138.67	2.40	$ 142.13	2.50	$ 145.54	2.40	$ 148.96	2.35
Intensive Foster Care (IFC)	$ 253.55	$ 259.63	2.40	$ 266.12	2.50	$ 272.51	2.40	$ 278.92	2.35
Residential Care (RES)	$ 507.10	$ 519.27	2.40	$ 532.25	2.50	$ 545.02	2.40	$ 557.83	2.35
Intensive Residential Care (IRC)	$ 829.79	$ 849.71	2.40	$ 870.95	2.50	$ 891.86	2.40	$ 912.81	2.35

Hypothetical unit price of one bed night in (using observed service price increases)	% price growth in 2018/19	Hypothetical price in 2018/19	% price growth in 2019/20	Hypothetical price in 2019/20	% price growth in 2020/21	Hypothetical price in 2020/21
General Foster Care (GFC)	2.40	$ 120.09	2.00	$ 122.49	1.75	$ 124.63
General Foster Care (GFC2)	2.40	$ 152.54	2.00	$ 155.59	1.75	$ 158.31
Intensive Foster Care (IFC)	2.40	$ 285.61	2.00	$ 291.32	1.75	$ 296.42
Residential Care (RES)	2.40	$ 571.22	2.00	$ 582.64	1.75	$ 592.84
Intensive Residential Care (IRC)	2.40	$ 934.72	2.00	$ 953.42	1.75	$ 970.10

Data selections

In this report, we summarise the observed costs to DCJ for pre- and post-PSP NGO-provided services in 2014/15 (starting from 1 October 2014), 2015/16 and 2016/17 (i.e., pre-PSP), and 2018/19 (starting from 1 October 2018), 2019/20 and 2020/21 (i.e., post PSP). Both periods cover 2.75 years. The cost tables in the appendix are based on the OOHC and PSP Payments data combined with Complex Needs data, Allowances data and Adoption and Guardianship Allowances data; and the OOHC data combined with CAT score data and monthly payments data.

We make selections from the PSP payments data and the OOHC data in such a way that the data used in the CBA align with the data used in the Effectiveness analyses. That is, we select data for the same pre- and post-PSP Ongoing Care and Entry / Re-entry cohorts as in the Effectiveness analyses. A detailed description of these selections is provided in Appendix C.6.

We also use various sources on actual payments to determine the amounts paid in DCJ Allowances and in one-off payments for each child during the pre- and post-PSP observation periods. These sources include:

- Allowances data and Guardianship and Adoption Allowances data for the post-PSP period.
- Complex Needs and Exceptions payments for the one-off payments in the post-PSP period.
- Monthly DCJ payments from 1 December 2014 to 30 June 2017 (including all allowances for children receiving DCJ services and all one-off payments (including exception payments) for children receiving either NGO or DCJ services).
- To ensure all cost related to Alternative Care Arrangements are excluded we drop pre-PSP payments where the variable indicating the type of expenditure (variable ExpenditureType) has the value "Emergency Accommodation Payment" or "Establishment Placement-Crisis".

The above selections and operations allow us to determine what NGO services and PSP packages are provided to the children in the data, and over what period these services are provided. Combining the quantity of services provided with the cost per unit or package allows us to calculate the cost for a child in a specific financial year. To these we then add the dollar amounts spent on DCJ Allowances, Adoption and Guardianship Allowances and one-off payments.

Benefits

For the CBA, we put values on benefits such as employment, health and education-related benefits but consider wellbeing separately. However, at this stage, we have only limited information for a short period of time on these outcomes. We have liaised with DCJ's FACSIAR Economics team to ensure that: we use the latest approach available for monetising outcomes, our assumptions are the same as in other cost-benefit analyses for DCJ.

Use of the Effectiveness analyses

In addition to the observed costs up to June 2021, we need predicted costs of DCJ services and PSP services into the future depending on where the child is at the end of the observation period. The FACSIAR Economics Benefits Guide provides information on avoided costs from OOHC, for children who exit OOHC through restoration or who move from OOHC to guardianship. Although this is relevant for a small number of children only, it would also be important to estimate the benefits of adoption. However, children who

exit care to adoption are difficult to track in ChildStory and across other systems (i.e., they would be assigned a new ChildStory ID and may have a legal name change). As a result, there is no information on their outcomes after adoption.

The Benefits Guide also provides estimates in relation to the benefits of other positive outcomes that may arise from the access to PSP services. These could include, for example, fewer placement changes, completing a certain level of education, avoiding health issues, avoiding a ROSH report for longer after being restored, or avoiding the Justice system. The Effectiveness analysis has produced a significant predicted impact on some of these outcomes that are used with the Benefits Guide to produce a dollar value of the impact.

FACSIAR Economics Benefits Guide

In this subsection we illustrate how the Benefits Guide can be used for our calculations. There is little information on education from our evaluation, but we provide an example using improved education outcomes as this is clearly an important pathway to better outcomes and would be important to measure in future evaluations.

Using the FACISIAR Economics Benefit Guide

For example, suppose that the children receiving PSP services are 20 percentage points more likely to complete Year 12. The benefits reported in the FACSIAR Benefits Guide (2022; p. 28) show an additional $247,682 per person per lifetime for completing Year 12 relative to completing Year 10. This means that the expected value of the benefit for a child is: 0.20*$247,682 =$49,536.40. We could obtain the total benefits by multiplying this amount by the number of children in our population experiencing this improvement in education outcomes.

A similar approach is taken for each of the significant changes in outcome arising from the PSP changes. The estimated benefits are then added together to calculate the total benefit.

Some of these benefits could potentially be adapted to be more appropriate for the population of children in OOHC. For example, by extending the time period used to approximate a lifetime given the young age of our population (leading to a greater expected benefit), as the benefits of an improved outcome may be reaped over a longer time period. Or alternatively, by sourcing information regarding impacts for specific (disadvantaged) subpopulations to tailor the expected benefits to our population of interest.

We follow a similar approach, as outlined in the box above, for all outcomes estimated in the Effectiveness analyses that are included in the Benefits Guide. All outcomes considered in the CBA are in the Benefits Guide. However not all outcomes may be (fully) quantifiable, and for the outcomes that fall in this category, we include a qualitative discussion of the benefit of the outcome to be considered in addition to the monetised benefits.

The largest financial benefit is expected to arise from children being more likely to exit OOHC (safely) if they receive NGO-PSP services. A successful and permanent exit could save several years of OOHC expenditure and substantially improve children's wellbeing. A key question to answer using the Effectiveness analyses is therefore whether exit from OOHC can be increased sufficiently as a result of NGO-delivered PSP services, and whether this differs between the Ongoing Care cohort and the Entry/Re-entry cohort.

4.5.3. Qualitative analysis of interviews and focus groups

Interviews and focus groups were undertaken with PSP service providers, DCJ staff and children, parents, carers and PSP caseworkers/managers at the three Aboriginal case study sites. All qualitative data was audio recorded with participants' permission and sent for professional transcription and/or detailed interview notes were made by the field researchers. CEI used a framework analysis approach to qualitative data analysis – a pragmatic method of identifying, charting and synthesising codes into higher order themes often used in evaluation research (Gale, Heath, Cameron et al., 2013). We further investigated which program, organisation and system constructs (derived from CFIR) were most commonly experienced across PSP service providers, and the extent to which they acted as implementation enablers and barriers using a similar qualitative valence rating process to that described by Damschroder and Lowery (2013). Full details are included in the Appendix B.

CIRCA coded transcriptions and interview notes according to themes corresponding to the evaluation questions and more nuanced discussion guide questions, using NVivo software. Coding by a single researcher allowed for uniformity in coding.

4.5.4. Qualitative analysis of the case reviews

The case review employed a bottom-up research approach developed to support a detailed investigation of the PSP processes, casework, and service delivery practices to build a strong understanding of the different type of case pathways and case characteristics that make up NSW's child protection and OOHC population. The case review data was analysed by service theme (e.g., risk and safety monitoring, carer support, provision of services) to provide a systematic way of analysing the extensive and detailed case level information captured across case management systems and documents. This approach enabled the rapid identification of barriers and enablers at each phase of PSP service delivery from the perspective of PSP providers, children, family members, carers, DCJ and Children's Court. The analytic process involved:

- Sample reviewing the extraction templates using a direct analysis approach to ensure familiarity with the key insights (Greenwood, Kendrick, Davies, & Gill, 2017); and
- Categorising findings into functions and themes.

4.5.5. Analysis of the survey

The closed-ended questions from the PSP service provider survey data were analysed using descriptive statistical analysis. The data was separated by the following inner settings domains: organisational setting, culture, learning climate, leadership engagement, available resources and questions related to COVID to analyse the key implementation barriers and facilitators from the perspective of PSP providers. Open-ended questions were summarised into key themes through a content analysis approach. These findings were used to supplement data collected through closed-ended questions.

4.6. Triangulation of data across information sources and findings

In line with the use of a hybrid effectiveness-implementation design to assess PSP, we organised and triangulated findings across data sources according to key evaluation questions. In general, triangulation took the form of complementarity - that is, using different methods to answer a related series of questions (Palinkas et al., 2011) – although we were also able to support and deepen our understanding of PSP by expanding on findings from the effectiveness quantitative analyses with qualitative data from, for example, the case reviews.

4.7. Ethics approval and processes

We received ethics approval for the conduct of this evaluation through the NSW Aboriginal Health & Medical Research Council (AH&MRC; Ref no. 1638/20) for a process which included:

- *Providing participants with a plain language explanatory statement* — that outlined the purpose of the survey, interview or focus group and how any information that was provided would be used.
- *Obtaining informed consent from participants prior to their participation* — either through use of a consent form or a recorded verbal consent process.
- *Protecting the confidentiality of research participants* — by de-identifying any information that was collected and reporting it in aggregate so that individuals or organisations could not be identified.
- *Respecting the time and interests of participants* — by limiting the time commitment and providing an incentive payment to participants, and
- *Using culturally appropriate engagement processes* – by obtaining approval from ACCOs and other community members in undertaking case studies in communities.

4.8. Limitations of our approach

We adopted a pragmatic approach to the evaluation of PSP by balancing the available budget, resources, and program information with a rigorous methodology. There are some important limitations to our approach, which should be kept in mind while reading the findings of our evaluation. In particular, the scope of this evaluation meant we were only able to assess the effectiveness of PSP service provider managed service provision through PSP packages. This is one component of the PSP reform and not the whole and caution should be applied in generalising these results too broadly. We acknowledge this evaluation took place over the timeframe in which COVID-19 restrictions were in place in NSW, and that this resulted in changes to PSP implementation and impediments to schooling (see below), although PSP service providers indicated this impact was minimal to moderate (see PSP Service Provider survey findings).

The evaluation questions are answered based on how PSP was implemented and delivered and not on PSP in theory as it was designed. The design of PSP was based on assumptions about the system, stakeholders and context within which it was implemented (see mechanism and assumptions over in Section 2.2). This is important to consider as our evaluation found that a number of these assumptions did not hold (see sustainability

results in Section 8), creating a gap between how PSP was designed and how PSP was implemented and delivered.

We were limited in our response to some evaluation questions by the availability of data. In particular, questions related to PSP service delivery are reliant on qualitative data from case file review, interviews or focus groups because this level of data (i.e., what service a child actually received) is not currently collected by DCJ. These findings should be viewed as exploratory only, and we hope – in the case of the case file review – could be built on in the development of a fit for purpose system so both DCJ and PSP service providers are able to adequately monitor (and adapt) the delivery of PSP services. Specific evaluation limitations, organised by evaluation component, include:

- We have necessarily defined the concept of Reach differently in this evaluation (i.e., reach is classically defined as the proportion of people who take up a service) because PSP is not an optional service. See Table 1.3 for how reach has been operationalised within the PSP evaluation sample.
- Due to the wide reach of PSP we were not able to create a concurrent comparison group to compare the effectiveness of PSP in the majority of our cohorts. We matched instead with historical comparison groups and thus historical variance (e.g. the COVID-19 pandemic, potential differences in reporting and record keeping) may have influenced the results. One such limitation was an administration change that occurred to guardianship records during the historical evaluation period which restricted our evaluation of the effect of PSP on exits to Guardianship.
- Focus groups, surveys and interviews with PSP service providers and DCJ staff were undertaken at different points of time, up to a year apart, and therefore reflect PSP at different stages of implementation. We acknowledge some implementation challenges raised in late 2020, may not have still been salient 12-months later, and/or new challenges (and enablers for that matter) may have come to the forefront over that time.
- The case review did not include the review of PSP Family Preservation cases and only reviewed the case management systems of the participating PSP providers and not DCJ. As a result, the provision of family preservation services by PSP providers, the provision of case management and services by DCJ and the DCJ run functions including case allocation, legal and court work, package application, secondary case management were not reviewed.

Despite our considerable efforts, we were unable to acquire referrals or agreement to participate from all the different cohorts we sought to collect data from at each of the three Aboriginal case study sites (noting that participation in interviews and focus groups was voluntary). The result of this is that at site A, we were unable to consult with birth parents, at site B we were unable to consult with children and at site C we were unable to consult with non-Aboriginal carers in the PSP program. This limited our capacity to obtain a 360-degree perspective of the program in each site. Additionally, it took us some time to recruit three service providers implementing PSP willing to participate in the evaluation. This may have been due to any number or combination of factors, including a lack of interest or time among service providers, lack of trust in being involved in an external evaluation, or their dissatisfaction with the PSP program or its implementation. Recruitment of three service providers consequently took time and meant that data was gathered across the three sites at different periods from January 2021 to February 2022. Elements of the program and its implementation may have changed over the course of the data collection as the PSP program was rolled out and refined and, so, issues raised at one site may have been resolved or worsened by the time information was gathered at another site.

For several reasons there are some limitations to the monetisation of benefits arising from the introduction of PSP in this evaluation:

- The first limitation is the short amount of time since PSP was introduced that is available for the evaluation of PSP in this report. Implementation was further complicated due to the COVID pandemic.
- The second, perhaps even more important, limitation is the lack of information on education, health (physical and mental) and wellbeing outcomes of children in OOHC. We have no information on health or wellbeing, and only limited information on education. Due to COVID, the usual NAPLAN tests were cancelled during the year's most relevant to this evaluation. Providing children with continued education has also been more challenging than usual with children being required to learn from home. This is likely to be more of a disadvantage to children with difficult family/home circumstances.

Part three

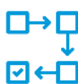
Implementation: how was PSP delivered?

5. Implementation results

Key takeaways

PSP successfully embedded permanency planning and permanency practice across the OOHC system. This was evidenced both in changes to caseworker's 'mindset' and a range of operational changes made by PSP service providers to deliver PSP including recruiting specialist PSP staff, developing site-specific case management templates and forms which embedded permanency planning principles, and establishing local PSP implementation teams. These changes were enabled by Permanency Coordinators who acted as 'change managers', supporting PSP providers to adapt to new ways of working.

Overall, these changes, coupled with increased funding, did not result in children achieving permanency goals within the two-year timeframe. Other factors, often beyond the control of PSP providers, appeared to play a greater role in whether the goal was met 'on time'. These factors included the amount of preliminary permanency planning to be completed, administration for legal work and court delays. We note that PSP service providers in general placed an emphasis on legal permanency rather than a holistic approach across all forms of permanency - relational, cultural, physical and legal permanency.



PSP introduced substantial changes to funding, roles and responsibilities, practices, ways of working and processes for both PSP providers and DCJ. This level of change is expected to be distributive and requires ongoing adaptions, continuous improvement and robust implementation practices to resolve system inefficiencies and gaps which emerge.

5.1. Introduction

The key evaluation question for this component is: *What services and casework are being delivered through PSP, and what are the barriers and enablers to this delivery?* This question is investigated from the perspective of PSP providers, DCJ and Aboriginal people who have engaged with the NSW Child Protection and OOHC system and explored across a sample of children's case notes with different characteristics.

5.2. Data

This section includes results from both the general (i.e., all relevant populations) and Aboriginal implementation evaluation components. The research was conducted by CEI and CIRCA. CEI conducted the survey, focus groups and interviews with PSP service provider and DCJ staff and the review of cases managed by PSP service providers including ACCOs. CIRCA conducted qualitative data collection and analysis in three Aboriginal case study sites to provide contextual information about the experiences of Aboriginal PSP clients, their families, carers and workers with the PSP program. Details on the methods for data collection are summarised in Section 3.2. A description of the methods we used to analyse this data is summarised in Section 3.3.

5.2.1. Data limitations and implications for findings

Data used to describe PSP delivery and casework and draw insights from the implementation of PSP is almost exclusively reliant on qualitative methods. The survey questions with responses elicited according to a rating scale (e.g., from strongly disagree to strongly agree) represent the only quantitative data collected by CEI and CIRCA.

In part, this is because some implementation questions are qualitative in nature (i.e., they are directed toward capturing information about an individual's experience with PSP or the context in which PSP was implemented). These qualitative questions are geared toward developing an in-depth and nuanced understanding of different stakeholder's perceptions and experience with PSP and this cannot be gleaned from quantitative data. As such, these findings do not need to adhere to criteria related to generalisability.

For many of the implementation questions however, qualitative data collected through the case review is used in place of quantitative data. This is because casework (i.e., data on what type of casework is carried out to review permanency goals) and service-level data (i.e., data on what type of services were delivered, for how long and how much) was not available in ChildStory, nor held electronically in a consistent and usable database format (rather than in case note text) by PSP service providers. Furthermore, the in-depth, detailed and targeted nature of qualitative observational data is very useful and insightful when evaluating complex implementations. As is the case with the implementation and delivery of PSP due to the large number of changes introduced, the number of stakeholders and organisations involved and the diversity in the type of casework practices and services covered. For example, the case reviews were able to provide rich data on the type of casework delivered, challenges slowing down the permanency planning process and unintended impacts emerging.

A key implication with using a qualitative approach instead of a quantitative approach is that data can only be collected across a small number of cases due to its manual nature. In addition to the smaller sample, it was not practically possible to randomly select the PSP service providers, or the cases included in the review, as would have been required to maximise the representativeness of the data. Instead, the PSP service providers were selected based on their willingness to participate and the type of services they deliver

(with the aim of including a set of diverse PSP service providers). The cases were selected using a purposive sampling approach (i.e., non-probability sampling) with the objective of sampling evenly across the characteristics of interest identified by DCJ (e.g., permanency goals, level of need, rurality) to ensure sufficient data coverage for each evaluation question. This sampling approach means that the case review findings only represent a small number of the PSP service providers and the breakdown of case characteristics across the sample is not representative of the breakdown of case characteristics across PSP. For this reason, the case review data are not generalisable and therefore cannot be used to reliably estimate prevalence and incident rates (e.g., number of permanency goals achieved) across PSP cases.

Overall, our use of qualitative research methods has substantial implications for how these findings should be interpreted. In general, we do not provide information on the number of respondents or observations for qualitative data. This is consistent with standards for qualitative research (O'Brien et al., 2014), which are concerned with understanding the themes and recognising patterns and phenomena that emerge in relation to the constructs (i.e., barriers and enablers) explored within evaluation questions (Ritchie et al., 2013).

We recommend these findings be interpreted cautiously and be considered exploratory – and in the case of the case file reviews, be viewed as an exemplar for what both DCJ and PSP service providers could achieve given the systematic quantification of PSP service data and by adopting a systematic case review practice across PSP.

5.3. Results

At the most basic level, implementation evaluation is concerned with understanding what people receive as part of a service. Intended service delivery and actual service delivery can differ based on several factors, and this can have implications for service effectiveness. We have organised the general implementation results by the following key evaluation questions (questions relating to enablers and barriers are subsumed within these questions):

- What services are PSP service providers delivering to meet the permanency case plan goals?
- What casework is being carried out by PSP service providers to review permanency case plan goals to determine if it is the appropriate goal for that child and to meet the permanency case plan goal selected?
- Have PSP service providers increased their capacity to deliver PSP?
- Were permanency outcomes achieved for children within the allocated two-year timeframe?

Questions and findings focused on the experience of PSP for Aboriginal children, families and communities is presented in a separate case study section, although some findings are triangulated within other sections where appropriate. These sections are clearly marked throughout the chapter.

5.3.1. What services are PSP service providers delivering to meet the permanency case plan goals?

Questions in this section are addressed using data from the case reviews, PSP service provider focus groups, focus groups and interviews with DCJ staff, and Aboriginal case studies. PSP service providers are responsible for delivering services in line with the contracted PSP service requirements to meet the needs of the children, family members

and carers they are supporting. The delivery of services is planned and guided by the development and monitoring of case plans and covers all the OOHC PSP functions: placement set-up, permanency planning, case management and casework, adoption services (for accredited adoption service providers), placement support including managing safety risks and cultural planning and support, such as life story work and family time.

The services delivered to children, family members and carers as part of PSP are extremely varied, depending on the needs of each person as they arise. The PSP funding model provides flexibility for PSP service providers to determine what practices and services will best meet the needs of the children, family members and carers they are working with. They are able, for example to source and implement evidence-based programs and evidence-informed practices, although this is not prescribed by DCJ. Services delivered through PSP include health care, dental care, disability care, educational support, training, legal, housing, drug and alcohol, parenting support, domestic and family violence support, childcare, respite care, and any other social and community services. In addition to these services, PSP providers are responsible for organising the support required for children, family members and carers to access and engage with the services. Case Management tasks include transport, administrative support, scheduling, attending appointments and liaising with professionals. The PSP providers are also expected to keep records of all activities and professional opinions in line with legislative requirements and NSW Office of the Children's Guardian standards.

What services were delivered to a child or young person and families (in the context of restoration) or carers (adoption and guardianship or to support a restoration)?

The level of involvement required from caseworkers to support parents with restoration, and carers with adoption, guardianship observed in the cases reviewed appeared largely influenced by the level of autonomy of parents and carers. This was also observed across cases without permanency goals. An aspect of the work delivered by PSP service providers, which appeared particularly important across the cases with restorations, guardianship and adoptions goals reviewed, was the focus on supporting parents and carers with developing and demonstrating their capacity to take over the responsibilities held by the PSP service provider and independently provide the care required to meet the child's needs. For example, we found in the cases reviewed that family visits will generally start off being organised and supervised by caseworkers and will gradually shift to being conducted without or with minimal involvement from the caseworker. Throughout this transition, PSP service providers monitor the safety of the child by assessing the risks associated with reducing their level of involvement and conducting adequate monitoring of the placement, the interactions between the child and parents or carers and how well the child's needs are being met.

The following groupings of PSP services is drawn from information extracted from the case file review (n = 74). Note we do not have information on services delivered through Family Preservation packages, as Family Preservation cases were not reviewed as part of the case review. Please see Table 3.3 for a breakdown of cases by PSP permanency goal.

Common types of services, service coordination and other supports provided by PSP service providers across all case types reviewed including cases without a permanency goal:

Coordination of services for children and families consisting of:

- Overseeing the delivery of mandated regular health assessments and other required appointments.

- Arranging medical, behavioural and psychiatric assessments.
- Engaging with service providers to plan ongoing service delivery and monitor progress.

Most services delivered to children can be classified as general child health, psychological and allied health services. The combination of behavioural, occupational and speech therapy to address emotional regulation and communication challenges was common among the cases reviewed. The services which appeared slightly less commonly sought out by PSP providers included: psychologist specialised in sexual behaviours; mentoring; social work; and tutoring.

PSP providers also arranged the provision of personal, household and safety items according to the specific needs of the parent or carer, including: clothing items; home renovations; furniture; phone; and security cameras.

A sizeable portion of the family focused work delivered by PSP providers involved facilitating family consultation and family time contact through:

- Family Group Conferencing services[35]
- Arranging family visits
- Supervising family visits
- Finding new relatives for the purposes of expanding a child's networks of supports and family relationships, and establishing regular contact
- Building trust with new relatives
- Therapeutic case consultation to assess suitability of unsupervised family time
- Organising logistics and accommodation for long distance family visits, including some interstate.

Other services delivered to families appeared less common, and included:

- Play therapy[36] was delivered to support children with expressing themselves, their traumatic experiences and how this has impacted them, to professionals, their carers or their parents.
- Parents or carers working with professionals supporting children in their placement to help with developing an understanding of their challenges and to develop tailored strategies.
- Other family therapies.

Common services, coordination and other supports provided in restoration cases

The services provided to parents in restoration cases were often managed by other community services. There were some instances where PSP providers assisted parents with accessing services, including some instances where providers funded the delivery of private services. The most common services provided to parents included:

- Psychological, forensic psychological and psychiatric services

[35] Family Group Conferencing is a way to bring family members together in a positive way with an impartial facilitator to make a plan for their child or young person.
[36] Play therapy involving a child and either a parent or a carer was included as part of Family Action plans for both restoration and adoption cases.

- Drug and alcohol services
- Housing services
- Domestic and family violence support
- Trauma informed parenting training courses
- Legal support, often linked to Apprehended Violence Order (AVO) applications.

Much of the support provided by PSP providers to parents who required a high level of support included regular conversations to provide emotional support, parenting mentoring and coaching during family visits or phone calls, facilitating contact and relationships with other family members, arranging respite care and ad-hoc support with completing day-to-day activities and chores. Where possible this support was complemented by parenting courses organised by the PSP service provider.

Common services, service coordination and other supports specific to guardianship and adoption work

The services, service coordination and other supports delivered to carers in cases reviewed with adoption and guardianship goals is similar in nature to that of restoration cases, with an expectation that approved carers are unlikely to require as much support, especially with meeting their own needs. The work of PSP providers focuses on supporting the carer with independently meeting all the needs of the child, ensuring the child's safety, ensuring that the child will remain connected to their culture and family and completing the casework required to support the case.

PSP service providers also work with birth parents and family members to involve them in the permanency and case planning processes and to support them through the guardianship and adoption process. The casework and support provided depends on the level of involvement of the parent with the child, their willingness to engage with the PSP provider and the extent to which they agree with the legal permanency goal being pursued.

In some reviewed cases, the PSP service provider struggled with contacting parents and other family members. This created issues for providers in demonstrating that parents and other known family members were consulted, and that the carer had the ability to maintain contact with the child's birth family. In contrast, a few cases reviewed involved situations where parents and family members did not agree with the permanency goal being pursed, which often led to particularly challenging interactions with family members for caseworkers and carers, as well as a significant amount of additional casework and placement support work for PSP service providers.

Aboriginal case studies of PSP experience

Key services delivered by ACCOs

In the three Aboriginal case study sites, parents, carers and children were able to identify a diverse range of services made available to them. For example, services delivered to children included: assistance to access Aboriginal day care; assistance with school enrolment and material needs (e.g., uniform, clothing, shoes and food vouchers); arrangement of after school care/homework classes; tutoring; child counselling; occupational therapy; family finding and support to participate in community activities.

Services delivered to parents included: assistance to obtain housing (where the parent was previously homeless) and to set up the house; support to access drug and alcohol rehabilitation; providing access to a parenting program; support to access NDIS; provision of medical/specialist help; assistance with transport; support for restoration of their child in OOHC; and support for a child to self-place with their birth mother. Services delivered to carers included carer support, respite and guidance.

While these case studies represent only a few PSP clients, they indicate that PSP service providers are assisting children, their parents and carers to access a wide array of services, where they are available. The case studies did not reveal the level of service delivery or whether these services met all, most or some of the client needs.

How much of those services did they receive?

We addressed this question using the qualitative case review data by considering issues with the demand and supply of services. Difficulties with arranging access to external services were observed in the cases reviewed, especially among PSP providers who did not deliver health, behavioural or parenting services themselves (often smaller providers with minimal in-house service infrastructure). Services regularly reported experiencing additional COVID-19 related pressures and difficulties in instances where referrals were not accepted or the predicted waiting times were extensive.

The services which appeared least able to meet demand were services targeting complex needs and behaviours and specialising in trauma. These services included:

- Play therapy.
- Specialised trauma informed therapies (e.g., Eye Movement Desensitisation and Reprocessing[37]).
- Interventions addressing inappropriate sexual behaviours.
- Interventions for victims of sexual violence.

Overall, the case plans reviewed appeared to show flexibility in caseworker selection of services to meet need. Caseworkers were persistent with pursuing different avenues to overcome the service availability challenges they faced, and as a result, in most of the 74 cases reviewed, PSP providers were able to arrange access to services. Some consequences from the service availability challenges identified were:

- Longer waiting times and less convenient locations.
- Caseworkers spending time making numerous referrals and frequent follow up contacts.
- Services accessed and service intensity offered not being aligned to the level of need or the severity of the safety risks associated.
- This appeared particularly true when PSP providers were seeking services to address inappropriate sexual behaviours and serious criminal and violent behaviours.

[37] Eye Movement Desensitisation and Reprocessing, often referred to as EMDR, is a structured psychotherapy technique to address trauma.

- PSP providers funding expensive private service providers.

PSP providers are expected to fund most services using the funding from PSP packages they receive. Where case related expenses are extraordinary (e.g., medical and dental procedures, costs of repairing damage to carer's homes) or not considered standard (e.g., provision of additional casework support due to very challenging behaviours taking place in placement, funding for private services where services are not publicly available), PSP providers can apply for funding from DCJ through seeking a one-off time limited complex need specialist package. From the cases reviewed, it appears funding requested for these extraordinary expenses is generally approved by DCJ.

Separate to the funding and access challenges faced by PSP providers, it was also common for children, family members and carers to decide not to engage with services. A range of factors were identified as contributing to this:

- Lack of trust for services often created by past negative experiences.
- Not believing that the service would benefit them.
- Not feeling ready to access the service.

DCJ representatives reported a perceived need for more information and support to assist carers to achieve permanency. This includes providing information and support for meeting specific criteria to be eligible for adoption or guardianship.

Are these services, where indicated, evidence-informed?

A substantial portion of the services delivered, in the cases reviewed, are standard universal care services (e.g., occupational therapy), which may include provision of best-practice, evidence-informed approaches or assessment tools – although we were unable to determine this from the case reviews. Overall, the majority of services delivered across the cases reviewed did not appear to be selected under the umbrella of a practice framework or to fit within a self-contained program. As a result, it is not possible to assess the extent that services delivered were informed by evidence.

We were only able to identify potential evidence-informed services by their name in the case notes. While there were no recognisable evidence-informed practices (e.g., motivational interviewing to support behaviour change), there were a small number of casework and services which may contain evidence-informed practices including:

- Positive Response Intervention Plan: an evidence-based approach to develop behaviour plans.
- Practice framework used to assess whether secure attachment is being developed within a placement.
- Coordinated care practice framework.

What services are being provided in relation to the specialist services to support permanency?

Aboriginal Cultural Planning

All of the 39 cases reviewed involved Aboriginal children had a cultural plan in place. Several the cultural plans reviewed were older than 12 months including cultural plans were many of its activities appeared not be updated regularly. The case review data cannot determine how prevalent this was across the cases reviewed as only some cultural

plans were reviewed. A small number of the cases with cultural plans did not receive the Cultural Plan (Aboriginal) packages. The information and activities included in the cultural plan and across casework practice varied substantially. The ACCOs that participated in the case review also embedded cultural support practices across most of their interactions with children, family members and carers. For example, home visits included regular discussion about the child's family history and culture, as well as providing learning materials on language, art, and local Aboriginal history to the carers.

Cultural planning and support identified through the case review included learning about and documenting the child's family history, gathering photos and facilitating frequent contact between the child and Aboriginal family members. The cultural plans also set out a cultural program and activities for the child and their family members or carers to attend. It was not always clear if, and how often these events were attended - however this could be the result of a large number of events being cancelled due to COVID. Cultural programs including mentorship programs and camps appeared to be largely run by schools and ACCOs. The important role played by schools in providing cultural support was clear from the cases reviewed, suggesting that where schools do not provide many programs or support to Aboriginal children the quality of cultural support received may be negatively impacted.

Aboriginal case studies of PSP experience

Aboriginal Cultural Planning

Children, parents and some carers interviewed in the Aboriginal case study sites highly valued efforts to support cultural and community connection. Most children, parents and carers who were interviewed were able to report that cultural plans were in place, although they were not always fully aware of plan contents. However, some of those who were interviewed were unaware of any cultural plans in place and thought that these would be helpful.

Services to CALD children

Case reviews identified only a small number of CALD packages and slightly more cultural plans (cultural plans are funded within the baseline package). The CALD funding within the reviewed cases was primarily used to search and support culturally matched placements.

4+ Sibling placement packages

In line with the findings in the Reach section, only a small number of 4+ Sibling Placement packages were identified in the case reviews. In the majority of cases reviewed the children involved had numerous siblings, some of which were in their placements and others not, and it was very rare for four siblings to be placed together. In these cases, the 4+ Sibling placement package appeared to fund the work required to place the siblings together. This required moving siblings into a new placement with their siblings, one case involved moving children interstate.

Aboriginal case studies of PSP experience

Siblings Placement

Interviews with children and carers in the Aboriginal case study sites revealed that PSP goals for sibling placement are not always met. Of the children who were interviewed, two had been placed with their siblings, while three children reported that they had never been placed with their siblings or supported to see their siblings. One child indicated they had not had a full family contact with all their siblings together for several years. These children very much wanted increased contact with their siblings.

'They [case workers] always have excuses that they can't get in contact with my parents. All my siblings are in different organisations, and they won't let us all have contact together. They say it's too hard' - Aboriginal child interview

Sibling placement and support for siblings to maintain contact is made more complicated when children from the same birth family are being supported by different PSP service providers.

Leaving care packages and 15+ Reconnect packages

In all the 16 cases reviewed with children over the age of 15, the PSP providers worked with children and their support networks to develop leaving care plan and associated financial plans. This process appeared thorough and consistent across the cases reviewed. All leaving and financial plans identified in the case review were approved by DCJ. The casework and services delivered as part of the leaving plans were broad and covered financial, work, educational, housing, social, health, behavioural, cultural and driving needs. The casework and support from PSP service providers included hands on support with drafting resumes, contacting local business to seek out work experience opportunities and ongoing frequent conversations with the young person.

The 15+ Reconnect package was not common among the cases reviewed and when present in the cases reviewed the nature of the casework and services delivered did not appear to change. However, it was noticeable that the level of support required by children before leaving varied widely. In the cases with leaving care packages reviewed, it was common that children had carers or family members who were committed to fully supporting them after they turned 18. These cases tended to involve stable long-term placements, where the carers did not believe guardianship was in the best interest of the young person because it would reduce their access to services and financial support. In these cases, PSP service providers and carers often worked well together to support the young person. While in the rest of the cases, which included self-placements, the support from PSP service providers often appeared to be the main source of support, and in some cases, this meant that the PSP provider caseworkers acted as 'pseudo' carers to the children.

To what extent do services provided differ depending on the type of permanency case plan goal or level of need?

The level of need of the child, family members and carer (inferred from Child Needs Package level and case information from the PSP service providers and in the case notes) appear in the case reviews to be strongly associated with the services and casework provided by PSP service providers to work toward permanency outcomes and to support placements. The changes in CAT scores resulting in changes to the Child Needs Package level observed in the cases reviewed appeared to be concentrated around the cases that we observed as having the most extreme level of needs (e.g., children requiring full time supervision due to a history of frequent high-risk behaviours). However, the level of need observed in the cases reviewed commonly did not appear accurately reflected in the assessed level of needs using CAT scores - the level of need observed across cases with low needs scores varies greatly (e.g., reported challenges with inappropriate behaviours at school or in placement). This is in line with the Reach finding which found that over 90% of cases were assigned low needs packages initially and that level of need tended to increase overtime. This suggests that the CAT score assigned does not consistently reflect the amount of effort required by PSP providers to deliver services, especially when children first enter OOHC. In addition, the case reviews identified very few instances where DCJ had reviewed a needs assessment. We note there is currently no requirement for DCJ to review needs assessments, although PSP service providers may request a review if there has been a change in circumstances for the child.

The relationship between perceived level of need of children and extent of services delivered by PSP service providers appeared different across cases reviewed where a child was covered by a NDIS plan. In these cases, the needs of children were largely met through NDIS funded packages. In some cases where children presented with high needs and did not have NDIS plans in place, PSP service providers completed NDIS applications. The application processes captured within the cases reviewed appeared time and resources intensive (e.g., collecting and collating evidence from a range of professionals for the assessments), particularly in cases with limited existing evidence or in cases with needs not clearly linked to a diagnosis (e.g., impairments impacting independent living skills). However, once a NDIS plan was in place the work involved for PSP service providers reduced significantly and largely focused on overseeing the delivery of the NDIS plan and coordinating care with the assigned NDIS case manager.

In general, the volume of services delivered appeared linked to the level of need of children, family members and carers, unless a NDIS plan was in place. This was particularly observed in restoration cases reviewed, as the parents involved generally had a higher level of need, which required more support, case planning and monitoring.

To what extent do services provided differ depending on the length of time that children have been in out-of-home care?

Some trends observed across the case reviews suggest that certain events or stages along care pathways, that are associated with length of time in OOHC, appear linked with different levels of service requirements and support from PSP providers. These care pathway events and stages include:

- Having recently been taken into care appears linked to higher levels of services and supporting work both for:
  - Babies who require extensive medical monitoring and non-stop care, and
  - Older children taken into care, who tend to have experienced high levels of trauma, which has often not been addressed by services.

- Having been in care for a long time appears linked to the level of services required for a considerable proportion of older children, as they are more likely to display particularly challenging behaviours.

To what extent do services provided differ depending on the type of care arrangement (foster care, kinship care and self-placements were considered)?

Service provision was observed in the case reviews to be largely comparable across different types of care arrangements - except for kinship placements, where there appeared to be a higher level of placement support delivered to ensure placement safety and meet the needs of the child. Several kinship placement characteristics stand out as requiring a higher level of support:

- Kin placement with older carers or carers with a medical condition.
- Kin placement with carers who speak limited English or have low literacy.

What are the enablers to quality delivery of PSP services?

Enablers to the delivery of PSP derive from PSP service provider focus groups and survey, focus group and interviews with DCJ staff and Aboriginal case studies. In general, enablers refer to PSP delivery within the early stages of implementation of the reform.

The program goal of restoring children to their families and working with families helped to change mindsets of PSP providers and carers

The *concept* of permanency – or the intent of PSP to support permanency – was seen to promote a positive shift in mindsets of caseworkers and carers. Focusing on permanency helped caseworkers and carers to consider different permanency options for children entering care and assume a more inclusive approach with birth families. In particular, an explicit focus on restoration as the 'first option' for children who have had recently entered care was seen to have several benefits.

> *'[PSP] has made caseworkers think more broadly about what we could be doing in reconnecting kids to their families.' - PSP provider*

Permanency Coordinators acted as external change agents for the implementation of PSP and served as a conduit between PSP providers and DCJ

A key enabler to quality delivery of PSP services was the establishment of PC roles, including Aboriginal PCs. For ACCOs, the presence and support of Aboriginal PCs was also described as an enabler to implementation. PCs played a critical role in the capacity building and upskilling of PSP providers. Implementation of PSP required service providers to adapt and develop a new way of working. DCJ representatives – including PCs themselves – stated that a sizeable portion of their work revolved around change management.

> *'[PSP providers] were really experienced in out of home care, but we introduced a whole new range of ways of working and so, such a huge amount of work PCs were doing was actually change management work.'*

– DCJ representative

DCJ representatives and PSP service provider staff further described PCs as a conduit between DCJ and PSP providers, often providing insights to DCJ central on ground-work operations. For example, DCJ representatives stated that PCs alleviated the barrier caused by poor transparency of funding allocations. DCJ staff reported some difficulties in assessing cases for increased funding, as DCJ was unclear about how and where previous funding was spent. As PCs work directly with service providers, they often bridged this gap, offering insights into *why* additional funding was warranted.

'Contracting's not interested in whether there's a great cultural plan on there or not. A lot of that stuff the PC work has done and in making sure that that work is being – is of quality.'

– DCJ Representative

Internal leadership, culture and learning climates were largely supportive of PSP

When team leaders and executives were available, supportive and knowledgeable about PSP, they acted as a key enabler to assist caseworkers in the implementation of PSP. Findings from the Inner Setting survey administered to PSP providers were similar – indicating a supportive environment for caseworkers and other staff in the delivery of PSP. This includes a strong and supportive learning climate, culture and leadership engagement within the organisations implementing PSP (see Appendix D.2).

DCJ identified emerging barriers to implementation early and made adaptations to mitigate these challenges

DCJ made adaptations to PSP to address emerging barriers to the delivery of PSP services throughout early implementation. Adaptations included the introduction of the PSP Learning Hub and repositioning of PCs within the organisational structure. Acknowledging a 'knowledge gap' within the sector, these adaptations were made to further promote the upskilling and capacity building of PSP providers.

The PSP Learning Hub provides an opportunity for PSP providers to increase their understanding of PSP and its guiding principles, associated legislation and case planning practices for supporting successful preservation and restoration.

'We added the PSP Learning Hub into the PSP reform process. It wasn't part of the original design. It was an extra thing that we added to try and upskill the sector and that process is still ongoing.' – DCJ representative

Organisational restructuring placed PCs in a position to provide direct guidance more readily to PSP provider staff. The ability to identify and address barriers early through the provision of increased supports acted as a strong enabler to PSP implementation.

Aboriginal case studies of PSP experience

Internal stability and resourcing within PSP service providers

Participants in the three Aboriginal case study sites identified that PSP providers which had sufficient numbers of Aboriginal caseworkers, low turnover of staff and lower caseloads seemed better able to assess and meet the needs of birth parents, carers and children in care. This was particularly so when caseworkers maintained good communication with all parties, prepared and updated cultural plans and maintained children's connection to family and culture.

What are the barriers to quality delivery of PSP services?

Numerous barriers to the delivery of quality PSP services were identified through discussions with PSP providers (including those in the Aboriginal case studies) and DCJ staff. For PSP providers, this is supported by the application of valence ratings, as detailed in the Appendix D.1. These valence ratings show that PSP program characteristics, including the intervention source, design quality, complexity and cost, as well as implementation processes, system architecture and resource continuity had a consistent negative influence on implementation across PSP providers – at least in the first two years of PSP implementation. The most common and deeply experienced barriers can be grouped into the key findings as described below.

Program design and implementation encouraged a focus on complex administration, financing and compliance rather than on improving quality, evidence-based casework

PSP providers viewed PSP as a very complex program to implement and those who had worked on other programs viewed PSP as more complex by comparison. PSP service providers reported that PSP significantly increased caseworker workloads. This is partly seen to be due to the additional work required for restoration, guardianship and adoption cases. It is also due to an increase in administrative tasks under PSP. PSP was described as an 'administratively heavy' program in which the caseworker role was at risk of becoming a 'data entry job.'

PSP service providers voiced concerns that program complexity, workload, and bureaucratic processes to access funding packages may draw their focus away from the work that directly improves outcomes for children– that is, quality casework. There was little systematic or structured focus within PSP on supporting caseworkers in evidence-based practice and little time or space for PSP providers to focus on improving casework skills internally.

We note that complexity (and ensuing workload) is part of the intention behind PSP – that PSP service providers are paid materially more for undertaking complex permanency work. It appears however that these challenges were greater than initially anticipated by PSP service providers.

Program design and administrative requirements created resourcing problems

PSP providers claimed there were gaps in packages and unaccounted-for costs in delivering quality PSP services. Important aspects of work, such as cultural care or increased supports for vulnerable children and families, were not adequately funded within the package

structure. Service providers identified gaps in packages for children who self-place, sibling groups of varying sizes and children who live in rural or regional areas or whose family lives far away. They also claimed there were insufficient funds available to provide intensive family services to achieve restoration, cover large or unexpected expenses such as dental costs or provide sufficient services to higher needs children. These providers stated the structure of packages did not account for work required in the lead-up to a case plan goal change. This was viewed as essential work if permanency is to be achieved within two years.

'We've got to jump through hoops and do so much more just to cater to the basic needs of these kids.' – PSP provider

In the first two-years of implementation, PSP providers claimed there were significant payment issues related to payment approvals and receipt of payment. Delays were caused in part by the back-and-forth nature of the application process and the quarterly nature of reconciliation of funding. Inaccuracies in payments due to issues with DCJ's IT system meant there were large backlogs of payments to PSP providers.

It was reported by PSP service providers that both the workload that goes into applying for packages, and the complexity of financial reconciliation, places greater administrative requirements on PSP providers. Financial reconciliation is seen to be more difficult now that children have multiple layers of funding packages. There is also a limit to the extent to which pooling of packages can overcome interruptions to resourcing. While these resourcing issues were not seen to create perverse incentives, payment issues limited the ability of PSP providers to proactively support placements - and placed a particular strain on the ability of smaller PSP providers to provide services needed by children.

Aboriginal case studies of PSP experience

Funding shortfalls and gaps

Funding shortfalls were identified as a barrier by case workers and community members in the three Aboriginal case study sites.

'Services tend to be based and funded on the population of the town, not the need' - Case worker / manager

Case workers and managers in these sites identified funding gaps around: family preservation, keeping siblings together, and support for kin carers (e.g., through an order allocating Parental Responsibility or Guardianship). They also spoke of unaccounted for costs of cultural care (e.g., cultural planning and family finding) or increased supports for vulnerable children and families (e.g., for children living with disability and children with more challenging behaviours).

Inconsistencies in DCJ decision-making and low levels of collaboration between DCJ and PSP providers hampered implementation efforts, although this has changed over time

The relationship and decision-making structures between DCJ and PSP service providers acted as an overarching barrier to quality service delivery, particularly in the early phases of PSP implementation. Although there are instances of increasing collaboration, PSP was initially characterised by a directive approach and a lack of trust between DCJ and PSP providers. PSP providers did not believe DCJ recognised their professional expertise and knowledge of the children and families with whom they worked. PSP providers believed work was being pushed onto them with few reasons provided by DCJ for changes to policies and procedures. The strained nature of this relationship was perceived to negatively affect joint decision-making (i.e., around reviewing case plan goals) and effective communication between DCJ and PSP providers. This caused challenges accessing sufficient and timely information, which in turn limited the ability of PSP providers to meet the needs of children and families.

Inconsistency in the interpretation and application of PSP policies and procedures throughout DCJ in early implementation was seen to add to the complexity of the program, creating confusion among PSP providers and contributing to cause delays. These inconsistences occurred within and between DCJ districts and between DCJ and PSP providers. Inconsistences were experienced at both an organisational level (i.e., where PSP providers have offices in different locations) and by individual PSP provider staff (i.e., where one caseworker has clients across different CFDUs).

> *'We certainly know when we get new referrals, depending on who the manager or caseworker is, … how easy or difficult it's going to be to work on that restoration.' – PSP provider*

The relationship between DCJ and PSP providers was strained by a lack of clarity around roles and responsibilities of DCJ staff, including PCs, and PSP providers. Poorly defined roles caused tension between DCJ and service providers in the early phases of implementation.

> *Initially there was a little bit of head butting, I think, with what our [DCJ] responsibilities were, what the FSPs were responsible for.' – DCJ representative*

There is some evidence that relationships between DCJ and PSP providers have strengthened over time as implementation has progressed and challenges have been overcome. Some PSP service providers related examples of collaboration in joint decision-making to identify case plan goals, undertake joint home visits and how to improve processes for accessing funding. DCJ representatives note collaboration between DCJ central and DCJ districts as a strong enabler to PSP implementation. DCJ central relies heavily on information provided by DCJ districts, describing district staff as a 'critical touch point' between DCJ central and the PSP providers.

Insufficient planning before implementation of PSP caused challenges during the initial roll out and early implementation of the program.

Insufficient planning was a significant barrier to the early implementation of PSP. DCJ representatives voiced that although PSP was designed with the clear aim to achieve

permanency outcomes, limited planning was done to outline how this goal was to be achieved.

> *'I think the biggest [challenge] is the fact that a lot of the detail around the program was yet to be worked out. I think we had a very high level of information about what the intent of the program wanted to achieve – and that was planning permanency for children – but how were we going to do that?' – DCJ representative*

This was particularly true when establishing mechanisms for data collection. Representatives from DCJ noted that when PSP was launched, there was no data collection system in place to support them. This caused challenges in documenting critical information and processing accurate payments. The subsequent introduction of ChildStory and associated data remediation led to an administrative burden for both PSP service providers and DCJ. This lack of planning led to the inefficient use of program funding and resourcing during early implementation.

A practice gap observed in early implementation of PSP contributed to implementation challenges

According to representatives from DCJ, implementation and delivery of PSP required significant practice change from PSP service providers. DCJ representatives described a 'practice gap' between what PSP providers were contracted to do and business as usual. The introduction of PSP was generally seen by PSP service providers to have involved a steep (and ongoing) learning curve.

> *'Even people that were part of the OOHC space prior to PSP had a lot that they needed to learn' – PSP service provider focus group*

Some PSP service providers noted training and skill gaps in effective casework for family preservation, restoration, and adoption permanency goals. They related this to the poor availability of evidence-informed practices, staff turnover and a new way of thinking, particularly for those organisations and staff that had not delivered those services previously.

> *'Having to tweak [caseworkers'] mindset to that child protection/family preservation skillset, which is a really different way of working in families — _genuinely different to child protection work or OOHC work — ... _has taken the best part of 12 months' – PSP service provider focus group*

This required significant upskilling and training of PSP service providers – which was supported in time by the introduction of the PSP Learning Hub.

Aboriginal case studies of PSP experience

Challenges for PSP providers

Participants in the three Aboriginal case study sites identified several challenges for service providers in implementing PSP:

- Regional areas typically have fewer staff and services available than urban areas, which places greater demands on staff (and families, who may have had to travel long distances to access services like paediatricians, mentoring, psychologists).
- A lack of cross-sector coordination (e.g., between OOHC and disability services), duplication of services, and gaps in services can lead to an inconsistency of support being provided across families and carers.
- When different services are working with children from the same family, it can create difficulty for birth parents and their children or siblings to maintain connections with each other).
- Poor handover during staff turnover within PSP service providers can reduce communication and trust that children, carers and birth parents have in caseworkers and the service.

PSP providers experienced challenges in recruiting and supporting carers, particularly in legal processes

PSP providers are now solely responsible for the recruitment and provision of carers who can provide different placement types. This shift increased the scope of carer recruitment for PSP providers. PSP service providers hold primary case management responsibilities for cases before a final order, which means they are more involved with recruiting and supporting carers who provide temporary care arrangements. The increased focus on permanency planning and achieving legal permanency also had an impact, as it relies on PSP providers recruiting more carers who are looking for permanent care arrangements.

We identified some new challenges in the case reviews with recruiting and supporting carers faced by PSP providers. This included some instances of the Children's Court placement recommendations ignoring the type of placement a carer was providing and would like to provide. One example included a Children's Court asking a carer to apply for legal guardianship in a case where permanency planning was still in active discussion among the PSP service provider, DCJ and family members and the carer had not being considered for legal guardianship. Further, the increase in PSP service providers' involvement in the legal process has meant that providers are increasingly working to support the delivery of assessments and to provide evidence (contained in PSP service providers' case files) required for drafting court documents (e.g., care plans, court orders), which are the responsibility of DCJ. In some cases, carers reported feeling confused and frustrated due to receiving a stream of requests for information and documents from both their PSP service provider and DCJ staff working to draft legal documents for the case.

These challenges highlight that PSP processes involving DCJ, the Children's Court and PSP providers have not been adequately reviewed and adapted to properly support the delivery of PSP.

5.3.2. What casework is being carried out by PSP service providers to review the permanency case plan goals to determine if it is the appropriate goal for that child and to meet the permanency case plan goal selected?

We have addressed questions in this section using data from the case reviews, ChildStory, and PSP service provider focus groups. Permanency planning and casework is intrinsically linked with placement goal set, placement support, service provision and developing trusting relationships between caseworkers and children, family members and carers. This is particularly true for cases where children do not already have long-term stable placements or where regular family contact has not been established. The nature, complexity and quantity of casework to be completed to determine whether a permanency case plan goal is appropriate depends greatly on the characteristics of the case, the existing placement arrangements and the availability of suitable kin carers. For example, in some cases extensive preliminary casework is required to determine whether a permanency goal is viable. The main types of activities involved in permanency planning and casework, as observed across the cases reviewed (n = 74) are detailed below:

- Consultation with the child, family members, carers and professionals to inform permanency planning including:
    - Family finding
    - Regular discussions with the child
    - Family member consultations
    - Family group conferencing
    - Broader case planning consultation

- Identifying potential permanent carer(s) in line with the Aboriginal and permanency placement principles including:
    - Discussions with the child, family members, carers and professionals (see above)
    - Searching for a foster carer with common culture
    - Asking potential carers identified whether they would consider being a permanent carer
    - Determining whether to pursue placement set up

- Setting up a placement with the objective of achieving a legal permanent outcome through supporting:
    - Carer assessment and training
    - Placement transition
    - Financial and housing

- Setting up support networks, regular family contact and cultural support within the potential permanent placement including:

- Arranging and supporting safe family time visits.
- Coaching carers around sharing updates with family and facilitating family time visits.
- Providing family, community and welfare services.
- Providing cultural support.

In parallel to permanency planning and casework, the PSP provider delivered ongoing placement support or restoration services to:

- Achieve restoration goals set out in the Family Action Plan.
- Prevent placement breakdown.
- Ensure the placement is safe.
- Ensure the needs of the child, carer and other household members are met.
- Ensure carers can meet the ongoing needs of the child.

The important role of preliminary permanency planning and casework and ongoing placement and restoration support, in achieving permanency is demonstrated in the cases reviewed, where it was common for cases to have at least three permanency case goal changes in less than two years. The PSP service providers need to deliver casework and placement support to address a variety of circumstances identified as common reasons for permanency goal changes in the cases reviewed:

- Unsuccessful restorations.
- Placement breakdowns.
- Changes in carer's circumstances including family breakdowns and carer illness.
- Potential permanent carers changed their minds about applying for guardianship.
- New family members identified throughout the permanency planning process being considered.
- Permanency case plan goal being contested by family members.
- Carer not considered suitable to provide permanent placement by PSP provider or DCJ.

The review of permanency goals and associated case plans is supported by a set of formal permanency casework activities including:

- Collaborative permanency goal reviews.
- Restoration, guardianship and adoption assessments.
- Other structured decision-making tools.

The collaborative permanency goal reviews, as observed in the cases reviewed, were used to discuss the specifics of a case, preliminary permanency casework completed, outcomes from assessments and the challenges experienced with regards to achieving permanency and for DCJ to make a set of recommendations mostly aimed at achieving permanency for the PSP service provider to follow. The recommendations made by DCJ included:

- Conducting family group conferencing
- Increasing family visits
- Reaching to DCJ or other service providers, where appropriate
- Accessing certain services
- Conducting formal assessments

In the cases reviewed, it was most common for assessments to be requested by DCJ during the case goal reviews after a decision on the most appropriate goal was made. For example, in several cases reviewed, DCJ recommended the completion of a guardianship assessment, after extensive family consultation and permanency goal planning with DCJ, where the outcome was very likely to be supported.

In some cases, DCJ requested the completion of assessments and casework that were not in line with the casework being delivered by the PSP service provider. Some instances observed included:

- DCJ requesting the completion of a restoration assessment to justify a change of goal from restoration to guardianship.
- Undertaking steps to support a parent with restoration while also completing preliminary work for a guardianship goal in case restoration was not a safe option - including DCJ requesting a guardianship assessment for a kin carer when restoration continued to be pursued with a birth parent.

How many children had their case plan developed/reviewed in the OOHC data within a year?[38]

We planned to investigate the proportion of children who had their case plans reviewed within a year in ChildStory and link this with the OOHC placement data for children in both the Entry/Re-entry and Ongoing Care cohorts. However, the rates of case plan reviews in the data provided from ChildStory were very low and are not reported here due to potential data quality issues. In the early implementation of PSP, it was not mandatory to report completed case plan reviews each quarter to DCJ via ChildStory in addition to PSP service providers completing on their own client management systems. Reporting such data would likely be a substantial underrepresentation.

The qualitative case review findings (n=74) suggest that the participating PSP service providers consistently (approximately annually) conducted case plan meetings with family members, practitioners, carers and older children to create new case plans. In the cases reviewed, this process generally involved consulting with the child and their extensive network including their school before the meeting. The early consultation aimed to gather input from the child and their support network using forms or conversations, as well as invite them to the case plan meeting if appropriate. There was little evidence found that DCJ actively monitored the frequency or quality of case plans developed by PSP service providers and consequently the level of compliance with the minimum review requirements.

It is important to note that ChildStory and PSP were rolled out around the same time, and as can be expected, new data collection systems and processes take time before they are

[38] It is important to note that there are differences what is reported here and in the National reporting of case plan reviews due to differences in population, data sources and counting rules.

implemented as intended. The true proportion of children who had their case plans reviewed within a year cannot be inferred precisely, it is likely underrepresented in the quantitative data due to data quality issues and may be overrepresented in the subset of cases provided in the qualitative approach. Future research on this will be greatly improved when systems are better integrated and reporting is more streamlined and consistent.

How many and how often have children had their permanency case plan goals changed following a permanency case plan goal review?

The permanency case plan goal reviews (see their description Section 2.3) are separate to the case plan reviews discussed in the evaluation question above. They are required to take place regularly in line with PSP services requirements, conducted by Permanency Coordinators and involve participants from DCJ and PSP service providers. This question is addressed using observations from the case review only as DCJ does not collect ChildStory data on whether or when the Permanency case plan goal reviews have taken place. This data is limited in scope and the small sample is non-representative, meaning the following should be interpreted cautiously.

In the 75 cases reviewed, we observed that few had recorded permanency case plan goal reviews within the minimum frequency requirements set out in DCJ's service requirements, which range from every three months to annual, in line with a case's permanency goals. In this sample, PSP service providers were most often the agency requesting and planning the case plan reviews. The timing with regards to planning a permanency case plan goal review appeared linked to whether a case was at a stage where the review would be most beneficial including whether enough progress had been made regarding addressing earlier DCJ recommendations.

The process followed by DCJ and PSP providers to change permanency case plan goals appeared inconsistent across the cases reviewed. Across the cases reviewed, the case data stored in ChildStory, including permanency goals, was found to be inaccurate in a significant number of cases (as reported in the Permanency case plan goal review forms stored in case files). The data inconsistencies were commonly noticed during a permanency goal review or by a Permanency Coordinator at another time. Additionally, there was often a lag observed between a recommendation to change a permanency goal being made in a permanency goal review and a formal request and approval to change the goal being made by the Permanency Coordinator with the support of the PSP provider. This lag was due to the DCJ staff who hold the permission to approve permanency goal changes not attending the permanency goal reviews. After the case plan goal was formally approved it was also possible for there to be a lag between the approval and the change being reflected in ChildStory. As a result, we suspect that the ChildStory data on permanency goals does not consistently reflect changes in permanency goals in real time.

What are the barriers and enablers to quality review of permanency case plan goals?

We addressed this question using data from the PSP service providers and DCJ focus groups and interviews. Barriers to permanency case plan goal setting and review included a perceived lack of rigour in identifying appropriate criteria for permanency case plan goals, difficulties of parallel planning, a lack of collaboration between PSP providers and DCJ and delayed feedback from DCJ about the outcome of a review. One barrier for guardianship work under PSP was perceived pressure from DCJ to pursue guardianship in cases where PSP providers saw this as inappropriate. For children who were already in care when PSP was introduced, many case plan goals were changed quickly, and a lack of pre-work was seen to set these up to fail.

Other barriers, linked to the capacity constraints discussed under Section 4.2, were identified as having a large impact on the quality of permanency planning when PSP was first implemented including limited understanding of permanency concepts across PSP service providers, organisational structures and practices developed to deliver OOHC placements and lack of clarity over how PSP should be operationalised by PSP service providers across different districts.

'It was pretty hard on the funded service providers but also really more so the families and the young people and then that's why you didn't actually see success in the program at the start because everybody was trying to find their feet within it' – DCJ Representative

Enablers to quality review of case plan goals included the role of PCs (described above). One PSP provider also mentioned the use of group supervision and Family Group Conferencing (FGCs) was an enabler.

Aboriginal case studies of PSP experience

Enablers to review of case plan goals

Enablers identified at the three Aboriginal case study sites included: personalising cultural plans at the onset of development; including children's and birth family members' views into plan development; and revising them as things change.

To what extent does casework differ depending on the type of permanency case plan goal or level of need?

Our responses to this question and the following two questions are drawn from the case reviews. This means that while we can observe potential links between casework and other characteristics, these qualitative observations are necessarily exploratory and should be confirmed with further case review research. The volume of casework completed by PSP providers is linked to the services delivered and the preliminary permanency planning and casework requirements of the case. Our observation is that casework volume and planning is positively associated with level of need. This trend was less pronounced in cases described (in the case notes) as having an established stable placement with a carer well equipped to support the child in placement independently. It is important to note that existence of a stable placement can itself be associated with level of need (reduced likelihood of placement breakdowns) or other factors being considered such as length of time in placement.

We observed that the positive relationship between extent of casework delivered and level of need commonly carried through to the permanency case plan goal in the restoration cases reviewed, which involved parents who consistently required extensive support and monitoring from PSP service providers. This was deduced from the higher amount of casework related information generally found in the case file notes of the restoration cases reviewed. It suggests that PSP service providers spend substantial time completing the core casework involved with cases including developing case plans, family action plans for change (i.e., identifying actions required for restoration), completing risk assessments

when placement arrangements changed (e.g., starting overnight visits or setting up supervision with a family member), developing safety plans (e.g., to minimise risk on overnight visits and set clear guidelines), delivering the casework associated with case and safety plans (e.g., regular drug testing), documenting all interactions with the parent, supporting the parent with demonstrating parenting capacity, tracking and documenting progress with external services and informing DCJ of case specifics.

Other than across the restoration cases reviewed, we do not observe any links between casework requirements and permanency case plan goal.

To what extent does casework differ depending on the length of time that children have been in out-of-home care?

In the cases reviewed, we observed the level of involvement from DCJ and the Children's Court in permanency casework to be higher before a final order has been granted by the court, and this is associated with more casework to meet the statutory time requirements and develop the court documents including a final case plan. In these cases, DCJ retains a high level of involvement in the case including sending regular requests for input and supporting casework from PSP providers.

Across reviewed cases, where children had been in care for a long time, PSP service providers appeared to consistently engage in frequent conversations about permanency with children, carers and family members. This suggests that the introduction of PSP did increase the amount of permanency planning and casework across cases in the in-care cohort. In the cases with final orders reviewed, casework appeared to be influenced largely by placement stability, placement needs and the outstanding preliminary permanency planning and casework activities.

To what extent does casework differ depending on the type of care arrangement (foster care, kinship care and self-placements were considered)?

Casework relating to achieving permanency outcomes did not appear linked to the type of care arrangements in place in our observations of the cases reviewed. The only placement type which was observed to impact the amount and type of casework delivered were self-placements. This placement type involved supporting a child who had decided to live with a non-approved carer, which appeared to involve more casework. This interpretation is supported by the PSP service provider focus groups where casework with young people who self-place was described as "extremely intensive work" and under resourced.

In addition to this finding and in line with our observation that kinship care placements appear to require higher level of services and placement support (see Section 4.2.1), we expect that kinship care placements would also require more casework overall.

5.3.3. Have PSP service providers increased their capacity to deliver PSP?

It can take several years to increase capacity and embed change within a system so that services are delivered consistently as part of business-as-usual functioning. While we are unable to compare PSP service provider capacity to deliver PSP services before and after the introduction of PSP (i.e., we do not have a baseline for reference), we can – using data from the DCJ interviews and focus group, PSP service provider focus groups and case reviews – infer that capacity is being built in this area.

PSP introduced a new set of service requirements and processes, which were described by DCJ representatives as introducing a whole new way of working for the PSP service providers. The PSP service providers were described by DCJ representatives as very experienced with providing OOHC care services and as lacking experience with delivering child protection services which sit outside of the OOHC care services they were involved in delivering before PSP (e.g., permanency planning and support). The level of understanding and capacity to delivery permanency planning and support was depicted as varying greatly across PSP service providers and across districts. DCJ representatives explained that DCJ underestimated the amount of change management and practice support needed to support PSP service providers with adopting the new ways of working introduced by PSP, where the amount of learning and development required from some PSP service providers to delivery PSP was extensive. It is important to note that the diversity in capacity across PSP service providers is not captured in cases reviews, due to only a small subset of the PSP service providers being represented.

'We changed the funding for service providers and said, "Here you go. Here's a bucket of money and we're going to get you to do this." And, we did that to service providers that actually didn't have the capability to do the work that we were funding them for. – DCJ Representative

Permanency Coordinators were seen by PSP service providers and DCJ as key to capacity building through providing conceptual knowledge, advice and assistance on cases (e.g., by stepping through conversations that caseworkers will have with carers or birth families, and by assisting with Family Finding); sharing resources about PSP; assuming a collaborative approach; facilitating initial entry-to-care meetings; and organising some local training or seminars. In addition, it was reported that many PSP service providers realised when PSP was introduced that they needed to make significant structural and practice changes.

A range of operational adaptions made by PSP service providers were identified by DCJ representatives, PSP services providers and within the cases reviewed, including:

- Adding headcount (i.e., FTE) to increase their capacity to delivery PSP.
- Creating PSP specific roles and teams.
- Sourcing and delivering training to address staff skills gap (e.g., a lawyer to deliver training to caseworkers on legal writing).
- Designing and implementing PSP forms and processes which included:
    - Embedding lists of PSP related tasks into casework forms.
    - Embedding structured decision process requirements based on PSP principles into tools and forms used to inform and document the delivery of certain case management responsibilities. For example, one PSP provider developed a placement matching tool which includes a question on whether the new placement being set-up is associated with a new permanency goal.
- Setting up a PSP implementation working group within regular leadership meetings to consider the suitability of PSP processes and discuss all the PSP process issues which emerged throughout the agency.
- Adopting new structured decision-making mechanisms including introducing an assessment tool to measure the risk associated with a potential restoration.

The implementation of PSP also introduced new ways of working for DCJ districts which involved providing permanency goal specific case management expertise and support to PSP service providers in the court and legal work required to process permanency outcomes. While DCJ Districts understood these processes because they were responsible for delivering these services prior to PSP, they faced substantial changes and challenges in implementation support work to support PSP service providers. For example, DCJ District teams started working with a range of PSP services providers, who had different casework practices and used different case management system not accessible to DCJ. It was consistently reported by PSP service providers and DCJ representatives, as well as observed in the cases reviewed, that DCJ Districts did not have sufficient resources to deliver this work efficiently and in a timely manner. It was also reported by DCJ representatives that additional resources allocated to DCJ Districts during the implementation period to support the transition had helped DCJ districts resource the increase in workload brought on by PSP.

'It's been a struggle without having those additional resources (previously delivered through implementation funding)' – DCJ representative

5.3.4. Were permanency outcomes achieved for children within the allocated two-year timeframe?

This question is addressed using both administrative data and the qualitative data collected through the case review and the PSP service provider focus groups. The ChildStory data are relied on to provide an estimate of the proportion of the legal permanency outcomes achieved within a two-year timeframe. The qualitative data explore potential links between being able to achieve permanency outcomes within a two-year timeframe, case characteristics, casework practices and other contextual factors to explore how and when permanency outcomes tend to be achieved within the context of PSP.

The findings in this section are included for the purpose of evaluating to what extent the implementation of PSP is associated with PSP service providers being able to achieve permanency outcomes within a two-year timeframe. This section is complemented by a detailed overview of how PSP impacted permanency outcomes (i.e., the likelihood that the different types of permanency outcomes were impacted by PSP within the evaluation period of 2 years 9 months), presented in the Effectiveness section (see Chapter 6).

The analysis of the ChildStory data, presented in Chapter 6, found that a relatively low proportion of children who received PSP packages (of any type) experienced permanency outcomes within the two-year timeframe (with higher rates for some permanency outcomes than others). Of those who were initially given specific permanency goal packages (and who had 2 years of follow-up time during the study period), we also saw relatively low rates of permanency outcomes achieved within 2 years (Table 4.1). For example, only 1 in 5 children who were allocated a PSP permanency goal package for Restoration were restored to their families within 2 years; this finding was consistent for both those in the Entry/Re-entry cohort (assessed from their new entry into OOHC and receipt of PSP packages) for those in the Ongoing Care cohort (assessed from 1st October 2018, but they could have started receiving PSP packages up to three months prior; Table 4.1). Moreover, for the Ongoing Care Cohort, it was unclear whether permanency planning began even before PSP inception (i.e., adoption planning often takes years due to its legal requirements and complexities around parental rights).

Table 5.1 Permanency outcomes achieved within certain timeframes from the 1st of October 2018 for children in the Ongoing care cohort who held a PSP permanency case plan goal package, and within 2 years for those receiving restoration case plan goal packages in the Entry/Re-entry cohort

Cohort	PSP package	Number that achieved package goal within 6 months of evaluation start	Number that achieved package goal within 1 year of evaluation start	Number that achieved package goal within 2 years of evaluation start or entry
PSP package held at 1st October 2018 (Ongoing Care cohort)	Adoption	38 (17.0%)	80 (35.7%)	98 (43.7%)
	Guardianship	11 (3.2%)	22 (6.3%)	44 (12.7%)
	Restoration	55 (8.3%)	94 (14.1%)	131 (19.7%)
PSP package at entry (Entry/Re-entry cohort)	Restoration[39]			44 (17.2%)

We can look to the case review (n=74) and PSP service provider focus group data to explore the circumstances within which permanency outcomes were achieved for children within two years. While these data give us insights into casework and services delivered by PSP service providers to achieve permanency outcomes, any trends in this small dataset should not be extrapolated more broadly. In line with the ChildStory data present in Table 5.1 above, the case review identified only a small number of cases that achieved legal permanency within two years. Most cases reviewed, however, appeared close to achieving legal permanency or had achieved permanency within a three-year timeframe. The majority of cases reviewed encountered challenges – related, for example, to lack of engagement from family members, delays with organising family group conferences, disagreements over permanency goals, court delays and delays with obtaining identification documents – which appeared to impede their ability to meet the two-year timeframe.

Our observations across the qualitative implementation data lead us to cautiously suggest that achieving permanency outcomes within the allocated two-year timeframe tends to occur in cases which:

- Do not require a lot of preliminary permanency planning and casework. In other words, cases where the most appropriate permanent placement is clear and agreed upon by the child, family members, carers, PSP providers, DCJ and other professionals consulted.
- Do not require a high level of support from PSP services to meet the needs of the children, family members and carers.
- Legal requirements associated with the permanency outcome can be completed quickly.
- Have sufficient access to the right expertise and resources.

[39] Only includes children that had 2 year follow up time (i.e. those that entered care over or equal to 2 years prior the end of the evaluation period on 30th June 2021).

It is common for permanency planning to start before permanency case goal is assigned and thus before funding is increased. In some of the reviewed cases, PSP providers had delivered permanency planning and casework for over multiple years before permanency goals were assigned. This was observed in case file review cases where:

- Adoption related casework (e.g., discussing Adoption as a potential outcome with carers and family members) was started over three years before PSP provider requested the case plan goal change to Adoption.
- Guardianship assessments were completed ahead of requesting for the case plan goal to change to Guardianship.
- General OOHC casework including family finding and consulting family members to inform permanency planning.

This suggests that some PSP service providers understand that the process of achieving legal permanency will likely take longer than 2-years and that they are willing to conduct the work without the funding being approved. PSP service providers related similar in the focus groups – that they continued to work with children, families and carers if the case plan goal was not met within the two-year timeframe. This was however, often undertaken within a context of emotional and financial pressure for PSP service providers and was a cause of significant frustration when PSP was introduced, and a number of permanency case plan goals were changed instantly.

PSP service providers can access funding extensions for cases taking longer than two-years, although this was seen to create administrative burden, and providers did not always receive additional funding (e.g., DCJ does not grant funding extensions for casework delays for example). This encouraged in some cases the pooling of packages (a principle of the PSP program), although this was not always seen as a positive by PSP service providers:

> *'Our funding reverts back to long-term care [when extensions are denied] … it's not that we stop doing the work because we're not funded – the money is going to come out of another child's package effectively.' – PSP service provider*

These findings, which appear to be related to both the complexity of permanency casework and foundational casework tasks (see quote below), suggest the two-year timeframe has not been practical for achieving permanency outcomes. PSP service providers also expressed concerns about the timeframe for families and carers who need time to process potential changes and adjust where necessary. Two-years was not seen to be a long enough period for these adjustments to occur. This was especially the case in adoption.

> *'[Building and maintaining relationships with families] are things that need to naturally happen. I can have those conversations as much as I want, but unless the … adoptive parents are onboard and so are the birth family, then that's a really tricky space to work with and make sure it happens within a two-year space.' – PSP service provider*

Aboriginal case studies of PSP experience

Two-year timeframe to achieve permanency

Case workers, case managers and community stakeholders interviewed in the three Aboriginal case study sites echoed the view of the PSP service providers who participated in the focus groups. They considered the two-year timeframe too short to effectively engage with and achieve outcomes for families, particularly where birth families are dealing with multiple issues (e.g., drug or alcohol addiction, housing insecurity, family separation).

> *The timeframes for working with families who are using the PSP program is unrealistic. It takes time to build rapport with families and it seems that the destination is already determined by DCJ at referral stage." – Case worker / Manager Focus Group*

What is the impact of the two-year timeframe on case management practice?

This question was addressed using data from focus groups with PSP service providers, focus groups and interviews with DCJ staff, the case file review and the Aboriginal case studies. The two-year timeframe had a mixed impact on case management practice. It enhanced case management practice by placing a sense of urgency on achieving permanency outcomes, leading to a change in caseworker 'mindset'. Caseworkers also sometimes undertook parallel planning (i.e., planning for more than one case plan goal in case the original goal is unsuccessful) in an attempt to successfully meet goals within the timeframe.

In other ways, the two-year timeframe did not appear to change practice as attended. The case management practices observed in the case review appeared to be impacted by many factors other than the two-year timeframe. The influential factors identified include PSP service provider beliefs about case priorities, recommendations from permanency case plan goal reviews, case characteristics and complexity, and DCJ and PSP provider capacity and expertise.

We suspect that these factors overpowered the two-year timeframe's potential effect on the case management practices employed by PSP service providers across a significant proportion of cases.

5.3.5. Case studies of Aboriginal children, families and communities experience of PSP

The following section presents data from the three Aboriginal case study sites. The purpose of the case studies is to provide qualitative data that lends valuable contextual information to the more representative quantitative data. The case studies provide qualitative insights to what participants in three different sites may or may not know about the program and how they experience its services.

How has PSP been communicated with Aboriginal children, families and communities?

Aboriginal children, parents, carers and community stakeholders interviewed across the three Aboriginal case study sites indicated that, generally PSP and OOHC had been poorly communicated with them:

> *'I think there's a huge gap in educating community, in regard to child protection in general, let alone the offsides of PSP and what that means' - Case Worker/Manager*

Most of the Aboriginal children, parents, carers and some community stakeholders who were interviewed across the three sites were unaware of or had a limited understanding of the PSP program, and its differences from previous programs or reforms introduced for Aboriginal people. These participants suggested that better communication about PSP could: (i)inform families so that they see the program more as a support network rather than about removal of children; (ii) encourage more Aboriginal carers; (iii) assist parents with their restoration applications; (iv) improve client engagement with case workers; (v) reduce Aboriginal community antagonism towards PSP workers, given the negative historical legacy of child removal policies for Aboriginal communities; and (vi) improve accountability of the program.

Is PSP delivery meeting the needs of Aboriginal children and families

Across the three Aboriginal case study sites, most parents, carers and community members were positive about the services they were receiving from their (PSP) service provider meeting their needs and were able to give examples of how this was happening. However, not all children, parents, carers and community members who were interviewed indicated that all their needs were being met. Some children who were interviewed for the case studies were dissatisfied with the level of their case worker support and were unaware of their case plans. One parent said their service provider had provided no restoration support, nor assisted their children to receive needed trauma counselling. Some carers found their PSP service provider unhelpful in setting up appointments, felt their feedback was not appreciated and attributed any good support for children in their care to individual case workers rather than the organisation.

Case workers/managers and community stakeholders at all three Aboriginal case study sites identified funding short falls, both specific to PSP and to the OOHC system more generally. This resulted in service gaps for PSP, for example: for family preservation; family finding; and for family members who are carers (e.g., through an order allocating Parental Responsibility or Guardianship). Other identified needs gaps relating to the OOHC system were around: an inconsistency of support available to families and carers (e.g., less support for children with high needs); insufficient health services and educational support in regional areas; caseworker turnover and poor record keeping leading to gaps for clients; and lack of cross-sector coordination (e.g., to support children with disability).

> *'If you have services come in doing one off things or things that aren't connected, it just adds more confusion. For example, they get a bit of therapy here for trauma. ... This one's doing a bit on how they communicate. This one's doing a bit about … how to be safe. And the child's just in the middle, bouncing around - the outcome's just not as effective as it could be.' - Community stakeholder interview*

Case workers/managers interviewed in the three Aboriginal case study sites identified some opportunities for improving the system including: case managers to meet with DCJ prior to taking on a referral, to give input to achievable goals; case managers (rather than DCJ) to write the Family Action Plan to be more realistic for the families they are working with; case workers to have more time to work with families to create positive outcomes.

Have the Aboriginal Child Placement Principles been applied consistently and appropriately?

While case managers/workers at all three Aboriginal case study sites indicated that they are following Aboriginal Child Placement Principles and actively assess cases involving Aboriginal children, they also observed that placement principles across the service system are not being strictly followed in all cases or by all workers.

Some community partners, carers and parents attributed the effective implementation of these principles, where that occurs, to the commitment of a particular PSP service provider and individual case workers, rather than the PSP program and its innovations.

> *'[Placement principles are] not prioritised. Case managers have experienced children entering the OOHC service with no knowledge of what family finding has been explored. On removal, they [DCJ] jump straight to point 5 of the Aboriginal Placement Principles instead of exploring point 1 with family.' - Aboriginal Case Manager/Worker focus group*

In the three Aboriginal case study sites, children, parents, carers and community members raised practices they identified in the childcare/OOHC system, which may pre-date PSP and include issues that the program seeks to address, which do not align with the Aboriginal Child Placement Principles:

- Children not being placed with family members who could be carers.
- Placements changing without informing children beforehand.
- Non-Aboriginal OOHC services receiving government funds to make care arrangements for Aboriginal children.
- Insufficient numbers of Aboriginal Case Workers to guide Aboriginal families and support them through the OOHC system.
- Removal of Aboriginal children without sufficient investigation of reasons underlying risk or support for families to keep their children (i.e., family preservation) and families being insufficiently informed as to what is happening to them.
- Care plans, Family Action Plans and decisions being made without family involvement, signaling a need to engage more with the family as a driver of change towards restoration.
- Requirement that non-Aboriginal carers give agreement prior to Aboriginal children in their care being transitioned from a non-Aboriginal OOHC provider to an Aboriginal OOHC provider (see the funding agreement for OOHC services in Section 2.3), seen by one community stakeholder as "horrific" and contravening principles of self-determination.

Three unrelated children in care who were interviewed for the Aboriginal case studies said they had never been placed with an Aboriginal carer. All three children wanted a greater connection with birth family members and did not feel supported to do so by their case

workers. They expressed considerable dissatisfaction with placement decisions and a lack of understanding about why such decisions were made:

> *'They took our childhood away from us by growing up with people who are not family and as soon as we get attached, they remove us again.' - Child interview*
>
> *'It is so annoying to change placements, as we need to change schools and start a new school; we lose our friends. There was a time when I had to go to [different town] and I missed a whole term of school and they did not enrol me, so now I am behind. They did not let my parent know that I moved to another town.' - Child interview*
>
> *'It's like they remove us because the carers don't want us anymore' - Child interview*

Has PSP been implemented in culturally safe, inclusive and respectful way?

Have the principles of Aboriginal self-determination (s11), participation in decision making (s12) and Aboriginal child placement (s13) outlined in the Care and Protection Act 1998 (NSW) been practiced within PSP?

Participants interviewed at all three Aboriginal case study sites reported on some deficiencies in the implementation of PSP around cultural safety. Principally, these deficiencies pointed to situations where Aboriginal reform principles are not being followed and insufficient funding in the Aboriginal cultural plan package per child (which is in addition to the baseline packages) to effectively support cultural connection and family finding.

Have adaptations been made to better meet the needs of Aboriginal children and families?

While the Cultural Plan Annual package was an adaptation within PSP, neither this nor any other adaptations were mentioned by participants interviewed in the three Aboriginal case study sites. One case worker/manager stated:

> *'No changes to the program. The difficulty is trying to actually expand on those programs more so than anything else, not necessarily changing.' – Caseworker/Manager*

Do children, families and communities feel that the PSP services that they have received or observed are culturally safe and offered in a way that support feelings of cultural safety?

We note that COVID-19 restrictions impacted on direct service delivery in supporting cultural activities and face-to-face carer support. Despite this, in the three Aboriginal case study sites, most children, parents, carers and community members who were interviewed indicated that PSP services supported their cultural safety to some degree. Cultural activities cited by participants included caseworkers/managers working with carers to support children to learn Aboriginal cultural history and language; participate in cultural events; engage in Aboriginal studies at school; get access to study support for Aboriginal people; access an Aboriginal mentor; access after-school cultural activities, walk on country and visit cultural sites; attend a cultural camp; and develop a cultural plan.

'So sometimes we find that we go out to [location] and we do cultural stuff. … I did it and it was also fun learning that all the other things and stuff. And I had to weave and make bracelets and it was so fun, and I made this little ring as well.' - Aboriginal child interview

However, three Aboriginal children and one parent who were interviewed across the three sites expressed dissatisfaction around cultural support provided by their PSP provider. The three children who were in OOHC stated that they wanted greater cultural connection but had not been supported by their case worker or carers to maintain family or community ties, or to learn about Aboriginal culture. During their interview, two of the children asked their carer if the carer was Aboriginal. A parent seeking restoration, who was interviewed, was concerned that their children were not supported by their PSP service provider to engage in cultural activities, connect with family or their Aboriginal community, or be allowed to attend family Sorry Business (i.e., funerals).

Across the three Aboriginal case study sites, community stakeholders identified some structural challenges to cultural connection posed when children are in care arrangements away from their community and off country, or when Aboriginal children engage with their culture only intermittently. They strongly felt that PSP case workers should facilitate comfortable, simple and consistent ways for Aboriginal children to engage in culture day-to-day, e.g.: through cultural planning; Aboriginal-led family supervision; engagement with both sides of a child's family; cultural mentoring; teaching children Songlines and Aboriginal history; connecting children with cultural food, music, art, totems, language; and walking on Country.

Case workers/managers, community members and parents interviewed at the three Aboriginal case study sites perceived that some non-ACCO providers are culturally unsafe for Aboriginal clients and workers, having an inadequate understanding of the history and situations facing Aboriginal people, not providing staff with cultural mentoring or leadership, and maintaining inherent biases, rather than applying a cultural lens to situations for Aboriginal families. Two community stakeholders suggested ways to embed culturally safe practices: provision of cultural training for staff; conducting staff group supervision sessions; and providing Aboriginal case work guidance and supports. Case workers/managers at one site expressed strong concerns about DCJ practices being culturally unsafe to them as workers, e.g.: when PSP started, they were given a very short timeframe to recommend eligible cases for guardianship or restoration.

'They asked us to identify children and young people who have potential guardianship or restoration cases. … So without us doing any [assessment] work, we were asked to identify potential kids that we had here on who could go as guardianship or restoration. … And I think we in [location] identified about 30 something kids and then, when we got around to starting the assessments, they weren't supported but… they were already triggered. [i.e. allocated extra funding for guardianship and restoration]' - Case worker/manager focus group

Some case workers/managers interviewed for the Aboriginal case studies suggested ways in which PSP could be more culturally safe: increased funding to support family preservation; extension of the "*limited*" time PSP allocates for provision of intensive

family-based services; and prioritisation for cases with Aboriginal children to be managed by an ACCO or placed with an Aboriginal carer to promote their access to culture. We note that the potential for a non-ACCO case management arrangement for Aboriginal children pre-dates PSP and that the program seeks to fully transfer all Aboriginal children in OOHC to Aboriginal controlled organisations and Aboriginal carers. Barriers to this process were identified as insufficient numbers of Aboriginal carers and the potential for guardianship or adoption of Aboriginal children to continue, which these workers did not support.

What is the level of engagement and satisfaction with services received?

At all three Aboriginal case study sites, PSP provider casework staff said they meet with children and families regularly (daily, weekly, monthly or less often), depending on level of need and their goals. Certainly, the parents and carers at all three sites expressed greater satisfaction with services received when contact with case workers was consistent (in person and by phone and email), when they felt listened to and supported, and where parents had good communication with workers when their child is in OOHC.

However, the satisfaction of children, parents and carers was reduced when they perceived that casework staff were providing a standardised rather than tailored response to their needs. For example, three children who were interviewed were less satisfied with services provided, reporting that their case workers met them with their carers present, asked the same questions every time, did not do any fun activities with them, and that they experienced a high turnover of case workers. These children wanted better communication with their case workers and for workers to demonstrate a greater interest in them and their needs. A parent seeking restoration who was interviewed was also dissatisfied, reporting they were only contacted by case workers when something was wrong with their children and reported being only allowed to see their children four times a year.

Is PSP acceptable for/to Aboriginal children, families and communities? Which elements are deemed most/least acceptable?

The qualitative data from the three Aboriginal case study sites indicate that the most acceptable elements of PSP for Aboriginal interviewees were: Aboriginal foster care; cultural planning (including birth family input to cultural planning); opportunities for children to engage with culture; support for preservation and restoration; and appointment of Aboriginal case workers - where these are in place.

Were Aboriginal-specific reform components (i.e., Aboriginal foster care and cultural planning, Aboriginal coordinator positions) acceptable, appropriate and effective?

Data from the three Aboriginal case study sites found that participants interviewed considered the Aboriginal placement principles and reform components of PSP to be acceptable, appropriate and effective (as described above) when they are in place. Aboriginal children, parents, carers, casework staff and community members who were interviewed were most dissatisfied when these elements of PSP were not in place (e.g., siblings not placed together; Aboriginal children not being placed with Aboriginal carers; where Aboriginal children's cases are with non-Aboriginal service providers of PSP; lack of cultural planning). Case workers/managers and community partners who were interviewed expressed dissatisfaction with elements of PSP in terms of: a lack of focus on or funding for family preservation; insufficient funding for packages (e.g. in regional areas where services are harder to come by); requirement of agreement by non-Aboriginal carers to transition Aboriginal children to an ACCO; and the two-year timeframe to work with families, which they saw as insufficient.

Are the experiences for Aboriginal children and families in line with intended outcomes of improving the safety, permanency and wellbeing of Aboriginal children?

Using ChildStory data (and some linked data), PSP was in general not observed to affect Aboriginal children differently in terms of safety, permanency and wellbeing than non-Aboriginal children (see the Effectiveness chapter).

Data from the three Aboriginal case studies found the experiences of safety and permanency of Aboriginal children who were interviewed to be mixed. Two unrelated children who were interviewed had been in care since an early age but at their current placements for a substantial number of years, indicating stable placements. In terms of wellbeing, these two children indicated that they were happy, liked their carers, and were connected with their birth families. Further, they felt supported by their case workers, were doing well at school, had goals for the future and felt connected to their culture. In contrast, three other unrelated children who were interviewed reported that they had been placed with multiple non-Aboriginal carers, sometimes moving without notice, although this had recently stabilised. In terms of wellbeing, these three children were reasonably content with their current placement and felt cared for but did not feel supported by their carers or caseworkers to maintain connections with friends or family members, or connections to their Aboriginal culture.

Participants interviewed at the three Aboriginal case study sites pointed to certain factors that they considered supported child safety, permanency and wellbeing outcomes. These include: family preservation support; Aboriginal foster care (including kin care); case management provided by an ACCO; involvement of children and birth families in cultural planning and implementation; provision of holistic support to children (particularly those with high needs); and good coordination of services. Additionally, they saw that providing stability of care arrangements and a loving environment enabled children to focus on their family, friendships and other relationships, to actively participate in school, sport/recreation and work, and to maintain cultural connections and develop future aspirations, which are important to children thriving.

How are these experiences and outcomes perceived by Aboriginal children, families and communities when compared to experiences and outcomes for DCJ's former service delivery model (where Aboriginal children, families and communities have previous experiences with former service delivery models)?

Whether OOHC service delivery under PSP is better meeting the needs of Aboriginal children and families interviewed in the three Aboriginal case study sites than before is difficult to gauge. Some case study participants could identify positive changes they have experienced since the introduction of PSP, which they attributed to the PSP provider or case worker or case workers having more time, rather than due to the PSP program itself. Other participants thought there had been no obvious changes since the introduction of PSP. Some casework staff who were interviewed thought PSP had improved OOHC processes and had good principles but also that some elements were under-funded and that, in any case, their service was continuing its usual practices that were already culturally appropriate. Some caseworkers/managers and community partners were also critical that other, non ACCO, organisations were not following PSP principles.

What factors have influenced outcomes for Aboriginal children and families receiving PSP (e.g., Aboriginal family led decision making, Aboriginal controlled mechanisms being involved in decision making)?

In the three Aboriginal case study sites, factors positively affecting outcomes for the Aboriginal children, parents and carers who were interviewed included: family preservation support; placing Aboriginal children with Aboriginal families or kin where possible; having an ACCO do the case management; providing holistic support to children; involving children and birth families in cultural planning and implementation; tailoring

services as needed to individual children, parents and carers; providing stability of care; children, carers and parents feeling supported by case workers with good communication.

5.4. Discussion

At its most fundamental, an evaluation of implementation should chronicle exactly what was delivered – because children and young people cannot benefit from a service they did not receive. Given service-level data were not available in DCJ's ChildStory or PSP providers' electronic case management systems, we undertook a 'hand-search' review of a sample of cases using a fit-for-purpose case review tool. This had the added benefit of allowing us to not only review what was delivered and how (i.e., casework and services) but also the context in which this was undertaken, including what decisions were made for a child, family and/or carer, challenges and enablers, and an indication of how much work was involved (i.e., gleaned through the level of documentation and comments in caseworker notes). While small in scale, the case reviews provide a rich and detailed insight into how PSP is practiced by PSP providers in achieving permanency goals for children and young people.

We supplemented this case review data, with information from focus groups with a sample of PSP providers, a survey with all PSP providers, focus groups and interviews with DCJ representatives, case studies with Aboriginal communities in three PSP sites and ChildStory data. This mix of data collection methods and results, triangulated throughout, has produced robust findings on the implementation of PSP. Even so, we recommend the findings be interpreted cautiously, particularly when attempting to generalise or extrapolate results from the case reviews or Aboriginal case studies to the broader population of children and families receiving PSP.

Overall, PSP appeared to lead to changes in casework practice and caseworker's 'mindset' in working toward children's permanency, including promoting regular and proactive consultations about permanency planning with family members. Permanency planning and casework principles were embedded into processes, activities and service delivery. The possibility and suitability of legal permanency appeared to be considered and discussed more consistently. These shifts were supported by PSP providers' strong organisational culture and a range of operational changes including increasing staff, establishing specific PSP roles, developing site-specific forms and processes and establishing local PSP implementation teams. These changes were enabled by Permanency Coordinators who acted as 'change managers', supporting PSP service providers to adapt to new ways of working.

Overall, these changes, coupled with increased funding, did not result in permanency goals being achieved within the two-year timeframe. Other factors, beyond the control of PSP providers, appeared to play a greater role in whether the goal was met 'on time'. For example, PSP provider beliefs over case priorities, timely case plan goal reviews, child and family characteristics and complexity, court delays, challenges with information received about genealogy, and DCJ and PSP provider capacity and expertise appeared to have more influence on whether a permanency goal was achieved within two-years than the casework and services provided to the child, family and carer to actively work toward the goal.

In the case review sample, children who achieved permanency within two-years tended to have 'cases' that did not require a lot of preliminary permanency planning and casework, and legal requirements associated with the permanency outcome could be completed quickly and had a high level of support from PSP service providers, who had sufficient

access to the right expertise and resources to meet the needs of the children, family members and carers. Further we noted many PSP service providers, and particularly those that were larger with more capacity, began planning before the permanency goal was assigned and engaged in parallel planning – that is, planning for more than one case plan goal in the event the original goal was unsuccessful. This suggests that even in those cases where a permanency goal for a child was recorded as achieved within the two-year timeframe, this may not reflect the real cumulative time.

PSP providers in the focus groups and Aboriginal case study sites consistently relayed that two-years is too short a time to achieve permanency outcomes for children, particularly when intensive work is required in finding and supporting kin placements toward restoration and guardianship. Even though we know in many cases PSP service providers extend the time to permanency when required, there remains a risk that the two-year timeframe may pressure some PSP providers to move children inappropriately to a permanency outcome to meet funding arrangements.

There was little evidence found that DCJ actively monitors the frequency of case plan and permanency case plan goal reviews and consequently the level of compliance with the minimum review requirements. The timing of the permanency case plan goal reviews seems to consider whether the case is at a stage where the review would be most beneficial and whether enough progress has been made to address earlier DCJ recommendations.

We noted that the PSP case management policies and permanency case plan goal reviews, in general placed an emphasis on legal permanency rather than a holistic approach across all forms of permanency - relational, cultural, physical, and legal permanency and wellbeing and safety outcomes. This potentially contributed to wellbeing, safety and cultural outcomes not being prioritised to receive the attention they need. While this interpretation is speculative, in some cases reviewed where wellbeing, safety or placement stability outcomes were identified as the most important priorities for the child by PSP service providers, legal permanency planning remained a core focus of the permanency case plan goal review - the only planned collaborative case review between DCJ and PSP service providers. This issue may be compounded by the current PSP model which does not have specific formal mechanisms for DCJ and PSP service provider collaboration on, for example, wellbeing outcomes.

PSP implementation was not a straightforward process and numerous barriers to implementation were identified in the first two years of operation. Some barriers – related to a lack of role clarity across DCJ and PSP providers, inconsistencies in the interpretation and application of PSP policies, a lack of funding for some elements of casework that are resource intensive such as family finding, and an increase in administrative work relating to courts – are still live issues for PSP providers. Further DCJ providers highlighted the following functions as needing more support from DCJ: crisis and risk management including avoiding incarceration or placement breakdowns; overseeing and supporting the delivery of health, educational and community services; coordination across the care continuum; and information gathering on siblings and managing sibling contact across agencies. We also noted a shortage of therapeutic services available for children and young people to address the impacts of maltreatment such as Play Therapy, specialised trauma informed therapies, interventions addressing inappropriate sexual behaviours, and interventions for victims of sexual violence.

To improve outcomes across a large number of cases, DCJ needs to develop a stronger understanding of the barriers and enablers which emerge across the range of different cases and situation. This understanding can only be gathered by completing and

consolidating frequent holistic reviews of open and closed cases with the perspective of the different individuals and agencies involved in the case.

DCJ providers emphasised the steep learning curve PSP service providers were on to understand and implement PSP casework, particularly given most lacked experience in delivering child protection services outside of OOHC. Capacity and capability differed wildly across PSP service providers, and many had to make significant structural and practice changes to implement PSP. DCJ representatives believed DCJ had underestimated the amount of change management and practice support needed to support PSP service providers with adopting the new ways of working under the reform. DCJ Districts also had to adapt their practice, moving from a casework and court process delivery role to a support role for PSP service providers undertaking that work. This also proved challenging, particularly in working with PSP service providers who had different casework practices and used different case management system not accessible to DCJ. DCJ Districts did not have sufficient resources to deliver this work efficiently and in a timely manner, although they did receive additional resources to support the transition and increase in workload.

Data from the three Aboriginal case study sites indicates that services are sometimes but not always delivered through PSP. This includes support to access services for birth parents seeking restoration or in preservation (e.g., accommodation, drug and alcohol, parenting), for children in out-of-home care (e.g., mentoring, school support, health care, cultural planning, sibling placement) and for carers (e.g., carer support or respite). Aboriginal participants at these sites considered having an ACCO deliver PSP services to be a critical factor in determining the appropriateness of services delivered to Aboriginal children and their birth families.

The key barriers to PSP implementation identified through the Aboriginal case study sites were: funding shortfalls (e.g. for cultural planning or family finding); two years being too short a time to work with birth families towards restoration; insufficient PSP resources for family preservation; limited financial support for family members who are carers (e.g. through an order allocating Parental Responsibility or Guardianship); demand typically exceeding service capacity; inconsistency of support across families and carers; different PSP providers working with siblings from the same family (i.e. creating difficulty for birth parents to maintain connection with children); case worker turnover and poor handover during staff turnover by PSP providers; insufficient mental and physical health services and educational support in regional areas; and a lack of cross-sector coordination.

Key enablers for PSP implementation identified through the Aboriginal case study sites were: matching an Aboriginal child to an Aboriginal PSP service provider; family preservation support; placing Aboriginal children with Aboriginal families or kin; sibling placements; providing mentoring and education support for children; involving children and birth families in cultural plans and implementation; providing stability of care arrangements; reducing caseloads for case workers; good coordination between services; and presence of Aboriginal Permanency Coordinators.

Part four

Reach: who did PSP funding reach?

6. Reach results

Key findings

Most children entering care were initially given case plan goal packages of Restoration (95.3 per cent). As children stayed in care over the course of the evaluation period, the number of children receiving Restoration packages decreased, and those with Long Term Care packages increased from 1.6 per cent to 45 per cent.

Children entering care were initially given a lower Child's Needs package than their most recent CAT score suggested. Over time, children were generally moved to higher Child's Needs packages. The same pattern holds for children already in care.

There were only 380 packages apportioned to Family Preservation, so only a small fraction of households eligible for the PSP Family Preservation package actually received it.

Only 36.9 per cent of children identified as Aboriginal received a cultural plan package within a month of entry into OOHC with a PSP package. Only 44.8% received a cultural plan package within 6 months of entry into OOHC.

6.1. Introduction

The key evaluation question for this component of the evaluation was the extent to which PSP packages were provided to: eligible high-risk children and families being assessed for child maltreatment concerns; new and returning entries to care; and children already in care. Specifically, the component focused on which children and families received PSP packages compared to those who did not, and the extent to which specialist packages were utilised among those who were likely to be eligible.[40]

6.2. Data

For this component of the evaluation, we sampled all children in our three cohorts[41] that received at least one PSP package (see Table 6.1). All the comparisons and tables presented here focus on understanding the reach and eligibility of PSP packages, and the key characteristics of those who received them, following the start of PSP on the 1st of July 2018. Tables and figures were generated prior to matching the children to similar counterfactuals, a match that was used for analysis (see Chapter 7).

The characteristics used were calculated at the start of receiving PSP, start of entry or on the 1st of October, depending on the cohort (for more details on how variables were constructed see Appendix C). When comparing those eligible for a package to those who received the package, we calculated the timing of each package differently depending on the relevant cohort (see Table 6.1).

Table 6.1 Cohorts used in the Reach component of this evaluation and the numbers in each cohort prior to matching

Cohort	Cohort 1: Family Preservation	Cohort 2: Entry/Re-entry	Cohort 3: Ongoing Care
Analysis level	Household	Child	Child
Eligibility	Households who received a family preservation package following an assessment between 1st July 2018 and 30th April 2021[42]	Children who entered a new episode[43] of foster or kinship care between October 2018 and December 2020[44] and received a PSP package within 32 days of entry	Children who were in foster or kinship care and held an active PSP package on the 1st of October 2018[45]

[40] The original research question in the evaluation plan was "What is the distribution of PSP packages and services across children managed by NGOs, and how do these differ from children who do not receive PSP packages?"
[41] See Appendix C and the effectiveness methods section in Chapter 7 for more detail on cohorts.
[42] Data on PSP family preservation packages were only provided up to 30th April 2021. However, outcomes were measured until 30th June 2021.
[43] The term 'episode' is used by DCJ to denote a continuous period of time in which a child is placed in OOHC. Other international jurisdictions often use the term 'spell' but, in order to avoid confusion, we are using the DCJ term. An episode can include one or more placements. Children can also have numerous episodes, so child's first spell within the PSP period may not be the first time a child has been in care.
[44] Outcomes were measured until 30th June 2021.
[45] Outcomes were measured until 30th June 2021.

Cohort	Cohort 1: Family Preservation	Cohort 2: Entry/Re-entry	Cohort 3: Ongoing Care
Number receiving PSP packages	371	640	7091
Timing of covariates used in analyses	Covariates were determined at the start of receiving the Family Preservation package	Covariates were determined at the start of entry into OOHC	Covariates were determined on the 1st of October 2018
Timing of packages received	Package must start between 1st July 2018 and 30th April 2021	Package must start within a month prior and a month post entry into OOHC (or within a year prior for specialist packages)	Package must be active on the 1st of October 2018 (specialist packages are deemed active for a year)

6.3. Results

6.3.1. What are the characteristics of children who received PSP packages as opposed to those who did not receive PSP packages?

To understand how the characteristics of children differed between those who received PSP packages versus those who did not, we compared all children who received services over the evaluation period of 1st October 2018 to 30th June 2021 to those who did not. Comparisons were made in the concurrent time period to better understand whether the packages were targeted towards households or children with particular histories or characteristics. A secondary rationale was to ensure that such differences were accounted for in the subsequent statistical matching process used to generate comparison samples for the effectiveness evaluation. Thus, prior to identifying matched comparison groups, we compared the ways in which households who received Family Preservation packages differed from those that did not. We also compared children who had a new entry (or re-entry) into out-of-home care within the evaluation period who received a PSP package compared with children in the same evaluation period who did not. If a child entered OOHC multiple times over the course of the evaluation period, only the first entry was considered. Finally, we compared all children who were in out-of-home care and were receiving an active PSP package on 1st October 2018 with children who were in care but not receiving PSP funding on 1st October 2018.

The key differences between the comparisons are outlined below. For full tables of all the variables/characteristics we compared, see Tables E.1, E.2 and E.3 in Appendix E.

Family Preservation

The PSP Family Preservation Package was intended to improve the safety of children in the home and thus help keep families together. The service is delivered at a household, rather than individual child, level and the package was only provided to families with children whose safety and risk had been assessed through Child Protection but who had not yet been removed from the home.[46] Interventions, such as the PSP Family Preservation

[46] Families were eligible for Family Preservation if their face-to-face assessment following a recent ROSH report for the household was rated High or Very High Risk on the SDM Risk Assessment tool,

package, that occur before children are removed are considered 'front end', as they help prevent children from entering the system (as opposed to 'back end' interventions that help to assist children in and/or help progress them out of the system).

The PSP package group (n=371) includes all households that received a PSP family Preservation package. The characteristics of the PSP package group were compared to the first record of all eligible[47] households that did not receive a PSP package between 1st July 2018 and 30th April 2021[48] (n=17022). For more details see Table E.1 in Appendix E.

Overall, families who received PSP Family Preservation packages were more likely to have younger children and more likely to have more serious or risky household circumstances than the larger population of households eligible for Family Preservation. Specifically, households receiving a PSP Family Preservation package compared to those that did not present the following characteristics:

- More children per household
- A greater proportion of children identified as Aboriginal
- A higher likelihood of having children younger than 2 years old in the household (and a lower average minimum age for the youngest child)
- A higher number of prior ROSH reports
- A higher proportion of children who were younger at the time of their first ROSH
- More incidents of Prior ROSH for physical abuse, neglect, sexual abuse, emotional abuse, and domestic violence
- A higher likelihood of children diagnosed with psychological, behavioural, emotional or medical problems
- A higher likelihood of children with developmental, intellectual, learning or physical disabilities
- More carers with a history of substance abuse
- More unsafe housing or homelessness present
- More parent/carers with a history of child protection
- More family violence present.

This comparison indicates that the PSP Family Preservation packages reached high risk families, as intended, but also that it reached only a very small proportion (2.1 per cent) of eligible households. Given that all eligible families were at high or very high risk, the

were rated as 'Safe' or 'Safe with Plan' on the SDM Safety Assessment, and the children remained in the home. They were ineligible for the program if they were receiving an alternate intensive family preservation package, such as MST. For more details on the eligibility criteria for families to receive Family Preservation Packages, please refer to Appendix F.

[47] The number of eligible households is an estimation and was calculated identifying all qualifying children (safety assessment and associated high or very high rating on risk assessment) within the time period, taking the first safety assessment for each child (children can have more than one over time), then taking the first safety assessment identifier if there was a duplicate (if there were multiple children in the same family, there would otherwise have been duplicate households).

[48] Data on PSP family preservation packages were only provided up to 30th April 2021. However, outcomes were measured until 30th June 2021.

number of Family Preservation packages available (with 371 out of 380 allocated within the evaluation period) merely scratched the surface of unmet need. A very large proportion of eligible households would likely have one or more subsequent ROSH reports over time.[49] In sum, there is huge potential for further PSP family preservation support and reach.

Entry/Re-entry

The PSP package group (n=587)[50] included all children who had a new episode of out-of-home care in the evaluation period and received a PSP package within 32 days of their start date. This group was compared to all children who entered or re-entered care in the same evaluation period (1st October 2018 to 31st December 2020[51]) who did not receive a PSP package (n=283). For more details see Table E.2 in Appendix E. If a child entered and exited OOHC multiple times over the course of the evaluation period, only the first entry was considered.

Overall, children who entered care and began receiving PSP packages tended to be younger, placed in foster care rather than kinship care, and were not identified as being Aboriginal when compared with children who did not receive a PSP package.

Specifically, children who received a PSP package compared to those who did not were:

- Less likely to be Aboriginal
- Younger
- Much more likely to be in foster care (vs kinship care)
- More likely to be in a household with a child younger than 2 years old
- More likely to have a parent/carer with a history of child protection
- Less likely to have a prior ROSH for physical abuse
- Less likely to be in a household that had a child placed in care the year before.

As a matter of policy, if there is a kinship caregiver available and appropriate in the early stages of placement in care, DCJ will place and maintain management if the child continues to reside with that same caregiver (i.e., they do not receive a PSP package). Kinship care tends to be fairly stable, so such children often remain in DCJ managed care and do not receive a PSP package over time. Also related, Aboriginal children are more likely to be placed with kin or extended kin, further differentiating these two groups. Differences between who receives NGO care versus DCJ managed care are clearly driving differences between children who receive a PSP package and those who do not. For instance, younger children may enter NGO care more frequently due to preferences of agencies and/or their caregivers. In any case, large differences were present, and had to be factored into our matching process (see Appendix C), and this should be considered by readers when interpreting outcomes.

[49] Analysis not conducted but is based on the underlying risk algorithm which calculates the risk of maltreatment recurrence as measured by a new ROSH.
[50] This number is different to the number in the Entry/Re-entry cohort used in subsequent sections (n=640), because this section comparing characteristics of children in the concurrent timeframe was conducted prior to a data refresh undertaken in Nov 2021. The new data changed the number children receiving PSP and eligible for this cohort from n=587 to n=640.
[51] Outcomes were measured until 30th June 2021.

Ongoing Care

The PSP package group included all children who were in OOHC on the 1st of October 2018 and were receiving an active PSP package on that date (n=7094).[52] These children were compared to children in OOHC who were not receiving PSP funding on the 1st of October 2018 (n=8990). For more details see Table E.3 in Appendix E.

Like the Entry/Re-entry cohort but more pronounced, there were many differences between children in care on 1st October 2018 who received a PSP package and those who did not. The key differences were that children receiving PSP packages were much more likely to be in foster care than those in DCJ managed care, and they tended to have been in their current episode of OOHC for substantially longer periods of time. Specifically, children who received a PSP package compared to those who did not were:

- Older
- Less likely to be Aboriginal
- Younger when they first entered OOHC
- More likely to be male
- Much more likely to be placed in foster care (vs kinship care)
- More likely to have been in their current care episode for much longer
- More likely to have a higher number of prior ROSH reports
- Younger at the time of their first ROSH
- More likely to have had at least one Prior ROSH for physical abuse, neglect, sexual abuse, or emotional abuse
- Less likely to have had a Prior ROSH for domestic violence

These important differences are reflective of a sample of children who had entered care long ago and had been provided PSP packages when the program was initiated across the state. The challenge for PSP, then, is that in most cases the length of time services provided was a small part of children's overall time in care, making it difficult to affect the types of meaningful change the program was designed to deliver. In other words, it was unlikely that PSP packages would overcome both the serious issues facing children who have been maltreated and the potentially negative effects of long-term OOHC.

Summary across Family Preservation, Entry/Re-entry, and Ongoing Care cohorts

Differences between children who received a PSP package and those who did not were substantial and guided the selection of matching variables used in the study. In terms of the reach of PSP, the PSP Family Preservation package appears to have been greatly underutilised given that 98 per cent of potentially eligible households did not receive the service. This remains a potential area of service expansion. For children entering OOHC, it appears that most children who entered care over the evaluation period received at least

[52] This number is different to the number in the Ongoing Care cohort used in subsequent sections (n=7091), because this section comparing characteristics of children in the concurrent timeframe was conducted prior to a data refresh undertaken in Nov 2021. The new data changed the number children receiving PSP and eligible for this cohort from n=7094 to n=7091.

one PSP package. Similarly, a large proportion of children already in care when PSP began were provided with PSP packages.

6.3.2. What is the mix of packages allocated?

We answered this question by describing the proportion of children who were allocated different types of PSP packages[53]. There are four broad categories of PSP packages:

- Baseline packages: received by the PSP provider to cover overheads, carer training and administration costs.
- Case Plan Goal packages: based on a child's approved and recorded case plan goal.
- Child's Needs packages: based on the Child Assessment Tool (CAT) outcome.
- Specialist packages: designed to address a child's additional complex or specific needs.

Between 1st July 2018 and 30th June 2021, a total of 107,686 PSP packages were provided. These packages were received by a total of 10,431 unique children. Of the total PSP packages given during this period, a total of 55,155 (51.2 per cent) had a package start date of 1st July 2018 (the day PSP began).

Table 6.2 details the overall distribution of packages split out by:

- All children who received any PSP package over the period 1st July 2018 and 30th June 2021 (n = 10,431) and the proportion of children who received at least one period of service of that package type over the stated period.
- Children in the Entry/Re-entry cohort (n = 640) and the proportion that received at least one period of each package at the start of their entry into OOHC (package was deemed to be provided at entry if the package start date was within a month either side of their recorded entry into OOHC).
- Children in the Ongoing Care cohort (n = 7091) and the proportion that had an active package of that name on the 1st of October 2018.

Table 6.2 Types of PSP packages allocated to a) all children b) the Entry/Re-entry cohort at the start of OHHC and c) the Ongoing Care cohort at the time of 1st October 2018

Package description	Children who received package between 1st July 2018 and 30th June 2021	Children who received package at entry	Children who held active package on 1st October 2018
	All children (n=10431)	Entry/Re-entry cohort (n=640)	Ongoing Care cohort (n=7091)
Baseline Packages n (%)			
Aboriginal Foster Care	1673 (16.0)	87 (13.6)	1219 (17.2)

[53] For more detail on the packages available through PSP, see https://www.facs.nsw.gov.au/providers/children-families/deliver-psp/psp-funding-model-and-service-packages

Package description	Children who received package between 1st July 2018 and 30th June 2021	Children who received package at entry	Children who held active package on 1st October 2018
Foster Care	8047 (77.1)	542 (84.7)	5859 (82.6)
Child's Needs Packages n (%)			
High Needs	1084 (10.4)	5 (0.8)	80 (1.1)
Medium Needs	2372 (22.7)	29 (4.5)	1429 (20.2)
Low Needs	8268 (79.3)	604 (94.4)	5573 (78.6)
Case Plan Goal Packages n (%)			
Adoption	503 (4.8)	< 5	253 (3.6)
Continue Permanency Beyond 2 Years	100 (1.0)	0 (0.0)	0 (0.0)
Guardianship	761 (7.3)	5 (0.8)	351 (4.9)
Long Term Care	8418 (80.7)	33 (5.2)	5833 (82.3)
Restoration	2956 (28.3)	610 (95.3)	667 (9.4)
Specialist Packages n (%)			
15+ Years Old Reconnect	712 (6.8)	0 (0.0)	407 (5.7)
4+ Sibling Group Package	218 (2.1)	< 5	120 (1.7)
Additional Carer Support – Current Child Needs (High)	80 (0.8)	0 (0.0)	0 (0.0)
Additional Carer Support – Current Child Needs (Low)	108 (1.0)	< 5	< 5
Additional Carer Support – Current Child Needs (Medium)	377 (3.6)	0 (0.0)	22 (0.3)
Cultural Plan Annual	3242 (31.1)	29 (4.5)	2392 (33.7)
Cultural Plan Establishment	389 (3.7)	83 (13.0)	57 (0.8)
Cultural Plan in Care	2789 (26.7)	8 (1.2)	2393 (33.7)
Culturally and Linguistically Diverse	1240 (11.9)	35 (5.5)	908 (12.8)
Leaving Care	2095 (20.1)	0 (0.0)	917 (12.9)
Legal Adoption Payment	44 (0.4)	0 (0.0)	11 (0.2)

Broadly speaking, there was little difference between the proportion of baseline packages provided to children in the Entry/Re-entry compared to those in the Ongoing Care cohort. Also, across all children, while 16 per cent received an Aboriginal foster care package, almost twice that proportion (31 per cent) received an annual cultural plan package at some point during the evaluation period. The vast majority (94 per cent) of the Entry/Re-entry cohort received a low needs package and a restoration package (95 per cent) upon

entering[54], while the Ongoing Care cohort had a somewhat lower proportion (79 per cent) of active low needs packages and a far lower proportion of restoration packages (9 per cent). These differences reflect the children's location in their OOHC placement trajectory, with children having been in care for longer periods of time having greater needs (either through discovery of these or through developing needs over time) and a decreased emphasis on restoration. A smaller proportion of children entering care received each specialist package type (except the Cultural Plan Establishment package and Additional Carer Support – Current Child Needs (Low) package) compared to those whose needs were more established in ongoing care.

Two specific packages were available that began at specific points in time during the OOHC service continuum (Table 6.3). Case Coordination – Restoration Support is designed to assist agencies to support children who have returned to their parents during the early stages of restoration (i.e., while they are still in the care of the Minister). The Supported Independent Living program is available for children aged 16-17 who are ready to exit OOHC with support, but who cannot be restored. They are provided with subsidised accommodation and casework support.

Table 6.3 Allocation of end specific PSP packages to a) all children, b) the Entry/Re-entry cohort and c) the Ongoing Care cohort

Package description	Children who received package between 1st July 2018 and 30th June 2021	Children who received package prior to a month after exit (or 30th June 2021 if it came earlier)	Children who received package prior to a month after exit (or 30th June 2021 if it came earlier)
	All children (n=10431)	Entry/Re-entry cohort (n=640)	Ongoing Care cohort (n=7091)
Baseline Packages (%)			
Case Coordination – Restoration Support	185 (1.8)	31 (4.8)	95 (1.3)
Supported Independent Living	211 (2.0)	< 5	51 (0.7)

6.3.3. How many children were transitioned to long term care versus other case plan goals?

To understand this, we looked at the change in all Case Plan Goal packages received by children over time. The dynamics of change were very different for each cohort, so each is detailed below.

Entry/Re-entry cohort

To investigate the change in a child's goal over time in the Entry/Re-entry cohort we compared the first Case Plan Goal package a child received upon entering OOHC, to their next change in goal (if a change occurred), and finally to the last Case Plan Goal package a child received prior to the end of the evaluation period 30th June 2021 (see Table 6.4).

[54] These two packages are generally the default packages given at entry into care.

Table 6.4 Change in Case Plan Goal packages over time for the Entry/Re-entry cohort, n = 640

Package	Case Plan Goal package at entry n (%)	Next Case Plan Goal package (same as entry if no change) n (%)	Case Plan Goal package at end of evaluation period n (%)
Adoption	< 5 (0.8% or less)	6 (0.9%)	20 (3.1%)
Continue Permanency Beyond 2 Years	-	10 (1.6%)	20 (3.1%)
Guardianship	< 5 (0.8% or less)	16 (2.5%)	22 (3.4%)
Long Term Care	10 (1.6%)	174 (27.2%)	287 (44.8%)
Restoration	610 (95.3%)	434 (67.8%)	291 (45.5%)
No Package	15 (2.3%)	-	-

In this cohort, the duration each child was in care was variable, making it difficult to make definitive statements involving the passage of time. However, there was a clear trend for children to transition away from restoration packages and towards long term care packages the longer children remained in care. Given the fairly low rate of restoration in this cohort (see Chapter 7), it would seem that a large number of children likely remain with a restoration goal without moving to another form of permanence for fairly long stretches of time.

Ongoing Care cohort

In the Ongoing Care cohort, we compared the first Case Plan Goal package a child started with (package start closest but earlier to 1st October 2018), to their next Case Plan Goal package (if they changed) and finally to their last Case Plan Goal prior to exit or 30th June 2021, whichever came first (see Table 6.5).

Table 6.5 Change in Case Plan Goal packages over time for the Ongoing Care cohort, n = 7091

Package	Case Plan Goal package at 1st October 2018 n (%)	Next Case Plan Goal package (same as 1st October 2018 if no change) n (%)	Case Plan Goal package at end of evaluation period n (%)
Adoption	253 (3.6%)	337 (4.8%)	308 (4.3%)

Package	Case Plan Goal package at 1st October 2018 n (%)	Next Case Plan Goal package (same as 1st October 2018 if no change) n (%)	Case Plan Goal package at end of evaluation period n (%)
Continue Permanency Beyond 2 Years	-	46 (0.6%)	146 (2.1%)
Guardianship	349 (4.9%)	483 (6.8%)	415 (5.9%)
Long Term Care	5809 (81.9%)	5645 (79.6%)	5761 (81.2%)
Restoration	660 (9.3%)	578 (8.1%)	459 (6.5%)
No Package	20 (0.3%)	2 (<0.1%)	2 (<0.1%)

Compared to the Entry/Re-entry cohort, there was not much movement between case plan goals in the Ongoing Care cohort, which is understandable given the length of time most of the sample had been in their current placement episode. There were slightly more children who ended care or their follow-up period in long term care (when you consider the package 'Continue Permanency Beyond 2 Years is also long term) - 81.9 per cent at start (first goal) and up to 83.3 per cent at the end (final goal).

6.3.4. Are children with high needs being allocated an appropriate level of needs packages?

We answered this question by looking at the initial allocation of needs package as it related to a child's most recent CAT score (an indication of needs level required).[55] We also compared the initial needs package to the last needs package allocated to that child (prior to exit and at the end of the evaluation period). Again, these trends were examined by cohort as the two relevant cohorts have very different compositions.

Entry/Re-entry cohort

In the Entry/Re-entry cohort we compared the most recent available CAT scores[56] to the first Child Needs package allocated at entry into OOHC, and the final package at the end of the evaluation period (30th June 2021; Table 6.6).

Table 6.6 Change in Childs Needs packages over time for the Entry/Re-entry cohort, n = 640

Package	CAT score prior to entry into OOHC	First Needs package at entry into OOHC[57]	Final Needs package during the study period

[55] A High Needs package triggers a referral to ITC.ITC was not part of this evaluation.
[56] A CAT score of 5 or 6 was deemed High, a score of 3 or 4 was deemed Medium, and a score of 1, 2 or missing data was deemed Low.
[57] Needs Packages are supposed to be allocated according to most recent CAT score.

	n (%)	n (%)	n (%)
Low	606[58] (94.5%)	604 (94.4%)	576 (90.0%)
Medium	29 (4.5%)	13 (2.0%)	50 (7.8%)
High	5 (0.8%)	4 (0.6%)	10 (1.6%)
No Needs package	-	19 (3.0%)	4 (0.6%)

Overall, children entering care were initially given a lower Child's Needs package than their most recent CAT score suggested. The Low Needs package is currently the default package provided. Over time, these packages began to better align with their previous CAT score assessed level. At the end of the evaluation period, the percentage of children receiving High Needs packages was relatively higher than those with a high CAT score prior to entry.

Ongoing Care cohort

In the Ongoing Care cohort we compared the most recent available CAT scores[59] to the Child Needs package active on the 1st of October 2018 (closest start date prior to that date), and the final package at the end of the evaluation period (30th June 2021) (Table 6.7).

Table 6.7 Change in Childs Needs packages over time for the Ongoing Care cohort, n = 7091

Package	CAT score prior to entry into OOHC n (%)	Needs package on 1st October 2018 (or most recent before) [60] n (%)	Final Needs package during the study period n (%)
Low	5228 [61] (73.7%)	5571 (78.6%)	5022 (70.9%)
Medium	1779 (25.1%)	1424 (20.1%)	1625 (23.0%)
High	84 (1.2%)	78 (1.1%)	439 (6.2%)
No Needs package	-	18 (0.3%)	5 (<0.1%)

Overall, the same pattern as the Entry/Re-entry cohort was observed, namely that children in care were initially given a lower Child's Needs package than their most recent CAT score would suggest they should have been assigned. Over time, children were generally given higher Child's Needs packages, but high needs packages were not provided very often. For a visual representation of how Childs Needs packages in this cohort changed over time,

[58] If no CAT score was recorded prior to entry into OOHC then the CAT score was classified as Low. Of the 606 who were classified as having a Low CAT score, 176 were originally missing.
[59] A CAT score of 5 or 6 was deemed High, a score of 3 or 4 was deemed Medium, and a score of 1, 2 or missing data was deemed Low.
[60] Needs Packages are supposed to be allocated according to most recent CAT score.
[61] If no CAT score was recorded prior to entry into OOHC then the CAT score was classified as Low. Of the 5228 who were classified as having a Low CAT score, 1314 were originally missing.

and the proportions who retained or changed packages during the study period, see Figure E.4 in Appendix E.

Has there been uptake of the 4+ sibling package?

Due to the lack of relationship data recorded in the data, we were unable to determine which children were eligible for the 4+ sibling package and thus how many children/carers were entitled to the package. We were therefore limited in our reporting the reach of this service. For future studies, we suggest that the relationship field in ChildStory is made mandatory in to explore this service and sibling placement experiences more globally.

The 4+ Sibling package was recorded in the data under one representative child (usually the eldest). Packages are designed to be given annually. Rather than simply report those numbers, we plotted the number of packages given out in each six-month period between 1st July 2018 and 30th June 2021 to ascertain the extent that ongoing uptake of the package was occurring (Figure 6.1).

Figure 6.1 Number of 4+ sibling packages provided by six-month period

On the start date of PSP (1st July 2018), a total of 121 Sibling packages were provided, the highest number on a single day. The second highest on a single day was a year later on 1st July 2019 when 63 packages were provided.

Overall, even with the limited scope necessitated by the data available, there does not appear to be a sustained pattern of uptake in the number of 4+ Sibling packages over time. While sibling data were not available, it is unlikely that only 1.6% of the entire population of children in OOHC receiving PSP packages have fewer than four siblings in care. The package is likely to be underutilised and appears to be mainly used for placements already in existence, these are growing smaller over time, or they are being used for less permanent placement arrangements (i.e., temporary care). It is likely that this is a result of difficulty in finding suitable homes upon entry to care (i.e., sufficient size and vacancies, willingness of caregiver/provider) and the inherent difficulty of moving siblings from other homes who are not currently placed together or who are placed into OOHC at different times. To better understand this service, and patterns of sibling placements in general, the data would need to include sibling relationships.

Interviews conducted at the three Aboriginal case study sites (outlined in Chapter 5) revealed that while some children were preferentially placed with siblings, other children stated that they had never been placed with their siblings or supported to see siblings, which they wanted. These interviews and the lack of uptake of the 4+ Sibling package

suggest that sibling placements (and their potential benefits) are certainly an area of PSP that could use more focus, resources and documentation in NSW.

How many children aged 15+ and over have leaving care packages and 15+ reconnect packages?

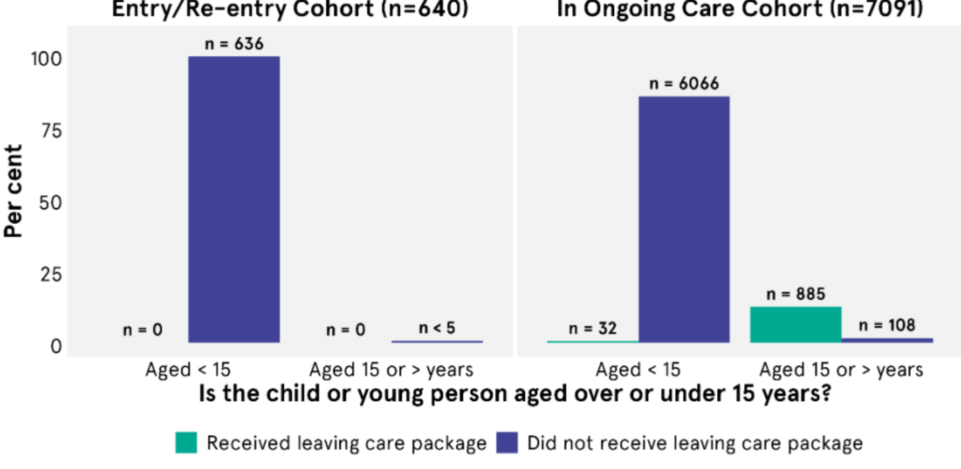
We answered this question by looking at the number of children aged 15 or over in each cohort and comparing this to the number of children who received packages at the start (Entry/Re-entry cohort) or had a package active on 1st October 2018 (Ongoing Care cohort).

Leaving Care package

There were less than 5 children in the Entry/Re-entry cohort who were 15 years or older at the time of entry (see earlier section detailing selection of children for receipt of PSP packages – older children who enter care are far less likely than younger children to receive a PSP package). Of these, none were provided with a Leaving Care package within a month of their start date (Figure 6.2).

There were 993 children in the Ongoing Care cohort that were 15 years of age or older on the 1st of October 2018. The vast majority of these (n=885 representing 89.1% of the total eligible) held an active Leaving Care package on 1st October 2018 (Figure 6.2). These figures indicate a very high uptake rate of this package for children in ongoing care.

Figure 6.2 Percent and count of children, stratified by age, who received a Leaving Care package in the Entry/Re-entry and Ongoing Care cohorts



We compared the children aged over 15 years that held a leaving care package and those that did not in the Ongoing Care cohort. Key differences include that children holding an active package on 1st Oct 2018 were older, were in foster care (over kinship care), and were more likely to also hold a long-term care package or a 15+ Reconnect package. The main comparisons are outlined in Table 5.8 below.

Table 5.8 Comparison of characteristics between those children aged over 15 years who held a leaving package and those who did not, in the Ongoing Care cohort

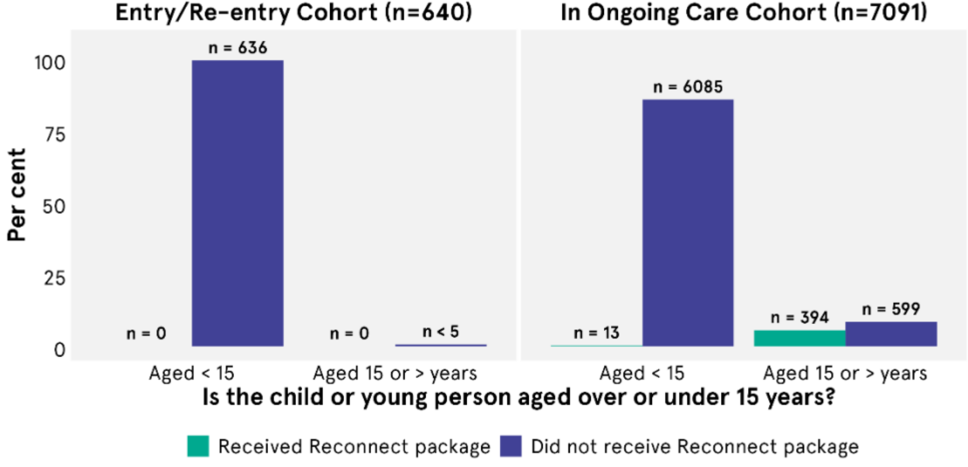
Variables	Had an active Leaving Care package (n=885)	Did not have an active Leaving Care package (n=108)	*p* value
Female (n (%))	407 (46.0)	45 (41.7)	0.454
Aboriginal (n (%))	235 (26.6)	30 (27.8)	0.876
Age on 1 October 2018 (years; mean (SD))	16.44 (0.82)	15.82 (0.76)	<0.001
Foster care (n (%))	695 (78.5)	74 (68.5)	0.026
Kinship care (n (%))	190 (21.5)	34 (31.5)	0.026
Spent more than half of their life in current OOHC episode (n(%))	650 (73.4)	70 (64.8)	0.075
Had an active Long Term Care case plan goal package (n(%))	838 (94.7)	77 (71.3)	<0.001
Had an active 15+ Reconnect specialist package (n(%))	389 (44.0)	5 (4.6)	<0.001

15+ Reconnect package

Similarly, among the few (i.e., less than 5) children in the Entry/Re-entry cohort who were 15 years of age or older at the time of entry, none were provided with the 15+ Reconnect package within a month of their start date (Figure 6.3).

Among the 993 children in the Ongoing Care cohort who were age 15 years or older on the 1st of October 2018, a total of 394 (39.7 per cent) held an active 15+ Reconnect package on the 1st of October 2018 (Figure 6.3). While this uptake rate is lower than the Leaving Care package, this would be expected, as would uptake of both services by the same young person (e.g., reconnecting could be part of the leaving care plan).

Figure 6.3 Percent and count of children, stratified by age, who received a 15+ Reconnect package in the Entry/Re-entry and Ongoing Care cohorts



What is the allocation rate for family preservation packages?

The allocation rate is low at the population level and is estimated to be 2.1 per cent. Due to the low number of packages allocated to Family Preservation (380), families presenting to child protection at ROSH who are assessed face-to-face (roughly 30 per cent of eligible ROSH's are triaged for further assessment) are not at all likely to receive PSP Family Preservation packages.

Case workers and managers consulted across the three Aboriginal case study sites strongly argued that there are insufficient funds for the family preservation stage in PSP, despite there being significant concern in Aboriginal communities to provide adequate services at the outset to families at risk, to support children to remain safely with their birth families (see Chapter 5 for more details).

What is the allocation rate for case coordination restoration support packages?

There are a number of case coordination supports available to children following restoration to their parents. Depending on whether the child is under the parental responsibility of the minister (PRM) or not, there are two different PSP baseline packages they may be eligible for:

- Case Coordination – Restoration Support
- Case Coordination (Post Permanency Casework Support)

Both these packages are given after the child has exited OOHC. Due to the nature of the data available (and the often limited follow up time post restoration) it was not often possible to distinguish the type of case coordination support being provided.

In the PSP-specific group of Entry/Re-entry, there were 73 children that exited to restoration over the course of the evaluation period. Roughly one-third (n=25) of children who exited OOHC to restoration received a Case Coordination - Restoration Support package at some point between 1st July 2018 and a month after their exit date (Table 5.9). A further 18 (24.7%) received some level of additional case coordination post permanency support within a month after their restoration (Table 5.9).

Table 5.9 Percent and count of the children that underwent restoration (n = 73) and received case coordination support and/or a case coordination package in the Entry/Re-entry cohort, n = 640

	Received case coordination support within a month post restoration n (%)	Did not receive case coordination support within a month post restoration n (%)
Received Case Coordination – Restoration Support package	13 (17.8%)	12 (16.4%)
Did not receive Case Coordination – Restoration Support package	18 (24.7%)	30 (41.1%)

Similarly, roughly 40 per cent (n=91) of the children who were restored to their parents (n=228) in the Ongoing Care cohort received a Case Coordination – Restoration Support package between 1st July 2018 and a month after their exit date (Table 5.10). A further 64 (28.1%) received some level of additional case coordination post permanency support within a month after their restoration (Table 5.10).

Table 5.10 Percent and count of the children that underwent restoration (n = 228) and received case coordination support and/or a case coordination package in the Ongoing Care cohort

	Received case coordination support within a month post restoration n (%)	Did not receive case coordination support within a month post restoration n (%)
Received Case Coordination – Restoration Support package	64 (28.1%)	27 (11.8%)
Did not receive Case Coordination – Restoration Support package	64 (28.1%)	73 (34.2%)

6.3.5. Do children who are flagged in the DCJ system as Aboriginal or CALD receive the relevant packages?

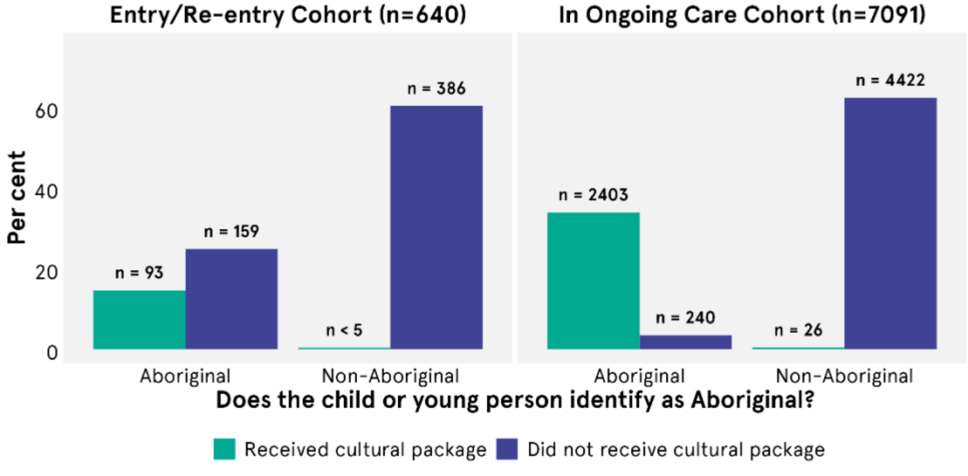
We answered this question by looking at the numbers of children eligible for cultural and CALD packages and comparing them to the numbers of children that received each package.

Cultural Packages

There were 252 children in the Entry/Re-entry cohort who were identified as Aboriginal at the time of entry (39.4 per cent of all children in the cohort). Of these, 93 (36.9 per cent)

were given at least one cultural package (either Cultural Plan Annual, Cultural Plan Establishment or Cultural Plan in Care) within a month of their start date (Figure 6.4). Within 6 months of their start date, 113 (44.8%) of children identified as Aboriginal at the time of entry had received at least one cultural package (either Cultural Plan Annual, Cultural Plan Establishment or Cultural Plan in Care).

Figure 6.4 Percent and count of Aboriginal and non-Aboriginal children who received a cultural package in the Entry/Re-entry and Ongoing Care cohorts



There were 2,643 children in the Ongoing Care cohort who were identified as Aboriginal on the 1st of October 2018 (37.3 per cent of all children in the cohort). Of these, over 90 per cent (n=2,403; 91.0%) held an active cultural package (either Cultural Plan Annual, Cultural Plan Establishment or Cultural Plan in Care) on the 1st of October 2018 (Figure 6.4).

In the cases observed in the case review, we found that each Aboriginal child had a cultural plan, even if they did not appear to receive any of the cultural packages. The quality and appropriateness of the cultural plans is assessed through the Aboriginal case studies and the case reviews in the implementation section (Chapter 5).

Culturally and Linguistically Diverse packages

According to the article 'Business Rules: Eligibility criteria for PSP Service Packages',[62] the main eligibility criteria for receiving a culturally and linguistically diverse package is that children must be from a CALD background, defined as: "born overseas, in countries other than those classified by the Australian Bureau of Statistics (ABS) as 'English speaking countries' (UK, New Zealand, Republic of Ireland, Canada, USA, South Africa)."

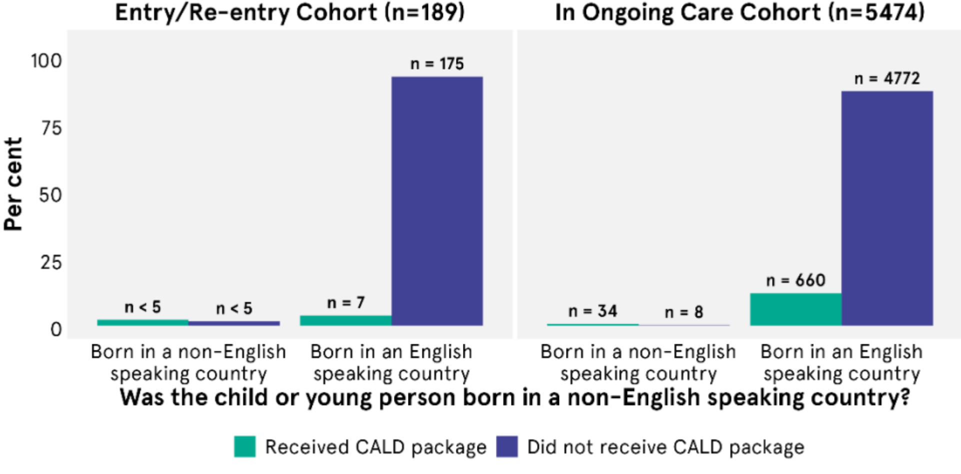
The ChildStory dataset we received did not have information on the birthplace or diversity of background for children. Instead, we linked the cohort data from ChildStory to the NSW Department of Education data extract to ascertain information on individual child country of birth and Language background other than English (LBOTE). In this way, we were able to determine eligibility for school aged children to obtain an estimate of package utilisation for those who are eligible.

[62] (https://www.facs.nsw.gov.au/__data/assets/pdf_file/0004/648841/Business-Rules-for-Eligibility-of-PSP-Service-Packages-FC,-ITC-Feb-19.pdf)

In the Entry/Re-entry cohort, there were 189 children (29.5 per cent) who linked to the education data. This low match rate is likely being driven by the large numbers of children who are younger than school age in this cohort. Of these, only 7 were born in a non-English speaking country, and roughly half of these (n < 5) received a CALD package within a month of their entry into OOHC (Figure 6.5).

In the Ongoing Care cohort there were 5474 children (77.2 per cent) who were linked to the education data. Of these, 42 children were recorded as born in a non-English speaking country, and just over 80 per cent (n=34; 80.2 per cent) held an active CALD package on the 1st October 2018 (Figure 6.5).

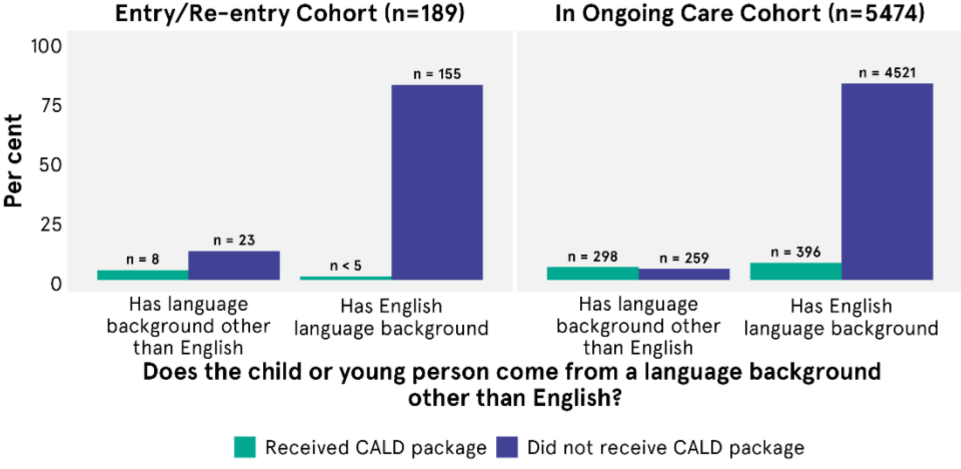
Figure 6.5 Percent and count of children born in a non-English speaking background who received a CALD package in the Entry/Re-entry and Ongoing Care cohorts



LBOTE was used as a more stringent check on CALD package received. In the Entry/Re-entry cohort only 25.8 per cent of children recorded as LBOTE received a CALD package within a month of entry (Figure 6.6). In the Ongoing Care cohort 53.5 per cent of those deemed LBOTE were receiving a CALD package on the 1st of October 2018[63] (Figure 6.6).

[63] Specialist packages, such as CALD, were considered active for a year after their package start date.

Figure 6.6 Percent and count of children identified as LBOTE who received a CALD package in the Entry/Re-entry and Ongoing Care cohorts



6.3.6. To what extent is funding from packages reaching the intended child? Or to what extent do PSP service providers 'pool' the funding from the packages or allocate it to the child who has received that package?

The DCJ administrative data on PSP payments only include the amounts paid per type of package, so given the option of pooling funding, the data cannot be used to assess how much is spent on each child exactly. As a result, we cannot assess whether spending more on a child leads to better outcomes, or whether spending more on one service over another is recommended. Theoretically, the only certainty regarding the funding allocation is the total amount of funding that a PSP provider received overall, and the number of children receiving services paid for by that funding.

While packages are designed to follow the individual child, there is an option for PSP providers to combine or 'pool' PSP packages across cases. Focus group data from non-Aboriginal sites indicates that while the majority of PSP providers do pool funding where necessary, this is not their preferred way of working. When funding is pooled, this is typically used to cover large, unexpected expenses not covered by the child's package.

On review of case notes, there was limited transparency over funding allocation unless PSP agencies are sourcing funding to pay for costs additional to what PSP providers or carers are expected to deliver. This includes:

- Medical and dental procedures (complex needs),
- Establishment costs, including furniture or small renovations, and
- Leaving care services and supports included in the financial plan, such as planned or projected health costs and leaving care related expenses (e.g., driving lessons)

Limited transparency over funding allocation was echoed by DCJ representatives, who indicated some PSP providers do not appear to have a system in place to track funding allocation for each child. Representatives from DCJ believe this reduces the accountability of PSP providers and makes reviewing applications for increased funding more difficult.

'The number of [...] complex needs applications are increasing quite significantly, yet we have no means to go back to them and ask, 'what have you spent on the child as far as contingency items go?', so it's hard to know. You feel like you're caught between a rock and a hard place considering those applications.' – DCJ representative

6.4. Discussion

In summary, PSP packages were provided to a large number of eligible children and families (n=10,431), and a large proportion of these were included in one or more cohorts used in the subsequent analyses. Packages for family preservation appeared to reach the right population of households (i.e., high risk following face to face assessments for ROSH), but only a tiny proportion of the eligible population received a PSP Family Preservation package (2.1 per cent), due to the limited number of packages available (n=380). In contrast, most PSP packages initiated over the evaluation period were provided to children in ongoing care who had generally been in care for long periods of time (more detail is provided in Chapter 6), with a large number (>7000) of these children receiving PSP on 1st July 2018. Together, this indicates that the focus of the PSP program has, to date, been on the 'back end' of the child protection and OOHC system, as it has focused on supporting children already in the system (some of whom had been in the system for many years) rather than at the 'front end', to help children remain at home and prevent them from entering the system.

Children who entered care and received PSP packages tended to be younger, placed in foster care rather than kinship care, and were not identified as being Aboriginal when compared with children who entered care but did not receive a PSP package. For those in ongoing care, children receiving PSP packages were much more likely to be in foster care, and they tended to have been in their current episode of OOHC for substantially longer periods of time. Although the majority of children who received PSP packages entering OOHC initially received restoration packages (95.3%), very few in that cohort eventually received Case Coordination – Restoration Support packages (4.8%) during the evaluation period. This low percentage likely reflects the low restoration rate (discussed in Chapter 6: Effectiveness). These broader trends are reflected in changes in permanency goals, which – for those entering an episode of care -- largely started as restoration and later shifted to long term care. In contrast, for those already in ongoing care, permanency goals remained static over the course of the observation period and centred around long term care.

Overall, it seems that PSP packages were concentrated on permanency options at the 'back end' of the OOHC system (i.e., long-term foster care, guardianship, and adoption) - rather than those at the 'front end' (e.g., family preservation) or in-between (restoration).

Part five

Effectiveness: what was the impact of PSP on targeted outcomes?

7. Effectiveness results

Key takeaways

Family Preservation cohort:

- PSP did not decrease new reports of significant harm (ROSH), which indicate serious child maltreatment concerns, or entries to OOHC for at risk households.

Entry/Re-Entry Cohort:

- Children were not often restored and, if they were, it made no difference whether they received a PSP package.
- Children who received a PSP package had greater placement stability than children who did not, although this difference was not maintained for longer than four months.

Ongoing care cohort:

- Children were rarely restored to their parent(s), but those receiving a PSP package were restored slightly more often than those who did not.
- Children who received a PSP package were less likely to be charged with an offence than the historical sample of children who did not, although overall decreases in youth criminal offences bring this finding into question.
- Adoption continues to be rare overall, but children who received PSP were more likely to be adopted than those who did not[64].

[64] The authors acknowledge that this coincides with a change in adoption policy over time, that a single organization (deliberately) handles the majority of adoptions, and that there are alternate programs and additional funding other than from the PSP program to support the adoption of children from care. In recent times, the majority of children in general foster care placements have been managed by PSP providers, which means that the majority of adoptions (in recent years) are achieved by NGOs.

- There were no differences in whether children who received packages had a new ROSH or another entry to OOHC following restoration, nor were there any differences in known homelessness after age 18.

7.1. Introduction and Data

The key evaluation question for the effectiveness component of this evaluation is: *Has PSP delivered by PSP providers improved safety, permanency and wellbeing outcomes for children and families who come into contact with the NSW child protection and OOHC system?*

Although all children who received child protection or OOHC services on or after July 2018 experienced some form of practice or policy associated with the PSP reform, not all children received dedicated PSP packages delivered by contracted PSP providers. That is, many children received supports that were not part of the PSP package scheme. In order to compare to children and young people who were similar to those who received PSP packages, we created counterfactuals using a statistical matching process known as propensity score matching or PSM (see Chapter 4 and Appendix C for further details).

We found a matched group of similar children for three distinct cohorts (see also Table 6.1):

- Family preservation cohort: households reported for a child maltreatment concern that were assessed as high or very high risk.
- Entry/Re-entry cohort: children entering a new episode of care either for the first time ever or after having a previous stay in care that had ended.
- Ongoing care cohort: children in care at a single point in time.

The matching procedure resulted in matched groups of similar children (with similar histories) for each cohort (Table 7.1), which were then used to test the effectiveness of PSP packages across a range of outcomes. The timing of covariates used in the analysis and the timing of outcomes measured differed between groups, depending on data availability and the question being addressed (outlined in Table 7.1).

Table 7.1 The three different cohorts of children in this study: Family Preservation, Entry/Re-entry, and Ongoing Care

Cohort	Cohort 1: Family Preservation	Cohort 2: Entry/Re-entry	Cohort 3: Ongoing Care
Analysis level	Household	Child	Child
Eligibility	Households who received a family preservation package following an assessment between 1st July 2018 and 30th April 2021	Children who entered into a new episode of foster or kinship care between Oct 2018 and 31st Dec 2020 and received a PSP package within 32 days of entry	Children who were in foster or kinship care and held an active PSP package on the 1st of October 2018

Cohort	Cohort 1: Family Preservation	Cohort 2: Entry/Re-entry	Cohort 3: Ongoing Care
Number receiving PSP packages	371	640	7091
Number receiving PSP packages (matched)[65]	309[66]	539	6200
Description of comparison group	Households eligible for a family preservation package between 1st July 2018 and 30th April 2021, but did not receive one (concurrent)	Children who entered a new episode of foster or kinship care between 1st Oct 2014 and 31st Dec 2016 (historical)	Children who were in foster or kinship care on the 1st of October 2014 (historical)
Number in comparison (matched)[67]	315	528	6156
Timing of covariates used in analyses	Covariates were determined at the start of receiving the Family Preservation package (or equivalent comparison date)	Covariates were determined at the start of entry into OOHC	Covariates were determined on the 1st of October (2018 or 2014)
Timing of outcomes	The date of the first event (i.e. outcome, such as next ROSH or next entry into OOHC) following the start of receiving Family Preservation (or equivalent comparison date) through to 30th June 2021	The date of the first event (i.e. outcome, such as exit from OOHC for restoration) following the start of entry into OOHC through to 30th June 2021 and 30th June 2017 (historical)	The date of the first event (i.e. outcome, such as exit from OOHC for restoration, time to next youth justice offence) following the 1st October (2018 or 2014) through to 30th June 2021 and 30th June 2017 (historical)

To assess the impact of PSP on the outcomes, we applied a series of time to event models, particularly Kaplan Meier and Cox Proportional Hazards Regressions, throughout this

[65] Numbers of those in the PSP matched groups in the entry/re-entry cohort and ongoing care cohort were reduced due to a post-matching shift in the scope of the project to only include children in foster care and kinship care at the start of the study period as well as some minor changes in data during the November 2021 data refresh.

[66] Households known to have received concurrent intensive preservation services (e.g., MST; but not Brighter Futures or Youth Hope) were excluded after matching in order to account for their potential influence on outcomes. To account for this, the original match incorporated multiple matches per family. In the Non-PSP Family Preservation comparison group, only the closest match per pair (after excluding families receiving intensive programs) was carried forward for analysis.

[67] Numbers of those in the comparison groups were originally identical to those in the matched PSP groups, per cohort. However, due to the shift in the scope of the project to include only children in foster care and kinship care at the start of the study period (for the Entry/Re-Entry and the Ongoing Care cohorts), some minor changes in data during the November 2021 data refresh, and the exclusion due to other intensive family preservation programs (for the Family Preservation cohort), the final numbers of the matched PSP versus comparison groups had some discrepancies. Any persisting significant differences between groups were identified and controlled for in subsequent analyses.

chapter. These models enabled us to compare the two matched samples while controlling for both multiple risk factors and differences in follow up times for participants. From the hazard ratios generated by these models, we determined the relative likelihood that PSP was impacting each outcome at any given point in time (see explanation box, below, for more detail).

Cox Proportional Hazards Regression and interpreting the hazard ratio (HR)

Cox proportional hazard models are regression models that analyse the time between the 'starting point' of a study and a subsequent observed event (Cox, 1972). These models are commonly used for 'survival analyses' in health research - they investigate the association between patient survival and one or more predicator variables.

With Cox Proportional Hazards models, the measure of the effect of each variable is the hazard ratio (HR)[68]. If the hazard ratio of a variable *is less than 1*, then the variable is associated with a lower rate of that event/outcome. If the hazard ratio is *greater than 1*, the variable is associated with a higher rate of that event/outcome. In other words, the hazard ratio is an estimate of the relative risk – the likelihood that each participant in a study will experience the event. A hazard ratio of exactly 1 indicates each participant (regardless of whether they have the variable, or risk factor) will be *equally likely* to encounter the event (i.e. their risk or hazard is the same). Thus, if the HR is higher, a participant with that variable is more likely to experience the event over time and vice versa for a lower HR.

If the p-value of the variable is less than 0.05 (i.e., the 95% confidence interval) then the rate difference is statistically significant, and the associated hazard ratio indicates the overall likelihood of the outcome increasing/decreasing over time. If the p-value is greater than 0.05 then the difference is not significantly different and any differences in the HR are not meaningful.[69]

Example 1: a HR of 1.5 means that the group receiving PSP would have a higher likelihood (by a factor of 1.5 or 50%) to experience the outcome relative to the other group at any point in time.

[68] Note that Cox Proportional Hazard models rely on an important assumption to be met, which is that the hazard ratios of each variable need to be proportional through time (i.e., the Proportional Hazard Assumption).

[69] For this reason, the hazard ratios and confidence intervals for variables that were not statistically significant are not presented in this report, although they can be found in the relevant tables in Appendix F.

Example 2: a HR of 0.33 means that the group receiving PSP would be much less likely to experience the outcome (by a factor of 3, i.e. 3 times less likely relative to the other group at any point in time.

Where possible, we also examined the impact of the COVID-19 pandemic by running separate models that limited the study period to before the commencement of the pandemic (up to March 2020 and equivalent in the comparison period) and compared these to our 'standard model' of the full evaluation period. The results of the COVID-19 comparisons are presented in Appendix F.

For a more detailed methodology on how cohorts were matched and analysed, please refer to Appendix C.

7.2. Results

7.2.1. What happened following receipt of PSP services in terms of children's safety?

To determine whether receiving PSP packages improved children's safety, we assessed the effect of PSP on four main outcomes:

1. The likelihood of a new ROSH report following package start (Family Preservation cohort),
2. The likelihood that families had a child enter OOHC following package start (Family Preservation cohort),
3. The likelihood of a new ROSH report following restoration (Ongoing Care cohort), and
4. The likelihood of a child returning to OOHC following restoration (Ongoing Care cohort).

To assess the effectiveness of PSP on these four outcomes we measured how long passed between a household (Family Preservation cohort) or child (Ongoing Care cohort) receiving the PSP package (or an equivalent time in the matched sample) and the time each outcome occurred. Time to each outcome was measured to account for the different length of time each household or child was followed (i.e., it is not fair to compare whether there is a new ROSH report post-restoration for children who are followed for 2 years compared to those who are followed for only 3 months).

Has PSP contributed to fewer reported maltreatment incidents or entries into care for those receiving Family Preservation packages?

The PSP Family Preservation Package[70] was designed to keep families together and to improve the safety of children in the home. The package was delivered at a household, rather than individual child, level and was only provided to families with children whose safety and risk had been assessed by DCJ but who had not yet been removed from the

[70] For more detail on the packages available through PSP, see https://www.facs.nsw.gov.au/providers/children-families/deliver-psp/psp-funding-model-and-service-packages.

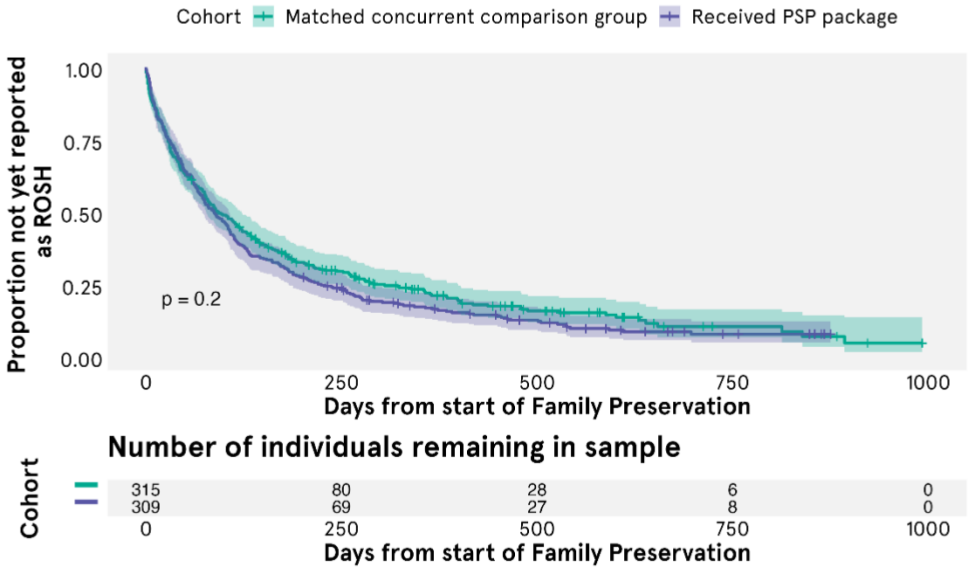
home[71]. We examined whether receiving a PSP Family Preservation Package would reduce the likelihood that the household would have a new ROSH report sooner or that one or more children from a household would enter OOHC sooner, compared to similar concurrent households that did not receive the package.

Time to next ROSH for those in Family Preservation

This analysis examined whether families receiving the PSP family preservation package (n=309) were more or less likely to have a new ROSH report sooner than their statistically matched comparison group (n=315) after the start of services (or its equivalent). Specifically, the analysis measured whether there were relative differences in time — measured in days — that elapsed between when a household/family started receiving Family Preservation packages (or equivalent) and when the household had another ROSH report.

At a simple level (univariate), the Kaplan-Meier analysis — depicted graphically in Figure 7.1 – suggests that there is no statistically significant difference (p = 0.205[72]) in the time to next ROSH between those children who received a PSP Family Preservation package in the current period and those that received Non-PSP Family Preservation packages. Overall, of the families that had a 12 month follow up time,[73] 389 of 479 (81.21%) had at least one new ROSH within 12 months.[74]

Figure 7.1 Kaplan-Meier survival curve for time to next ROSH report for those children who received a PSP package relative to a matched concurrent comparison group in the Family Preservation cohort



[71] Families were eligible for Family Preservation if their face-to-face assessment following a recent ROSH report for the household was rated High or Very High Risk on the SDM Risk Assessment tool, were rated as 'Safe' or 'Safe with Plan' on the SDM Safety Assessment, and the children remained in the home. They were ineligible for the program if they were receiving an alternate intensive family preservation package, such as MST. For more details on the eligibility criteria for families to receive Family Preservation Packages, please refer to Appendix F.

[72] i.e. at the 95% confidence interval

[73] In other words, only including households that started receiving PSP (or equivalent start for the comparison) within a year of the end of the evaluation period (30th June 2021).

[74] In this report, where Kaplan-Meier curves and Cox regression models are non-significant, we provide a combined value (those that received PSP and their comparison) to give an indication of magnitude.

Interpreting a Kaplan-Meier Curve

A Kaplan-Meier curve shows the probability of an event ('outcome') occurring at a certain time interval after the start of a study period. Kaplan-Meier curves indicate if similar groups that differ in one particular way – such as if they received a PSP package or not -- are more or less likely to experience an outcome.

In a Kaplan-Meier curve, a higher survival curve indicates that group was less likely to have the outcome at each time interval (usually measured in days or months after the start of the study/treatment/intervention). A lower survival curve indicates that the group was more likely to have the outcome at each time interval, as relatively more people in this group experienced the outcome sooner. Which direction represents a *better* result entirely depends on the outcome of interest; for example, it would be *better* to have longer time until a child's next ROSH report (indicated by a higher curve) but also *better* to have shorter time until a child is successfully and safely restored to its parents (indicated by a lower curve).

Although robust and excellent for visualising the curves, the Kaplan-Meier curve is a univariate analysis. Controlling for differences between the groups (such as age, or if more children are in foster care vs kinship care) requires a similar but more complex approach: the Cox Proportional Hazards Regression.

For this report, we include Kaplan Meier curves in the main report if the univariate analysis is significant and in Appendix F if not statistically significant. The results are always reported but depictions are only presented for significant findings. The above Kaplan Meier curve is not significant (the lines describing the outcome are no different between the PSP and comparison group), but has been included for illustrative purposes.

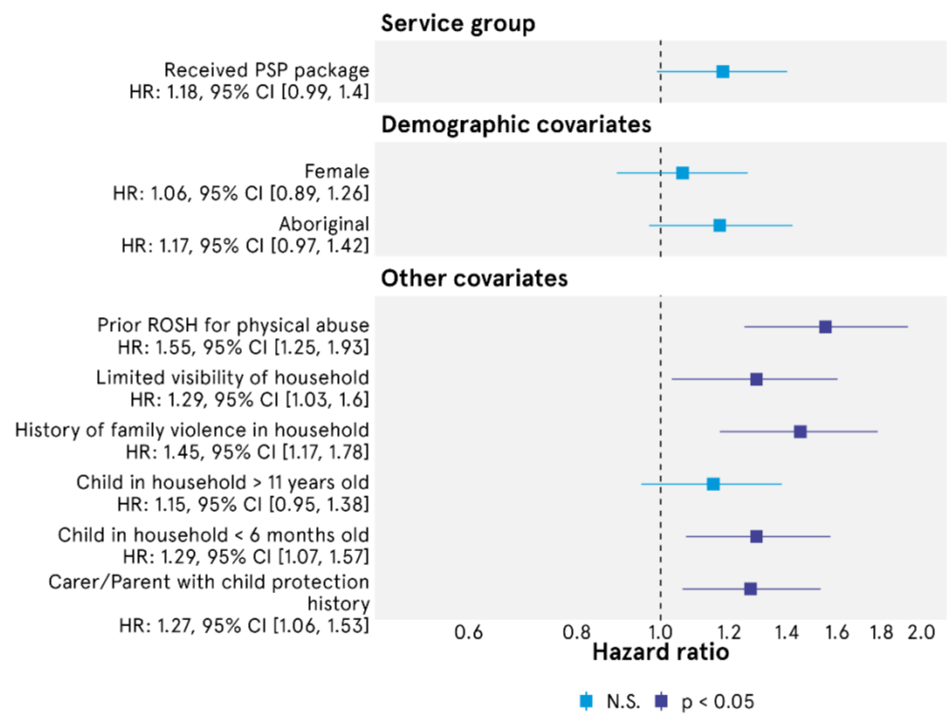
We considered whether there were any factors which influenced the time to next ROSH by using a Cox Proportional Hazards regression model. The results suggest that, once we controlled for other variables in the model:

- There was no statistically significant difference in the time to next ROSH report between those children who received a PSP Family Preservation package and those who received Non-PSP Family Preservation packages (HR: 1.18, 95% CI: [0.99, 1.40], $p = 0.059$).
- Once we controlled for other variables there was no significant difference between Aboriginal and non-Aboriginal children. There was also no difference between males or females.

- However, several other factors[75] were significantly associated with the time to next ROSH report — for children in both the PSP and Non-PSP Family Preservation groups. Each of the following had a significantly increased hazard of being reported as ROSH during the study period:
  - Households who had a prior ROSH for physical abuse before receiving PSP Family Preservation services or equivalent (HR: 1.55, 95% CI: [1.25, 1.93], $p < 0.001$)
  - Households with limited visibility[76] (HR: 1.29, 95% CI: [1.03, 1.60], $p = 0.024$)
  - Households with a child under 6 months old (HR: 1.29, 95% CI: [1.07, 1.57], $p = 0.009$)
  - Households with a history of family violence (HR: 1.45, 95% CI: [1.17, 1.78], $p < 0.001$)
  - Households where the parents had a child protection history (HR: 1.27, 95% CI: [1.06, 1.53], $p = 0.009$).

Results of our model (described above) are visualised in the plot in Figure 7.2 below. The model is presented in Table F.1 in Appendix F.

Figure 7.2 Factors associated with the time to next ROSH report for those who received a PSP package relative to a matched historical comparison in the Family Preservation cohort



[75] Please refer to Appendix F for details on the other factors included as covariates in the Cox Proportional Hazards models, and how these were defined and measured.

[76] "Limited visibility" is defined from Safety and Risk assessments. It refers to children/households that have less frequent contact with services that have mandatory reporting (e.g. social services, schools, police). Infants and pre-schoolers often have limited visibility.

This analysis and model (assessing time to next ROSH) was replicated for those in PSP Family Preservation and those not receiving PSP Family Preservation to assess if there was a difference in the time to next *non-ROSH*[77]. The overall results for time to next non-ROSH were almost identical to those for time to next ROSH, with both models showing no significant differences for households that received PSP packages versus those that did not. Also similar, there were no gender differences and Aboriginal children had the same likelihood of a new non-ROSH report as non-Aboriginal children. Further detail on other factors associated with a new non-ROSH report are in Appendix F: Figure F.1 and Table F.2.

Time to next entry into out-of-home care for those in Family Preservation

This analysis examined whether a matched sample of families receiving the PSP family preservation package (n=309) were more or less likely than their statistically matched comparison group (n=315) to have at least one child (or young person) in the family enter OOHC sooner after the start of services (or its equivalent). Specifically, the analysis measured whether there were differences in time — measured in days — that elapsed between when a household/family started receiving Family Preservation packages (or equivalent) and when an individual child from the household entered OOHC.

At a simple level (univariate), the Kaplan-Meier survival curves[78] show that there is a no statistically significant difference (p = 0.313) in the time to OOHC entry between those children who received a PSP family preservation package and those who did not. Overall, in both groups, less than a fifth of families had a child enter OOHC within 12 months (80 families out of 479).[79]

At a more complex level (multivariate), we considered whether there were any factors that influenced the time to OOHC entry by using Cox Proportional Hazards regression. The results suggest that, once we controlled for other variables in the model:

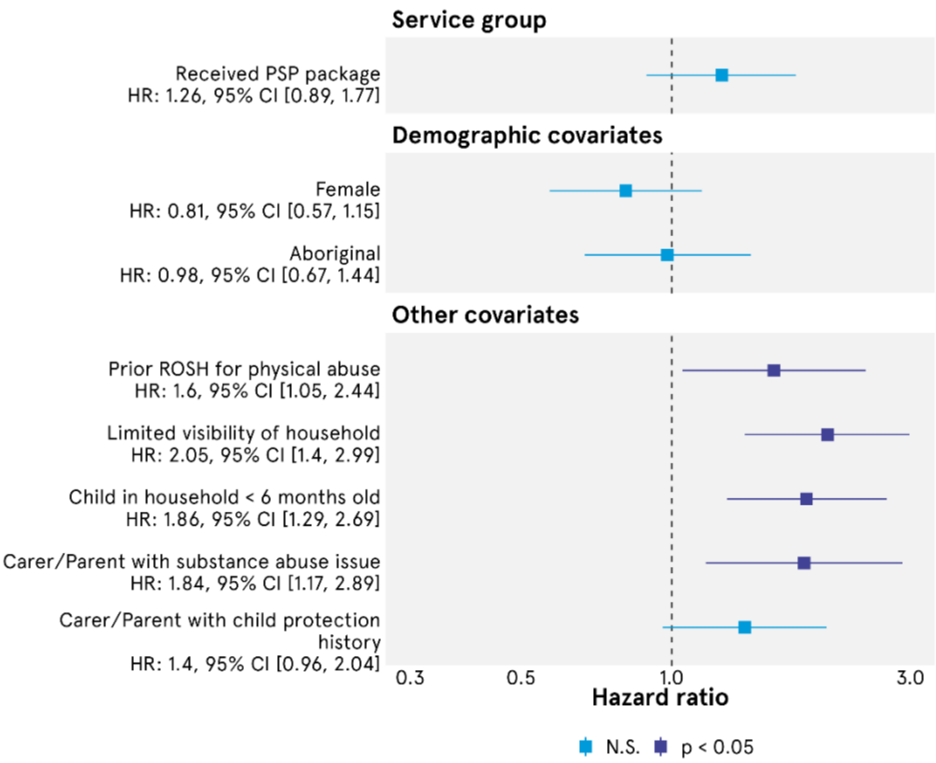
- There was no statistically significant difference in the likelihood of entry to OOHC at any point in time of the study period between those children who received a PSP package and those who did not (HR: 1.26, 95% CI: [0.89, 1.77], p = 0.195).
- Once we controlled for other variables, there was no significant difference between Aboriginal and non-Aboriginal children (HR: 0.98, 95% CI: [0.67, 1.44], p = 0.934) at any point in time of the study period. That is, Aboriginal children were just as likely to enter care as non-Aboriginal children. There was also no difference between females compared to males (HR: 0.81, 95% CI: [0.57, 1.15], p = 0.242).
- However, several other factors were significantly associated with OOHC entry — for families in both the PSP package and comparison groups. Each of the following factors was associated with an elevated hazard (risk) of entering OOHC:
  - Families with limited visibility, according to the most recent Safety and Risk Assessment, prior to receipt of family preservation services (HR: 2.05, 95% CI: [1.40, 2.99], p < 0.001)
  - Families that had a child who was the subject of a prior ROSH for physical abuse before they commenced family preservation services (HR: 1.60, 95% CI: [1.05, 2.44], p = 0.030)

[77] A non-ROSH was defined as a child protection report which did not meet the ROSH threshold.
[78] Depicted in Figure F.2 in Appendix F.
[79] These numbers only include families that had at least one year follow up time – in other words it does not include families that started receiving PSP (or equivalent start for the comparison) within a year of the end of the evaluation period (30th June 2021).

- Families with a child in their household less than 6 months old at the time they commenced receiving family preservation services (HR: 1.86, 95% CI: [1.29, 2.69], $p < 0.001$)
- Families with a carer or parent with a substance abuse issue before they commenced receiving family preservation services (HR: 1.84, 95% CI: [1.17, 2.89], $p = 0.008$).

Results of our model are visualised in the forest plot in in Figure 7.3 below. The statistical model is presented in Table F.3 in Appendix F.

Figure 7.3 Factors associated with entering OOHC for families that received a PSP package relative to a historical comparison in the Family Preservation cohort



Has PSP contributed to fewer reported maltreatment incidents or re-entries into care following restoration?

To determine whether receiving PSP packages contributed to fewer re-entries into care, we used the Ongoing Care cohort. This is a limitation brought on by the fact that more follow-up time was needed to measure outcomes for the Entry/Re-entry cohort (i.e., it takes time to restore and takes time to return). This Ongoing Care cohort encompassed all children in care on the 1st October 2018 and compared them to all children in care on the 1st October 2014. The long follow up time and large sample enabled us to observe what occurred to children following an exit for restoration, and whether PSP was associated with different outcomes between the two matched groups.

Time to next ROSH following restoration

Has PSP decreased the likelihood that children will have a new ROSH report after restoration?

We examined whether receiving PSP packages would reduce the likelihood that children would have a new ROSH sooner following an exit to restoration, compared to similar children who were not exposed to PSP. This comparison used a time-to-event analysis (Kaplan-Meier Curves and Cox Proportional Hazards Regression) that measured the time from a child exiting OOHC to restoration to the time that the same child received a new ROSH or the observation period ended. In a Kaplan-Meier curve, a higher survival curve indicates that group was less likely to have the outcome — in this case, there is no significant difference between children who received a PSP package versus the matched comparison group. Specifically, the analysis measured whether there were differences in time — measured in days — that elapsed between when a child exited to restoration and when the same child received their next ROSH.

At a simple level (univariate), the Kaplan-Meier survival curve[80] shows no statistically significant difference ($p = 0.143$) in the time to a new ROSH report between those children who received a PSP package and those who did not. Of the children who left to restoration in the evaluation period (and had a 12 month follow up time), about half had a new ROSH within 12 months: 162 out of 314 (51.6%).

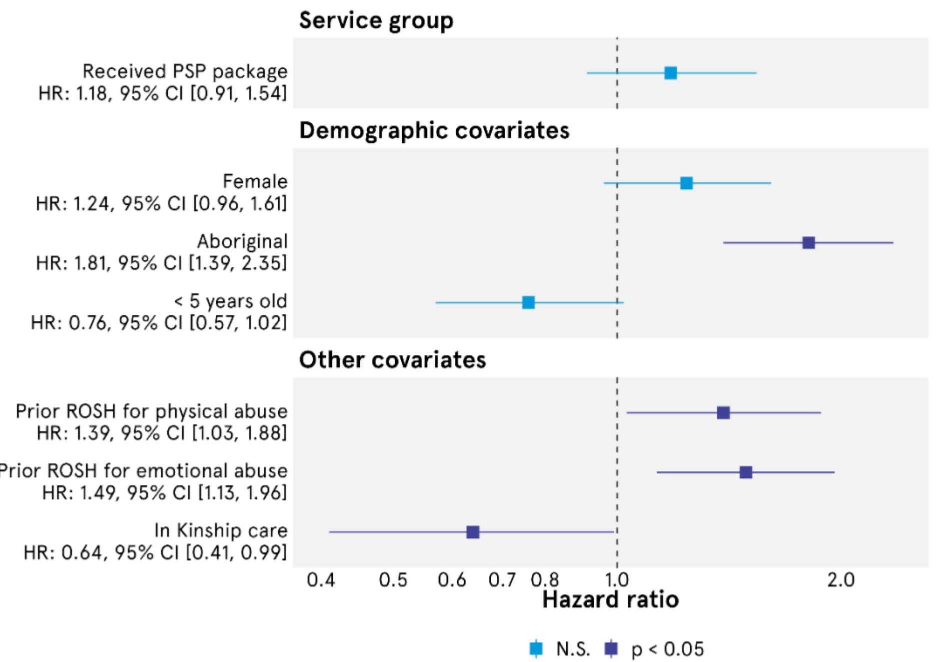
At a more complex level (multivariate), we considered whether there were any factors that influenced the time to next ROSH after exit to restoration using Cox Proportional Hazards regression. The results (Figure 7.4) suggest that, once we controlled for other variables in the model:

- There was no statistically significant difference in the likelihood of having a ROSH report sooner after restoration between those children who received a PSP package and those in the historical comparison (HR: 1.18, 95% CI: [0.91, 1.54], $p = 0.218$).
- Once we controlled for other variables, there was no significant difference between females compared to males (HR: 1.24, 95% CI: [0.96, 1.61], $p = 0.104$). There was no significant difference between children aged under five years of age compared to those age five or older (HR: 0.76, 95% CI: [0.57, 1.02], $p = 0.064$).
- Children who were identified as Aboriginal were more likely to have a new ROSH report sooner following an exit to restoration (HR: 1.81, 95% CI: [1.39, 2.35], $p < 0.001$).
- Those who had a prior ROSH report for physical (HR: 1.39, 95% CI: [1.08, 1.88], p = 0.033) or emotional abuse (HR: 1.49, 95% CI: [1.13, 1.96], $p = 0.005$) were also more likely to have a new ROSH report sooner following an exit to restoration.
- Children restored from kinship care were less likely at any point of time to have a new ROSH report post restoration, compared to those in foster care (HR: 0.64, 95% CI: [0.41, 0.99], $p = 0.045$).

Results of our model are visualised in the plot in Figure 7.4 below. The model is presented in Table F.4 in Appendix F. The statistical model in Table F.4 also compared the results to a replicate model that followed children from 1st October 2018 to 1st March 2020 in the PSP package group compared to 1st October 2014 to 1st March 2016. This replicate model was designed to investigate whether outcomes for PSP packages were consistent when only considering a pre-COVID era. The results held – whether a child received PSP did not significantly affect their likelihood of having a ROSH report after restoration (Appendix F: Table F.4).

[80] Depicted in Figure F.3 in Appendix F.

Figure 7.4 Factors associated with time to next ROSH following restoration for those who received a PSP package relative to a matched historical comparison in the Ongoing Care cohort



Time to next entry into OOHC following restoration

We examined whether receiving PSP packages would reduce the likelihood that a child would re-enter OOHC sooner than similar children who were not exposed to PSP, following an exit to restoration. This comparison used a time-to-event analysis (Kaplan-Meier Curves and Cox Proportional Hazards Regression) that measured the time a child exited to restoration to the time that the same child re-entered care or the observation period ended. Specifically, the analysis measured whether there were differences in time — measured in days — that elapsed between when a child exited to restoration and when the same child re-entered OOHC.

At a simple level (univariate), the Kaplan-Meier survival curve[81] shows no statistically significant difference (p = 0.356) in the time to OOHC re-entry between those children who received a PSP package and those who did not. Of the children that left to restoration in the evaluation period (and had a 12 month follow up time), 9.2% of children entered OOHC again within 12 months (29 of 314).

At a more complex level (multivariate), we considered whether there were any factors that influenced the time to OOHC re-entry using Cox Proportional Hazards regression. The results suggest that once we controlled for other variables in the model.

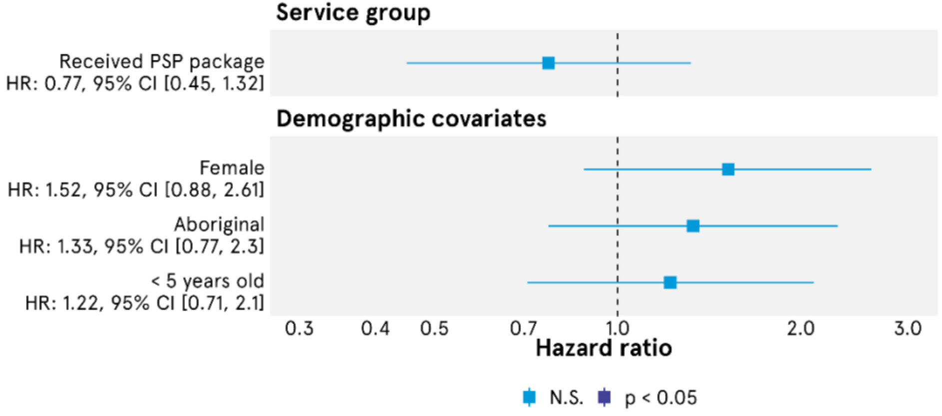
- There was no statistically significant difference in the likelihood of re-entry to OOHC sooner (following restoration) between those children who received a PSP package and those in the historical comparison (HR: 0.77, 95% CI: [0.45, 1.32], p = 0.336).
- Once we controlled for other variables, there was no significant difference between Aboriginal and non-Aboriginal children (HR: 1.33, 95% CI: [0.77, 2.30], p = 0.310). There was also no significant difference between females compared to males (HR:

[81] Depicted in Figure F.4 in Appendix F.

1.52, 95% CI: [0.88, 2.61], $p = 0.130$) or between children aged under five or 5 years of age and over (HR: 1.22, 95% CI: [0.71, 2.10], $p = 0.470$).

Results of our model are visualised in the plot in Figure 6.5 below.

Figure 6.5 Factors associated with time to entry into OOHC following restoration for those who received a PSP package relative to a matched historical comparison in the Ongoing Care cohort



The statistical model is presented in Table F.5 in Appendix F. The statistical model in Table F.5 also compares the results to a replicate model that followed children from 1st October 2018 to 1st March 2020 in the PSP package group compared to 1st October 2014 to 1st March 2016. This replicate model was designed to investigate whether outcomes for PSP packages were consistent when only considering a pre-COVID era. The models had similar findings - whether a child received PSP did not significantly affect their likelihood of post restoration re-entry to care.

What does this mean?

→ The PSP Family Preservation package did not decrease the rate of new ROSH reports during the study period.

→ The PSP Family Preservation package did not decrease the rate of entries to OOHC during the study period.

→ Differences between Aboriginal and non-Aboriginal children were limited. Aboriginal children were more likely to have a new ROSH both after beginning family preservation and after being restored within the study period. However, they were no more likely than non-Aboriginal children to enter OOHC after beginning family preservation or being restored within the study period.

→ PSP packages did not decrease the rate of new reports of serious child maltreatment concerns within the study period for children who were restored.

→ PSP packages did not decrease the rate of re-entries to OOHC within the study period for children who were restored.

7.2.2. What happened following receipt of PSP services in terms of children's permanency?

We used matched comparison groups to assess whether receiving PSP packages affected the likelihood, over time, of exiting from care to different permanency outcomes. In other words, if a child receive one or more PSP packages, were they more likely to exit care to restoration or adoption than if they did not?

To determine whether receiving PSP packages improved children's permanency compared with those who did not receive PSP packages, we assessed three main outcomes:

1. The likelihood of exiting from OOHC for restoration (Entry/Re-entry cohort),
2. The likelihood of exiting from OOHC for restoration (Ongoing Care cohort), and
3. The likelihood of exiting from OOHC for adoption (Ongoing Care cohort).

Has receiving one or more PSP packages resulted in increased exits from care into a permanent, safe home through restoration to their family?

We examined whether children's permanency outcomes changed by looking at the following outcomes:

1. Time until a child exited to restoration (if recently Entering / Re-entering care), and
2. Time until a child exited to restoration (if in Ongoing Care)

For these outcome events, we explored the impact of PSP package receipt on restoration outcome events by comparing the time to an outcome event for children who received a PSP package relative to a statistically similar group of children from a historical sample.

Exit to restoration for children in the Entry/Re-entry to care cohort

We used time-to-event models to assess whether a child who entered or re-entered care would be more or less likely to exit care for restoration sooner, depending on whether they received a PSP package or not. This analysis looked at the differences in time — measured in days — that elapsed between the Entry/Re-Entry cohort start date and when an individual exited OOHC to restoration. It examined whether there was a difference in time between those children in the Entry/Re-entry cohort who received PSP (n=539) relative to a matched historical comparison (n=524).

At a simple level (univariate), the Kaplan-Meier analysis[82] shows that there is a no statistically significant difference (p = 0.083) in the time to exit to restoration between those children who received a PSP package in the current period and those who received services as usual in the past. Overall, the key message here is that there are few exits to

[82] Depicted graphically in Figure F.4 in Appendix F.

restoration in this cohort: within 12 months of entry,[83] there were 99 (10.1%) exits to restoration.

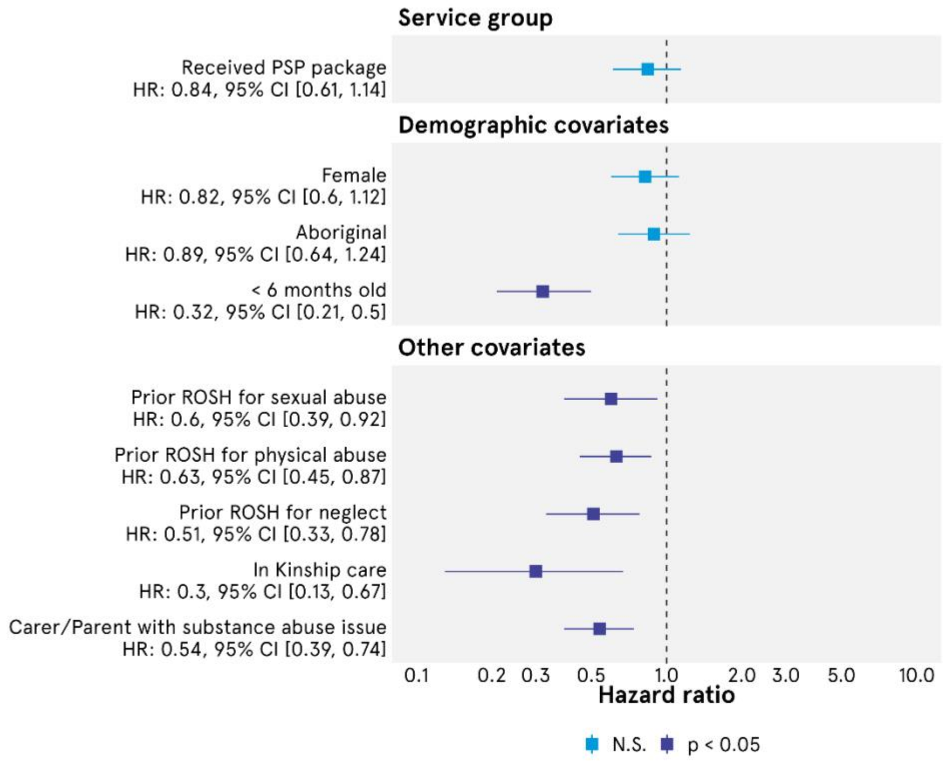
At a more complex level (multivariate), we considered whether there were any factors which influenced the time to exit to restoration using a Cox Proportional Hazards regression. The results suggest that, once we controlled for other variables in the model:

- There was no statistically significant difference in the likelihood of exiting to restoration sooner between those children who received a PSP package and those in the historical comparison (HR: 0.84, 95% CI: [0.61, 1.14], $p = 0.262$).
- Once we controlled for other variables, there was no significant difference between Aboriginal and non-Aboriginal children (HR: 0.89, 95% CI: [0.64, 1.24], $p = 0.488$), nor was there a difference between females compared to males (HR: 0.82, 95% CI: [0.60, 1.24], $p = 0.205$).
- However, several other factors were significantly associated with the time taken to exit to restoration — for children in both the PSP package and historical groups. Each of the following were significantly associated with a lower likelihood of exit to restoration sooner:
    - Children younger than 6 months old at Entry/Re-entry into care (HR: 0.32, 95% CI: [0.21, 0.50], $p < 0.001$)
    - Children who were placed in kinship care arrangements (HR: 0.30, 95% CI: [0.13, 0.67], $p = 0.004$)
    - Children who had a prior ROSH for neglect (HR: 0.51, 95% CI: [0.33, 0.78], $p = 0.002$), sexual abuse (HR: 0.60, 95% CI: [0.39, 0.92], $p = 0.018$), or physical abuse (HR: 0.63, 95% CI: [0.45, 0.87], $p = 0.005$) before Entry/Re-entry into care
    - Children with a carer or parent with a substance abuse issue before Entry/Re-entry into care (HR: 0.54, 95% CI: [0.39, 0.74], $p < 0.001$)

Results of our model are visualised in the plot in Figure 6.6 below. The model is presented in Table F.6 in Appendix F. In summary, there are numerous predictors of restoration in the Entry/Re-Entry cohort, but receipt of a PSP package is not one of them.

[83] Only including children that had 12 months follow up time.

Figure 6.6 Factors associated with the time to exit to restoration for those who received a PSP package relative to a historical comparison in the Entry/Re-entry into care cohort



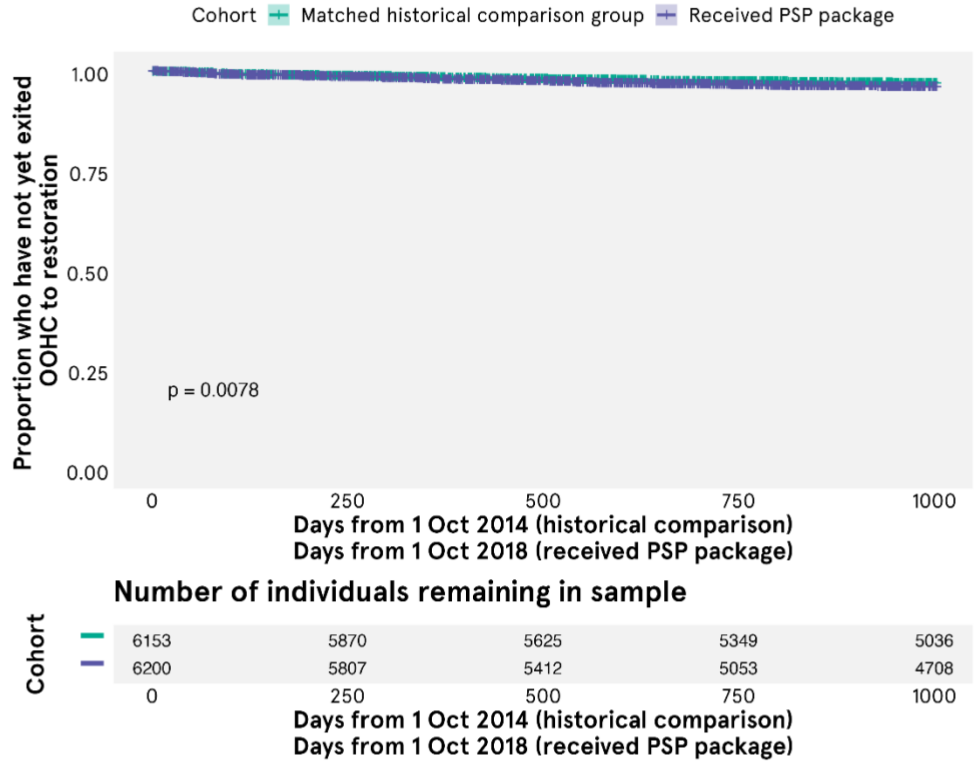
Exit to restoration for children in the Ongoing Care cohort

This analysis examined the differences in time — measured in days — that elapsed between the 1st October 2018 (1st October 2014 in the comparison) and when a child or young person exited OOHC to restoration or the observation period ended on 30th June 2021 (30st June 2017 in the comparison). Specifically, we examined whether there was a difference in time to restoration between those children in the Ongoing Care cohort who received a PSP package (n=6200) relative to a matched historical comparison (n=6153).

At a simple level (univariate), the Kaplan-Meier survival curves — depicted in Figure 6.7- show a statistically significant difference ($p = 0.008$) in the time to exit to restoration between those children who received a PSP package in the current period and those who received services as usual in the past. Although the magnitude of the difference is very small, this means that, visually, the survival curve that is *lower* indicates the group with the better outcome — in this case, children who received a PSP package. However, while significant, the key message here is that there are few exits to restoration in both the PSP package and comparison groups: out of the 12,353 children in this analysis, only three per cent (n=396) exited to restoration over the more than two years they were followed.[84] To put this finding in context, after 12 months: 98.0 per cent (95% CI [97.7, 98.4]) of children who received a PSP package had not been restored, compared to 98.5 per cent (95% CI [98.2, 98.8]) in the historical comparison group.

[84] Please note: children could have exited for a number of other reasons including turning 18, guardianship, or adoption.

Figure 6.7 Kaplan-Meier survival curve for time to exit to restoration for those who received a PSP package relative to a matched historical comparison group in the Ongoing Care cohort



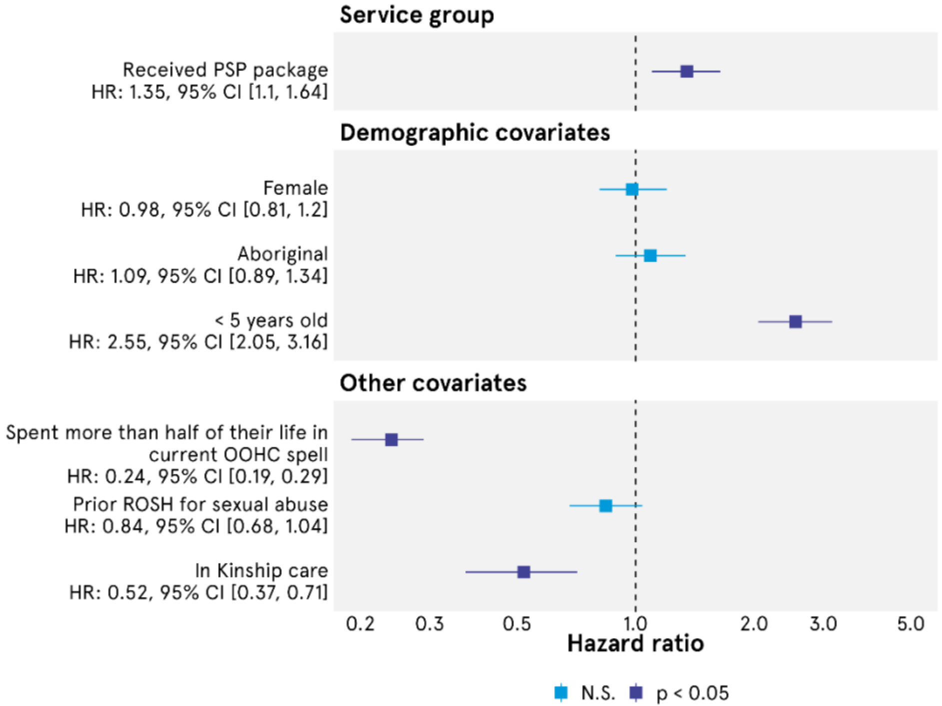
At a more complex level (multivariate), we considered whether there were any factors that influenced the time to exit to restoration using a Cox Proportional Hazards regression. The results suggest that, once we controlled for other variables in the model:

- Children who received a PSP package were still slightly more likely to exit to restoration sooner than those in the historical comparison (HR: 1.35, 95% CI: [1.1, 1.64], $p = 0.004$). While this difference is statistically significant, we say 'slightly' because the magnitude of the difference (1.35 HR) is small.
- Once we controlled for other variables there was no significant difference between Aboriginal and non-Aboriginal children (HR: 1.09, 95% CI: [0.89, 1.34], $p = 0.400$), nor was there a difference between females compared with males (HR: 0.98, 95% CI: [0.81, 1.20], $p = 0.866$).
- Children under 5 years of age were significantly more likely to exit to restoration than older children (HR: 2.55, 95% CI: [2.05, 3.16], $p < 0.001$).
- Children who had spent over half their life in their current care episode were far less likely to exit to restoration (HR: 0.24, 95% CI: [0.19, 0.29], $p < 0.001$).
- Those in kinship care on 1st October were much less likely to exit to restoration than those in foster care (HR: 0.52, 95% CI: [0.37, 0.71], $p < 0.001$).

Results of our model are visualised in the plot in Figure 6.8 below. The model is presented in Table F.7 in Appendix F. The statistical model in Table F.7 also compares the results to a replicate model that followed children only until 1st March 2020 to assess whether the COVID-19 response had an impact on these findings. The hazard ratio was similar but was

no longer significant when excluding observations during the COVID-19 response (Appendix F: Table F.7).

Figure 6.8 Factors associated with the time to exit to restoration for those who received a PSP package relative to a matched historical comparison in the Ongoing Care cohort



Has PSP resulted in increased exits from care into guardianship or adoption?

This analysis looked at the differences in time — measured in days — that elapsed between 1st October 2018 (1st October 2014 in the comparison) and when a child exited OOHC to adoption or the observation period ended on 30th June 2021 (30th June 2017 in the comparison). Unfortunately, the use of guardianship could not be comparatively assessed using the matched historical sample generated for this study due to an initiative by DCJ to administratively shift large numbers of children to guardianship on the same day in November 2014 – shortly after the study period commenced.[85]

We focused, instead, on adoption only. Specifically, we examined whether children in the Ongoing Care cohort who received PSP packages (n=3245) were more likely to be adopted sooner compared with a matched historical comparison (n=3270). Children were excluded from this analysis if they were in kinship care or if they were identified as Aboriginal due to the very rare use of this permanency option within these two related groups (i.e.,

[85] If we measured guardianship using our unadjusted matched sample, it would artificially look as if PSP (overall) had moved large numbers of children into guardianship within a month (which is not physically possible and certainly does not reflect children's experience in care) – we would be biased against PSP packages. If we measured after the shift (i.e., compared the PSP packages sample after the guardianship), we would be comparing the children left without guardianship in the historical sample to those with PSP packages where these children would still be present – we would be biased in favour of those with PSP packages.

Aboriginal children are far more likely to be placed in kinship care and, even on its own, kinship caregivers are very unlikely to adopt their relatives).

At a simple level (univariate), Kaplan-Meier survival analysis — depicted graphically in Figure 6.9 - shows a statistically significant difference ($p < 0.001$) in the time to exit to adoption between those children who received a PSP package in the current period and those that received services as usual in the past. In this case, the survival curve that is *lower* indicates the group with the better outcome — in this case, those children who received a PSP package. In other words, within 12 months 97.4 per cent (95% CI: [96.9, 98.0]) of children who received a PSP package had not been adopted, compared to 99.6 per cent (95% CI: [99.4, 99.9]) in the historical comparison group. According to the model that adjusts for the influence of other covariates, those receiving PSP packages had 1.6 times the hazard of exiting to adoption than those in who did not receive PSP (HR: 1.63, 95% CI: [1.24,2.14], $p < 0.001$; Figure 6.10 & Table F.8).

However, the overall rates of adoption in both groups were low. For non-Aboriginal children who were in foster care on 1st October (2014/2018), only 4.1 per cent (n=132 of 3245) of those who were receiving PSP packages were adopted compared with 2.6 per cent (n=85 of 3270) of those who were in the matched historical comparison group. Therefore, the key message is that there are few exits to adoption in the ongoing care cohort: out of the 6,515 children in this analysis, only 217 exited to adoption.[86]

Figure 7.9 Kaplan-Meier survival curve for time to exit to adoption for those who received a PSP package relative to a matched historical comparison group in the Ongoing Care cohort

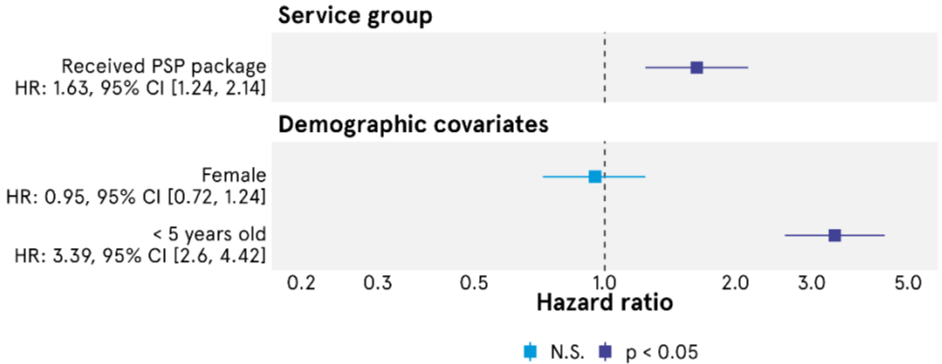
[86] Note that adoption policies at DCJ may have changed over time so historical bias is a consideration in these results.

At a more complex level (multivariate), we considered whether there were any factors which influenced the time to exit to adoption using a Cox Proportional Hazards regression. The results suggest that, once we controlled for other variables in the model:

- Children under 5 years of age were far more likely to exit to adoption than older children (HR: 3.39, 95% CI: [2.6,4.42], $p < 0.001$).

This result is visualised in Figure 7. below. The model is presented in Table F.8 in Appendix F. The replicate model in the pre-COVID era showed that the significant effect of receiving PSP did not change but the hazard ratio was higher in the replicate model that only considered the pre-pandemic period. This suggests that, while those receiving PSP packages were more likely to be adopted relative to those who did not, more of these adoptions occurred prior to the pandemic; this is consistent with the historical increase in carer adoptions through time[87] as well as altered procedures during the COVID-19 response that would have subsequently reduced the rate of adoption in the later part of the study.

Figure 7.10 Factors associated with the time to exit to adoption for those who received a PSP package relative to a matched historical comparison in the Ongoing Care cohort



Are some service providers delivering better outcomes (i.e., are service providers with particular attributes delivering better outcomes)?

Due to the scope of the data available, the research team was unable to assess agency-specific information regarding the combination of services provided, staff characteristics, qualifications/training, or combinations of services. As the PSP program develops further and the types of services provided using PSP packages become more clearly defined, data needs to be collected on these topics to enable such questions to be addressed. Specifically, tracking the types (categories) of services provided to individuals, as well as the timing and delivery of such services, in a database outside of individual case notes will greatly improve the ability of researchers to assess the implementation of the program and determine why certain service providers may have delivered better outcomes.

To understand how differences between service providers may have influenced permanency outcomes we ran additional Cox Proportional Hazards regressions using only those children who received PSP packages on:

[87] Australian Institute of Health and Welfare 2021. Adoptions Australia 2019–20. Child welfare series no. 73. Cat. no. CWS 79. Canberra: AIHW

- Time to restoration in the Entry/Re-entry cohort
- Time to restoration in the Ongoing Care cohort
- Time to adoption in the Ongoing Care cohort, and
- Time to guardianship[88] in the Ongoing Care cohort.

This time we included different covariates that related to PSP service providers – specifically the size of agency (small being less than 100 contracted placements) and the location of agency (whether rural, regional or metropolitan). If either of these two covariates were far from significant, i.e., $p \geq 0.1$, they were removed from the final model.

Results of the PSP package only model for time to restoration in the Entry/Re-entry cohort are presented in Table F.9 in Appendix F. Neither agency size nor location of agency were influential in predicting whether children exited to restoration. Other factors significantly predicted time to restoration. Children were less likely to exit to restoration sooner if they:

- Were female (HR: 0.61, 95% CI: [0.37,0.99], $p = 0.045$),
- Were less than 6 months old (HR: 0.36, 95% CI: [0.21,0.62], $p < 0.001$),
- Had a prior ROSH for neglect (HR: 0.38, 95% CI: [0.21,0.68], $p = 0.001$) or sexual abuse (HR: 0.38, 95% CI: [0.18,0.80], $p = 0.011$),
- Had any developmental, intellectual, learning or physical disability (HR: 0.42, 95% CI: [0.18,0.98], $p = 0.044$), or
- Had a carer/parent with child protection history (HR: 0.56, 95% CI: [0.34,0.93], $p = 0.025$).

Results of the PSP package only model for time to restoration in the Ongoing Care cohort are presented in Table F.10 in Appendix F. Neither agency size nor location of agency were influential in predicting whether a child or young person exited to restoration. Other factors significantly predicted time to restoration. Children were less likely to exit to restoration sooner if they:

- Were more than 5 years old (<5 years: HR: 2.64, 95% CI: [2.00,3.48], $p < 0.001$),
- Were in kinship care (HR: 0.56, 95% CI: [0.36,0.86], $p = 0.008$),
- Had spent more than half of their life in current OOHC episode (HR: 0.25, 95% CI: [0.19,0.33], $p < 0.001$), or
- Had a most recent CAT score of medium or high (Low CAT: HR: 1.91, 95% CI: [1.29,2.84], $p = 0.001$).

Results of the PSP package only model for time to adoption in the Ongoing Care cohort are presented in Table F.11 in Appendix F. In this case, agency location and size were associated with being adopted. Originally, children were less likely to exit to adoption sooner if they:

[88] Since this analysis only included children following the receipt of one or more PSP packages, it was not possible to look at guardianship (a guardianship administration change in November 2014 made it non-viable to use a comparison model)

- Were in an agency in a rural/regional location (HR: 0.55, 95% CI: [0.39,0.77], $p < 0.001$).

Children were more likely to exit to adoption sooner if they:

- Received PSP packages from a large agency (i.e. more than 300 contracted placements) (HR: 1.7, 95% CI: [1.22,2.37], $p = 0.002$),
- Were less than 5 years old (HR: 2.56, 95% CI: [1.81,3.61], $p < 0.001$), or
- Received a low needs package (HR: 2.74, 95% CI: [1.46,5.15], $p = 0.002$).

However, these unique findings are from a small sample. As one large agency (an Accredited Adoption Service Provider) had 42 per cent of all adoptions in this study, we conducted a sensitivity analysis by removing this particular agency from the model. We found that without this one agency, those children at a large agency were less likely to have completed adoptions sooner within the time frame and those in metropolitan locations were just as likely (HR for large agency: 0.39, 95% CI: [0.23, 0.70], $p = 0.001$; HR for rural/regional: 0.80, 95% CI: [0.52, 1.25], $p = 0.343$ refer to Appendix F for more detail).

We could not assess the differences between those exiting to guardianship between those receiving PSP packages and a matched historical sample due to an administration change in the historical time frame, but we could look within those who received PSP packages to assess what differences between service providers were associated with children exiting to guardianship. Results of the model for those receiving PSP packages for time to guardianship in the Ongoing Care cohort are presented in Table F.12 in Appendix F. Agency location did not significantly predict exit to guardianship; however, the size of agency was a significant factor. The factors that significantly predicted time to guardianship were as follows, a child or young person was less likely to exit to guardianship sooner if they:

- Were in an agency of large size (>300 contracted placements) (HR: 0.63, 95% CI: [0.43,0.94], $p = 0.023$),
- Were female (HR: 0.56, 95% CI: [0.38,0.82], $p = 0.003$),
- Were Aboriginal (HR: 0.63, 95% CI: [0.42,0.93], $p = 0.020$),
- Spent less than half their life in the current care episode (>50% of life: HR: 1.95, 95% CI: [1.19,3.18], $p = 0.008$), or
- Received a medium or high needs package (Received low needs package: HR: 2.45, 95% CI: [1.39,4.32], $p = 0.002$).

Supplementary findings from the PSP service provider case reviews

The case review findings suggest that when a permanency goal was achieved it generally took longer than 2 years to achieve from the start of permanency planning, even where there appear to be relatively few barriers present. In the cases reviewed, it was common for PSP service providers to frequently reconsider the most appropriate permanency goal and the steps involved with each of the permanency goals being considered. These permanency planning activities were reflected in case plans, home visit reports, case notes and the DCJ permanency case plan review forms. Generally, in the cases reviewed, we found that a change in permanency case plan goal and subsequent changes in PSP packages only took place after sufficient and at times extensive permanency planning and casework had been completed by PSP service providers and DCJ to determine the feasibility of the new permanency goal being achieved. While this action is appropriate, it does contribute to insights into the time taken to achieve permanency for some children.

The case review identified three main reasons for permanency outcomes taking longer than two years to achieve. First, family finding and family consultation (including conducting family group conferences) are often time intensive processes that are affected by different family members' level of engagement. Second, conflicting views from children, family members, carers, practitioners, PSP service providers and DCJ on the suitability and acceptability of the permanency goal can delay achieving legal permanency. Third, there are frequent delays with completing assessments and case plans, sourcing documentation (e.g., birth certificates, police checks) and drafting court documents. These processes rely on different teams across PSP service providers and DCJ CFDUs working together to meet all the relevant legislative and Children's Court requirements.

These challenges, some of which describe impediments in foundational casework practice and not just permanency planning, provide one potential explanation for why the evaluation did not find many statistically significant differences regarding the likelihood of exiting to different permanency outcomes (e.g., restoration) for children who received a PSP package compared with those in the matched historical comparison. Other possible explanations relate to children being inappropriately assigned restoration and guardianship packages and operational differences across PSP service providers.

What does this mean?

→ Children were no more likely to be restored during the study period if they were in urban areas versus rural areas.

→ Children in large agencies (> 300 contracted placements) were less likely to exit to guardianship sooner. Children at one large accredited adoption agency were more likely to exit to adoption sooner, a trend not reflected in other large agencies. Children were less likely to exit to adoption over time if they were in a rural/regional agency.

→ More detailed information about the specific type, timing, and level of services is needed in order to ascertain which agencies are most effective at achieving permanency outcomes. Current information is limited to program type, not the actual service or information about its delivery.

7.2.3. What happened following receipt of PSP services in terms of placement stability?

We used matched comparison groups to assess whether receiving PSP packages affected the likelihood of placement changes while in OOHC. In other words, if a child received PSP packages, were they more likely to have greater placement stability in OOHC than a matched historical comparison? In other words, are those receiving PSP packages more or less likely to have a placement change sooner than if they did not.

To determine whether receiving PSP packages improved placement stability for children, we framed our study to address the following questions:

1. Are children who received PSP packages *when entering care* more likely to have OOHC placement changes sooner than those who did not?

2 Are children who had received PSP packages *while in care* more likely to have OOHC placement changes sooner than those who did not?

3 Are children who had received PSP packages *while in care* more likely to move schools sooner than those who did not?

Has PSP resulted in a reduction in placement changes?

We examined whether children's placement stability while in OOHC changed by looking at the following outcome in two cohorts:

1 Time until a child moved to their next out-of-home care placement (if recently Entering / Re-entering care), and

2 Time until a child moved to their next out-of-home care placement (if in Ongoing Care)

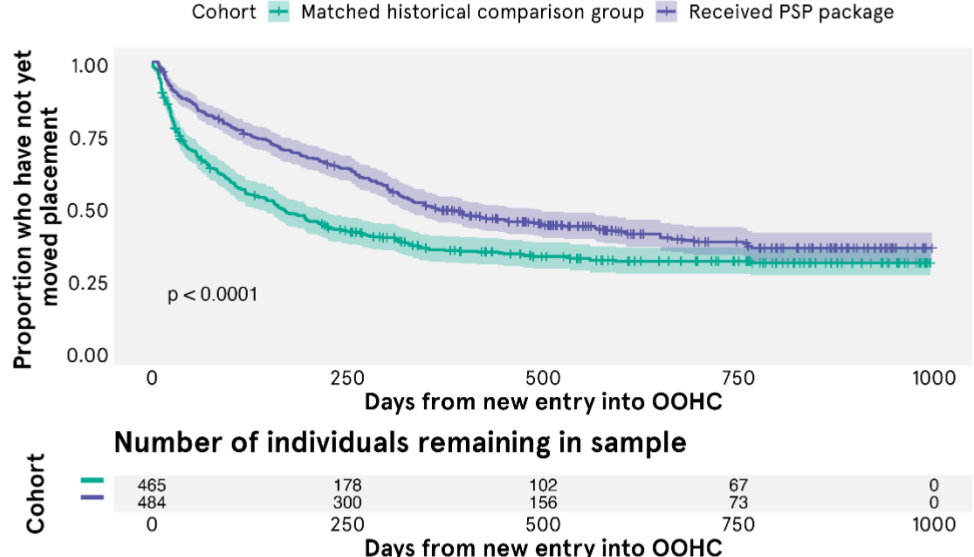
Time to next placement change in the Entry/Re-entry to care cohort

We implemented a time-to-event model to assess whether a child entering or re-entering an episode of care was more or less likely to experience placement changes depending on whether they received a PSP package or not. This analysis looked at the differences in time — measured in days — that elapsed between the Entry/Re-Entry cohort start date and when a child or young person moved to their next OOHC placement[89]. It examined whether there was a difference in time between those children in the Entry/Re-entry cohort who started in foster care and received PSP (n=484) relative to a matched historical comparison (n=465). Kinship care was excluded in this analysis due to a statistical issue. Namely, there were few children placed in kinship care (n=55 who received PSP packages, n=59 in historical comparison) and those who had been placed in kinship care tended to be very stable.

At a simple level (univariate), the Kaplan-Meier analysis — depicted graphically in the Figure 7. – suggests that there is a significant difference ($p < 0.001$) in the time to next placement change between those children who received a PSP package in the current period and those who received services as usual in the past. This means that, visually, the survival curve that is *higher* indicates the group with the better outcome (and more stability) — in this case, this is (initially) the children who received a PSP package. For children with a 12 month follow up time, 49.3 per cent (95% CI [44.9, 54.0]) of children who received a PSP package had not had a placement change within 12 months, compared to 33.5 per cent (95% CI [29.1, 38.4]) in the historical comparison group. However, this method relies on an important assumption to be met, which is that the hazard ratios need to be proportional through time (i.e., the Proportional Hazard Assumption); unlike previous analyses, this assumption was violated (i.e. it was not met) in this basic model as the difference in the curves was not maintained over time. Thus, this analysis required using a more complex model that controlled for both the influence of other variables and how the main effect (i.e., receiving PSP packages) interacted with time.

[89] The initial placement was defined as the first out-of-home placement lasting more than 7 days that started within the first month of the out-of-home care episode. The first placement change was the start of the next placement that lasted more than 7 days, if there was one, and it was not a 'temporary' placement. For further details, please refer to Appendix F.

Figure 7.11 Kaplan-Meier survival curve for time to next OOHC placement change for those children who received a PSP package relative to a matched historical comparison group in the Entry/Re-entry cohort



At this more complex level (using the multivariate model and controlling for the influence of other factors and how the main effect of PSP changed through time), we considered whether there were any factors which influenced the time to next placement move using Cox Proportional Hazards regression. The results (Appendix F: Table F.13) suggest that, once we controlled for other variables in the model:

- Children receiving PSP packages were less likely to have a placement change sooner than those who did not, in the first 125 days after entering out-of-home care (HR: 0.46, 95% CI: [0.37, 0.58], $p < 0.001$). However, this difference was not maintained over a longer time period (see original and adjusted hazard ratios in Table F.13 in Appendix F). Those who received PSP packages initially had a lower likelihood of having a placement change sooner, but that advantage diminished over time.
- Once we controlled for other variables, there was no significant difference between Aboriginal and non-Aboriginal children (HR: 1.06, 95% CI: [0.89, 1.25], $p = 0.533$); nor was there a difference between females compared with males (HR: 1.07, 95% CI: [0.91, 1.29], $p = 0.434$).
- Children were slightly more likely to have an OOHC placement move sooner than a matched historical comparison if they had experienced Prior ROSH for neglect (HR: 1.38, 95% CI: [1.06, 1.79], $p = 0.016$) or if their household of origin resided in hazardous conditions (HR: 1.24, 95% CI: [1.05, 1.46], $p = 0.010$).

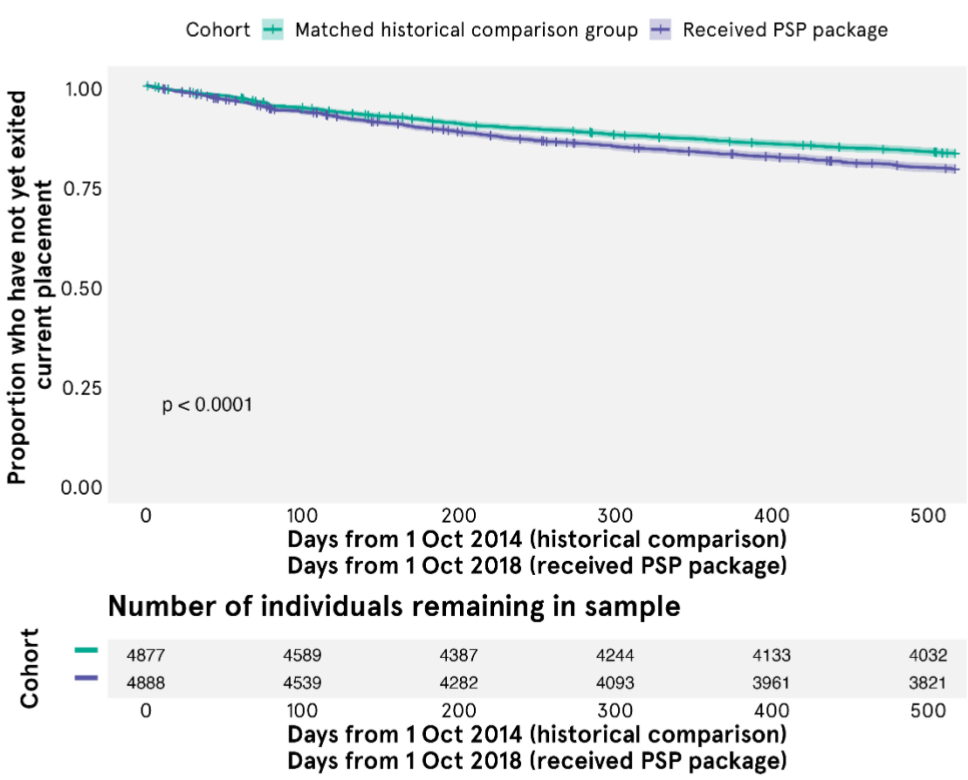
Time to next placement change in the Ongoing Care cohort

We implemented a time-to-event model to assess whether children who were in ongoing care would be more or less likely to experience placement stability (i.e. have a placement change sooner) depending on whether they received a PSP package or not. This analysis looked at the differences in time — measured in days — that elapsed between 1st October 2018 (1st October 2014 in the comparison) and when children moved to their next OOHC

placement[90]. Specifically, we examined whether children in foster care in the Ongoing Care cohort had differences in the likelihood of placement moves between those who received PSP packages (n=4888) relative to a matched historical comparison (n=4877). Those who started in kinship care were excluded in this analysis due to a statistical issue[91].

At a simple level (univariate), the Kaplan-Meier analysis — depicted graphically in the Figure 7. – suggests that there is a statistically significant difference ($p < 0.001$) in the time to next placement change between those children who received a PSP package in the current period and those who received services as usual in the past. This means that, visually, the survival curve that is *higher* indicates the group with the better outcome (and more stability) — in this case, those in the matched historical comparison group. Overall this means that within 12 months, 82.1 per cent (95% CI [81.9, 84.0]) of children who received a PSP package had not had a placement change, compared to 86.1 per cent (95% CI [85.1, 87.1]) in the historical comparison group.

Figure 7.12 Kaplan-Meier survival curve for time to next OOHC placement change for those children who received a PSP package relative to a matched historical comparison group in the Ongoing Care cohort[92]



[90] The initial placement was defined as their out-of-home placement on 1st October 2018 (or 1st October 2014 for the historical comparison). The first placement change was the start of the next placement that lasted more than 7 days and was not a 'temporary' placement. For further details, please refer to Appendix F.

[91] Due to violations of the Proportional Hazards Assumption, this model only examined the likelihood of placement changes in children who were in foster care on 1st October 2014/2018 and followed them through the pre-pandemic period (i.e. before 1st March 2020). For further details, please refer to Appendix F.

[92] Due to violations of the Proportional Hazards Assumption, this model only examined the likelihood of placement changes in children who were in foster care on 1st October 2014/2018 and followed them through the pre-pandemic period (i.e. until 1st March 2020). For further details, please refer to Appendix F.

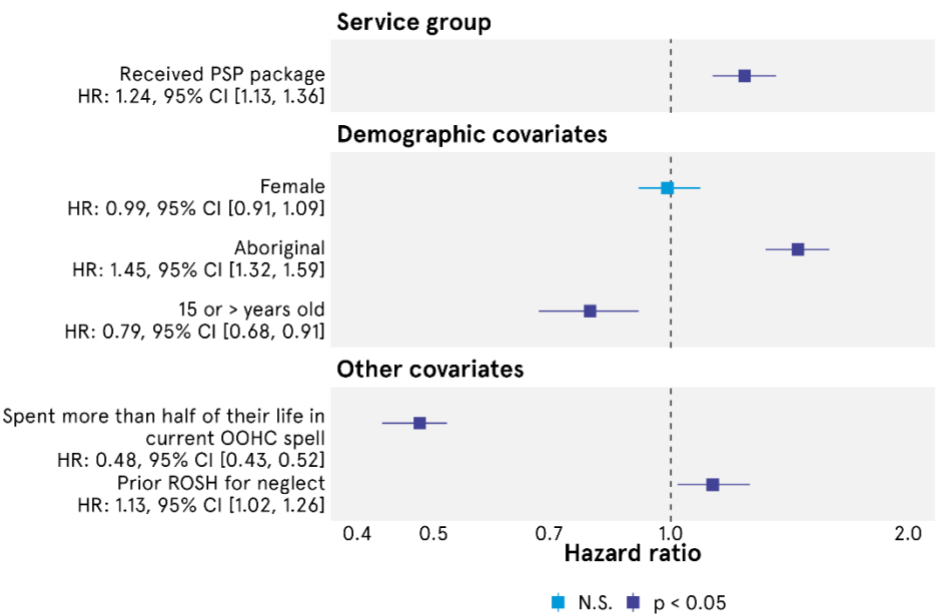
At a more complex level (using the multivariate model and controlling for the influence of other factors and how the main effect of PSP changed through time), we considered whether there were any factors which influenced the time to next placement move using the Cox Proportional Hazards regression. The results suggest that, once we controlled for other variables in the model:

- Children receiving PSP packages were more likely to have a placement change sooner than those who did not receive PSP packages prior to the COVID-19 pandemic (HR: 1.24, 95% CI: [1.13, 1.36], $p < 0.001$)
- Once we controlled for other variables, there was a significant difference between Aboriginal and non-Aboriginal children (HR: 1.45, 95% CI: [1.32, 1.59], $p < 0.001$), with Aboriginal children in foster care significantly more likely to have a placement change sooner than those in foster care who were non-Aboriginal. There was no significant difference between females compared with males (HR: 0.99, 95% CI: [0.91, 1.09], $p = 0.902$).
- Children were less likely to have a placement move sooner if they had spent more than half their life in the current episode of out-of-home care (HR: 0.48, 95% CI: [0.43, 0.52], $p < 0.001$) or if they were 15 years of age or older (HR: 0.79, 95% CI: [0.68, 0.91], $p = 0.002$).
- Those who had a prior ROSH for neglect were more likely to have a placement move sooner than those who had not (HR: 1.13, 95% CI: [1.02, 1.26], $p = 0.024$)

Results of this model are visualised in the forest plot in Figure 7. below. The statistical model is presented in Table F.14 in Appendix F and only follows children only until 1st March 2020 in order to mitigate violations of the proportional hazards assumption when the entire study period is included.[93] The key message here is that even though this cohort shows significant, negative differences in time to next placement move between those who receive PSP and those who do not, the magnitude of the difference is small.

[93] COVID-19 lockdowns beginning March 2020 decreased movement of the entire population, including placement changes.

Figure 7.13 Factors associated with the time to next OOHC placement move for those who received a PSP package relative to a historical comparison in the Ongoing Care cohort



Supplementary findings from the PSP service provider case reviews

These results, and the fact that the vast majority of children in the Ongoing Care cohort experienced placement stability within the first year of our evaluation, are consistent with the findings from the case review, which suggest that PSP providers prioritise placement stability for children in out of home care. PSP providers appear to value placement stability because they prioritise case management to prevent placement breakdowns. Some of the services and support delivered to prevent placement breakdowns include: carer support teams and workers, frequent debriefing and mentoring sessions for carers, and respite plans.

However, the case review findings also highlighted that placement stability and legal permanency goals are not necessarily aligned. There were a number of cases reviewed where the child had been in a stable placement for many years and the carer(s) was committed to providing care long term, but the carer did not want to pursue Guardianship or Adoption. One reason mentioned in several cases reviewed is that the carer believed it was in the best interest of the child to keep receiving support from their PSP provider. Another reason mentioned in cases reviewed was that the carer did not want to go through the legal process and did not believe that changing the legal status would make a meaningful impact. This suggests that slow progress towards legal permanency does not necessarily equate to a lack of stability while in care, but that stability in care is perhaps necessary but insufficient for achieving legal permanence.

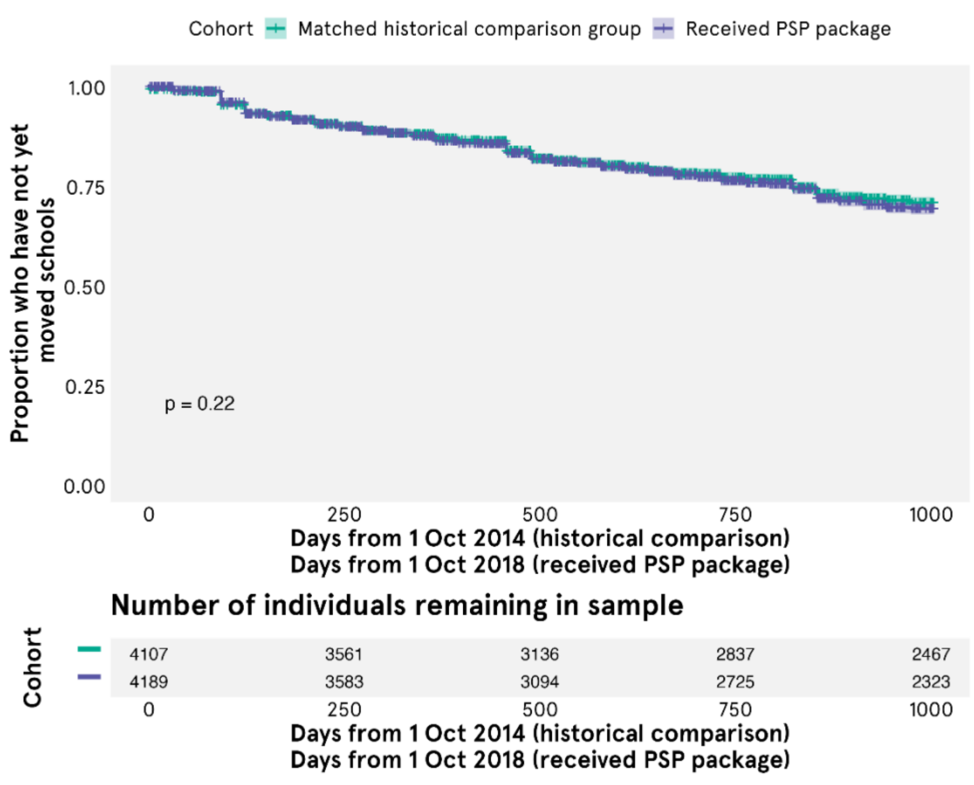
Time to next school move in the Ongoing Care cohort

In order to analyse education outcomes, data in ChildStory were linked by the Department of Education to data on school enrolment. Of the 12,356 children in the Ongoing care cohort, 8,297 (67.15%) were able to be linked to enrolment data.

For these children, we implemented a time-to-event model to assess the likelihood that children in ongoing care would experience a school move[94] depending on whether they received a PSP package or not. For this analysis, we looked at the differences in time — measured in days — that elapsed between 1st October 2018 (1st October 2014 in the comparison) and when children moved to their next school, if they moved. The model examined whether children in the Ongoing Care cohort who received PSP packages (n=4189) were more or less likely to experience a change in school sooner than a matched historical comparison (n=4108).[95]

The Kaplan-Meier survival curves[96] show that there is a no statistically significant difference (p = 0.224) in the time to next school move between those children who received a PSP package in the current period and those who received services as usual in the past. Of the 8,296 children in this analysis, 1,118 (13.5%) of children had a school move within 12 months of the start of the evaluation period.

Figure 7.5 Kaplan-Meier survival curve for time to next school move for those children who received a PSP package relative to a matched historical comparison group in the Ongoing Care cohort



[94] A school move was defined as a change in census school (children can attend several specialist schools concurrently but are only enrolled in one census school at a time). In the few instances that the data showed overlapping census schools for a single ChildStoryID in a year, any school moves evident during that year were deemed inaccurate (likely an error in data linkage) and excluded. A change in school following a child's last year in grade 6 was also not considered a valid school move in this analysis.

[95] The number of children in this analysis differs from the other models because it only includes those in the Ongoing Care cohort who had at least one record that linked with the Education data, i.e. it excluded all children who were not school age (Appendix F).

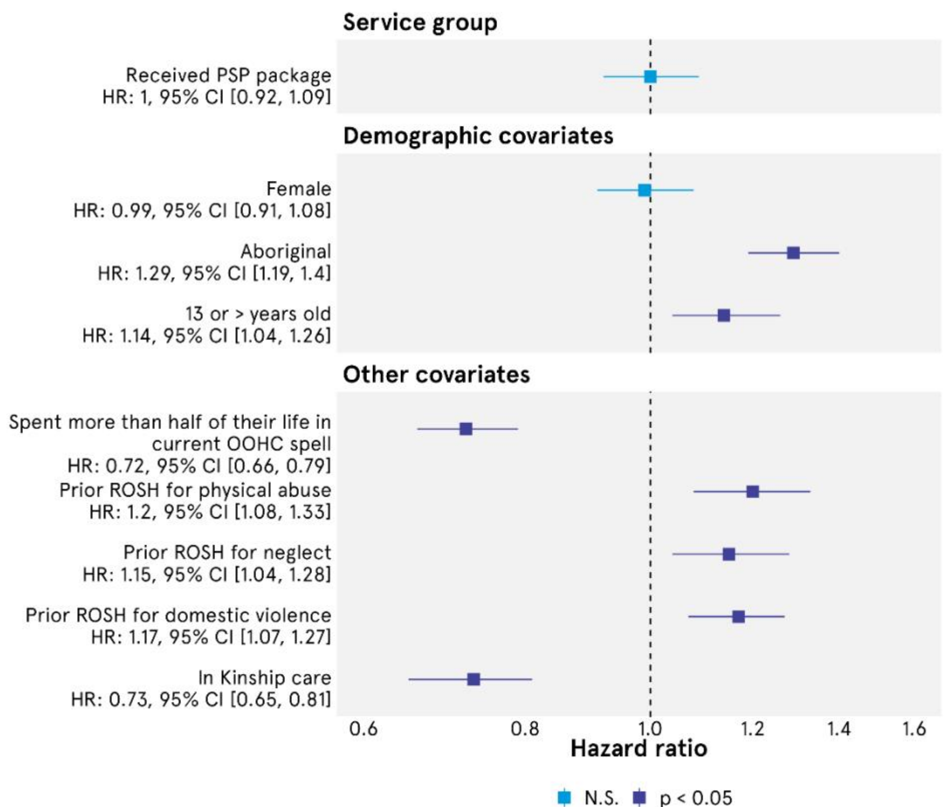
[96] Depicted in Figure XX.

We considered whether there were any factors which influenced the time to first next school move by using a Cox Proportional Hazards regression. The results suggest that, once we controlled for other variables in the model:

- There was no statistically significant difference in the likelihood of moving schools over time between those children who received a PSP package and those in the matched historical comparison (HR: 1.0, 95% CI: [0.92, 1.09], $p = 0.949$).
- Children who were identified as Aboriginal were slightly more likely to have a school move sooner compared with those who were not (HR: 1.29, 95% CI: [1.19, 1.4], $p < 0.001$); while this difference is statistically significant, we say 'slightly' because the magnitude of the difference (1.29 HR) is small.
- There was no significant difference between females compared to males (HR: 0.99, 95% CI: [0.91, 1.08], $p = 0.841$).
- However, several other factors were significantly associated with the time to next school move – for children in both the PSP package and historical groups. Each of the following were significantly associated with a *lower* likelihood of having a school move sooner (in other words, these characteristics were associated with being more likely to remain in their current school longer):
    - Children who were in a kinship care placement (compared with those who were in foster care) at the start of the study period were significantly less likely to move schools sooner (HR: 0.73, 95% CI: [0.65, 0.81], $p < 0.001$).
    - Children were also less likely to move schools sooner if they had spent more than half their life in the current episode of out-of-home care (HR: 0.72, 95% CI: [0.66, 0.79], $p < 0.001$).
- In contrast, each of the following – for those in both the PSP package and historical groups -- were significantly associated with a *higher* likelihood of moving schools sooner:
    - Children who were aged over 13 at the start of the study period (HR: 1.14, 95% CI: [1.04, 1.26], $p = 0.007$) had a higher risk of moving schools over time relative to children younger than 13 years old on 1 Oct 2014/2018.
    - Children had a higher risk of moving schools sooner who had a prior ROSH for physical abuse (HR: 1.2, 95% CI: [1.08, 1.33], $p = 0.005$) or for domestic violence (HR: 1.17, 95% CI: [1.07, 1.27], $p < 0.001$) or for neglect (HR: 1.15, 95% CI: [1.04, 1.28], $p = 0.005$). However, the size of these effects is small (as evidenced by the Hazard Ratio [HR] being not much larger than 1).

Results of this model are visualised in the forest plot in Figure 7. below. The model is presented in Table F.15 in Appendix F. The statistical model in Table F.15 also compares the results to a replicate model that followed children only until 1st March 2020 to assess whether the COVID-19 response had an impact on these findings. The results held – whether a child received PSP packages did not significantly affect their likelihood of moving schools.

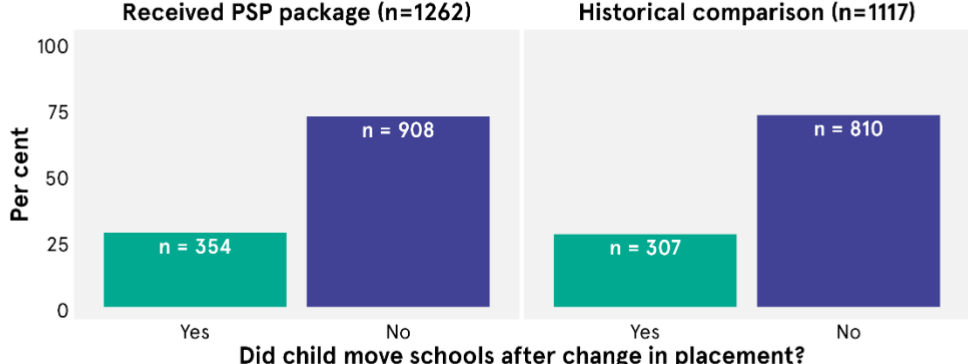
Figure 7.14 Factors associated with the time to next school move for those who received a PSP package relative to a historical comparison in the Ongoing Care cohort



Frequency of school moves after a change in OOHC placement

We observed no difference in the number of school moves following a change in placement amongst those children who received a PSP package (n=1262) and those in the historical comparison group (n=1117). This descriptive comparison was made for those in the Ongoing Care cohort who had a placement change within the study period and who had linked school enrolment data available. In both groups, just over a quarter of children moved school following a change in placement (PSP: 28.1 per cent; Comparison: 27.5 per cent; Figure 7.).

Figure 7.15 Children who moved schools after a change in OOHC placement: received PSP package versus historical comparison



What does this mean?

- → Children entering or re-entering an episode of OOHC who received a PSP package had greater placement stability (and a lower likelihood of moving between OOHC placements) within the first 125 days than historically similar children who did not receive a PSP package.
- → Children already in care when PSP began and who received a PSP package had slightly lower placement stability (and a higher likelihood of moving between OOHC placements sooner) than historically similar children who did not receive a PSP package.
- → Children who were already in care when PSP began and who received a PSP package were just as likely to move schools during the study period than historically similar children who did not receive a PSP package.
- → About 25 per cent of children who had a placement move had an associated school move – and this was true for both those who received a PSP package and those who did not.

7.2.4. What happened following receipt of PSP services in terms of children's wellbeing?

Children's wellbeing is conceptualised in terms of: a) mental and physical health; and b) child educational outcomes. Unfortunately, non-linked data provide very few direct measures of these concepts and linked health data were not available for this study.[97] As a measure of these concepts, we were able to use available linked data to assess whether older children sought homelessness services, committed known youth justice offences, and completed their secondary schooling. These analyses were limited to children in the

[97] These data may be obtained for future studies using the Human Services Dataset (HSDS), which was still under construction when this study was commissioned.

Ongoing Care cohort because this was the only cohort with suitable numbers of older children with sufficient follow-up time.

Has PSP resulted in improved child mental and physical health outcomes?

We examined whether child mental and physical health outcomes changed by looking at the following:

1. Presentation at specialist homelessness services (SHS) for housing reasons, and
2. Commission of an offence.

For each of these outcomes we undertook both a univariate and a multivariate analysis.

Do children present at SHS for housing reasons once they turn age 18?

This analysis looked at the time until a child first presented at SHS for housing reasons[98] after their 18th birthday (this analysis was limited to children who turned 18 in the evaluation period [1st October 2018 - 30th June 2021 for those receiving PSP-funded services and 1st October 2014 - 30th June 2017 for the historical comparison]) .

We began with an analysis that looked at the difference in time — measured in days — that elapsed between the child's 18th birthday and when they first presented at SHS for housing reasons. It examines whether there is a difference in time to first presentation at SHS between those children in the Ongoing Care cohort who received PSP (n=150) relative to a matched historical comparison (n=168).

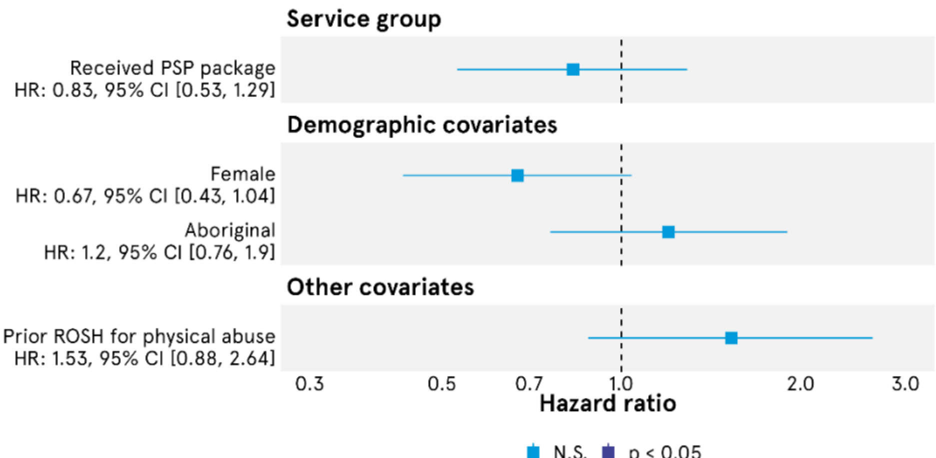
The Kaplan-Meier survival curves[99] show that there is a no statistically significant difference (p = 0.600) in the time to first SHS presentation for housing reasons between those children who received a PSP package in the current period and those who received services as usual in the past. Due to the nature of the outcome, this analysis only encompassed 318 children, of those 65 (20.4%) presented to Specialist Homelessness Services (SHS) within 12 months of the start of the evaluation period.

We then considered whether there were any factors which influenced the time to present to Specialist Homelessness Services (SHS) using a Cox Proportional Hazards regression. The results suggest that, once we controlled for other variables in the model, there was no statistically significant difference in the likelihood of presenting at SHS for housing reasons at any point in time between those children who received a PSP package and those in the historical comparison (HR: 0.83, 95% CI: [0.53, 1.29], p = 0.403). Once we controlled for other variables, there was no significant difference between Aboriginal and non-Aboriginal children (HR: 1.2, 95% CI [0.76, 1.9], p = 0.439). There were also no differences between other variables considered in the model.

Results of our model are visualised in Figure 7. below. The model is presented in Table F.16 in Appendix F.

[98] Arriving at SHS for 'housing reasons' included if the main reason for seeking assistance at SHS was classified as any of the following options: Housing Affordability Stress, Housing Crisis, Inadequate or Inappropriate Dwelling Conditions, Previous Accommodation Ended, Transition from Custodial Arrangements, Transition from Foster Care or Child Safety Residential Placements, Transition from Other Care Arrangements, or Unable to Return Home Due to Environmental Reasons.
[99] Depicted in Figure F.5 in Appendix F.

Figure 7.16 Factors associated with the time to first presentation at SHS for housing reasons for those who received a PSP package relative to a historical comparison in the Ongoing Care cohort



Do children commit offences while in OOHC?

This analysis looks at whether children in Ongoing Care who were aged 10 or older[100] committed an offence[101] after October 1st (2018 for those receiving PSP-funded services and 2014 for the historical comparison) .

Impact of PSP on whether a child or young person commits a criminal offence

Here we observe the difference in time — measured in days — that elapsed between 1st October 2018 (1st October 2014 in the comparison) and whether (and when) an individual committed an offence during the follow-up period. It examines whether there is a difference in time to commit an offence between those children in the Ongoing Care cohort who received PSP (n=2841) relative to a matched historical comparison (n=2667).

The Kaplan-Meier survival curves — depicted in Figure 7. below — show that there is a statistically significant difference (*p* = 0.035) in the time to first offence between those children who received a PSP package in the current period and those that received services as usual in the past. The y-axis shows the probability of not offending over time - in this case having a higher probability of not offending is the superior outcome. The slope of both groups is constant (i.e., the rate of change is the same), indicating that the rate at which children offend does not change over time.[102] To put this finding in context, after 12

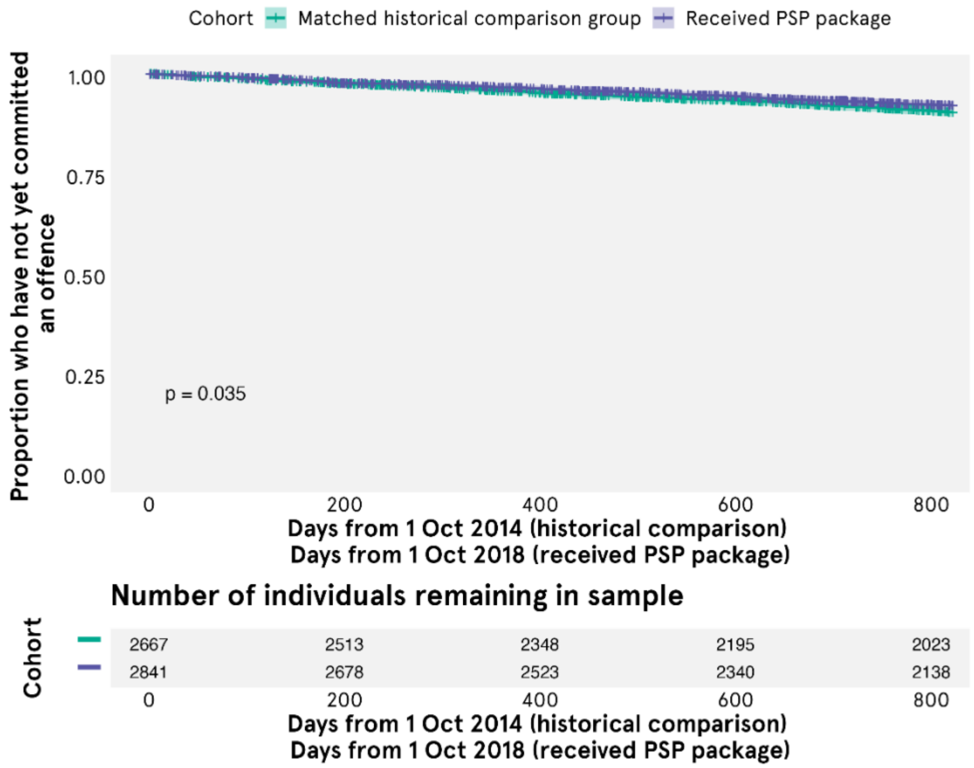
[100] There were 5, 508 children (42.2%) in this cohort that were aged 10 years and older. Of these children, 2,533 (46.0%) were female, 1,681 (30.5%) were Aboriginal and the average age was 13.44 years.

[101] To define 'offence', we first linked children in the PSP cohorts in ChildStory to children with offences listed in the NSW Bureau of Crime Statistics and Research's Reoffending Database (ROD). We included offence types of proven court cases, cautions and youth conferences. Court appearances that were recorded as having an outcome of "not guilty", "withdrawn", "mental health dismissal" or "otherwise disposed of" were excluded. Warning offence types were also excluded as these were advised as having been inconsistent over time. Data was obtained up until the 30th of September 2021 and therefore any offences that occurred in the evaluation period but were finalised after the 30th September 2021 were not included. Any offences that occurred during the historical evaluation period and were finalised after 30th September 2017 were also excluded for balance.

[102] In this Kaplan-Meier analysis and the Cox Proportional Hazards model below we used an evaluation end date of 31st Dec 2016 and 31st Dec 2020. This was because the data we received was only cases that were finalised, and finalisation of cases often took a long time. Reducing the end of the evaluation period allowed for at least 9 months for an offence to be finalised (noting our data went until 30th Sept 2021) and thus included in analyses.

months: 96.6 per cent (95% CI: [96.0, 97.3]) of children who received a PSP package had not committed an offence, compared to 95.7 per cent (95% CI: [95.0, 96.5]) in the historical comparison group.

Figure 7.17 Kaplan-Meier survival curve for time to next offence for those children who received a PSP package relative to a matched historical comparison group in the Ongoing Care cohort



We then considered whether there were any factors that influenced the time to first offence using Cox Proportional Hazards regression. The results suggest that, once we controlled for other variables in the model:

- Children who received a PSP package had a lower risk of committing an offence sooner relative to those who received services as usual in the historical comparison group (HR: 0.71, 95% CI: [0.59, 0.86], $p < 0.001$). However, this finding needs to be considered in terms of historical bias as well – we did not just compare those receiving PSP services to those who did not, but also compared two populations at different historical periods. In this case, other studies and data sources have found that youth detention rates and the number of youth crimes that proceeded to court dropped between 2016 and 2020[103] meaning that it is very likely that some or all of the differences between the PSP group and the historical comparison can be accounted for by larger historical trends.
- Aboriginal children had a higher risk (HR: 1.50, 95% CI: [1.24, 1.82], $p < 0.001$) of offending relative to non-Aboriginal children. However, this finding should be

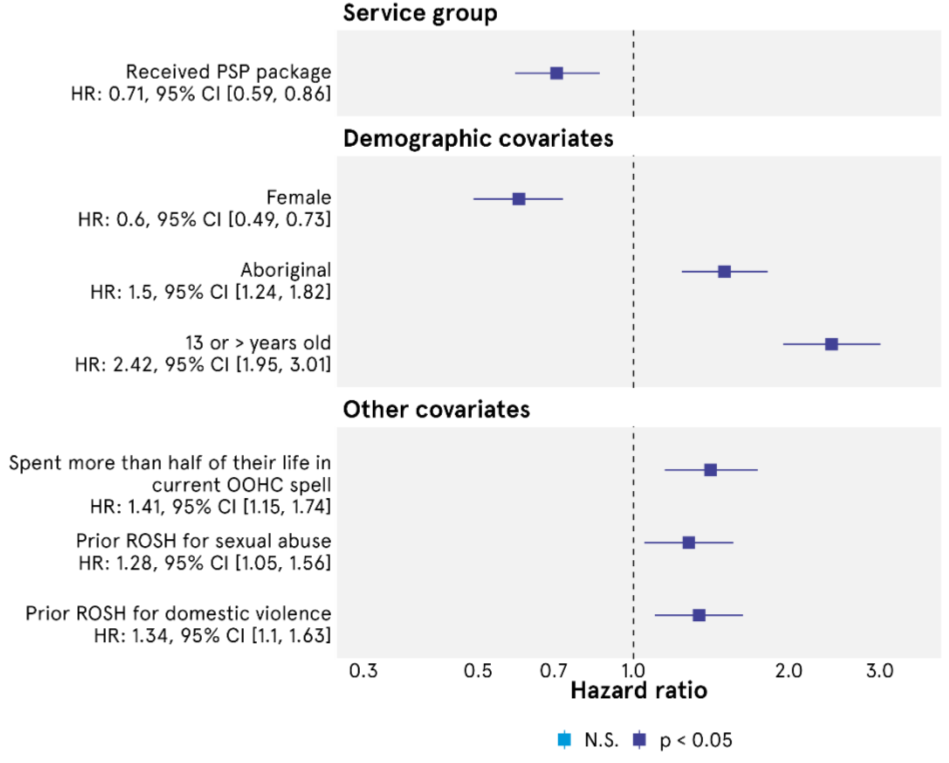
[103] Australian Institute of Health and Welfare 2021. Youth detention population in Australia 2020. Cat. no. JUV 135. Canberra: AIHW (WQA, http://www.bocsar.nsw.gov.au/Publications/BB/2019-Report-NSW-trends-in-the-age-specific-rates-of-offending-BB143.pdf and https://www.bocsar.nsw.gov.au/Pages/bocsar_pages/Young-people.aspx

interpreted with caution for the same historical bias reason described above. Looking at broader patterns in BOCSAR data during this time period, criminal offences that proceeded to court for Aboriginal children increased and then decreased during the historical period while they decreased during the entire PSP observation period.[104]

- Females had a lower risk of offending compared to males (HR: 0.60, 95% CI: [0.49, 0.73], $p < 0.001$).
- Children who had spent more than half their life in the current episode of out-of-home care had a higher risk of offending (HR: 1.41, 95% CI: [1.15, 1.74], $p < 0.001$) relative to those who had spent less than half their life.
- Children who were aged 13 and over at the start of the study period (HR: 2.42, 95% CI: [1.95, 3.01], $p < 0.001$) had higher risk of offending relative to children younger than 13 years old on 1 Oct 2014/2018.
- There was a statistically significant greater risk of offending for children who had a prior ROSH for sexual abuse (HR: 1.28, 95% CI: [1.05, 1.56], $p = 0.015$), or domestic violence (HR: 1.34 [1.10, 1.63], $p = 0.004$) relative to those who had not had not had a ROSH report for these reasons.

Results of our model are visualised in the forest plot in Figure 7.. The model is presented in Table F.17 in Appendix F.

Figure 7.18 Factors associated with the time to next offence for those who received a PSP package relative to a historical comparison in the Ongoing Care cohort



[104] http://www.bocsar.nsw.gov.au/Publications/BB/2021-Report-Decline-Aboriginal-youth-custody-BB153.pdf and https://www.bocsar.nsw.gov.au/Pages/bocsar_pages/Young-people.aspx

We examined the impact of the COVID-19 pandemic by running separate models that limited the study period to before the commencement of the pandemic (up to March 2020 and equivalent in the comparison period) and compared these to our 'standard model' of the full evaluation period.

Comparing the two models, the effect estimates, hazard ratios and p-values on the impact of PSP relative to the historical comparison are very similar. Due to the similarities between the main models and the pre-COVID-19 models we conclude that the factors that influence the outcomes — as described above for the main models — are not solely attributed to the fact that those in the current PSP-funded group experienced a global pandemic and those in the historical comparison did not.[105] A comparison of these two models for time to first SHS presentation for housing reasons (Table F.16) and time to next offence (Table F.17) are included in Appendix F.

Has PSP resulted in improved child educational outcomes?

Our ability to determine how PSP has influenced educational outcomes was limited by several occurrences outside of our control. The annual NAPLAN test that rates the progress of students every two years was not conducted in 2020 due to the COVID-19 pandemic. In addition, the progress growth rates of numeracy and reading were not yet available, or missing, when we received education data in early 2022. Due to these two factors, we were unable to compare the educational progress of children receiving PSP versus their matched historical counterparts. Lastly, we were also unable to compare attendance rates of children because attendance data was only provided from 2018 (prior to 2018 attendance data was recorded at a school level and not a child level).

To investigate education outcomes, we explored two areas of interest:

- A comparison of those children receiving PSP packages that completed their HSC in 2019 or 2020 against the numbers that completed their HSC in 2015 or 2016 in the matched historical group (Ongoing Care cohort), and
- A visual comparison of children and their NAPLAN band scores in the key elements of numeracy and reading, with a focus on the numbers that scored below the national minimum standard in each year.

HSC completion

We considered whether there were any factors influenced the number of children in Ongoing Care who completed their Higher School certificate (HSC)[106] in the evaluation period (2019 or 2020 for those receiving PSP packages and 2015 or 2016 for their historical counterparts). To analyse any differences between the two matched comparison groups we used a binomial regression generalised linear model (GLM).[107]

The results suggest that, once we controlled for other variables in the model:

[105] For greater detail on the impact of COVID-19 on youth justice, see http://www.bocsar.nsw.gov.au/Publications/BB/2021-Report-Impact-of-COVID-19-on-young-people-in-the-criminal-justice-system-BB151.pdf

[106] The HSC was considered achieved in the year all required components were completed (components can be undertaken over several years).

[107] GLM produces Odds Ratios for binary outcomes. Similar to Hazard Ratios, they are approximations of relative risk (the likelihood that one group will experience an outcome compared to another group).

- The likelihood of completing their HSC was not significantly different for those receiving a PSP package compared with those in the historical comparison group (OR: 1.26, 95% CI [0.92-1.73], $p = 0.142$).
- Only one characteristic was associated with higher odds of completing an HSC: female students were more likely than male students to have completed their HSC (OR: 1.63, 95% CI: [1.2, 2.23], $p = 0.002$).
- The following characteristics and factors were associated with lower odds of completing an HSC:
  - Aboriginal students 50% lower odds than non-Aboriginal students to have completed their HSC (OR: 0.52, 95% CI: [0.36, 0.76], $p = 0.001$), and
  - Children who had a placement move in the 12 months prior to the 1st October 2014/2018 were less likely to complete their HSC than those who did not have a placement move (OR: 0.44, 95% CI: [0.28, 0.68], $p < 0.001$).
- The number of children who completed their HSC did not significantly differ between those who were in year 10 on the 1st October 2014/2018 (HR: 1.22, 95% CI: [0.89, 1.67], $p = 0.211$), nor in those who had a prior ROSH for physical abuse (HR: 0.73, 95% CI: [0.51, 1.05], $p = 0.091$).

Results of this model are summarised in Table 7.2 below.

Table 7.2 Factors that are associated with HSC completion for those who received a PSP package relative to a historical comparison in the Ongoing Care cohort

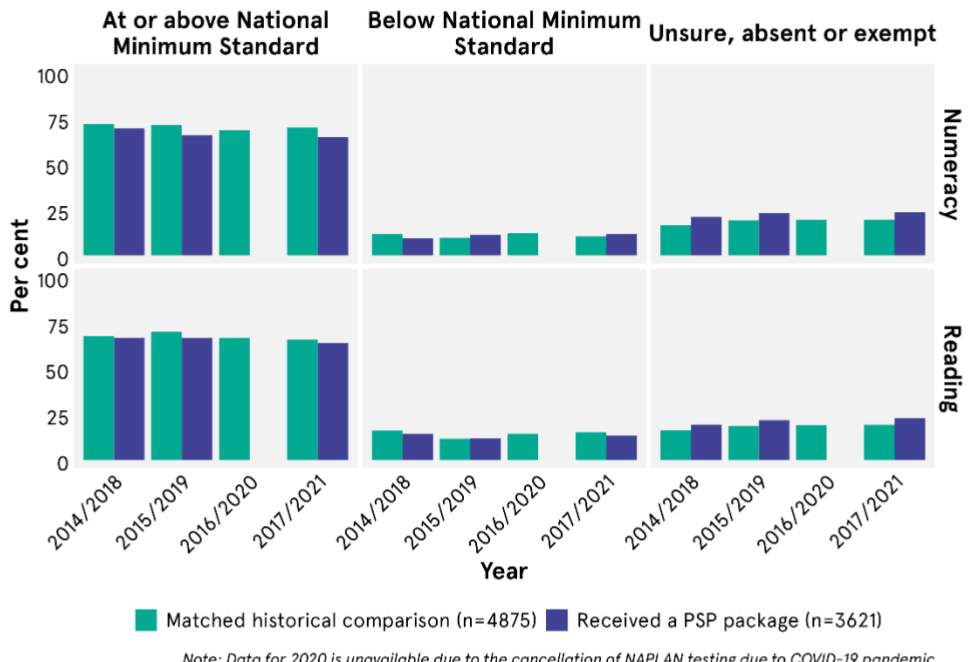
Term	Odds ratio [95% CI]	Standard error	*p* value
Received PSP package	1.26 [0.92, 1.73]	0.16	0.142
Female	1.63 [1.2, 2.23]	0.16	0.002
Aboriginal	0.52 [0.36, 0.76]	0.19	0.001
In Year 10 on 1st October 2014/2018	1.22 [0.89, 1.67]	0.16	0.211
Had placement change within prior 12 months	0.44 [0.28, 0.68]	0.23	<0.001
Prior ROSH for physical abuse	0.73 [0.51, 1.05]	0.18	0.091

NAPLAN results

To investigate differences in NAPLAN results (which were not conducted in 2020), we looked at the proportion of children that were below the national minimum standards each year and compared those receiving PSP packages (n = 3621) against their historical counterparts (n = 4875)[108]. Overall, there were only minor differences between the proportion of children who were below the national minimum standards while receiving PSP packages versus the historical sample (Figure 7.).

[108] These numbers include only those in the Ongoing Care cohort that linked with the Education data.

Figure 7.19 Proportion of NAPLAN numeracy and reading scores in different bands for children who received a PSP package relative to a matched historical comparison in the Ongoing Care cohort



What does this mean?

- After turning 18, children who received a PSP package were no less likely to be assessed for homelessness services sooner than historically similar children.
- Children who received a PSP package were less likely than their historical comparisons to be charged with an offence sooner than historically similar children. However, this difference may be attributed to a broader historical trend showing overall decreases in youth justice offences over time.
- There were no differences in education attainment between children who received a PSP package when compared to historically similar children.

7.2.5. How do PSP safety, permanency and wellbeing outcomes for Aboriginal children and families compare with outcomes for non-Aboriginal children and families?

To understand whether PSP lead to different safety, permanency, and well-being outcomes for children identified as Aboriginal compared with non-Aboriginal children, we created a separate variable called an ‘interaction term’. This variable establishes whether,

and the extent to which, Aboriginal children fare differently than non-Aboriginal children when they receive PSP. If the interaction term is significant, it means that the effect of PSP cannot be considered without accounting for whether the child is Aboriginal or not. If it is not significant, PSP effectiveness is the same for Aboriginal and non-Aboriginal children.

We also further investigated the safety, permanency and wellbeing outcomes for Aboriginal children by running PSP specific models (detailed below) that covered only the post-PSP evaluation period.

Outcomes where those identified as Aboriginal had positive improvements

No models showed that children that were identified as Aboriginal had a more positive outcome than non-Aboriginal children. There were also no models that contained a significant interaction term between children that received PSP services and those that were identified as Aboriginal. This means that any differences in outcomes we observed between Aboriginal and non-Aboriginal children in this study were not the result of having received PSP.

Outcomes that were negative for those identified as Aboriginal

Four complex models showed persistent, negative outcomes for Aboriginal children in both the PSP package group and the historical comparison. Aboriginal children were:

- More likely to have a new ROSH after Restoration sooner (Ongoing Care cohort; HR: 1.81, 95% CI: [1.39, 2.35], $p < 0.001$). Results from the PSP-specific model for next ROSH post restoration were consistent (HR: 1.93, 95% CI: [1,34, 2.76], $p < 0.001$). In other words, Aboriginal children were reported for a new ROSH post-restoration almost twice as quickly as non-Aboriginal children (HR = 1.81 and HR = 1.93).
- More likely to have an OOHC placement change sooner. They changed placements about 50 per cent more quickly than non-Aboriginal children (Ongoing Care cohort; HR: 1.45, 95% CI: [1.32, 1.59], $p < 0.001$). Results from the PSP-specific model for next placement change were consistent (HR: 1.33, 95% CI [1.18, 1.5], $p < 0.001$).
- More likely to offend sooner (Ongoing Care cohort; HR: 1.50, 95% CI: [1.24, 1.82], $p < 0.001$). Results from the PSP-specific model for time until next offence were consistent (HR: 1.45, 95% CI [1.14, 1.86], $p = 0.003$).
- Slightly more likely to have a school move sooner (Ongoing Care cohort; HR: 1.29, 95% CI: [1.19, 1.4], $p < 0.001$). Results from the PSP-specific model for school moves were consistent (HR: 1.32, 95% CI [1.19, 1.48], $p < 0.001$).
- Less likely to complete an HSC (High School Certificate; Ongoing Care cohort; OR: 0.52, 95% CI: [0.36, 0.76], $p = 0.001$).

Outcomes where there were no differences between those identified as Aboriginal or non-Aboriginal

Across most models, Aboriginal children were no more or less likely to experience the outcomes measured than non-Aboriginal children. That is, when we statistically adjust for their circumstances, the gap between Aboriginal and non-Aboriginal children begins to disappear. This tells us that the unadjusted differences we see between Aboriginal and non-Aboriginal children (i.e., just looking at raw numbers) are potentially misleading. They likely speak to broader, structural issues that are faced by a greater proportion of Aboriginal children and families than non-Aboriginal children in the larger population – not a difference in services provided by the Department or NGOs. This does not mean that there is not bias in the system or that Aboriginal children and families are not over-represented in child protection and OOHC services. It simply means that there is evidence

that larger issues are at play (i.e., poverty, lack of services in rural/remote areas) that, perhaps, have improved over time but that are still influencing how children do within the child protection system.

Beyond the four differences noted above, no other models showed differences in the outcomes for those identified as Aboriginal versus non-Aboriginal when adjusting for other demographic variables (e.g., age or gender) or for variables that represented their situation (e.g., whether they were first placed in kinship care versus foster care) or history (e.g., whether they had a history of Prior ROSH for neglect). Specifically, children who were identified as Aboriginal versus non-Aboriginal children were **just as likely** to experience the following outcomes (i.e., did not significantly differ with respect to timing of)[109]:

- New entry into care (Family Preservation cohort; HR: 0.98, 95% CI: [0.67, 1.44], p = 0.934),
- Next entry into OOHC following restoration (Ongoing Care cohort; HR: 1.33, 95% CI: [0.77, 2.30], p = 0.310),
- Exit to restoration (Entry/Re-entry cohort; HR: 0.89, 95% CI: [0.64, 1.24], p = 0.488),
- Exit to restoration (Ongoing Care cohort; HR: 1.08, 95% CI: [0.80, 1.34], p = 0.864),
- Placement changes (Entry/Re-entry cohort; HR: 1.06, 95% CI: [0.89, 1.25], p = 0.533),
- Presentation at SHS for housing reasons after age 18 (Ongoing Care cohort; HR: 1.2, 95% CI [0.76, 1.9], p = 0.439),
- Be reported for ROSH after receiving Family Preservation services (HR: 1.17, 95% CI: [0.97, 1.42], p = 0.105), and
- Be reported for Non-ROSH after receiving Family Preservation services (HR: 1.19, 95% CI: [0.98, 1.46], p = 0.086).

Supplementary findings from the PSP service provider case reviews

Overall, PSP service providers appear to conduct more extensive family finding and family consultation for cases involving Aboriginal children, which is likely to slow down the process of achieving legal permanency outcomes in certain circumstances. This includes ensuring that all kin placement options have been adequately explored before a non-kin placement's suitability for Guardianship is considered. However, when a child has been in a non-kin placement for an extended period, new potential kinship placements are not necessarily considered. Rather, the focus in these cases tends to shift to consulting the child(ren) concerned and their family members to gather their views on the suitability of the current placement.

[109] These results show whether Aboriginal / non-Aboriginal was a significant predictor in each of the models that compared those receiving PSP or in the matched historical comparison. Each of these models is described previously in this chapter. Results from the corresponding PSP-specific models were consistent (unless otherwise indicated). The differences between those identified as Aboriginal versus non-Aboriginal were not assessed for time to adoption due to the extremely low uptake of this permanency option in this segment of the population. Children were excluded from the analysis regarding time to adoption if they were in kinship care or if they were identified as Aboriginal. Please refer to Appendix F for more details.

What does this mean?

→ Overall, PSP did not affect Aboriginal children differently than non-Aboriginal children.

→ On most measures, Aboriginal children fared about as well as non-Aboriginal children.

→ Aboriginal children fared worse than non-Aboriginal children on a few key outcomes, the largest differences being new ROSH after restoration and completing the HSC.

→ These findings are consistent with ongoing, broader efforts to 'close the gap' in outcomes between Aboriginal and non-Aboriginal peoples and do not appear to be specifically related to the provision of PSP packages.

→ There is no evidence that the provision of PSP has resulted in worse outcomes for Aboriginal children and families.

7.2.6. **To what extent do any of the outcomes differ by type of PSP package received or length of time in OOHC?**

Do the outcomes differ depending on the PSP case plan goal package or other package (e.g., child needs package, cultural package, leaving care package)?

We answered this question by replicating all[110] our models and limiting them to only those children who received at least one PSP package (i.e., we dropped the comparison group from the analysis). This was done for us to investigate whether PSP-specific factors such as package type impacted each outcome. The results of these models are presented below and a snapshot of the results regarding the relevant PSP-specific factors is outlined in Table 7.3.

- The following PSP-specific factors[111] were initially included in all models if significant[112] but were removed from the final models if non-significant to maintain power and create the model of best fit:
  - Received a Long Term Care PSP package,
  - Received a Low Needs PSP package,
  - Was at a large (>300 contracted placements), medium or small (<100 contracted placements) agency,

[110] Except the Family Preservation cohort models
[111] Factors that were highly correlated with each other could not be included in the model (e.g., only one Case Plan Goal package and one Child's Needs package could be included at a time).
[112] Variables were included in the models if a univariate analysis showed p < 0.1 and/or if there was a significant difference between the comparison groups. Some variables were excluded after assessing correlations between variables. For more detail on methods, please refer to Appendix F.

- Was in a rural/regional[113] or metropolitan area,
- Received a '15+ years' Reconnect PSP package,
- Recent CAT score: low, medium or high.

Table 7.3 PSP specific factors and their likelihood of influencing the analysis outcomes of each model. All relevant significant factors are stated in a way to show the positive outcome

Model	Received a Long Term Care PSP package	Received a Low Needs PSP package	Received a 15+ Years Reconnect PSP package	Agency location	Agency size	Recent CAT score
Safety Outcomes						
Next ROSH post restoration	NS[114]	NS	NS	NS	Lower likelihood at a medium or small agency	NS
New OOHC entry post restoration	NS	NS	NS	Lower likelihood at a metropolitan location	NS	NS
Permanency outcomes						
Exit to Restoration (Entry/Re-entry)	NS	NS	NS	NS	NS	NS
Exit to Restoration (Ongoing Care)	NS	NS	NS	NS	NS	Higher likelihood if recent CAT score is low
Exit to Adoption (Ongoing Care)	NS	Higher likelihood	NS	Higher likelihood at a metropolitan location	Unclear – see below	NS
Exit to Guardianship (Ongoing Care)	NS	Higher likelihood	NS	NS	Higher likelihood at a medium or small agency	NS

[113] Whether a child or young person was receiving services in a rural/regional vs metropolitan region was based on the district in which they received services, as data provided was at the 'district level'. For more information, please refer to Appendix F.
[114] NS indicates that the PSP-specific factor was initially placed in the model but did not show a statistically significant difference. The factor may have been removed from the final model preserve power while creating a model of best fit.

Model	Received a Long Term Care PSP package	Received a Low Needs PSP package	Received a 15+ Years Reconnect PSP package	Agency location	Agency size	Recent CAT score
Placement Stability outcomes						
Next placement change (Entry/Re-entry)	NS	Lower likelihood	NS	NS	NS	NS
Next placement change (Ongoing Care)	NS	NS	NS	NS	Lower likelihood at a large agency	NS
Next school move (Ongoing Care)	NS	Lower likelihood	NS	NS	NS	NS
Wellbeing outcomes						
Next SHS services after age 18 (Ongoing Care)	NS	NS	NS	NS	NS	NS
Next offence (Ongoing Care)	NS	Lower likelihood	NS	Lower likelihood at a rural/regional location	NS	Lower likelihood if CAT score was not high
Proportion that completed their HSC	NS	NS	NS	NS	NS	NS

Safety outcomes

After developing the comparison models covering how PSP impacted safety outcomes, we reran the models in the Ongoing Care cohort relating to safety post restoration (time to new ROSH post restoration, and time to new OOHC entry post restoration) for children receiving a PSP package. For these models, the demographics, case and service factors that were associated with a **lower**[115] likelihood of a new ROSH post restoration included children who were:

[115] Due to the vast amount of results in this section (and for clarity and readability), we present the variables in a way that describes which attributes are associated with each beneficial outcome. In this case it is beneficial not to get a new ROSH, so we list the characteristics/attributes that are associated with lower likelihood of new ROSH. As a result, some of the findings described here are the same as those in the appendix, but some of them may be reversed.

- Non-Aboriginal (Aboriginal[116]: HR: 1.93, 95% CI: [1.34, 2.76], $p < 0.001$),
- In Kinship Care (compared to foster care) (HR: 0.44, 95% CI: [0.23, 0.82], $p = 0.010$),
- In the current episode of OOHC for at least half of their lives (HR: 0.62, 95% CI: [0.43, 0.89], $p = 0.009$),
- Receiving PSP services from a small or medium sized agency (< 300 placements) (Large agency: HR: 1.56, 95% CI: [1.10, 2.20], $p = 0.013$), and
- Less than 5 years old (HR: 0.45, 95% CI: [0.31, 0.65], $p < 0.001$).

- The following factors were associated with a **lower** likelihood of a new OOHC entry post restoration sooner (for those in the Ongoing Care cohort):
  - Children who received PSP services in a metropolitan location (Rural: HR: 3.27, 95% CI: [1.24, 8.63], $p = 0.017$).

Further details on these model summaries and hazard ratios can be found in Appendix F Table F.18 and Table F.19.

Permanency outcomes

The comparison models looking at PSP-specific factors in permanency outcomes were covered in an earlier section. For children receiving a PSP package, the factors associated with a **faster** (higher likelihood) time to restoration (for those in the Entry/Re-entry cohort) included children who were:

- Identified as male (Female: HR: 0.61, 95% CI: [0.37, 0.99], $p = 0.045$),
- Six months old or older (<6 months: HR: 0.36, 95% CI: [0.21, 0.62], $p < 0.001$),
- Not previously reported at ROSH for neglect (Had a ROSH for neglect: HR: 0.38, 95% CI: [0.21, 0.68], $p = 0.001$), or sexual abuse (Had ROSH for sexual abuse: HR: 0.38, 95% CI: [0.18, 0.80], $p = 0.011$),
- Not reported to have any developmental, intellectual, learning or physical disability on the SARA (Had such report: HR: 0.42, 95% CI: [0.18, 0.98], $p = 0.044$), and
- Not reported to have a parent/carer with a history of child protection (Had such report: HR: 0.56, 95% CI: [0.34, 0.93], $p = 0.025$).

The following factors were associated with a **higher** likelihood of exiting to restoration sooner (for those in the Ongoing Care cohort): Children who were:

- Less than 5 years of age (HR: 2.64, 95% CI: [2.00, 3.48], $p < 0.001$),
- In foster care (compared to kinship care) (Kinship: HR: 0.56, 95% CI: [0.36, 0.86], $p = 0.008$),
- In the current episode of OOHC for at least half of their lives (Over half their lives: HR: 0.25, 95% CI: [0.19, 0.33], $p < 0.001$), and

[116] This is a reversal example. Here, the text notes that non-Aboriginal have a lower likelihood of a new ROSH but HR and CI is presented for Aboriginal children (as this was how it was included in the statistical model underpinning the finding). Aboriginal children were reported for a new ROSH almost twice as quickly as non-Aboriginal children.

- Rated ‘Low’ on their most recent CAT (HR: 1.91, 95% CI: [1.29, 2.84], $p = 0.001$).

The following factors were associated with a **higher** likelihood of exiting to adoption sooner (for those in the Ongoing Care cohort) included children who:

- Were less than 5 years old (HR: 2.56, 95% CI: [1.81, 3.61], $p < 0.001$),
- Received a Low Needs PSP package (HR: 2.74, 95% CI: [1.46, 5.15], $p = 0.002$),
- Received PSP services from a large agency (HR: 1.70, 95% CI: [1.22, 2.37], $p = 0.002$), and
- Received PSP services in a metropolitan location (Rural: HR: 0.55, 95% CI: [0.39, 0.77], $p < 0.001$).

However, as discussed previously, these are findings are from analyses with a relatively small sample size. One large agency had 42 per cent of all adoptions so we conducted a sensitivity analysis by removing the one large agency. We found that when this one large agency was controlled for, those at other large agencies were actually **less likely** to have completed adoptions within the time frame (HR: 0.39, 95% CI: [0.23, 0.70], $p = 0.001$) and those in metropolitan locations were **just as likely** (HR: 0.80, 95% CI: [0.52, 1.25], $p = 0.343$; refer to Appendix F for more detail).

The following factors were associated with a **higher** likelihood of exiting to guardianship sooner (for those in the Ongoing Care cohort) included children who:

- Are male (Female: HR: 0.56, 95% CI: [0.38, 0.82], $p = 0.003$),
- Non-Aboriginal (Aboriginal: HR: 0.63, 95% CI: [0.42, 0.93], $p = 0.020$),
- Spent more than half of their life in the current OOHC episode (HR: 1.95, 95% CI: [1.19, 3.18], $p = 0.008$),
- Received a Low Needs PSP package (HR: 2.45, 95% CI: [1.39, 4.32], $p = 0.002$), and
- Received PSP services from a small or medium sized agency (< 300 placements) (Large agency: HR: 0.63, 95% CI: [0.43, 0.94], $p = 0.023$).

Further details on these model summaries, hazard ratios and forest plots can be found in Appendix F: Tables F.9 to F.12.

Placement stability outcomes

The comparison models covering how PSP impacted placement stability outcomes were covered in an earlier section. We reran all three models measuring placement stability using only children who received PSP packages to understand the potential impact of PSP-specific variables. The following demographic, case and service factors were associated with a **lower** likelihood of having a placement change sooner (for those in the Entry/Re-entry cohort) for children who:

- Received a PSP Low Needs package (HR: 0.52, 95% CI: [0.33, 0.83], $p = 0.006$).

The following factors were associated with a **lower** likelihood of having a placement change sooner (for those in the Ongoing Care cohort) for children who were:

- Non-Aboriginal (Aboriginal: HR: 1.33, 95% CI: [1.18, 1.50], $p < 0.001$),

- Aged 15 years or older (HR: 0.77, 95% CI: [0.63, 0.93], $p = 0.007$),
- Spent more than half their life in the current OOHC episode (HR: 0.49, 95% CI: [0.43, 0.55], $p < 0.001$), and
- Received PSP services from a large agency (HR: 0.87, 95% CI: [0.77, 0.98], $p = 0.022$).

The following factors were associated with a **lower** likelihood of having a school move sooner (for those in the Ongoing Care cohort) for children who were:

- Non-Aboriginal (Aboriginal: HR: 1.32, 95% CI: [1.19, 1.48], $p < 0.001$),
- In Kinship care (compared to foster care) (HR: 0.76, 95% CI: [0.66, 0.88], $p < 0.001$),
- Spent more than half their life in the current OOHC episode (HR: 0.62, 95% CI: [0.56, 0.70], $p < 0.001$), and
- Received a PSP Low Needs package (HR: 0.71, 95% CI: [0.63, 0.80], $p < 0.001$).

Further details on these model summaries, hazard ratios and forest plots can be found in Appendix F: Tables F.20 to F.22.

Wellbeing outcomes

The comparison models covering how PSP impacted wellbeing outcomes were covered in an earlier section. We reran both Cox Proportional Hazards models and the Generalised Linear model using only children who received a PSP package to understand the potential impact of PSP-specific variables. For the Cox models, the demographic, case and service factors that achieved a lower rate of the outcome were more positive. Demographic, case and service factors in the GLM that showed higher odds were more positive. The key findings were:

- There were no factors (PSP-specific or otherwise) that were associated with a statistically significantly **lower** likelihood of a presenting at SHS for housing sooner (for those in the Ongoing Care cohort).
- Factors associated with a **lower** likelihood of offending sooner (for those in the Ongoing Care cohort) for children who:
  - Are female (HR: 0.60, 95% CI: [0.46, 0.78], $p < 0.001$),
  - Non-Aboriginal (Aboriginal: HR: 1.45, 95% CI: [1.14, 1.86], $p = 0.003$),
  - Received PSP services in a rural or regional location (HR: 0.75, 95% CI: [0.58, 0.96], $p = 0.021$),
  - Received a Low Needs PSP package (HR: 0.66, 95% CI: [0.51, 0.85], $p = 0.001$), and
  - Their most recent CAT score was not rated High (High CAT score: HR: 1.90, 95% CI: [1.17, 3.08], $p = 0.009$).
- The following factors were associated with **higher** odds of a child completing their HSC (for those in the Ongoing Care cohort): Children who:
  - Are female (OR: 1.83, 95% CI: [1.25, 2.67], $p = 0.002$),
  - Non-Aboriginal (Aboriginal: OR: 0.54, 95% CI: [0.35, 0.83], $p = 0.005$),

- In year 11 on the 1st October 2018 (In year 10: OR: 0.61, 95% CI: [0.41, 0.90], p = 0.010), and
- Did not have a placement change within the year before the 1st October 2018 (Had placement change: OR: 0.37, 95% CI: [0.21, 0.68], p = 0.001).

Further details on these model summaries, hazard ratios and forest plots can be found in Appendix F: Tables F.23 to F.25.

Do the outcomes differ depending on the length of time that children have been in OOHC?

To understand how the safety, permanency, and well-being outcomes for children differed depending on the length of time that children had been in care, we incorporated a measure of duration in care into most comparison and PSP-specific models for the Ongoing Care cohort. It was not possible to account for duration explicitly in years, as this was highly correlated with the age of the children (e.g., a child younger than five could not be in care for more than five years). Instead, we created a binomial covariate to track whether children had been in their current out-of-home care episode for more than half of their life.[117] This was essentially a scaled term and was incorporated into every Cox Proportional Hazards model used with the Ongoing Care cohort. It was removed for the final model if not significant.

Positive outcomes for those who had been in care for more than half of their lives

A number of permanency and safety outcomes showed significant and strong, positive associations with having been in care for more than half of a child's life.

Children who had been in care for more than half of their lives were **more likely** to:

- Exit to Guardianship sooner (Ongoing Care, PSP-specific model; HR:1.95, 95% CI: [1.19, 3.18], p = 0.008),
- Offend sooner (Ongoing Care: HR: 1.41, 95% CI [1.15, 1.74], $p < 0.001$).

  and **less likely** to:

- Have a ROSH following restoration sooner (Ongoing Care, PSP-specific model: HR: 0.62, 95% CI: [0.43, 0.89], p = 0.009),
- Change out-of-home care placements sooner (Ongoing Care: HR: 0.48, 95% CI [0.43, 0.52], $p < 0.001$; and Ongoing Care, PSP-specific model: HR: 0.49, 95% CI: [0.43, 0.55], $p < 0.001$), and
- Move schools sooner (Ongoing Care: HR: 0.72, 95% CI: [0.66, 0.79], $p < 0.001$; and Ongoing Care, PSP-specific model: HR: 0.62, 95% CI: [0.56, 0.7], $p < 0.001$).

[117] Note that this variable was applicable for those in the Ongoing Care cohort only. Specifically, it assessed whether the child had been in the current episode of care for more than half of their lives; thus, it did not account for time in care in prior episodes in out-of-home care and was not applicable to the Entry/Re-entry cohort. In the Entry/Re-entry cohort a different variable was used – whether the child or young person had had a prior episode of care – to indicate a child's previous association with OOHC.

Negative outcomes for those who had been in care for more than half of their lives

One permanency outcome showed a significant negative association with having been in care for more than half of a child's life. Children who had been in care for more than half of their lives were **far less likely** to:

- Exit to Restoration (Ongoing Care: HR: 0.24, 95% CI: [0.19, 0.29], $p < 0.001$; and Ongoing Care, PSP-specific model: HR: 0.25, 95% CI: [0.19, 0.33] $p < 0.001$)

No differences between those who had been in care for more than half of their life or not for a number of outcomes

Whether children had been in care for more than half of their lives did not positively or negatively affect the likelihood of experiencing a number of outcomes sooner. Outcomes that were statistically **just as likely** for those who had been in care for more than half of their lives or not (and therefore were not included in the final fitted models) were:

- Time to Adoption
- Time to SHS presentation
- Time to next out-of-home entry following restoration
- HSC completion

What does this mean?

→ The type of PSP packages do not appear to be highly associated with measured outcomes

→ Many demographic factors strongly predict outcomes, both positive and negative. For example, females are less likely to offend sooner and more likely to complete their HSC, which is a positive outcome for this demographic. However, males are more likely to exit to restoration or guardianship sooner than females.

→ Far more detail about the services within packages are needed including the quality, timing, and frequency of services, to both properly evaluate and potentially improve them.

7.3. Discussion

Overall, examining predictors of positive and negative outcomes[118] grants insight into potential benefits associated with different PSP packages. However, most of these were not significant, which indicates that other factors were largely at play. The receipt of PSP

[118] The authors acknowledge that other outcomes such as health and school attendance, which we were unable to obtain for this analysis, may have provided additional insight into the impact of PSP.

packages does not appear to play as strong of a role in predicting outcomes as demographic and historical factors.

Demographic and historical factors can strongly influence the trajectory of children through the various stages of the OOHC system, including the proportion of time children spent in their current episode of care. Children's overall length of stay in OOHC has an obvious relationship with outcomes that require time to unfold such as guardianship and adoption. Aboriginal children generally fared more poorly, but the differences between Aboriginal and non-Aboriginal children were not as large as would be expected given the substantial overrepresentation of Aboriginal children in child protection and OOHC.[119] This study is different in that it factored in, either directly or by proxy, many of the factors that predict outcomes across the entire population of children. Findings were mixed and are broadly reflective of the diverse experiences that all children have prior to entry and once they are in OOHC. The choice of PSP package is also inextricably linked with the intended course of service, which may be known before the first package begins and is reflective of any package changes that come after that (i.e., a restoration package can be provided after the decision to restore is made). It is probably fair to say that the package types need to be individually pilot tested and prospectively validated, both for their effectiveness and for the quality of their implementation, before scaling up rather than simply observed after the fact.

[119] See https://aifs.gov.au/resources/short-articles/growing-over-representation-aboriginal-and-torres-strait-islander-children

Part six

Economic analysis

8. Economic analysis

Key takeaways

The average additional cost of post PSP services compared to pre-PSP services is $50,548 per child in the Ongoing Care cohort, and $15,153 per child in the Entry / Re-entry cohort. Both costs are for the observation window of 2.75 years. The costs per family receiving PSP Family Preservation services is $57,462.

For Aboriginal children, the average additional costs of post PSP services increase to $52,818 and $25,717 for the Ongoing Care cohort and Entry / Re-entry cohort respectively. The larger increase for the Aboriginal Entry / Re-entry cohort appears mostly due to the relatively low expenditure for this cohort before PSP was introduced. Introduction of Cultural Plan (Aboriginal) and Aboriginal Foster Care baseline packages has increased the funding directed towards Aboriginal children.

For the Entry / Re-entry cohort, estimated benefits arising from a reduction in placement changes are $1,308 per child in Foster Care.

For children in the Ongoing Care cohort who are in Foster Care, estimated benefits arising from increases in restoration and adoption are $6,687 and rise to $7,020 per child for children over 10 years of age due to an expected decrease in juvenile offences. For children in Kinship Care the estimated benefits arising from an increase in restoration are $3,287, and for older children, the estimated benefits further increase to $3,620 per child due to an expected decrease in juvenile offences for children in Kinship Care over 10 years of age.

No significant improvements in outcomes (and thus benefits) are estimated for children in families receiving Family Preservation packages.

All Benefits-Costs Ratios are calculated to be well below one, indicating that the estimated net present values of the benefits are smaller than the estimated net present values of the costs.

Costs can be measured relatively well, but there are two limitations in the measurement of benefits:

- the relatively short amount of time available for observing improved outcomes after PSP was introduced, which was further hampered by the COVID pandemic, and
- the lack of information on education, health (physical and mental), and wellbeing outcomes for children.

Due to these important limitations with regard to the benefit side of the cost-benefit analysis, the evaluation may seriously underestimate the value of benefits arising from the introduction of PSP. No firm conclusions can be drawn on the basis of the current results.

8.1. Introduction

This section uses various data sources (described in section 3.4.2) to calculate the costs and benefits associated with the introduction of PSP for NGO service providers. It answers three key evaluation questions:

1. What is the cost of providing Family Preservation services?
2. What is the average cost of OOHC services provided by OOHC providers before and after PSP was introduced?
3. Is PSP a more cost-effective way of administering the child protection system in NSW than the pre-PSP usual service provision? Do the benefits of PSP, measured in terms of estimated savings based on immediate and some future consequences of a change in the duration to certain outcomes, outweigh the costs to government of providing PSP services?

First, we use information on the cost of Family Preservation packages and compare this to the average benefits per child arising from improved outcomes that can be attributed to these packages as estimated in the Effectiveness analysis in Chapter 7. Significant improvements in outcomes are translated into monetised benefits using the most recent Benefits Guide (FACSIAR, 2022) as outlined in section 3.5.2.

Second, information on the cost of PSP packages and cost of specific pre-PSP services is combined with child-level information on the amount of time they receive these packages/services to calculate the average cost per child during our observation period. This is done by adding up all the costs observed in the data for the children in the PSP group and children in the pre-PSP (control) group and computing an average cost per child (adjusting for inflation between the pre-PSP and the post-PSP costs, so that all costs are expressed in 2020/21 dollars). The cost of Permanency Coordinators (post-PSP) and the cost of maintaining vacancies in the system (pre- and post-PSP) are also computed/collected and divided equally across all relevant children receiving NGO

services. If children are transferred to DCJ at any point in time during our observation period and received DCJ Care Allowances, or Guardianship or Adoption Allowances before the end of the observation period, then these are also added to the cost (both in the pre-PSP and post-PSP period). The difference between pre- and post-PSP costs is then compared to the average benefits per child arising from any changes in outcomes that can be attributed to the introduction of PSP as estimated in the Effectiveness analysis in Chapter 7.

The average costs per child for our full sample of analysis are reported in section 7.2.1 using descriptive data analysis, while section 7.2.2 reports the average per child costs for Aboriginal children in isolation to determine to what extent PSP directs additional funding to this group. The average benefits per child are only available for the full sample of analysis and cannot be separately calculated for Aboriginal children. The CBA can therefore only be done at the overall level; the results on benefits are reported in section 8.3. Outcomes to be considered in computing the benefits are preservation and permanency outcomes, as well as youth justice and education outcomes. Only statistically significant outcomes are used in estimating the benefits associated with PSP.

A discussion in section 8.4 compares the benefits with the costs required to achieve these benefits, with the aim to determine whether PSP has been cost-effective (so far). Benefit Cost Ratios (BCRs) are also reported based on the current information on costs and benefits.

8.2. Cost of pre- and post-PSP services

8.2.1. Costs of services for children in the full sample of analysis

Calculation of post-PSP costs

An average cost per child of $201,263 was calculated for the Ongoing Care cohort for the 2.75 years from 1 October 2018 to 30 June 2021, and $116,204 for the Entry / Re-entry cohort over the same period.[120] The difference in average cost is mostly due to a shorter period in care (on average) for the Entry / Re-entry cohort, and the average costs of the Entry / Re-entry and Ongoing Care cohorts should not be directly compared. What is of interest in the CBA is the difference in cost between pre- and post-PSP period for the Entry / Re-entry cohort and the Ongoing Care cohort separately.

We have arrived at the above overall average cost by adding up several components, which are described below.

[120] This would translate to an average cost per child per year of $73,187 for the Ongoing Care Cohort and $42,256 for the Entry / Re-Entry cohort. However, these annual amounts are not directly comparable to the usual annual OOHC cost per child, as we also include zero costs for the time that the child is not in OOHC care rather than only include the cost for the time that the child is in OOHC care. For the Ongoing Care cohort, we for example expect some children to exit OOHC care over the 2.75 years that we observe. For example, the Ongoing Care cohort consists of 6,263 children in OOHC in the 2018/2019 financial year, 5,859 children in OOHC in the 2019/2020 financial year and 5,308 children in OOHC in the 2020/2021 financial year. As a result, the average cost per child per year would go down over time as children exit OOHC so that in the first year the average cost is likely to be higher than $73,187 and in the last year the average cost is likely to be lower than the $73,187. In addition, PSP Case Plan Goal packages aimed at achieving permanency for children are in principle only paid over the first two years after which time these PSP packages would stop or be paid at a lower rate. The latter is occurring for a few children: 195 children in the Ongoing Care cohort and 22 children in the Entry / Re-entry cohort (see the row with “”Continue permanency beyond 2 years” in Table G.1). In exceptional circumstances, the higher PSP Case Plan Goal payments can continue after the initial two years but this is not yet observed in the current data.

PSP packages comprise modular elements with price lists that are pre-agreed with PSP providers. What PSP services are provided is determined by the needs of individual children, introducing variation in the packages received by children. However, almost every child receives a Case Plan Goal, Baseline and Child Needs package. Table G.1 in Appendix E shows the number of children receiving specific PSP packages in the observation period between 1 October 2018 and 30 June 2021, distinguishing between children in the Ongoing Care cohort and children in the Entry / Re-entry cohort. Appendix Table G.1 lists all PSP packages that children could potentially receive, with the annual price for 2020/21 reported in the final column. Children can move in and out of packages during their time in the OOHC system.

To compute the actual expenditure for each child in the sample of analysis, we collect information from the PSP payments data regarding the amount of time that children receive certain packages within our period of observation of 2.75 years.[121] The total cost of each package within the observation period is obtained by multiplying the annual fee by the number of children and by the average amount of time these children have been receiving the package.[122] The overall amount spent on PSP packages is just over $1.2 billion over 2.75 years for the Ongoing Care cohort (of 6,263 children) and just over $60.5 million for the Entry / Re-entry cohort (of 555 children). The children in these two cohorts are the same as the children who are part of the samples used in the Effectiveness analysis.

Children in the Ongoing Care cohort, who may have been in OOHC for a long period of time already, have a much more extensive prior involvement with the OOHC system (e.g. duration of prior episodes of care) as well as greater proportions of children with prior histories of foster care, kinship care, and residential care. This is reflected in the types of packages they receive versus the type of packages received by the Entry / Re-entry cohort.

Appendix Table G.1 shows that "Long-term Care" is the Case Plan Goal package provided to the majority of children in the Ongoing Care cohort (5,685 children out of 6,263 children receive this package at some point in time over the 2.75 years) while "Restoration" is the main Case Plan Goal package provide to the Entry / Re-entry cohort (with 537 out of 555 children receiving this package at some point in time over the 2.75 years), indicating that the primary objective is to return children to their birth families where possible. "Foster Care" is the Baseline Package provided to the majority of children in both cohorts (84% of all children in the Ongoing Care cohort and 88% of all children in the Entry / Re-entry cohort receive this package at some point in time over the 2.75 years). Comparing the packages provided to children already in OOHC when PSP was introduced and children entering OOHC after PSP was introduced, shows clear differences. Many of these are in accordance with expectations, such as the higher likelihood of being provided with a restoration package for new entries into OOHC and children already in OOHC being more likely to need a "Medium" or "High Needs" package than children in the Entry / Re-entry cohort. Naturally, the "Cultural Plan: One off, new children (Establishment)" is more prevalent amongst new entries.

In addition to the PSP package costs, some overhead costs and non-PSP payments are also included. Although we assume that in general the cost of DCJ staff involved in case management tasks associated with children in NGO services is the same before and after PSP was introduced, Permanency Coordinators are an additional resource employed by DCJ to implement PSP. The costs of providing this additional staffing are included in the

[121] Information on the average amount of time receiving packages is reported separately for the Ongoing Care cohort and the Entry / Re-entry cohort in columns 2 and 5, respectively, with the number of children receiving a package during the observation period reported in columns 3 and 6.
[122] These total costs are reported in columns 4 and 7 for the Ongoing Care cohort and Entry / Re-entry cohort respectively.

overall post-PSP cost.[123] The costs of maintaining vacancies in the OOHC system are also included by allowing for the Placement Capacity Payments in the post-PSP period.[124]

In order to obtain a complete picture of all costs involved in providing services to the children in our sample of analysis during the 2.75-year observation period, we also include observed payments on Guardianship and Adoption Allowances and DCJ Care Allowance in the relevant period.

Calculation of post-PSP costs for all children receiving at least one package

To obtain an understanding of the costs for the children in our specific post-PSP sample of analysis relative to all children in the post-PSP observation period, we also computed the overall and average cost for *all* children receiving at least one PSP package during this period. This allows us to assess the percentage of children exposed to PSP who are included in the Effectiveness analysis in this report, and the percentage of payments to the children included in the Effectiveness analysis, as well as the average costs per child for the sample of analysis relative to the average costs per child when all children in PSP during the relevant period are included. This provides an indication of how representative the children included in the analyses are of the full population of children receiving services from PSP providers over this period.

Table G.3 in Appendix E replicates Appendix E Table G.1 for the full population of children receiving at least one PSP package between 1 October 2018 to 30 June 2021. This shows that the post-PSP sample of analysis represents 74% of all children entering during the 2.75 years of the observation period and it represents 78% of all children who were already in OOHC on 1 October 2018. In terms of the percentage of PSP payments that our sample of analysis represents: 82% of all payments to children entering during the 2.75 years of the observation period are included and 73% of all payments to children who were already in OOHC on 1 October 2018 are included.

Compared to all children who received at least one PSP package during the relevant period, the Ongoing Care cohort in the sample of analysis is likely to be less disadvantaged

[123] There were 52 Permanency Coordinators employed by DCJ. The cost of 52 Permanency Coordinators is estimated at $11,078,689 per financial year. This is based on a Grade 9 salary in December 2021 of $122,761 in the first year and $126,213 in following years (using the midpoint of $124,487), plus 21.5% salary on-costs and $61,800 for the indirect labour cost per caseworker as outlined in the DCJ Unit Cost Manual (FACSIAR 2020b) (Information on the salary level and number of Permanency Coordinators was received from DCJ). Using the PSP payments data, we counted 8,748 children with at least one PSP package in 2018/19, this was 8,860 in 2019/20 and 9,082 in 2020/21. Assuming that each child receives the same amount of services from the Permanency Coordinators (this seems reasonable given that it is likely that children who are entering or exiting OOHC may need more services counteracting the shorter period of time in OOHC for these children within the financial year). Assuming there were 52 Permanency Coordinators during each of the relevant financial years, the average cost per child for their services was $1,266.43 in 2018/19, $1,250.42 in 2019/20 and $1,219.85 in 2020/21.

[124] Similar to the Permanency Coordinators, we divide the cost of the Placement Capacity Payments over all children covered by these Payments in each financial year. Placement Capacity Payments in relation to Foster/Kinship Care through PSP providers were $8,146,834.78 in 2018/19, $9,145,259.25 in 2019/20 and $7,599,231.48 in 2020/21 with the final year still to be reconciled at the time of writing (based on information received from DCJ). The available OOHC data show there were 9,009 children receiving non-residential services from NGO providers in 2018/19. In 2019/20 there were 8,722 children and in 2020/21 there were 8,233 children. We use OOHC data so we can generate comparable numbers for the period before PSP was introduced. As for dividing the cost of Permanency Coordinators over all children, we do not take into account the length of time the child spent in OOHC in the relevant financial year. The average cost per child was $904.30 in 2018/19, $1,048.53 in 2019/20 and $923.02 in 2020/21.

than the population of all children. This is evident through the larger proportion of children with high needs, the larger number of children who receive Complex Needs payments (with a higher payment on average than for the sample of analysis), and the larger proportion of children in ITC or ITTC when considering *all* children.[125] As a result of these higher payments for the children not included in the sample of analysis, a smaller proportion of all payments is included in the sample of analysis compared to the proportion of children that is included. That is, the children who are included in the sample of analysis have a lower average cost of $201,263 compared to the average cost of $214,169 when including all children.

For the Entry / Re-entry cohort there is also a higher percentage of children with high needs and in ITC when including all children with at least one package. Nevertheless, the average cost per child is lower at $104,667 (compared to $116,204 for the children in the sample of analysis) as we do not limit the time of entry to be before the end of 2020, so that shorter durations in OOHC are included in the numbers in Table G.3 and this more than compensates for the higher cost for some children.

Calculation of pre-PSP costs

An average cost per child of $150,715 is calculated for the Ongoing Care cohort for the 2.75 years from 1 October 2014 to 30 June 2017, and $101,051 for the Entry / Re-entry cohort over the same period.[126] The difference in cost is mostly due to a shorter period in care (on average) for the Entry / Re-entry cohort, and as mentioned before, the average cost of the Entry / Re-entry and Ongoing Care cohorts should not be directly compared.

Using a similar approach as for the post-PSP costs, we have arrived at the above overall average cost by adding up several components, which are described below.

Table G.2 in Appendix E shows the number of children receiving specific NGO services in the observation period between 1 October 2014 and 30 June 2017, distinguishing between children in the Ongoing Care cohort and children in the Entry / Re-entry cohort. Appendix E Table G.2 lists all types of services that children could potentially receive, with the annual price (a hypothetical price, expressed in 2020/21 dollars)[127] reported in the final column. Children can move in and out of receiving specific services during their time in the OOHC system. To compute the actual expenditure for each child in the sample of analysis, we collect information from the OOHC data regarding the amount of time that children receive certain services within the period of observation of 2.75 years.[128] The total cost of each service within the observation period is obtained by multiplying the annual fee by the number of children and by the average amount of time these children spend receiving the service.[129] The overall amount spent on all services is just over $857 million over 2.75 years for the Ongoing Care cohort (of 6,240 children) and just over $39 million for the Entry / Re-

[125] Children who were in ITC or residential care at the start of the observation window were out of scope for the analyses in this report, leading to a lower proportion of children in ITC or ITTC in the sample of analysis.

[126] This would translate to an average cost per child per year of $54,805 for the Ongoing Care Cohort and $37,088 for the Entry / Re-Entry cohort. Noting again that these annual amounts are not directly comparable to the usual annual OOHC cost per child as explained in the footnote at the start of section 7.2.1.

[127] See Table 3.5 in section 3.5.2 for the calculation of hypothetical 2020/21 prices.

[128] Information on the average amount of time receiving services is reported separately for the Ongoing Care cohort and the Entry / Re-entry cohort in columns 2 and 5, respectively, with the number of children receiving a specific service during the observation period reported in columns 3 and 6.

[129] These total costs are reported in columns 4 and 7 for the Ongoing Care cohort and Entry / Re-entry cohort respectively.

entry cohort (of 555 children). The children in these two cohorts are the same as the children who are part of the samples used in the Effectiveness analysis.

Similar to the post-PSP period, children in the Ongoing Care cohort, who may have been in OOHC for a long period of time already, have a much more extensive prior involvement with the OOHC system (e.g. prior episodes of care) as well as greater proportions of children with prior histories of foster care, kinship care, and residential care. This is reflected in the types of services they receive versus the type of services received by the Entry / Re-entry cohort.

Appendix E Table G.2 shows that "General Foster Care" is the most prevalent service provided to both the Ongoing Care cohort and the Entry / Re-entry cohort. However, the Ongoing Care cohort is much more likely to require a level of care that is higher than General Foster Care; i.e. General Foster Care +1 (received by 649 out of 6,230 children in the Ongoing Care cohort versus 29 out of 554 children in the Entry / Re-entry cohort), General Foster Care +2 (603 out of 6,230 children versus 31 out of 554 children) or Intensive Foster Care (418 out of 6,230 children versus 10 out of 554 children), and they are also more likely to be in (Intensive) Residential Care (77 out of 6,230 children versus 6 out of 554 children).

In addition to the service costs, one-off payments as reported in the monthly DCJ payments data are also included. As mentioned in section 3.5.2, we exclude one-off payments related to Alternative Care Arrangements.

As we assume that in general the cost of DCJ staff involved in case management tasks associated with children in NGO services is the same before and after PSP was introduced, we have not included these overhead costs. However, the pre-PSP overhead costs of maintaining vacancies in the OOHC system are included.[130]

Similar to the approach in the post-PSP period, we also include observed payments on Guardianship and Adoption Allowances and DCJ Care Allowance during the relevant period.

Difference between average pre-PSP and post-PSP costs per child

What is the cost of providing Family Preservation services?

The Family Preservation package is priced at $40,861.75 per family, which with an additional $16,600.20 for case coordination adds up to $57,461.95 per family receiving PSP Family Preservation services. The families in the comparison group are not receiving any family preservation services, but otherwise receive the same services as the families receiving a Family Preservation package. The additional cost of PSP is thus $57,461.95 per family.

[130] The average cost per child is calculated in a similar way to the cost of the Placement Capacity Payments. The cost of maintaining vacancies in relation to Foster/Kinship Care through NGOs was $2,356,685 in 2014/15, $4,377,038 in 2015/16 and $7,687,535 in 2016/17 (based on information received from DCJ). The available data show there were 8,848 children receiving services from PSP providers in 2014/15. In 2015/16 this was 9,531 children, and in 2016/17 this was 9,335 children. We received alternative numbers from DCJ of between 11,000 and 12,000 children per financial year, but for consistency with the data used for the post-PSP Placement Capacity Payments, we use the numbers derived from the unit record data available to us. As a result, the average cost per child calculated here may be a slight overestimate but using the alternative numbers would not make a material difference for any of the conclusions from this evaluation. The average cost per child was $266.35 in 2014/15, $459.24 in 2015/16 and $823.52 in 2016/17.

What is the average cost of OOHC services provided by OOHC providers before and after PSP was introduced?

The previous subsections discuss the full cost tables (reported in Appendix E Table G.1 and Table G.2) for the pre- and post-PSP group of children. Table 8.1 summarises the average costs per child for the different groups, as well as the difference between pre- and post-PSP costs per child. This difference is much larger for the Ongoing Care cohort than for the Entry / Re-entry cohort, indicating that the increase in resources targeted at them was relatively larger for children in the Ongoing Care cohort (+34%) than for children in the Entry / Re-entry cohort (+15%). That is, the majority of additional resources were invested in the children already in care at the time PSP was introduced. As a result, for PSP to be "cost effective", the impact on children already in OOHC has to be much larger than for children entering OOHC.

Table 8.1 Average cost per child for the period of 1 October 2018/2014 to 30 June 2021/2017

	PSP		Pre-PSP		Difference (PSP cost – pre PSP cost)	
	Ongoing Care	Entry / Re-entry	Ongoing Care	Entry / Re-entry	Ongoing Care	Entry / Re-entry
All children in sample of analysis[a]	$201,263 [6,263]	$116,204 [555]	$150,715 [6,240]	$101,051 [554]	$50,548	$15,153
All children with at least one PSP package	$214,169 [8,010]	$104,667 [752]				

Note: number of children in the relevant cohort in square brackets. The sample of analysis excludes all children in residential care at the start of the observation period (either on 1 October 2014/2018 if in Ongoing Care cohort or at the time of entry for the Entry / Re-entry cohort).

To obtain a better understanding of how the costs are distributed over the financial years, we present the costs by financial year in Table 8.2.[131] As the observation period starts on 1 October 2018 and 1 October 2014 for the PSP and pre-PSP groups, respectively, the first financial year covers 9 months only.

Starting with the PSP Ongoing Care cohort, row 1 in Table 8.2 shows that in the first financial year (when translating the 9-month amount to a full year), $57,998*12/9=$77,331 would have been spent per child which then goes down to $73,856 and $69,408 in the following two years (rows 2 and 3). This decrease is completely due to children from this cohort exiting OOHC, as shown by rows 4 to 6 where we calculate the average cost per child who is still in OOHC in that financial year. These show increases from $77,331, to $78,949 to $81,896. That is, the cost per child in the Ongoing Care cohort slightly increases for children who remain in OOHC for longer. The pre-PSP Ongoing Care cohort shows a smaller decline in the average cost per child over time: from $55,448 (calculated by $41,586*12/9, when translating the 9-month amount to a full-year amount) in the first year to $54,534 in the third year. The smaller decline is due to the lower number of children leaving OOHC in the pre-PSP period compared to the post-PSP period,

[131] More detail on the costs for each financial year in the pre- and post-PSP period is included in Appendix E Table G.4 to Table G.9.

and to the larger increase in costs per child for the children remaining in OOHC in the pre-PSP period (as can be seen in rows 4 to 6 in Table 7.2). As a result, the difference in costs per child between the post-PSP and pre-PSP period first increases and then decreases. This is the case when accounting for children who left OOHC (whose cost are set to zero) as well as when the average cost is calculated based on the children who remain in OOHC only: from the second to the third year this goes from $19,262 to $14,874 when zero costs are included and from $21,145 to $20,145 when costs are only averaged across children who remained in OOHC in the relevant financial year.

Table 8.2 Average cost per child [a] by financial year (1 October 2018/2014 to 30 June 2021/2017)

	PSP		Pre-PSP		Difference (PSP cost – pre PSP cost)	
	Ongoing Care	Entry / Re-entry	Ongoing Care	Entry / Re-entry	Ongoing Care	Entry / Re-entry
Average costs per child per financial year when including all children in the cohort sample of analysis:						
Year 1: 2018/19 and 2014/15 (last 9 months only)[b] [number of children in the cohort sample]	$57,998 *$77,331* [6,263]	$10,583 *$14,111* [555]	$41,586 *$55,448* [6,230]	$10,051 *$13,401* [554]	$16,412 *$21,883*	$532 *$710*
Year 2: 2019/20 and 2015/16 [number of children in the cohort sample]	$73,856 [6,263]	$41,510 [555]	$54,594 [6,230]	$40,147 [554]	$19,262	$1,363
Year 3: 2020/21 and 2016/17 [number of children in the cohort sample]	$69,408 [6,263]	$64,111 [555]	$54,534 [6,230]	$50,853 [554]	$14,874	$13,258
Average costs per child per financial year when only children in the cohort sample of analysis who were in OOHC in that financial year are included to compute the average cost:						
Year 1: 2018/19 and 2014/15 (last 9 months only)[b] [number of children in the cohort sample who were in OOHC in this year]	$57,998 *$77,331* [6,263]	$23,683 *$31,577* [248]	$41,586 *$55,448* [6,230]	$20,249 *$26,999* [275]	$16,412 *$21,883*	$3,434 *$4,578*
Year 2: 2019/20 and 2015/16 [number of children in the cohort sample who were in OOHC in this year]	$78,949 [5,859]	$44,050 [523]	$57,804 [5,884]	$50,779 [493]	$21,145	-$6,729
Year 3: 2020/21 and 2016/17 [number of children in the cohort sample who were in OOHC in this year]	$81,896 [5,308]	$73,820 [482]	$61,750 [5,502]	$70,785 [398]	$20,146	$3,035

Note: a) number of children in the relevant cohort in square brackets. The sample of analysis excludes all children in residential care at the start of the observation period (either on 1 October 2014/2018 if in Ongoing Care cohort or at the time of entry for the Entry / Re-entry cohort).

b) Average costs reported in this row are for a 9-month period only, **not** a full financial year. Multiplying by 12 and dividing by 9 provides approximate yearly amounts, which are provided in the italicized amounts below the 9-month amounts.

The patterns observed for the Entry/re-entry cohorts are more difficult to interpret as these depend on the speed of inflow and outflow of children to and from OOHC over the 2.75-year observation window. Compared to children in the Ongoing Care cohort, children in the Entry/re-entry cohort have lower cost on average in most years and independent of whether all children in the cohort are included. The only exception to this is for the third year in the pre-PSP period when only considering children who were in OOHC in the relevant financial year (see row 6 of Table 7.2). The difference in the average cost for the Ongoing Care and the Entry/re-entry cohort decreases over time (and reverses in one case as just mentioned). This is due to a larger proportion of children in the Entry/re-entry cohort having entered in a previous year, so that they are more likely to be in OOHC for the full financial year instead of entering halfway through the year. In the first year, the costs for most children are for part of the year instead of the full year. In the second and third year, a larger proportion of children will be in OOHC for the full year. In addition, it may take time before packages and services are organised and paid for children who just entered OOHC. When children in the Entry / Re-entry cohort have been in OOHC for a longer period of time, they start to look more similar to the Ongoing Care cohort. Within PSP, the costs per child are expected to decrease again after approximately two years when the provision of Case Plan Goal packages ceases. However, this does not seem to have occurred to any substantial extent yet.

From the children entering OOHC between 1 October 2018 and 31 December 2020, a larger proportion remains on OOHC in the third financial year: 482 out of 555 (87%) versus 398 out of 554 (72%) for children entering between 1 October 2014 and 31 December 2016. It is not clear why children receiving PSP services would be more likely to remain on OOHC in the third financial year; the Effectiveness analysis does not reveal a significant difference in exit rates to restoration between the two groups of children. When including all children who enter over this period, there is a steady increase in the additional average annual cost per child over time in the post-PSP period as more children enter, and children have been in OOHC for a longer period of time.

After the initial financial year, the difference between the pre- and post-PSP period is smaller for the average cost when only including children who are in OOHC in the relevant year (compared to including all children in the Entry / Re-entry cohort). In the second year the average cost is even smaller for the post-PSP than the pre-PSP period. However, this seems mostly driven by the larger number of new entries in the second year of the post-PSP observation period (compared to the second year of the pre-PSP observation period), reducing the average cost when only considering children in OOHC in that year. A larger number of new entries in a year means there is a larger proportion of children who are only present in OOHC for part of that year (thus leading to lower average costs). Since fewer children exit OOHC in the third year of the post-PSP period compared to the pre-PSP period (only 43 out of 523 versus 95 out of 493), the difference in pre- and post-PSP costs is substantially larger in the third year than in the second year. This is driven by both the lower post-PSP exit rate from OOHC for the Entry/re-entry cohort as well as the slightly higher average cost for the children who remain in OOHC post-PSP.

Overall, we see a steady increase in the average cost per child per financial year over the 2.75-year observation period for children remaining in OOHC for all cohorts in Table 8.2 (see rows 4 to 6). Therefore, any reduction in average cost from one financial year to the next (and in the difference in cost between post-PSP and pre-PSP periods) seems to have arisen from a higher exit rate post-PSP for the Ongoing Care cohort.

8.2.2. Costs of pre- and post-PSP services for Aboriginal children in the sample of analysis

Calculation of post-PSP costs

An average cost per child of $207,061 is calculated for the Ongoing Care cohort for the 2.75 years from 1 October 2018 to 30 June 2021, and $121,285 for the Entry / Re-entry cohort over the same period.[132] The average expenditure per Aboriginal child is about $5,000 more for the Entry / Re-entry cohort and $6,000 more for the Ongoing Care cohort than for the overall OOHC population of children.

Using a similar approach as for the post-PSP costs for sample of analysis for all children, we have arrived at the above overall average cost by adding up several components, which are briefly described below.

Table G.10 replicates Table G.1 in Appendix E for Aboriginal children in isolation. It shows the number of Aboriginal children receiving specific PSP packages in the observation period between 1 October 2018 and 30 June 2021, again distinguishing between children in the Ongoing Care cohort and children in the Entry / Re-entry cohort. It shows clearly the very large overrepresentation of Aboriginal children in OOHC, who make up over one third of the overall sample of analysis in the Ongoing Care and Entry / Re-entry cohorts. The overall amount spent on PSP packages is just over $460 million over 2.75 years for the Ongoing Care cohort (of 2,227 children) and nearly $25 million for the Entry / Re-entry cohort (of 205 children).

As for the overall population in OOHC, “Long-term Care” is the Case Plan Goal package provided to the majority of children in the Ongoing Care cohort (2,075 children out of 2,227 children, i.e. 93% of children, receive this at some point during the 2.75 years) while “Restoration” is the main Case Plan Goal package provided to the Entry / Re-entry cohort (198 children out of 205 children, i.e. 97% of children) receive this at some point during the 2.75 years). Compared to the overall population, Restoration plays a big role for Aboriginal children especially in the Ongoing Care cohort (421 out of 2,227 children, i.e. 19% of children, versus 1,011 out of 6,263, i.e. 16% of children, in the sample with all children) while (as expected) Adoption is much less likely to occur as a Case Plan Goal (only for 22 children out of 2,227 children, i.e. 1% of children, in the Ongoing Care cohort versus 415 out of 6,263 children, i.e. 7% of children, for the sample with all children, and for none of the children in the Entry / Re-entry cohort versus 21 out of 555 children, i.e. 4% of children, for the sample with all children). The number of children receiving any Adoption or Guardianship Allowances is much smaller for Aboriginal children in the sample of analysis than for children in the overall sample of analysis.

“Foster Care” is the Baseline Package provided to the majority of children in both cohorts. Compared to the overall population of children in OOHC, Aboriginal children in OOHC are less likely to receive a general Foster Care package (1,274 out of 2,227 Ongoing Care cohort children, i.e. 57% of children, and 144 out of 205 Entry / Re-entry cohort children, i.e. 70% of children), but this is compensated through the Aboriginal Foster Care package (1,049 out of 2,227 Ongoing Care cohort children, i.e. 47% of children, and 78 out of 205 Entry / Re-entry cohort children, i.e. 38% of children), making the proportion of children receiving Foster Care similar for Aboriginal and non-Aboriginal children.

[132] This would translate to an average cost per child per year of $75,295 for the Ongoing Care Cohort and $44,104 for the Entry / Re-Entry cohort. Noting again that these annual amounts are not directly comparable to the usual annual OOHC cost per child as explained in the footnote at the start of Section 7.

Calculation of pre-PSP costs

An average cost per child of $154,243 is calculated for the Ongoing Care cohort for the 2.75 years from 1 October 2014 to 30 June 2017, and $95,568 for the Entry / Re-entry cohort over the same period.[133] Surprisingly, given the greater disadvantage experienced by Aboriginal children, the average cost per child for the Entry / Re-entry cohort is slightly higher for the overall population of children entering OOHC than for Aboriginal children entering OOHC. The average expenditure per Aboriginal child is over $6,000 less for the Entry / Re-entry cohort and about $3,500 more for the Ongoing Care cohort than for the corresponding cohorts within the overall OOHC population of children.

Using a similar approach as for the previous cost calculations, we have arrived at the above overall average cost by adding up several components, which are briefly described below.

Table G.11 in Appendix E shows the number of children receiving specific NGO services in the observation period between 1 October 2014 and 30 June 2017, distinguishing between children in the Ongoing Care cohort and children in the Entry / Re-entry cohort. This table replicates Table G.2 for Aboriginal children only. The overall amount spent on all services is just over $336 million over 2.75 years for the Ongoing Care cohort (of 2,180 children) and just over $20 million for the Entry / Re-entry cohort (of 214 children). Similar to the post-PSP numbers, Aboriginal children are overrepresented and make up over one third of the sample of analysis.

As for the overall pre-PSP sample of analysis, "General Foster Care" remains the most prevalent service provided to both the Ongoing Care cohort (1,061 out of 2,180 children, i.e. 49% of children) and the Entry / Re-entry cohort (140 out of 214 children, i.e. 65% of children). However, the proportion of children receiving care from a relative or kinship carer is higher for Aboriginal children than for other children (219 out of 2,180 children, i.e. 10% of children, versus 458 out of 6,230 children, i.e. 7% of children, in the Ongoing Care cohort), and Aboriginal children are more likely to be in Intensive Residential Care (36 out of 2,180 children, i.e. 1.7% of children, versus 77 out of 6,230 children, i.e. 1.2% of children in the Ongoing Care cohort). As for the post-PSP period, Aboriginal children are less likely to receive Guardianship and Adoption Allowances, but the difference is much smaller in the pre-PSP period due to relatively more non-Aboriginal children receiving these services in the post-PSP period compared to the pre-PSP period.

Difference between average pre-PSP and post-PSP costs per Aboriginal child

What is the average cost of OOHC services provided to Aboriginal children by OOHC providers before and after PSP was introduced?

The previous subsections discuss the full cost tables (reported in Appendix E Table G.10 and Table G.11) for the pre- and post-PSP group of Aboriginal children. Table 8.3 summarises the average costs per child for the different groups, as well as the difference between pre- and post-PSP costs per child. As for the overall sample of analysis (also included in the table for ease of comparison), the increase in resources was relatively larger for the Ongoing Care cohort (+34%) than for the Entry / Re-entry cohort (+27%), but the difference between the Ongoing Care and Entry / Re-entry cohort is not as large as for the overall sample of analysis. The larger allocation of resources to the Entry / Re-entry cohort of Aboriginal children through, for example, specific funding for Aboriginal children in the form of Aboriginal Foster Care baseline packages and Cultural Plan (Aboriginal) specialist packages relative to the allocation of resources to the Entry / Re-entry cohort of

[133] This would translate to an average cost per child per year of $56,088 for the Ongoing Care Cohort and $34,752 for the Entry / Re-Entry cohort. Noting again that these annual amounts are not directly comparable to the usual annual OOHC cost per child as explained in the footnote at the start of Section 7.2.1.

non-Aboriginal children ensures that post-PSP, more per child is spent on Aboriginal children while before PSP the expenditure per child in the Entry / Re-entry cohort was less for Aboriginal children than for non-Aboriginal children.

Table 8.3 Average cost per Aboriginal child for the period 1 October 2018/2014 to 30 June 2021/2017

	PSP		Pre-PSP		Difference (PSP cost – pre PSP cost)	
	Ongoing Care	Entry / Re-entry	Ongoing Care	Entry / Re-entry	Ongoing Care	Entry / Re-entry
Aboriginal children in sample of analysis[a]	$207,061 [2,227]	$121,285 [205]	$154,243 [2,180]	$95,568 [214]	$52,818	$25,717
All children in sample of analysis[a]	$201,263 [6,263]	$116,204 [555]	$150,715 [6,240]	$101,051 [555]	$50,548	$15,153

Note: number of children in the relevant cohort in square brackets. The sample of analysis excludes all children in residential care at the start of the observation period (either on 1 October 2014/2018 if in Ongoing Care cohort or at the time of entry for the Entry / Re-entry cohort.

As for the overall sample of analysis, for PSP to be "cost effective", the impact on Aboriginal children already in OOHC has to be larger than for Aboriginal children entering OOHC.

8.3. Benefits of Post-PSP services

Results from the Effectiveness analyses indicate that at this early stage there is evidence of a limited number of significantly improved outcomes (arising from the introduction of PSP) for children whose care is managed by NGO service providers. We use the estimated coefficients reported in the Effectiveness analysis to generate average durations up to an event or the probability of an event occurring by a certain point in time, depending on what information is available in the Benefits Guide (FACSIAR, 2022). The Hazard Ratio coefficients (and corresponding confidence intervals) are reported in Table 7.4, together with the associated impacts used to calculate benefits.

The improvement in outcomes for children receiving PSP services compared to children in the pre-PSP period (reported in Table 7.4) includes for the Entry / Re-entry cohort:

- An increase in the time to the next placement change for children in Foster Care with an additional 11.8% of children avoiding a placement change in the first year after entry in care (i.e. the proportion of children who face a placement change in the first year reduces by 11.8 percentage points).

While for children in the Ongoing Care cohort, who receive PSP services, there is

- A decrease in time to restoration with an additional 0.98% of children in Foster or Kinship care restored by the end of the 2.75-year observation period,

- A decrease in time to adoption for non-Aboriginal children in Foster Care, leading to an additional 1.47% of non-Aboriginal foster children being adopted by the end of the 2.75-year observation period, and
- An increase in time until the next Youth Justice offence is observed, leading to a reduction by 2.79 percentage points in the proportion of children for whom a justice offence occurs within a two-year observation period.[134]

Table 8.4 Estimated impacts to use in benefit calculations, based on estimated coefficients

	Estimated Hazard Ratio coefficient (95% confidence interval)		Estimated impact to be used in benefit calculation	
Outcome variable in Effectiveness analysis – variable used in benefit calculation [relevant population]	Ongoing Care	Entry / Re-entry	Ongoing Care	Entry / Re-entry
Time to next placement - change in proportion of children with a placement change in first year [children in Foster Care]	ns [a]	0.46[b] [0.37, 0.58]	ns	-11.8ppt
Time to restoration – change in the proportion of children restored by the end of the 2.75-year observation period [children in Foster or Kinship Care]	1.35 [1.1, 1.64]	ns	+0.98ppt	ns
Time to adoption – change in the proportion of children being adopted by the end of the 2.75-year observation period [non-Aboriginal children in Foster Care]	1.63 [1.24,2.14]	ns	+1.47ppt	ns
Time to next Youth Justice offence– change in the proportion of children for whom a justice offence occurs within a 2.25-year observation period [children in Foster or Kinship Care who are 10 years or older]	0.71 [0.59-0.86]	ns	-2.79ppt	ns

Note: ns indicates not significant at the 5% level and ppt indicates percentage points. Hazard Ratio coefficients are reported as estimated in the Effectiveness analyses in Section 6.

a) Only the pre-COVID model produced a small significant result, which indicated a Hazard Ratio coefficient larger than one (HR 1.24, 95% CI [1.13, 1.36]), predicting that children receiving PSP services experienced a shorter time to the next placement, which would have reduced the estimated benefits.

b) This is the Hazard Ratio coefficient for the first 125 days, The Hazard Ratio coefficient for day 126 to 250 is insignificant and larger than one, while the Hazard Ratio coefficient for day 251 to 375 is larger than one and significant. All coefficients are used to determine the impact after one year. Therefore, the percentage point change in the proportion of children with a first placement change in the first 125 days would have been even larger than -11.8ppt.

The first two effects are quite small, as only very few children exit from OOHC to these destinations. The Youth Justice effects are slightly larger but coincide with a general decline in children ending up in the Youth Justice system, so it may not be reasonable to

[134] To allow for finalisation of offences, a shorter observation period of just over two years until the end of 2016 and 2020 for pre-PSP and post-PSP respectively, is used for this outcome. As BOCSAR data are available up to September 2021, this leaves at least 9 months for the offence to be finalised and appear in the data.

attribute the full impact to PSP.[135] Furthermore, the COVID-19 pandemic is likely to have had an impact on outcomes from March 2020 onwards. Chan (2021) shows declines in the number of children in youth remand (due to higher discharges to bail) and in the sentenced custody population with fewer cases being finalised in the Children's Court. We can make alternative assumptions around this to assess the impact on estimated benefits due to PSP.

For children in families who received a Family Preservation package, the negative impact of a near-significant decrease in the time to the next ROSH report for a child in the family is observed. Although not significant either, further negative impacts on outcomes are that the time to entering OOHC and the time to the next non-ROSH report are both estimated to decrease as well. As the number of Family Preservation packages provided is small, the sample on which to estimate the impact is small as well resulting in effects being estimated imprecisely, so that small effects may not be detected.

In the following subsections we use the Benefits Guide (FACSIAR, 2022) combined with the difference in "survival" probabilities before one of the events mentioned above occurs for children receiving PSP versus children not receiving PSP to estimate the above avoided costs. These survival probabilities are derived from the estimations in the Effectiveness analysis.

8.3.1. Benefits for the Entry / Re-entry cohort

Fewer placement changes are a desirable outcome; thus, an increase in time until the next placement change is a good outcome.[136] The estimated effect for children in Foster Care is quite substantial. If we translate it in the expected duration until the first change in placement occurs (limiting our observations to the first year), this increases from just over 285 days before PSP was introduced to just over 327 days after PSP was introduced. Alternatively, we can express it as just over 30.2% of children experiencing a placement change in the first year pre-PSP compared to 18.4% post-PSP.

If we assume that the placement change was a negative change, we can apply a $11,082 benefit of avoiding one negative placement change (FACSIAR 2022: p.81) for 11.8% of all children, leading to an average net present value (NPV) benefit of $1,307.68 per child in Foster Care. This is the expected benefit to government in terms of avoided future cost of higher levels of service.

8.3.2. Benefits for the Ongoing Care cohort

Part of the benefits from a decreased time to restoration and adoption are already reflected in the reduced costs of PSP packages which are paid over a shorter period of time due to slightly earlier exits. In the case of adoption, a lower Adoption Allowance may be paid instead of for example Foster Care Allowances. However, in addition to the reduced costs during the 2.75 years of the observation period, further benefits can be expected in

[135] The number of children who end up in the Youth Justice system went from 3.3 per 10,000 in June 2016 to 2.6 per 10,000 in June 2020, a decline of more than 20% (AIHW, 2021). This decline is part of a longer-term decline in offences in NSW, especially among young people, as noted by Trimboli (2019). Donelly et al. (2021) note the decrease in the number of Aboriginal children being proceeded to court by police between 2015 and 2019 which leads to a reduction of the number of Aboriginal children in custody.

[136] The negative impact of a placement change is confirmed when estimating the probability of high school completion in the effectiveness analysis. We do not find a significant effect of receiving PSP on high school completion, but having had a placement change in the previous year significantly reduces the probability of completing high school.

future years if these children do not return to OOHC. We again use the Benefits Guide (FACSIAR, 2022) to estimate these future benefits.

Exit to restoration

The Benefits Guide (FACSIAR 2022: p.80) estimates an avoided cost to the government of $335,431 (per lifetime) per child in Foster or Kinship Care who is successfully restored. If we assume that the additional 0.98% of children restored by the end of the 2.75-year observation period for this evaluation remain out of OOHC, this would lead to an average NPV benefit per child of $3,287.22.

Exit to adoption

Similarly benefits arise if a child in Foster Care is successfully adopted. The Effectiveness analysis estimates that by the end of the observation period of 2.75 years an additional 1.47% of children have been adopted. If, given the same value of the allowance for guardianships and adoptions, we make the reasonable assumption that the benefits arising from this are the same as for a successful transition to a Guardianship, we can use the estimated NPV benefit of $231,305 per child per lifetime (FACSIAR 2022: p.79). This would lead to an estimated NPV benefit of $3,400.18 per child.

Reduced Youth Justice offences

The benefits associated with the reduced proportion of children who have had a Youth Justice offence by the end of the observation period vary substantially depending on the exact nature of the offence and subsequent justice actions. There was a reduction in the probability of a justice offence occurring within the two-year observation period. From pre-PSP to post-PSP, there has been a reduction by 2.79 percentage points in the proportion of children experiencing such an event.

The costs of a Youth Justice offence vary substantially depending on whether the child needs to appear in court or not, and on what type of penalty is received. Imprisonment carries a high cost, but this is a rare event according to the data, with less than five children receiving this penalty in the pre- and post-PSP group of children. Post PSP, any of the penalty types occur in very small numbers only which cannot be modelled separately. Except for imprisonment, most penalty types are relatively low cost. Therefore, we do not include the avoided cost of these in the benefits calculations.

From the information in the Benefits Guide, it appears that another of the more costly aspects of an offence occurs if the child has to appear in court. The available data allow us to assess in a descriptive way the number of children having to appear in court (including in which type of court), so we use this to estimate a reduction in cost due to fewer children having to go through this process in the post-PSP period.[137]

Based on the Youth Justice data, we observe a reduction in the proportion of children in our sample going through court by 2.52 percentage points from 4.87% of children in the pre-PSP period appearing in court to 2.36% of children in the post-PSP period. The Benefits Guide (FACSIAR 2022: pp.96, 95, 97) provides estimates of the cost of different types of court appearances for youth, including Children's Court at $12,819, Local or Magistrates' Court at $12,879, and District Court at ($24,114). None of the children are observed in the Supreme Court. The costs are per criminal finalisation and encompass Court costs, Office of the Director of Public Prosecution costs and Police costs. Using the observed number of appearances in the different court types, the avoided costs can be calculated. The average

[137] The outcome of having to appear in court is not included in the multivariate analyses of the Effectiveness Evaluation as the number of cases is quite small. We use it here to make an informed guestimate of the avoided costs of Youth Justice offences.

pre-PSP cost per child was $643.48 and the average post-PSP cost per child had reduced to $306.46. Thus, the benefits due to avoided court costs are estimated at $337.03 per child.

For the children not going through Court, we observe the number of police cautions (costed at $461 per caution), and the number of Youth Justice Conferences (costed at $835 per child attending) (FACSIAR 2022: pp.86, 94). Combined, the average cost per child is $19.83 during the pre-PSP period and $23.84 during the post-PSP period. This reduces the per child avoided costs by $4.01.

There may be other avoided costs (for example, due to increased safety within communities) associated with a reduction in Youth Justice offences on which we have no information. This would mean $333.02 in avoided cost per child is an underestimate, but as mentioned in the introduction, some of the reduction in juvenile offences appears to be due to a broader downward trend in New South Wales and other jurisdictions (i.e., not due to PSP), which would mean the above is likely to be an overestimate.

The above avoided costs also do not incorporate the costs to the child of having a Youth Justice record. As a result of such a record, there would be likely to be longer-term consequences: e.g., they would be likely to complete less education and be less likely to be employed in adult life.

8.3.3. Benefits from Family Preservation

None of the estimated effects potentially arising from receiving the Family Preservation package are significant. As a result, from the evidence currently available there are no benefits arising from the expenditures on family preservation packages.

8.3.4. Sensitivity to alternative assumptions

Compared to the overall difference between pre- and post PSP costs, the benefits calculated in sections 7.3.1 to 7.3.3 are relatively small to non-existent. As a result, any reasonable variation in the key assumptions made to compute these benefits is unlikely to make a sufficient difference to change any of the conclusions based on these early results. For example, even if the impacts were (an unreasonable) 50% larger than the estimated impacts, or if the benefits reported in the Benefits Guide would be 50% larger (e.g. if using a 3% discount rate instead of the standard 7% discount rate for future benefits/avoided costs), it would not make a material difference for the conclusions drawn from the results.

8.3.5. Limitations

For several reasons there are important limitations to the monetisation of benefits arising from the introduction of PSP in this evaluation.

A first limitation is the short amount of time since PSP was introduced that is available for the evaluation of PSP in this report, combined with the complexity of introducing PSP. Implementation was further complicated due to the COVID pandemic.

A second limitation is the lack of information on education, health (physical and mental) and wellbeing outcomes of children in OOHC. We have no information on health or wellbeing at all, and only limited information on education. Due to COVID, the usual NAPLAN tests were cancelled during the year's most relevant to this evaluation. Providing children with continued education has also been more challenging than usual with children being required to learn from home. This is likely to be more of a disadvantage to children with difficult family/home circumstances.

Longer-term data on health, wellbeing and education outcomes would provide important additional information on the potential impacts of PSP.

8.4. Discussion

Is PSP a more cost-effective way of administering the child protection system in NSW than the pre-PSP usual service provision? Do the benefits of PSP, measured in terms of estimated savings based on immediate and some future consequences of a change in the duration to certain outcomes, outweigh the costs to government of providing PSP services?

In terms of the costs and benefits that have been estimated in this evaluation, the costs are much larger than the benefits so far, with relatively modest impacts estimated on just a few selected outcomes. This leads to benefits-costs ratios (BCRs) that are all well under one. For children in Foster care in the Entry / Re-entry cohort, the BCR is 0.086 assuming that the average cost for them is the same as the average cost for all children in the Entry / Re-entry cohort which is reasonable given that most children in PSP are in Foster care. For Foster children in the Ongoing Care cohort, the BCR is 0.132 which increases to 0.139 for Foster children over 10 years of age if we assume that the reduced Youth Justice costs are all due to PSP. Given the longer-term trend in reduced Youth Justice offences and potential COVID impacts, this assumption seems unreasonable. For children in Kinship care in the Ongoing Care cohort, the BCR is 0.065 (which increases to 0.072 for children over 10 years of age if including the avoided Youth Justice costs). Finally, with no significant benefits estimated for Family Preservation, its BCR is 0. This indicates that the average costs outweigh the average benefits for all cohorts evaluated in this report.

However, given the limitations mentioned in the previous subsection, these BCR values need to be interpreted with caution. The period of observation was relatively short-term and several potentially important outcomes on health, wellbeing and education could not be included in the benefits calculated in this report. In addition, the limited information we had on education was affected by the COVID pandemic which meant the NAPLAN testing did not go ahead in the years that were crucial to this evaluation. Furthermore, available education outcomes on high school completion may have been negatively affected by the pandemic, and any negative impacts are likely to have been the largest for the most disadvantaged groups in society including children in OOHC.

Education, health and wellbeing outcomes are relevant in their own right, but in addition they are also likely to feed into future outcomes. For example, a child that is healthy and happy is more likely to do well at school, complete Year 12 and continue in further education. Improved education outcomes are known to lead to better life outcomes well into the future. The estimated benefits associated with improvements in education as reported in the Benefits Guide (FACSIAR, 2022) indicate that such improvements can lead to substantial savings over a lifetime. Achieving such improvements for a large proportion of young children could lead to very substantial savings to the Government in terms of reduced income support payments, health services costs and crime, and additional revenue in terms of income tax, as well as being likely to lead to much better future life outcomes for children leaving OOHC.

In the short amount of time since PSP was introduced, it may have been unlikely to see concrete improvements in education or physical health. However, if PSP managed to achieve more stability in terms of children’s home environments, children’s wellbeing may have improved. Unfortunately, no measure was available to gauge this. As a result, the monetised benefits in this section do not include the (hopefully) improved wellbeing of children.

Finally, the costs of PSP included in this evaluation are the costs over a 2.75-year period. The costs of PSP computed in this evaluation do not include the cost of Alternative Care Arrangements, so if this excluded cost is substantial, the overall costs presented here would be underestimated. For the children in the Ongoing Care cohort, it seems reasonable to assume that this this total cost over 2.75 years covers the majority of additional cost associated with PSP, where additional services to achieve permanency are provided over a time-limited period of two years. Without the additional services to achieve permanency, the post-PSP costs can be expected to be similar to the pre-PSP costs. For example, the PSP Foster care package has a slightly lower annual cost associated with it than expected (of about $4,000 per year less) if extrapolating the pre-PSP Foster care payments using the annual percentages of fee increases. Combining the PSP Foster care package with the Child Low Needs package would result in a slightly higher cost (of about $800 more) compared to pre-PSP Foster care.

However, such a reduction in the average cost per child for the children remaining in OOHC after 2.75 years has not been observed yet. Instead, we see a steady increase in the average cost per child over the 2.75-year observation period for children remaining in OOHC for all cohorts (see Table 8.2). So far, any reduction in average cost from one financial year to the next (and in the difference in cost between post-PSP and pre-PSP periods) seems to have arisen from a higher exit rate post-PSP for the Ongoing Care cohort.

With available data limited to the first 2.75 years at the start of the PSP implementation, what will happen in one or two more years is still not clear. This is particularly true for the Entry / Re-entry cohort which is much smaller than the Ongoing Care cohort and where children entering between October 2018 and December 2020 are considered in the evaluation so that this cohort has had shorter post-PSP time in OOHC, on average. If we were to limit this cohort to the children entering PSP in the 2018/2019 financial year (so that we can observe them for at least two years) we would be left with just 251 children (instead of the current 555) for the evaluation. This sample size would be too small for most of the Effectiveness analyses.

Besides children leaving OOHC (more quickly) through restoration, adoption or guardianship, another possible impact of PSP through the provision of additional support services early on in the OOHC episode could be to reduce the level of need of children remaining in OOHC later on. This could for example mean that instead of needing residential care, more children could remain in Foster care post-PSP, reducing the cost per child.[138] To determine whether this occurs, children receiving PSP services need to be followed for a longer period of time, and the comparison group would need to be selected from earlier years (before the current starting point of October 2014) to allow a longer period of time before PSP is introduced for the children in the comparison group as well.

To the extent that such lower need levels are already occurring in the first 2.75-year observation period, any corresponding lower cost would already be reflected in the cost calculations in this report.

[138] Appendix E Table G.1 to Table G. G.7 provide some evidence that this may already be occurring to a modest degree, with a slightly smaller proportion of children living in residential care by the end of the 2.75-year observation period in the post-PSP period than in the pre-PSP period.

Part seven

Further implementation considerations for PSP

9. Further implementation considerations

Key takeaways

The failure to achieve positive outcomes for children through PSP is related to implementation barriers associated with PSP's funding and operating model that appeared to inhibit PSP service providers' ability, in conjunction with DCJ districts, to achieve positive outcomes and result in substantial unintended impacts. The barriers also limited the extent to which PSP's funding model was able to incentivise the achievement of positive child safety, permanency and wellbeing outcomes.

The PSP funding model is not sustainable. The costs of PSP are much larger than the benefits so far and it is not clear, using the current data, this will change in the future. The social and financial sustainability of PSP is limited by wider system inefficiencies in line with many of the key findings from the Tune report (2016). To improve the sustainability and cost-effectiveness of PSP, the NSW government will need to address a set of barriers associated with the NSW's child protection and OOHC investment approach, the service and care continuum, and PSP operating model and cultural norms.

To achieve PSP's objectives in improving children's wellbeing, safety and permanency outcomes, and reducing the number of Aboriginal children in care, PSP will need to embed regular feedback processes on PSP services across PSP service providers and use this to address barriers, in conjunction with strengthening the child protection and OOHC system's ability to systematically develop and implement evidence-informed practices across the care continuum.

9.1. Introduction

Achieving sustainability in complex systems is an ongoing process of monitoring, adaptation and improvement to find an optimal fit between PSP, PSP service providers, DCJ and the wider system. The purpose of this section is to evaluate how sustainable PSP is in its current state and how it can be improved. In doing so, we draw on all components of the evaluation including the findings and recommendations from earlier reviews and reforms of NSW's child protection and OOHC system, the objectives and mechanisms which underpin PSP's design and implementation, and all evaluation findings. The section considers the suitability of the design of PSP, the external factors impacting the delivery of PSP, the unintended impacts associated with PSP, and the validity of the assumptions underpinning the design of PSP (see section 2.2.4: Mechanisms of change and assumptions underpinning the design of PSP) to assess the overall sustainability of the PSP funding model.

9.2. Results

9.2.1. If permanency outcomes are not being achieved, is it due to: the design of the PSP funding model, or a broader issue either within DCJ or PSP providers or both?

In summary, the failure to achieve positive outcomes for children through PSP is related to the interaction between all three factors – poor design of the PSP funding model, and challenges within, and between, DCJ and PSP providers. This finding is evidenced using data from the case reviews (n = 74), PSP service provider focus groups, DCJ focus group and interviews and ChildStory data. It is important to recognise that PSP service providers manage a very diverse range of cases in terms of the characteristics of children, their carers, their birth family, paired with different case objectives, beliefs and preferences, level of trust, level of engagement and level of cohesion with the birth families and carers. This is coupled with each PSP service provider and DCJ districts having different levels of knowledge, experience, capacity, ways of working, and priorities, which evolved since PSP was first introduced. This creates vastly different case conditions, requirements, and challenges for PSP service providers to manage as part of case management, casework, and service delivery, which are likely to affect the achievement of permanency outcomes and consequently the type and importance of the issues which emerge. The findings below are categorised according to the main themes identified as the reasons for permanency outcomes not being achieved[139].

Theme 1: Cases where legal permanency is not considered an appropriate priority

A large proportion of cases in PSP during the observation period had a permanency case plan goal of long-term care (refer to Reach findings in section 5), which implies that the main objectives of casework and services delivered was not (legal) permanency at the time the permanency case plan goal was set or reviewed and that no (legal) permanency outcome was achieved for these cases. In some cases, it appeared that long-term care was

[139] Permanency outcomes described as not achieved does not imply that legal permanency will never be achieved in a case, only that legal permanency had not been achieved at the time a case was being considered. Cases were considered either by the PSP service providers and DCJ staff discussing cases during interviews and focus groups or during the case review for the cases reviewed.

considered the most suitable goal temporarily while PSP service providers focused on other case plan goals considered more important and necessary to being able to pursue (legal) permanency. The type of challenges observed as reasons for not prioritising permanency related casework included:

- Placement was not stable
- Recent placement breakdown
- Current high level of need and lack of support network for potential permanent carer or parent
- High level of need of the child
- Carers not wanting to obtain legal permanency as they do not see a benefit.

In some cases, long-term care was considered to be the most suitable permanency case plan goal for a child until they aged out of care. The type of reasons identified in the cases reviewed for this decision were:

- Ongoing level of need of the child
- Young person is close to leaving care
- Carers in current placement do not believe legal permanency is in the best interest of the child or in their own best interest (e.g., carers do not want to stop receiving agency support)
- Agency believes permanency placement will require ongoing agency support (in the case for example of existing disability or health conditions).

The cases reviewed consistently showed that in the cases where legal permanency was not considered an appropriate priority PSP service providers focused on achieving relational and physical permanency, as well as cultural permanency for Aboriginal children. Cultural permanency appeared to be in important focus in some cases with CALD children, but the case review also identified cases where this was not the case. While only a small number of CALD cases were reviewed, some factors observed as impacting cultural permanency for CALD children of cases reviewed were: the lack of desire or reluctance to explore culture expressed by parents and children and limited access to the child's community and cultural knowledge. The achievement of relational (e.g., reconnecting with family members) and cultural (e.g., children reporting being connected to cultural, regular contact with member of their community) permanency outcomes, which are not captured in the quantitative data, were commonly observed in cases reviewed. Some examples of these outcomes include:

- A close relationship maintained between a carer and young person who aged out of care after a placement breakdown due to the carer's difficulty in coping with challenging behaviours over time.
- Children reconnected with family members after extended periods of no contact.
- Most commonly, young people with long-term care arrangements staying with their carers after turning 18 because carers expressed that the young people were part of their families and that they were committed to them.
- Children reporting feeling connected and proud of their culture .
- Establishment of stable and regular contact focused on learning about culture between children and members of their communities with a family member or mentors.

Theme 2: Cases where legal permanency is considered an appropriate priority

As described in the Permanency Case Management Policy, permanency casework is planned and delivered according to completing steps (e.g., consulting all families) and reaching and documenting milestones (e.g., completion of assessments) that need to be met to progress toward permanency. Overall, the case review highlighted that the steps involved in achieving permanency are not completed according to set timeframes. In some cases reviewed, the delivery of permanency planning and casework required to achieve a permanency outcome appeared relatively straightforward. Across these cases the number and complexity of barriers to address appeared minimal and it was common for some milestones to already be partially completed before permanency goals were set. We observed in the case review that these cases were commonly characterised by the following characteristics:

- The current placement has been stable for a long time or a large part of the child's life.
- Child, family members, PSP service providers and DCJ agree that the current placement meets the needs of the child and represents the best permanent outcome for the child.
- Frequent and regular family contact is taking place through established and independent relationships between the child, carer, and family members.

In cases where PSP service providers and DCJ prioritised the achievement of a legal permanency outcome, it was consistently reported by DCJ representatives and PSP service providers that they face varying levels of complexity across the different steps required to achieve (legal) permanency outcomes. The following components of permanency planning, casework and support work were identified, through the case review, as important 'steps' which commonly vary in complexity: identifying the more appropriate permanency goal, permanency planning, providing permanency support, putting together sufficient evidence to document the appropriateness of the permanency outcome being pursued in line with requirements from DCJ and the Children's Court, and completing the court processes including drafting court documents.

The permanency planning and casework delivered to identify the most appropriate permanency goal, conduct permanency planning, and provide permanency support, in line with legislated placement principles, is delivered by PSP service providers with support from DCJ. The following factors were consistently identified across the cases reviewed and by PSP service providers and DCJ representative as impacting the nature, quantity, complexity, appropriateness and effectiveness of the permanency planning and casework delivered by PSP service providers and consequently whether permanency outcomes were achieved:

- The completeness of family history and knowledge available to PSP service providers
- Differences in opinions over what the most appropriate permanency goal or what should be considered as part of permanency planning were common in the cases reviewed and could involve disagreements between any of the following parties: children, family members, carers, non-family member support network, PSP service providers, DCJ representatives, Child's Court and the practitioners consulted.
- The number of family members and professionals to be consulted.
- The number of individuals being considered as potential permanent carers.
- Lack of clarity over the split of responsibility and decision-making powers between DCJ and PSP providers.
- Inconsistent level of involvement and decision making across cases from DCJ.

- DCJ capacity constraints impacting provision of case management oversight, permanency specialist support, risk and child need assessments, and case plan review and monitoring activities.
- Whether the permanency planning and casework was guided by appropriate, structured, and embedded processes aligned with the permanent placement principles and evidence-informed frameworks and practices.
- PSP service provider capacity constrains slowing down the completion of the casework planned.

Some cases required extensive casework from PSP service providers to consult all family members and demonstrate that sufficient and appropriate casework was undertaken to identify the most appropriate permanency goal and guide permanency planning. For example, DCJ generally recommends the PSP service provider organise family group conferencing to facilitate and demonstrate family-led decision making and to foster the development support networks before identifying the most appropriate permanency arrangements. While family group conferencing is a common practice across cases, the casework required to organise a family case conference varied substantially. In several cases reviewed, PSP service providers had to undertake extensive family finding activities followed by contacting newly identified family members who were not yet aware of the existence of the child, which in turn could lead to additional family members being identified. Additionally, PSP service providers regularly needed to consider and adapt to complex family dynamics and relationships, including:

- History of domestic and family violence and abuse between family members.
- Distress experienced by family members as a result of the casework to be completed.
- Conflict between family members (e.g., contested adoptions).
- Family members being incarcerated.

PSP service providers commonly reported that their ability to achieve permanency outcomes within two-years was related to delays in the permanency process. Even cases that progressed well towards permanency experienced delays. It was widely reported across DCJ representatives, PSP service providers and in the cases reviewed that the cases which progressed well toward permanency commonly faced significant delays throughout the gathering of evidence, preparation of court documents and assessments, and the court proceedings. The factors identified as key contributors to the frequent delays impacting the later stages of permanency work include:

- PSP service provider not being familiar with the process to be followed and tasks to be completed during the process.
- DCJ capacity constraints impacting provision of case management oversight, permanency specialist support, risk and child need assessments, case plan review and monitoring activities and preparing legal documents.
- Low level of ongoing involvement and support from DCJ.
- Lack of clarity over split of responsibility between DCJ and PSP providers.
- Lengthy legal process related to, for example, DCJ recommendations being contested in court and administrative challenges.

> *'No matter how much practice change we're doing on the ground and how many goal changes were doing, the barrier of the court remains the biggest barrier to us getting our exits and our outcomes of permanency for children'*
>
> *– DCJ representative*

Across the 74 cases reviewed we commonly observed challenges with achieving permanency outcomes which appeared linked to at least multiple and at times many of the factors described above. Due to the large number of factors identified, our analysis does provide insight on the relative importance of the different factors regarding their perceived impact on permanency outcomes.

Are the necessary supports provided to agencies adequate?

The level of support provided by DCJ varied district by district and case by case and similarly the level of support required varied across PSP service providers and cases. As a result, the nature and the intensity of the support necessary to ensure all the PSP functions are delivered appropriately needs to be considered for all PSP service providers.

PSP service providers faced a different set of barriers and enablers affecting their ability to foster a strong and long-lasting connection between the child and their birth family and culture, to improve child wellbeing and to ensure child safety across different cases associated with the permanency goals being pursued, depending on the characteristics of the case and challenges that emerged through the case. To improve outcomes across a large number of cases, DCJ needs to develop a stronger understanding of the barriers and enablers which emerged across the range of different cases and situation. This understanding can only be gathered by completing and consolidating frequent holistic reviews of open and closed cases with the perspective of the different individuals and agencies involved in the case.

The functions identified as least well supported in the cases reviewed were:

- Crisis and risk management including avoiding incarceration or placement breakdowns.
- Overseeing and supporting the delivery of health, educational and community services. A large portion of PSP funding was used to fund and case manage these services, taking resources away from the provision of family and community services which PSP providers were also expected to deliver
- Coordination across the care continuum
- Information gathering on siblings and managing sibling contact across agencies. PSP providers have limited and inconsistent access to data on siblings and limited ability to arrange sibling contact.

Aboriginal case studies of PSP experience

Perceptions of PSP service providers

In the three Aboriginal case study sites, caseworkers/managers stated that, while they worked closely with families and established a rapport with them, they perceived that DCJ was dismissive of issues they raised about cases and that the Department had power to make decisions about families that the PSP provider should be making. Additionally, while Aboriginal Permanency Coordinator roles were in place and highly valued, they are not always filled.

Are the packages fit for purpose?

In this section, we consider findings related to the acceptability and suitability of PSP packages in facilitating the casework and service delivery required to achieve children's permanency. We draw primarily on findings from the case reviews, supported by PSP service provider focus groups, Aboriginal case studies and ChildStory data to identify the scenarios and casework requirements which do not appear to fit well within the current PSP package structure. These are described below:

Case plan goal packages

- There are substantial differences in case complexity and casework requirements driving the amount of casework required to conduct permanency planning. This is especially true for cases involving Aboriginal children, which require more extensive family finding and family consultation.

Baseline packages

- Kinship care is included as part of foster care. However, the nature of the casework required to support kinship care arrangements appears to be consistently more complex and time intense. This was founded across both kinship cases managed by ACCOs and the small number of kinship cases reviewed not managed by ACCOs. Creating a kinship care baseline package would allow DCJ to tailor its business rules, service requirements and funding to kinship care specificities.

Level of need

- The funding allocation based on level of need relies on a child needs assessment (CAT) outcomes of either low or medium. This effectively provides a two-unit scale, which is not nuanced enough to capture meaningful differences in level of need observed across cases. This results in insufficient funding flexibility to enable casework and services that adequately match a child's needs level.
- We note many cases were classified as low need, even where a child appeared to have significant physical, mental and behavioural conditions.
- CAT re-assessments are rare and appear to come only after a placement is considered at risk.
- Level of need can change quickly and drastically and this is not easily managed through this package type.

Specialist packages

- While the 4+ Sibling package focuses on the provision of items and support for permanency placement, PSP service providers undertake a significant amount casework to keep siblings connected including gathering historical information, engaging with other PSP service providers, and facilitating family time. In most cases reviewed, the children had multiple siblings who were not in their placement and their siblings (if in OOHC) where generally not managed by the same PSP service provider. As a result, facilitating relational permanency in the context of sibling relationships, frequently appeared to be time intensive and impractical for PSP service providers and even

outside of their sphere of influence. These challenges did not appear to be addressed adequately within the PSP packages or through DCJ support.

- Even though cultural planning and support is provided in baseline package costs, we noted both PSP service provider focus groups and the Aboriginal case studies identified a need for further funding in this area because it was not sufficient to meet the level of casework required when children have limited connection to their family and culture.
- The Additional Carer Support (ACS) package, a package introduced in 2019, appears to have addressed a funding gap where carers require additional support.
  - The package did not appear to be allocated consistently across cases, where some cases appeared eligible (having similar characteristics to another case receiving ACS) but did not receive it.
  - In certain instances where the carer faced very challenging circumstances the package is unlikely to be enough to support the carer. This included placements where children require full time supervision and the carer was not able to work.

Family Preservation

- Our ability to assess the acceptability and suitability of the family preservation packages was very limited due to not being able to include them in the case review and to the very small number of family preservation packages provided.
- In line with the findings that family preservation packages had very limited reach across the PSP cases, at all three Aboriginal case study sites, community members and case workers/managers strongly called for more funding and time to work on family preservation. This was considered by them to be vital to preventing high numbers of Aboriginal children being taken into care, yet they were restricted in the support and attention they could direct to this phase due to limited funds.

Package coordination

We identified several challenges with package coordination, across all data sources, including:

- Some packages are not allocated consistently, especially cultural packages which appear to be allocated in some instances but not others for cases with similar characteristics.
- ChildStory is not consistently updated with package information and it is at times unclear to agencies and permanency coordinators whether a package is being received.
- The PSP service provider focus groups and the Aboriginal case studies found there were bureaucratic challenges in accessing packages.
- More coordination from districts would ensure packages are distributed more consistently.

Are some PSP providers performing better than others in achieving outcomes and what has contributed to this?

We used data from the case reviews, supplemented by PSP service provider focus groups and Aboriginal case studies, to qualitatively identify areas where there appear to be differences in capacity and capability across PSP service providers. Note this approach did not allow us to compare PSP service provider performance. We identified differences in size, area of expertise, prior experience with the different permanency planning and casework, internal capacity to deliver services, location and cultural competencies (i.e., ACCOs) across PSP service providers which appeared to affect their capacity and abilities to delivery different type of services and casework. The observed differences are:

- Larger PSP service providers and PSP providers who deliver a broad set of community services, including services provided by health and behaviour professionals, can reduce their reliance on external services and this appears to reduce the cost and waiting times associated with delivering services.
- ACCOs had noticeable expertise with regards to delivering culturally safe case management practices, cultural programs and learning materials, cultural mentoring and fostering trusted relationships with Aboriginal children and family members.
- Providers with prior experience in delivering guardianship and adoption services had a stronger understanding of the permanency planning, permanency casework and legal processes and the use of parallel planning.
- PSP providers specialising in intensive care were best able to meet the needs of children with complex needs.

These observations suggest there are benefits associated with enabling PSP providers to specialise in delivering some services or programs themselves.

The Aboriginal case study sites revealed a diversity of experiences with PSP service delivery by Aboriginal children, their birth parents and carers. For those who were more satisfied with the level of service provided by PSP service providers, key factors affecting satisfaction appeared to be: having engaged and supportive caseworkers (i.e., who are available when needed, who listen, are responsive to queries, and know what is going on with the child); parents being informed and involved in decisions being made for their child; birth parents receiving family preservation or restoration support; children being assisted to plan for the future (e.g., educational and employment goals); children being supported in cultural planning and implementation; children having access to needed educational and medical services; and children being engaged by caseworkers in fun activities. In contrast, Aboriginal children, parent and carer satisfaction with service delivery tended to be lower where: there was high turnover of caseworkers; children's needs for therapeutic support for trauma and abuse were unmet; children's desire for connection to family members and culture was not supported; parents felt unsupported by caseworkers in their efforts for restoration. In the case study sites, ACCO PSP service providers appeared to be performing better in delivery of these services than the non-ACCO provider.

9.2.2. What are the unintended impacts (if any) in delivery of PSP?

We addressed this question using data from the case reviews, PSP service provider focus groups and DCJ focus group and interviews.

One unintended impact of PSP, perceived by some PSP service providers, is that the focus on permanency embedded within PSP and its payment structure can operate at the expense of specific groups of children. Specifically, PSP service providers believe PSP has resulted in fewer resources being available for children with permanency goals of long-term care, despite the often, high needs of these children, and the large numbers of children in this category. This impact was described as particularly noticeable when PSP was first introduced and there was a high level of uncertainty about what PSP meant for children who had already been in long-term care for some time. Another other group identified as being disadvantaged by PSP's focus on permanency are siblings due to perceived tensions between keeping siblings together and pursuing different permanency goals within the two-year timeframe. Similarly, numerous gaps in support were identified for young people who self-place.

Another perceived unintended impact associated with increasing the focus on permanency through restoration, guardianship and adoption is that it takes place at the expense of

appropriate case planning and casework. This was particularly clear in cases where wellbeing, safety and placement stability require significant attention. For example, some PSP service providers in the focus groups described a pressure to pursue guardianship where they did not see this as appropriate. Similarly, PSP service providers described the reclassification of permanency case plan goals to restoration without necessary 'pre-work', when PSP was first introduced, as a key contributor to the low number of permanency goals achieved within two years of setting a permanency goal. Some PSP service providers linked what they assessed as the premature pursuit of legal permanency with further complexity being added to already challenging cases. Another mechanism identified was linked to the permanency case plan goal reviews[140] between DCJ and PSP service providers, which are designed to focus on permanency outcomes. These reviews were consistently observed, by PSP service providers, DCJ representatives and within the cases reviewed, as a potential source of essential and valuable support from DCJ to PSP service providers for cases where pursuing legal permanency was regarded as an appropriate priority. However, these reviews were also commonly characterised, by PSP service providers and in the cases reviewed, as much less helpful and at times detrimental for cases where prioritising legal permanency was not assessed to be an appropriate priority. One scenario observed in a number of cases reviewed where this phenomenon was identified is PSP service providers being asked to focus on finding carers open to guardianship during permanency case plan goal reviews concerning cases where placements were repeatedly breaking down due to carers not being able to cope with the children's needs, instead of prioritising finding a placement where the children's needs could be met.

'I think sometimes that it's 'let's go down a guardianship pathway' because essentially that's one less Aboriginal kid as a number in the care system, but is that guardianship option really in the best interest of that child?'

- PSP service provider focus group

Overall, it appears that the potential effect (either positive and negative) of setting primary goals for each case and conducting collaborative case reviews where DCJ shares their expertise, provide support and makes recommendations is largely affected by how suitable the goal prioritised is perceived to be. This suggests that the potential benefits of this approach could apply to a larger proportion of cases if the primary focus shifted between wellbeing, safety and permanency outcomes, in line with the circumstances of cases.

An increase in administration, data entry and compliance tasks at the expense of practice-related work or a focus on evidence-based services for both DCJ and PSP service providers was also identified as an unintended impact. This impact was recognised by both PSP service providers and DCJ representatives, who both identified the focus on permanency goal classifications, applications for funding packages and a layered review process as causes.

'The whole process is overly bureaucratised or heavily burdened around all these approval of people that don't really know anyway. I

[140] The minimum requirements governing how frequently permanency case plan goal reviews needed to take place for each different permanency goal changed in December 2021

wouldn't say tokenistic, but it's almost like checks and balances for no purpose other than to have checks and balances.' –

DCJ representative

PSP service providers commonly expressed that the increase in administrative work for caseworkers came at the expense of family visits and relationship-building with clients. In addition, PSP service providers described capacity-building within their financial and administrative sections in order to meet the compliance drive aspects of the system.

'The administrative work has increased quite a bit and … it has come … at a price … I'm not spending half as much time with my children as I did in the past' –

PSP service provider focus group

The changes in roles and responsibility brought on by PSP, especially the allocation of primary parenting responsibility to PSP service providers before final orders are granted, increased PSP service provider's involvement with court processes. This was observed consistently by DCJ representatives, PSP service providers and within the cases reviewed as creating substantial process inefficiencies and consequently unintended increases in workload for by PSP services providers and DCJ. These process inefficiencies were attributed a range of factors including duplication of work, lack of clarity over the level of responsibility retained by DCJ and limited access to legal and permanency expertise throughout permanency planning. For example, DCJ casework and legal staff who are responsible for meeting statutory requirements including drafting court documents such as final case plans and affidavit no longer have access to the case notes and documents their documents are based on. This means that the PSP services providers are required to provide DCJ staff, who have generally had limited involvement with the case prior to drafting the court documents, with all the information that needs to be included. This process often appeared very time consuming for PSP service providers, DCJ staff and the parents and carers involved, when observed in the cases reviewed.

'We still see some great collaboration but sometimes it's, "You guys have case management. We're not going to speak to you until we need something" or it's, "Well, no you can just do this and we'll do all of this." Which might be no confidence in the agencies. It might be a breakdown of relationships.' –

DCJ representative

One of the unintended impacts attributed to the introduction of PSP observed mainly by DCJ representatives is a reduction in DCJ's ability to match children to carers quickly or in cases of emergency. As part of PSP, DCJ stopped maintaining its own pool of carers and relied on PSP service providers to provide suitable carers as required in their PSP contracts. This has not worked as intended because ChildStory was not able to facilitate and monitor the referral process in line with the planned process and PSP service providers have struggled to recruit carers required to meet their contracted number of placements.

Other potential unintended impacts of PSP identified in the PSP service provider focus group include the increased staff turnover possibly due to increased workload and greater difficulty with recruiting carers from the changes to financial plans. The increase in contact with carers who were involved prior to PSP has also led some carers to feel they are being monitored or scrutinised.

We did not identify any unintended impacts in delivery of PSP from the Aboriginal case study sites.

9.2.3. Does the new payment structure within the Program Level Agreements provide an incentive to achieve positive outcomes?

Does the fee schedule provide incentives to achieve positive outcomes in theory?

To investigate whether the new payment structure within the Program Level Agreements provides incentives which contribute to improvements in outcomes across the child protection and OOHC system we considered:

1. Whether PSP service providers appeared to be responding to the incentives set out in the Program Level Agreements
2. Whether positive outcomes were sufficiently rewarded or penalised by the fee schedule
3. Whether the incentives in place to incentivise early intervention and family preservation, and efforts directed at supporting exits from the system through family restoration, guardianship and adoption appear sufficient. This consideration is closely linked to Mechanism 1, presented in the section 2.2.4, which describes one of the key principles which motivated the design of PSP.

The relevant evaluation findings – drawn from DCJ interviews and focus group, PSP service provider focus groups, case review, ChildStory and cost data and PSP program and policy material - suggest that the PSP program level agreements did not effectively incentivise the achievement of positive outcomes.

'You have a system where you wanted to pay for outcomes and give the extra funding for achieving those outcomes, but when those outcomes weren't met, it didn't matter anyway "because you're still getting the money."'

- DCJ representative

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1. The PSP providers appeared not to be operating in line with Program Level Agreements. For example, PSP service providers did not provide the placement vacancies they were funded and contracted to provide, creating inefficiencies in the system and resulting in additional children in alternative non-foster care arrangements. This is related to an insufficient pool of carers across the state and DCJ districts have reported finding it harder to allocate carers to cases. PSP service providers were funded through baseline packages to conduct carer assessments, and vacancies were funded via the placement capacity payment (which is the difference between the number of contracted placements and the number of actual placements provided). DCJ was not able to operationalise contract abatements for not providing placements in line with contracted service agreements.

2. There is no direct financial reward for achieving positive outcomes under the current PSP package payment system. For example, successful guardianship arrangements result in PSP service providers no longer receiving funding for the placement. The only designed incentive to achieve permanency within two years is that the packages aimed at achieving this outcome are paid for a limited period of time, which neither rewards or penalises the achievement of permanency outcomes. We also note that the fee schedule was not designed to incentivise activities toward the achievement of any other positive outcomes, such as improved education or health outcomes:

   a. Although priced to reflect differing effort, PSP package-based funding does not adequately address the substantial and observable differences in the resources and effort required to achieve permanency, wellbeing and safety outcomes across different cases. This is reflected is the findings on the suitability of case plan goal and child need packages in section 9.2.1. These findings suggest that packages are not being adjusted according to the level of complexity associated with permanency planning and casework including relational and cultural permanency and are not sufficiently adjusted in line with wellbeing and safety needs.

   b. The two-year timeframe was observed as having mixed impacts on outcomes. Positive impacts were observed where legal permanency appears well suited to a case (e.g., widely supported by family members and educational and health support network) and had not previously been prioritised. The two-year timeframe was also observed as a potential barrier to optimal permanency planning and consequently service provider's ability to achieve improved safety and wellbeing outcomes which largely contribute to achieving the best permanency outcome. These appeared consistently in cases where child and parent wellbeing, as well as family and placement support, needed to be prioritised and improved before permanency planning could progress.

'A huge important part of a child's permanency is culture. No matter what cultural background they are. Not just for aboriginal children but for all children to have that connection to family and their culture. There has to be some sort of accountability into where the fundings going.'

– DCJ Representative

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3. The evaluation findings do not suggest that PSP was able to focus resources and efforts toward early intervention and exits from OOHC, in line with the expectations set out under Mechanism 1. The key findings which drive this conclusion that PSP does not appear to have shifted investment toward the front end are:

   a. There was a limited number of PSP Family Preservation packages funded through PSP, and the number of packages available were considerably less than the number of children who were eligible for this service. Demand clearly outstripped supply.

   b. Most PSP funding was directed toward the back end of the system and was not effective in encouraging front-end prevention-focused work. The PSP packages are demand driven (i.e., can be applied for) and therefore the overall distribution of the packages reflect the needs and characteristics of the cases included in PSP. A consequence of this is that the majority of PSP cases are ongoing OOHC cases, meaning that the services funded by PSP were highly focused on cases at the

back-end of the system. This is to be expected, especially when the reform was first introduced as PSP was created to include all foster care cases across NSW and ongoing foster care cases making up a large proportion of the overall number of OOHC cases. The proportion of ongoing care cases in PSP will reduce over time as new entries enter the OOHC system in PSP. In contracts, PSP only accounts for a small portion of the Family Preservation services and programs funded by PSP and cases are only included on a discretionary basis by DCJ.

c Sectors in which there is significant unmet need – such as the child protection and OOHC system - experience challenges in recognising savings at the back-end of the system, and redistributing investment in prevention to the front-end. This is known as the 'savings paradox', where any freed-up capacity is likely to be spent on meeting rising unmet demand without DCJ prioritising an alternate use of savings generated.

The impact of other PSP design and delivery components on incentives to achieve positive outcomes

The incentive structure which underpins the child protection and OOHC system impacts the decisions and behaviours of the children, family members, carers, practitioners and other DCJ roles involved in this system. The shift from a placement-based system to a personalised package service system also introduced substantial changes, likely to impact incentive structures, to dimensions of the system other than the funding model and fee schedule. These changes are largely linked to the third Mechanism identified as a design principle which motivated significant changes to the way DCJ, and PSP service providers work together. These changes included new processes, governance frameworks, objectives, case management responsibilities, accountabilities, objectives, and types of services to deliver. Some examples of these changes which were observed as impacting the child protection and OOHC system's incentive structure identified are:

- An increase in PSP service provider's involvement with Children's Court processes - specifically the case work associated with embedding the placement and other relevant principles and contained in the Act which govern aspects of case management, case planning, structured decision processes, and case work delivery including documentation and data obligations. Taken together, these changes have significantly changed the nature, potential complexity and amount of work being delivered by PSP providers.
- An increase in administrative processes for DCJ and PSP providers associated with placement set up activities and allocating funding.
- An increase in reliance on system driven processes to monitor compliance and allocate funding, and
- New practices to be developed and adopted.

Other factors (not linked to incentives) impacting whether stakeholders achieve positive outcomes

Incentives influence behaviour through motivation, yet factors other than motivation also impact whether stakeholders can achieve positive outcomes for children and families. Motivation, capability and opportunity are three key contributors to the behaviour[141] of individuals and consequently what they can achieve[142] (Michie, van Stralen, & West, 2011).

[141] The term behaviour is being used widely to include any action, effort, or task to be completed by stakeholders.
[142] The COM-B framework identifies capability (C), opportunity (O), and motivation (M) as key factors that shape behaviour (B)

Capability (i.e., can the target behaviour happen in theory?) and opportunity (i.e., are there sufficient opportunities to make it practically possible to achieve the target behaviour?) impact behaviour through, for example, knowledge and skills, familiarity and experience with the behaviour, linked processes and procedures, and the prevalence and practicality of opportunities to engage in targeted behaviour – all of which are affected by resource availability and time pressures.

'I think for those of us that are on the ground, it's quite frustrating because we keep getting these new incentives or new, "We're going to do a task force" and "We're going to do this" and "We're going to do that" and it's those of us that have been doing this for years now are going, "Yeah, well we're still going to get the same problem" and that is the bottleneck of the work that needs to be done.'

– DCJ representative

Many of the barriers described in the implementation results relate to PSP stakeholders' capacity and opportunities to delivery PSP and are almost certainly preventing the adoption of the hoped-for and incentivised behaviours – and perhaps other behaviours associated with achieving positive outcomes. In addition, all three of the mechanisms of change identified as design principles rely on assumptions based on capability and opportunity including access to evidence-based services, availability of appropriate evidence-informed practice frameworks, capacity and capability to take on new responsibilities and reliable information on wellbeing outcomes. The combination of capacity, opportunity and motivation barriers identified inhibits our ability to determine whether the Program Level Agreements and the fee schedule introduced could potentially incentivise the achievement of positive outcomes.

9.2.4. How sustainable is the funding model?

The costs of PSP are much larger than the benefits so far. The average costs outweigh the average benefits for all cohorts evaluated in this report, with only relatively modest impacts estimated on just a few selected outcomes. It is not clear, using the current data, that this will change into the future. Even with the limitations described earlier in the economic evaluation section, this strongly suggests the PSP funding model is not sustainable.

Given the challenges to PSP implementation, clearly outlined throughout the report, we also examine the sustainability of the PSP funding within a system context. PSP is inherently linked to NSW's child protection and OOHC system as a whole and to its service and care continuum that supports vulnerable Aboriginal, CALD and other children and families. The Tune report (Tune , 2016) describes the importance of establishing both social and financial sustainability across NSW's child protection and OOHC system and highlights that the system's capability and capacity to achieve sustainability is underpinned by the features of its investment approach and its personalised support packages – which characterise its funding model. To evaluate the social and financial sustainability of PSP, we consider its operating model (processes, split of responsibilities), the capacity of its organisations and stakeholders to deliver PSP, and the external factors impacting PSP (e.g., availability of evidence-informed services), in addition to its funding model. This broad inquiry accounts for the interconnectedness of these PSP components, captured by the assumptions identified as underpinning the PSP targeted mechanisms of change embedded within the design of PSP, as detailed in section 2.2.4.

The social and financial sustainability of PSP is explored through the questions, presented below, formulated to consider the pre-conditions required to implement a child protection and OOHC delivery model through personalised tailored packages (set out by in the PSP funding model overview in section 2.2.6) and the assumptions underpinning the design of PSP. While we acknowledge there are differences in scope (i.e., PSP primarily focuses on children in-care) and approach between The Tune report recommendations and PSP design, it is instructive to consider PSP sustainability within this frame.

- **Are the interventions funded by PSP well targeted and evaluated and subsequently informed by outcome data?** We identified substantial capability-based issues which are impeding PSP service provider's ability to coordinate the delivery of well targeted evidence-based services including:
  - The Quality Assurance Framework (QAF) was not implemented fully, meaning PSP-funded interventions cannot be informed, targeted or evaluated using a common outcome framework.
  - DCJ and PSP service providers do not rely on a common risk and needs assessment tool informed by data analytics to target interventions and other resources, to consistently and frequently measure risk and needs level.
  - PSP does not provide its service providers with a practice framework, informed by evidence, to guide how they target their interventions.
- **Does PSP have the ability to develop client-centred service delivery, intervene early, and assess the effectiveness of interventions?**
  - The NSW child protection and OOHC system in which PSP operates is not considered through a continuous, integrated service and care continuum. The objectives and eligibility criteria of the different programs and services available to vulnerable children and families across the system are not clearly articulated or integrated.
  - PSP includes the delivery of all foster care cases in NSW and only a small portion of the services delivered as part of family preservation and early intervention across NSW. As a result, PSP's overall ability to intervene early (and be observed in the evaluation) was limited due to the small proportion of front-end cases included in PSP.
- **Are PSP funded investments based on knowledge about care pathways through the system, family needs and their outcomes?** This relies on PSP service providers having the ability to develop client-centred service delivery, intervene early, and assess the effectiveness of interventions. This ability is highly constrained by the limitations explored above. In addition, we found that:
  - PSP packages did not adequately consider the complexity of cases and particularly the level of need of children, family members and carers involved in cases.
  - The delivery of PSP funded services did not appear to be consistently guided by evidence-informed practice frameworks based on knowledge about care pathways. In line with this observation, we observed a lack of appropriate locally evaluated practice frameworks being available to PSP service providers during the evaluation observation period[143]
    - This was particularly noticeable for care leavers in contact with the criminal justice system and care leavers who face greater risks, such as children of

[143] DCJ is currently funding the development and evaluation of a permanency practice framework to be co-developed with four PSP service providers, as detailed in Section 2.3.3.

care leavers and for Aboriginal and CALD people as the evidence-base they rely on is underdeveloped.

- **Were the services delivered as part of the PSP packages integrated, timely, tailored and grounded in evidence to address the specific and complex needs of vulnerable children and families?** The evaluation found that PSP service providers were limited in their ability to deliver integrated, timely and tailored evidence-informed services due to limited access to evidence-informed interventions, appropriate evidence-informed frameworks, and the absence of a holistic outcome framework and common risk and needs tool.
  - The PSP packages were administered without the frequent use of a common risk and needs tool.
  - The evaluation found that DCJ could not effectively monitor or ensure the quality or appropriateness of services funded as part of PSP packages.

> *'Just slapping on any old cultural plan is not good enough. That's not the intention of the packages. It was around offering incentive to do a good cultural plan and those things aren't really being checked.'*
>
> *– DCJ Representative*

- **Is PSP expenditure well targeted?**
  - PSP funding is much more focused on long-term care (i.e., end of the care continuum) than on family preservation and restoration services (i.e., start/midway of the care continuum). While this reflects where most children are within the system, it ignores the greater impacts that could be achieved with effective programs and practices through earlier intervention.
  - PSP funding is largely focused on achieving legal permanency and increasing the number of exits from OOHC. This focus does not seem appropriate in cases where there are high level of needs and safety concerns, which needs to be addressed before legal permanency can be properly considered. Expenditure could be better targeted if case management practices and the funding structure were tailored to differences in level of need with regards to holistic understanding of needs. For example, the NSW QAF model currently being trialed by DCJ takes a holistic view of outcomes and includes the following domains: cultural and spiritual identity, social functioning, emotional and psychological wellbeing, good health and development, educational potential, belonging and stability and safety. These domains were largely excluded from the outcome data collected by DCJ as part of monitoring the delivery of PSP and consequently within this evaluation, which results in inadequate monitoring and consideration over whether PSP services are meeting children's needs in a holistic way.
  - The extent to which DCJ can target PSP funding is limited because of the relative discretion that PSP providers have in how they spend the available funding. Whether the PSP providers target the expenditure well cannot be observed due to the lack of information on how PSP providers spend PSP funding. To ensure expenditure is well targeted, more information needs to be collected regarding what services are provided for which children, and what outcomes have been achieved for these children, including outcomes other than permanency.

    We found across the cases reviewed, that a substantial portion of DCJ funding appears to be spend on education, health and justice services including tutoring

costs, legal fees, medical and allied health services fees, as well as transport costs associated with accessing these services. Due to the lack of transparency over what PSP service providers fund through PSP packages, we cannot verify or quantify the magnitude of this funding. However, we expect that this trend is likely to be reducing PSP's capacity to strengthen the delivery of social work and welfare services, which ought to be its primary focus.

- Is PSP's operating model aligned to the sustainable delivery of the PSP funding model?

In addition to the sustainability limitations described above, the sustainability of PSP is also impacted by the practices, norms and culture of DCJ and the PSP service providers. This is clearly explained in the quote from the Family Is Culture report (2019) below.

'Bureaucracy is a large beast that, we know from the research, takes on a life of its own, with its own practices, norms and culture. Often this culture can be indifferent or resistant to the intentions of legislators. This means that the regulatory framework—the laws and policies that govern a bureaucracy—often compete with, or are neutralised by, the dominant culture of a department.'

- From Family Is Culture Report (2019)

Overall, the evaluation found that key elements of PSP's operating model including practices, processes, norms, culture and capacity and capability across PSP service providers and DCJ districts were not well understood and considered during the implementation of PSP.

The support and coordination function delivered by the Permanency Coordinators during the implementation and on an ongoing basis appeared crucial to the effective functioning of PSP including the coordination of DCJ and PSP service providers' role, informing PSP service provider's practice and monitoring the quality and appropriateness of the services delivered under PSP. While the Permanency Coordinators were able to deliver extensive support and coordination across PSP, they were limited in their ability to fill the knowledge, practice and resource constraints gaps they identified and in their influence over the way processes were designed.

The suitability and appropriateness of the PSP operating model features need to be considered and adapted to address the barriers identified to ensure the sustainability of PSP's funding, practice and operating models is continually reviewed and improved. This is in line with a number of DCJ driven adaptations already taking place, as described in section 3.3.

Are there funding gaps?

The effective delivery of PSP relies on setting up an effective service and support delivery system across the full care continuum. This can only be achieved by addressing both internal (i.e., within the remit of DCJ's work) and external factors affecting service and support delivery.

The internal factors that require additional funding and resources include:

- Expanding investment toward developing, trialing and delivering evidence-informed services aligned to the needs of children and family in cases with family preservation and restoration permanency goals, and
- Funding social work and welfare services that provide food, clothing, and general welfare support in line with the QAF outcomes (e.g., social functioning) and focused on the provision of services targeting complex needs.

The external factors that need to be addressed include:

- The collaboration and coordination between agencies across the service and care continuum, and
- The variability in the availability of services across locations, particularly rural and remote.

9.3. Discussion

PSP was implemented within a complex system and involved extensive changes to the way OOHC care, and a portion of family preservation services, are delivered through the simultaneous introduction of a new funding model and operating model. Complex system change needs to be iterative, informed and continuously supported. To achieve PSP's objectives around improving wellbeing, safety and permanency outcomes and reducing the number of Aboriginal children in care we suggest:

- Embedding regular and consistent processes to gather detailed feedback and information about the type, amount, quality and appropriateness of services being delivered by all different PSP service providers and across a wide range of cases. For example, this could be done using case review-based and observational research practices in line with a recommendation made in the Independent Review of Aboriginal Children and Young People in OOHC (Family is Culture, 2019),
- Using this feedback to guide continuous improvements and adaptations of PSP co-designed with all the relevant PSP stakeholders, and
- Rolling out a holistic outcome framework (e.g., QAF) and a common risk and needs assessment tool across all child protection and OOHC cases to collect regular, consistent and integrated data on children's wellbeing, needs and risks across the service and care continuum.

The sustainability of PSP should be explored at different levels in order to disentangle the different factors impacting its sustainability and consequently the reform's ability to deliver positive outcomes in a cost-effective manner. These layers are PSP as it was designed, PSP as it was implemented and PSP as a large reform to a complex system. The sustainability of PSP as it was designed hinges on the extent to which the assumptions which underpin the key design mechanisms can be met. This is not what we can observe during an evaluation - assumptions not holding could be due to either the assumptions not being feasible, or the assumptions not being met as a result of implementation challenges. Further, PSP is highly interconnected with all functions across the NSW child protection and OOHC system. The sustainability of PSP is inherently affected by the entire system and its service and support continuum. This is also true of functions managed by DCJ, PSP service providers and the Children's Court.

To improve the social sustainability and cost-effectiveness of PSP all the barriers and challenges impacting the assumptions need to be addressed. This includes barriers associated with stakeholder's capability (i.e., do they know how to do it) and opportunities (i.e., are they able to deliver in practice), as well as barriers associated with motivation (i.e., are they incentivised to achieve the positive outcomes being targeted). A key focus for improving sustainability needs to be strengthening the child protection and OOHC system's ability to develop and implement evidence-informed decisions, frameworks, programs and services. In other jurisdictions, such as the UK, this has been achieved via system-wide sector-led 'What Works centres' – which span agencies and have a primary goal of improving outcomes for vulnerable children and families. As part of their mandate they:

- Work systematically toward developing an evidence-informed service, support and case management care continuum informed by the knowledge of previous reviews, feedback and observations from all system stakeholders and inclusive of universal services and all services needed and available across a continuum spanning from community strengthening to child protection functions.
- Adopt a test, trial and adapt approach and fund projects and evaluations with well-defined, articulated and achievable goals.
- Identify and map gaps in the system across the sector using a systematic bottom-up approach informed by behavioural sciences, implementation science and other sectors including health, educational and other family and community services.

Lastly, we found that services funded as part of PSP largely focused on cases where children have already been in care for a long time and included only a very small amount of funding for family preservation or new entry into OOHC cases. This suggests that PSP services were primarily delivered at the back end of the care continuum and that the implementation of PSP did not result in a shift of funding toward vulnerable children and families at the front end of the continuum. This represents a missed opportunity to provide early support and prevent escalations in the needs of vulnerable children and families - which in turn, is likely to lead to a higher proportion of children receiving intensive child protection and OOHC services at the back end of the service and care continuum.

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Appendix A Supplementary information about PSP

A.1 Overview of DCJ funded Family Preservation Services outside of PSP

This summary was provided to PSP service providers to identify all the Family Preservation services outside of PSP that cannot be delivered at the same time as PSP Family Preservation packages. The summary was extracted from the Business Rules: Permanency Support Program (PSP) & Family Preservation Program (DCJ, 2020) document.

SERVICE MODEL	AGE COHORT	GOAL	LENGTH
Brighter Futures	Birth – 9 years or unborn children.	Early intervention and family preservation.	18 months (up to 24 months in exceptional circumstances).
Youth Hope	9 – 15 years.		
Intensive Family Preservation (IFP)	Birth – 18 years.	Family preservation, restoration support or OOHC placement stability.	6 months (up to maximum 9 months in exceptional circumstances).
Intensive Family Based Service (IFBS)	Birth – 18 years For Aboriginal families only.		
Newpin	Under 6 years.	Family preservation and restoration.	12–18 months.
Resilient Families	6 years or under.	Family preservation.	Up to 12 months.
Multi-Systemic Therapy – Child Abuse & Neglect (MST-CAN)	6 – 17 years.	Family preservation and restoration.	6-9 months.
Functional Family Therapy – Child Welfare (FFT-CW)	Birth – 17 years.	Family preservation and restoration.	Up to 9 months (low stream) or 6 months (high).

Appendix B Qualitative Methods

B.1 Inner setting survey questions

Question type	Survey questions
Org information	What is the name of your organisation? In which district are you based? If you're based in more than one district, please select the place you spend the most time.
Respondent information	What is your role within the organisation? Approximately how long have you worked in this organisation? Approximately how many days do you work in this organisation each week? Approximately how long have you (personally) been providing PSP services?
Inner setting survey question (Q12)	To what extent to do you agree with the following statements - from strongly disagree to strongly agree *Within your organisation... - We regularly take time to reflect on how we do things* *Within your organisation... - After trying something new, we take time to think about how it worked* *Within your organisation... - Difficult problems are solved through face-to-face discussions* *Within your organisation... - People at all levels openly talk about what is and isn't working* *Within your organisation... - Most people in this organisation are willing to change how they do things in response to feedback from others* *Within your organisation... - It is hard to get things to change in our organisation* *Within your organisation... - I can rely on the other people in this organisation to do their jobs well* *Within your organisation... - People in this organisation operate as a real team*
Inner setting survey question (Q13)	To what extent to do you agree with the following statements - from strongly disagree to strongly agree *Within your organisation... - We regularly take time to consider ways to improve how we do things* *Within your organisation... - People in our organisation actively seek new ways to improve how we do things* *Within your organisation... - This organisation encourages everyone to share ideas* *Within your organisation... - This organisation learns from its mistakes* *Within your organisation... - When we experience a problem in the organisation, we make a serious effort to figure out what's really going on*

Question type	Survey questions
	Within your organisation... - Leadership strongly supports organisation change efforts *Within your organisation... - The organisation leadership promotes an environment that is an enjoyable place to work* *Within your organisation... - Leadership in this organisation creates an environment where things can be accomplished* *Within your organisation... - The organisation leadership makes sure that we have the time and space necessary to discuss changes to improve care* *"Within your organisation: In general, when there is agreement that change needs to happen in the organisation, we have the necessary support in terms of: - Budget or financial resources"* *"Within your organisation: In general, when there is agreement that change needs to happen in the organisation, we have the necessary support in terms of: - Training"* *"Within your organisation: In general, when there is agreement that change needs to happen in the organisation, we have the necessary support in terms of: - Staff"*
Covid-19 impact question	To what extent has COVID-19 affected your (personal) ability to provide high-quality PSP services to clients? To what extent has COVID-19 affected your organisation's ability to provide high-quality PSP services to clients? What changes have you noticed in your (personal) capacity to provide PSP services since COVID-19? What changes have you noticed in your organisation's capacity to provide PSP services since COVID-19?
Additional free text question	Is there anything else we should know in relation to the questions asked in the survey?

B.2 Criteria used to assign ratings to constructs

Rating	Criteria
-2	The construct impedes PSP service provider efforts to implement PSP or otherwise acts as a negative influence on the PSP service provider. Focus group participants describe explicit examples of how the key or all aspects (or the absence) of a construct manifests itself in a negative way, and/or refer to the feature as a 'top three' barrier. *(Note: If the majority of focus group participants describe explicit examples and/or refer to the feature as a 'top three' barrier, but one has a slightly positive or neutral experience, this is coded as a -2).*
-1	The construct impedes PSP service provider efforts to implement PSP or otherwise acts as a negative influence on the PSP service provider. Focus group participants make general statements about the construct manifesting in a negative way but without concrete examples, e.g.: • The construct is mentioned only in passing or at a high level without examples or evidence of actual, concrete descriptions of how that construct manifests;

	• There is a mixed effect of different aspects of the construct but with general overall negative effect; • There is sufficient information to make an indirect inference about the generally negative influence; and/or • Judged as weakly negative by the absence of the construct.
0	A construct has neutral influence if: • The PSP service provider has managed to use internal processes to mitigate the negative effects of a barrier; • It appears to have neutral effect (purely descriptive) or is mentioned generically without valence; • There is no evidence of positive or negative influence; • Focus group participants contradict each other; • There are positive and negative influences at different levels in the PSP service provider that balance each other out; and/or • Different aspects of the construct have positive influence while others have negative influence and, overall, the effect is neutral.
+1	The construct facilitates PSP service provider efforts to implement PSP or otherwise acts as a positive influence on the PSP service provider. Focus group participants make general statements about the construct manifesting in a positive way but without concrete examples, e.g.: • The construct is mentioned only in passing or at a high level without examples or evidence of actual, concrete descriptions of how that construct manifests; • There is a mixed effect of different aspects of the construct but with general overall positive effect; and/or • There is sufficient information to make an indirect inference about the generally positive influence.
+2	The construct facilitates PSP service provider efforts to implement PSP or otherwise acts as a positive influence on the PSP service provider. Focus group participants describe explicit examples of how the key or all aspects of a construct manifests itself in a positive way, and/or refer to the feature as a ‘top three’ enabler. *(Note: If the majority of focus group participants describe explicit examples and/or refer to the feature as a ‘top three’ enabler, but one has a slightly negative or neutral experience, this is coded as a +2).*
Missing	Focus group participants were either not asked about the presence or influence of the construct; or were asked about a construct, but gave a response corresponding to another construct (and which was coded accordingly).

Appendix C Quantitative Methods

C.1 Identifying who received PSP packages

C.1.1. For those in Family Preservation

The data for those who received Family Preservation PSP packages is maintained outside of the ChildStory database. We received 29 separate workbooks with information for each child in each family / household that was receiving Family Preservation, corresponding to each PSP Provider that provided PSP Family Preservation services during the evaluation period. The separate sheets provided were combined into a final dataset that listed every child who received PSP Family Preservation packages, along with their start and end dates, Family ID and Package number (where these were available). However, data regarding who was in each household (i.e., Family ID) was missing for a large portion of the dataset. Thus, children and young people were allocated into households according to who else was listed in the same household on the closest Safety Assessment to their first eligible face-to-face assessment (after linking with the ChildStory Child Protection data).[144] The data for those who received PSP Family Preservation packages was integrated, and compared with, the data of those who were eligible for Family Preservation from the ChildStory database.

C.1.2. For those in OOHC (relevant to all cohorts except those in Family Preservation)

Children and young people in an out-of-home care (OOHC) placement were identified as ‘receiving PSP funded packages’ according to whether they received one or more distinct or overlapping PSP packages from PSP Providers. For those in OOHC, the relevant PSP packages received by the child or young person should have been linked to particular placements and have three core associated PSP package types: ‘Baseline’, ‘Needs’, or ‘Goals’, but the child may also have received additional ‘Specialist’ packages. Thus, we calculated whether a child or young person (in or entering OOHC) was actively receiving PSP packages according to whether they had an active PSP package of any/all of those types. PSP specialist packages (including cultural plans) were generally single payments and lasted one day in the dataset.

Excluded from all analyses were PSP packages that had a start date after the package end date.

Case Coordination records (maintained separately from ChildStory) were integrated with the PSP Package information (from ChildStory) to provide a more comprehensive picture of the duration of time in which a child or young person received support from PSP.

Where the *package* start date and the associated *placement* start date were not identical (which we rarely observed for Baseline packages but did for Goal packages, as goals could and did change through time), start dates for each package were determined as the latest date between the package start date and the placement start date.

[144] The method of identifying ‘who else was in the family/household’ also had to be done in a consistent way as for the comparison group.

C.2 Defining each cohort prior to matching

C.2.1. Why defining cohorts is necessary

Those who received PSP packages and support from this program spanned the entire spectrum of children at risk, from babies and children who were still living with their families but at risk of being removed and placed into OOHC to young people who had already been in care for over a decade but still had not achieved permanency outcomes. Thus, if all children who had received any type of PSP support were included in a single analysis, the diversity of their situations and their backgrounds would likely mask any impact of receiving PSP packages. Furthermore, finding a suitable (and rigorous) counterfactual would be problematic for such a diverse group. Therefore, the most appropriate approach was to define and identify particular 'cohorts' of children at particular points in their family preservation / out-of-home care histories who had received PSP packages. For each of these cohorts, we then found suitable children with similar backgrounds (and in the case of Family Preservation: from similar households) who were not receiving PSP when they were in similar situations (e.g. entering or re-entering OOHC, or households who had a face-to-face assessment with particular eligibility criteria); these children were identified using statistical matching (see propensity score matching, below) to act as the counterfactuals for each cohort.

C.2.2. Cleaning and merging the datasets

Once it was determined who was receiving PSP packages, these data were linked with other datasets using each child's unique ChildStory ID. These data were used to create variables that we later used for matching to counterfactuals and analysing outcomes. The other datasets were ChildStory OOHC, Child Protection (CP), Safety and Risk Assessments (SARA), CAT Scores, Youth Justice (BOCSAR)[145], and NSW education data (NSW Department of Education and NSW Education Standards Authority).[146] Prior to merging, all datasets were cleaned by fixing any formatting issues and identifying and dealing with any missing data (data was removed if identifiers were missing).

PSP package data were linked with the ChildStory OOHC data in order to determine where, in terms of their OOHC journey, children were situated when PSP began and to set up the evaluation cohorts. In OOHC data, episodes of time in out-of-home care are already denoted by the 'Care Category'; however, we have identified that sometimes subsequent Care Categories start on or before the end date of the previous one. Thus, if different OOHC Care Categories (the 'gold standard' data for if a child or young person is in care or not) overlapped with another Care Category, or another started within 7 days of the previous one, then this was considered a continuous period of care and thus part of one 'episode'. In other words, the child or young person was not considered to have left or exited care at the end of the first Care Category. Within a 'Care Category', particular placements were identified by official 'Priority Placements'. If the Priority Placement end date extended beyond the end of the Care Category, which is some of the most rigorously validated data, we assumed that the Priority Placement had ended at the same time as the corresponding Care Category.

[145] All possible names and DOB connected to each ChildStoryID were compiled by DCJ (FACSIAR) and sent to the Bureau of Crime Statistics and Research (BOCSAR) who matched the ChildStoryIDs with their Re-offending Database (ROD). De identified data was provided to the evaluation team.
[146] Department of Education and NSW Education Standards Authority (NESA) provided attendance, NAPLAN and HSC data under a data linkage agreement with DCJ. ChildStory ID was not available in the data source for this data, so DCJ provided DoE with a statistical linkage key (SLK) for matching. DoE used the SLK to match to their data.

C.2.3. Eligibility rules for each cohort

Next, we identified which children qualified for inclusion in each of the cohorts, based on their CP and/or OOHC history and only for those receiving PSP packages (the counterfactuals that do not receive PSP packages are defined later). The three general cohorts were:

1. Family Preservation: children in households who received a PSP Family Preservation package between 1st October 2018 and 30th April 2021
2. Entry/Re-entry: children who entered or re-entered an episode of care between 1st October 2018 and 31st December 2020
3. Ongoing OOHC: children who were in an episode of care on 1st October 2018

For all cohorts, the reach of packages was followed through until 30th June 2021.[147]

Determining who was eligible for each cohort (and whether a child or young person was receiving a PSP package or not) was done according to a series of rules for each cohort (summarised in Table C.1) and using the following general rules:

- Whether a child or young person was receiving a PSP package for each cohort was considered first, based on if the child or young person had an eligible start and was in a PSP package at the given time.
- To understand the reach of the PSP program, we compared children who received a PSP package with those who met eligibility criteria but did not receive a PSP package (and were not listed in the 'Data Quality' file148, which provided a cross-check of those who were [or should have been] receiving PSP packages). A comparison of the children that were eligible for each cohort and the differences between who received PSP or not can be found in Chapter 6 and Table E.1, Table E.2 and Table E.3 in Appendix E.
- For the Entry/Re-entry or Ongoing Care cohorts, an eligible OOHC Care Category was only considered if it lasted more than 7 days (i.e., 8 days or longer) and if it contained at least one Priority Placement lasting more than seven days in duration.
- Across the Entry/Re-entry or Ongoing Care cohorts, 242 children were listed in the 'Data Quality' file prior to 30th June 2020 but did not have records of receiving PSP packages.149 Thus, these children were excluded from the comparison regarding the Reach of PSP (concurrent receiving PSP package vs not receiving PSP package); if included, they would have appeared as not receiving PSP packages (which is not necessarily correct either).
- Within each cohort of eligible children, we identified who was receiving a PSP package, according to whether they were receiving a PSP package during or at the 'start' of their eligible time in the cohort. For example, those in the Entry/Re-entry cohort were included if they either had an active PSP package when they entered a new OOHC care category or if they started a PSP package within 32 days of the start of their OOHC episode. In contrast, children in the Ongoing OOHC cohort (which

[147] Although the effectiveness of all outcomes was similarly followed through until 30th June 2021 for all PSP cohorts and the matched group for those in Family Preservation, the dates differed for the matched comparison groups for the out-of-home cohorts, which were historical comparisons and were followed through until 30th June 2017.

[148] The Data Quality file is a reference for the checking and confirming the quality of data regarding those who received PSP packages.

[149] Depending on the timing of the PSP packages that they received.

potentially includes some who have been in care for many years) were included if they also had an active PSP package on 1st October 2018.

Table C.1 The process for determining who was eligible for inclusion in each cohort based on whether a child received PSP packages

Data handling rules	Cohort 1: Family Preservation	Cohort 2: Entry / Re-entry to OOHC	Cohort 3: In Ongoing OOHC on 1st October 2018
Eligible face-to-face assessment or OOHC episode to be considered for inclusion	Must have new face-to-face assessment between 1st October 2018 and 30th April 2021	Must have an OOHC Care Category that starts after (but not including) 1st October 2018 and before 31st December 2020	Must have an OOHC Care Category that starts on or before 1st October 2018 and ends after 1st October 2018
Eligible PSP package episode(s) for identifying who was included in each PSP-funded group (receiving PSP package funding)	Started PSP Family Preservation package between 1st October 2018 and 30th April 2021	Had an episode of PSP Packages that started after 1st October 2018 and before 31st December 2021 (from PSP Package data, from ChildStory)	Had an active PSP package episode on 1st October 2018 (from PSP Package data, from ChildStory)
Identifying who was receiving PSP packages or not	Merged eligible face-to-face assessments (that started on or after 1st October 2018) with when children first received PSP services for Family Preservation	Merged eligible PSP package episodes with new eligible OOHC care categories that started after 1st October 2018. Identified the 'best match' between multiple PSP package and OOHC records per child by prioritising: (1) PSP package records that started within 1 month (<32 days) of the entry/re-entry to care (2) PSP package records where the child or young person was in a current PSP episode when started OOHC	Merged current PSP package episodes with current OOHC care categories (active on 1st October 2018). Determined if any PSP package episodes were currently active on 1st October 2018 as well
Which eligible face-to-face or OOHC entry to choose for PSP package group	First face-to-face assessment that is associated with entry into PSP Family Preservation	The first OOHC entry/re-entry after 1st October 2018 associated with an active PSP package episode (active on or within 32 days of OOHC start)	OOHC episode on 1st October 2018 (only one possibility per child)
Were any children or young people excluded if they did not have CP / SARA / OOHC histories?	CP & SARA: yes, they had to have a face-to-face assessment (with Safety and Risk information) to be included in this cohort. OOHC: no, this was only considered for context for understanding their histories (and may be used as covariates) but was not essential as the majority of children in this group are not expected to have an OOHC history	CP & SARA : yes, identification of eligibility was based on OOHC history (detailed above) but children could only be included in this cohort if they also had a CP record and a complete safety / risk assessment history, as this data is essential for matching later	OOHC: yes, identification of eligibility was based on OOHC history (detailed above) CP & SARA: no, these were not considered essential for inclusion in this cohort, as matching and analyses was primarily based on OOHC history. In cases where the child or young person was in care for an extensive period they may not have a complete or recent CP / SARA history
SARA histories summarised as:	Closest face-to-face assessment associated with the start of PSP Family Preservation (face-to-face assessment up to 6 months prior).	Within range of the 'start' of entry/re-entry to care: the closest Safety and Risk assessments to the start date of the new entry/re-entry to care that were associated with a face-to-face assessment that was active 90 days before to 14 days after the start of the new entry/re-entry to care	Most recent Safety and Risk Assessment before 1st October 2018

Date all variables for matching/analysis are calculated at	The date of the first face-to-face assessment that is associated with entry into PSP Family Preservation	The date of entry into OOHC after 1st October 2018	1st October 2018

C.2.4. Additional information regarding Cohort 1: Family Preservation

The Child Protection records from ChildStory were used to identify all children who were eligible for receiving PSP Family Preservation. An 'eligible' face-to-face assessment had to be active within the study period, include both a completed Safety Assessment and a completed Risk Assessment, have a final safety level of "Safe" or "Safe with plan", and have at least one ROSH that corresponded to a risk level of "High" or "Very High". The investigation number for each eligible F2F (whether it was the first / second / third, etc., eligible investigation in the study period) was calculated for each child's record. For all children, the other members of the household at the time of each face-to-face investigation was determined according to who else was listed on the first Safety Assessment within the investigation period; the individuals who were listed on the Safety Assessment comprise the 'household' for which the prior histories were determined, and the subsequent outcomes were summarised.

The face-to-face investigation that precipitated the family's entry into PSP Family Preservation was identified as the most recent eligible face-to-face investigation that started on or prior to the date of entry into Family Preservation. If an individual (or household) was present in the PSP Family Preservation data but had no linked data in the Child Protection Records, they were excluded from analyses. If a child within a household was *not* part of the most recent face-to-face investigation prior to the start of PSP Family Preservation, then they were excluded from this household group and from further analysis. This is an essential step, as determining 'who was on the Safety Assessment' is the only way to consistently determine who was in the household in the analogue (i.e., the comparison group that did not receive PSP Family Preservation services - see details in the Effectiveness Chapter). The number of children in the household was recorded per household.

From each of the households who received PSP Family Preservation, a single child was randomly selected as the 'representative' of the family; because the services were delivered at the household level and all SARA variables are at the household level, the analysis must also be performed with each unit at the household level. This procedure also helped us avoid issues of non-independence in the data. A random child was selected, instead of simply choosing the youngest, to provide greater representation across age groups in the matched sample; this should not significantly affect the suitability of matched households or impact how outcomes (at the family level) are calculated, as the majority of variables and outcomes were summarised and matched at the household level.

C.2.5. Additional information regarding Cohort 3: In Ongoing OOHC

The Ongoing OOHC Cohort had a large proportion of individuals who started receiving PSP funding on 1st July 2018 but were mid-placement. Thus, potentially a large proportion of those in the In Ongoing OOHC Cohort were administrative transfers. To allow the program three months to get running from the day it initially started, we framed our analysis around those in care on 1st October 2018 rather than the official PSP start in on 1st July 2018.

C.3 Propensity Score Matching

C.3.1. General matching procedure

Propensity score matching (PSM) is a statistical technique that allows researchers to create an artificial control group that are matched to the treatment group through similar characteristics or histories (which must be independent of the treatment). PSM is designed to reduce confounding biases in observational studies and mimic randomisation. The propensity score (which is created during the matching process) is a balancing measure used to ensure the distributions of each characteristic matched on are similar between the two final matched groups. Rather than a direct 1:1 match to link similar individuals (or units being treated), PSM aims to match characteristics at a group level and ensure the two populations matched follow similar ratios or distributions.

We used PSM to match the children in our three cohorts that received PSP packages to a similar sample of children who either received no PSP packages concurrently (Family Preservation cohort), or that were in care prior to the introduction of PSP (Entry/Re-entry and Ongoing Care cohorts). In this way, we are able to 'control for' or account for, the influence certain key variables might have on whether children received one or more PSP packages. By matching, we create two matched groups for each cohort that have similar distributions in key characteristics.

The summary of the key matching criteria for each cohort is outlined in Table C.2ore details on who was eligible for the comparison group in each cohort is detailed below.

Table C.2 Summary of key matching criteria used for each cohort

	Cohort 1: Family Preservation	Cohort 2: Entry/Re-entry	Cohort 3: Ongoing Care
Type of matching	Propensity Score Matching	Propensity Score Matching	Propensity Score Matching
Ratio used, PSP:comparison	1:5	1:1	1:1
Caliper of match	0.2	0.2	0.1
Number matched in PSP	320	565	6540
Number matched in comparison	1477	565	6540
Number of variables used in match	19	13	12
Number of foster and kinship care children in PSP[150]	309	539	6200
Number of foster and kinship care children in comparison	315	528	6156

C.3.2. Comparison eligibility criteria: Family Preservation cohort

To determine those eligible for the comparison/analogue group in the Family Preservation cohort, we summarised the household variables for each child in each household at every eligible face-to-face investigation. We excluded investigations if they were not eligible

[150] These are the final numbers for each cohort carried forward to the analysis.

according to the criteria (described in additional information above) or if they included any children present in the PSP Family Preservation data. For the potential comparison group, data was summarised for a randomly selected child per household (according to Safety Assessment Data) at each eligible face-to-face assessment. For the comparison group, all of the same variables were calculated at the household level for *every child in the household at each eligible face-to-face investigation.*

Note that individuals were not excluded prior to matching if they had previously received funding from other Non-PSP Preservation Programs, as this would potentially bias the potential comparison group quite significantly. However, after matching, any households that were receiving funding from other intensive[151] preservation programs at the time they started receiving funding for Family Preservation (or equivalent timing in the comparison group) were excluded from the matched groups.

The covariates used to match were calculated at the date of the first face-to-face assessment that is associated with receiving PSP Family Preservation (for the PSP package), or any eligible face-to-face assessment per child (for the comparison) during the study period. However, after matching occurred, for analytic covariates the data was summarised at the start date of the PSP Family Package, or equivalent number of days from the relevant face-to-face assessment.

Matching in this cohort was done at the ratio 1:5. This matching process was divided into two parts where:

1. Households that started receiving PSP Family Preservation packages within 6 months of their closest and first eligible (for PSP Family Preservation) face-to-face assessment in the study period were matched against households that also had a first potentially eligible face-to-face assessment within the study period (but did not receive PSP Family Preservation packages).
    a. Prior to matching: PSP Family Preservation n=178 and Non-PSP Family Preservation n=12,925.
    b. After matching: PSP Family Preservation n=175 and Non-PSP Family Preservation n=849.
2. Households who started receiving PSP Family Preservation packages within 6 months of the (closest) face-to-face assessment in the study period that was ***not*** the first eligible (for PSP Family Preservation) one were matched against households that also had a potentially eligible face-to-face assessment that was ***not*** the first eligible one for the household within the study period.
    a. Prior to matching: PSP Family Preservation n=156 and Non-PSP Family Preservation n=6,390.
    b. After matching: PSP Family Preservation n=145 and Non-PSP Family Preservation n=628.

These two matching parts were combined to create an overall matched cohort of: PSP Family Preservation n=320 and Non-PSP Family Preservation n=1477.[152]

[151] Intensive meaning any program except Brighter Futures or Youth Hope.

[152] These numbers are prior to before reducing to a 1:1 match and prior to removing households who were in other intensive programs (see methods that continue after variable list), so these numbers will differ from those used in the final Family Preservation models.

Variables used in the Family Preservation cohort match:

- Representative child-level variables:
  - Female
  - Aboriginal
  - Age at face-to-face assessment date (rounded to year)
- Household level variables:
  - Number of children in the household
  - Number of ROSH received per children per household
  - Recent ROSH for physical abuse
  - Recent ROSH for neglect
  - Recent ROSH for prenatal reasons
  - Whether the household has limited visibility
  - A child has been diagnosed with psychological, behavioural, emotional or medical problems
  - A child has developmental, intellectual, learning or physical disabilities
  - The carer has a history of substance abuse
  - The parent / carer has psychological, cognitive, or mental health issues
  - The housing is unsafe or are family is homeless
  - The parent / carer has a history of child protection
  - The household has experienced family violence
- Other important variables matched on:
  - Days to face-face assessment start from the start of the evaluation period
  - The maximum number of prior eligible face-to-face assessment for the household in the evaluation period (only for the second part of the matching for this cohort).

Of the 19 variables matched, 15 variables had at least one significant difference prior to matching (in either of the matching parts: for households with first eligible face-to-face versus subsequent eligible face-to-face assessments). After matching, only the maximum number of ROSH reports per child per household was significantly different, and only in the matched group that had subsequent eligible face-to-face assessments during the period).

After matching, the number of days between the face-to-face assessment and the start of receiving a PSP package was added to the date of the up to 5 matched comparison households to create an artificial 'potential start date' for each comparison household. Any of the comparison households who were in an intensive family preservation program[153] at

[153] Intensive meaning any program except Brighter Futures or Youth Hope.

the time of their potential start date were excluded from the matched cohort. Once this was completed, the best match was chosen among those remaining and a 1:1 matched cohort was created (PSP Family Preservation n=320 and Non-PSP Family Preservation n=320). After the ChildStory data was refreshed in November 2021, we discovered a small number of these families had one or more children exiting to OOHC between their most recent eligible face-to-face assessment and the start of receiving PSP Family Preservation services (or equivalent): thus, we removed these households from subsequent analysis as they no longer met eligibility criteria (final numbers for all Family Preservation models: PSP Family Preservation n=309 and Non-PSP Family Preservation n=317).

C.3.3. Comparison eligibility criteria: Entry/Re-entry cohort

Due to the non-existent or short history of care in this cohort, the Safety and ROSH data were necessary variables to match individuals to valid counterfactuals in the Entry/Re-entry cohort. Due to the small size of potential concurrent matches where selection bias was not a major concern, this cohort was matched with a historical selection of children. The study period was defined as:

1. PSP group: Must have an OOHC Care Category that starts after (but not including) 1st October 2018 and before 31st December 2020 (outcomes followed until 30th June 2021)
2. Comparison group: Must have an OOHC Care Category that starts after (but not including) 1st October 2014 and before 31st December 2016 (outcomes followed until 30th June 2017)

The eligible OOHC entry that was used was:

1. PSP group: The first OOHC entry/re-entry after 1st October 2018 associated with an active PSP package episode (active on or within 32 days of OOHC start) and before 1st October 2018
2. Comparison group: The first eligible OOHC entry/re-entry after 1st October 2014 and before 31st December 2016

From the results presented in Table C.3, we believe the match was broadly successful at creating matched groups with similar characteristic distributions. Any key characteristics that were still significantly different between the two groups we made sure to use in the analytic models (described in the analysis section below).

Table C.3 Demographic characteristics and history of children in the PSP groups and the historical control both prior to and after using propensity score matching in Cohort 2: Entry/Re-entry.[154]

	Prior to matching			After matching			
	Received PSP	Historical comparison	P-value	Matched, Received PSP	Matched, historical comparison	P-value	Used to match
n	613	1844		565	565		12
Demographic characteristics							
Female (n (%))	290 (47.3)	884 (47.9)	0.823	265 (46.9)	266 (47.1)	1.0	✓

[154] Variables are calculated at date of Entry/Re-entry.

Aboriginal (n (%))	217 (35.4)	698 (37.9)	0.298	206 (36.5)	220 (38.9)	0.425	✓
Age at start of OOHC episode (years; mean (SD))	3.51 (3.63)	4.65 (4.29)	<0.001	3.60 (4.25)	3.69 (3.69)	0.701	✓
OOHC history							
Had prior OOHC episode (n (%))	81 (13.2)	163 (8.8)	0.002	71 (12.6)	83 (14.7)	0.34	✓
# OOHC care episodes, including current episode (mean (SD))	1.18 (0.57)	1.13 (0.55)	0.06	1.17 (0.56)	1.21 (0.69)	0.235	
Residential care, ever before (n (%))	< 5	< 5	0.51	< 5	< 5	0.616	
Foster care, ever before (n (%))	52 (8.5)	79 (4.3)	<0.001	43 (7.6)	46 (8.1)	0.825	
Kinship care, ever before (n (%))	24 (3.9)	70 (3.8)	0.991	21 (3.7)	39 (6.9)	0.024	
Youth justice, ever before (n (%))	0.0 (0.0)	0.0 (0.0)	-	0.0 (0.0)	0.0 (0.0)	-	
History of disability placement, ever before (n (%))	0 (0.0)	< 5	0.74	0 (0.0)	3 (0.5)	0.248	
Residential care in year before (n (%))	< 5	< 5	1.0	< 5	< 5	1.0	
Foster care in year before (n (%))	19 (3.1)	17 (0.9)	<0.001	13 (2.3)	13 (2.3)	1	
Kinship care in year before (n (%))	6 (1.0)	12 (0.7)	0.581	< 5	7 (1.2)	0.545	
Current placement							
In residential care, 'current' (n (%))	9 (1.5)	86 (4.7)	0.001	9 (1.6)	10 (1.8)	1.0	✓
In foster care, 'current' (n (%))	529 (86.3)	1442 (78.2)	<0.001	483 (85.5)	470 (83.2)	0.326	
In kinship care, 'current' (n (%))	58 (9.5)	183 (9.9)	0.799	56 (9.9)	59 (10.4)	0.844	✓
Placement stability							
Had multiple short visits (< 8 day duration) in year before (n (%))	0 (0.0)	< 5	0.74	0 (0.0)	< 5	0.479	
# short visits (< 8 days duration) in year before (mean (SD))	0.00 (0.07)	0.01 (0.33)	0.576	0.00 (0.06)	0.02 (0.25)	0.194	
# placements (>= 8 days duration) in year before	0.08 (0.39)	0.02 (0.22)	<0.001	0.06 (0.34)	0.05 (0.30)	0.581	
Household placement history							

[155] The type of placement that a child or young person entered

A member of the household has been in care (n (%))	111 (18.1)	245 (13.3)	0.004	93 (16.5)	129 (22.8)	0.009	
A member of the household has been in care within the year prior (n (%))	251 (40.9)	371 (20.1)	<0.001	209 (37.0)	181 (32.0)	0.091	✓
A member of the household has been in foster care (n (%))	81 (13.2)	174 (9.4)	0.01	65 (11.5)	99 (17.5)	0.005	
A member of the household has been in foster care within the year prior (n (%))	189 (30.8)	205 (11.1)	<0.001	152 (26.9)	111 (19.6)	0.005	
Child protection history							
Number of ROSH per child (mean (SD))	9.98 (9.03)	8.01 (8.20)	<0.001	10.15 (9.21)	8.30 (7.40)	<0.001	
The age of first ROSH report (years; mean (SD))	0.86 (2.27)	1.15 (2.43)	0.009	0.93 (2.35)	0.79 (1.69)	0.249	
History of ROSH for physical abuse (n (%))	345 (56.3)	1031 (55.9)	0.91	323 (57.2)	324 (57.3)	1.0	
History of ROSH for neglect (n (%))	538 (87.8)	1081 (58.6)	<0.001	490 (86.7)	488 (86.4)	0.931	✓
History of ROSH for sexual abuse (n (%))	147 (24.0)	445 (24.1)	0.983	137 (24.2)	134 (23.7)	0.889	
History of ROSH for emotional abuse (n (%))	237 (38.7)	393 (21.3)	<0.001	221 (39.1)	130 (23.0)	<0.001	
History of ROSH for domestic violence (n (%))	217 (35.4)	781 (42.4)	0.003	209 (37.0)	229 (40.5)	0.246	
Safety and risk assessment history							
There is a child younger than 2 years old in the household (n (%))	315 (51.4)	854 (46.3)	0.033	285 (50.4)	276 (48.8)	0.634	
A child has been diagnosed with psychological, behavioural, emotional or medical problems (n (%))	282 (46.0)	780 (42.3)	0.12	258 (45.7)	238 (42.1)	0.255	✓
A child has developmental, intellectual, learning or physical disabilities (n (%))	119 (19.4)	333 (18.1)	0.491	113 (20.0)	117 (20.7)	0.825	
The carer has a history of substance abuse (n (%))	432 (70.5)	1303 (70.7)	0.97	402 (71.2)	403 (71.3)	1.0	

The parent / carer has psychological, cognitive, or mental health issues (n (%))	368 (60.0)	904 (49.0)	<0.001	328 (58.1)	327 (57.9)	1.0	✓
The housing is unsafe or are family is homeless (n (%))	263 (42.9)	879 (47.7)	0.045	245 (43.4)	236 (41.8)	0.63	✓
The parent / carer has a history of child protection (n (%))	280 (45.7)	825 (44.7)	0.721	258 (45.7)	263 (46.5)	0.811	
The household has experienced family violence (n (%))	366 (59.7)	1190 (64.5)	0.036	344 (60.9)	344 (60.9)	1.0	✓

A.1.1. Comparison eligibility criteria: Ongoing Care cohort

In the Ongoing Care cohort, children were matched primarily on their longer OOHC histories. All individuals who met eligibility criteria were included in the comparison (and the OOHC history summary), whether or not the child or young person had a full history from CP and SARA; this differs from those in the Entry/Re-entry cohort, as all children in those groups had to have both a CP and SARA record to be included. The study period was defined as:

1. PSP group: Must have an OOHC Care Category that starts on or before 1st October 2018 and ends after 1st October 2018
2. Comparison group: Must have an OOHC Care Category that starts on or before 1st October 2014 and ends after 1st October 2014

From the results presented in Table C.4, we believe the match was broadly successful at creating matched groups with similar characteristic distributions. Any key characteristics that were still significantly different between the two groups we made sure to use in the analytic models (described in the analysis section below).

Table C.4 Demographic characteristics and history of children in the PSP group and the historical control both prior to and after using propensity score matching in Cohort 3: Ongoing Care.[156]

	Prior to matching			After matching			
	Received PSP packages	Historical comparison	p-value	Matched, Received PSP packages	Matched, historical comparison	p-value	Used to match
n	7424	7988		6540	6540		
Demographic characteristics							
Female (n (%))	3432 (46.2)	3667 (45.9)	0.7	3037 (46.4)	2981 (45.6)	0.335	✓

[156] Variables are calculated at 1st October 2014 (matched historical comparison) and 1st October 2018 (Received PSP packages)

Aboriginal (n (%))	2736 (36.9)	2613 (32.7)	<0.001	2316 (35.4)	2270 (34.7)	0.41	✓
Age at 1st October (years; mean (SD))	9.90 (4.61)	9.38 (4.80)	<0.001	9.58 (4.66)	9.44 (4.64)	0.073	✓
Age at start of OOHC episode (years; mean (SD))	3.53 (3.64)	4.32 (4.19)	<0.001	3.74 (3.74)	3.82 (3.80)	0.251	✓
OOHC history							
Had prior OOHC episode (n (%))	1305 (17.6)	1898 (23.8)	<0.001	1244 (19.0)	1294 (19.8)	0.279	✓
# OOHC care episodes, including current episode (mean (SD))	1.25 (0.68)	1.41 (1.07)	<0.001	1.27 (0.70)	1.34 (0.95)	<0.001	
Residential care, ever before (n (%))	448 (6.0)	632 (7.9)	<0.001	429 (6.6)	395 (6.0)	0.235	
Foster care, ever before (n (%))	6792 (91.5)	7056 (88.3)	<0.001	5950 (91.0)	5876 (89.8)	0.03	
Kinship care, ever before (n (%))	2856 (38.5)	3147 (39.4)	0.245	2602 (39.8)	2414 (36.9)	0.001	
Youth justice, ever before (n (%))	8 (0.1)	15 (0.2)	0.281	8 (0.1)	5 (0.1)	0.579	
History of disability placement, ever before (n (%))	105 (1.4)	171 (2.1)	0.001	101 (1.5)	102 (1.6)	1.0	
Residential care in year before (n (%))	317 (4.3)	540 (6.8)	<0.001	306 (4.7)	338 (5.2)	0.209	
Foster care in year before (n (%))	5869 (79.1)	5851 (73.3)	<0.001	5067 (77.5)	5035 (77.0)	0.539	
Kinship care in year before (n (%))	1586 (21.4)	2012 (25.2)	<0.001	1503 (23.0)	1497 (22.9)	0.925	
Current placement							
In residential care, 'current' (n (%))	285 (3.8)	469 (5.9)	<0.001	277 (4.2)	300 (4.6)	0.349	✓
In foster care, 'current' (n (%))	5674 (76.4)	5545 (69.4)	<0.001	4876 (74.6)	4881 (74.6)	0.936	
In kinship care, 'current' (n (%))	1414 (19.0)	1682 (21.1)	0.002	1336 (20.4)	1290 (19.7)	0.326	✓

[157] Placement type of a child or young person on the 1st October 2018

Placement stability							
Had multiple long visits (≥ 8 day duration) in year before (n (%))				1193 (18.2)	1249 (19.1)	0.217	✓
Had multiple short visits (< 8 day duration) in year before (n (%))	91 (1.2)	191 (2.4)	<0.001	90 (1.4)	91 (1.4)	0.998	✓
# short visits (< 8 days duration) in year before (mean (SD))	0.07 (0.71)	0.11 (0.53)	<0.001	0.08 (0.75)	0.07 (0.40)	0.279	
# placements (>= 8 days duration) in year before	1.24 (0.65)	1.35 (0.81)	<0.001	1.27 (0.68)	1.29 (0.72)	0.074	
Child protection history							
n	7424	7988		6536	6532		
Number of ROSH per child (mean (SD))	11.53 (9.44)	10.73 (9.52)	<0.001	11.72 (9.57)	10.21 (9.02)	<0.001	
The age of first ROSH report (years; mean (SD))	0.73 (1.70)	1.01 (2.10)	<0.001	0.76 (1.74)	0.91 (1.95)	<0.001	
History of ROSH for physical abuse (n (%))	5381 (72.5)	5419 (67.9)	<0.001	4764 (72.9)	4345 (66.5)	<0.001	
History of ROSH for neglect (n (%))	5053 (68.1)	5078 (63.7)	<0.001	4518 (69.1)	4013 (61.4)	<0.001	✓
History of ROSH for sexual abuse (n (%))	3687 (49.7)	3077 (38.6)	<0.001	3258 (49.8)	2462 (37.7)	<0.001	
History of ROSH for emotional abuse (n (%))	2657 (35.8)	2956 (37.1)	0.109	2349 (35.9)	2376 (36.4)	0.617	
History of ROSH for domestic violence (n (%))	3628 (48.9)	3757 (47.1)	0.028	3230 (49.4)	3027 (46.3)	<0.001	
Safety and risk assessment history							
n	3003	878		3033	612		
There is a child younger than 2 years old in the household (n (%))	1557 (51.8)	420 (47.8)	0.04	1542 (50.8)	259 (42.3)	<0.001	
A child has been diagnosed with psychological, behavioural, emotional or medical problems (n (%))	1289 (42.9)	407 (46.4)	0.078	1300 (42.9)	261 (42.6)	0.958	✓

A child has developmental, intellectual, learning or physical disabilities (n (%))	801 (26.7)	207 (23.6)	0.072	796 (26.2)	126 (20.6)	0.004	
The carer has a history of substance abuse (n (%))	2224 (74.1)	627 (71.4)	0.129	2229 (73.5)	399 (65.2)	<0.001	
The parent / carer has psychological, cognitive, or mental health issues (n (%))	1622 (54.0)	487 (55.5)	0.47	1615 (53.2)	318 (52.0)	0.591	✓
The housing is unsafe or are family is homeless (n (%))	1355 (45.1)	369 (42.0)	0.113	1370 (45.2)	250 (40.8)	0.055	✓
The parent / carer has a history of child protection (n (%))	1642 (54.7)	409 (46.6)	<0.001	1629 (53.7)	256 (41.8)	<0.001	
The household has experienced family violence (n (%))	2105 (70.1)	597 (68.0)	0.251	2111 (69.6)	399 (65.2)	0.036	✓

A.1.2. Notes on matching variables: All cohorts

Correlations between variables were tested and variables were excluded if the correlation was > 0.35.

In the Entry/Re-entry cohort, the two groups were also matched on a variable that calculated the days from the evaluation start period (1st October 2014/2018) until entry/re-entry date (to account for and mitigate variability in follow-up time).

In the Entry/Re-entry cohort, age at care category start was rounded when used in the match (although not rounded in the variable comparison table above).

A.2 Analysis

A.2.1. Variables used in analysis and how they were defined

For the analysis, we constructed a series of covariate and outcomes variables to use in a series of multivariate models. The covariates and outcomes were constructed in binary form; covariates are described in Table C.5 while the outcome variables are described in each model in Appendix F.

Table C.5 includes additional detail about how variables were created and where data was sourced from. It describes which models (by cohort) each variable could potentially be included in (before removing non-significant covariates at the 90% significance level [p > 0.1]; refer to analysis section for more detail): ✓ = possibly included and X = not included.

Notably, prior to analysis, age was also transformed into a series of binomial variables; of these, only one was selected for inclusion in Entry/Re-entry and Ongoing Care models, depending on the age distribution of the children included in the analysis.

Table C.9.1 Variables for multivariate models: how they were created, where data was sourced from, and in which models they were eligible for inclusion

Variable	How variables were created	Family Preservation	Entry/Re-entry	Ongoing Care	PSP-specific models
Received PSP Package	Did the child or young person receive PSP package? (PSP Package data and Family Preservation data; refer to previous sections regarding eligibility criteria and timing)	✓	✓	✓	X – only those in the PSP group were included
Female	Was the child or young person identified as Female?	✓	✓	✓	✓
Aboriginal	Was the child ever identified as Aboriginal in the ChildStory data?	✓	✓	✓	✓
Age variables	***At the 'Start Date' for the model, how old was the child?*** *Both age categories possible for household-level models; only one age category for child-level models*				
< 6 months old	- were they younger than 6 months old?	X	✓	✓	✓
< 2 years old	- were they younger than 2 years old?	X	✓	✓	✓
< 5 years old	- were they younger than 5 years old?	X	✓	✓	✓
>= 13 years old	- were they older than 13 years old?	X	✓	✓	✓
Any child in the household < 6 months	- was any child in the household younger than 6 months old?	✓	X	X	X
Any child in the household > 11 years	- was any child in the household older than 11 years old?	✓	X	X	X
In Kinship Care	At the 'Start Date' was the child in	X	✓	✓	✓

	Kinship Care? (vs Foster Care): From OOHC data				
Prior ROSH for neglect	From Child Protection data	✓	✓	✓	✓
Prior ROSH for sexual abuse	From Child Protection data	✓	✓	✓	✓
Prior ROSH for physical abuse	From Child Protection data	✓	✓	✓	✓
Prior ROSH for domestic violence	From Child Protection data	✓	✓	✓	✓
Prior ROSH for emotional abuse	From Child Protection data	✓	✓	✓	✓
Any child in household < 2 years old	From Safety and Risk Assessments	✓	✓	X	✓ if Entry/Re-entry
Limited visibility in community	From Safety and Risk Assessments	✓	✓	X	✓ if Entry/Re-entry
Does the child have any diagnosed psychological, behavioural, emotional, or medical problems?	From Safety and Risk Assessments	✓	✓	X	✓ if Entry/Re-entry
Does the child have any developmental, intellectual, learning, or physical disabilities?	From Safety and Risk Assessments	✓	✓	X	✓ if Entry/Re-entry
Does the carer have a history of substance abuse? (drug and/or alcohol)	From Safety and Risk Assessments	✓	✓	X	✓ if Entry/Re-entry
Does the parent/ carer have any psychological, cognitive, or mental health issues?	From Safety and Risk Assessments	✓	✓	X	✓ if Entry/Re-entry
Is housing unsafe or are they homeless?	From Safety and Risk Assessments	✓	✓	X	✓ if Entry/Re-entry
Did the parent / carer have a history of child protection?	From Safety and Risk Assessments	✓	✓	X	✓ if Entry/Re-entry
Is there any family violence in the household? (Domestic violence in past year / Any prior DV ROSH?)	From Safety and Risk Assessments	✓	✓	X	✓ if Entry/Re-entry

Child has spent more than 50% of life in current OOHC spell	Calculated from age at Start Date vs length of time in current out-of-home care episode to date	X	X	✓	✓ if Ongoing care
Prior history of OOHC	Prior episode of out-of-home care, before current continuous episode	X	✓	X	✓ if Entry/Re-entry
Received PSP Needs Package: Low Needs	From PSP Package Data, according to Package 'type'	X	X	X	✓
Received PSP Needs Package: Long Term Care	From PSP Package Data, according to Package 'type'	X	X	X	✓
Received PSP Specialist Package: 15 years+ Reconnect Package	From PSP Package Data, according to Package 'type'	X	X	X	✓
Most recent Child Assessment Tool score: Low	CAT Data	X	X	X	✓
Most recent Child Assessment Tool score: High	CAT Data	X	X	X	✓
Received PSP services from a small agency?	PSP Provider (agency) information was from PSP Package data. Small agencies were defined as at an agency with a contracted volume of < 100 placements	X	X	X	✓
Received PSP services from a large agency?	PSP Provider (agency) information was from PSP Package data. Large agencies were defined as at an agency with a contracted volume of >= 300 placements	X	X	X	✓
Received PSP services in a rural or regional location?	District-level information from OOHC data (refer to Table C.6)	X	X	X	✓

To construct a location classification variable, which describes whether the child was receiving services in a rural/regional versus metropolitan area, we converted District-level information into a binary variable (Table C.6).

Table C.9.2 Location classification: rural/regional versus metropolitan according to District data

Districts	CSC group / 'district cluster'	Location classification
Mid North Coast District	Mid North Coast & Northern NSW	rural/regional
Northern NSW District		rural/regional
Western NSW District	Far West, Western NSW and Murrumbidgee	rural/regional
Far West		rural/regional
Murrumbidgee District		rural/regional
Illawarra Shoalhaven District	Illawarra Shoalhaven and Southern NSW	rural/regional [161]
Southern NSW District		rural/regional
Nepean Blue Mountains District	Nepean Blue Mountain and Western Sydney	metro
Western Sydney District		metro
South Western Sydney District	South Western Sydney	metro
Sydney District	Sydney, Northern Sydney and South Eastern Sydney	metro
Northern Sydney District		metro
South Eastern Sydney District		metro
Hunter District	Hunter, Central Coast and New England	rural/regional
New England District[162]		rural/regional
Central Coast District		rural/regional [163]

A.3 Analytic process

Our analytic strategy was similar across each of the effectiveness evaluation questions. After identifying the cohorts, matching the counterfactuals, constructing the predictor and outcome variables, we built multivariate analytical models (Cox Proportional Hazards models and Generalised linear models).

A.3.1. General approach: Cox Proportional Hazard Models

We built a series of statistical models that assessed the impact of PSP while controlling for differences in individuals and their prior involvement with Child Protection (including Safety and Risk Assessments) and the out-of-home care system. Children and families who received services through PSP commenced and/or exited at different time points; as a result, we have different follow up lengths for children across our matched samples. To account for this, we used a statistical modelling technique that accounts for this range in follow up time. The Cox Proportional Hazards Regression allows us to model the time to an

[158] Those classified under 'Statewide Services' were removed from the analysis.
[159] District level data was provided in the ChildStory OOHC data.
[160] These groups are according to the classifications at the top of the website: https://web.archive.org/web/20220306210932/https://dcj.nsw.gov.au/contact-us/csc.html which is a prior version from May 2022 of the current page https://www.dcj.nsw.gov.au/contact-us/csc.html
[161] According to the classifications from the Department of Health, these districts are considered 'metro' rather than 'regional' according to: https://www.health.nsw.gov.au/lhd/Pages/default.aspx
[162] New England was previously classified in a cluster with Hunter and Central Coast, but has recently moved into a new cluster with Mid North Coast and Northern NSW. However, this has not changed the classification of rural/regional vs metropolitan (i.e., metro).
[163] According to the classifications from the Department of Health, these districts are considered 'metro' rather than 'regional' according to: https://www.health.nsw.gov.au/lhd/Pages/default.aspx

event (i.e., time in days to which a client experienced the outcome) occurring while considering a range of other factors which may have influenced it (Cox, 1972[164]). This model provides an estimate of the hazard ratio and its confidence interval. A simplified version (Kaplan-Meier curve) provides a univariate estimate for the main effect (receiving PSP or not) and provides a visualisation of the survival curves.

A.3.2. GLMs and why we used it for HSC completion

When investigating the outcome HSC completion, there was no no timed aspect so we could not apply a Cox Proportional Hazards regression. Instead, we ran a binomial regression generalised linear model (GLM).

We ran a GLM on the proportion of young people who attained their HSC in the Ongoing Care cohort. The GLM here compared the proportion of young people eligible to achieve their HSC in the PSP and comparison periods (i.e., those with the potential to complete year 12 in the time frame), and the proportion of those that achieved an HSC.

A.3.3. Construction of the multivariate models

Construction of the multivariate models (Cox Proportional Hazards and GLM models) involved:

1. Variables in these models that were significant at the 90 per cent level were included in an omnibus model - i.e., a model that examines fit - along with gender, Aboriginality and any significant differences between PSP and services as usual / in the matched comparison group.
2. Correlations between variables were tested and variables were excluded if the correlation was > 0.35.
3. The model was refined using backward elimination until the remaining predictors (except gender, Aboriginality and any significantly different variables were all significant to the 90% level ($p < 0.1$).
4. The final model was tested to ensure that it met proportional hazards assumptions. For those that did not, predictors that violated the assumption were stratified to allow for their inclusion in the model (stratified models allow different baseline hazards, which are then aggregated). Model fit was assessed through visual inspection of residual symmetry.
5. For models where the main effect of Receiving PSP packages was significant, we computed adjusted survival curves to assess the survival rate after 1 year while adjusting for other covariates (this was incorporated into the cost-benefit analysis discussion).
6. All out-of-home care comparison models (for the Entry/Re-entry and Ongoing Care cohorts) were also run as PSP-specific models, with the additional PSP-specific covariates (Table C.5) to tease apart how the outcomes were affected by types of PSP packages received, agency sizes (small / medium / large), and locations of providers (rural/regional vs metropolitan).

[164] Cox, D. R. “Regression Models and Life-Tables.” *Journal of the Royal Statistical Society. Series B (Methodological)* 34, no. 2 (1972): 187–220. http://www.jstor.org/stable/2985181.

7 Ongoing Care models with sufficient sample sizes were replicated and censored at 1 March 2020 to determine whether the results of the models hold when only considering the period of time prior to the COVID-19 pandemic in Australia.

A.4 Selecting information from PSP Payments and OOHC data

Details in relation to the selection of observations from the PSP Payments data and from the OOHC data are provided below.

From the PSP Payments data:

- We select only the active packages, the packages awaiting approval and draft packages from the PSP Payments data. The observations that indicate missing on this variable ('packagestatus') are excluded. There are 71,016 package observations for 10,579 children during the 2.75 years observation window.
- For the 2018/19 financial year, we keep all observations which started before 1st July 2019; and we exclude observations which ended before 1st October 2018.
- For the 2019/20 financial year, we keep all observations which started before 1st July 2020; and we exclude observations which ended before 1st July 2019.
- For the 2020/21 financial year, we keep all observations which started before 1st July 2021; and we exclude observations which ended before 1st July 2020.
- We link the PSP Payments data to the OOHC data, in order to cross-check whether all children observed in the PSP Payments data are present in the OOHC data. In total, 1,817 children covering 12,304 observations of PSP packages are not linked (with two-third of these children only observed in 2020/21 PSP payments data) and are therefore excluded from the analysis in this section.165 We observe 8,762 children over the nearly three financial years of PSP Payments data.
- To measure the Full-time Equivalent (FTE) by placement type, we count the number of days receiving the service type by child and financial year (and over the 2.75 years). FTE is calculated as the number of days receiving the service type divided by 365 days (or 366 days for 2020).
- The number of distinct placement types decreases while the average FTE increases as we combine placement type observations whenever the same placement type and care arrangement occurs at least twice for a child within a financial year and sum the FTE of these observations.
- We link the PSP Payments data to the matched Entry/Re-entry cohort (555 children) and Ongoing Care cohort (6,263 children), excluding any cases that are not in these cohorts, to ensure we only select cases that are included in the Effectiveness analyses.

We assume that if a child does not appear in the PSP payments data, they have not received a PSP package. We understand that there may be a delay in entering information in the system in some cases, which could erroneously lead to some children being classified as not receiving PSP services. To assess the potential extent of this issue, we

[165] It is not clear why this is the case, but the higher prevalence for the most recent financial year suggests that it may be due to delays in entering the data or perhaps a later extraction date was used for the PSP payments data, leading to more recent records in the PSP payments data. As the OOHC data are the starting point for selecting the various cohorts used in the analyses, these observations cannot be used in any of the analyses in this report.

compare how many extra PSP cases have appeared in the data for 2019/20 using the current extract compared to the extract of one year ago. In the financial year 2019/20 the number of distinct children who received at least one PSP package was counted as 8,616. Using the latest data, we count 8,667 children. This provides an indication of the number of cases that may be missing for the most recent year of PSP payments data, which seems likely to be small.

From the OOHC data, which contain observations for DCJ- and NGO-delivered services, the following selections are made:

- Only children receiving non-DCJ services at the time of entry or on 1st October 2014 or 2018 (if time of entry was before 1st October 2014 or 2018) are included.[166] Children in residential care at this point in time are also excluded. In the pre-PSP period 11,338 children are observed with these characteristics, while post PSP 9,545 children are observed in the OOHC data.
- We exclude the records in the OOHC data reporting on start and end dates for DCJ services that these children may have received during the observation period to avoid double-counting, as we use the payment amounts on these services during the relevant period from other data sources (as discussed below).
- Duplicates, defined as observations with identical child identity numbers, financial year, priority placement types and start and end dates, are excluded.167
- Using priority placement date variables, we avoid complications due to many (potential) actual movements by the children, as the rows with the same values on these variables are excluded even if there are some differences in the actual placement date variables due to these movements.
- For the 2014/15 financial year, we keep all observations which started before 1st July 2015; and we exclude observations which ended before 1st October 2014.
- For the 2015/16 financial year, we keep all observations which started before 1st July 2016; and we exclude observations which ended before 1st July 2015.
- For the 2016/17 financial year, we keep all observations which started before 1st July 2017; and we exclude observations which ended before 1st July 2016.
- We link information from the CAT score data, so that the level of payment is known (i.e., whether it is General Foster Care, General Foster Care +1, General Foster Care +2, Intensive Foster Care, Residential Care, or Intensive Residential Care). Foster carers and kinship carers receive the same Allowance rates, depending on the needs of the child. From the CAT score data, we keep only one CAT score per child per financial year; the most recent one is selected.
- For observations without CAT score data, we use information on priority placement type and assume the Standard level of care is required as this is the most common level.
- To measure the Full-time Equivalent (FTE) by placement type, we count the number of days receiving the service type by child and financial year (and over the 2.75 years).

[166] We use the variable 'priorityplacementprovidergrouped' to identify this group.
[167] The variables used for this are: childid, financialyear, priorityplacementtype, priorityplacementstartdate and priorityplacementenddate.

FTE is calculated as the number of days receiving the service type divided by 365 days (or 366 days for 2016 or 2020).

- The number of distinct placement types decreases while the average FTE increases as we combine placement type observations whenever the same placement type and care arrangement occurs at least twice for a child within a financial year and sum the FTE of these observations.

Appendix B Supplementary Implementation Results

B.1 Inner Setting Survey Valence ratings

Table D.1 Valence ratings showing commonly experienced barriers and enablers, by CFIR construct

Construct	1*	2*	3*	4	5	6	7	8	9	10	11	12	13	14
Program Characteristics														
Intervention Source	-2	-2	Missing	-2	-1	-2	-2	+1	-2	Missing	0	Missing	+1	0
Design Quality and Packaging	-2	-2	-2	-2	-2	-2	-2	-2	-1	-2	-2	-2	-2	-2
Complexity (reversed)	-2	-1	Missing	-2	-2	-1	-2	-2	Missing	-2	-2	0	Missing	-1
Costs	-2	-2	-2	-2	-2	-2	-2	Missing	-2	Missing	-1	Missing	-2	-1
Individual Characteristics														
Beliefs about Intervention	0	0	Missing	Missing	Missing	+2	+2	+1	+1	+2	Missing	+2	+2	+2
Inner Setting														
Structural Characteristics	+1	+2	-1	0	-2	-1	+1	-2	+1	-1	Missing	0	-1	+2
Readiness – Resources	+1	+1	0	+1	-1	-1	-2	-1	+1	-1	0	0	+1	+2
Outer Setting														
Client Needs	-1	0	0	-2	-2	-2	-2	-2	-2	-2	-2	-1	-1	-1
Community Characteristics	-2	+2	-1	-1	0	+1	-2	-2	-1	-1	Missing	-1	Missing	+1
Process														
Decision-making	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-1	-2
Internal Leaders	Missing	+2	Missing	Missing	Missing	+2	+2	+2	Missing	+2	+1	+2	Missing	+2

External Agents	Missing	+2	0	-1	+2	-2	+2	+1	+2	+2	+2	0	+2	+2
System Characteristics														
Systems Architecture	-2	Missing	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-1
Resource Continuity	-2	-2	-2	-2	-1	-2	-2	-1	-2	-2	-2	-2	-2	-2

B.2 Survey findings

Learning climate

Five questions explored respondent perceptions of the learning climate within their organisation. Responses were consistent across each of the five questions, with the vast majority of respondents indicated that they agreed or strongly agreed with each item. When responses were divided between those in management roles and all others, some variation was observed with those in management more likely to perceive a positive sentiment. The variation in responses by role was examined using a two-sample Wilcoxon test and the difference by job role *was* statistically significant for three of the five questions:

- People in our organisation actively seek new ways to improve how we do things,
- This organisation learns from its mistakes, and
- We regularly take time to consider ways to improve how we do things.

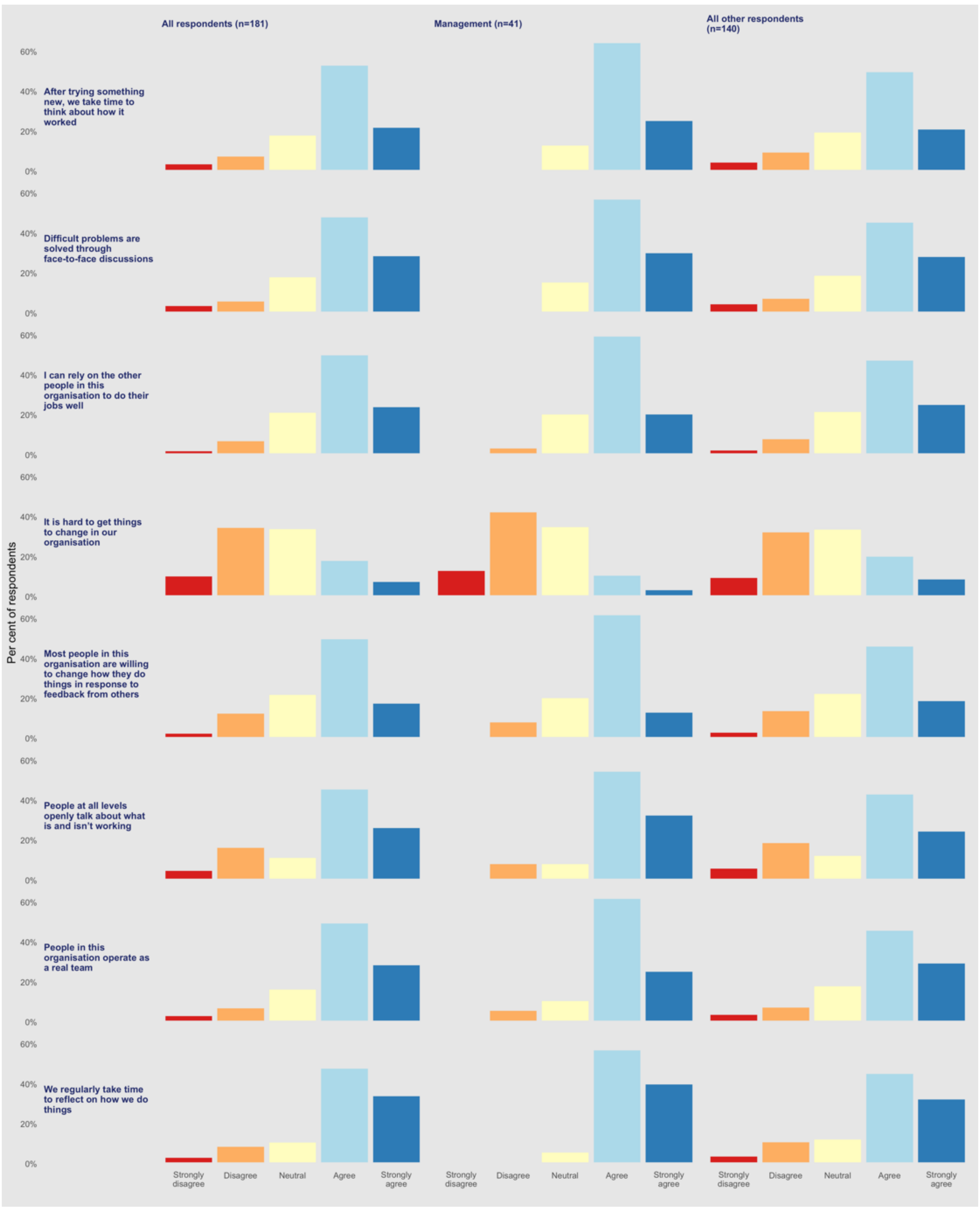
Figure D.2.9.1 Perceptions of survey respondents on the learning climate within their agency (which provides PSP services)

Culture

Eight questions explored respondent perceptions of culture within their agency. Overall, responses were consistent across seven of the eight included questions, with the vast majority of respondents indicated that they agreed or strongly agreed with each item. This varied with the question *It is hard to get things to change in our organisation* where the most common response disagreed (34 per cent), followed by neutral (33 per cent), however this is explained by the reversing of the scales for this question.

When responses were divided between those in management roles and all others, some variation was observed with those in management more likely to perceive a positive sentiment. The variation in responses by role was examined using a two-sample Wilcoxon test and the difference by job role was *not* statistically significant for any of the eight questions.

Figure D.2.9.2 Perceptions of survey respondents on their agency's culture



Leadership engagement

Four questions explored respondent perceptions of leadership engagement within their NGO. Responses were consistent across each of the four questions, with the vast majority of respondents indicating they agreed or strongly agreed with each. When responses were divided between those in management roles and all others, some variation was observed with those in management more likely to perceive a positive sentiment. The variation in responses by role was examined using a two-sample Wilcoxon test and the difference by job role was *not* statistically significant for any of the four questions.

Available resources

Three questions explored respondent perceptions of the available resources (i.e. budget, personnel and training) within their agency. Responses were consistent across each of the five questions, with the majority of respondents indicated that they agreed or were neutral. However, there was also solid minority that disagreed with each statement, particularly the 23.2 per cent of respondents who disagreed that they had sufficient budget or financial resources.

Table D.2.3 Available resources, responses by question

Question	Responses (%)				
	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
We have the necessary support in terms of: Budget or financial resources	3.3	23.2	32	**33.7**	7.7
We have the necessary support in terms of: Staff	6.6	17.7	23.2	**43.1**	9.4
We have the necessary support in terms of: Training	3.3	13.3	19.4	**47.8**	16.1

When responses were divided between those in management roles and all others, some variation was observed with those in management more likely to perceive a positive sentiment. The variation in responses by role was examined using a two-sample Wilcoxon test and the difference by job role was *not* statistically significant for any of the three questions.

Figure D.2.4 Perceptions of survey respondents on the level of engagement shown by their agency's leadership

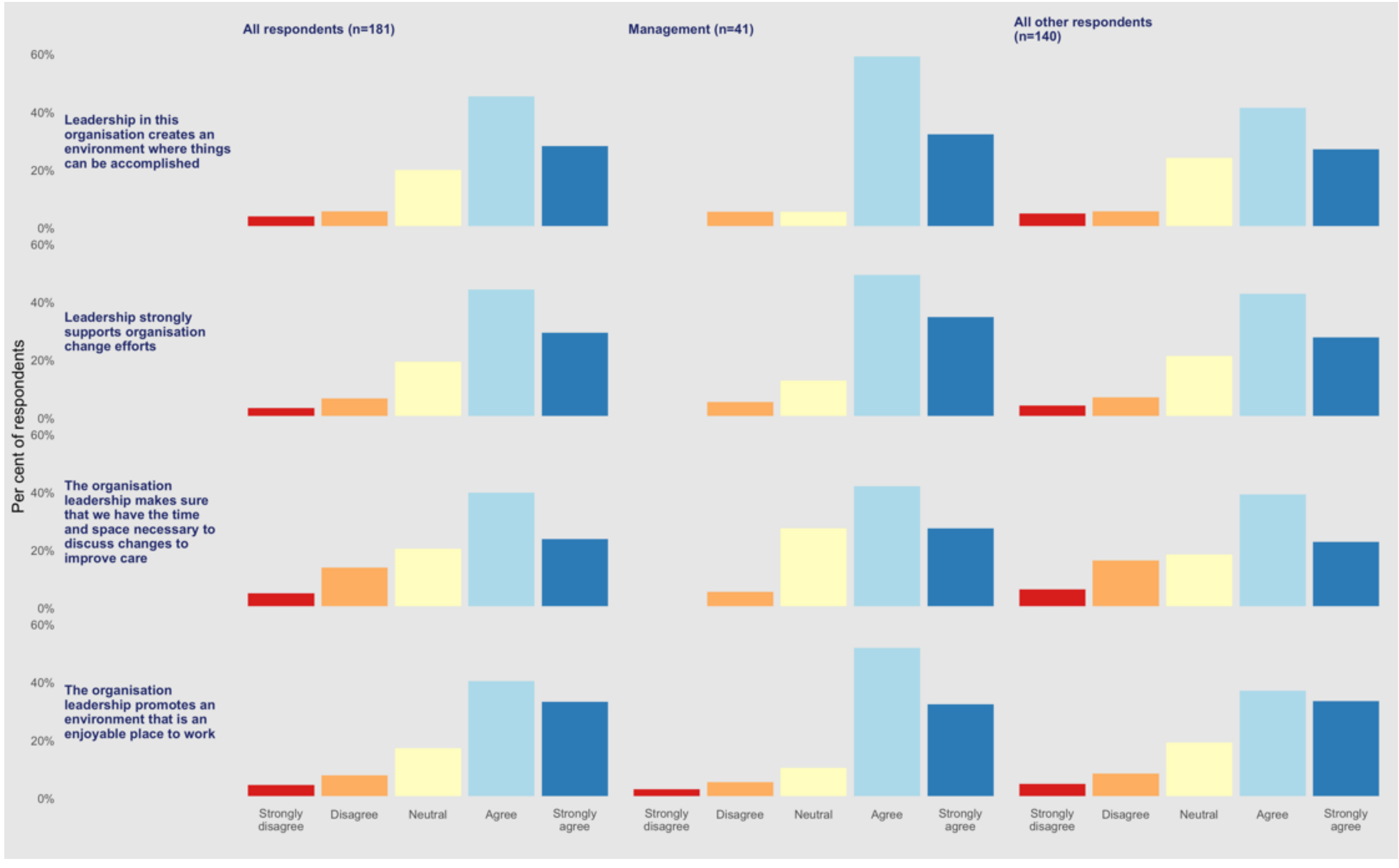
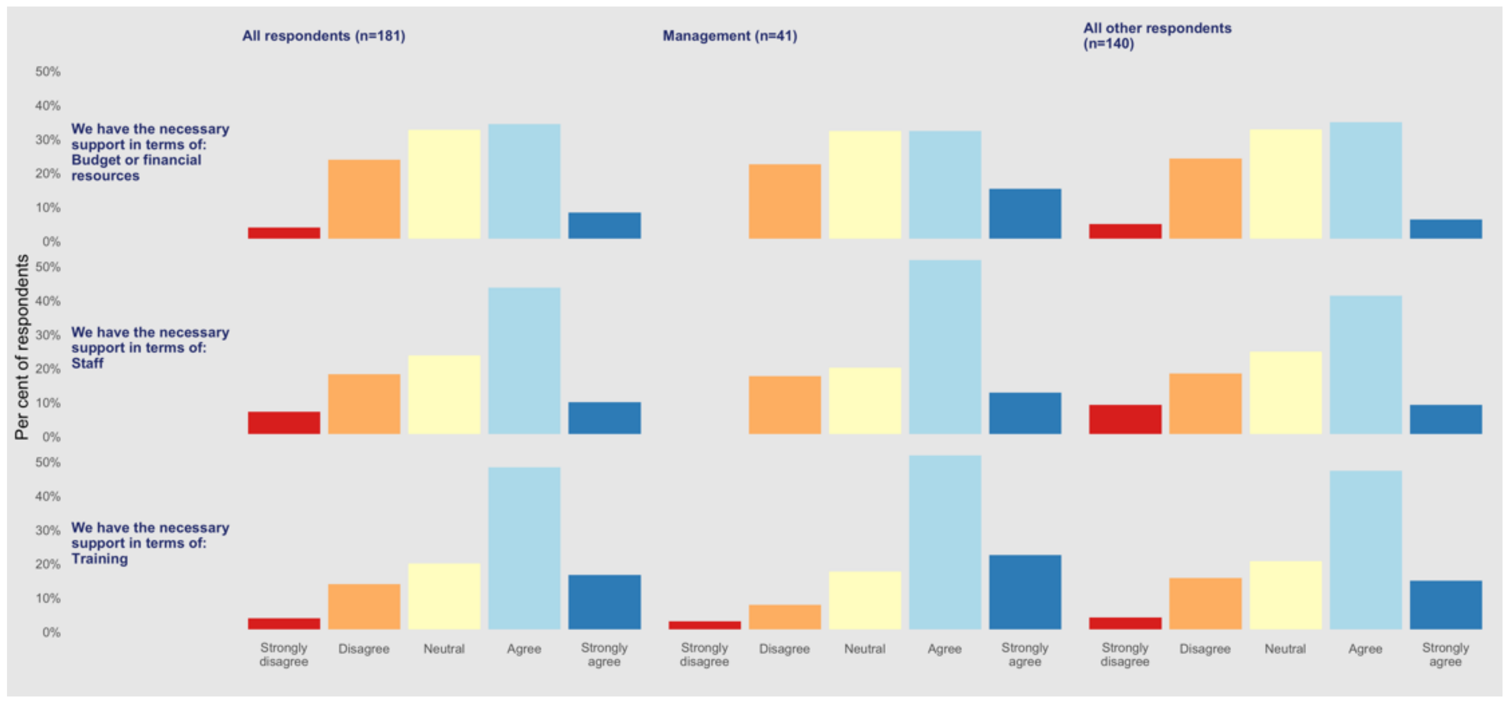


Figure D.2.5 Perceptions of survey respondents on the availability of resources in their agency



Appendix C Supplementary Reach Results

The information in this Appendix is intended to provide additional supporting information for the relevant sections in Chapter 5: Reach. It is not intended to be read as a stand-alone document.

C.1 What are the characteristics of children being seen by PSP Providers versus those who were not?

To understand how the characteristics of children differed between children seen by PSP providers versus those who were not, we compared all children over the evaluation period of 1st October 2018 to 30th June 2021. Comparisons were made in the concurrent time period to better understand whether the packages were targeted towards households or children with particular histories or characteristics and to ensure that such differences were accounted for in the subsequent statistical matching process. Thus, prior to identifying matched comparison groups, we compared how families who received Family Preservation packages differed from those who did not (Table E.1). We also compared children who had a new entry (or re-entry) into out-of-home care within the evaluation period who were seen by PSP providers and received PSP packages compared with children in the same evaluation period who did not (Table E.2); notably, if a child entered OOHC multiple times over the course of the evaluation period, only the first entry was considered. Finally, we compared all children who were in out-of-home care and receiving an active PSP package on 1st October 2018 with children who were in care but not receiving PSP funding on 1st October 2018 (Table E.3).

Table E.1 Comparison of characteristics between those households who received a PSP package and those that were eligible for one, in the Family Preservation cohort

Variables	Received PSP package in Family Preservation cohort (n=371)	Eligible for Family Preservation cohort, but did not receive one (n=17,022)	*p* value
Received a PSP package (n (%))	371 (100.0)	0 (0.0)	<0.001
Number of kids in household (mean (SD))	2.87 (1.76)	2.47 (1.54)	<0.001
Ratio of female children (mean (SD))	0.46 (0.35)	0.48 (0.38)	0.275
Ratio of Aboriginal children (mean (SD))	0.68 (0.45)	0.35 (0.46)	<0.001
Mean age of Household (mean (SD))	6.08 (4.35)	6.46 (4.62)	0.117
Minimum age of Household (mean (SD))	3.53 (3.99)	4.28 (4.54)	0.002
Max age of Household (mean (SD))	8.60 (5.73)	8.59 (5.67)	0.973

Variables	Received PSP package in Family Preservation cohort (n=371)	Eligible for Family Preservation cohort, but did not receive one (n=17,022)	*p* value
Median age of Household (mean (SD))	6.13 (4.50)	6.50 (4.76)	0.142
Number of prior ROSH in household (mean (SD))	14.81 (12.01)	6.57 (6.93)	<0.001
Age at first ROSH in household (mean (SD))	0.41 (1.43)	1.01 (2.35)	<0.001
Household had prior ROSH for Physical Abuse (n (%))	265 (71.4)	11183 (65.7)	0.025
Household had prior ROSH for Neglect (n (%))	322 (86.8)	12203 (71.7)	<0.001
Household had prior ROSH for Sexual Abuse (n (%))	171 (46.1)	6222 (36.6)	<0.001
Household had prior ROSH for Emotional Abuse (n (%))	189 (50.9)	7368 (43.3)	0.004
Household had prior ROSH for Domestic Violence (n (%))	228 (61.5)	8507 (50.0)	<0.001
Is there a child younger than 2 years old in the household? (n (%))	193 (52.0)	7381 (43.4)	0.001
Is there 'limited visibility' for the child(ren)? (n (%))	68 (18.3)	2814 (16.5)	0.395
Does the child have any diagnosed psychological, behavioural, emotional or medical problems? (n (%))	101 (27.2)	3062 (18.0)	<0.001
Does the child have any developmental, intellectual, learning or physical disabilities? (n (%))	125 (33.7)	4416 (25.9)	0.001
Does the carer have a history of substance abuse? (drug and/or alcohol) (n (%))	267 (72.0)	9925 (58.3)	<0.001
Does the parent / carer have any psychological, cognitive, or mental health issues? (n (%))	217 (58.5)	9190 (54.0)	0.095
Is housing unsafe or are they homeless? (n (%))	52 (14.0)	1793 (10.5)	0.038
Did the parent / carer have a history of child protection? (n (%))	227 (61.2)	7429 (43.6)	<0.001
Is there any family violence in the household? (Domestic violence in past year / any prior DV ROSH?) (n (%))	276 (74.4)	11040 (64.9)	<0.001
Household has had a child in OOHC previously (n (%))	32 (8.6)	1270 (7.5)	0.457
Household had a child in OOHC in the previous year (n (%))	15 (4.0)	447 (2.6)	0.129

Table E.2 Comparison of characteristics between those children who received a PSP package from a PSP provider and those who did not receive a PSP package, in the Entry/Re-entry cohort

Variables	Received a PSP package from a PSP Provider in the Entry/Re-entry cohort (n=587[168])	Did not receive a PSP package but were eligible for the Entry/Re-entry cohort (n=283)	*p* value
Female (n (%))	277 (47.2)	142 (50.2)	0.451
Indigenous (n (%))	210 (35.8)	124 (43.8)	0.027
Age in years at start of OOHC episode (mean (SD))	3.04 (3.71)	4.56 (4.41)	<0.001
Had prior OOHC episode (n (%))	65 (11.1)	38 (13.4)	0.371
# OOHC care episodes, including 'entry' (mean (SD))	1.14 (0.51)	1.16 (0.46)	0.584
Foster care, ever before (n (%))	41 (7.0)	19 (6.7)	0.996
Kinship care, ever before (n (%))	16 (2.7)	21 (7.4)	0.002
Foster care (n (%))	529 (90.1)	78 (27.6)	<0.001
Kinship care (n (%))	58 (9.9)	205 (72.4)	<0.001
Is there a child younger than 2 years old in the household? (n (%))	308 (52.5)	115 (40.6)	0.001
Does the child have any diagnosed psychological, behavioural, emotional or medical problems? (n (%))	268 (45.7)	135 (47.7)	0.621
Does the child have any developmental, intellectual, learning or physical disabilities? (n (%))	107 (18.2)	53 (18.7)	0.932
Does the parent / carer have a history of substance abuse? (drug and/or alcohol) (n (%))	417 (71.0)	196 (69.3)	0.645
Does the parent / carer have any psychological, cognitive, or mental health issues? (n (%))	354 (60.3)	154 (54.4)	0.115
Is housing unsafe or are they homeless? (n (%))	254 (43.3)	137 (48.4)	0.175
Did the parent / carer have a history of child protection? (n (%))	267 (45.5)	101 (35.7)	0.008
Is there any family violence in the household? (Domestic violence in past year / any prior DV ROSH?) (n (%))	349 (59.5)	167 (59.0)	0.959
How many ROSH per child? (mean (SD))	9.37 (8.04)	9.65 (8.17)	0.642
Age at first ROSH (years; mean (SD))	0.72 (1.88)	0.97 (2.09)	0.076
History of ROSH for physical abuse (n (%))	322 (54.9)	176 (62.2)	0.048
History of ROSH for neglect (n (%))	515 (87.7)	243 (85.9)	0.507

[168] This table was constructed prior to matching and prior to a data refresh in November 2021. The cohort number here is different to that presented in subsequent reach tables (n= 640).

Variables	Received a PSP package from a PSP Provider in the Entry/Re-entry cohort (n=587[168])	Did not receive a PSP package but were eligible for the Entry/Re-entry cohort (n=283)	*p* value
History of ROSH for sexual abuse (n (%))	128 (21.8)	65 (23.0)	0.765
History of ROSH for emotional abuse (n (%))	216 (36.8)	115 (40.6)	0.309
History of ROSH for domestic violence (n (%))	204 (34.8)	111 (39.2)	0.226
# short visits (< 8 days duration) in year before (mean (SD))	0.01 (0.07)	0.00 (0.00)	0.229
History of prior OOHC placement for any child in the household	96 (16.4)	49 (17.3)	0.796
History of prior OOHC placement in the year before for any child in the household	236 (40.2)	143 (50.5)	0.005

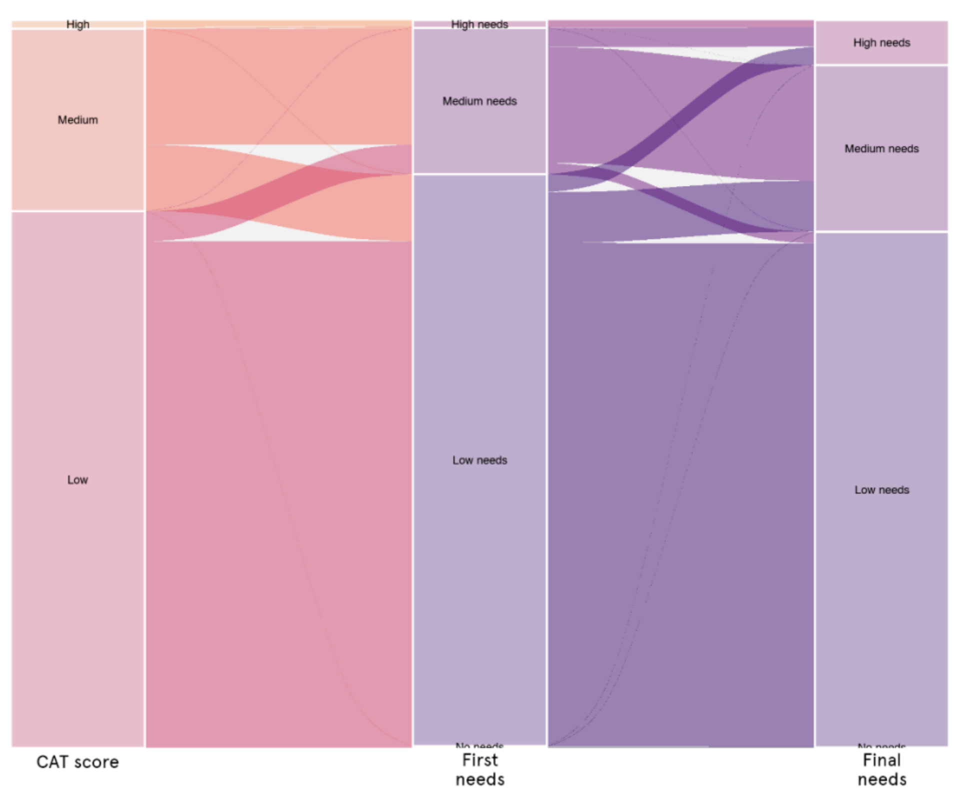
Table E.3 Comparison of characteristics between those children who received a PSP package from a PSP provider and those who did not receive a PSP package, in the Ongoing Care cohort

Variables	Received a PSP package from a PSP provider in the Ongoing Care cohort (n=7094[169])	Did not receive a PSP package but were eligible for the Ongoing Care cohort (n=8990)	*p* value
Female (n (%))	3305 (46.6)	4445 (49.4)	<0.001
Aboriginal (n (%))	2627 (37.0)	3900 (43.4)	<0.001
Age on 1 October 2018 (years; mean (SD))	9.65 (4.55)	9.51 (4.65)	0.046
Age in years at start of OOHC episode (mean (SD))	3.25 (3.29)	4.34 (4.00)	<0.001
Had prior OOHC episode (n (%))	1149 (16.2)	1399 (15.6)	0.283
# OOHC care episodes, including 'entry' (mean (SD))	1.22 (0.63)	1.20 (0.61)	0.081
Foster care, ever before (n (%))	6526 (92.0)	4349 (48.4)	<0.001
Kinship care, ever before (n (%))	2706 (38.1)	7863 (87.5)	<0.001
Foster care (n (%))	5679 (80.1)	1464 (16.3)	<0.001
Kinship care (n (%))	1415 (19.9)	7526 (83.7)	<0.001
Length of time in current care episode (years; mean (SD))	6.40 (3.94)	5.16 (4.01)	<0.001
# short visits (< 8 days duration) in year before (mean (SD))	0.06 (0.56)	0.04 (0.39)	0.017
How many ROSH per child? (mean (SD))	10.99 (8.81)	10.17 (8.54)	<0.001

[169] This table was constructed prior to matching and prior to a data refresh in November 2021. The cohort number here is different to that presented in subsequent reach tables (n= 7091).

Variables	Received a PSP package from a PSP provider in the Ongoing Care cohort (n=7094[169])	Did not receive a PSP package but were eligible for the Ongoing Care cohort (n=8990)	*p* value
Age at first ROSH (years; mean (SD))	0.66 (1.56)	0.92 (1.89)	<0.001
History of ROSH for physical abuse (n (%))	5071 (71.5)	5895 (65.7)	<0.001
History of ROSH for neglect (n (%))	4770 (67.3)	5894 (65.7)	0.033
History of ROSH for sexual abuse (n (%))	3415 (48.2)	3584 (39.9)	<0.001
History of ROSH for emotional abuse (n (%))	2455 (34.6)	2761 (30.8)	<0.001
History of ROSH for domestic violence (n (%))	3425 (48.3)	4696 (52.3)	<0.001

Figure E-4 Change in needs for the Ongoing Care cohort[170]



Note: The 'Low needs' category includes cases with missing data

[170] CAT score (depicted in the first column) is not a PSP needs package but rather an assessed score that is designed to provide an indication of a child's need level.

Appendix D Supplementary Effectiveness Results

The information in this Appendix is intended to provide additional supporting information for the relevant sections in Chapter 6: Effectiveness results. It is not intended to be read as a stand-alone document.

D.1.1. What happened following receipt of PSP services in terms of children's safety? Has PSP contributed to fewer reported maltreatment incidents or entries into care for those receiving Family Preservation packages?

To assess whether *households* receiving PSP packages were less likely to have a new ROSH report, a new Non-ROSH report, or at least one child or young person enter care from the household, we implemented time-to-event models to assess the likelihood that a household would experience any of these outcomes if they were receiving a PSP Family Preservation package (n=309) compared with a Non-PSP Family Preservation package (n=315). These comparisons were in a concurrent time period (from 1st October 2018 to 30th June 2021) and at the household level (i.e., variables were calculated at the household level). The outcome was measured as the time that the household had a new ROSH or Non-ROSH report or the time that the first child or young person from the household entered out-of-home care. The models were run from the start of receiving Family Preservation services or equivalent. Households were excluded from the analysis if they were receiving any intensive family preservation packages (e.g., MST) other than Brighter Futures or Youth Hope. This reduced the numbers included in all Family Preservation analyses from original number of matches (originally n=320 for PSP Family Preservation, with 1:5 matches for Non-PSP Family Preservation, which meant there were also originally n=320 'best matches' for Non-PSP Family Preservation).

For these models, all variables and outcomes were calculated at the household level except for gender and Aboriginality. Rather, these data are for one random, 'representative' child or young person from the household. These data were accounted for during the matching process, which aimed to find a similar representative child from a similar household for the comparison group for this cohort (for more details on the matching process, please refer to Appendix C. Since the program was delivered at the household level, the majority of variables and all outcomes were also at the household level.

D.1.2. Time to next household ROSH for those in the Family Preservation Cohort

The Kaplan-Meier survival curves — depicted in Figure 6.1 in the Effectiveness chapter — show that there is a no statistically significant difference ($p > 0.05$) in the time to next ROSH between those children who received a PSP package in the current period and those that received services as usual in the past.

Results of the multivariate model are presented in Table F.1 and discussed in full in the main chapter.

Table F.1 Cox Factors associated with the time to next ROSH report for those who received a PSP package relative to a matched concurrent comparison group in the Family Preservation cohort

Term	Hazard ratio (95% CI)	Standard error	*p* value
Received PSP package	1.18 [0.99, 1.4]	0.09	0.059
Female	1.06 [0.89, 1.26]	0.09	0.521
Aboriginal	1.17 [0.97, 1.42]	0.1	0.105
Limited visibility of household	1.29 [1.03, 1.6]	0.11	0.024
Carer/Parent with child protection history	1.27 [1.06, 1.53]	0.09	0.009
History of family violence in household	1.45 [1.17, 1.78]	0.11	0.001
Prior ROSH for physical abuse	1.55 [1.25, 1.93]	0.11	<0.001
Child in household < 6 months old	1.29 [1.07, 1.57]	0.1	0.009
Child in household > 11 years old	1.15 [0.95, 1.38]	0.09	0.145

D.1.3. Time to next household non-ROSH for those in the Family Preservation Cohort

The Kaplan-Meier survival curves — depicted in Figure F.1 below — show that there is a no statistically significant difference ($p > 0.05$) in the time to next non-ROSH between those children who received a PSP package in the current period and those that received services as usual.

We considered whether there were any factors which influenced the time to next non-ROSH by using a Cox Proportional Hazards regression. As this model is not discussed in full in Chapter 6: Effectiveness, we discuss the results in full here. The results suggest that, once we controlled for other variables in the model:

- There was no statistically significant difference in the time to next non-ROSH report between those children who received a PSP package and those in the comparison (HR: 1.15, 95% CI: [0.96, 1.39], $p > 0.05$).
- Once we controlled for other variables there was no significant difference between Aboriginal and non-Aboriginal children. There was also no difference between males or females.
- However, several other factors were significantly associated with the time to next non-ROSH report — for children in both the PSP and comparison groups. Each of the following had a significantly increased hazard of being reported as non-ROSH:
  - Children who had a prior ROSH for physical abuse before receiving PSP services (or equivalent date) (HR: 1.5, 95% CI: [1.17, 1.92], $p < 0.001$)
  - Children who had a prior ROSH for neglect before receiving PSP services (or equivalent date) (HR: 1.39, 95% CI: [1.01, 1.91], $p < 0.05$)

- Children who had a prior ROSH for sexual abuse before receiving PSP services (or equivalent date) (HR: 1.24, 95% CI: [1.02, 1.52], $p < 0.05$)
- Children who came from households with a child < 6 months old at the time they started receiving PSP services (or equivalent date) (HR: 1.28, 95% CI: [1.03, 1.58], $p < 0.05$)
- Children who came from households with a child > 11 years old at the time they started receiving PSP services (or equivalent date) (HR: 1.26, 95% CI: [1.03, 1.54], $p < 0.05$)

Results of our model are presented below (Table F.2).

Figure F.1 Kaplan-Meier survival curve for time to next non-ROSH report for those children who received a PSP package relative to a matched concurrent comparison group in the Family Preservation cohort

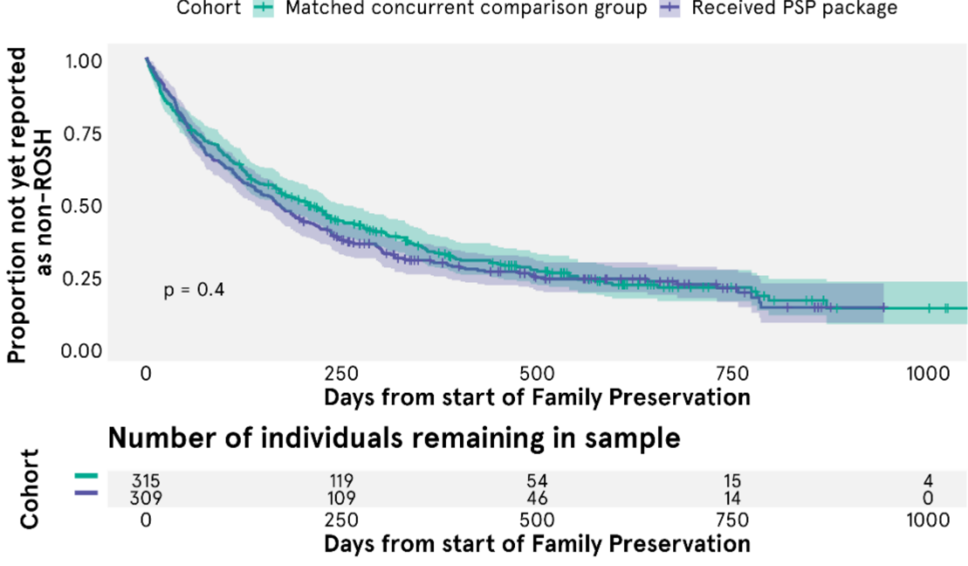


Table F.2 Factors associated with the time to next non-ROSH report for those who received a PSP package relative to a matched concurrent comparison group in the Family Preservation cohort

Term	Hazard ratio (95% CI)	Standard error	*p* value
Received PSP package	1.15 [0.96, 1.39]	0.09	0.125
Female	1.01 [0.84, 1.22]	0.09	0.906
Aboriginal	1.19 [0.98, 1.46]	0.1	0.086
Prior ROSH for physical abuse	1.5 [1.17, 1.92]	0.13	<0.001
Prior ROSH for neglect	1.39 [1.01, 1.91]	0.16	0.043
Prior ROSH for sexual abuse	1.24 [1.02, 1.52]	0.1	0.030
Child in household < 6 months old	1.28 [1.03, 1.58]	0.11	0.024

Term	Hazard ratio (95% CI)	Standard error	*p* value
Child in household > 11 years old	1.26 [1.03, 1.54]	0.1	0.025

D.1.4. Time to next entry into out-of-home care for those in the Family Preservation Cohort

Results of the Kaplan-Meier survival curves are below (Figure F.2) and the results of the statistical model that accounts for multiple covariates (Cox Proportional Hazards model) are presented in Table F.3 and visualised in the forest plot in the Effectiveness Chapter (Figure 6.3). Results are discussed in full in the main chapter.

Figure F.2 Kaplan-Meier survival curve for time to entry into OOHC for those who received a PSP package relative to a matched comparison group in the Family Preservation cohort

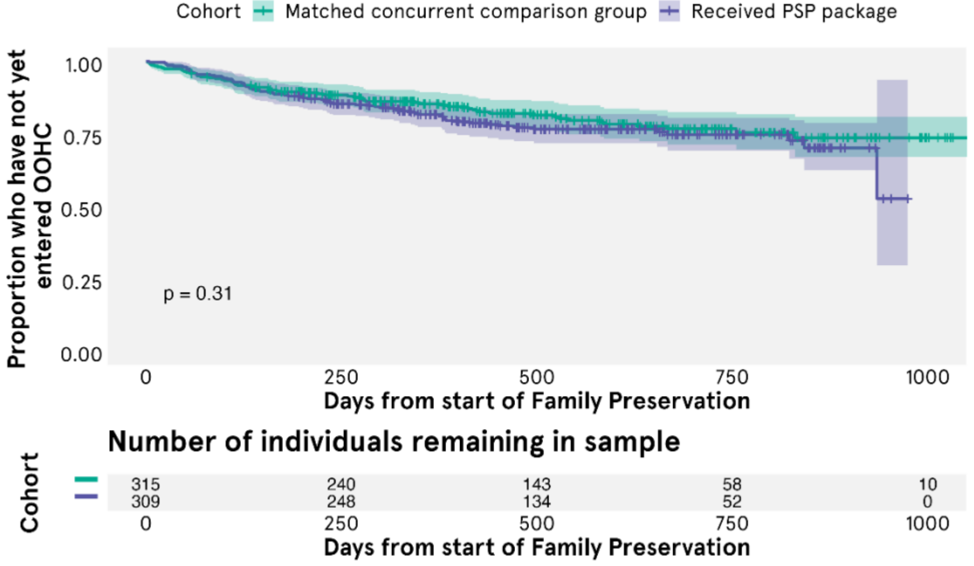


Table F.3 Factors associated with the time to next OOHC entry for those who received a PSP package in the Family Preservation cohort

Term	Hazard ratio (95% CI)	Standard error	*p* value
Received PSP package	1.26 [0.89, 1.77]	0.18	0.195
Female	0.81 [0.57, 1.15]	0.18	0.242
Aboriginal	0.98 [0.67, 1.44]	0.19	0.934
Limited visibility of household	2.05 [1.40, 2.99]	0.19	<0.001
Carer/Parent with substance abuse issue	1.84 [1.17, 2.89]	0.23	0.008
Carer/Parent with child protection history	1.40 [0.96, 2.04]	0.19	0.085
Prior ROSH for physical abuse	1.60 [1.05, 2.44]	0.22	0.03
Child in household < 6 months old	1.86 [1.29, 2.69]	0.19	0.001

D.1.5. Has PSP contributed to fewer reported maltreatment incidents or re-entries into care following restoration?

We examined whether receiving PSP packages would reduce the likelihood that a child would receive a new ROSH (following an exit to restoration) or re-enter care (following an exit to restoration), compared to similar children who were not exposed to PSP. Thus, these analyses focused on children who were in either the In Ongoing Care cohort and in the matched historical comparison group but who had exited for restoration (n=222 and n=174, respectively). This comparison used a matched group from the historical time period (from 1st October 2014 to 30th June 2017) and at the child level (i.e., variables were calculated for each child). The outcome was measured as the time from exiting care until either receiving a new ROSH or returning to OOHC. Children were excluded from the analysis if their OOHC placement was on 1st October 2014/2018 (for historical matched comparison vs those who received PSP packages, respectively) was not in foster care or kinship care. All young people were censored at age 18 or the end of the follow up period of the study, whichever came first.

D.1.6. Time to next ROSH following restoration: Has PSP contributed to fewer new ROSH reports, after restoration?

Results of the univariate model (Kaplan-Meier survival curve) are presented below in Figure F.3, and the results of the statistical model that accounts for other covariates (Cox Proportional Hazards model) are presented in Table F.4. and visualised in the forest plot in the Effectiveness Chapter in Figure 6.4. The statistical model in Table F.4. also compares the results to a replicate model that followed children only until 1 March 2020, which was prior to the worldwide COVID-19 pandemic. This replicate model was designed to investigate whether the findings were consistent when only considering a pre-COVID-19 era and showed that the effect of receiving PSP did not change when only considering the pre-pandemic period.

Figure F.3 Kaplan-Meier survival curve for time to ROSH following restoration for those children who received a PSP package relative to a matched comparison group in the Ongoing Care cohort

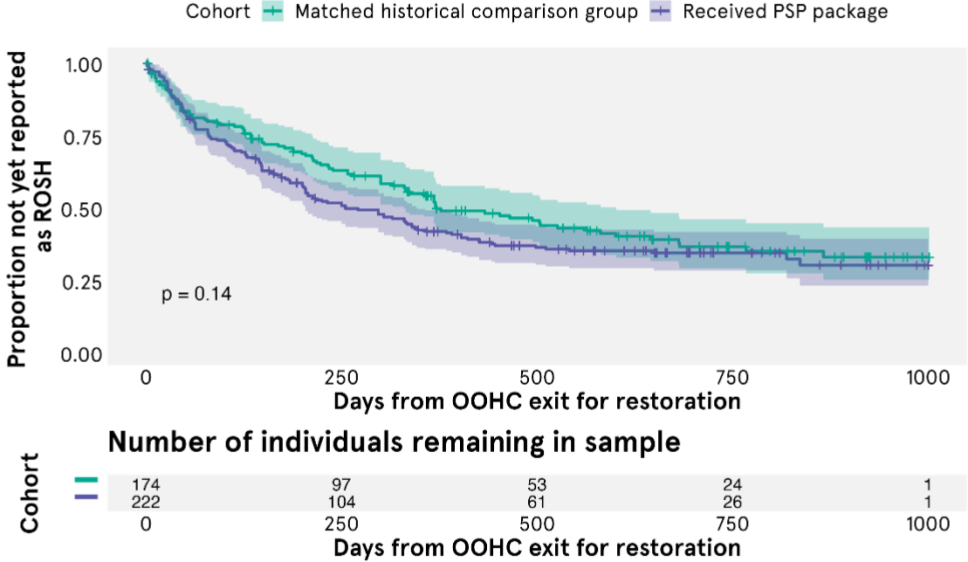


Table F.4 Factors associated with the time to next ROSH (after restoration) for those who received a PSP package relative to a historical comparison in the In Ongoing Care cohort: standard model versus COVID-19 model

Term	Model 1: Standard model			Model 2: COVID-19 model		
	Hazard ratio (95% CI)	Standard error	*p* value	Hazard ratio (95% CI)	Standard error	*p* value
Received PSP package	1.18 [0.91, 1.54]	0.14	0.218	1.25 [0.85, 1.84]	0.2	0.249
Female	1.24 [0.96, 1.61]	0.13	0.104	—	—	—
Aboriginal	1.81 [1.39, 2.35]	0.13	<0.001	1.85 [1.26, 2.73]	0.2	0.002
< 5 years old	0.76 [0.57, 1.02]	0.15	0.064	0.62 [0.4, 0.95]	0.22	0.026
In Kinship care	0.64 [0.41, 0.99]	0.23	0.045	0.61 [0.31, 1.19]	0.35	0.148
Prior ROSH for physical abuse	1.39 [1.03, 1.88]	0.15	0.033	2.01 [1.21, 3.32]	0.26	0.007
Prior ROSH for emotional abuse	1.49 [1.13, 1.96]	0.14	0.005	1.36 [0.91, 2.04]	0.2	0.129

D.1.7. Time to next entry into out-of-home care following restoration: Has PSP contributed to fewer re-entries into care after restoration?

We implemented a time-to-event model to assess whether a child or young person who had been in care - and who had exited for restoration -- would be more or less likely to re-enter care depending on if they received PSP packages or not. Thus, this analysis focused

on children who were in either the In Ongoing Care cohort and in the matched historical comparison group but who had exited for restoration (n=222 and n=174, respectively). This comparison used a matched group from the historical time period (from 1st October 2014 to 30th June 2017) and at the child level (i.e., variables were calculated for each child), and the outcome was measured as the time from exiting care until returning to out-of-home care. Children were excluded from the analysis if they did not exist for restoration during the study period (i.e., if they did not exit from care, or if they exited for an alternate permanency outcome). Children were also excluded from this analysis if their out-of-home care placement on 1st October 2014/2018 (for historical matched comparison vs those who received PSP packages, respectively) was not in foster care or kinship care. All young people were censored at age 18 or the end of the follow up period of the study, whichever came first.

Results of the univariate model (Kaplan-Meier survival curve) are presented in Figure F.4, and the results of the statistical model that accounts for other covariates (Cox Proportional Hazards model) are presented in Table F.5 and visualised in the forest plot in the Effectiveness Chapter in Figure 6.6. The statistical model in Table F.5 also compares the results to a replicate model that followed children only until 1 March 2020, which was prior to the worldwide COVID-19 pandemic. This replicate model was designed to investigate whether the findings were consistent when only considering a pre-COVID-19 era and showed that the effect of receiving PSP did not change when only considering the pre-pandemic period.

Figure F.4 Kaplan-Meier survival curve for time to entry into OOHC following restoration for those children who received a PSP package relative to a matched comparison group in the Ongoing Care cohort

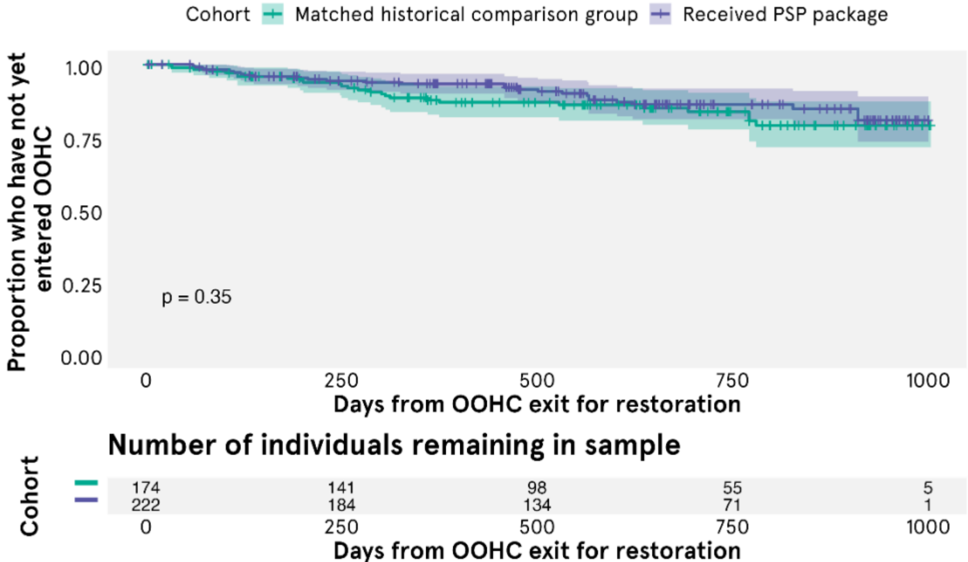


Table F.5 Factors associated with the time to next OOHC entry (after restoration) for those who received a PSP package relative to a

historical comparison in the In Ongoing Care cohort: standard model versus COVID-19

Term	Model 1: Standard model			Model 2: COVID-19 model		
	Hazard ratio (95% CI)	Standard error	*p* value	Hazard ratio (95% CI)	Standard error	*p* value
Received PSP package	0.77 [0.45, 1.32]	0.27	0.336	0.46 [0.18, 1.17]	0.48	0.103
Female	1.52 [0.88, 2.61]	0.28	0.130	1.11 [0.45, 2.74]	0.46	0.822
Aboriginal	1.33 [0.77, 2.3]	0.28	0.310	0.73 [0.26, 2.04]	0.52	0.555
< 5 years old	1.22 [0.71, 2.1]	0.28	0.470	2.47 [0.97, 6.27]	0.48	0.058

D.2 What happened following receipt of PSP services in terms of children's permanency?

We used matched comparison groups to assess if receiving PSP packages affected the likelihood of exiting from care to different permanency outcomes. In other words, if a child receives PSP packages, are they more likely to exit care to restoration or adoption than if they did not?

To determine if receiving PSP packages improved children's permanency (following receipt of the package until the end of the evaluation period), we assessed three main outcomes:

1. If children who received PSP packages when entering care were more likely to exit OOHC for restoration sooner
2. If children who had received PSP packages while in care were more likely to exit OHHC for restoration sooner
3. If children who had received PSP packages while in care were more likely to exit OOHC for adoption sooner.

D.2.1. Exit to restoration for children in the Entry/Re-entry cohort

We implemented a time-to-event model to assess whether a child who entered or re-entered care would be more or less likely to exit care for restoration depending on if they received PSP packages or not. This analysis focused on children in the Entry/Re-entry cohort and looked at the differences in time — measured in days — that elapsed between the Entry/Re-entry cohort start date and when a child exited OOHC to restoration. It examined whether there was a difference in time between those children in the Entry/Re-entry cohort who received PSP (n=539) relative to a matched historical comparison (n=524)[171]. Children were excluded from this analysis if their first placement lasting more than 7 days within the first 32 days of entering out-of-home care was not in foster care or

[171] At the time of identifying a matched historical sample, in which starting placement type was controlled for, the numbers in each group were exactly even. However, after the ChildStory data was refreshed in November 2021, several of the children who were originally matched in the Propensity Score Match were no longer eligible to be included in the Entry/Re-entry cohort due to changes in dates in care and/or changes to their placement type.

kinship care. Data were censored for the first of the following reasons: the time that the child exited from care for any reason other than restoration, the date they turned 18 years old, or the end of the follow-up period (end of historical period: 30th June 2017; end of current period: 30th June 2021).

Results of the univariate model (Kaplan-Meier survival curve) are presented below in Figure F.4, and the results of the statistical model that accounts for other covariates (Cox Proportional Hazards model) are presented in Table F.6 (below) and visualised in the forest plot in the Effectiveness Chapter (Figure 6.7).

Figure F.4 Kaplan-Meier survival curve for time to exit to restoration for those children who received a PSP package relative to a matched historical comparison group in the Entry/Re-entry cohort

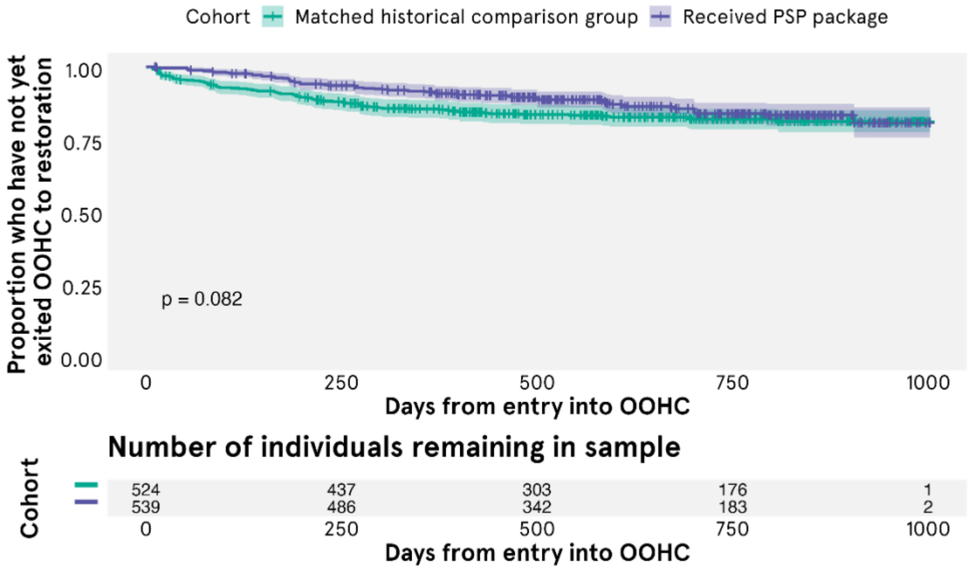


Table F.6 Factors associated with the time to exit to restoration for those who received a PSP package relative to a historical comparison in the Entry/Re-entry cohort

Term	Hazard ratio (95% CI)	Standard error	*p* value
Received PSP package	0.84 [0.61, 1.14]	0.16	0.262
Female	0.82 [0.6, 1.12]	0.16	0.205
Aboriginal	0.89 [0.64, 1.24]	0.17	0.488
< 6 months old	0.32 [0.21, 0.5]	0.23	<0.001
In Kinship care	0.3 [0.13, 0.67]	0.42	0.004
Prior ROSH for neglect	0.51 [0.33, 0.78]	0.22	0.002
Prior ROSH for sexual abuse	0.6 [0.39, 0.92]	0.22	0.018
Prior ROSH for physical abuse	0.63 [0.45, 0.87]	0.17	0.005
Carer/Parent with substance abuse issue	0.54 [0.39, 0.74]	0.16	<0.001

D.2.2. Exit to restoration for children in the Ongoing Care cohort

This analysis looked at the differences in time — measured in days — that elapsed between 1st October 2018 (1st October 2014 in the comparison) and when a child exited OOHC to restoration. It examined whether there was a difference in time between those children in the In Ongoing Care cohort who received PSP (n=6200) relative to a matched historical comparison (n=6153)[172]. This comparison used a matched group from the historical time period (from 1st October 2014 to 30th June 2017) and at the child level (i.e., variables were calculated for each child. The outcome was measured as the time from exiting care until exiting care for restoration. Children were excluded from this analysis if their out-of-home care placement on 1st October 2014/2018 (for historical matched comparison vs those who received PSP packages, respectively) was not in foster care or kinship care. Data were censored for the first of the following reasons: the time that the child exited from care for any reason other than restoration, the date they turned 18 years old, or the end of the follow-up period (end of historical period: 30th June 2017; end of current period: 30th June 2021).

Results of the univariate model (Kaplan-Meier survival curve) are presented in the Effectiveness Chapter in Figure 6.8, and the results of the statistical model that accounts for other covariates (Cox Proportional Hazards model) are presented in Table F.7 and visualised in the forest plot in the Effectiveness Chapter in Figure 6.9. The statistical model in Table F.7 also compares the results to a replicate model that followed children only until 1st March 2020, which was prior to the worldwide COVID-19 pandemic. This replicate model was designed to investigate whether the findings were consistent when only considering a pre-COVID-19 era and showed that, while the significant impact of PSP was no longer significant in the pre-pandemic period, the hazard ratio was similar (Table F.7).

Table F.7 Factors associated with the time to exit to restoration for those who received a PSP package relative to a matched historical comparison in the Ongoing Care cohort: standard model versus COVID-19 model

Term	Model 1: Standard model			Model 2: COVID-19 model		
	Hazard ratio (95% CI)	Standard error	*p* value	Hazard ratio (95% CI)	Standard error	*p* value
Received PSP package	1.35 [1.1, 1.64]	0.1	0.004	1.27 [1, 1.62]	0.12	0.055
Female	0.98 [0.81, 1.2]	0.1	0.866	0.98 [0.77, 1.25]	0.12	0.864
Aboriginal	1.09 [0.89, 1.34]	0.1	0.400	0.98 [0.76, 1.26]	0.13	0.871
< 5 years old	2.55 [2.05, 3.16]	0.11	<0.001	2.82 [2.17, 3.66]	0.13	<0.001
In Kinship care	0.52 [0.37, 0.71]	0.16	<0.001	0.53 [0.36, 0.79]	0.2	0.002

[172] At the time of identifying a matched historical sample, in which starting placement type was controlled for, the numbers in each group were exactly even. However, after the ChildStory data was refreshed in November 2021, several of the children who were originally matched in the Propensity Score Match were no longer eligible to be included in the Ongoing Care cohort due to changes in dates in care and/or changes to their placement type on 1 October 2014/2018.

Term	Model 1: Standard model			Model 2: COVID-19 model		
	Hazard ratio (95% CI)	Standard error	*p* value	Hazard ratio (95% CI)	Standard error	*p* value
Spent more than half of their life in current OOHC episode	0.24 [0.19, 0.29]	0.11	<0.001	0.19 [0.15, 0.25]	0.13	<0.001
Prior ROSH for sexual abuse	0.84 [0.68, 1.04]	0.11	0.114	0.79 [0.61, 1.04]	0.14	0.092

D.2.3. Exit to adoption for children in the Ongoing Care cohort

This analysis looked at the differences in time — measured in days — that elapsed between 1st October 2018 (1st October 2014 in the comparison) and when a child person exited OOHC to adoption. This analysis was at the child level (i.e., variables were calculated for each child and examined whether there was a difference in time between non-Aboriginal children in the In Ongoing Care cohort who received PSP (n=3245) relative to a matched historical comparison (n=3270) [173]. Children were excluded from this analysis if they were identified as Aboriginal, as adoption is not a culturally appropriate outcome for this group. Children were also not considered in this analysis if their out-of-home care placement on 1st October 2014/2018 (for historical matched comparison vs those who received PSP packages, respectively) was not in foster care. Data were censored for the first of the following reasons: the time that the child or young person exited from care for any reason other than adoption, the date they turned 18 years old, or the end of the follow-up period (end of historical period: 30th June 2017; end of current period: 30th June 2021).

Results of the univariate model (Kaplan-Meier survival curve) are presented in the Effectiveness Chapter in Figure 6.10, and the results of the statistical model that accounts for other covariates (Cox Proportional Hazards model) are presented in Table F.8 and visualised in the forest plot in the Effectiveness Chapter in Figure 6.11. The statistical model in Table F.8 also compares the results to a replicate model that followed children only until 1st March 2020, which was prior to the worldwide COVID-19 pandemic. This replicate model was designed to investigate whether the findings were consistent when only considering a pre-COVID-19 era and showed that, even though the significant effect of receiving PSP did not change, the hazard ratio was higher in the model that only considered the pre-pandemic period.

Table F.8 Factors associated with the time to exit to adoption for those who received a PSP package relative to a matched historical

[173] At the time of identifying a matched historical sample, in which starting placement type was controlled for, the numbers in each group were exactly even. However, after the ChildStory data was refreshed in November 2021, a number of the children who were originally matched in the Propensity Score Match were no longer eligible to be included in the Ongoing Care cohort due to changes in dates in care and/or changes to their placement type on 1 October 2014/2018.

comparison in the Ongoing Care cohort: standard model versus COVID-19 model

Term	Model 1: Standard model			Model 2: COVID-19 model		
	Hazard ratio (95% CI)	Standard error	*p* value	Hazard ratio (95% CI)	Standard error	*p* value
Received PSP package	1.63 [1.24, 2.14]	0.14	<0.001	5.62 [3.4, 9.29]	0.26	<0.001
Female	0.95 [0.72, 1.24]	0.14	0.686	0.96 [0.67, 1.38]	0.19	0.823
< 5 years old	3.39 [2.6, 4.42]	0.14	<0.001	2.75 [1.9, 3.98]	0.19	<0.001

D.2.4. Are some service providers delivering better outcomes (i.e., are service providers with particular attributes delivering better outcomes)?

To understand how differences between service providers may have influenced permanency outcomes, we ran additional Cox Proportional Hazards regressions using only those children that received PSP packages for the following outcomes per cohort:

1. Time to restoration in the Entry/Re-entry cohort
2. Time to restoration in the In Ongoing Care cohort
3. Time to adoption in the In Ongoing Care cohort, and
4. Time to guardianship[24] in the In Ongoing Care cohort.

In this iteration of the models, we included different covariates that related to PSP service providers – specifically the size of agency (small being less than 100 contracted placements), and the location of agency (whether rural, regional or metropolitan). Where these two covariates were strongly not significant, they were removed from the final model in order to create the most parsimonious and appropriate model.

Results of the model for children receiving PSP packages and their time to restoration in the Entry/Re-entry cohort are presented in Table F.9. This model only included children who received a PSP package in the Entry/Re-entry cohort (n=629 with 73 events).

Table F.9 Factors associated with the time to exit to restoration for those who received a PSP package in the Entry/Re-entry into care cohort

Term	Hazard ratio (95% CI)	Standard error	*p* value
Female	0.61 [0.37, 0.99]	0.25	0.045
Aboriginal	0.87 [0.53, 1.43]	0.25	0.576
< 6 months old	0.36 [0.21, 0.62]	0.28	<0.001
In Kinship care	0.47 [0.19, 1.19]	0.47	0.111
Prior ROSH for neglect	0.38 [0.21, 0.68]	0.3	0.001

Term	Hazard ratio (95% CI)	Standard error	*p* value
Prior ROSH for sexual abuse	0.38 [0.18, 0.8]	0.38	0.011
Any developmental, intellectual, learning or physical disability	0.42 [0.18, 0.98]	0.44	0.044
Carer/Parent with child protection history	0.56 [0.34, 0.93]	0.26	0.025

Results of the model for children receiving PSP packages and their time to restoration in the In Ongoing Care cohort are presented in Table F.10. This model only included children who received a PSP package in the In Ongoing Care cohort (n=7077 with 228 events).

Table F.10 Cox Factors associated with the time to restoration for those who received a PSP package in the In Ongoing Care cohort

Term	Hazard ratio (95% CI)	Standard error	*p* value
Female	1.06 [0.82, 1.38]	0.13	0.645
Aboriginal	1.01 [0.77, 1.32]	0.14	0.969
< 5 years old	2.64 [2, 3.48]	0.14	<0.001
In Kinship care	0.56 [0.36, 0.86]	0.22	0.008
Spent more than half of their life in current OOHC episode	0.25 [0.19, 0.33]	0.13	<0.001
Most recent Child Assessment Tool score: Low	1.91 [1.29, 2.84]	0.2	0.001

Results of the model for children receiving PSP packages and their time to adoption in the In Ongoing Care cohort are presented in Table F.11.

Table F.11 Factors associated with the time to adoption, for those who received a PSP package in the In Ongoing Care cohort

Term	Hazard ratio (95% CI)	Standard error	*p* value
Female	1.06 [0.76, 1.49]	0.17	0.72
< 5 years old	2.56 [1.81, 3.61]	0.18	<0.001
Received PSP Needs Package: Low Needs	2.74 [1.46, 5.15]	0.32	0.002
Received PSP services from a large agency (> 300 contracted placements)	1.7 [1.22, 2.37]	0.17	0.002
Received PSP services in a rural or regional location	0.55 [0.39, 0.77]	0.17	<0.001

Results of the model for children receiving PSP packages and their time to guardianship in the In Ongoing Care cohort are presented in Table F.12.

Table F.12 Factors associated with the time to guardianship, for those who received a PSP package in the In Ongoing Care cohort

Term	Hazard ratio (95% CI)	Standard error	*p* value
Female	0.56 [0.38, 0.82]	0.19	0.003
Aboriginal	0.63 [0.42, 0.93]	0.2	0.020
Spent more than half of their life in current OOHC episode	1.95 [1.19, 3.18]	0.25	0.008
< 5 years old	0.71 [0.44, 1.15]	0.25	0.165
Received PSP Needs Package: Low Needs	2.45 [1.39, 4.32]	0.29	0.002
Received PSP services from a large agency (> 300 contracted placements)	0.63 [0.43, 0.94]	0.2	0.023
Received PSP services in a rural or regional location	1.42 [0.95, 2.14]	0.21	0.089

D.3 What happened following receipt of PSP services in terms of placement stability?

To determine if receiving PSP packages improved placement stability for children, we assessed the following outcomes:

- If children who received PSP packages when entering care were more likely to have placement changes than those who did not
- If children who had received PSP packages while in care were more likely to have placement changes than those who did not, and
- If children who had received PSP packages while in care were more likely to move schools than those who did not.

D.3.1. Time to next placement change in the Entry/Re-entry to care cohort

We implemented a time-to-event model to assess whether a child who entered or re-entered care would be more or less likely to experience placement stability depending on whether they received a PSP package or not. This analysis looked at the differences in time — measured in days — that elapsed between the Entry/Re-Entry cohort start date and when a child or young person moved to their next OOHC placement.

The initial placement was defined as the first out-of-home care placement lasting more than 7 days that started within the first month of the out-of-home care episode (for reasons described below, the initial placement in this model was in foster care). The first placement *change* was when the child or young person moved to their next placement after the initial placement that also lasted more than 7 days and was not classified as a 'temporary placement'. A temporary placement included any of the following placements with a purpose of Respite, or a placement type of Boarding School, Camp, Disability – Hospital, or Hotel / Motel (according to the data provided in ChildStory). Records were

censored at the first (if any) of the following dates: if the child or young person exited care, if the young person turned 18 years old, or at the end of the study period.

This model examined whether there was a difference in time between those children in foster care in the Entry/Re-entry cohort who received PSP (n=484) relative to a matched historical comparison (n=465). This analysis included fewer children than in other models for the Entry/Re-entry cohort because it only included children in foster care due to a violation of the Proportional Hazards Assumption with respect to placement type. This model had multiple issues with the underlying assumption of proportional hazards, i.e., that the hazard ratio does not vary through time and that the relative risk per variable is proportional through time. The usual approach to managing any violation of this assumption is to stratify the model by the offending variable, which could not be done in this model because the strongest violation involved the main effect (i.e., whether the child was receiving PSP packages or not). Thus, we had to stratify this model according to an interaction with time for those who received PSP packages or not. Since placement type (i.e., foster vs kinship care) also significantly violated the proportional hazard assumption, we had to restrict this analysis to only include children in foster care because we could not stratify by multiple offending variables when one involved an interaction with time. There were few children placed in kinship care (n=55 who received PSP packages, n=59 in historical comparison) and those who had been placed in kinship care tended to be very stable.

Results from the univariate Kaplan Meier curve of the time to next placement change (for children in the Entry/Re-entry cohort who started in foster care) are presented in the Effectiveness chapter in Figure 7.. Results of the associated multivariate model are presented in Table F.13.

Table F.13 Factors associated with the time to next OOHC placement move for those who received a PSP package relative to a historical comparison in the Entry/Re-entry cohort

Term	Hazard ratio (95% CI)	Standard error	*p* value
Received PSP package (<125 days)	0.46 [0.37, 0.58]	0.11	<0.001
Received PSP package (125-249 days)	1.33[174] [0.86, 2.05]	0.22	0.198
Received PSP package (250 to 374 days)	3.18[175] [1.92, 5.27]	0.26	<0.001
Received PSP package (375 or > days)	4.61[176] [2.37, 8.97]	0.34	<0.001
Female	1.07 [0.91, 1.26]	0.08	0.434

[174] This hazard ratio adjusts to 0.61, when adjusted for the interaction by time between this time interval and the first time interval. This is based on the exponentiated value of the sum of the original coefficients, and it means that those receiving PSP in the second time interval were similarly (like those receiving PSP in the first time interval) less likely to have a placement move than those who did not receive PSP packages.

[175] This hazard ratio adjusts to 1.46, when adjusted for the interaction by time between this time interval and the first time interval. This is based on the exponentiated value of the sum of the original coefficients, and it means that those receiving PSP in the third time interval were significantly more likely to have a placement move in this interval than those who did not receive PSP packages.

[176] This hazard ratio adjusts to 2.21, when adjusted for the interaction by time between this time interval and the first time interval. This is based on the exponentiated value of the sum of the original coefficients, and it means that those receiving PSP in the fourth time interval were more likely to have a placement move in this interval than those who did not receive PSP packages.

Term	Hazard ratio (95% CI)	Standard error	*p* value
Aboriginal	1.06 [0.89, 1.25]	0.09	0.533
Prior ROSH for neglect	1.38 [1.06, 1.79]	0.13	0.016
Prior ROSH for sexual abuse	1.2 [0.99, 1.45]	0.1	0.061
Household resides in hazardous conditions	1.24 [1.05, 1.46]	0.08	0.01

D.3.2. Time to next placement change in the Ongoing Care cohort

We implemented a time-to-event model to assess whether a child who was in ongoing care would be more or less likely to experience placement stability depending on whether they received a PSP package or not. This analysis looked at the differences in time — measured in days — that elapsed between 1st October 2018 (1st October 2014 in the comparison) and when a child moved to their next OOHC placement.

The initial placement was defined as the out-out-of-home care placement on 1st October 2018 (or 1st October 2014 for the historical comparison). The first placement *change* was when the child moved to their next placement after the initial placement that also lasted more than 7 days and was not classified as a 'temporary placement'. A temporary placement included any of the following placements with a purpose of Respite, or a placement type of Boarding School, Camp, Disability – Hospital, or Hotel / Motel (according to the data provided in ChildStory). Records were censored at the first (if any) of the following dates: if the child exited care, if the child turned 18 years old, or at the end of the study period.

The model examined whether children in the Ongoing Care cohort had differences in the likelihood of placement moves between those who received PSP packages (n=4888) relative to a matched historical comparison (n=4877). Due to issues with violations of the Proportional Hazards Assumption, this model also only included children who were in foster care on 1st October 2014/2018 and the follow-up period was censored at 1 March 2020, so it only considered placement moves within the pre-pandemic period.[177] The number of children who started in kinship care were much higher in this group. Records were censored at the first (if any) of the following dates: if the child exited care, if the child turned 18 years old, or at the end of the study period.

Results from the univariate Kaplan Meier curve of the time to next placement change (for children in the In Ongoing Care cohort who started in foster care) are presented in the Effectiveness chapter in Figure 6.13. Results of the associated multivariate model are presented below in Table F.14 and visualised in a forest plot in the Effectiveness chapter in Figure 6.14.

Table F.14 Results showing factors that are associated with the time to next OOHC placement move for those who received a PSP package

[177] A similar censoring (at 1 March 2020) in the previous model -- that examined time to next placement move for those in the Entry/Re-entry cohort -- was not possible in that model due to the large number that would have been excluded, as many children in that cohort entered care after 1 March 2020.

relative to a historical comparison in the In Ongoing Care cohort [COVID-19 model only]

Term	Hazard ratio (95% CI)	Standard error	*p* value
Received PSP package	1.24 [1.13, 1.36]	0.05	<0.001
Female	0.99 [0.91, 1.09]	0.05	0.902
Aboriginal	1.45 [1.32, 1.59]	0.05	<0.001
15 or > years old	0.79 [0.68, 0.91]	0.08	0.002
Prior ROSH for neglect	1.13 [1.02, 1.26]	0.06	0.024
Spent more than half of their life in current OOHC episode	0.48 [0.43, 0.52]	0.05	<0.001

D.3.3. Time to next school move in the In Ongoing Care cohort

We implemented a time-to-event model to assess the likelihood that a child in ongoing care would experience a school move depending on whether they received a PSP package or not. This analysis looked at the differences in time — measured in days — that elapsed between 1st October 2018 (1st October 2014 in the comparison) and when a child moved to their next school, according to linked data from the Department of Education. Due to overlapping records, a school move was defined as a change in census school (children can attend several specialist schools concurrently but are only enrolled in one census school at a time). In the small instances that the data showed overlapping census schools for a single ChildStoryID in a year, any school moves evident during that year were deemed inaccurate (likely an error in data linkage) and were excluded. A change in school following a child's last year in grade 6 was also not considered a valid school move for the purpose of this analysis. School data was recorded as monthly, so the exact date of the month was determined as the first day of the month after the change in school (I.e., if a child was in school A in June and school B in July then the move that recorded as the 1st of July).

The model examined whether children in the Ongoing Care cohort had differences in the likelihood of school moves between those who received PSP packages (n=4189) relative to a matched historical comparison (n=4108). These numbers differed from other analyses for those in the In Ongoing Care cohort because we could only include children who had at least one record in the Education data, i.e., it excluded all children who were not yet at school age. Records were censored at the first (if any) of the following dates: if the child exited care or at the end of the study period.

Results from the univariate Kaplan Meier curve of the time to next school move are presented in Figure F.5. Results of the associated multivariate model are presented below in Table F.15 and visualised in the Effectiveness Chapter in Figure 7..

Figure F.5 Kaplan-Meier survival curve for time to next school move for those children who received a PSP package relative to a matched historical comparison group in the Ongoing Care cohort

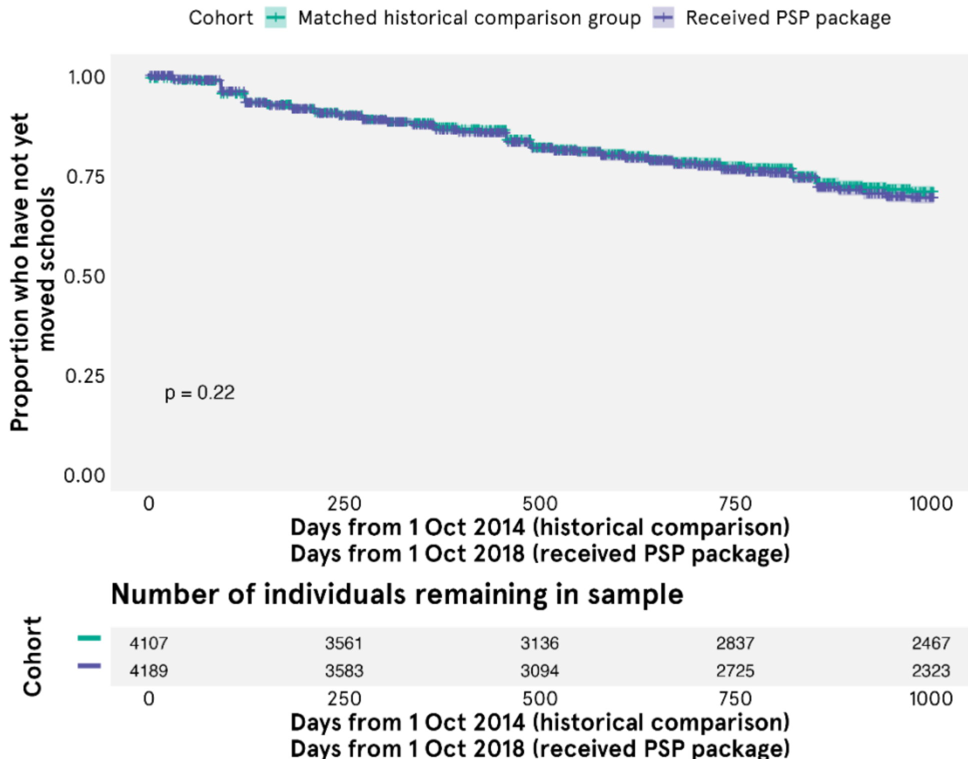


Table F.15 Factors associated with the time to next school move for those who received a PSP package relative to a historical comparison in the In Ongoing Care cohort: standard model versus COVID-19 model

Term	Model 1: Standard model			Model 2: COVID-19 model		
	Hazard ratio (95% CI)	Standard error	*p* value	Hazard ratio (95% CI)	Standard error	*p* value
Received PSP package	1 [0.92, 1.09]	0.04	0.949	0.96 [0.87, 1.06]	0.05	0.405
Female	0.99 [0.91, 1.08]	0.04	0.841	1 [0.9, 1.1]	0.05	0.949
Aboriginal	1.29 [1.19, 1.4]	0.04	<0.001	1.26 [1.14, 1.4]	0.05	<0.001
13 or > years old	1.14 [1.04, 1.26]	0.05	0.007	1.22 [1.09, 1.36]	0.06	0.001
In Kinship care	0.73 [0.65, 0.81]	0.05	<0.001	0.69 [0.6, 0.79]	0.07	<0.001
Spent more than half of their life in current OOHC episode	0.72 [0.66, 0.79]	0.04	<0.001	0.73 [0.66, 0.81]	0.05	<0.001
Prior ROSH for physical abuse	1.2 [1.08, 1.33]	0.05	0.001	1.21 [1.06, 1.38]	0.07	0.005

Term	Model 1: Standard model			Model 2: COVID-19 model		
	Hazard ratio (95% CI)	Standard error	*p* value	Hazard ratio (95% CI)	Standard error	*p* value
Prior ROSH for domestic violence	1.17 [1.07, 1.27]	0.04	<0.001	1.23 [1.11, 1.37]	0.05	<0.001
Prior ROSH for neglect	1.15 [1.04, 1.28]	0.05	0.005	1.17 [1.03, 1.33]	0.06	0.016

D.3.4. Note on school moves following a placement move

A school move was considered to be after a placement move if the school move occurred within 31 days prior and 62 days post the placement move. This range was wide because the school data was provided monthly, and it was impossible to know at what exact date in the month the school move occurred.

D.4 Has PSP resulted in improved child mental and physical health outcomes?

We examined whether child mental and physical health outcomes changed by looking at the following:

1. Presentation at specialist homelessness services (SHS) for housing reasons, and
2. Commission of an offence.

For each of these outcomes we undertook the following analyses.

D.4.1. Do young people present at SHS for housing reasons once they turn age 18?

This analysis looked at the time until a child first presented at SHS for housing reasons after their 18th birthday (this analysis was limited to children who turned 18 in the evaluation period [1st October 2018 - 30th June 2021 for those receiving PSP-funded services and 1st October 2014 - 30th June 2017 for the historical comparison]).

Arriving at SHS for 'housing reasons' included if the main reason for seeking assistance at SHS was classified as any of the following options: Housing Affordability Stress, Housing Crisis, Inadequate or Inappropriate Dwelling Conditions, Previous Accommodation Ended, Transition from Custodial Arrangements, Transition from Foster Care or Child Safety Residential Placements, Transition from Other Care Arrangements, or Unable to Return Home Due to Environmental Reasons.

Results from the univariate Kaplan Meier curve of the time to presentation at SHS are presented in Figure F.6. Results of the associated multivariate model are presented below in Table F.16. and visualised in the Effectiveness Chapter in Figure 7..

Figure F.6 Kaplan-Meier survival curve for time to first SHS presentation for housing reasons for those children who received a

PSP package relative to a matched historical comparison group in the In Ongoing Care cohort

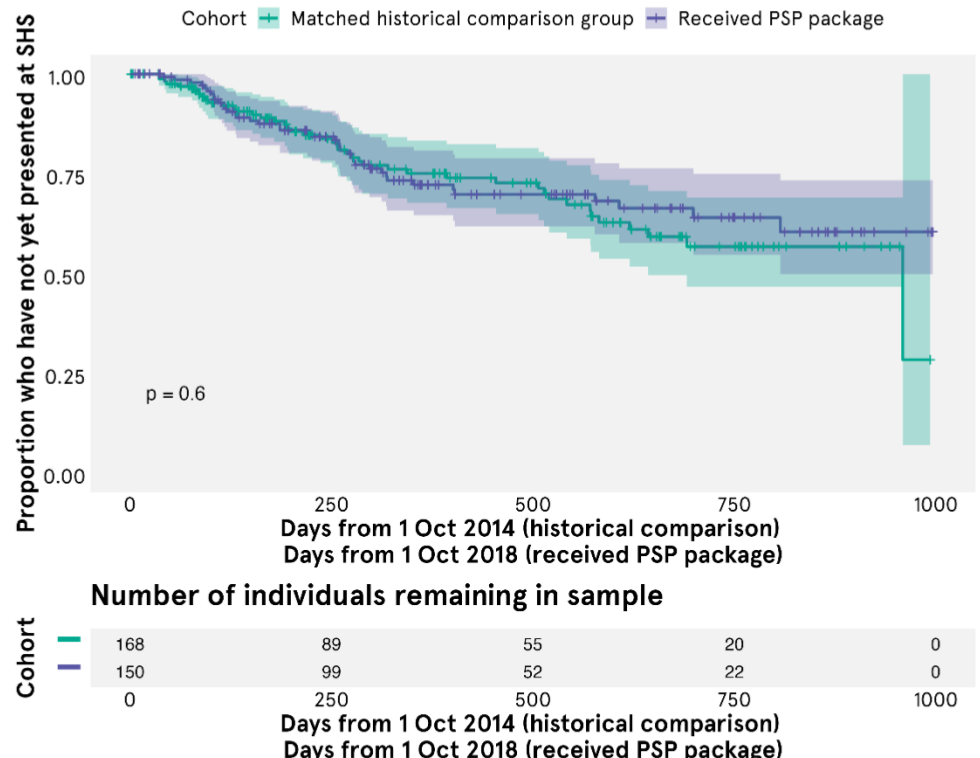


Table F.16 Cox Proportional Hazard model results showing factors that are associated with the time to first SHS presentation for housing reasons for those who received a PSP package relative to a historical comparison in the In Ongoing Care cohort: standard model

Term	Model 1: Standard model			Model 2: COVID-19 model		
	Hazard ratio (95% CI)	Standard error	*p* value	Hazard ratio (95% CI)	Standard error	*p* value
Received PSP package	0.83 [0.53, 1.29]	0.22	0.403	0.94 [0.58, 1.51]	0.24	0.784
Female	0.67 [0.43, 1.04]	0.22	0.072	0.55 [0.34, 0.9]	0.25	0.017
Aboriginal	1.2 [0.76, 1.9]	0.24	0.439	1.12 [0.67, 1.85]	0.26	0.668
Prior ROSH for physical abuse	1.53 [0.88, 2.64]	0.28	0.131	1.68 [0.9, 3.12]	0.32	0.101

D.4.2. Do young people commit criminal offences while in OOHC?

An “offence” was defined as any offence listed with an offence date in the BOCSAR Reoffending Database (ROD) except for warnings and unproven[178] court appearances. This included cautions, youth conferences and proven court offences. Warnings were excluded as they are a minor offence that has not been consistently recorded over time. For the youth justice models (including the PSP specific model), the end of the evaluation period

[178] Court appearances were deemed unproven if they had a recorded outcome of “not guilty”, “withdrawn”, “mental health dismissal” or “otherwise disposed of”.

was amended to the 31st of December 2016 and 31st December 2020 to allow for at least 9 months for an offence to be finalised and thus included in our analyses.[179] Observations were censored either when a child turned 18 or when the evaluation period ended. Note that, as with all our analyses, children were not censored when they stopped receiving PSP funding (an outcome experiences after this point could still be an effect of the program). The date used in these analyses was offence date and not finalisation date. All offence types were included if they fitted the above criteria.

We created a variable for those children that had committed an offence prior to the 1st October 2014/2018. This variable was stratified in the final model as it did not satisfy the proportional hazards assumption of the model.[180] By stratifying by this variable, we were able include it and control for its effects but could not report on the magnitude of hazard. This variable was also stratified in the PSP only model on time to next offence (Table F.24).

Results from the univariate Kaplan Meier curve of the time to next offence are presented in the Effectiveness Chapter in Figure 7.. Results of the associated multivariate model are presented below in Table F.17 and visualised in the Effectiveness Chapter in Figure 7..

Table F.17 Factors associated with the time to next offence for those who received a PSP package relative to a historical comparison in the In Ongoing Care cohort: standard model versus COVID-19 model

Term	Model 1: Standard model			Model 2: COVID-19 model		
	Hazard ratio (95% CI)	Standard error	p value	Hazard ratio (95% CI)	Standard error	*p* value
Received PSP package	0.71 [0.59, 0.86]	0.10	<0.001	0.72 [0.56, 0.92]	0.12	0.008
Aboriginal	1.50 [1.24, 1.82]	0.10	<0.001	1.54 [1.21, 1.96]	0.12	<0.001
Female	0.60 [0.49, 0.73]	0.10	<0.001	0.59 [0.45, 0.76]	0.13	<0.001
13 or > years old	2.42 [1.95, 3.01]	0.11	<0.001	2.81 [2.08, 3.80]	0.15	<0.001
Spent more than half of their life in current OOHC episode	1.41 [1.15, 1.74]	0.10	<0.001	1.48 [1.14, 1.92]	0.13	0.003
Prior ROSH for domestic violence	1.34 [1.10, 1.63]	0.10	0.004	1.25 [0.97, 1.59]	0.13	0.082
Prior ROSH for sexual abuse	1.28 [1.05, 1.56]	0.10	0.015	1.18 [0.92, 1.52]	0.13	0.181

[179] All offences that occurred during the evaluation period and were finalised by the 30th September 2016/2020 were included in the analyses.
[180] This variable was also stratified in the time to next offence PSP-specific model (Table C.24).

D.5 To what extent do any of the outcomes differ: Depending on the PSP case plan goal or other package?

To determine the impact of PSP-specific factors such as packages, we ran the models again including only those that received at least one PSP package. The summary output of the models are below, sorted by type of outcome looked at.

D.5.1. Safety Outcomes

Results of the model for children receiving PSP packages and their time to next ROSH following an exit to restoration in the In Ongoing Care cohort are presented in Table F.18.

Table F.18 Factors associated with the time to next ROSH following restoration, for those who received a PSP package in the In Ongoing Care cohort

Term	Hazard ratio (95% CI)	Standard error	*p* value
Female	0.91 [0.65, 1.29]	0.17	0.607
Aboriginal	1.93 [1.34, 2.76]	0.18	<0.001
In Kinship care	0.44 [0.23, 0.82]	0.32	0.01
Spent more than half of their life in current OOHC episode	0.62 [0.43, 0.89]	0.18	0.009
Received PSP services from a large agency (> 300 contracted placements)	1.56 [1.10, 2.20]	0.18	0.013
< 5 years old	0.45 [0.31, 0.65]	0.19	<0.001

Results of the model for children receiving PSP packages and their time to next OOHC entry following an exit to restoration in the In Ongoing Care cohort are presented in Table F.19.

Table F.19 Factors associated with the time to next OOHC placement following restoration, for those who received a PSP package in the In Ongoing Care cohort

Term	Hazard ratio (95% CI)	Standard error	*p* value
Female	1.3 [0.61, 2.76]	0.39	0.502
Aboriginal	1.3 [0.61, 2.8]	0.39	0.497
Received PSP services in a rural or regional location	3.27 [1.24, 8.63]	0.5	0.017

D.5.2. Permanency Outcomes

The summary output for the four PSP-specific models are outlined under the question 'Are some service providers delivering better outcomes?' The four permanency outcome models are:

- Time to restoration (Entry/Re-entry cohort)
- Time to restoration (In Ongoing Care cohort)
- Time to adoption (In Ongoing Care cohort)
- Time to guardianship (In Ongoing Care cohort)

D.5.3. Placement Stability Outcomes

Results of the model for children receiving PSP packages and their time to next placement move in the Entry/Re-entry cohort are presented in Table F.20.

Table F.20 Factors associated with the time to placement move, for those who received a PSP package in the Entry/Re-entry cohort

Term	Hazard ratio (95% CI)	Standard error	*p* value
Female	1.10 [0.89, 1.38]	0.11	0.376
Aboriginal	1.07 [0.85, 1.34]	0.12	0.574
Carer/Parent with cognitive issue	0.81 [0.65, 1.02]	0.11	0.068
Received PSP Needs Package: Low Needs	0.52 [0.33, 0.83]	0.23	0.006

Results of the model for children receiving PSP packages and their time to next placement move in the In Ongoing Care cohort are presented in Table F.21.

Table F.21 Factors associated with the time to next placement move, for those who received a PSP package in the In Ongoing Care cohort

Term	Hazard ratio (95% CI)	Standard error	*p* value
Female	1.05 [0.93, 1.18]	0.06	0.415
Aboriginal	1.33 [1.18, 1.5]	0.06	<0.001
15 or > years old	0.77 [0.63, 0.93]	0.1	0.007
Spent more than half of their life in current OOHC episode	0.49 [0.43, 0.55]	0.06	<0.001
Received PSP services from a large agency (> 300 contracted placements)	0.87 [0.77, 0.98]	0.06	0.022

Results of the model for children receiving PSP packages and their time to next school move in the In Ongoing Care cohort are presented in Table F.22.

Table F.22 Factors associated with the time to next school move, for those who received a PSP package in the In Ongoing Care cohort

Term	Hazard ratio (95% CI)	Standard error	*p* value
Female	1.07 [0.96, 1.2]	0.06	0.203
Aboriginal	1.32 [1.19, 1.48]	0.06	<0.001
In Kinship care	0.76 [0.66, 0.88]	0.07	<0.001
Spent more than half of their life in current OOHC episode	0.62 [0.56, 0.7]	0.06	<0.001
Received PSP Needs Package: Low Needs	0.71 [0.63, 0.8]	0.06	<0.001

D.5.4. Wellbeing Outcomes

Results of the model for children receiving PSP packages and their time to first SHS presentation for housing reasons in the In Ongoing Care cohort are presented in Table F.23.

Table F.23 Factors associated with the time to first SHS presentation for housing reasons for those who received a PSP package in the In Ongoing Care cohort

Term	Hazard ratio (95% CI)	Standard error	*p* value
Female	0.73 [0.41, 1.32]	0.3	0.299
Aboriginal	1.78 [0.99, 3.21]	0.3	0.054
Received PSP Specialist Package: 15 years+ Reconnect	1.81 [0.99, 3.31]	0.31	0.055

Results of the model for children receiving PSP packages and their time to criminal offence in the Ongoing Care cohort are presented in Table F.24.

Table F.24 Factors associated with the time to offence for those who received a PSP package in the In Ongoing Care cohort

Term	Hazard ratio (95% CI)	Standard error	*p* value
Female	0.60 [0.46, 0.78]	0.13	<0.001
Aboriginal	1.45 [1.14, 1.86]	0.12	0.003

13 or > years old	2.44 [1.81, 3.27]	0.15	<0.001
Received PSP services in a rural or regional location	0.75 [0.58, 0.96]	0.13	0.021
Received PSP Needs Package: Low Needs	0.66 [0.51, 0.85]	0.13	0.001
Most recent Child Assessment Tool score: High	1.90 [1.17, 3.08]	0.25	0.009
Prior ROSH for domestic violence	1.32 [1.03, 1.71]	0.13	0.030
Prior ROSH for sexual abuse	1.38 [1.07, 1.80]	0.13	0.015

Results of the GLM model for children receiving PSP packages and the proportion that completed an HSC in the In Ongoing Care cohort are presented in Table F.25.

Table F.25 Generalised linear model results showing factors that are associated with HSC completion for those who received a PSP package in the In Ongoing Care cohort

Term	Odds ratio (95% CI)	Standard error	*p* value
Female	1.83 [1.25, 2.67]	0.19	0.002
Aboriginal	0.54 [0.35, 0.83]	0.22	0.005
In Year 10 on 1st October 2014/2018	0.61 [0.41, 0.90]	0.20	0.01
Had placement change within prior 12 months	0.37 [0.21, 0.68]	0.30	0.001
Received PSP services from a large agency (> 300 contracted placements)	0.76 [0.51, 1.11]	0.20	0.16

Appendix E Detailed Cost Tables

Table G.1 Amount and cost of PSP services for children in our evaluation sample for the period between 1st October 2018 and 30th June 2021 (in 2020/21 prices)

	Ongoing Cohort			Entry Cohort			
	Mean FTE	**Frequency**	**Total cost**	**Mean FTE**	**Frequency**	**Total cost**	**Annual fee in 2020/2021**
Case plan goal							
Adoption	1.2775	415	$14,797,717	0.9784	21	$573,511	$27,912
Guardianship	1.2665	674	$9,982,982	0.8863	26	$269,497	$27,912
Long Term Care	2.2328	5,685	$354,297,731	0.9718	306	$8,299,867	$11,695
Restoration	1.0015	1,011	$11,841,386	0.9463	537	$5,942,702	$27,912
Continued permanency beyond 2 years	0.7033	195	$3,827,706	0.3293	22	$202,187	$11,695
Baseline							
Foster Care	2.3411	5,288	$513,713,959	1.4459	489	$29,339,367	$41,497
Aboriginal Foster Care	2.3495	1,053	$106,403,716	1.3383	81	$4,662,078	$43,008
Therapeutic Home Based Care	1.2717	6	$1,050,250				$137,645
Intensive Therapeutic Care Home	1.0381	95	$29,761,171	0.6208	8	$1,498,697	$301,782
Therapeutic Supported Independent Living	0.8985	18	$1,694,688	suppressed	< 5	$98,465	$104,781

	Ongoing Cohort			Entry Cohort			
	Mean FTE	**Frequency**	**Total cost**	**Mean FTE**	**Frequency**	**Total cost**	**Annual fee in 2020/2021**
Supported Independent Living	0.7386	84	$5,468,346	suppressed	< 5	$25,114	$88,140
Case Coordination - Restoration	0.9474	108	$1,698,511	0.6715	32	$356,684	$16,600
Intensive Therapeutic Transitional Care (a)	0.3135	16	$2,352,556	suppressed	< 5	$127,107	$469,069
Child Needs							
Low	2.2355	5,135	$54,510,308	1.4527	536	$3,697,404	$4,749
Medium	1.8420	1,721	$23,639,174	1.0187	55	$417,819	$7,457
High	1.1628	444	$5,996,437	0.9789	16	$181,911	$11,614
Complex Needs payment (average amount per receiving child in $)	$68,114	609	$41,481,475	$19,123	183	$3,499,525	
Specialist (b)							
Cultural Plan Annual		5,159	$2,214,398		161	$69,106	$429
Cultural Plan in Care		2,257	$4,435,298		24	$47,163	$1,965
Cultural Plan Establishment		162	$586,437		160	$579,197	$3,620
Culturally and Linguistically D..		1,152	$1,693,106		84	$123,456	$1,470

	Ongoing Cohort			Entry Cohort			
	Mean FTE	**Frequency**	**Total cost**	**Mean FTE**	**Frequency**	**Total cost**	**Annual fee in 2020/2021**
15+ Years Old Reconnect		841	$1,683,119		< 5	suppressed	$2,001
Leaving Care		2,446	$3,230,628		5	$6,604	$1,321
4+ Sibling Group Package		315	$6,624,781		12	$252,373	$21,031
Legal Adoption Payment		35	$416,298		< 5	suppressed	$11,894
Additional Carer Support - Current Child Needs (Low)		108	$2,196,790		< 5	suppressed	$20,341
Additional Carer Support - Current Child Needs (Medium)		403	$7,105,837		7	$123,426	$17,632
Additional Carer Support - Current Child Needs (High)		73	$983,675		4	$53,900	$13,475
Sum of all PSP payments			$1,213,688,478			$60,532,525	
Non-PSP payments and overheads							
Average Guardianship and Adoption Allowance amounts (DCJ)	$17,647	239	$4,217,635	$5,563	8	$44,506	
Average DCJ Allowance amounts	$17,146	224	$3,840,726	$5,650	199	$1,124,309	

	Ongoing Cohort			Entry Cohort			
	Mean FTE	**Frequency**	**Total cost**	**Mean FTE**	**Frequency**	**Total cost**	**Annual fee in 2020/2021**
Permanency Coordinator Costs (average per child)	$3,470	6,263	$21,732,829	$2,804	555	$1,556,012	
Placement Capacity Payments (average per child)	$2,719	6,263	$17,028,233	$2,226	555	$1,235,628	
							Ongoing and Entry Cohort Combined
Total cost			$1,260,507,901			$64,492,980	$1,325,000,881
Number of children			6,263			555	6,818
Average cost per child			$201,263			$116,204	$194,339

a) We have computed an average fee for intensive Therapeutic Transitional Care by using the percentage of 4-bed and 6-bed homes (47 per cent and 53 per cent) and calculated the average cost per bed as ($ 2.57 million * 0.53 + $ 2.15 million * 0.47) / (0.53 * 6 + 0.47 * 4) .

b) Specialist packages are not pro rata but are provided on an annual basis for the full annual fee regardless of the length of time in care during the financial year.

Table G.2 Amount and cost of pre-PSP NGO-provided services for children in our evaluation sample for the period between 1st October 2014 and 30th June 2017 (in 2020/21 prices)

	Ongoing Cohort			Entry Cohort			
	Mean FTE	**Frequency**	**Total cost**	**Mean FTE**	**Frequency**	**Total cost**	**Annual fee in 2020/2021**
CAT Sore							
General Foster Care	2.4027	2,957	$323,195,741	1.1157	374	$18,982,600	$45,490
General Foster Care +1	2.2672	649	$66,934,553	1.2645	27	$1,553,063	$45,490
General Foster Care +2	2.1630	603	$75,368,317	1.0501	31	$1,881,026	$57,784
Intensive Foster Care	1.9784	418	$89,472,801	1.2965	10	$1,402,677	$108,193
Intensive Residential Care	1.6122	77	$43,956,888	1.9650	6	$4,174,668	$354,087
Low Needs	suppressed	< 5	$341,613				$45,490
Medium Needs	suppressed	< 5	$421,377				$45,490
Residential Care	1.4698	116	$36,893,323	1.4021	8	$2,427,183	$216,386
Observations without CAT Score							
Absent - Location Unknown	0.0767	< 5	$0				$0
Carer - Foster Carer	2.1472	1,696	$165,656,555	0.6207	155	$4,376,328	$45,490
Carer - Other Suitable Person	suppressed	< 5	$191,835			$0	$45,490
Carer - Relative or Kinship Carer	2.0555	458	$42,824,468	1.3578	55	$3,397,219	$45,490

	Ongoing Cohort			Entry Cohort			
	Mean FTE	**Frequency**	**Total cost**	**Mean FTE**	**Frequency**	**Total cost**	**Annual fee in 2020/2021**
Disability - Group Home	suppressed	< 5	$991,443	suppressed	< 5	$967	$354,087
Disability - Residential	suppressed	< 5	$474,774	suppressed	< 5	$13,581	$354,087
Family Group home	1.3443	5	$1,454,447				$216,386
Hospital				0.0164	< 5		assume included in one-off payments
Hotel / Motel	0.1691	11		0.0578	23		assume included in one-off payments
Independent living	1.0110	46					assume included in one-off payments
Youth Justice	0.0109	< 5					
Non-related person							$45,490
Parent/s - Both Parents	0.0630	< 5					assume no payment
Parent/s - Father	0.0301	< 5		0.0356	< 5		assume no payment
Parent/s - Mother				0.0356	< 5		assume no payment
Residential Care	1.0553	39	$8,905,612	suppressed	< 5	$428,472	$216,386
Self-Placed - Not Authorised	0.3803	< 5					assume no payment
Supported Independent living	0.7151	< 5					assume included in one-off payments
Youth refuge	0.0397	< 5					assume no payment

	Ongoing Cohort			Entry Cohort			
	Mean FTE	**Frequency**	**Total cost**	**Mean FTE**	**Frequency**	**Total cost**	**Annual fee in 2020/2021**
Sum of all non-DCJ payments			$857,083,748			$39,158,870	
One off payments and other non-PSP provider payments (in 2020/21 dollars)							
Average Guardianship and Adoption Allowance amounts (DCJ)	$10,956	132	$1,446,241	$18,339	9	$165,053	
Average DCJ Allowance amounts	$27,865	897	$24,994,474	$14,520	334	$4,849,747	
Pre-PSP vacancy cost (average per child)	$ 1,578	6,230	$ 9,832,772	$ 1,199	554	$ 664,186	
Total amount of all one-off payments	$24,461	1,864	$45,595,360	$21,483	543	$11,665,350	
							Ongoing and Entry Cohort Combined
Total cost			$938,952,595			$55,982,120	$994,934,715
Number of children			6,230			554	6,784
Average cost per child			$150,715			$101,051	$146,659

Table G.3 Amount and cost of PSP services for all children receiving at least one PSP package for the period between 1st October 2018 and 30th June 2021 (in 2020/21 prices)

	Ongoing Cohort			Entry Cohort			
	Mean FTE	**Frequency**	**Total cost**	**Mean FTE**	**Frequency**	**Total cost**	**Fee in 2020/2021**
Case Plan Goal							
Adoption	1.2919	471	$16,983,552	0.9484	25	$661,814	$27,912
Guardianship	1.2661	756	$11,193,914	0.8270	28	$270,808	$27,912
Long Term Care	2.1491	7,248	$434,760,272	0.9426	353	$9,287,070	$11,695
Restoration	0.9763	1,302	$14,866,197	0.8737	719	$7,346,515	$27,912
Continue Permanency beyond 2 years	0.7038	221	$4,341,278	0.2919	28	$228,110	$11,695
Baseline							
Foster Care	2.2790	6,297	$595,526,166	1.2780	633	$33,569,681	$41,497
Aboriginal Foster Care	2.2992	1,359	$134,383,372	1.1842	109	$5,551,252	$43,008
Therapeutic Home Based Care	1.1696	17	$2,736,715				$137,645
Intensive Therapeutic Care Home	1.2979	478	$187,225,978	0.9185	18	$4,989,354	$301,782
Therapeutic Supported Independent Living	0.8375	103	$9,038,180	suppressed	< 5	$194,921	$104,781

	Ongoing Cohort			Entry Cohort			
	Mean FTE	**Frequency**	**Total cost**	**Mean FTE**	**Frequency**	**Total cost**	**Fee in 2020/2021**
Supported Independent Living	0.8072	181	$12,878,056	suppressed	< 5	$236,047	$88,140
Case Coordination - Restoration	0.8911	131	$1,937,764	0.8016	47	$625,398	$16,600
Intensive Therapeutic Transitional Care (a)	0.3477	38	$6,197,417	0.2413	5	$566,032	$469,069
Therapeutic Sibling Option Placement	0.8521	< 5		0.8521	< 5		case-by-case
Child Needs							
Low	2.1506	6,268	$64,010,526	1.2836	711	$4,333,745	$4,749
Medium	1.8051	2,156	$29,020,343	0.9591	63	$450,572	$7,457
High	1.2160	911	$12,865,861	1.0141	32	$376,887	$11,614
Complex Needs payments (average amount per receiving child in $)	$87,991	878	$77,256,230	$14,015	229	$3,209,366	
Specialist (b)							
Cultural Plan Annual		6,521	$2,799,009		179	$76,832	$429
Cultural Plan in Care		2,876	$5,651,714		22	$43,233	$1,965
Cultural Plan Establishment		223	$807,256		191	$691,416	$3,620

	Ongoing Cohort			Entry Cohort			
	Mean FTE	**Frequency**	**Total cost**	**Mean FTE**	**Frequency**	**Total cost**	**Fee in 2020/2021**
Culturally and Linguistically D..		1,333	$1,959,123		104	$152,850	$1,470
15+ Years Old Reconnect		1,153	$2,307,533		< 5	suppressed	$2,001
Leaving Care		3,612	$4,770,657		11	$14,529	$1,321
4+ Sibling Group Package		364	$7,655,302		17	$357,528	$21,031
Legal Adoption Payment		39	$463,875		< 5	$0	$11,894
Additional Carer Support - Current Child Needs (Low)		124	$2,522,241		7	$142,385	$20,341
Additional Carer Support - Current Child Needs (Medium)		500	$8,816,175		7	$123,426	$17,632
Additional Carer Support - Current Child Needs (High)		98	$1,320,550		5	$67,375	$13,475
Sum of all PSP payments			$1,654,295,256			$73,571,148	
Non-PSP payments and overheads							

	Ongoing Cohort			Entry Cohort			
	Mean FTE	**Frequency**	**Total cost**	**Mean FTE**	**Frequency**	**Total cost**	**Fee in 2020/2021**
Average Guardianship and Adoption Allowance amounts (DCJ)	$18,101	271	$4,905,279	$6,634	14	$92,873	
Average DCJ Allowance amounts	$16,306	502	$8,185,361	$5,684	283	$1,608,454	
Permanency Coordinator Costs (average per child)	$3,367	8,010	$26,971,472	$2,550	752	$1,917,547	
Placement Capacity Payments (average per child)	$2,639	8,010	$21,136,147	$2,020	752	$1,519,342	
							Ongoing and Entry Cohort Combined
Total cost			$1,715,493,516			$78,709,363	$1,794,202,879
Number of children			8,010			752	8,762
Average cost per child			$214,169			$104,667	$204,771

d) We have computed an average fee for intensive Therapeutic Transitional Care by using the percentage of 4-bed and 6-bed homes (47 per cent and 53 per cent) and calculated the average cost per bed as ($ 2.57 million * 0.53 + $ 2.15 million * 0.47) / (0.53 * 6 + 0.47 * 4).

e) Specialist packages are not pro rata but are provided on an annual basis for the full annual fee regardless of the length of time in care during the financial year.

Table G.4 Amount and cost of PSP services for children in our evaluation sample for the period between 1 October 2018 and 30 June 2019 (in 2020/21 prices)

	In-care Cohort			Entry Cohort			
	Mean FTE	Freq.	Total Cost	Mean FTE	Freq.	Total Cost	Fee in 2020/2021
Case Plan Goal							
Adoption	0.5822	282	$4,582,618	suppressed	< 5	$16,747	$27,912
Guardianship	0.5836	411	$2,805,294	suppressed	< 5	$15,443	$27,912
Long Term Care	0.7018	5,293	$103,677,718	0.2704	28	$211,287	$11,695
Restoration	0.5342	762	$4,760,055	0.3071	238	$854,795	$27,912
Continue Permanency beyond 2 years			$0			$0	$11,695
Baseline							
Foster Care	0.7144	5,247	$155,546,450	0.3218	208	$2,777,447	$41,497
Aboriginal Foster Care	0.7055	1,033	$31,345,372	0.3618	40	$622,378	$43,008
Therapeutic Home Based Care	suppressed	< 5	$153,484				$137,645
Intensive Therapeutic Care Home	0.4904	19	$2,811,947			$0	$301,782
Therapeutic Supported Independent Living	suppressed	< 5	$93,585			$0	$104,781
Supported Independent Living	0.5448	13	$624,226			$0	$88,140
Case Coordination - Restoration..	0.3596	37	$220,851	suppressed	< 5	$3,957	$16,600
Intensive Therapeutic Transitional Care (a)	suppressed	< 5	$98,954			$0	$469,069
Child Needs							

	In-care Cohort			Entry Cohort			
	Mean FTE	Freq.	Total Cost	Mean FTE	Freq.	Total Cost	Fee in 2020/2021
Low	0.7065	5,015	$16,825,026	0.3282	244	$380,282	$4,749
Medium	0.6693	1,326	$6,617,665	0.2533	11	$20,777	$7,457
High	0.5086	152	$897,929			$0	$11,614
Complex Needs payments (average amount per receiving child in $)	$35,192	173	$6,088,210	$914	18	$16,449	
Specialist (b)							
Cultural Plan Annual		1,988	$853,309		19	$8,155	$429
Cultural Plan in Care		1,966	$3,863,446		8	$15,721	$1,965
Cultural Plan Establishment		64	$231,679		41	$148,419	$3,620
Culturally and Linguistically D..		838	$1,231,617		23	$33,803	$1,470
15+ Years Old Reconnect		365	$730,485			$0	$2,001
Leaving Care		872	$1,151,720			$0	$1,321
4+ Sibling Group Package		113	$2,376,509		< 5	suppressed	$21,031
Legal Adoption Payment		31	$368,721			$0	$11,894
Additional Carer Support - Current Child Needs (Low)		< 5	suppressed			$0	$20,341
Additional Carer Support - Current Child Needs (Medium)		19	$335,015			$0	$17,632
Additional Carer Support - Current Child Needs (High)		< 5	suppressed			$0	$13,475
sum of all PSP payments			$348,325,698			$5,167,724	

	In-care Cohort			Entry Cohort			
	Mean FTE	Freq.	Total Cost	Mean FTE	Freq.	Total Cost	Fee in 2020/2021
Non-PSP payments and overheads							
Average Guardianship and Adoption Allowance amounts (DCJ)	$4,514	71	$320,472	$0	0	$0	
Average DCJ Allowance amounts	$5,973	132	$788,467	$1,986	80	$158,891	
Permanency Coordinator Costs (average per child)	$1,266	6,263	$7,931,651	$1,266	248	$314,075	
Placement Capacity Payments (average per child)	$939	6,263	$5,878,013	$939	248	$232,755	

							In-care and entry cohort combined
Total cost:			$363,244,301			$5,873,445	$369,117,745
Number of children in the sample of analysis:			6,263			555	6,818
number of children who were in OOHC in 2018/19:			6,263			248	6,511
Average cost per child in the sample of analysis:			$57,998			$10,583	$54,139
Average cost per child in OOHC in 2018/19:			$57,998			$23,683	$56,691

Notes: a) We have computed an average fee for Intensive Therapeutic Transitional Care by using the percentage of 4-bed and 6-bed homes (47% and 53%) and calculating the average cost per bed as ($2.57million*0.53+$2.15million*0.47)/(0.53*6+0.47*4)
b) Specialist packages are not pro rata, but are provided on an annual basis for the full annual fee regardless of the length of time in care during the financial year.

Table G.5 Amount and cost of PSP services for children in our evaluation sample for the period between 1 July 2019 and 30 June 2020 (in 2020/21 prices)

	In-care Cohort			Entry Cohort			
	Mean FTE	Freq.	Total Cost	Mean FTE	Freq.	Total Cost	Fee in 2020/2021
Case Plan Goal							
Adoption	0.7828	309	$6,751,773	0.4791	15	$200,567	$27,912
Guardianship	0.7107	483	$4,014,635	0.5146	15	$90,266	$27,912
Long Term Care	0.8983	5,180	$129,881,213	0.4633	165	$2,133,708	$11,695
Restoration	0.6087	650	$4,627,099	0.4915	479	$2,753,056	$27,912
Continue Permanency beyond 2 years			$0			$0	$11,695
Baseline							
Foster Care	0.9430	4,823	$188,731,075	0.6066	454	$11,427,507	$41,497
Aboriginal Foster Care	0.9442	974	$39,551,333	0.5980	70	$1,800,458	$43,008
Therapeutic Home Based Care	suppressed	< 5	$275,666				$137,645
Intensive Therapeutic Care Home	0.6531	45	$8,868,763	suppressed	< 5	$408,148	$301,782
Therapeutic Supported Independent Living	0.4185	11	$482,391			$0	$104,781
Supported Independent Living	0.4959	32	$1,398,684			$0	$88,140
Case Coordination - Restoration..	0.5615	76	$708,411	0.3627	12	$72,252	$16,600
Intensive Therapeutic Transitional Care (a)	0.1983	7	$651,057	suppressed	< 5	$43,575	$469,069
Child Needs							

	In-care Cohort			Entry Cohort			
	Mean FTE	Freq.	Total Cost	Mean FTE	Freq.	Total Cost	Fee in 2020/2021
Low	0.9274	4,597	$20,245,779	0.6112	494	$1,433,703	$4,749
Medium	0.8442	1,357	$8,542,649	0.5073	35	$132,391	$7,457
High	0.6311	262	$1,920,294	0.5157	8	$47,917	$11,614
Complex Needs payments (average amount per receiving child in $)	$71,456	257	$18,364,150	$3,328	99	$329,424	
Specialist (b)							
Cultural Plan Annual		1,949	$836,569		60	$25,754	$429
Cultural Plan in Care		149	$292,804		8	$15,721	$1,965
Cultural Plan Establishment		47	$170,139		76	$275,118	$3,620
Culturally and Linguistically D..		165	$242,502		37	$54,379	$1,470
15+ Years Old Reconnect		312	$624,415			$0	$2,001
Leaving Care		921	$1,216,438		< 5	suppressed	$1,321
4+ Sibling Group Package		116	$2,439,602		5	$105,155	$21,031
Legal Adoption Payment		< 5	suppressed			$0	$11,894
Additional Carer Support - Current Child Needs (Low)		42	$854,307		< 5	suppressed	$20,341
Additional Carer Support - Current Child Needs (Medium)		216	$3,808,588			$0	$17,632
Additional Carer Support - Current Child Needs (High)		37	$498,575		< 5	suppressed	$13,475
sum of all PSP payments			$446,046,490			$21,397,711	

	In-care Cohort			Entry Cohort			
	Mean FTE	Freq.	Total Cost	Mean FTE	Freq.	Total Cost	Fee in 2020/2021
Non-PSP payments and overheads							
Average Guardianship and Adoption Allowance amounts (DCJ)	$9,816	152	$1,491,989	$0	0	$0	
Average DCJ Allowance amounts	$11,476	126	$1,445,936	$3,600	119	$428,425	
Permanency Coordinator Costs (average per child)	$1,250	5,859	$7,326,211	$1,250	523	$653,970	
Placement Capacity Payments (average per child)	$1,067	5,859	$6,250,844	$1,067	523	$557,978	

							In-care and entry cohort combined
Total cost:			$462,561,470			$23,038,083	$485,599,553
Number of children in the sample of analysis:			6,263			555	6,818
Average cost per child in the sample of analysis:			$73,856			$41,510	$71,223
Number of children who were in OOHC in 2019/20:			5,859			523	6,382
Average cost per child in the sample of analysis in 2019/20:			$78,949			$44,050	$76,089
Number of children who were in OOHC in 2018/19 and/or 2019/20:			6,263			538	6,801
Average cost per child who is or has been in OOHC in 2018/19 and/or 2019/20:			$73,856			$42,822	$71,401

Notes: a) We have computed an average fee for Intensive Therapeutic Transitional Care by using the percentage of 4-bed and 6-bed homes (47% and 53%) and calculating the average cost per bed as ($2.57million*0.53+$2.15million*0.47)/(0.53*6+0.47*4)
b) Specialist packages are not pro rata, but are provided on an annual basis for the full annual fee regardless of the length of time in care during the financial year.

Table G.6 Amount and cost of PSP services for children in our evaluation sample for the period between 1 July 2020 and 30 June 2021 (in 2020/21 prices)

	In-care Cohort			Entry Cohort			
	Mean FTE	Freq.	Total Cost	Mean FTE	Freq.	Total Cost	Fee in 2020/2021
Case Plan Goal							
Adoption	0.7090	175	$3,463,326	0.7507	17	$356,197	$27,912
Guardianship	0.6762	400	$3,163,053	0.5836	24	$163,788	$27,912
Long Term Care	0.9208	4,698	$120,738,789	0.7408	288	$5,954,872	$11,695
Restoration	0.5672	370	$2,454,232	0.6358	314	$2,334,851	$27,912
Continue Permanency beyond 2 years	0.7033	195	$3,827,706	0.3293	22	$202,187	$11,695
Baseline							
Foster Care	0.9511	4,293	$169,436,413	0.9005	405	$15,134,413	$41,497
Aboriginal Foster Care	0.9371	881	$35,507,010	0.8678	60	$2,239,241	$43,008
Therapeutic Home Based Care	0.7521	6	$621,100				$137,645
Intensive Therapeutic Care Home	0.6657	90	$18,080,462	0.4517	8	$1,090,549	$301,782
Therapeutic Supported Independent Living	0.8213	13	$1,118,712	suppressed	< 5	$98,465	$104,781
Supported Independent Living	0.5665	69	$3,445,437	suppressed	< 5	$25,114	$88,140
Case Coordination - Restoration..	0.6916	67	$769,249	0.5450	31	$280,475	$16,600
Intensive Therapeutic Transitional Care (a)	0.3106	11	$1,602,544	suppressed	< 5	$83,533	$469,069
Child Needs							

	In-care Cohort			Entry Cohort			
	Mean FTE	Freq.	Total Cost	Mean FTE	Freq.	Total Cost	Fee in 2020/2021
Low	0.9258	3,967	$17,439,502	0.8994	441	$1,883,419	$4,749
Medium	0.8448	1,346	$8,478,859	0.6825	52	$264,650	$7,457
High	0.7126	384	$3,178,213	0.7211	16	$133,994	$11,614
Complex Needs payments (average amount per receiving child in $)	$59,751	285	$17,029,114	$30,035	105	$3,153,652	
Specialist (b)							
Cultural Plan Annual		1,222	$524,519		82	$35,197	$429
Cultural Plan in Care		142	$279,048		8	$15,721	$1,965
Cultural Plan Establishment		51	$184,619		43	$155,659	$3,620
Culturally and Linguistically D..		149	$218,987		24	$35,273	$1,470
15+ Years Old Reconnect		164	$328,218		< 5	suppressed	$2,001
Leaving Care		653	$862,469		< 5	suppressed	$1,321
4+ Sibling Group Package		86	$1,808,670		5	$105,155	$21,031
Legal Adoption Payment			$0			$0	$11,894
Additional Carer Support - Current Child Needs (Low)		65	$1,322,142		< 5	suppressed	$20,341
Additional Carer Support - Current Child Needs (Medium)		168	$2,962,235		7	$123,426	$17,632
Additional Carer Support - Current Child Needs (High)		35	$471,625		< 5	suppressed	$13,475
sum of all PSP payments			$419,316,254			$33,967,090	

	In-care Cohort			Entry Cohort			
	Mean FTE	Freq.	Total Cost	Mean FTE	Freq.	Total Cost	Fee in 2020/2021
Non-PSP payments and overheads							
Average Guardianship and Adoption Allowance amounts (DCJ)	$10,642	226	$2,405,175	$5,563	8	$44,506	
Average DCJ Allowance amounts	$10,363	155	$1,606,323	$8,661	62	$536,993	
Permanency Coordinator Costs (average per child)	$1,220	5,308	$6,474,964	$1,220	482	$587,968	
Placement Capacity Payments (average per child)	$923	5,308	$4,899,390	$923	482	$444,896	

							In-care and entry cohort combined
Total cost:			$434,702,105			$35,581,453	$470,283,558
Number of children in the sample of analysis:			6,263			555	6,818
Average cost per child in the sample of analysis:			$69,408			$64,111	$68,977
number of children who were in OOHC in 2020/21:			5,308			482	5,790
Average cost per child in the sample of analysis in 2020/21:			$81,896			$73,820	$81,223

Notes: a) We have computed an average fee for Intensive Therapeutic Transitional Care by using the percentage of 4-bed and 6-bed homes (47% and 53%) and calculating the average cost per bed as ($2.57million*0.53+$2.15million*0.47)/(0.53*6+0.47*4)
b) Specialist packages are not pro rata, but are provided on an annual basis for the full annual fee regardless of the length of time in care during the financial year.

Table G.7 Amount and cost of NGO services for children in our evaluation sample for the period between 1 October 2014 and 30 June 2015 (in 2020/21 prices)

	In-care Cohort			Entry Cohort			
CAT Score	Mean FTE	Freq.	total cost	Mean FTE	Freq.	total cost	Annual fee in 2020/21 dollars
General Foster Care	0.7155	2,832	$92,182,469	0.2946	152	$2,037,094	$45,490
General Foster Care +1	0.7179	565	$18,450,378	0.3427	13	$202,650	$45,490
General Foster Care +2	0.7314	445	$18,806,060	suppressed	< 5	$19,314	$57,784
Intensive Foster Care	0.7003	302	$22,880,342	suppressed	< 5	$119,161	$108,193
Intensive Residential Care	0.4758	48	$8,086,761	0.2438	6	$518,034	$354,087
Low Needs	suppressed	< 5	$68,049				$45,490
Medium Needs	suppressed	< 5	$102,073				$45,490
Residential Care	0.5260	70	$7,967,157	suppressed	< 5	$215,793	$216,386
Observations without CAT score							
Absent - Location Unknown			$0			$0	$0
Carer - Foster Carer	0.7219	1,685	$55,332,563	0.2111	83	$796,891	$45,490
Carer - Other Suitable Person	suppressed	< 5	$20,066			$0	$45,490
Carer - Relative or Kinship Carer	0.7082	438	$14,111,348	0.2860	21	$273,191	$45,490
Disability - Group Home	suppressed	< 5	$283,269			$0	$354,087
Disability - Residential	suppressed	< 5	$264,838	suppressed	< 5	$13,581	$354,087
Family Group home	suppressed	< 5	$647,380				$216,386
Hospital							assume included in one-off payments

	In-care Cohort			Entry Cohort			
CAT Score	Mean FTE	Freq.	total cost	Mean FTE	Freq.	total cost	Annual fee in 2020/21 dollars
Hotel / Motel	suppressed	< 5		suppressed	< 5		assume included in one-off payments
Independent living	0.5458	30					assume included in one-off payments
Juvenile Justice							
Non-related person			$0			$0	$45,490
Parent/s - Both Parents	suppressed	< 5					assume no payment
Parent/s - Father	suppressed	< 5					assume no payment
Parent/s - Mother				suppressed	< 5		assume no payment
Residential Care	0.3395	13	$955,063			$0	$216,386
Self Placed - Not Authorised							assume no payment
Supported Independent living							assume included in one-off payments
Youth refuge	suppressed	< 5					assume no payment
Sum of all non-DCJ payments			$240,157,815			$4,195,710	
One off payments and other non-NGO payments (in 2020/21 dollars)							
Average Guardianship and Adoption Allowance amounts (DCJ)	$5,679	30	$170,366	$7,769	5	$38,847	
Average DCJ Allowance amounts	$10,363	782	$8,103,653	$3,444	130	$447,744	
Pre-PSP vacancy cost (average per child)	$304	6,230	$1,894,466	$304	275	$83,624	
total amount of all one-off payments	$8,138	1,076	$8,755,969	$3,615	222	$802,526	

	In-care Cohort			Entry Cohort			
CAT Score	Mean FTE	Freq.	total cost	Mean FTE	Freq.	total cost	Annual fee in 2020/21 dollars
							In-care and entry cohort combined
Total cost:			$259,082,269			$5,568,450	$264,650,720
Number of children in the sample of analysis:			6,230			554	6,784
Average cost per child in the sample of analysis:			$41,586			$10,051	$39,011
Number of children who were in OOHC in 2014/15:			6,230			275	6,505
Average cost per child in the sample of analysis in 2014/15:			$41,586			$20,249	$40,684

Table G.8 Amount and cost of NGO services for children in our evaluation sample for the period between 1 July 2015 and 30 June 2016 (in 2020/21 prices)

	In-care Cohort			Entry Cohort			
CAT Score	Mean FTE	Freq.	total cost	Mean FTE	Freq.	total cost	Annual fee in 2020/21 dollars
General Foster Care	0.9521	2,787	$120,712,311	0.5902	284	$7,625,347	$45,490
General Foster Care +1	0.9443	587	$25,216,556	0.7620	18	$623,938	$45,490
General Foster Care +2	0.9543	504	$27,791,468	0.4702	22	$597,737	$57,784
Intensive Foster Care	0.9007	332	$32,354,792	0.6562	6	$425,974	$108,193
Intensive Residential Care	0.5529	82	$16,052,904	0.7333	5	$1,298,318	$354,087
Low Needs	suppressed	< 5	$136,844				$45,490
Medium Needs	suppressed	< 5	$136,595				$45,490
Residential Care	0.6166	93	$12,407,907	0.5252	13	$1,477,456	$216,386
Observations without CAT score							
Absent - Location Unknown			$0			$0	$0
Carer - Foster Carer	0.9629	1,342	$58,782,203	0.4742	88	$1,898,165	$45,490
Carer - Other Suitable Person	suppressed	< 5	$80,789			$0	$45,490
Carer - Relative or Kinship Carer	0.9455	348	$14,967,188	0.6258	46	$1,309,525	$45,490
Disability - Group Home	suppressed	< 5	$354,087	suppressed	< 5	$967	$354,087
Disability - Residential	suppressed	< 5	$209,937			$0	$354,087

	In-care Cohort			Entry Cohort			
CAT Score	Mean FTE	Freq.	total cost	Mean FTE	Freq.	total cost	Annual fee in 2020/21 dollars
Family Group home	suppressed	< 5	$787,503				$216,386
Hospital				suppressed	< 5		assume included in one-off payments
Hotel / Motel	suppressed	< 5		0.0452	17		assume included in one-off payments
Independent living	0.6174	28					assume included in one-off payments
Juvenile Justice	suppressed	< 5					
Non-related person			$0			$0	$45,490
Parent/s - Both Parents							assume no payment
Parent/s - Father							assume no payment
Parent/s - Mother							assume no payment
Residential Care	0.6673	21	$3,032,361	suppressed	< 5	$54,983	$216,386
Self Placed - Not Authorised	suppressed	< 5					assume no payment
Supported Independent living							assume included in one-off payments
Youth refuge							assume no payment
Sum of all non-DCJ payments			$313,023,444			$15,312,411	
One off payments and other non-NGO payments (in 2020/21 dollars)							

CAT Score	In-care Cohort Mean FTE	Freq.	total cost	Entry Cohort Mean FTE	Freq.	total cost	Annual fee in 2020/21 dollars
Average Guardianship and Adoption Allowance amounts (DCJ)	$6,929	66	$457,316	$7,729	7	$54,100	
Average DCJ Allowance amounts	$12,821	729	$9,346,804	$7,483	226	$1,691,052	
Pre-PSP vacancy cost (average per child)	$512	5,884	$3,009,780	$512	438	$224,045	
total amount of all one-off payments	$13,263	1,077	$14,283,995	$11,808	420	$4,959,558	
							In-care and entry cohort combined
Total cost:			$340,121,339			$22,241,166	$362,362,505
Number of children in the sample of analysis:			6,230			554	6,784
Average cost per child in the sample of analysis:			$54,594			$40,147	$53,414
Number of children who were in OOHC in 2015/16:			5,884			438	6,322
Average cost per child in the sample of analysis in 2015/16:			$57,804			$50,779	$57,318
Number of children who were in OOHC in 2014/15 and/or 2015/16:			6,230			493	6,723
Average cost per child who is or has been in OOHC in 2014/15 and/or 2015/16:			$54,594			$45,114	$53,899

Table G.9 Amount and cost of NGO services for children in our evaluation sample for the period between 1 July 2016 and 30 June 2017 (in 2020/21 prices)

	In-care Cohort			Entry Cohort			
CAT Score	Mean FTE	Freq.	total cost	Mean FTE	Freq.	total cost	Annual fee in 2020/21 dollars
General Foster Care	0.9413	2,576	$110,300,956	0.7911	259	$9,320,158	$45,490
General Foster Care +1	0.9233	554	$23,267,617	0.7259	22	$726,474	$45,490
General Foster Care +2	0.9307	535	$28,770,787	0.7056	31	$1,263,975	$57,784
Intensive Foster Care	0.9146	346	$34,237,664	1.1323	7	$857,542	$108,193
Intensive Residential Care	0.6584	85	$19,817,221	0.9515	7	$2,358,315	$354,087
Low Needs	suppressed	< 5	$136,720				$45,490
Medium Needs	suppressed	< 5	$182,709				$45,490
Residential Care	0.6415	119	$16,518,259	0.3392	10	$733,934	$216,386
Observations without CAT score							
Absent - Location Unknown	suppressed	< 5	$0			$0	$0
Carer - Foster Carer	0.9578	1,183	$51,541,787	0.7247	51	$1,681,273	$45,490
Carer - Other Suitable Person	suppressed	< 5	$90,981			$0	$45,490
Carer - Relative or Kinship Carer	0.9654	313	$13,745,931	0.9497	42	$1,814,503	$45,490
Disability - Group Home	suppressed	< 5	$354,087			$0	$354,087
Disability - Residential			$0			$0	$354,087
Family Group home	suppressed	< 5	$19,564				$216,386
Hospital							assume included in one-off payments

	In-care Cohort			Entry Cohort			
CAT Score	Mean FTE	Freq.	total cost	Mean FTE	Freq.	total cost	Annual fee in 2020/21 dollars
Hotel / Motel	0.1065	8		0.1096	5		assume included in one-off payments
Independent living	0.5584	23					assume included in one-off payments
Juvenile Justice							
Non-related person			$0			$0	$45,490
Parent/s - Both Parents							assume no payment
Parent/s - Father				suppressed	< 5		assume no payment
Parent/s - Mother							assume no payment
Residential Care	0.6888	33	$4,918,188	suppressed	< 5	$373,488	$216,386
Self Placed - Not Authorised	suppressed	< 5					assume no payment
Supported Independent living	suppressed	< 5					assume included in one-off payments
Youth refuge							assume no payment
Sum of all non-DCJ payments			$303,902,470			$19,129,663	
One off payments and other non-NGO payments (in 2020/21 dollars)							
Average Guardianship and Adoption Allowance amounts (DCJ)	$7,244	113	$818,558	$12,018	6	$72,106	
Average DCJ Allowance amounts	$14,101	535	$7,544,019	$12,102	224	$2,710,953	
Pre-PSP vacancy cost (average per child)	$896	5,502	$4,928,527	$896	398	$356,516	
total amount of all one-off payments	$23,718	951	$22,555,395	$16,582	356	$5,903,266	

CAT Score	In-care Cohort Mean FTE	Freq.	total cost	Entry Cohort Mean FTE	Freq.	total cost	Annual fee in 2020/21 dollars
							In-care and entry cohort combined
Total cost:			$339,748,969			$28,172,505	$367,921,474
Number of children in the sample of analysis:			6,230			554	6,784
Average cost per child in the sample of analysis:			$54,534			$50,853	$54,234
Number of children who were in OOHC in 2016/17:			5,502			398	5,900
Average cost per child in the sample of analysis in 2016/17:			$61,750			$70,785	$62,360

Table G.10 Amount and cost of PSP services for Aboriginal children in our evaluation sample for the period between 1st October 2018 and 30th June 2021 (in 2020/21 prices)

	Ongoing Cohort			Entry Cohort			
	Mean FTE	**Frequency**	**Total cost**	**Mean FTE**	**Frequency**	**Total cost**	**Fee in 2020/2021**
Case Plan Goal							
Adoption	1.4245	22	$874,736			$0	$27,912
Guardianship	1.2748	227	$3,384,049	0.5028	6	$35,283	$27,912
Long Term Care	2.2970	2,073	$132,907,407	1.1034	113	$3,480,264	$11,695
Restoration	1.0077	421	$4,961,450	0.9548	198	$2,210,972	$27,912
Continue Permanency beyond 2 years	0.7424	56	$1,160,356	0.3216	8	$71,805	$11,695
Baseline							
Foster Care	2.2989	1,274	$121,537,867	1.3930	144	$8,323,676	$41,497
Aboriginal Foster Care	2.3521	1,049	$106,115,551	1.3513	78	$4,533,093	$43,008
Therapeutic Home Based Care	suppressed	< 5	$491,751				$137,645
Intensive Therapeutic Care Home	0.9497	38	$10,890,565	0.4427	5	$668,032	$301,782
Therapeutic Supported Independent Living	1.0823	8	$907,246				$104,781
Supported Independent Living	0.6218	23	$1,260,580	suppressed	< 5	$21,975	$88,140
Case Coordination - Restoration	0.8611	40	$571,772	0.6971	12	$138,869	$16,600

	Ongoing Cohort			Entry Cohort			
	Mean FTE	**Frequency**	**Total cost**	**Mean FTE**	**Frequency**	**Total cost**	**Fee in 2020/2021**
Intensive Therapeutic Transitional Care (a)	0.1752	11	$904,187	suppressed	< 5	$127,107	$469,069
Child Needs							
Low	2.2684	1,871	$20,154,039	1.4685	200	$1,394,688	$4,749
Medium	1.7946	592	$7,922,222	1.1754	19	$166,530	$7,457
High	1.1331	181	$2,381,918	0.8106	5	$47,072	$11,614
Complex Needs payment (average amount per receiving child in $)	$65,163	211	$13,749,330	$17,296	61	$1,055,049	
Specialist (b)							
Cultural Plan Annual		5,077	$2,179,201		160	$68,677	$429
Cultural Plan in Care		2,219	$4,360,623		23	$45,198	$1,965
Cultural Plan Establishment		155	$561,097		157	$568,337	$3,620
Culturally and Linguistically D..		100	$146,971			$0	$1,470
15+ Years Old Reconnect		274	$548,364			$0	$2,001
Leaving Care		646	$853,224		< 5	suppressed	$1,321

	Ongoing Cohort			Entry Cohort			
	Mean FTE	**Frequency**	**Total cost**	**Mean FTE**	**Frequency**	**Total cost**	**Fee in 2020/2021**
4+ Sibling Group Package		143	$3,007,440		9	$189,279	$21,031
Legal Adoption Payment			$0			$0	$11,894
Additional Carer Support - Current Child Needs (Low)		43	$874,648		< 5	suppressed	$20,341
Additional Carer Support - Current Child Needs (Medium)		110	$1,939,559		< 5	suppressed	$17,632
Additional Carer Support - Current Child Needs (High)		33	$444,675			$0	$13,475
Sum of all PSP payments			$445,090,829			$23,204,153	
Non-PSP payments and overheads							
Average Guardianship and Adoption Allowance amounts (DCJ)	$16,844	36	$606,396	$6,036	< 5	suppressed	
Average DCJ Allowance amounts	$17,125	83	$1,421,353	$6,938	88	$610,581	

	Ongoing Cohort			Entry Cohort			
	Mean FTE	**Frequency**	**Total cost**	**Mean FTE**	**Frequency**	**Total cost**	**Fee in 2020/2021**
Permanency Coordinator Costs (average per child)	$3,526	2,227	$7,853,262	$2,836	205	$581,464	
Placement Capacity Payments (average per child)	$2,763	2,227	$6,152,960	$2,250	205	$461,161	
							Ongoing and Entry Cohort Combined
Total cost			$461,124,800			$24,863,394	$485,988,195
Number of children			2,227			205	2,432
Average cost per child			$207,061			$121,285	$199,831

We have computed an average fee for intensive Therapeutic Transitional Care by using the percentage of 4-bed and 6-bed homes (47 per cent and 53 per cent) and calculated the average cost per bed as ($ 2.57 million * 0.53 + $ 2.15 million * 0.47) / (0.53 * 6 + 0.47 * 4).
Specialist packages are not pro rata but are provided on an annual basis for the full annual fee regardless of the length of time in care during the financial year.

Table G.11 Amount and cost of pre-PSP NGO-provided services for Aboriginal children in our evaluation sample for the period between 1st October 2014 and 30th June 2017 (in 2020/21 prices)

	Ongoing Cohort			Entry Cohort			
	Mean FTE	**Frequency**	**Total cost**	**Mean FTE**	**Frequency**	**Total cost**	**Annual fee in 2020/2021**
CAT Score							
General Foster Care	2.3904	1,061	$115,374,699	1.1893	140	$7,573,999	$45,490
General Foster Care +1	2.3490	237	$25,325,112	1.7114	8	$622,821	$45,490
General Foster Care +2	2.1744	223	$28,019,696	1.0093	17	$991,487	$57,784
Intensive Foster Care	1.9543	132	$27,910,645	suppressed	< 5	$221,426	$108,193
Intensive Residential Care	1.6667	36	$21,245,007	suppressed	< 5	$354,087	$354,087
Low Needs	suppressed	< 5	$125,005				$45,490
Medium Needs	suppressed	< 5	$250,259				$45,490
Residential Care	1.4652	35	$11,096,926	1.0970	5	$1,186,889	$216,386
Observations without CAT Score							
Absent - Location Unknown							$0
Carer - Foster Carer	2.1222	519	$50,103,363	0.6309	64	$1,836,726	$45,490
Carer - Other Suitable Person							$45,490

	Ongoing Cohort			Entry Cohort			
	Mean FTE	**Frequency**	**Total cost**	**Mean FTE**	**Frequency**	**Total cost**	**Annual fee in 2020/2021**
Carer - Relative or Kinship Carer	2.1034	219	$20,954,824	1.3024	30	$1,777,404	$45,490
Disability - Group Home							$354,087
Disability - Residential							$354,087
Family Group home	suppressed	< 5	$19,564				$216,386
Hospital							assume included in one-off payments
Hotel / Motel	0.2090	8		0.0404	13		excluded
Independent living	0.9063	20					assume included in one-off payments
Youth Justice	suppressed	< 5					
Non-related person							$45,490
Parent/s - Both Parents							assume no payment
Parent/s - Father							assume no payment
Parent/s - Mother				suppressed	< 5		assume no payment
Residential Care	1.0817	15	$3,511,010				$216,386
Self-Placed - Not Authorised	suppressed	< 5					assume no payment
Supported Independent living							assume included in one-off payments

	Ongoing Cohort			Entry Cohort			
	Mean FTE	**Frequency**	**Total cost**	**Mean FTE**	**Frequency**	**Total cost**	**Annual fee in 2020/2021**
Youth refuge							assume no payment
Sum of all non-DCJ payments			$303,936,109			$14,564,837	
One off payments and other non-PSP provider payments (in 2020/2021)							
Average Guardianship and Adoption Allowance amounts (DCJ)	$9,755	31	$302,411	suppressed	< 5	$30,301	
Average DCJ Allowance amounts	$27,963	461	$12,891,095	$15,811	134	$2,118,682	
Pre-PSP vacancy cost (average per child)	$1,590	2,180	$3,466,207	$1,243	214	$266,098	
Total amount of all one-off payments	$21,563	726	$15,654,448	$16,532	210	$3,471,655	
							Ongoing and Entry Cohort Combined
Total cost			$336,250,268			$20,451,573	$356,701,841
Number of children			2,180			214	2,394

	Ongoing Cohort			Entry Cohort			
	Mean FTE	**Frequency**	**Total cost**	**Mean FTE**	**Frequency**	**Total cost**	**Annual fee in 2020/2021**
Average cost per child			$154,243			$95,568	$148,998

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CEI refers to the global organisation and may refer to one or more of the member companies of the CEI Group, each of which is a separate legal entity.

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